From: Florida Department of Health <fdh@mycusthelp.net>
Date: Tuesday, November 10, 2020 at 11:47 AM
To: AO Records <records@americanoversight.org>
Subject: Public Records Request :: P058466-032620

EXTERNAL SENDER

--- Please respond above this line ---

Good afternoon,

This email is to advise your responsive records are available by logging into your account at https://mycusthelp.info/FDH/_cs/supporthome.aspx?sSessionID.

Please note, redactions made pursuant to sections 381.0031(6) and 119.0712(1) Florida Statutes, and Rules 64D-3.036, 64D-3.028(12), and 64D-3.041, Florida Administrative Code.

To access your records please click on the link above and follow the instructions provided.

Instructions

1. Click on My Request Center

2. Click on View My Request.

3. Log in with your email address and the password

4. Under the corresponding request number click on View Files

5. To view the responsive files click on the file name at the top of the page

(To download files, click on Download All)

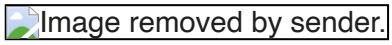
Best,

AMERICAN OVERSIGHT

Kendra Washington
Public Records Manager

Florida Department of Health
Office of the General Counsel
4052 Bald Cypress Way, Bin A-02
Tallahassee, FL 32399
Telephone: 850-617-1408
Fax: 850-245-4790

Email: Kendra.Washington@flhealth.gov



AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Thursday, March 5, 2020 7:21:59 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0

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Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

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***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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CDC COVID-19 Epidemiology Task Force

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Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0

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Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

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***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; and 6) major avoidable issues we hope to overcome with your assistance. We plan for the noted changes to go into effect at **5 pm ET, Sunday, March 1.**

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **we anticipate that all jurisdictions will be onboarded to 'Phase 2' during the week of March 2.** As soon as your jurisdiction is able to confirm its 'Phase 2' status, please email eocevent118@cdc.gov.

As part of the 'Phase 2' rollout, CDC needs to better understand each jurisdiction's plan for providing data to CDC for the PUI and Case Report Form via DCIPHER, an electronic PUI and case reporting system. We request that each jurisdiction provides a list of ≤5 DCIPHER users before **Monday, March 2 at 5pm ET,** if they have not already done so. In addition, we ask that jurisdictions confirm their intent to input data on PUI and case-patients directly into the DCIPHER platform (preferred option) or if alternative arrangements need to be made to send data to CDC. Please email eocevent118@cdc.gov with the requested information by **March 2 at 5pm ET**.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

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- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings

For reporting jurisdictions that have the capacity to do their own testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs or Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.

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2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

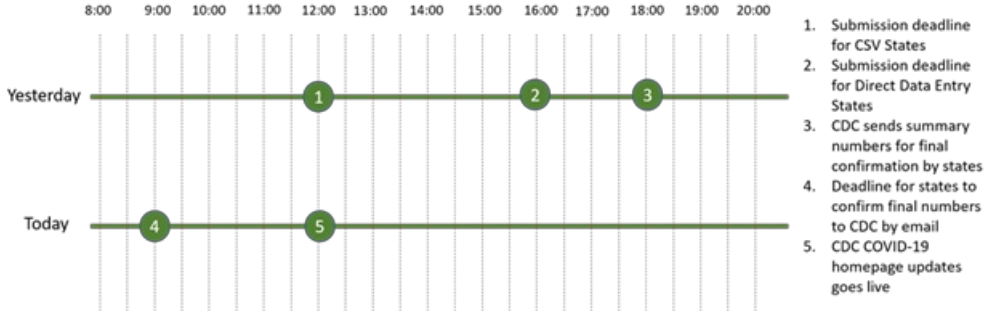
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
>
>
> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

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From:	Pritchard, Scott
To:	CDC IMS 2019 NCOV Response Epi TF Case Tracking Team; Bowen, Virginia B. (CDC/DDID/NCHHSTP/DSTDP); Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Wen, John (CDC/DDPHSIS/CGH/DGHT); Wiese, Michael T.; Blackmore, Carina
Subject:	#2 FL Health Care Contact Invest

Please join us to discuss a small HCP provider contact investigation at a urgent care for presumptive positive case #2.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC COVID-19 Key Points
Date:	Wednesday, March 4, 2020 10:47:51 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_3_2020_final.pdf

Dear Colleagues:

Attached are the **CDC COVID-19 Key Points for March 3rd, 2020**. Feel free to share with partners and appropriate parties.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC COVID-19 Key Points
Date:	Wednesday, March 4, 2020 10:43:53 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_3_2020_final.pdf

Dear Colleagues:

Attached are the **CDC COVID-19 Key Points for March 3rd, 2020**. Feel free to share with partners and appropriate parties.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Statement: CDC Announces Additional COVID-19 Infections
Date:	Tuesday, March 3, 2020 6:16:59 PM

Media Statement

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Announces Additional COVID-19 Infections

At noon on Tuesday, March 3 the Centers for Disease Control and Prevention (CDC) reported 60 cases of COVID-19 from 12 states. Twenty-two of these cases are travel-related; 11 are believed to be person-to-person spread; and for the remaining 27 the source of exposure is still under investigation. Noteworthy developments in recent days include:

- Florida announced its first and second presumptive positive cases of COVID-19, one in a person with recent travel history (to Italy), the other with no currently known travel or contact history.
- Georgia announced its first and second confirmed cases of COVID-19, one is a person with recent travel history (to Italy), the other in a close contact of the first patient.
- New Hampshire also reported its first presumptive positive case of COVID-19 in a person with recent travel history (to Italy).
- New York state announced its first case of COVID-19 in a person with recent travel history (to Iran).
- Rhode Island announced its first presumptive positive case of COVID-19 in a person with recent travel history (to Italy).
- Washington state announced more cases of COVID-19 associated with an outbreak in a long-term care facility. Washington has announced it now has 14 cases of COVID-19, including 6 COVID-19 deaths.

The 12 states that have reported cases include: Arizona, California, Florida, Georgia, Illinois, Massachusetts, New Hampshire, New York, Oregon, Rhode Island, Washington, and Wisconsin.

As the outbreak of COVID-19 continues to expand and as testing capacity in the U.S. increases, CDC expects more cases to be detected across the country, including more instances of person-to-person spread in more states. While information so far suggests that most COVID-19 illness is mild, a report out of China suggests serious illness occurs in 16% of cases. Older people and people with certain underlying health conditions like heart disease, lung disease and diabetes, for example, seem to be at greater risk of serious illness.

The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health

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emergency. CDC expects additional instances of person-to-person spread in the coming days and weeks.

Cases reported to CDC include those confirmed by CDC as well as presumptive positive cases reported by states. A presumptive positive result is when a patient has tested positive by a public health laboratory, but results are pending confirmation at CDC. For public health purposes, a presumptive positive result using the CDC test is treated as a positive.

CDC will report total presumptive and confirmed cases weekdays at noon. This number is based on all state reports received by 4 p.m. the previous day. CDC is no longer reporting number of persons-under-investigation (PUIs) nor those PUIs that test negative because now that states are testing and reporting their own results, these numbers would not be representative of the testing being done nationally. States are reporting results quickly and in the event of a discrepancy between CDC and state case counts, the state case counts should always be considered more up-to-date.

For more information about COVID-19 visit www.cdc.gov/covid19.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Statement: CDC Announces Additional COVID-19 Infections
Date:	Tuesday, March 3, 2020 6:20:39 PM

Media Statement

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Announces Additional COVID-19 Infections

At noon on Tuesday, March 3 the Centers for Disease Control and Prevention (CDC) reported 60 cases of COVID-19 from 12 states. Twenty-two of these cases are travel-related; 11 are believed to be person-to-person spread; and for the remaining 27 the source of exposure is still under investigation. Noteworthy developments in recent days include:

- Florida announced its first and second presumptive positive cases of COVID-19, one in a person with recent travel history (to Italy), the other with no currently known travel or contact history.
- Georgia announced its first and second confirmed cases of COVID-19, one is a person with recent travel history (to Italy), the other in a close contact of the first patient.
- New Hampshire also reported its first presumptive positive case of COVID-19 in a person with recent travel history (to Italy).
- New York state announced its first case of COVID-19 in a person with recent travel history (to Iran).
- Rhode Island announced its first presumptive positive case of COVID-19 in a person with recent travel history (to Italy).
- Washington state announced more cases of COVID-19 associated with an outbreak in a long-term care facility. Washington has announced it now has 14 cases of COVID-19, including 6 COVID-19 deaths.

The 12 states that have reported cases include: Arizona, California, Florida, Georgia, Illinois, Massachusetts, New Hampshire, New York, Oregon, Rhode Island, Washington, and Wisconsin.

As the outbreak of COVID-19 continues to expand and as testing capacity in the U.S. increases, CDC expects more cases to be detected across the country, including more instances of person-to-person spread in more states. While information so far suggests that most COVID-19 illness is mild, a report out of China suggests serious illness occurs in 16% of cases. Older people and people with certain underlying health conditions like heart disease, lung disease and diabetes, for example, seem to be at greater risk of serious illness.

The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health

AMERICAN OVERSIGHT

emergency. CDC expects additional instances of person-to-person spread in the coming days and weeks.

Cases reported to CDC include those confirmed by CDC as well as presumptive positive cases reported by states. A presumptive positive result is when a patient has tested positive by a public health laboratory, but results are pending confirmation at CDC. For public health purposes, a presumptive positive result using the CDC test is treated as a positive.

CDC will report total presumptive and confirmed cases weekdays at noon. This number is based on all state reports received by 4 p.m. the previous day. CDC is no longer reporting number of persons-under-investigation (PUIs) nor those PUIs that test negative because now that states are testing and reporting their own results, these numbers would not be representative of the testing being done nationally. States are reporting results quickly and in the event of a discrepancy between CDC and state case counts, the state case counts should always be considered more up-to-date.

For more information about COVID-19 visit www.cdc.gov/covid19.

###

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Statement: CDC Announces Additional COVID-19 Infections
Date:	Tuesday, March 3, 2020 6:13:07 PM

Media Statement

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Tuesday, March 3, 2020 10:29:42 AM

Media Advisory

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 1:00 p.m. ET Tuesday, March 3, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-517-308-9127
PASSCODE: 4603973

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Tuesday, March 3, 2020 10:32:53 AM

Media Advisory

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

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When 1:00 p.m. ET Tuesday, March 3, 2020

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International: 1-517-308-9127
PASSCODE: 4603973

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U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Tuesday, March 3, 2020 10:23:04 AM

Media Advisory

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

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U.S. Department of Health and Human Services

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AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Cc:	Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019; CDC CSELS DSEPD EWB
Subject:	100% of EIS officers and LLS fellows are needed for the COVID-19 response
Date:	Wednesday, March 18, 2020 2:46:15 PM

EIS and LLS supervisors,

I am writing again, asking for your support in having EIS officers and LLS fellows deploy or take on other roles for CDC's response to COVID-19. I want to emphasize that **completing CALs (graduation requirements) should NOT factor into whether an EIS officer or LLS fellow deploys**. Supervisors should not be asking to review deployment roles or objectives before approving a deployment. In the past we wanted to ensure deployments aligned with our training objectives. We no longer have that luxury, the primary responsibility of the EIS and LLS programs needs to be supporting the response until we are informed otherwise.

We will deal with CAL completion and how COVID-19 might impact graduation on a case-by-case basis. I want to assure you we will be very understanding in finding ways to compensate if involvement with the COVID-19 response prevented anyone from fulfilling the requirements to graduate.

We understand that some EISOs or LLS fellows may not be able to deploy to the field because of obligations to care for family members or themselves. There are response roles that can be completed while teleworking and do not require travel. We are available to assist in finding deployment roles – contact us at EpiAid@cdc.gov and we can discuss their particular circumstance. In addition, any fellows who are not currently deployed can volunteer by:

1. Emailing us at EpiAid@cdc.gov
2. Volunteer for a Go Team by submitting name in ReADI
3. Responding directly to any calls for volunteers they receive through other communication channels

Thank you for your support of the EIS and LLS programs and of your officers or fellows. We know a lot is being asked of you as well and CDC leadership appreciates all you are doing with respect to your individual contributions and your support of the EIS officers and LLS fellows.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

AMERICAN OVERSIGHT

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.



please consider the environment before printing this e-mail.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 CDC Media Telebriefing: Update on COVID-19 AND 2-20-20 COVID-19 CDC Key Points
Date:	Friday, February 21, 2020 11:11:26 AM
Attachments:	CDC_COVID-19_Daily Key Points_2.20.20.pdf

2-20-20 CDC COVID-19 Key Points are attached. Feel free to share with partners. See media advisory below.

Media Advisory

For Immediate Release
Friday, Feb. 21, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

Ian Brownlee, Principal Deputy Assistant Secretary,
Bureau of Consular Affairs, Department of State

When 12:15 p.m. ET Friday, February 21, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT

AMERICAN OVERSIGHT

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U.S. Department of Health and Human Services

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 CDC Media Telebriefing: Update on COVID-19 AND 2-20-20 COVID-19 CDC Key Points
Date:	Friday, February 21, 2020 11:02:40 AM
Attachments:	CDC_COVID-19_Daily Key Points_2.20.20.pdf

2-20-20 CDC COVID-19 Key Points are attached. Feel free to share with partners. See media advisory below.

Media Advisory

For Immediate Release
Friday, Feb. 21, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19
Date:	Friday, February 21, 2020 5:26:24 PM
Attachments:	COVID-19_GuidanceList_21FEB20.pdf

Dear Colleagues,

Attached is a list of current interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19, as of 02-21-2020.

Please feel free to share with partners. Please note that the names of the guidance documents may be updated in the future.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19
Date:	Friday, February 21, 2020 5:28:11 PM
Attachments:	COVID-19_GuidanceList_21FEB20.pdf

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19
Date:	Friday, February 21, 2020 5:18:02 PM
Attachments:	COVID-19_GuidanceList_21FEB20.pdf

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-25-2020 CDC COVID-19 Daily Key Points and STLT Westerdam Information
Date:	Wednesday, February 26, 2020 1:10:07 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_25_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points for Tuesday, February 25, 2020.

Below you will find a CDC media statement regarding the Westerdam cruise ship.

> Westerdam Media Statement:
>
> No testing of passengers from the Westerdam Cruise Ship for SARS-CoV-2, the virus that causes COVID-19, has been done at CDC. CDC is aware that an American passenger on the Westerdam tested positive for infection with SARS-CoV-2 in Malaysia and that two sequential tests on samples from that same person were negative. CDC is aware that follow-up testing among more than 1,500 passengers from the Westerdam has all been negative.
>
> At this time, CDC considers passengers from the Westerdam to be at "low risk" of SARS-CoV-2 infection during the 14 days after their last exposure per the agency's Risk Assessment guidance at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html. Given this level of risk, testing of Westerdam passengers for SARS-CoV-2 is not recommended unless additional exposures are identified to warrant testing.

Thank you,

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-25-2020 CDC COVID-19 Daily Key Points and STLT Westerdam Information
Date:	Wednesday, February 26, 2020 1:12:46 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_25_2020_FINAL.pdf

Dear Colleagues:

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State Coordination Task Force

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-25-2020 CDC COVID-19 Daily Key Points and STLT Westerdam Information
Date:	Wednesday, February 26, 2020 1:06:57 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_25_2020_FINAL.pdf

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AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 2-26-20 CDC COVID-19 Key Points and CDC"s New COVID-19 "What"s New Weekly Update"
Date: Thursday, February 27, 2020 8:20:22 AM
Attachments: CDC_COVID-19_Daily Key Points__2_26_2020.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Wednesday, February 26, 2020. Feel free to share among partners and appropriate parties.

Thank you,

State Coordination Task Force

EPIC Extra

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

Dear CDC EPIC Partners and Subscribers,

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

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

Sincerely,

CDC's EPIC Team

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To: State and Local Readiness (CDC)
Subject: 2-26-20 CDC COVID-19 Key Points and CDC"s New COVID-19 "What"s New Weekly Update"
Date: Thursday, February 27, 2020 8:23:04 AM
Attachments: CDC_COVID-19_Daily Key Points__2_26_2020.pdf

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To: State and Local Readiness (CDC)
Subject: 2-26-20 CDC COVID-19 Key Points and CDC"s New COVID-19 "What"s New Weekly Update"
Date: Thursday, February 27, 2020 8:17:36 AM
Attachments: CDC_COVID-19_Daily Key Points__2_26_2020.pdf

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-28-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, February 28, 2020 11:22:03 AM

Media Advisory

For Immediate Release
Friday Feb. 28, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Friday, Feb. 28, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 6656039

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

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

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-28-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, February 28, 2020 11:24:29 AM

Media Advisory

For Immediate Release
Friday Feb. 28, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-28-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, February 28, 2020 11:19:19 AM

Media Advisory

For Immediate Release
Friday Feb. 28, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	ARLN Health
To:	Darryl.Pendergrass@adph.state.al.us; Darryl.Pendergrass@adph.state.al.us; ramandeep.kaur@adph.state.al.us; Melanie.Chervony@adph.state.al.us; Sharon.Massingale@adph.state.al.us; Aretha.Williams@adph.state.al.us; uzo0@cdc.gov; qpf1@cdc.gov; nub7@cdc.gov; qwi4@cdc.gov; qov3@cdc.gov; vqq9@cdc.gov; ARLN@cdc.gov; ibesser@cdc.gov; Jwp6@cdc.gov; ekersh@cdc.gov; vsrinivasan@cdc.gov; qvi2@cdc.gov; idz4@cdc.gov; iyk6@cdc.gov; Tammy.Jernigan@flhealth.gov; Carina.Blackmore@flhealth.gov; nychie.dotson@flhealth.gov; Susanne.Crowe@flhealth.gov; Kendra.Edwards@flhealth.gov; Patty.Lewandowski@flhealth.gov; Sasha.Nelson@flhealth.gov; Sarah.Schmedes@flhealth.gov; Nicole.Castro@flhealth.gov; Jason.Blanton@flhealth.gov; Mary.Connelly@dph.ga.gov; Tonia.Parrott@dph.ga.gov; cherie.drenzek@dph.ga.gov; Michael.Anderson@dph.ga.gov; Joanna.Wagner@dph.ga.gov; amanda.jara@dph.ga.gov; Jeanne.Negley@dph.ga.gov; Doug.Blomberg@dph.ga.gov; Tiffany.Rivers@dph.ga.gov; Theresa.Sokol@LA.GOV; Lauren.Kleamenakis@la.gov; Stephanie.Kleinpeter@LA.GOV; Ashley.Terry@la.gov; alexa.ramirez@la.gov; Jean-Jacques.Aucoin@LA.GOV; Erica.Washington@LA.gov; Fatima.Brakta@la.gov; raoult.ratard@la.gov; Kirbie.StJames@la.gov; Theresa.Sokol@la.gov; paul.byers@msdh.ms.gov; Cynthia.Allard@msdh.ms.gov; Daphne.Ware@msdh.ms.gov; ilsa.villegas@salud.pr.gov; Militza.Echevarria@salud.pr.gov; inelia.otero@salud.pr.gov; Norma.Diaz@salud.pr.gov; Sara Belknap; Linda Thomas; Dorothy Baynham; Tracy McLemore; Jessica Barnes; Tabatha East; Daniel Golson; Henrietta Hardin; Richard Steece; Albert Burks; Randall Morris; Matthew Estes; Katie Thure; Paula L. Gibbs; Xiaorong Qian; Amelia A. Keaton; Carol Rauch; Robin M. Rasnic; Natasha Lindahl; Victoria Stone; lhsmith@utah.gov; arossi@utah.gov
Cc:	Allison Chan; Carolyn Stover
Subject:	2019 SE Regional AR Lab Network Report and Newsletter
Date:	Thursday, February 27, 2020 10:47:51 AM
Attachments:	image001.png image002.png AR Lab Network SE Regional Newsletter Vol2_Iss4.pdf 2019 SE AR Lab Network Report.pdf

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Please see the attached 2019 report and Q4 2019 newsletter. This report includes the aggregate numbers for the SE Region for the calendar year 2019.
We look forward to continue working with you all.

Thanks and please let us know if you have questions.

Allison Chan, MPH | Epidemiologist
Healthcare Associated Infections and Antimicrobial Resistance Program
Communicable and Environmental Diseases and Emergency Preparedness
Andrew Johnson Tower, 3rd Floor, 3.317C
710 James Robertson Parkway, Nashville, TN 37243
p. 615-532-6401 | allison.chan@tn.gov
tn.gov/health
Connect with TDH on Facebook and Twitter @TNDeptofHealth!

Our Mission – To protect, promote and improve the health and prosperity of people in Tennessee.

AMERICAN OVERSIGHT


Please consider the environment before printing this email

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	2019-nCoV Key Points and Updated Guidance Documents
Date:	Monday, February 10, 2020 7:15:51 PM
Attachments:	CDC_2019-nCoV Daily Key Points__2_10_2020_final.pdf

Dear Colleagues,

Please find today's 2019-nCoV key points attached. Feel free to share amongst your staff and appropriate parties.

In addition, several guidance documents have been posted/updated on the CDC 2019-nCoV website.

Updated Guidance Documents

Information for Businesses and Employers: Interim guidance that may help prevent workplace exposures to acute respirator illness, including nCoV, in non-healthcare settings.

Information for Travelers: This page includes information about 2019 novel coronavirus (2019-nCoV) for travelers going to and returning from China, and information for aircrew and resources ship industry.

- Travelers from China arriving in the US
- Interim Recommendations for Airlines and Airline Crew: Novel Coronavirus in China
- Interim Guidance for Ships on Managing 2019 Novel Coronavirus

Interim Guidance of Emergency Medical Services (EMS) and 911 Public Safety Answering Points (PASPs) for 2019-nCoV in the US: Interim guidance for EMS including recommendations for 911 PSAPs, clinician practices, PUI/Patient transport, cleaning EMS vehicles, follow-up/reporting measures, and EMS employer responsibilities.

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV): This interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV.

Interim Considerations for Disposition of Hospitalized Patients with 2019-nCoV Infection: The following is intended to serve as a framework for patient disposition. All patients should be evaluated on a case-by-case basis and their disposition discussed with health care providers and public health departments.

Healthcare Supply of Personal Protective Equipment: CDC specific PPE recommendations based on the current 2019-nCoV situation and availability of PPE.

Frequently Asked Questions about Respirators and their Use: This document is intended to address frequently asked questions about respirators and their use.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	2019-nCoV Key Points, Business and Employers Guidance, Information for Travelers
Date:	Friday, February 7, 2020 7:42:46 PM
Attachments:	CDC_2019-nCoV Daily Key Points__2_7_2020_final.pdf

Please find today's 2019-nCoV key points attached. Feel free to share amongst your staff and appropriate parities.

In addition, several guidance documents have been posted/updated on the CDC 2019-nCoV website.

Information for Businesses and Employers

Information for Travelers

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: 3 PM EST TODAY- COVID-19 Press Briefing Livestream
Date: Tuesday, February 25, 2020 2:25:01 PM

Dear State and Local Partners,

Today, the Department of Health and Human Services (HHS) will host a press briefing to provide an update on the Administration's response to COVID-19.

You can join the briefing via livestream at https://www.hhs.gov/live/live-1/index.html#11607

As always, please do not hesitate to contact me if you have questions.
Darcie Johnston,
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-11-20 CDC COVID-19 Key Points, Grand Princess Movement and Monitoring Summary, and Community Intervention and PPE Guidance
Date:	Thursday, March 12, 2020 8:09:44 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_11_2020_FINAL.pdf GP movement monitoring Exec Sum FINAL 20200310.pdf

Dear Colleagues,

Attached please find the **CDC COVID-19 Key Points for March 11, 2020.** Feel free to share with partners and appropriate parties.

Also attached, is the **Grand Princess Movement and Public Health Monitoring executive summary**.

Finally, below are links to new/updated **CDC COVID-19 Community Intervention and PPE Guidance**.

Preventing COVID-19 Spread in Communities:
https://www.cdc.gov/coronavirus/2019-ncov/community/index.html

Implementation of mitigation strategies for communities: https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf

Healthcare Supply of Personal Protective Equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-11-20 CDC COVID-19 Key Points, Grand Princess Movement and Monitoring Summary, and Community Intervention and PPE Guidance
Date:	Thursday, March 12, 2020 8:11:34 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_11_2020_FINAL.pdf GP movement monitoring Exec Sum FINAL 20200310.pdf

Dear Colleagues,

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Implementation of mitigation strategies for communities: https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf

Healthcare Supply of Personal Protective Equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-11-20 CDC COVID-19 Key Points, Grand Princess Movement and Monitoring Summary, and Community Intervention Guidance
Date:	Thursday, March 12, 2020 8:07:21 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_11_2020_FINAL.pdf GP movement monitoring Exec Sum FINAL 20200310.pdf

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Healthcare Supply of Personal Protective Equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-12-20 CDC COVID-19 Key Points, Considerations for School Closures Guidance, and Force Health Protection Guidance
Date:	Friday, March 13, 2020 8:19:04 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_12_2020_FINAL.pdf Considerations for school closure Draft 031220 Updated.pdf Force Health Protection Guidance (Supplement 4) (002).pdf

Dear Colleagues:

Attached, please find

1. **CDC COVID-19 Key Points for Thursday, March 12, 2020. Please feel free to share with staff and appropriate parties.**
2. **CDC draft of Considerations for School closure guidance**. Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.
3. **Force Health Protection Guidance**

An additional note on U.S. Military guidance during the COVID-19 pandemic: Many of you have military bases and personnel in your states and communities. Attached for your information is the Department of Defense Force Protection Guidance, including a risk based table for global implementation of guidance for military members returning home from either CDC travel health notice (THN) Level 3 (Avoid non-essential travel) or Level 2(Special precautions for high-risk travelers) areas to stay home for 14 days, social distance and self-monitor.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-12-20 CDC COVID-19 Key Points, Considerations for School Closures Guidance, and Force Health Protection Guidance
Date:	Friday, March 13, 2020 8:21:43 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_12_2020_FINAL.pdf Considerations for school closure Draft 031220 Updated.pdf Force Health Protection Guidance (Supplement 4) (002).pdf

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To:	State and Local Readiness (CDC)
Subject:	3-12-20 CDC COVID-19 Key Points, Considerations for School Closures Guidance, and Force Health Protection Guidance
Date:	Friday, March 13, 2020 8:16:11 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_12_2020_FINAL.pdf Considerations for school closure Draft 031220 Updated.pdf Force Health Protection Guidance (Supplement 4) (002).pdf

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AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-13-20 CDC Media Telebriefing: Update on COVID-19 and updated Considerations for School Closure Guidance
Date: Friday, March 13, 2020 10:45:02 AM
Attachments: considerations-for-school-closure.pdf

Dear Colleagues:

Final CDC Considerations for School Closure Draft attached. See below for media briefing information.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 1:00 p.m. ET Friday, March 13, 2020

Dial-In

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-13-20 CDC Media Telebriefing: Update on COVID-19 and updated Considerations for School Closure Guidance
Date: Friday, March 13, 2020 10:46:44 AM
Attachments: considerations-for-school-closure.pdf

Dear Colleagues:

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-13-20 CDC Media Telebriefing: Update on COVID-19 and updated Considerations for School Closure Guidance
Date:	Friday, March 13, 2020 10:43:20 AM
Attachments:	considerations-for-school-closure.pdf

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-14-20 OSHA Enforcement Memo on Respirator Annual Fit Testing
Date:	Sunday, March 15, 2020 7:50:08 AM

Dear Colleagues:

Yesterday the Occupational Safety and Health Administration (OSHA) released **Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak**. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit

A fit test is required for anyone wearing a respirator to protect against COVID-19. Annual fit test can be temporarily suspended if employee has already been fit tested to that respirator.

See relevant bullets from memo below:

- Perform initial fit tests for each HCP with the same model, style, and size respirator that the worker will be required to wear for protection against COVID-19 (initial fit testing is essential to determine if the respirator properly fits the worker and is capable of providing the expected level of protection);

- Inform workers that the employer is temporarily suspending the annual fit testing of N95 filtering facepiece respirators to preserve and prioritize the supply of respirators for use in situations where they are required to be worn.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-14-20 OSHA Enforcement Memo on Respirator Annual Fit Testing
Date:	Sunday, March 15, 2020 7:52:12 AM

Dear Colleagues:

Yesterday the Occupational Safety and Health Administration (OSHA) released **Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak**. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-14-20 OSHA Enforcement Memo on Respirator Annual Fit Testing
Date:	Sunday, March 15, 2020 7:47:10 AM
Importance:	High

Dear Colleagues:

Yesterday the Occupational Safety and Health Administration (OSHA) released **Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak**. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit

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See relevant bullets from memo below:

- Perform initial fit tests for each HCP with the same model, style, and size respirator that the worker will be required to wear for protection against COVID-19 (initial fit testing is essential to determine if the respirator properly fits the worker and is capable of providing the expected level of protection);

- Inform workers that the employer is temporarily suspending the annual fit testing of N95 filtering facepiece respirators to preserve and prioritize the supply of respirators for use in situations where they are required to be worn.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-17-20 CDC Weekly Key Messages, Daily Key Points, and Links to Updated COVID-19 Guidance
Date:	Wednesday, March 18, 2020 8:28:36 AM
Attachments:	CDC_COVID-19_Daily Key Points__3.17.2020_FINAL.pdf CDC_COVID-19 Weekly Key Messages__3.17.20_FINAL.pdf
Importance:	High

Dear Colleagues:

Attached please find the CDC COVID-19 weekly key messages (Week of 3/8) and CDC COVID-19 Key Points for Tuesday, March 17, 2020. Please feel free to share with your staff and other partners.

In addition, The CDC COVID-19 Website has been updated with several new/updated interim guidance documents. Click the links below to find the guidance.

- Updated **home isolation guidance**
- Updated information on when to end isolation on **What to do it you are sick**
- New Guidance – **Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected (COVID-19)**
- New Guidance – **Ending home isolation for people who are immunocompromised**

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: 3-18-20 CDC COVID-19 Key Points and New/Updated Guidance on Web
Date: Thursday, March 19, 2020 9:14:49 AM
Attachments: CDC_COVID-19_Daily Key Points__3_18_2020_FINAL.pdf

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For the duplication……..

Dear Colleagues,

Attached are the **CDC COVID-19 key points for Wednesday, March 18, 2020**. Please feel free to share with your staff and other partners.

Also, CDC has released/updated several COVID-19 interim guidance websites. Links below.

New/ Updated CDC COVID-19 Guidance:

- Prepare to Care for COVID-19: Get Your Practice Ready
- FAQs about Hand Hygiene for Healthcare Personnel Responding to COVID-2019
- New At-Risk landing page with new content:
  - Older Adults
  - People with Asthma and COVID-19
  - COVID-19: What people with HIV should know
  - Caring for someone at home

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913

AMERICAN OVERSIGHT

email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-18-20 CDC COVID-19 Key Points and New/Updated Guidance on Web
Date:	Thursday, March 19, 2020 8:46:29 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_18_2020_FINAL.pdf

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New/ Updated CDC COVID-19 Guidance:

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Kind Regards,

State Coordination Task Force

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-19-20 CDC COVID-19 Key Points and Updated CDC COVID-19 Guidance
Date:	Friday, March 20, 2020 8:57:51 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_19_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Thursday, March 19, 2020. Please feel free to share with your staff and other partners.

In addition, see below, for updates to several CDC COVID-19 guidance documents.

- Symptom self-checker on What To Do if You Are Sick
- New PDF "Protect Your Patients and Staff from COVID-19: CDC's Recommended Infection Control Procedures"
- Disinfecting Your Facility if Someone is Sick
- Interim Guidance for Administrators of US Institutions of Higher Education
- Institutes of Higher Education: FAQs for Administrators
- After travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-2-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Monday, March 2, 2020 11:11:42 AM

Media Advisory

For Immediate Release
Monday March 2, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

Stephen M. Hahn, M.D., Food and Drug Administration
Commissioner

When 12 p.m. ET Monday, March 2, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

AMERICAN OVERSIGHT

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U.S. Department of Health and Human Services

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

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-2-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Monday, March 2, 2020 11:13:42 AM

Media Advisory

For Immediate Release
Monday March 2, 2020

Contact: CDC Media Relations
(404) 639-3286

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What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

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AMERICAN OVERSIGHT

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-2-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Monday, March 2, 2020 11:09:03 AM

Media Advisory

For Immediate Release
Monday March 2, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

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National Center for Immunization and Respiratory Diseases

Stephen M. Hahn, M.D., Food and Drug Administration
Commissioner

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AMERICAN OVERSIGHT

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: 3-20-20 CDC COVID-19 Key Points
Date: Saturday, March 21, 2020 3:02:59 PM
Attachments: CDC_COVID-19_Daily Key Points__3_20_2020_FINAL.pdf

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Attached please find the CDC COVID-19 daily key points for Thursday, March 20, 2020. Please feel free to share with your staff and other partners.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-20-20 CDC COVID-19 Key Points
Date:	Saturday, March 21, 2020 2:40:32 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_20_2020_FINAL.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 daily key points for Thursday, March 20, 2020. Please feel free to share with your staff and other partners.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-23-20 CDC COVID-19 Key Points and Summary of Updated Guidance Documents
Date:	Monday, March 23, 2020 11:20:42 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_23_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Monday, March 23, 2020. Please feel free to share with your staff and other partners.

Below is a summary of CDC COVID-19 new/updated guidance documents as of Monday, March 23, 2020.

New Guidance= Highlighted
All others, updated since March 21, 2020.

At-Risk

- Children and Coronavirus Disease 2019 (COVID-19)
- Interim Guidance for responding to coronavirus disease 2019 (COVID-19) among people experiencing unsheltered homelessness
- List of underlying medical Conditions (updated)

Communication Resources:

- Print Resources: Stay at home if you are sick!

Community Mitigation:

- Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities
- Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19)

Cruise Ships

- Cruise Passengers returning via charter flights

Healthcare

- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)
- Interim Infection Control Guidance on COVID-19 for Personnel at Blood and Plasma Collection Facilities

AMERICAN OVERSIGHT

- Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020
- Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

Infection Control

- Environmental Cleaning Guidance for community facilities and households

Risk Assessment

- Risk Assessment and Management Guidance (updated)

Travel Notices:

- Level 3 Travel Health Notices: Chile, Pakistan, Thailand, Turkey

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

CDC State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-23-20 CDC COVID-19 Weekly Key Messages and Updated Website Guidance
Date:	Monday, March 23, 2020 8:45:28 AM
Attachments:	CDC_COVID-19 Weekly Key Messages__3.22.2020_FINAL.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 weekly key messages for Sunday, March 22, 2020. Feel free to share with your staff and other partners.

In addition, CDC released/updated several guidance documents on the CDC COVID-19 webpage.

- New People who are at higher risk for severe illness (consumer page)
- New COVID-19 and Underlying Medical Conditions (healthcare professional page)
- New Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness
- Updates to Information for Health Departments on Reporting Cases of COVID-19
    - COVID-19 Case Report Form Instructions
    - Completing a CRF and Specimen guidance
- New FAQs for consumers on Higher Risk & Underlying Conditions

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-24-2020 CDC COVID-19 Key Points, Telehealth Expansion Notice, and Updated CDC Guidance
Date:	Wednesday, March 25, 2020 8:17:11 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_24_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Tuesday, March 24, 2020. Please feel free to share with your staff and other partners.

Please see below for updated CDC COVID-19 guidance posted on the CDC COVID-19 webpage.

- **New Tool**: Coronavirus Disease 2019 (COVID-19) Outpatient Dialysis Facility Preparedness Assessment Tool
- **Level 3 Travel Health Notices** for: Ecuador, Singapore, Indonesia, Romania, Saudi Arabia, Qatar, Philippines, India, South Africa

Secretary Azar Announces Historic Expansion of Telehealth Access to Combat COVID-19

On Tuesday, the President and the Department of Health and Human Services (HHS) announced unprecedented steps to expand Americans' access to telehealth services during the COVID-19 outbreak. The Centers for Medicare & and Medicaid Services (CMS) expanded Medicare coverage for telehealth visits, the HHS Office for Civil Rights (OCR) announced it will waive potential HIPAA penalties for good faith use of telehealth during the emergency, and the HHS Office of Inspector General (OIG) provided flexibility for healthcare providers to reduce or waive beneficiary cost-sharing for telehealth visits paid by federal healthcare programs.

This includes major shifts in various laws that makes telehealth more accessible:

- See CMS's press release: https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak
- See OCR's guidance: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
- See OIG's policy statement: https://oig.hhs.gov/compliance/alerts/index.asp

Kind Regards,

CDC State Coordination Task Force

AMERICAN OVERSIGHT

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-4-2020 CDC COVID-19 Key Points and Travel Health Alert Notice (THAN) Cards
Date:	Thursday, March 5, 2020 11:52:37 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf 03-03-2020_COVID-19_THAN_Level 3s.pdf

Dear Colleagues:

Attached, please find **CDC COVID-19 Key Points from 03-04-2020**. Feel free to share with partners and appropriate parties.

In addition, CDC has updated **COVID-19 Travel Health Alert Notice (THAN) Cards** for travelers, a PDF version is attached.

CDC has launched a new webpage for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.

The full link is: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html
The shortened link is: www.cdc.gov/COVIDTravel

The shortened link is printed on the back of the updated Travel Health Alert Notice (THAN) card, which is attached. The THAN cards will be distributed to all travelers from countries with a Level 3 travel notice. Travelers from China will continue to receive the **Check and Record Everyday (CARE) booklet, available here:** https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

The launch of the above webpage corresponds with changes to travel notice language. Level 3 travel notices can be accessed from the above page and advise travelers to "stay home and monitor their health during travel and for 14 days after returning to the United States."

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-4-2020 CDC COVID-19 Key Points and Travel Health Alert Notice (THAN) Cards
Date:	Thursday, March 5, 2020 11:54:37 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf 03-03-2020_COVID-19_THAN_Level 3s.pdf

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-4-2020 CDC COVID-19 Key Points and Travel Health Alert Notice (THAN) Cards
Date:	Thursday, March 5, 2020 11:49:57 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf 03-03-2020_COVID-19_THAN_Level 3s.pdf

Dear Colleagues:

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State Coordination Task Force

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AMERICAN OVERSIGHT

From: ASTHO President

To: amy.acton@odh.ohio.gov; Nicole Alexanderscott; sadia.ali@doh.vi.gov; bruce.s.anderson@doh.hawaii.gov; Sonia.angell@cdph.ca.gov; gary.anthone@nebraska.gov; Rachelle Ashe; jeanne.ayers@dhs.wisconsin.gov; jazzam@health.nv.gov; louise.baa@doh.vi.gov; aislinn.barnett@state.co.us; tbarnettno@pa.gov; Tami Barrett; lacey.barry1@maryland.gov; pbeene@pa.gov; mark.benton@dhhs.nc.gov; Eva.benvenga@maryland.gov; Terry Bergener; tanya.bethel@dc.gov; Monica Bharel; alexander.billioux@la.gov; Kelly Bogert; kbox@isdh.in.gov; Carolyn Byrnes; Jennifer Caskey; kacech@mt.gov; Cara M. Christ; Gerd Clabaugh; betsycoleman@utah.gov; Renee.Coleman-Mitchell@ct.gov; GaryC@health.ok.gov; Misty.Daniels@dhw.idaho.gov; Catherine.delacruz@salud.pr.gov; adearinger@ky.gov; Linda.denorcey@dphss.guam.gov; Odette Desgeorges; Thomas Dobbs; Egelskil@michigan.gov; justa.encarnacion@doh.vi.gov; Bonnie Engel; Ngozi.Ezike@illinois.gov; Reva Ferguson; jpfilippi@health.nv.gov; Andrea Fisher; Linda.Fullem@flhealth.gov; carolyn.geter@dshs.texas.gov; Sarah Gregorek; Jenny Griffin; Janet Guerrero; Diane M. Hanley; Monica Harding; ScottHarris; Alexia Harrist; heidi.hedberg@alaska.gov; John Hellerstedt; Teresa Higgins; Sheila Hogan; Gholzman@mt.gov; amaal.idheileh@doh.vi.gov; lalie.ikluk@palauhealth.org; Dana Jensen; Kalani Kaneko; Suzanne Kaneshiro; KhaldunJ@michigan.gov; Jane.Killen2@La.gov; Mailynn Konelios-Langinlur; kathy.kunkel@state.nm.us; Peggie Lawrence; Mark Levine; Rachel Levine; Peggy.Lindley@dhw.idaho.gov; richard.little@delaware.gov; marlineloeak@gmail.com; jan.malcolm@state.mn.us; Kim Malsam-Rysdon; Lesa McFarlane; angelica.mcgrier@dph.ga.gov; Debbie Mebruer; Rita Menard; Joe Miner; Carla Moore; Deanna Morris; Lisa Morris; Esther Muna; Shirley Musgrave; robert.neall@maryland.gov; LaQuandra Nesbitt; lee.norman@ks.gov; norm.oliver@vdh.virginia.gov; Oluwaseun.Oyeniran@illinois.gov; Judith.Persichilli@doh.nj.gov; fran.phillips@maryland.gov; Lisa.Piercey@tn.gov; Sandy Pizzuti; tesha.plunkett@doh.vi.gov; Michelle.Pringle@maryland.gov; dawn.l.quitugua@state.or.us; karyl.rattay@delaware.gov; Kellie.Richetti@mt.gov; scott.rivkees@flhealth.gov; Emais Roberts; Rafael Rodriguez; jill.hunsakerryan@state.co.us; Marcus H. Samo, MPH; Magen.Schachta@nebraska.gov; Denise.Schimmel@ks.gov; nirav.shah@maine.gov; elke.shaw-tulloch@dhw.idaho.gov; l.sherych@health.nv.gov; lillian.shirley@state.or.us; Jacqueline Silvia; Catherine Slemp, MD, MPH; dannette.smith@nebraska.gov; Nate Smith; Wendy Snyder; Angela Soliz; Fancy Soloman; Tammy Stanton; Sharon.Tangonan@doh.hawaii.gov; pthompson@nd.gov; Betsey.Tilson@dhhs.nc.gov; Motusa Nua; kathleen.toomey@dph.ga.gov; rick.toomey@dhec.sc.gov; Mylynn Tufte; Eti Uiagalelei; Peggy Ullom; tara.vasby@dhs.wisconsin.gov; fanny.vazquez@dph.ga.gov; kyrad.vermillion@ky.gov; Patricia Vinson; Barbara White; Rebecca White; John Wiesman; Randall Williams; Ashley.Wilson@odh.ohio.gov; Maryanne.wollman@vdh.virginia.gov; anne.zink@alaska.gov; Howard Zucker; Deb Colston; idalmi90@gmail.com; KFarrell@hrsa.gov; bhandler@health.nv.gov; Lance Himes; IngersollJ2@michigan.gov; ngl1@cdc.gov; Jose T. Montero, MD, MPH; ppontones@isdh.in.gov; Mark.Pyle@nebraska.gov; Stephanie Pyle; Connie White; Stephanie Williams; ASTHO-All-Staff; LTaulung2@fsmhealth.fm; eric.france@state.co.us; Jennifer.dillaha@arkansas.gov; joel.tumlison@arkansas.gov; Shirley.louie@arkansas.gov; laurie.forlano@vdh.virginia.gov; steven.stack@ky.gov; Margaret.kelly@state.mn.us; mbecker@nga.org; eric.chenier@state.nm.us; Kellie.Giefer@state.mn.us; gary.wheeler@arkansas.gov

Cc: carolyn.mccoy@gmail.com

Subject: ASTHO All S/THO Call (COVID-19-focused)

Agenda forthcoming

One-tap dialing: 6468769923,,185680719#

Phone Number: 646-876-9923

Meeting ID: 185 680 719

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AMERICAN OVERSIGHT

From: ASTHO President

To: fran.phillips@maryland.gov; jill.hunsakerryan@state.co.us; joel.tumlison@arkansas.gov; Shirley.louie@arkansas.gov; Jennifer.dillaha@arkansas.gov; amy.acton@odh.ohio.gov; Nicole Alexanderscott; sadia.ali@doh.vi.gov; bruce.s.anderson@doh.hawaii.gov; Sonia.angell@cdph.ca.gov; gary.anthone@nebraska.gov; Rachelle Ashe; jeanne.ayers@dhs.wisconsin.gov; jazzam@health.nv.gov; louise.baa@doh.vi.gov; aislinn.barnett@state.co.us; tbarnettno@pa.gov; Tami Barrett; lacey.barry1@maryland.gov; pbeene@pa.gov; mark.benton@dhhs.nc.gov; Eva.benvenga@maryland.gov; Terry Bergener; tanya.bethel@dc.gov; Monica Bharel; bbilimon@hotmail.com; alexander.billioux@la.gov; Kelly Bogert; kbox@isdh.in.gov; Carolyn Byrnes; ccanfieldsmither@ky.gov; Jennifer Caskey; kacech@mt.gov; Cara M. Christ; Gerd Clabaugh; betsycoleman@utah.gov; Renee.Coleman-Mitchell@ct.gov; GaryC@health.ok.gov; Misty.Daniels@dhw.idaho.gov; Catherine.delacruz@salud.pr.gov; adearinger@ky.gov; Linda.denorcey@dphss.guam.gov; Odette Desgeorges; Thomas Dobbs; Egelskil@michigan.gov; justa.encarnacion@doh.vi.gov; Bonnie Engel; Ngozi.Ezike@illinois.gov; Reva Ferguson; jpfilippi@health.nv.gov; Andrea Fisher; carolyn.geter@dshs.texas.gov; Sarah Gregorek; Jenny Griffin; Janet Guerrero; Diane M. Hanley; Monica Harding; ScottHarris; Alexia Harrist; heidi.hedberg@alaska.gov; John Hellerstedt; Teresa Higgins; Sheila Hogan; Gholzman@mt.gov; amaal.idheileh@doh.vi.gov; lalie.ikluk@palauhealth.org; Dana Jensen; Suzanne Kaneshiro; KhaldunJ@michigan.gov; Jane.Killen2@La.gov; Mailynn Konelios-Langinlur; kathy.kunkel@state.nm.us; Peggie Lawrence; Mark Levine; Rachel Levine; Peggy.Lindley@dhw.idaho.gov; richard.little@delaware.gov; marlineloeak@gmail.com; jan.malcolm@state.mn.us; Kim Malsam-Rysdon; Lesa McFarlane; angelica.mcgrier@dph.ga.gov; Debbie Mebruer; Rita Menard; Joe Miner; Carla Moore; Deanna Morris; Lisa Morris; Esther Muna; Shirley Musgrave; robert.neall@maryland.gov; LaQuandra Nesbitt; patricia.nest@state.or.us; lee.norman@ks.gov; norm.oliver@vdh.virginia.gov; Oluwaseun.Oyeniran@illinois.gov; Judith.Persichilli@doh.nj.gov; Lisa.Piercey@tn.gov; Sandy Pizzuti; tesha.plunkett@doh.vi.gov; Michelle.Pringle@maryland.gov; karyl.rattay@delaware.gov; Kellie.Richetti@mt.gov; scott.rivkees@flhealth.gov; Emais Roberts; Rafael Rodriguez; Marcus H. Samo, MPH; Magen.Schachta@nebraska.gov; Denise.Schimmel@ks.gov; nirav.shah@maine.gov; elke.shaw-tulloch@dhw.idaho.gov; l.sherych@health.nv.gov; lillian.shirley@state.or.us; Jacqueline Silvia; Catherine Slemp, MD, MPH; dannette.smith@nebraska.gov; Nate Smith; Wendy Snyder; Angela Soliz; Fancy Soloman; Tammy Stanton; Sharon.Tangonan@doh.hawaii.gov; pthompson@nd.gov; Betsey.Tilson@dhhs.nc.gov; Jade.Tindle@flhealth.gov; Motusa Nua; kathleen.toomey@dph.ga.gov; rick.toomey@dhec.sc.gov; Mylynn Tufte; Eti Uiagalelei; Peggy Ullom; tara.vasby@dhs.wisconsin.gov; fanny.vazquez@dph.ga.gov; Patricia Vinson; Barbara White; Rebecca White; John Wiesman; Randall Williams; Ashley.Wilson@odh.ohio.gov; Maryanne.wollman@vdh.virginia.gov; anne.zink@alaska.gov; Howard Zucker; James Blumenstock; Gerrit Bakker; Regina Hawkins; Jerry Rhodes; Lisa Peterson; Sharon Miller; LTaulung2@fsmhealth.fm; eric.france@state.co.us; gary.wheeler@arkansas.gov; sstack2@utk.edu; steven.stack@ky.gov; Andy Baker-White; Margaret.kelly@state.mn.us; Kellie.giefer@state.mn.us

Cc: Lillian Shirley; EMT; Danny Staley; Michael Fraser; Mary A. Cooney; John Mericsko; Boateng, Sarah; Jane Esworthy; Zarnaaz Bashir; Amber Williams; Meredith Allen; Melissa Peek-Bullock; Carolyn Mullen; Luna-Pinto, S. Carolina (CDC/DDPHSIS/CSTLTS/DPPS); Ashleigh Faulstich; Marcus Plescia

Subject: ASTHO All S/THO Call: 2019-nCoV

Agenda materials forthcoming

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From: ASTHO President

To: amy.acton@odh.ohio.gov; Nicole Alexanderscott; sadia.ali@doh.vi.gov; bruce.s.anderson@doh.hawaii.gov; Sonia.angell@cdph.ca.gov; gary.anthone@nebraska.gov; Rachelle Ashe; jeanne.ayers@dhs.wisconsin.gov; jazzam@health.nv.gov; louise.baa@doh.vi.gov; aislinn.barnett@state.co.us; tbarnettno@pa.gov; Tami Barrett; lacey.barry1@maryland.gov; pbeene@pa.gov; mark.benton@dhhs.nc.gov; Eva.benvenga@maryland.gov; Terry Bergener; tanya.bethel@dc.gov; Monica Bharel; bbilimon@hotmail.com; alexander.billioux@la.gov; Kelly Bogert; kbox@isdh.in.gov; Carolyn Byrnes; ccanfieldsmither@ky.gov; Jennifer Caskey; kacech@mt.gov; Cara M. Christ; Gerd Clabaugh; betsycoleman@utah.gov; Renee.Coleman-Mitchell@ct.gov; GaryC@health.ok.gov; Misty.Daniels@dhw.idaho.gov; Catherine.delacruz@salud.pr.gov; adearinger@ky.gov; Linda.denorcey@dphss.guam.gov; Odette Desgeorges; Thomas Dobbs; Egelskil@michigan.gov; justa.encarnacion@doh.vi.gov; Bonnie Engel; Ngozi.Ezike@illinois.gov; Reva Ferguson; jpfilippi@health.nv.gov; Andrea Fisher; carolyn.geter@dshs.texas.gov; Sarah Gregorek; Jenny Griffin; Janet Guerrero; Diane M. Hanley; Monica Harding; ScottHarris; Alexia Harrist; heidi.hedberg@alaska.gov; John Hellerstedt; Teresa Higgins; Sheila Hogan; Gholzman@mt.gov; amaal.idheileh@doh.vi.gov; lalie.ikluk@palauhealth.org; Dana Jensen; Suzanne Kaneshiro; KhaldunJ@michigan.gov; Jane.Killen2@La.gov; Mailynn Konelios-Langinlur; kathy.kunkel@state.nm.us; Peggie Lawrence; Mark Levine; Rachel Levine; Peggy.Lindley@dhw.idaho.gov; richard.little@delaware.gov; marlineloeak@gmail.com; jan.malcolm@state.mn.us; Kim Malsam-Rysdon; Lesa McFarlane; angelica.mcgrier@dph.ga.gov; Debbie Mebruer; Rita Menard; Joe Miner; Carla Moore; Deanna Morris; Lisa Morris; Esther Muna; Shirley Musgrave; robert.neall@maryland.gov; LaQuandra Nesbitt; patricia.nest@state.or.us; lee.norman@ks.gov; norm.oliver@vdh.virginia.gov; Oluwaseun.Oyeniran@illinois.gov; Judith.Persichilli@doh.nj.gov; fran.phillips@maryland.gov; Lisa.Piercey@tn.gov; Sandy Pizzuti; tesha.plunkett@doh.vi.gov; Michelle.Pringle@maryland.gov; karyl.rattay@delaware.gov; Kellie.Richetti@mt.gov; scott.rivkees@flhealth.gov; Emais Roberts; Rafael Rodriguez; jill.hunsakerryan@state.co.us; Marcus H. Samo, MPH; Magen.Schachta@nebraska.gov; Denise.Schimmel@ks.gov; nirav.shah@maine.gov; elke.shaw-tulloch@dhw.idaho.gov; l.sherych@health.nv.gov; lillian.shirley@state.or.us; Jacqueline Silvia; Catherine Slemp, MD, MPH; dannette.smith@nebraska.gov; Nate Smith; Wendy Snyder; Angela Soliz; Fancy Soloman; Tammy Stanton; Sharon.Tangonan@doh.hawaii.gov; pthompson@nd.gov; Betsey.Tilson@dhhs.nc.gov; Jade.Tindle@flhealth.gov; Motusa Nua; kathleen.toomey@dph.ga.gov; rick.toomey@dhec.sc.gov; Mylynn Tufte; Eti Uiagalelei; Peggy Ullom; tara.vasby@dhs.wisconsin.gov; fanny.vazquez@dph.ga.gov; Patricia Vinson; Barbara White; Rebecca White; John Wiesman; Randall Williams; Ashley.Wilson@odh.ohio.gov; Maryanne.wollman@vdh.virginia.gov; anne.zink@alaska.gov; Howard Zucker; James Blumenstock; Gerrit Bakker; Regina Hawkins; Jerry Rhodes; Lisa Peterson; Sharon Miller; LTaulung2@fsmhealth.fm; eric.france@state.co.us; gary.wheeler@arkansas.gov; Jennifer.dillaha@arkansas.gov; joel.tumlison@arkansas.gov; Shirley.louie@arkansas.gov; sstack2@utk.edu; steven.stack@ky.gov; Andy Baker-White; Margaret.kelly@state.mn.us; Kellie.giefer@state.mn.us

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Subject: ASTHO All S/THO Call: 2019-nCoV

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Washington, Kendra

From: Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Sent: Thursday, March 12, 2020 2:11 PM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Subject: Accepted: Call with Florida COVID-19

AMERICAN OVERSIGHT

From: Fullem, Linda R on behalf of Rivkees, Scott A
To: Poser, Sarah (CDC/DDID/NCEZID/OD)
Subject: Accepted: Plans to Notify COVID-19 Exposed Persons in Florida Port

AMERICAN OVERSIGHT

From: Villalta, Yesenia D
To: CDC IMS State Coordination Task Force (SCTF) Operations
Subject: Accepted: Senior Administration Officials Briefing Call on COVID-19 // Regarding President Trump issuing proclamation under section 212(f) of the Immigration and Nationality Act (INA), restricting travel

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Attached: Update on COVID-19 response to Governors (2-20-2020 COVID-19 SHO & State Epi Call)
Date:	Thursday, February 20, 2020 5:28:23 PM
Attachments:	02 20 2020 MEMO AMA call with governors on COVID-19.docx

Dear Colleagues,

Attached is the "Update on COVID-19 response to Governors" document mentioned on today's CDC COVID-19 SHO & State Epi Call.

Thank you,

State Coordination Task Force

Sent by BCC to State Health Officials and State Epidemiologists

AMERICAN OVERSIGHT

From: Coppola, Courtney
To: Deleon, Melissa E MAJ USARMY NG FLARNG (USA)
Subject: Automatic reply: Airport Personnel
Date: Wednesday, March 25, 2020 1:54:39 PM

Thank you for your email. I am currently activated in the State Emergency Operations Center for COVID-19. During this time I will be delayed in replying to email. If you need immediate assistance, please contact Jade Tindle at Jade.Tindle@FLHealth.gov

Thank you

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: State and Local Readiness (CDC)
Subject: Automatic reply: CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date: Monday, February 24, 2020 4:40:08 PM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Pesik, Nicki (CDC/DDID/NCEZID/OD)
Subject: Automatic reply: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington
Date: Tuesday, February 25, 2020 12:58:16 PM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ)
Subject: Automatic reply: Coronavirus Guidance
Date: Friday, February 28, 2020 6:07:51 PM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	EPIXUpdate@cdc.gov
Subject:	Automatic reply: Important: DGMQ 2019-nCoV Entry Screening: Contact List for Flight DL 0026 on 02/24/2020 for FL
Date:	Monday, February 24, 2020 9:10:10 AM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

AMERICAN OVERSIGHT

From: Coppola, Courtney
To: Gilliard, Deric (HHS/IEA)
Subject: Automatic reply: Please give me a call when you can
Date: Tuesday, March 24, 2020 2:03:28 PM

Thank you for your email. I am currently activated in the State Emergency Operations Center for COVID-19. During this time I will be delayed in replying to email. If you need immediate assistance, please contact Jade Tindle at Jade.Tindle@FLHealth.gov

Thank you

AMERICAN OVERSIGHT

From:	Schedule, Gov
To:	Lukis, Adrian; Strum, Shane; FDLE, Mansion; Swearingen, Rick; Rivkees, Scott; Moskowitz, Jared; Eifert, James; Mayhew, Mary; Corcoran, Richard
Subject:	Briefing regarding Coronavirus

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

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To:	Lukis, Adrian; Strum, Shane; FDLE, Mansion; Swearingen, Rick; Rivkees, Scott; Moskowitz, Jared; Eifert, James
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From:	Schedule, Gov
To:	Lukis, Adrian; Rivkees, Scott; Eifert, James; Mayhew, Mary; Corcoran, Richard; Spencer, Chris; Moulton, Diane
Subject:	Briefing with Agency Heads regarding Coronavirus

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Subject:	Briefing with Agency Heads regarding Coronavirus

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AMERICAN OVERSIGHT

From:	ASHE, CHRISTOPHER
To:	Rosenfarb, Charles H; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force; CBP HQ EOC
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); BAZILL, MARK; CONCOLATO, ELIZABETH; ALVEZ, CHRISTINA
Subject:	CBP POC Required - Coordination/Information for Royal Caribbean/Silver Shadow Disembarkation and Return to CONUS via Recife, Brazil
Date:	Monday, March 16, 2020 1:33:50 PM

Non-CBP Addressees: strangely – even as a CBP employee – my e-mail to the CBP Corona Virus TF got kicked back indicating I do not have permission to send to that address. If you experience a similar issue - please use the cbphqeoc@cbp.dhs.gov e-mail address (which was copied on my message) – which did go through.

CBP EOC Personnel: please see request below.

Christopher C. Ashe
Latin America and Caribbean Division
Office of International Affairs
U.S. Customs and Border Protection
Phone: (202) 538-1062
Department of State Detailee

From: ASHE, CHRISTOPHER
Sent: Monday, March 16, 2020 1:29 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force <CBPCoronaVirusTaskForce@cbp.dhs.gov>; CBP HQ EOC <cbphqeoc@cbp.dhs.gov>
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; BAZILL, MARK <MARK.BAZILL@cbp.dhs.gov>; CONCOLATO, ELIZABETH <ELIZABETH.CONCOLATO@cbp.dhs.gov>; ALVEZ, CHRISTINA <CHRISTINA.ALVEZ@CBP.DHS.GOV>
Subject: CBP POC Required - Coordination/Information for Royal Caribbean/Silver Shadow Disembarkation and Return to CONUS via Recife, Brazil

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Thank you Charles and Hello Eleni and Yesenia,

The CBP Coronavirus Task Force will serve as your CBP Lead as they are working with CBP's Office of Field Operations and coordinating with CDC on screening and quarantine issues at Ports of Entry (land, sea, air), as well as adherence to current travel restrictions.

Please let me know if I can provide any additional help – or if you do not receive a response from my Task Force colleagues.

Thanks,

Chris

Christopher C. Ashe
Latin America and Caribbean Division
Office of International Affairs
U.S. Customs and Border Protection
Phone: (202) 538-1062
Department of State Detailee

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Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

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certainly the best way to get you the answers you need. Christopher Ashe from CBP's Latin America and Caribbean Division has been our primary contact at CBP (CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov). A second contact is to the CBPCoronaVirusTaskForce@cbp.dhs.gov.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
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U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

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Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM

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To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
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- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
- Health screening of passengers would be done by the cruise line company prior to boarding in Recife, with no additional screening performed at the funneling airport (unless the individual has become obviously ill on the initial flight).
- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)

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U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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From:	ASHE, CHRISTOPHER
To:	Rosenfarb, Charles H; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force; CBP HQ EOC
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); BAZILL, MARK; CONCOLATO, ELIZABETH; ALVEZ, CHRISTINA
Subject:	CBP POC Required - Coordination/Information for Royal Caribbean/Silver Shadow Disembarkation and Return to CONUS via Recife, Brazil
Date:	Monday, March 16, 2020 1:29:21 PM

Thank you Charles and Hello Eleni and Yesenia,

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Please let me know if I can provide any additional help – or if you do not receive a response from my Task Force colleagues.

Thanks,

Chris

Christopher C. Ashe
Latin America and Caribbean Division
Office of International Affairs
U.S. Customs and Border Protection
Phone: (202) 538-1062
Department of State Detailee

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Regards,
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- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already

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told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

CONFIDENTIALITY NOTE: This message may contain confidential or legally privileged information. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on these contents is strictly prohibited and may be unlawful. If you have received this communication in error, please notify us immediately by responding to this e-mail and then delete it from your system.

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Schwartz, Erica (HHS/OASH); Horahan, Kevin (OS/ASPR/EMMO); Greene, Jonathan (OS/ASPR/EMMO); Yeskey, Kevin (OS/ASPR/IO); Cote, Mick (OS/ASPR/EMMO); Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV)
Subject:	CBTS test specimen daily limit
Date:	Monday, March 23, 2020 9:13:06 AM

All

I have heard your concerns regarding the CBTS 250 specimens per day. I refer you to RADM Schwartz who is heading up that program as I have no authority to change any parameters. Dr. Schwartz and team are leading that program. Her contact information is as follows

RADM Erica Schwartz, MD, JD, MPH
Deputy Surgeon General
Office of the Surgeon General
United States Public Health Service
U.S. Department of Health and Human Services
200 Independence Ave SW, Suite 701-H
Washington, DC 20201
Office Phone: 202-401-4660
Email: erica.schwartz@hhs.gov

Thank you

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov

AMERICAN OVERSIGHT

email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Schwartz, Erica (HHS/OASH); Horahan, Kevin (OS/ASPR/EMMO); Greene, Jonathan (OS/ASPR/EMMO); Yeskey, Kevin (OS/ASPR/IO); Cote, Mick (OS/ASPR/EMMO); Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV)
Subject:	CBTS test specimen daily limit
Date:	Monday, March 23, 2020 9:12:53 AM

All

I have heard your concerns regarding the CBTS 250 specimens per day. I refer you to RADM Schwartz who is heading up that program as I have no authority to change any parameters. Dr. Schwartz and team are leading that program. Her contact information is as follows

RADM Erica Schwartz, MD, JD, MPH
Deputy Surgeon General
Office of the Surgeon General
United States Public Health Service
U.S. Department of Health and Human Services
200 Independence Ave SW, Suite 701-H
Washington, DC 20201
Office Phone: 202-401-4660
Email: erica.schwartz@hhs.gov

Thank you

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov

AMERICAN OVERSIGHT

email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC 2019-nCoV Guidance
Date:	Wednesday, February 5, 2020 7:54:20 PM
Attachments:	TIM_factsheet-FAQ_forPH_02.02.2020.pdf 2019nCoV_InterimHousingGuidance_CDC_02012020.pdf CDC_2019-nCoV Daily Key Points__2_5_2020_final.pdf CDC_2019-nCoV Weekly Key Messages_2-4-2020_Final_Corrected.pdf 314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-English.jpg 314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-Mandarin.jpg

Dear Partners,

On Monday, February 3, the Centers for Disease Control and Prevention (CDC) released new movement and monitoring guidelines, "**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings"**. For your convenience, you can find it here.

In addition, please see the following attachments:

- CDC Interim Housing Guidance
- CDC Daily Key Points
- CDC Weekly Key Messages
- Text Illness Monitoring (T.I.M.) Fact Sheet
- Updated Travel Cards

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/03/2020
Date: Tuesday, March 3, 2020 8:10:10 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported Cases.msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent today from the CSTE COVID-19 Leadership Team (attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction. We are doing this in order to coordinate consistent public messaging and improve data visualization on CDC's public-facing website for the COVID-19 response. **Currently, this will be a daily process (Monday–Friday)**. As the response evolves, the frequency of these requests will likely decrease.

At the bottom of this email, you will find a table with the current preliminary case counts for each jurisdiction **as of 4 pm ET on Tuesday, March 3, 2020**. These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the U.S. via State Department-chartered flights.

This email is being sent to the State Epidemiologist for each jurisdiction. Please, **by 9 am ET Wednesday, March 4**, reply to this email and provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:

- confirm the case count information provided (cases as of 4 pm ET), or,
- if incorrect, provide updated values by using the table shell below

	Value as of 4pm ET
Jurisdiction Name	
Presumptive Cases	
Lab-confirmed Cases*	
Total Cases (Presumptive + Lab-confirmed Cases)	
Total Deaths among Cases (Presumptive + Lab-confirmed Cases)	

**Currently, all confirmatory testing occurs at CDC*
Note: These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. It does not include people who returned to the U.S. via State Department-chartered flights.

Per discussion with the CSTE COVID-19 Leadership Team, CDC will post **only the total case count [presumptive + lab-confirmed] on the CDC website, which will be updated daily at 12 pm ET. Jurisdictions with one to five cases will be depicted as having "1–5 cases"; others will be listed as having "0 cases" or their actual number of cases (e.g. "6").** The other information collected (e.g. number of deaths) will be used for internal awareness and will not be shared publicly at this time. **We ask that the preliminary information shared in this email not be distributed**.

DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Thank you for your partnership,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	**Code**	**Lab Category***			**Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0

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Arkansas	AR	0	0	0	0
California	CA	19	10	29	0
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	2	2	4	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	0	0	0	0
New Hampshire	NH	1	0	1	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York	NY	0	0	0	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	0	0	0	0
Texas	TX	0	0	0	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA	25	2	27	9
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0

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Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	2	0	2	0
Northern Marianas Islands	MP	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/04/2020
Date: Wednesday, March 4, 2020 6:43:38 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 4**.
- By **9 am ET Thursday, March 5**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET today)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	23	14	37	0
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0

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Idaho	ID	0	0	0	0
Illinois	IL	2	2	4	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	0	0	0	0
New Hampshire	NH	1	1	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	1	0	1	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	2	1	3	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	0	0	0	0
Texas	TX	0	0	0	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA	32	7	39	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	0	1	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0

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Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Thursday, March 5, 2020 7:21:59 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0

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Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

AMERICAN OVERSIGHT

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/08/2020
Date: Sunday, March 8, 2020 7:43:38 PM
Attachments: Attachment1_ReportingUpdates_2020March8.docx
CSTE COVID-19 Response New CDC Standard Process for Displaying Reported Cases.msg

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Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 8**.
- By **9 am ET Monday, March 9**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 8)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	3	2	5	0
Arkansas	AR	0	0	0	0
California	CA			110	1
Colorado	CO	8	1	9	0
Connecticut	CT	1	0	1	0
Delaware	DE	0	0	0	0
Florida	FL	3	3	6	0
Georgia	GA	2	5	7	0
Hawaii	HI	2	0	2	0
Idaho	ID	0	0	0	0

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Illinois	IL	3	4	7	0
Indiana	IN	2	0	2	0
Iowa	IA	0	0	0	0
Kansas	KS	1	0	1	0
Kentucky	KY	1	0	1	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	3	0	3	0
Massachusetts	MA	13	1	14	0
Michigan	MI	0	0	0	0
Minnesota	MN	1	0	1	0
Mississippi	MS	0	0	0	0
Missouri	MO	1	0	1	0
Montana	MT	0	0	0	0
Nebraska	NE	2	0	2	0
Nevada	NV	3	0	3	0
New Hampshire	NH	0	2	2	0
New Jersey	NJ	6	0	6	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	28	0	28	0
North Carolina	NC	2	0	2	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	1	1	0
Oregon	OR	13	1	14	0
Pennsylvania	PA	6	0	6	0
Rhode Island	RI	1	2	3	0
South Carolina	SC	6	0	6	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	3	3	6	0
Utah	UT	1	0	1	0
Vermont	VT	1	0	1	0
Virginia	VA	1	0	1	0
Washington	WA			136	18
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	1	0	1	0
Guam	GU	0	0	0	0
New York City	NYC	11	1	12	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

AMERICAN OVERSIGHT

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/10/2020
Date: Tuesday, March 10, 2020 9:20:36 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
Attachment1_ReportingUpdates_2020March8.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Tuesday, March 10**.
- By **9 am ET Wednesday, March 11**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Tuesday, March 10**) using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	6	2	8	0
Arkansas	AR	0	0	0	0
California	CA			135	2
Colorado	CO	17	0	17	0
Connecticut	CT	1	0	1	0
Delaware	DE	0	0	0	0
Florida	FL	12	7	19	2
Georgia	GA	11	8	19	0
Hawaii	HI	2	0	2	0
Idaho	ID	0	0	0	0

AMERICAN OVERSIGHT

Illinois	IL	15	4	19	0
Indiana	IN	5	0	5	0
Iowa	IA	8	0	8	0
Kansas	KS	1	0	1	0
Kentucky	KY	4	0	4	2
Louisiana	LA	1	0	1	0
Maine	ME	0	0	0	0
Maryland	MD	6	3	9	0
Massachusetts	MA	38	1	39	0
Michigan	MI	0	0	0	0
Minnesota	MN	2	0	2	0
Mississippi	MS	0	0	0	0
Missouri	MO	1	0	1	0
Montana	MT	0	0	0	0
Nebraska	NE	3	1	4	0
Nevada	NV	3	1	4	0
New Hampshire	NH	2	2	4	0
New Jersey	NJ	13	0	13	4
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY			125	0
North Carolina	NC	7	0	7	0
North Dakota	ND	0	0	0	0
Ohio	OH	3	0	3	0
Oklahoma	OK	1	1	2	0
Oregon	OR	13	1	14	0
Pennsylvania	PA	12	0	12	1
Rhode Island	RI	2	2	4	0
South Carolina	SC	7	1	8	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	11	4	15	0
Utah	UT	2	0	2	0
Vermont	VT	1	0	1	0
Virginia	VA	4	1	5	0
Washington	WA			207	25
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	32	1	33	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0

AMERICAN OVERSIGHT

Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/11/2020
Date: Wednesday, March 11, 2020 6:54:03 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
Attachment1_ReportingUpdates_2020March8.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 11**.
- By **9 am ET Thursday, March 12**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Wednesday, March 11)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	7	2	9	0
Arkansas	AR	2	0	2	0
California	CA			152	3
Colorado	CO	17	0	17	0
Connecticut	CT	2	0	2	0
Delaware	DE	2	0	2	0
Florida	FL	19	7	26	2
Georgia	GA	14	9	23	0
Hawaii	HI	1	0	1	0
Idaho	ID	0	0	0	0

AMERICAN OVERSIGHT

Illinois	IL	23	4	27	0
Indiana	IN	9	0	9	0
Iowa	IA	13	0	13	0
Kansas	KS	1	0	1	0
Kentucky	KY	4	0	4	0
Louisiana	LA	6	0	6	0
Maine	ME	0	0	0	0
Maryland	MD	6	3	9	0
Massachusetts	MA	85	6	91	0
Michigan	MI	3	0	3	0
Minnesota	MN	4	1	5	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	1	1	0
Montana	MT	0	0	0	0
Nebraska	NE	4	1	5	0
Nevada	NV	4	1	5	0
New Hampshire	NH	3	2	5	0
New Jersey	NJ	17	0	17	1
New Mexico	NM	3	0	3	0
New York (excluding New York City)	NY			164	0
North Carolina	NC	7	0	7	0
North Dakota	ND	0	0	0	0
Ohio	OH	3	0	3	0
Oklahoma	OK	1	1	2	0
Oregon	OR	14	1	15	0
Pennsylvania	PA	16	0	16	0
Rhode Island	RI	3	2	5	0
South Carolina	SC	5	4	9	0
South Dakota	SD	5	0	5	1
Tennessee	TN	7	0	7	0
Texas	TX	18	5	23	0
Utah	UT	3	0	3	0
Vermont	VT	1	0	1	0
Virginia	VA	7	1	8	0
Washington	WA			366	29
West Virginia	WV	0	0	0	0
Wisconsin	WI	2	1	3	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	32	1	33	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0

AMERICAN OVERSIGHT

Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/12/2020
Date: Thursday, March 12, 2020 6:18:16 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
Attachment1_ReportingUpdates_2020March8.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 12**.
- By **9 am ET Friday, March 13**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 12)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	7	2	9	0
Arkansas	AR	4	0	4	0
California	CA			175	3
Colorado	CO	33	1	34	0
Connecticut	CT	3	0	3	0
Delaware	DE	4	0	4	0
Florida	FL	24	7	31	2
Georgia	GA	0	31	31	1
Hawaii	HI	1	0	1	0
Idaho	ID	0	0	0	0
Illinois	IL	28	4	32	0
Indiana	IN	10	0	10	0
Iowa	IA	14	0	14	0
Kansas	KS	4	0	4	0
Kentucky	KY	5	0	5	0

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Louisiana	LA	14	0	14	0
Maine	ME	1	0	1	0
Maryland	MD	9	3	12	0
Massachusetts	MA	90	6	96	0
Michigan	MI	3	0	3	0
Minnesota	MN	5	1	6	0
Mississippi	MS	1	0	1	0
Missouri	MO	0	1	1	0
Montana	MT	1	0	1	0
Nebraska	NE	4	1	5	0
Nevada	NV	5	2	7	0
New Hampshire	NH	3	2	5	0
New Jersey	NJ	25	0	25	1
New Mexico	NM	5	0	5	0
New York (excluding New York City)	NY			230	0
North Carolina	NC	10	1	11	0
North Dakota	ND	1	0	1	0
Ohio	OH	5	0	5	0
Oklahoma	OK	2	1	3	0
Oregon	OR	17	2	19	0
Pennsylvania	PA	21	2	23	0
Rhode Island	RI	2	3	5	0
South Carolina	SC	8	2	10	0
South Dakota	SD	8	0	8	1
Tennessee	TN	9	0	9	0
Texas	TX	17	7	24	0
Utah	UT	4	0	4	0
Vermont	VT	2	0	2	0
Virginia	VA	15	0	15	0
Washington	WA			366	29
West Virginia	WV	0	0	0	0
Wisconsin	WI	7	1	8	0
Wyoming	WY	1	0	1	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	52	2	54	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/15/2020
Date: Sunday, March 15, 2020 7:18:45 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 15**.
- By **9 am ET Monday, March 16**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 15)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Updated guidance: See Attachment 1 that addresses commonly asked questions and the effects of new laboratory testing guidance on use of the National Case Report Form. Key changes are highlighted in yellow. These updates are reflected in the National Case Report Form Instruction Guide (attachment: 2019nCoV_PUICRF instructions_2020Mar15_final), which will be posted to the CDC website later this week.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**
Alabama	AL	11	0
Alaska	AK	1	0
Arizona	AZ	12	0
Arkansas	AR	14	0
California	CA	369	5
Colorado	CO	86	1
Connecticut	CT	20	0
Delaware	DE	8	0

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Florida	FL	108	4
Georgia	GA	66	1
Hawaii	HI	4	0
Idaho	ID	5	0
Illinois	IL	64	0
Indiana	IN	15	0
Iowa	IA	18	0
Kansas	KS	8	1
Kentucky	KY	17	0
Louisiana	LA	77	1
Maine	ME	15	0
Maryland	MD	26	0
Massachusetts	MA	144	0
Michigan	MI	36	0
Minnesota	MN	21	0
Mississippi	MS	6	0
Missouri	MO	5	0
Montana	MT	7	0
Nebraska	NE	17	0
Nevada	NV	16	0
New Hampshire	NH	7	0
New Jersey	NJ	90	2
New Mexico	NM	13	0
New York (excluding New York City)	NY	400	1
North Carolina	NC	23	0
North Dakota	ND	1	0
Ohio	OH	26	0
Oklahoma	OK	9	0
Oregon	OR	36	0
Pennsylvania	PA	48	0
Rhode Island	RI	20	0
South Carolina	SC	19	0
South Dakota	SD	9	1
Tennessee	TN	32	0
Texas	TX	51	0
Utah	UT	19	0
Vermont	VT	4	0
Virginia	VA	41	1
Washington	WA	642	40
West Virginia	WV	0	0
Wisconsin	WI	27	0
Wyoming	WY	3	0
American Samoa	AS	0	0
District of Columbia	DC	16	0
Guam	GU	0	0
New York City	NYC	269	1
Northern Marianas Islands	MP	0	0
Palau	PW	0	0

AMERICAN OVERSIGHT

Puerto Rico	PR	1	0
U.S. Virgin Islands	VI	1	0
Federated States of Micronesia	FSM	0	0
Republic of Marshall Islands	RMI	0	0

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/16/2020
Date: Monday, March 16, 2020 6:49:58 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Monday, March 16**.
  - general community level transmission characterization (current options: Yes [community transmission is occurring], Undetermined, N/A)
- By **9 am ET Tuesday, March 17**, please use the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Monday, March 16)**
  - if needed, modify your "community level transmission characterization" by using the "additional information" field in the link below

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - General community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Resending updated guidance [initially sent on 3/15]: See Attachment 1 that addresses commonly asked questions and the effects of new laboratory testing guidance on use of the National Case Report Form. Key changes are highlighted in yellow. These updates are reflected in the National Case Report Form Instruction Guide (attachment: 2019nCoV_PUICRF instructions_2020Mar15_final), which will be posted to the CDC website later this week.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission
Alabama	AL	22	0	Undetermined
Alaska	AK	1	0	Undetermined
Arizona	AZ	18	0	Undetermined

AMERICAN OVERSIGHT

Arkansas	AR	22	0	Undetermined
California	CA	369	5	Yes
Colorado	CO	144	1	Undetermined
Connecticut	CT	26	0	Undetermined
Delaware	DE	8	0	Undetermined
Florida	FL	136	4	Undetermined
Georgia	GA	119	1	Undetermined
Hawaii	HI	7	0	Undetermined
Idaho	ID	5	0	Undetermined
Illinois	IL	103	0	Yes
Indiana	IN	19	0	Undetermined
Iowa	IA	22	0	Undetermined
Kansas	KS	11	1	Undetermined
Kentucky	KY	21	0	Undetermined
Louisiana	LA	101	2	Undetermined
Maine	ME	19	0	Undetermined
Maryland	MD	37	0	Undetermined
Massachusetts	MA	169	0	Undetermined
Michigan	MI	54	0	Undetermined
Minnesota	MN	54	0	Undetermined
Mississippi	MS	10	0	Undetermined
Missouri	MO	6	0	Undetermined
Montana	MT	7	0	Undetermined
Nebraska	NE	18	0	Undetermined
Nevada	NV	16	0	Undetermined
New Hampshire	NH	13	0	Undetermined
New Jersey	NJ	171	2	Undetermined
New Mexico	NM	22	0	Undetermined
New York (excluding New York City)	NY	487	2	Yes
North Carolina	NC	40	0	Undetermined
North Dakota	ND	1	0	Undetermined
Ohio	OH	37	0	Undetermined
Oklahoma	OK	11	0	Undetermined
Oregon	OR	39	1	Undetermined
Pennsylvania	PA	68	0	Undetermined
Rhode Island	RI	22	0	Undetermined
South Carolina	SC	28	0	Undetermined
South Dakota	SD	9	1	Undetermined
Tennessee	TN	39	0	Undetermined
Texas	TX	67	0	Undetermined
Utah	UT	21	0	Undetermined
Vermont	VT	9	0	Undetermined
Virginia	VA	51	1	Undetermined
Washington	WA	769	42	Yes
West Virginia	WV	0	0	N/A
Wisconsin	WI	27	0	Undetermined
Wyoming	WY	3	0	Undetermined
American Samoa	AS	0	0	N/A
District of Columbia	DC	17	0	Undetermined
Guam	GU	3	0	Undetermined
New York City	NYC	463	5	Yes
Northern Marianas Islands	MP	0	0	N/A

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Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	1	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/17/2020
Date: Tuesday, March 17, 2020 7:26:12 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Tuesday, March 17**.
  - general community level transmission characterization
- By **9 am ET Wednesday, March 18**, **please use the CDC Case Confirmation Portal** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Tuesday, March 17)**
  - if needed, modify your "community level transmission characterization"

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission
Alabama	AL	29	0	Undetermined
Alaska	AK	1	0	Undetermined
Arizona	AZ	18	0	Undetermined
Arkansas	AR	22	0	Undetermined
California	CA	447	7	Yes
Colorado	CO	160	1	Undetermined
Connecticut	CT	41	0	Undetermined
Delaware	DE	9	0	Undetermined
Florida	FL	145	5	Undetermined
Georgia	GA	143	1	Undetermined
Hawaii	HI	10	0	Undetermined

AMERICAN OVERSIGHT

Idaho	ID	5	0	Undetermined
Illinois	IL	105	0	Yes
Indiana	IN	24	1	Undetermined
Iowa	IA	23	0	Undetermined
Kansas	KS	16	1	Undetermined
Kentucky	KY	22	0	Undetermined
Louisiana	LA	137	3	Undetermined
Maine	ME	19	0	Undetermined
Maryland	MD	57	0	Undetermined
Massachusetts	MA	202	0	Undetermined
Michigan	MI	65	0	Undetermined
Minnesota	MN	60	0	Yes
Mississippi	MS	19	0	Undetermined
Missouri	MO	8	0	Undetermined
Montana	MT	7	0	Undetermined
Nebraska	NE	18	0	Undetermined
Nevada	NV	45	1	Undetermined
New Hampshire	NH	17	0	Undetermined
New Jersey	NJ	193	2	Undetermined
New Mexico	NM	22	0	Undetermined
New York (excluding New York City)	NY	730	1	Yes
North Carolina	NC	47	0	Undetermined
North Dakota	ND	1	0	Undetermined
Ohio	OH	63	0	Undetermined
Oklahoma	OK	19	0	Undetermined
Oregon	OR	47	1	Undetermined
Pennsylvania	PA	76	0	Undetermined
Rhode Island	RI	23	0	Undetermined
South Carolina	SC	33	1	Undetermined
South Dakota	SD	11	1	Undetermined
Tennessee	TN	52	0	Undetermined
Texas	TX	57	0	Undetermined
Utah	UT	29	0	Undetermined
Vermont	VT	10	0	Undetermined
Virginia	VA	67	2	Undetermined
Washington	WA	904	48	Yes
West Virginia	WV	0	0	N/A
Wisconsin	WI	53	0	Undetermined
Wyoming	WY	3	0	Undetermined
American Samoa	AS	0	0	N/A
District of Columbia	DC	22	0	Undetermined
Guam	GU	5	0	Undetermined
New York City	NYC	670	6	Yes
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	2	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/18/2020
Date: Wednesday, March 18, 2020 8:39:15 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 18**.
  - general community level transmission characterization
- By **9 am ET Thursday, March 19**, **please use the CDC Case Confirmation Portal** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Wednesday, March 18)**
  - if needed, modify your "community level transmission characterization"

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission
Alabama	AL	29	0	Undetermined
Alaska	AK	1	0	Undetermined
Arizona	AZ	18	0	Undetermined
Arkansas	AR	22	0	Undetermined
California	CA	652	14	Yes
Colorado	CO	160	1	Undetermined
Connecticut	CT	41	0	Undetermined
Delaware	DE	9	0	Undetermined
Florida	FL	145	5	Undetermined
Georgia	GA	143	1	Undetermined
Hawaii	HI	10	0	Undetermined

AMERICAN OVERSIGHT

Idaho	ID	5	0	Undetermined
Illinois	IL	105	0	Yes
Indiana	IN	24	1	Undetermined
Iowa	IA	23	0	Undetermined
Kansas	KS	16	1	Undetermined
Kentucky	KY	22	0	Undetermined
Louisiana	LA	137	3	Undetermined
Maine	ME	19	0	Undetermined
Maryland	MD	57	0	Undetermined
Massachusetts	MA	202	0	Undetermined
Michigan	MI	65	0	Undetermined
Minnesota	MN	60	0	Yes
Mississippi	MS	19	0	Undetermined
Missouri	MO	8	0	Undetermined
Montana	MT	7	0	Undetermined
Nebraska	NE	18	0	Undetermined
Nevada	NV	45	1	Undetermined
New Hampshire	NH	17	0	Undetermined
New Jersey	NJ	193	2	Undetermined
New Mexico	NM	22	0	Undetermined
New York (excluding New York City)	NY	730	1	Yes
North Carolina	NC	47	0	Undetermined
North Dakota	ND	1	0	Undetermined
Ohio	OH	63	0	Undetermined
Oklahoma	OK	19	0	Undetermined
Oregon	OR	47	1	Undetermined
Pennsylvania	PA	76	0	Undetermined
Rhode Island	RI	23	0	Undetermined
South Carolina	SC	33	1	Undetermined
South Dakota	SD	11	1	Undetermined
Tennessee	TN	52	0	Undetermined
Texas	TX	57	0	Undetermined
Utah	UT	29	0	Undetermined
Vermont	VT	10	0	Undetermined
Virginia	VA	67	2	Undetermined
Washington	WA	904	48	Yes
West Virginia	WV	0	0	N/A
Wisconsin	WI	53	0	Undetermined
Wyoming	WY	3	0	Undetermined
American Samoa	AS	0	0	N/A
District of Columbia	DC	22	0	Undetermined
Guam	GU	5	0	Undetermined
New York City	NYC	670	6	Yes
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	2	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/19/2020
Date: Thursday, March 19, 2020 7:25:34 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
FW CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no longer required.msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 19**.
  - general community level transmission characterization
- By **9 am ET Friday, March 20**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 19)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	51	0	Undetermined
Alaska	AK	9	0	Undetermined
Arizona	AZ	27	0	Undetermined
Arkansas	AR	45	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	652	14	Yes, distinct clusters or widespread (please specify)

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Colorado	CO	216	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	96	1	Undetermined
Delaware	DE	26	0	Undetermined
Florida	FL	299	8	Undetermined
Georgia	GA	262	6	Yes, widespread community transmission across several geographical areas
Hawaii	HI	11	0	Undetermined
Idaho	ID	10	0	Undetermined
Illinois	IL	288	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	39	2	Undetermined
Iowa	IA	38	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	35	1	Undetermined
Kentucky	KY	35	1	Undetermined
Louisiana	LA	261	7	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	52	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	107	1	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	262	0	Yes, widespread community transmission across several geographical areas
Michigan	MI	91	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	89	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	50	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	24	1	Undetermined
Montana	MT	12	0	Undetermined
Nebraska	NE	27	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	63	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	39	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

AMERICAN OVERSIGHT

New Jersey	NJ	698	9	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	35	0	Undetermined
New York (excluding New York City)	NY	1683	1	Yes, distinct clusters or widespread (please specify)
North Carolina	NC	108	0	Undetermined
North Dakota	ND	7	0	Undetermined
Ohio	OH	98	0	Undetermined
Oklahoma	OK	33	0	Undetermined
Oregon	OR	75	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	186	1	Undetermined
Rhode Island	RI	33	0	Undetermined
South Carolina	SC	60	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	11	1	Undetermined
Tennessee	TN	98	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	83	2	Undetermined
Utah	UT	40	0	Undetermined
Vermont	VT	16	2	Undetermined
Virginia	VA	94	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	1376	74	Yes, distinct clusters or widespread (please specify)
West Virginia	WV	2	0	Undetermined
Wisconsin	WI	106	0	Undetermined
Wyoming	WY	16	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	39	0	Undetermined
Guam	GU	8	0	Undetermined
New York City	NYC	3555	21	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	3	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	CDC COVID-19 Case Count Confirmation 03/23/2020
Date:	Monday, March 23, 2020 7:01:58 PM
Attachments:	CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg 2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx Attachment1_ReportingUpdates_2020March15_final.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Monday, March 23**.
  - general community level transmission characterization
- By **9 am ET Tuesday, March 24**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Monday, March 23)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	157	0	Undetermined
Alaska	AK	22	0	Undetermined
Arizona	AZ	152	2	Yes, widespread community transmission across several geographical areas
				Yes, distinct clusters of cases in a, or a few, defined geographical

AMERICAN OVERSIGHT

Arkansas	AR	195	0	area(s)
California	CA	1709	32	Yes, widespread community transmission across several geographical areas
Colorado	CO	591	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	327	8	Undetermined
Delaware	DE	56	0	Undetermined
Florida	FL	937	13	Undetermined
Georgia	GA	757	25	Yes, widespread community transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	47	0	Undetermined
Illinois	IL	1049	9	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	201	6	Undetermined
Iowa	IA	90	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	65	2	Undetermined
Kentucky	KY	103	3	Undetermined
Louisiana	LA	1035	29	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	110	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	288	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	5	Yes, widespread community transmission across several geographical areas
Michigan	MI	1035	8	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	236	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	249	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	106	3	Undetermined
Montana	MT	34	0	Undetermined
Nebraska	NE	50	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
				Yes, distinct clusters of cases in a,

AMERICAN OVERSIGHT

Nevada	NV	190	2	or a few, defined geographical area(s)
New Hampshire	NH	78	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	2751	25	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	75	0	Undetermined
New York (excluding New York City)	NY	8570	24	Yes, distinct clusters or widespread
North Carolina	NC	255	0	Undetermined
North Dakota	ND	30	0	Undetermined
Ohio	OH	351	3	Undetermined
Oklahoma	OK	67	2	Yes, widespread community transmission across several geographical areas
Oregon	OR	161	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	645	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Rhode Island	RI	97	0	Undetermined
South Carolina	SC	195	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	23	1	Undetermined
Tennessee	TN	505	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	5	Undetermined
Utah	UT	169	1	Undetermined
Vermont	VT	75	2	Undetermined
Virginia	VA	254	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	2221	110	Yes (defined area or widespread)
West Virginia	WV	16	0	Undetermined
Wisconsin	WI	381	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	116	2	Undetermined
Guam	GU	27	1	Undetermined
New York City	NYC	12110	99	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A

AMERICAN OVERSIGHT

Palau	PW	0	0	N/A
Puerto Rico	PR	23	1	Undetermined
U.S. Virgin Islands	VI	17	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/24/2020
Date: Tuesday, March 24, 2020 6:59:51 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Tuesday, March 24**.
  - general community level transmission characterization
- By **9 am ET Wednesday, March 25**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Tuesday, March 24)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	196	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Alaska	AK	36	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
				Yes, widespread community transmission across several

AMERICAN OVERSIGHT

Arizona	AZ	253	2	geographical areas
Arkansas	AR	227	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	1931	35	Yes, widespread community transmission across several geographical areas
Colorado	CO	720	7	Yes, widespread community transmission across several geographical areas
Connecticut	CT	415	10	Yes, widespread community transmission across several geographical areas
Delaware	DE	87	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Florida	FL	1141	17	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Georgia	GA	1015	31	Yes, widespread community transmission across several geographical areas
Hawaii	HI	66	0	Undetermined
Idaho	ID	51	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Illinois	IL	1285	12	Yes, widespread community transmission across several geographical areas
Indiana	IN	259	7	Undetermined
Iowa	IA	105	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	82	2	Undetermined
Kentucky	KY	124	4	Undetermined
Louisiana	LA	1172	34	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	120	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	288	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	777	9	Yes, widespread community transmission across several geographical areas
Michigan	MI	1328	15	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
				Yes, distinct clusters of cases in a, or a few, defined geographical

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Minnesota	MN	262	1	area(s)
Mississippi	MS	320	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	183	3	Undetermined
Montana	MT	37	0	Undetermined
Nebraska	NE	52	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	245	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	101	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	3649	44	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	87	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York (excluding New York City)	NY	10761	31	Yes, distinct clusters or widespread
North Carolina	NC	398	0	Undetermined
North Dakota	ND	37	0	Undetermined
Ohio	OH	442	6	Undetermined
Oklahoma	OK	81	2	Yes, widespread community transmission across several geographical areas
Oregon	OR	191	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	852	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Rhode Island	RI	106	0	Undetermined
South Carolina	SC	298	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	28	1	Undetermined
Tennessee	TN	615	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	8	Undetermined
Utah	UT	280	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Vermont	VT	75	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Virginia	VA	290	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

AMERICAN OVERSIGHT

Washington	WA	2221	110	Yes (defined area or widespread)
West Virginia	WV	20	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wisconsin	WI	416	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wyoming	WY	26	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	137	2	Undetermined
Guam	GU	30	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York City	NYC	14511	131	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	31	2	Undetermined
U.S. Virgin Islands	VI	17	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/25/2020
Date: Wednesday, March 25, 2020 8:03:48 PM
Attachments: 2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx
Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg

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Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 25**.
  - general community level transmission characterization
- By **9 am ET Thursday, March 26**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Wednesday, March 25)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
				Yes, distinct clusters of cases in a,

AMERICAN OVERSIGHT

Alabama	AL	242	0	or a few, defined geographical area(s)
Alaska	AK	42	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Arizona	AZ	326	5	Yes, widespread community transmission across several geographical areas
Arkansas	AR	290	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	2511	44	Yes, widespread community transmission across several geographical areas
Colorado	CO	921	11	Yes, widespread community transmission across several geographical areas
Connecticut	CT	618	12	Yes, widespread community transmission across several geographical areas
Delaware	DE	104	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Florida	FL	1373	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Georgia	GA	1119	38	Yes, widespread community transmission across several geographical areas
Hawaii	HI	70	0	Undetermined
Idaho	ID	71	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Illinois	IL	1535	16	Yes, widespread community transmission across several geographical areas
Indiana	IN	365	12	Undetermined
Iowa	IA	124	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	98	2	Undetermined
Kentucky	KY	163	4	Undetermined
Louisiana	LA	1388	46	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	145	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	349	4	Yes, widespread community transmission across several geographical areas
				Yes, widespread community

AMERICAN OVERSIGHT

Massachusetts	MA	1224	12	transmission across several geographical areas
Michigan	MI	1791	24	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	287	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	377	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	255	5	Undetermined
Montana	MT	48	0	Undetermined
Nebraska	NE	53	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	278	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	108	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	4376	62	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	101	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York (excluding New York City)	NY	12955	39	Yes, distinct clusters or widespread
North Carolina	NC	504	0	Yes, widespread community transmission across several geographical areas
North Dakota	ND	38	0	Undetermined
Ohio	OH	564	8	Undetermined
Oklahoma	OK	106	3	Yes, widespread community transmission across several geographical areas
Oregon	OR	209	8	Yes, widespread community transmission across several geographical areas
Pennsylvania	PA	1128	10	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Rhode Island	RI	124	0	Yes, widespread community transmission across several geographical areas
South Carolina	SC	342	7	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	35	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

AMERICAN OVERSIGHT

Tennessee	TN	789	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	715	11	Undetermined
Utah	UT	298	1	Yes, widespread community transmission across several geographical areas
Vermont	VT	121	7	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Virginia	VA	391	9	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	2469	123	Yes (defined area or widespread)
West Virginia	WV	39	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wisconsin	WI	457	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wyoming	WY	30	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	183	2	Undetermined
Guam	GU	30	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York City	NYC	16585	199	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	39	2	Undetermined
U.S. Virgin Islands	VI	17	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	CDC COVID-19 Case Count Confirmation 3/22/2020
Date:	Sunday, March 22, 2020 6:20:27 PM
Attachments:	Attachment1_ReportingUpdates_2020March15_final.docx FW CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no longer required.msg 2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 22**.
  - general community level transmission characterization
- By **9 am ET Monday, March 23**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 22)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	131	0	Undetermined
Alaska	AK	14	0	Undetermined
Arizona	AZ	104	1	Undetermined
Arkansas	AR	168	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

AMERICAN OVERSIGHT

California	CA	1534	27	Yes, distinct clusters or widespread
Colorado	CO	475	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	223	5	Undetermined
Delaware	DE	45	0	Undetermined
Florida	FL	706	12	Undetermined
Georgia	GA	555	20	Yes, widespread community transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	42	0	Undetermined
Illinois	IL	753	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	126	4	Undetermined
Iowa	IA	68	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	55	2	Undetermined
Kentucky	KY	87	3	Undetermined
Louisiana	LA	763	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	94	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	190	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	4	Yes, widespread community transmission across several geographical areas
Michigan	MI	787	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	137	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	140	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	90	3	Undetermined
Montana	MT	27	0	Undetermined
Nebraska	NE	42	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	154	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	65	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	1831	19	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	75	0	Undetermined
New York (excluding New York City)	NY	6123	21	Yes, distinct clusters or widespread
North Carolina	NC	227	0	Undetermined
North Dakota	ND	28	1	Undetermined
Ohio	OH	247	3	Undetermined

AMERICAN OVERSIGHT

Oklahoma	OK	53	1	Undetermined
Oregon	OR	137	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	482	2	Undetermined
Rhode Island	RI	66	0	Undetermined
South Carolina	SC	173	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	21	1	Undetermined
Tennessee	TN	371	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	5	Undetermined
Utah	UT	125	0	Undetermined
Vermont	VT	49	2	Undetermined
Virginia	VA	152	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	1793	95	Undetermined
West Virginia	WV	12	0	Undetermined
Wisconsin	WI	281	4	Undetermined
Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	98	1	Undetermined
Guam	GU	14	0	Undetermined
New York City	NYC	6211	43	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	21	0	Undetermined
U.S. Virgin Islands	VI	6	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020
Date:	Monday, February 17, 2020 9:15:32 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_2-16-20 final.pdf CDC_COVID-19_Daily Key Points__2_16_2020_final.pdf

Dear Colleagues,

Attached are the CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020. Feel free to share with your colleagues and other partners.

Thank you!

State Coordination Task Force

Sent by BCC to PHEP Directors, State Health Officials, State Epidemiologists, and Non-governmental partners

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date:	Monday, February 24, 2020 4:37:27 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_24_2020 FINAL.pdf CDC_COVID-19 Weekly Key Messages_2-24-20 FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points **AND** weekly key messages for Monday, February 24, 2020.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date:	Monday, February 24, 2020 4:39:57 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_24_2020 FINAL.pdf CDC_COVID-19 Weekly Key Messages_2-24-20 FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points **AND** weekly key messages for Monday, February 24, 2020.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date:	Monday, February 24, 2020 4:42:41 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_24_2020 FINAL.pdf CDC_COVID-19 Weekly Key Messages_2-24-20 FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points **AND** weekly key messages for Monday, February 24, 2020.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020
Date:	Monday, February 17, 2020 9:12:02 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_2-16-20 final.pdf CDC_COVID-19_Daily Key Points__2_16_2020_final.pdf

Dear Colleagues,

Attached are the CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020. Feel free to share with your colleagues and other partners.

Thank you!

State Coordination Task Force

Sent by BCC to PHEP Directors, State Health Officials, State Epidemiologists, and Non-governmental partners

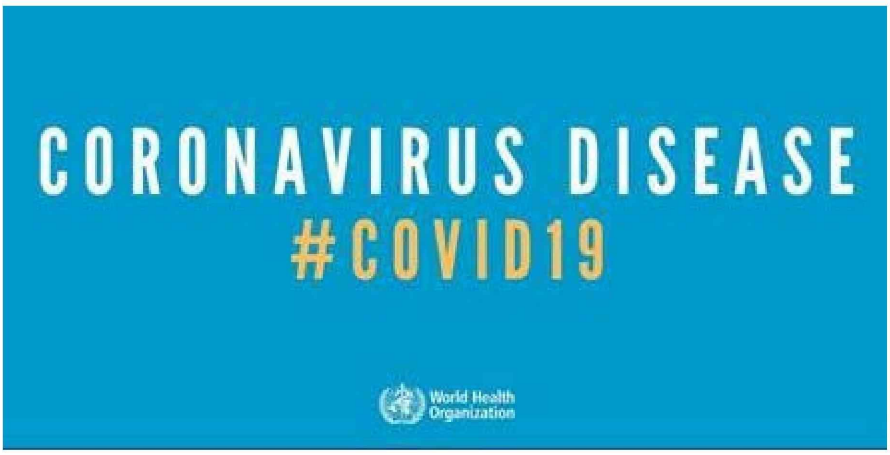
AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Daily Key Points for February 13, 2020
Date:	Thursday, February 13, 2020 5:32:51 PM
Attachments:	CDC_COVID-19 Daily Key Points__2_13_2020_final.pdf

Dear Colleagues,

CDC COVID-19 Daily Key Points for February 13, 2020 are attached.

Additionally, on February 11, 2020 the World Health Organization announced an official name for the novel (new) coronavirus outbreak, **COVID-19**. CDC will be updating our website and other CDC materials to reflect the official disease name. For the most up to date information on Coronavirus Disease-2019, please visit cdc.gov.



Thank you,

State Coordination Task Force

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points for Friday, March 6, 2020
Date:	Saturday, March 7, 2020 3:18:40 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_6_2020.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 daily key points from Friday, March 6.

Respectfully,

Jade Anderson, MPA
Special Advisor/Public Health Analyst
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
404-718-5723 Office | 470-747-9289 Cell | 404-639-2847 fax
e-mail: Jade.Anderson@cdc.hhs.gov

CDC 24-7 Logo__EMAIL_Small



AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points for Friday, March 6, 2020
Date:	Saturday, March 7, 2020 3:20:28 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_6_2020.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 daily key points from Friday, March 6.

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Daily Key Points for Friday, March 6, 2020
Date:	Saturday, March 7, 2020 3:17:03 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_6_2020.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 daily key points from Friday, March 6.

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	CDC COVID-19 Daily Key Points for March 4, 2020
Date:	Thursday, March 5, 2020 8:34:18 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf

FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Daily Key Points for March 5, 2020
Date: Thursday, March 5, 2020 10:54:17 PM
Attachments: CDC_COVID-19_Daily Key Points__3_5_2020.pdf

Dear Colleagues:

Please find CDC COVID-19 daily key points attached to this email.

Additionally, please take a moment to review video link below on proper nasopharyngeal swabbing techniques for lab samples.

- https://www.youtube.com/watch?v=hXohAo1d6tk

Thank you!

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points for March 5, 2020
Date:	Thursday, March 5, 2020 10:58:48 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_5_2020.pdf

Dear Colleagues:

Please find CDC COVID-19 daily key points attached to this email.

Additionally, please take a moment to review video link below on proper nasopharyngeal swabbing techniques for lab samples.

- https://www.youtube.com/watch?v=hXohAo1d6tk

Thank you!

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	CDC COVID-19 Daily Key Points for March 5, 2020
Date:	Friday, March 6, 2020 8:40:59 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_5_2020.pdf

FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
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HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Daily Key Points for March 5, 2020
Date:	Thursday, March 5, 2020 10:43:02 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_5_2020.pdf

Dear Colleagues:

Please find CDC COVID-19 daily key points attached to this email.

Additionally, please take a moment to review video link below on proper nasopharyngeal swabbing techniques for lab samples.

- https://www.youtube.com/watch?v=hXohAo1d6tk

Thank you!

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points, Updated Guidance List, Consular Notification, and Interim Cleaning Guidance
Date:	Sunday, March 1, 2020 2:47:36 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf COVID-19_GuidanceList_01MAR20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.pdf

Dear Colleagues:

Attached are several CDC COVID-19 related guidance documents and CDC COVID-19 Daily Key points.

Attached

- 2-29-2020 CDC COVID-19 Daily Key Points. Feel free to share with partners and appropriate parties.
- CDC Consular Notification Guidance (FAQs) regarding Foreign Nationals
- CDC COVID-19 Updated Guidance List (3-1-2020)
- Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

In addition, CDC has created several new landing pages for specific response groups on the CDC COVID-19 website (https://www.cdc.gov/coronavirus/2019-ncov/index.html)

- Resources for Health Departments (https://www.cdc.gov/coronavirus/2019-ncov/php/index.html)
- Resources for Healthcare Facilities(https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.htm)
- Laboratories (https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html)

Kind Regards,

State Coordination Task Force (SCTF)

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points, Updated Guidance List, Consular Notification, and Interim Cleaning Guidance
Date:	Sunday, March 1, 2020 2:49:50 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf COVID-19_GuidanceList_01MAR20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.pdf

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Kind Regards,

State Coordination Task Force (SCTF)

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points, Updated Guidance List, Consular Notification, and Interim Cleaning Guidance
Date:	Sunday, March 1, 2020 2:44:38 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf COVID-19_GuidanceList_01MAR20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.pdf

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State Coordination Task Force (SCTF)

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance)
Date: Monday, March 16, 2020 11:05:29 PM

Dear Colleagues:

Please see the link below for new **CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance).**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html



Disposition of Non-Hospitalized Patients with COVID-19 | CDC

Who this is for: Healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation. What this is for: To help prevent the spread of COVID-19 in the community. How to use: Reference to guide healthcare staff and

www.cdc.gov

Guidance as of March 16, 2020

- New guidance is added for a strategy to discontinue home isolation without testing.
- Updated guidance for a test-based strategy: The recommendation to collect both NP and OP swabs at each sampling has been changed so that only one swab is necessary, preferably NP, at each sampling.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance)
Date: Monday, March 16, 2020 11:07:25 PM

Dear Colleagues:

Please see the link below for new **CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance).**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html



Disposition of Non-Hospitalized Patients with COVID-19 | CDC

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State Coordination Task Force

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance)
Date:	Monday, March 16, 2020 11:03:24 PM

Dear Colleagues:

Please see the link below for new **CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance).**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html



Disposition of Non-Hospitalized Patients with COVID-19 | CDC

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Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Key Points (02-19-2020)
Date:	Thursday, February 20, 2020 8:23:32 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_19_2020_final.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 daily key points for Wednesday, February 19, 2020. Feel free to share with your staff and other partners.

Thank you,

State Coordination Task Force (SCTF)

Sent by BCC to State Health Officials, PHEP Directors, Non-governmental Partners, Lab Directors, State Epidemiologists, and STLT partners

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Key Points (02-19-2020)
Date:	Thursday, February 20, 2020 10:15:55 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_19_2020_final.pdf

Dear Colleagues,

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Sent by BCC to State Health Officials, PHEP Directors, Non-governmental Partners, Lab Directors, State Epidemiologists, and STLT partners

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Key Points (02-19-2020)
Date:	Thursday, February 20, 2020 8:19:46 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_19_2020_final.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 daily key points for Wednesday, February 19, 2020. Feel free to share with your staff and other partners.

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Sent by BCC to State Health Officials, PHEP Directors, Non-governmental Partners, Lab Directors, State Epidemiologists, and STLT partners

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Travel Health Alert Notice (THAN) Cards, Updated CARE Booklets, and Travel Alert Language
Date:	Tuesday, March 3, 2020 6:42:44 PM
Attachments:	03-03-2020_COVID-19_THAN_Level 3s.pdf

Dear Colleagues:

Attached is the updated Travel Health Alert Notice (THAN) card. The cards have a link to that a NEW traveler information webpage that has **not yet gone live, but will be live soon.**

In addition, the **updated Level 2 and Level 3 travel alert language will go live tomorrow.**

- When it does, it will be here: https://www.cdc.gov/coronavirus/2019-ncov/travelers.
- The language will instruct travelers from countries with a Level 3 alert to "stay home and monitor their health for 14 days after returning to the United States." It also instructs travelers from countries with a Level 2 alert to "monitor their health and limit interactions with others for 14 days after returning to the United States."

As was shared previously, the updated **CARE booklet for China travelers** is available here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

Kind Regards,

State Coordination Task Force

(Sent by BCC to state epidemiologists and state health officials)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Updated Guidance and CARE Booklets
Date:	Tuesday, March 3, 2020 7:24:32 PM
Attachments:	COVID-19_GuidanceList_03MAR20.pdf

Dear Colleagues:

Attached is the CDC COVID-19 Updated guidance list for 03-03-2020.

As was shared previously, the updated **CARE booklet for China travelers** is available here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

Updated Guidance Includes:

Interim Guidance for Administrators of US Institutions of Higher Education (IHE) to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- Information for administrators of public and private institutions of higher education (IHE) prevent the spread of COVID-19 among students, staff, and faculty.

Guidance for Student Foreign Travel for Institutions of Higher Education

- This guidance is for Institutes of Higher Education with students participating in foreign exchange or study abroad programs.

Interim Guidance: Public Health Communicators Get Your Community Ready for Coronavirus Disease 2019 (COVID-19)

- Information for state and local public health information officers, health communication specialists, health educators, and other public health professionals responsible for planning communication strategies before, during, and after an outbreak of coronavirus disease (COVID-19).

Preventing COVID-19 Spread in Communities: Landing page for community mitigation guidance. How to prepare and take action for COVID-19

What Law Enforcement Personnel Need to Know about Coronavirus Disease 2019 (COVID-19)

- Interim guidance for Law Enforcement Personnel

AMERICAN OVERSIGHT

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Updated Guidance and CARE Booklets
Date:	Tuesday, March 3, 2020 7:27:31 PM
Attachments:	COVID-19_GuidanceList_03MAR20.pdf

Dear Colleagues:

Attached is the CDC COVID-19 Updated guidance list for 03-03-2020.

As was shared previously, the updated **CARE booklet for China travelers** is available here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

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Kind Regards,

AMERICAN OVERSIGHT

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Updated Guidance and CARE Booklets
Date:	Tuesday, March 3, 2020 7:22:13 PM
Attachments:	COVID-19_GuidanceList_03MAR20.pdf

Dear Colleagues:

Attached is the CDC COVID-19 Updated guidance list for 03-03-2020.

As was shared previously, the updated **CARE booklet for China travelers** is available here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

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Kind Regards,

AMERICAN OVERSIGHT

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date:	Monday, March 9, 2020 11:49:15 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_3-8-20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 weekly key messages, Consular Notification Guidance, and the bridgeline for today's **CDC Media Telebriefing at 12:15 PM EDT provided below**.

Please reference the "Consular Notification Guidance for State and Local Authorities." This document was developed by the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained (i.e., a case when a quarantine order is issued because of possible exposure to COVID-19 disease).

Media Advisory

For Immediate Release
Monday, March 9, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Monday, March 9, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to

AMERICAN OVERSIGHT

indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

State Coordination Task Force (SCTF)
CDC COVID-19 Weekly Key Messages & Consular Notification Guidance for State and Local Authorities Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date:	Monday, March 9, 2020 11:52:49 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_3-8-20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

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Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date:	Monday, March 9, 2020 11:46:44 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_3-8-20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

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

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019; LLS (CDC); Epi Aid (CDC)
Subject:	CDC COVID-19 airport screener volunteers wanted
Date:	Friday, February 28, 2020 9:44:40 AM

Hello EIS/LLS,

The Global Migration Task Force (GMTF) in the CDC Emergency Operations Center is currently seeking available FTEs to deploy to the 11 US airports to serve as tertiary screeners and medical officers.

> **Tertiary screeners** are responsible for conducting and documenting passenger screening interviews/triage case reviews; distributing communication materials and health information updates; conducting data entry and transport coordination activities; and providing basic quarantine station support, including purchasing, property management, document processing, timekeeping, and answering inquiries, etc.
>
> **Medical officers** are responsible for reviewing the clinical information collected at the quarantine stations, evaluating the history and presenting symptoms, assessing available laboratory data, consulting with specialists, and making a clinical recommendation for disposition of ill travelers. We are accepting licensed medical physicians, physician assistants, and nurse practitioners for this role.

We are also looking for deployers who are fluent in Mandarin to fill both the tertiary screener and medical officer roles.

All positions above require that you pass a medical clearance exam and are respiratory fit tested. You will be required to interact with travelers and wear personal protective equipment that includes respiratory protection. Upon return to your duty stations you will be advised to self-monitor for 14 days while you go about your normal activities of daily living. Additional information is available on DeployCDC.

Deployments are 29 days in length and we have vacancies at all 11 station locations for March and April. The station locations include:

Los Angeles
New York
San Francisco
Atlanta
Chicago
Newark
Seattle
Honolulu
Detroit
Washington DC
Dallas

AMERICAN OVERSIGHT

If you are interested in a deployment opportunity with GMTF, please respond to eocdgmqsrldaid@cdc.gov with your supervisory approval and answer the following.

Supervisor approval (please attach an email from your supervisor)
Dates of Availability (29 days):
Current duty location (e.g. Atlanta, GA):
Mobile number:

Many thanks for your consideration,

Michael Gronostaj, MD, MPH, FACPM
CDR, United States Public Health Service
Epi-Aid/Lab-Aid Response Team Lead | EIS/LLS Deployment Coordinator

Fellowship Response and Support Team | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE, MS V24-5, Atlanta, GA 30329-4027
Work Phone: 404-498-6167 / Fax: 404-498-6535
vie0@cdc.gov

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: CDC COVID-19 guidance
Date: Sunday, March 1, 2020 11:49:40 AM

ALL

With so many new guidance documents being produced in the last few days, we wanted to make sure you had easy access to them.
This list also contains a document aimed at LTCs.

Healthcare Supply of Personal Protective Equipment

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html
- https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html

Resources for Healthcare Facilities

- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/steps-to-prepare.html
- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html
- https://wwwdev.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Optimizing N95 Strategies

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/conventional-capacity-strategies.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/contingency-capacity-strategies.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/crisis-alternate-strategies.html

Also pushed Lab pages

- https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/lab/tool-virus-requests.html
- https://www.cdc.gov/coronavirus/2019-ncov/lab/rt-pcr-detection-instructions.html
- https://www.cdc.gov/coronavirus/2019-ncov/lab/rt-pcr-panel-primer-probes.html

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)

AMERICAN OVERSIGHT

Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

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AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Rubino, Heather; Pritchard, Scott; Stanek, Danielle R; Riggen, Amy; Blackmore, Carina; Kendrick, Katie; Torres, Yari; Bogucki, Amy; Troelstrup, Thomas
Cc:	Gumke, Megan R; Schmitz, Ann; Leapley, Andrea C; Foster, Tricia; Higgins, Sue M; Atrubin, David L.; Elliott, Karen E; Samuel, Ashley N; Fawaz, Shelby R; Mahler, Erin; Doyle, Tim; Eisenstein, Leah; Mtenga, Mwedu; Prahlow, Samuel; Matthias, Laura P; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)
Subject:	CDC Conference Call: COVID-19

CDC's 2019 Novel Coronavirus (COVID-19) response team will continue to host a national call series from 2 p.m. to 2:45 p.m. EST every Monday, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)921-9091

Participant Passcode: 1324420

For your convenience, call series dates are provided below.

* Monday, March 9 --> Room 105E
* Monday, March 16 --> Room 220P
* Monday, March 23 --> None booked
* Monday, March 30 --> None booked

CDC State Coordination Task Force (SCTF) - Operations

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

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

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Guthrie, Kevin; Moskowitz, Jared; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Link, Paul (OS/ASPR/EMMO); Mann, Travis (OS/ASPR/EMMO); Sturrock, Lochlin (OS/ASPR/EMMO); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; Bowman, Thomas (OS/ASPR/EMMO); Dickinson, Jeanette (OS/ASPR/EMMO); Raspberry, Jenny (OS/ASPR/EMMO)
Subject:	CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 10:52:06 PM
Attachments:	Cruise Ship SOP Talking Points_FINAL Cleared.pdf PH Recommendations for Cruise Ships Arriving at US Ports_FINAL Cleared.pdf 20_316043-A_FS_Guide_disembark_ship_March20.pdf Cruise Passengers returning charter flights_final_3.21.20.pdf

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Dr. Rivkees

As always it is a pleasure to speak with you. I spoke with our HHS Liaison to the Department of State and he is willing to work to set up a call with the Department of State. Based on your desire we can include CDC. I included the CDC guidance on cruise ships.

I should have a name of a Customs and Border Protection (CBP) representative for you shortly.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Guthrie, Kevin; Moskowitz, Jared; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Link, Paul (OS/ASPR/EMMO); Mann, Travis (OS/ASPR/EMMO); Sturrock, Lochlin (OS/ASPR/EMMO); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; Bowman, Thomas (OS/ASPR/EMMO); Dickinson, Jeanette (OS/ASPR/EMMO); Raspberry, Jenny (OS/ASPR/EMMO)
Subject:	CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 10:51:42 PM
Attachments:	Cruise Ship SOP Talking Points_FINAL Cleared.pdf PH Recommendations for Cruise Ships Arriving at US Ports_FINAL Cleared.pdf 20_316043-A_FS_Guide_disembark_ship_March20.pdf Cruise Passengers returning charter flights_final_3.21.20.pdf

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COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC HAN 427: (Correction to Link for PUI Case Investigation Form in this Version) Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)
Date:	Saturday, February 1, 2020 1:48:37 PM
Importance:	High

Correction: In the Recommendations for Reporting, Testing, and Specimen Collection section, the link for the 2019-nCoV PUI case investigation form has been corrected.

This is an official
CDC HEALTH UPDATE

Distributed via the CDC Health Alert Network
February 1, 2020, 0900 ET (9:00 AM ET)
CDCHAN-00427

Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)

Summary
The Centers for Disease Control and Prevention (CDC) continues to closely monitor an outbreak of respiratory illness caused by a novel coronavirus (2019-nCoV) that was initially detected in Wuhan City, Hubei Province, China in December 2019.

This CDC Health Alert Network (HAN) Update provides a situational update and interim guidance to state and local health departments that supersedes guidance in CDC's HAN 426 distributed on January 17, 2020. It also adds

- guidance for clinicians caring for patients with 2019-nCoV (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html),
- and for public health officials on the evaluation and testing of patients under investigation (PUIs) for 2019-nCoV (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html), and
- updated infection prevention and control guidance specific to 2019-nCoV (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html).

Early in the outbreak, many of the patients with respiratory illness caused by 2019-nCoV in China had exposure to a large seafood and live animal market, suggesting animal-to-human transmission. More recently, cases have been confirmed with no exposure to animal markets, indicating that person-to-person spread of the virus has occurred. Chinese officials report that sustained person-to-person spread in the community is occurring in China.

The first US case-patient was identified on January 21, 2020, and had recently traveled from Wuhan, China. Since that time, six additional cases have been confirmed in the United States, four among persons who traveled from Wuhan, and one a close contact of a confirmed case. Globally, reported illnesses in people with 2019-nCoV have ranged from mild (no or few signs and symptoms), to severe, including death. These findings are consistent with other coronaviruses, including Severe Acute Respiratory Syndrome (SARS) (https://www.cdc.gov/sars/) and Middle East Respiratory Syndrome (MERS) (https://www.cdc.gov/coronavirus/mers/index.html). Additional information about 2019-nCoV is needed to better understand transmission, disease severity, and risk to the general population. The goal of the ongoing US public health response is to identify and contain this outbreak and prevent sustained spread of 2019-nCoV in the United States.

Recommendations for Screening of Patients for 2019-nCoV in Healthcare Facilities

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Recommendations for screening of patients for possible 2019-nCoV infection are based on (1) current knowledge of the characteristics of clinical illness observed in early cases, and (2) the geographic distribution of current cases. They reflect the current public health goal of rapidly containing and preventing transmission of 2019-nCoV illness.

Patients presenting to healthcare facilities should be assessed for exposures associated with risk of 2019-nCoV infections (e.g., travel to China or close contact with a confirmed case) and for symptoms consistent with 2019-nCoV infection (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html). The assessment is intended to allow healthcare providers to make decisions about appropriate infection control and management of patients. Note that the signs and symptoms of 2019-nCoV overlap with those associated with other viral respiratory tract infections. Given the time of year, common respiratory illnesses, including influenza, should also be considered in patients who are screened. (Figure 1)

Clinicians should ask:

- Does the person have fever or symptoms of lower respiratory infection, such as cough or shortness of breath?

AND

- Has the patient traveled to mainland China within 14 days of symptom onset?

OR

- Has the patient had close contact[1] with a person confirmed with 2019-nCoV infection?

Figure 1.

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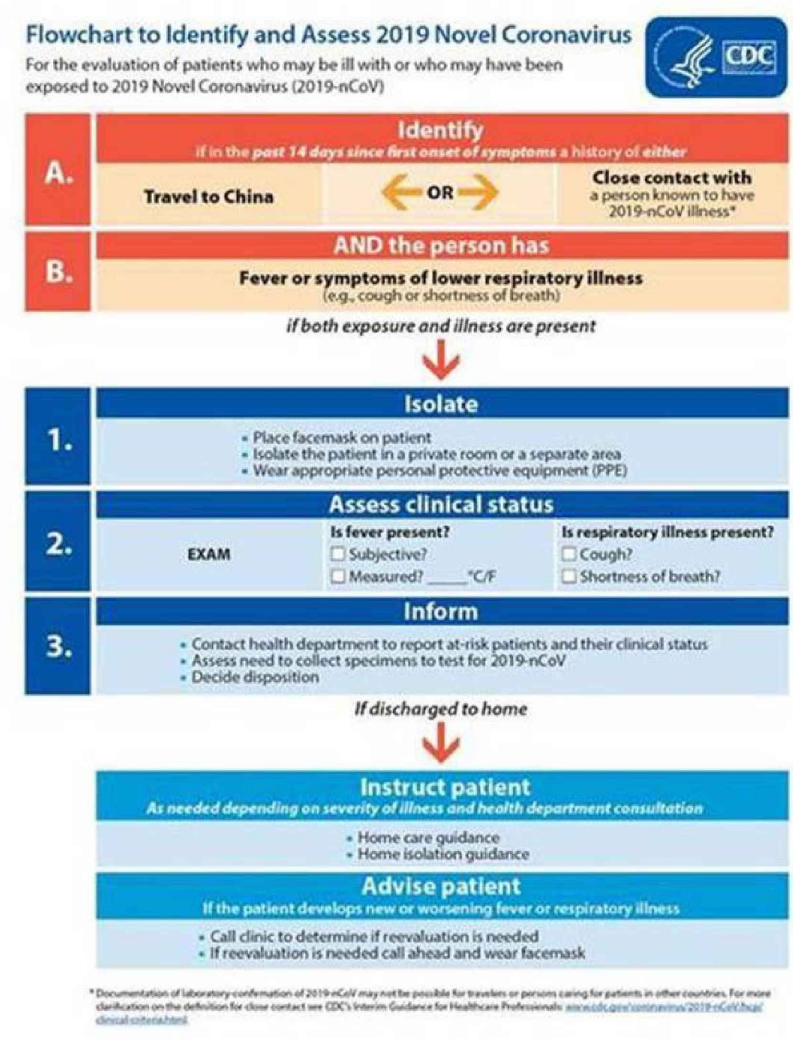

If a patient meets these criteria:

- To minimize the risk that other people will be exposed to individuals who may have 2019-nCoV, patients who report having these symptoms should be asked to wear a surgical mask as soon as they are identified and directed to a separate area, if possible, with at least 6 feet (2 meters) separation from other persons. Patients should be evaluated in a private room with the door closed, ideally an airborne infection isolation room (AIIR), if available. Healthcare personnel entering the room should use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., goggles or a face shield). For more information about this, see CDC's *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html).

Clinicians should immediately notify the healthcare facility's infection control personnel and local health department. The health department will determine if this patient needs to be considered a PUI for 2019-nCoV and be tested for infection.

Criteria to Guide Evaluation and Testing of Patients Under Investigation (PUI) for 2019-nCoV
Local health departments, in consultation with clinicians, should determine whether a patient is a PUI for 2019-nCoV. The CDC clinical criteria for 2019-nCoV PUIs have been developed based on available information about this novel virus, as well as what is known about SARS and MERS. These criteria are subject to change as additional information becomes available.

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Clinical Features	AND	Epidemiologic Risk
Fever[2] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers, who has had close contact[1] with a laboratory-confirmed[3] 2019-nCoV patient within 14 days of symptom onset
Fever[2] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever[2] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization[4]	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

These criteria are intended to serve as guidance for evaluation and testing. Patients should be evaluated and discussed with public health departments on a case-by-case basis for possible 2019-nCoV infection. Testing decisions might be further informed by the clinical presentation or exposure history (e.g., uncertain travel or exposure), and the presence of an alternative diagnosis that explains their clinical presentation .

Recommendations for Reporting, Testing, and Specimen Collection

Healthcare providers should **immediately** notify infection control personnel at their healthcare facility if a patient is classified a PUI for 2019-nCoV. State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a 2019-nCoV PUI case investigation form (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html#reporting-testing-specimen-collection). CDC's EOC will assist local and state health departments with obtaining, storing, and shipping appropriate specimens to CDC, including afterhours or on weekends or holidays. Currently, diagnostic testing for 2019-nCoV can be done only at CDC. Testing for other respiratory pathogens should not delay specimen shipping to CDC.

For initial diagnostic testing for 2019-nCoV, CDC recommends collecting and testing upper respiratory (nasopharyngeal AND oropharyngeal swabs), and lower respiratory (sputum, if possible)) for those patients with productive coughs. Induction of sputum is not indicated. Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See *Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV)* (https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html).

Recommendations for Healthcare Providers

No vaccine or specific treatment for 2019-nCoV infection is available. At present, medical care for patients with 2019-nCoV is supportive.

Persons with confirmed or suspected 2019-nCoV infection who are hospitalized should be evaluated and cared for in a private room with the door closed, ideally an airborne infection isolation room, if available.

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For more information, see *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html).

Home care and isolation may be an option, based on clinical and public health assessment, for some persons. Please see *Interim Guidance for Preventing the Spread of 2019 Novel Coronavirus (2019-nCoV) in Homes and Communities* (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html).

Those isolated at home should be monitored by public health officials to the extent possible. Refer to *Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)* (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html) for more information.

Notes

[1]Close contact is defined as:
a) being within approximately 6 feet (2 meters), or within the room or care area, of a 2019-nCoV case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a 2019-nCoV case
- *or* -
b) having direct contact with infectious secretions of a 2019-nCoV case (e.g., being coughed on) while not wearing recommended personal protective equipment.

[2]Fever may be subjective or confirmed
See CDC's updated *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (https://www.cdc.gov/coronavirus/2019-ncov/infection-control.html).
Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with 2019-nCoV (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

[3] Documentation of laboratory-confirmation of 2019-nCoV may not be possible for travelers or persons caring for patients in other countries.

[4] Category also includes any member of a cluster of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which 2019-nCoV is being considered that requires hospitalization. Such persons should be evaluated in consultation with state and local health departments regardless of travel history.

For More Information
More information is available at the 2019 Novel Coronavirus website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) or by calling 800-CDC-INFO | (800-232-4636) | TTY: (888) 232-6348

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:
Health Alert Requires immediate action or attention; highest level of importance
Health Advisory May not require immediate action; provides important information for a specific incident or situation
Health Update Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service Does not require immediate action; provides general public health information

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

If you would like to unsubscribe from this ListServ LIST, please send an email to LIST@cdc.gov, enter CDC in the email Subject, and include the following "one" line in the Body of the email: signoff CDC-HAN-PRIORITY-LIST

Distributed by:

Russell Baker
CDC EOC Duty Officer
770-488-7100
eocreport@cdc.gov

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Respectfully,

Jade Anderson, MPA
Special Advisor/Public Health Analyst
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
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e-mail: Jade.Anderson@cdc.hhs.gov

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

AMERICAN OVERSIGHT

From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response Field Investigations Team; CDC IMS 2019 NCOV Response At Risk; CDC IMS 2019 NCOV Response Clinical On-Call Unit; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP); Fagan, Ryan (CDC/DDID/NCEZID/DHQP); Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 1:51:25 PM

Hello Dr. Blackmore,

I wanted to introduce you to Srinivas Nanduri who will help with the infection prevention and control aspects of this investigation. As we discussed on the phone today, his deployment will be about 5 days and will largely be focused on the following objectives:

1. To provide targeted infection control assessment and observation of the affected healthcare facility to included hand hygiene, transmission based precaution use, and environmental cleaning.
2. To provide training on essential infection control activities such as hand hygiene and PPE donning and doffing
3. Provide technical support on healthcare worker and patient/resident monitoring during this time
4. To build internal capacity within the health departments for these types of assessments moving forward through mechanisms such as tele-infection control assessments (ICAR) or focused onsite ICARs
5. If times allows, to conduct preparedness assessment at other healthcare facilities

We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Statement: CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.
Date:	Thursday, February 27, 2020 8:43:16 AM

Media Statement

For Immediate Release
Wednesday, February 26, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.

The Centers for Disease Control and Prevention (CDC) has confirmed an infection with the virus that causes COVID-19 in California in a person who reportedly did not have relevant travel history or exposure to another known patient with COVID-19.

At this time, the patient's exposure is unknown. It's possible this could be an instance of community spread of COVID-19, which would be the first time this has happened in the United States. Community spread means spread of an illness for which the source of infection is unknown. It's also possible, however, that the patient may have been exposed to a returned traveler who was infected.

This case was detected through the U.S. public health system — picked up by astute clinicians. This brings the total number of COVID-19 cases in the United States to 15.

The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat. Unprecedented, aggressive efforts have been taken to contain the spread and mitigate the impact of this virus.

This is a rapidly evolving situation. CDC will continue to update the public as circumstances warrant. For more information about COVID-19 visit www.cdc.gov/covid19.

###

U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Statement: CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.
Date:	Thursday, February 27, 2020 8:50:56 AM

Media Statement

For Immediate Release
Wednesday, February 26, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.

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U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Statement: CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.
Date:	Thursday, February 27, 2020 8:40:52 AM

Media Statement

For Immediate Release
Wednesday, February 26, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.

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###

U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Telebriefing: Update on 2019 Novel Coronavirus (2019-nCoV)
Date:	Wednesday, February 5, 2020 10:47:44 AM

Media Advisory

For Immediate Release
Wednesday, February 5, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on 2019 Novel Coronavirus (2019-nCoV)

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the 2019 Novel Coronavirus response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

RADM Denise Hinton, Chief Scientist
Food and Drug Administration

When 12:15 p.m. ET Wednesday, February 5, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 2684824

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site: www.cdc.gov/media.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Telebriefing: Update on COVID-19 - Today at 3 P.M. EST
Date:	Saturday, February 29, 2020 1:00:53 PM

Media Advisory

For Immediate Release
Saturday Feb. 29, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 3 p.m. ET Saturday, Feb. 29, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 4677929

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AMERICAN OVERSIGHT

deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC Media Telebriefing: Update on COVID-19 at 3 P.M. EST Today
Date:	Saturday, February 29, 2020 12:56:54 PM

Media Advisory

For Immediate Release
Saturday Feb. 29, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 3 p.m. ET Saturday, Feb. 29, 2020

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Telebriefing: Update on COVID-19 at 3 P.M. EST
Date:	Saturday, February 29, 2020 12:49:51 PM

Media Advisory

For Immediate Release
Saturday Feb. 29, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 3 p.m. ET Saturday, Feb. 29, 2020

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

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC Releases Interim Movement & Monitoring Guidance
Date:	Monday, February 3, 2020 8:29:35 PM
Attachments:	CDC_2019-nCoV Daily Key Points__2_3_2020_Final.pdf

Dear Partners,

Today, the Centers for Disease Control and Prevention (CDC) released new movement and monitoring guidelines, "**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings"**. For your convenience, you can find it here. In addition, summary key points are attached.

Feel free to send any questions to preparedness@cdc.gov. For the latest information on the 2019 Novel Coronavirus (2019-nCoV), please visit the response webpage.

Thank you,

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Text Illness Monitoring (T.I.M) System Update
Date:	Friday, February 28, 2020 2:54:53 PM
Attachments:	T.I.M. FAQ_forPH_02.27.2020.pdf

Dear Colleagues,

The Text Illness Monitoring (T.I.M.) system has recently been modified to allow county-level campaigns to be added under state campaigns. This allows for local use of T.I.M. for COVID-19 symptom monitoring.

If a state would like to add county-level users in T.I.M., they should provide the names of the counties that should be activated. Once the T.I.M. support team activates these counties, states may then add county-level users as appropriate.

Local jurisdictions will be assigned at the county level and will have access to the data for that county only, and states will have access to all data within the state.

Local jurisdictions should coordinate with their state for access. States may send the list of counties they wish to activate in T.I.M. to eocevent340@cdc.gov.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Text Illness Monitoring (T.I.M) System Update
Date:	Friday, February 28, 2020 2:56:36 PM
Attachments:	T.I.M. FAQ_forPH_02.27.2020.pdf

Dear Colleagues,

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Thank you,

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Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Text Illness Monitoring (T.I.M) System Update
Date:	Friday, February 28, 2020 2:53:05 PM
Attachments:	T.I.M. FAQ_forPH_02.27.2020.pdf

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AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: CDC Weekly Key Messages
Date: Monday, March 2, 2020 12:51:25 PM
Attachments: CDC_COVID-19 Weekly Key Messages__3-1-20_FINAL.pdf

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FYI

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: CDC guidance updates
Date: Friday, March 6, 2020 8:24:52 AM

CDC guidance updates:

Evaluating and Reporting PUIs

Interim Guidance for Public Health Professionals Managing People with COVID-19 in Home Care and Isolation Who Have Pets or Other Animals

Interim Guidance: Get Your Community- and Faith-Based Organizations Ready for Coronavirus Disease 2019 (COVID-19)

"Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures" **:**
https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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From:	Davis, Ashley
To:	Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	Roberts, James; Kincaid, Brooke; Scott, John; Siddall, Paul; Coppola, Courtney
Subject:	CDC links reference reusable materials
Date:	Saturday, March 21, 2020 10:06:55 AM

Samantha or Aaron, can you please share w/ your CHD's?

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Saturday, March 21, 2020 9:47 AM
To: Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] PPE RFI

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Below are the CDC links reference reusable materials that you requested.

The last paragraph of the pdf covers homemade masks.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
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AMERICAN OVERSIGHT

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To:	Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	Roberts, James; Kincaid, Brooke; Scott, John; Siddall, Paul; Coppola, Courtney
Subject:	CDC links reference reusable materials
Date:	Saturday, March 21, 2020 10:06:43 AM

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Sent: Saturday, March 21, 2020 9:47 AM
To: Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC-- Taking Advantage of the 15-Day Pause to Slow the Spread of COVID-19
Date:	Friday, March 20, 2020 10:57:48 AM
Attachments:	15 Day Pause_Final_PDF.pdf
Importance:	High

Dear Colleagues,

Please find attached and hyperlinked the CDC Taking Advantage of the 15-day Pause to Slow the Spread of COVID-19 plan document. https://www.cdc.gov/coronavirus/2019-ncov/community/15-day-pause.html

What is the 15-day pause?

While every community is unique and experiencing varying levels of community transmission, the 15-day pause recommended by the White House presents the entire country with an opportunity to assess how prepared we are and take steps to implement actions designed to slow and limit the spread of COVID-19. We understand that the pause may last longer than 15 days.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors)

AMERICAN OVERSIGHT

From:	Amy Chang
To:	apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Robert Casey; Moyer, Ben	APHL; Hainstock, Lisa (MDARD); Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Collaro, Thomas - FSIS; Laura Wildey
Subject:	CIFOR Promote DT - February Meeting Notes and Action Items
Date:	Wednesday, February 19, 2020 11:24:18 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Guidelines Third Edition Postcard Draft 11Feb2020.pdf Promote DT Meeting Notes 02-18-20 .docx

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Good Morning,

Please see the attached notes from the meeting yesterday.

Immediate Action Items:

- 3rd Ed. Guidelines Promotion Plan
  - Promotion Plan
    - Newsletter blurb/couple social media - Michelle Shapiro will draft and send to group before she leaves at the end of February.
      - Postcard flyer (attached)
        - Action Item: If you have edits, send it to Michelle by 2/21.
      - Use Elizabeth's promotional plan 2020 - Amy posted updated copy post on Basecamp.
        - Action item: fill in and update the promotional plan where you can contribute.

Thank you,
Amy

Amy Chang
Senior Program Analyst
Environmental Health
National Association of County and City Health Officials ¦1201 Eye Street NW 4th Floor ¦ Washington, DC 20005
Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
www.naccho.org

AMERICAN OVERSIGHT







AMERICAN OVERSIGHT

From:	Amy Chang
To:	chris.rustin@dph.ga.gov; apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Robert Casey; Moyer, Ben	APHL; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Kurylo, Elizabeth (CDC/OID/NCEZID); Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Collaro, Thomas - FSIS
Subject:	CIFOR Promote DT - February Meeting
Attachments:	Promote DT Meeting_Agenda_02-18-20.docx CIFOR Guidelines Third Edition Postcard Draft 11Feb2020.pdf

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Achang@naccho.org <mailto:Achang@naccho.org> is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/507646459

Meeting ID: 507 646 459

One tap mobile
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+16699006833,,507646459# US (San Jose)

Dial by your location
+1 929 205 6099 US (New York)
+1 669 900 6833 US (San Jose)
Meeting ID: 507 646 459
Find your local number: https://naccho.zoom.us/u/ahhDdSCQg

AMERICAN OVERSIGHT

From:	Amy Chang
To:	apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Robert Casey; Moyer, Ben	APHL; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Kurylo, Elizabeth (CDC/OID/NCEZID); Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss; Collaro, Thomas - FSIS; Laura Wildey; Rustin, Chris; szimmerman@cste.org
Subject:	CIFOR Promote DT Updates and Action Items
Date:	Monday, March 16, 2020 9:01:44 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Guidelines Copy Request.pdf CIFOR Cover20_d5.pdf CIFOR Guidelines Third Edition Promotions LMW Suggestions 3-6-20.pdf CIFOR Third Edition Guidelines_Twitter.png CIFOR Third Edition Guidelines_Facebook.png

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Hi CIFOR Promote DT,

We hope everyone is well. In lieu of having our Promote DT meeting this month, please see below for updates and input needed.

1. **Spring Meeting Announcement**
   - Due to various employee travel bans at the state, local and federal levels, CSTE is developing alternative plans for the Spring meeting. More information will be shared in an all-Council email.

2. **3rd Ed Guidelines Updates**
   - 3rd Ed Guidelines Printing Needs survey – The printing needs survey at the following link: https://app.smartsheet.com/b/form/15cdaf107153491db9d67870d6699187. This form hosted on Smartsheet allows anyone with the link to fill out the form. Additionally, it allows us to maintain and track the number of guidelines requested as well as track the status of the request. Please see the three attached pdf files to see the form, the tracking sheet and the confirmation receipt. Please provide any feedback on the form to India.

   - Update on 3rd Ed Guidelines Printing Status – The Guidelines are nearing completion with graphic design and formatting. As of today, we've received Chapters 1-6, the table of contents and the acknowledgements. Following the completion, a full layout will be provide for review prior to sending to the printers. The printers are prepared to produce the guidelines in 4 weeks. In the interim, the pdf version will be available online on the CIFOR website.

   - New 3rd Ed Guidelines Cover - Please see the final cover attached (page 1). FSIS asked that we remove the live cattle and replace it with a burger.

   - Options for Guidelines promotion if some/all of the spring and summer conferences are postponed or cancelled. Any suggestions would be helpful (e.g. webinar series, etc.)

AMERICAN OVERSIGHT

- Postcard flyers – is there still a need for printed postcards since many upcoming in-person meetings/conferences are being cancelled?

-

- Promotional blurbs
    - Finalized blurbs for the 3rd Ed. Guidelines are forthcoming. Attached are draft blurbs and are currently being reviewed by CSTE's communications specialist. Once finalized, India will send the promotional blurbs to the Council to send out via respective communication channels prior to the digital copies being released onto the CIFOR website.

Let us know if you have any questions.

Thanks,
Amy

Amy Chang
Senior Program Analyst
Environmental Health
National Association of County and City Health Officials (NACCHO) ¦1201 Eye Street NW 4th Floor ¦ Washington, DC 20005
Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
www.naccho.org



AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Cc:	Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019; CDC CSELS DSEPD EWB
Subject:	CLARIFICATION RE: 100% of EIS officers and LLS fellows are needed for the COVID-19 response
Date:	Wednesday, March 18, 2020 2:55:48 PM

CLARIFICATION: We consider all EISOs and LLS fellows assigned to state and local health departments to be deployed working on COVID-19. This email is mostly intended for EIS and LLS assigned to CDC facilities. We did want field supervisors to know that we are NOT focused on CAL completion and fully support having EISOs and LLS dedicated to COVID-19 response.

Sorry for any confusion.

Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

please consider the environment before printing this e-mail.

From: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
Sent: Wednesday, March 18, 2020 2:46 PM
To: CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>; CDC LLS Supervisor 2018 <LLSSupervisor2018@cdc.gov>; CDC LLS Supervisors 2019 <DDPHSSCSELSDSEPDEWB2019LLSSupervisor@cdc.gov>
Cc: Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) <pms6@cdc.gov>; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) <mai9@cdc.gov>; CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC LLS Class 2018 <LLSClass2018@cdc.gov>; CDC LLS Class 2019 <LLSClass2019@cdc.gov>; CDC CSELS DSEPD EWB <OSELSSEPDPOEISStaff@cdc.gov>
Subject: 100% of EIS officers and LLS fellows are needed for the COVID-19 response

EIS and LLS supervisors,

I am writing again, asking for your support in having EIS officers and LLS fellows deploy or take on other roles for CDC's response to COVID-19. I want to emphasize that **completing CALs (graduation requirements) should NOT factor into whether an EIS officer or LLS fellow deploys**. Supervisors should not be asking to review deployment roles or objectives before approving a deployment. In the past we wanted to ensure deployments aligned with our training objectives. We no longer have that luxury, the primary responsibility of the EIS and LLS programs needs to be supporting the

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response until we are informed otherwise.

We will deal with CAL completion and how COVID-19 might impact graduation on a case-by-case basis. I want to assure you we will be very understanding in finding ways to compensate if involvement with the COVID-19 response prevented anyone from fulfilling the requirements to graduate.

We understand that some EISOs or LLS fellows may not be able to deploy to the field because of obligations to care for family members or themselves. There are response roles that can be completed while teleworking and do not require travel. We are available to assist in finding deployment roles – contact us at EpiAid@cdc.gov and we can discuss their particular circumstance. In addition, any fellows who are not currently deployed can volunteer by:

1. Emailing us at EpiAid@cdc.gov
2. Volunteer for a Go Team by submitting name in ReADI
3. Responding directly to any calls for volunteers they receive through other communication channels

Thank you for your support of the EIS and LLS programs and of your officers or fellows. We know a lot is being asked of you as well and CDC leadership appreciates all you are doing with respect to your individual contributions and your support of the EIS officers and LLS fellows.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
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For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

please consider the environment before printing this e-mail.

AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019; Brower, Melissa (CDC/DDPHSS/CSELS/OD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Duggan, Natalie (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Olivares, Dagny (CDC/DDPHSIS/CPR/DEO)
Subject:	CLARIFICATION RE: how to handle any COVID-19 speaking requests
Date:	Tuesday, March 3, 2020 11:55:08 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_29_2020_FINAL.pdf CDC_COVID-19 Weekly Key Messages_3-1-20_FINAL.pdf

EISOs and LLSers,

I know there have been a lot of questions following my email, "am I allowed to be part of a panel, I am supposed to speak at my graduate school, or, I was asked to speak about influenza and there will likely be questions about COVID-19."

Please continue to fulfill planned speaking engagements at primary schools, universities, and lay audience presentations not specific to COVID-19. You should expect questions about COVID-19. You should redirect questions by letting people know "it is a constantly evolving situation and the most up-to-date information is available on CDC's website." What we are asking you to avoid are situations where you may be asked to speak on behalf of CDC re COVID-19 as all messaging is coming from CDC leadership given the seriousness, magnitude, and complexity of the situation.

I have attached for your reference "CDC's Daily Key Points" and "Weekly Key Messages." In the "Weekly Key Messages" document I would be familiar with the section "What CDC is Doing." In general, it is best to avoid specifics and making any recommendations and again say the because it is a constantly evolving situation it is best to refer to CDC's webpage for the latest recommendations.

If you have deployed for COVID-19 you can talk about your experience and the type of work you were doing to help protect the publics health. If you are asked to be part of any large meetings, press conferences, or COVID-19 specific sessions please reach out to the JIC eocjicmedia2@cdc.gov.

Thanks,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

please consider the environment before printing this e-mail.

From: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
Sent: Friday, February 28, 2020 5:05 PM

AMERICAN OVERSIGHT

To: CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC LLS Class 2018 <LLSClass2018@cdc.gov>; CDC LLS Class 2019 <LLSClass2019@cdc.gov>
Cc: CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>; CDC LLS Supervisor 2018 <LLSSupervisor2018@cdc.gov>; CDC LLS Supervisors 2019 <DDPHSSCSELSDSEPDEWB2019LLSSupervisor@cdc.gov>; Brower, Melissa (CDC/DDPHSS/CSELS/OD) <ggk5@cdc.gov>; Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD) <tbn9@cdc.gov>; Duggan, Natalie (CDC/DDPHSS/CSELS/DSEPD) (CTR) <whv7@cdc.gov>; Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD) <ctg7@cdc.gov>; Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD) <aws8@cdc.gov>; Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD) <hld0@cdc.gov>; Olivares, Dagny (CDC/DDPHSIS/CPR/DEO) <dvp2@cdc.gov>
Subject: how to handle any COVID-19 speaking requests

Dear EISOs and LLS Fellows,

As the response to COVID-19 continues to evolve, it is increasingly likely that many of you (especially EISOs and LLS assigned to states) will be approached to participate in media interviews. During any emergency response that requires the activation of CDC's EOC, all communication functions are handed through the Joint Information Center (JIC) in the EOC. Decisions about who may serve as a CDC spokesperson with regard to media interviews are made by the public affairs specialists working in the JIC in collaboration with the Indecent Manager and CDC leadership. Those decisions are also guided by HHS's Office of the Assistant Secretary for Public Affairs (ASPA).

During EOC-led responses, a very limited number of spokespeople are approved to speak to media on behalf of CDC. In a rapidly evolving emergency response, it is critical that our messages remain as consistent as possible, are based on the most current information, and include important framing and nuances. The staff best positioned to deliver these nuanced messages are on all the calls, involved in all the conversations, and briefed on every aspect of the response = senior leaders at CDC (picture attached of EIS alum delivering key messages).

Please understand we want you to have as many opportunities as possible to talk with media about your work. This is a time when it's in the best interest of the agency and the public to limit the number of people talking to media for the reasons described above. This is also in your best interest, as it helps ensure that you will not be put in the position of being asked to speak and comment about things that are beyond the scope of your specific work. When media quote a CDC employee, that employee is invariably presented as speaking on behalf of the entire agency. Asking you to speak now offers far more risk than benefit given the fast-moving and politically complicated nature of the response.

Guidance is being developed and will be issued soon for all staff deployed to the field. **Any requests to speak about COVID-19 should be directed to the following address** eocjicmedia2@cdc.gov. Thanks for your cooperation and contributions to a complicated and ever evolving response.

For those of you that get a good weekend, have a good weekend. For those of you working – thanks

AMERICAN OVERSIGHT

for your service on behalf of EIS/LLS and CDC.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
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Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.


please consider the environment before printing this e-mail.

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Byrd, Shirley K. (CDC/OCOO/OFR/OGS); Roush, Sandra (CDC/DDID/NCIRD/OD); Brammer, Lynnette (CDC/DDID/NCIRD/ID); Gross, Melanie S. (CDC/DDID/NCIRD/ID); Lamont, Brock (CDC/DDID/NCIRD/ISD); CDC IMS State Coordination Task Force (SCTF) ELC LNO
Subject:	COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST
Date:	Sunday, February 16, 2020 9:55:36 PM

The CDC will be hosting an all-state COVID-19 call on Tuesday, February 18 from 2:00pm-2:45pm EST. The ELC is not coordinating this call; however, we wanted to share this information in the event you had not received it through other channels.

CDC's Coronavirus Disease-2019 (COVID-19) response team will host a national call from 2 p.m. to 2:45 p.m. EST on Tuesday, February 18, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)790-1880
Participant Passcode: 8138992

Please note, this update call is being held on a Tuesday, in lieu of President's Day observance. Future calls will be held on Mondays.

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 10:38:18 AM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

Dear Colleagues:

Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 10:39:44 AM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

Dear Colleagues:

Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 2:28:23 PM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

FYI

Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 2:30:00 PM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

FYI

Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 10:36:48 AM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

Dear Colleagues:

Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Guidance for Election Polling Locations, Community Actions, and Student Travel for Higher Education
Date:	Tuesday, March 3, 2020 8:32:45 AM
Attachments:	Guidance for Election Polling Locations_draft_3.2.20_Final.pdf

Dear Colleagues:

Attached is CDC COVID-19 Guidance for Election Polling Locations.

Please see the links below for updated community guidance and guidance for student travel for higher education.

Community guidance: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html
Student travel for Higher Education: https://www.cdc.gov/coronavirus/2019-ncov/community/student-foreign-travel.html

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Guidance for Election Polling Locations, Community Actions, and Student Travel for Higher Education
Date:	Tuesday, March 3, 2020 8:36:03 AM
Attachments:	Guidance for Election Polling Locations_draft_3.2.20_Final.pdf

Dear Colleagues:

Attached is CDC COVID-19 Guidance for Election Polling Locations.

Please see the links below for updated community guidance and guidance for student travel for higher education.

Community guidance: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html
Student travel for Higher Education: https://www.cdc.gov/coronavirus/2019-ncov/community/student-foreign-travel.html

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Guidance for Election Polling Locations, Community Actions, and Student Travel for Higher Education
Date:	Tuesday, March 3, 2020 8:29:44 AM
Attachments:	Guidance for Election Polling Locations_draft_3.2.20_Final.pdf

Dear Colleagues:

Attached is CDC COVID-19 Guidance for Election Polling Locations.

Please see the links below for updated community guidance and guidance for student travel for higher education.

Community guidance: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html
Student travel for Higher Education: https://www.cdc.gov/coronavirus/2019-ncov/community/student-foreign-travel.html

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject:	COVID-19 Guidance/Response Updates - March 23, 2020
Date:	Monday, March 23, 2020 9:14:20 PM
Attachments:	COVID-19 Priority Testing Patients Graphic 03.23.2020.pdf

Dear Colleagues:

The Administration continues to place its full weight and resources behind the response to COVID-19. FEMA now leads federal operations on behalf of the White House Coronavirus Task Force which oversees the whole-of-government response to the pandemic. As part of the White House Coronavirus Task Force, HHS will continue to provide their subject matter expertise as the nation's pre-eminent public health responders.

Because there are so many updates coming out daily from across the divisions at HHS --FDA, CDC, CMS, ASPR, and others – I want to help you and your teams track what's issued. While my emails will not be a comprehensive list, it will certainly include important items for you to review relative to your industry.

Today's information and guidance includes:

Clear Recommendations: Who Should Get Tested?
Today, HHS provided recommendations for prioritizing COVID-19 testing for individuals. Given that we are still ramping of testing availability in the private sector, this uniform guidance is particularly important for states and private labs.

There are three categories for States and clinical laboratories to utilize as they develop strategies to prioritize COVID-19 testing in their communities:

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Priority 3 Testing for COVID-19

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

Non-Priority

- Individuals without symptoms

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Attached is a graphic with some additional details about the three categories and why we must prioritize these populations.

No Hoarding, Price Gouging, or Peddling of Fraudulent Products President Trump signed an Executive Order to prevent the hoarding and price gouging of critical supplies needed to combat the coronavirus. This action will help ensure that hospitals, first-responders, and doctors receive sufficient supplies of critical medical equipment and the Department of Justice will prosecute entities that violate this order.

What Types of Ventilators Can be Used to Expand Supply? The FDA issued guidance to expand the availability of ventilators as well as other respiratory devices and their accessories during this pandemic. Wherever possible, health care facilities should use FDA-cleared conventional/standard full featured ventilators when necessary to support patients with respiratory failure. However, to expand availability, FDA will not object to limited modifications to the *indications, claims, functionality, or to the hardware, software, or materials of FDA-cleared devices used* to support patients with respiratory failure or respiratory insufficiency. This policy applies only during the public health emergency.

How to Avoid Rumors and Fraudulent Products?: FEMA has released a website, FEMA Rumor Control, that lists common rumors and accurate information, while FDA also issued a notice warning consumers that there is not presently an approved home test kit.

How Can States Apply for COVID-19 Medicaid Waivers? The agency has made it easier for states to receive federal waivers and implement flexibilities in their Medicaid program by creating four checklists that together will make up a comprehensive Medicaid COVID-19 federal authority checklist. The tools include information on how to apply for an 1115 Waiver Opportunity and Application Checklist, 1135 Waiver Checklist, 1915(c) Appendix K Template, Medicaid Disaster State Plan Template.

How to Report COVID-19 Cases? CDC released information for state health departments on how to report COVID-19 cases to better track the impact of the outbreak and public health response.

Flexibility for Deadlines and Exceptions for Medicare Quality Reporting Requirements CMS announced it is providing relief for clinicians, providers, hospitals and facilities by granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The new deadlines and exceptions for reporting can be found here.

How has Nursing Home Inspection Guidance Changed? CMS released the findings from their inspection of Kirkland Nursing Home in Washington. As a result, nursing home guidance has changed and CMS has a new inspection process that will focus only on complaint inspections, targeted infection control inspections, and self-assessments.

What is the Latest Information for Individuals, Especially Those At-Risk and Older Individuals?

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CDC released a self-checker that helps users make decisions about seeking appropriate medical care. This system is not intended for diagnosis or treatment of COVID-19 or other diseases but can advise on next steps. CDC has updated their webpage that identifies the high risk populations including adults older than 65, residents of nursing homes or long-term care facilities, individuals with high risk conditions (asthma, heart disease or immunocompromised individuals), and monitoring for people who are pregnant. CDC has also released additional information for older adults as well. Additional guidance was released for local and state health departments, homelessness service systems, housing authorities, healthcare facilities and others on responding to COVID-19 among people experiencing unsheltered homelessness.

What is the Latest Information for Seniors' Facilities? CDC updated their guidance and information for retirement communities and independent living facilities to plan, prepare for, and respond to COVID-19 as well as how to prevent the spread of COVID-19 in facilities. This webpage provides information on how to disinfect your facility if someone is sick. This webpage provides guidance to personnel at blood and plasma collection facilities, a key support entity in the healthcare delivery system.

A Call for Hospitals to Delay Non-Essential Procedures: The Surgeon General published an op-ed in USA Today to encourage hospitals to cancel or delay non-essential planned medical and dental procedures to conserve resources for COVID-19 response.

What Is the Latest Information for Healthcare Professionals? CDC updated their frequently asked questions for healthcare professionals to include more information for pregnant healthcare workers. New information was released for clinicians on therapeutic options for COVID-19 patients that provides information on the current drugs being studied to treat the virus.

What is the Latest Information for Laboratories: CDC has updated their information for laboratories webpage with additional guidance, resources and FAQs.

Laura

Laura C. Trueman
Director, Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington D.C. 20201
Laura.Trueman@hhs.gov
202-690-6060 (main office)

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Achim, John (CDC/DDID/NCEZID/DPEI); Bellis, Kimberly (CDC/DDID/NCEZID/DPEI); Borrelli, Aaron (CDC/DDID/NCEZID/DPEI); Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Chung, Christina L. (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Hall, Christopher (Jason) (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Light, Megan (CDC/DDID/NCEZID/DPEI); Montgomery, Meagan (CDC/DDID/NCEZID/DPEI) (CTR); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pappas, Danielle (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI)
Subject:	COVID-19 Jurisdictional call series (sending on behalf of State Coordination Task Force)
Date:	Monday, March 9, 2020 12:53:15 PM

Below is the dial in information for an 'all state' call today hosted by the COVID-19 CDC State Coordination Task Force. It is my understanding that this call information has been shared with SHOs and State Epis. In an effort to make sure that you receive the most current information, I encourage you to work with these POCs in your jurisdiction to receive information and updates about this series of calls (and any others) important to your current activities.

CDC's 2019 Novel Coronavirus (COVID-19) response team will continue to host a national call series from 2 p.m. to 2:45 p.m. EST every Monday, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)921-9091
Participant Passcode: 1324420

For your convenience, call series dates are provided below.

- Monday, March 9
- Monday, March 16
- Monday, March 23
- Monday, March 30

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	Perry, Kaylynn
To:	Miller, Carly; chris@waltoncountyem.org; Courtney.Coppola@flhealth.gov; EduardoBustillo@semtribe.com; EOC-Plans; Bussey, Jon; Guthrie, Kevin; Waterman, Laura; Cintron, Morgan; espe0001@shands.ufl.edu; edward.f.toombs2.mil@mail.mil; Chance, Betsy (Dept. of State); County Emergency Management Directors
Subject:	COVID-19 Situation Report #21
Date:	Monday, March 23, 2020 2:02:10 PM
Attachments:	COVID-19 Sit Rep 21.pdf

Good afternoon,

Attached is the latest COVID-19 Situation Report.

Kaylynn Perry
All-Hazard Preparedness Unit / SERT ESF 5
Florida Division of Emergency Mangement
Kaylynn.perry@em.myflorida.com
Office: (850) 815-4337
Mobile: (850) 254-5657

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject:	COVID-19 Testing Prioritization
Date:	Monday, March 23, 2020 6:58:02 PM
Attachments:	COVID-19 Priority Testing Patients Graphic 03.23.2020.pdf
Importance:	High

Dear Governors and State Health Officials,

The U.S. Department of Health and Human Services is writing to provide recommendations for prioritizing COVID-19 testing for individuals. We have developed three categories that we strongly recommend States and clinical laboratories utilize as they develop strategies to prioritize COVID-19 testing in their communities:

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Priority 3 Testing for COVID-19

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

Non-Priority

- Individuals without symptoms

Attached is a document with some additional details about the three categories and why we must prioritize these populations. Please share with partners and others in your community.

Thank you for your attention and help spreading this important communication.

Darcie Johnston, Director
Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From:	Mejia-Echeverry, Alvaro
To:	Aguilar, Alexandra; Alexandre, Antonine; Alghawi, Wissam; Amores, Norma A.; Anderson, Erica C; Arseda, Nurya; Arshad, Amena; Barrera, Anne; Becerra, Ana; Bula, Evelyn A; Calle, Stephanie; Camacho, Walter; Cartaya, Gabriella W; Castillo, Klelia S; Celorio, Oscar; Charlot-Aladin, Mary; Coello, Erika X; Concepcion, Chaveli; Corzo-Sanchez, Elisa M; Cuevas, Carlos; Curbelo, Oswaldo; Cyril, Lorrie; Davidson, Khaleeq J; Dobson, Jolie T; Ejiofor, Ngozichukwuka; Eldanaf, Amal H; Estrada, Juan Jose; Etienne, Marie Ketty (Epi); FernandezdeCastro, Ana; Goldberg, Cynthia; Gonzalez, Irima V; Grajales, Janet; Jit, Mohnisha; Johnson, Venus; Joseph, Keren; Laine, Claudia B; Llau, Anthoni; Lopez, Jose M; Lopez, Victor J; Lyonel, Elsie; Martinez, Anita; Martinez, Yuray; Mauck, Daniel E; Mejia-Echeverry, Alvaro; Melus, Vickie; Menoscal, Paola C; Morales, Fernando X; Muse, Nicole J; Nowotny, Kyle; Noya-Chaveco, Pedro A; Oliver, Christine M; Paramo, Christian; Paul, Paulette J; Paulynice, Berthamise; Ramos, Vivian L; Rodriguez, Daniel; Rojas, Mercedes C; Salvador, Cristina G; Sandoval, Lydia; Schroeder, Wayne A; Stallworth, Barbara; Suarez, Juan; Suazo, Ingrid E; Summers, Debbie; Tassy-Toussaint, Gastrude; Torrecilla, Ana; Urbina, Angelica; Uribarri, Enrique S; Vera, Raul A; Veras, Braulio; Villamil, Vanessa; Webb, Jenna; Zhang, Guoyan
Cc:	Beaton, Heather L; Rico, Edhelene; Goldberg, Cynthia; Schmitz, Ann; White, Stephen L; Davenport, Emily Patricia (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Jean, Reynald; Caballero, Reinaldo; Casimir, Yanick; Lowe, Camille N; Munoz, Virginia E; Olguin, Lourdes; Ortega, Marisabel; Toledo, Marilyn X; Villalta, Yesenia D
Subject:	COVID-19 Training/TTX
Date:	Friday, February 14, 2020 5:51:04 PM
Attachments:	image001.png

Good afternoon.

I would like to thank all EpiRT members for attending the COVID-19 Training/TTX today. This was a great opportunity to review current public health protocols and actions in response to this outbreak! I appreciate your interest in the matter and your willingness to respond to a potential call for action.

I also want to thank speakers for taking the time to prepare and deliver their talks about the different fields covered in the training. I really appreciate your sharing your expertise with the team!

Alvaro Mejia-Echeverry, MD, MPH
Florida Department of Health in Miami-Dade County
Advanced Practice Registered Nurse
Email: Alvaro.Mejia-Echeverry@flhealth.gov
Phone: (305) 470-5660 x 6932
Mailing Address: 8600 NW 17TH STREET Floor: 02 Room: 2 Bin : Epi
MIAMI, FL 33126



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AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: COVID-19 Updates for Friday, March 13, 2020
Date: Friday, March 13, 2020 9:14:46 PM

Dear State and Local Partners:

Every day brings new information and developments on COVID-19, many of which impact your efforts to address the Coronavirus. We value our strong partnership with you all as we continue to work on the COVID-19 response. We aim to ensure that you have access to the resources and information that you need for your communities.

Here are key highlights:

National Emergency Declaration: Today, President Trump signed a National Emergency Declaration in response to COVID-19. The Emergency Declaration will allow HHS to provide emergency funding to state and local entities (up to $50 billion) and specifically will enable HHS to waive provisions of certain laws and regulations to provide increased flexibility to healthcare providers. Additional flexibilities will be able to be exercised around the use of telehealth, state licensing requirements for providers to practice in areas of greatest need, increasing the supply of providers, loosening restrictions on where hospitals can care for patients within a hospital, and flexibilities on the number of beds and lengths of stay for Critical Access Hospitals.

Increasing Capacity for Testing: The Administration designated Assistant Secretary for Health, ADM Brett Giroir, M.D., to take the lead in coordinating testing efforts to ensure seamless access for patients, doctors, and hospitals. HHS is working to help expedite the availability of tests by utilizing the private sector and allowing states to offer and develop their own tests. Yesterday, the FDA authorized a diagnostic test developed by Roche, to rapidly expand the capacity and timeliness of testing for COVID-19 diagnostics. The FDA also approved the New York State Department of Health to directly authorize labs to begin patient testing. More information about these actions can be found here. For technical information on diagnostic testing, FDA posted frequently asked questions related to the development and performance of diagnostic testing.

With help from public-health and private-sector lab capabilities, HHS has also enabled states and healthcare providers to implement sample collection for pre-screened patients, similar to what is being done at the Mayo Clinic and Minnesota Department of Health, by the Colorado Health Department and by the University of Washington. CMS has also published the Medicare reimbursement amounts to providers for COVID-19 testing, which can be found here.

Lab Test Questions – As public and private testing labs continue to gear up capabilities and review the new options being created through the FDA, they may have questions. To help answer those questions that are technical in nature, the FDA has stood up a 24/7 hotline for things related to COVID-19: 1-888-INFO-FDA or 1-888-463-6332.

Essential Health Benefit Coverage of COVID-19: The FAQs released today, March 13, detail existing federal rules governing health coverage provided through the individual and small group insurance markets that apply to the diagnosis and treatment of COVID-19. The FAQs clarify which COVID-related services, including testing, isolation/quarantine, and vaccination, are generally currently covered as EHBs in these markets. The purpose of the FAQs is to provide guidance to Americans enrolled in individual or small group market health plans, including HealthCare.gov consumers. As questions and issues continue to come to CMS, they will be addressed and added to these FAQs. The document can be found here.

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Community Response: All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy. CDC has released updated information on Preventing the Spread of COVID-19 in Communities as well as issuing considerations for school closures.

Surgical Masks and Gowns: The FDA sent a letter to healthcare providers on conservation strategies for personal protective equipment. The recommendations include strategies for conventional, contingency and crisis level of supplies.

Cruise Advisory: CDC and the State Department recommend travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide. At this point, all passengers from the Grand Princess cruise have disembarked from the ship.

If there are any questions, please don't hesitate to reach out.

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	COVID-19, Supplemental Case Investigation Form
Date:	Sunday, March 22, 2020 12:37:16 PM
Attachments:	COVID-19_Case_Investigation_Form.pdf

Dear Partners,

Thank you for your collaboration in case reporting.

We are reaching out to you as CDC has developed a supplemental case investigation form (see attached) for an in-depth investigation of a sample of COVID-19 cases. CDC is looking to gather information from approximately 5-10 cases in each jurisdiction, from different age groups and of different severities. Pooling data from supplemental forms nationally will provide critically needed information on the relationship between severity of illness and transmissibility. This information can help inform state and national response efforts.

We know that you are very busy with this unprecedented response. CDC may be able to provide staff to assist in collecting these data. Please let us know if you could help in this effort by contacting the State Coordination Team directly (eocevent118@cdc.gov).

Sincerely,

Tom

Tom Shimabukuro, MD, MPH, MBA
Captain, U.S. Public Health Service
Deputy
COVID-19 Epidemiology Task Force
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, Atlanta, GA 30329

Phone: 404-498-0679, Fax: 404-498-0666
Email: TShimabukuro@cdc.gov

AMERICAN OVERSIGHT

From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Erin Morton; mlipsitc@hsph.harvard.edu; rek160@mail.harvard.edu; Perz, Joseph (CDC/DDID/NCEZID/DHQP)
Subject:	CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST
Date:	Monday, February 24, 2020 2:13:16 PM
Attachments:	image001.png image002.png image003.png 00 pm EST (94.8 KB).msg



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

CSTE's ad hoc weekly COVID-19 All State Epi call is **TODAY at 4:00 pm EST**. These calls provide an open forum for discussion of emerging issues and response-related needs**.** Please see the call information highlighted below and note this call is intended for State Epidemiologists, CLUE, and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist
2. Washington Liaison Update, Erin Morton, CRD Associates, LLC
3. Presentation on COVID-19 Community Transmission Modeling, Marc Lipsitch and Rebecca Kahn, Harvard T.H. Chan School of Public Health
4. CDC COVID-19 Infection Prevention and Control Updates and Discussion, Joseph Perz, Healthcare Infection Control Team Lead, MCCM Task Force
5. Next Ad Hoc Call, Monday, March 2, 2020, 4:00-5:00 pm EST

Council of State and Territorial Epidemiologists • 2635 Century Parkway NE, Ste 700 • Atlanta, Georgia 30345 T 770.458.3811 F 770.458.8516

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

Please click the link below to see more information, or to start the session.

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Access code: 794 313 782

For assistance

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AMERICAN OVERSIGHT

From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Scott Becker; Scott Lindquist; Kathy Turner; O"Connor, Angelica (CDC/OID/NCEZID)
Subject:	CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST
Date:	Monday, March 2, 2020 1:25:50 PM
Attachments:	image001.png image002.png image003.png



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – Today's CSTE ad hoc weekly COVID-19 All State Epi call is set for **4:00 pm EST**. Please see the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
    a. State Epidemiologist Transitions
        1. IL: Craig Conover, Acting
        2. TX: Stephen Pont, Acting
        3. TN: John Dunn, Permanent
2. COVID-19 Lab Testing Update, Scott Becker, APHL Chief Executive Officer
3. Notes from the Field: Washington State Update, Scott Lindquist, Washington State Epidemiologist
4. Update on SARS-CoV-2 Case Definition Discussions, Kathy Turner, Idaho Deputy State Epidemiologist
5. ELC Meeting Update, Angelica O'Connor, ELC Program Coordinator
6. ACIP Meeting Update, Chris Hahn, Idaho State Epidemiologist
7. Jurisdictional Experiences and Open Forum Discussion

Next Call, Monday, March 9, 2020, 4:00-5:00 pm EDT

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Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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AMERICAN OVERSIGHT

From: Jeremy Arieh

To: Aifili Tufa; Alesha Thompson; Alexia Harrist; Alexis Darden; Alyaa Altabbaa; Amanda Masters; Angela Dunn; Ann Pobutsky; Anna Likos; Ashley Vineyard; Becky Lampkins; Benjamin Chan; Beverly Christner; Brooke Beaulieu; Cailyn Lingwall; Caitlin Pedati; Carina Blackmore; Carmen Deseda; Catherine Brown; Cathy Wasserman; Charisse LaVell; Cherie Drenzek; Christina Tan; Christine Hahn; Craig Conover; Danielle Boyd; David Blythe; Dean Sidelinger; Debra Blog; Dhara Shah; Doug Thoroughman; Esther Ellis; Farah Ahmed; George Turabelidze; Hayleigh McCall; India Bowman; Ishan Azzam; James Watt; Janet Hamilton; Jeff Engel; Jennifer Lemmings; Jessica Arrazola; John Davies-Cole; John Dunn; Jonathan Meiman; Jordan Peart; Joseph McLaughlin; Joshua Clayton; Kathy Turner; Katrina Hedberg; Kenneth Komatsu; Kerry Pride; Laura Williamson; Laurence Burnsed; Laurene Mascola; Lilian Peake; Lilian Peake; Linda Gaul; Linda Bell; Lori Cragin; Maria del Rosario; Maria Patselikos; Matt Masiello; Matthew Cartter; Megan Irving; Megan Toe; Melissa Bullock; Meredith Lichtenstein; Mia Israel; Michelle Brown; Mike Landen; Mimi Huynh; Molly Howell; Mone Sharpe; Monica Schroeder; Nikka Sorrells; Pamela Pontones; Patsy Kelso; Paul Byers; Paul White; Puja Shah; Rachel Herlihy; Raoult Ratard; Rickey Tolliver; Ruth Lynfield; Ryan Westergaard; Sarah Lyon-Callo; Sarah Park; Sarah Zimmerman; Scott Lindquist; Shaily Krishan; Sharon Watkins; Shelby Lyons; Sherri Davidson; Shirley Louie; Shundra Clinton; Sietske de Fijter; Siiri Bennett; Song Xue; Stephen Ostroff; Stephen Pont; Symone Richardson; Tabatha Offutt-Powell; Thomas Jeanne; Tom Safranek; Tracy Miller; Utpala Bandy; Valerie Goodson; Vita Akapito Skilling; Zack Moore; Ada Huang; Alan Dorsinville; Alison Arwady; Anchalee Chillond; Andrew Hennenfent; Ann Winters; Annie Fine; Bernadette Albanese; Brian Reed; Caroline Johnson; Cora Hoover; David Stier; Dawn Terashita; Devin Raman; Don Weiss; Edhelene Rico; Ellen Lee; Emily Blake; Eric Bakota; Eric McDonald; Francisco Garcia; Heidi Threadgill Honza; Jacqueline Reuben; Jean Reynald; Jeffrey Duchin; Jenifer Jaeger; Jennifer Fiddner; Jessica Castorena; Joann Schulte; Julia Gunn; Julie Morita; Juliet Stoltey; Kathy Ritger; Kerry Chalkley; Kossia Dassie; Kristen Feemster; Kristen Mertz; Laeann Liu; Lauren Orkis; LuAnn Brink; Marcelle Layton; Mary Debry; Massimo Pacilli; Matthew Zahn; Meagan Kay; Melissa Ongpin; Peter Ruestow; Prabhu Gounder; Preetha Lyengar; Rachel Civen; Rebecca Sunenshine; Rita Espinoza; Roshan Reporter; Russ Jones; Sally Slavinski; Salma Khuwaja; Sarah Kemble; Sasha McGee; Scott Harper; Sharon Balter; Stephanie Black; Stephen Forest; Steve Alless; Susan Phillip; Susan Scheer; Taylor Pinsent; Wayne Enanoria; Wendy Chung; Barbara Gabella; Kate Goodin; Matt Cone; Melissa Jordan; Richard Danila; Shelia Scott; Stephanie Tucker; Berger, Sherri (CDC/OCOO/OD); Holloway, Rachel (CDC/OCOO/OD)

Subject: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - Monday, March 16

Attachments: image001.png
image002.png
image003.png

Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – The CSTE ad hoc weekly COVID-19 All State Epi call is Monday, March 16 at 4:00 pm EDT. See the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist

2. COVID-19 Jurisdictional Supplemental Funding Coordination via Crisis Cooperative Agreement, Sherri Berger, CDC Chief Operating Officer
3. COVID-19 CDC Response Update, Dan Jernigan, CDC IMS Incident Manager
4. COVID-19 Data Preparedness Update, Stephanie Bialek, CDC IMS Epi Task Force Lead
5. COVID-19 Bioinformatics Update, Greg Armstrong, CDC IMS Deputy Incident Manager
6. COVID-19 Nursing Home Preparedness, Satish Pillai, CDC IMS MCCM Task Force Lead
7. CSTE's COVID-19 Resource Repository Basecamp Demo, Meredith Lichtenstein Cone, CSTE
8. Open Forum Discussion

Next Call, Monday, March 23, 2020, 4:00 pm EDT

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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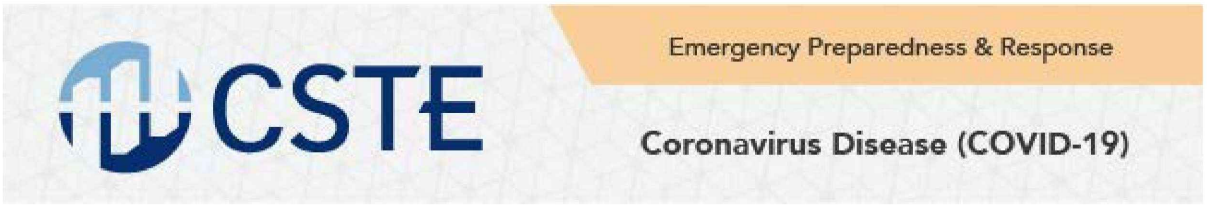
AMERICAN OVERSIGHT

From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Sandra Roush; Yoon, Paula (CDC/OPHSS/CSELS/DHIS)
Subject:	CSTE COVID-19 Response	Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST
Date:	Wednesday, February 19, 2020 12:57:18 PM
Attachments:	image001.png image002.png image004.png CSTE COVID-19 Response Ad Hoc Weekly All State Epi Call - Wednesday Feb... (80.1 KB).msg



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

CSTE's ad hoc weekly COVID-19 All State Epi call is **TODAY at 4:00 pm EST**. These calls provide an open forum for the discussion of emerging issues and response-related needs**.** Please see the WebEx info below, and note this call is intended for State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Introductory Remarks, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. Implementation Update for Phase 1 to Phase 2 Transition for COVID-19 Response, CDC IMS Response Staff for COVID-19 Response
   a. Introducing phased reporting and rationale for a staggered approach—Joseph Bresee and Marc Fischer
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4. Text Illness Monitoring (TIM) System Poll and Discussion

Please note the routine February All State Epi call scheduled for Monday, February 24, 2020 at 3:00 pm EST is cancelled in lieu of the next ad hoc weekly COVID-19 All State Epi call, which is Monday, February 24, 4:00-5:00 pm EST

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Topic: CSTE COVID-2019 Response Ad Hoc Weekly All State Epi Call
Host: Jeremy Arieh
Date: Wednesday, February 19, 2020

AMERICAN OVERSIGHT

Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)
Session number: 797 772 498
Session password: epi4321

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jarieh@cste.org

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	eocevent118@cdc.gov; CSTE Novel Coronavirus 2019
Subject:	CSTE COVID-19 Response | CDC Phase 2 Rollout
Date:	Wednesday, February 26, 2020 10:38:24 AM
Attachments:	image001.png image002.png Attachment1_COVID19_Phase2Instructions_2020Feb25[1].docx Attachment2_COVID19_PUI_Case_ReportForm_2020Feb24[1].pdf Attachment3_COVID19_PUI_Case_Data Dictionary_2020Feb24[1].pdf Attachment4_COVID19_PUI_Case_ReportForm_Instructions_2020Feb24[3].pdf Attachment5_COVID19_SpecimenSubmission_2020Feb24[3].pdf



Forwarded to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good morning,

Please see below for a message from the CDC COVID-19 Epi Task Force, regarding **Phase 2** of COVID-19 jurisdictional identification and reporting.

Colleagues,

Thank you for your continued partnership in the ongoing emergency response to the novel coronavirus, COVID-19. As we presented at the 50-state CSTE call on Wednesday, February 19th, we will begin to transition today, February 25th, to 'Phase 2' of jurisdictional identification and reporting of persons under investigation (PUI) and laboratory-confirmed cases of COVID-19.

This transition to Phase 2 will occur for all reporting jurisdictions that are able to do the following:

- Assess ill persons and determine PUI status
- Assign unique identifiers to PUI and cases using the specified format
- Report PUI and laboratory-confirmed cases to CDC using a brief, combined, report form

For the purposes of COVID-19 PUI and case reporting, a 'reporting jurisdiction' refers to any jurisdiction that submits data directly to the National Notifiable Disease Surveillance System. A complete list of the 59 jurisdictions included as reporting jurisdictions is contained in Attachment 1. Although COVID-19 is not a nationally notifiable disease, limiting reporting to only these jurisdictions will provide greater assurance of unique ID assignment and ensure higher data quality during this rapidly evolving outbreak.

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If your reporting jurisdiction is able to meet criteria to move to Phase 2, please email the State Coordination Unit of the CDC COVID-19 Epidemiology Task Force at eocevent118@cdc.gov to confirm your readiness.

Full details of the Phase 2 rollout are documented in the 5 attachments:

- Attachment 1: Clear description of Phase 2 implementation, including nCoV ID assignment
- Attachment 2: Combined PUI and Case Report Form
- Attachment 3: PUI and Case Report Form Data Dictionary
- Attachment 4: Instructions for completing the PUI and Case Report Form
- Attachment 5: Information on how to ship specimens to CDC

CDC is available to answer questions about the PUI and laboratory-confirmed case-reporting process. For inquiries, please email eocevent118@cdc.gov. We appreciate your continued efforts.

Best,
CDC COVID-19 Epidemiology Task Force

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Berger, Sherri (CDC/OCOO/OD); Holloway, Rachel (CDC/OCOO/OD); Jernigan, Daniel B. (CDC/DDID/NCIRD/ID); Stephanie Bialek; Armstrong, Gregory (CDC/DDID/NCEZID/OD); Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Meredith Lichtenstein
Subject:	CSTE COVID-19 Response | Reminder: Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EDT
Date:	Monday, March 16, 2020 11:20:24 AM
Attachments:	image001.png image002.png image003.png

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Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – Today's CSTE ad hoc weekly COVID-19 All State Epi call is set for 4:00 pm EDT. See the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board. ***Please note: Invitations for this call will only come from Preparedness@cste.org, jarieh@cste.org or mcone@cste.org.***

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. COVID-19 Jurisdictional Supplemental Funding Coordination via Crisis Cooperative Agreement, Sherri Berger, CDC Chief Operating Officer
3. COVID-19 CDC Response Update, Dan Jernigan, CDC IMS Incident Manager
4. COVID-19 Data Preparedness Update, Stephanie Bialek, CDC IMS Epi Task Force Lead
5. COVID-19 Bioinformatics Update, Greg Armstrong, CDC IMS Deputy Incident Manager
6. COVID-19 Nursing Home Preparedness, Satish Pillai, CDC IMS MCCM Task Force Lead
7. CSTE's COVID-19 Resource Repository Basecamp Demo, Meredith Lichtenstein Cone, CSTE
8. Open Forum Discussion

Next Call, Monday, March 23, 2020, 4:00-5:00 pm EDT. ***The previously scheduled March All State Epi call on Monday, March 23 at 3:00 pm EDT is replaced by this 4:00 pm EDT ad hoc call.***

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

Please click the link below to see more information, or to start the session.

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1. Go to https://cste.webex.com/cste/k2/j.php?MTID=tfebaa57e8bddcd420341120137d59a94
2. Log in to your account.
3. Click "Start Now".
4. Follow the instructions that appear on your screen.

To view in other time zones or languages, please click the link
https://cste.webex.com/cste/k2/j.php?MTID=tde7958b3ee30a95af0d6f666cb01aa2c

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Call-in toll number (US/Canada):1-408-792-6300
Show toll-free dialing restrictions: https://www.webex.com/pdf/tollfree_restrictions.pdf
Access code: 794 313 782

For assistance

You can contact Matt Cone at:
mcone@cste.org

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Erin Morton; Jeff Engel; Patel, Anita (CDC/DDID/NCIRD/OD)
Subject:	CSTE COVID-19 Response	Reminder: Ad Hoc Weekly COVID-19 All State Epi Call - TODAY at 4:00 pm EDT
Date:	Monday, March 23, 2020 12:49:06 PM
Attachments:	image001.png image002.png image003.png

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Sent to State Epidemiologists, CLUE and the CSTE Executive Board

As a reminder, today's CSTE ad hoc weekly COVID-19 All State Epi call is set for 4:00 pm EDT. See the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. Washington Liaison Update, Erin Morton, CRD Associates
3. Update on 2020 CSTE Annual Conference, Jeff Engel, CSTE Executive Director
4. CDC COVID-19 Adult and Pediatric Online Self-Checker, Anita Patel, CDC IMS Deputy Incident Manager
5. Open Forum Discussion

Next Call, Monday, March 30, 2020, 4:00-5:00 pm EDT

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Wroblewski, Kelly	APHL; Chaitram, Jasmine; Kuhnert-Tallman, Wendi (CDC/DDID/NCEZID/OD); Scott Becker; Sandra Roush; Shult, Peter; Gautom, Romesh (DOH); Chandrasekera, Ruvani (OS/ASPR/SPPR)
Subject:	CSTE COVID-19 Response | Reminder: Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EDT
Date:	Monday, March 9, 2020 3:26:06 PM
Attachments:	image001.png image002.png image003.png

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Sent to State Epidemiologists, CLUE and the CSTE Executive Board

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1. Welcome and Announcements, Christine Hahn, Idaho State Epidemiologist
2. COVID-19 Diagnostic Laboratory Testing Updates and Discussion
    a. CDC Lab Testing Updates, Wendi Kuehnert, COVID-19 CDC IMS Response Lab Task Force Lead
    b. Public Health Reporting by Commercial Laboratories, Jasmine Chaitram, CDC CSELS/Division of Laboratory Services
    c. APHL Lab Testing Updates, Scott Becker, APHL Chief Executive Officer
    d. Notes from the Field: State Public Health Laboratory Experiences
        i. Washington State Public Health Lab, Romesh Gautom, Lab Director
        ii. Wisconsin State Public Health Lab, Pete Shult, Associate Lab Director
3. COVID-19 Sample Collection for Therapeutics and Vaccine R&D, Ruvani Chandrasekera, Executive Secretariat, HHS/ASPR USG Sample Sharing Working Group
4. Open Forum Discussion

Next Call, Monday, March 16, 2020, 4:00-5:00 pm EDT

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Sandra Roush; Yoon, Paula (CDC/OPHSS/CSELS/DHIS)
Subject:	CSTE COVID-19 Response	Slides from Today"s Ad Hoc Weekly All State Epi Call
Date:	Wednesday, February 19, 2020 5:36:34 PM
Attachments:	image001.png image002.png image003.png COVID19_CSTE call_02.19.2020_for distribution.pdf



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

Thank you to everyone who joined today's ad hoc All State Epi call. A PDF version of slides from the CDC IMS Response Staff COVID-19 presentation are attached. For questions pertaining to SyS data sharing for COVID-19 response, please email nssp@cdc.gov. The next ad hoc weekly All State Epi Call will be Monday, February 24 at 4 pm EST with call information coming soon.

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Sent: Wednesday, February 19, 2020 12:57 PM
To: CSTE Emergency Response <Preparedness@cste.org>
Cc: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>; Sharon Watkins <shawatkins@pa.gov>; Christine Hahn <Christine.Hahn@dhw.idaho.gov>; Sandra Roush <swr1@cdc.gov>; Yoon, Paula (CDC/OPHSS/CSELS/DHIS) <pay3@cdc.gov>
Subject: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST

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Topic: CSTE COVID-2019 Response Ad Hoc Weekly All State Epi Call
Host: Jeremy Arieh
Date: Wednesday, February 19, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)
Session number: 797 772 498
Session password: epi4321

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From:	Tiara Smith
To:	India Bowman; Jesse C. Bliss; Robert Casey; apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Moyer, Ben	APHL; Hainstock, Lisa (MDARD; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro; Sharp, Donald (CDC/DDID/NCEZID/DFWED; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID; Scott E. Holmes; christina.ferguson@dph.ga.gov; Collaro, Thomas - FSIS; Laura Wildey; Amy Chang; Tiara Smith
Subject:	Canceled: CIFOR Promote DT Meeting
Importance:	High

Meeting Cancellation

Due to response efforts around COVID-19, this meeting is being canceled. In lieu of the scheduled meeting, an email with updates and action items is forthcoming.

Thanks,

Tiara

Dear All,

Please save the date, the 3rd Monday of each month, for the CIFOR Promote DT Meeting.

Regards,

Tiara

tsmith@naccho.org <mailto:tsmith@naccho.org> is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/871476261

Meeting ID: 871 476 261

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Dial by your location
+1 929 205 6099 US (New York)
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Meeting ID: 871 476 261
Find your local number: https://naccho.zoom.us/u/acel60w87R

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From: COVID-19

To: Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; DL DOH CHD Administrators_Directors; DL DOH CHD Nursing Directors; COVID-19

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Cc: peter.jennings@ascension.org; Stalcup, Jeanetta; Love, Andrew; Wright, Sarah A; Edwards, Sharlene E; Keyes, Becky (County Health Systems); Moffses, Thomas P; Juengst, Benjamin D; Washington, Tawanda S; Deana Montella, MSN, RN; Jordan, Melissa Murray; Edwards, Jerri S; Speake, Susan; Chapman, Shay; Medalla, Ruben; Lynn, Donna K; Iriye, Jeannette; Lander, Mark S; Johnson, Karen S (HolmesCHD); RuizVillar, Natasha; Moore, Donna H; McClelland, Colleen X; Kirsch, Holly S; Blackburn, Claudia P; DAlessio, Rebecca; DiFede, Matthew; Scheck, RoseAnn X; Harvey, Laura R; Stasko, Audrey R; Bagley, Rebecca L; Bolton, Beate H; Campbell, Sieglinde D; Combs, Sue S; Demott, Monica; Morgan, Cindy D; Waldron, Kerry S; Hinds, Sarah JQ; Maglievaz, Robert A; Seibert, Patricia A; Rolle, Pauline J; Bailey, William H; Sandoval, Randi C; Ramos, Cynthia I; Stremmel, Anita R; Grabelle, Dorothy A; Hickey, Tessa L; Clark, Mindi N; Barron, Robin G; Hart, Ashley E; Hamrick, Kendra D; Mericle, Deanna L; Saulsby, Pamela L; Black, Melanie A; Huffman, Heather E; Pippin, Jessie W; Garcia, Mary L; Sumagpang, Vicki L; Brown, James K; Street, Karen K; Jackson, Sharon D; McGowen, Pamela S; Boobyer, Pamela D; RAYNES, SCOTT; Eastman, Elena A; Tammy Pruse; Hoagland, Jill A; Glenn, Amy; Lanza, John J; Smith, Char-Nequa; Tittel, Christopher J; Paul Glisson; Balsters, Alana H; Buhrow, Rena; Elkins, Vickie; Ranie, Brianna N; Taylor, Beverly A; Hassan, Merfat E; Barron, Kayla M; Lucas, Selena F; McCarty, Joya; Ajayi, Labake M; Willey, Sabrina E; Stewart, Gail; Chapman, Karen A; Mott, Marie B; DL CHD35 Leadership Team; DL CHD35 Hep A Response; Kissler, Aaron X; Choe, Ulyee; Moscoso, Alberto; Williams, Bloscile T; Duque, Diana C; Agens, Mary; Pound, Kerri A; DL CHD29 Corona IMT; James-Glasgow, Olivia N.; Castonguay, Steven M.; Lewis Garvin; Johnson, Natalie N; Altidort, Barbara; Kaye Robinson; McMillan, Emily A; Sarah Mathis; Swearingen, Susannah M; Fellows, Amanda R; Mays, Trilla; Brenda Sears (don.northflorida); Carnley, Debbie L; Adrian Abner; Bass, Emily G; Kent, Linda H; Garrett, Daryl T.; Ronni Bowen; Hickey, Patrick X; Robbin Pumphrey; Rose Crews; Sharp, Tanya; Brad Nobles (admin.courtyard); Sarah Peat; Traci Thomas; spineandneuropain@gmail.com; Lewis, Jylmarie; CERULLO, TIMOTHY; Jennifer Peterson (admin.northflorida); Donna Signature health (adon.northflorida@signaturehealthcarellc.com); Patricia Wilkerson ; Ramos, Victoria L; Smith, Kathy J; Elliot, Jonathan N CDR USN (USA); Roberts, Missy; Wiese, Michael T.; Andrea Levitt; Johnson, Brittany J; Pepe, Joseph D; S Golder; Riggen, Amy; Bencie, Jennifer L; WILLIAMS, RAYMOND; Watler, Kevin; Jason Jerkins; Sewell, Susie W; Conklin, Kelly H; Carson, Margaret G; Dawne Dries; Sutton-Johnson, Sherri; kkripper@kanecenter.org; Rouse, Renay C; Bradley, Edward; Tuero, Kim L; Clifton, Nicholas L; McKay, Leslie W; Young, Shauna L; Reinhold, Todd A; Kevin Daniel; Jernigan, Tammy; Taylor, Lisa G; Hernandez, Carmen A; Albano, John P CIV USN NAVMED OTC NAMI FL (USA); Martin, Donna C; Pritchard, Scott; Gumke, Megan R; Chandra Smiley; Barfield, Jana C; Peggy Norris; Harris, Nicole E.; George Smith M.D.; Rubio, Tito G.; Hogan, Anna M; Suarez, Sarah B; Devin Simmons; kristine lathinghouse; Grant, Dinah; Kern, Lisa; Faustin, Marilyne; Malcolm Thomas; Clincea, Radu; Donado, Louviminda P; Adams, Brenda M; Bontrager, Doris H; Ray, Nichole G; Hudson, Candice L; Fagan, Sean M; Dale Simmons; King, Kelly E; Ketha Hunter (don.courtyard); Amy Sue Ponce; Pino, Raul; Farmer, Brenda J.; ahein@cfhconline.org; Barbara Turner; Eleanor Davis (EMDavis@peacerivercenter.org); Heartland Medicine (shilpasm12@gmail.com); Heartland Pediatrics; heartlandpeds01@gmail.com; James Pyle, DDS (jpyledental@gmail.com); Sonni"s Pediatrics (sonnispeds@gmail.com; Susana Boyett (sboyett@cfhconline.org); william.gill@adventhealth.com; wpeds@sonnipediatrics.com; Coggins, James D.; Doug Underhill; Santos, Efrain; Beal, Jeff A; Arons, Paul; Paul Arons; paronsmd@gmail.com; bwyer@gcmcc.info; Teresa Landau; Dekany, Kristine; Charlette Hayes; Stevens, Teresa; Clark, Tricia L; Wegner, Steven; Casey_Richards@navyfederal.org; Klucznik, Shaun; Danielle White; Gabrielle Pettiford; Dr. Charurut Somboonwit - USF Health (charurut@usf.edu); Wright, Diane K; Marguerite Morgan; Fair, Theresa B

Subject: Canceled: COVID-19 Weekly Clinician Call

Attachments: Healthcare Provider Agenda W 1130.docx

Importance: High

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AMERICAN OVERSIGHT

From: COVID-19

To: Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; DL DOH CHD Administrators_Directors; DL DOH CHD Nursing Directors; COVID-19

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Attachments: Healthcare Provider Agenda W 1130.docx

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To:	Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; DL DOH CHD Administrators_Directors; DL DOH CHD Nursing Directors; COVID-19
Cc:	peter.jennings@ascension.org; Stalcup, Jeanetta; Love, Andrew; Wright, Sarah A; Edwards, Sharlene E; Keyes, Becky (County Health Systems); Moffses, Thomas P; Juengst, Benjamin D; Washington, Tawanda S; Deana Montella, MSN, RN; Jordan, Melissa Murray; Edwards, Jerri S; Speake, Susan; Chapman, Shay; Medalla, Ruben; Lynn, Donna K; Iriye, Jeannette; Lander, Mark S; Johnson, Karen S (HolmesCHD); RuizVillar, Natasha; Moore, Donna H; McClelland, Colleen X; Kirsch, Holly S; Blackburn, Claudia P; DAlessio, Rebecca; DiFede, Matthew; Scheck, RoseAnn X; Harvey, Laura R; Stasko, Audrey R; Bagley, Rebecca L; Bolton, Beate H; Campbell, Sieglinde D; Combs, Sue S; Demott, Monica; Morgan, Cindy D; Waldron, Kerry S; Hinds, Sarah JQ; Maglievaz, Robert A; Seibert, Patricia A; Rolle, Pauline J; Bailey, William H; Sandoval, Randi C; Ramos, Cynthia I; Stremmel, Anita R; Grabelle, Dorothy A; Hickey, Tessa L; Clark, Mindi N; Barron, Robin G; Hart, Ashley E; Hamrick, Kendra D; Mericle, Deanna L; Saulsby, Pamela L; Black, Melanie A; Huffman, Heather E; Pippin, Jessie W; Garcia, Mary L; Sumagpang, Vicki L; Brown, James K; Street, Karen K; Jackson, Sharon D; McGowen, Pamela S; Boobyer, Pamela D; RAYNES, SCOTT; Eastman, Elena A; Tammy Pruse; Hoagland, Jill A; Glenn, Amy; Lanza, John J; Smith, Char-Nequa; Tittel, Christopher J; Paul Glisson; Balsters, Alana H; Buhrow, Rena; Elkins, Vickie; Ranie, Brianna N; Taylor, Beverly A; Hassan, Merfat E; Barron, Kayla M; Lucas, Selena F; McCarty, Joya; Ajayi, Labake M; Willey, Sabrina E; Stewart, Gail; Chapman, Karen A; Mott, Marie B; DL CHD35 Leadership Team; DL CHD35 Hep A Response; Kissler, Aaron X; Choe, Ulyee; Moscoso, Alberto; Williams, Bloscile T; Duque, Diana C; Agens, Mary; Pound, Kerri A; DL CHD29 Corona IMT; James-Glasgow, Olivia N.; Castonguay, Steven M.; Lewis Garvin; Johnson, Natalie N; Altidort, Barbara; Kaye Robinson; McMillan, Emily A; Sarah Mathis; Swearingen, Susannah M; Fellows, Amanda R; Mays, Trilla; Brenda Sears (don.northflorida); Carnley, Debbie L; Adrian Abner; Bass, Emily G; Kent, Linda H; Garrett, Daryl T.; Ronni Bowen; Hickey, Patrick X; Robbin Pumphrey; Rose Crews; Sharp, Tanya; Brad Nobles (admin.courtyard); Sarah Peat; Traci Thomas; spineandneuropain@gmail.com; Lewis, Jylmarie; CERULLO, TIMOTHY; Jennifer Peterson (admin.northflorida); Donna Signature health (adon.northflorida@signaturehealthcarellc.com); Patricia Wilkerson ; Ramos, Victoria L; Smith, Kathy J; Elliot, Jonathan N CDR USN (USA); Roberts, Missy; Wiese, Michael T.; Andrea Levitt; Johnson, Brittany J; Pepe, Joseph D; S Golder; Riggen, Amy; Bencie, Jennifer L; WILLIAMS, RAYMOND; Watler, Kevin; Jason Jerkins; Sewell, Susie W; Conklin, Kelly H; Carson, Margaret G; Dawne Dries; Sutton-Johnson, Sherri; kkripper@kanecenter.org; Rouse, Renay C; Bradley, Edward; Tuero, Kim L; Clifton, Nicholas L; McKay, Leslie W; Young, Shauna L; Reinhold, Todd A; Kevin Daniel; Jernigan, Tammy; Taylor, Lisa G; Hernandez, Carmen A; Albano, John P CIV USN NAVMED OTC NAMI FL (USA); Martin, Donna C; Pritchard, Scott; Gumke, Megan R; Chandra Smiley; Barfield, Jana C; Peggy Norris; Harris, Nicole E.; George Smith M.D.; Rubio, Tito G.; Hogan, Anna M; Suarez, Sarah B; Devin Simmons; kristine lathinghouse; Grant, Dinah; Kern, Lisa; Faustin, Marilyne; Malcolm Thomas; Clincea, Radu; Donado, Louviminda P; Adams, Brenda M; Bontrager, Doris H; Ray, Nichole G; Hudson, Candice L; Fagan, Sean M; Dale Simmons; King, Kelly E; Ketha Hunter (don.courtyard); Amy Sue Ponce; Pino, Raul; Farmer, Brenda J.; ahein@cfhconline.org; Barbara Turner; Eleanor Davis (EMDavis@peacerivercenter.org); Heartland Medicine (shilpasm12@gmail.com); Heartland Pediatrics; heartlandpeds01@gmail.com; James Pyle, DDS (jpyledental@gmail.com); Sonni"s Pediatrics (sonnispeds@gmail.com; Susana Boyett (sboyett@cfhconline.org); william.gill@adventhealth.com; wpeds@sonnipediatrics.com; Coggins, James D.; Doug Underhill; Santos, Efrain; Beal, Jeff A; Arons, Paul; Paul Arons; paronsmd@gmail.com; bwyer@gcmcc.info; Teresa Landau; Dekany, Kristine; Charlette Hayes; Stevens, Teresa; Clark, Tricia L; Wegner, Steven; Casey_Richards@navyfederal.org; Klucznik, Shaun; Danielle White; Gabrielle Pettiford; Dr. Charurut Somboonwit - USF Health (charurut@usf.edu); Wright, Diane K; Marguerite Morgan; Fair, Theresa B
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From:	Tomas Guilarte
To:	bhayden@banyanhealth.org; smarcus@hfsf.org; MFundora@HCNetwork.org; tjames@hcnetwork.org; ptorres@hcnetwork.org; aaafflitto@alz.org; charlesm@allianceforaging.org; Karen.Weller@flhealth.gov; eriko.grover@flhealth.gov; Yesenia.Villalta@flhealth.gov; bkubilus@projectaccessfoundation.net; Trivel.Mckire@flhealth.gov; Edhelene.rico@flhealth.gov; Juan.Suarez@flhealth.gov; Virginia.Munoz@flhealth.gov; MargaretSo@baptisthealth.net; vqi8@cdc.gov; Barbara.Moliere@miamidade.gov; Robinson, Eriko M; hfernandez@camillus.org; cwigutow@entrinsichealth.com; arodr137@fiu.edu; pmartinez@gamechangertec.com; rene@nchdevelopment.com; Ailin Rodriguez-Atia; Janisse Schoepp; cmccoy@med.miami.edu; renee.podolsky@fhealth.gov; kgkimg@gmail.com; Soto, Alina; Mark Macgowan; Yasenka Peterson; Paola Moreno; Miladys Martinez Palacios; Pedro Greer; Tomas Guilarte
Cc:	Hilda Fernandez
Subject:	Canceled: Community Advisory Board Meeting
Attachments:	image001.png Accreditation celebration.png Directions to the FIU Modesto Maidique Campus-Virtual Parking Pass.doc
Importance:	High

Good morning,

In an effort to follow the recommendations of experts for social distancing due to the coronavirus outbreak, the Dean decided to cancel this meeting for now.

We will inform you as soon as a new date has been selected for this meeting.

Thank you!

Kind regards,

Miladys (Milly) Martínez

Senior Executive Assistant to Dean Tomás R. Guilarte

Robert Stempel College of Public Health & Social Work

Florida International University
MMC, AHC5 506

(305) 348-5344| milmarti@fiu.edu <mailto:milmarti@fiu.edu>

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AMERICAN OVERSIGHT

From: Rivkees, Scott A

To: Shepard, Lela; "mcarter@flmedical.org"; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; MThomas@flmedical.org; DL DOH CHD Administrators Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; "Molly.McKinstry@ahca.myflorida.com"; "mary.mayhew@ahca.myflorida.com"; "jeanetta.stalcup@uhsinc.com"; "michelle@foma.org"; "andrew@foma.org"; "govaffairs@foma.org"; "CPrine@flmedical.org"; MThomas@flmedical.org; Rivkees, Scott A

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

AMERICAN OVERSIGHT

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

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When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From: Rivkees, Scott A

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When: Each Wednesday at 2:00 p.m. EST

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

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When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From: Rivkees, Scott A

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When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

AMERICAN OVERSIGHT

From: Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH)

To: Lesinger, Cindy (CDC adph.state.al.us); Nakema.Moss@adph.state.al.us; Michael.Cima@arkansas.gov; McCartney, Kellye (CDC arkansas.gov); Aaron Otis (CDC flhealth.gov); Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); Mark.ONeill@flhealth.gov; Andrea.Leapley@flhealth.gov; Wendy.Sweigert@flhealth.gov; Amy.Riggen@flhealth.gov; Ben.Sloat@dph.ga.gov; Ami.Gandhi@dph.ga.gov; Tracy.Kavanaugh@dph.ga.gov; Lovett, Sheila (CDC dph.ga.gov); Thoroughman, Douglas (CDC ky.gov); Robeson, Sara (CDC ky.gov); Amanda.Hunt@ky.gov; Johnson, Tisha (CDC ky.gov); jennifer.khoury@ky.gov; Schweitzer, Jody (CDC ky.gov); Anderson, Emily A. (CDC ky.gov); Sokol, Theresa (CDC la.gov); stacy.hall@la.gov; Jenna.IbergJohnson@la.gov; Frank Welch; Paul.Byers@msdh.ms.gov; Jannifer.Anderson@msdh.ms.gov; Kittle, Theresa (CDC msdh.ms.gov); Shipp, Rebecca; erica.wilson@dhhs.nc.gov; christina.caputo@dhhs.nc.gov; natalie.bontrager@dhhs.nc.gov; justin.albertson@dhhs.nc.gov; susan.sullivan@dhhs.nc.gov; Holmes, Wendy (CDC dhhs.nc.gov); Drociuk, Dan (CDC dhec.sc.gov); White, Stephen (CDC dhec.sc.gov); Cassandra.Jones@tn.gov; SHOC.Epidemiologist@tn.gov; Michelle.Fiscus@tn.gov; Haralson, Catherine (CDC tn.gov); Latoya.Antoine@tn.gov; John.Benitez@tn.gov; SHOC.Planning@tn.gov; Amy.Cox@tn.gov; Shavetta.Conner@tn.gov; Sean.J.Kice@tn.gov; Peter Koonz; Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Montgomery, Martha (CDC/DDID/NCHHSTP/DVH); Weng, Mark (CDC/DDID/NCHHSTP/DVH); Augustine, Ryan (CDC/DDID/NCHHSTP/DVH); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Teshale, Eyasu H. (CDC/DDID/NCHHSTP/DVH); Cooley, Laura A. (CDC/DDID/NCHHSTP/DVH); Chappell, Shauntrelle L. (CDC/DDID/NCIRD/ISD); Awwad, Hanan (CDC/DDID/NCIRD/ISD); Schwartz-Kitchens, Tricia (CDC/DDID/NCIRD/ISD); Crawford, Nathan E. (CDC/DDID/NCIRD/ISD); mschroeder@cste.org; Hamilton, Janet (CDC cste.org); Shah, Dhara (CDC cste.org); Danila, Richard (CDC state.mn.us); traxlelb@dhec.sc.gov; Sanders.Kelsey (DSHS); Leos.Greg (DSHS); Salinas.Andrea (DSHS); Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH)

Cc: william.ledford@arkansas.gov

Subject: Canceled: Hepatitis A Regional Call - HHS Regions 4 & 6

Importance: High

Hi All,

We know you're busy either responding to COVID-19 or covering for colleagues who are responding, so out of respect for the competing demands on your time we're going to cancel this round of hepatitis A regional calls. Please don't hesitate to reach out or email viralhepatitisoutbreak@cdc.gov <mailto:viralhepatitisoutbreak@cdc.gov> with any questions or concerns. We're still available to help in any way we can.

Thanks,

Megan

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From:	Karl Ensign
To:	Esther Muna; Livinson Taulung (LTaulung2@fsmhealth.fm); Laurent Duenas, MPH, BSN, RN; Emais Roberts; Catherine de la Cruz Duran; Bruce Bilimon; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com); Nate Smith; Angell, Sonia Y@CDPH; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; Howard Zucker; John Wiesman; Motusa Nua; Karl Ensign
Cc:	Reva Ferguson; Rachelle Ashe; Peggy Ullom; linda.fullem@flhealth.gov; Tangonan, Sharon S.; Jacqueline Silvia; Terry Bergener; Eti Uiagalelei; Janet Guerrero; Fancy Soloman; Suzanne Kaneshiro; Lalie Ikluk; Marline Loeak; Louise Baa; Aniah John; Carolyn Mullen; Michael Fraser; Joe Davis; Taveras, Sam (CDC/OSTLTS/DPHCD); Jose T. Montero, MD, MPH; Subroto Banerji; lauri.ogumoro@dph.gov.mp; Danny Staley; Carolyn McCoy; Cendra Clarke; Christi Mackie; Mark Mioduski; Emi Chutaro (emic@pihoa.org); Gallo, Bill (CDC/OSTLTS/DPHCD); Ottley, Basil C
Subject:	Canceled: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Attachments:	image001.png Agenda-Insular Affairs Subcommittee Dinner Convening.Final Agenda.docx ASTHO Insular Areas Background.Short.docx Insular Areas Subcommittee Priorities Identified to Date.2.2020.docx
Importance:	High

Dear Subcommittee on Insular Affairs Members & Meeting Participants –

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

Apologies for multiple emails.

Thanks,

Karl

From: Karl Ensign
Sent: Sunday, February 23, 2020 3:35 PM
To: esther.muna@dph.gov.mp <mailto:esther.muna@dph.gov.mp> ; Livinson Taulung (LTaulung2@fsmhealth.fm <mailto:LTaulung2@fsmhealth.fm>) <LTaulung2@fsmhealth.fm <mailto:LTaulung2@fsmhealth.fm> >; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov <mailto:laurent.duenas@dphss.guam.gov> >; Emais Roberts MD (emais.roberts@palauhealth.org <mailto:emais.roberts@palauhealth.org>) <emais.roberts@palauhealth.org <mailto:emais.roberts@palauhealth.org> >; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov <mailto:catherine.delacruz@salud.pr.gov> >; Bruce Bilimon <rmiminister.mohhs@gmail.com <mailto:rmiminister.mohhs@gmail.com> >; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com <mailto:justa.elisa@gmail.com>) <justa.elisa@gmail.com <mailto:justa.elisa@gmail.com> >; Nate Smith, MD <Nathaniel.Smith@arkansas.gov <mailto:Nathaniel.Smith@arkansas.gov> >; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov <mailto:Sonia.Angell@cdph.ca.gov> >; scott.rivkees@flhealth.gov <mailto:scott.rivkees@flhealth.gov> ; bruce.s.anderson@doh.hawaii.gov <mailto:bruce.s.anderson@doh.hawaii.gov> ; howard.zucker@health.ny.gov <mailto:howard.zucker@health.ny.gov> ; John Wiesman <jmwiesman@doh.wa.gov <mailto:jmwiesman@doh.wa.gov> >; Motusa Nua <tuinua@doh.as <mailto:tuinua@doh.as> >
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Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

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

Tuesday, February 25th, 2020

4:00 – 5:30 pm ET

Madison Hotel – Adams B

1177 15th Street, NW

Washington, DC 20005

A calendar invite will follow.

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

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

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

The Insular Affairs Subcommittee to the ASTHO Government Affairs Policy Committee was formed in 2018 to identify the unique policy needs and priorities of the Pacific and Atlantic jurisdictions. The subcommittee provides a forum for ASTHO's members to exchange information on policy challenges and solutions within the insular areas. Additionally, the subcommittee provides recommendations to the full committee on policy priorities.

See you soon!

Karl

Karl Ensign, Chief
Territorial Support

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials

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

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Cc:	Barker, Brenda; Debra Hibbard; Karen Meyer; Candice Frude; Rodack, Kristen; Kari Earle; Early, Kimberly; Mauldin, Lindsey; Anne R Lindsay; Daskalov, Rachel; Schrode, Dianne; Karanda, Kimberly; Jill Gresham; Yaryna Onufrey; Kelly H Webber; Berube, Jayne (HRSA); Deanna.Herold@jfs.ohio.gov
Subject:	Canceled: OMNI ASTHOConnects: Plans of Safe Care
Attachments:	image001.png
Importance:	High

Due to ASTHO's heightened response to COVID-19 and our priority to support our members, we are indefinitely postponing this ASTHOConnects on Plans of Safe Care. Please let the ASTHO team know if you have any questions.

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AMERICAN OVERSIGHT

From:	Allison Chan
To:	Darryl.Pendergrass@adph.state.al.us; ramandeep.kaur@adph.state.al.us; Melanie.Chervony@adph.state.al.us; Sharon.Massingale@adph.state.al.us; Aretha.Williams@adph.state.al.us; uzo0@cdc.gov; gpf1@cdc.gov; pwj4@cdc.gov; nub7@cdc.gov; goy3@cdc.gov; ivk6@cdc.gov; vgg9@cdc.gov; ARLN@cdc.gov; jbesser@cdc.gov; Jwp6@cdc.gov; ekersh@cdc.gov; vsrinivasan@cdc.gov; gyi2@cdc.gov; idz4@cdc.gov; Tammy.Jernigan@flhealth.gov; nychie.dotson@flhealth.gov; Susanne.Crowe@flhealth.gov; Kendra.Edwards@flhealth.gov; Patty.Lewandowski@flhealth.gov; Carina.Blackmore@flhealth.gov; Sasha.Nelson@flhealth.gov; Jason.Blanton@flhealth.gov; Nicole.Castro@flhealth.gov; Sarah.Schmedes@flhealth.gov; Jeanne.Negley@dph.ga.gov; Mary.Connelly@dph.ga.gov; Tiffany.Rivers@dph.ga.gov; cherie.drenzek@dph.ga.gov; amanda.jara@dph.ga.gov; Michael.Anderson@dph.ga.gov; Tonia.Parrott@dph.ga.gov; Joanna.Wagner@dph.ga.gov; Doug.Blomberg@dph.ga.gov; Erica.Washington@LA.gov; Lauren.Kleamenakis@la.gov; Ashley.Terry@la.gov; Jean-Jacques.Aucoin@LA.GOV; Stephanie.Kleinpeter@LA.GOV; Theresa.Sokol@LA.GOV; raoult.ratard@la.gov; Fatima.Brakta@la.gov; alexa.ramirez@la.gov; Kirbie.StJames@la.gov; Cynthia.Allard@msdh.ms.gov; Daphne.Ware@msdh.ms.gov; paul.byers@msdh.ms.gov; Militza.Echevarria@salud.pr.gov; inelia.otero@salud.pr.gov; ilsa.villegas@salud.pr.gov; Norma.Diaz@salud.pr.gov; Tabatha East; Linda Thomas; Dorothy Baynham; Richard Steece; Matthew Estes; Jessica Barnes; Henrietta Hardin; Daniel Golson; Amelia A. Keaton; Tracy McLemore; Victoria Stone; Katie Thure; Paula L. Gibbs; Xiaorong Qian; Kara Levinson; Carol Rauch; Sara Belknap; Robin M. Rasnic; Natasha Lindahl; Randall Morris; Albert Burks; lhsmith@utah.gov; arossi@utah.gov; Allison Chan
Subject:	Canceled: Q1 SE Regional AR Lab Network Call
Attachments:	ATT23545 1.jpg
Importance:	High

COVID-19 is an emerging, rapidly evolving situation and we recognize that AR Lab Network lab staff and epidemiologists are being asked to shift their focus away from regular duties to the COVID-19 response. We have decided to postpone our next SE Regional call after receiving feedback from the jurisdictions in the SE Region.

We plan to choose an alternative date for our next regional call and will keep you all updated.

Thanks!

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From: TMS Mailbox (CDC)

To: CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD); CDC EISO Class 2018; Carroll, Dianna D. (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD); Robinson, Byron (CDC/DDPHSS/CSELS/DSEPD); Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD); Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD); Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Liang, Jennifer (FDA/CDER); Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD); Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD); CDC EISO EAC Roster 2018; Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Henning, Tara C. (CDC/DDPHSS/CSELS/DSEPD); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Kennedy, Cynthia (CDC/DDPHSS/CSELS/DSEPD); Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD); Teresa and John Horan; Ralph H. Henderson,M.D.; Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Amos, Renee J. (CDC/DDPHSS/CSELS/DSEPD) (CTR); Bradley, Seliscia A. (CDC/DDPHSS/CSELS/DSEPD); Cordeira, Kelly (CDC/DDPHSS/CSELS/DSEPD); Wiese, Nicholas (CDC/DDID/NCEZID/DHCPP); Mayer, Oren (CDC/DDID/NCEZID/DHCPP); York, Shannon (CDC/DDPHSS/CSELS/DSEPD); Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP); Hott, Amanda (CDC/DDID/NCHHSTP/DTE); Woodson, Evonne (CDC/DDID/NCHHSTP/DSTDP); Stokes, Kindra (CDC/DDPHSS/CSELS/DLS); Scherer, Erin (CDC/DDID/NCIRD/DBD); Jacobs, Jesica (CDC/DDPHSS/CSELS/DSEPD); Buono, Sean (CDC/DDID/NCIRD/DBD); Carlson, Christina (CDC/DDPHSIS/CGH/DPDM); Freeman, Brandi (CDC/DDID/NCIRD/DVD); Levinson, Kara (CDC/DDPHSS/CSELS/DSEPD); Wadhwa, Ashutosh (CDC/DDID/NCEZID/DHQP); Barkley, Joi (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC LLS Class 2018; CDC LLS Class 2019; CDC EISO Class 2019; TMS Mailbox (CDC)

Subject: Canceled: THIS SEMINAR HAS BEEN CANCELLED: TMS Presents: Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

Attachments: image003.jpg

Importance: High

AS A RESULT OF THE COVID-19 RESPONSE, THIS SEMINAR HAS BEEN CANCELLED.

Maureen will be asked to present her work at a later date.

Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

SPEAKER

Maureen Miller, MD MPH

EIS officer in the National Center for Chronic Disease Prevention and Health Promotion

Attendance Options and Continuing Education

* Remote options: • IPTV <http://cdciptv.cdc.gov/> • Envision <http://crss.cdc.gov/EnvisionList.aspx> • Adobe webinar <https://virtualsepd.adobeconnect.com/tms2/>

• Audio conference (1-866-761-5101, passcode "8445480#")

* Continuing education (CE) is available; see the TMS CE instructions <http://intranet.cdc.gov/csels/dsepd/pdfs/HowToGetContinuingEd.pdf> .

* See the TMS schedule and CE statements <http://intranet.cdc.gov/csels/dsepd/ewb/tuesday-monthly-seminars.html> .

* There is no cost for this activity.

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From:	EIS (CDC)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019
Cc:	CDC CSELS DSEPD EWB; Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Black, Erin (CDC/DDPHSS/CSELS/DSEPD)
Subject:	Cancellation of EIS conference – next steps
Date:	Monday, March 16, 2020 12:40:45 PM

EISOs,

I am writing to inform you of the cancellation of the EIS conference scheduled for May 4–7th. As of March 15, 2020, CDC is recommending the cancellation or postponement of in-person events consisting of 50 people or more throughout the U.S. We have been working on contingency planning for weeks and we determined that even a virtual conference is not feasible given the presenters and audience are needed for the COVID-19 response. During this time, response priorities take precedence over developing presentations for EIS Conference.

We understand that cancelling conference has broad implications for all of you, especially the 2nd year EISOs. We are cognizant of the potential impacts on CAL completion, job searching, graduation, and other elements that are important to all of you and the program. We want you to know the following:

- The match for the incoming class will be conducted virtually with an extended recruitment period starting on March 23, 2020 and an extended period for virtual interviewing from April 20 – May 8.
- We will work with 2nd year officers on a case-by-case basis if your COVID-19 response involvement might compromise your ability to complete your CALs. We do not want CAL completion to be a deterrent to your involvement. If you have concerns, please reach out to your EWB supervisor or CIO liaison to discuss your situation.
- We are working to plan a 2-day EIS presentation and graduation event for June. The event would include presentations from 2nd year EISOs who needed conference to fulfill the CAL requirement, a graduation ceremony, and the EIS satirical review.
- We know that EIS conference is a time when many of you were planning to network and interview for jobs. We are working to identify alternative ways to support your search for CDC jobs.

For all of you currently or preparing to deploy, we hope that the cancellation of the conference alleviates any tension you might have been experiencing regarding how to prepare your presentation in the midst of COVID-19, Ebola, and polio responses.

EISO's are playing a vital role in supporting this nation's public health response, at the local, state, and federal level. Thank you for your service. Your dedication and contributions are valued and appreciated. At this time, we expect every EISO to contribute to the response in some way. We expect most field EISOs are supporting the response within their assigned jurisdiction and do not expect you to deploy elsewhere. If you are not already involved in response activities, please volunteer now. If you need guidance on how to find a deployment role, please contact us at EpiAid@cdc.gov. If you have had difficulty obtaining supervisory approval to support the response,

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please contact your CIO liaison or EWB supervisor so that we can assist.

Please reserve time on your schedules for a **call on March 18, 2020 at 12 pm EST** to answer your questions and discuss planning for an EIS presentation and graduation event for all EISOs tentatively scheduled for June. We will be sending the link for the Skype Meeting ASAP.

Respectfully,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.



AMERICAN OVERSIGHT

From:	Brad Neal
To:	gabastouj@paho.org; infectiousdiseases@wustl.edu; ruth.lynfield@state.mn.us; jpatters@txbiomed.org; michael.macnaughton@swri.org; HSR7.COVID@dshs.texas.gov; lfrenkel@uw.edu; john.aitchison@seattlechildrens.org; kdl8@cdc.gov; april.davis@health.ny.gov; costas.danis@santepubliquefrance.fr; sjp97@medschl.cam.ac.uk; elke.mertens@niga.niedersachsen.de; globalhealth@hhs.gov; pi@usaid.gov; yadira.medrano@cdph.ca.gov; joseph.mclaughlin@alaska.gov; sherri.davidson@adph.state.al.us; a.tufa@doh.as; shirley.louie@arkansas.gov; ken.komatsu@azdhs.gov; James.watt@cdph.ca.gov; rachel.herlihy@state.co.us; rickey.tolliver@state.co.us; matt.cartter@ct.gov; john.davies-cole@dc.gov; Tabatha.Offutt-Powell@state.de.us; vskilling@fsmhealth.fm; Carina.Blackmore@flhealth.gov; Cherie.Drenzek@dph.ga.gov; Ann.Pobutsky@dphss.guam.gov; sarah.park@doh.hawaii.gov; caitlin.pedati@idph.iowa.gov; hahnc@dhw.idaho.gov; Craig.Conover@illinois.gov; ppontones@isdh.in.gov; farah.ahmed@ks.gov; Douglas.thoroughman@ky.gov; raoult.ratard@la.gov; catherine.brown@state.ma.us; david.blythe@maryland.gov; Siiri.bennett@maine.gov; lyoncallos@michigan.gov; george.turabelidze@health.mo.gov; paul.byers@msdh.ms.gov; lwilliamson@mt.gov; Zack.Moore@dhhs.nc.gov; tkmiller@nd.gov; tom.safranek@nebraska.gov; Benjamin.Chan@dhhs.nh.gov; christina.tan@doh.state.nj.us; michael.landen@state.nm.us; paul.white@dph.gov.mp; mpeekbullock@health.nv.gov; debra.blog@health.ny.gov; Sietske.deFijter@odh.ohio.gov; Laurence@health.ok.gov; dean.e.sidelinger@dhsoha.state.or.us; shawatkins@pa.gov; carmen.deseda@salud.pr.gov; utpala.bandy@health.ri.gov; belllw@dhec.sc.gov; joshua.clayton@state.sd.us; john.dunn@tn.gov; Stephen.Pont@dshs.texas.gov; esther.ellis@doh.vi.gov; angeladunn@utah.gov; lilian.peake@vdh.virginia.gov; patsy.kelso@vermont.gov; Lori.Cragin@vermont.gov; scott.lindquist@doh.wa.gov; cathy.wasserman@doh.wa.gov; jonathan.meiman@dhs.wisconsin.gov; Ryan.Westergaard@dhs.wisconsin.gov; Maria.C.Delrosario@wv.gov; alexia.harrist1@wyo.gov
Subject:	Cheap and Possibly Effective Virucide for COVID-19
Date:	Wednesday, March 18, 2020 3:34:57 AM

Dear Distinguished Officials,

I write to you all - leaders in public health - asking that you please consider recommending Copper Sulfate (CuSO4) as a virucide against "SARS-CoV-2" .

I recently read that the COVID-19 virus dies much more quickly on copper/copper-alloy surfaces, than on other smooth (metal) or porous or fibrous materials. I found, in a 2015 article by the (US) NHS, that copper sulfate solutions were found to be particularly destructive to corona virus' shells.
Therefore, given copper sulfate's availability, low cost, low toxicity (to humans), and effectiveness as a virucide (against corona viruses), please consider recommending – at least testing – the use of a dilute, aqueous solution of this mineral in our collective fight against COVID-19.
Possible modes of employment:

- Disinfect surfaces – and leave a disinfecting residue – by spraying or wiping dilute solutions on them.
- Disinfect clothing and linens – and impregnating them with a disinfecting residue – by dipping them into dilute solutions…This could be effected in automatic washing machines by adding (dry) crystals during the rinse cycle. [Understand that, if employed in this latter method, biological wastewater treatment systems could be adversely affected, temporarily.]
- Disinfect skin and hair – and leave a disinfecting residue – by adding an appropriate amount to a body spray or a bath water.

I've no financial interest in the mining or sale of this mineral. I do have a financial interest in the global economy not grinding to a halt.
I'm approaching you all, rather than take my theory/idea to social media, so that you can vet the suggestion's viability and suitability.

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Sincerely,
Brad Neal
Houston, Texas

AMERICAN OVERSIGHT

From:	Kincaid, Brooke
To:	Peterson, Amy; LogisticsDesk2; Deleon, Melissa (FLNG); Bequer, Samantha; Guidicelli, Ian; McWhorter, Linda; Dumas, Wendell; EOC-Plans; Mahon, Jason; Anspaugh-Naples, Stephanie; courtney.coppola@flhealth.gov
Subject:	Community Based Testing Sites- SitRep from 3-23-20
Date:	Tuesday, March 24, 2020 9:43:33 AM
Attachments:	POC Sit Report 03232020.xlsx

All,

Please see the attached SitRep, for personnel and potential burn rates for the Community Based Testing Sites. However, new numbers came in during the morning briefing on tests conducted. The most up to date numbers can be found in below:

Jacksonville- TIAA Stadium
Federal Tests- 254
Not Meeting Criteria- 184

Orlando- Convention Center
First Responder Testing- 3/25
General Public Testing- 3/26

Broward- CB Smith Park
Tested- 799
Not Meeting Criteria- 272

Miami- Hard Rock
Federal Tests- 200
State Testing- 575
Not Meeting Criteria- 187

Brooke Kincaid, MPA | Recovery Regional Manager and Region 2
Bureau of Recovery
Florida Division of Emergency Management
Rebuilding Together
(850)-567-6197 (c)
(850) 815-4437 (o)
Email: Brooke.Kincaid@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From:	Kincaid, Brooke
To:	Guthrie, Kevin; courtney.coppola@flhealth.gov; Peterson, Amy; LogisticsDesk2; Deleon, Melissa (FLNG); Bequer, Samantha; Guidicelli, Ian; McWhorter, Linda; Dumas, Wendell; EOC-Plans; Mahon, Jason; Anspaugh-Naples, Stephanie; EOC Logistics Section
Subject:	Community Based Testing Sites- SitRep from 3-25-20
Date:	Wednesday, March 25, 2020 6:35:43 PM
Attachments:	CBTS Daily Master SitRep 032520.xlsx

Please find attached.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons
Date:	Tuesday, February 25, 2020 7:29:24 PM
Attachments:	CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please find attached a document that **summarizes important information for state and local health departments regarding the medical detention of foreign nationals.**

This document comes from the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained, such as in the case when a quarantine order is issued because of possible exposure to COVID-19 disease.

We hope this information will offer guidance and a timely summary of notification requirements whenever a jurisdiction deems it necessary to isolate, quarantine, or otherwise medically detain a foreign national.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons
Date:	Tuesday, February 25, 2020 7:31:22 PM
Attachments:	CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please find attached a document that **summarizes important information for state and local health departments regarding the medical detention of foreign nationals.**

This document comes from the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained, such as in the case when a quarantine order is issued because of possible exposure to COVID-19 disease.

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Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons
Date:	Tuesday, February 25, 2020 7:26:22 PM
Attachments:	CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf
Importance:	High

Dear Colleagues:

Please find attached a document that **summarizes important information for state and local health departments regarding the medical detention of foreign nationals.**

This document comes from the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained, such as in the case when a quarantine order is issued because of possible exposure to COVID-19 disease.

We hope this information will offer guidance and a timely summary of notification requirements whenever a jurisdiction deems it necessary to isolate, quarantine, or otherwise medically detain a foreign national.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	Corrected - CDC COVID-19 Daily Key Points for February 29th
Date:	Sunday, March 1, 2020 12:44:04 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf

FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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Alternate phone numbers
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cell: 202.909.6950 Verizon (secondary)

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

To: jacqueline@doh.as; bensili@doh.as; Nathan.Koffarnus@health.mo.gov; john.bos@health.mo.gov; Kelso, Patsy (CDC vermont.gov); Cook, Sally (CDC vermont.gov); William.Fritch@vermont.gov; Read, Jennifer (CDC vermont.gov); Turner, Kathryn (CDC dhw.idaho.gov); scott.hutton@dhw.idaho.gov; Iyengar, Preetha (CDC dc.gov); McGee, Sasha (CDC dc.gov); jennifer.myers@cdph.ca.gov; Lowenthal, Phil (CDC cdph.ca.gov); Ed.Powers@cdph.ca.gov; Charsey.Porse@cdph.ca.gov; Robert.Snyder@cdph.ca.gov; selam.Tecle@cdph.ca.gov; Charlotte.Girocco@cdph.ca.gov; jhmsablan@gmail.com; ginger.stringer@state.co.us; tasha.poissant@state.or.us; emilio.e.debess@state.or.us; alexia.y.zhang@state.or.us; amanda.e.faulkner@state.or.us; Linda.DeNorcey@dphss.guam.gov; Madeline.K.Levasseur@dhsoha.state.or.us; Powell, Melissa (CDC state.or.us); kelly.e.cogswell@state.or.us; Rekant, Steven (CDC dhsoha.state.or.us); Clayton, Joshua (CDC state.sd.us); Horan, Vickie (CDC state.sd.us); dustin.ortbahn@state.sd.us; Kipp.Stahl@state.sd.us; 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Subject:	DCIPHER DEMO: COVID-19 Traveler Health Screening Data
Attachments:	COVID-19 Response Travel Training Document.pdf

Please join us at the next demonstration of how to access COVID-19 Traveler Health Screening Data in the Data Collation & Integration for Public Health Event Response (DCIPHER) platform. This demo is similar to the first demo held last week, and appropriate for new DCIPHER users, or users who would like a refresher. Please forward to relevant members of your state teams, as necessary.

This demo will be facilitated by CDC DCIPHER technical staff, and CDC DGMQ staff.

Please note The demo will be live, however, participants are not required or expected to log into DCIPHER and follow along. If participants do not currently have access to DCIPHER, the demo is still a beneficial introduction to how the system is being utilized in the CDC COVID-19 Response.

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[!OC([1033])!]

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Cc:	Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR)
Subject:	DCIPHER Users: CDC Aggregate Travel Module is due March 4 and there will be another Training March 6th- details below.
Date:	Tuesday, March 3, 2020 1:09:18 PM
Attachments:	DCIPHER QA Monitoring_03March2020.pdf

Good afternoon,

This email serves as a reminder that aggregate counts for monitoring of travelers in your jurisdiction are **due weekly each Wednesday by 8 p.m. ET.**

Jurisdictions that successfully entered initial information should submit aggregate counts for each variable for the period from **February 26, 2020, through March 3, 2020** by 8p.m. March 4, 2020**.**

Jurisdictions first entering information on March 4, 2020 should submit two entries. First, complete the form with aggregate counts **from February 5, 2020, through February 25, 2020.** Then submit a second form with aggregate counts from **February 26, 2020, through March 3, 2020.**

Refer to the attached Q/A if you have questions about the monitoring form.

Another DCIPHER training is planned for Friday, March 6, 2020 at 1:30pm. Below is the call in information. A calendar invitation for the training was also sent today.

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Kimberly
Kimberly Cantrell

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State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

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Subject: DCIPHER Users: CDC Weekly Aggregate Travel Report due March 18

Date: Tuesday, March 24, 2020 1:40:02 PM

Attachments: DCIPHER QA Monitoring_03March2020.pdf

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Good afternoon,

This email serves as a reminder that aggregate counts for monitoring of travelers in your jurisdiction are **due weekly each Wednesday by 8 p.m. ET.**

A variable to indicate **Reporting Period** was added to the form. Submit one report for each time period that has passed; there is no need to update previously submitted information. Jurisdictions up to date on submissions, only need to submit aggregate counts by March 25, 2020 for each variable for the period from **March 18, 2020, through March 24, 2020.**

Refer to the attached Q/A if you have questions about the monitoring form.

Thank you, Devi

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

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

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Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR)

Subject: DCIPHER Users: CDC Weekly Aggregate Travel Report due March 18

Date: Tuesday, March 17, 2020 6:38:49 PM

Attachments: DCIPHER QA Monitoring_03March2020.pdf

Good afternoon,

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This email serves as a reminder that aggregate counts for monitoring of travelers in your jurisdiction are **due weekly each Wednesday by 8 p.m. ET.**

A variable to indicate **Reporting Period** was added to the form. Submit one report for each time period that has passed; there is no need to update previously submitted information. Jurisdictions up to date on submissions, only need to submit aggregate counts by March 18, 2020 for each variable for the period from **March 11, 2020, through March 17, 2020.**

Refer to the attached Q/A if you have questions about the monitoring form.

Thank you, Devi

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

Wendy Holmes: 404-452-9792

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From: DNPAO Program (CDC)

To: rlw0031@auburn.edu; llewis@thewellnesscoalition.org; jvincent@uaex.edu; llopezlove@uams.edu; erica.smith@pima.gov; Chesley.Blevins@sdcounty.ca.gov; Eugenio.Garcia@cdph.ca.gov; Priscila.Hegger@sdcounty.ca.gov; Cowling, Linda (CDC cdph.ca.gov); joan.brucha@state.co.us; smild001@hartford.gov; Marcia.Pessolano@ct.gov; alisoncberg@uga.edu; hgsouthall@uga.edu; carolyn.minter@dph.ga.gov; paula@healthysavannah.org; Toni.Nettles1@dph.ga.gov; janna.simon@iphionline.org; jedwards@marionhealth.org; alison.gustafson@uky.edu; jlian2@uky.edu; Brian.Boisseau@ky.gov; jfreightman@agcenter.lsu.edu; aguilart@worcesterma.gov; bolenc@worcesterma.gov; clarkke@worcesterma.gov; Msteve37@emich.edu; sshopinski@nkfm.org; cherylee.sherry@state.mn.us; Bishop, Susan (CDC state.mn.us); Cindy.Deblauw@health.mo.gov; Simmons, Pat (CDC health.mo.gov); msmith@ext.msstate.edu; jroach@msphi.org; tcollins@msphi.org; ACarmenia@raoassist.org; dave.gardner@dhhs.nc.gov; emilie@copeproject.org; npope@phs.org; smartin@caiglobal.org; daniel.french@health.ny.gov; mbenko@ccbh.net; nshaw@ccbh.net; Mildred Williamson (CDC aol.com); kelly.corfman@odh.ohio.gov; lacey.wallace@okstate.edu; charlene.a.mcgee@multco.us; aja.wilkerson@AlleghenyCounty.US; hannah.hardy@alleghenycounty.us; jzechman1@pennstatehealth.psu.edu; Bransteitter, Tiffany (CDC pa.gov); kedward@clemson.edu; bhinds@utk.edu; anna.macnak@sanantonio.gov; Denise.Benoit-Moctezuma@sanantonio.gov; Joan.Enderle@heart.org; valeria.jauregui@ag.tamu.edu; Fronberg, Rebecca (CDC utah.gov); jan.capps@kingcounty.gov; Ellings, Amy (CDC doh.wa.gov); ann.potempa@alaska.gov; tparker@thewellnesscoalition.org; cpalenske@uaex.edu; mmmeredith@uams.edu; Ptolliver@uams.edu; abigail.kesner@state.co.us; Chelsea.Cobb@dph.ga.gov; chambree.harris@dph.ga.gov; Kelly.Clay@dph.ga.gov; Jenna.frkovich@iphionline.org; Josh.Gryniewicz@iphionline.org; jdeskins@marionhealth.org; EllenH.Cartmell@ky.gov; RLosavio@agcenter.lsu.edu; cgiles@nkfm.org; mgerlach@nkfm.org; esensing@nkfm.org; jthompson@fcgworks.com; melissa.rockett@dhhs.nc.gov; mary.larson2@ndsu.edu; mcrousillat@caiglobal.org; Brett.spencer@dshs.texas.gov; dmecham@utah.gov; Lara.Sim@seattlechildrens.org; Douglas.Wagoner@doh.wa.gov; Killman, Molly (CDC adph.state.al.us); becky.adams2@arkansas.gov; bonnie.williams@azdhs.gov; stephanie.martinez@azdhs.gov; joann.jolly@dc.gov; Diggs, Robin (CDC dc.gov); Gatto, Fred (CDC state.de.us); shebra.hall@delaware.gov; Asma.Odeh@flhealth.gov; sade.collins@flhealth.gov; Roberson, Shamarial (CDC flhealth.gov); Hansen-Smith, Heidi (CDC doh.hawaii.gov); Irvin, Lola (CDC doh.hawaii.gov); ivie.smart@dhw.idaho.gov; Katie.Lamansky@dhw.idaho.gov; Miles, Cheryl (CDC illinois.gov); Jimenez, Paula (CDC illinois.gov); kbarrick@isdh.in.gov; Bouza, Lindsey (CDC isdh.in.gov); Olson, Erin (CDC idph.iowa.gov); sarah.taylorwatts@idph.iowa.gov; Jennifer.Church@ks.gov; Warren.Hays@ks.gov; Daisha.bonhomme@la.gov; Rhodes, Robin (CDC la.gov); kim.etingoff@state.ma.us; Pier, Kristi (CDC maryland.gov); Littlefield, Dawn (CDC maine.gov); DelatorreJ@michigan.gov; Imes, Gwen (CDC michigan.gov); maria.evora2@state.ma.us; James.Martin@msdh.ms.gov; Grant, Tiffani (CDC msdh.ms.gov); Hughes, Kara (CDC mt.gov); Zanto, Mandi (CDC mt.gov); jlpastir@nd.gov; Coyle, Brian BC (CDC nebraska.gov); Scholz, Tammie (CDC nebraska.gov); Janis.Mayer@doh.nj.gov; Melita.Jordan@doh.nj.gov; jaosalvo@health.nv.gov; stephanieu@health.ok.gov; JENNIFER.J.CHANDLER@dhsoha.state.or.us; carol.hallwalker@health.ri.gov; Sue.AnderBois@commerceri.com; Boykin, Erica EB (CDC dhec.sc.gov); Phillips, Lori (CDC dhec.sc.gov); Skjonsberg, Larissa (CDC state.sd.us); Alverson, Susan (CDC state.sd.us); Kamp, Susan (CDC vermont.gov); Gisel.Prado@sanantonio.gov; Sonia.Gonzales@sanantonio.gov; suzanne.kelley@vermont.gov; Lexi.Davis@dhs.wisconsin.gov; Pesik, Mary (CDC wisconsin.gov); Wright, Jessica (CDC wv.gov); CDC ONDIEH NCCDPHP NCCD DNPAO PDEB; Thomas, Christopher N. (CDC/DDNID/NCCDPHP/DNPAO); Tensuan, Lisa (CDC/DDNID/NCCDPHP/DNPAO) (CTR); DNPAO Program (CDC)

Subject: DNPAO Networking Call - What Makes a News Story?

Dear SPAN, HOP, and REACH program recipients,

Please join CDC's Division of Nutrition, Physical Activity, and Obesity for the following Networking Call:

"What Makes a News Story?"

Thursday, April 9, 2020

2:00-3:30 pm EDT

Who should participate?

Principal Investigators, Program Managers, communication staff, and other interested staff

*Principal Investigators – please forward this invitation to other staff working on communication activities.

How do I connect?

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Participants must register <https://fhi360smc.adobeconnect.com/sct_april2020/event/registration.html> for this event.

Let us know if you have any accessibility accommodations (e.g., captioning) by April 6.

What will the networking call cover?

The networking call will cover:

* Spokesperson tips to help with local media interviews
* Methods for connecting with local media to get news stories
* Successful local news stories on program efforts

Who are the presenters and panelists?

Presenters and panelists will include recipients along with staff and contractors from CDC/DNPAO's Strategic Communication Team.

* Chris Thomas, DNPAO Strategic Communication Team
* Lisa Tensuan, FHI 360 Contractor, DNPAO Strategic Communication Team
* Amy Elizer, University of Tennessee
* Carmen Heredia, California Department of Public Health
* Mike Johnson, The Institute for Family Health

Have example news stories to share?

Send two earned media news stories (e.g., newspaper, radio, TV, or digital media) to DNPAOCommTA@cdc.gov <mailto:DNPAOCommTA@cdc.gov> from the last 6-12 months by April 3. We will share examples during the networking call. Below are two examples:

* CDC: 28% of Georgia adults admit to being physically inactive <https://www.ajc.com/news/local/cdc-georgia-adults-admit-being-physically-inactive/rI44wWh0hzRlkX1mmJdilL> (Atlanta Journal Constitution)
* Where A Child Grows Up Plays A Major Role In Future Opportunities <https://www.npr.org/2019/12/18/789218060/where-a-child-grows-up-plays-a-major-role-in-future-opportunities> (NPR)

Hints and reminders for the event

1. Register <https://fhi360smc.adobeconnect.com/sct_april2020/event/registration.html> to get event login details.
2. Check your connection and Adobe Connect access the day before <http://admin.adobeconnect.com/common/help/en/support/meeting_test.htm> the session.
3. Contact your organization's IT staff if you have trouble accessing Adobe Connect.
4. Visit Adobe Connect Support <https://helpx.adobe.com/adobe-connect/connect-support.html> if you need help.
5. Log onto Adobe Connect (website) and phone line 10 minutes before the start time.

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From:	Newman, Sunny
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Subject:	DSOC Meeting Materials and Webinar Information
Attachments:	SCSO Budget change request FY18 Money.xlsx FY2018 Sustainment of Fusion Centers Budget Change Request.xlsx Miami_budget_change_request March 2020.xlsx 19-1119 DSOC draft minutes.docx 20-0325 DSOC Agenda.doc

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Good afternoon,

Attached are meeting materials for the DSOC webinar and the webinar information. If you are logging into the webinar through the guest option, please provide your name. We will not accept individuals logging in as "guest".

Call in information:
US Dial In #: (888) 585-9008
Conference Room #: 215-384-938 then #
Webinar Link:
https://share.dhs.gov/dsoc_3252020/ <https://share.dhs.gov/dsoc_3252020/>

Please do not hesitate to contact me if you have any questions or concerns.

Thanks!
Sunny

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AMERICAN OVERSIGHT

From:	Newman, Sunny
To:	Domestic Security Oversight Council; "abecraft@miamigov.com"; "ashaw@hcso.tampa.fl.us"; "Benjamin.Burns@freshfromflorida.com"; Brenda Compton; "brent.wise@dhs.gov"; "CarolBishop@flhsmv.gov"; Christie Luce; Davenport, Jessica; "dbrand@flsheriffs.org"; Desguin, Shane; Diana Gryder; Donna Lusczynski; "douglas.goerke@cityoforlando.net"; Duffey, Mike; Ed Dwyer; "Elizabeth Ryon (Ryon.Elizabeth@flsenate.gov)"; "ElizabethDenmark@flhsmv.gov"; "Garrett.Wienckowski@ocfl. net"; "GeneSpaulding@flhsmv.gov"; Gordon, Kristi; "Jay.Etheridge@myfloridacfo.com"; "John.Kohnke@myfloridacfo.com"; "jrios@hcso.tampa.fl.us"; "Kevin.Johnson@ocfl.net"; "Larry.Zwieg@ocfl.net"; "lawrence.revell@talgov.com"; Lila Mestas; "linda.mcwhorter@em.myflorida.com"; "Lynne.Drawdy@flhealth.gov"; "Margaret.Medina@flhealth.gov"; Mark Pergola; "mdunagan@flsheriffs.org"; "meggsw@leoncountyfl.gov"; Mizell, Lori; Nicole Nelson; Rexroad, Samantha; Samantha Cooksey; "Sarah.Hofmeister@flhealth.gov"; Scott McAllister; "Sherry.hare@ocfl.net"; "Sue.Rantuccio@freshfromflorida.com"; "Tammy.Miller2@ocfl.net"
Cc:	Harvey, Robyn; Sasser, Billy E; Kelly, Damien; Wiggins, James; John Wilgis; Swearingen, Rick; Phillips, Mike; Ladd, Michael A COL USARMY NG FLARNG (USA); Burroughs, Joyce; Mark Dubina; Pollard, Vaden; Walker, Troy; Bradshaw, Ric L.; Vaughn, Thomas; Steve Casey; Thomas Storrar Jr - 0145; Halas, Julius; Burke, John; Lemma, Sheriff Dennis; Walt McNeil; Keenan, Gwen; Guthrie, Kevin; Lorin L. Mock; Daniels, Darryl; chiefdowneydc@gmail.com; quin romay; Brutnell, Mark; McPherson, Michael F. (TP) (FBI); Buccione, Charlene K. (TP) (FBI); Brad King; Burns, Ben; Rivkees, Scott A; Hevia, Robert; Luce, Christie; Steven.Thomas@ocfl.net; Moreland, Charles; Perez, Mark; Massie, Lee; Garry Lisiewski; Mandell, Milton; Bradley, Rose; McNeil, Beth; Foy, Tom; Brown, Chasity; Bucci, Joseph; "Yehuda.Green@ocfl.net"; CHRONISTER, CHAD; "Cintron, Morgan"
Subject:	DSOC Meeting Materials and Webinar Information
Attachments:	SCSO Budget change request FY18 Money.xlsx FY2018 Sustainment of Fusion Centers Budget Change Request.xlsx Miami_budget_change_request March 2020.xlsx 19-1119 DSOC draft minutes.docx 20-0325 DSOC Agenda.doc

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Thanks!
Sunny

Sunny Newman
Office of Domestic Security
Florida Department of Law Enforcement
Government Analyst II
Work: 850-410-8435
Cell: 850-510-3364
sunnynewman@fdle.state.fl.us <mailto:sunnynewman@fdle.state.fl.us>

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Work: 850-410-8435
Cell: 850-510-3364
sunnynewman@fdle.state.fl.us <mailto:sunnynewman@fdle.state.fl.us>

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:29:26 PM

Received the following from our LNO with DoS for your awareness
I am thinking they may be medivac'd to FL?

Costa Magica and Costa Favolosa are north of Cuba heading north toward the U.S. Costa Magica has a crew member in critical condition (male, 32, Philippines, bilateral pneumonia)and in is need of urgent medical evacuation. The Company is coordinating with USCG to perform a medivac (details being worked). Magica has an additional 3 crew members who need medical support ashore and Favolosa has 5 crew members who need medical support ashore. The Company is also working a plan to repatriate ~300 EU, ~600 Philippine and ~250 Indonesia asymptomatic crew members later this week.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:28:38 PM

Received the following from our LNO with DoS for your awareness
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FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From:	Pottebaum, Nic D. EOP/WHO
Cc:	Butler, Jay C. (CDC/DDID/OD); Darcie Johnston (darcie.johnston@hhs.gov)
Subject:	Draft PDF -- Community Mitigation Approach
Date:	Monday, March 9, 2020 9:11:24 PM
Attachments:	Community_Mitigation_Strategy_3_9_for_states.pdf

Governors' Senior Staff and State Health Officers,

Please send feedback or edits to Dr. Jay Butler (Deputy Director for Infectious Diseases at the CDC) by tomorrow (Tuesday, March 10) by late morning Eastern Time.

Email feedback to: jcb3@cdc.gov.

Thanks,
Nic

--
Nicholas D. Pottebaum
Special Assistant to the President and Deputy Director
White House Office of Intergovernmental Affairs
O: 202-456-2132 | C: 202-881-7803| E: Nicholas.D.Pottebaum@who.eop.gov

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawls; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; jcampagna@mesotheliomaguide.com; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. 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Subject: ECHCC General Coalition Meeting

Date: Wednesday, February 12, 2020 8:29:15 AM

AMERICAN OVERSIGHT

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this will serve as a reminder that there is NO general coalition meeting today in Washington County
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Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD)

To: EIS (CDC); CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC EIS EAC Roster 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Gaertner, Sonnet Jeong Im (CDC/DDPHSS/CSELS/OD); Blackstock, Anna J. (CDC/DDID/NCEZID/DFWED); McColloch, Caitlin (CDC/DDPHSS/CSELS/DSEPD); Wilson, Kendra (CDC/DDPHSS/CSELS/DSEPD); DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Owens, Kevin (CDC/OCOO/OCIO) (CTR); Bauer, Darrell (CDC/DDPHSS/CSELS/DSEPD); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Guerra, Marta (CDC/DDPHSIS/CGH/DGHP); Ali, Hammad (CDC/DDPHSIS/CGH/DGHT); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Cantey, Paul T. (CDC/DDPHSIS/CGH/DPDM); Minta, Anna Akua (CDC/DDPHSIS/CGH/GID); Hsu, Christopher (CDC/DDPHSIS/CGH/GID); Blau, Dianna M. 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	(CDC wyo.gov); Rajasingham, Anangu (CDC/DDPHSIS/CGH/DGHP); Henao, Olga (CDC/DDPHSIS/CGH/DGHP); Martin, Michael (CDC/DDPHSIS/CGH/DGHT); Diekman, Shane T. (CDC/DDPHSIS/CGH/DGHT); Khetsuriani, Nino (CDC/DDPHSIS/CGH/GID); Wilkinson, Amanda (CDC/DDPHSIS/CGH/GID); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Danielson, Melissa (CDC/DDNID/NCBDDD/DHDD); Shaw, Kelly (CDC/DDNID/NCBDDD/DHDD); Saydah, Sharon (CDC/DDNID/NCCDPHP/DDT); Loustalot, Fleetwood (CDC/DDNID/NCCDPHP/DHDSP); Perrine, Cria G. (CDC/DDNID/NCCDPHP/DNPAO); Pan, Liping (CDC/DDNID/NCCDPHP/DNPAO); Ussery, Emily Neusel (CDC/DDNID/NCCDPHP/DNPAO); Serbanescu, Florina (CDC/DDNID/NCCDPHP/DRH); Courtney-Long, Elizabeth A. (CDC/DDNID/NCCDPHP/OSH); Pennington, Audrey (CDC/DDNID/NCEH/DEHSP); Chang, Arthur (Art) (CDC/DDNID/NCEH/DEHSP); Gleason, Brigette (CDC/DDID/NCEZID/DFWED); Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Pindyck, Talia (CDC/DDID/NCEZID/DFWED); Hlavsa, Michele C. (CDC/DDID/NCEZID/DFWED); Marano, Nina (CDC/DDID/NCEZID/DGMQ); Hughes, Christine (CDC/DDID/NCEZID/DHCPP); Petersen, Brett W. (CDC/DDID/NCEZID/DHCPP); Kracalik, Ian (CDC/DDID/NCEZID/DHQP); Christensen, Bryan E. (CDC/DDID/NCEZID/DHQP); Wu, Hsiu (CDC/DDID/NCEZID/DHQP); Hills, Susan (CDC/DDID/NCEZID/DVBD); Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD); Waterman, Steve (CDC/DDID/NCEZID/DVBD); Dasgupta, Sharoda (CDC/DDID/NCHHSTP/DHPSE); Silk, Benjamin J. (CDC/DDID/NCHHSTP/DTE); Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH); Watson, John (CDC/DDID/NCIRD/DVD); Chen, Michael (CDC/DDID/NCIRD/ISD); Whelan, Elizabeth A. (CDC/NIOSH/DFSE/FRB); Reynolds, Laura (CDC/NIOSH/DFSE/HETAB); Sweeney, Marie (CDC/NIOSH/DFSE/HIB); Reichard, Audrey A. (CDC/NIOSH/DSR/SFIB); Watt, James (CDC cdph.ca.gov); Mullins, Jocelyn (CDC ct.gov); Wortley, Pascale (CDC dph.ga.gov); Warren-Mears, Victoria (CDC npaihb.org); "diedhia@dhec.sc.gov"; Klos, Rachel (CDC wi.gov); Busacker, Ashley (CDC wyo.gov); CDC EIS EAC Roster 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Gaertner, Sonnet Jeong Im (CDC/DDPHSS/CSELS/OD); Blackstock, Anna J. (CDC/DDID/NCEZID/DFWED); McColloch, Caitlin (CDC/DDPHSS/CSELS/DSEPD); Wilson, Kendra (CDC/DDPHSS/CSELS/DSEPD); DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Owens, Kevin (CDC/OCOO/OCIO) (CTR); Bauer, Darrell (CDC/DDPHSS/CSELS/DSEPD); Ko, Jean Y. (CDC/DDNID/NCCDPHP/DRH); Lofy, Kathy KL (CDC doh.wa.gov)
Cc:	Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD); DeSalvo, Traci (CDC dhs.wisconsin.gov); Mbaeyi, Sarah (CDC/DDID/NCIRD/OD); Adams, Laura E. (CDC/DDID/NCEZID/DVBD); Hedges, Sarah (CDC/DDPHSIS/CGH/DGHP); Archer, Roodly (CDC/DDPHSIS/CGH/GID); Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Liang, Arthur P. (CDC/DDID/NCEZID/DFWED); Rinsky, Jessica Lynn (CDC/NIOSH/DFSE/HETAB); Yard, Ellen E. (CDC/DDNID/NCIPC/DIP); Dcruz, Jina J. (CDC/DDPHSS/CSELS/DSEPD); Adjemian, Jennifer (CDC/DDPHSS/CSELS/DHIS); Greenspan, Arlene (CDC/DDNID/NCIPC/OD); Grey, Jeremy A. (CDC/DDID/NCHHSTP/DSTDP); Marcus, Ruthanne (CDC/DDID/NCHHSTP/DHPSE); Neil, Karen P. (CDC/DDID/NCEZID/DFWED); Grigg, Cheri T. (CDC/DDID/NCEZID/DHQP); Basler, Colin A. (CDC/DDID/NCEZID/DFWED); Nichols, Megin C. (CDC/DDID/NCEZID/DFWED); Lozier, Matthew J. (CDC/DDID/NCEZID/DFWED); Collins, Jennifer (CDC/DDID/NCEZID/DFWED); Logan, Naeemah (CDC/DDID/NCEZID/DFWED); Nett, Randall J. (CDC/NIOSH/RHD/FSB); Harvey, Reid (CDC/NIOSH/RHD/FSB); Halldin, Cara N. (CDC/NIOSH/RHD/SB); Blackley, David (CDC/NIOSH/RHD/SB); Cherry, Cara C. (CDC/DDID/NCEZID/DVBD); Behel, Stephanie (CDC/DDPHSIS/CGH/DGHT); Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Razzaghi, Hilda (CDC/DDNID/NCBDDD/DHDD); Curran, Kathryn (CDC/DDPHSIS/CGH/DGHT); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Havers, Fiona (CDC/DDID/NCIRD/DBD)
Subject:	EIS Supervisor Seminar Virtual Match Slides
Date:	Wednesday, March 18, 2020 3:37:47 PM
Attachments:	EIS Supervisor Seminar_Virtual Match_2020.pdf

EIS Supervisors –

Slides from today's seminar on the virtual match are attached. The presentation recording will be shared with you when available.

Thanks,
Larry

Larry Cohen, MD, MPH
EIS CIO Support Coordinator / EIS Program Staff Epidemiologist
Epidemiology Workforce Branch
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From: EIS (CDC)

To: Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC EIS EAC Roster 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Abara, Winston E. (CDC/DDID/NCHHSTP/DSTDP); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Annor, Francis (CDC/DDNID/NCIPC/DVP); Appiah, Grace D (CDC/DDID/NCEZID/DFWED); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Arvay, Melissa (CDC/DDID/NCIRD/DBD); awv4@cdc.gov; Bagchi, Suparna (CDC/DDID/NCEZID/DHQP); Balter, Sharon (CDC ph.lacounty.gov); barbara.montana@doh.nj.gov; Barfield, Wanda D. (CDC/DDNID/NCCDPHP/DRH); Basavaraju, Sridhar (CDC/DDID/NCEZID/DHQP); Beer, Karlyn D. 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Subject: EIS Supervisor Seminar: EIS Conference and Match Orientation

Importance: High

This seminar is primarily for supervisors who have been approved to match at the 2020 EIS Conference; however, all supervisors are welcome to participate. As a reminder, final dispositions on approvals to participate in the 2020 EIS match will be sent on March 9.

EIS Supervisors –

Do you have questions about the 2020 EIS Conference and match?

Would you like to become familiar with the recruitment venue?

Would you like to see an overview on how to schedule interviews, and assign and enter your match scores?

Then please join us for the next EIS Supervisor Seminar, where we will be discussing the EIS Conference and match!

During the seminar, we will review 2020 EIS match process, including the recruitment venue, how to enter your interview slots, and how to enter your scores.

If you already have questions about EIS Conference or match that you would like addressed during the seminar, please send them ahead of time to Larry Cohen at cbu1@cdc.gov <mailto:cbu1@cdc.gov> . We will compile the submitted questions and answer them during the seminar.

We look forward to your participation at the next EIS Supervisor Seminar!

Thank you,

EIS Program

Adobe Connect Webinar Information

https://adobeconnect.cdc.gov/ruqnt1n2uhla

If you have never attended an Adobe Connect meeting before:

Test your connection: https://virtualsepd.adobeconnect.com/common/help/en/support/meeting_test.htm

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Get a quick overview: http://www.adobe.com/products/adobeconnect.html

Phone Line Information

(770) 488-3600

Conference ID: 3183827

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From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Achim, John (CDC/DDID/NCEZID/DPEI); Bellis, Kimberly (CDC/DDID/NCEZID/DPEI); Borrelli, Aaron (CDC/DDID/NCEZID/DPEI); Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Chung, Christina L. (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Hall, Christopher (Jason) (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Light, Megan (CDC/DDID/NCEZID/DPEI); Montgomery, Meagan (CDC/DDID/NCEZID/DPEI) (CTR); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pappas, Danielle (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI)
Subject:	ELC Annual Meeting cancelled
Date:	Monday, March 2, 2020 8:43:38 AM
Importance:	High

Greetings,

With COVID-19 response activities intensifying nationwide, the ELC is electing to cancel the 2020 ELC Annual Meeting (March 11-13, 2020). We sincerely regret any inconvenience this late cancellation causes. In the coming days, the ELC will work to organize webinars aimed at communicating key content that would have been covered during the meeting.

Please stay tuned for additional details. Thank you for your understanding and your continued work to protect the public's health!

Best,

Angelica O'Connor, Jason Snow, and your ELC Team

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	ELC-Internal-Partners (CDC); Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC); Achim, John (CDC/DDID/NCEZID/DPEI); Bellis, Kimberly (CDC/DDID/NCEZID/DPEI); Borrelli, Aaron (CDC/DDID/NCEZID/DPEI); Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Chung, Christina L. (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Hall, Christopher (Jason) (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Light, Megan (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pappas, Danielle (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI); Walke, Henry (CDC/DDID/NCEZID/DPEI); Raziano, Amanda J. (CDC/DDID/NCEZID/DPEI); Browning, Sandra (CDC/DDID/NCEZID/DPEI) (CTR); Zansky, Shelley (CDC/DDID/NCEZID/DPEI) (CTR); O"Connor, Angelica (CDC/DDID/NCEZID/DPEI)
Subject:	ELC CONTINUATION APPLICATION UPDATE
Date:	Friday, March 6, 2020 4:42:30 PM
Importance:	High

Greetings.

Appreciating the challenges the COVID-19 response has placed on ELC-funded recipients, the publication of the BP2 ELC Continuation Guidance this year is likely to only add to current stress-levels. Given the complexity of the ELC portfolio we understand that the standard approach of completing workplans & budget by program/project, while important, is something that is likely to not receive the usual attention because health department resources are stretched thin.

Therefore, please suspend any/all work on completing all program/project application & budget templates for BP2. The ELC is implementing a streamlined application approach for BP2 only to help reduce the burden so that efforts can continue to focus on COVID-19 response activities.

There will be a webinar on Thursday, March 12 from 2:30 – 4:30pm ET that will provide more details and answer any questions you might have around the special application process.

ELC Programmatic Webinar

- **Date:** March 12, 2020
- **Time**: 2:30-4:30 pm, ET
- **Audience:** ELC Recipients
- **Phone:** 1-210-234-8636 or 1-888-946-7208
- **Participant Passcode:** 9749449

For Participants:

- URL: https://www.mymeetings.com/nc/join/
- Conference number: PWXW9986028
- Audience Passcode: 9749449

Participants can join the event directly at:
https://www.mymeetings.com/nc/join.php?i=PWXW9986028&p=9749449&t=c

Sincerely,
Jason Snow, Angelica O'Connor, & the ELC Team

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI)
Subject:	ELC Reminders
Date:	Tuesday, February 18, 2020 10:09:09 PM

Greetings.
We are looking forward to seeing everyone at the upcoming ELC Annual Meeting on March 11 – 13, 2020. As a reminder, the Annual Meeting will now be held at the Decatur Courtyard Marriott (details can be found on the ELC website here: https://www.cdc.gov/ncezid/dpei/elc/index.html).

In addition to providing important application information and opportunities for technical assistance, we also plan to share the latest guidance related to financial support of your COVID-19 outbreak response efforts. In the interim, please also remember:

1. If/when funding is made available to support COVID-19 response activities via the ELC, the most expeditious method to get these funds to recipients would likely be through funding those 'approved but unfunded' (ABU) activities from the BP1 Emerging Issues (E) budgets. This method does not require a separate application and can be executed very quickly.
2. For current needs that exceed the available ABU budget under your Emerging Issues (E) Project, please remember that the ELC may always receive 'recipient-initiated supplemental requests'. These requests may be submitted at any time and funded as resources are made available. We ask that you let your ELC Project Officer know if you foresee requiring a supplemental request so they may ensure you have all necessary items included in your submission.

Should any relevant information be made available prior to the ELC Annual Meeting we will share it with you immediately. If you have any questions prior to the meeting, please do not hesitate to reach out directly to your Project Officer.

We look forward to seeing you in March and wish you safe travels!

-Your ELC Team

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	yet7@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C
Subject:	EOC PUI team Questions
Date:	Saturday, February 1, 2020 8:28:45 AM

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

Subject: Emerald Coast Healthcare Coalition Information
Date: Monday, March 16, 2020 1:31:41 PM
Attachments: dem-order-no-20-002-in-re-covid-19-public-health-emergency-issued-03-11-2020.pdf
Clinical Guidance Chart_3-15-20_Final-1.pdf

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Please continue to monitor the Florida Department of Health COVID website for the most up to date information on the situation in Florida. http://www.floridahealth.gov/diseases-and-conditions/covid-19/

Please see the attached: Florida Division of Emergency Management Order No. 20-002 prohibiting visitors to certain types of health care facilities within the State. Please read carefully to determine if your facility falls under this order and to understand the actions you may need to take to comply.

The COVID-19 Call Center is available 24/7 (866) 779-6121 or email COVID-19@FLHealth.gov

Please contact me or anyone in our office if we can assist you during this response.

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Emergency Planning- R4 HHS emPOWER Emergency Planning De-identified Datasets (March 2020)
Date:	Sunday, March 22, 2020 10:07:08 AM
Attachments:	Florida_FL_CMSData_De_Identified_SCZ_2020_03.xlsx
Importance:	High

R4 emPOWER Emergency Planning De-identified Datasets for dissemination to the states to support emergency planning.

I have attached the HHS emPOWER Initiative Emergency Planning de-identified dataset that includes data at the state/territory, county, and zip code levels. The de-identified (HIPAA masked) dataset includes at-risk Medicare beneficiaries from the Medicare Fee-For-Service (FFS/Parts A& B) and Medicare Advantage (CMS' HMO plans/Part C) Programs that rely upon the electricity-dependent durable medical equipment (DME) and cardiac implantable devices and healthcare services that include ESRD (dialysis), oxygen tank services, and home health visits. Detailed information regarding the dataset are included in the Menu tab and the Data Overview tabs of the attached workbook.

State/Territory Zip Aggregation: We weren't able to identify geospatial boundary data for a number of the zip codes in the state/territory. Due to this we have had to aggregate the data for those zip codes (child zip code) with another zip code that it resides in or next to (parent zip code) to ensure we didn't lose population data associated with those zip codes. The third tab in the dataset provides the mapping for zip codes that meet this criteria.

Purpose: ASPR, in partnership with CMS, are providing limited de-identified Medicare data to State and local health departments to enhance situational awareness of and support emergency planning for and public health response activities for at-risk individuals that rely upon select electricity-dependent durable medical equipment (DME), facility-based dialysis and oxygen tank services prior to, during, or after an emergency or disaster. The DME that are included are: ventilators, oxygen concentrators, IV infusion pumps, suction pumps, at-home dialysis, electric wheelchairs and electric beds.

Data Source: The CMS dataset is developed from Medicare Fee For Service (FFS) Part A and B beneficiary administrative claims data (~32M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children) and Medicare Advantage claims data (~17M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children). This data does not include individuals that are only enrolled in a State Medicaid Program. It is important to note that Medicare DME are subject to insurance claim reimbursement caps (e.g. rental caps) that differ by type and therefore may have a different "look-back" periods (e.g. ventilators are 13 months and oxygen concentrators are 36 months) all of which are provided in the Menu and Data Overview tabs of the workbook.

Approved Data Uses: The de-identified dataset is approved for use by the state/territory and local health department, either directly or in collaboration with their ESF-8, 6, recovery or other partners, as appropriate, for public health emergency preparedness, response, recovery, mitigation and resilience activities. This data is not approved for research and all other potential uses of this data require prior approval from ASPR and CMS that must be sent c/o their ASPR REC to Kristen Finne at

AMERICAN OVERSIGHT

Kristen.finne@hhs.gov.

Privacy Protections: As Medicare beneficiary privacy protection is our priority, all personal identifiable information has been removed from this dataset and numerous de-identified methods have been applied to significantly minimize, if not completely mitigate, any potential for deduction of small cells or re-identification risk. For example, any cell size found between the range of 1 and 10 is masked and shown as 11. Additional information about our privacy protection/de-identification methods can be located on the Menu tab. If a State or local health department were to identify a potential risk for deducing a small cell or re-identification, notification must be immediately sent to Kristen Finne at Kristen.finne@hhs.gov.

Thanks again for all your time and collaboration on this important response effort. As always, please feel free to call or email me with any additional questions.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
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HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Emergency Planning- R4 HHS emPOWER Emergency Planning De-identified Datasets (March 2020)
Date:	Sunday, March 22, 2020 10:05:24 AM
Attachments:	Florida_FL_CMSData_De_Identified_SCZ_2020_03.xlsx
Importance:	High

R4 emPOWER Emergency Planning De-identified Datasets for dissemination to the states to support emergency planning.

I have attached the HHS emPOWER Initiative Emergency Planning de-identified dataset that includes data at the state/territory, county, and zip code levels. The de-identified (HIPAA masked) dataset includes at-risk Medicare beneficiaries from the Medicare Fee-For-Service (FFS/Parts A& B) and Medicare Advantage (CMS' HMO plans/Part C) Programs that rely upon the electricity-dependent durable medical equipment (DME) and cardiac implantable devices and healthcare services that include ESRD (dialysis), oxygen tank services, and home health visits. Detailed information regarding the dataset are included in the Menu tab and the Data Overview tabs of the attached workbook.

State/Territory Zip Aggregation: We weren't able to identify geospatial boundary data for a number of the zip codes in the state/territory. Due to this we have had to aggregate the data for those zip codes (child zip code) with another zip code that it resides in or next to (parent zip code) to ensure we didn't lose population data associated with those zip codes. The third tab in the dataset provides the mapping for zip codes that meet this criteria.

Purpose: ASPR, in partnership with CMS, are providing limited de-identified Medicare data to State and local health departments to enhance situational awareness of and support emergency planning for and public health response activities for at-risk individuals that rely upon select electricity-dependent durable medical equipment (DME), facility-based dialysis and oxygen tank services prior to, during, or after an emergency or disaster. The DME that are included are: ventilators, oxygen concentrators, IV infusion pumps, suction pumps, at-home dialysis, electric wheelchairs and electric beds.

Data Source: The CMS dataset is developed from Medicare Fee For Service (FFS) Part A and B beneficiary administrative claims data (~32M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children) and Medicare Advantage claims data (~17M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children). This data does not include individuals that are only enrolled in a State Medicaid Program. It is important to note that Medicare DME are subject to insurance claim reimbursement caps (e.g. rental caps) that differ by type and therefore may have a different "look-back" periods (e.g. ventilators are 13 months and oxygen concentrators are 36 months) all of which are provided in the Menu and Data Overview tabs of the workbook.

Approved Data Uses: The de-identified dataset is approved for use by the state/territory and local health department, either directly or in collaboration with their ESF-8, 6, recovery or other partners, as appropriate, for public health emergency preparedness, response, recovery, mitigation and resilience activities. This data is not approved for research and all other potential uses of this data require prior approval from ASPR and CMS that must be sent c/o their ASPR REC to Kristen Finne at

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Kristen.finne@hhs.gov.

Privacy Protections: As Medicare beneficiary privacy protection is our priority, all personal identifiable information has been removed from this dataset and numerous de-identified methods have been applied to significantly minimize, if not completely mitigate, any potential for deduction of small cells or re-identification risk. For example, any cell size found between the range of 1 and 10 is masked and shown as 11. Additional information about our privacy protection/de-identification methods can be located on the Menu tab. If a State or local health department were to identify a potential risk for deducing a small cell or re-identification, notification must be immediately sent to Kristen Finne at Kristen.finne@hhs.gov.

Thanks again for all your time and collaboration on this important response effort. As always, please feel free to call or email me with any additional questions.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Epi-X notifications for COVID-19 entry screenings
Date:	Tuesday, February 18, 2020 12:39:48 PM

Dear State Partners,

This is an update regarding Epi-X notifications for COVID-19 entry screenings. Please circulate it to state epidemiology staffers.

Epi-X notifications with entry screening data were not sent out on Monday (2/17/2020) while we made changes to improve data quality. Today, you will see several changes to the Excel file attached to Epi-X notifications. We understand there may be challenges for you when the Epi-X format changes. Thank you for your patience. We hope that the new data format will provide you with better, more complete data for monitoring.

During this transition, you may find duplicate records for the same traveler. For instance, you may receive a notification for a passenger you already received on 2/16/2020 with a different DGMQ ID. We recommend using today's notification for duplicates. Passengers' contact information is updated in the notifications you receive today.

In addition, notifications from today (2/18/2020) may be sent throughout the day (not at 9AM and 4PM, as usual). We plan to resume 9AM and 4PM distribution as soon as possible.

Thank you,

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

Sent by BCC to first and second COVID-19 POCs and State Epidemiologists

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From:	Mejia-Echeverry, Alvaro
To:	Aguilar, Alexandra; Alexandre, Antonine; Amores, Norma A.; Anderson, Erica C; Arseda, Nurya; Arshad, Amena; Barrera, Anne; Becerra, Ana; Bula, Evelyn A; Calle, Stephanie; Camacho, Walter; Cartaya, Gabriella W; Castillo, Klelia S; Celorio, Oscar; Charlot-Aladin, Mary; Coello, Erika X; Concepcion, Chaveli; Corzo-Sanchez, Elisa M; Cuevas, Carlos; Curbelo, Oswaldo; Cyril, Lorrie; Davidson, Khaleeq J; Dobson, Jolie T; Ejiofor, Ngozichukwuka; Eldanaf, Amal H; Estrada, Juan Jose; FernandezdeCastro, Ana; Goldberg, Cynthia; Gonzalez, Irima V; Grajales, Janet; Jit, Mohnisha; Johnson, Venus; Laine, Claudia B; Llau, Anthoni; Lopez, Victor J; Lyonel, Elsie; Martinez, Anita; Martinez, Yuray; Mauck, Daniel E; Melus, Vickie; Menoscal, Paola C; Morales, Fernando X; Muse, Nicole J; Nowotny, Kyle; Noya-Chaveco, Pedro A; Oliver, Christine M; Paul, Paulette J; Paulynice, Berthamise; Ramos, Vivian L; Rodriguez, Daniel; Rojas, Mercedes C; Salvador, Cristina G; Schroeder, Wayne A; Stallworth, Barbara; Suarez, Juan; Suazo, Ingrid E; Summers, Debbie; Tassy-Toussaint, Gastrude; Torrecilla, Ana; Urbina, Angelica; Uribarri, Enrique S; Vera, Raul A; Veras, Braulio; Villamil, Vanessa; Webb, Jenna; Schmitz, Ann; White, Stephen L; Connor, Olga; Jean, Reynald; Villalta, Yesenia D; egarc264@fiu.edu; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Alghawi, Wissam; Etienne, Marie Ketty (Epi); Joseph, Keren; Lopez, Jose M; Paramo, Christian; Rico, Edhelene; Sandoval, Lydia; Zhang, Guoyan
Cc:	Caballero, Reinaldo; Casimir, Yanick; Lowe, Camille N; Munoz, Virginia E; Olguin, Lourdes; Ortega, Marisabel; Toledo, Marilyn X
Subject:	EpiRT Training/Tabletop exercise
Attachments:	COVID19 training agenda_02142020.pdf

Good afternoon, team members!

Attached, please find the agenda for our training/tabletop exercise this Friday, February 14. The address is included in the calendar invite. I have copied your supervisors for awareness. Please note that parking is in the back of the building, and it is important to arrive early, as the parking lot fills up soon. Please, make an effort to attend as this is a great opportunity to prepare to respond to large infectious disease outbreaks in case you are deployed. Please, remember to contact Amena Arshad at 305-470-5657 or amena.arshad@flhealth.gov <mailto:amena.arshad@flhealth.gov> if you have any questions. Thank you for your attention and I hope to see you all at the training/exercise on Friday!

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From:	Stevens, Lee (OS/IEA)
To:	Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA); Baker, Michael (OS/IEA)
Subject:	FDA: States Are Now In Charge of Testing
Date:	Thursday, March 19, 2020 11:15:37 AM
Attachments:	States are Now In Charge of Testing 03192020.pdf

Dear State Health Officials,

Please find an important info-graphic attached outlining new testing guidance from FDA. We are standing by to answer questions. 1-888-INFO-FDA.

Best,

Darcie

Darcie Johnston, Director
Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Moskowitz, Jared; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc: Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Toro, Manny J; ASPR Region 4 (HHS/ASPR/OEM)
Subject: FDOH/FDEM request for synchronization
Date: Thursday, March 19, 2020 8:14:22 PM
Attachments: HHS_ASPR_Request for Resources Form_blank_05Mar2020.pdf

Good evening Florida

This email is meant to seek clarity on your requests and to determine a path forward for improved synchronization between FDOH and FDEM.

I am in receipt of the following requests and need some clarification to process in a timely manner. It is imperative that we understand Florida's need so we can source these requests appropriately. The DEM RRFs have been forwarded through the WebEOC system but the justification and need has not been received for all of them. Just like the document provided (attached below) this gives you an opportunity to provide the rationale for the need. Please coordinate the requests (FDOH/FDEM) so we do not have to slow the process with the need to seek further clarification. Also, we need to understand the priority and actual need. Just putting requests "in the queue" is not helpful and slows the prioritization process.

Please help me understand what you really need. I know you answered a White House RFI today but questions still remain. Incorporating your response to the RFI I tried to only include the outstanding items in the table below. I believe we could have worked these issues into your initial RRFs and we all could be working on the next issue at this time.

Date	Tracking Number	Resource Request	HHS Need/Request
3/14/2020	FL-0477	500,000 COVID-19 Test Kits and 100,000 16 oz bottles and 50,000 2 oz bottles of hand sanitizer	Florida has zero remaining in state caches, despite placing orders for over 1,000,000 specimen collection supplies. Test kits for the CBIS have all arrived • (arrived 3/18 1606 at JAX, 3/19 0854 at Orlando, 3/19 1005 at Miami) Based on conversations with FDEM and FDOH it appears that FDEM was managing the CBIS independent of FDOH. Please coordinate the activity and ensure all are working together. If swabs remain an issue please notify immediately. Sanitizer requests pushed to the Task Force
3/14/2020	FL-0524	150,000 Goggles, Tyvek Suits, Gowns, and Booties	SNS has begun its delivery allocation to states. I am told FL has received their initial push. We recognize the burn rate has been high in FL and have pushed the request up to the Task Force
3/15/2020	FL-0605	5,000 Ventilators for hospital and patient care	With current requests increasing and the directive to expand isolation capacities to stand alone clinics, ambulatory services, and alternate care sites we are requesting 5,000 additional ventilators What type of ventilator is to be requested. SNS has three types • Covidien (Puritan Bennett) LP10 • Vyaire (CareFusion) LTV1200 • and the Zoll (Impact Implementation) Does FL have the respiratory therapists needed to manage these ventilators? Are there enough ICU beds or hospital locations to manage these vents?
3/16/2020	FL-0667	1,000,000 N95 Respirator Masks	This order is in conflict with the request for 1.5M masks Sourced through the SNS initial distribution and have been told this has been received.
3/16/2020	FL-0672	5,000 Portable Medical Field Cots with IV Pole	Define the type of cots are requested; shelter, bariatric or both? Where and how are these to be used? Have you exhausted the state cache of cots? Are there regional caches managed by the coalitions and have they been exhausted? Who will staff the locations identified where these cots are to be placed? Are there wrap around services identified for the location of where the cots are to be used?
3/17/2020	FL-0896	USS Mercy & USS Hope	There is no USS Hope ship. The ships are the Mercy and the Comfort. Please describe what function these ships will be expected to perform. Is the FL healthcare system without any beds at this time? What type of patient does FL intend to put on these ships? How does FL plan to supplement the staffing of the ships?
3/17/2020	FL-0944	1 DMAT Team for Broward ALF	What is the mission you are trying to accomplish with a DMAT team? What number of residents and type are in this ALF? Identify and describe the capability that needs to be sourced. Is there a need for EPI education? How long is the team expected to be on site?
3/17/2020	FL-1249	5 Mobile ICUs	This is not a "typed" resources. What are you requesting? How many ICU beds are needed? Are all the ICU beds in the state occupied? How do you intend to staff these resources? Do you have critical care nurses, respiratory therapist and support staff to manage this population?
3/17/2020	FL-1261	1,000,000 N95 Respirator Masks, 500,000 gloves, 250,000 Tyvek Coveralls, 500,0000 gowns	SNS has begun its delivery allocation to states. I am told FL has received their initial push. We recognize the burn rate has been high in FL and have pushed the N-95 mask request up to the Task Force.

From the State of Florida ESF 8 today (3/19 1100)

- **Ventilators for 5000 intensive care patients**. - Florida has an existing cache of 380 ventilators and has ordered an additional 500 with an approximate delivery date of 3/31/20. These ventilators have been allocated based on a ratio for licensed beds. However, this allocation is not sufficient to support the projected needs of Florida's healthcare system. With current requests increasing and the directive to expand isolation capacities to stand alone clinics, ambulatory services, and alternate care sites we are requesting 5,000 additional ventilators. These units will be distributed using similar allocation strategies.
- **Field intensive care units with medical staffing in order to provide expanded ICU capabilities in the field for each of Florida's five most populated counties**. Florida has

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two state medical assistance teams and existing MOUs with volunteer medical organizations but due to widespread impact of this response, very limited personnel are available to support missions based on commitments to primary employers in the healthcare sector. Florida has contracted with nurse augmentation staff but their ability to operate an intensive care unit is limited.

- **Medical-grade cots of field care for 5000 patients** – Florida plans to fully deploy all special needs cots and capabilities with a significant gap.
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Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Moskowitz, Jared; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc: Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Toro, Manny J; ASPR Region 4 (HHS/ASPR/OEM)
Subject: FDOH/FDEM request for synchronization
Date: Thursday, March 19, 2020 8:14:08 PM
Attachments: HHS_ASPR_Request for Resources Form_blank_05Mar2020.pdf

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Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; Jacobs Slifka, Kara (CDC/DDID/NCEZID/DHQP); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Subject:	FL Call Follow-up
Date:	Tuesday, March 17, 2020 11:35:28 AM
Attachments:	HCP symptom monitoring from.docx PPE Strategies for LTCFs_ES.docx 20200315 Strategies for Optimizing the Supply of Eye protection_clean.docx 20200315 Strategies for optimizing the supply of facemasks_clean.docx 20200315 Strategies for Optimizing the Supply of Isolation Gowns_clean.docx LTC_nursing home letter to families_share.docx Plain language_Cleaning and disinfection tips for SARS_CoV_2_Upd 3.10.docx LTCLine List_3.7.20.docx rapid facility phone assessment.docx

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Hello Everyone,

Thank you for chatting with us today.

As I mentioned the CDC Healthcare Infection Control can be reached for further TA via eocevent141@cdc.gov or via phone at 404-414-8385

I think your biggest challenge is going to be figuring out the contracted staff and how they have interacted with other facilities. It would be reasonable to apply many of the below listed concepts to other at risk facilities based upon how these staff moved to detect cases earlier among residents and staff. If helpful someone from our team developed a rapid facility phone assessment which could be deployed (attached).

Here are some good links:
LTC guidance which can apply to AL: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
General IPC guidance: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
Criteria for return to work for HCP (healthcare personnel): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Please remember many of the docs I have attached are not CDC cleared. Some were created as tools by our field team or by other jurisdictions so feel free to modify to your own needs.

A couple important points and lessons learned from other states:

1. Ensure a good active monitoring system for residents (at least once a day although more often if possible). They should be mindful (as you know) the elderly may present in other and potentially less dramatic fashion especially if they have baseline lung disease. I have attached a symptom/temp checking that we created for HCP but could be modified for use with residents.
2. Likewise a good monitoring system for all HCP is key. They should be self-monitoring with delegation (i.e., they know who to call with symptoms) when at home and then have a symptom/temp check before starting their shift. This pre-shift check could happen upon

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facility arrival or via something like facetime before leaving for work. Just make sure they take their temp and show while on facetime.

3. Implement universal masking for HCP while in the facility. Attached is a PPE strategy for LTC which accounts for shortages in gowns and extend use of masks and eye protection. In addition, I have attached some docs about general PPE for all HCF which we do expect to be posted to the web soon.
4. Ideally gowns, gloves, mask/respirator, eye should be used for all cases, PUIs, and anyone with unknown respiratory illness. Again may need to refer to the PPE strategy doc if not doable. NTEC has a good video that helps with donning and doffing: https://repository.netecweb.org/items/show/688
5. Restrict visitors. Any visitor that must enter should have symptom/temp check, masked, and controlled movement in and out of resident rooms. I have attached an example letter to families that can be modified.
6. Restrict resident movements, no congregate settings.
7. I have attached some cleaning consideration as well to include the use of nursing/CNAs to wipe high touch surfaces for cases or PUIs instead of EVS.
8. I have also attached a line list if you want it.
9. Contact tracing and risk assessment is not practical in this setting and ideally time should be spent in the above activities plus IPC. We understand that work restricting staff may shutter the entire facility and thus the emphasis of the good monitoring of HCP. We discuss this in the new risk assessment at the very bottom of the page: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
10. You and other PH staff should be wearing a facemask when you enter the facility and institute self-monitoring as well.

Please feel free to reach out with questions.

Best,
Elizabeth and Nicola

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	ftu2@cdc.gov; Drennon, Michael T; Henry, Charles H; Blackmore, Carina; CDC IMS 2019 NCOV Response Epi TF Case Tracking Team; Bowen, Virginia B. (CDC/DDID/NCHHSTP/DSTDP); Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Wen, John (CDC/DDPHSIS/CGH/DGHT)
Subject:	FL Health Care Contact Investigation Call

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	ftu2@cdc.gov; Drennon, Michael T; Henry, Charles H; Blackmore, Carina; CDC IMS 2019 NCOV Response Epi TF Case Tracking Team
Subject:	FL Health Care Contact Investigation Call

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Andy.Mullins@adph.state.al.us; Tim.Hatch@adph.state.al.us; (Jcraig@msdh.state.ms.us); wayne.vaughn@msdh.ms.gov; Combs, Brian (CDC dhhs.nc.gov); Clement, Kimberly D; Blair, Jamie D.; Dawona.Hough@dph.ga.gov; christie.craft@msdh.ms.gov; amanda.b.williford@dhhs.nc.gov; paul.petersen@tn.gov; peter.koonz@tn.gov; sean.j.kice@tn.gov; john.hooper@adph.state.al.us; Stephanie Anspaugh-Naples (Stephanie.Anspaugh-Naples@flhealth.gov); Leah Hoffacker (Leah.Hoffacker@dph.ga.gov); Johnson, Rick D (CHFS DPH EPB); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Kik, Angela M.; Mattingly, Jay; White, Connie (CDC ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Cc:	R4 PHUL (FEMA.DHS.GOV); ASPR Region 4 (HHS/ASPR/OEM)
Subject:	FOUO FW: COVID 19 Update dated 22 Mar at (FMS Fact Sheet, A1 Medcom Guidance, Alt Healthcare Facilities)
Date:	Monday, March 23, 2020 7:17:24 PM
Attachments:	FMS Fact Sheet.pdf H2HC and A2HC - HOTEL+ ARENA COAs 191930Mar20 (002).pdf Corporate Partners Items-Equipment.xlsx Medical Support Task Force Initial Questions.docx

---

UPC team

This is some of what I was speaking to on the phone today about alternate care sites and isolation facilities. More to coma as the days continue.
Thank you Rick for sending.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

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FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Andy.Mullins@adph.state.al.us; Tim.Hatch@adph.state.al.us; (Jcraig@msdh.state.ms.us); wayne.vaughn@msdh.ms.gov; Brian.Combs@dhhs.nc.gov; Clement, Kimberly D; Blair, Jamie D.; Dawona.Hough@dph.ga.gov; christie.craft@msdh.ms.gov; amanda.b.williford@dhhs.nc.gov; paul.petersen@tn.gov; peter.koonz@tn.gov; sean.j.kice@tn.gov; john.hooper@adph.state.al.us; Stephanie Anspaugh-Naples (Stephanie.Anspaugh-Naples@flhealth.gov); Leah Hoffacker (Leah.Hoffacker@dph.ga.gov); Johnson, Rick D (CHFS DPH EPB); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Kik, Angela M; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Cc:	R4 PHUL (FEMA.DHS.GOV); ASPR Region 4 (HHS/ASPR/OEM)
Subject:	FOUO FW: COVID 19 Update dated 22 Mar at (FMS Fact Sheet, A1 Medcom Guidance, Alt Healthcare Facilities)
Date:	Monday, March 23, 2020 7:15:12 PM
Attachments:	FMS Fact Sheet.pdf H2HC and A2HC - HOTEL+ ARENA COAs 191930Mar20 (002).pdf Corporate Partners Items-Equipment.xlsx Medical Support Task Force Initial Questions.docx

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UPC team

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Regards,
Jeanne

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AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: FW: 3-23-20 CDC COVID-19 Weekly Key Messages and Updated Website Guidance
Date: Monday, March 23, 2020 9:26:41 AM
Attachments: CDC_COVID-19 Weekly Key Messages__3.22.2020_FINAL.pdf

FYI…apologize if dupe

Attached please find the CDC COVID-19 weekly key messages for Sunday, March 22, 2020. Feel free to share with your staff and other partners.

In addition, CDC released/updated several guidance documents on the CDC COVID-19 webpage.

- New People who are at higher risk for severe illness (consumer page)
- New COVID-19 and Underlying Medical Conditions (healthcare professional page)
- New Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness
- Updates to Information for Health Departments on Reporting Cases of COVID-19
    - COVID-19 Case Report Form Instructions
    - Completing a CRF and Specimen guidance
- New FAQs for consumers on Higher Risk & Underlying Conditions

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
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From: Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
To: Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
Subject: FW: CDC COCA Call: COVID-19 Update—Information for Clinicians Caring for Children and Pregnant Women
Date: Tuesday, March 10, 2020 12:39:47 PM
Attachments: image004.png

Dear USZPIR and SET-NET partners,

We wanted to share this information about the COCA call this Thursday.

Best,
Megan

Megan Reynolds, MPH, MDiv, CPH
Coordinator, US Zika Pregnancy and Infant Registry
Emerging Threats Team
Infant Outcomes Monitoring, Research, and Prevention Branch
Division of Birth Defects and Infant Disorders
National Center on Birth Defects and Developmental Disabilities
Email: xah6@cdc.gov
Phone: 404-498-0604



From: Centers for Disease Control and Prevention <no-reply@emailupdates.cdc.gov>
Sent: Tuesday, March 10, 2020 11:59 AM
To: Polen, Kara N. (CDC/DDNID/NCBDDD/DBDID) <fvc1@cdc.gov>
Subject: CDC COCA Call: COVID-19 Update—Information for Clinicians Caring for Children and Pregnant Women

National Center on Birth Defects and Developmental Disabilities Partner Alert



March 10, 2020

Special Edition

CDC COCA Call: COVID-19 Update—Information for Clinicians Caring for Children and Pregnant Womenr

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Pregnant woman with doctor



Join us for this week's COCA call, which focuses on current information about COVID-19 as it relates to children and pregnant women. Topics will include infection prevention and control measures in inpatient obstetric healthcare settings (CDC's Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings) and resources available to care for pediatric patients.

When: Thursday March 12, 2020
Time: 2:00-3:00 pm (ET)

How to join?
Please click the link below:
https://zoom.us/j/200932054

Or iPhone one-tap:
US: +16468769923,,200932054# or +16699006833,,200932054#

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

Webinar ID: 200 932 054
International numbers available: https://zoom.us/u/anixAVgIV
If you are unable to attend this live COCA Call, it will be available to view on-demand a few hours after the call.

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

Watch on Facebook: You may also participate in this COCA Call by joining COCA's Facebook Live.

Continuing Education will not be offered for this COCA Call.

For more information on this call, visit CDC's COCA website:
https://emergency.cdc.gov/coca/calls/2020/callinfo_031220.asp

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Get NCBDDD'sd 2018 Annual Report here.



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Centers for Disease Control and Prevention

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

Questions or Problems | Unsubscribe

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov)
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: FW: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Friday, March 6, 2020 10:16:10 AM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Good morning Carina,

We are following up on the email below. At your earliest, could you please confirm the COVID-19 case counts for March 5? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit

eocevent118@cdc.gov

CDC 2019-nCoV Response

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Thursday, March 5, 2020 7:22 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

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https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0

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New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	FW: CDC COVID-19 Daily Key Points for 24Mar20
Date:	Tuesday, March 24, 2020 10:26:45 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_24_2020_FINAL.pdf

UNCLASSIFIED // FOR OFFICIAL USE ONLY

Good evening,

Please see the attached CDC COVID-19 Daily Key Points for **24Mar20**.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

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email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

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From:	Amy Chang
To:	chris.rustin@dph.ga.gov; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Kurylo, Elizabeth (CDC/OID/NCEZID); Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman
Subject:	FW: CIFOR Promote DT - February Meeting
Attachments:	Promote DT Meeting_Agenda_02-18-20.docx CIFOR Guidelines Third Edition Postcard Draft 11Feb2020.pdf

Hi everyone, just sending this out as a reminder of our call this afternoon. Hope everyone can be on the call.

Scott

-----Original Appointment-----
From: Amy Chang <Achang@naccho.org>
Sent: Monday, February 3, 2020 7:36 AM
To: Amy Chang; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc: Collaro, Thomas - FSIS
Subject: CIFOR Promote DT - February Meeting
When: Tuesday, February 18, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://naccho.zoom.us/j/507646459

Achang@naccho.org <mailto:Achang@naccho.org> is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/507646459

Meeting ID: 507 646 459

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	FW: COVID-19 CONCOPs and Process Flow
Date:	Thursday, March 19, 2020 4:11:36 PM
Attachments:	image001.png 16Mar20 - HHS COVID-19 Process Flow.pptx COVID_CBTS_SOP_03 17 2020.docx

May be a dupe email

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Tuesday, March 17, 2020 5:55 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA) <Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>; Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO)

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<Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: COVID-19 CONCOPs and Process Flow

Hi All,

Please find attached the final COVID-19 CONOPs and Process Flow for the community-based drive thru testing sites. Please share with regional and state partners. The ASH planning team is establishing regional POCs for questions. More to come on how information will flow.

Artensie

Artensie Flowers, PhD, MPH
CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	FW: COVID-19 CONCOPs and Process Flow
Date:	Thursday, March 19, 2020 4:10:11 PM
Attachments:	image001.png 16Mar20 - HHS COVID-19 Process Flow.pptx COVID_CBTS_SOP_03 17 2020.docx

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May be a dupe email

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Tuesday, March 17, 2020 5:55 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA) <Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>;

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Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: COVID-19 CONCOPs and Process Flow

Hi All,

Please find attached the final COVID-19 CONOPs and Process Flow for the community-based drive thru testing sites. Please share with regional and state partners. The ASH planning team is establishing regional POCs for questions. More to come on how information will flow.

Artensie

Artensie Flowers, PhD, MPH
CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	FW: COVID-19 Stakeholder Call to Acton
Date:	Monday, March 2, 2020 5:57:18 PM
Attachments:	COVID-19 Healthcare Planning Checklist.pdf
Importance:	High

Sorry for the dupe and short notice

From: BHPP Medical Directors and Coordinators <BHPPGRANTEES@LIST.NIH.GOV> **On Behalf Of** Hannah, Jennifer (OS/ASPR/EMMO)
Sent: Monday, March 2, 2020 5:19 PM
To: BHPPGRANTEES@LIST.NIH.GOV
Subject: COVID-19 Stakeholder Call to Acton
Importance: High

Office of the Assistant Secretary for Preparedness and Response hosts COVID-19 stakeholder call

The United States is currently responding to an outbreak of respiratory disease caused by a novel (new) coronavirus. Our public health and medical response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States, understanding virus transmission, and reducing potential spread and impact.

We know that planning for an emerging infectious disease outbreak, like COVID-19, is critical to protecting the health and welfare of our nation. As such, we invite you to join a call with representatives from the U.S. Department of Health and Human Services to discuss emerging developments in the COVID-19 response and to learn about activities your jurisdictions can do now to prepare for, respond to, and be resilient in the face of COVID-19.

Invited participants include Health Care Coalitions; National Hospital Preparedness Program participants; and nongovernmental associations serving the needs of long term care facilities and vulnerable populations.

What: COVID-19 Stakeholder Call to Action
When: Monday, March 2, 2020 (6:00-7:00 pm ET)
Dial-in Number: 1-800-369-1924
Passcode: 8652907

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: FW: COVID-19 information and updated guidances
Date: Friday, March 6, 2020 5:52:26 PM

From our partners in Georgia. Thank you Georgia.
Forgive any duplication.

Colleagues,
Here are some information links that may be helpful and have been recently updated. We heard that an updated Health Alert Network notice is being prepared, so we will send that along as soon as it is available.

CDC Guidance for People at Higher Risk for COVID-19 Complications
https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html

CDC Healthcare Supply of Personal Protective Equipment
https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html
CDC PPE Poster
https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19-PPE.pdf

CDC Guidance for Travelers from Countries with Widespread Sustained (ongoing) Transmission Arriving in the United States
https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

CDC Communication Resources
https://www.cdc.gov/coronavirus/2019-ncov/communication/index.html

NETEC coronavirus page includes PPE validation checklists and video resource, in addition to many other great resources.
https://protect2.fireeye.com/url?k=6bb14ce2-37e445f1-6bb17ddd-0cc47adb5650-2ae2ceb528ee1b58&u=https://repository.netecweb.org/exhibits/show/ncov/ncov

Regards,
Jeanne

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From:	FieldSupport (CDC)
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Cc:	Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD); Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD); Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD)
Subject:	FW: Cancellation of EIS conference – next steps
Date:	Monday, March 16, 2020 3:07:00 PM

Dear prematched supervisors, many of you have already received the message below. For those who do not have a current officer, in light of the ongoing response we have made the difficult decision to cancel EIS conference this year. If you have made travel arrangements, please go ahead and cancel those. For those who have the time, consider dropping a note to your incoming officer to touch base in lieu of seeing them at conference.

If you have any questions, please reach out to us. Thank you for all you are doing and for hosting an incoming EISO.

Thank you – Jennifer

From: EIS (CDC) <eisepo@cdc.gov>
Sent: Monday, March 16, 2020 12:41 PM
To: CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>
Cc: CDC CSELS DSEPD EWB <OSELSSEPDPOEISStaff@cdc.gov>; Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD) <hld0@cdc.gov>; Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD) <tbn9@cdc.gov>; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) <mai9@cdc.gov>; Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) <pms6@cdc.gov>; Black, Erin (CDC/DDPHSS/CSELS/DSEPD) <epm7@cdc.gov>
Subject: Cancellation of EIS conference – next steps

EISOs,

I am writing to inform you of the cancellation of the EIS conference scheduled for May 4–7th. As of March 15, 2020, CDC is recommending the cancellation or postponement of in-person events consisting of 50 people or more throughout the U.S. We have been working on contingency planning for weeks and we determined that even a virtual conference is not feasible given the presenters and audience are needed for the COVID-19 response. During this time, response priorities take precedence over developing presentations for EIS Conference.

We understand that cancelling conference has broad implications for all of you, especially the 2nd year EISOs. We are cognizant of the potential impacts on CAL completion, job searching, graduation,

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and other elements that are important to all of you and the program. We want you to know the following:

- The match for the incoming class will be conducted virtually with an extended recruitment period starting on March 23, 2020 and an extended period for virtual interviewing from April 20 – May 8.

- We will work with 2nd year officers on a case-by-case basis if your COVID-19 response involvement might compromise your ability to complete your CALs. We do not want CAL completion to be a deterrent to your involvement. If you have concerns, please reach out to your EWB supervisor or CIO liaison to discuss your situation.

- We are working to plan a 2-day EIS presentation and graduation event for June. The event would include presentations from 2nd year EISOs who needed conference to fulfill the CAL requirement, a graduation ceremony, and the EIS satirical review.

- We know that EIS conference is a time when many of you were planning to network and interview for jobs. We are working to identify alternative ways to support your search for CDC jobs.

For all of you currently or preparing to deploy, we hope that the cancellation of the conference alleviates any tension you might have been experiencing regarding how to prepare your presentation in the midst of COVID-19, Ebola, and polio responses.

EISO's are playing a vital role in supporting this nation's public health response, at the local, state, and federal level. Thank you for your service. Your dedication and contributions are valued and appreciated. At this time, we expect every EISO to contribute to the response in some way. We expect most field EISOs are supporting the response within their assigned jurisdiction and do not expect you to deploy elsewhere. If you are not already involved in response activities, please volunteer now. If you need guidance on how to find a deployment role, please contact us at EpiAid@cdc.gov. If you have had difficulty obtaining supervisory approval to support the response, please contact your CIO liaison or EWB supervisor so that we can assist.

Please reserve time on your schedules for a **call on March 18, 2020 at 12 pm EST** to answer your questions and discuss planning for an EIS presentation and graduation event for all EISOs tentatively scheduled for June. We will be sending the link for the Skype Meeting ASAP.

Respectfully,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
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For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

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From: Garcia, Macarena (CDC/DDPHSS/CSELS/OD)

To: bensili@doh.as; Nathan.Koffarnus@health.mo.gov; john.bos@health.mo.gov; Kelso, Patsy (CDC vermont.gov); Cook, Sally (CDC vermont.gov); William.Fritch@vermont.gov; Read, Jennifer (CDC vermont.gov); Turner, Kathryn (CDC dhw.idaho.gov); scott.hutton@dhw.idaho.gov; Iyengar, Preetha (CDC dc.gov); jacqueline@doh.as; McGee, Sasha (CDC dc.gov); jennifer.myers@cdph.ca.gov; Lowenthal, Phil (CDC cdph.ca.gov); Ed.Powers@cdph.ca.gov; Charsey.Porse@cdph.ca.gov; Robert.Snyder@cdph.ca.gov; selam.Tecle@cdph.ca.gov; Charlotte.Girocco@cdph.ca.gov; jhmsablan@gmail.com; ginger.stringer@state.co.us; tasha.poissant@state.or.us; emilio.e.debess@state.or.us; alexia.y.zhang@state.or.us; amanda.e.faulkner@state.or.us; Madeline.K.Levasseur@dhsoha.state.or.us; Powell, Melissa (CDC state.or.us); kelly.e.cogswell@state.or.us; Rekant, Steven (CDC dhsoha.state.or.us); Clayton, Joshua (CDC state.sd.us); Horan, Vickie (CDC state.sd.us); dustin.ortbahn@state.sd.us; Kipp.Stahl@state.sd.us; angela.jackley@state.sd.us; 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Subject: FW: DCIPHER DEMO: COVID-19 Traveler Health Screening Data

Attachments: COVID-19 Response Travel Training Document.pdf

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-----Original Appointment-----
From: Garcia, Macarena (CDC/DDPHSS/CSELS/OD) <kou3@cdc.gov>
Sent: Friday, February 28, 2020 3:59 PM
To: Garcia, Macarena (CDC/DDPHSS/CSELS/OD); Burdyshaw, Serena (CDC/DDID/NCEZID/OD) (CTR); Soroka, Stephen (CDC/DDID/NCEZID/OD); Hemby, Taylor (CDC/DDID/NCEZID/OD) (CTR); Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR)
Cc: Roush, Sandra (CDC/DDID/NCIRD/OD); Lichtenstein, Meredith (CDC cste.org); CDC IMS State Coordination Task Force (SCTF) Operations; Shah, Dhara (CDC cste.org); 'hemby_taylor@bah.com'; Williams, Ian (CDC/DDID/NCEZID/DFWED); CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject: DCIPHER DEMO: COVID-19 Traveler Health Screening Data
When: Friday, March 6, 2020 1:30 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Skype Meeting - CDC Blgd 21, Room 4118

Please join us at the next demonstration of how to access COVID-19 Traveler Health Screening Data in the Data Collation & Integration for Public Health Event Response (DCIPHER) platform. This demo is similar to the first demo held last week, and appropriate for new DCIPHER users, or users who would like a refresher. Please forward to relevant members of your state teams, as necessary.

This demo will be facilitated by CDC DCIPHER technical staff, and CDC DGMQ staff.

Please note The demo will be live, however, participants are not required or expected to log into DCIPHER and follow along. If participants do not currently have access to DCIPHER, the demo is still a beneficial introduction to how the system is being utilized in the CDC COVID-19 Response.

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Join Skype Meeting <https://webconf.cdc.gov/kou3/M2P83N1H>

Trouble Joining? Try Skype Web App <https://webconf.cdc.gov/kou3/M2P83N1H?sl=1>

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[!OC([1033])!]

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From:	EIS (CDC)
To:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC EIS EAC Roster 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Gaertner, Sonnet Jeong Im (CDC/DDPHSS/CSELS/OD); Blackstock, Anna J. (CDC/DDID/NCEZID/DFWED); McColloch, Caitlin (CDC/DDPHSS/CSELS/DSEPD); Wilson, Kendra (CDC/DDPHSS/CSELS/DSEPD); DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Owens, Kevin (CDC/OCOO/OCIO) (CTR); Bauer, Darrell (CDC/DDPHSS/CSELS/DSEPD)
Subject:	FW: EIS Supervisor Seminar: EIS Conference and Match Orientation
Importance:	High

This seminar is primarily for supervisors who have been approved to match for the EIS Class of 2020; however, all supervisors are welcome to participate.

EIS Supervisors –

With the cancellation of the EIS Conference, the match for the incoming EIS class will now be conducted virtually. Please join us for this important supervisor seminar on the EIS virtual match.

During this EIS virtual match orientation, we will go over

* Cancellation of EIS Conference considerations
* Virtual match timeline
* Overview of logistics
* Virtual match host site support
* Q&A

For those unable to attend, this session will be recorded.

Thank you,

EIS Program

Adobe Connect Webinar Information

https://adobeconnect.cdc.gov/ruqnt1n2uhla

If you have never attended an Adobe Connect meeting before:

Test your connection: https://virtualsepd.adobeconnect.com/common/help/en/support/meeting_test.htm

Get a quick overview: http://www.adobe.com/products/adobeconnect.html

Phone Line Information

(770) 488-3600

Conference ID: 3183827

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From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Roberson, Shamarial (CDC flhealth.gov)
Cc:	Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ)
Subject:	FW: Florida Cruise Ship Summary 3.17.20 4 pm
Date:	Tuesday, March 17, 2020 5:22:23 PM
Attachments:	Florida Cruise Ship Summary 3.17.20 4 pm.docx

Dear Dr. Roberson,
It was good to talk to you just now about the arriving charter flights expected from the 2 cruise ships in Brazil and Chile. Please find the attached summary from the earlier call. As I mentioned, Dr. Cindy Friedman, the CDC Cruise Ship Task Force Lead, spoke to Dr. Rivkees earlier today.

I am copying Cindy, Paul (co-lead of the Task Force). I am part of their team and assisting with these two ships. I am also copying Michelle Decenteceo, Officer-in-Charge at the Miami Quarantine Station, and Andy Klevos, Regional Officer in Charge – both from the CDC Division of Global Migration and Quarantine.

Please feel free to contact me with any questions.

I will forward the correspondence with the cruise line to you.

Kindly,
Michelle

Michelle Weinberg, MD, MPH
Detailed to Cruise Ship Task Force/COVID-19 Response
Mobile: 1 404 456 4559

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 4:08 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: Florida Cruise Ship Summary 3.17.20 4 pm

Dear Mr. McGough,

Attached please find a summary of our phone call with the Florida Governor's Deputy Chief of Staff regarding two Royal Caribbean cruise ships and pending charter flights to Miami from both Brazil and Chile. Please let me know if you have any other questions.

Kind regards,

AMERICAN OVERSIGHT

Cindy

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

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From: Rivkees, Scott A

To: ABaiken; bbarash; Abhall; Abojo; AdamMayle Aventura Hospital; admin@cgrehab.net; admin@keysready.org; andrewchecchia01@gmail.com; administration@homedcareinc.com; admwgh; Agatha Samuel; agomez@chsfla.com; agency@integralhomehealth.com; Alicia Horner; ailynferrera@yahoo.com; Aklevos; Alara Select Specialty Hospital; Alazandria Cruze; Albert.Howe@flhealth.gov; Alejandro.Nossar; alliancehcmb@gmail.com; Alinag; ALOPEZ6; Amemon; amooss@bsrinstitute.org; amy.polanco@Hcr-manorcare.com; Ana Cladera; Ana Mederos; AndreaBl@baptisthealth.net; Angel Colon; Angel Pallin Mount Sinai Medical Center; Angela Ren; Ann Schmitz; annamoor@uco-ucpsfl.org; Anne.m.gonzalez@fmc-na.com; April Hoyt Mount Sinai Medical Center; Arelyr; Arlene.Mayo-Davis@ahca.myflorida.com; Arlene Merrill Aventura Hospital; arusso2@jhsmiami.org; Asolar@plazahealthnetwork.org; Aupadhyay; avaldes@larkinhospital.com; barbaras Baptist Hospital of Miami; bcabrera; Benjamin.Davis; betty.mendez Kindred Hospital; betterlivinghome@bellsouth.net; 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Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

---

Good Morning MDCHPC Partners,

This is a reminder and future calendar reminder for the FDOH Stakeholder call on COVID-19.

Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From: Rivkees, Scott A

To: ABaiken; bbarash; Abhall; Abojo; AdamMayle Aventura Hospital; admin@cgrehab.net; admin@keysready.org; andrewchecchia01@gmail.com; administration@homedcareinc.com; admwgh; Agatha Samuel; agomez@chsfla.com; agency@integralhomehealth.com; Alicia Horner; ailynferrera@yahoo.com; Aklevos; Alara Select Specialty Hospital; Alazandria Cruze; Albert.Howe@flhealth.gov; Alejandro.Nossar; alliancehcmb@gmail.com; Alinag; ALOPEZ6; Amemon; amooss@bsrinstitute.org; amy.polanco@Hcr-manorcare.com; Ana Cladera; Ana Mederos; AndreaBl@baptisthealth.net; Angel Colon; Angel Pallin Mount Sinai Medical Center; Angela Ren; Ann Schmitz; annamoor@uco-ucpsfl.org; Anne.m.gonzalez@fmc-na.com; April Hoyt Mount Sinai Medical Center; Arelyr; Arlene.Mayo-Davis@ahca.myflorida.com; Arlene Merrill Aventura Hospital; arusso2@jhsmiami.org; Asolar@plazahealthnetwork.org; Aupadhyay; avaldes@larkinhospital.com; barbaras Baptist Hospital of Miami; bcabrera; Benjamin.Davis; betty.mendez Kindred Hospital; betterlivinghome@bellsouth.net; 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Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

---

Good Morning MDCHPC Partners,

This is a reminder and future calendar reminder for the FDOH Stakeholder call on COVID-19.

Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From: Rivkees, Scott A

To: "Smith, Todd"; "Woodard, Steven"; Schaudel, James; David Castleman; "Blanton, Jake"; "Moreland, Charles"; "Elias, Bradley"; "Maxwell Ervanian"; "Peterson, Brian"; "Johnson, Belinda"; "Cichowlas, Monica"; "Hastings, Annette"; "Hilbrant, Paul"; "Wishard, Randy"; lrosie1965@gmail.com; Arrindell, Aja L; Zaheer, Saad MD; "chad.neilsen@jax.ufl.edu"; "jennifer.silvey@jax.ufl.edu"; "vkoelebryan@visitjacksonville.com"; "Meaghan Smalley"; "soaresp@duvalschools.org"; "Kimbleton, Nikki"; Davis, Terri C; "Ronald Lendvay"; "Rowley, Mark"; "Viafora Ray, Laura"; Wilsey, Leigh; Eric Anderson; "Arthur, Scott"; Auguste, Rachel A; "Ayoub, Andre E."; "Barth, Micah"; "Bates, Kari"; "marion.a.gregg2.mil@mail.mil"; "Berlinghoff, Jim"; "Bethea John"; Boutte, Mary J.; "Bradford, Keithe"; "Brown, Tawana"; "Burch, Yvette"; "Chapman, David"; "Cipriani, Joe"; "Coffey, John"; "Copeland, Shanti"; "Cowan, Leigh"; "DeGennaro, Donna"; "Devin, Tim"; "Dixon, James"; "Durgin, Kevin"; "Elliott, Billy"; "Geraci, Chris"; Gibbs, Winston E; "Hemmingway, Tammy L."; Higginbotham, Ken; "Hillyard Steve"; "Jacobs, Diann"; "Jolivette, Lawana"; "Kingery, Jenny"; "Knight, Danny"; "Kotsis, Kevin"; "Lichtman, Joe"; Wesley Marsh; "McDonald, Sandra"; Danny McPhaul; Miller, Jason S; Payne, Elizabeth; "Pendley, James A."; "Pereira, Carolina"; "Peterson, Larry"; "Reynolds, John"; "Roberts, Scott"; Rodgers, Sonny J; "Saftner, Marissa"; "Shay, Brittny"; "Shropshire, Dana"; "Stores, Joe"; "Torrence, Theo"; Ward, Richard; "Williams, Bob"; "Wolff, Mark"; "Young Sam"; "Hooten, Tracy"; "Fine, Brent"; "eweisz@pruitthealth.com"; "COJEPD"; "HSEPD - Executive Conference RM"; "Hall, Shawn"; "McManus, Richard"; "Southall, Brian"; "Ray, Noah"; "Ervanian, Maxwell"; "Jeff Winkler"; "Johnson, Zandra"; "Smith, Timothy"; "Amy.Riley@hcahealthcare.com"; "Sharron.Seitz@hcahealthcare.com"; "Patricia Winters"; "Sherriff, Autumn"; "Brown, Adam"; "Ricks, James D."; "Meysenburg, David"; "Durham, Karen"; Hipps, Angie; "Hellum, Cody"; "Young, Sam"; "Norton, Miller"; Turner, Scott M; "Nelson, Shannon"; "Thompson, Jeffrey - OASAM ATL"; "chad.neilsen@jax.ufl.edu"; "Ramos, Joseph F - OASAM ATL"

Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

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-----Original Appointment-----
From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Monday, March 2, 2020 1:20 PM
To: Rivkees, Scott A; Turner, Scott M; Arrindell, Aja L; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
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Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

From: Rivkees, Scott A
Sent: Tuesday, February 11, 2020 2:36:19 PM (UTC-05:00) Eastern Time (US & Canada)
To: Rivkees, Scott A; Arrindell, Aja L; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
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Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday from 2:00 PM to 3:00 PM effective 2/12/2020.
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with interested parties as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

Best,

Aja L. Arrindell, M.P.H., M.S.

Surveillance Epidemiologist

Florida Department of Health in Duval County

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FLORIDA HEALTH PERFORMS

INCREASE CHILDHOOD VACCINES
Increase vaccination of children to prevent disease and keep all of Florida's children protected from health threats.

DECREASE HIV INFECTIONS
Reduce the incidence of HIV infections to allow more Floridians to live longer healthier lives.

DECREASE INFANT MORTALITY
Reduce infant mortality to improve health outcomes for all infants.

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail, therefore, may be subject to public disclosure.

From: Rolle, Pauline J <Pauline.Rolle@flhealth.gov> on behalf of Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Wednesday, February 26, 2020 2:44 PM
To: Arrindell, Aja L
Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday from 2:00 PM to 3:00 PM effective 2/12/2020.
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

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STONE, THOMAS; doug.faircloth@doctorsmemorial.com; david.ottati@fhms.org; jermaine.bucknor@ahss.org; jthompson@healthmarkregional.com; lmeese@jackhosp.org; Krovito@jackhosp.org; HUTCHINS, MICHAEL; keith.strickling@bhcpns.org; brandy.call@bhcpns.org; rroche@lmcpbc.org; briley@lmcpbc.org; dan.mcLean@lpnt.net; debra.noyes@lpnt.net; MELEAR, P; robin.arrieta@hcahealthcare.com; rhall@shhpens.org; christy.rizza@shhpens.org; robin.godwin@ascension.org; rhonda.sherrod@hma.com; cdavidjay@aol.com; jsmsith@aol.com; awiman@bigbendahec.org; aingram@bigbendahec.org; support@hrhn.org; jfeller@wellflorida.org; Abarca, Chris; Moderie, Julie; astephenson@lorhn.org; Tiffany Parrish; ecallwood@lorhn.org; lholmes@lorhn.org; mrangel@lorhn.org; vgauze@healthcareswfl.org; sconnell@holmescountyfl.org; hendricksa@ci.marathon.fl.us; mwalters@mywakulla.com; rblewis1107@gmail.com; pburkel@union-ems.net; Fireco@madisoncountyfl.com; flakeysambulance@gmail.com; randytruette@gmail.com; allen_parrish@bradfordcountyfl.gov; eddieh@suwgov.org; swilliams@panhandleareahealthnetwork.com; Susan Grich; melissa.thibodeau@hrhn.org; lynn.witt@hma.com; garyowens@nwfrhn.com; Rpearson@rhnmc.org; HALL, ROGER; Reich, Debbie A; Dunn, Nathan P; Beedie, Katherine A; psparks@uwf.edu; Kirsch, Holly S; Stewart, Gail; DAlessio, Rebecca; Smith, Kathy J; Oliver, Rosalie; Walsh, Donna; PLATT, CARROL; Moscoso, Alberto; SHERROD, RHONDA; Brown, Richard; Perez, Ellis E; Asim Jani; Struble,Wayne Gordon; Matt Meyers; peterpappas52@gmail.com; Crowe, David R; Jonathan Lord; Baker, Kevin M; Bencie, Jennifer L; Poniatowski, Michael; Klein, Jason L.; Rutledge, Laura X; Napier, Robin; Ziegler, Carolyn H; McDaniel, Allison L; Smith, Rita M; Ashley Beigle; Melyssa Callahan; DiFede, Matthew; MacDonell, Sam; Blevins, Allison M; Jenkins Kelley; Burns, Mary K; Lewis, Susan M.; Welter, Bonnie J; Stewart, Lewis Shayne; rhambrick@ncf.edu; Brafford, Melba G.; Loftin, Edwin; Schuffert, Michael; Andrews, Phil; Jo.Alverson@Steward.org; REED, PAMELA; Mann, William; Johns, Paul M.; Abbasi, Muhammad J; Harder, Terri A; Hollingsworth, Kristine M; Marr, Kathleen J; Mercado, Carlos A.; Pedigo, Ryan J.; Miller, Brian L.; Gordon, Leslene E.; Lanza, John J; Bolton, Beate H; Georgine Kruedelbach; Marcia Catania; Hendershot, Jeri; Albert, Michele M; Burns, David; Clincea, Radu; Moore, Valarie E; Roberson, Candice S; Smith, Bret A; Whitston, Shannon M; Combs, Sue S; Kimberly Sample; Jackson, Joy L; Joseph, Ashley; Claire Sutherland; Scott, Katie E; Beauchamp, Brittany J; Larkin, Emerald A; Simmons, Deanna T; Pippin, Jessie W; Richards, Shelby D; Fugate, Betty K; Fisher, Ashley; Stalnaker,Jeffrey C., MD; Reagan Husong; Langston, Taylor; Eadie, Bob; Senyshyn, William; Richards, Patricia; McMillan, Emily A; Reese, Suzette W; DL DEPCS00 BPR HCCTF; Wilsey, Leigh; Allicock, Dawn; Caldwell, Jamie S; Caitlyn Eck; Campbell, Sieglinde D; Dr. Corin DeChirico; Schenk, Terry; Mooney, Dayle; Rashena Clark; John James; Koncelik,Denise Lavern; Carhart, Ty; Collins, Tiffany L; Hardacre, Tod B; Shipley, Valerie D; Kelly Keys; Michele Jones; Cabrera, Mary Ann; Clifton, Nicholas L; Bradley, Edward; McKay, Leslie W; Tuero, Kim L; Bryant, Rachel W; Marilia VanKeeken; Eric Anderson; Ackerman, Craig; Crowley, Meaghan K; Bjelke, David; DL CHD13 SENIOR LEADERSHIP TEAM; Nickola-Williams, Noreen B; Dorans, Christopher; Bailey, Bobby; Rowe, Ann; Kelley, Debbie A; Stenberg, Christina; James, Susan; Alonso, Zuzel; Ngo-Seidel, Eugenia J; Zayas, Maribel A; Keyes, Becky (County Health Systems); Smith, Thomas M; Alison Doeing; Foerster, Lisa R.; Peggy Brown; Quigley, Jacob B; Harris, Nicole E.; Morris, Cindy K.; Hill, Ann; Weller, Karen; Yow, Annmarie; Bielling, Jeffery; acburke8@gmail.com; Luce, Christie; Nelson, Joanna; Robinson, Eriko M; Davis, Ashley; Vaughn, Freda G; Shedlock, Andrew (AndrewShedlock@fdle.state.fl.us); Woodlief, Douglas; Jackson, Iris F; Tracey Vause; Ciereck, Christina M.; HSU MD, Vincent; Taryn Kryzda; Steve Wolfberg; ddyess@ci.stuart.fl.us; commissioners@ci.stuart.fl.us; William Schobel; Gaylord, Laurie; comish@martin.fl.us; wdsnyder@sheriff.martin.fl.us; jtummine@ci.stuart.fl.us; Michelle Miller; Rouse, Renay C; Bowzer, Leah F; Powell, Sheryl L; Doug Smith; Watkins, Shirley; Kevin Herndon; Don Donaldson; Domenica Labbate; George Stokus; Meier, Mike; Katelyn White; Reinhold, Todd A; County Health Systems; Mich Mongel; Ronnie Daves; David Whalen; Darrel Welborn; Matthew D. Abbott (mabbott@sheriff-okaloosa.org); BonicaLauren; SummersDan; ShawMichael; Kevin Gingras; Astrid Ramirez; Scuteri, Ana C; EmergencyManagementEmployees; Manuel Cela; Connor, Olga; zannett@thearpc.com; Eneida Roldan; Ashley Krutz; Smoak, Kimberly; Best, Jay; William Johnston - Northbay; brian.cook@hcahealthcare.com; ray@healthmarkregional.com; becky.washler@ascension.org; llamarche@mywakulla.com; adamms@hendryfla.net; Morell, Venita W; YOUNG, Brenna; Dominguez, Orlando J; Debra Boyce; Clark, Heath; Pokryfke, John; Glass Leighton, Kelli; Harold Jenkins; Amy Aiken
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday from 2:00 PM to 3:00 PM effective 2/12/2020.
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.
Please share this invitation with your membership as appropriate.
When: Each Wednesday at 2:00 p.m. EST
Call in Information: 888-585-9008 Pin 208-305-233

AMERICAN OVERSIGHT

From: Rivkees, Scott A
To: DL DEPCS00 BPR HCCTF
Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

---

FYI

-----Original Appointment-----
From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov <mailto:Scott.Rivkees@flhealth.gov> >
Sent: Tuesday, February 11, 2020 2:36 PM
To: Rivkees, Scott A; DL DOH CHD Administrators_Directors; Molly.McKinstry@ahca.myflorida.com <mailto:Molly.McKinstry@ahca.myflorida.com> ; Laura MacLafferty; Kinsley, Chris; mary.mayhew@ahca.myflorida.com <mailto:mary.mayhew@ahca.myflorida.com> ; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; jeanetta.stalcup@uhsinc.com <mailto:jeanetta.stalcup@uhsinc.com> ; steve winn; michelle@foma.org <mailto:michelle@foma.org> ; andrew@foma.org <mailto:andrew@foma.org> ; govaffairs@foma.org <mailto:govaffairs@foma.org> ; Shepard, Lela; mcarter@flmedical.org <mailto:mcarter@flmedical.org> ; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; MThomas@flmedical.org <mailto:MThomas@flmedical.org> ; CPrine@flmedical.org <mailto:CPrine@flmedical.org>
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

AMERICAN OVERSIGHT

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
To: Wallace, Marla D.; Clark, Marah
Cc: DSLRCrisisCoag (CDC); Stanek, Danielle R; Morrison, Andrea; Blackmore, Carina; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project
Date: Monday, February 24, 2020 2:25:27 PM
Importance: High

Good Afternoon Marla, Marah,

After speaking with OGS, the recommendation is for the State of FL to move forward with submitting the request as an official amendment in GrantSolutions.

Using official state letterhead, a process which you should be familiar, I would strongly advise breaking down the following:

- Show what the prior activities and amounts were (and why they are no longer feasible)
- Show what the new activities and amounts are (and how they are supported under the NOFO)
    - For the trailers, please be sure to provide ample justification and if possible necessary specs, quotes, and vendors. The more thoroughly tied to the NOFO, the more helpful it will be.

If you need any assistance, or would like me to view the official draft prior to submission, I would be happy to review.

Kind regards,
Kevin Sevak

From:
Sent: Monday, February 24, 2020 1:59 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Good Afternoon,

In order for CDC To make an informed decision regarding their proposed request an official request should be submitted to CDC via grant solutions.

Damond

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Friday, February 21, 2020 1:54 PM
To: Barnes, Damond (CDC/OCOO/OFR/OGS) <xhp5@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project
Importance: High

Good afternoon Damond,

I am reaching out to you on behalf of Sabrina Hansen, who is the Project Officer for Florida under Hurricane Crisis CoAg TP18-1802. Sabrina is currently supporting Coronavirus response activities.

Her jurisdiction has requested a redirection of funds for two activities. Prior to submission into GMM we were wanting to get some feedback. The first of which is straight forward, but the second may require more attention.

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The request entails that funds would actually be staying in the same budget category, however they are proposing a chance in two activities.

1. The first is to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control. The justification they provided aligns with Domain 5 of approved activities under the grant. I found this to be an allowable use of funds, but wanted to get your concurrence. More information on this can be found highlighted in this color below.

2. Secondly, FL is proposing to purchase two trailers: One trailer to move equipment around the county, increasing their capacity in post storm treatment response. The other is interested in using the trailer to educate their constituents. Detailed justification and estimates can be found attached. I have requested quotes and further information already, but sought your advice on such a purchase. Further justification on this can be found **attached** and below in this color.

Thank you for all your help!

Kind regards,

Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@freshfromflorida.com>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

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From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) [mailto:ydh1@cdc.gov]
Sent: Friday, February 14, 2020 1:13 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing **LA**'s vector project needs and are proposing some alternative use of funds. **Do you means FL?**

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

In other words, we need to see clearly see what the money was originally approved for, and how much, and where the money is going toward now, how much, justifications, and associated quotes… Based on that, we will review and get the necessary prior approval, and if approved, have the appropriate changes documented in GMM.

Please let me know if this makes sense. Thank you!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the

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CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

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Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From:	Scott, John
To:	jacqueline.s.zuluaga.mil@mail.mil; yesenia.villalta@flhealth.gov; eddie.borrego@jhsmiami.org
Cc:	McWhorter, Linda; Kincaid, Brooke
Subject:	FW: LAB FORMS AND PROCESS DOCUMENTS
Date:	Friday, March 20, 2020 8:20:26 PM
Attachments:	image001.png Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Black and White.pdf Greeting Script and Process 3_18_v2.docx Lab Process Guidelines_17 MAR.docx Informed Consent Instructional_17 MAR.docx COVID-19 Testing Center Requisition Form 2020.03.17_v13 for private partners.docx 3_Community-Based Testing Sites_Test and Result Info Sheet_3_19 v GENERAL_Black and White.pdf
Importance:	High

Good Evening

Attached are the updated versions to Emil I sent to you all earlier. They currently have been sent to print and I will let you know when they are ready….

Please disregard the previous email…….

v/r

John "JW" Scott III, EMT-P, CFI
Hazardous Materials Coordinator
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, FL 32399
Cell: (850) 567-4795



From: Kincaid, Brooke <Brooke.Kincaid@em.myflorida.com>
Sent: 20 March, 2020 20:14
To: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Cc: Scott, John <JohnW.Scott@em.myflorida.com>
Subject: RE: LAB FORMS AND PROCESS DOCUMENTS

Linda,

They have updated 1 of the forms and pushed it out to DOH at 6:52. This new version is the one I am pushing out to the printer for Miami and Orlando, and all the stuff being printed be found attached/who gets which printout and quantities can be found below:

- 3,000- What to Expect
- 3,000- Test Result Info Sheets
- 3,000- Requisition Form, that citizens should be filling out and handing back during the screening process. (Station 2) - The recommendation is **3,000 of each.**

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- 10,000-Info Sheet for Not Meeting Criteria
- 150- Scripts for those who will be doing initial greetings with the citizens arriving for testing. (Station 1)
- 150- Lab Processing Instructions for those doing the sample collection. (Station 3)
- 150- Informed Consent Instructions, for staff working at station 2.

If you have any more questions, please let me know .

Brooke Kincaid, MPA | Recovery Regional Manager and Region 2
Bureau of Recovery
Florida Division of Emergency Management
Rebuilding Together
(850)-567-6197 (c)
(850) 815-4437 (o)
Email: Brooke.Kincaid@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

From: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Sent: Friday, March 20, 2020 5:57 PM
To: Kincaid, Brooke <Brooke.Kincaid@em.myflorida.com>
Cc: Scott, John <JohnW.Scott@em.myflorida.com>
Subject: FW: LAB FORMS AND PROCESS DOCUMENTS
Importance: High

Brooke,

Please make sure these are the correct forms

Linda J. McWhorter
Preparedness Bureau Chief
2555 Shumard Oak Blvd
Tallahassee, FL 32399-21000
Office: (850) 815-4301
Mobile: (850) 528-7528
Linda.mcwhorter@em.myflorida.com

From: Scott, John <JohnW.Scott@em.myflorida.com>
Sent: Friday, March 20, 2020 5:56 PM
To: yesenia.villalta@flhealth.gov; eddie.borrego@jhsmiami.org
Cc: nicholas.m.fasanella.mil@mil.mil; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Subject: LAB FORMS AND PROCESS DOCUMENTS
Importance: High

Attached are the forms you requested.

Please contact me directly with any questions you may have.

AMERICAN OVERSIGHT

John "JW" Scott III, EMT-P, CFI
Incident Commander, Hard Rock Stadium Complex
Hazardous Materials Coordinator
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, FL 32399
Cell: (850) 567-4795



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Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: LAB Requisition Form and Process Guideline docs
Date:	Thursday, March 19, 2020 4:09:31 PM
Attachments:	image001.png COVID-19 Testing Center Requisition Form 2020.03.17_v13 for private partners.docx COVID-19 Testing Center Requisition Form 2020.03.17_vCVSBoston5.docx Informed Consent Instructional_17 MAR.docx Lab Process Guidelines_17 MAR.docx

More than likely a dupe email

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Tuesday, March 17, 2020 9:59 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA) <Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>;

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Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Fw: LAB Requisition Form and Process Guideline docs

Hi All,

Additional guidance for the community-based testing sites is attached. Please share with your regional, state, and local partners.

Artensie

Artensie Flowers, PhD, MPH
CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: LAB Requisition Form and Process Guideline docs
Date:	Thursday, March 19, 2020 4:07:59 PM
Attachments:	image001.png COVID-19 Testing Center Requisition Form 2020.03.17_v13 for private partners.docx COVID-19 Testing Center Requisition Form 2020.03.17_vCVSBoston5.docx Informed Consent Instructional_17 MAR.docx Lab Process Guidelines_17 MAR.docx

More than likely a dupe email

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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cell: 202.909.6950 Verizon (secondary)

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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Tuesday, March 17, 2020 9:59 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA) <Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>;

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Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Fw: LAB Requisition Form and Process Guideline docs

Hi All,

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Artensie

Artensie Flowers, PhD, MPH
CDR, US Public Health Service
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U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
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200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



AMERICAN OVERSIGHT

From:	Ernst, Colleen
To:	StLaurent, Louise; Grow, Stefan; Carbone, Francis; Enriquez, Javier; Faircloth, Chuck; Montfort, Kerven; Tritschler, Richard
Subject:	FW: MEMORANDUM: Executive Orders 20-82 and 20-83
Date:	Wednesday, March 25, 2020 9:21:47 AM
Attachments:	20-82.pdf 20-83.pdf

From: Governor's Press Office <Governor'sPressOffice@eog.myflorida.com>
Sent: Tuesday, March 24, 2020 9:49 PM
Subject: MEMORANDUM: Executive Orders 20-82 and 20-83

MEMORANDUM

TO: Members of the Press

FROM: Helen Aguirre Ferré, Director of Communications, Governor Ron DeSantis

DATE: March 24, 2020

RE: Executive Orders 20-82 and 20-83

Good evening:

Today, Governor Ron DeSantis issued Executive Order 20-82, directing all persons who enter the State of Florida from an area with substantial community spread, to include the New York Tri-State Area (Connecticut, New Jersey and New York), to isolate or quarantine for a period of 14 days from the time of entry into the State of Florida or the duration of the person's presence in the State of Florida, whichever is shorter.

The Governor also issued Executive Order 20-83, directing the State Surgeon General and State Health Officer to issue a public health advisory to all persons over 65 years of age urging them to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

PDF copies of the Executive Orders are attached to this email and provided below.

Sincerely,

Helen Aguirre Ferré
Director of Communications
Governor Ron DeSantis

AMERICAN OVERSIGHT

STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-82

(Emergency Management - COVID-19 –Isolation of Individuals Traveling to Florida)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 9, 2020, I issued Executive Order 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19; and

WHEREAS, many cases of COVID-19 in Florida have resulted from individuals coming into the State of Florida from international travel and other states, posing great risk to Florida residents; and

WHEREAS, on March 23, 2020, I issued Executive Order 20-80 requiring the screening, isolation and quarantine of individuals whose point of departure originated outside the State of Florida in an area with substantial community spread, to include the New York Tri-State Area; and

WHEREAS, Florida is experiencing an increase in individuals fleeing to Florida from states where "shelter-in-place" orders are being implemented, including from the New York Tri-State Area; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, Chapter 252,

AMERICAN OVERSIGHT

Florida Statutes, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1.

A. I hereby direct all persons who enter the State of Florida from an area with substantial community spread, to include the New York Tri-State Area (Connecticut, New Jersey and New York), to isolate or quarantine for a period of 14 days from the time of entry into the State of Florida or the duration of the person's presence in the State of Florida, whichever is shorter. This Order shall not apply to persons employed by the airlines and those performing military, emergency or health response. This Order shall take effect immediately and apply retroactively to all persons who have entered Florida after being in any area with substantial community spread within the previous 14 days. All persons isolating or quarantining under this Section shall be responsible for all costs associated with their isolation or quarantine, including transportation, lodging, food, medical care and any other expenses to sustain the person during the period of isolation or quarantine.

B. I hereby direct all persons covered under Section 1(A) of this Order to inform any individual in Florida with whom they have had direct physical contact in the past 21 days that they traveled from an area with substantial community spread.

Section 2. Failure to follow Section 1 of this Order is a second-degree misdemeanor pursuant to section 252.50, Florida Statutes, and is punishable by imprisonment not to exceed 60 days, a fine not to exceed $500, or both.

Section 3.

A. Pursuant to section 252.47, Florida Statutes, I hereby direct all state, county and local law enforcement authorities to enforce this Order. Any law enforcement authority that interacts with a person in violation of Section 1(A) of

AMERICAN OVERSIGHT

this Order shall immediately report the individual, along with personal identifying and contact information, to the Florida Department of Health.

B. Pursuant to section 381.0012(5), Florida Statutes, "it shall be the duty of every state and county attorney, sheriff, police officer, and other appropriate city and county officials upon the request to assist the Department of Health" in enforcing any isolation or quarantine, state health law and order of the Department of Health issued pursuant to this Order.

Section 4. This Executive Order shall expire upon the expiration of Executive Order 20-52, including any extensions, or upon an Executive Order lifting the isolation or quarantine after advice from the State Health Officer and Surgeon General.

STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-83

(Emergency Management - COVID-19 –Protective Measures for Vulnerable Populations, Gatherings of Private Citizens and Density of the Workforce)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 9, 2020, I issued Executive Order 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19; and

WHEREAS, according to the Centers for Disease Control and Prevention (CDC), older adults and people of any age with serious underlying medical conditions are particularly

AMERICAN OVERSIGHT

at risk for severe illness or death due to COVID-19; and

WHEREAS, on March 16, 2020, President Donald J. Trump and the CDC issued "15 Days to Slow the Spread" guidance advising individuals to avoid social gatherings in groups of more than 10 people and advising older persons and persons with serious underlying health conditions to stay home and away from others; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, Chapter 252, Florida Statutes, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1.

A. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory to all persons over 65 years of age urging them to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

B. I further direct the State Surgeon General and State Health Officer to issue a public health advisory to persons that have a serious underlying medical condition that places them at a high risk of severe illness from COVID-19. Consistent with CDC guidance, such conditions include, but not limited to, chronic lung disease or moderate to severe asthma; serious heart conditions; immunocompromised status, including those in cancer treatment; and severe obesity. The Surgeon General's advisory must urge these persons to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

Section 2. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory against all social or recreational gatherings of 10 or more people.

Section 3. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory to those who can work remotely urging them to do so.

Section 4. Any action(s) taken or document(s) issued by the State Surgeon General

AMERICAN OVERSIGHT

and State Health Officer pursuant to this Executive Order shall not constitute a rule as defined in section 120.52(16), Florida Statutes, and are specifically exempted from any and all requirements or procedures outlined in chapter 120 and section 252.46, Florida Statutes.

Section 5. This Executive Order shall expire upon the expiration of Executive Order 20-52, including any extensions.

###

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
To:	Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
Cc:	Lewis, Elizabeth L. (CDC/DDNID/NCBDDD/DBDID) (CTR); Akosa, Amanda (CDC/DDNID/NCBDDD/DBDID) (CTR); Castillo, Keila (CDC/DDNID/NCBDDD/DBDID) (CTR); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Lessely O BrownShuler; Ysaias E Presas
Subject:	FW: March 5: COCA Call on COVID-19
Date:	Thursday, March 5, 2020 7:39:00 AM

Good morning USZPIR and SET-NET partners,

We wanted to make sure that you were all aware of the below resources for the novel coronavirus, COVID-19.

This **Thursday, March 5, at 2:00pm Eastern**, there will be a Clinician Outreach and Communication Activity (COCA) call where clinicians "will learn what they can do to prepare for COVID-19 including identifying persons under investigation, applying infection prevention and control measures, assessing risks for exposures, optimizing the use of personal protective equipment supplies, and managing and caring for patients (inpatient and at home)."

Call information is found at the link below. Participants are asked to access the call in a group format due to high demand. Target audience is physicians, nurses, pharmacists, veterinarians, physician assistants, health educators, and other clinicians.
https://emergency.cdc.gov/coca/calls/2020/callinfo_030520.asp

The following page has everything in one place from CDC:
https://www.cdc.gov/coronavirus/2019-ncov/index.html

Within that site, there is also a specific page with information on pregnancy, breastfeeding, and children:
https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/pregnant-women.html

Just sharing in case it is helpful for you or your colleagues.

Please let us know if you have any questions.

Best,
Megan

Megan Reynolds, MPH, MDiv, CPH
Coordinator, US Zika Pregnancy and Infant Registry
Emerging Threats Team
Infant Outcomes Monitoring, Research, and Prevention Branch
Division of Birth Defects and Infant Disorders
National Center on Birth Defects and Developmental Disabilities
Email: xah6@cdc.gov
Phone: 404-498-0604

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From:	Borrego, Eddie
To:	jimmy.arias.mil@mail.mil; sdean@miamigov.com
Cc:	Villalta, Yesenia D; lilianriv@gmail.com
Subject:	FW: Marlins Park Collection Site
Date:	Monday, March 23, 2020 4:24:58 PM
Attachments:	image001.png PreTesting Instructions or Guidelines03.23.2020.FINAL.pdf Where to Get Tested (3-23-2020).FINAL.pdf COVID19 SCREENING TOOL - MARLINS (002).pdf COVID19TESTINGSITE 03.23.2020.pdf
Importance:	High

See attached documents developed for this project.

From: Villalta, Yesenia D <Yesenia.Villalta@flhealth.gov>
Sent: Monday, March 23, 2020 3:53 PM
To: Borrego, Eddie <edward.borrego@jhsmiami.org>; inson.kim@miamidade.gov; Liz.silva@miamidade.gov
Cc: Rivera, Lillian <Lillian.Rivera@flhealth.gov>; Jackson, Iris F <Iris.Jackson@flhealth.gov>; Suarez, Sarah B <Sarah.Suarez@flhealth.gov>; Paterniti, Beth A <Beth.Paterniti@flhealth.gov>
Subject: Marlins Park Collection Site
Importance: High

WARNING: This email originated outside of Jackson Health System. Do not click links or attachments unless you recognize the sender and know the content is safe.

Good afternoon,

Please find the latest documents. Please let me know if you have any questions.

1. Script for Call Center
2. Pre-Specimen collection information (internal reference only)
3. COVID-Screening tool
4. Post specimen collection brochure

Thank you,

Yesenia D. Villalta, APRN, DNP, MSN
Florida Department of Health in Miami-Dade County
Administrator/Health Officer
Email: Yesenia.Villalta@flhealth.gov
Phone:(786)336-1260
Address: 8323 NW 12th Street Floor:02 Room:212
Miami, FL 33126



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How is my customer service? Please let me know by taking our survey at www.FDOHMDCares.com

Our Mission is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has very broad public records law. Most written communication to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From:	Moulton, Diane
To:	Rivkees, Scott; Eifert, James; Moskowitz, Jared; Swearingen, Rick; Mayhew, Mary; Corcoran, Richard
Cc:	Coppola, Courtney; Oglesby, Mark; Guthrie, Kevin; Philpot, Toby; Kelly, Alex; Lukis, Adrian
Subject:	FW: Meeting TODAY @ 3:30
Date:	Wednesday, February 19, 2020 10:29:56 AM

The meeting will be held in our large conference room (next to our reception area). Please let me know if you plan to attend in person or if you plan to participate via phone. The conference line is listed below. Also, please provide me with a list of your staff who plan to attend. Thank you!

1-888-585-9008
Conference room 260-782-751

From: Moulton, Diane
Sent: Wednesday, February 19, 2020 7:25 AM
To: Rivkees. Scott <scott.rivkees@flhealth.gov>; Eifert, James <James.o.eifert.mil@mail.mil>; Moskowitz, Jared <jared.moskowitz@em.myflorida.com>; Swearingen, Rick <rickswearingen@fdle.state.fl.us>; Mayhew, Mary <mary.mayhew@ahca.myflorida.com>; Corcoran, Richard <Richard.Corcoran@fldoe.org>
Subject: Meeting TODAY @ 3:30

The Governor would like to have a briefing regarding the Coronavirus today at 3:30. The briefing will be held in our small conference room. Please let me know if you can attend in person. If some of you can't attend in person, I will provide a conference line. Thank you all!

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: Please Disseminate: Handouts for Community-based Testing Sites
Date:	Thursday, March 19, 2020 4:08:12 PM
Attachments:	image001.png Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Color.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Black and White.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Color.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Color.pdf

FYI

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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61 Forsyth Street, SW Suite 5B95
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email: Jeanne.eckes@hhs.gov
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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Wednesday, March 18, 2020 10:09 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA)

AMERICAN OVERSIGHT

<Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>; Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Please Disseminate: Handouts for Community-based Testing Sites

****PLEASE DISSEMINATE TO YOUR STATES AND LOCAL HEALTH PARTNERS PARTICIPATING IN THE CBTS INITIATIVE****

Intended Use of the Handouts Provided to Community-based Testing Sites:

These 3 documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below our capacity numbers. (Note: When the website is launched, the same information will also be available in text format with a print option.)

2) Information:

Purpose: To provide individuals who will not be tested because of capacity issues or because they do not meet testing criteria at that site have useful information on what to do next.

Instructions:

Hand out this document to the following:

- people who are in line but will not receive testing because we have exceeded capacity
- people who are in line but will not receive testing because they are not healthcare facility workers or first-responders

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested instructions on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

Hand out this document at the final station and instruct people to keep the paper until they receive the test results.

Artensie Flowers, PhD, MPH

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CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



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To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: Please Disseminate: Handouts for Community-based Testing Sites
Date:	Thursday, March 19, 2020 4:06:35 PM
Attachments:	image001.png Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Color.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Black and White.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Color.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Color.pdf

FYI

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Wednesday, March 18, 2020 10:09 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA)

AMERICAN OVERSIGHT

<Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>; Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Please Disseminate: Handouts for Community-based Testing Sites

****PLEASE DISSEMINATE TO YOUR STATES AND LOCAL HEALTH PARTNERS PARTICIPATING IN THE CBTS INITIATIVE****

Intended Use of the Handouts Provided to Community-based Testing Sites:

These 3 documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below our capacity numbers. (Note: When the website is launched, the same information will also be available in text format with a print option.)

2) Information:

Purpose: To provide individuals who will not be tested because of capacity issues or because they do not meet testing criteria at that site have useful information on what to do next.

Instructions:

Hand out this document to the following:

- people who are in line but will not receive testing because we have exceeded capacity
- people who are in line but will not receive testing because they are not healthcare facility workers or first-responders

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested instructions on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

Hand out this document at the final station and instruct people to keep the paper until they receive the test results.

Artensie Flowers, PhD, MPH

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CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



AMERICAN OVERSIGHT

From:	Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)
To:	Heinzerling, Amy (CDC cdph.ca.gov); Blau, Erin (CDC ky.gov); Blau, Erin (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo (CDC adph.state.al.us); Heinzerling, Amy Patricia (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo Vincent (CDC/DDPHSS/CSELS/DSEPD); Szablewski, Christine (CDC dph.ga.gov); Szablewski, Christine (CDC/DDPHSS/CSELS/DSEPD); Torres, Yaritbel (CDC flhealth.gov); Torres-Mendoza, Yaritbel (CDC/DDPHSS/CSELS/DSEPD); James, Allison (CDC arkansas.gov); James, Allison (CDC/DDPHSS/CSELS/DSEPD); Ghinai, Isaac; Ghinai, Isaac (CDC/DDPHSS/CSELS/DSEPD); Steinberg, Jonathan (CDC state.sd.us); Feder, Kenneth (CDC/DDPHSS/CSELS/DSEPD); Kenneth Feder -MDH-; Steinberg, Jonathan (CDC/DDPHSS/CSELS/DSEPD)
Cc:	Blackmore, Carina (CDC flhealth.gov); Davidson, Sherri (CDC adph.state.al.us); Drenzek, Cherie (CDC dhr.state.ga.us); Edison, Laura (CDC dph.ga.gov); Materna, Barbara (CDC cdph.ca.gov); Robeson, Sara (CDC ky.gov); Stanek, Danielle (CDC flhealth.gov); Thoroughman, Douglas (CDC/DDPHSIS/CPR/DSLR); Wilken, Jason (CDC cdph.ca.gov); Wortley, Pascale (CDC dph.ga.gov); Balamurugan, Appathurai (CDC arkansas.gov); Clayton, Joshua (CDC state.sd.us); Austin, Connie (CDC illinois.gov); Blythe, David (CDC maryland.gov); Crum, David (CDC maryland.gov); Soda, Elizabeth (CDC illinois.gov); Layden, Jennifer (CDC illinois.gov); Duwell, Monique MD (CDC maryland.gov); Rothfeldt, Laura (CDC arkansas.gov); Tarkhashvili, Nato (CDC state.sd.us)
Subject:	FW: Protecting Your Health and Safety During the COVID-19 Response
Date:	Thursday, March 5, 2020 2:54:35 PM

Hi everyone,

Please be aware of the highlighted sentence in the email from CDC OD pertaining to cancellation of travel, copied here.

To ensure CDC maintains its response readiness, CDC/ATSDR is canceling all travel except mission-critical and response-related travel.

Thanks,

Suzanne

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)
Epidemic Intelligence Service | Epidemiology Workforce Branch
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

From: Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD) <dhe0@cdc.gov>
Sent: Thursday, March 5, 2020 2:49 PM
To: Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD) <dwi4@cdc.gov>; Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD) <kmb6@cdc.gov>; Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD) <gii5@cdc.gov>; Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD) <cbu1@cdc.gov>; Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD) <vie0@cdc.gov>; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD) <osk0@cdc.gov>; Priest, Priscilla (CDC/DDPHSS/CSELS/DSEPD) (CTR) <fys8@cdc.gov>; Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD) <pzw5@cdc.gov>
Subject: FW: Protecting Your Health and Safety During the COVID-19 Response

Just wanted to make sure you saw the highlighted sentence below.

AMERICAN OVERSIGHT

From: CDC OD Announcements <CDCODANNOUNCE@cdc.gov>
Sent: Thursday, March 5, 2020 2:41 PM
To: CDC OD Announcements <CDCODANNOUNCE@cdc.gov>
Subject: Protecting Your Health and Safety During the COVID-19 Response

As Dr. Redfield has said, CDC's efforts to respond to the novel coronavirus disease 2019 (COVID-19) are a remarkable demonstration of your commitment to public health and to those whom we serve. As we continue to see the spread of COVID-19 in communities across the country, including recent cases in Georgia, I wanted to share what we're doing to both protect your health and safety and to ensure CDC's ability to respond to this global outbreak.

Health and Safety for CDC Staff
The health and safety of our staff are critically important. While the immediate health risk for most Americans is considered low, current events have raised the risk in some communities. We should all practice everyday preventive actions to help prevent the person-to-person and community spread of COVID-19, including staying home when you are sick.

Inside CDC, our DeployCDC site is an excellent resource. Whether you're preparing to deploy, returning from a deployment, or supporting a deployer, I encourage you to check this site regularly for important information.

The Office of Personnel Management Tuesday released preliminary guidance for federal agencies. I encourage all supervisors to take advantage of workplace flexibilities like telework to ensure the health and safety of CDC staff. If CDC is forced to alter operations, we will follow CDC's recently updated Pandemic Workforce Protection Plan and our Continuity of Operations Plan. CDC also has a number of preparedness resources, including how you can prepare your health for an emergency.

Ensuring CDC's Ability to Respond
CDC has moved quickly to secure the resources needed for this evolving response. In addition to using our Infectious Diseases Rapid Response Reserve Fund, CDC recently received a transfer from HHS and Congress is expected to act this week on a supplemental funding request. We continue to see positive support for CDC's work and hope we receive the supplemental funding to support this complex, fast-moving response.

To ensure CDC maintains its response readiness, CDC/ATSDR is canceling all travel except mission-critical and response-related travel. Please work with members of your CIO leadership team, who are reviewing current travel plans as we have done in the past. We will evaluate this and other guidance as this response evolves.

Whether you're involved directly with the response or helping to keep all our other important work going, thank you for all you're doing to keep Americans safe and healthy.

Sherri Berger, MSPH
Chief Operating Officer, CDC

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From: Stanek, Danielle R
To: Amador, Nelly; Asmita Gupta; Blackmore, Carina; Bommineni, Reddy; Carlos Risco (riscoc@ufl.edu); "Cherabuddi,Kartik"; Clark-Curtiss,Josephine; Clemons, Bambi; Cunningham, Mark; Daniel Wolf (Daniel.Wolf@fdacs.gov); Diane Kitchen (Diane.Kitchen@fdacs.gov); Dix Harrell (cdix.harrell@usda.gov); Doblecki-Lewis, Susanne; Gibbs, Paul; Gibbs, Samantha; Gillis, Karen; Greg Gray; Gregory Christy (Gregory.Christy@fdacs.gov); Gregory Glass; Hall, Parker T - APHIS; hernandezja@ufl.edu; Hooker, Kara; Hunter, Pamela; Iovine,Nicole Marie; jeremy.d.butts@aphis.usda.gov; Johnson, David (Bay Pines); Landsberg, Jan; Lanza, John J; leahdgillis@gmail.com; Lichtenberger, Paola; Lisa Conti; Marc Engel; Mary Gessert; Mary Leigh Merrill; Mary Moore (Mary.E.Moore@aphis.usda.gov); MAUNSELL,FIONA PAULINE; Michael Whicker; Michael.P.Milleson@aphis.usda.gov; Morrison, Andrea; Progulske, Barbara A; Ramira, Isaza; Rehme, Paul A; Richard Austin; Sayler,Katherine A; "Shender, Lisa"; Short, Mike; Stauffer, Kendra E. (CDC/CGH/DGHP); Loerzel, Susan; Teresa Chapman; Terry Doonan (terry.doonan@myfwc.com); Thomas Holt; Tom Belcuore; Tuanyok,Apichai; Vittor,Amy Yomiko; william.fisch@freshfromflorida.com; Wisely,Samantha M; Torres, Yari
Subject: FW: TODAY! CDC ZOHU Call March 4, 2020
Date: Wednesday, March 4, 2020 11:09:42 AM

ZOHU Calls are 1-hour monthly webinars that provide timely education on zoonotic and infectious diseases, One Health, antimicrobial resistance, food safety, vector-borne diseases, recent outbreaks, and related health threats at the animal-human-environment interface.

Join us for the next ZOHU Call on March 4, 2020 - 2-3 pm ET.

Please note that we now use Zoom to present ZOHU Call webinars.

Simply click this link https://zoom.us/j/697892934 to see and hear the presentations.
All questions will now be submitted online instead of by phone.
Information to listen only by phone is available on the March 4 ZOHU Call webpage.

Presentations

One Health News from CDC
Casey Barton Behravesh, MS, DVM, DrPH, DACVPM
Captain, U.S. Public Health Service
Director, One Health Office
Centers for Disease Control and Prevention
dlx9@cdc.gov

Mammal decline, linked to invasive Burmese python, shifts host use of vector mosquito towards reservoir hosts of a zoonotic disease
Nathan Burkett-Cadena, PhD
Assistant Professor
University of Florida
Florida Medical Entomology Laboratory
nburkettcadena@ufl.edu

Companion Animals and Domestic Violence as a One Health Issue

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Melinda D. Merck, DVM
Forensic Veterinarian
Veterinary Forensics Consulting, LLC
catdvm@drmerck.com

Psittacosis Outbreak among Workers at Chicken Slaughter Plants, Virginia and Georgia, USA, 2018
Julia M. Murphy, DVM, MS, DACVPM
State Public Health Veterinarian
Virginia Department of Health
julia.murphy@vdh.virginia.gov

Join the Next ZOHU Call

Free Continuing Education is available for **physicians, nurses, health educators, veterinarians, and others.**

- The ZOHU Call course number is **2962**, and access code is **onehealth2020**.
- If you were unable to attend a live call, archived ZOHU Calls are available online.

Get Free CE for ZOHU Call

One Health News from CDC - March 2020

HIGHLIGHTS

- Coronavirus Disease 2019 (COVID-19) outbreak - Check CDC's website for the latest information about this response, including FAQs about animals. See CDC's Pet Disaster Preparedness Kit for pet preparedness info.
- Patient Stories Show Seriousness of Foodborne Illness
- Pool Inspection Training for Environmental Health Professionals
- CDC's One Health Office has created an email newsletter for the Healthy Pets, Healthy People program. Subscribe

Events & Observances

- March 9-12 - CANCELED InFORM (Integrated Foodborne Outbreak Response and Management) 2020 Conference, Atlanta, Georgia.
- March 31-April 3 - 2020 Preparedness Summit - Dallas, Texas
- May 4-7 - 2020 Epidemic Intelligence Service (EIS) Conference, Atlanta, Georgia.
- June 14-18 - World One Health Congress, Edinburgh, Scotland.

PUBLICATIONS

- Health Security Supplement (2020) What Works? Lessons Learned in Global Health Security Implementation
- Preliminary Evaluation of Human Personal Protective Measures Against the Nymphal Stage of the Asian Longhorned Tick (Acari: Ixodidae)
- The March 2020 issue of *EID Journal* has articles relevant to One Health.

Morbidity and Mortality Weekly Report (MMWR)

- Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak — United States, December 31, 2019–February 4, 2020
- Persons Evaluated for 2019 Novel Coronavirus — United States, January 2020
- Autochthonous Chagas Disease — Missouri, 2018
- Anhydrous Ammonia Chemical Release — Lake County, Illinois, April 2019
- Travel-Associated and Locally Acquired Dengue Cases — United States, 2010–2017
- Human Rabies — Utah, 2018

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US OUTBREAKS
New

- Outbreak of *E. coli* Infections Linked to Clover Sprouts

Updated

- Coronavirus Disease 2019 (COVID-19)
- Outbreak of *Salmonella* Infections Linked to Cut Fruit

See a selected list of ongoing and past US outbreaks of zoonotic diseases on the Healthy Pets, Healthy People website.

See the CDC Current Outbreak List, including foodborne outbreaks, at cdc.gov/outbreaks.

One Health uses a collaborative, multisectoral, and trans-disciplinary approach — working at the local, regional, national, and global levels — with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment.

Email topic suggestions or provide feedback to ZOHUCall@cdc.gov.

Centers for Disease Control and Prevention
1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348
Questions or Problems | Unsubscribe

AMERICAN OVERSIGHT

From: Sayler, Erik
To: St Laurent, Louise R; Grow, Stefan
Cc: Larson, Bradford U (Brad) Col USAF NG FLANG (USA); Deleon, Melissa (FLNG)
Subject: FW: [EXTERNAL] FW: MOA for CST testing lab (UNCLASSIFIED)
Date: Wednesday, March 25, 2020 5:18:42 PM
Attachments: MOA FLARNG CST and DOH 20200324.docx

Louise & Stefan,
Attached is the FLNG MOA for the testing machine between DOH and FLNG. Col. Bradford's team drafted it. Are these the right state parties to the MOA? The Colonel said the lab comes with some NG personnel, but they are not currently CLIA certified. Also, supplies and wrap-around services will need to be procured. Do you have any edits? If you have any questions, please let me know.

All,
Some logistics items to be addressed/questions to be answered about the lab, but don't necessarily need to be addressed in the MOA. These are logs/finc/management questions but worth noting and sharing internally.

1. Staffing the lab
    a. How many lab techs are needed to operate the lab at full capacity.
    b. The Colonel says the lab can test 500 samples per day, but is that in an 8, 12, or 24 hour period?
    c. Currently the NG personnel are not CLIA certified; so lab techs will need to be procured – who pays for the lab techs (DOH, AHCA, DEM)
2. Testing materials
    a. What materials are included with the lab (what not included)
    b. What materials are needed to operate the lab at full capacity
    c. Procuring those material that help the lab operate – who procures/pays for these material
3. Wrap-around services
    a. What services are needed (ie, 24-hr security, food for staff, maintenance of lab, etc.)
    b. Who pays for the wrap-around services (DOH, AHCA, DEM)?
4. Timing – It will take at least a week to get the lab.
5. Location – where to stage the lab – that's a logs/mgt decision
6. Other items??

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

Florida has a very broad public records law. Written communications to or from state officials regarding state business constitute public records. Public records are available to the public and media upon request, unless the information is subject to a specific statutory exemption. Therefore, any information that you send to this address, including your contact information, may be subject to public disclosure.

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-----Original Message-----
From: Larson, Bradford U (Brad) Col USAF NG FLANG (USA) <bradford.u.larson.mil@mail.mil>
Sent: Wednesday, March 25, 2020 4:25 PM
To: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: [EXTERNAL] FW: MOA for CST and DOH (UNCLASSIFIED)

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

CLASSIFICATION: UNCLASSIFIED

Erik

Attached is the draft MOA we discussed. Please let me know if you have any suggestions. I contacted LTC Eastman and asked what we would need and what we may receive to run this machine. The National Guard Bureau is still working those details as far as what PPE, pipets, kits, etc. may come with the machine. He will get back with me. NGB is sending 2 to NY, so we will have a good idea of what to expect based on what they receive. He did say this would not get to us for about a week even if we do get one.

V/R
Brad

BRADFORD U. LARSON, Col, FLANG
Command Judge Advocate
Florida National Guard
Work: 904-823-0683
Cell: 850-774-3000

CLASSIFICATION: UNCLASSIFIED

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To: Roberson, Shamarial (CDC flhealth.gov); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE)
Subject: FW: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date: Tuesday, March 17, 2020 7:36:52 PM

Dear Dr. Roberson,
Here is the latest update that we received from Royal Caribbean.
I understand that my team lead, Cindy Friedman, has just spoken with Dr. Rivkees who reported that the plan has not been approved by the state at this time.

Best,
Michelle

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 7:25 PM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

Until then, I will arrange for Dr. Green to receive 60 Quest Novel Coronavirus (2019-nCoV)/COVID-19 test kits from my office, so that he can make final determinations on those who are ill. Ms. Stephanie Buchler will follow Quest collection instructions and will ensure courier specimen pickup, if necessary.

Dr. Green will direct his Medical staff to triage the arrival of these patients to either Jackson Memorial Hospital or Hotel St. Michel in Coral Gables, depending on their physical condition.

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Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 2:17 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.

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c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.

d. Passengers who are not ill will be allowed to continue their travel on commercial flights.

6. After arrival
   a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.

   b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.

7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
   a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

      i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

      ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

   b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 1:57 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)

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<yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
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Senior Brazil Desk Officer
WHA/BSC

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>
> ***Currently detailed to the COVID-19 Response***
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> Cindy R. Friedman, MD
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Subject:	FW: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:37:42 PM

Further information from Royal Caribbean

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At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

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Subject:	FW: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 5:28:57 PM
Attachments:	SCREENINGFORM_v4.docx SOP for disembarking international cruise ships with passengers arriving in charter flights (ver 3_17_2020).docx 20_316043-A_FS_Guide_disembark_ship_March17.pdf

Here is the earlier correspondence that I mentioned. Dr. Rivkees was copied but not sure that he has had time to review.

Best,
Michelle
Mobile: 1 404 456 4559

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Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

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EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival

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a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.

b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.

7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
   a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

      i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

      ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

   b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
> **To:** Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
> **Subject:** Royal Caribbean Ships off Brazil/Chile

AMERICAN OVERSIGHT

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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AMERICAN OVERSIGHT

From:	DNPAO Program (CDC)
To:	DNPAO Program (CDC)
Cc:	CDC ONDIEH NCCDPHP NCCD DNPAO PDEB; Annie Hardison-Moody
Subject:	Faith-Based Networking Call Postponed
Date:	Thursday, March 19, 2020 11:50:58 AM

Hello!

Due to the COVID-19 response efforts, today's CDC-DNPAO Networking Call entitled "Faith-Based Settings: Peer Sharing" is postponed due to less than half of our recipients working in faith-based settings being available.

Thank you to those who responded regarding their availability. We will send an announcement with a new date once this Networking Call has been rescheduled.

If you would like information on CDC's COVID-19 response, please visit coronavirus.gov.

Kindest regards,

DNPAO Program

AMERICAN OVERSIGHT

From:	Beynon, Valerie
To:	DL DEPCS00 BPR HCCTF
Cc:	Paul Link; Wilgis, John; Yow, Annmarie; Peggy Brown; John James; Hill, Ann; Schenk, Terry; Kelley, Debbie A; Mooney, Dayle; Wilsey, Leigh; Eric Anderson; Carhart, Ty; Kevin Gingras; Matt Meyers; Jeanne Eckes-Roper; Denise Imbler; Webb, Dawn; Riddle, Franklin; Knox, Thomas; Central Florida Disaster Medical Coalition; Zyna Wright
Subject:	February HCC Task Force Meeting
Attachments:	012320 HCCTF Minutes DRAFT.docx February 2020 HCCTF Consent Agenda Draft.docx

This is a reminder of the monthly conference call for the HCC Task Force. Please submit consent agenda reports and proposed agenda items by Monday, February 17.

Thanks,

Valerie

AMERICAN OVERSIGHT

From: DNPAO Comm TA (CDC)
To: DNPAO Comm TA (CDC)
Subject: Feedback requested by Mar 26 @ 9pm ET – DNPAO Comm TA mailbox
Date: Tuesday, March 24, 2020 4:21:01 PM

Dear DNAPO Ambassador Media/Communication Contacts,

During the COVID-19 response, we would like your feedback on content and frequency of emails from the DNPAOCommTA@cdc.gov mailbox.

Please click the link below and complete the assessment by March 26 at 9:00pm Eastern. We estimate this will take about 1-2 minutes. Your responses are anonymous and will inform email content and frequency during the COVID-19 response.
https://www.surveymonkey.com/r/95MLK75

You can find COVID-19 content including information on Protecting Your Family, Pregnancy & Breastfeeding, Schools and Childcare, High Risk groups including those with severe obesity, and Managing Stress & Anxiety which includes mention of physical activity and healthy diet. Syndicated content for these pages and many more that you can use on your own webpages are found at here.

Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	Final Interim Cleaning Guidance for Persons Under Quarantine Attached
Date:	Sunday, March 1, 2020 1:29:03 PM
Attachments:	FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.docx
Importance:	High

For distribution - FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
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cell: 404.772.9701
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cell: 202.909.6950 Verizon (secondary)

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AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fit testing

AMERICAN OVERSIGHT

Date: Wednesday, March 11, 2020 4:38:53 PM

Emerald Coast Healthcare Coalition has instructors and kits to do Fit Testing
We can come to your facility for multiple personnel needing to be fit tested or you can come to our facility
We have several instructors and kits for testing abilities
Please contact me for information on availability and pricing for the fit testing

Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fit testing

AMERICAN OVERSIGHT

Date: Wednesday, March 11, 2020 4:38:53 PM

Emerald Coast Healthcare Coalition has instructors and kits to do Fit Testing
We can come to your facility for multiple personnel needing to be fit tested or you can come to our facility
We have several instructors and kits for testing abilities
Please contact me for information on availability and pricing for the fit testing

Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alachua County Emergency Management; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Halbritter, Julia; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. 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Subject: Florida Arbovirus Surveillance Week 10: March 1-7, 2020

Date: Monday, March 9, 2020 5:36:54 PM

Attachments: image003.png
2020Week10ArbovirusReport_3-7-20.pdf

Florida Arbovirus Surveillance
Week 10: March 1-7, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 1-7, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. No sentinel chickens tested positive for antibodies to WNV this week. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Three sentinel chickens tested positive for antibodies to EEEV this week in Orange and Volusia counties. In 2020, 10 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: No cases of dengue fever were reported this week in persons that had international travel. In 2020, seventeen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: One case of locally acquired dengue fever was reported this week in Monroe County. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alachua County Emergency Management; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Ford, Jace; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Halbritter, Julia; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. 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Subject: Florida Arbovirus Surveillance Week 11: March 8-14, 2020

Date: Monday, March 16, 2020 5:47:59 PM

Attachments: image003.png
2020Week11ArbovirusReport_3-14-20.pdf

Florida Arbovirus Surveillance
Week 11: March 8-14, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 8-14, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. No sentinel chickens tested positive for antibodies to WNV this week. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Two sentinel chickens tested positive for antibodies to EEEV this week in Citrus and Orange counties. In 2020, 12 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, 18 travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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*please note my last name has changed from Bingham

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Cc: Morrison, Andrea; Rowe, Devin R

Subject: Florida Arbovirus Surveillance Week 12: March 15-21, 2020

Date: Monday, March 23, 2020 6:29:47 PM

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2020Week12ArbovirusReport_3-21-20 (003).pdf

Florida Arbovirus Surveillance

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Week 12: March 15-21, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 15-21, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week Four sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 34 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, 12 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, 19 travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

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There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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From: Morrison, Andrea

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Subject: Florida Arbovirus Surveillance Week 5: January 26-February 1, 2020

Date: Monday, February 3, 2020 4:34:30 PM

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Florida Arbovirus Surveillance
Week 5: January 26-February 1, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of January 26-February 1, 2020, the following arboviral activity was recorded in Florida.

This report contains information for 2019 and 2020. This week's report will be the last update for 2019.
Please visit the following website for up to date 2019 human case numbers as final data cleaning occurs: FloridaHealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Four sentinel chickens tested positive for antibodies to WNV this week in Citrus, Hillsborough, and Palm Beach counties. In 2020, 19 sentinel chickens have been reported from seven counties. In 2019, positive samples from two humans, one blood donor, ten horses, one eagle, and 808 sentinel chickens have been reported from 31 counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported. In 2019, positive samples from eight sentinel chickens have been reported from eight counties.

EEEV activity: No human cases of EEEV infection were reported this week. One horse with EEEV infection was reported this week in Volusia County. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, three sentinel chickens, one horse, and one mosquito pool have been reported from four counties. In 2019, positive samples from 28 horses, one emu, one eagle, and 115 sentinel chickens have been reported from 31 counties.

International Travel-Associated Dengue Fever Cases: One 2019 case of dengue fever was reported this week in a person that had international travel. In 2019, 406 travel-associated cases have been reported. Seven 2020 cases of dengue fever were reported this week in persons that had international travel. In 2020, seven travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2019, 16 cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2019, eight travel-associated cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2019, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2019, 36 travel-associated cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were

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reported this week. In 2019, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Broward County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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Subject: Florida Arbovirus Surveillance Week 6: February 2-8, 2020

Date: Monday, February 10, 2020 5:19:37 PM

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Florida Arbovirus Surveillance
Week 6: February 2-8, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 2-8, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Three sentinel chickens tested positive for antibodies to WNV this week in Citrus and Indian River counties. In 2020, 22 sentinel chickens have been reported from eight counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Three sentinel chickens tested positive for antibodies to EEEV this week in Hernando and Orange counties. In 2020, six sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, eight travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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Subject: Florida Arbovirus Surveillance Week 7: February 9-15, 2020

Date: Monday, February 17, 2020 2:52:03 PM

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2020Week7ArbovirusReport_2-15-20.pdf

Florida Arbovirus Surveillance
Week 7: February 9-15, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 9-15, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 24 sentinel chickens have been reported from eight counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, six sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: Five cases of dengue fever were reported this week in persons that had international travel. In 2020, thirteen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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From: Stanek, Danielle R

To: Morrison, Andrea; Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Cosgrove, Robert G; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. 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Cc: Morrison, Andrea; Rowe, Devin R; McDermott, Catherine

Subject: Florida Arbovirus Surveillance Week 8: February 16-22, 2020

Date: Monday, February 24, 2020 5:03:12 PM

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2020Week8ArbovirusReport_2-22-20.pdf

Florida Arbovirus Surveillance

Week 8: February 16-22, 2020

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Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 16-22, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Four sentinel chickens tested positive for antibodies to WNV this week in Hillsborough and Brevard counties. In 2020, 28 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. One sentinel chicken tested positive for antibodies to EEEV this week in Orange County. In 2020, seven sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, fourteen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America,

AMERICAN OVERSIGHT

Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

-

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Subject: Florida Arbovirus Surveillance Week 9: February 23-29, 2020

Date: Monday, March 2, 2020 5:44:47 PM

Attachments: image003.png
2020Week9ArbovirusReport_2-29-20.pdf

Florida Arbovirus Surveillance

Week 9: February 23-29, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 23-29, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, seven sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: Three cases of dengue fever were reported this week in persons that had international travel. In 2020, seventeen travel-associated cases have been reported.
Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be

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found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

Vector-Borne Disease Surveillance Coordinator
Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Epidemiology
4052 Bald Cypress Way, Bin # A12
Tallahassee, Florida 32399-1710
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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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From:	Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI)
To:	State and Local Readiness (CDC)
Cc:	Simmons, Jerome (CDC/DDPHSIS/CPR/DSLR); O"Connor, Angelica (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Blackmore, Carina (CDC flhealth.gov); Marla.Wallace@flhealth.gov
Subject:	Florida Department of Health COVID-19 Request
Date:	Tuesday, March 10, 2020 4:14:56 PM
Attachments:	Florida Department of Health Funding Request (2.48 MB).msg
Importance:	High

Good afternoon,

The ELC has been informed all funding for COVID-19 response is being funded thru the Crisis NOFO. Therefore, I am forwarding this request I received for financial assistance from Florida Department of Health in the amount of $874,632.

Thanking you in advance for your consideration of this request. Please let me know if you need further assistance from the ELC.

De'Lisa

De'Lisa D. Simpson, MBA
Program Advisor/Project Officer
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)
Division of Preparedness and Emerging Infections
National Center for Emerging & Zoonotic Infectious Diseases (NCEZID)
Centers for Disease Control and Prevention
1600 Clifton Rd, Mailstop C-12
Atlanta, GA 30333
Office: 404-639-3629
Blackberry: 404-372-5928
Fax: 404-718-1874
ion9@cdc.gov

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From:	Wallace, Marla D.
To:	Simpson, De"Lisa D. (CDC/OID/NCEZID)
Cc:	Blackmore, Carina
Subject:	Florida Department of Health Funding Request
Date:	Wednesday, March 4, 2020 12:39:20 PM
Attachments:	COVER LETTER COVID-19.pdf ELC Budget Emerging Cross-Cutting COVID-19 3-4-20.pdf Florida Indirect Rate Agreement.pdf Florida ELC 424A COVID-19.xls

De'Lisa

Please find the attached request from the Florida Department of Health for supplemental ELC funding from the Cross Cutting Emerging Issues Project. This request will be used to support Florida's Epidemiology and Laboratory Response to the current COVID-19 Outbreak. This funding was previously applied for in funding opportunity number: CDC RFA-CK19-1904 and was approved but was not funded. Please feel free to reach out to Dr. Blackmore or myself if you have any questions or concerns regarding this matter.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

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From:	Wallace, Marla D.
To:	Simpson, De"Lisa D. (CDC/OID/NCEZID)
Cc:	Blackmore, Carina
Subject:	Florida ELC Redirection Request
Date:	Wednesday, March 11, 2020 5:47:27 PM
Attachments:	COVER LETTER COVID-19.pdf ELC Redirection Non-Influenza.pdf ELC Redirection A2 Laboratory Cross Cutting.pdf REDIRECTION ELC.pdf

---

De'Lisa

I submitted 2 project redirections for COVID-19 in REDCap and Grant Solutions. Please email or call me if you have any questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

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From:	Blackmore, Carina
To:	Johansson, Michael (CDC/OID/NCEZID); Biggerstaff, Matthew (CDC/DDID/NCIRD/ID)
Subject:	Florida model
Date:	Tuesday, March 24, 2020 12:45:45 PM

Hi Matt and Mike. I am sure you are both busy with the COVID response. As many states are, we are dabbling with modeling. Came across this the model below. Do you know anything about it? Also in the modeling you are doing, anything that would be of value to learn from your work from a state (Florida specifically). Any guidance on priorities we should try to model (where we may have solid enough data to inform policy). We have some thoughts of course but if we can make short cuts we are all for it. If more easily discussed over the phone and you have the time my cell is +18505281595 Take care Carina

https://covidactnow.org/state/FL

Please note that under Florida law correspondence, which is not confidential or exempt pursuant to the Florida Statutes, is a public record made available upon request.

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From:	Cohn, Amanda (CDC/DDID/NCIRD/OD)
To:	Meaney Delman, Dana M. (CDC/DDNID/NCBDDD/DBDID); Blackmore, Carina (CDC flhealth.gov)
Subject:	Florida plan
Date:	Thursday, March 12, 2020 6:03:34 PM
Attachments:	Florida_Community_Mitigtion_12MAR2020.docx

Amanda Cohn, MD
CAPT, USPHS
Chief Medical Officer
National Center for Immunization
And Respiratory Diseases
Centers for Disease Control and Prevention
Phone: 404-639-6039
Email: acohn@cdc.gov

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From: Roberson, Shamarial
To: MMeltzer@cdc.gov
Cc: Grant, Courtni J; Blackmore, Carina
Subject: Florida
Date: Wednesday, March 25, 2020 12:35:00 PM

Good Afternoon Dr. Meltzer,

Thanks for your support, as we continue to enhance public health efforts. Please share any materials and tools as it relates to modeling that may be helpful in this response. We are interested in learning more about the FluSurge tool and participating in any beta testing of this tool and other tools as they become available. Additionally, please share literature as it relates to these topics that we can review to enhance our understanding of these topics. We sincerely appreciate the continuous support of the Centers for Disease Control and Prevention.

Best Regards,

Shamarial Roberson, DrPH, MPH
Deputy Secretary for Health
Florida Department of Health
4052 Bald Cypress Way, Bin A-13
Tallahassee, FL 32399-1721
Phone: 850-245-4391
Email: shamarial.roberson@flhealth.gov
****

pha

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts. Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media on request. Your e-mail communications may therefore be subject to public disclosure.

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From:	Schauer, Gillian (CDC/DDNID/NCCDPHP/OSH) (CTR)
To:	Ali Hamade; Amanda Borup; Michele.nakata@doh.hawaii.gov; Amanda Cue; Amanda Faulkner; Andre Ourso; Andrea Wojcik; Andrew Brisbo; Arian Gibson; Bagley, Bridget; Beth McLaughlin; Brian Lopez; Caitlin Barry-King; Cheryl Petersen-Kroeber; Chris Tholkes; Christina Dempsey; Christine Theriault; Cichowski, Cheryl; Courtney Coppola; Cristal Connelly; Tomiyasu, Danette W. (CDC doh.hawaii.gov); David Olsen; Doug Schultz; Eden Wells; Eliza Muse; Elyse Contreras; Erik Gundersen; Erin Reed; Errica Ferrelli; Ilana Kurtzig; Markiewicz, James (CDC maine.gov); Jamie Margetta; Jared Welehodsky; Jason Frame; Jason Wahl; Jennifer Epstein; Layden, Jennifer (CDC illinois.gov); Jessica Filley; Jessica Neuwirth; Jim Burak; McLaughlin, Joseph (CDC alaska.gov); Judy Barrett; Julia Dilley; Julia Hitchingham; Peek, Julia (CDC health.nv.gov); Julie Johnson; Karen Girard; Karyl Rattay; Katelyn Hall; Lofy, Kathy KL (CDC doh.wa.gov); Kay Doyle; Kristen Haley; Kyle Devine; Kyle Lambert; Kyril Plaskon; Linda Scarpetta; Lori Dodson; Lori Uerz; Lyla Hunt; Lyndall Fraker; Nascarella, Marc (CDC state.ma.us); Margaret Flerchinger; Margaret Machaiek; Marie Dotseth; Mark Hurst; Mark Krueger; Mark Pettinger; Mark Starr; Martha Stanbury; Megan Lockwood; Melissa Finnegan; Beardsley, Nancy (CDC maine.gov); Nancy McBrady; Ngozi Ezike; Nirav Shah; Paul Hyland; Rebecca Rodman; Rebecca Walsh; Rick Garza; Samantha Doonan; Sara Broschart; Shannon OFallon; Sharlet Kroll; Shelly Rowden; Stephanie Klapstein; Stephanie Woodard; Steve Marks; Steve Smothers; Steven Rekand; Susan Fanelli; Sydney King; Thomas Jeanne; TJ Sheehy; Todd Orlando; Travis Kirkpatrick; Trecia Ehrlich; Trevor Christensen; Tricia Blocher; gregory.mcilvaine@state.oh.us; Haegerich, Tamara M. (CDC/DDNID/NCIPC/DOP); Grant, Althea M. (CDC/DDNID/OD); norman.birenbaum@exec.ny.gov
Cc:	Klein, Miren@CDPH; SIDELINGER DEAN E; Tapscott, Ryan (CDC/DDNID/NCIPC/DOP); heather.krug@state.co.us; Putnam, Michelle (CDC/DDNID/NCIPC/DOP); Thimjon, Lisa (MDH); Ferguson, Christopher K; farahaths.dave@maryland.gov; Scott, Megan; Pierre, Ermion; brandon.jeffery@state.co.us
Subject:	Follow up from: Monthly Multi-State Collaborative and Cannabis Regulators discussion call on vaping
Date:	Monday, February 3, 2020 3:23:51 PM
Attachments:	Notes from lung injury and cannabis call 011720_For States.pdf

Dear State Colleagues,

It's hard to believe February is already upon us. **I wanted to send out the notes from our cannabis vaping call earlier in January** (see attached). Per our discussions on that call, we'll be **moving to hold these multi-state, all state calls on a quarterly basis**, and will continue to facilitate discussion on cannabis vaping issues, but will incorporate other cannabis and public health topics that are of interest to both medical and adult use states. If you are interested in continuing to participate in all-state cannabis and public health calls, please complete this When2Meet poll so we can try to schedule a March call. We'll talk on that call about getting a standing quarterly call on the calendar (e.g., X day of the last week of the second month of the quarter, or something like that). As a reminder, When2Meet automatically saves your entries. Please remember to select your timezone before completing the poll.

We will also pick back up with quarterly topic-based calls for adult use states only (the multi-state collaborative group), since some additional public health and policy issues exist in the adult use landscape. Adult use states - I will be sending a separate poll to try to schedule one of those calls in February, as I know some of you already have issues you'd like to discuss with each other, with legislative sessions underway.

For both the all-state and adult use state calls, I will continue to develop the agenda in the same manner - reaching out to a variety of states to solicit topics. Please feel free to reach out to me any time with policy questions, TA requests, or topics for these multi-state calls.

Thanks again for all you do in the field!

Respectfully,

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Gillian

Gillian L. Schauer, PhD, MPH
Senior Consultant to:
Division of Overdose Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
gschauer@cdc.gov

From: Schauer, Gillian (CDC/DDNID/NCCDPHP/OSH) (CTR)
Sent: Thursday, January 2, 2020 10:09 PM
To: <Multi-State Cannabis and Public Health Listserv>
Subject: Monthly Multi-State Collaborative and Cannabis Regulators discussion call on vaping
When: Friday, January 17, 2020 10:30 AM-11:30 AM.
Where: Call in line: 1-877-680-2010 Participant code: 23065250

Updated with call in and agenda
Call in line: 1-877-680-2010 Participant code: 23065250

Proposed Agenda for multi-state vaping discussion call:

- Brief roll call by state
- Call purpose/announcements
  - Brief CDC announcement about standing down EVALI Emergency Operations Center
  - Future of these discussion calls
  - Vaping policy tracking
- Updates from states re: marijuana related vaping responses/policy changes
  - General vaping policy & implementation updates, Executive order updates, Legislative session vaping updates, State Cannabis Vaping Response updates
- Specific discussion about:
  - Excipient bans and FDAs inactive ingredient database
  - Regulations to improve the safety of vaping devices
  - Comparing the epidemiology of cases from state to state
  - Flavor bans
- Non-vaping packaging & labeling question from CO (time permitting)
- Next steps and Adjourn

Original message

This time looked the best for those of you who responded to the When2Meet call. As with our prior monthly multi-state collaborative/cannabis regulator EVALI calls, the purpose of this call is to provide a forum for individuals from state public health and regulatory agencies to discuss issues pertinent to state-related work on EVALI. CDC will not provide extensive EVALI updates on this call. CDC holds regular Thursday calls to provide those updates. This call will be discussion based. An agenda will be

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developed in collaboration with attendees and will be sent in advance of the call.

Please let me know if you have any specific EVALI topics you would like to discuss as part of the agenda.

Respectfully,
Gillian

Gillian L. Schauer, PhD, MPH
Senior Consultant to:
Division of Overdose Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
gschauer@cdc.gov

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(855) 644-0229,,25802673# (Chamblee Dial-in Conference Region)	English (United States)

Find a local number

Conference ID: 25802673

Forgot your dial-in PIN?

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Follow-up Call
Date:	Friday, March 20, 2020 7:20:02 AM

Hello Dr. Blackmore,

We were alerted that you would like to schedule a follow-up call regarding the LTC facility. The healthcare infection control team is happy to chat. Let us know what time works best.

Thanks,
Elizabeth Soda

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From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: Follow-up items from today"s call on COVID-19
Date: Thursday, February 20, 2020 6:18:30 PM

Dear Partner –

Thank you to all that joined us on today's call on COVID-19 with Secretary Azar, HHS, and DHS officials. While the immediate risk to the American public is still currently low, that has the potential to change rapidly. We strive to continue to provide updates to you, our valuable state partners, so that you have the best information available when developing and executing your preparedness plans.

As mentioned on the call, we wanted to provide you with some further information about available resources and to share again some prompts for consideration when planning state actions.

First, please find below links to CDC and select partner organization sites that focus on state and local readiness. Some of these link to the latest COVID-19 information, while others link to sites focused on resources for any response. As has been noted, pandemic influenza plans often provide some overlap for other infectious disease outbreak plans, so some link to CDC or external partner influenza preparedness guides.

CDC Resources

- Coronavirus Disease 2019 homepage
- State and Local Readiness homepage
- State and Local Government Planning for Influenza
- Public Health Emergency Preparedness (PHEP) Cooperative Agreement
- Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC)

Related Links

- Association of State and Territorial Health Officials (ASTHO): Pandemic Influenza
- National Association of County and City Health Officials Local Health Department Pandemic Influenza Guide

In addition to the above links, we wanted to share with you some questions that can inform preparedness plans. These will be particularly important if the U.S. response has to move from aggressive containment to a mitigation response. We encourage you to use these to reflect on these as you explore possible necessary response actions. In a response focused on mitigation rather than containment, state and local officials will be responsible for three key pieces of a state's response:

- Transportation;
- Housing for individuals under observation or quarantine; and
- Communication and Coordination with local and private sector partners.

We encourage you to confer and collaborate with your Attorneys General and legislature leaders to confirm and identify what authorities that you have and any that you may need to be granted.

Authorities & Responsibilities for Prudent State and Local Planning:

- Have you reviewed the scope of your emergency authorities as Governor to respond to a public health crisis in your state?
    - When have you last exercised these authorities?
    - Do you have plans to in the future?

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What are your quarantine and isolation authorities, roles, and responsibilities?

- Do you have plans for canceling large events and community gatherings?
- Do you have a mechanism to encourage or compel school closures, if necessary? If so, what is its scope? (public v. private, secondary v. university, time limited, etc.)?
- What are your policies for limiting or discouraging mass transit?
- Coordination and Communication with Local Governments – what authorities do local governments have in your state? What is your coordination plan between state, local, and tribal governments?
- What public health and human resource resources do you have for local governments, the private sector, and non-profits on hygiene or social distancing?
- What are your critical infrastructure, key resources, and essential services that might face personnel shortages?
- Do you have policies and plans in place for state and local government workers?

Finally, the U.S. State Department has posted guidance for cruise ship passengers in the event of planned travel to or within East Asia and the Asia-Pacific Region . That guidance can be found here.

Please don't hesitate to follow up with the Office of Intergovernmental and External Affairs if there are any questions!

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

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From:	Walke, Henry (CDC/DDID/NCEZID/DPEI)
To:	scott.rivkees@flhealth.gov
Cc:	Bresee, Joseph (CDC/DDID/NCIRD/ID); Butler, Jay C. (CDC/DDID/OD)
Subject:	Follow-up on modeling and social distancing
Date:	Tuesday, March 24, 2020 9:52:52 AM

Scott,

Jay said you have a couple of questions.

- I am connecting you to Joe Bresee, 404 421 5648, who has wide visibility on the modeling activities at CDC and can help answer your questions.

- The evidence base for social distancing is best found in the 2017 Community Mitigation Guidelines to Prevent Pandemic Influenza.
  https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

Best, Henry

Henry Walke, MD, MPH
Deupty Incident Manager
Jurisdiction Support
CDC COVID-19 Response
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hwalke@cdc.gov

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Friday, February 14: CDC Media Telebriefing: Update on COVID-19
Date:	Friday, February 14, 2020 11:44:47 AM

Media Advisory

For Immediate Release
Friday, February 14, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:30 p.m. ET Friday, February 14, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

CDC works 24/7protecting America's health, safety and security. Whether diseases start at

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home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Sent by BCC to PHEP Directors, State Health Officials, State Epidemiologists, and Non-Governmental Partners

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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: Fw: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 10:21:15 PM
Attachments: image001.png

From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Thursday, March 12, 2020 12:51 PM
To: State and Local Readiness (CDC) <preparedness@cdc.gov>
Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our

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office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs
The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the

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Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.

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- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
    - In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
    - In February, the President restricted travel for individuals recently traveling from Iran.
    - The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
    - Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.
- Today, the President directed his Administration to make general-use face masks available to our healthcare workers.
    - The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.
- President Trump signed into law more than $8 billion to fund response efforts.
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
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ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

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ON ABC's GOOD MORNING AMERICA



WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

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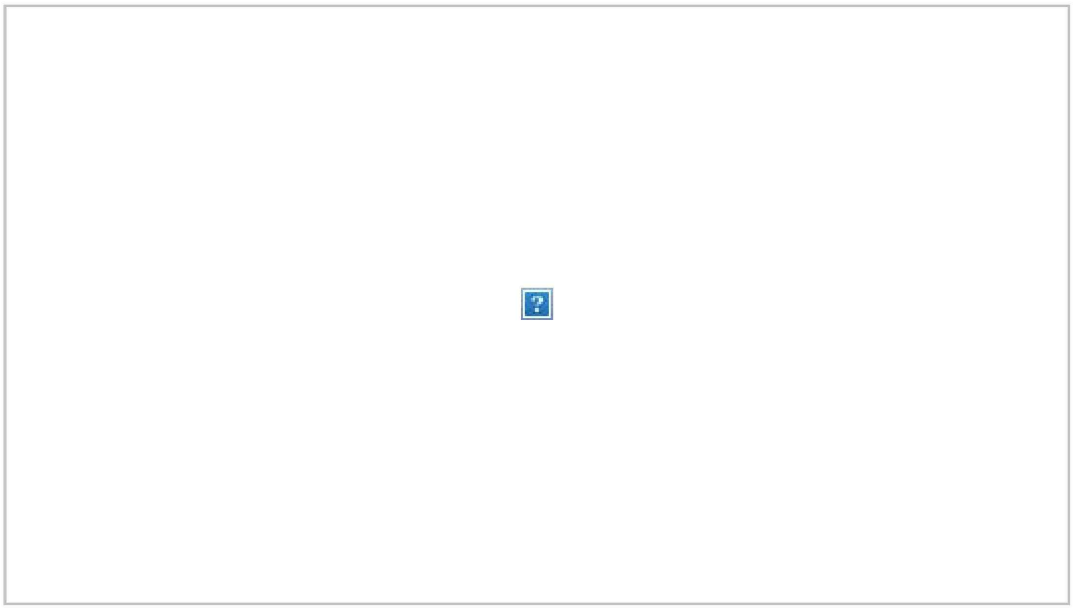

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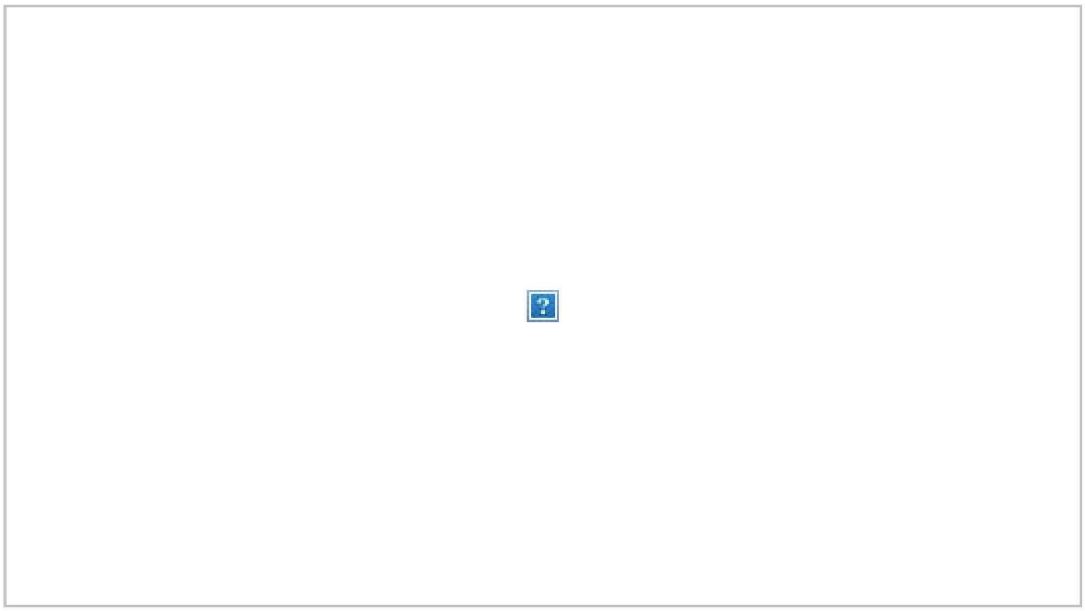

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> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

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Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

> "For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

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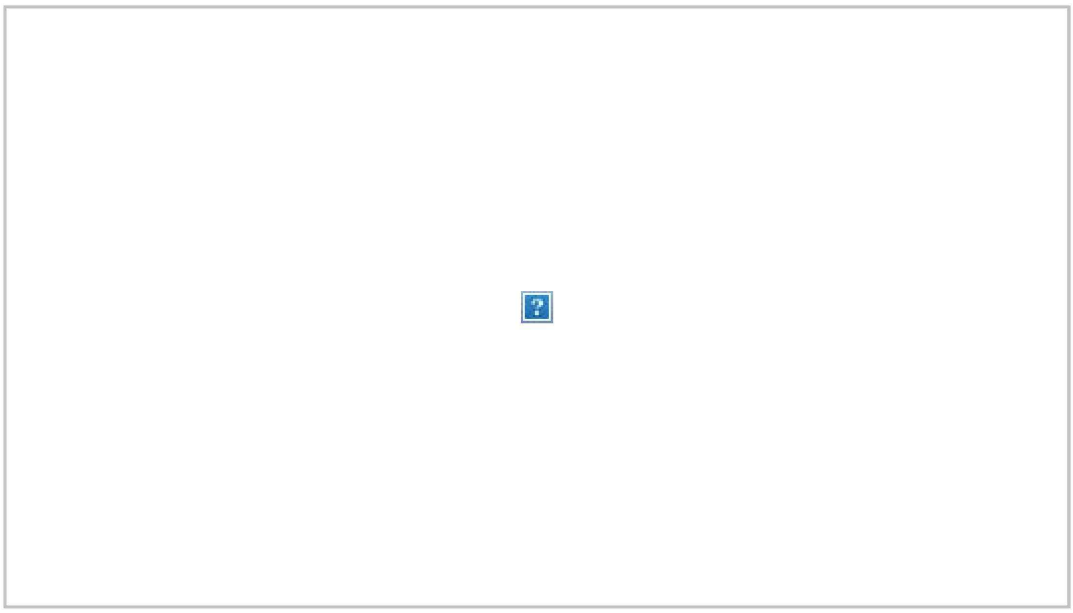

WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

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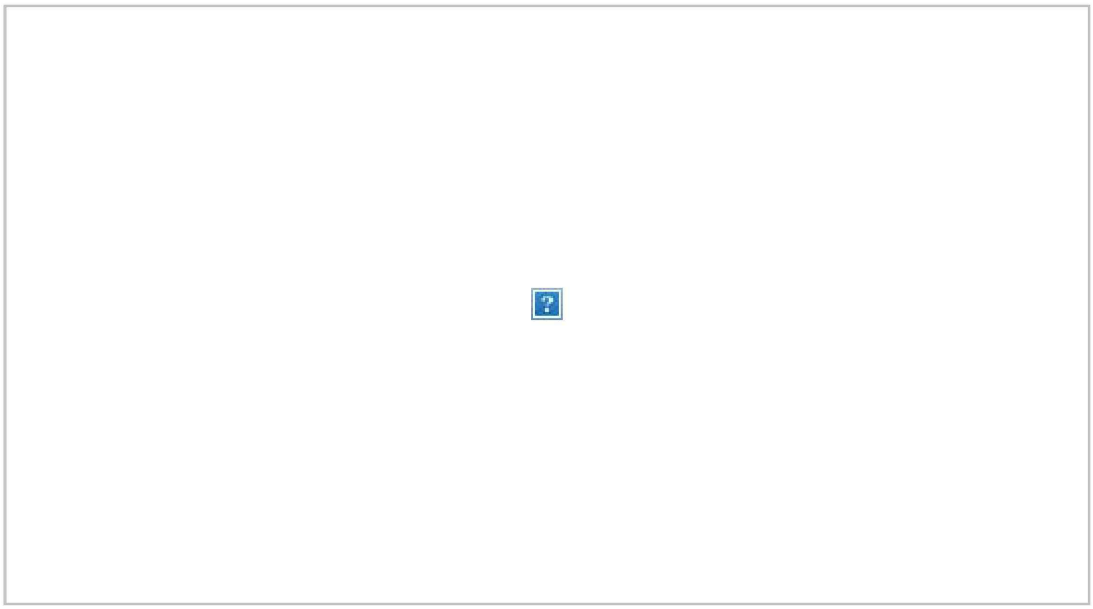
want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: Fw: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 12:53:45 PM
Attachments: image001.png

From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Thursday, March 12, 2020 12:51 PM
To: State and Local Readiness (CDC) <preparedness@cdc.gov>
Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our

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office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs
The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the

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Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.

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- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
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    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
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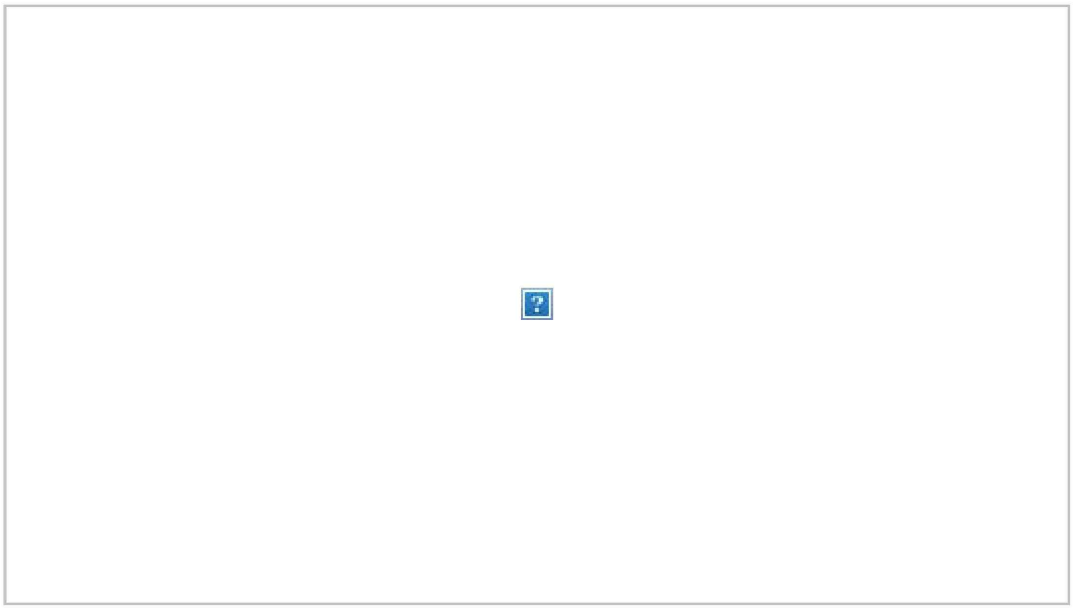

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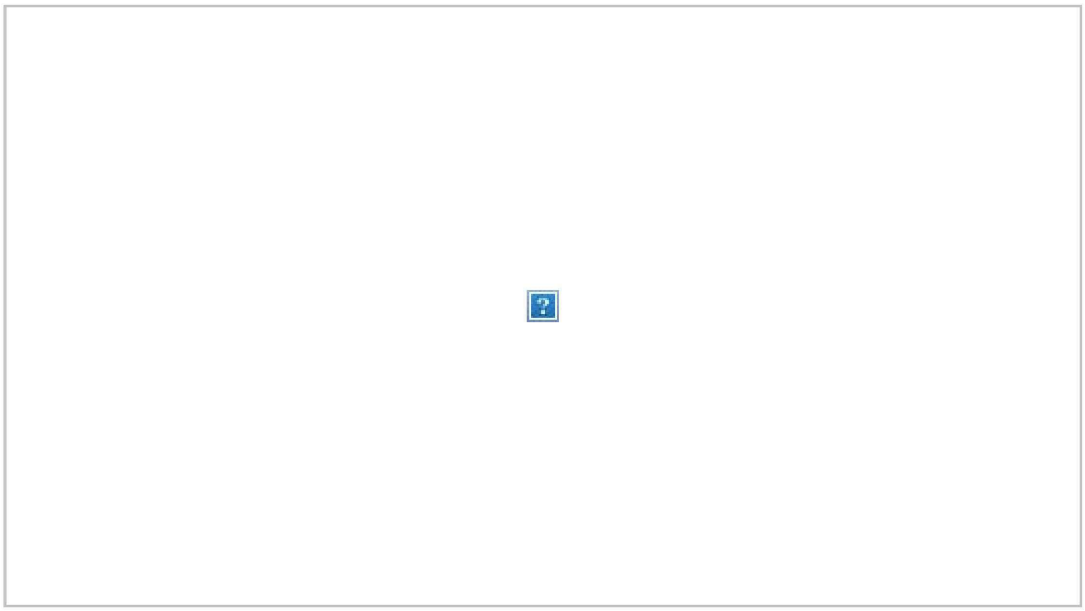

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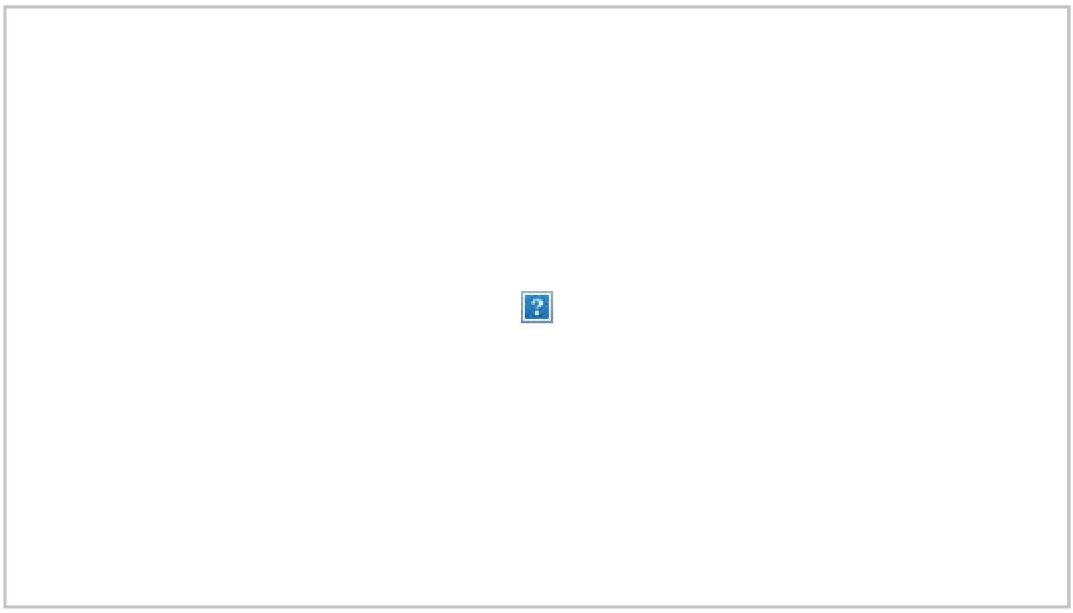

WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

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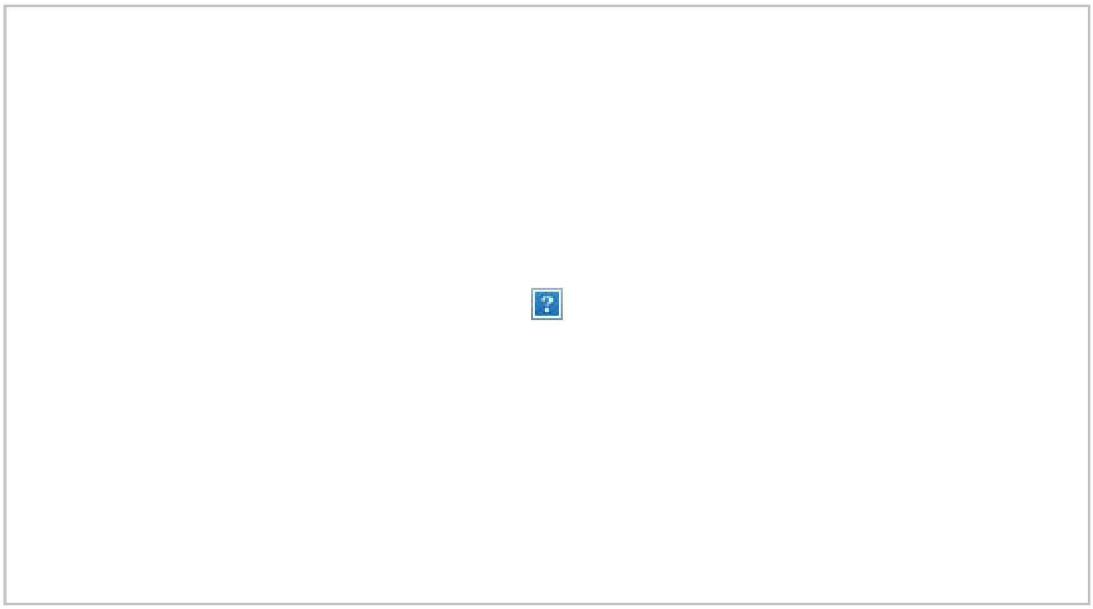
want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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From: Ann Hill

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Subject: Fwd: 2019 Novel Coronavirus Guidance

Date: Thursday, March 12, 2020 11:59:12 AM

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From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Thu, Mar 12, 2020 at 10:05 AM
Subject: 2019 Novel Coronavirus Guidance
To: <ann.echcc@gmail.com>

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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Thursday, March 12, 2020

News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

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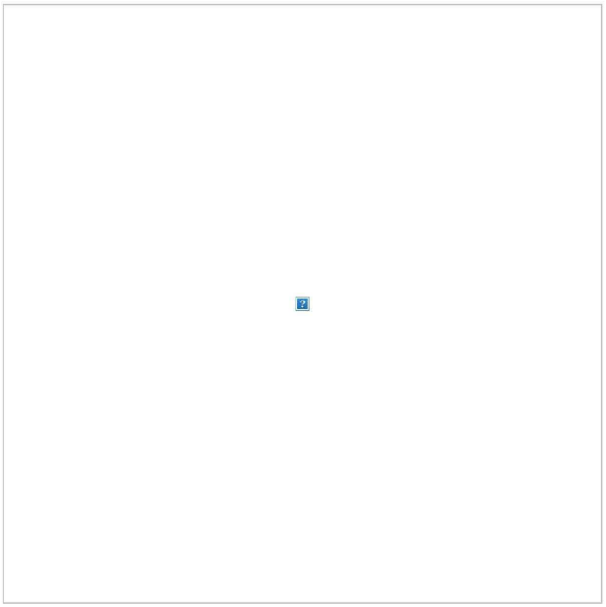

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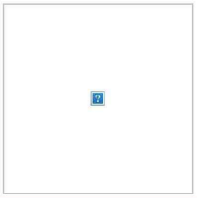

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
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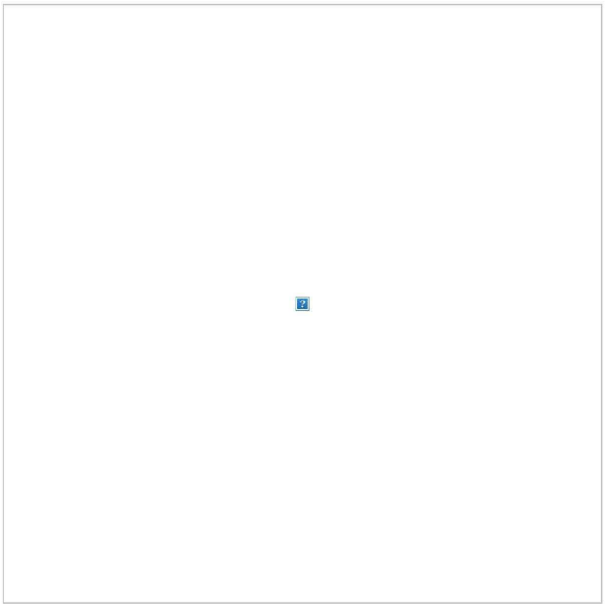

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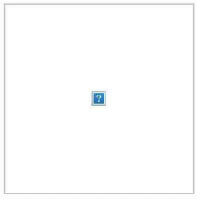

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Thaqi, Paula M
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Subject:	Fwd: ALF NH Info
Date:	Sunday, March 22, 2020 5:58:40 PM
Attachments:	ALF Outreach Questionnaire Short Form 3_21.docx Facility Inspection.docx

Sent from my Verizon, Samsung Galaxy smartphone
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From: Podolsky, Renee C <Renee.Podolsky@flhealth.gov>
Sent: Sunday, March 22, 2020 5:26:34 PM
To: Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: FW: ALF NH Info

Renee Podolsky, MBA
Community Health Director
Florida Department of Health in Broward County
780 S.W. 24th Street
Ft Lauderdale FL 33315
(954) 847-8188
Renee.Podolsky@flhealth.gov
Visit our website: http://broward.floridahealth.gov

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Vision: To be the **Healthiest State** in the Nation

Values: (ICARE)

Innovation: We search for creative solutions and manage resources wisely.
Collaboration: We use teamwork to achieve common goals & solve problems.
Accountability: We perform with integrity & respect.
Responsiveness: We achieve our mission by serving our customers& engaging our partners.
Excellence: We promote quality outcomes through learning & continuous performance improvement.
****
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From: Torres, Yari
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Stanek, Danielle R; Blackmore, Carina
Subject: Fwd: Action Required: COVID-19 impact on your polio TDY
Date: Friday, March 13, 2020 3:13:35 AM

FYI- At the moment my new return date is March 24th which is within that time frame, I will let you know if that changes.

Thank you and see you soon!

Yari
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From: Vertefeuille, John F. (CDC/DDPHSIS/CGH/GID) <dki4@cdc.gov>
Sent: Friday, March 13, 2020 3:23:29 AM
To: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP) <pja5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>
Cc: Frank, Daniel (CDC/DDPHSIS/CGH/GID) <fcd3@cdc.gov>; Rouse, Edward N. (CDC/DDPHSIS/CPR/DEO) <dmz0@cdc.gov>; Taylor, Bryan (CDC/DDPHSIS/CPR/DEO) <yzi8@cdc.gov>; Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>; Wiesen, Eric (CDC/DDPHSIS/CGH/GID) <ejw2@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>
Subject: Action Required: COVID-19 impact on your polio TDY

Hi everyone,

Let me first say that we appreciate everyone's effort on the polio surge and your flexibility in these uncertain and rapidly changing times with the COVID-19 response. We in the polio EOC, as well as CDC as whole, have your safety and health as our top priority.

You are receiving this email because you are currently set to return home from your polio TDY between 7-14 days from now. We ask that you work with the EOC to immediately curtail your travel and return to the US.

If you believe that anything may impact your date for return to work at your home office, please let us know and we can reach out to your supervisory chain. New agency guidance regarding post-deployment telework and monitoring policies should be coming out by the end of the week and will be sent to you.

Please continue to monitor all information you receive from the post where you are located which may impact your travel, as well as any guidance you receive from the EOC. Thank you for your contributions to polio eradication, the contributions you may be being asked to make regarding COVID-19 in your TDY location, and your commitments to CDC's mission.

John F. Vertefeuille, PhD, MHS
Incident Manager

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CDC Polio Activation

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From:	Cheryl Stroud
To:	Bruce Kaplan (bkapdvm@verizon.net); Carter, Craig; Keith Goldman; King, Lonnie; Laura H. Kahn; Lisa Conti; William Stokes; wrdehaven@comcast.net; alex.thiermann@gmail.com; at97@cornell.edu; biosburn@ucdavis.edu; bdunham@email.gwu.edu; bkapdvm@verizon.net; Carter, Craig; prof.grossklaus@gmx.de; dnoah21@gmail.com; famurphy@UTMB.EDU; hmm2@cdc.gov; hmainzer@cdc.gov; isabel.kantor@gmail.com; jack.a.shere@usda.gov; jrcliffordjr@aol.com; kelley-donham@uiowa.edu; konradeugster@gmail.com; lkahn@Princeton.EDU; LXC2001@gmail.com; Lonnie.King@cvm.osu.edu; mpappa1821@gmail.com; primoarambulo@gmail.com; racran@juno.com; bgjorgydvm@yahoo.com; robert.whitney@comcast.net; ruscurrier@yahoo.com; srjenkins@comcast.net; tfm@vetmed.wsu.edu; tpmonath@gmail.com; wrdehaven@comcast.net; Huest001@umn.edu; billmacdvm@comcast.net; williamstokes.asg@gmail.com; yoshi-oz@h07.itscom.net; abeck@purdue.edu; Amaccabe@aavmc.org; aehill@ucdavis.edu; b.olugasa@ui.edu.ng; bernadette.dunham@fda.hhs.gov; bonniebuntain@calgary.ca; e-pi-vet@hotmail.com; bakey@tvmdl.tamu.edu; candacejacobs99@gmail.com; Carina.Blackmore@FLHealth.gov; Chr1@CDC.gov; CBartonBehravesh@cdc.gov; cmuscop@umn.edu
Subject:	Fwd: Announcing Dr. Jack Shere, the AVES Pres-Elect to the AVES Board of Directors and the full membership!
Date:	Tuesday, February 11, 2020 9:14:26 PM
Attachments:	meclgeeachkbohkk.png

Craig, Jack and Harz Mountain:

Thank you for your continued service to AVES and for your belief in and support of One Health.

May we all continue our efforts to implement it at all levels of academia, research, government and policy. Had it been fully in place we just might not be dealing with Covid-19 now??

Warmly,

Cheryl Stroud, DVM, PhD
Executive Director, One Health Commission
cstroud@onehealthcommission.org
Direct Phone: 224-622-1839

http://bit.ly/2k7NPSe
Connect, Create, Educate for One Health

"Never underestimate the power of a few committed people to change the world. Indeed, it is the only thing that ever has". – Margaret Meade
"We have the choice to use the gift of our life to make the world a better place--or not to bother" Jane Goodall

-------- Forwarded Message --------
Subject: Announcing Dr. Jack Shere, the AVES Pres-Elect to the AVES Board of Directors and the full membership!
Date: Tue, 11 Feb 2020 18:14:48 +0000
From: Carter, Craig <craig.carter@uky.edu>
To: Bruce Kaplan (bkapdvm@verizon.net) <bkapdvm@verizon.net>, Carter, Craig <craig.carter@uky.edu>, Keith Goldman <kgoldman@hartz.com>, King, Lonnie <king.1518@osu.edu>, Laura H. Kahn <lkahn@Princeton.EDU>, Lisa Conti <lxc2001@gmail.com>, William Stokes <williamstokes.asg@gmail.com>,

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CC: Shere, Jack A - APHIS (jack.a.shere@usda.gov) <jack.a.shere@usda.gov>

All:

I am very proud to announce that Dr. Jack Shere has accepted his elected role of President-Elect in the American Veterinary Epidemiology Society and will be inducted at the end of the AVMA awards breakfast meeting in San Diego on Monday, Aug 3rd, location TBD. He will serve for three years in this position. I have pasted in Dr. Shere's bio below. Most recently, he was appointed the Associate Administrator of the USDA Animal Plant Health Inspection Service (APHIS). He has had a long and very productive career with ever-increasing responsibilities and has led the response to many important animal disease outbreaks in US history.

Dr. Jack Shere, Associate Administrator, APHIS



Dr. Jack Shere was appointed Associate Administrator in August 2019. He works in partnership with Administrator Kevin Shea and fellow Associate Administrators Dr. Mike Watson and Dr. Mark Davidson to carry out the Agency's day-to-day operations, represent APHIS on Departmental-level and cross-Agency working groups, and oversee the activities of every APHIS program area and support unit on behalf of employees and stakeholders. Particularly, Dr. Shere will concentrate on emergency preparedness and planning, as well as homeland and national security issues. Among his duties will be a special focus on the emerging African swine fever threat throughout the world.

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Dr. Shere was Veterinary Services' (VS) Deputy Administrator since March 2016, where he served as the nation's Chief Veterinary Officer and led VS in protecting and improving the health, quality, and marketability of U.S. agricultural animals, animal products, and veterinary biologics. Dr. Shere joined VS in 1990 as a field veterinary medical officer in Nebraska and Wisconsin and has held many leadership positions since then, including VS' Associate Deputy Administrator, Eastern Regional Director, and Associate Western Regional Director.

Dr. Shere has extensive experience with animal disease outbreaks, including salmonella enteritidis, foot-and-mouth disease in England, low pathogenic avian influenza, Exotic Newcastle Disease (END), and highly pathogenic avian influenza. During the extensive 2002-2003 END outbreak in California, Texas, New Mexico, and Utah, Dr. Shere served as the Joint Area Commander and Incident Commander, leading a massive federal and state eradication effort for nine months until the disease was eradicated from the United States.

Dr. Shere received a Bachelor of Science in Biology and Chemistry in 1981, a Doctor of Veterinary Medicine in 1987, and a Master of Science in Education with a minor in Counseling in 1988 – all from Iowa State University. He received PhD's in Poultry Science and Microbiology in 2001 from the University of Wisconsin. He also practiced veterinary clinical medicine for 3 years in Georgia.

From the entire Board of Directors of the AVES, we send hearty congratulations—we know that your mentors Drs. Jim Steele and Charles Thoen are smiling down on you! We all look forward to working with you to help take the AVES from its early beginnings by Jim in 1964 on into the future!

Many thanks as always to Hartz Mountain for the sole sponsorship of the AVES all the way back to 1964. We also want to thank Mr. Keith Goldman, our Hartz liaison for all of his efforts to help us sustain the AVES and to recognize our awardees for their contributions to animal health, human health and One Health!

Sincerely,

Craig

CRAIG N. CARTER
President, AVES

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

Subject: Fwd: CDC - Prevent Spread - Long Term Care Facilities
Date: Monday, March 16, 2020 3:54:50 PM

---------- Forwarded message ---------
From: **Verlaan, Thomas D** <Thomas.Verlaan@flhealth.gov>
Date: Mon, Mar 16, 2020 at 2:41 PM
Subject: CDC - Prevent Spread - Long Term Care Facilities
To: Margie Hobbs <margie.hobbs@hcahealthcare.com>, Aleta <aleta.hoodless@hma.com>, Anne <paceasc@gmail.com>, Anthony Brown <anbrown@gchc.com>, April Gilmore - Berryhill Manor <berryhillmanor@aol.com>, April Parsons - Covenant Hospice <April.Parsons@covenanthospice.org>, Ary Habig <ary.habig@bhcpns.org>, McMillion, Barbara J <Barbara.McMillion@flhealth.gov>, Beata Kundera <beata.kundera@fmc-na.com>, Beau Pollard - Administrator GB Hosp <bpollard@bhcpns.org>, Bonnie Hunter - Navarre Gardens <Elizabeth_Black@hotmail.com>, Brad Baker - Santa Rosa County EM <BradB@santarosa.fl.gov>, Carol Belitsos - Veritas <cbelitsos@veritasincare.com>, Carol Ettelson <carolettelson@gmail.com>, Cathy Blanchard - Gentiva <Cathy.blanchard@gentiva.com>, Charity Bailey - Pruitt Health <CHBailey@pruitthealth.com>, Cheryl Pence - Davita <Cheryl.Pence@davita.com>, Cheryl Whisman <cwhisman@gchc.com>, Christopher Kennison - Lifeguard Ambulance <Christopher.Kennison@amr.net>, Cindy Almand <cindy.almand@bhcpns.org>, Cindy Westergard - Baptist Healthcare Systems <cwestergard@bhcpns.org>, Corey Lofton - Kindred Hospice Care <Corey.Lofton@kindredhospicecare.com>, CRISTIN CARR-PETERSON <admin@sandyridgehealthandrehab.com>, Daniel Hahn - Santa Rosa County District Schools <Hahnd@santarosa.k12.fl.us>, Darline Earl - Watermark of Gulfbreeze <dearl@watermarkofgulfbreeze.com>, David Kauffman - Sacred Heart Hospital <david.kauffman@ascension.org>, Dawn Mann - Baptist Healthcare Systems <dawn.mann@bhcpns.org>, Deanna Edwards-Walton - Emerald Coast Hospice <Deanna.EdwardsWalton@kindredhospicecare.com>, Debra Burr <Debra.Burr@fmc-na.com>, Denice Curtis - UWF <dcurtis@uwf.edu>, Diane McKeon <diane.mckeon@hma.com>, dluongo@bhcpns.org <dluongo@bhcpns.org>, Dobson, Roger M <Roger.Dobson@flhealth.gov>, Don Russell - Baptist Healthcare Systems <don.russell@bhcpns.org>, Dr. Landry - Lifeguard Ambulance <klandry@mchsi.com>, Dwayne Tullos - Lifeguard Ambulance <Dwayne.Tullos@amr.net>, Eamonn Wheelock - Baptist Healthcare Systems <eamonn.wheelock@bhcpns.org>, Elizabeth Foster - Santa Rosa Medical Center <Elizabeth.Foster@srmcfl.com>, Enid Sisskin - UWF <esisskin@uwf.edu>, Fletcher Forte - Bureau of Parole <Fletcher.Forte@fdc.myflorida.com>, Fran Rohling - Baptist Healthcare Systems <fran.rohling@bhcpns.org>, Frank Daniel <fdanielmpt@aol.com>, Genny Holley - Kindred <genny.holley@kindred.com>, Ginny Palmer - Santa Rosa County EM <GinnyP@santarosa.fl.gov>, Grissom, Dana L <Dana.Grissom@flhealth.gov>, Heather Cornett - Santa Rosa Medical Center <Heather.Cornett@srmcfl.com>, Hill, Ann <ann.echcc@gmail.com>, Howard Clinic <howardclinic1354@att.net>, HUTCHINS, MICHAEL <mike.hutchins@bhcpns.org>, Isaac Newlin <itnewlin@gmail.com>, Jaimie Hudson - Gentiva <jaimie.hudson@gentiva.com>, Jana Lynder - Santa Rosa Medical Center <jana.lyner@srmcfl.com>, Jeffrey Walters - Santa Rosa Medical Clinic <jeffrey.waltersjr@srmcfl.com>, Jennefer Melnyk - Sandy Ridge Health & Rehab <don@sandyridgehealthandrehab.com>, Jessie Stafford - Lifeguard Ambulance <jessie.stafford@amr.net>, Jody Massey - White-Wilson <jmassey@white-wilson.com>, Joyce Amor - SRMC <Joyce.amor@hma.com>, Julie Gaither - Bureau of Parole <Julie.Gaither@fdc.myflorida.com>, JUSTIN GIBSON <jgibson@gchc.com>, Karen

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Here's a good informational link from the CDC:

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Thank you,

Tom

Thomas D. Verlaan

Planner IV

Santa Rosa County Health Department

5527 Stewart Street

Milton, Florida 32570

PH: 850.564.2278

FX: 850.983.5278

State iPhone: 850.291.8329 (no texts)

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: CDC - Prevent Spread - Long Term Care Facilities
Date: Monday, March 16, 2020 3:54:50 PM

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From: **Verlaan, Thomas D** <Thomas.Verlaan@flhealth.gov>
Date: Mon, Mar 16, 2020 at 2:41 PM
Subject: CDC - Prevent Spread - Long Term Care Facilities
To: Margie Hobbs <margie.hobbs@hcahealthcare.com>, Aleta <aleta.hoodless@hma.com>, Anne <paceasc@gmail.com>, Anthony Brown <anbrown@gchc.com>, April Gilmore - Berryhill Manor <berryhillmanor@aol.com>, April Parsons - Covenant Hospice <April.Parsons@covenanthospice.org>, Ary Habig <ary.habig@bhcpns.org>, McMillion, Barbara J <Barbara.McMillion@flhealth.gov>, Beata Kundera <beata.kundera@fmc-na.com>, Beau Pollard - Administrator GB Hosp <bpollard@bhcpns.org>, Bonnie Hunter - Navarre Gardens <Elizabeth_Black@hotmail.com>, Brad Baker - Santa Rosa County EM <BradB@santarosa.fl.gov>, Carol Belitsos - Veritas <cbelitsos@veritasincare.com>, Carol Ettelson <carolettelson@gmail.com>, Cathy Blanchard - Gentiva <Cathy.blanchard@gentiva.com>, Charity Bailey - Pruitt Health <CHBailey@pruitthealth.com>, Cheryl Pence - Davita <Cheryl.Pence@davita.com>, Cheryl Whisman <cwhisman@gchc.com>, Christopher Kennison - Lifeguard Ambulance <Christopher.Kennison@amr.net>, Cindy Almand <cindy.almand@bhcpns.org>, Cindy Westergard - Baptist Healthcare Systems <cwestergard@bhcpns.org>, Corey Lofton - Kindred Hospice Care <Corey.Lofton@kindredhospicecare.com>, CRISTIN CARR-PETERSON <admin@sandyridgehealthandrehab.com>, Daniel Hahn - Santa Rosa County District Schools <Hahnd@santarosa.k12.fl.us>, Darline Earl - Watermark of Gulfbreeze <dearl@watermarkofgulfbreeze.com>, David Kauffman - Sacred Heart Hospital <david.kauffman@ascension.org>, Dawn Mann - Baptist Healthcare Systems <dawn.mann@bhcpns.org>, Deanna Edwards-Walton - Emerald Coast Hospice <Deanna.EdwardsWalton@kindredhospicecare.com>, Debra Burr <Debra.Burr@fmc-na.com>, Denice Curtis - UWF <dcurtis@uwf.edu>, Diane McKeon <diane.mckeon@hma.com>, dluongo@bhcpns.org <dluongo@bhcpns.org>, Dobson, Roger M <Roger.Dobson@flhealth.gov>, Don Russell - Baptist Healthcare Systems <don.russell@bhcpns.org>, Dr. Landry - Lifeguard Ambulance <klandry@mchsi.com>, Dwayne Tullos - Lifeguard Ambulance <Dwayne.Tullos@amr.net>, Eamonn Wheelock - Baptist Healthcare Systems <eamonn.wheelock@bhcpns.org>, Elizabeth Foster - Santa Rosa Medical Center <Elizabeth.Foster@srmcfl.com>, Enid Sisskin - UWF <esisskin@uwf.edu>, Fletcher Forte - Bureau of Parole <Fletcher.Forte@fdc.myflorida.com>, Fran Rohling - Baptist Healthcare Systems <fran.rohling@bhcpns.org>, Frank Daniel <fdanielmpt@aol.com>, Genny Holley - Kindred <genny.holley@kindred.com>, Ginny Palmer - Santa Rosa County EM <GinnyP@santarosa.fl.gov>, Grissom, Dana L <Dana.Grissom@flhealth.gov>, Heather Cornett - Santa Rosa Medical Center <Heather.Cornett@srmcfl.com>, Hill, Ann <ann.echcc@gmail.com>, Howard Clinic <howardclinic1354@att.net>, HUTCHINS, MICHAEL <mike.hutchins@bhcpns.org>, Isaac Newlin <itnewlin@gmail.com>, Jaimie Hudson - Gentiva <jaimie.hudson@gentiva.com>, Jana Lynder - Santa Rosa Medical Center <jana.lyner@srmcfl.com>, Jeffrey Walters - Santa Rosa Medical Clinic <jeffrey.waltersjr@srmcfl.com>, Jennefer Melnyk - Sandy Ridge Health & Rehab <don@sandyridgehealthandrehab.com>, Jessie Stafford - Lifeguard Ambulance <jessie.stafford@amr.net>, Jody Massey - White-Wilson <jmassey@white-wilson.com>, Joyce Amor - SRMC <Joyce.amor@hma.com>, Julie Gaither - Bureau of Parole <Julie.Gaither@fdc.myflorida.com>, JUSTIN GIBSON <jgibson@gchc.com>, Karen

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Here's a good informational link from the CDC:

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Thank you,

Tom

Thomas D. Verlaan

Planner IV

Santa Rosa County Health Department

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PH: 850.564.2278

FX: 850.983.5278

State iPhone: 850.291.8329 (no texts)

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Subject: Fwd: CMS Develops Additional Code for Coronavirus Lab Tests - Agency Issues Fact Sheets Detailing Coverage under Programs

Date: Friday, March 6, 2020 10:16:46 AM

---------- Forwarded message ---------

From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>

Date: Fri, Mar 6, 2020 at 8:54 AM

Subject: CMS Develops Additional Code for Coronavirus Lab Tests - Agency Issues Fact Sheets Detailing Coverage under Programs

To: <ann.echcc@gmail.com>

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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MLN Connects Header Graphic



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Special Edition – Friday, March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million

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beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

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On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

Like our newsletter? Have suggestions? Please let us know!

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Subject: Fwd: CMS Develops Additional Code for Coronavirus Lab Tests - Agency Issues Fact Sheets Detailing Coverage under Programs

Date: Friday, March 6, 2020 10:16:46 AM

---------- Forwarded message ---------

From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>

Date: Fri, Mar 6, 2020 at 8:54 AM

Subject: CMS Develops Additional Code for Coronavirus Lab Tests - Agency Issues Fact Sheets Detailing Coverage under Programs

To: <ann.echcc@gmail.com>

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Special Edition – Friday, March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million

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beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

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On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

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Subject: Fwd: COVID-19 Coding Guidance

Date: Thursday, February 27, 2020 2:19:22 PM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Thu, Feb 27, 2020 at 12:28 PM
Subject: COVID-19 Coding Guidance
To: <ann.echcc@gmail.com>

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Thursday, February 27, 2020

News

- Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31
- Anesthesia Modifiers: Comparative Billing Report in March

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Claims, Pricers & Codes

- COVID-19: New ICD-10-CM Code and Interim Coding Guidance
- SNF PDPM Claims Issue
- FQHC: Mass Adjustment of Claims

Events

- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19

MLN Matters® Articles

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update
- Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims — Revised
- Accepting Payment from Patients with a Medicare Set-Aside Arrangement — Revised
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 — Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2
- Quality Payment Program: 2020 Resources

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Subject: Fwd: COVID-19 Coding Guidance

Date: Thursday, February 27, 2020 2:19:22 PM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Thu, Feb 27, 2020 at 12:28 PM
Subject: COVID-19 Coding Guidance
To: <ann.echcc@gmail.com>

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Thursday, February 27, 2020

News

- Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31
- Anesthesia Modifiers: Comparative Billing Report in March

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Claims, Pricers & Codes

- COVID-19: New ICD-10-CM Code and Interim Coding Guidance
- SNF PDPM Claims Issue
- FQHC: Mass Adjustment of Claims

Events

- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19

MLN Matters® Articles

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update
- Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims — Revised
- Accepting Payment from Patients with a Medicare Set-Aside Arrangement — Revised
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 — Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2
- Quality Payment Program: 2020 Resources

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
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From:	Ernst, Colleen
To:	StLaurent, Louise; Grow, Stefan; Tritschler, Richard; Carbone, Francis; Enriquez, Javier; Faircloth, Chuck; Montfort, Kerven
Subject:	Fwd: COVID-19 EO
Date:	Monday, March 9, 2020 7:09:43 PM
Attachments:	EO 20-52.pdf

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From: Primrose, Nicholas <Nicholas.Primrose@eog.myflorida.com>
Sent: Monday, March 9, 2020 5:58:23 PM
To: Pratt, Joshua <Joshua.Pratt@eog.myflorida.com>; Uthmeier, James <James.Uthmeier@eog.myflorida.com>; O'Connor, Kasey <Kasey.O'Connor@eog.myflorida.com>; Ernst, Colleen <Colleen.Ernst@eog.myflorida.com>
Cc: Sayler, Erik <erik.sayler@em.myflorida.com>
Subject: COVID-19 EO

Attached. Please send to your agency GC.

Nicholas A. Primrose
Deputy General Counsel
Executive Office of the Governor
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Tallahassee, Florida 32399
Office: (850) 717-9310
Facsimile: (850) 488-9810
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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayscenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Maveur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Date: Monday, March 23, 2020 4:13:47 PM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Mon, Mar 23, 2020 at 2:46 PM
Subject: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment
To: <ann.echcc@gmail.com>

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Special Edition – Monday, March 23, 2020

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

COVID-19 Provider Enrollment Relief FAQs

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

On March 22, CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration's response to 2019 Novel Coronavirus (COVID-19).

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CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for several CMS programs. For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report.

CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions, and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

CMS will continue monitoring the developing COVID-19 situation and assess options to provide additional relief to clinicians, facilities, and their staff so they can focus on caring for patients.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Webpage on CMS.Gov.

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COVID-19 Provider Enrollment Relief FAQs

On March 22, CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19, including the toll-free hotlines available to provide expedited enrollment and answer questions related to COVID-19 enrollment requirements.

A copy of the FAQs can be found here: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the Current Emergencies Website.

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From: Hill, Ann

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Subject: Fwd: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Date: Monday, March 23, 2020 4:13:53 PM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Mon, Mar 23, 2020 at 2:46 PM
Subject: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment
To: <ann.echcc@gmail.com>

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Special Edition – Monday, March 23, 2020

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

COVID-19 Provider Enrollment Relief FAQs

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

On March 22, CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration's response to 2019 Novel Coronavirus (COVID-19).

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CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for several CMS programs. For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report.

CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions, and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

CMS will continue monitoring the developing COVID-19 situation and assess options to provide additional relief to clinicians, facilities, and their staff so they can focus on caring for patients.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Webpage on CMS.Gov.

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COVID-19 Provider Enrollment Relief FAQs

On March 22, CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19, including the toll-free hotlines available to provide expedited enrollment and answer questions related to COVID-19 enrollment requirements.

A copy of the FAQs can be found here: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the Current Emergencies Website.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayscenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Maveur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Date: Monday, March 23, 2020 4:13:47 PM

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From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>

Date: Mon, Mar 23, 2020 at 2:46 PM

Subject: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

To: <ann.echcc@gmail.com>

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Special Edition – Monday, March 23, 2020

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

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Ann Hill, Executive Director
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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Maveur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: AAP News OnCall--March 9, 2020

Date: Monday, March 9, 2020 11:18:39 AM

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Date: Mon, Mar 9, 2020 at 9:24 AM
Subject: FW: AAP News OnCall--March 9, 2020
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More for pediatric practices

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From: aapnewsoncall@aap.org <aapnewsoncall@aap.org>
Sent: Monday, March 9, 2020 9:21 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: AAP News OnCall--March 9, 2020

Please click here if you have problems viewing this message or if using a mobile device.

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March 9, 2020 · Volume 4 Issue 42

CDC HPV Vaccine

COVID-19 resources and updates for pediatricians

The American Academy of Pediatrics is advising members of the steps they can take now to prepare as the outbreak continues to spread. Visit the *AAP News* Coronavirus disease outbreak page for regular COVID-19 news updates. Here are some additional resources on COVID-19:

- AAP Red Book Online: 2019 Novel Coronavirus (COVID-19) Infections
- CDC: COVID-19 Information for healthcare professionals
- CDC: Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children
- AAP: Preparedness Checklist for Pediatric Practices
- World Health Organization: Coronavirus
- HealthyChildren.org: 2019 Novel Coronavirus (COVID-19)

Top stories in *AAP News*

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COVID-19 testing criteria expanded
As the availability of diagnostic tests increases, the CDC is telling clinicians to use their judgment when deciding whether to test someone for COVID-19.

CDC: 136 children have died of flu; virus activity still high

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Deaths among children are higher than during the same period in every other season since reporting started in 2004-'05 with the exception of the 2009 H1N1 pandemic.

Prioritizing children in national disaster preparedness planning
Since 9/11, greater focus has been placed on the impact of disasters on children, which influenced national and local preparedness and planning efforts. As a result, pediatricians may be asked to advise on preparing for disasters.

FDA strengthens warning about mental health side effects linked to montelukast
The FDA implemented a boxed warning for Montelukast (Singulair and generics) following continued reports of neuropsychiatric events such as agitation, depression, sleeping problems and suicidal thoughts and actions.



This week from the AAP

RadioMD: Infant Safe Sleep

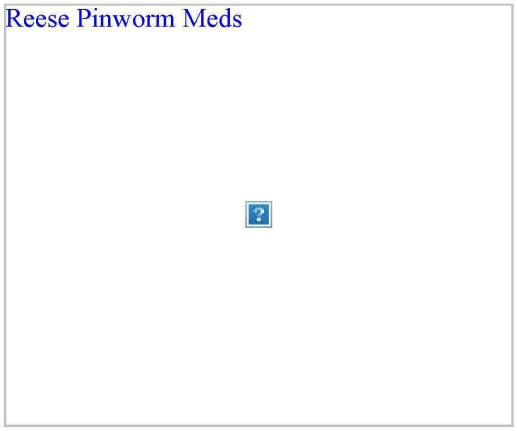
Having a new baby is exciting, and parents want to do everything right. RadioMD has just released a HealthyChildren.org podcast "Infant Safe Sleep" to help answer questions of young parents about how to keep babies snug and safe at night. Dr. Elizabeth Murray joins host Melanie Cole, MS to discuss safe infant sleeping practices.

Pediatric Dermatology Case of the Month feature

The AAP Section on Dermatology (SOD) continues to sponsor a Pediatric Dermatology Case of the Month feature. This online, educational tool was created to address pediatric dermatology knowledge gaps among practicing pediatricians and pediatric trainees. Cases of interest and those that address the American Board of Pediatrics content specifications are presented each month in vignette form. Please contact jgorlewski@aap.org if you would like to be notified when a new case is posted or if you would like to contribute a case.

Webinar: Achieving Optimal Nutrition
The Important Role of Schools and Pediatricians

Tuesday, March 17
12:00 PM (Eastern) | 11:00 AM (Central) | 10:00 AM (Mountain) | 9:00 AM (Pacific)



The American Academy of Pediatrics, with support from National Dairy Council, is hosting a Webinar on the importance of school meals. Join us for a lunchtime discussion on the vital role school meals play in child growth and development as well as helping children learn about and practice healthy eating.

- Robert Murray, MD, FAAP, will share opportunities to help pediatricians work effectively with schools on practical approaches to address nutrition during the office visit.
- Donna Martin, EdS, RD, LD, School Nutrition Director for Burke County Schools in Georgia will share a case study about practical implementation approaches of the school meal program.

Register today

New from ShopAAP

Pediatric Education for Prehospital Professionals (PEPP), Fourth Edition Now Available!

Celebrating its 20th anniversary, PEPP is an evidence-based resource of essential medical content for the assessment and management of infants and children in the field. This respected and ground-breaking program paired physicians and EMS providers together to ensure the content reflects current best practices and the realities of the field. Developed by the American Academy of Pediatrics, PEPP is designed to give prehospital professionals the knowledge, skills, and confidence they need to effectively assess and manage pediatric patients. Visit shop.aap.org for more information and to order PEPP, Fourth Edition.

Take advantage of early-bird pricing for the 2020 Diagnosis and Treatment of Common Pediatric Mental Health Disorders Course

Register by March 24, 2020 and save $150. This course is designed to enable participants to learn critical concepts in the recognition of pediatric mental health disorders and apply evidence-based strategies to manage patients' illnesses

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effectively and efficiently. Earn a maximum of 16.5 *AMA PRA Category 1 Credits* . Visit shop.aap.org/mentalhealth2020 for more information and to register.

Effectively diagnose and treat various skin conditions with AAP resources

Save $15 when you purchase together *Pediatric Dermatology: A Quick Reference Guide* and *Pediatric Dermatology: A Quick Diagnosis Deck*. Effectively identify and treat more than 100 pediatric and adolescent skin conditions with the aid of these handy resources. Includes 300+ high-quality images. Visit shop.aap.org for more information and to order.

Your membership makes a difference for children everywhere, thank you!

The AAP's ability to advocate on behalf of children is only as strong as the support we receive from our members. Encourage your colleagues to join today by visiting the **AAP website** or calling 866-THE-AAP1 (843-2271).

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Ann Hill, Executive Director
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From: Ann Hill

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Subject: Fwd: FW: AAP News OnCall--March 9, 2020

Date: Monday, March 9, 2020 11:18:38 AM

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From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 9:24 AM
Subject: FW: AAP News OnCall--March 9, 2020
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More for pediatric practices

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From: aapnewsoncall@aap.org <aapnewsoncall@aap.org>
Sent: Monday, March 9, 2020 9:21 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: AAP News OnCall--March 9, 2020

Please click here if you have problems viewing this message or if using a mobile device.

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March 9, 2020 · Volume 4 Issue 42

CDC HPV Vaccine

COVID-19 resources and updates for pediatricians

The American Academy of Pediatrics is advising members of the steps they can take now to prepare as the outbreak continues to spread. Visit the *AAP News* Coronavirus disease outbreak page for regular COVID-19 news updates. Here are some additional resources on COVID-19:

- AAP Red Book Online: 2019 Novel Coronavirus (COVID-19) Infections
- CDC: COVID-19 Information for healthcare professionals
- CDC: Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children
- AAP: Preparedness Checklist for Pediatric Practices
- World Health Organization: Coronavirus
- HealthyChildren.org: 2019 Novel Coronavirus (COVID-19)

Top stories in *AAP News*

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COVID-19 testing criteria expanded
As the availability of diagnostic tests increases, the CDC is telling clinicians to use their judgment when deciding whether to test someone for COVID-19.

CDC: 136 children have died of flu; virus activity still high

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Deaths among children are higher than during the same period in every other season since reporting started in 2004-'05 with the exception of the 2009 H1N1 pandemic.

Prioritizing children in national disaster preparedness planning
Since 9/11, greater focus has been placed on the impact of disasters on children, which influenced national and local preparedness and planning efforts. As a result, pediatricians may be asked to advise on preparing for disasters.

FDA strengthens warning about mental health side effects linked to montelukast
The FDA implemented a boxed warning for Montelukast (Singulair and generics) following continued reports of neuropsychiatric events such as agitation, depression, sleeping problems and suicidal thoughts and actions.



This week from the AAP

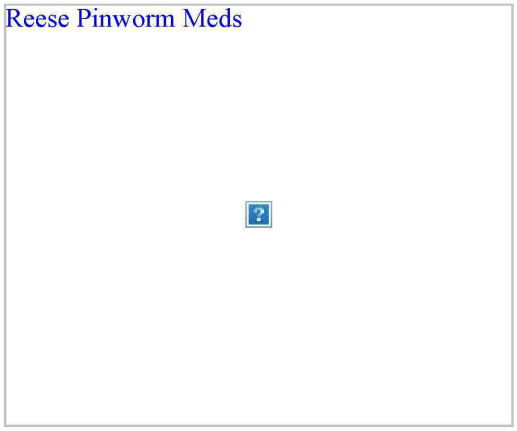
RadioMD: Infant Safe Sleep

Having a new baby is exciting, and parents want to do everything right. RadioMD has just released a HealthyChildren.org podcast "Infant Safe Sleep" to help answer questions of young parents about how to keep babies snug and safe at night. Dr. Elizabeth Murray joins host Melanie Cole, MS to discuss safe infant sleeping practices.

Pediatric Dermatology Case of the Month feature

The AAP Section on Dermatology (SOD) continues to sponsor a Pediatric Dermatology Case of the Month feature. This online, educational tool was created to address pediatric dermatology knowledge gaps among practicing pediatricians and pediatric trainees. Cases of interest and those that address the American Board of Pediatrics content specifications are presented each month in vignette form. Please contact jgorlewski@aap.org if you would like to be notified when a new case is posted or if you would like to contribute a case.

Webinar: Achieving Optimal Nutrition
The Important Role of Schools and Pediatricians
Tuesday, March 17
12:00 PM (Eastern) | 11:00 AM (Central) | 10:00 AM (Mountain) | 9:00 AM (Pacific)



The American Academy of Pediatrics, with support from National Dairy Council, is hosting a Webinar on the importance of school meals. Join us for a lunchtime discussion on the vital role school meals play in child growth and development as well as helping children learn about and practice healthy eating.

- Robert Murray, MD, FAAP, will share opportunities to help pediatricians work effectively with schools on practical approaches to address nutrition during the office visit.
- Donna Martin, EdS, RD, LD, School Nutrition Director for Burke County Schools in Georgia will share a case study about practical implementation approaches of the school meal program.

Register today

New from ShopAAP

Pediatric Education for Prehospital Professionals (PEPP), Fourth Edition Now Available!

Celebrating its 20th anniversary, PEPP is an evidence-based resource of essential medical content for the assessment and management of infants and children in the field. This respected and ground-breaking program paired physicians and EMS providers together to ensure the content reflects current best practices and the realities of the field. Developed by the American Academy of Pediatrics, PEPP is designed to give prehospital professionals the knowledge, skills, and confidence they need to effectively assess and manage pediatric patients. Visit shop.aap.org for more information and to order PEPP, Fourth Edition.

Take advantage of early-bird pricing for the 2020 Diagnosis and Treatment of Common Pediatric Mental Health Disorders Course

Register by March 24, 2020 and save $150. This course is designed to enable participants to learn critical concepts in the recognition of pediatric mental health disorders and apply evidence-based strategies to manage patients' illnesses

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effectively and efficiently. Earn a maximum of 16.5 *AMA PRA Category 1 Credits* . Visit shop.aap.org/mentalhealth2020 for more information and to register.

Effectively diagnose and treat various skin conditions with AAP resources

Save $15 when you purchase together *Pediatric Dermatology: A Quick Reference Guide* and *Pediatric Dermatology: A Quick Diagnosis Deck*. Effectively identify and treat more than 100 pediatric and adolescent skin conditions with the aid of these handy resources. Includes 300+ high-quality images. Visit shop.aap.org for more information and to order.

Your membership makes a difference for children everywhere, thank you!

The AAP's ability to advocate on behalf of children is only as strong as the support we receive from our members. Encourage your colleagues to join today by visiting the **AAP website** or calling 866-THE-AAP1 (843-2271).

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Ann Hill, Executive Director
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From: Ann Hill

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Subject: Fwd: FW: CDC COVID Tips for Everyday

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Date: Tuesday, March 10, 2020 4:15:04 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:04 PM
Subject: FW: CDC COVID Tips for Everyday
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matroni, Michael <Mike.Matroni@medxcelfm.com>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch

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Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

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PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 1:34 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: CDC COVID Tips for Everyday

CDC posted some new resources last night regarding simple things Americans can do every day to protect themselves from COVID-19. They target families, schools, and workplaces. Please find these resources online at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/workplace-school-and-home-guidance.pdf

Samantha Cooksey Strickland

COVID-19 Response Team

Bureau of Preparedness & Response

Florida Department of Health

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition

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850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: CDC COVID Tips for Everyday

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Date: Tuesday, March 10, 2020 4:15:04 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:04 PM
Subject: FW: CDC COVID Tips for Everyday
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matroni, Michael <Mike.Matroni@medxcelfm.com>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch

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Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
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PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 1:34 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: CDC COVID Tips for Everyday

CDC posted some new resources last night regarding simple things Americans can do every day to protect themselves from COVID-19. They target families, schools, and workplaces. Please find these resources online at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/workplace-school-and-home-guidance.pdf

Samantha Cooksey Strickland

COVID-19 Response Team

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

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Email| Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition

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850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19 - Updated Provider Algorithm

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Date: Monday, March 2, 2020 5:59:06 PM
Attachments: nCoVProviderAlgorithm2020-02-28.pdf
nCoVProviderAlgorithmCHD2020-02-28.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Fri, Feb 28, 2020 at 3:02 PM
Subject: FW: COVID-19 - Updated Provider Algorithm
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Dan Flynn <dflynn@cityofpensacola.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Steven Barry <district5@myescambia.com>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A

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Latest, easy to follow algorithm for decision making for clinical staff at your locations.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
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Office: 850-595-6500 xt1001

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PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, February 28, 2020 2:53 PM
To: DL DCBE Primary Epi CHD Contacts <DLDCBEPrimaryEpiCHDContacts@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Riggen, Amy <Amy.Riggen@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>; DL DOH CHD Administrators_Directors <DLDOHCHDAdministrators_Directors@flhealth.gov>
Subject: COVID-19 - Updated Provider Algorithm
Importance: High

Please see the updated COVID-19 algorithm to be shared with health care providers.

An updated provider letter is currently being routed and will be shared as soon as possible.

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Sincerely,

Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19 - Updated Provider Algorithm

AMERICAN OVERSIGHT

Date: Monday, March 2, 2020 5:59:03 PM
Attachments: nCoVProviderAlgorithm2020-02-28.pdf
nCoVProviderAlgorithmCHD2020-02-28.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Fri, Feb 28, 2020 at 3:02 PM
Subject: FW: COVID-19 - Updated Provider Algorithm
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Dan Flynn <dflynn@cityofpensacola.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Steven Barry <district5@myescambia.com>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A

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<Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

Latest, easy to follow algorithm for decision making for clinical staff at your locations.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, February 28, 2020 2:53 PM
To: DL DCBE Primary Epi CHD Contacts <DLDCBEPrimaryEpiCHDContacts@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Riggen, Amy <Amy.Riggen@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>; DL DOH CHD Administrators_Directors <DLDOHCHDAdministrators_Directors@flhealth.gov>
Subject: COVID-19 - Updated Provider Algorithm
Importance: High

Please see the updated COVID-19 algorithm to be shared with health care providers.

An updated provider letter is currently being routed and will be shared as soon as possible.

AMERICAN OVERSIGHT

Sincerely,

Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services

AMERICAN OVERSIGHT

Date: Thursday, March 5, 2020 1:13:17 PM
Attachments: QSO-20-14-NH.pdf
QSO-20-13-Hospitals.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:51 AM
Subject: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com

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Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
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regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Thursday, March 5, 2020 11:39 AM

AMERICAN OVERSIGHT

To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
Importance: High

CHDs,

For your situational awareness, please find newly released standards for hospitals and nursing homes related to COVID-19 from Centers for Medicaid & Medicare Services. These are being distributed by AHCA directly to providers. They both include guidance for screening visitors and employees for these facilities.

Please distribute locally as appropriate.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

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Mobile | 850.251.2553

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition

AMERICAN OVERSIGHT

850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services

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Date: Thursday, March 5, 2020 1:13:16 PM
Attachments: QSO-20-14-NH.pdf
QSO-20-13-Hospitals.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:51 AM
Subject: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com

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From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Thursday, March 5, 2020 11:39 AM

AMERICAN OVERSIGHT

To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
Importance: High

CHDs,

For your situational awareness, please find newly released standards for hospitals and nursing homes related to COVID-19 from Centers for Medicaid & Medicare Services. These are being distributed by AHCA directly to providers. They both include guidance for screening visitors and employees for these facilities.

Please distribute locally as appropriate.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition

AMERICAN OVERSIGHT

850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19: Declaration of Public Health Emergency In Florida

AMERICAN OVERSIGHT

Date: Monday, March 2, 2020 5:28:10 PM
Attachments: SLG-BIZHUB20030109040.pdf
Declaration of Public Health Emergency COVID-19 3.1.20.pdf

---------- Forwarded message ---------
From: **StateESF8.Planning** <StateESF8.Planning@flhealth.gov>
Date: Sun, Mar 1, 2020 at 9:28 PM
Subject: FW: COVID-19: Declaration of Public Health Emergency In Florida
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>

FYI

The Governor has issued Executive Order 20-51, directing a Public Health Emergency and establishing Florida's Response Protocol for COVID-19. As a result, the State Surgeon General has issued a Declaration of Public Health Emergency for the State of Florida. Please review the attached Executive Order and Declaration.

Thank you for your continued support of our public health preparedness and response.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email| Samantha.Cooksey@flhealth.gov

AMERICAN OVERSIGHT

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19: Declaration of Public Health Emergency In Florida

AMERICAN OVERSIGHT

Date:	Monday, March 2, 2020 5:28:10 PM
Attachments:	SLG-BIZHUB20030109040.pdf Declaration of Public Health Emergency COVID-19 3.1.20.pdf

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To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>

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AMERICAN OVERSIGHT

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Ann Hill, Executive Director
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Subject: Fwd: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP

Date: Monday, March 9, 2020 11:21:30 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:40 AM
Subject: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com)

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For pediatric providers

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From: American Academy of Pediatrics <information@aap.org>
Sent: Friday, March 6, 2020 5:01 PM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: COVID-19: Message from AAP President Sally Goza, MD, FAAP

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Message from AAP President Sally Goza, MD, FAAP

As COVID-19 continues to spread in communities, pediatricians can prepare to handle suspected cases in their patient population in the same way they prepare for other infectious disease outbreaks, such as influenza or RSV. The same principles apply:

- Keep children out of the health care system if it's not necessary
- Advise individuals to stay home if they are sick.
- Review infection-control measures. This can include asking patients with symptoms to call ahead, so they can be evaluated in isolation from other patients.
- Collaborate with hospitals and health systems on local response and to prepare for surges.
- Check with local and state health departments for information on specific local and state responses.

We have also heard from members that children and adolescents in their practice have expressed fear and anxiety about the outbreak. Pediatricians can be a calm, reassuring voice that can help alleviate these fears.

As a general pediatrician myself who has been in practice through especially severe RSV and flu outbreaks, I understand how important it is to remain reassuring to worried parents, clear in my guidance and practical and transparent in my approach to talking to patients who are old enough to understand what's going on.

David Schonfeld, MD, FAAP, a member of the AAP Council on Disaster Preparedness and Recovery, recommends keeping the conversation straightforward and direct, while avoiding graphic details. More information is available in the HealthyChildren.org article on talking to children about disasters and other events in the news. He also offers advice specific to COVID-19 in this interview for CNN.

AAP also offers general information for parents on COVID-19 in the HealthyChildren.org article authored by H. Cody Meissner, M.D., FAAP. This article will be updated to reflect the most recent information as the outbreak evolves.

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AAP continues to be in close communication with leaders at the Centers for Disease Control & Prevention. We are committed to providing you with updates and information about practice recommendations and infection-control measures as it is developed.

Updated information will also be posted on the Red Book Online Outbreaks page and in *AAP News*.

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From: Ann Hill

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Subject: Fwd: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP

Date: Monday, March 9, 2020 11:21:30 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:40 AM
Subject: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com)

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For pediatric providers

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As COVID-19 continues to spread in communities, pediatricians can prepare to handle suspected cases in their patient population in the same way they prepare for other infectious disease outbreaks, such as influenza or RSV. The same principles apply:

- Keep children out of the health care system if it's not necessary
- Advise individuals to stay home if they are sick.
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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Department of Education Information

AMERICAN OVERSIGHT

Date: Tuesday, March 10, 2020 4:17:22 PM
Attachments: COVID-19 University Travel Precaution.pdf
COVID-19 DOE Preparedness Spanish.pdf
COVID-19 DOE Preparedness_2-28-20.pdf
COVID-19 DOE Preparedness_3-3-20.pdf
COVID-19 DOE Travel Precaution.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:02 PM
Subject: FW: Department of Education Information
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>,

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Education related travel precautions

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."

AMERICAN OVERSIGHT

Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 12:42 PM
Subject: Department of Education Information

Please see attached Department of Education information which has been sent to all Florida School Districts.

Please Note: BCC recipients include CHD Administrators, Nursing Directors, Primary Epi Contacts and Preparedness Planners.

Jefferson Welle, R.N., FPEM

Planning Analyst, FDOH ESF-8
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support
4052 Bald Cypress Way,
Tallahassee, FL 32399

Phone: 850-617-1546

Mobile: 239-206-6329

http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html

On Twitter: @healthyfla

Mission of the Department of Health:

To protect, promote & improve the health of all people in Florida through integrated state, county & community

AMERICAN OVERSIGHT

efforts.

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--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Date: Tue, Mar 10, 2020 at 3:02 PM
Subject: FW: Department of Education Information
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>,

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Education related travel precautions

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
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Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."

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Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 12:42 PM
Subject: Department of Education Information

Please see attached Department of Education information which has been sent to all Florida School Districts.

Please Note: BCC recipients include CHD Administrators, Nursing Directors, Primary Epi Contacts and Preparedness Planners.

Jefferson Welle, R.N., FPEM

Planning Analyst, FDOH ESF-8
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support
4052 Bald Cypress Way,
Tallahassee, FL 32399

Phone: 850-617-1546

Mobile: 239-206-6329

http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html

On Twitter: @healthyfla

Mission of the Department of Health:

To protect, promote & improve the health of all people in Florida through integrated state, county & community

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--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: FCOVID-19 Information Toolkit

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Date: Monday, March 9, 2020 11:20:45 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:44 AM
Subject: FW: FCOVID-19 Information Toolkit
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Paul A. McLeod (paul.mcleod@med.fsu.edu) <paul.mcleod@med.fsu.edu>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph

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This has lots of pictographs for display purposes.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
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Florida Department of Health in
Escambia County
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may therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Friday, March 6, 2020 2:00 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Information Toolkit

CHDs,

Attached please find a link to our public facing toolkit with a variety of information resources for COVID-19. Numerous new resources have been added today and more will be added throughout the day, of particular interest is a visitor screening tool for healthcare facilities. Please share these with your local partners and continue to check this link for updated resources.

Link: http://ww11.doh.state.fl.us/comm/_partners/action/

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email| Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: Fwd: FW: FCOVID-19 Information Toolkit

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Date: Monday, March 9, 2020 11:20:45 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:44 AM
Subject: FW: FCOVID-19 Information Toolkit
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Paul A. McLeod (paul.mcleod@med.fsu.edu) <paul.mcleod@med.fsu.edu>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph

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This has lots of pictographs for display purposes.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

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may therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Friday, March 6, 2020 2:00 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Information Toolkit

CHDs,

Attached please find a link to our public facing toolkit with a variety of information resources for COVID-19. Numerous new resources have been added today and more will be added throughout the day, of particular interest is a visitor screening tool for healthcare facilities. Please share these with your local partners and continue to check this link for updated resources.

Link: http://ww11.doh.state.fl.us/comm/_partners/action/

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

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Email| Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill
To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayceterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdalelving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/ SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angiomarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Baines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bw1972@cox.net; Calhoun Emergency Manager; Candice Mayeux; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Banew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulle; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@nvescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cois; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Cinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dweiborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rvard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.rosa@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather.slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Bawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnievic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; John.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gilliman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skaltzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Boulier; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pixley; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Filalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mixhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette.Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afey.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Back; Sandra Nunes; Sandra Watson; Sandy K. 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Subject: Fwd: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
Date: Thursday, March 19, 2020 1:11:51 PM

---------- Forwarded message ---------
From: **Mooney, Dayle** <Dayle.Mooney@flhealth.gov>
Date: Thu, Mar 19, 2020 at 12:10 PM
Subject: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
To: DL DEPC$00 BPR HCCTF <DLDEPC$00BPRHCCTF@flhealth.gov>

Sincerely,

Dayle D. Mooney

Manager, Community Preparedness Section

Bureau of Preparedness and Response

Division of Emergency Preparedness and Community Support

Logo

Some or all of the information contained within this message may be confidential pursuant to sections 381.003 and 381.0031(6), Florida Statutes, Rule 64D-3.036, Florida Administrative Code, or other applicable state or federal privacy laws.

From: Joint Information Center on COVID-19 for the State of Florida <FLSERT@public.govdelivery.com>
Sent: Thursday, March 19, 2020 11:17 AM
To: Mooney, Dayle <Dayle.Mooney@flhealth.gov>
Subject: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

Banner

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FOR IMMEDIATE RELEASE March 19, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

~360 positive cases in Florida Residents and 30 positive cases in non-Florida residents~

TALLAHASSEE — To keep Florida residents and visitors safe, informed and aware about the status of the virus, The Florida Department of Health has launched a COVID-19 dashboard that will be updated twice daily. Today, as of 10 a.m., there are 390 total** Florida cases.

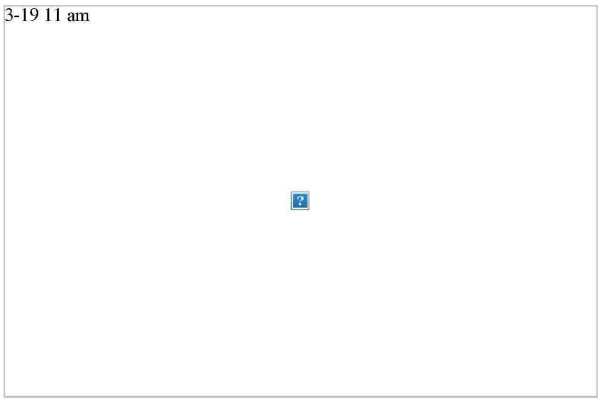
New Florida cases include:

- 62 additional positive COVID-19 cases (61 Florida residents and 1 non-Florida resident) reported to the Florida Department of Health.
- There are currently 360 positive cases in Florida residents and 30 positive cases in non-Florida residents.

Florida recently partnered with private laboratories around the state to expand COVID-19 laboratory testing capacity. This partnership will increase the number of tests conducted each day and ensure Floridians receive the critical health information they need in a timely manner.

Expansion to private laboratories changes the COVID-19 testing landscape in Florida. Private laboratories will run tests as they receive swab samples from practitioners. Testing and reporting times will vary among commercial and DOH laboratories. Demographic information may be updated during investigations. These twice daily reports reflect the state's efforts to accurately and transparently share information.

More information on a case-by-case basis can also be found here.



For more detail on Florida resident cases, please visit the live DOH Dashboard here.

* Florida residents that are diagnosed with COVID-19 and isolated out of state are not reflected on the Florida map.

**Total cases overview includes positive cases in Florida residents and non-Florida residents tested in Florida.

More Information on COVID-19

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About the Florida Department of Health

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AMERICAN OVERSIGHT

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Hill, Ann
To: 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdalelliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@engmarcompanies.com; Betsy Schatt; Betty Scott; bfmaint@southerntc.com; Bill Storck; Bitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Maveur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER.BARBER; Chelsea Banew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; claire@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Pauley, Codie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey Dobridnia; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; CRISTIN CARR-PETERSON; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. 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Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southerntc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Luka, Greg; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwen Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawls; James.edwards@brookdalerehab.org; James.nutt@bhcpns.org; Carmichael, Jamie B; Jamie Tutnievic; KINNEY, JANET; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jerant, Jennifer S; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; Ard, John; John Dosh; John Gainous; John Hatfield; Ottesen, John P; John.Hatfield; Lanza, John J; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Milligan, Joseph D; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gilman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Chapman, Karen A; Karen Urquhart; Beedle, Katherine A; Kathlyn Campbell White; Kathrine Lee; Scott, Katie E; Kayla Henderson; Kay Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skaltzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Lonas, Kim; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Boulier; Webb, Robert K; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Bridgeway Center, Inc.; Larry Petty; Laura Messer; Laura Pixley; 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Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; Rajackson@gchc.com; Randall McClellan; Sandoval, Randi C; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Talbert, Rick; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afey.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Martin, Sandy K; Sarah Demotto; DONALD H RIPLEY; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Stewart, Lewis Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Knox, Thomas; Thomas McDaniel; Smith, Thomas M; 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Subject: Fwd: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
Date: Thursday, March 19, 2020 1:11:58 PM

---------- Forwarded message ---------
From: **Mooney, Dayle** <Dayle.Mooney@flhealth.gov>
Date: Thu, Mar 19, 2020 at 12:10 PM
Subject: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
To: DL DEPC$00 BPR HCCTF <DLDEPCS00BPRHCCTF@flhealth.gov>

Sincerely,

Dayle D. Mooney

Manager, Community Preparedness Section

Bureau of Preparedness and Response

Division of Emergency Preparedness and Community Support

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From: Joint Information Center on COVID-19 for the State of Florida <FLSERT@public.govdelivery.com>
Sent: Thursday, March 19, 2020 11:17 AM
To: Mooney, Dayle <Dayle.Mooney@flhealth.gov>
Subject: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

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AMERICAN OVERSIGHT

FOR IMMEDIATE RELEASE March 19, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

~360 positive cases in Florida Residents and 30 positive cases in non-Florida residents~

TALLAHASSEE — To keep Florida residents and visitors safe, informed and aware about the status of the virus, The Florida Department of Health has launched a COVID-19 dashboard that will be updated twice daily. Today, as of 10 a.m., there are 390 total** Florida cases.

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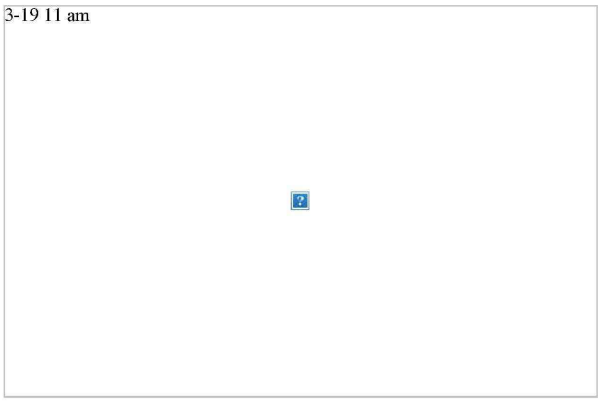

For more detail on Florida resident cases, please visit the live DOH Dashboard here.

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AMERICAN OVERSIGHT

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill
To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayecenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdalelving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/ SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatt; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Baines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeux; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Banew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
Date: Thursday, March 19, 2020 1:11:51 PM

---------- Forwarded message ---------
From: **Mooney, Dayle** <Dayle.Mooney@flhealth.gov>
Date: Thu, Mar 19, 2020 at 12:10 PM
Subject: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
To: DL DEPC$00 BPR HCCTF <DLDEPC$00BPRHCCTF@flhealth.gov>

Sincerely,

Dayle D. Mooney

Manager, Community Preparedness Section

Bureau of Preparedness and Response

Division of Emergency Preparedness and Community Support

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From: Joint Information Center on COVID-19 for the State of Florida <FLSERT@public.govdelivery.com>
Sent: Thursday, March 19, 2020 11:17 AM
To: Mooney, Dayle <Dayle.Mooney@flhealth.gov>
Subject: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

Banner

AMERICAN OVERSIGHT

FOR IMMEDIATE RELEASE March 19, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

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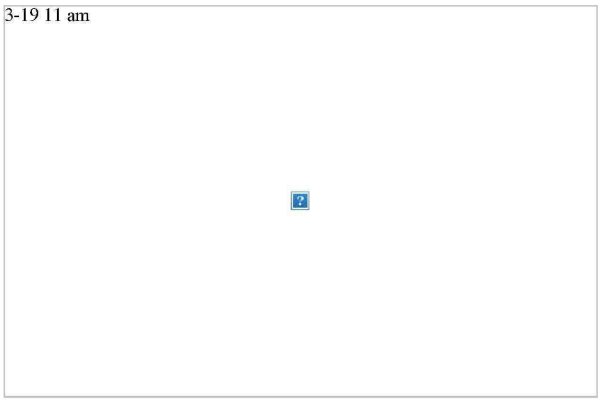

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AMERICAN OVERSIGHT

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Ann Hill, Executive Director
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AMERICAN OVERSIGHT

From: Ann Hill

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AMERICAN OVERSIGHT

Subject: Fwd: FW: Guidance from AHCA
Date: Thursday, March 19, 2020 11:16:50 AM
Attachments: ATT00001.htm
Guidance_and_Clarification for EO 20-006.pdf
ATT00002.htm

---------- Forwarded message ---------
From: **Smith, Thomas M** <Thomas.Smith@flhealth.gov>
Date: Thu, Mar 19, 2020 at 6:59 AM
Subject: FW: Guidance from AHCA
To: Hill, Ann <ann.echcc@gmail.com>, Bobby Martin (marbobby@co.walton.fl.us) <marbobby@co.walton.fl.us>, Catie Feeney (catie@visitsouthwalton.com) <catie@visitsouthwalton.com>, Charlie Morse (morsec@walton.k12.fl.us) <morsec@walton.k12.fl.us>, Christopher Mitchell <grants@defuniaksprings.net>, Cory Webster (cwebster@waltonso.org) <cwebster@waltonso.org>, Eddie (Eddie.PathofGrace@AOL.com) <Eddie.PathofGrace@aol.com>, Fletcher Forte (Fletcher.forte@FDC.myflorida.com) <Fletcher.forte@fdc.myflorida.com>, Gabrielle Kilgore (gabrielle@waltonareachamber.com) <gabrielle@waltonareachamber.com>, Gina Waddell (wadgina@co.walton.fl.us) <wadgina@co.walton.fl.us>, Hurley James (hurleyjw@dfspd.net) <hurleyjw@dfspd.net>, James McMillan (mcmjames@waltonso.org) <mcmjames@waltonso.org>, Jeff Infinger (infingej@walton.k12.fl.us) <infingej@walton.k12.fl.us>, Jerry Hall (jhall@defuniaksprings.net) <jhall@defuniaksprings.net>, Julie Gaither (Julie.Gaither@FDC.myflorida.com) <Julie.Gaither@fdc.myflorida.com>, Lindsey Darby (darlindsey@waltonso.org) <darlindsey@waltonso.org>, Svehla, Louis <svelouis@co.walton.fl.us>, Mell Smigielski (citymanager@defuniaksprings.net) <citymanager@defuniaksprings.net>, Nathan Kervin <kernathan@co.walton.fl.us>, Philip Austin (austinpj@dfspd.net) <austinpj@dfspd.net>, Sarah Eailey (earsarah@waltonso.org) <earsarah@waltonso.org>, Shayne Betts (shaynebetts@yahoo.com) <shaynebetts@yahoo.com>, Stephanie King (stephanie.king@chhealthcare.org) <stephanie.king@chhealthcare.org>, Sterling Strickland (sstrickland@swfd.org) <sstrickland@swfd.org>, Tim Orenic (torenic@swfd.org) <torenic@swfd.org>, Tom Baker <baktom@co.walton.fl.us>, Trish Meadows <meadowst@walton.k12.fl.us>, Barley, Kathryn C <Kathryn.Barley@flhealth.gov>, Carmichael, Jamie B <Jamie.Carmichael@flhealth.gov>, Drummond, Robert D <Robert.Drummond@flhealth.gov>, Gill, Brandi N <Brandi.Gill@flhealth.gov>, Holt, Holly <Holly.Holt@flhealth.gov>, Mims, Ryan E <Ryan.Mims@flhealth.gov>, Morell, Venita W <Venita.Morell@flhealth.gov>, Ottesen, John P <John.Ottesen@flhealth.gov>, Roberts, Missy <Missy.Roberts@flhealth.gov>, Roberts, Patricia J <Patricia.Roberts@flhealth.gov>, Simmons, Harriet A <Harriet.Simmons@flhealth.gov>, Smith, Marissa <Marissa.Smith@flhealth.gov>, Smith, Thomas M <Thomas.Smith@flhealth.gov>, Steele, Crystal C <Crystal.Steele@flhealth.gov>, Alma Solano (asolano@elc-ec.org) <asolano@elc-ec.org>, Ann McCannon (amccannon@somerbyliving.com) <amccannon@somerbyliving.com>, CHrissy Howell (chrissy.howell@gentiva.com) <chrissy.howell@gentiva.com>, Connie Zuraff <CZuraff@gchc.com>, Daniel Shearn (daniel_shearn@chs.net) <daniel_shearn@chs.net>, Daniela (dmejia@pancarefl.org) <dmejia@pancarefl.org>, Danny Wilkins (dwilkins@healthmarkregional.com) <dwilkins@healthmarkregional.com>, Darren M. Staggers (darren.staggers@medxcelfm.com) <darren.staggers@medxcelfm.com>, Graham Campbell (admin.chautauqua@shccs.com) <admin.chautauqua@shccs.com>, Gwen Cobb (cobbg@elderaffairs.org)

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Updated information from ACHA on Long-term and residential care facilities.

Respectfully,

Tom Smith

Planning Consultant II

Florida Department of Health Walton County

356 State Highway 83 N

DeFuniak Springs, FL. 32433

Thomas.smith@flhealth.gov

Phone: 850-401-6364

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Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Vision: To be the Healthiest State in the Nation

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From: Jeff Goldberg <jeff@waltoncountyem.org>
Sent: Thursday, March 19, 2020 6:47 AM
To: Holt, Holly <Holly.Holt@flhealth.gov>; Smith, Thomas M <Thomas.Smith@flhealth.gov>; Roberts, Patricia J <Patricia.Roberts@flhealth.gov>; Donna Free <donna@waltoncountyem.org>; Chris Eliadis <chris@waltoncountyem.org>; Svehla, Louis <svelouis@co.walton.fl.us>
Subject: Fwd: Guidance from AHCA

Thanks!

Jeff

Jeffrey M. Goldberg, FPEM, FMI, CHS-III
Director
Walton County Emergency Management
75 South Davis Lane
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Work: (850) 892-8530
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Sent from my iPhone

Begin forwarded message:

> **From:** "Guthrie, Kevin" <Kevin.Guthrie@em.myflorida.com>
> **Date:** March 19, 2020 at 06:38:35 CDT
> **To:** County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
> **Subject: FW: Guidance from AHCA**

Kevin Guthrie | Deputy Director

Office: (850) 815-4101

Cell: (850) 294-8250

AMERICAN OVERSIGHT

Kevin.Guthrie@em.myflorida.com

From: Twomey, Stephanie <Stephanie.Twomey@em.myflorida.com>
Sent: Wednesday, March 18, 2020 11:49 AM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>
Cc: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: Guidance from AHCA

Good Afternoon,

Please see attached AHCA guidance released regarding DEM No.20-006

Very Respectfully,

Stephanie Twomey

Stephanie Twomey

Senior Attorney

Florida Division of Emergency Management

Cell: (850)-815-5762

Direct: (850) 815-4160

Stephanie.Twomey@em.myflorida.com

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AMERICAN OVERSIGHT



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Hill, Ann

To: 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Guidance from AHCA
Date: Thursday, March 19, 2020 11:16:56 AM
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From: **Smith, Thomas M** <Thomas.Smith@flhealth.gov>
Date: Thu, Mar 19, 2020 at 6:59 AM
Subject: FW: Guidance from AHCA
To: Hill, Ann <ann.echcc@gmail.com>, Bobby Martin (marbobby@co.walton.fl.us) <marbobby@co.walton.fl.us>, Catie Feeney (catie@visitsouthwalton.com) <catie@visitsouthwalton.com>, Charlie Morse (morsec@walton.k12.fl.us) <morsec@walton.k12.fl.us>, Christopher Mitchell <grants@defuniaksprings.net>, Cory Webster (cwebster@waltonso.org) <cwebster@waltonso.org>, Eddie (Eddie.PathofGrace@AOL.com) <Eddie.PathofGrace@aol.com>, Fletcher Forte (Fletcher.forte@FDC.myflorida.com) <Fletcher.forte@fdc.myflorida.com>, Gabrielle Kilgore (gabrielle@waltonareachamber.com) <gabrielle@waltonareachamber.com>, Gina Waddell (wadgina@co.walton.fl.us) <wadgina@co.walton.fl.us>, Hurley James (hurleyjw@dfspd.net) <hurleyjw@dfspd.net>, James McMillan (mcmjames@waltonso.org) <mcmjames@waltonso.org>, Jeff Infinger (infingej@walton.k12.fl.us) <infingej@walton.k12.fl.us>, Jerry Hall (jhall@defuniaksprings.net) <jhall@defuniaksprings.net>, Julie Gaither (Julie.Gaither@FDC.myflorida.com) <Julie.Gaither@fdc.myflorida.com>, Lindsey Darby (darlindsey@waltonso.org) <darlindsey@waltonso.org>, Svehla, Louis <svelouis@co.walton.fl.us>, Mell Smigielski (citymanager@defuniaksprings.net) <citymanager@defuniaksprings.net>, Nathan Kervin <kernathan@co.walton.fl.us>, Philip Austin (austinpj@dfspd.net) <austinpj@dfspd.net>, Sarah Eailey (earsarah@waltonso.org) <earsarah@waltonso.org>, Shayne Betts (shaynebetts@yahoo.com) <shaynebetts@yahoo.com>, Stephanie King (stephanie.king@chhealthcare.org) <stephanie.king@chhealthcare.org>, Sterling Strickland (sstrickland@swfd.org) <sstrickland@swfd.org>, Tim Orenic (torenic@swfd.org) <torenic@swfd.org>, Tom Baker <baktom@co.walton.fl.us>, Trish Meadows <meadowst@walton.k12.fl.us>, Barley, Kathryn C <Kathryn.Barley@flhealth.gov>, Carmichael, Jamie B <Jamie.Carmichael@flhealth.gov>, Drummond, Robert D <Robert.Drummond@flhealth.gov>, Gill, Brandi N <Brandi.Gill@flhealth.gov>, Holt, Holly <Holly.Holt@flhealth.gov>, Mims, Ryan E <Ryan.Mims@flhealth.gov>, Morell, Venita W <Venita.Morell@flhealth.gov>, Ottesen, John P <John.Ottesen@flhealth.gov>, Roberts, Missy <Missy.Roberts@flhealth.gov>, Roberts, Patricia J <Patricia.Roberts@flhealth.gov>, Simmons, Harriet A <Harriet.Simmons@flhealth.gov>, Smith, Marissa <Marissa.Smith@flhealth.gov>, Smith, Thomas M <Thomas.Smith@flhealth.gov>, Steele, Crystal C <Crystal.Steele@flhealth.gov>, Alma Solano (asolano@elc-ec.org) <asolano@elc-ec.org>, Ann McCannon (amccannon@somerbyliving.com) <amccannon@somerbyliving.com>, CHrissy Howell (chrissy.howell@gentiva.com) <chrissy.howell@gentiva.com>, Connie Zuraff <CZuraff@gchc.com>, Daniel Shearn (daniel_shearn@chs.net) <daniel_shearn@chs.net>, Daniela (dmejia@pancarefl.org) <dmejia@pancarefl.org>, Danny Wilkins (dwilkins@healthmarkregional.com) <dwilkins@healthmarkregional.com>, Darren M. Staggers (darren.staggers@medxcelfm.com) <darren.staggers@medxcelfm.com>, Graham Campbell (admin.chautauqua@shccs.com) <admin.chautauqua@shccs.com>, Gwen Cobb (cobbg@elderaffairs.org)

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<cobbg@elderaffairs.org>, James Howell (docjwh2888@aol.com) <docjwh2888@aol.com>, Jeff Duncan (jduncan@veritashcg.com) <jduncan@veritashcg.com>, Jennifer martinez (jennifer@coastalpediatricgroup.com) <jennifer@coastalpediatricgroup.com>, Joan Beard (jbeard@healthmarkregional.com) <jbeard@healthmarkregional.com>, Katerine Cosby (katherine.cosby@fmc-na.com) <katherine.cosby@fmc-na.com>, Kelli Maynard (kmaynard@healthmarkregional.com) <kmaynard@healthmarkregional.com>, KWebster@PanCareFL.org <KWebster@pancarefl.org>, Lida Deonarine <lida_deonarine@chs.net>, Lisa Price (pricel@elderaffairs.org) <pricel@elderaffairs.org>, Mary Sutton (msutton@docatdmc.com) <msutton@docatdmc.com>, Page Butler (page.howell@chhealthcare.org) <page.howell@chhealthcare.org>, Patsy Myrick (adon.chautauqua@signaturehealthcarellc.com) <adon.chautauqua@signaturehealthcarellc.com>, Paul Castiglione (pcastiglione@somerbyliving.com) <pcastiglione@somerbyliving.com>, Rachel Gillis <rachel.gillis@chhealthcare.org>, Sherri (rubengmd@yahoo.com) <rubengmd@yahoo.com>, Tami Miles (tmiles@brookdale.com) <tmiles@brookdale.com>, Victoria Montalvo (victoria_montalvo@chs.net) <victoria_montalvo@chs.net>, Violet Kianison, RN, RM <vkennison@healthmarkregional.com>, Whitney Rusnis (adon2.chautauqua@shccs.com) <adon2.chautauqua@shccs.com>

Updated information from ACHA on Long-term and residential care facilities.

Respectfully,

Tom Smith

Planning Consultant II

Florida Department of Health Walton County

356 State Highway 83 N

DeFuniak Springs, FL. 32433

Thomas.smith@flhealth.gov

Phone: 850-401-6364

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Vision: To be the Healthiest State in the Nation

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From: Jeff Goldberg <jeff@waltoncountyem.org>
Sent: Thursday, March 19, 2020 6:47 AM
To: Holt, Holly <Holly.Holt@flhealth.gov>; Smith, Thomas M <Thomas.Smith@flhealth.gov>; Roberts, Patricia J <Patricia.Roberts@flhealth.gov>; Donna Free <donna@waltoncountyem.org>; Chris Eliadis <chris@waltoncountyem.org>; Svehla, Louis <svelouis@co.walton.fl.us>
Subject: Fwd: Guidance from AHCA

Thanks!

Jeff

Jeffrey M. Goldberg, FPEM, FMI, CHS-III
Director
Walton County Emergency Management
75 South Davis Lane
DeFuniak Springs, FL 32435
Work: (850) 892-8530
Mobile: (850) 307-4121

Sent from my iPhone

Begin forwarded message:

> **From:** "Guthrie, Kevin" <Kevin.Guthrie@em.myflorida.com>
> **Date:** March 19, 2020 at 06:38:35 CDT
> **To:** County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
> **Subject: FW: Guidance from AHCA**

Kevin Guthrie | Deputy Director

Office: (850) 815-4101

Cell: (850) 294-8250

AMERICAN OVERSIGHT

Kevin.Guthrie@em.myflorida.com

From: Twomey, Stephanie <Stephanie.Twomey@em.myflorida.com>
Sent: Wednesday, March 18, 2020 11:49 AM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>
Cc: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: Guidance from AHCA

Good Afternoon,

Please see attached AHCA guidance released regarding DEM No.20-006

Very Respectfully,

Stephanie Twomey

Stephanie Twomey

Senior Attorney

Florida Division of Emergency Management

Cell: (850)-815-5762

Direct: (850) 815-4160

Stephanie.Twomey@em.myflorida.com

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AMERICAN OVERSIGHT



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

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Subject: Fwd: FW: Guidance from AHCA
Date: Thursday, March 19, 2020 11:16:50 AM
Attachments: ATT00001.htm
Guidance_and_Clarification for EO 20-006.pdf
ATT00002.htm

---------- Forwarded message ---------
From: **Smith, Thomas M** <Thomas.Smith@flhealth.gov>
Date: Thu, Mar 19, 2020 at 6:59 AM
Subject: FW: Guidance from AHCA
To: Hill, Ann <ann.echcc@gmail.com>, Bobby Martin (marbobby@co.walton.fl.us) <marbobby@co.walton.fl.us>, Catie Feeney (catie@visitsouthwalton.com) <catie@visitsouthwalton.com>, Charlie Morse (morsec@walton.k12.fl.us) <morsec@walton.k12.fl.us>, Christopher Mitchell <grants@defuniaksprings.net>, Cory Webster (cwebster@waltonso.org) <cwebster@waltonso.org>, Eddie (Eddie.PathofGrace@AOL.com) <Eddie.PathofGrace@aol.com>, Fletcher Forte (Fletcher.forte@FDC.myflorida.com) <Fletcher.forte@fdc.myflorida.com>, Gabrielle Kilgore (gabrielle@waltonareachamber.com) <gabrielle@waltonareachamber.com>, Gina Waddell (wadgina@co.walton.fl.us) <wadgina@co.walton.fl.us>, Hurley James (hurleyjw@dfspd.net) <hurleyjw@dfspd.net>, James McMillan (mcmjames@waltonso.org) <mcmjames@waltonso.org>, Jeff Infinger (infingej@walton.k12.fl.us) <infingej@walton.k12.fl.us>, Jerry Hall (jhall@defuniaksprings.net) <jhall@defuniaksprings.net>, Julie Gaither (Julie.Gaither@FDC.myflorida.com) <Julie.Gaither@fdc.myflorida.com>, Lindsey Darby (darlindsey@waltonso.org) <darlindsey@waltonso.org>, Svehla, Louis <svelouis@co.walton.fl.us>, Mell Smigielski (citymanager@defuniaksprings.net) <citymanager@defuniaksprings.net>, Nathan Kervin <kernathan@co.walton.fl.us>, Philip Austin (austinpj@dfspd.net) <austinpj@dfspd.net>, Sarah Eailey (earsarah@waltonso.org) <earsarah@waltonso.org>, Shayne Betts (shaynebetts@yahoo.com) <shaynebetts@yahoo.com>, Stephanie King (stephanie.king@chhealthcare.org) <stephanie.king@chhealthcare.org>, Sterling Strickland (sstrickland@swfd.org) <sstrickland@swfd.org>, Tim Orenic (torenic@swfd.org) <torenic@swfd.org>, Tom Baker <baktom@co.walton.fl.us>, Trish Meadows <meadowst@walton.k12.fl.us>, Barley, Kathryn C <Kathryn.Barley@flhealth.gov>, Carmichael, Jamie B <Jamie.Carmichael@flhealth.gov>, Drummond, Robert D <Robert.Drummond@flhealth.gov>, Gill, Brandi N <Brandi.Gill@flhealth.gov>, Holt, Holly <Holly.Holt@flhealth.gov>, Mims, Ryan E <Ryan.Mims@flhealth.gov>, Morell, Venita W <Venita.Morell@flhealth.gov>, Ottesen, John P <John.Ottesen@flhealth.gov>, Roberts, Missy <Missy.Roberts@flhealth.gov>, Roberts, Patricia J <Patricia.Roberts@flhealth.gov>, Simmons, Harriet A <Harriet.Simmons@flhealth.gov>, Smith, Marissa <Marissa.Smith@flhealth.gov>, Smith, Thomas M <Thomas.Smith@flhealth.gov>, Steele, Crystal C <Crystal.Steele@flhealth.gov>, Alma Solano (asolano@elc-ec.org) <asolano@elc-ec.org>, Ann McCannon (amccannon@somerbyliving.com) <amccannon@somerbyliving.com>, CHrissy Howell (chrissy.howell@gentiva.com) <chrissy.howell@gentiva.com>, Connie Zuraff <CZuraff@gchc.com>, Daniel Shearn (daniel_shearn@chs.net) <daniel_shearn@chs.net>, Daniela (dmejia@pancarefl.org) <dmejia@pancarefl.org>, Danny Wilkins (dwilkins@healthmarkregional.com) <dwilkins@healthmarkregional.com>, Darren M. Staggers (darren.staggers@medxcelfm.com) <darren.staggers@medxcelfm.com>, Graham Campbell (admin.chautauqua@shccs.com) <admin.chautauqua@shccs.com>, Gwen Cobb (cobbg@elderaffairs.org)

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<cobbg@elderaffairs.org>, James Howell (docjwh2888@aol.com) <docjwh2888@aol.com>, Jeff Duncan (jduncan@veritashcg.com) <jduncan@veritashcg.com>, Jennifer martinez (jennifer@coastalpediatricgroup.com) <jennifer@coastalpediatricgroup.com>, Joan Beard (jbeard@healthmarkregional.com) <jbeard@healthmarkregional.com>, Katerine Cosby (katherine.cosby@fmc-na.com) <katherine.cosby@fmc-na.com>, Kelli Maynard (kmaynard@healthmarkregional.com) <kmaynard@healthmarkregional.com>, KWebster@PanCareFL.org <KWebster@pancarefl.org>, Lida Deonarine <lida_deonarine@chs.net>, Lisa Price (pricel@elderaffairs.org) <pricel@elderaffairs.org>, Mary Sutton (msutton@docatdmc.com) <msutton@docatdmc.com>, Page Butler (page.howell@chhealthcare.org) <page.howell@chhealthcare.org>, Patsy Myrick (adon.chautauqua@signaturehealthcarellc.com) <adon.chautauqua@signaturehealthcarellc.com>, Paul Castiglione (pcastiglione@somerbyliving.com) <pcastiglione@somerbyliving.com>, Rachel Gillis <rachel.gillis@chhealthcare.org>, Sherri (rubengmd@yahoo.com) <rubengmd@yahoo.com>, Tami Miles (tmiles@brookdale.com) <tmiles@brookdale.com>, Victoria Montalvo (victoria_montalvo@chs.net) <victoria_montalvo@chs.net>, Violet Kianison, RN, RM <vkennison@healthmarkregional.com>, Whitney Rusnis (adon2.chautauqua@shccs.com) <adon2.chautauqua@shccs.com>

Updated information from ACHA on Long-term and residential care facilities.

Respectfully,

Tom Smith

Planning Consultant II

Florida Department of Health Walton County

356 State Highway 83 N

DeFuniak Springs, FL. 32433

Thomas.smith@flhealth.gov

Phone: 850-401-6364

Cell: 850-259-9989

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AMERICAN OVERSIGHT

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Sent: Thursday, March 19, 2020 6:47 AM
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Subject: Fwd: Guidance from AHCA

Thanks!

Jeff

Jeffrey M. Goldberg, FPEM, FMI, CHS-III
Director
Walton County Emergency Management
75 South Davis Lane
DeFuniak Springs, FL 32435
Work: (850) 892-8530
Mobile: (850) 307-4121

Sent from my iPhone

Begin forwarded message:

> **From:** "Guthrie, Kevin" <Kevin.Guthrie@em.myflorida.com>
> **Date:** March 19, 2020 at 06:38:35 CDT
> **To:** County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
> **Subject: FW: Guidance from AHCA**

Kevin Guthrie | Deputy Director

Office: (850) 815-4101

Cell: (850) 294-8250

AMERICAN OVERSIGHT

Kevin.Guthrie@em.myflorida.com

From: Twomey, Stephanie <Stephanie.Twomey@em.myflorida.com>
Sent: Wednesday, March 18, 2020 11:49 AM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>
Cc: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: Guidance from AHCA

Good Afternoon,

Please see attached AHCA guidance released regarding DEM No.20-006

Very Respectfully,

Stephanie Twomey

Stephanie Twomey

Senior Attorney

Florida Division of Emergency Management

Cell: (850)-815-5762

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Stephanie.Twomey@em.myflorida.com

--

AMERICAN OVERSIGHT



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: PPE Clarification

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Date: Wednesday, March 11, 2020 2:56:48 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Wed, Mar 11, 2020 at 1:33 PM
Subject: FW: PPE Clarification
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, dale simmons (dsimmons@hillcrestchurch.com) <dsimmons@hillcrestchurch.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Glenn, Amy <AGlenn@pcci.edu>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, julie gaither (julie.gaither@FDC.myflorida.com) <julie.gaither@fdc.myflorida.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lanza1@cox.net <lanza1@cox.net>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce

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AMERICAN OVERSIGHT

Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Smith, Rita M <Rita.Smith@flhealth.gov>
Sent: Wednesday, March 11, 2020 12:53 PM
To: DL DOH CHD Nursing Directors <DLCHDND@flhealth.gov>; DL CHD Medical Directors <DLCHDMedicalDirectors@flhealth.gov>
Cc: Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject: PPE Clarification

The attached poster covers the minimum standards recommended by CDC for PPE use in COVID-19 test collection.

If a CHD includes additional equipment to the PPE list, that is acceptable.

Hopefully this clears any confusion.

Rita Smith, DNP, APRN, NP-C

Statewide Nursing Director

Public Health Practice Unit

Florida Department of Health

Office of the Deputy Secretary for County Health Systems

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: PPE Clarification

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From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Wed, Mar 11, 2020 at 1:33 PM
Subject: FW: PPE Clarification
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, dale simmons (dsimmons@hillcrestchurch.com) <dsimmons@hillcrestchurch.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Glenn, Amy <AGlenn@pcci.edu>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, julie gaither (julie.gaither@FDC.myflorida.com) <julie.gaither@fdc.myflorida.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lanza1@cox.net <lanza1@cox.net>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce

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Vision: "To be the Healthiest State in the Nation"
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PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Smith, Rita M <Rita.Smith@flhealth.gov>
Sent: Wednesday, March 11, 2020 12:53 PM
To: DL DOH CHD Nursing Directors <DLCHDND@flhealth.gov>; DL CHD Medical Directors <DLCHDMedicalDirectors@flhealth.gov>
Cc: Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject: PPE Clarification

The attached poster covers the minimum standards recommended by CDC for PPE use in COVID-19 test collection.

If a CHD includes additional equipment to the PPE list, that is acceptable.

Hopefully this clears any confusion.

Rita Smith, DNP, APRN, NP-C

Statewide Nursing Director

Public Health Practice Unit

Florida Department of Health

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
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From: Ann Hill

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Subject: Fwd: FW: The State of Florida Issues Updates on COVID-19

Date: Tuesday, March 17, 2020 11:03:08 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 17, 2020 at 7:28 AM
Subject: FW: The State of Florida Issues Updates on COVID-19
To: (m.brandhorst@yahoo.com) <m.brandhorst@yahoo.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, abe singh <execdir@areahousing.org>, Alain Espinosa <aespinosa@myescambia.com>, Alex Nettles <Frederick.Nettles@va.gov>, Amanda Armstrong <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Andy Hobbs (anhobbs@escambiaso.com) <anhobbs@escambiaso.com>, Anges Rivers <arivers@healthcarewithinreach.org>, Hill, Ann <ann.echcc@gmail.com>, Anthony Manning <dc18@myescambia.com>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brad Hattaway <Brad_Hattaway@co.escambia.fl.us>, Brenda Van Brussel (CDC) <BVANBRUSSEL@escambiaclerk.com>, Brian Allen Waters <bwaters@waterfrontmission.org>, Brian Wyer <bwyer@gcmcc.info>, Brittany Johnson <b.n.johnson@cox.net>, Brock Dester <bdester@cityofpensacola.com>, Bruce Watson (Bwatson@elcescambia.org) <Bwatson@elcescambia.org>, Byron Burkhart <bburkhart@cityofpensacola.com>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Casey Boatwright <ccboatwright@myescambia.com>, Casey Richards <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, charlotte mccorvey <mccorveycx@gmail.com>, Chip Campbell <chip.campbell2@gmail.com>, Christine Crespo <cmcrespo@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Craig Ammons <cammons@myescambia.com>, d. 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Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

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From: CHD17, PIO <PIO.CHD17@flhealth.gov>
Sent: Monday, March 16, 2020 8:30 PM
To: CHD17, PIO <PIO.CHD17@flhealth.gov>
Subject: The State of Florida Issues Updates on COVID-19

Banner

FOR IMMEDIATE RELEASE March 16, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

The State of Florida Issues Updates on COVID-19

TALLAHASSEE, Fla. — The State of Florida is responding to COVID-19. In an effort to keep Florida residents and visitors safe and aware regarding the status of the virus, the Florida Department of Health will issue this update every day, seven days per week.

Governor Ron DeSantis is in constant communication with Florida Division of Emergency Management Director Jared Moskowitz and State Surgeon General Dr. Scott Rivkees as the State of Florida continues to monitor and respond to the threat of COVID-19.

Today, in a briefing at the State Emergency Operations Center, Governor DeSantis announced the following:

- Governor DeSantis announced he is going to supplement federal Small Business Administration (SBA) loans. The Governor activated the Florida Small Business Emergency Loan Program. Up to $50 million has been allocated for the program.
- Governor Ron DeSantis directed the Department of Revenue to provide flexibility on the deadlines of taxes due such as corporate income tax and sales tax to assist businesses that are adversely impacted from COVID-19 mitigation measures.
- Floridians throughout the state are lending a hand to stop the spread of COVID-19:
  - Members of the Florida House of Representatives have been activated to their National Guard units,
  - The Players Championship donated thousands of pounds of food to Feeding Northeast Florida,
  - Miami-Dade County school administrators are handing out computers and mobile devices, and
  - Comcast agreed to provide free WiFi for the next 60 days to kids who do not have it.

- The Miami Dolphins, Jacksonville Jaguars and the Orange County Convention Center have agreed to open their parking lots to stage supplies and locate testing sites.
- Restaurants throughout the state including Jimmy John's in Tallahassee and Toasted Restaurant in Orange County are providing children with free lunch throughout the week.
- Drive through testing sites are expected to open, throughout the state, in addition to the first proposed state site at Memorial Healthcare System in Broward. So far, sites are being developed in in Myers, Pensacola, West Palm Beach and Tallahassee.
- The Floridians who were at held at the Dobbins Air Reserve Base are on their way back to Florida; 15 Floridians have elected to stay at the base to care for their family members.
- On March 9, Governor DeSantis issued Executive Order 20-52, declaring a State of Emergency for COVID-19. By declaring a State of

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Emergency, Governor DeSantis is ensuring that state and local governments have the resources and flexibility they need to prepare and respond.

More Information on COVID-19

To find the most up-to-date information and guidance on COVID-19, please visit the Department of Health's dedicated COVID-19 webpage. For information and advisories from the Centers for Disease Control (CDC), please visit the CDC COVID-19 website. For more information about current travel advisories issued by the U.S. Department of State, please visit the travel advisory website.

For any other questions related to COVID-19 in Florida, please contact the Department's dedicated COVID-19 Call Center by calling **(866) 779-6121. The Call Center is available 24 hours per day**. Inquiries may also be emailed to **COVID-19@flhealth.gov.**

What you Should Know

COVID-19 can spread from person to person through small droplets from the nose or mouth, including when an individual coughs or sneezes. These droplets may land on objects and surfaces. Other people may contract COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth.

Symptoms of COVID-19 are fever, cough and shortness of breath. Symptoms may appear in as few as two days or as many as 14 days following exposure. Most people recover from COVID-19 without needing special treatment. The elderly and those with underlying medical problems like high blood pressure, heart problems and diabetes are more likely to develop serious illness.

There is currently no vaccine to prevent COVID-19. The best way to prevent illness is to avoid being exposed to the virus. The Department recommends everyday preventive actions to help stop the spread of respiratory diseases, including:

- Avoiding close contact with people who are sick;
- Staying home when you are sick and avoiding contact with persons in poor health;
- Avoiding touching your eyes, nose and mouth with unwashed hands;
- Covering your cough or sneezing into a tissue, then disposing of the tissue;
- Washing your hands often with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, after blowing your nose, coughing or sneezing;
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty; and
- Cleaning and disinfecting frequently touched objects and surfaces using a regular household cleaning spray or wipe.

The CDC does not recommend that asymptomatic, healthy people wear a facemask to protect themselves from respiratory diseases, including COVID-19. Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).
A person that experiences a fever and symptoms of respiratory illness, such as fever, cough or shortness of breath, within 14 days after travel from any other destination with community transmission should call ahead to their health care provider and local CHD and mention their recent travel or close contact.

If a person has had close contact with someone showing these symptoms who has recently traveled from this area or been in contact with a person with laboratory-confirmed COVID-19, he or she should call ahead to a health care professional and the CHD. The health care provider will work with the Department to determine if the person should be tested for COVID-19.

Actions the state has taken to prepare for and respond to COVID-19:

DEPARTMENT OF HEALTH

- At the direction of Governor DeSantis, State Surgeon General Dr. Scott Rivkees declared a Public Health Emergency for COVID-19 in Florida.
- Governor DeSantis announced that the State ordered an additional 2,500 test kits to supplement the adequate resources already available to test for COVID-19. These additional test kits will enable the Department of Health, working with Florida health care providers, to test up to an additional 625,000 individuals. The Governor also suspended non-essential in state and all out-of-state travel for state employees for 30 days.
- Established an Incident Management Team to coordinate response operations.
- Defined a high-level phased response strategy for COVID-19.
- Activated a dedicated incident command post for on-site response activities.
- Conducted three public health and health care stakeholder conference calls to provide statewide updates on the current outbreak situation, response actions and guidance for pandemic planning. Over five hundred participants joined the calls.
- Established a public call center for questions regarding COVID-19. The call center launched Monday, March 2.
- Developed and distributed COVID-19 presentation materials to County Health Departments (CHD) for use at community meetings.
- Activated the Joint Information Center in coordination with the Division of Emergency Management.
- Developed and implemented protocols for investigation, surveillance and monitoring for COVID-19 to rapidly detect and contain cases.
- Established mechanisms for monitoring and coordination with the Centers for Disease Control and Prevention (CDC) regarding epidemiological activities.
- Distributed CDC Interim Guidance for public health personnel evaluating Persons Under Investigation (PUI) and asymptomatic close contacts of confirmed cases at their home or non-home residential settings to CHDs.
- Approved and disseminated an updated Clinician Screening Tool for identifying COVID-19 PUIs.
- Distributed a health care provider letter regarding enhanced surveillance and preparedness for COVID-19 to associations, licensed providers, Health Care Coalitions and CHDs.
- Implemented testing at all three State Public Health Laboratories.
- Distributed updated CDC guidance for schools to CHDs and the Department of Education.
- Distributed updated laboratory guidance regarding implementation of testing at State Public Health Laboratories.
- Developing a laboratory surge plan.
- Developing a clinician-level briefing for medical audiences.
- Identifying and monitoring close contacts of presumptive cases. Any close contacts with symptoms will be tested.
- Implemented private lab testing.
- Developed and disseminated pandemic planning guidance.
- Advised CHDs and HCCs to retain expired personal protective equipment until further until further notice.
- Continued development of public information resources.
- Developing infographics for first responders (fire, law enforcement and EMS) regarding infection control and personal protection for COVID-19.
- At the Governor's direction, a public-private partnership has been put in place between Memorial Healthcare in Broward and the National

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Guard to set up a mobile testing unit.
- At the direction of Governor DeSantis hiring additional epidemiologists from university health programs to help with workload.
- Governor DeSantis directed the Agency for Health Care Administration (AHCA) to extend all existing nursing home and assisted living facility licenses for 90 days to remove distraction from patient care.

AGENCY FOR HEALTH CARE ADMINISTRATION

- AHCA distributed a provider alert to licensed health care providers regarding the Division of Emergency Management's new Emergency Order tightening visitation restrictions at residential and long-term care facilities.
- AHCA, in coordination with the DEM and the Department, is hosting ongoing statewide calls for nursing homes, assisted living facilities, intermediate care facilities, the Agency for Persons with Disabilities, group homes, and adult family care homes in conjunction with the Florida Health Care Association. Secretary Mayhew and Surgeon General Rivkees are continuing to address critical issues impacting these providers such as restricting visitors and providing updates.
- AHCA, in coordination with DEM and the Department, is hosting ongoing statewide calls for hospitals in conjunction with the Florida Hospital Association. Secretary Mayhew and Surgeon General Rivkees to provide the most up-to-date information to hospital partners and residential facilitates caring for aging and vulnerable populations.
- After previously opening an event on the Emergency Status System (ESS) for hospitals to enter census information, emergency room status updates and isolation beds, AHCA expanded the ESS event to track nursing homes and assisted living facility bed capacity, effective March 15.
- The Agency for Health Care Administration (AHCA) will be granting a 90-day extension to all licenses for health care providers and regulated facilities.
- AHCA is distributing information regarding regulatory flexibilities created by waivers from the Centers for Medicare and Medicaid Services (CMS) related to skilled nursing facilities, critical access hospitals, home health agencies, durable medical equipment, provider enrollment, etc.
- AHCA participated in a collaborative call with the Florida Health Care Association, Florida Hospital Association and LeadingAge Florida to discuss patient transfer arrangements between health care facilities such as nursing homes and hospitals.
- The Florida Medicaid Program announced coverage of commercial testing for COVID-19 for dates of service back to February 4.
- AHCA submitted requests to CMS for flexibility for Florida's program under the federal declaration of a state of emergency.

AGENCY FOR PERSONS WITH DISABILITIES

- The agency's three state-run centers in Marianna, Gainesville and Chattahoochee, as well as APD-licensed group homes, are restricting visitors in compliance with the Executive Order to protect the health and safety of our customers.
- APD Adult Day Training programs across the state are screening visitors for possible exposure to COVID-19 using a visitor questionnaire. The questionnaire is also being used to screen visitors coming into APD Regional Offices.
- APD continues to provide an up-to-date status on COVID-19, best practices, preventative tips, and CDC guidance to APD providers, Waiver Support Coordinators, Stakeholders and APD employees.

DEPARTMENT OF ELDER AFFAIRS

- The Department of Elder Affairs (DOEA), in coordination with the Administration for Community Living (ACL), facilitated a virtual Town Hall meeting at the request of Hallandale Beach Mayor Joy Cooper. More than 2,700 seniors were online for the meeting. Charlotte Mather Taylor, Executive Director of the Aging and Disability Resource Center (ADRC) of Broward County, led the discussion with participation from ACL Representative Constantino Miskos, Chen Senior Medical Center, and representatives from Emergency Medical Services. Their primary topics of conversation centered on the work being done, specifically by the Area Agency on Aging, to continue to provide people resources and services to maximize support during COVID-19.
- Through Departmental Leadership and the Area Agency on Aging contract managers, DOEA provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the safe delivery of home-delivered meals to prevent spread of respiratory infection.
- DOEA continues to provide updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, they are provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.
- "The Vision 2020: Looking Towards Your Age-Friendly Future Tour" to five communities across Florida originally planned for April 20th - April 24th and co-hosted by the Department and AARP has been postponed to protect the health and wellness of seniors, volunteers and staff.
- All Serving Health Insurance Needs of Elders (SHINE) participation in scheduled outreach events, presentations, and in-person SHINE/Senior Medicare Patrol (SMP) counseling has been suspended until further notice. SHINE volunteers and staff will continue to provide counseling services, but the services will be conducted over-the-phone with future considerations for the use of webinars and Facebook LIVE.
- DOEA Secretary Prudom held a conference call with The Comprehensive Assessment and Review for Long-term Care Services (CARES) supervisors to discuss the suspension of face-to-face assessments. CARES assessors will provide reviews through phone or tele-technology to reduce client/staff exposure and reduce spread.
- Through Departmental Leadership and the Area Agency on Aging contract managers, we provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the provision on completing assessments for multiple program types, specifically for clients who have chosen to self-isolate.
- DOEA provided updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers, and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.

DEPARTMENT OF CHILDREN AND FAMILIES

- The Department of Children and Families' (DCF) Office of Child Welfare is sending regular communication about COVID-19 specifically to licensed child care providers, directing them to follow the CDC's Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19). An FAQ document for providers was also posted prominently on DCF's Child Care webpage.
- DCF's Office of Child Welfare is disseminating a survey to licensed child care providers to assess closures throughout the state. Currently, the decision to close is at the discretion of each individual facility.
- DCF Secretary Chad Poppell sent thorough communication to all DCF staff, contracted partners, and licensed facilities (including child care providers) about COVID-19, including precautionary measures (as outlined by the CDC) and temporary policy updates.
- DCF is working with AHCA, DOEA, and APD to compile and develop guidance for agency staff and stakeholders who work directly with Florida's elderly population and have a higher risk of being exposed to COVID-19.
- DCF is leading status update calls with both internal leadership and leadership from external contracted partners. For the time being, these calls will take place twice weekly, every Tuesday and Friday.

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- DCF General Services staff throughout the state are working with lessors and janitorial contractors to increase sanitizing measures in office buildings, especially restrooms and common areas. They also began taking inventory of sanitizing supplies (disinfecting wipes, Lysol spray, hand-sanitizer, etc.) and are ordering more as needed.
- DCF established strategies for COVID-19 prevention at all three state mental health treatment facilities, as well as the South Florida mental health facilities run by Wellpath Recovery Solutions, a contracted partner. They are reporting daily updates to ensure compliance with virus prevention and monitor potential outbreaks.
- DCF has established a visitation protocol for all state-owned and contracted mental health treatment facilities, as well as vendors and patient families, requiring all outside parties to complete a Visitors Viral Symptoms Screening prior to entering a facility. At this time, there are no cases of patients or facility staff testing positive for COVID-19.
- DCF's Office of Economic Self-Sufficiency is communicating with DEO regarding work requirements and CareerSource operations and availability.
- DCF's Office of Economic Self-Sufficiency implemented screening procedures, including a set of questions that must be asked prior to entry, at all economic self-sufficiency storefronts.

FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

- Effective March 11, 2020, FDVA is restricting visitor access to its State Veterans' Nursing Homes and Domiciliary until further notice, with the exception of essential visitors, such as family members of those residents undergoing end-of-life care.
- The U.S. Department of Veterans Affairs (VA) has also temporarily restricted access to their nursing and community living center facilities to only essential visitors until further notice.
- All VA Medical Centers in Florida are implementing enhanced screening protocols at their facilities. VA Outpatient Clinics are also implementing enhanced screening protocols. Please plan to arrive at the facility well in advance of your appointment to allow additional time for the screening process.
- Veterans who are concerned they may have symptoms of Coronavirus (COVID-19) are encouraged to contact the VISN 8 Clinical Contact Center at 1-877-741-3400 (toll free). Clinical staff provide 24/7 virtual care and support, including nurse advice and triage. The service is available at no cost to veterans enrolled for care in the VA Sunshine Healthcare Network (VISN 8).
- All FDVA and VA facilities remain fully operational.

DEPARTMENT OF MILITARY AFFAIRS

- There have been over 200 Florida National Guardsmen placed on state active duty in support of COVID-19.
- The Florida National Guard is activating all of their medical professionals (Army Combat medic specialists and Air Force medical technicians) to support Florida Department of Health's drive-through screening operations. Guardsmen have reported in and formed Task Force Medical already.
- The Florida National Guard has activated soldiers to augment the State Logistics Readiness Center in Central Florida.

VOLUNTEER FLORIDA

- Volunteer Florida is working with state counterparts and FEMA to develop volunteer plans.
- Volunteer Florida's National Service Department has discussed using AmeriCorps members in food banks as feeding needs increase.
- Volunteer Florida is having conversations with Mass Care on the anticipated needs of volunteers. Together, we are working on a plan for volunteers with volunteer safety guidelines to ensure that we are protecting our service providers (volunteers and clients).
- Volunteer Florida has asked all Voluntary Organizations Active in Disaster (VOAD) partners to review their continuity of operations so that there is no service delivery disruption.

FLORIDA DEPARTMENT OF EDUCATION

- Commissioner of the Florida Department of Education (FDOE) Richard Corcoran provided strong recommendations for extending spring break following Centers for Disease Control and Prevention (CDC) issuing guidance specific to COVID-19 in Florida. As all Florida school districts and public charter schools have different schedules, please click here to see the recommended spring break changes for each district. In addition, the department also announced that the start of state testing will be delayed by a minimum of two weeks. To stay up to date on school closure information, visit: org/em-response.
- FDOE sent updated guidance to school districts and superintendents ahead of spring break. To view that memo, visit: fldoe.org/em-response.
- In an effort to be proactive, and only as a precautionary measure if COVID-19 evolves in Florida, Florida Virtual School (FLVS) has partnered with the Florida Department of Education to offer all school districts student support and teacher professional development tailored to the online learning environment. The Florida Department of Education in partnership with FLVS is training an additional 10,000 teachers statewide on the Virtual Teacher Training for COVID-19. Superintendents who are interested in offering their teachers the Virtual Teacher Training for COVID-19 should work with their County Virtual Principals to provide a list of teachers to FLVS through: https://www.flvs.net/FLVSTeacherTraining.
- Education Commissioner Corcoran is in constant communication with Florida Superintendents and districts to provide guidance on COVID-19 preparedness and response and will be holding weekly calls to update districts on preparation efforts.
- FDOE has sent weekly memos providing updates to school districts, superintendents, Florida Colleges, parents, teachers and stakeholders.
- FDOE launched a survey to school districts and public charter schools about their preparations, policies, and their capacity to serve their students virtually to help meet and determine any preparedness needs.

STATE UNIVERSITY SYSTEM

- The State University System will continue to evaluate the effectiveness of remote learning and the need to teach remotely in order to protect our students and the university community.
- The State University System will continue to work with the Florida Department of Health and the Emergency Operations Center to determine if the initial two weeks of remote learning is sufficient.
- Effective immediately, all universities will make plans to transition to remote instruction as soon as possible.
- State universities with students who have returned from spring break, which includes Florida Gulf Coast University, Florida International University, Florida Polytechnic University, and the University of Florida, should implement a process to transition to remote instruction immediately and encourage students to return home for at least 2 weeks. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- State universities with students who are currently on spring break or about to be on break should direct their students to NOT return to campus for at least 2 weeks following the conclusion of spring break. This includes students at Florida Agricultural and Mechanical University, Florida Atlantic University, Florida State University, New College of Florida, the University of North Florida, the University of Central Florida, the University of South Florida, and the University of West Florida. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- RESIDENTIAL HOUSING - While students are encouraged to remain off-campus, each university should develop a plan for providing

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residential accommodations for students who need assistance or must remain in place.
- All state universities have implemented campus-wide critical incident or emergency management teams that are meeting regularly to prepare for the impacts of the COVID-19 virus.
- All universities are preparing to transition to remote instructional delivery for a two-week period during March and early April, depending on each institution's Spring Break, and are informing students not to return to campus during this period.
- The Board of Governors will be conducting its March meeting via conference call and will not have a face-to-face meeting at USF as was originally scheduled.
- For more information visit: https://www.flbog.edu/2020/03/11/state-university-system-statement-on-covid-19/.

FLORIDA DEPARTMENT OF CORRECTIONS

- Florida Department of Corrections (FDC) has no known or suspected cases of COVID-19 within its correctional institutions at this time.
- FDC Community Corrections officers are working with offenders on supervision to adjust reporting schedules to minimize congregating at probation offices and prevent the spread of COVID-19.
- FDC's Office of Health Services coordinates with the Department for guidance on any type of outbreak and is closely monitoring new information as it is disseminated from the Department and the CDC.
- FDC has suspended visitation at all correctional institutions statewide through April 5, 2020. The decision to reinstate the normal visitation schedule will be evaluated in consultation with the Department.
    - Inmates will continue to have access to mail, email, phone calls and video visitation.
    - Legal visits will not be impacted.
    - FDC has partnered with vendors to provide some complimentary phone and video visitation services.
- Anyone entering a correctional institution will be screened, and entrance will be restricted if they:
    - Have traveled internationally or on a cruise within the last 14 days.
    - Have signs or symptoms of a respiratory infection such as fever, cough or shortness of breath.
    - Have had contact with someone who has been or is under investigation for COVID-19.
- All non-critical inmate transfers have been suspended.
- FDC has a plan in place and dedicated staff members trained in the prevention and containment of infectious diseases.
- FDC initiated its Incident Command System in response to COVID-19.
- Education has been provided to staff, inmates and visitors to prevent the spread of any infectious disease, including COVID-19.
- Precautions are in place at facilities to protect inmates and staff from exposure to flu, COVID-19 or any other respiratory illness; preventative measures are being followed per CDC recommendations.

FLORIDA DEPARTMENT OF STATE

- The Division of Elections offers a toll-free Voter Assistance Hotline, 1.866.308.6739 (in English and Español), available Monday - Friday, 8:00 am - 5:00 pm ET, with extended hours during statewide elections. For hearing or speech impaired, please contact the Division using the Florida Relay Service, 1.800.955.8771 (TDD), 1.800.955.8770 (Voice), or 1.877.955.8773 (Español). Voters can also contact their local Supervisor of Elections
- The Florida Department of State is in constant communication with Supervisors of Elections regarding Tuesday's Presidential Preference Primary Election and is providing guidance and information to voters through traditional and social media messages:
- The Florida Department of State been informing voters of the various options Florida provides in order to cast their ballot ahead of Tuesday's election and on Election Day. Further, we have assured Florida's voters that otherwise healthy poll workers can work on Election Day. DOS has notified voters who have been ordered to self-isolate or who are experiencing symptoms of COVID-19 and who have not yet voted, of the option to have someone pick up their ballot for them.
    - As with any election, before a voter goes to the polls on Tuesday, they should check with their local Supervisor of Elections. Now more than ever, it is critical that we continue to provide voters with clear and consistent information regarding polling place locations. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be on the voter's respective **Supervisor of Elections website**.
    - The Division of Elections website provides prominent placement of the Voter Information Lookup where voters can check their voter status and find their polling place information. This polling place information is linked to the voters' respective Supervisor of Elections database. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be from the voter's respective **Supervisor of Elections.**
- The Florida Department of State continues to support and work with local Supervisors of Elections and Emergency Management officials to ensure the Supervisors needs are met regarding sanitization and cleaning needs for the Presidential Preference Primary Election on Tuesday.

FLORIDA DEPARTMENT OF TRANSPORTATION

- FDOT is coordinating with other state and local agencies to help ensure mobility around the temporary testing site in Broward County. Once the site is open, FDOT plans to publicize testing site information on highway advisory radio.
- FDOT completed a request to provide necessary supplies to harbor pilots working at seaports.
- At the direction of Governor DeSantis, Florida Department of Transportation (FDOT) Secretary Kevin J. Thibault, along with Surgeon General Dr. Scott Rivkees, hosted a conference call with all Florida ports and their governing bodies as well as all public use airports to discuss Florida's ongoing response to the COVID-19 virus.
- FDOT Secretary Thibault and staff from the department will host weekly conference calls with all passenger seaports and public use airports to provide updates related to COVID-19.
- FDOT is monitoring temporary lane closures near hospitals and Department of Health facilities. If congestion near these facilities and lane closures occur, FDOT will remove lane restrictions to help ensure mobility within the area.
- Pursuant to Executive Order 20-52 issued by Governor DeSantis, FDOT Secretary Thibault has suspended size and weight restrictions for divisible loads on any vehicles transporting emergency equipment, services, supplies, and necessary agricultural commodities on state roads.
- COVID-19 educational materials have been posted in FDOT facilities, which include welcome centers, service plazas and rest areas across the state.
- COVID-19 materials have been posted at all FDOT work sites across the state to help educate contractors, vendors, and stakeholders.
- FDOT toll collectors have been given additional training and are required to wear gloves as well as continue with enhanced cleansing.
- SunRail has posted COVID-19 educational materials inside all trains and on all platforms, focusing on areas near entrances and bathrooms.
- SunRail trains are being cleaned and sanitized daily and SunRail staff have been provided sanitizing towelettes and encouraged to wash their hands frequently throughout the day.

FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

- At the direction of Governor Ron DeSantis, Florida Department of Highway Safety and Motor Vehicles Executive Director Terry L. Rhodes has issued an Emergency Order extending all Florida driver licenses and identification cards that will expire in the next 30 days.
- Pursuant to Executive Order 20-52, FLHSMV Executive Director Rhodes waived commercial truck hours of service regulations and other related regulations so that emergency supplies, equipment, commodities and resources can be moved more quickly and efficiently throughout the state.
- FLHSMV continues to encourage Floridians through social media and other channels to use convenient online options, rather than visiting an

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office location, to complete transactions for driver licenses, ID cards, motor vehicle or vessel registrations, and more.
- FLHSMV has been in regular communication with the Florida Tax Collectors Association as well as Tax Collectors across the state to provide the latest COVID-19 information and guidance from the Florida Department of Health and other state partners.

DEPARTMENT OF ECONOMIC OPPORTUNITY

- Governor DeSantis has requested the federal Small Business Administration (SBA) make the Economic Injury Disaster Loan program available for Florida's small businesses impacted by COVID-19. The Florida Department of Economic Opportunity (DEO) stands ready to assist Florida's small businesses in accessing this funding when available.
- Governor Ron DeSantis has activated the Business Damage Assessment survey to assess the impact of COVID-19 on Florida's local business operations. The survey, managed by DEO, will evaluate businesses affected by COVID-19 and the impacts the virus has had on the local economy so actions to implement appropriate relief programs can begin. The survey can be taken online at https://floridadisaster.biz/.

VISIT FLORIDA

- VISIT FLORIDA is wholly focused on providing health and safety information to travelers and Floridians. This includes the activation of Florida Now, which includes the latest updates from state emergency response professionals hosted on VisitFlorida.com.
- VISIT FLORIDA is planning for future marketing campaigns to ensure that Florida's tourism industry has a strong, unified voice following COVID-19
- To protect the health and safety of the traveling public and staff, VISIT FLORIDA's four welcome centers will be closed until further notice.
- VISIT FLORIDA is tracking traveler sentiment across online platforms and social media to monitor how COVID-19 may impact travel and travel booking to Florida.
- VISIT FLORIDA remains in close contact with industry partners and travel organizations and is communicating all new information as it becomes available.

DEPARTMENT OF REVENUE

- The Department of Revenue is advising child support customers who are scheduled for court hearings related to their child support cases to check with the local courts where the hearings are scheduled in case the courts have new requirements, such as appearing telephonically.
- The Department of Revenue's Child Support Program is working to reduce when customers are required to visit a local child support office and is providing new connect/customer service options.
- Efforts include rescheduling genetic testing sample collection appointments and postponing other types of appointments. The Program will soon be implementing the ability for parents to enter into written agreements over the phone, and the Program will be providing new fax, email and form drop-off processes.
- The Department of Revenue's General Tax Administration (GTA) program is working with its tax processing vendor to ensure continuity in tax data and payment processing.
- GTA is closely monitoring any future guidance issued by the Internal Revenue Service for potential corporate income tax due date extensions.
- The Department has increased messaging on preventative measures through the deployment of DOH/CDC posters, ensured hand sanitizer is available, and increased cleaning of high-traffic areas in our public areas of our service centers.

OFFICE OF INSURANCE REGULATION

- The Office of Insurance Regulation (OIR) Insurance Commissioner David Altmaier is actively engaged with insurers and key partners at the state and national level regarding COVID-19. Commissioner Altmaier is collaborating with other state insurance commissioners and the National Association of Insurance Commissioners to share information and resources.
- OIR has issued Informational Memorandum OIR-20-01M to all health insurers and health maintenance organizations, directing them to:
  - Use every channel available to them to communicate with their policyholders and share official CDC and Department of Health information;
  - Devote resources to inform consumers of available benefits, quickly respond to inquiries, and avoid and dispel misinformation;
  - Work with public health officials to do everything possible to prepare and respond; and
  - Consider all practicable options to reduce the barriers of cost-sharing for testing and treatment of COVID-19.
- OIR is reaching out to insurers regarding their response to COVID-19 and working with insurers to make sure they are properly communicating to consumers.
- OIR has activated its incident management team and has met to review disaster response procedures.
- OIR has issued Informational Memorandum OIR-20-02M as a reminder to all health insurers, health maintenance organizations and other health entities to allow for early prescription refills following the Governor's Executive Order 20-52 declaring a state of emergency in Florida.
- OIR has spoken with multiple insurers who are voluntarily waiving cost-sharing for consumers in an effort to remove barriers to testing for COVID-19.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

- Florida Department of Law Enforcement (FDLE) is working with state and local agencies and the Florida National Guard to set up testing collection sites in multiple locations across Florida.

- The Florida Department of Law Enforcement (FDLE) Regional Operations Centers are working with Regional Domestic Security Task Forces to prepare for any responses needed.

- FDLE's Office of Mutual Aid prepared and distributed a law enforcement guide on COVID-19 for law enforcement partners and state agencies and FDLE's General Counsel prepared a law enforcement guide for protocols in a quarantine.

- FDLE Commissioner Rick Swearingen sent an email to all members outlining simple ways to prevent the spread of COVID-19 as well as links to the Florida Department of Health and CDC websites. Signs have been posted in all FDLE Regions and at Headquarters with prevention information.

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

- The Florida Department of Juvenile Justice's Office of Health Services developed COVID-19 guidance for all facilities serving DJJ youth. This guidance included Center for Disease Control criteria on how to assess and care for youth who are exhibiting fever and respiratory symptoms and environmental cleaning and disinfection recommendations.

- The Florida Department of Juvenile Justice has modified screening protocols and procedures for youth taken into custody by law enforcement who are brought to juvenile assessment centers and detention screening units to now include precautionary coronavirus screening questions and protocols. This modified screening protocol was shared with law enforcement partners statewide.

- The Florida Department of Juvenile Justice has developed a visitor screening tool which is now mandatory to use inside of our juvenile detention centers and residential commitment programs to ensure both the safety of the youth and staff in these programs. The

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Florida Department of Juvenile Justice has sent a notice to parents and guardians of youth in programs regarding the new visitor screening requirements.

- The Florida Department of Juvenile Justice has instituted additional screening measures for outside vendors who work within juvenile facilities and non-essential travel of staff members has been stopped. Visitors are limited to business-related visitors only (i.e., vendors, no personal visitors, no volunteers at this time). The department will work with these entities on alternatives to visiting programs to ensure critical services are not interrupted. Clinical personnel, however, are still permitted to visit youth for treatment purposes, and attorneys are still permitted to conduct legal visits with youth.

FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

- Governor DeSantis directed all agencies to suspend for 30 days licensing and registration renewal requirements for existing processional licenses (e.g. realtors).
- Governor DeSantis has directed the Department of Business and Professional Regulation Secretary Halsey Beshears, in coordination with the Florida Department of Health, to issue social distancing guidance to restaurants and bars.
- Governor DeSantis sent a letter to the federal Small Business Administration to turn on the SBA loan program for small businesses.
- The Florida Department of Business and Professional Regulation (DBPR) has suspended all official business visits, including inspections, that involve licenses located at a facility covered under the visitation restrictions implemented pursuant to FDEM Emergency Order 20-002.
- DBPR is incorporating informational comments on all on-site inspection reports issued to public lodging, public food service, and alcohol and tobacco license holders that will promote situational awareness of the current public health emergency and will direct parties to the FDOH COVID-19 webpage for guidance and resources related to prevention best practices. Copies of informational flyers from the FDOH COVID-19 toolkit will also be available for inspectors to distribute when interacting with managers of these premises.

FLORIDA DEPARTMENT OF MANAGEMENT SERVICES

- Governor DeSantis directed the Department of Management Services Secretary Jonathan Satter to allow state employees to donate and transfer their available leave time to other state employees to mitigate the impacts of school closures.
- The Florida Department of Management Services' (DMS) Emergency Support Function-7 (ESF-7) Logistics team continues to coordinate with the Department of Health and the Division of Emergency Management on identifying the equipment or supplies that may be necessary for a mass response to COVID-19.
- DMS' Division of Human Resource Management has provided guidance to agencies on implementing preventive actions in the workplace, reporting symptoms, using leave, utilizing health insurance benefits, and applying travel restrictions and telework policies.
- DMS' Division of State Group Insurance continues to coordinate with health plan providers to ensure that state employee health plan members receive the health benefits that can assist them and their dependents if needed.
- DMS' Division of Real Estate Development and Management (REDM) continues to provide guidance to agency facility managers across the state on steps to take to prevent workplace contamination and to pre-position environmental vendors to mobilize in the event a viricidal cleaning is needed.
- DMS' Division of Real Estate Development and Management continues to identify, purchase, and distribute additional hand sanitizing gel and cleaning supplies to state-maintained facilities.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with users and vendor of the Statewide Law Enforcement Radio System (SLERS) vendors to ensure the continuation of mission critical services if a reduction of staffing resources occurs.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with statewide public safety communications personnel on their plans to ensure emergency communications systems are not impacted by potential reductions in staffing resources.

FLORIDA DEPARTMENT OF ENVIRONMENTAL PROTECTION

- All State Parks have adjusted their operating hours to 8 a.m. to 5 p.m. daily. The Department continues to monitor new developments closely and will make further adjustments as necessary based on any new Department of Health or CDC guidance received to ensure protection of our staff and visitors. For the latest information on park operating hours and operational status, please visit floridastateparks.org.
- Currently all Florida State Parks and campgrounds, and Office of Resilience and Coastal Protection facilities (aquatic preserves and National Estuarine Research Reserves), remain open to the public. However, in an abundance of caution and consistent with Center for Disease Control and Prevention (CDC) guidance, DEP announced on March 13 that it is cancelling all events and activities at these facilities effective immediately and until further notice.
    - This includes DEP events and includes activities such as tours and visitor centers that involve large groups and/or or people in close proximity to others. People with questions regarding any privately scheduled event should check with the host of the event or the facility directly. For the latest closure and cancellation information, please visit floridastateparks.org.
- If your travel plans have changed and you need to modify camping or cabin reservations, please visit ReserveAmerica.com, call Reserve America at 1-800-326-3521 or TDD 888-433-0287 or text to 904-204-3216.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

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Subject: Fwd: FW: The State of Florida Issues Updates on COVID-19

Date: Tuesday, March 17, 2020 11:03:08 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 17, 2020 at 7:28 AM
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Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

From: CHD17, PIO <PIO.CHD17@flhealth.gov>
Sent: Monday, March 16, 2020 8:30 PM
To: CHD17, PIO <PIO.CHD17@flhealth.gov>
Subject: The State of Florida Issues Updates on COVID-19

Banner

FOR IMMEDIATE RELEASE March 16, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

The State of Florida Issues Updates on COVID-19

TALLAHASSEE, Fla. — The State of Florida is responding to COVID-19. In an effort to keep Florida residents and visitors safe and aware regarding the status of the virus, the Florida Department of Health will issue this update every day, seven days per week.

Governor Ron DeSantis is in constant communication with Florida Division of Emergency Management Director Jared Moskowitz and State Surgeon General Dr. Scott Rivkees as the State of Florida continues to monitor and respond to the threat of COVID-19.

Today, in a briefing at the State Emergency Operations Center, Governor DeSantis announced the following:

- Governor DeSantis announced he is going to supplement federal Small Business Administration (SBA) loans. The Governor activated the Florida Small Business Emergency Loan Program. Up to $50 million has been allocated for the program.
- Governor Ron DeSantis directed the Department of Revenue to provide flexibility on the deadlines of taxes due such as corporate income tax and sales tax to assist businesses that are adversely impacted from COVID-19 mitigation measures.
- Floridians throughout the state are lending a hand to stop the spread of COVID-19:
  - Members of the Florida House of Representatives have been activated to their National Guard units,
  - The Players Championship donated thousands of pounds of food to Feeding Northeast Florida,
  - Miami-Dade County school administrators are handing out computers and mobile devices, and
  - Comcast agreed to provide free WiFi for the next 60 days to kids who do not have it.

- The Miami Dolphins, Jacksonville Jaguars and the Orange County Convention Center have agreed to open their parking lots to stage supplies and locate testing sites.
- Restaurants throughout the state including Jimmy John's in Tallahassee and Toasted Restaurant in Orange County are providing children with free lunch throughout the week.
- Drive through testing sites are expected to open, throughout the state, in addition to the first proposed state site at Memorial Healthcare System in Broward. So far, sites are being developed in in Myers, Pensacola, West Palm Beach and Tallahassee.
- The Floridians who were at held at the Dobbins Air Reserve Base are on their way back to Florida; 15 Floridians have elected to stay at the base to care for their family members.
- On March 9, Governor DeSantis issued Executive Order 20-52, declaring a State of Emergency for COVID-19. By declaring a State of

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Emergency, Governor DeSantis is ensuring that state and local governments have the resources and flexibility they need to prepare and respond.

More Information on COVID-19

To find the most up-to-date information and guidance on COVID-19, please visit the Department of Health's dedicated COVID-19 webpage. For information and advisories from the Centers for Disease Control (CDC), please visit the CDC COVID-19 website. For more information about current travel advisories issued by the U.S. Department of State, please visit the travel advisory website.

For any other questions related to COVID-19 in Florida, please contact the Department's dedicated COVID-19 Call Center by calling **(866) 779-6121. The Call Center is available 24 hours per day**. Inquiries may also be emailed to **COVID-19@flhealth.gov.**

What you Should Know

COVID-19 can spread from person to person through small droplets from the nose or mouth, including when an individual coughs or sneezes. These droplets may land on objects and surfaces. Other people may contract COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth.

Symptoms of COVID-19 are fever, cough and shortness of breath. Symptoms may appear in as few as two days or as many as 14 days following exposure. Most people recover from COVID-19 without needing special treatment. The elderly and those with underlying medical problems like high blood pressure, heart problems and diabetes are more likely to develop serious illness.

There is currently no vaccine to prevent COVID-19. The best way to prevent illness is to avoid being exposed to the virus. The Department recommends everyday preventive actions to help stop the spread of respiratory diseases, including:

- Avoiding close contact with people who are sick;
- Staying home when you are sick and avoiding contact with persons in poor health;
- Avoiding touching your eyes, nose and mouth with unwashed hands;
- Covering your cough or sneezing into a tissue, then disposing of the tissue;
- Washing your hands often with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, after blowing your nose, coughing or sneezing;
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty; and
- Cleaning and disinfecting frequently touched objects and surfaces using a regular household cleaning spray or wipe.

The CDC does not recommend that asymptomatic, healthy people wear a facemask to protect themselves from respiratory diseases, including COVID-19. Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).
A person that experiences a fever and symptoms of respiratory illness, such as fever, cough or shortness of breath, within 14 days after travel from any other destination with community transmission should call ahead to their health care provider and local CHD and mention their recent travel or close contact.

If a person has had close contact with someone showing these symptoms who has recently traveled from this area or been in contact with a person with laboratory-confirmed COVID-19, he or she should call ahead to a health care professional and the CHD. The health care provider will work with the Department to determine if the person should be tested for COVID-19.

Actions the state has taken to prepare for and respond to COVID-19:

DEPARTMENT OF HEALTH

- At the direction of Governor DeSantis, State Surgeon General Dr. Scott Rivkees declared a Public Health Emergency for COVID-19 in Florida.
- Governor DeSantis announced that the State ordered an additional 2,500 test kits to supplement the adequate resources already available to test for COVID-19. These additional test kits will enable the Department of Health, working with Florida health care providers, to test up to an additional 625,000 individuals. The Governor also suspended non-essential in state and all out-of-state travel for state employees for 30 days.
- Established an Incident Management Team to coordinate response operations.
- Defined a high-level phased response strategy for COVID-19.
- Activated a dedicated incident command post for on-site response activities.
- Conducted three public health and health care stakeholder conference calls to provide statewide updates on the current outbreak situation, response actions and guidance for pandemic planning. Over five hundred participants joined the calls.
- Established a public call center for questions regarding COVID-19. The call center launched Monday, March 2.
- Developed and distributed COVID-19 presentation materials to County Health Departments (CHD) for use at community meetings.
- Activated the Joint Information Center in coordination with the Division of Emergency Management.
- Developed and implemented protocols for investigation, surveillance and monitoring for COVID-19 to rapidly detect and contain cases.
- Established mechanisms for monitoring and coordination with the Centers for Disease Control and Prevention (CDC) regarding epidemiological activities.
- Distributed CDC Interim Guidance for public health personnel evaluating Persons Under Investigation (PUI) and asymptomatic close contacts of confirmed cases at their home or non-home residential settings to CHDs.
- Approved and disseminated an updated Clinician Screening Tool for identifying COVID-19 PUIs.
- Distributed a health care provider letter regarding enhanced surveillance and preparedness for COVID-19 to associations, licensed providers, Health Care Coalitions and CHDs.
- Implemented testing at all three State Public Health Laboratories.
- Distributed updated CDC guidance for schools to CHDs and the Department of Education.
- Distributed updated laboratory guidance regarding implementation of testing at State Public Health Laboratories.
- Developing a laboratory surge plan.
- Developing a clinician-level briefing for medical audiences.
- Identifying and monitoring close contacts of presumptive cases. Any close contacts with symptoms will be tested.
- Implemented private lab testing.
- Developed and disseminated pandemic planning guidance.
- Advised CHDs and HCCs to retain expired personal protective equipment until further until further notice.
- Continued development of public information resources.
- Developing infographics for first responders (fire, law enforcement and EMS) regarding infection control and personal protection for COVID-19.
- At the Governor's direction, a public-private partnership has been put in place between Memorial Healthcare in Broward and the National

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Guard to set up a mobile testing unit.
- At the direction of Governor DeSantis hiring additional epidemiologists from university health programs to help with workload.
- Governor DeSantis directed the Agency for Health Care Administration (AHCA) to extend all existing nursing home and assisted living facility licenses for 90 days to remove distraction from patient care.

AGENCY FOR HEALTH CARE ADMINISTRATION

- AHCA distributed a provider alert to licensed health care providers regarding the Division of Emergency Management's new Emergency Order tightening visitation restrictions at residential and long-term care facilities.
- AHCA, in coordination with the DEM and the Department, is hosting ongoing statewide calls for nursing homes, assisted living facilities, intermediate care facilities, the Agency for Persons with Disabilities, group homes, and adult family care homes in conjunction with the Florida Health Care Association. Secretary Mayhew and Surgeon General Rivkees are continuing to address critical issues impacting these providers such as restricting visitors and providing updates.
- AHCA, in coordination with DEM and the Department, is hosting ongoing statewide calls for hospitals in conjunction with the Florida Hospital Association. Secretary Mayhew and Surgeon General Rivkees to provide the most up-to-date information to hospital partners and residential facilitates caring for aging and vulnerable populations.
- After previously opening an event on the Emergency Status System (ESS) for hospitals to enter census information, emergency room status updates and isolation beds, AHCA expanded the ESS event to track nursing homes and assisted living facility bed capacity, effective March 15.
- The Agency for Health Care Administration (AHCA) will be granting a 90-day extension to all licenses for health care providers and regulated facilities.
- AHCA is distributing information regarding regulatory flexibilities created by waivers from the Centers for Medicare and Medicaid Services (CMS) related to skilled nursing facilities, critical access hospitals, home health agencies, durable medical equipment, provider enrollment, etc.
- AHCA participated in a collaborative call with the Florida Health Care Association, Florida Hospital Association and LeadingAge Florida to discuss patient transfer arrangements between health care facilities such as nursing homes and hospitals.
- The Florida Medicaid Program announced coverage of commercial testing for COVID-19 for dates of service back to February 4.
- AHCA submitted requests to CMS for flexibility for Florida's program under the federal declaration of a state of emergency.

AGENCY FOR PERSONS WITH DISABILITIES

- The agency's three state-run centers in Marianna, Gainesville and Chattahoochee, as well as APD-licensed group homes, are restricting visitors in compliance with the Executive Order to protect the health and safety of our customers.
- APD Adult Day Training programs across the state are screening visitors for possible exposure to COVID-19 using a visitor questionnaire. The questionnaire is also being used to screen visitors coming into APD Regional Offices.
- APD continues to provide an up-to-date status on COVID-19, best practices, preventative tips, and CDC guidance to APD providers, Waiver Support Coordinators, Stakeholders and APD employees.

DEPARTMENT OF ELDER AFFAIRS

- The Department of Elder Affairs (DOEA), in coordination with the Administration for Community Living (ACL), facilitated a virtual Town Hall meeting at the request of Hallandale Beach Mayor Joy Cooper. More than 2,700 seniors were online for the meeting. Charlotte Mather Taylor, Executive Director of the Aging and Disability Resource Center (ADRC) of Broward County, led the discussion with participation from ACL Representative Constantino Miskos, Chen Senior Medical Center, and representatives from Emergency Medical Services. Their primary topics of conversation centered on the work being done, specifically by the Area Agency on Aging, to continue to provide people resources and services to maximize support during COVID-19.
- Through Departmental Leadership and the Area Agency on Aging contract managers, DOEA provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the safe delivery of home-delivered meals to prevent spread of respiratory infection.
- DOEA continues to provide updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, they are provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.
- "The Vision 2020: Looking Towards Your Age-Friendly Future Tour" to five communities across Florida originally planned for April 20th - April 24th and co-hosted by the Department and AARP has been postponed to protect the health and wellness of seniors, volunteers and staff.
- All Serving Health Insurance Needs of Elders (SHINE) participation in scheduled outreach events, presentations, and in-person SHINE/Senior Medicare Patrol (SMP) counseling has been suspended until further notice. SHINE volunteers and staff will continue to provide counseling services, but the services will be conducted over-the-phone with future considerations for the use of webinars and Facebook LIVE.
- DOEA Secretary Prudom held a conference call with The Comprehensive Assessment and Review for Long-term Care Services (CARES) supervisors to discuss the suspension of face-to-face assessments. CARES assessors will provide reviews through phone or tele-technology to reduce client/staff exposure and reduce spread.
- Through Departmental Leadership and the Area Agency on Aging contract managers, we provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the provision on completing assessments for multiple program types, specifically for clients who have chosen to self-isolate.
- DOEA provided updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers, and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.

DEPARTMENT OF CHILDREN AND FAMILIES

- The Department of Children and Families' (DCF) Office of Child Welfare is sending regular communication about COVID-19 specifically to licensed child care providers, directing them to follow the CDC's Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19). An FAQ document for providers was also posted prominently on DCF's Child Care webpage.
- DCF's Office of Child Welfare is disseminating a survey to licensed child care providers to assess closures throughout the state. Currently, the decision to close is at the discretion of each individual facility.
- DCF Secretary Chad Poppell sent thorough communication to all DCF staff, contracted partners, and licensed facilities (including child care providers) about COVID-19, including precautionary measures (as outlined by the CDC) and temporary policy updates.
- DCF is working with AHCA, DOEA, and APD to compile and develop guidance for agency staff and stakeholders who work directly with Florida's elderly population and have a higher risk of being exposed to COVID-19.
- DCF is leading status update calls with both internal leadership and leadership from external contracted partners. For the time being, these calls will take place twice weekly, every Tuesday and Friday.

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- DCF General Services staff throughout the state are working with lessors and janitorial contractors to increase sanitizing measures in office buildings, especially restrooms and common areas. They also began taking inventory of sanitizing supplies (disinfecting wipes, Lysol spray, hand-sanitizer, etc.) and are ordering more as needed.
- DCF established strategies for COVID-19 prevention at all three state mental health treatment facilities, as well as the South Florida mental health facilities run by Wellpath Recovery Solutions, a contracted partner. They are reporting daily updates to ensure compliance with virus prevention and monitor potential outbreaks.
- DCF has established a visitation protocol for all state-owned and contracted mental health treatment facilities, as well as vendors and patient families, requiring all outside parties to complete a Visitors Viral Symptoms Screening prior to entering a facility. At this time, there are no cases of patients or facility staff testing positive for COVID-19.
- DCF's Office of Economic Self-Sufficiency is communicating with DEO regarding work requirements and CareerSource operations and availability.
- DCF's Office of Economic Self-Sufficiency implemented screening procedures, including a set of questions that must be asked prior to entry, at all economic self-sufficiency storefronts.

FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

- Effective March 11, 2020, FDVA is restricting visitor access to its State Veterans' Nursing Homes and Domiciliary until further notice, with the exception of essential visitors, such as family members of those residents undergoing end-of-life care.
- The U.S. Department of Veterans Affairs (VA) has also temporarily restricted access to their nursing and community living center facilities to only essential visitors until further notice.
- All VA Medical Centers in Florida are implementing enhanced screening protocols at their facilities. VA Outpatient Clinics are also implementing enhanced screening protocols. Please plan to arrive at the facility well in advance of your appointment to allow additional time for the screening process.
- Veterans who are concerned they may have symptoms of Coronavirus (COVID-19) are encouraged to contact the VISN 8 Clinical Contact Center at 1-877-741-3400 (toll free). Clinical staff provide 24/7 virtual care and support, including nurse advice and triage. The service is available at no cost to veterans enrolled for care in the VA Sunshine Healthcare Network (VISN 8).
- All FDVA and VA facilities remain fully operational.

DEPARTMENT OF MILITARY AFFAIRS

- There have been over 200 Florida National Guardsmen placed on state active duty in support of COVID-19.
- The Florida National Guard is activating all of their medical professionals (Army Combat medic specialists and Air Force medical technicians) to support Florida Department of Health's drive-through screening operations. Guardsmen have reported in and formed Task Force Medical already.
- The Florida National Guard has activated soldiers to augment the State Logistics Readiness Center in Central Florida.

VOLUNTEER FLORIDA

- Volunteer Florida is working with state counterparts and FEMA to develop volunteer plans.
- Volunteer Florida's National Service Department has discussed using AmeriCorps members in food banks as feeding needs increase.
- Volunteer Florida is having conversations with Mass Care on the anticipated needs of volunteers. Together, we are working on a plan for volunteers with volunteer safety guidelines to ensure that we are protecting our service providers (volunteers and clients).
- Volunteer Florida has asked all Voluntary Organizations Active in Disaster (VOAD) partners to review their continuity of operations so that there is no service delivery disruption.

FLORIDA DEPARTMENT OF EDUCATION

- Commissioner of the Florida Department of Education (FDOE) Richard Corcoran provided strong recommendations for extending spring break following Centers for Disease Control and Prevention (CDC) issuing guidance specific to COVID-19 in Florida. As all Florida school districts and public charter schools have different schedules, please click here to see the recommended spring break changes for each district. In addition, the department also announced that the start of state testing will be delayed by a minimum of two weeks. To stay up to date on school closure information, visit: org/em-response.
- FDOE sent updated guidance to school districts and superintendents ahead of spring break. To view that memo, visit: fldoe.org/em-response.
- In an effort to be proactive, and only as a precautionary measure if COVID-19 evolves in Florida, Florida Virtual School (FLVS) has partnered with the Florida Department of Education to offer all school districts student support and teacher professional development tailored to the online learning environment. The Florida Department of Education in partnership with FLVS is training an additional 10,000 teachers statewide on the Virtual Teacher Training for COVID-19. Superintendents who are interested in offering their teachers the Virtual Teacher Training for COVID-19 should work with their County Virtual Principals to provide a list of teachers to FLVS through: https://www.flvs.net/FLVSTeacherTraining.
- Education Commissioner Corcoran is in constant communication with Florida Superintendents and districts to provide guidance on COVID-19 preparedness and response and will be holding weekly calls to update districts on preparation efforts.
- FDOE has sent weekly memos providing updates to school districts, superintendents, Florida Colleges, parents, teachers and stakeholders.
- FDOE launched a survey to school districts and public charter schools about their preparations, policies, and their capacity to serve their students virtually to help meet and determine any preparedness needs.

STATE UNIVERSITY SYSTEM

- The State University System will continue to evaluate the effectiveness of remote learning and the need to teach remotely in order to protect our students and the university community.
- The State University System will continue to work with the Florida Department of Health and the Emergency Operations Center to determine if the initial two weeks of remote learning is sufficient.
- Effective immediately, all universities will make plans to transition to remote instruction as soon as possible.
- State universities with students who have returned from spring break, which includes Florida Gulf Coast University, Florida International University, Florida Polytechnic University, and the University of Florida, should implement a process to transition to remote instruction immediately and encourage students to return home for at least 2 weeks. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- State universities with students who are currently on spring break or about to be on break should direct their students to NOT return to campus for at least 2 weeks following the conclusion of spring break. This includes students at Florida Agricultural and Mechanical University, Florida Atlantic University, Florida State University, New College of Florida, the University of North Florida, the University of Central Florida, the University of South Florida, and the University of West Florida. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- RESIDENTIAL HOUSING - While students are encouraged to remain off-campus, each university should develop a plan for providing

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residential accommodations for students who need assistance or must remain in place.
- All state universities have implemented campus-wide critical incident or emergency management teams that are meeting regularly to prepare for the impacts of the COVID-19 virus.
- All universities are preparing to transition to remote instructional delivery for a two-week period during March and early April, depending on each institution's Spring Break, and are informing students not to return to campus during this period.
- The Board of Governors will be conducting its March meeting via conference call and will not have a face-to-face meeting at USF as was originally scheduled.
- For more information visit: https://www.flbog.edu/2020/03/11/state-university-system-statement-on-covid-19/.

FLORIDA DEPARTMENT OF CORRECTIONS

- Florida Department of Corrections (FDC) has no known or suspected cases of COVID-19 within its correctional institutions at this time.
- FDC Community Corrections officers are working with offenders on supervision to adjust reporting schedules to minimize congregating at probation offices and prevent the spread of COVID-19.
- FDC's Office of Health Services coordinates with the Department for guidance on any type of outbreak and is closely monitoring new information as it is disseminated from the Department and the CDC.
- FDC has suspended visitation at all correctional institutions statewide through April 5, 2020. The decision to reinstate the normal visitation schedule will be evaluated in consultation with the Department.
    - Inmates will continue to have access to mail, email, phone calls and video visitation.
    - Legal visits will not be impacted.
    - FDC has partnered with vendors to provide some complimentary phone and video visitation services.
- Anyone entering a correctional institution will be screened, and entrance will be restricted if they:
    - Have traveled internationally or on a cruise within the last 14 days.
    - Have signs or symptoms of a respiratory infection such as fever, cough or shortness of breath.
    - Have had contact with someone who has been or is under investigation for COVID-19.
- All non-critical inmate transfers have been suspended.
- FDC has a plan in place and dedicated staff members trained in the prevention and containment of infectious diseases.
- FDC initiated its Incident Command System in response to COVID-19.
- Education has been provided to staff, inmates and visitors to prevent the spread of any infectious disease, including COVID-19.
- Precautions are in place at facilities to protect inmates and staff from exposure to flu, COVID-19 or any other respiratory illness; preventative measures are being followed per CDC recommendations.

FLORIDA DEPARTMENT OF STATE

- The Division of Elections offers a toll-free Voter Assistance Hotline, 1.866.308.6739 (in English and Español), available Monday - Friday, 8:00 am - 5:00 pm ET, with extended hours during statewide elections. For hearing or speech impaired, please contact the Division using the Florida Relay Service, 1.800.955.8771 (TDD), 1.800.955.8770 (Voice), or 1.877.955.8773 (Español). Voters can also contact their local Supervisor of Elections
- The Florida Department of State is in constant communication with Supervisors of Elections regarding Tuesday's Presidential Preference Primary Election and is providing guidance and information to voters through traditional and social media messages:
- The Florida Department of State been informing voters of the various options Florida provides in order to cast their ballot ahead of Tuesday's election and on Election Day. Further, we have assured Florida's voters that otherwise healthy poll workers can work on Election Day. DOS has notified voters who have been ordered to self-isolate or who are experiencing symptoms of COVID-19 and who have not yet voted, of the option to have someone pick up their ballot for them.
    - As with any election, before a voter goes to the polls on Tuesday, they should check with their local Supervisor of Elections. Now more than ever, it is critical that we continue to provide voters with clear and consistent information regarding polling place locations. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be on the voter's respective **Supervisor of Elections website**.
    - The Division of Elections website provides prominent placement of the Voter Information Lookup where voters can check their voter status and find their polling place information. This polling place information is linked to the voters' respective Supervisor of Elections database. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be from the voter's respective **Supervisor of Elections.**
- The Florida Department of State continues to support and work with local Supervisors of Elections and Emergency Management officials to ensure the Supervisors needs are met regarding sanitization and cleaning needs for the Presidential Preference Primary Election on Tuesday.

FLORIDA DEPARTMENT OF TRANSPORTATION

- FDOT is coordinating with other state and local agencies to help ensure mobility around the temporary testing site in Broward County. Once the site is open, FDOT plans to publicize testing site information on highway advisory radio.
- FDOT completed a request to provide necessary supplies to harbor pilots working at seaports.
- At the direction of Governor DeSantis, Florida Department of Transportation (FDOT) Secretary Kevin J. Thibault, along with Surgeon General Dr. Scott Rivkees, hosted a conference call with all Florida ports and their governing bodies as well as all public use airports to discuss Florida's ongoing response to the COVID-19 virus.
- FDOT Secretary Thibault and staff from the department will host weekly conference calls with all passenger seaports and public use airports to provide updates related to COVID-19.
- FDOT is monitoring temporary lane closures near hospitals and Department of Health facilities. If congestion near these facilities and lane closures occur, FDOT will remove lane restrictions to help ensure mobility within the area.
- Pursuant to Executive Order 20-52 issued by Governor DeSantis, FDOT Secretary Thibault has suspended size and weight restrictions for divisible loads on any vehicles transporting emergency equipment, services, supplies, and necessary agricultural commodities on state roads.
- COVID-19 educational materials have been posted in FDOT facilities, which include welcome centers, service plazas and rest areas across the state.
- COVID-19 materials have been posted at all FDOT work sites across the state to help educate contractors, vendors, and stakeholders.
- FDOT toll collectors have been given additional training and are required to wear gloves as well as continue with enhanced cleansing.
- SunRail has posted COVID-19 educational materials inside all trains and on all platforms, focusing on areas near entrances and bathrooms.
- SunRail trains are being cleaned and sanitized daily and SunRail staff have been provided sanitizing towelettes and encouraged to wash their hands frequently throughout the day.

FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

- At the direction of Governor Ron DeSantis, Florida Department of Highway Safety and Motor Vehicles Executive Director Terry L. Rhodes has issued an Emergency Order extending all Florida driver licenses and identification cards that will expire in the next 30 days.
- Pursuant to Executive Order 20-52, FLHSMV Executive Director Rhodes waived commercial truck hours of service regulations and other related regulations so that emergency supplies, equipment, commodities and resources can be moved more quickly and efficiently throughout the state.
- FLHSMV continues to encourage Floridians through social media and other channels to use convenient online options, rather than visiting an

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office location, to complete transactions for driver licenses, ID cards, motor vehicle or vessel registrations, and more.
- FLHSMV has been in regular communication with the Florida Tax Collectors Association as well as Tax Collectors across the state to provide the latest COVID-19 information and guidance from the Florida Department of Health and other state partners.

DEPARTMENT OF ECONOMIC OPPORTUNITY

- Governor DeSantis has requested the federal Small Business Administration (SBA) make the Economic Injury Disaster Loan program available for Florida's small businesses impacted by COVID-19. The Florida Department of Economic Opportunity (DEO) stands ready to assist Florida's small businesses in accessing this funding when available.
- Governor Ron DeSantis has activated the Business Damage Assessment survey to assess the impact of COVID-19 on Florida's local business operations. The survey, managed by DEO, will evaluate businesses affected by COVID-19 and the impacts the virus has had on the local economy so actions to implement appropriate relief programs can begin. The survey can be taken online at https://floridadisaster.biz/.

VISIT FLORIDA

- VISIT FLORIDA is wholly focused on providing health and safety information to travelers and Floridians. This includes the activation of Florida Now, which includes the latest updates from state emergency response professionals hosted on VisitFlorida.com.
- VISIT FLORIDA is planning for future marketing campaigns to ensure that Florida's tourism industry has a strong, unified voice following COVID-19
- To protect the health and safety of the traveling public and staff, VISIT FLORIDA's four welcome centers will be closed until further notice.
- VISIT FLORIDA is tracking traveler sentiment across online platforms and social media to monitor how COVID-19 may impact travel and travel booking to Florida.
- VISIT FLORIDA remains in close contact with industry partners and travel organizations and is communicating all new information as it becomes available.

DEPARTMENT OF REVENUE

- The Department of Revenue is advising child support customers who are scheduled for court hearings related to their child support cases to check with the local courts where the hearings are scheduled in case the courts have new requirements, such as appearing telephonically.
- The Department of Revenue's Child Support Program is working to reduce when customers are required to visit a local child support office and is providing new connect/customer service options.
- Efforts include rescheduling genetic testing sample collection appointments and postponing other types of appointments. The Program will soon be implementing the ability for parents to enter into written agreements over the phone, and the Program will be providing new fax, email and form drop-off processes.
- The Department of Revenue's General Tax Administration (GTA) program is working with its tax processing vendor to ensure continuity in tax data and payment processing.
- GTA is closely monitoring any future guidance issued by the Internal Revenue Service for potential corporate income tax due date extensions.
- The Department has increased messaging on preventative measures through the deployment of DOH/CDC posters, ensured hand sanitizer is available, and increased cleaning of high-traffic areas in our public areas of our service centers.

OFFICE OF INSURANCE REGULATION

- The Office of Insurance Regulation (OIR) Insurance Commissioner David Altmaier is actively engaged with insurers and key partners at the state and national level regarding COVID-19. Commissioner Altmaier is collaborating with other state insurance commissioners and the National Association of Insurance Commissioners to share information and resources.
- OIR has issued Informational Memorandum OIR-20-01M to all health insurers and health maintenance organizations, directing them to:
  - Use every channel available to them to communicate with their policyholders and share official CDC and Department of Health information;
  - Devote resources to inform consumers of available benefits, quickly respond to inquiries, and avoid and dispel misinformation;
  - Work with public health officials to do everything possible to prepare and respond; and
  - Consider all practicable options to reduce the barriers of cost-sharing for testing and treatment of COVID-19.
- OIR is reaching out to insurers regarding their response to COVID-19 and working with insurers to make sure they are properly communicating to consumers.
- OIR has activated its incident management team and has met to review disaster response procedures.
- OIR has issued Informational Memorandum OIR-20-02M as a reminder to all health insurers, health maintenance organizations and other health entities to allow for early prescription refills following the Governor's Executive Order 20-52 declaring a state of emergency in Florida.
- OIR has spoken with multiple insurers who are voluntarily waiving cost-sharing for consumers in an effort to remove barriers to testing for COVID-19.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

- Florida Department of Law Enforcement (FDLE) is working with state and local agencies and the Florida National Guard to set up testing collection sites in multiple locations across Florida.

- The Florida Department of Law Enforcement (FDLE) Regional Operations Centers are working with Regional Domestic Security Task Forces to prepare for any responses needed.

- FDLE's Office of Mutual Aid prepared and distributed a law enforcement guide on COVID-19 for law enforcement partners and state agencies and FDLE's General Counsel prepared a law enforcement guide for protocols in a quarantine.

- FDLE Commissioner Rick Swearingen sent an email to all members outlining simple ways to prevent the spread of COVID-19 as well as links to the Florida Department of Health and CDC websites. Signs have been posted in all FDLE Regions and at Headquarters with prevention information.

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

- The Florida Department of Juvenile Justice's Office of Health Services developed COVID-19 guidance for all facilities serving DJJ youth. This guidance included Center for Disease Control criteria on how to assess and care for youth who are exhibiting fever and respiratory symptoms and environmental cleaning and disinfection recommendations.

- The Florida Department of Juvenile Justice has modified screening protocols and procedures for youth taken into custody by law enforcement who are brought to juvenile assessment centers and detention screening units to now include precautionary coronavirus screening questions and protocols. This modified screening protocol was shared with law enforcement partners statewide.

- The Florida Department of Juvenile Justice has developed a visitor screening tool which is now mandatory to use inside of our juvenile detention centers and residential commitment programs to ensure both the safety of the youth and staff in these programs. The

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Florida Department of Juvenile Justice has sent a notice to parents and guardians of youth in programs regarding the new visitor screening requirements.

- The Florida Department of Juvenile Justice has instituted additional screening measures for outside vendors who work within juvenile facilities and non-essential travel of staff members has been stopped. Visitors are limited to business-related visitors only (i.e., vendors, no personal visitors, no volunteers at this time). The department will work with these entities on alternatives to visiting programs to ensure critical services are not interrupted. Clinical personnel, however, are still permitted to visit youth for treatment purposes, and attorneys are still permitted to conduct legal visits with youth.

FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

- Governor DeSantis directed all agencies to suspend for 30 days licensing and registration renewal requirements for existing processional licenses (e.g. realtors).
- Governor DeSantis has directed the Department of Business and Professional Regulation Secretary Halsey Beshears, in coordination with the Florida Department of Health, to issue social distancing guidance to restaurants and bars.
- Governor DeSantis sent a letter to the federal Small Business Administration to turn on the SBA loan program for small businesses.
- The Florida Department of Business and Professional Regulation (DBPR) has suspended all official business visits, including inspections, that involve licenses located at a facility covered under the visitation restrictions implemented pursuant to FDEM Emergency Order 20-002.
- DBPR is incorporating informational comments on all on-site inspection reports issued to public lodging, public food service, and alcohol and tobacco license holders that will promote situational awareness of the current public health emergency and will direct parties to the FDOH COVID-19 webpage for guidance and resources related to prevention best practices. Copies of informational flyers from the FDOH COVID-19 toolkit will also be available for inspectors to distribute when interacting with managers of these premises.

FLORIDA DEPARTMENT OF MANAGEMENT SERVICES

- Governor DeSantis directed the Department of Management Services Secretary Jonathan Satter to allow state employees to donate and transfer their available leave time to other state employees to mitigate the impacts of school closures.
- The Florida Department of Management Services' (DMS) Emergency Support Function-7 (ESF-7) Logistics team continues to coordinate with the Department of Health and the Division of Emergency Management on identifying the equipment or supplies that may be necessary for a mass response to COVID-19.
- DMS' Division of Human Resource Management has provided guidance to agencies on implementing preventive actions in the workplace, reporting symptoms, using leave, utilizing health insurance benefits, and applying travel restrictions and telework policies.
- DMS' Division of State Group Insurance continues to coordinate with health plan providers to ensure that state employee health plan members receive the health benefits that can assist them and their dependents if needed.
- DMS' Division of Real Estate Development and Management (REDM) continues to provide guidance to agency facility managers across the state on steps to take to prevent workplace contamination and to pre-position environmental vendors to mobilize in the event a viricidal cleaning is needed.
- DMS' Division of Real Estate Development and Management continues to identify, purchase, and distribute additional hand sanitizing gel and cleaning supplies to state-maintained facilities.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with users and vendor of the Statewide Law Enforcement Radio System (SLERS) vendors to ensure the continuation of mission critical services if a reduction of staffing resources occurs.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with statewide public safety communications personnel on their plans to ensure emergency communications systems are not impacted by potential reductions in staffing resources.

FLORIDA DEPARTMENT OF ENVIRONMENTAL PROTECTION

- All State Parks have adjusted their operating hours to 8 a.m. to 5 p.m. daily. The Department continues to monitor new developments closely and will make further adjustments as necessary based on any new Department of Health or CDC guidance received to ensure protection of our staff and visitors. For the latest information on park operating hours and operational status, please visit floridastateparks.org.
- Currently all Florida State Parks and campgrounds, and Office of Resilience and Coastal Protection facilities (aquatic preserves and National Estuarine Research Reserves), remain open to the public. However, in an abundance of caution and consistent with Center for Disease Control and Prevention (CDC) guidance, DEP announced on March 13 that it is cancelling all events and activities at these facilities effective immediately and until further notice.
    - This includes DEP events and includes activities such as tours and visitor centers that involve large groups and/or or people in close proximity to others. People with questions regarding any privately scheduled event should check with the host of the event or the facility directly. For the latest closure and cancellation information, please visit floridastateparks.org.
- If your travel plans have changed and you need to modify camping or cabin reservations, please visit ReserveAmerica.com, call Reserve America at 1-800-326-3521 or TDD 888-433-0287 or text to 904-204-3216.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Updated HCP Risk Assessment

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Date: Thursday, March 5, 2020 12:08:35 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:03 AM
Subject: FW: Updated HCP Risk Assessment
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson

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FYI for health care facilities. Latest CDC guidance on health care worker exposures.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
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Office: 850-595-6500 xt1001

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 5, 2020 8:25 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: FW: Updated HCP Risk Assessment

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Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Wednesday, March 04, 2020 7:22 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>
Subject: Updated HCP Risk Assessment

Hi Scott,

We want to alert you to the release of CDC's updated **Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)** now available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

There are several changes we want to highlight in the new guidance compared to the old guidance:

1. **In regards to conducting risk assessments for healthcare personnel (HCP) for areas with community transmission**: For areas within the U.S. that are demonstrating community transmission, all healthcare personnel (HCP) are considered at some risk for COVID-19 whether through patient interactions or from general community interactions. In these instances, devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities. Instead, facilities may decide to shift their emphasis to more routine

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practices, which includes asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not reporting to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP.

2. **In regards to HCP furlough:** The old guidance recommended work restrictions for HCP with medium or high risk exposure. In the new guidance, facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.
3. **If a risk assessment is pursued for exposed HCP:**

    a. Table 1. *Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations* has been simplified with a focus on presence/absence of source control measures; use of personal protective equipment (PPE) by HCP; and degree of contact with the patient (i.e., prolonged versus brief).
    b. In addition, for those who are assessed as requiring "self-monitoring with delegated supervision" the requirement to actively verify absence of fever and respiratory symptoms when healthcare personnel (HCP) report for work is now optional.
    c. The category of HCP who fully adhered to recommended PPE was removed from Table 1. but is still addressed under section III, #3. These HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

Please let us know if you have any questions. We are always happy to chat.

Best,

Elizabeth, Shelley, and Sarah

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawls; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas; Wyatt Barton

Subject: Fwd: FW: Updated HCP Risk Assessment

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Date: Thursday, March 5, 2020 12:08:34 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:03 AM
Subject: FW: Updated HCP Risk Assessment
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson

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<tanderson@healthcarewithinreach.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A <Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

FYI for health care facilities. Latest CDC guidance on health care worker exposures.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 5, 2020 8:25 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: FW: Updated HCP Risk Assessment

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Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Wednesday, March 04, 2020 7:22 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>
Subject: Updated HCP Risk Assessment

Hi Scott,

We want to alert you to the release of CDC's updated **Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)** now available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

There are several changes we want to highlight in the new guidance compared to the old guidance:

1. **In regards to conducting risk assessments for healthcare personnel (HCP) for areas with community transmission**: For areas within the U.S. that are demonstrating community transmission, all healthcare personnel (HCP) are considered at some risk for COVID-19 whether through patient interactions or from general community interactions. In these instances, devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities. Instead, facilities may decide to shift their emphasis to more routine

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practices, which includes asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not reporting to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP.

2. **In regards to HCP furlough:** The old guidance recommended work restrictions for HCP with medium or high risk exposure. In the new guidance, facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.
3. **If a risk assessment is pursued for exposed HCP:**

    a. Table 1. *Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations* has been simplified with a focus on presence/absence of source control measures; use of personal protective equipment (PPE) by HCP; and degree of contact with the patient (i.e., prolonged versus brief).
    b. In addition, for those who are assessed as requiring "self-monitoring with delegated supervision" the requirement to actively verify absence of fever and respiratory symptoms when healthcare personnel (HCP) report for work is now optional.
    c. The category of HCP who fully adhered to recommended PPE was removed from Table 1. but is still addressed under section III, #3. These HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

Please let us know if you have any questions. We are always happy to chat.

Best,

Elizabeth, Shelley, and Sarah

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Blackmore, Carina
To: Vuong, Nga (CDC/OID/NCEZID) <ypg2@cdc.gov>
Cc: Clark, Marah
Subject: Fwd: Florida Hurricane Crisis CoAg Vector Control Project
Date: Friday, February 28, 2020 12:07:12 PM

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From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Monday, February 24, 2020 12:25 PM
To: Wallace, Marla D.; Clark, Marah
Cc: DSLRCrisisCoag (CDC); Stanek, Danielle R; Morrison, Andrea; Blackmore, Carina; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project

Good Afternoon Marla, Marah,

After speaking with OGS, the recommendation is for the State of FL to move forward with submitting the request as an official amendment in GrantSolutions.

Using official state letterhead, a process which you should be familiar, I would strongly advise breaking down the following:

- Show what the prior activities and amounts were (and why they are no longer feasible)
- Show what the new activities and amounts are (and how they are supported under the NOFO)
    - For the trailers, please be sure to provide ample justification and if possible necessary specs, quotes, and vendors. The more thoroughly tied to the NOFO, the more helpful it will be.

If you need any assistance, or would like me to view the official draft prior to submission, I would be happy to review.

Kind regards,
Kevin Sevak

From:
Sent: Monday, February 24, 2020 1:59 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Good Afternoon,

In order for CDC To make an informed decision regarding their proposed request an official request should be submitted to CDC via grant solutions.

Damond

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Friday, February 21, 2020 1:54 PM
To: Barnes, Damond (CDC/OCOO/OFR/OGS) <xhp5@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>

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Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project
Importance: High

Good afternoon Damond,

I am reaching out to you on behalf of Sabrina Hansen, who is the Project Officer for Florida under Hurricane Crisis CoAg TP18-1802. Sabrina is currently supporting Coronavirus response activities.

Her jurisdiction has requested a redirection of funds for two activities. Prior to submission into GMM we were wanting to get some feedback. The first of which is straight forward, but the second may require more attention.

The request entails that funds would actually be staying in the same budget category, however they are proposing a chance in two activities.

1. The first is to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control. The justification they provided aligns with Domain 5 of approved activities under the grant. I found this to be an allowable use of funds, but wanted to get your concurrence. More information on this can be found highlighted in this color below.

2. Secondly, FL is proposing to purchase two trailers: One trailer to move equipment around the county, increasing their capacity in post storm treatment response. The other is interested in using the trailer to educate their constituents. Detailed justification and estimates can be found attached. I have requested quotes and further information already, but sought your advice on such a purchase. Further justification on this can be found **attached** and below in this color.

Thank you for all your help!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@freshfromflorida.com>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

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Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) [mailto:ydh1@cdc.gov]
Sent: Friday, February 14, 2020 1:13 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing **LA**'s vector project needs and are proposing some alternative use of funds. **Do you means FL?**

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

In other words, we need to see clearly see what the money was originally approved for, and how much, and where the money is going toward now, how much, justifications, and associated quotes… Based on that, we will review and get the necessary prior approval, and if approved, have the appropriate changes documented in GMM.

Please let me know if this makes sense. Thank you!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

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From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share

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best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: Long Term Care Resources for Pandemic Planning

AMERICAN OVERSIGHT

Date: Friday, February 21, 2020 12:58:30 PM

please see attached information and checklist on pandemic preparedness
thank you

---------- Forwarded message ---------
From: **Cooksey, Samantha** <Samantha.Cooksey@flhealth.gov>
Date: Thu, Feb 20, 2020 at 2:35 PM
Subject: Long Term Care Resources for Pandemic Planning
To: Melanie Motiska <MMotiska@fhca.org>, Bob Asztalos <basztalos@fhca.org>, Laura MacLafferty <Laura.MacLafferty@ahca.myflorida.com>, StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>, Pritchard, Scott <Scott.Pritchard@flhealth.gov>

Long Term Care Partners,

Hope things are well with you all. As I am sure you are aware, the Department has activated an incident management team for responding to the novel coronavirus COVID-19. While we have no cases in Florida, we are taking this opportunity to review pandemic preparedness plans should this outbreak escalate to a global pandemic.

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AMERICAN OVERSIGHT

Can you all share with long term care facilities and/or post this resource on your websites? Thank you.

Samantha Cooksey Strickland

Alternate Emergency Coordination Officer

State ESF8 Planning & Operations Section Manager

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email| Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: More COVID-19 references

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Date: Tuesday, March 3, 2020 2:44:14 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 3, 2020 at 12:14 PM
Subject: More COVID-19 references
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>,

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https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-for-schools.html

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html

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Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

"Children are one third of our population and all of our future." The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

"I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character." Martin Luther King, Jr.

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regarding state business are public records available to the public and media upon request. Your email

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communication may therefore be subject to public disclosure.

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: More COVID-19 references

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Date: Tuesday, March 3, 2020 2:44:13 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 3, 2020 at 12:14 PM
Subject: More COVID-19 references
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https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-for-schools.html

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html

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Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

"Children are one third of our population and all of our future." The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

"I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character." Martin Luther King, Jr.

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communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

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Subject: Fwd: Note Coronavirus self-checker at this URL
Date: Monday, March 23, 2020 4:14:10 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 23, 2020 at 1:55 PM
Subject: Note Coronavirus self-checker at this URL
To: (m.brandhorst@yahoo.com) <m.brandhorst@yahoo.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, abe singh <execdir@areahousing.org>, PRINCIPE, ADAM <aprincipe@selectmedical.com>, Alain Espinosa <aespinosa@myescambia.com>, Alex Nettles <Frederick.Nettles@va.gov>, Amanda Armstrong <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Andy Hobbs (anhobbs@escambiaso.com) <anhobbs@escambiaso.com>, Angela.Strumeyer@myflfamilies.com <Angela.Strumeyer@myflfamilies.com>, Anges Rivers <arivers@healthcarewithinreach.org>, Hill, Ann <ann.echcc@gmail.com>, Anthony Manning <dc18@myescambia.com>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brad Hattaway <Brad_Hattaway@co.escambia.fl.us>, Brenda Van Brussel (CDC) <BVANBRUSSEL@escambiaclerk.com>, Brian Allen Waters <bwaters@waterfrontmission.org>, Brian Wyer <bwyer@gcmcc.info>, Brittany Johnson <b.n.johnson@cox.net>, Brock Dester <hdester@cityofpensacola.com>, Bruce Watson (Bwatson@elcescambia.org) <Bwatson@elcescambia.org>, Byron Burkhart <bburkhart@cityofpensacola.com>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Casey Boatwright <ccboatwright@myescambia.com>, Casey Richards <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, charlotte mccorvey <mccorveycx@gmail.com>, Chip Campbell <chip.campbell2@gmail.com>, Christine Crespo <cmcrespo@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Craig Ammons <cammons@myescambia.com>, d. Marcus <dmarcus@bop.gov>, Dale Flynn <dflynn@cityofpensacola.com>, Dale Simmons <dsimmons@hillcrestchurch.com>, Danny Marcus <danny.marcus123@yahoo.com>, David Conkle <missbabbie@att.net>, David Stafford <soe@escambiavotes.com>, Dawn Engel <dengel@elcescambia.org>, Debbie Chavers <dchavers@pediatricassociatespa.com>, Debbieray Kings <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Derek Pratt <dpratt@cityofpensacola.com>, Devin Simmons <Dsimmons@waterfrontmission.org>, Diane Wilkinson <dmw101@ufl.edu>, District 1 <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, Doug Underhill <district2@myescambia.com>, Dr. Kelli Wells <doctorkelli@live.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric Gilmore (egilmore@myescambia.com) <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Erin Jeffreys <erinejeffreys@gmail.com>, Esc County Administrator <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, Frederick Henderson <fhenderson@waterfrontmission.org>, Freer, Christine M <Christine.Freer@flhealth.gov>, gay Nord <gay.nord@hcahealthcare.com>, George Smith, MD <gsmith@healthcarewithinreach.org>, Ginny Carnor <gcraner@cityofpensacola.com>, Giny Cranor <GCranor@cityofpensacola.com>, Gordon, David D

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https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html

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Mission: "To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

"Children are one third of our population and all of our future." The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

"I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character." Martin Luther King, Jr.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email

communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Hill, Ann

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Subject: Fwd: Note Coronavirus self-checker at this URL
Date: Monday, March 23, 2020 4:14:18 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 23, 2020 at 1:55 PM
Subject: Note Coronavirus self-checker at this URL
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https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html

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Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

"Children are one third of our population and all of our future." The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

"I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character." Martin Luther King, Jr.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email

communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
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From: Ann Hill

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Subject: Fwd: Note Coronavirus self-checker at this URL
Date: Monday, March 23, 2020 4:14:10 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 23, 2020 at 1:55 PM
Subject: Note Coronavirus self-checker at this URL
To: (m.brandhorst@yahoo.com) <m.brandhorst@yahoo.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, abe singh <execdir@areahousing.org>, PRINCIPE, ADAM <aprincipe@selectmedical.com>, Alain Espinosa <aespinosa@myescambia.com>, Alex Nettles <Frederick.Nettles@va.gov>, Amanda Armstrong <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Andy Hobbs (anhobbs@escambiaso.com) <anhobbs@escambiaso.com>, Angela.Strumeyer@myflfamilies.com <Angela.Strumeyer@myflfamilies.com>, Anges Rivers <arivers@healthcarewithinreach.org>, Hill, Ann <ann.echcc@gmail.com>, Anthony Manning <dc18@myescambia.com>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brad Hattaway <Brad_Hattaway@co.escambia.fl.us>, Brenda Van Brussel (CDC) <BVANBRUSSEL@escambiaclerk.com>, Brian Allen Waters <bwaters@waterfrontmission.org>, Brian Wyer <bwyer@gcmcc.info>, Brittany Johnson <b.n.johnson@cox.net>, Brock Dester <hdester@cityofpensacola.com>, Bruce Watson (Bwatson@elcescambia.org) <Bwatson@elcescambia.org>, Byron Burkhart <bburkhart@cityofpensacola.com>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Casey Boatwright <ccboatwright@myescambia.com>, Casey Richards <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, charlotte mccorvey <mccorveycx@gmail.com>, Chip Campbell <chip.campbell2@gmail.com>, Christine Crespo <cmcrespo@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Craig Ammons <cammons@myescambia.com>, d. Marcus <dmarcus@bop.gov>, Dale Flynn <dflynn@cityofpensacola.com>, Dale Simmons <dsimmons@hillcrestchurch.com>, Danny Marcus <danny.marcus123@yahoo.com>, David Conkle <missbabbie@att.net>, David Stafford <soe@escambiavotes.com>, Dawn Engel <dengel@elcescambia.org>, Debbie Chavers <dchavers@pediatricassociatespa.com>, Debbieray Kings <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Derek Pratt <dpratt@cityofpensacola.com>, Devin Simmons <Dsimmons@waterfrontmission.org>, Diane Wilkinson <dmw101@ufl.edu>, District 1 <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, Doug Underhill <district2@myescambia.com>, Dr. Kelli Wells <doctorkelli@live.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric Gilmore (egilmore@myescambia.com) <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Erin Jeffreys <erinejeffreys@gmail.com>, Esc County Administrator <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, Frederick Henderson <fhenderson@waterfrontmission.org>, Freer, Christine M <Christine.Freer@flhealth.gov>, gay Nord <gay.nord@hcahealthcare.com>, George Smith, MD <gsmith@healthcarewithinreach.org>, Ginny Carnor <gcraner@cityofpensacola.com>, Giny Cranor <GCranor@cityofpensacola.com>, Gordon, David D

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https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html

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John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director and Health Officer
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1000

Cell: 850-528-5201

Follow us on Twitter: @HealthyEscambia

Mission: "To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

"Children are one third of our population and all of our future." The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

"I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character." Martin Luther King, Jr.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email

communication may therefore be subject to public disclosure.

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject:	Fwd: cdc consult
Date:	Wednesday, March 11, 2020 8:55:46 AM

Dr. Blackmore,

We are more than happy to assist and roster a group of CDC SMEs for a call. Just let us know where things land internally for you and what needs, if any, remain.

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Wednesday, March 11, 2020 8:18 AM
To: CDC IMS 2019 NCOV Response Clinical On-Call Unit
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Subject: FW: cdc consult

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 6:44 AM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Yes I believe we do need to circle back. What you describe didn't address the issues at the port itself. Let me check with the health officer first thing

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

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I communicated to our morning team that there was follow up needed with you all. Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: Re: cdc consult

Did you not hear from anyone today?

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

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Caroline Schrodt

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	andy.mullins@adph.state.al.us; Christopher.Shields@cityofchicago.org; Provenzano, Francesca; patrick.ashley@dc.gov; Christie.Luce@flhealth.gov; Scott.Minarcine@dph.ga.gov; Dudley, Matthew - EMS; Lytle, Megan; Denise L. Kelly [KDHE]; RickD.Johnson@ky.gov; Stella Fogleman; Doris Brown; Sherry.adams@maryland.gov; kerin.milesky@state.ma.us; Macqueen, Mary (DHHS); RPongliyab@fsmhealth.fm; cheryl.petersen-kroeber@state.mn.us; Nickelson, Paula; O"Loughlin, Kevin; warren.villagomez@dph.gov.mp; eric.sergeant@nebraska.gov; Malinda Southard; Daly, Elizabeth; Dana.johnson@doh.nj.gov; Christopher.emory@state.nm.us; Primeau, Michael J (HEALTH); bmaldin@health.nyc.gov; jsickler@nd.gov; scotts@health.ok.gov; ritter.udui@palauhealth.org; jcabrera@salud.gov.pr; paul.petersen@tn.gov; jeff.hoogheem@dshs.state.tx.us; Kevin Mcculley; Francine.lang@doh.vi.gov; Halvorson, Clark (CDC doh.wa.gov); donnie.w.haynes@wv.gov; Davidson, Sherri (CDC adph.state.al.us); Aifili Tufa; Louie, Shirley (CDC arkansas.gov); Watt, James (CDC cdph.ca.gov); Abdo, Mark (HHS/); Rachel-Philip, Disney (IHS/ABR/BCH); Davies-Cole, John (CDC dc.gov); Blackmore, Carina (CDC flhealth.gov); Drenzek, Cherie (CDC dph.ga.gov); ann.pobutksy@dphss.guam.gov; Park, Sarah Y., MD; Hahn, Christine G. <ID> (CDC dhw.idaho.gov); Pedati, Caitlin; farah.ahmed@ks.gov; Ratard, Raoult (CDC la.gov); Abdo, Mark (HHS/); Brown, Catherine (DPH); LyonCallo, Sarah (DHHS); Eliaser Johnson; Lynfield, Ruth (CDC state.mn.us); Tan, Christina (CDC doh.state.nj.us); Landen, Michael (CDC state.nm.us); Blog, Debra (CDC health.ny.gov); Layton, Marci (CDC health.nyc.gov); Burnsed, Laurence (CDC health.ok.gov); Dunn, John (CDC tn.gov); Gaul, Linda (CDC dshs.state.tx.us); Ellis, Esther (CDC doh.vi.gov); Lindquist, Scott SL (CDC doh.wa.gov); Dudley, Matthew - EMS; Francine.lang@doh.vi.gov; Louie, Shirley (CDC arkansas.gov); Eliaser Johnson; Williamson, Laura (CDC mt.gov)
Cc:	CDC IMS State Coordination Task Force (SCTF) MCCM LNO; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Tuesday, March 3, 2020 3:09:00 PM

Good Afternoon, We are following up with you on the request below. This is a gentle reminder to provide the outlined information by COB today, March 3, 2020. You can send all responses to **eocsctfmccmlno@cdc.gov** .

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at **eocsctfmccmlno@cdc.gov** .

We appreciate all you are doing to support COVID-19!

Thank you, Devi Hawkins-Prather

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

From: Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
Sent: Friday, February 28, 2020 1:31 PM
To: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Greetings PHEP Directors & State Epidemiologists –

The outbreak of COVID-19 in China has led to a disruption in the global supply chain of personal

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protective equipment (PPE). CDC recognizes that healthcare facilities may experience temporary shortages even if they do not care for patients with COVID-19. CDC has released guidance for optimizing the use of N95 respirators, which includes some recommendations that may be applicable to other types of PPE, including surgical masks. CDC also has guidance regarding who needs and does not need PPE to help prevent excessive use of PPE.

As you are aware, this is a delicate system with many factors. When CDC receives notifications from healthcare systems about supply chain shortages, we encourage the Healthcare Coalition Partners to work together to problem solve within the coalition and/or wider state system. Further we encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

We have heard from the healthcare system partners that have contacted us that they are unsure whom to contact in the state health department about supply chain shortages in their facilities. As a way to help mitigate this, **we are asking you to reply to eocsctfmccmlno@cdc.gov no later than March 3, 2020, with an identified primary and secondary point of contact for any supply chain issues within your state.**
Please provide the following information:

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

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From:	Jacobi, Amy (CDC/DDID/NCEZID/DFWED)
To:	PetersS6@michigan.gov; Stobierski, Mary Grace (CDC michigan.gov); Rebecca.Fugitt@odh.ohio.gov; Bryce.Kerr@odh.ohio.gov; Amanda.Koch@dhs.wisconsin.gov; Irving, Roy (CDC dhs.wisconsin.gov); Jordan.Mason@dhs.wisconsin.gov; Sarah.Koske@dhs.wisconsin.gov; Andy.Reich@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); Goff, Kendra (CDC flhealth.gov); Monika.Pitts@flhealth.gov; Michael.Balda@flhealth.gov; Michael.Mitchell@flhealth.gov; Elke.Ursin@flhealth.gov; Rick.Clark@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Dawn.Blackburn@flhealth.gov; CURTIS.G.CUDE@dhsoha.state.or.us; Rebecca.Hillwig@dhsoha.state.or.us; Fill, Margaret (CDC tn.gov); Jane.Yackley@tn.gov; Judy.Manners@tn.gov
Cc:	Roberts, Virginia (CDC/DDID/NCEZID/DFWED); Vigar, Marissa (CDC/DDID/NCEZID/DFWED); Luyindula, Dema (CDC/DDID/NCEZID/DFWED) (CTR)
Subject:	HAB Communication Survey from CDC
Date:	Monday, March 2, 2020 12:22:20 PM
Attachments:	HAB Risk Communicaiton Partner Survey_FINAL.docx

Dear colleagues,

We want to hear from you as we plan and develop HAB communication resources to support your work! **Please respond to this survey by March 13** to provide input on the HAB topics, audiences, and communication materials you are most interested in:
https://www.surveymonkey.com/r/Q6FLRY9

Please limit your response to one per state. We would like to hear from everyone that is interested in responding, but we ask that each state compile input from multiple people into one response to the survey. I've attached a Word document version of the survey in case that makes compiling your input easier. The survey should take about 10 minutes or less, and your insight is much appreciated.

Please feel free to reach out with any questions or comments.

Thank you,

Amy Jacobi, MPH
Health Communication Specialist
Waterborne Disease Prevention Branch
Division of Foodborne, Waterborne, and Environmental Diseases
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention
Email: puw6@cdc.gov | Office: 404.718.3715

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From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	HHS Announces Initial Funding to Jurisdictions Supporting COVID-19 Response
Date:	Wednesday, March 4, 2020 2:23:12 PM

Dear Partner –

Today, the U.S. Department of Health and Human Services (HHS), through the Centers for Disease Control and Prevention (CDC) is announcing upcoming action to provide initial resources to a limited number of state and local jurisdictions in support of our nation's response to the coronavirus disease 2019 (COVID-19).

"State and local governments are the backbone of our public health system. They have been essential partners in the ongoing work to contain and mitigate the spread of COVID-19 in the United States," said HHS Secretary Alex Azar. "The Trump Administration is acting swiftly through every avenue we have to ensure state and local governments have the support they need to combat this outbreak."

"CDC is committed to working with state, local, tribal and territorial public health departments to mitigate community spread of novel coronavirus in this nation," said CDC Director Robert R. Redfield, M.D. "Our partners are on the front lines of this response and we support their efforts to increase needed public health capacity to confront the challenges this virus presents."

Using funds provided to CDC through the HHS Secretary's Transfer, CDC will:

- Award an initial $25 million cooperative agreement to the states and local jurisdictions who have borne the largest burden of response and preparedness activities to date. This is an initial award for those jurisdictions who require immediate assistance for activities such as monitoring of travelers, data management, lab equipment, supplies, staffing, shipping, infection control, and surge staffing. Once supplemental funding is provided, support will be provided to all states and local jurisdictions for a variety of critical public health activities.
- Award an initial $10 million cooperative agreement to state and local jurisdictions to begin implementation of coronavirus surveillance across the U.S., building on existing influenza activities and other surveillance systems. This initial award is for a limited number of jurisdictions. Once supplemental funding is provided, additional support will be provided to all states and local jurisdictions to enhancing testing and surveillance.

CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding.

For more information about COVID-19, please visit CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs

AMERICAN OVERSIGHT

U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	HHS Announces Initial Funding to Jurisdictions Supporting COVID-19 Response
Date:	Wednesday, March 4, 2020 2:22:52 PM

Dear Partner –

Today, the U.S. Department of Health and Human Services (HHS), through the Centers for Disease Control and Prevention (CDC) is announcing upcoming action to provide initial resources to a limited number of state and local jurisdictions in support of our nation's response to the coronavirus disease 2019 (COVID-19).

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CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding.

For more information about COVID-19, please visit CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs

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U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

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From:	Mariani, Lisa (HRSA)
To:	Rivkees, Scott A
Cc:	Mariani, Lisa (HRSA); McGough, John (HHS/IEA)
Subject:	HHS Awards Health Centers Funds to Support COVID-19 Response in Florida
Date:	Wednesday, March 25, 2020 2:54:35 PM

Dear Dr. Rivkees,

Yesterday, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), awarded **$4,518,410** to **47** health centers in Florida with funding provided by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. Health center recipients in Florida may use these awards to address screening and testing needs, acquire medical supplies and boost their telehealth capacity in response to the Coronavirus Disease 2019 (COVID-19) pandemic. Recognizing the urgency of the situation, and the important role health centers play in their communities, HHS is making funding for health center recipients in Florida available immediately.

Thank you for your critically important work in responding to the COVID-19 pandemic. The HRSA Office of Regional Operations and HHS Office of the Regional Director are committed to supporting your COVID-19 response efforts. Please do not hesitate to reach out to us with questions, concerns or requests for support and engagement.

Best,

Lisa Mariani
HRSA Regional Administrator, Region 4

John McGough
HHS Regional Director, Region 4

See the HHS press release for more information on these awards:
https://www.hhs.gov/about/news/2020/03/24/hhs-awards-100-million-to-health-centers-for-covid-19-response.html

For a list of all award recipients, visit https://bphc.hrsa.gov/emergency-response/coronavirus-covid19-FY2020-awards.

For more information about COVID-19, visit http://coronavirus.gov/ and https://www.hrsa.gov/coronavirus.

For more information about HRSA's Office of Regional Operations Region 4 visit https://www.hrsa.gov/about/organization/bureaus/oro/region-4.html

For more information about HHS' Regional Offices Region 4 visit https://www.hhs.gov/about/agencies/iea/regional-offices/region-4/index.html

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: HHS COVID-19 Update, 3-25
Date: Wednesday, March 25, 2020 6:47:19 PM

Dear Governor and State Health Officials:

The federal government continues to take aggressive and proactive steps to address the coronavirus (COVID-19) pandemic. The health and safety of the American people is our top priority.

Many of you have been asking how your companies can assist in meeting the needs imposed by this pandemic. This includes everyone from individuals and families, to companies who want to manufacture, donate, or sell PPE and other materials to help the effort.

We have the answer!

How Can You Help? FEMA released information for how to help via donations, volunteering and for the private sector. Their specific guidance includes:

- **Businesses that have medical supplies or equipment to donate** are asked to go to www.fema.gov and provide of the offer through our online medical supplies and equipment form. The direct web link is www.fema.gov/coronavirus/covid-19-donations.
- **Businesses that want to sell medical supplies or equipment** to the federal government, please email specifics to covidsupplies@fema.dhs.gov.
- **Licensed medical volunteers can offer their services** by registering with the Emergency System for Advance Registration of Volunteer Health Professionals. You can access a direct link to do so through fema.gov
- **Donate Blood**: One thing people can do to help is to donate blood. Many blood drives have been cancelled, impacting the supply. Blood donation centers have the highest standards of safety and infection control. To find where you can donate blood, visit redcross.org.

Here are other items released today:

CMS Lessening Provider Financial Burdens: CMS announced modifications to its accelerated /advanced payment programs for health care providers and suppliers experiencing cash flow concerns due to COVID-19. This guidance allows CMS to streamline the payment calculations and eliminates regional office approval and review of supporting documents in an effort to further help providers and lessen their financial hardships.

How to Manage COVID-19 in Correctional and Detention Facilities: CDC published interim guidance to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors.

1.

What to Do If You are A Traveler Returning from a High-Risk Country? CDC has released information on guidance for recommended actions to take upon returning from a high-risk country in terms of isolation procedures and what to do if you are sick.

How to Ensure Your Hospital is Prepared: CDC posted a comprehensive hospital preparedness checklist to help hospitals assess and improve their preparedness for responding to a community-wide outbreak of COVID-19.

Help for Facilities to Assess When to Discontinue Transmission-Based Precautions: To help prevent the spread of the virus that causes COVID-19 in healthcare facilities, CDC released a reference to guide healthcare regarding discontinuing transmission-based precautions and discharging hospitalized patients with COVID-19.

CMS Continues to Approve 1135 Waivers: CMS announced the approval of seven additional state Medicaid 1135 waivers bringing the total to 23 states with approved waivers. The list of states and waivers can be found here.

Updates on How to Collect, Handle, and Test Clinical Specimens: CDC updated their guidance for handling specimens to

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allow for only nasal swabs if a nasopharyngeal is not available when collecting specimens to test for COVID-19. FDA also released new FAQs on diagnostic testing for labs, manufacturers and general questions.

Watch Public Health Leaders Answer Your Public Health Questions:

- How Can You Keep the Most Vulnerable Safe from Coronavirus? (VIDEO)
- How Can You Engage in Social Distancing? (VIDEO)
- Is It Still Safe to Donate Blood? (VIDEO)
- Dr. Deborah Birx: If You Feel Sick, Stay Home (VIDEO)

Stay safe and keep 6 feet away!

Laura

Laura Trueman, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
(202) 690-6060

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Releases Funding and Other Resources for COVID-19
Date: Wednesday, March 11, 2020 3:56:42 PM

Dear Partner –

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19. We highly value our strong ongoing partnership, and hope to continue to be a resource to you as you implement community mitigation techniques. As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

Funding for States to Address COVID-19
Perhaps of keenest interest to you and your health officials is an update on funding for states and communities to address mitigation of COVID-19. Today, the Department of Health and Human Services (HHS) is announcing upcoming action by the Centers for Disease Control and Prevention (CDC) to provide resources to state and local jurisdictions in support of our nation's response to the coronavirus disease 2019 (COVID-19).

The $8.3 billion dollar Supplemental passed by Congress included statutory language which prescribed the exact formula for disbursing the money: states will receive 90% of their 2019 CDC PHEP grants. This marks the first tranche of funding to states from the $8.3 billion supplemental. Today, CDC is contacting State Health Officers to move forward with awarding over $560 million to states, localities, territories, and tribes. CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding. To view the list of CDC funding actions to jurisdictions, click here.

Helping Communities Know Mitigation Strategies
Yesterday, CDC released their "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission." Essentially, this is a guide for communities describing possible mitigation strategies for communities dealing with transmission at three different levels: (1) None/Minimal, (2) Moderate, or (3) Substantial. Community mitigation strategies, which are non-pharmaceutical interventions, are often the most available interventions to help slow the transmission of COVID-19 in communities. The Mitigation Plans include a set of actions that persons and communities can take to slow the spread of respiratory virus infections. The Community Mitigation Plan can be found here.

Guidance on Infection Control For Healthcare Workers
Yesterday, CDC released updated guidance on infection prevention and control recommendations. Healthcare workers are fighting this outbreak on the front lines, and this guidance is intended to provide assistance to healthcare settings that are handling suspected or confirmed cases of COVID-19. This guidance is applicable to all U.S. healthcare settings, but not for non-healthcare settings. There is separate guidance for that. The new guidance on infection control can be found here.

Guidance on Laboratories
The CDC has been actively working to address the need for testing across the country. In addition to public health laboratories, private labs are doing testing. In addition to reviewing

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the Updated Guidance on Evaluating and Testing Persons for Coronavirus Disease 2019, the CDC recently updated the FAQ website for laboratories, and we encourage you to read through the site to answer preliminary questions, though we stand ready to answer other questions that you may have.

OMB Flexibilities

On March 9, 2020, OMB issued a memo that provides administrative relief for recipients and applicants of Federal financial assistance who are directly impacted by COVID-19. The grant flexibilities include 10 actions that HHS can take to provide short-term administrative and financial management relief, allowing funds to be awarded quicker and giving grantees the ability to focus on their critical response, research, or services. More information can be found here.

General Preparation Information

On March 9, 2020, the White House Coronavirus Task Force released practical steps that we recommend posting and sharing to keep workplaces, school, home and commercial establishments safe. This information can be found here.

As the President, the Vice President, and the entire White House team continue to stress, the COVID-19 response is a whole-of-government effort. Each department has a number of specific resources. We encourage you to explore those resources as necessary to respond to the situation in your communities.

If you have any questions on these items or other issues, please feel free to reach out.

Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Releases Funding and Other Resources for COVID-19
Date: Wednesday, March 11, 2020 3:55:51 PM

Dear Partner –

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19. We highly value our strong ongoing partnership, and hope to continue to be a resource to you as you implement community mitigation techniques. As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

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If you have any questions on these items or other issues, please feel free to reach out.

Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Statement on Coronavirus Supplemental Request
Date: Monday, February 24, 2020 10:04:25 PM

Dear Partner –

Please find below HHS's statement on the coronavirus supplemental request.

"The Administration has been effectively utilizing all available resources to protect the American people from COVID-19. Today, the White House sent a supplemental request to Congress to make $2.5 billion available for COVID-19 response efforts, including an emergency supplemental appropriation of $1.25 billion. HHS will also use the Secretary's transfer authority to provide needed resources to continue the Department's robust and multi-layered public health preparedness and response efforts – including public health surveillance, epidemiology, laboratory testing, support for state and local governments and other key partners, advanced research and development of new vaccines, therapeutics and diagnostics, advanced manufacturing enhancements, and support for the Strategic National Stockpile."

Read the letter here: https://www.whitehouse.gov/wp-content/uploads/2020/02/Coronavirus-Supplemental-Request-Letter-Final.pdf

Please let us know if there are any questions.

Sincerely,
Darcie

Darcie Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

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From:	Bowen, Virginia B. (CDC/DDID/NCHHSTP/DSTDP)
To:	Heather.Rubino@flhealth.gov
Cc:	Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott; Curns, Aaron (CDC/DDID/NCIRD/DVD); Anderson, Kayla (CDC/DDNID/NCBDDD/DBDID); Roguski, Katherine (CDC/DDID/NCEZID/DFWED); CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Epi TF Data Team; Chow, Nancy Ann Marie (CDC/DDID/NCHHSTP/DTE); Whitham, Hilary (CDC/DDID/NCEZID/DFWED)
Subject:	Helpful documents for submitting COVID-19 cases via CSV upload
Date:	Tuesday, March 3, 2020 2:55:18 PM
Attachments:	Instructions on Submission of CSV Files_2020Feb25.docx PUI_CRF_Short_Form_CSV_Template.csv Copy of 2019-nCoV Data Dictionary_PUI and CRF_2020Feb29v2_highlight.xlsx

Hi, Dr. Rubino,

I got your name from Scott Pritchard and wanted to email you proactively to provide a few helpful documents as you prepare to format your first CSV file for COVID-19 case reporting. These attachments provide helpful information about where and how frequently to send your file, and the attached template provides a clear picture of how your file should formatted. The attached data dictionary in Excel format may also be helpful as you develop your own data collection module.

We would love to schedule a quick 20-minute call with you to discuss these documents and answer any questions you may have.

Please let me know if you might have time to chat tomorrow, **March 4th**.

Regards,
Ginny Bowen

Virginia B. (Ginny) Bowen, PhD, MHS
Lieutenant Commander, U.S. Public Health Service
Deputy Team Lead, Case-Tracking Team
Epidemiology Task Force, CDC COVID-19 Response
Mail: 1600 Clifton Rd., NE; US 12-2; Atlanta, GA 30329

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From: Montgomery, Martha (CDC/DDID/NCHHSTP/DVH)

To: Aaron Otis (CDC.flhealth.gov); "Albertson, Justin"; Traxler, Brannon; Ami.Gandhi@dph.ga.gov; Amy Cox; andrea.romero@state.nm.us; Anh Pham; Arthuro Mehretu; Atkins, Amy (CDC wv.gov); Augustine, Ryan (CDC/DDID/NCHHSTP/DVH); Awwad, Hanan (CDC/DDID/NCIRD/ISD); Bagley, Bobbie; Ballard, Jonathan; Bernard, Kimberly; Blackmore, Carina (CDC.flhealth.gov); Boulanger, Lena; Bradley, Richard; BRANDI.TAYLOR@odh.ohio.gov; brenna.garrett@azdhs.gov; Brett.Nance@doh.nj.gov; Burke, Jill; Calope, Theresa; Cassandra Jones; Haralson, Catherine (CDC tn.gov); Chappell, Shauntrelle L. (CDC/DDID/NCIRD/ISD); Cheney, Leigh A.; Christian Murua; Church, Dan (MA) (CDC state.ma.us); Comstock - CDPHE, Nicole; Crawford, Nathan E. (CDC/DDID/NCIRD/ISD); Dailey, Jason (CDC/DDID/NCIRD/ISD); Daniels, Gayle (CDC/DDID/NCIRD/ISD); DeNubila, Megan; Devin Raman; doh.cdsort@doh.nj.gov; Robinson, Donovan E. (CDC/DDID/NCIRD/ISD); Dr. Marielle Fricchione; Drociuk, Dan (CDC dhec.sc.gov); Eckert, Maribeth (CDC/DDID/NCIRD/ISD); Elizabeth A. Talbot; Eric McIntyre; Fenlon, Nancy (CDC/DDID/NCIRD/ISD); Ferlazzo, Damon (CDC health.mo.gov); Flynn, John M. (CDC/DDID/NCIRD/ISD); Foodborne and Waterborne Diseases - ADHS; Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Frank Welch; Gagner, Alexandra (CDC cityofchicago.org); genny.grilli@state.mn.us; Gray, Christine; greg.stasinos@state.co.us; Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Hagan, Liesl (CDC/DDID/NCHHSTP/DVH); Haley Blake; Haselow, Dirk (CDC arkansas.gov); Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH); Jannifer.Anderson@msdh.ms.gov; Jenna.IbergJohnson@la.gov; jennifer.yara-zelenski@state.co.us; Jervis - CDPHE, Rachel; John Benitez; Joseph, John (CDC odh.ohio.gov); Kavanaugh, Tracy; kerri.brown@state.co.us; Khoury, Jennifer A (CHFS DPH DEHP; Kimberly Hertin; Kittle, Theresa (CDC msdh.ms.gov); kristin.sweet@state.mn.us; Latoya Antoine; Leapley, Andrea C; Lesinger, Cindy (CDC adph.state.al.us); lindsay.bouton@state.ma.us; Lira, Rosa (CDC azdhs.gov); Lovett, Sheila (CDC dph.ga.gov); Mackenzie Tewell; Madoff, Larry (DPH; Mallory, Krystle; Mann, Erin K (DPH; MarciaLevin; marilee.butterfield@azdhs.gov; Marlo Tonge; Martin, Flavia; Martinez, Erica, DOH; McBee, Shannon (CDC wv.gov); Mccombs, Katherine; McCormic, Zachary; McKnight, Harry (CDC/DDID/NCIRD/ISD); Melissa Peek-Bullock; Melissa.A.Scott@wv.gov; Micah King; Michelle Fiscus; Mike Cima, PhD; Miracle, Julie (CHFS-PH; Morse, Darlene; Murphy, Tierney, DOH; nicole.ortiz@state.co.us; Nims, Dawn (CDC illinois.gov); NStone2@isdh.IN.gov; ONeill, Mark; Orkis, Lauren; outbreak@azdhs.gov; Paul.Byers@msdh.ms.gov; Paulk, Jennifer; Paulk, Jennifer L. (CDC/DDID/NCIRD/ISD); Peter Koonz; Petzold, Heidi; Reed, Greg (CDC maryland.gov); Roddy, Margaret (CDC state.mn.us); Rosemary.Kidder@doh.nj.gov; Ruestow, Peter (CDC cityofchicago.org); Saady, Dawn; Graitcer, Samuel B. (CDC/DDID/NCIRD/ISD); Schwartz-Kitchens, Tricia (CDC/DDID/NCIRD/ISD); Schweitzer, Jody (CDC ky.gov); Scott.Pritchard@flhealth.gov; Seal, Shumethia A (DPH; Sean J. Kice; Seeto, Kurt (CDC maryland.gov); Shavetta Conner; Shipp, Rebecca; SHOC Planning; SHOC.Epidemiologist@tn.gov; Sievers, Marla, DOH; Sloat, Ben; Smart, Nia; Sokol, Theresa (CDC la.gov); stacy.hall@la.gov; steven.bors@doh.state.nj.us; Stringer - CDPHE, Ginger; Sullivan, Susan; susan.lett@state.ma.us; Sweigert, Wendy N; Tan, Christina (CDC doh.state.nj.us); Thomas, Jaiju, DOH; Thomasson, Erica (CDC wv.gov); Thoroughman, Douglas (CDC ky.gov); Trefren, Lynn (CDC state.co.us); VanBooven, Jennifer; Victoria Burris; Waller, Kirsten (CDC pa.gov); Weng, Mark (CDC/DDID/NCHHSTP/DVH); West, Angela (CDC vdh.virginia.gov); William Bendik; Wilson, Erica F; Zuwen Qiu-Shultz; Goldoft, Marcia MG (CDC doh.wa.gov); Gonzales, Elysia; Gruber, Joanee (CDC pa.gov); Kline, Kelly; Weltman, Andre (CDC pa.gov); Benjamin.Robison@odh.ohio.gov; Tamara.McBride@odh.ohio.gov; karen.nicosia@odh.ohio.gov; Dana.Perella@phila.gov; Danila, Richard (CDC state.mn.us); Hamilton, Janet (CDC cste.org); Shah, Dhara (CDC cste.org); Kingsbury, Jeff; Rebecca.Sunenshine@maricopa.gov; Mitchell.Lach@maricopa.gov; Brady, Shane (CDC azdhs.gov); scott.hutton@dhw.idaho.gov; Monica Schroeder; New, Sarah@CDPH; Chan, Mary (DOH); Caputo, Christina R; Bontrager, Natalie A; Lydia.m.luther@state.or.us; Town, Cecile (CDC state.or.us); jlatash1 (jlatash1@health.nyc.gov); Kuhles, Daniel J (HEALTH); Anand, Madhu M (HEALTH); Blog, Debra (CDC health.ny.gov); Dufort, Elizabeth M (HEALTH); Talbott, James (CDC state.de.us); nikki.kupferman@delaware.gov; Kenneth Feder -MDH-; Smith, Lou C (HEALTH); Robbins, Amy E (HEALTH); Pulver, Wendy P (HEALTH); emma.weber@cityofchicago.org; amy.eagon@doh.wa.gov; Shauna Douglas -MDH-; Nicolai, Laura Ann (CDC vermont.gov); Brennan, Julia; Finley, Christine; natasha.lamens@cityofchicago.org; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)

Cc: laura.rust@azdhs.gov; Zipprich, Jennifer (MDH); liam.hicks@azdhs.gov; Kauerauf, Judy (CDC illinois.gov); susan.robinson@azdhs.gov; Layden, Jennifer (CDC illinois.gov); Scott, Sarah (CDC azdhs.gov); McHugh, Lisa A; Tan, Christina CT (CDC doh.nj.gov); michal.thornton@maryland.gov; Wendy.Lara@azdhs.gov; hannah.lee@maryland.gov; Edison, Laura (CDC dph.ga.gov); Pierce, Lindsay (CDC dhhs.nh.gov); Hansen, Katrina; Karie.Starkey@odh.ohio.gov; Tim.Egan@odh.ohio.gov; Quinn, Kim (CDC odh.ohio.gov); Theresa.Bonn@odh.ohio.gov; Barker, Laurie (CDC/DDID/NCHHSTP/DVH); Teshale, Eyasu H. (CDC/DDID/NCHHSTP/DVH); Jorgensen, Cynthia (CDC/DDID/NCIRD/OD); Cooley, Laura A. (CDC/DDID/NCHHSTP/DVH); Newman, Alexandra (CDC health.ny.gov); Baker, Tai N. (CDC/DDID/NCIRD/ISD); Kellie Watkins; Hinnenkamp, Rachel

Subject: Hepatitis A - all impacted states call

Date: Tuesday, February 18, 2020 3:11:10 PM

Hi everyone,

Just a quick reminder that the hepatitis A call for all impacted states is scheduled for this **Friday, February 21 at 2pm ET**. We don't have a specific topic scheduled. We want to give you an opportunity to have an open forum to discuss and share any recent questions, challenges, or successes you've had in your outbreaks. If you have any topics that you know you'd like to discuss, please email in advance.

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If you're busy with COVID-19, we understand if you're unable to join. However, we want to continue to support the hepatitis A response however is most helpful. Please let us know if you have any questions or concerns.

Thanks,

Hepatitis A Outbreak Response Team

Agenda

Roll call – Due to the large size, please have one representative from each jurisdiction to say "present". We will **not** be asking for case counts, hospitalizations, and deaths on this call.
CDC announcements
State announcements & questions
Action items

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From: Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH)

To: Lesinger, Cindy (CDC adph.state.al.us); Nakema.Moss@adph.state.al.us; Michael.Cima@arkansas.gov; McCartney, Kellye (CDC arkansas.gov); Aaron Otis (CDC flhealth.gov); Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); Mark.ONeill@flhealth.gov; Andrea.Leapley@flhealth.gov; Wendy.Sweigert@flhealth.gov; Amy.Riggen@flhealth.gov; Ben.Sloat@dph.ga.gov; Ami.Gandhi@dph.ga.gov; Tracy.Kavanaugh@dph.ga.gov; Lovett, Sheila (CDC dph.ga.gov); Thoroughman, Douglas (CDC ky.gov); Robeson, Sara (CDC ky.gov); Amanda.Hunt@ky.gov; Johnson, Tisha (CDC ky.gov); jennifer.khoury@ky.gov; Schweitzer, Jody (CDC ky.gov); Kristy.Royalty@ky.gov; Anderson, Emily A. (CDC ky.gov); Sokol, Theresa (CDC la.gov); stacy.hall@la.gov; Jenna.IbergJohnson@la.gov; Frank Welch; Paul.Byers@msdh.ms.gov; Jannifer.Anderson@msdh.ms.gov; Kittle, Theresa (CDC msdh.ms.gov); Shipp, Rebecca; erica.wilson@dhhs.nc.gov; christina.caputo@dhhs.nc.gov; natalie.bontrager@dhhs.nc.gov; justin.albertson@dhhs.nc.gov; susan.sullivan@dhhs.nc.gov; Holmes, Wendy (CDC dhhs.nc.gov); Drociuk, Dan (CDC dhec.sc.gov); White, Stephen (CDC dhec.sc.gov); Cassandra.Jones@tn.gov; SHOC.Epidemiologist@tn.gov; Michelle.Fiscus@tn.gov; Haralson, Catherine (CDC tn.gov); Latoya.Antoine@tn.gov; John.Benitez@tn.gov; SHOC.Planning@tn.gov; Amy.Cox@tn.gov; Shavetta.Conner@tn.gov; Sean.J.Kice@tn.gov; Peter Koonz; Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Montgomery, Martha (CDC/DDID/NCHHSTP/DVH); Weng, Mark (CDC/DDID/NCHHSTP/DVH); Augustine, Ryan (CDC/DDID/NCHHSTP/DVH); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Teshale, Eyasu H. (CDC/DDID/NCHHSTP/DVH); Cooley, Laura A. (CDC/DDID/NCHHSTP/DVH); Chappell, Shauntrelle L. (CDC/DDID/NCIRD/ISD); Awwad, Hanan (CDC/DDID/NCIRD/ISD); Schwartz-Kitchens, Tricia (CDC/DDID/NCIRD/ISD); Crawford, Nathan E. (CDC/DDID/NCIRD/ISD); mschroeder@cste.org; Hamilton, Janet (CDC cste.org); Shah, Dhara (CDC cste.org); Danila, Richard (CDC state.mn.us); traxlelb@dhec.sc.gov; Sanders.Kelsey (DSHS); Leos.Greg (DSHS); Salinas.Andrea (DSHS); Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)

Cc: william.ledford@arkansas.gov

Subject: Hepatitis A Regional Call - HHS Regions 4 & 6

Date: Monday, February 3, 2020 12:14:56 PM

Hi Everyone,

We're still planning to hold the hepatitis A regional call this week, but understand that health departments may be overwhelmed with responding or preparing to respond to the novel Coronavirus. Please let me know today or tomorrow if a representative from your health department is planning to call in on Thursday. We want to be respectful of your time and competing priorities, so if there's not a "quorum" I'm happy to cancel the call and talk to anyone individually if specific issues have come up.

Thanks,
Megan

Megan Hofmeister, MD, MS, MPH
Division of Viral Hepatitis
Centers for Disease Control and Prevention
LXN7@cdc.gov
404-718-5458

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From: Pritchard, Scott
To: eocevent185@cdc.gov
Cc: Blackmore, Carina
Subject: ID Provider Request - PUI 0001106
Date: Wednesday, February 12, 2020 12:48:38 PM

See a note from the ID doc treating PUI 0001106, who tested negative for nCoV (NP/OP/sputum) yesterday. If a clinical expert on coronavirus could talk to Dr. Hsu we would appreciate it. Please call me on my cell to coordinate.

Thanks for informing us about the negative coronavirus result and appreciate you sending the written documentation to us when you receive. Even though the test result came after our conversation below, his condition is not improving. He remains febrile, and yesterday patient had some desats and transient hypotension with worsening R lung infiltrate, not responding to antimicrobials, increasing bands and LFTs as well, although he is a bit more stable now. We've elected to keep him on airborne / contact at this point as we don't know what pathogen he might have. Dr. Levent (the treating peds ID physician) & I discussed last night and we have a few questions:

1. While RT-PCR is clearly very sensitive, there could be some factors that could suggest false negative – the quality of the swabs collected and also the timing of swab collection within the natural course of this disease. For most viral diseases, I would expect positive PCR early during his febrile illness (which he was), but not sure. In other words, clinically he remains ill without a diagnosis. What is the likelihood of a false negative in this setting and would CDC be agreeable to recollecting a sample?
2. Would it still be possible to talk with the coronavirus CDC expert?

We're not doubting CDC's result, but as clinicians we are trained to put the puzzle pieces together and so far not successful. We recognize epidemiologically he neither fit the close contact with nCoV nor was he from Hubei, but despite all our commercial PCR tests / urine antigen, etc everything has come back negative so no alternative diagnoses. We will keep searching & managing him appropriately.

Vincent Hsu

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
Division of Disease Control and Health Protection

Phone: 850-245-4406
Cell: 850-251-5558
Fax: 850-414-6894

AMERICAN OVERSIGHT

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Tallahassee, FL 32399-1720

Mailing Address:
4052 Bald Cypress Way, Bin A-12
Tallahassee, FL 32399-1720

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From:	Gellis, Sean
To:	Brian.Berkowitz@djj.state.fl.us; Francis.Carbone@apdcares.org; bill.chorba@deo.myflorida.com; dunsonda@flalottery.com; javier.enriquez@myflfamilies.com; fairclothc@fdva.state.fl.us; Erik.Fenniman@dot.state.fl.us; terrence.a.gorman@us.army.mil; stefan.grow@ahca.myflorida.com; mark.hamilton@floridarevenue.com; jasonjones@fdle.state.fl.us; lisamartin@fcor.state.fl.us; Brad.Mcvay@dos.myflorida.com; Matthew.Mears@fldoe.org; kerven.l.montfort.mil@mail.mil; Norton.Emily; erik.sayler@em.myflorida.com; kenneth.Steely@fdc.myflorida.com; StLaurent, Louise; Craig Thomas; Ray.treadwell@myfloridalicense.com; christieutt@flhsmv.gov; Justin.g.wolfe@dep.state.fl.us; tritschlerr@elderaffairs.org
Cc:	Jacquot, Joe; Primrose, Nicholas; Uthmeier, James; Colleen.Ernst@eog.myflorida.com; Pratt, Joshua; O"Connor, Kasey
Subject:	IMPORTANT: Telework Guidance and Template Agreement for Consideration for Employees of the State Personnel System (COVID-19)
Date:	Friday, March 13, 2020 3:33:25 PM
Attachments:	image001.png image003.png image005.png image007.png DMS Telework Agreement Template.doc
Importance:	High

Good afternoon,

Telework can be an effective and useful tool for supporting an agency's Continuity of Operations Plan (COOP) during a declared health emergency such as COVID-19.

The purpose of this document is to aid and guide state agencies as telework is being evaluated and considered as part of each agency's response to COVID-19 to ensure required staffing levels are maintained while addressing employee health concerns.

- Telework connected with a declared health emergency must be evaluated on a case by case basis. Not all positions will be eligible for telework nor will all employees be suited for telework due to a variety of reasons. However, telework is a viable option to assist agencies in maintaining continuity of operations during a health emergency.

- If not already determined, agencies should evaluate if the duties of a given position/job or a portion of the work can be effectively performed away from the regular work location.

- If the nature of an employee's work responsibilities can be accomplished away from the regular work location and if any necessary technological/equipment needs can be satisfied, the agency may permit and encourage employees to telework as a way to reduce the face-to-face contacts between employees (social distancing).

- Agencies should identify available equipment (laptops, telephones, etc.) to be assigned to employees for the purpose of teleworking. Consideration should be given to which positions are essential to operations when prioritizing the use of appropriate equipment for telework.

- Agencies should review their telework policies to ensure they are current and consider whether any component of their policies should be modified to allow broader use of telework as appropriate.

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If a position is deemed eligible for telework, the manager and employee will need to complete a written agreement that specifies the terms and conditions of the arrangement and provides for the termination of the telework arrangement upon the agency's determination that it is no longer necessary.
    - Agencies may want to prepare a telework agreement that includes the basic components for short-term telework arrangements associated with the current health emergency. (See attached template)

- In evaluating telework eligibility, considerations should include:
    - Is the position essential to the agency's required responsibilities?
    - Although an essential position, can the duties be performed away from the official worksite for a defined, short period of time? If so, how long?
    - Are there significant portions of the job that can be done away from the official worksite?
    - Does the position need continual supervision or input from others that is only available from the official worksite?
    - Is contact with other employees/customers required every day? Can contacts be accomplished through various forms of technology?
    - Are needed reference materials to perform the work available/accessible?
    - Is data security maintained?
    - Is specialized equipment or technology available at the employee's home?
    - Is the home workspace appropriate for telework?

- Although a position or job class may be identified by the agency as telework eligible, an evaluation of whether a given employee is an appropriate candidate for telework should be conducted. Agencies should consider individual employee factors such as the employee's:
    - Ability to work independently;
    - Comfort level with the required technology;
    - Past performance levels;
    - Dependability and trustworthiness; and
    - Level of self-motivation.

- Employees who are unable to work due to illness or who have sick family members under their care will not be good candidates for telework.

- Employees who are caring for well children due to school or day care closures may be able to perform portions of their work from home, depending on individual circumstances (e.g., the age and level of independence of the child).

- For additional guidance on telework, please refer to the DMS-HRM policy guideline titled *Identifying Positions Appropriate for Telework and Determining Employee Eligibility*.

Thank you!

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Sean W. Gellis | Interim General Counsel
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Florida Department of Management Services
We Serve Those Who Serve Florida



How Are We Doing? Click Here to Take the DMS Customer Satisfaction Survey

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From:	Gellis, Sean
To:	Brian.Berkowitz@djj.state.fl.us; Francis.Carbone@apdcares.org; bill.chorba@deo.myflorida.com; dunsonda@flalottery.com; javier.enriquez@myflfamilies.com; fairclothc@fdva.state.fl.us; Erik.Fenniman@dot.state.fl.us; terrence.a.gorman@us.army.mil; stefan.grow@ahca.myflorida.com; mark.hamilton@floridarevenue.com; jasonjones@fdle.state.fl.us; lisamartin@fcor.state.fl.us; Brad.Mcvay@dos.myflorida.com; Matthew.Mears@fldoe.org; kerven.l.montfort.mil@mail.mil; Norton.Emily; erik.sayler@em.myflorida.com; kenneth.Steely@fdc.myflorida.com; StLaurent, Louise; Craig Thomas; Ray.treadwell@myfloridalicense.com; christieutt@flhsmv.gov; Justin.g.wolfe@dep.state.fl.us; tritschlerr@elderaffairs.org
Cc:	Jacquot, Joe; Primrose, Nicholas; Uthmeier, James; Colleen.Ernst@eog.myflorida.com; Pratt, Joshua; O"Connor, Kasey
Subject:	IMPORTANT: Use of Sick Leave and Emergency Leave Transfer (COVID-19)
Date:	Monday, March 16, 2020 2:11:03 PM
Attachments:	image001.png image003.png image005.png image007.png 63 DMS Suspension of Rules 3-16-2020.pdf EmergencyLeaveDonationForm.docx COVID-19 Emergency Leave Transfer Program.docx

Good afternoon,

In response to our public health emergency and to help contain the spread of COVID-19, the Governor is allowing state employees the flexibility to donate and transfer available leave (sick, annual, special compensatory, and regular compensatory leave) to other state employees (intra- and inter-agency). This flexibility will also help mitigate the impacts of school closures and observe the Centers for Disease Control and Prevention and the Florida Department of Health's social distancing recommendations.

In order to assist employees who may not have enough leave to cover necessary absences, the Department of Management Services (DMS) is suspending the administrative rule provisions governing the existing sick leave transfer program to expand the opportunities for employees to transfer sick, annual, special compensatory, and regular compensatory leave to fellow employees.

Under this temporary COVID-19 Emergency Leave Transfer program, employees will have the ability to donate sick, annual, special compensatory leave, or regular compensatory leave to employees in need. The following requirements will govern this program:

- Employees who donate must retain at least 80 hours of sick leave.
- Employees who donate must transfer at least eight hours of leave to the recipient.
- Employees eligible for disability leave may not receive donations.
- Intra-agency and inter-agency donations are allowed.
- Unused leave donations will be returned to donating employees once Executive Order 20-52 expires.

Employees in need of leave donations and employees willing to donate leave should work directly with their agency HR offices. DMS has created the attached form that can be used to facilitate the leave donation process.

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In addition, DMS has suspended Rule 60L-34.0042(3), Florida Administrative Code for the particular purpose of allowing State Personnel System employees the flexibility to utilize sick leave for childcare or dependent care purposes.

If you have any questions regarding this temporary COVID-19 Emergency Leave Transfer program, please contact Matt Gregory at 850-921-4618, John Apthorp at 850-922-1274, or Mark Helms at 850-487-1508.

This message is being cascaded to Chiefs of Staff, Administration Directors, HR Directors, Communications Directors, and Legislative Directors.

Thank you!!

Sean W. Gellis | Interim General Counsel
Office of the General Counsel
850-922-6617 (office) | 850-508-9219 (mobile)
Florida Department of Management Services
We Serve Those Who Serve Florida



How Are We Doing? Click Here to Take the DMS Customer Satisfaction Survey

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date:	Thursday, March 12, 2020 12:51:40 PM
Attachments:	image001.png



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs

AMERICAN OVERSIGHT

The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.

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- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
    - In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
    - In February, the President restricted travel for individuals recently

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traveling from Iran.
    - The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
    - Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.
- Today, the President directed his Administration to make general-use face masks available to our healthcare workers.
    - The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.
- President Trump signed into law more than $8 billion to fund response efforts.
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
- The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

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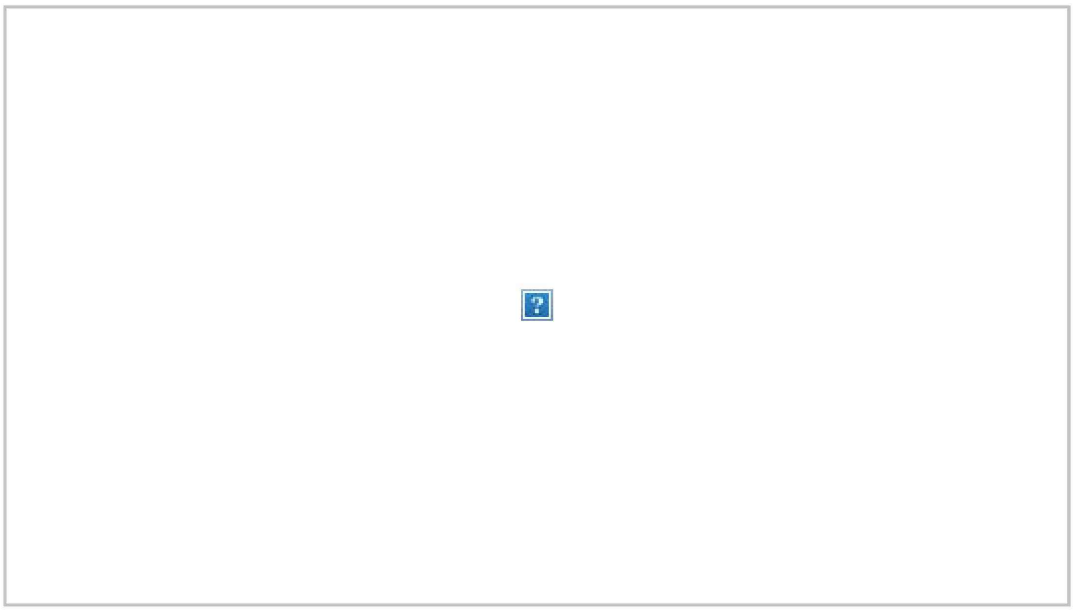

WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

> "The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American

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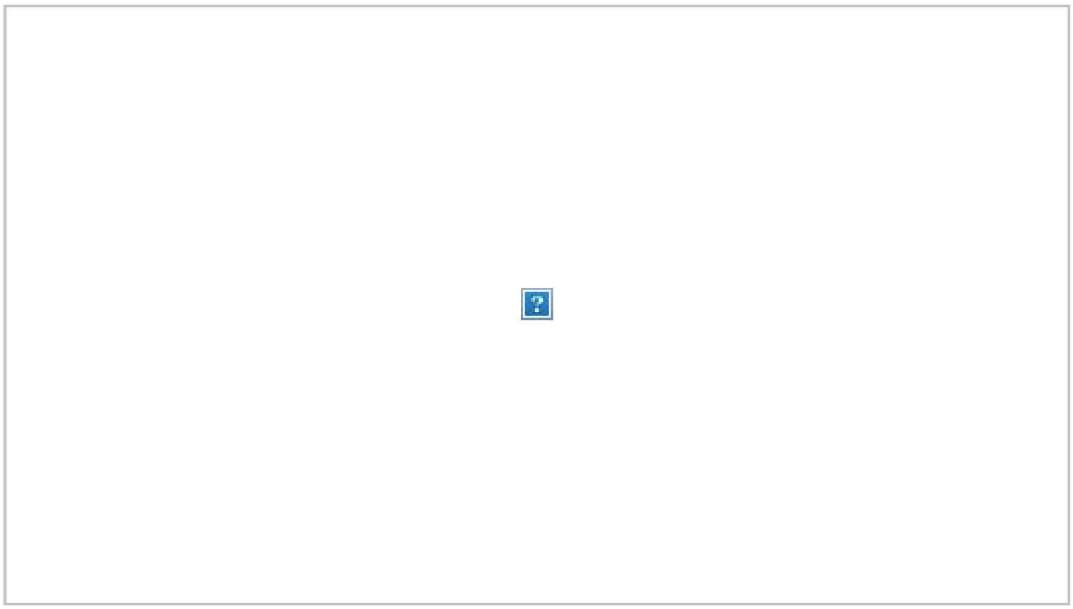
people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment... As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW



WATCH HERE.

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no

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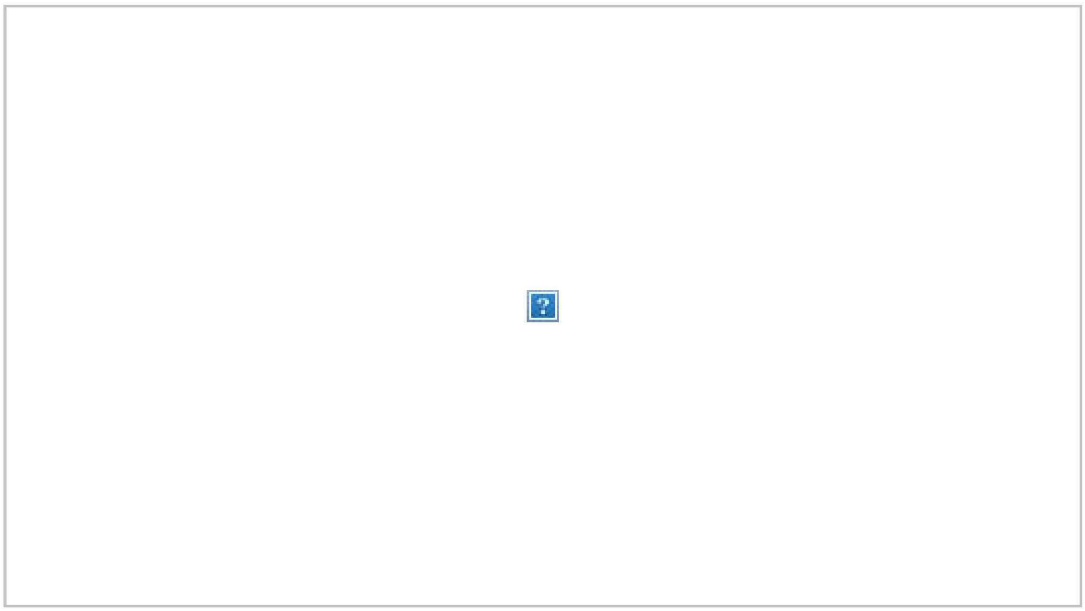
higher priority than the health, safety and well-being of the American people.

> "The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country. You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS



WATCH HERE AND HERE.

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

> "The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as

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possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

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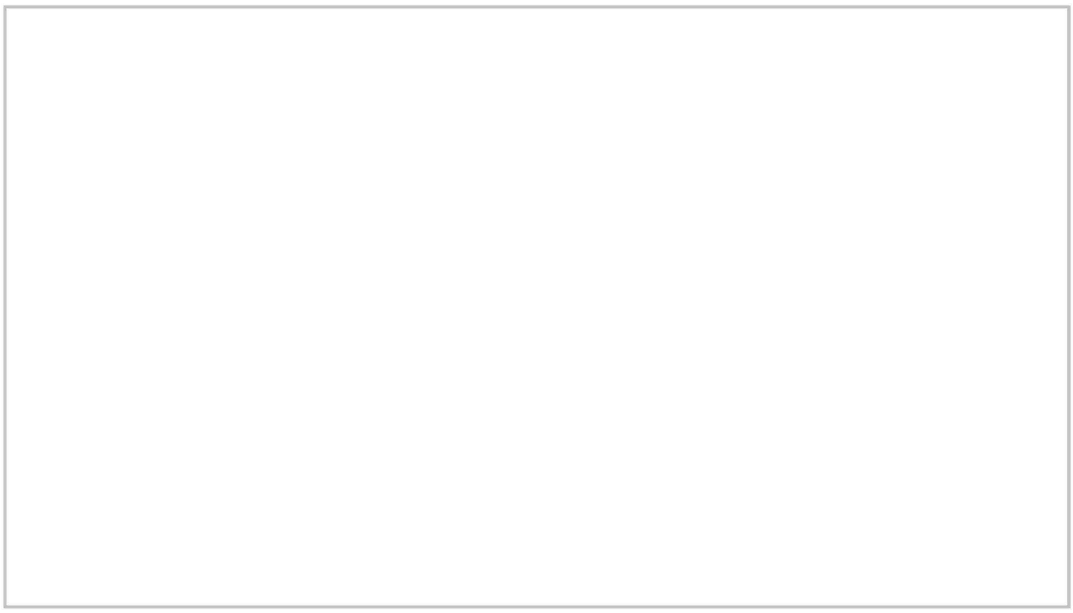

WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

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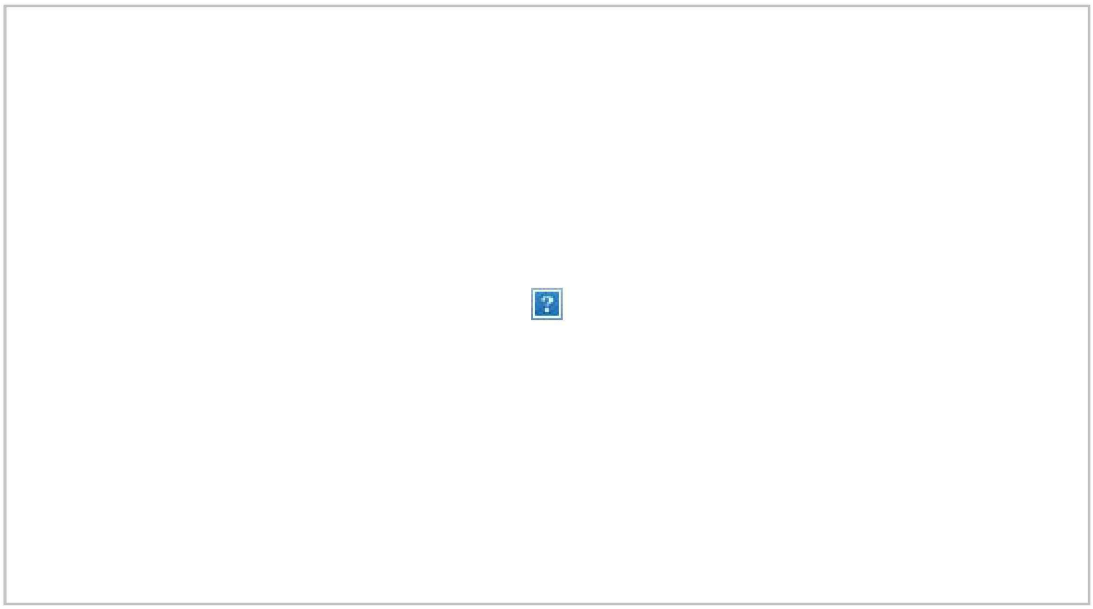
want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

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"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

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"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 12:49:34 PM
Attachments: image001.png



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs
The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

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President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take

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place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
    - In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
    - In February, the President restricted travel for individuals recently traveling from Iran.
    - The Administration put into place mandatory screening for all

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travelers coming into the country from Italy and South Korea.
    - Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.
- Today, the President directed his Administration to make general-use face masks available to our healthcare workers.
    - The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.
- President Trump signed into law more than $8 billion to fund response efforts.
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
- The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

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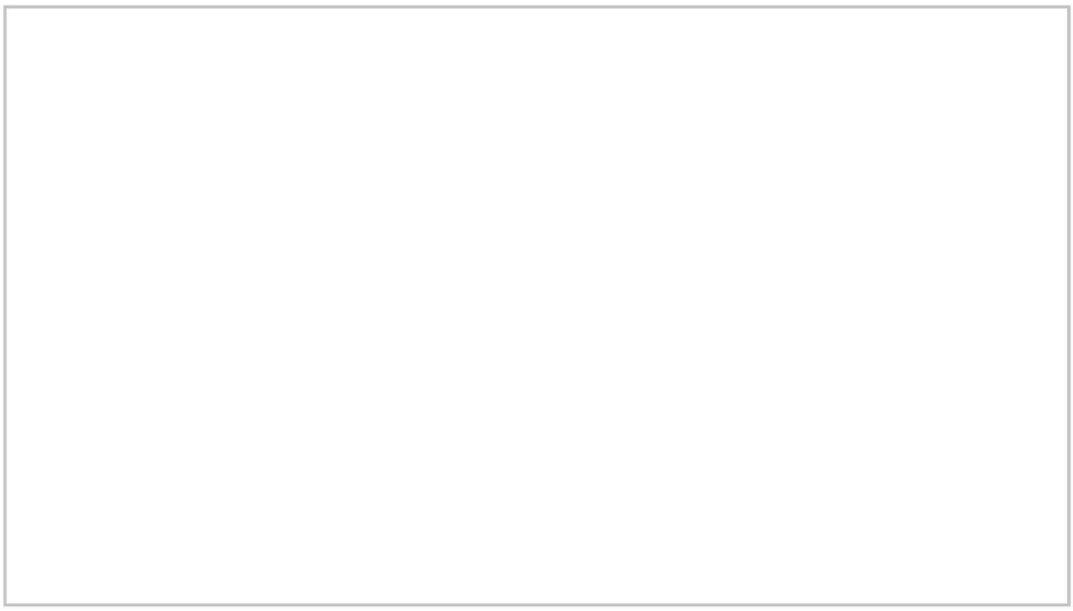


WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

> "The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American

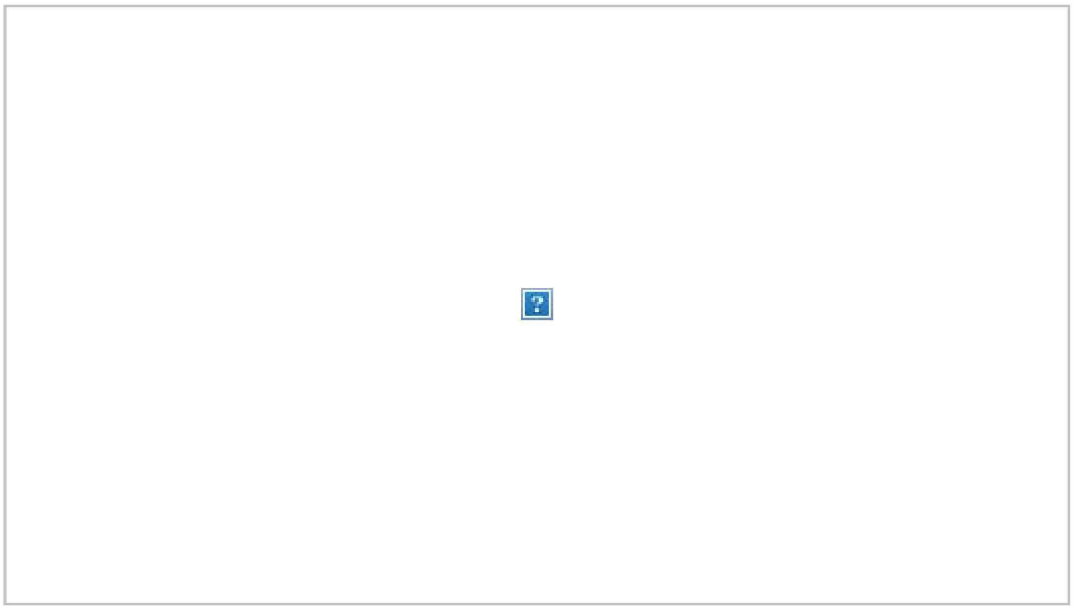
AMERICAN OVERSIGHT

people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment... As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW



WATCH HERE.

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

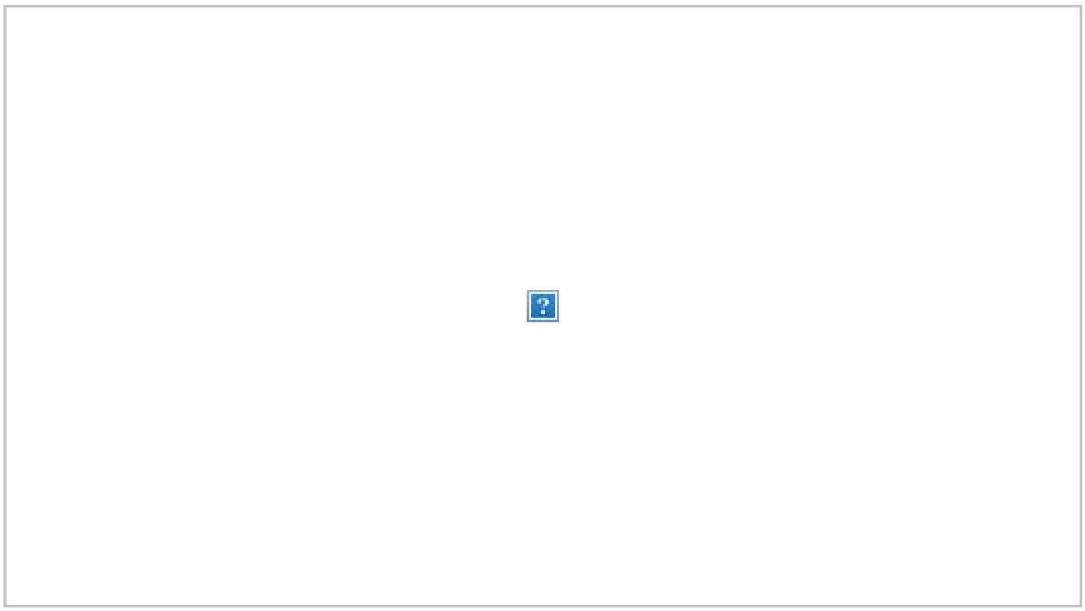
The American people should know that President Trump has no

AMERICAN OVERSIGHT

higher priority than the health, safety and well-being of the American people.

> "The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country. You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS



WATCH HERE AND HERE.

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

> "The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as

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possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

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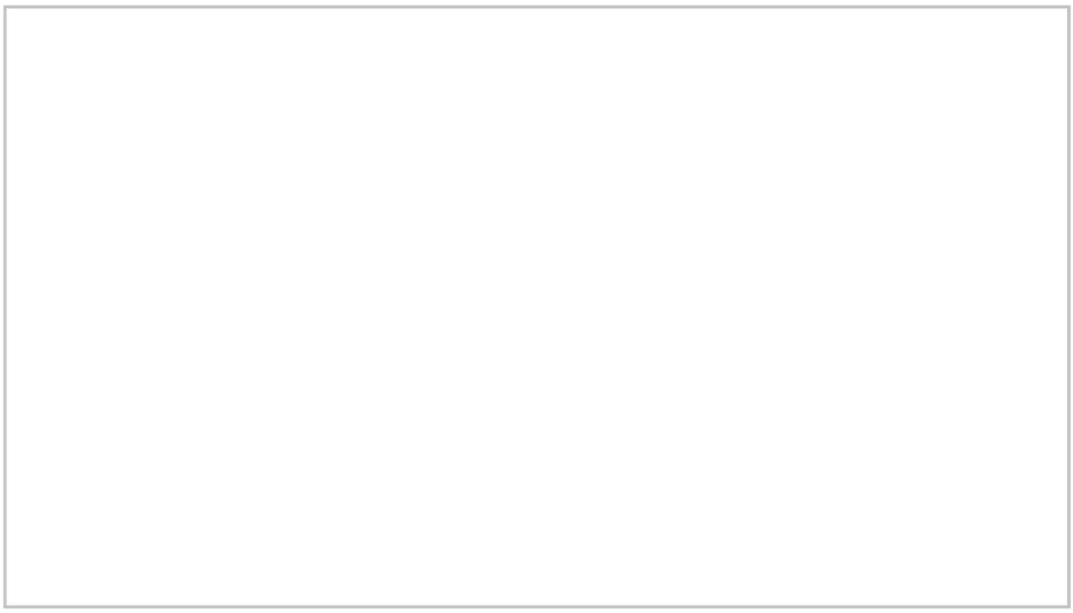

WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

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want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

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From: DNPAO Comm TA (CDC)
To: DNPAO Comm TA (CDC)
Subject: Important Updates to April-June 2020 sample social media packet
Date: Monday, March 16, 2020 2:01:32 PM

Dear State and Community Health Media/Communication Contacts,

In the sample social media packet we sent last week, we included posts regarding April 18 physical activity events. See below for an update on those. Please feel free to edit these posts-- and all the posts-- to reflect what is taking place in your location and to be sensitive to what is happening related to COVID-19 locally.

- National Park Week's Junior Ranger Day and Fee Free Day – Some site are temporarily closed; this may impact National Park Week activities. Visit the National Park Service website for more information.

- Rails to Trails Opening Day – Rails-to-Trails Conservancy has postponed the event.

- YMCA Healthy Kids Day® – Visit the web page or contact your local YMCA for updates.

Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

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From: DNPAO Comm TA (CDC)
To: DNPAO Comm TA (CDC)
Subject: Important Updates to April-June 2020 sample social media packet
Date: Monday, March 16, 2020 2:01:23 PM

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Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

AMERICAN OVERSIGHT

From:	Garcia, Vicky (Aviation)
To:	"CHRISTOPHER.D.MASTON@CBP.DHS.GOV"; "MPH MBA Andrew D. Klevos (Aklevos@cdc.gov)"; "yesenia.villalta@flhealth.gov"
Cc:	Sola, Lester (Aviation); Rull Valenciaga, Arlyn (Aviation); Pyatt, Ken (Aviation); Hatfield Jr., Mark O. (Aviation)
Subject:	Interim revision: Miami International Airport Communicable Disease Emergency Response Plan
Date:	Friday, February 28, 2020 5:09:54 PM
Attachments:	image001.png image002.png image003.png MIA Communicable Disease Plan - 02.2020.pdf

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Attached is an updated copy of the Interim Update of the Communicable Disease Emergency Response Plan. Please advice as soon as possible, of any changes you would like to make to this interim document. Once your changes have been incorporated, we will send the revised document, along with a signature page for your respective agencies to sign.

Thank you,

Vicky Garcia, Departmental Administrative Coordinator
Miami-Dade Aviation Department
P.O. Box 025504
Miami, FL 33102-5504
305-876-0266 Phone 305-876-0948 Fax
mvgarcia@miami-airport.com
www.miami-airport.com

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From:	Torres, Yari
To:	FieldSupport (CDC); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Blackmore, Carina; Stanek, Danielle R; Sanchez, Guillermo Vincent (CDC/DDPHSS/CSELS/DSEPD); lgz9@cdc.gov; Blau, Erin (CDC/DDPHSS/CSELS/DSEPD); Browne, Springer (CDC/DDPHSS/CSELS/DSEPD)
Subject:	January Monthly Report
Date:	Tuesday, February 4, 2020 9:12:58 AM
Attachments:	TorresY202001.docx

Good morning,

I hope everyone is having a great week so far. Attached you will find my monthly report.

V/r

Yari

Yaritbel Torres-Mendoza, DVM, MPH
Lieutenant, U.S. Public Health Service
CDC Epidemic Intelligence Service Officer
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Phone: 850 -901-6933
Mobile: 850 -815-0059
E-mail: Yari.Torres@flhealth.gov | hvb0@cdc.gov

DOH Mission: To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Please Note: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

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From:	Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE)
To:	courtney.coppola@flhealth.gov
Cc:	alberto.moscoso@flhealth.gov; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
Subject:	Letters from Princess Cruise Line to passengers and crew of Sky Princess
Date:	Saturday, March 14, 2020 6:57:36 PM
Attachments:	YP Y008A Y009 - Health Advisory PEL - Debark.pdf YP Y010 Y010A - Health Advisory PEL - Embark.pdf

Good evening Ms. Coppola,

Dr. Rivkees gave me your name and email to forward these letters sent by Princess Cruise Line to passengers and crew of the Sky Princess voyages on 2/22 and 2/29. Alberto Moscoso (cc'd here) was involved with the crafting of the letters.

Thank you and please acknowledge receipt.

On Detail to COVID-19 Response

Paul J. Weidle, PharmD, MPH, CAPT USPHS
Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30329
404-639-6155
pweidle@cdc.gov

From: Peyton, Dennis (PCL) <dpeyton@hagroup.com>
Sent: Saturday, March 14, 2020 6:14 PM
To: Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; alberto.moscoso@flhealth.gov
Cc: Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; White, Stefanie B. (CDC/DDID/NCEZID/DGMQ) <ixy3@cdc.gov>; Poser, Sarah (CDC/DDID/NCEZID/OD) <wzk8@cdc.gov>; Rinker, Robin (CDC/OD/OADPS) <vqb2@cdc.gov>; Brooks, Ashley (CDC/DDID/NCIRD/OD) <ylo5@cdc.gov>; Tarling, Grant (PCL) <gtarling@hagroup.com>; Howard, Daniel (PCL) <dhoward@hagroup.com>; Drumalds, Aleks (PCL) <adrumalds@hagroup.com>
Subject: RE: Connection - Princess with State of Florida Comms

Good Day Paul and Kara,

Thank you kindly for reaching out today.

As per telephonic guidance received the evening of 12 March 2020 from Alberto Moscoso and team at Florida Department of Health, as well as Cindy Friedman and Paul Weidle from US CDC, it was recommended that an email notification to be sent to individuals with travel history aboard Sky Princess voyage A [22-29 February 2020] and voyage B [29 February – 7 March]. Attached are the email notifications sent on 13 March 2020.

Thanks,

Dennis Peyton Jr., MPH, CIC

AMERICAN OVERSIGHT

Epidemiologist | Health Services
Holland America Group | Princess Cruises, Holland America Line, Seabourn, P&O Australia, & HAP Alaska
+1 (661) 753-2353 office | +1 (661) 645-4013 mobile | dpeyton@hagroup.com
24/7 Emergency Line: +1-661-753-2355

AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	Melanie Motiska; Bob Asztalos; Laura MacLafferty; StateESF8.Planning
Cc:	Blackmore, Carina; Pritchard, Scott
Subject:	Long Term Care Resources for Pandemic Planning
Date:	Thursday, February 20, 2020 3:35:13 PM

Long Term Care Partners,

Hope things are well with you all. As I am sure you are aware, the Department has activated an incident management team for responding to the novel coronavirus COVID-19. While we have no cases in Florida, we are taking this opportunity to review pandemic preparedness plans should this outbreak escalate to a global pandemic.

Older populations and people with underlying health issues appear to be at increased risk for this virus. We believe it is important that long-term care facilities begin planning now and ensuring they have protocols in place for a pandemic scenario. Specific actions include:

- Criteria and protocols for closing units or the entire facility to new admissions when the pandemic virus is in the facility
- Criteria and protocols for enforcing visitor limitations
- A plan for cohorting symptomatic residents or groups
- An occupational health plan for addressing staff absences
- Plans for increased cleaning of common surfaces

The linked checklist is an excellent resource for long-term care and other residential facilities to assist them with pandemic planning. While the document references influenza, coronavirus is a respiratory disease and most of the same activities apply. Link: https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf

Can you all share with long term care facilities and/or post this resource on your websites? Thank you.

Samantha Cooksey Strickland
Alternate Emergency Coordination Officer
State ESF8 Planning & Operations Section Manager
Bureau of Preparedness & Response
Florida Department of Health
Office | 850.617.1506
Mobile | 850.251.2553
Email | Samantha.Cooksey@flhealth.gov

AMERICAN OVERSIGHT

From:	Fitzgerald, John M CDR
To:	"Davis, Ashley"; "Guthrie, Kevin"
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:00:08 PM

Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald
D7 LNO to the FL EOC

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
Division of Global Migration and Quarantine

AMERICAN OVERSIGHT

Centers for Disease Control and Prevention
Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

AMERICAN OVERSIGHT

From:	Fitzgerald, John M CDR
To:	"Davis, Ashley"; "Guthrie, Kevin"
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 1:59:54 PM

Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald
D7 LNO to the FL EOC

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Thank you and all the best,
Emily

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AMERICAN OVERSIGHT

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Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:25:29 PM

Sam/Ashley

This is the string I got below and why I asked if you had this ship on the radar. Let me know if you find something out. HHS has no ask….we just want to make sure you are aware this may be headed to Miami.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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Jeanne,

See below. Is FL DOH tracking this?

Joe

AMERICAN OVERSIGHT

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

18MAR: Indications that an Oceania cruise ship will be arriving at Port of Miami sometime next week with various COVID-19 positives on it. Consular Affairs from the Australian Embassy contacted to say they had been notified overnight that the MS Marina (Oceania) is returning to Miami from South America via the Panama Canal after it was denied docking by several countries. The latest advice the Embassy has is that it is passing through the Canal could take 5 or 6 days. Australian Embassy in Mexico and Honorary Consul in Panama are trying to assist at least 49 Australians on board - some of whom are starting to run short of medications etc. - but are having difficulty contacting the crew and Oceania's agents in Panama. CONS provided them with the contact for Norwegian cruise lines which is a parent company of Oceania. OFM indicates Port of Miami is not aware of the ship coming to Miami and questioned where it would even dock as all available ports are occupied. OFM in touch with Norwegian.

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:25:19 PM

Sam/Ashley

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Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
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cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

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AMERICAN OVERSIGHT

From:	Borrego, Eddie
To:	patricia.abril@miamidade.gov; tere.florin@miamidade.gov; Leets, Tania; myriam.marquez@miamidade.gov; jesse.o.manzano.mil@mail.mil; jcarroll@miamigov.com
Cc:	Silva, Liz (COM); Villalta, Yesenia D; sdean@miamigov.com; jimmy.arias.mil@mail.mil; Steigman, Don S; Kim, Inson (COM)
Subject:	Marlins Park Collection Site
Date:	Monday, March 23, 2020 5:05:42 PM
Attachments:	image002.png PreTesting Instructions or Guidelines03.23.2020.FINAL.pdf Where to Get Tested (3-23-2020).FINAL.pdf COVID19 SCREENING TOOL - MARLINS (002).pdf COVID19TESTINGSITE 03.23.2020.pdf
Importance:	High

PIOs,

This email is to link in all the PIOs on the relevant details of this drive through. Please note that the PreTesting Instructions document is for internal use only and not authorized to be shared.

All the best,

Eddie

--
Edward (Eddie) Borrego
Vice President & Chief Executive Officer
Jackson West Medical Center
786-999-2977 Mobile

From: Villalta, Yesenia D <Yesenia.Villalta@flhealth.gov>
Sent: Monday, March 23, 2020 3:53 PM
To: Borrego, Eddie <edward.borrego@jhsmiami.org>; inson.kim@miamidade.gov; Liz.silva@miamidade.gov
Cc: Rivera, Lillian <Lillian.Rivera@flhealth.gov>; Jackson, Iris F <Iris.Jackson@flhealth.gov>; Suarez, Sarah B <Sarah.Suarez@flhealth.gov>; Paterniti, Beth A <Beth.Paterniti@flhealth.gov>
Subject: Marlins Park Collection Site
Importance: High

WARNING: This email originated outside of Jackson Health System. Do not click links or attachments unless you recognize the sender and know the content is safe.

Good afternoon,

Please find the latest documents. Please let me know if you have any questions.

1. Script for Call Center
2. Pre-Specimen collection information (internal reference only)
3. COVID-Screening tool

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4. Post specimen collection brochure

Thank you,

Yesenia D. Villalta, APRN, DNP, MSN
Florida Department of Health in Miami-Dade County
Administrator/Health Officer
Email: Yesenia.Villalta@flhealth.gov
Phone:(786)336-1260
Address: 8323 NW 12th Street Floor:02 Room:212
Miami, FL 33126



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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Materials from 2-18-2020 SHO & State Epi Touchbase webinar (COVID-19)
Date:	Wednesday, February 19, 2020 2:16:36 PM
Attachments:	COVID_19 Leaders_Intent (002)_JW Final.pdf Novel CoV_2_14_20 Health Care Pre-Meeting.pdf CSC SHO Call 2.18.2020 UPDATED SP.pdf SRC_Respirator 2020-2-13 DRAFT (002).pdf CSC SHO Call 2.18.2020 UPDATED_updated.pptx 7 Key Questions_MCCM_2.18.20.pptx public-health-management-decision-making algorithm feb 18 2020.pdf

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Dear Colleagues,

This email contains materials from the 2-18-2020 SHO & State Epi Touchbase webinar (COVID-19) .

Attached:

- Considerations for Crisis Standards of Care Slides
- WA DOH SHO's leader's intent document to the IMT on leaning into community readiness
- WA DOH slide set: Health Care Readiness Pre-Planning
- MCCM "7 Key Questions"
- Strategies for Scare Resource Situations
- Webinar Slides
- COVID-19 Risk Assessment and PH Management Decision Making Algorithm

Thank you for attending,

State Coordination Task Force

Sent by BCC to State Health Officials and State Epidemiologists

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Media Advisory: CDC Media Telebriefing: Update on COVID-19
Date:	Wednesday, February 12, 2020 10:32:34 AM

Media Advisory

For Immediate Release
Wednesday, February 12, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 11:30 am. ET Wednesday, February 12, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 2684824

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

CDC works 24/7protecting America's health, safety and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is

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headquartered in Atlanta and has experts located throughout the United States and the world.

Sent by BCC to PHEP directors, State Health Officials, State Epidemiologists, Lab Directors, and Non-Governmental partners

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Media Statement: CDC Confirms 15th Case of Coronavirus Disease (COVID-19)
Date:	Thursday, February 13, 2020 10:38:19 AM

Media Statement

For Immediate Release
Thursday, February 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms 15th Case of Coronavirus Disease (COVID-19)

CDC today confirmed another infection with Coronavirus Disease (COVID-19) in the United States. The patient is among a group of people under a federal quarantine order at JBSA-Lackland in Texas because of their recent return to the U.S. on a State Department-chartered flight that arrived on February 7, 2020.

All people who lived or travelled in Hubei Province, China, are considered at high risk of having been exposed to this virus and are subject to a temporary 14-day quarantine upon entry into the United States. This is the first person under quarantine at JBSA-Lackland who had symptoms and tested positive for COVID-19. The individual is currently isolated and receiving medical care at a designated hospital nearby.

This brings the total number of COVID-19 cases in the United States to 15. There will likely be additional cases in the coming days and weeks, including among other people recently returned from Wuhan. While 195 people were discharged from quarantine on Tuesday, more than 600 people who returned on chartered flights from Wuhan remain under federal quarantine and are being closely monitored to contain the spread of the virus.

For the latest information on the outbreak, visit CDC's Novel Coronavirus 2019 website.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

Sent by BCC to PHEP directors, State Health Officials, State Epidemiologists, Lab Directors, and Non-Governmental partners

AMERICAN OVERSIGHT

From: Moulton, Diane
To: Rivkees, Scott; Eifert, James; Moskowitz, Jared; Swearingen, Rick; Mayhew, Mary; Corcoran, Richard
Subject: Meeting TODAY @ 3:30
Date: Wednesday, February 19, 2020 7:25:24 AM

The Governor would like to have a briefing regarding the Coronavirus today at 3:30. The briefing will be held in our small conference room. Please let me know if you can attend in person. If some of you can't attend in person, I will provide a conference line. Thank you all!

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Dobson, Jolie T
To:	Burger, Ron; Cicerrella, Richard; Connor, Olga; Cyrille, Charles; Davis, Joanna; Disbrow, Scott; Jeanne Eckes-Roper; Elmir, Samir; Erase, Romualde X; Franco, Benjamin; Frost, Matthew; Garcia, Maikel; Gomez, Tatiana ; Hernandez, Richard; Horner, Alicia; Jean, Reynald; Kelly Keys; Lara, William; Lewandowski, Patty A; Loo, Georgina; Lopez, Jose M; Mejia-Echeverry, Alvaro; Milian, Victor ; Nunez, R. Jaime; Presmanes, Cristina; Quave, Elesi A; Rafky, Brian; Schmitz, Ann; Senyshyn, William; Serrano, Maria; Steele, Michelle; Sudden, Terri M; Toñanez, Alvaro Lt.; Trim, Anthony Capt.; Vaughn, Freda G; Villalta, Yesenia D; White, Stephen L; Chao Morales, Christina A; Castillo, Klelia S; Celorio, Oscar; Villamil, Vanessa
Cc:	Suarez, Ana; Pognon, Monica; Jaime Hernandez; jzambella@icerif.com; John Antapasis; Chambliss, James; James Russo; Franco, Benhamin; Davis, Joanna S - APHIS; Lara, William (RER); Bello, Joel; vmmilian@gmail.com; Zambella, Joseph; Serrano, Maria (ASD)
Subject:	Miami-area BAC Quarterly Meeting
Attachments:	image001.jpg Agenda_031220.pdf 20200102 BWNCC Framework_022020.pdf Super Bowl 54 Miami BAC.pptx 2019-COVID BioWatch.pptx

---

Please find the updated COVID-19 ppt.

Thank you.

Jolie Dobson

Biological Scientist IV
Florida Department of Health in Miami-Dade County

Email: Jolie.Dobson@flhealth.gov <mailto:Jolie.Dobson@flhealth.gov>

Phone: (305) 470-5558

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AMERICAN OVERSIGHT

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To:	Burger, Ron; Cicerrella, Richard; Connor, Olga; Cyrille, Charles; Davis, Joanna; Disbrow, Scott; Jeanne Eckes-Roper; Elmir, Samir; Erase, Romualde X; Franco, Benjamin; Frost, Matthew; Garcia, Maikel; Gomez, Tatiana ; Hernandez, Richard; Horner, Alicia; Jean, Reynald; Kelly Keys; Lara, William; Lewandowski, Patty A; Loo, Georgina; Lopez, Jose M; Mejia-Echeverry, Alvaro; Milian, Victor ; Nunez, R. Jaime; Presmanes, Cristina; Quaye, Elesi A; Rafky, Brian; Schmitz, Ann; Senyshyn, William; Serrano, Maria; Steele, Michelle; Sudden, Terri M; Toñanez, Alvaro Lt.; Trim, Anthony Capt.; Vaughn, Freda G; Villalta, Yesenia D; White, Stephen L; Chao Morales, Christina A; Castillo, Klelia S; Celorio, Oscar; Villamil, Vanessa
Cc:	Suarez, Ana; Pognon, Monica; Jaime Hernandez; jzambella@icerif.com; John Antapasis; Chambliss, James; James Russo; Franco, Benhamin; Davis, Joanna S - APHIS; Lara, William (RER); Bello, Joel; vmmilian@gmail.com; Zambella, Joseph; Serrano, Maria (ASD)
Subject:	Miami-area BAC Quarterly Meeting
Attachments:	image001.jpg Agenda_031220.pdf 2019-COVID BioWatch.pptx 20200102 BWNCC Framework_022020.pdf Super Bowl 54 Miami BAC.pptx

Hello,

Please see attached agenda and documents which will be discussed in tomorrow's meeting. We anticipate that this meeting will end earlier than 12pm.

See you tomorrow!

Jolie Dobson

Biological Scientist IV
Florida Department of Health in Miami-Dade County

Email: Jolie.Dobson@flhealth.gov <mailto:Jolie.Dobson@flhealth.gov>

Phone: (305) 470-5558

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From:	Blackmore, Carina
To:	Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc:	Pritchard, Scott; Rubino, Heather
Subject:	Monday
Date:	Sunday, March 1, 2020 10:26:24 PM

Hi Tim, The good news is you are coming right at the best time. Expect to be plugged into the Coronavirus response from day one. The bad news is that tomorrow morning will likely be a tad chaotic. We may have our two first cases confirmed tomorrow and we have just declared an emergency. I have a meeting between 830-9 am. It may drag out a little. I will try to meet you at 8 and we will get your badge and computer etc set up started. Then we will all get together as soon as we have a chance. Hopefully shortly after 9. Just wanted to give you a heads up and wish you a warm welcome :). Carina

Get Outlook for iOS

AMERICAN OVERSIGHT

From:	Public Health Leadership and Practice
To:	Candice McDaniel; Jennie Hefelfinger; Abby Lowe-Wilson; Hahn, Jamie K; lea.ojamaa@state.ma.us; Lisa.Sanders@msdh.ms.gov; Samaha Hodges; DeShara Johnson; lisa.mccooey@ct.gov; kathleen.arnold-lewis@doh.vi.gov; Kelly McCracken; Kathleen Lewis-Arnold; aflaherty@pa.gov; Emily.Moores@maine.gov; lrp0@cdc.gov; dlw7@cdc.gov; nhh1@cdc.gov; flw2@cdc.gov; cwu9@cdc.gov; hri0@cdc.gov; hcc3@cdc.gov; prs5@cdc.gov; kuv7@cdc.gov; rnh2@cdc.gov; Anya Karavanov; Julie Dudley; Amanda Martinez; Ann Forburger; Ann Marie Shields; Kimberly Miller; lhelzer@health.nv.gov
Cc:	Candice McDaniel; Tari O"Connor; Sondra Reese; Appathurai Balamurugan; teresa.manygoats; Caroline Peck; laurie.schneider; Monica Morales; Gabriel Kaplan; Mehul Dalal; Robin Diggs Outlaw; helen.arthur@state.de.us; Shamarial Roberson; Kia Toodle; lola.irvin; Jack Miller; J Myers-Geadelmann; tiffanie.pressley@illinois.gov; Ann Alley; Ryan Lester; Thomas-Cox, Sue (CHFS PH); melissa.r.martin; Kristi Pier; Linda Scarpetta; Mary Manning; Steve Cramer; victor.sutton@healthyMS.com; Campbell, Stacy; Susan Kansagra; ilpastir@nd.gov; Hurst, Gwen; whitney.hammond@dhhs.nh.gov; Melita Jordan; Catron, Britt, DOH; Judith Gabriele; Wallace, Barbara J (HEALTH); Michele Shough; Stephanie U"Ren; Girard Karen E; Sutton, Nancy (RIDOH); Kiley.hump; Charlotte Woods; Nimisha Bhakta; Antonio L. Cases Rosario; Daguise, Virginie; Janae Duncan; heather.board@vdh.virginia.gov; Julie.Arel; pama.joyner; Pesik, Mary J - DHS; Jessica.G.Wright; Lisa Wordeman; Jeanne Alongi; victor.sutton@msdh.ms.gov; Kristi Robusto; Arthur, Helen (DHSS); Nancy Sutherland; Thompson, Carolyn; Robin Rhodes; Levine, Britt, DOH; John Robitscher
Subject:	NACDD Chronic Disease Directors Forum First Thursday Webinar

Dear Colleagues,

Update to our 3/5 webinar speaker line up: In addition to the speakers listed below, Dr. Karen Hacker and Dr. Peter Briss will be providing an update on coronavirus on the webinar this Thursday.

For our March 2020 webinar we are looking at leading to address upstream factors. We are excited to have the following speakers join us:

* Carol Hall Walker and Deborah Garneau (Rhode Island Department of Health) to discuss the Rhode Island Health Equity Measures.

* Shamarial Roberson (Florida) as our Chronic Disease Director respondent.

* Karla Sneegas from CDC's Office on Smoking and Health to share information on Tips 2020.

Please join us and bring your questions, comments, and experiences to share.

Register in advance for upcoming webinars with this link: https://chronicdisease.zoom.us/meeting/register/uJYvc-urpjwrOcPx6hOXeJ3eSfuM4yRpSA <https://chronicdisease.zoom.us/meeting/register/uJYvc-urpjwrOcPx6hOXeJ3eSfuM4yRpSA> . After registering, you will receive a confirmation email containing information about joining the meeting. Note that you will need to register each month.

Slides and webinar recordings are available here: https://www.chronicdisease.org/page/CDDF_First_Thursday.

For more information please contact Abby Lowe-Wilson at alwilson@chronicdisease.org <mailto:alwilson@chronicdisease.org> .

Jeanne Alongi, DrPH, MPH (she/her)
Senior Public Health Consultant - Public Health Leadership & Practice
National Association of Chronic Disease Directors
jalongi@chronicdisease.org
www.chronicdisease.org
916-452-2440 (pacific time zone)

AMERICAN OVERSIGHT

From:	Lushbaugh, Justin (CDC/DDNID/NCBDDD/DHDD)
To:	Claudia.Johnson@ky.gov; Pier, Kristi (CDC maryland.gov); Cramer, Steve (CDC health.mo.gov); Paras, Kathy (CDC utah.gov); Kamp, Susan (CDC vermont.gov); Laurie.Eldridge-Auffant@adph.state.al.us; Roberson, Shamarial (CDC flhealth.gov); bryan.russell@flhealth.gov; maggie.ferguson@idph.iowa.gov; jhall@ku.edu; Kbruns@ku.edu; hoffmana5@michigan.gov; Manning, Mary (CDC state.mn.us); Bluhm, Jim JB (CDC state.mn.us); Meg.Traci@mso.umt.edu; Susan.havercamp@osumc.edu; vanessas@uark.edu; Rodrigo.Monterrey@MassMail.State.MA.US; Barbara.wallace@health.ny.gov; weaverro@ohsu.edu; SMCDERMO@mailbox.sc.edu; devlinj@mailbox.sc.edu; Barb.Locker@ky.gov; Allison.perline@vermont.gov; Wimberley, Richard (CDC michigan.gov); HWelch@mt.gov; erin.ashinghurst@maryland.gov; bdkilpat@uark.edu; ann.robinson@osumc.edu; Kimberly.Phillips@unh.edu; holly.teal@health.ny.gov; Brenda.Maley@health.mo.gov; Kimberley.Warsett@state.ma.us; hornerjo@ohsu.edu; nettie.romanzo-smith@health.ny.gov; Evan.England@unh.edu; nassira.d.nicola@state.ma.us; aBraner@utah.gov; ctamayo@phhp.ufl.edu; Rachael.Austin@health.ny.gov; Patrick.Hodge@flhealth.gov; Casey, Margaret MC (CDC health.ny.gov); maureen.spence@health.ny.gov; rodrigo.monterrey@state.ma.us; LeeC@michigan.gov; anna.fuller@uky.edu; lindsey.c.mullis@uky.edu; chithra.adams@uky.edu; David.Ellsworth@odh.ohio.gov; Edward.Clark@flhealth.gov; FrameA@michigan.gov; Bishop, Susan (CDC state.mn.us); emily.smoak@state.mn.us; Mackenzie.Jones@mt.gov; Schulte, Ann (MDH); Crotty, Anne E
Cc:	Tilahun, Selam (MDH); Erin Taylor; Vincent-Mark, Arlene (CDC/DDNID/NCBDDD/DHDD)
Subject:	NCHPAD Home workout toolkit
Date:	Friday, March 20, 2020 8:58:54 AM
Attachments:	Inclusive Home Workout Toolkit.pdf Inclusive Home Workout_Landscape.jpeg Inclusive Home Workout_Square.jpeg

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Good morning, all:

Please find attached NCHPAD's Inclusive Home Workout Toolkit, and please feel free to share the content with your networks.

Thanks, and please let me know if you have any questions.

Stay happy and healthy!

-Justin

Justin Lushbaugh
Public Health Analyst
Disability Science and Program Team ¦ Disability & Health Promotion Branch
Division of Human Development and Disability
National Center on Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
4770 Buford Hwy MS-S101-3
Chamblee, GA 30341-3717
Xko0@cdc.gov
(404) 498-3036 Office
(470) 421-0183 Mobile
(770) 488-0270 Fax

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: NEW Ventilator Guidance - COVID-19
Date: Monday, March 23, 2020 2:22:26 PM

Dear Governor and State Health Officials-

Below please find new FDA guidance to expand the availability of ventilators as well as other respiratory devices:

What Types of Ventilators Can be Used to Expand Supply? The FDA issued guidance to expand the availability of ventilators as well as other respiratory devices and their accessories during this pandemic. Wherever possible, health care facilities should use FDA-cleared conventional/standard full featured ventilators when necessary to support patients with respiratory failure. However, to expand availability, FDA will not object to limited modifications to the *indications, claims, functionality, or to the hardware, software, or materials of FDA-cleared devices used* to support patients with respiratory failure or respiratory insufficiency. This policy applies only during the public health emergency.

Examples of changes to the indications could include a significant change or modification in *design, material, chemical composition, energy source, or manufacturing process*. Specific examples of products FDA will allow include:

- The use of powered emergency ventilators and anesthesia gas machines for patients needing mechanical ventilation;
- The use of ventilators outside of their cleared environment for use (use of a ventilators in a health care facility when it is only cleared for use at home or during transport);
- the use of devices indicated for sleep apnea (including CPAP and BiPAP), provided that appropriate design mitigations are in place to minimize aerosolization; or
- The use of oxygen concentrators for primary supply when medically necessary and clinically appropriate.

FDA will also allow for modifications to the FDA-cleared *indications, claims, or functionality* of these devices, without a prior submission of a premarket notification. Examples of circumstances where FDA currently believes a modification would be allowable include:

- Modifications to motors, batteries, or other electrical components;
- Material changes to components in the gas pathway or with other patient tissue contact;
- Introduction of filtration to minimize aerosolization;
- Software modifications intended to modify the ventilation parameters including inspiratory pressure, tidal volumes, flow rates, positive end-expiratory pressure (PEEP) in accordance with any applicable device standard;
- Software modifications implementing physiological closed loop (automated)

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algorithms for oxygen titration where the algorithms/devices are the subject of an FDA-approved Investigational Device Exemption (IDE); and

- Hardware and/or software modifications implementing the capability for remote monitoring and remote adjustment of ventilator parameters (i.e., adjustment of parameters by trained health care providers from outside an isolation unit to avoid unnecessary exposures).

FDA is interested in interacting with manufacturers of ventilatory support devices that are not currently legally marketed in the U.S. as well as manufacturers who have not previously been engaged in medical device manufacturing with capabilities to increase supply of these devices. FDA will work interactively with these manufacturers through its Emergency Use Authorization (EUA) process. The guidance includes specific information to send to FDA and all information and questions can be sent to: CDRH-COVID19-Ventilators@fda.hhs.gov.

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: National Briefing 2 PM EST - Coronavirus Task Force
Date: Friday, February 7, 2020 12:31:45 PM

Please join us at 2 PM EST at www.hhs.gov/live for a national press briefing from the Coronavirus Task Force. *Link will be live shortly before the event.*

U.S. Department of Health and Human Services

Friday,
February
7, 2020

Today, the Department of Health and Human Services (HHS) will host a press briefing by members of President Trump's Coronavirus Task Force.

2:00 PM EST: Press Conference Begins. www.HHS.gov/live

###

Follow @SecAzar on Twitter, like HHS on Facebook, and sign up for HHS Email Updates

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: National Briefing 2 PM EST - Coronavirus Task Force
Date: Friday, February 7, 2020 12:28:22 PM

Please join us at 2 PM EST at www.hhs.gov/live for a national press briefing from the Coronavirus Task Force. *Link will be live shortly before the event.*

U.S. Department of Health and Human Services

Friday,
February
7, 2020

Today, the Department of Health and Human Services (HHS) will host a press briefing by members of President Trump's Coronavirus Task Force.

2:00 PM EST: Press Conference Begins. www.HHS.gov/live

###

Follow @SecAzar on Twitter, like HHS on Facebook, and sign up for HHS Email Updates

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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From: NCHS NVSS News (CDC)
Cc: Brown, Kelly D. (CDC/DDPHSS/NCHS/DVS); Tolson, George C. (CDC/DDPHSS/NCHS/DVS)
Subject: National Vital Statistics System Newsletter - February 2020
Date: Monday, March 2, 2020 9:11:01 AM



Division of Vital Statistics Newsletter — February 2020

-

Click here to view the full NVSS newsletter online

This month, we're focused on improvements. To begin, we will be proposing improvements to the next VSCP contract, and will be seeking your input. Please take a moment to read and find out how you can contribute your ideas. This issue also highlights our newest VSCP Special Project, Address Data for Geocoding, which is collecting data from every jurisdiction to improve our ability to calculate life expectancy and mortality at more local levels. You'll also find out how Iowa is improving data quality and timeliness through a new birth registration facility report card. Additionally, we connect you to upcoming NAPHSIS trainings that may be of interest, and to information on how jurisdictions can work with NCHS to test newly implemented data systems.

Whether it's by joining our projects, attending a training, or sharing your own ideas for the future, we encourage you to stay connected with us and be a part of making the National Vital Statistics System better.

Enjoy!
Steve

Steven Schwartz, PhD
Director – Division of Vital Statistics
National Center for Health Statistics
3311 Toledo Rd | Hyattsville, MD 20782

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	New CDC COVID-19 Check and Record Everyday (CARE) Booklet
Date:	Wednesday, February 26, 2020 8:09:25 AM
Attachments:	2019nCoV_CARE_EngChinese_Feb25.pdf
Importance:	High

Dear Colleagues:

Attached is CDC's new COVID-19 Check and Record Everyday (CARE) booklet. Here is what to know:

- **Who gets a CARE booklet? And when?** Every traveler referred by CBP from mainland China, whenever they get released during the screening process or the completion of secondary screening. This is the same process as the current T-HAN and Temperature and Symptom log. If the traveler is an unaccompanied minor, a booklet will be provided to the person in charge of picking them up at their final destination

- **What language is the booklet in?** English on one side and Simplified Chinese on the other for the print version. A Spanish version will be available online in the coming weeks.

- **When will CDC staff at quarantine stations start handing out the new booklet?** Distribution of the booklets will start by **Friday, February 28th.**

- **What is the role of CDC/QS staff?** The role of CDC/QS staff is to ensure every traveler referred from mainland China by CBP receives a CARE booklet in an envelope. Booklets are shipped pre-assembled in a labeled envelope.

- **What is the role of State and Local Health Departments?**Travelers are advised to connect with the State and Local Health Departments at their destination; these numbers are listed in the booklet.

- **How many CARE booklets will quarantine stations receive?**Each station will receive a different number of booklets every week based on the number of travelers entered in QARS the previous week. Because this is an estimate, we've added an additional 10% of booklets to each shipment.

- **What if the information in the booklet changes?**Information is quickly and frequently changing. If the CARE booklet changes, we will print and ship a new version of the booklet. The new version will have a different color on the outside label of the envelope containing the booklet. If this happens, quarantine stations will receive an email with the new information and outdated materials will be discarded. The first and current shipment contains ayellow outline on the label.

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- **Does the shipment contain thermometers and phones?**No, we will not be supplying thermometers or phones at this time.

- **Will the booklet be available online?** Yes, we plan on having an online version of the booklet available in the coming weeks.

Thank you,

State Coordination Task Force

Sent by BCC to State Health Officials, State Epidemiologists, PHEP Directors, and COVID-19 Primary/Secondary Contacts

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc: Pritchard, Scott; Rubino, Heather
Subject: Next week
Date: Wednesday, February 26, 2020 6:23:53 PM

We are excited to have you on site next week. Coronavirus is the first item on the menu as you can imagine. But we are also engaged in hep A and legionella response. Not to forget flu. What time do you think you will be in the office? We would like to sit down sometimes early in the day to discuss scientific on boarding. Carina

Get Outlook for iOS

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response PUI; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Monday, March 2, 2020 8:40:28 AM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2783039
FL2783057

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response PUI; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Monday, March 2, 2020 12:46:58 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2785091
FL2785125

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response PUI
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Friday, March 6, 2020 5:06:11 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2786318

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Clinical On-Call Unit; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Monday, March 9, 2020 6:09:39 PM

Dear Blackmore

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2785091
FL2787169

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Tuesday, March 10, 2020 4:05:21 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL 2789590
FL 2789655
FL27889624

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Clinical On-Call Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Wednesday, March 11, 2020 10:50:50 AM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2785091
FL2787619

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Clinical On-Call Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Friday, March 13, 2020 5:50:49 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2789656
FL2791177

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Clinical On-Call Unit; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Tuesday, March 17, 2020 7:59:48 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCOV#
FL2792229
FL2792320
FL2792316
FL2792718
FL2792318
FL2786318
FL2785125

Thanks,

Clinical On-call Unit & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response PUI
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19)
Date:	Friday, February 21, 2020 7:14:59 PM

Dear Carina,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID	Submitter Specimen ID
0001283	MRF20000027
0001283	MRF20000028

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

AMERICAN OVERSIGHT

From: omni

To: Abra Greenberg; Abra.Greenberg@odh.ohio.gov; abross@acog.org; achaudhry@amchp.org; Aflagg@aphsa.org; ailis.clyne@health.ri.gov; Alane.oconnor@mainegeneral.org; Alda.Osinaga@health.ny.gov; Alexandra Kearly; Alexia Harrist; alexis.tucey@dhcfp.nv.gov; allen.brenzel@ky.gov; amanda.c.bennett@illinois.gov; amy.acton@odh.ohio.gov; amy@pachc.org; angelaw.parker@ky.gov; ann.zerr@fssa.in.gov; Anna Bartels; anne.zink@alaska.gov; antraneise.jackson@ahca.myflorida.com; ANussbaum@marchofdimes.org; aogushi@health.nv.gov; apeterson2@roseman.edu; april_henry@mednax.com; arvind.goyal@illinois.gov; ashley.berliner@vermont.gov; ashley.busacker@wyo.gov; Ashley.Jeans@tn.gov; Ashley.Swarowski@uhc.com; atolliver@wvperinatal.org; aushry@acog.org; avelonis@uic.edu; bberry@southcentralfoundation.com; Benedetta.Bernardo@uhsinc.com; beverly.mason@dcfs.nv.gov; bki@hrpregnancy.com; borders.ann@gmail.com; Breena.Holmes@vermont.gov; brenda.barker@tipqc.org; buffingtona@unce.unr.edu; caitlin.cross-barnet@cms.hhs.gov; constantinis@thewrightcenter.org; carolyn.drazinic@myflfamilies.com; catherine.friedman@bhddh.ri.gov; Catherine Slemp, MD, MPH; cchance@indianapca.org; c-dakelley@pa.gov; cdf1@cdc.gov; chamilton@hsc.wvu.edu; charissa.fotinos@hca.wa.gov; choots@iphca.org; Christi Mackie; cio8@cdc.gov; cjohn@hsc.wvu.edu; ckendell@kyha.com; ckroelinger@cdc.gov; cmcdaniel@health.nv.gov; cmclachlan@dhcfp.nv.gov; coloradobabydoc@gmail.com; Connie White; cpaoli@washoecounty.us; cphinney@dhcfp.nv.gov; Cynthia.A.Parsons@wv.gov; Cynthia.Wohlford-Lotas@medicaid.ohio.gov; czj5@cdc.gov; danielle.howes@vermont.gov; danielle.kirby@illinois.gov; danielle.marks@wyo.gov; dcorritore@washoecounty.us; ddurham@uwyo.edu; Debbie.Croshaw@ClarkCountyNV.gov; deepa.sonpatki@gmail.com; denise.a.smith@wv.gov; Denise.Werner@tn.gov; dlevinson@hrsa.gov; DMadole@washoecounty.us; dmeador@kyha.com; dnp7@cdc.gov; Donna.L.PauleyWilson@wv.gov; DRab@hrsa.gov; drael@health.nv.gov; drbbartholomew@whasn.com; drdmiller@whasn.com; dshargo@mepca.org; dvn1@cdc.gov; DWeiss@northshore.org; dwz8@cdc.gov; dyoung@dhcfp.nv.gov; EBezy@isdh.IN.gov; edunlevey@pa.gov; ekk5@cdc.gov; elizabeth.conrey@odh.ohio.gov; elizabeth.harvey@tn.gov; Ellen Pliska; emma.white@wvpca.org; eon1@cdc.gov; erin.lynch@dhcfp.nv.gov; evonda.thomas-smith@illinois.gov; fkamyar@hrpregnancy.com; fob1@cdc.gov; ftaylor@adsd.nv.gov; fvc1@cdc.gov; Gabriela Garcia; gbaroi@cdc.gov; gina.pierotti-buthman@uhsinc.com; glen.klinkhart@alaska.gov; Gordon.smith@maine.gov; gstoner@geisinger.edu; gzander@pa.gov; henrietta.bada@ky.gov; Hilary.Daugherty@tn.gov; hjarolimek@dcfs.nv.gov; iazzam@health.nv.gov; ile4@cdc.gov; ilisa.stalberg@vermont.gov; j.thompson@cms.hhs.gov; jaimie.evins@dhcfp.nv.gov; james.b.becker@wv.gov; james.e.jeffries@wv.gov; jan@wvpca.org; janiner@wsha.org; Javier.Betancourt@flhealth.gov; jbreyel@hsc.wvu.edu; JBuerlein@hrsa.gov; jdavies@dhcfp.nv.gov; Jean.Blankenship@acf.hhs.gov; jeanine.evenden@dignityhealth.org; Jennifer Somdahl; Jennifer.brown2@anthem.com; jennifer.epstein@illinois.gov; Jennifer.Johnson@flhealth.gov; jevins@dhcfp.nv.gov; jill.marano@clarkcountynv.gov; jim.walsh@swedish.org; joan.chappell@hca.wa.gov; Joanna.Bacon@uhsinc.com; johnfirestone@tlccreno.org; joyce.starr@mha.ohio.gov; jpatton@dhcfp.nv.gov; jpgoslin@alaska.gov; jschoolmeester@dhcfp.nv.gov; jsteinberg@hrsa.gov; jtonkin@dhcfp.nv.gov; judy.theriot@ky.gov; jwo4@cdc.gov; jwolf@lacsn.org; kara.miller@medicaid.ohio.gov; Kari.Ellis@hcahealthcare.com; kariearle@gmail.com; Kat Patterson; kathryn.chapman@alaska.gov; katie.eilers@doh.wa.gov; Katie.Letcher@uhc.com; kbox@isdh.in.gov; kcraig2@renown.org; KDavis-Coelho@renown.org; kelly.boyle@dcyf.wa.gov; Kelly.Dougherty@vermont.gov; KFarrell@hrsa.gov; kharris997@aol.com; khx2@cdc.gov; kim.connolly@centerforbehavioralhealth.com; kims@fha.org; klayosa@step2reno.org; kmarschall@socialent.com; kmoran3@thehealthplan.com; Lawless, Kristen L (HEALTH); Kristen.Zycherman@cms.hhs.gov; kristi.pebley@centerforbehavioralhealth.com; Kristina.West@hhs.gov; kristine.campagna@health.ri.gov; kristine@symplexityconsulting.com; kroussos@ufl.edu; ktrocin@hrsa.gov; kuesugi@uic.edu; lamalinalovell@dhhs.nv.gov; laura.dobler@wyo.gov; laura.rooney@odh.ohio.gov; Lauren.Tobias@health.ny.gov; Laurin.Kasehagen@partner.vermont.gov; lhale@socialent.com; LHorlamus@hrsa.gov; libby.bunzli@ohhs.ri.gov; Lily.lou@alaska.gov; linda.mahoney@bhddh.ri.gov; linda.mccorkle@tn.gov; linda.streitfeld1@cms.hhs.gov; lindsaya@unce.unr.edu; lisa.cohen@illinois.gov; Lisa.Mantkus@uhc.com; llee@forrecovery.org; lmosier@uwyo.edu; lnv1@cdc.gov; Lori Reeves; Lori.Dorsey@bhddh.ri.gov; lori.reeves@flhealth.gov; lpaul@aap.org; lstapleton@hrsa.org; Luciana.Blosz@dignityhealth.org; Lusine Ghazaryan; LWaddell@marchofdimes.org; mackr2@unlv.nevada.edu; maggie.schroeder@ky.gov; Margo.Katz@health.ri.gov; maria.delrio@ascension.org; maria.mclay@dignityhealth.org; Maria.Morris@oasas.ny.gov; marid@uic.edu; Marietta.Scholten@partner.vermont.gov; Marilyn.Kacica@health.ny.gov; marissa@nvha.net; mark.hurst@mha.ohio.gov; mark.hurst@odh.ohio.gov; Mark Levine; Mary.Applegate@Medicaid.ohio.gov; Maryann.harakall@maine.gov; Maya.Zamir@anthem.com; mberry@casat.org; mcampbell@rihca.org; mclouse@ky.gov; mdygert@aphsa.org; Megan.Mitchell@vermont.gov; Mekell.L.Golden@wv.gov; Melissa.A.Baker@wv.gov; melissa.jordan@flhealth.gov; Mesfin_Woldesenbet@mednax.com; mhmgreer@aol.com; mhutchinson@step2reno.org; Michele Walsh; Michelle.probert@maine.gov; michelle.shepard@med.uvm.edu; Miranda.J.Scott@illinois.gov; mlawler@hrsa.gov; mmeaney@renown.org; moira.crowley@uhhospitals.org; Monica Clouse; morgan.mcdonald@tn.gov; mrh7@cdc.gov; mrice@cdc.gov; mterplan@gmail.com; muw1@cdc.gov; nadine@doylestrategies.com; nancy.miller@vermont.gov; nancy@alaskapca.org; Natalie Foster; Natalie.Norberg@alaska.gov; nbowen@nvpca.org; Neodoc1124@gmail.com; Newja@clarkcountynv.gov; nhu4@cdc.gov; Nicole.L.Figles@silversummithealthplan.com; nirav.shah@maine.gov; njn6@cdc.gov; nlamboley@renown.org; nmulho2@uic.edu; ntyus@hrsa.gov; Pamela.england@dignityhealth.org; pap5@cdc.gov; patricia.king@northwestern.edu; patsy.kelso@vermont.gov; pblank@pa.gov; PCarlston@marchofdimes.org; peter.slom@dcyf.ri.gov; Philip_Vaughn@mednax.com; pmaris@ric.edu; PMasonMarti@marchofdimes.org; pmorphew@indianapca.org; rachael.comeau@uvm.edu; rammon@hrsa.gov; Ramya Dronamraju; Rebecca.Buhner@fssa.IN.gov; Rebecca.e.roth@wv.gov; Reena.Oza-Frank@odh.ohio.gov; Renee.Fox@cms.hhs.gov; rgustafson@washoecounty.us; Richa Ranade; Richard.Massatti@mha.ohio.gov; Robert Morrison; Robert.H.Hansen@wv.gov; rschultz@kypca.net; rutu.ezhuthachan@uhc.com; ryan.erickson@governor.ri.gov; sali@health.nv.gov; SAmatetti@hrsa.gov; Sanaa Akbarali; Sarah.Beard@flhealth.gov; Sarah.bowman@health.ri.gov; Sarah.E.Fox@silversummithealthplan.com; sarah.mansouri@tn.gov; sarah.pine@hca.wa.gov; sashmore@iphca.org; saylem.m.depasquale@wv.gov;

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	SCollins@amchp.org; scott.strenio@vermont.gov; sdearborn@dhcfp.nv.gov; shannon.lightner@illinois.gov; Shay.Chapman@flhealth.gov; sherrell.holtshouser@alaska.gov; Shevaun.Harris@ahca.myflorida.com; sjensen@step2reno.org; sjf4@cdc.gov; skincaid@ohiochildrenshospitals.org; sleslie@socialent.com; slin@hrsa.gov; smcgill@tlccreno.org; smiller2@hrsa.gov; SNair1@hrsa.gov; Jennifer Somdahl; spayne@isdh.in.gov; stephanie.Bates@ky.gov; Stephanie.Frank@illinois.gov; stephanie.terry@dcyf.ri.gov; Susan.fitzpatrick2@hcahealthcare.com; suzanne.bierman@dhcfp.nv.gov; Suzanne.Shibley@vermont.gov; swold@hrpregnancy.com; swoodard@health.nv.gov; taylorl@unce.unr.edu; Tami Barrett; tbenitez@dhcfp.nv.gov; tcalliguri@gmail.com; tclay@adsd.nv.gov; Tequam Tiruneh; terri.sabella@tnpca.org; theresa.carsten@dhcfp.nv.gov; tiffani.buck@doh.wa.gov; tiffany.mcnair@cms.hhs.gov; tmueller@cdc.gov; tnguye13@uwyo.edu; Trisha@wsha.org; TSpitz@marchofdimes.org; vania.rudolf@swedish.org; victor.wu@tn.gov; vives@health.nv.gov; webberk@unce.unr.edu; Wendi.Afualo@uhc.com; william_trawick@mednax.com; goldsteine@thewrightcenter.org; Cram, Jessica
Cc:	Barker, Brenda; Kari Earle; Berube, Jayne (HRSA); Radford, Dora L; Elizabeth Ruebush; Anne R Lindsay; McGown, Molly Frances; Charles Damon; cduarte@socialent.com; Kindle Craig; Eustice, Sarah M (CHFS DPH); Jill Martin; Marks, Katie (BHDID)
Subject:	OMNI ASTHOConnects: PCA Involvement
Attachments:	image001.png OMNI_ASTHOConnect_Agenda_2.4.20.pdf OMNI_ASTHOConnects_Slides_2.4.20.pdf OMNI_ASTHOConnects_Speaker Bios_2.4.20.pdf

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Please join us for our OMNI ASTHOConnects on Primary Care Associations and Federally Qualified Health Centers, and how to best engage them in your work. Attached you'll find the agenda, slides, and speaker bios for today's webinar.

To access the webinar, please use the following:

Zoom Link: https://astho.zoom.us/j/290202789

Phone Number: 646-876-9923
Access Code: 290 202 789

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Office for Civil Rights (OCR) Announces Notification: Enforcement Discretion for Telehealth Remote Communications During the COVID-19
Date:	Thursday, March 19, 2020 11:33:59 AM

OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html

Today, the Office for Civil Rights (OCR) at the U.S Department of Health and Human Services (HHS) announced, effective immediately, that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency.

This exercise of discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.

In support of this action, OCR will be providing further guidance explaining how covered health care providers can use remote video communication products and offer telehealth to patients responsibly.

"We are empowering medical providers to serve patients wherever they are during this national public health emergency," said Roger Severino, OCR Director. "We are especially concerned about reaching those most at risk, including older persons and persons with disabilities," Severino added.

The Notification of Enforcement Discretion on telehealth remote communications may be found at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

For more information on HIPAA and COVID-19, see OCR's February 2020 Bulletin: https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf - PDF

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health

AMERICAN OVERSIGHT

laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	Gilliard, Deric (HHS/IEA)
To:	Jade.Tindle@FLHealth.gov
Cc:	Coppola, Courtney (Courtney.Coppola@flhealth.gov); Cales, Natalia (HHS/ORD)
Subject:	Office of the Secretary in Region IV reaching out for county health directors" contact list
Date:	Tuesday, March 24, 2020 2:15:17 PM
Attachments:	BIO - John McGough HHS Regional Director - Region 1 Boston & Region 4 Atlanta.pdf

Hello Jade.

I work for HHS Region IV Director John McGough, who has oversight of the eight southeastern states. He held a call with SG Rivkees that was coordinated by Courtney back in November to discuss the HHS priorities as they relate to the Florida county health directors. John has asked me to acquire contact information for all of the county health directors, in the event an emergency or fast-developing COVID-19 situation, either involving testing, PPEs, staffing, cruise ship arrivals, etc., requires him to reach someone on the weekends, or in the evening. Believe me, because he also leads the six Region I states, which include Boston, his plate is full and he would not be making a call unless there were no other options.

Courtney returned my call Friday evening and told me she would provide me with the list. Since I see that she is now deployed and out of pocket, I will refer the request to you, per her instructions.

Thanks in advance.

Sincerely,

Deric

DERIC GILLIARD, MA
Public Affairs Specialist
U.S. Department of Health and Human Services
Atlanta Federal Center
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404-562-7910 Office
202-868-9202 Cell

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: Opportunity for "drive-through" testing site synergy
Date: Tuesday, March 17, 2020 4:41:17 PM

State Health Official –

First, let me thank you for all the work that you are currently doing to respond to COVID-19. We value your dedication to this.

As we continue to monitor and respond to the ongoing COVID-19 outbreak, we are working to drastically increase the number of sites that are testing for coronavirus around the country. As you are aware from the communications from Admiral Brett Giroir, FEMA, and ASPR throughout the past few days, we – in partnership with state and local health authorities – are standing up a number of "drive-through" testing sites across the nation for populations that are most in need of testing. While we are working to operationalize these, we know that there are a number of independent or private sites that are simultaneously opening their own "drive-through" testing operations.

If you are aware of sites in your state that are doing this testing, and are comfortable with sharing those with HHS for publication on the website that we are developing for this response, please share those with the U.S. Health and Human Services team. We want to amplify the availability of these testing operations to connect individuals to testing. You can reply to this email, or call me at the number below.

Please let me know the locations of these operations as soon possible. We are hoping for the location, address, and contact information for those sites. We thank you for your continued partnership and support during this outbreak. The leadership that you provide in your state is invaluable, and we look forward to continuing to work together to protect the health and well-being of the nation.

Thank you,

Michael Baker
Office of Intergovernmental and External Affairs
Office of the Secretary
U.S. Department of Health and Human Services
202-439-7829

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	POSTPONED: 3-13-14 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, March 13, 2020 12:37:53 PM

Telebriefing postponed until tomorrow at 1pm.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When UPDATED: 1:00 p.m. ET Saturday, March 14, 2020

Dial-In

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

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U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	POSTPONED: 3-13-14 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, March 13, 2020 12:40:15 PM

Telebriefing postponed until tomorrow at 1pm.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When UPDATED: 1:00 p.m. ET Saturday, March 14, 2020

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Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	POSTPONED: 3-13-14 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, March 13, 2020 12:34:21 PM

Telebriefing postponed until tomorrow at 1pm.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When UPDATED: 1:00 p.m. ET Saturday, March 14, 2020

Dial-In

Media:800-857-9756
International: 1-212-287-1647
PASSCODE:CDC MEDIA

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

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U.S. Department of Health and Human Services

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; D"Angelo, Joseph ; Dellamura, Joseph ; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; RRCC LOGS Supply Box
Subject:	PPE Burn Rate Calculator, Excel Spreadsheet Model
Date:	Wednesday, March 25, 2020 8:23:11 PM
Attachments:	R8 Ventilator Estimates 2020-03-25 11_44_23.xlsx 200324 Determining PPE Requirements 2020-03-25 11_42_05.pptx

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All

One of our regions did some calculations on PPE burn rate and staffing estimate. It is one of the modeling opportunities out there. Please use if you like.
I also attached a sample document to review

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

Number of Full Time Staff per Bed Estimate: https://www.beckershospitalreview.com/lists/200-hospital-benchmarks-october-2012.html

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

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FEMA RRCC Atlanta, GA
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email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)

AMERICAN OVERSIGHT

cell: 202.909.6950 Verizon (secondary)

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	PPE Manufacturing Expertise and swab sample kits
Date:	Sunday, March 22, 2020 12:43:55 PM
Attachments:	FDA Hand Sanitizers Immediately in Effect Guidance Other Firms FINAL_0.pdf Strategies for Optimizing the Supply of N95 Respirators_ COVID-19 _ CDC.pdf Masks - cloth and common fabrics AOH 2010.pdf Simple resp mask EID 05-1468.pdf
Importance:	High

Here is additional information I just got from CDC regarding PPE. Several more attachments too. I'm sending this to much wider audience.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Swab sample test kit suppliers (unvetted)

Here are some suppliers you may want to contact for supplies:
Copan Diagnostics
26055 Jefferson Avenue Murrieta, CA 92562

Thermo Fisher Scientific
168 Third Avenue | Waltham, MA 02451

Princeton BioMeditech Corporation
P.O. Box 7139, Princeton, New Jersey 08543-7139 U.S.A. Tel: (732) 274-1000
4242 U.S. Route 1, Monmouth Junction, New Jersey 08852-1905 U.S.A. Fax: (732) 274-1010
Internet E-mail: info@pbmc.com
World Wide Web: http://www.pbmc.com/

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

AMERICAN OVERSIGHT

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	PPE RFI
Date:	Saturday, March 21, 2020 9:46:43 AM
Attachments:	Strategies for Optimizing the Supply of N95 Respirators_ COVID-19_ CDC.pdf

Below are the CDC links reference reusable materials that you requested.

The last paragraph of the pdf covers homemade masks.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
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cell: 404.772.9701
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cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

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Subject:	PPE RFI
Date:	Saturday, March 21, 2020 9:47:42 AM
Attachments:	Strategies for Optimizing the Supply of N95 Respirators_ COVID-19_ CDC.pdf

Below are the CDC links reference reusable materials that you requested.

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https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

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To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	PPE RFI
Date:	Saturday, March 21, 2020 9:46:41 AM
Attachments:	Strategies for Optimizing the Supply of N95 Respirators_ COVID-19_ CDC.pdf

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https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

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AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please RSVP: National Briefing Call Monday, February 3rd; 12 PM EST
Date: Sunday, February 2, 2020 8:27:25 PM

State and Local Leaders,

Please join us for a national briefing call on **Monday, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force. The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Briefing Call
Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
Call-In Information: CLICK HERE *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject:	Please RSVP: National Briefing Call Monday, February 3rd; 12 PM EST
Date:	Sunday, February 2, 2020 8:31:47 PM

State and Local Leaders,

Please join us for a national briefing call on **Monday, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force. The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

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Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
Call-In Information: CLICK HERE *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please RSVP: National Briefing Call Monday, February 3rd; 12 PM EST
Date: Sunday, February 2, 2020 8:20:34 PM

State and Local Leaders,

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Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please Register - COVID 19- National Call, Feb. 14th
Date: Thursday, February 13, 2020 5:39:01 PM

State and Local Leaders,

Please join us for a national briefing call **TOMORROW, Friday, February 14 at 1:45 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Additional Information

- You can find more information and resources at the CDC website here: https://www.cdc.gov/coronavirus/.
- ICYMI – USA Today: Our Coronavirus Response Is Protecting Americans (see full Op-Ed below)

Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

ICYMI - Our Coronavirus Response Is Protecting Americans
USA Today
By Secretary of State Mike Pompeo and HHS Secretary Alex Azar
February 11, 2020
Link to op-ed here.

The first duty of the federal government is to keep our citizens safe. Since the United States first became aware on Dec. 30 of what has become known as the novel coronavirus, America's public health officials have closely monitored the situation, worked to understand the virus and taken steps to limit Americans' exposure to it.

Our task force is ensuring that our whole of government, layered, public health plan has the resources necessary to protect Americans. We've treated the sick, and traced back their travel

AMERICAN OVERSIGHT

history and contacts to minimize the spread of the virus. We've worked swiftly to screen and safely receive American travelers returning from China, and bar foreign travelers who have recently visited the epicenter of the outbreak.

Consistent with the World Health Organization International Health Regulations, our travel restrictions were intentionally devised to complement the Chinese government's policy of isolating approximately 50 million of its own citizens in Hubei province. Other nations, such as Italy and South Korea, have taken similar measures.

Our efforts in China

Thus far, the United States has only had 12 confirmed cases of the virus. We were saddened to hear last week that one American, a 60-year-old woman in Wuhan, China, has died. But we're undeterred in our vigilance to protect our people. And we're mobilizing resources around the world to help other nations fight the disease, too. This is American altruism at its finest.

Let's start with our efforts focused on the country where the virus first appeared — China. In the words of President Donald Trump, "We're offering them tremendous help." During the first week of January, the Centers for Disease Control and Prevention made an offer of assistance in order to understand the disease and help bolster response efforts.

The Department of Health and Human Services subsequently provided to the WHO a list of world-class medical professionals ready to deploy their skills in China and learn from China's efforts to combat this new coronavirus. In the last week of January, Secretary Azar personally extended an offer of help to Health Minister Ma Xiaowei; Secretary Pompeo did the same with Chinese State Councilor Yang Jiechi. We hope the mission will commence immediately, whether bilaterally or under the auspices of the WHO.

We've also facilitated the delivery of vast amounts of medical supplies to the Chinese people. Just last week, the State Department helped transport 17.8 tons of relief supplies to Hubei. And more assistance will continue to be offered — the United States is prepared to spend up to $100 million in existing State and U.S. Agency for International Development funds to assist China and other impacted countries to contain and combat the virus.

While State managed the logistics, the donations themselves were provided by Samaritan's Purse, Boeing, Intermountain Healthcare and The Church of Jesus Christ of Latter-day Saints, and coordinated by a nongovernmental organization called Project HOPE. Time and again, when diseases and disasters strike, the American people have stepped up to help citizens of other countries without being asked. Our robust charitable giving and enthusiastic civil society groups are channeling the American people's concern for their fellow man.

Cooperation with other nations

Then there are America's actions to help the citizens of other countries, beyond China. CDC staff based in more than 60 countries are working closely with ministries of health and other health partners, often in conjunction with their colleagues at the State Department and other federal agencies.

AMERICAN OVERSIGHT

For instance, the United States has made coronavirus test kits available to 191 qualified laboratories around the world; so far, labs from 36 countries have put in orders. We've deployed staff to train health professionals in 15 hospitals in Vietnam. In Kenya, health experts at the U.S. Embassy in Nairobi, as part of our Infectious Diseases Task Force, engaged the government early on to recommend best practices in airport screening and public health.

Our quick and effective reaction abroad is facilitated by partnerships that America has carefully nurtured over decades — long before the latest outbreak.

We believe our actions will slow the transmission of the virus to and within the United States and other countries, solidify our ties of friendship with our allies and partners, and help save lives by giving us more time to refine preparedness measures and better understand the virus.

We all hope that our concerted efforts will control the virus and cause it to subside. But the world doesn't need to wait for that day to see how America remains a force for good throughout the globe.

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please Register - COVID 19- National Call, Feb. 14th
Date: Thursday, February 13, 2020 5:39:29 PM

State and Local Leaders,

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Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

ICYMI - Our Coronavirus Response Is Protecting Americans
USA Today
By Secretary of State Mike Pompeo and HHS Secretary Alex Azar
February 11, 2020
Link to op-ed here.

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please Register - COVID 19- National Call, Feb. 14th
Date: Thursday, February 13, 2020 5:38:57 PM

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Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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February 11, 2020
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject:	Please Register: National Briefing Call TODAY, February 3rd; 12 PM EST
Date:	Monday, February 3, 2020 9:22:10 AM

State and Local Leaders,

Please join us for a national briefing call **TODAY, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Briefing Call
Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
Call-In Information: CLICK HERE *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject:	Please Register: National Briefing Call TODAY, February 3rd; 12 PM EST
Date:	Monday, February 3, 2020 9:28:47 AM

State and Local Leaders,

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Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
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AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Stevens, Lee (OS/IEA)
Subject:	Please Register: National Briefing Call TODAY, February 3rd; 12 PM EST
Date:	Monday, February 3, 2020 9:18:25 AM

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Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Ashley Vineyard
To:	FRD3@CDC.GOV; CSZ5@CDC.GOV; SFV1@CDC.GOV; cnd8@cdc.gov; CUE0@cdc.gov; Carina Blackmore; Elizabeth.Dykstra@DOH.WA.GOV; Christine Scott-Waldron; elizabeth.schiffman@state.mn.us; Sally Slavinski; Jen Brown; Esther Ellis; krymason@pa.gov; Catherine Brown; Abelardo Moncayo; John Dunn; Melissa.Kretschmer@Maricopa.gov; jennifer.house@state.co.us; conlonamcata@gmail.com; cgridley-smith@naccho.org; mgustafson@neha.org; BHess@neha.org; Courtney Youngbar; kelly.wroblewski@aphl.org
Cc:	Justin Snair
Subject:	Please Review: Draft VBD Program Core Components Manuscript
Date:	Tuesday, March 3, 2020 9:29:31 AM
Attachments:	image001.png SGNL VBD Program Components Project_Draft Project Summary_final.docx

Good morning all,

Please review the attached draft "Defining the Components and Minimal Capabilities of Comprehensive State and Local Vector-Borne Disease Prevention and Control Programming" manuscript and submit any suggested edits, comments, and questions to Justin Snair (jsnair@sgnl.solutions) by **COB Friday, March 13th.**

Please also complete this doodle poll to indicate your availability for an upcoming webinar to present the final manuscript and discuss implementation.

Thanks,

Ashley Vineyard, MPH
Program Analyst II

CSTE

Council of State and Territorial Epidemiologists
"Using the power of epidemiology to improve the public's health"
CSTE.org • Membership • Facebook • Twitter • Instagram
2635 Century Parkway NE, Suite 700, Atlanta, GA 30345
Tel: 770.458.3811 | Fax: 770.458.8516

Documents with personal data and/or confidential information must be sent to CSTE's national office only through a secure ShareFile request and not through regular email.

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov)
Subject:	Please see the note below from Eric Hargarten
Date:	Wednesday, March 18, 2020 6:07:38 PM

****

From Eric Hargarten- HHS

Hi all -

We wanted to notify you that the provided supplies will arrive at the shipping locations you provided as early as 8 AM EST and as late as 8 PM EST today (Wednesday March 18th). Upon arrival the driver will contact the shipping point of contact you provided.

A few other important notes about the shipments and what to expect:

- **Shipment details**: Testing kits are coming from Henry Schein and other supplies will come from the following companies: McKesson, Medline (FedEx), Uline (UPS), Grainger (UPS), DuPont (UPS), Taylor Communications (UPS)
    - Some deliveries will be on pallets or skids, smaller shipments will not (for example, bar code labels will not be on skids)
- **Delivery timelines:** all **ESTIMATES** based on latest information:
    - By COB Wednesday: Henry Schein, McKesson, Uline, Grainger, DuPont, Medline
    - By 10:30 am Thurs: Taylor Communications (bar code labels)

Please note that due to the extraordinary circumstances we are trying to provide the most accurate and comprehensive information, but things are subject to change. We will provide updates in the morning and evening on Wednesday.

Thank you

Eric Hargarten
316-209-6279
Special Assistant, Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

AMERICAN OVERSIGHT

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov)
Subject:	Please see the note below from Eric Hargarten
Date:	Wednesday, March 18, 2020 6:07:27 PM

****

From Eric Hargarten- HHS

Hi all -

We wanted to notify you that the provided supplies will arrive at the shipping locations you provided as early as 8 AM EST and as late as 8 PM EST today (Wednesday March 18th). Upon arrival the driver will contact the shipping point of contact you provided.

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Please note that due to the extraordinary circumstances we are trying to provide the most accurate and comprehensive information, but things are subject to change. We will provide updates in the morning and evening on Wednesday.

Thank you

Eric Hargarten
316-209-6279
Special Assistant, Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

AMERICAN OVERSIGHT

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
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Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: President"s Coronavirus Guidelines For America: 15 Days to Slow the Spread
Date: Tuesday, March 17, 2020 12:18:54 PM
Attachments: image001.png



Dear Colleagues:

Yesterday, President Donald. J. Trump announced new guidelines to address COVID-19. Below, please find additional information on ***The President's Coronavirus Guidelines for America: 15 Days to Slow the Spread***. Please feel free to share broadly.

As a reminder, the CDC's official Coronavirus website – **www.coronavirus.gov** – is the best source for up-to-date information and guidance.

The President's Coronavirus Guidelines for America: 15 Days to Slow the Spread

1. Listen to and follow the directions of your state and local authorities.
2. If you feel sick, stay home. Do not go to work. Contact your medical provider.
3. If your children are sick, keep them at home. Do not send them to school. Contact your medical provider.
4. If someone in your household has tested positive for the coronavirus, keep the entire household at home. Do not go to work. Do not go to school. Contact your medical provider.
5. If you are an older person, stay home and away from other people.
6. If you are a person with a serious underlying health condition that can put you at increased risk (for example, a condition that impairs your lung or heart function or weakens your immune system), stay home and away from other people.
7. Even if you are young, or otherwise healthy, you are at risk and your activities can increase the risk for others. It is critical that you do your part to stop the spread of the coronavirus:
    a. Work or engage in schooling from home whenever possible.
    b. If you work in a critical infrastructure industry, as defined by the Department of Homeland Security, such as healthcare services and pharmaceutical and food supply, you have a special responsibility to maintain your normal work schedule. You and your employers should follow CDC guidance to protect your health at work.
    c. Avoid social gatherings in groups of more than 10 people.
    d. Avoid eating or drinking in bars, restaurants, and food courts – use drive-thru, pickup, or delivery options.
    e. Avoid discretionary travel, shopping trips, and social visits.
    f. Do not visit nursing homes or retirement or long-term care facilities unless to provide critical assistance.

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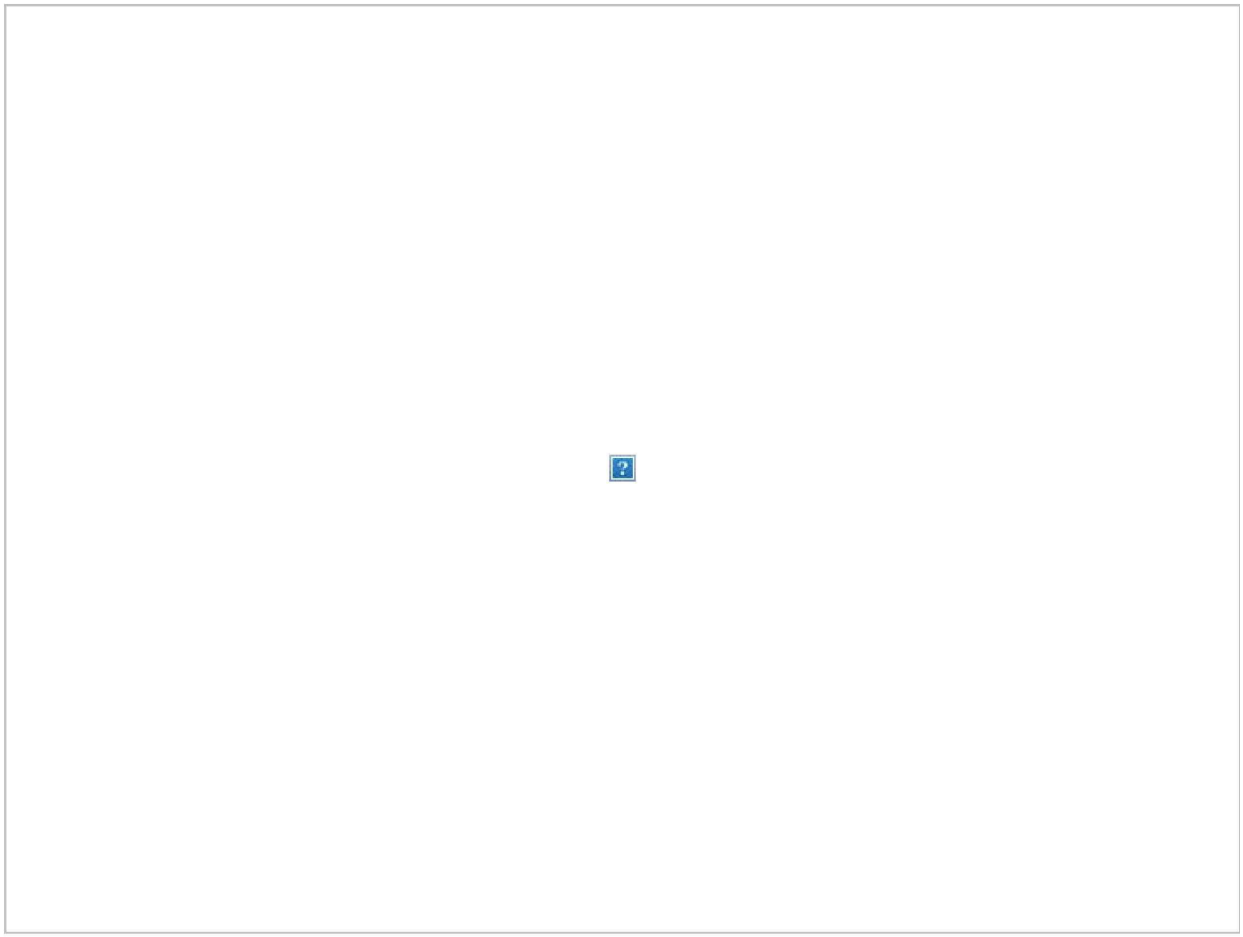
8. Practice good hygiene:
    a. Wash your hands, especially after touching any frequently used item or surface.
    b. Avoid touching your face.
    c. Sneeze or cough into a tissue, or the inside of your elbow.
    d. Disinfect frequently used items and surfaces as much as possible.

* School operations can accelerate the spread of the coronavirus. Governors of states with evidence of community transmission should close schools in affected and surrounding areas. Governors should close schools in communities that are near areas of community transmission, even if those areas are in neighboring states. In addition, state and local officials should close schools where coronavirus has been identified in the population associated with the school. States and localities that close schools need to address childcare needs of critical responders, as well as the nutritional needs of children.

** Older people are particularly at risk from the coronavirus. All states should follow Federal guidance and halt social visits to nursing homes and retirement and long-term care facilities.

*** In states with evidence of community transmission, bars, restaurants, food courts, gyms, and other indoor and outdoor venues where groups of people congregate should be closed.



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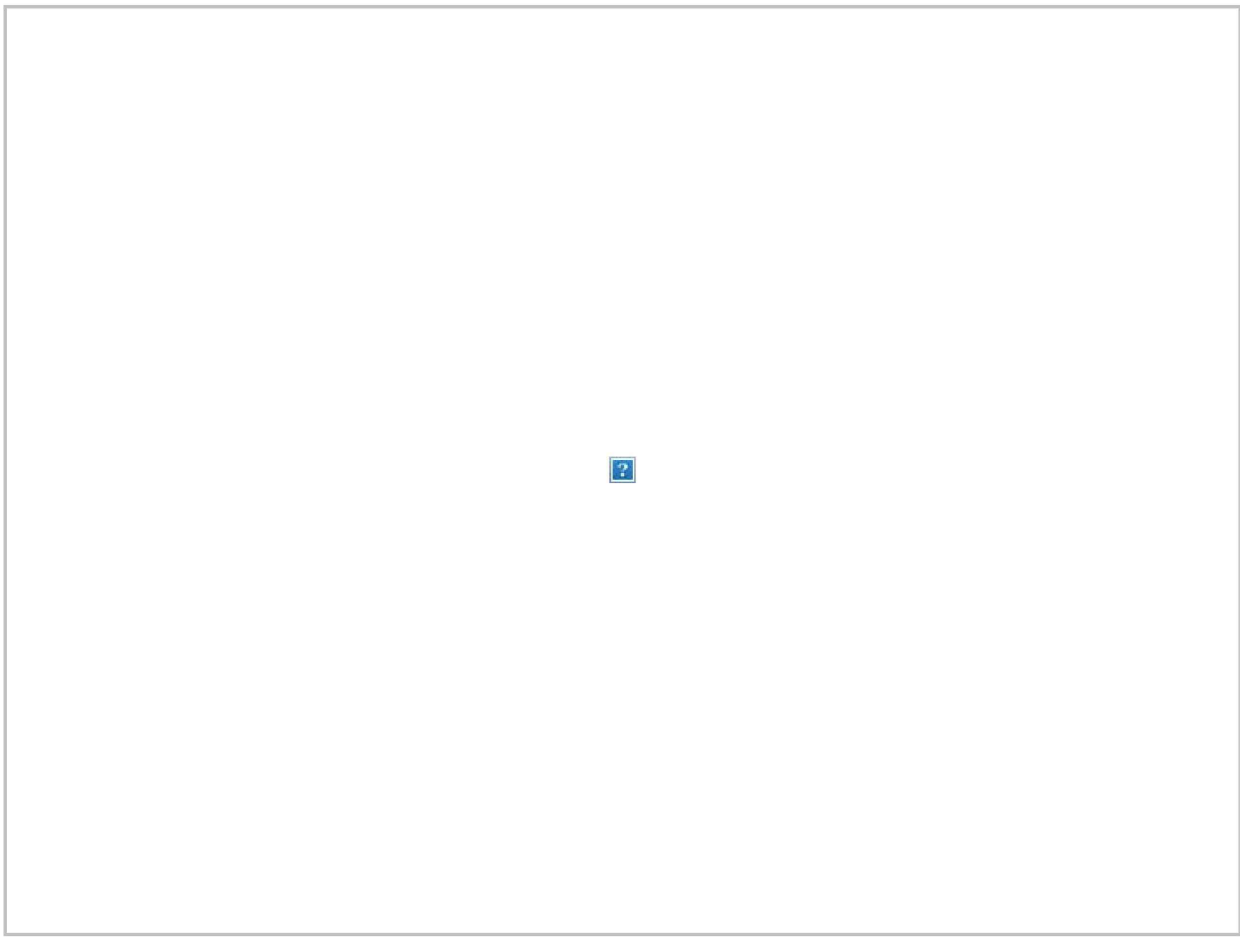

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From: Schauer, Gillian (CDC/DDNID/NCCDPHP/OSH) (CTR)

To: Ali Hamade; Amanda Borup; Michele.nakata@doh.hawaii.gov; Amanda Cue; Amanda Faulkner; Andre Ourso; Andrea Wojcik; Andrew Brisbo; Arian Gibson; Bagley, Bridget; Beth McLaughlin; Brian Lopez; Caitlin Barry-King; Cheryl Petersen-Kroeber; Chris Tholkes; Christina Dempsey; Christine Theriault; Cichowski, Cheryl; Courtney Coppola; Cristal Connelly; Tomiyasu, Danette W. (CDC doh.hawaii.gov); David Olsen; Doug Schultz; Eden Wells; Eliza Muse; Elyse Contreras; Erik Gundersen; Erin Reed; Errica Ferrelli; Ilana Kurtzig; Markiewicz, James (CDC maine.gov); Jamie Margetta; Jared Welehodsky; Jason Frame; Jason Wahl; Jennifer Epstein; Layden, Jennifer (CDC illinois.gov); Jessica Filley; Jessica Neuwirth; Jim Burak; McLaughlin, Joseph (CDC alaska.gov); Judy Barrett; Julia Dilley; Julia Hitchingham; Peek, Julia (CDC health.nv.gov); Julie Johnson; Karen Girard; Karyl Rattay; Katelyn Hall; Lofy, Kathy KL (CDC doh.wa.gov); Kay Doyle; Kristen Haley; Kyle Devine; Kyle Lambert; Kyril Plaskon; Linda Scarpetta; Lori Dodson; Lori Uerz; Lyla Hunt; Lyndall Fraker; Nascarella, Marc (CDC state.ma.us); Margaret Flerchinger; Margaret Machaiek; Marie Dotseth; Mark Hurst; Mark Krueger; Mark Pettinger; Mark Starr; Martha Stanbury; Megan Lockwood; Melissa Finnegan; Beardsley, Nancy (CDC maine.gov); Nancy McBrady; Ngozi Ezike; Nirav Shah; Paul Hyland; Rebecca Rodman; Rebecca Walsh; Rick Garza; Samantha Doonan; Sara Broschart; Shannon OFallon; Sharlet Kroll; Shelly Rowden; Stephanie Klapstein; Stephanie Woodard; Steve Marks; Steve Smothers; Steven Rekand; Susan Fanelli; Sydney King; Thomas Jeanne; TJ Sheehy; Todd Orlando; Travis Kirkpatrick; Trecia Ehrlich; Trevor Christensen; Tricia Blocher; gregory.mcilvaine@state.oh.us; Haegerich, Tamara M. (CDC/DDNID/NCIPC/DOP); Grant, Althea M. (CDC/DDNID/OD); norman.birenbaum@exec.ny.gov; tklimas@tax.state.ny.us

Cc: Klein, Miren@CDPH; SIDELINGER DEAN E; Tapscott, Ryan (CDC/DDNID/NCIPC/DOP); heather.krug@state.co.us; Putnam, Michelle (CDC/DDNID/NCIPC/DOP); Thimjon, Lisa (MDH); Ferguson, Christopher K; farahaths.dave@maryland.gov; Scott, Megan; Pierre, Ermion; brandon.jeffery@state.co.us; Jesse.Wimberly@pharmacy.ohio.gov; Roehler, Douglas R. (CDC/DDNID/NCIPC/DOP)

Subject: Quarterly Multi-State Collaborative All-State Discussion Call on Cannabis and Public Health

---

Please see the updated call in number and the proposed agenda (below).
Call in: 1-877-680-2010, Participant Code: 23065250. Call is at 11AM PST/2PM EST.

Thanks to all of you who are working on a covid19 response in your state, and to those of you who are keeping other important public health work going while your colleagues respond. We know not everyone will be able to attend this call, but are still planning to hold it, with a focus on the covid19/marijuana overlap. Marijuana operations (retail stores, processors, grows) have been deemed essential services in states so far, so we want to facilitate time for you all to talk about how you are approaching that, and to put forward any science-based questions that you need responses to for future work in this space.

Proposed agenda:

* Brief roll call
* Call purpose
* Covid19 response tracking
* Facilitated discussion about covid19 response and marijuana licensees
* Vaping updates and/or any other cannabis and public health topics (as time allows)

Let me know if you have any questions.

Respectfully,
Gillian

ORIGINAL MEETING REQUEST MESSAGE

Dear State Colleagues,

Thank you for completing the When2Meet poll. This looked like the best time for all states who responded. As a reminder, these quarterly calls will bring adult use and medical states together to provide updates related to cannabis vaping policy, prevention, and education, and to discuss other relevant cannabis and public health topics. CDC will provide updates about our cannabis related work as part of these calls, as well.

I will send a more detailed agenda closer to the call. In the meantime, please reach out to me if there are specific topics you would like to add to the agenda.

Respectfully,
Gillian

ORIGINAL MESSAGE

Dear State Colleagues,

It's hard to believe February is already upon us. I wanted to send out the notes from our cannabis vaping call earlier in January (see attached). Per our discussions on that call, we'll be moving to hold these multi-state, all state calls on a quarterly basis, and will continue to facilitate discussion on cannabis vaping issues, but will incorporate other cannabis and public health topics that are of interest to both medical and adult use states. If you are interested in continuing to participate in all-state cannabis and public health calls, please complete this When2Meet poll <https://www.when2meet.com/?8693306-VyueN> so we can try to schedule a March call. We'll talk on that call about getting a standing quarterly call on the calendar (e.g., X day of the last week of the second month of the quarter, or something like that). As a reminder, When2Meet automatically saves your entries. Please remember to select your timezone before completing the poll.

We will also pick back up with quarterly topic-based calls for adult use states only (the multi-state collaborative group), since some additional public

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health and policy issues exist in the adult use landscape. Adult use states - I will be sending a separate poll to try to schedule one of those calls in February, as I know some of you already have issues you'd like to discuss with each other, with legislative sessions underway.

For both the all-state and adult use state calls, I will continue to develop the agenda in the same manner - reaching out to a variety of states to solicit topics. Please feel free to reach out to me any time with policy questions, TA requests, or topics for these multi-state calls.

Thanks again for all you do in the field!

Respectfully,
Gillian

Gillian L. Schauer, PhD, MPH
Senior Consultant to:
Division of Overdose Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
gschauer@cdc.gov

.....

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
Cc: Torres, Yari
Subject: RE: 100% of EIS officers and LLS fellows are needed for the COVID-19 response
Date: Wednesday, March 18, 2020 3:21:42 PM

Hi Eric, our preference would be to plug Yari into our COVID response (She just returned from deployment and is self isolating). In fact, we have already started to bring her up to speed.
I hope that is ok.

From: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD) <ecp9@cdc.gov>
Sent: Wednesday, March 18, 2020 2:46 PM
To: CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>; CDC LLS Supervisor 2018 <LLSSupervisor2018@cdc.gov>; CDC LLS Supervisors 2019 <DDPHSSCSELSDSEPDEWB2019LLSSupervisor@cdc.gov>
Cc: Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) <pms6@cdc.gov>; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) <mai9@cdc.gov>; CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC LLS Class 2018 <LLSClass2018@cdc.gov>; CDC LLS Class 2019 <LLSClass2019@cdc.gov>; CDC CSELS DSEPD EWB <OSELSSEPDPOEISStaff@cdc.gov>
Subject: 100% of EIS officers and LLS fellows are needed for the COVID-19 response

EIS and LLS supervisors,

I am writing again, asking for your support in having EIS officers and LLS fellows deploy or take on other roles for CDC's response to COVID-19. I want to emphasize that **completing CALs (graduation requirements) should NOT factor into whether an EIS officer or LLS fellow deploys**. Supervisors should not be asking to review deployment roles or objectives before approving a deployment. In the past we wanted to ensure deployments aligned with our training objectives. We no longer have that luxury, the primary responsibility of the EIS and LLS programs needs to be supporting the response until we are informed otherwise.

We will deal with CAL completion and how COVID-19 might impact graduation on a case-by-case basis. I want to assure you we will be very understanding in finding ways to compensate if involvement with the COVID-19 response prevented anyone from fulfilling the requirements to graduate.

We understand that some EISOs or LLS fellows may not be able to deploy to the field because of obligations to care for family members or themselves. There are response roles that can be completed while teleworking and do not require travel. We are available to assist in finding deployment roles – contact us at EpiAid@cdc.gov and we can discuss their particular circumstance. In addition, any fellows who are not currently deployed can volunteer by:

1. Emailing us at EpiAid@cdc.gov
2. Volunteer for a Go Team by submitting name in ReADI
3. Responding directly to any calls for volunteers they receive through other communication

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channels

Thank you for your support of the EIS and LLS programs and of your officers or fellows. We know a lot is being asked of you as well and CDC leadership appreciates all you are doing with respect to your individual contributions and your support of the EIS officers and LLS fellows.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.


please consider the environment before printing this e-mail.

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From:	Armstrong, Paige A (CDC/DDID/NCEZID/DVBD)
To:	Ashley Vineyard; Catherine Brown; Abelardo Moncayo; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID/DVBD); Blackmore, Carina (CDC flhealth.gov); elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc:	Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject:	RE: 2020 CSTE VBD Workshop Planning
Date:	Monday, March 9, 2020 10:31:28 PM

Hello Ashley,

As you know, I am deployed for coronavirus, but would be happy to speak on TG as needed.

Best,
Paige

Paige Armstrong MD MHS
Epidemiology Team Lead
LCDR, US Public Health Service
Rickettsial Zoonoses Branch
Centers for Disease Control and Prevention
YZU9@cdc.gov | (404) 639-8450 Office | (404) 639-2778 Fax | www.cdc.gov/ticks

---

From: Ashley Vineyard <avineyard@cste.org>
Sent: Monday, March 9, 2020 2:32 PM
To: Catherine Brown <catherine.brown@state.ma.us>; Abelardo Moncayo <abelardo.moncayo@tn.gov>; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD) <bio1@cdc.gov>; Fischer, Marc (CDC/DDID/NCEZID/DVBD) <mxf2@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS) <Bonny.Mayes@dshs.texas.gov>; Broussard,Kelly (DSHS) <Kelly.Broussard@dshs.texas.gov>; Armstrong, Paige A (CDC/DDID/NCEZID/DVBD) <yzu9@cdc.gov>; Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD) <kzy2@cdc.gov>
Cc: Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD) <cue0@cdc.gov>
Subject: RE: 2020 CSTE VBD Workshop Planning

Good afternoon all,

Please review the attached draft skeleton agenda and notes below from our last call (action items bolded) in advance of our planning call on Wednesday.

- Panel on fleaborne diseases
    - Possible speakers
        - Paige Armstrong (DVBD) – **Paige, can you confirm?**
        - Laura Robinson and/or Bonny Mayes (TX) – **Bonny, can you confirm?**
        - Sarah Park (HI)
        - Plague – Carina recommended Danielle, Vicki Kramer (CA) – **Carina, any follow**

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up?

- Chagas and kissing bugs presentation/panel
  - Need speakers – **any ideas from AZ or TX?**
- TBRF – Bonny reached out to Job Lopez from TX
  - Hanna from WA – **Liz, can you follow up?**
- Vector control and risk reduction, focus on communication
  - Pros and cons of spraying, etc.
  - Risk communication during emergency response
  - Possible speakers:
    - Whitney Qualls (TX) – **Bonny can you confirm?**
    - Someone from WA – **Liz are our 3 WA speakers confirmed?**
    - Kiersten recommended CA
    - Roxanne (CDC)? – **Carina were you able to follow up?**
- EEE ecology (not in current draft agenda)
  - Possible speakers
    - Andrea Morrison (FL)
    - Katie Brown (MA)
    - Michigan
- Tick management (not in current draft agenda) – Abelardo can recommend speakers

Thanks and talk to you all on Wednesday!
Ashley

-----Original Appointment-----
From: Ashley Vineyard
Sent: Tuesday, February 4, 2020 9:28 AM
To: Ashley Vineyard; Brown, Catherine (DPH); Abelardo Moncayo; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID); Blackmore, Carina; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc: Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject: 2020 CSTE VBD Workshop Planning
When: Wednesday, March 11, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: RingCentral Meetings (see below)

Please save this date and time for our 2020 CSTE Annual Conference VBD Workshop planning calls.

To join and view screen: https://meetings.ringcentral.com/j/1493671493

Or Telephone:
Dial: US: +1 (773) 231 9226
Meeting ID: 149 367 1493

AMERICAN OVERSIGHT

From:	Stanek, Danielle R
To:	"Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)"; Torres, Yari; Blackmore, Carina
Subject:	RE: Action Required: COVID-19 impact on your polio TDY
Date:	Friday, March 13, 2020 8:15:38 AM

We sure are!

From: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>
Sent: Friday, March 13, 2020 7:58 AM
To: Torres, Yari <Yari.Torres@flhealth.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Action Required: COVID-19 impact on your polio TDY

Hi Yari,
Thanks for letting us know. Please let me know the status of your arrangements and your flight info when available. I'm sorry you can't finish your polio deployment, but I think it makes sense for you to return. I'm sure Dr. Stanek and Dr. Blackmore will be glad to have you back!
Suzanne

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)
Epidemic Intelligence Service | Epidemiology Workforce Branch
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

From: Torres, Yari <Yari.Torres@flhealth.gov>
Sent: Friday, March 13, 2020 3:20 AM
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Action Required: COVID-19 impact on your polio TDY

It is early in the morning... I will let you know my new date of arrival as I am expected to return sooner than the 24th :)

Get Outlook for iOS

From: Torres, Yari <Yari.Torres@flhealth.gov>
Sent: Friday, March 13, 2020 7:13:35 AM
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Fwd: Action Required: COVID-19 impact on your polio TDY

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FYI- At the moment my new return date is March 24th which is within that time frame, I will let you know if that changes.

Thank you and see you soon!

Yari
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From: Vertefeuille, John F. (CDC/DDPHSIS/CGH/GID) <dki4@cdc.gov>
Sent: Friday, March 13, 2020 3:23:29 AM
To: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP) <pja5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>
Cc: Frank, Daniel (CDC/DDPHSIS/CGH/GID) <fcd3@cdc.gov>; Rouse, Edward N. (CDC/DDPHSIS/CPR/DEO) <dmz0@cdc.gov>; Taylor, Bryan (CDC/DDPHSIS/CPR/DEO) <yzi8@cdc.gov>; Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>; Wiesen, Eric (CDC/DDPHSIS/CGH/GID) <ejw2@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>
Subject: Action Required: COVID-19 impact on your polio TDY

Hi everyone,

Let me first say that we appreciate everyone's effort on the polio surge and your flexibility in these uncertain and rapidly changing times with the COVID-19 response. We in the polio EOC, as well as CDC as whole, have your safety and health as our top priority.

You are receiving this email because you are currently set to return home from your polio TDY between 7-14 days from now. We ask that you work with the EOC to immediately curtail your travel and return to the US.

If you believe that anything may impact your date for return to work at your home office, please let us know and we can reach out to your supervisory chain. New agency guidance regarding post-deployment telework and monitoring policies should be coming out by the end of the week and will be sent to you.

Please continue to monitor all information you receive from the post where you are located which may impact your travel, as well as any guidance you receive from the EOC. Thank you for your contributions to polio eradication, the contributions you may be being asked to make regarding COVID-19 in your TDY location, and your commitments to CDC's mission.

John F. Vertefeuille, PhD, MHS
Incident Manager
CDC Polio Activation

AMERICAN OVERSIGHT

From:	McWhorter, Linda
To:	Guthrie, Kevin
Cc:	Coppola, Courtney; Cabral, Irene; Deleon, Melissa (FLNG)
Subject:	RE: Airport Personnel
Date:	Wednesday, March 25, 2020 2:04:01 PM
Attachments:	image001.png Airport Site Point of Contact List.docx

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Linda J. McWhorter
Preparedness Bureau Chief
2555 Shumard Oak Blvd
Tallahassee, FL 32399-21000
Office: (850) 815-4301
Mobile: (850) 528-7528
Linda.mcwhorter@em.myflorida.com

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Wednesday, March 25, 2020 1:41 PM
To: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Cc: Coppola, Courtney <Courtney.Coppola@flhealth.gov>; Cabral, Irene <Irene.Cabral@dot.state.fl.us>; Deleon, Melissa (FLNG) <Melissa.e.deleon.mil@mail.mil>
Subject: Airport Personnel

Linda,

Can you please reply all with what contract staff augmentation will be at each airport?

Thanks,

Kevin Guthrie, MA MEP CEM FPEM | Deputy Director
Office of the Director
Florida Division of Emergency Management
2555 Shumard Oak Blvd
Tallahassee, FL 32399-2100
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com
www.floridadisaster.org

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Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov); CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: RE: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Friday, March 6, 2020 12:25:09 PM

Thank you for confirming your March 5th case count. We have updated our counts for FL based on your response.

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 6, 2020 10:26 AM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 03/05/2020

We have another presumptive. So 1 presumtive, two confirmed. 3 total.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Friday, March 6, 2020 10:16 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 03/05/2020

Good morning Carina,

We are following up on the email below. At your earliest, could you please confirm the COVID-19 case counts for March 5? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit

eocevent118@cdc.gov

CDC 2019-nCoV Response

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Thursday, March 5, 2020 7:22 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
    - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
    - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1

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Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

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* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab
**Values to be shared on the CDC website
***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: RE: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Friday, March 6, 2020 10:26:13 AM

We have another presumptive. So 1 presumtive, two confirmed. 3 total.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Friday, March 6, 2020 10:16 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 03/05/2020

Good morning Carina,

We are following up on the email below. At your earliest, could you please confirm the COVID-19 case counts for March 5? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit

eocevent118@cdc.gov

CDC 2019-nCoV Response

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Thursday, March 5, 2020 7:22 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these

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requests will likely decrease.

- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
    - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
    - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0

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Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov)
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Epi TF Data Team; Eisenstein, Leah; Kendrick, Katie; Rubino, Heather; Scott.Pritchard@flhealth.gov
Subject: RE: CDC COVID-19 Case Count Confirmation 03/09/2020
Date: Monday, March 9, 2020 9:18:46 PM

Dear Dr. Blackmore,

A generic email went out tonight (see below) asking states to confirm their COVID-19 case-counts for tomorrow's web update. We wanted to reach out to you personally, though, because we did not receive confirmation of Florida's case counts for Monday's web update, and we realize numbers may have changed over the weekend.

At your earliest, could you please confirm the COVID-19 case counts for Florida as of March 9, and make any corrections as needed to the table below? Please also let us know if you would like us to add any alternate contacts for future case confirmation emails. We greatly appreciate your response.

Jurisdiction	Code	Presumptive	Confirmed	Total**	Deaths reported to CDC***
Florida	FL	3	3	6	0

Regards,

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Monday, March 9, 2020 8:45 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/09/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Monday, March 9**.
- By **9 am ET Tuesday, March 10**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Monday, March 9)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):

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The total case count [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**

- Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	4	2	6	0
Arkansas	AR	0	0	0	0
California	CA			135	2
Colorado	CO	8	0	8	0
Connecticut	CT	1	0	1	0
Delaware	DE	0	0	0	0
Florida	FL	3	3	6	0
Georgia	GA	6	5	11	0
Hawaii	HI	2	0	2	0
Idaho	ID	0	0	0	0
Illinois	IL	6	4	10	0
Indiana	IN	3	0	3	0
Iowa	IA	0	0	0	0
Kansas	KS	1	0	1	0
Kentucky	KY	1	0	1	0
Louisiana	LA	1	0	1	0
Maine	ME	0	0	0	0
Maryland	MD	5	0	5	0
Massachusetts	MA	27	1	28	0
Michigan	MI	0	0	0	0
Minnesota	MN	2	0	2	0
Mississippi	MS	0	0	0	0
Missouri	MO	1	0	1	0
Montana	MT	0	0	0	0
Nebraska	NE	3	1	4	0
Nevada	NV	3	0	3	0
New Hampshire	NH	2	2	4	0
New Jersey	NJ	8	0	8	0

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New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	30	0	30	0
North Carolina	NC	2	0	2	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	1	1	0
Oregon	OR	13	1	14	0
Pennsylvania	PA	7	0	7	0
Rhode Island	RI	1	2	3	0
South Carolina	SC	6	0	6	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	9	4	13	0
Utah	UT	1	0	1	0
Vermont	VT	1	0	1	0
Virginia	VA	2	1	3	0
Washington	WA			162	21
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	11	1	12	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: Eisenstein, Leah
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Cc: Troelstrup, Thomas; Kendrick, Katie; Munroe, Julia; Blackmore, Carina; Pritchard, Scott
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020
Date: Monday, March 23, 2020 1:41:56 PM

I submitted the survey for Florida this morning, and I see that the count is updated to what I submitted on the website (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html), but the community transmission is not (I selected "Yes, distinct clusters of cases in a, or a few, defined geographical area(s)"). Did I do something wrong on the survey? I want to be sure our data are appropriately reflected…

Thanks!
Leah

Leah Eisenstein, MPH
Surveillance Epidemiologist
Bureau of Epidemiology, Division of Disease Control and Health Protection
Florida Department of Health

4052 Bald Cypress Way, Bin A12 (mail)
Tallahassee, FL 32399-1720
4025 Esplanade Way, Room 240.01 (physical)
Tallahassee, FL 32311
Phone: (850) 901-6892
Fax: (850) 922-9299
Confidential Fax: (850) 414-6894
Email: Leah.Eisenstein@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Monday, March 23, 2020 10:18 AM
To: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020

Hi Leah,

CDC is confirming case counts with states Sunday through Thursday evening. Please use the Epi Info link provided in the email and not bookmarked links, we routinely make updates to the epi info survey so bookmarked links are often outdated.

Thanks,

Colin Schwensohn

State Coordination Unit

eocevent118@cdc.gov

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CDC COVID-19 Epidemiology Task Force

From: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>
Sent: Monday, March 23, 2020 10:02 AM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

The email below says that we should be reporting this daily. Do we use the same survey link every day?

Thanks!
Leah

Leah Eisenstein, MPH
Surveillance Epidemiologist
Bureau of Epidemiology, Division of Disease Control and Health Protection
Florida Department of Health

4052 Bald Cypress Way, Bin A12 (mail)
Tallahassee, FL 32399-1720
4025 Esplanade Way, Room 240.01 (physical)
Tallahassee, FL 32311
Phone: (850) 901-6892
Fax: (850) 922-9299
Confidential Fax: (850) 414-6894
Email: Leah.Eisenstein@flhealth.gov

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DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Sunday, March 22, 2020 6:21 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>; Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Sunday, March 22, 2020 6:20 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 3/22/2020

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

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frequency of these requests will likely decrease.
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    - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 22**.
    - general community level transmission characterization

- By **9 am ET Monday, March 23**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
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Connecticut	CT	223	5	Undetermined
Delaware	DE	45	0	Undetermined
Florida	FL	706	12	Undetermined
				Yes, widespread community

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Georgia	GA	555	20	transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	42	0	Undetermined
Illinois	IL	753	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	126	4	Undetermined
Iowa	IA	68	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	55	2	Undetermined
Kentucky	KY	87	3	Undetermined
Louisiana	LA	763	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	94	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	190	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	4	Yes, widespread community transmission across several geographical areas
Michigan	MI	787	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	137	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
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Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
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New York City	NYC	6211	43	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	21	0	Undetermined
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Republic of Marshall Islands	RMI	0	0	N/A

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From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Eisenstein, Leah; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Cc:	Troelstrup, Thomas; Kendrick, Katie; Munroe, Julia; Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject:	RE: CDC COVID-19 Case Count Confirmation 3/22/2020
Date:	Tuesday, March 24, 2020 9:12:16 AM

Hi Leah,

Thanks for bringing this to our attention. I don't see FL's response from yesterday in the Epi Info results but I do see your response from today at 6:45am confirming 1141 cases, 17 deaths, and (Yes, distinct clusters of cases in a, or a few, defined geographical area(s)). We will make sure the map is updated today and thank you for confirming case counts and contacting us if it doesn't look correct. We appreciate it.

Thanks,

Colin Schwensohn

State Coordination Unit

eocevent118@cdc.gov

CDC COVID-19 Epidemiology Task Force

From: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>
Sent: Monday, March 23, 2020 1:42 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>; Kendrick, Katie <Katie.Kendrick@flhealth.gov>; Munroe, Julia <Julia.Munroe@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020

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Thanks!
Leah

Leah Eisenstein, MPH
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Florida Department of Health

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4025 Esplanade Way, Room 240.01 (physical)
Tallahassee, FL 32311

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Phone: (850) 901-6892
Fax: (850) 922-9299
Confidential Fax: (850) 414-6894
Email: Leah.Eisenstein@flhealth.gov

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Sent: Monday, March 23, 2020 10:18 AM
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Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

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To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Cc: Troelstrup, Thomas; Kendrick, Katie; Munroe, Julia; Blackmore, Carina; Pritchard, Scott
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020
Date: Monday, March 23, 2020 1:41:56 PM

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Guam	GU	14	0	Undetermined
New York City	NYC	6211	43	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	21	0	Undetermined
U.S. Virgin Islands	VI	6	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: Villalta, Yesenia D
To: State and Local Readiness (CDC)
Subject: RE: CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date: Monday, March 9, 2020 12:12:33 PM
Attachments: image001.png

It states passcode is invalid.

Thank you,

Yesenia D. Villalta, APRN, DNP, MSN
Florida Department of Health in Miami-Dade County
Administrator/Health Officer
Email: Yesenia.Villalta@flhealth.gov
Phone:(786)336-1260
Address: 8323 NW 12th Street Floor:02 Room:212
Miami, FL 33126

How is my customer service? Please let me know by taking our survey at www.FDOHMDCares.com

Our Mission is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has very broad public records law. Most written communication to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Monday, March 9, 2020 11:53 AM
To: State and Local Readiness (CDC) <preparedness@cdc.gov>
Subject: CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT

Dear Colleagues:

Please see the attached CDC COVID-19 weekly key messages, Consular Notification Guidance, and the bridgeline for today's **CDC Media Telebriefing at 12:15 PM EDT provided below**.

Please reference the "Consular Notification Guidance for State and Local Authorities." This document was developed by the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained (i.e., a case when a quarantine order is issued because of possible exposure to COVID-19 disease).

Media Advisory

AMERICAN OVERSIGHT

For Immediate Release
Monday, March 9, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Monday, March 9, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

State Coordination Task Force (SCTF)
CDC COVID-19 Weekly Key Messages & Consular Notification Guidance for State and Local Authorities Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Guthrie, Kevin; Moskowitz, Jared; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Link, Paul (OS/ASPR/EMMO); Mann, Travis (OS/ASPR/EMMO); Sturrock, Lochlin (OS/ASPR/EMMO); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; Bowman, Thomas (OS/ASPR/EMMO); Dickinson, Jeanette (OS/ASPR/EMMO); Raspberry, Jenny (OS/ASPR/EMMO)
Subject:	RE: CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 11:11:08 PM

Danny Alonso from CBP is in charge of both ports I believe.
His contact info is email: DANIEL.ALONSO@CBP.DHS.GOV and phone is 305.395.2260.

Please let me know if you need anything else.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 10:52 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Moskowitz, Jared <Jared.Moskowitz@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis,

AMERICAN OVERSIGHT

Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Cc: Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; Manny J. Toro (manny.toro@fema.dhs.gov) <manny.toro@fema.dhs.gov>; Link, Paul (OS/ASPR/EMMO) <Paul.Link@hhs.gov>; Mann, Travis (OS/ASPR/EMMO) <Travis.Mann@hhs.gov>; Sturrock, Lochlin (OS/ASPR/EMMO) <Lochlin.Sturrock@hhs.gov>; FEMA-R4-RRCC-SITL <R04-rrcc-sitl@fema.dhs.gov>; FEMA-R4-WatchUnit (fema.dhs.gov) <FEMA-R4-WatchUnit@fema.dhs.gov>; Maiden, Shawn <shawn.maiden@fema.dhs.gov>; Strouse, Philip <Philip.Strouse@fema.dhs.gov>; Teague, Brian <Brian.Teague@fema.dhs.gov>; Bowman, Thomas (OS/ASPR/EMMO) <Thomas.Bowman@hhs.gov>; Dickinson, Jeanette (OS/ASPR/EMMO) <Jeanette.Dickinson@hhs.gov>; Raspberry, Jenny (OS/ASPR/EMMO) <Jenny.Raspberry@hhs.gov>
Subject: CDC Guidance for Cruise Ships

Dr. Rivkees

As always it is a pleasure to speak with you. I spoke with our HHS Liaison to the Department of State and he is willing to work to set up a call with the Department of State. Based on your desire we can include CDC. I included the CDC guidance on cruise ships.

I should have a name of a Customs and Border Protection (CBP) representative for you shortly.

Regards,
Jeanne

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R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

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Subject:	RE: CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 11:10:56 PM

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R4-phul@fema.dhs.gov
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Subject: CDC Guidance for Cruise Ships

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Alternate phone numbers
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cell: 202.909.6950 Verizon (secondary)

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response Field Investigations Team; CDC IMS 2019 NCOV Response At Risk; CDC IMS 2019 NCOV Response Clinical On-Call Unit; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP); Fagan, Ryan (CDC/DDID/NCEZID/DHQP); Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 2:45:43 PM

Thank you-that sounds like a great plan. Sri should be able to start work with you tomorrow. We are still sorting through the logistics.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 1:59 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

Great. We plan to be on site. Let me get back to you on who the POC will be.
What we were also hoping for is a training session with some of our staff who is augmenting the response (e.g. EMS, nurses) to build capacity. Our local epidemiologists have basic infection control expertise but they are very stretched right now. When is Sri able to deploy?

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 1:51 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: CDC Infection Prevention and Control Assistance

Hello Dr. Blackmore,

I wanted to introduce you to Srinivas Nanduri who will help with the infection prevention and control aspects of this investigation. As we discussed on the phone today, his deployment will be about 5 days and will largely be focused on the following objectives:

AMERICAN OVERSIGHT

1. To provide targeted infection control assessment and observation of the affected healthcare facility to included hand hygiene, transmission based precaution use, and environmental cleaning.
2. To provide training on essential infection control activities such as hand hygiene and PPE donning and doffing
3. Provide technical support on healthcare worker and patient/resident monitoring during this time
4. To build internal capacity within the health departments for these types of assessments moving forward through mechanisms such as tele-infection control assessments (ICAR) or focused onsite ICARs
5. If times allows, to conduct preparedness assessment at other healthcare facilities

We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

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From:	Pritchard, Scott
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Blackmore, Carina; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial; Schmitz, Ann; Dotson, Nychie; McCoy, Steve
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 3:56:18 PM

Small correction. Dr. Thaqi's cell is 954-295-9051.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:55 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks.

Dr. Thaqi - the number doesn't seem to work for me. Could you advise me the address and time where I need to get to tomorrow?
Thanks,
Srinivas

Get Outlook for iOS

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 2:45:50 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

It probably would be better to go to Ft Lauderdale airport
Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051

AMERICAN OVERSIGHT

Agency for Health Care Administration 561-573-5968.

Get Outlook for iOS

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:07:12 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Also, please let me know if it is better if I flew in to Fort-Lauderdale airport, given that this is Broward county.
Thanks,
Srinivas

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 2:55 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Hi Dr. Blackmore,
Glad to be supporting the response. Just wanted to know which city/location for making my accommodation request. Slated to arrive late tonight to Miami. Look forward to supporting your team in whichever manner possible.
Thanks,
Srinivas

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 2:45 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
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AMERICAN OVERSIGHT

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Best,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	McCoy, Steve
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Pritchard, Scott; Blackmore, Carina; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial; Schmitz, Ann; Dotson, Nychie
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 4:34:06 PM

Here are the contact numbers for the command staff we have on scene.

IMT

- Incident Commander - Nick Pachota - 407.340.5794
- Operations Section Chief - Chris Sorrentino - 954.448.0896
- Plans Section Chief - Joe Sorrentino, Jr. - 954.445.0229
- Logistics Section Chief - Paul Sumner - 954.536.3065

The IC should be on-scene between 4:30 and 5 PM.
The Section Chiefs should be on-scene by 4:00 PM.

Steve A. McCoy
Emergency Medical Services Administrator
Florida Department of Health
Office #: (850) 245-4927
Cell #: (850) 528-0012

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 4:00 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks!

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, March 20, 2020 2:56:18 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve

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<Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

Small correction. Dr. Thaqi's cell is 954-295-9051.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:55 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks.

Dr. Thaqi - the number doesn't seem to work for me. Could you advise me the address and time where I need to get to tomorrow?
Thanks,
Srinivas

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 2:45:50 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

It probably would be better to go to Ft Lauderdale airport
Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051
Agency for Health Care Administration 561-573-5968.

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From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:07:12 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

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Sent: Friday, March 20, 2020 2:55 PM
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Subject: Re: CDC Infection Prevention and Control Assistance

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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>

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Sent: Friday, March 20, 2020 1:59 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

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Sent: Friday, March 20, 2020 1:51 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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5. If times allows, to conduct preparedness assessment at other healthcare facilities

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We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

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From:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Monday, March 23, 2020 7:29:49 AM

Hi Dr. Blackmore,
Just wanted to check in with you about my deployment to Broward County so far. Dr. Thaqi likely looped you in already but I supported condensing of existing guidelines for SNFs and ALFs and training on them to public health staff and the IMT staff. Also helped with some site visits to these facilities supplementing existing Broward county infection control assessment protocols. Reaching out to you to let you know that my initial objectives for this mission could be considered complete. Let me know if you think there is anything else that I should be assisting the county or you with.
Thanks,
Srinivas

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 3:46 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

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Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051
Agency for Health Care Administration 561-573-5968.

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Sent: Friday, March 20, 2020 3:07:12 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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Subject: Re: CDC Infection Prevention and Control Assistance

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Subject: Re: CDC Infection Prevention and Control Assistance

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Sent: Friday, March 20, 2020 2:45 PM
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Subject: RE: CDC Infection Prevention and Control Assistance

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From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response Field Investigations Team; CDC IMS 2019 NCOV Response At Risk; CDC IMS 2019 NCOV Response Clinical On-Call Unit; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP); Fagan, Ryan (CDC/DDID/NCEZID/DHQP); Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 1:59:01 PM

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Best,
Elizabeth Soda

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From:	Anderson, Jade (CDC/DDPHSIS/CPR/DSLR)
To:	State and Local Readiness (CDC)
Subject:	RE: CDC Releases Interim Movement & Monitoring Guidance
Date:	Monday, February 3, 2020 8:45:52 PM
Attachments:	314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-English.jpg 314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-Mandarin.jpg

For your awareness, updated travel cards attached for your use.

From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Monday, February 3, 2020 8:29 PM
To: CDC IMS State Coordination Task Force (SCTF) Lead <eocsctflead@cdc.gov>
Subject: CDC Releases Interim Movement & Monitoring Guidance

Dear Partners,

Today, the Centers for Disease Control and Prevention (CDC) released new movement and monitoring guidelines, "**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings"**. For your convenience, you can find it here. In addition, summary key points are attached.

Feel free to send any questions to preparedness@cdc.gov. For the latest information on the 2019 Novel Coronavirus (2019-nCoV), please visit the response webpage.

Thank you,

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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From:	Pesik, Nicki (CDC/DDID/NCEZID/OD)
To:	Pritchard, Scott
Cc:	Blackmore, Carina (CDC flhealth.gov); Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD); Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Berger, Sherri (CDC/OCOO/OD); D"Angeli, Marisa (DOH)
Subject:	RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington
Date:	Tuesday, February 25, 2020 12:58:14 PM
Attachments:	image001.png

Scott
Thank you for taking time to speak with Sherri and myself. I will follow-up with you on the question regarding Fl residents.

Nicki

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Tuesday, February 25, 2020 11:54 AM
To: Pesik, Nicki (CDC/DDID/NCEZID/OD) <ndp9@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) <vig8@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <htv4@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Subject: RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Hi Nicki,
You can reach out to me 850-251-5558 (cell) or Dr. Blackmore (state epi) at 850-528-1595 (cell) to discuss the situation.
We understand the home care guidelines, but we have a lot of questions about this particular situation.

Additionally, we would like to request info on any other FL residents known to be infected with COVID-19.

Perhaps its best to schedule a conference call at your convenience. Let us know your preference.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Tuesday, February 25, 2020 11:38 AM

AMERICAN OVERSIGHT

To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: FW: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Here you go.
Best,
Marisa

From: Pesik, Nicki (CDC/DDID/NCEZID/OD) [mailto:ndp9@cdc.gov]
Sent: Monday, February 24, 2020 3:34 PM
To: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) <vig8@cdc.gov>
Cc: Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <htv4@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>
Subject: Re: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Marisa
I am including Sherri Berger on this email for SA.

Could you please provide more specifics on your contact with Florida and GA? Who specifically has been contacted by regarding the requested transfers?

There are a number of items that the accepting states have to have and place and agree to for individuals requiring isolation. CDC can provide guidance if home isolation is being considered and happy to address questions.

Thanks Nicki

Nicki Pesik MD
Assoc. Director for Infectious Disease Preparedness
NCEZID/CDC
404-661-5516

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Monday, February 24, 2020 4:27 PM
To: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI)
Cc: Pesik, Nicki (CDC/DDID/NCEZID/OD); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD); Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR)
Subject: RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

OK, thank you so much!

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From: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) [mailto:vig8@cdc.gov]
Sent: Monday, February 24, 2020 1:23 PM
To: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Cc: Pesik, Nicki (CDC/DDID/NCEZID/OD) <ndp9@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <hty4@cdc.gov>
Subject: Re: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Hi Marisa - I don't think I'm the right person but want to make sure I loop in our repatriation and global migration teams. Also our state coordination colleagues. I don't think it is a cdc decision but they may have a suggestion on who at cdc might be able to speak with FL DoH.
Get Outlook for iOS

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Monday, February 24, 2020 4:17 PM
To: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI)
Subject: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Hi Satish,
How are you? I'm contacting FL and GA Depts of Health to arrange for transfer home to FL and GA of two COVID-19 + from the Diamond Princess cruise ship who are clinically stable and hospitalized in Spokane, WA.

There are many logistics, first getting the state to accept the patient and then to arrange transportation. Scott Pritchard, Interim Director, Infectious Disease Prevention and Investigations Section of FL DOH was very concerned and wanted to know who the CDC contact is for this decision. He also thought that their state epi and commissioner of health would want to be on a call with CDC before accepting the patient.

Is there a CDC contact? May I pass on a message from you representing CDC saying that you approve of this effort? Thanks and sorry to bug you!
Best,
Marisa

Marisa D'Angeli, MD, MPH
Medical Epidemiologist
Healthcare Asociated Infections and Antimicrobial Resistance Program
Washington State Department of Health
Marisa.dangeli@doh.wa.gov
206-418-5595 | www.doh.wa.gov



AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	ndp9@cdc.gov
Cc:	Blackmore, Carina; vig8@cdc.gov; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR; Berger, Sherri (CDC/OCOO/OD; D"Angeli, Marisa (DOH)
Subject:	RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington
Date:	Tuesday, February 25, 2020 11:54:27 AM
Attachments:	image003.png

Hi Nicki,
You can reach out to me 850-251-5558 (cell) or Dr. Blackmore (state epi) at 850-528-1595 (cell) to discuss the situation.
We understand the home care guidelines, but we have a lot of questions about this particular situation.

Additionally, we would like to request info on any other FL residents known to be infected with COVID-19.

Perhaps its best to schedule a conference call at your convenience. Let us know your preference.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Tuesday, February 25, 2020 11:38 AM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: FW: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Here you go.
Best,
Marisa

From: Pesik, Nicki (CDC/DDID/NCEZID/OD) [mailto:ndp9@cdc.gov]
Sent: Monday, February 24, 2020 3:34 PM
To: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) <vig8@cdc.gov>
Cc: Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <htv4@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>
Subject: Re: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Marisa

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I am including Sherri Berger on this email for SA.

Could you please provide more specifics on your contact with Florida and GA? Who specifically has been contacted by regarding the requested transfers?

There are a number of items that the accepting states have to have and place and agree to for individuals requiring isolation. CDC can provide guidance if home isolation is being considered and happy to address questions.

Thanks Nicki

Nicki Pesik MD
Assoc. Director for Infectious Disease Preparedness
NCEZID/CDC
404-661-5516

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Monday, February 24, 2020 4:27 PM
To: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI)
Cc: Pesik, Nicki (CDC/DDID/NCEZID/OD); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD); Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR)
Subject: RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

OK, thank you so much!

From: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) [mailto:vig8@cdc.gov]
Sent: Monday, February 24, 2020 1:23 PM
To: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Cc: Pesik, Nicki (CDC/DDID/NCEZID/OD) <ndp9@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <htv4@cdc.gov>
Subject: Re: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Hi Marisa - I don't think I'm the right person but want to make sure I loop in our repatriation and global migration teams. Also our state coordination colleagues. I don't think it is a cdc decision but they may have a suggestion on who at cdc might be able to speak with FL DoH.
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From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Monday, February 24, 2020 4:17 PM
To: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI)

AMERICAN OVERSIGHT

Subject: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Hi Satish,
How are you? I'm contacting FL and GA Depts of Health to arrange for transfer home to FL and GA of two COVID-19 + from the Diamond Princess cruise ship who are clinically stable and hospitalized in Spokane, WA.

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Is there a CDC contact? May I pass on a message from you representing CDC saying that you approve of this effort? Thanks and sorry to bug you!
Best,
Marisa

Marisa D'Angeli, MD, MPH
Medical Epidemiologist
Healthcare Asociated Infections and Antimicrobial Resistance Program
Washington State Department of Health
Marisa.dangeli@doh.wa.gov
206-418-5595 | www.doh.wa.gov



AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	CDC IMS 2019 NCOV Response PUI
Cc:	Roberson, Shamarial; Blackmore, Carina
Subject:	RE: CDC nCoV Clinician Inquiry Follow-up
Date:	Wednesday, February 5, 2020 2:15:52 PM

Thank you I have spoken with Dr. Abdul and rule out the need for nCoV testing.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Sent: Wednesday, February 05, 2020 1:55 PM
To: clinic@myffbenefits.com
Cc: Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: CDC nCoV Clinician Inquiry Follow-up

Caller: Dr. Lauren Abdul

Caller phone: 561-969-6663

Caller location/health facility: Florida

Day and Time of Call: 2/5/2020 13:54

Dear Dr. Abdul

Thank you for contacting the CDC with a novel coronavirus person under investigation (PUI) inquiry. If you suspect you have a patient with possible novel coronavirus infection, please contact your local health department immediately for further guidance. General information on novel coronavirus, including infection control measures can be found online here. CDC is working closely with local and state health authorities. CDC will only be facilitating novel coronavirus referral testing in coordination with public health departments.

Regards,

CDC Novel Coronavirus Response PUI Team

CDC IMS 2019 NCOV Response PUI Team

2019 Novel Coronavirus Response

AMERICAN OVERSIGHT

eocevent185@cdc.gov

AMERICAN OVERSIGHT

From:	Amy Chang
To:	Shea, Shari | APHL; apierce@wakegov.com; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD); Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Laura Wildey
Subject:	RE: CIFOR Promote DT - February Meeting Notes and Action Items
Date:	Friday, March 6, 2020 9:48:24 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Third Edition Guidelines_Twitter.png CIFOR Third Edition Guidelines_Facebook.png CIFOR Guidelines Third Edition Promotions.docx

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I would be happy to collect any of the suggested edits. And if there happens to be a communication specialist available---it would be great to have their input/help.

I don't think an official release date has been announced? Maybe India has updates?

Thanks,
Amy

From: Shea, Shari | APHL <shari.shea@aphl.org>
Sent: Friday, March 6, 2020 9:21 AM
To: Amy Chang <Achang@naccho.org>; apierce@wakegov.com; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>; Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Laura Wildey <lwildey@neha.org>
Subject: RE: CIFOR Promote DT - February Meeting Notes and Action Items

I believe we have now lost Michelle, Beth and Elizabeth, who were are go-to Promote members for fine tuning our promotional messages.
Do we need any other eyes on the draft messages from Michelle before we start using them? Also, do we have a release date for the 3rd Edition?
Thanks,
Shari

From: Michelle Shapiro <mshapiro@naccho.org>
Sent: Monday, February 24, 2020 1:15 PM
To: Amy Chang <Achang@naccho.org>; apierce@wakegov.com; Shea, Shari | APHL <shari.shea@aphl.org>; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>;

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Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Collaro, Thomas - FSIS <thomas.collaro@usda.gov>; Laura Wildey <lwildey@neha.org>
Subject: RE: CIFOR Promote DT - February Meeting Notes and Action Items

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi all,

I attached draft newsletter and social media promotions for the Guidelines, as well as social media graphics for Twitter and Facebook. Feel free to suggest edits!

Thanks,
Michelle

From: Amy Chang <Achang@naccho.org>
Sent: Wednesday, February 19, 2020 11:24 AM
To: apierce@wakegov.com; Shea, Shari | APHL <shari.shea@aphl.org>; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>; Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Michelle Shapiro <mshapiro@naccho.org>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Collaro, Thomas - FSIS <thomas.collaro@usda.gov>; Laura Wildey <lwildey@neha.org>
Subject: CIFOR Promote DT - February Meeting Notes and Action Items

Good Morning,

Please see the attached notes from the meeting yesterday.

Immediate Action Items:

- 3rd Ed. Guidelines Promotion Plan
  - Promotion Plan
    - Newsletter blurb/couple social media - Michelle Shapiro will draft and send to group before she leaves at the end of February.
      - Postcard flyer (attached)
        - Action Item: If you have edits, send it to Michelle by 2/21.
      - Use Elizabeth's promotional plan 2020 - Amy posted updated copy post on Basecamp.

AMERICAN OVERSIGHT

- Action item: fill in and update the promotional plan where you can contribute.

Thank you,
Amy

Amy Chang
Senior Program Analyst
Environmental Health
National Association of County and City Health Officials (NACCHO) ¦1201 Eye Street NW 4th Floor ¦ Washington, DC 20005
Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
www.naccho.org



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From:	Michelle Shapiro
To:	Amy Chang; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD); Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Collaro, Thomas - FSIS; Laura Wildey
Subject:	RE: CIFOR Promote DT - February Meeting Notes and Action Items
Date:	Monday, February 24, 2020 1:14:39 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Guidelines Third Edition Promotions.docx CIFOR Third Edition Guidelines_Twitter.png CIFOR Third Edition Guidelines_Facebook.png

Hi all,

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Sent: Wednesday, February 19, 2020 11:24 AM
To: apierce@wakegov.com; Shea, Shari | APHL <shari.shea@aphl.org>; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>; Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Michelle Shapiro <mshapiro@naccho.org>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Collaro, Thomas - FSIS <thomas.collaro@usda.gov>; Laura Wildey <lwildey@neha.org>
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AMERICAN OVERSIGHT

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- Action item: fill in and update the promotional plan where you can contribute.

Thank you,
Amy

Amy Chang
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Environmental Health
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www.naccho.org



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From:	Amy Chang
To:	Tiara Smith; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro; Sharp, Donald (CDC/DDID/NCEZID/DFWED; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID; Scott E. Holmes; christina.ferguson@dph.ga.gov; Collaro, Thomas - FSIS; Laura Wildey; India Bowman; Jesse C. Bliss
Subject:	RE: CIFOR Promote DT Meeting
Date:	Thursday, March 12, 2020 9:38:10 AM

Good Morning, All,

Hope everyone is well. I know a lot of folks are involved with the COVID-19 response. Please let me know if you are able to attend this meeting at this time so we can plan accordingly.

Much thanks!
Amy

-----Original Appointment-----
From: Tiara Smith <tsmith@naccho.org>
Sent: Friday, February 21, 2020 3:51 PM
To: Tiara Smith; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro; Sharp, Donald (CDC/DDID/NCEZID/DFWED; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID; Scott E. Holmes; christina.ferguson@dph.ga.gov; Collaro, Thomas - FSIS; Laura Wildey; Amy Chang; India Bowman; Jesse C. Bliss
Subject: CIFOR Promote DT Meeting
When: Monday, March 16, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://naccho.zoom.us/j/871476261

Dear All,

Please save the date, the 3rd Monday of each month, for the CIFOR Promote DT Meeting.

Regards,
Tiara

tsmith@naccho.org is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/871476261

Meeting ID: 871 476 261

One tap mobile
+19292056099,,871476261# US (New York)

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+16699006833,,871476261# US (San Jose)

Dial by your location
+1 929 205 6099 US (New York)
+1 669 900 6833 US (San Jose)
Meeting ID: 871 476 261
Find your local number: https://naccho.zoom.us/u/acel60w87R

AMERICAN OVERSIGHT

From:	Laura Rothfeldt, DVM
To:	Pue, Howard; House - CDPHE, Jennifer; Heather Venkat; Abby Mathewson; patriciazinna@gmail.com; amber.singh@odh.ohio.gov; EBeeler; mchang@ph.lacounty.gov; Ehnert, Karen; BRIT O; JSinatra@PH.LACOUNTY.GOV; kelly.debaene@santacruzcounty.us; Woodall - CDPHE, Tracy; Kathy Kudish; nivedita.ravi-caldwell@dc.gov; Blackmore, Carina; barbara.progulske@flhealth.gov; Kerins, Jana (CDC cityofchicago.org); David.Day@ltdhd.org; KSigns; Beaudoin, Amanda (MDH); "Ghai, Ria (CDC/DDID/NCEZID/OD)"; Jenna Bjork; Holzbauer, Stacy (MDH); Malia Ireland; Smith, Kirk (MDH); jcalder@caa.columbia.edu; alison.kaufman@health.ny.gov; Maxted, Angie M (HEALTH); Erica Berl; Sally Slavinski; amanda.kieffer@dshs.texas.gov; Robinson,Laura (DSHS); Stonecipher,Shelley (DSHS); Ronald.Tyler@dshs.texas.gov; Dr. Patricia McKane; jen.sidge@gmail.com; gatto515@hotmail.com; brandy.darby@vdh.virginia.gov; Meagan Kay; Lipton, Beth; suzanne.gibbonsburgener@dhs.wi.gov; Sarah Koske; Mason, Jordan L - DHS; lynn.roberts@dhs.wisconsin.gov; Castrodale, Louisa J (HSS); Curtis Fritz; jocelyn.mullins@ct.gov; Stanek, Danielle R; Tengelsen, Leslie; Austin, Connie; Brown, Jennifer; Garvey, Ann [IDPH]; Ingrid Garrison; Kelly Giesbrecht; Gary Balsamo; Walsh, Michele; David Crum; Brown, Catherine (DPH); Stobierski, Mary Grace (DCH); Scheftel, Joni (MDH); kpride (kpride@mt.gov); Buss, Bryan; Newman, Alexandra P (HEALTH); Williams, Carl; LeMac Morris; Schroeder, Betsy; Stewart, Carol, DOH; Radcliffe, Rachel (CDC dhec.sc.gov); Daly, Russell (Russell.Daly@sdstate.edu); John Dunn; Kwit, Natalie; Julia Murphy (julia.murphy@vdh.virginia.gov); Rachel Klos; karl musgrave
Cc:	"Ghai, Ria (CDC/DDID/NCEZID/OD)"; Baker, Molly; Beddo, Monica
Subject:	RE: COVID Priority Services--Animal and Ag Industries
Date:	Friday, March 20, 2020 3:28:02 PM

Not that I know of yet.

Laura K. Rothfeldt, DVM, DACVPM
Arkansas Dept. of Health

From: Pue, Howard <Howard.Pue@health.mo.gov>
Sent: Friday, March 20, 2020 1:14 PM
To: Laura Rothfeldt, DVM <Laura.Rothfeldt@arkansas.gov>; House - CDPHE, Jennifer <jennifer.house@state.co.us>; Heather Venkat <heather.venkat@azdhs.gov>; Abby Mathewson <Abigail.Mathewson@dhhs.state.nh.us>; patriciazinna@gmail.com; amber.singh@odh.ohio.gov; EBeeler <ebeeler@ph.lacounty.gov>; mchang@ph.lacounty.gov; Ehnert, Karen <kehnert@ph.lacounty.gov>; BRIT O <boiulfstad@ph.lacounty.gov>; JSinatra@PH.LACOUNTY.GOV; kelly.debaene@santacruzcounty.us; Woodall - CDPHE, Tracy <tracy.woodall@state.co.us>; Kathy Kudish <Kathy.Kudish@ct.gov>; nivedita.ravi-caldwell@dc.gov; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; barbara.progulske@flhealth.gov; Kerins, Jana (CDC cityofchicago.org) <janna.kerins@cityofchicago.org>; David.Day@ltdhd.org; KSigns <signsk@michigan.gov>; Beaudoin, Amanda (MDH) <amanda.beaudoin@state.mn.us>; 'Ghai, Ria (CDC/DDID/NCEZID/OD)' <ofu9@cdc.gov>; Jenna Bjork <Jenna.Bjork@state.mn.us>; Holzbauer, Stacy (MDH) <stacy.holzbauer@state.mn.us>; Malia Ireland <malia.ireland@state.mn.us>; Smith, Kirk (MDH) <kirk.smith@state.mn.us>; jcalder@caa.columbia.edu; alison.kaufman@health.ny.gov; Maxted, Angie M (HEALTH) <angie.maxted@health.ny.gov>; Erica Berl <erica.berl@dhhs.nc.gov>; Sally Slavinski <sslavins@health.nyc.gov>; amanda.kieffer@dshs.texas.gov; Robinson,Laura (DSHS) <laura.robinson@dshs.texas.gov>; Stonecipher,Shelley (DSHS) <shelley.stonecipher@dshs.texas.gov>; Ronald.Tyler@dshs.texas.gov; Dr. Patricia McKane <mckanep@sbcglobal.net>; jen.sidge@gmail.com; gatto515@hotmail.com; brandy.darby@vdh.virginia.gov; Meagan Kay <Meagan.Kay@kingcounty.gov>; Lipton, Beth <beth.lipton@kingcounty.gov>; suzanne.gibbonsburgener@dhs.wi.gov; Sarah Koske <Sarah.Koske@dhs.wi.gov>; Mason, Jordan L - DHS <jordan.mason@dhs.wisconsin.gov>; lynn.roberts@dhs.wisconsin.gov; Castrodale, Louisa J (HSS) <louisa.castrodale@alaska.gov>; Curtis Fritz <cfritz@cdph.ca.gov>; jocelyn.mullins@ct.gov; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Tengelsen, Leslie <leslie.tengelsen@dhw.idaho.gov>; Austin,

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Subject: RE: COVID Priority Services--Animal and Ag Industries

Has CDC weighed in on this and if so, is it on their website?

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https://www.avma.org/resources-tools/animal-health-and-welfare/covid-19/veterinary-practices-are-essential-businesses

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Subject: COVID Priority Services--Animal and Ag Industries

NASPHV,

This morning during the active member call we discussed creating a list of priority services that should be excluded from mandatory shutdowns. The concern is a complete shutdown of these services (or quarantines on large numbers of employees) will lead to disruption of the food supply, increased risk to public health, significant welfare issues to animals, unnecessary euthanasia, and overall ethical dilemmas.

I generated this list based on today's call. Please add to this as needed.

Animal Food Supply Chain Services (specifically employees working in processing plants)
Veterinary Critical and Emergency Care
Initial Rabies Vaccines to animals in high risk areas
Rabies Booster Vaccines to rabies exposed pets and livestock
Other vaccinations in response to specific situations (example: parvo or distemper outbreaks)
Responding to reportable veterinary conditions (specifically foreign animal diseases and others requiring movement restrictions)
Animal Movement Regulations including required veterinary inspections

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Jennifer House, DVM, MPH, DACVPM

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State Public Health Veterinarian



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Cc:	"Ghai, Ria (CDC/DDID/NCEZID/OD)"; Baker, Molly; Beddo, Monica
Subject:	RE: COVID Priority Services--Animal and Ag Industries
Date:	Friday, March 20, 2020 2:15:11 PM

Has CDC weighed in on this and if so, is it on their website?

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Subject: COVID Priority Services--Animal and Ag Industries

NASPHV,

This morning during the active member call we discussed creating a list of priority services that should be excluded from mandatory shutdowns. The concern is a complete shutdown of these services (or quarantines on large numbers of employees) will lead to disruption of the food supply, increased risk to public health, significant welfare issues to animals, unnecessary euthanasia, and overall ethical dilemmas.

I generated this list based on today's call. Please add to this as needed.

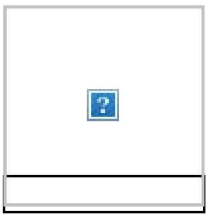
Animal Food Supply Chain Services (specifically employees working in processing plants)
Veterinary Critical and Emergency Care
Initial Rabies Vaccines to animals in high risk areas
Rabies Booster Vaccines to rabies exposed pets and livestock
Other vaccinations in response to specific situations (example: parvo or distemper outbreaks)
Responding to reportable veterinary conditions (specifically foreign animal diseases and others requiring movement restrictions)
Animal Movement Regulations including required veterinary inspections

--

Jennifer House, DVM, MPH, DACVPM

State Public Health Veterinarian

AMERICAN OVERSIGHT



Communicable Disease Branch

P 303.692.2700 | F 303.782.0338
4300 Cherry Creek Drive South - A3, Denver, CO 80246
jennifer.house@state.co.us | www.colorado.gov/cdphe

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI)
To:	Munroe, Julia
Cc:	Kendrick, Katie; Rubino, Heather; Blackmore, Carina (CDC flhealth.gov); Mark.ONeill@flhealth.gov; Marla.Wallace@flhealth.gov; Scott.Pritchard@flhealth.gov; Patty.Lewandowski@flhealth.gov; Heather.Rubino@flhealth.gov; julie.farmington@flhealth.gov; Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI)
Subject:	RE: COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST
Date:	Thursday, February 20, 2020 3:23:03 PM

Hi Julia,
My sincere apologies for the delay in responding to you on this! I've added you to my internal list. These calls are not being coordinated through the ELC so I don't know if the call information will update with each call. It is my understanding that the invites are going to, at minimum, PHEP Directors and State Epidemiologists; we have been sending them to ELC Governance Team members.

From: Munroe, Julia <Julia.Munroe@flhealth.gov>
Sent: Tuesday, February 18, 2020 2:06 PM
To: O'Connor, Angelica (CDC/DDID/NCEZID/DPEI) <apw1@cdc.gov>
Cc: Kendrick, Katie <Katie.Kendrick@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: FW: COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST

Hi Angelica,

I have been asked to host these calls for the Florida Department of Health, but I am not receiving these emails directly. Could you add me to your email distribution list so I receive these emails moving forward? Also, could you clarify if the call-in number and passcode listed here is the one we should use moving forward?

Thank you so much for your help!

Best,
Julia

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From: O'Connor, Angelica (CDC/DDID/NCEZID/DPEI) <apw1@cdc.gov> **On Behalf Of** Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Sent: Sunday, February 16, 2020 9:55 PM
Cc: Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI) <wsb2@cdc.gov>; Downing, Janice S. (CDC/DDID/NCEZID/DPEI) <jsb3@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI) <wkv2@cdc.gov>; Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI) <pen3@cdc.gov>; Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI) <nkm8@cdc.gov>; Shultz, Alvin (CDC/DDID/NCEZID/DPEI) <fcu9@cdc.gov>; Simpson, De'Lisa D. (CDC/DDID/NCEZID/DPEI) <ion9@cdc.gov>; Snow, Jason N. (CDC/DDID/NCEZID/DPEI) <itk0@cdc.gov>; Byrd, Shirley K. (CDC/OCOO/OFR/OGS) <yuo6@cdc.gov>; Roush, Sandra (CDC/DDID/NCIRD/OD) <swr1@cdc.gov>; Brammer, Lynnette (CDC/DDID/NCIRD/ID) <lsb1@cdc.gov>; Gross, Melanie S. (CDC/DDID/NCIRD/ID) <jvk5@cdc.gov>; Lamont, Brock (CDC/DDID/NCIRD/ISD) <bal2@cdc.gov>; CDC IMS State Coordination Task Force (SCTF) ELC LNO <eocsctfvtflno@cdc.gov>
Subject: COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST

The CDC will be hosting an all-state COVID-19 call on Tuesday, February 18 from 2:00pm-2:45pm EST. The ELC is not coordinating this call; however, we wanted to share this information in the event you had not received it through other channels.

CDC's Coronavirus Disease-2019 (COVID-19) response team will host a national call from 2 p.m. to 2:45 p.m. EST on Tuesday, February 18, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)790-1880
Participant Passcode: 8138992

Please note, this update call is being held on a Tuesday, in lieu of President's Day observance. Future calls will be held on Mondays.

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) Operations
To:	CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) Policy & Comm
Subject:	RE: COVID-19 Public Health Response Operations
Date:	Saturday, February 29, 2020 7:02:26 PM

Good Evening Colleagues,

As a follow-up to yesterday call, please find the "Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)" here.

Schools should continue to collaborate, share information, and review plans with local health officials to help protect the whole school community, including those with special health needs. School plans should be designed to minimize disruption to teaching and learning and protect students and staff from social stigma and discrimination. Plans can build on everyday practices (e.g., encouraging hand hygiene, monitoring absenteeism, communicating routinely) that include strategies for before, during, and after a possible outbreak.

Thank you!

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

-----Original Appointment-----
Subject: COVID-19 Public Health Response Operations
When: Friday, February 28, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Bridgeline: 1(888)455-7719 Passcode: 6905931

COVID-19 Public Health Response Operations
CDC's 2019 Novel Coronavirus (COVID-19) response team will host a recurring call series from 3 p.m. to 4 p.m. EST every Wednesday's and Friday's, to discuss plans for returning travelers, including movement & monitoring, quarantine, data reporting, and status reports or concerns. **Please note, this call is not open to the media**.

Invited participants include all 62 PHEP funded jurisdictions (state, local, and territorial preparedness directors, state epidemiologists, state health officials, public health laboratory directors, and emergency management officials), nongovernmental partner organization leadership (APHL, ASTHO, CSTE, and NACCHO), Big City

AMERICAN OVERSIGHT

Health Coalition (BCHC), and ASPR regional administrators. In order to ensure and maintain the appropriate target audience, please have **ONE** representative from each **CORE** function listed participate from your jurisdiction. Participant information can be found below.

Participant Information
Bridgeline: 1(888)455-7719
Passcode: 6905931

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

For your situational awareness, the forwarding option for this invite is DISABLED.

Please contact eocsctfops@cdc.gov if you have any questions.

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) Operations
To:	CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) Policy & Comm
Subject:	RE: COVID-19 Public Health Response Operations
Date:	Saturday, February 29, 2020 7:00:17 PM

Good Evening Colleagues,

As a follow-up to yesterday call, please find the "Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)" here.

Schools should continue to collaborate, share information, and review plans with local health officials to help protect the whole school community, including those with special health needs. School plans should be designed to minimize disruption to teaching and learning and protect students and staff from social stigma and discrimination. Plans can build on everyday practices (e.g., encouraging hand hygiene, monitoring absenteeism, communicating routinely) that include strategies for before, during, and after a possible outbreak.

Thank you!

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



-----Original Appointment-----
Subject: COVID-19 Public Health Response Operations
When: Friday, February 28, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Bridgeline: 1(888)455-7719 Passcode: 6905931

COVID-19 Public Health Response Operations
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AMERICAN OVERSIGHT

Health Coalition (BCHC), and ASPR regional administrators. In order to ensure and maintain the appropriate target audience, please have **ONE** representative from each **CORE** function listed participate from your jurisdiction. Participant information can be found below.

Participant Information
Bridgeline: 1(888)455-7719
Passcode: 6905931

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

For your situational awareness, the forwarding option for this invite is DISABLED.

Please contact eocsctfops@cdc.gov if you have any questions.

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: Pritchard, Scott
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP); Blackmore, Carina; Rubino, Heather
Subject: RE: Coronavirus Disease 2019 Information for Travel (New Travel Alerts)
Date: Thursday, February 27, 2020 8:53:41 AM
Attachments: image003.png
image004.png

Great Time!
We are in Building 4025 Esplanade Way. I arrive at 8:15 each morning, and can meet you in the downstairs lobby and walk you to your office.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Sent: Thursday, February 27, 2020 8:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: FW: Coronavirus Disease 2019 Information for Travel (New Travel Alerts)

FYI, there is a CDC weekly update re COVID-19, which highlights most recent guidance, documents, etc.

From: Centers for Disease Control and Prevention <no-reply@emailupdates.cdc.gov>
Sent: Wednesday, February 26, 2020 2:04 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Subject: Coronavirus Disease 2019 Information for Travel (New Travel Alerts)

This message includes weekly updates on the COVID-19 response from CDC. This is a rapidly evolving situation and information will be updated on the COVID-19 Situation Summary as it becomes available.

Thank you for signing up for the weekly COVID-19. CDC sends this email every Monday at 2pm ET. Here is a copy of the email that was sent on Monday, February 24.

AMERICAN OVERSIGHT

CDC Weekly Updates on COVID-19

February 24, 2020

This message includes weekly updates on the COVID-19 response from CDC. This is a rapidly evolving situation and information will be updated on the COVID-19 Situation Summary as it becomes available.

What's New

Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings
MONDAY, FEBRUARY 24, 2020

Coronavirus Disease 2019 Information for Travel (New Travel Alerts)
MONDAY, FEBRUARY 24, 2020

CDC in Action: Preparing Communities for Potential Spread of COVID-19
SATURDAY, FEBRUARY 23, 2020

Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children

AMERICAN OVERSIGHT

SATURDAY, FEBRUARY 22, 2020

Stigma Related to COVID-19
FRIDAY, FEBRUARY 21, 2020

More Updates

Resources and Guidance

State and Local Public Health Professionals

Healthcare Professionals

Laboratories

Travel

Businesses

Communication Resources

2019 Novel Coronavirus (2019-nCov)

Coronavirus Disease 2019 (COVID-19) in the U.S.

As of February 24, 2020

In the United States, there have been 14 confirmed cases of COVID-19 detected through U.S. public health surveillance systems. There have also been 39 cases of COVID-19 reported among people repatriated to the United States.

CDC provides updated U.S. case information online on Mondays, Wednesdays, and Fridays.

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Centers for Disease Control and Prevention

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

Questions or Problems | Unsubscribe



AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Fitzgerald, John M CDR; Christie Luce; Samantha Cooksey; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Scott.Rivkees@flhealth.gov; Ashley Davis; Kevin Guthrie; Aaron Otis (CDC flhealth.gov)
Cc:	ASPR Region 4 (HHS/ASPR/OEM); Toro, Manny J; Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Lamana, Joseph (OS/ASPR/EMMO)
Subject:	RE: Cruise ships due into port next 48 hours
Date:	Tuesday, March 24, 2020 9:53:52 AM

Awesome. Thank you

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Tuesday, March 24, 2020 8:49 AM
To: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Christie Luce <Christie.Luce@flhealth.gov>; Samantha Cooksey <Samantha.Cooksey@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Scott.Rivkees@flhealth.gov; Ashley Davis <Ashley.Davis@em.myflorida.com>; Kevin Guthrie <Kevin.Guthrie@em.myflorida.com>; Aaron Otis <Aaron.Otis@flhealth.gov>
Cc: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: RE: Cruise ships due into port next 48 hours

AMERICAN OVERSIGHT

Jeanne

Grandeur of the Seas is in
MSC Lirca is not inbound to Miami

v/r,

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Monday, March 23, 2020 9:33 PM
To: Christie Luce <Christie.Luce@flhealth.gov>; Samantha Cooksey <Samantha.Cooksey@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Scott.Rivkees@flhealth.gov; Ashley Davis <Ashley.Davis@em.myflorida.com>; Kevin Guthrie <Kevin.Guthrie@em.myflorida.com>; Aaron Otis <Aaron.Otis@flhealth.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Cc: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Szczech, Gracia <Gracia.Szczech@fema.dhs.gov>; Samaan, Robert <Robert.Samaan@fema.dhs.gov>; Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: [Non-DoD Source] Re: Cruise ships due into port next 48 hours

+ John Fitzgerald

Sorry John....

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

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cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

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On Mar 23, 2020, at 9:31 PM, Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov> wrote:

All

FYI.... I know nothing of what is happening on these ships, just they are due to arrive in the next 48 hours.

From the State Department...

- Tracking **33 cruise ships** that have/are set to debark in the next 48hrs.
- 3 out of 33 are sked to arrive in US ports in next 48 hrs – GRANDEUR OF THE SEAS (Miami, FL), MSC LIRCA (Miami, FL), SEVEN SEAS EXPLORER (Miami, FL) –

Just wanting to know if the Port of Miami remains open. I understand that the cruise lines are to follow normal practices for debarkation of ships as they do every day.

Let me know if you have any questions.
Thanks

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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HSDN: Jeanne.eckesroper@dhs.sgov.gov

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AMERICAN OVERSIGHT

From: Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD)

To: EIS (CDC); CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC EIS EAC Roster 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Gaertner, Sonnet Jeong Im (CDC/DDPHSS/CSELS/OD); Blackstock, Anna J. (CDC/DDID/NCEZID/DFWED); McColloch, Caitlin (CDC/DDPHSS/CSELS/DSEPD); Wilson, Kendra (CDC/DDPHSS/CSELS/DSEPD); DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Owens, Kevin (CDC/OCOO/OCIO) (CTR); Bauer, Darrell (CDC/DDPHSS/CSELS/DSEPD); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Guerra, Marta (CDC/DDPHSIS/CGH/DGHP); Ali, Hammad (CDC/DDPHSIS/CGH/DGHT); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Cantey, Paul T. (CDC/DDPHSIS/CGH/DPDM); Minta, Anna Akua (CDC/DDPHSIS/CGH/GID); Hsu, Christopher (CDC/DDPHSIS/CGH/GID); Blau, Dianna M. (CDC/DDPHSIS/CGH/OD); Ailes, Elizabeth (CDC/DDNID/NCBDDD/DBDID); Woodworth, Kate (CDC/DDNID/NCBDDD/DBDID); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Bitsko, Rebecca (CDC/DDNID/NCBDDD/DHDD); Maenner, Matthew J. (CDC/DDNID/NCBDDD/DHDD); Pollack, Loria A. (CDC/DDNID/NCCDPHP/DCPC); Mercado, Carla I. (CDC/DDNID/NCCDPHP/DDT); Thompson-Paul, Angela M. (CDC/DDNID/NCCDPHP/DHDSP); Hamner, Heather (CDC/DDNID/NCCDPHP/DNPAO); Park, Sohyun (CDC/DDNID/NCCDPHP/DNPAO); Omura, John Daniel (CDC/DDNID/NCCDPHP/DNPAO); Galang, Romeo Regi (CDC/DDNID/NCCDPHP/DRH); Romero, Lisa (CDC/DDNID/NCCDPHP/DRH); Zapata, Lauren (CDC/DDNID/NCCDPHP/DRH); VanFrank, Brenna (CDC/DDNID/NCCDPHP/OSH); Mirabelli, Maria (CDC/DDNID/NCEH/DEHSP); Chew, Ginger L. (CDC/DDNID/NCEH/DEHSP); Plumb, Ian (CDC/DDID/NCEZID/DFWED); Lyman, Meghan Marie (CDC/DDID/NCEZID/DFWED); Berendes, David (CDC/DDID/NCEZID/DFWED); Garcia-Williams, Amanda (CDC/DDID/NCEZID/DFWED); Merrill, Rebecca D. (CDC/DDID/NCEZID/DGMQ); Wallace, Ryan (CDC/DDID/NCEZID/DHCPP); Slayton, Rachel B. (CDC/DDID/NCEZID/DHQP); Park, Benjamin (CDC/DDID/NCEZID/DHQP); Jones, Jefferson (CDC/DDID/NCEZID/DHQP); Benowitz, Isaac (CDC/DDID/NCEZID/DHQP); Epstein, Lauren H. (CDC/DDID/NCEZID/DHQP); Bagchi, Suparna (CDC/DDID/NCEZID/DHQP); Nolen, Leisha (CDC/DDID/NCEZID/DPEI); Gould, Carolyn V. (CDC/DDID/NCEZID/DVBD); Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Adams, Monica (CDC/DDID/NCHHSTP/DHPSE); Ridpath, Alison D. (CDC/DDID/NCHHSTP/DSTDP); Haddad, Maryam (CDC/DDID/NCHHSTP/DTE); Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Ogden, Cynthia L. (CDC/DDPHSS/NCHS/DHNES); Lee, Robin (CDC/DDNID/NCIPC/DIP); Annor, Francis (CDC/DDNID/NCIPC/DVP); Verani, Jennifer R. (CDC/DDPHSIS/CGH/DGHP); Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD); Midgley, Claire (CDC/DDID/NCIRD/DVD); Tate, Jacqueline E. (CDC/DDID/NCIRD/DVD); Gargano, Julia Marie W. (CDC/DDID/NCIRD/DVD); Rolfes, Melissa (CDC/DDID/NCIRD/ID); Dawood, Fatimah S. 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Subject:	RE: EIS Supervisor Seminar: EIS Conference and Match Orientation
Date:	Wednesday, March 18, 2020 3:20:46 PM
Attachments:	EIS Supervisor Seminar_Virtual Match_2020.pdf

EIS Supervisors –

Slides from today's seminar on the virtual match are attached. The presentation recording will be shared with you when available.

Thanks,
Larry

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Roth, Joseph (CDC doh.vi.gov); Ryans, Eric (NIH/CIT) [C]; Saydah, Sharon (CDC/DDNID/NCCDPHP/DDT); Serbanescu, Florina (CDC/DDNID/NCCDPHP/DRH); Sferrazza, Giovanni (IHS/HQ) [C]; Shaw, Kelly (CDC/DDNID/NCBDDD/DHDD); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Silk, Benjamin J. (CDC/DDID/NCHHSTP/DTE); Skrobarcek, Kimberly (CDC/DDID/NCEZID/DGMQ); Slayton, Rachel B. (CDC/DDID/NCEZID/DHQP); Smith, Kirk (CDC state.mn.us); Socias-Morales, Christina M. (CDC/NIOSH/DSR/AFEB); Soeters, Heidi (CDC/DDPHSIS/CGH/GID); Sosa, Lynn (CDC ct.gov); Sparkman, Jessica E. (CMS/OFM); Stinn, John (CDC/OCOO/OCIO) (CTR); Straily, Anne (CDC/DDPHSIS/CGH/DPDM); Sweeney, Marie (CDC/NIOSH/DFSE/HIB); Tan, Christina CT (CDC doh.nj.gov); Tate, Jacqueline E. (CDC/DDID/NCIRD/DVD); Terashita, Dawn (CDC ph.lacounty.gov); Terranella, Andrew J (IHS/POR); Thompson-Paul, Angela M. (CDC/DDNID/NCCDPHP/DHDSP); Tomasi, Suzanne (CDC/NIOSH/RHD/FSB); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Trackemas, Jack D. (CDC/NIOSH/PMRD/GCB); Trout, Douglas (CDC/NIOSH/DFSE/HETAB); Twentyman, Evelyn Rebecca Ford (CDC/DDNID/NCCDPHP/OSH); Ussery, Emily Neusel (CDC/DDNID/NCCDPHP/DNPAO); VanFrank, Brenna (CDC/DDNID/NCCDPHP/OSH); Vanhouten, Clay (CDC wyo.gov); Wallace, Ryan (CDC/DDID/NCEZID/DHCPP); Warren-Mears, Victoria (CDC npaihb.org); Waterman, Steve (CDC/DDID/NCEZID/DVBD); Watson, John (CDC/DDID/NCIRD/DVD); Watt, James (CDC cdph.ca.gov); Weiser, Thomas (CDC npaihb.org); Whelan, Elizabeth A. (CDC/NIOSH/DFSE/FRB); Wiggins, Lisa (CDC/DDNID/NCBDDD/DHDD); Wilken, Jason (CDC cdph.ca.gov); Wilkinson, Amanda (CDC/DDPHSIS/CGH/GID); Wise, Matthew E. (CDC/DDID/NCEZID/DFWED); Woodworth, Kate (CDC/DDNID/NCBDDD/DBDID); Wortley, Pascale (CDC dph.ga.gov); Wu, Hsiu (CDC/DDID/NCEZID/DHQP); Zambrano, Laura (CDC/DDNID/NCBDDD/DBDID); Adams, Monica (CDC/DDID/NCHHSTP/DHPSE); Agnew Brune, Christine (CDC/DDID/NCHHSTP/DHPSE)

Subject: RE: EIS Supervisor Seminar: EIS Conference and Match Orientation
Date: Tuesday, February 25, 2020 2:44:13 PM

Thanks, I didn't receive this!

-----Original Appointment-----
From: Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH) <ydg9@cdc.gov> **On Behalf Of** EIS (CDC)
Sent: Tuesday, February 25, 2020 2:20 PM
To: Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH)
Subject: FW: EIS Supervisor Seminar: EIS Conference and Match Orientation
When: Wednesday, March 18, 2020 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Adobe Connect Webinar
Importance: High

Not sure if you already received this but wanted to pass this along as I'll be deployed for COVID-19 on this day. If it's slow at the quarantine station I'll try to join remotely.

Regards,
Monique

Monique A. Foster, MD MPH
LCDR, United States Public Health Service
Medical Epidemiologist, Division of Viral Hepatitis
Centers for Disease Control and Prevention
1600 Clifton Road NE
Mailstop G-37
Atlanta, GA 30333

Phone: 404-718-8561
Email: ydg9@cdc.gov

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-----Original Appointment-----
From: EIS (CDC)
Sent: Tuesday, February 25, 2020 2:07 PM
To: EIS (CDC); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC EIS EAC Roster 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Abara, Winston E. (CDC/DDID/NCHHSTP/DSTDP); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Annor, Francis (CDC/DDNID/NCIPC/DVP); Appiah, Grace D (CDC/DDID/NCEZID/DFWED); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Arvay, Melissa (CDC/DDID/NCIRD/DBD); awv4@cdc.gov; Bagchi, Suparna (CDC/DDID/NCEZID/DHQP); Balter, Sharon (CDC ph.lacounty.gov); barbara.montana@doh.nj.gov; Barfield, Wanda D. (CDC/DDNID/NCCDPHP/DRH); Basavaraju, Sridhar (CDC/DDID/NCEZID/DHQP); Beer, Karlyn D. (CDC/DDID/NCEZID/DFWED); Bell, Jeneita (CDC/DDID/NCEZID/DHQP); Bell, Linda (CDC dhec.sc.gov); Benowitz, Isaac (CDC/DDID/NCEZID/DHQP); Bish, Connie (CDC/DDNID/NCCDPHP/DRH); Bitsko, Rebecca (CDC/DDNID/NCBDDD/DHDD); Black, Stephanie SB (CDC cityofchicago.org); Blau, Dianna M. (CDC/DDPHSIS/CGH/OD); Bonwitt, Jesse (CDC/DDID/NCEZID/DHCPP); Bozio, Catherine H. (CDC/DDID/NCIRD/ID); Brown, Allison C. (CDC/DDID/NCEZID/DHQP); Bruce, Michael G. (CDC/DDID/NCEZID/DPEI); Busacker, Ashley (CDC wyo.gov); Cantey, Paul T. (CDC/DDPHSIS/CGH/DPDM); Carlson, Susan (CDC/DDNID/NCCDPHP/DNPAO); Carroll, Yulia (CDC/DDNID/NCEH/DEHSP); Cartter, Matthew (CDC ct.gov); Chaleunsy, Charlie (CMS/CMHPO); Chang, Arthur (Art) (CDC/DDNID/NCEH/DEHSP); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Chen, Michael (CDC/DDID/NCIRD/ISD); Cherry, Cara C. (CDC/DDID/NCEZID/DVBD); Chew, Ginger L. (CDC/DDNID/NCEH/DEHSP); Chiu, Sophia (CDC/NIOSH/DFSE/HETAB); Christensen, Bryan E. (CDC/DDID/NCEZID/DHQP); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Cieslak, Paul (CDC dhsoha.state.or.us); Clayton, Heather B. (CDC/DDID/NCHHSTP/DASH); CMMainConfRoom (CDC); Cogdill, Keith (NIH/OD/ORS) [E]; Courtney-Long, Elizabeth A. (CDC/DDNID/NCCDPHP/OSH); Curran, Kathryn (CDC/DDPHSIS/CGH/DGHT); Cwynar, Kevin (NIH/CIT) [C]; Dale, Helen M. (CDC/DDPHSIS/CGH/DGHT); DAngelo, Denise V. (CDC/DDNID/NCCDPHP/DRH); Danielson, Melissa (CDC/DDNID/NCBDDD/DHDD); Dasgupta, Sharoda (CDC/DDID/NCHHSTP/DHPSE); Davies-Cole, John (CDC dc.gov); Dawood, Fatimah S. (CDC/DDID/NCIRD/ID); DBITSD (CDC); Dieffenbach, Carl (NIH/NIAID) [E]; Diekman, Shane T. (CDC/DDPHSIS/CGH/DGHT); Drenzek, Cherie (CDC dph.ga.gov); Eakin, Ann (NIH/NIAID) [E]; Edison, Laura (CDC dph.ga.gov); Elam-Evans, Laurie (CDC/DDID/NCIRD/ISD); Ellis, Esther (CDC doh.vi.gov); Epstein, Lauren H. (CDC/DDID/NCEZID/DHQP); Eyassu, Abinet (CDC/DDID/NCIRD/ISD) (CTR); Fairley, Temeika (CDC/DDNID/NCCDPHP/DCPC); Fechter-Leggett, Ethan (CDC/NIOSH/RHD/FSB); Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD); Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Galang, Romeo Regi (CDC/DDNID/NCCDPHP/DRH); Garcia-Williams, Amanda (CDC/DDID/NCEZID/DFWED); Gargano, Julia Marie W. (CDC/DDID/NCIRD/DVD); Gleason, Brigette (CDC/DDID/NCEZID/DFWED); Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Gould, Carolyn V. (CDC/DDID/NCEZID/DVBD); Gould, Hannah HG (CDC health.nyc.gov); Groenewold, Matthew (CDC/NIOSH/DFSE/HIB); Guerra, Marta (CDC/DDPHSIS/CGH/DGHP); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Gwynn, Charon R (CDC health.nyc.gov); Halik, Lindsay (FDA/CFSAN) (CTR); Hall, Aron (CDC/DDID/NCIRD/DVD); Hall, Noemi (CDC/NIOSH/RHD/SB); Hamner, Heather

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(CDC/DDNID/NCCDPHP/DNPAO); Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH); Harrist, Alexia (CDC wyo.gov); Heath-Mason, Matthew (NIH/OD) [E]; Henao, Olga (CDC/DDPHSIS/CGH/DGHP); Herzig, Carolyn (CDC/DDID/NCEZID/DHQP); Hill, Holly A. (CDC/DDID/NCIRD/ISD); Hills, Susan (CDC/DDID/NCEZID/DVBD); Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD); Hocevar Adkins, Susan N. (CDC/DDID/NCHHSTP/DASH); Holzbauer, Stacy (CDC state.mn.us); Hsu, Christopher (CDC/DDPHSIS/CGH/GID); Hughes, Christine (CDC/DDID/NCEZID/DHCPP); Hughes, Michelle (CDC/DDNID/NCBDDD/DHDD); Ly, Alpha (FDA/CBER) (CTR); Iyengar, Preetha (CDC dc.gov); Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Jackson, Sandra L. (CDC/DDNID/NCCDPHP/DHDSP); Jain, Seema (CDC cdph.ca.gov); Jannath, Syeda (CDC/OCOO/OFR/OFAS) (CTR); jcorbett@lgc.org (CDC lgc.org); Jennings, Andre'a (CDC/DDPHSS/CSELS/DSEPD) (CTR); Jones, Jefferson (CDC/DDID/NCEZID/DHQP); Jyothi Prakashan, Senthil Kumar (FDA/OC) (CTR); KathleenBuckheit (CDC email.unc.edu); Khetsuriani, Nino (CDC/DDPHSIS/CGH/GID); Kimura, Akiko (CDC cdph.ca.gov); Klabansky, Jennifer (NIH/NCI) [C]; Klos, Rachel (CDC wi.gov); Kmet, Matthew (FDA/CFSAN) (CTR); Kneipp, Teresa (CDC/NIOSH/HELD/CBMB); Ko, Jean Y. (CDC/DDNID/NCCDPHP/DRH); Komatsu, Kenneth (CDC azdhs.gov); Kracalik, Ian (CDC/DDID/NCEZID/DHQP); Lakkamraju, Suneetha (FDA/ORA) (CTR); Laney, Anthony S. (CDC/NIOSH/RHD/SB); Langer, Adam J. (CDC/DDID/NCHHSTP/DTE); Langley, Gayle E. (CDC/DDID/NCIRD/DVD); Laufer Halpin, Alison S. (CDC/DDID/NCEZID/DHQP); Lawson, Christina (Tina) (CDC/NIOSH/DFSE/FRB); Leadbetter, Laurie (NIH/NLM) [C]; Leman, Richard (CDC dhsoha.state.or.us); Lessa, Fernanda (CDC/DDID/NCEZID/DHQP); Li, Ruowei (Rosie) (CDC/DDNID/NCCDPHP/DNPAO); Loustalot, Fleetwood (CDC/DDNID/NCCDPHP/DHDSP); Luckhaupt, Sara E. (CDC/NIOSH/DFSE/HIB); Lundeen, Elizabeth Ann (CDC/DDNID/NCCDPHP/DDT); Lyman, Meghan Marie (CDC/DDID/NCEZID/DFWED); m.weston@ana.org (CDC ana.org); Maenner, Matthew J. (CDC/DDNID/NCBDDD/DHDD); Marano, Nina (CDC/DDID/NCEZID/DGMQ); Marietta, Cheryl (NIH/NIAAA) [E]; Markowitz, Lauri (CDC/DDID/NCIRD/DVD); Martin, Stacey (CDC/DDID/NCEZID/DVBD); Marx, Grace (CDC/DDID/NCEZID/DVBD); Materna, Barbara (CDC cdph.ca.gov); Meites, Elissa M. (CDC/DDID/NCIRD/DVD); Mhali, Tanesha (FDA/ORA); Midgley, Claire (CDC/DDID/NCIRD/DVD); Minta, Anna Akua (CDC/DDPHSIS/CGH/GID); Mirabelli, Maria (CDC/DDNID/NCEH/DEHSP); mstoops@nationalhomeless.org (CDC nationalhomeless.org); Mullins, Jocelyn (CDC ct.gov); Murrill, Christopher S. (CDC/DDPHSIS/CGH/GID); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Nickel, Alexandra K (OIG/OMP) (CTR); Nolen, Leisha (CDC/DDID/NCEZID/DPEI); Omura, John Daniel (CDC/DDNID/NCCDPHP/DNPAO); Parashar, Umesh (CDC/DDID/NCIRD/DVD); Park, Benjamin (CDC/DDID/NCEZID/DHQP); Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD); Pazol, Karen (CDC/DDNID/NCBDDD/DHDD); Perrine, Cria G. (CDC/DDNID/NCCDPHP/DNPAO); Petersen, Brett W. (CDC/DDID/NCEZID/DHCPP); Pierce, Rebecca (CDC dhsoha.state.or.us); Pindyck, Talia (CDC/DDID/NCEZID/DFWED); Plumb, Ian (CDC/DDID/NCEZID/DFWED); Pollack, Loria A. (CDC/DDNID/NCCDPHP/DCPC); Psychas, Paul (CDC usaid.gov); Radcliffe, Rachel (CDC dhec.sc.gov); Rajasingham, Anangu (CDC/DDPHSIS/CGH/DGHP); Rao, Carol (CDC/DDPHSIS/CGH/DGHP); RDB Inquiries (CDC); Reichard, Audrey A. (CDC/NIOSH/DSR/SFIB); Reynolds, Laura (CDC/NIOSH/DFSE/HETAB); Ridpath, Alison D. (CDC/DDID/NCHHSTP/DSTDP); rmartinez@nas.edu (CDC nas.edu); Rolfes, Melissa (CDC/DDID/NCIRD/ID); Romero, Lisa (CDC/DDNID/NCCDPHP/DRH); Rose, Erica (CDC/DDID/NCEZID/DFWED); Roth, Joseph (CDC doh.vi.gov); Ryans, Eric (NIH/CIT) [C]; Saydah, Sharon (CDC/DDNID/NCCDPHP/DDT); Serbanescu, Florina (CDC/DDNID/NCCDPHP/DRH); Sferrazza, Giovanni (IHS/HQ) [C]; Shaw, Kelly (CDC/DDNID/NCBDDD/DHDD); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Silk, Benjamin J. (CDC/DDID/NCHHSTP/DTE); Skrobarcek, Kimberly

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(CDC/DDID/NCEZID/DGMQ); Slayton, Rachel B. (CDC/DDID/NCEZID/DHQP); Smith, Kirk (CDC state.mn.us); Socias-Morales, Christina M. (CDC/NIOSH/DSR/AFEB); Soeters, Heidi (CDC/DDPHSIS/CGH/GID); Sosa, Lynn (CDC ct.gov); Sparkman, Jessica E. (CMS/OFM); Stinn, John (CDC/OCOO/OCIO) (CTR); Straily, Anne (CDC/DDPHSIS/CGH/DPDM); Sweeney, Marie (CDC/NIOSH/DFSE/HIB); Tan, Christina CT (CDC doh.nj.gov); Tate, Jacqueline E. (CDC/DDID/NCIRD/DVD); Terashita, Dawn (CDC ph.lacounty.gov); Terranella, Andrew J (IHS/POR); Thompson-Paul, Angela M. (CDC/DDNID/NCCDPHP/DHDSP); Tomasi, Suzanne (CDC/NIOSH/RHD/FSB); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Trackemas, Jack D. (CDC/NIOSH/PMRD/GCB); Trout, Douglas (CDC/NIOSH/DFSE/HETAB); Twentyman, Evelyn Rebecca Ford (CDC/DDNID/NCCDPHP/OSH); Ussery, Emily Neusel (CDC/DDNID/NCCDPHP/DNPAO); VanFrank, Brenna (CDC/DDNID/NCCDPHP/OSH); Vanhouten, Clay (CDC wyo.gov); Wallace, Ryan (CDC/DDID/NCEZID/DHCPP); Warren-Mears, Victoria (CDC npaihb.org); Waterman, Steve (CDC/DDID/NCEZID/DVBD); Watson, John (CDC/DDID/NCIRD/DVD); Watt, James (CDC cdph.ca.gov); Weiser, Thomas (CDC npaihb.org); Whelan, Elizabeth A. (CDC/NIOSH/DFSE/FRB); Wiggins, Lisa (CDC/DDNID/NCBDDD/DHDD); Wilken, Jason (CDC cdph.ca.gov); Wilkinson, Amanda (CDC/DDPHSIS/CGH/GID); Wise, Matthew E. (CDC/DDID/NCEZID/DFWED); Woodworth, Kate (CDC/DDNID/NCBDDD/DBDID); Wortley, Pascale (CDC dph.ga.gov); Wu, Hsiu (CDC/DDID/NCEZID/DHQP); Zambrano, Laura (CDC/DDNID/NCBDDD/DBDID); Adams, Monica (CDC/DDID/NCHHSTP/DHPSE); Agnew Brune, Christine (CDC/DDID/NCHHSTP/DHPSE)
Subject: EIS Supervisor Seminar: EIS Conference and Match Orientation
When: Wednesday, March 18, 2020 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Adobe Connect Webinar
Importance: High

*****This seminar is primarily for supervisors who have been approved to match at the 2020 EIS Conference; however, all supervisors are welcome to participate. As a reminder, final dispositions on approvals to participate in the 2020 EIS match will be sent on March 9.*****

EIS Supervisors –

Do you have questions about the 2020 EIS Conference and match?
Would you like to become familiar with the recruitment venue?
Would you like to see an overview on how to schedule interviews, and assign and enter your match scores?

Then please join us for the next EIS Supervisor Seminar, where we will be discussing the EIS Conference and match!

During the seminar, we will review 2020 EIS match process, including the recruitment venue, how to enter your interview slots, and how to enter your scores.

If you already have questions about EIS Conference or match that you would like addressed during the seminar, please send them ahead of time to Larry Cohen at cbu1@cdc.gov. We will compile the submitted questions and answer them during the seminar.

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We look forward to your participation at the next EIS Supervisor Seminar!

Thank you,
EIS Program

Adobe Connect Webinar Information
https://adobeconnect.cdc.gov/ruqnt1n2uhla

If you have never attended an Adobe Connect meeting before:
Test your connection:
https://virtualsepd.adobeconnect.com/common/help/en/support/meeting_test.htm
Get a quick overview: http://www.adobe.com/products/adobeconnect.html

Phone Line Information
(770) 488-3600
Conference ID: 3183827

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From: Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD)
To: bvanderslice; Gregory, Christopher (CDC/DDID/NCEZID/DVBD)
Cc: Blackmore, Carina (CDC flhealth.gov); Christine Scott-Waldron; Varnado, Wendy (CDC msdh.ms.gov)
Subject: RE: Examples of good state support for IR testing
Date: Tuesday, March 3, 2020 10:22:18 AM

Good morning Bob,

The three states that I recommend are Florida, Mississippi, and Louisiana.

Florida contact is Dr. Carina Blackmore. Blackmore, Carina (CDC flhealth.gov) carina.blackmore@flhealth.gov
In this model, the State DOH received Zika and then Hurricane Funding that supported a contract with the University of Florida, Florida Medical Entomology Laboratory to conduct state-wide testing on Aedes aegypti, Aedes albopictus, and Culex spp.

Mississippi contact is Dr. Wendy Varnado. Varnado, Wendy Wendy.Varnado@msdh.ms.gov

Louisiana contact is Chrissie Waldron-Scott. Christine Scott-Waldron Christine.Scott-Waldron@la.gov
The State DOH has contracted with Louisiana State University to start testing this year.

Let me know if you need additional information.

Roxanne

Roxanne Connelly, PhD, BCE
Centers for Disease Control and Prevention
Division of Vector-Borne Diseases
Arboviral Diseases Branch
Entomology and Ecology Team Lead
3156 Rampart Road
Ft. Collins, CO 80521

970-266-3512 (office)

From: bvanderslice <bvanderslice@cox.net>
Sent: Thursday, February 27, 2020 2:01 PM
To: Gregory, Christopher (CDC/DDID/NCEZID/DVBD) <hgk4@cdc.gov>; Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD) <csz5@cdc.gov>
Subject: RE: Examples of good state support for IR testing

Hi Roxanne,

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ASTHO is working on a document to promote state health departments to support Insecticide Resistance testing. I think it would be valuable to include a few brief examples or mini-case studies of different state approaches to IR. Can you suggest 3 states that other states may want to model? Do you have information on who to contact?
Thanks,
Bob Vanderslice
401-864-7573

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: "Gregory, Christopher (CDC/DDID/NCEZID/DVBD)" <hgk4@cdc.gov>
Date: 2/26/20 4:06 PM (GMT-07:00)
To: bvanderslice@cox.net, "Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD)" <csz5@cdc.gov>
Subject: Examples of good state support for IR testing

Bob,

Wanted to connect you with Roxanne Connelly, our entomology and ecology team lead, to follow-up on our discussion from yesterday. Roxanne has some good examples of successful models for state support of IR testing.

Best,

Chris

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From:	Blackmore, Carina
To:	Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM)
Subject:	RE: FL request for CDC assistance
Date:	Thursday, March 12, 2020 4:16:32 PM

Are you on the call with us now ? We have a group of your colleagues on the line.

From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Thursday, March 12, 2020 4:12 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: FL request for CDC assistance

Carina,
In response to your question about assessing risk level of contacts, below is the approach that we have been using. Please let me know if you have additional questions. When you have time, I'd be interested in following up on the questions about port workers.
Stephanie

How contacts are assessed: There is not a precise time-defined criteria for determining what is "prolonged" contact. Low risk is generally considered to be very brief interactions such as a brief greeting conversation, handshake, generally of less than 10 minutes. Medium risk exposures typically include those that include an interaction of 30 minutes or longer within 6 feet such as eating a meal together. Types of exposures that fall between are assessed on a case by case basis and take into consideration careful assessment of all aspects of the interaction including whether the case was symptomatic and how close the contact was to the case.

https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

Close contact in the guidance above is defined as 1) being within approximately 6 feet of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case or 2) having direct contact with infectious secretions of a COVId-19 case (e.g. being coughed on).
Medium risk exposures include "Being on an aircraft, being seated within 6 feet of a traveler with symptomatic lab-confirmed COVID-19 infection…".
Low risk exposures include "Being in the same indoor environment as a person with symptomatic lab-confirmed COVID-19 for a prolonged period of time but not meeting the definition of close contact

---

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:35 PM
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Subject: Re: FL request for CDC assistance

Workplace exposure

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 8:31:02 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: FL request for CDC assistance

This info I got was confusing. It sounded like there were two different chains of communication and I wanted to make sure we hadn't left anything undone. What are your thoughts on the cases among the cruise port workers? Does it seem like a common workplace exposure or community transmission?
Thank you,
Stephanie

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:09:14 PM
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Subject: Re: FL request for CDC assistance

Ok. I am not familiar with that request. What we are interested in is a consult. We had a call the other night and had discussed a follow up call. I was working with someone else on that. Who made the request. Do you know.

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 7:17:35 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: FL request for CDC assistance

Dr. Blackmore,
I wanted to follow up on a call we had received through our EOC that Florida may have questions or possibly want assistance in investigating recent reports of cases of COVID-19 in Florida related to cruise port workers in Broward County. Please call me when it's convenient for you.
Thank you,
Stephanie
404-617-6374

Stephanie R. Bialek MD MPH
Epidemiology Task Force Lead
CDC COVID-19 Response

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From:	Budd, Alicia (CDC/DDID/NCIRD/ID)
To:	Scott.Pritchard@flhealth.gov
Cc:	Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Blackmore, Carina (CDC flhealth.gov); Andrea.Leapley@flhealth.gov; CDC IMS 2019 NCOV Response EPI Task Force
Subject:	RE: FL: EOC PUI team Questions
Date:	Saturday, February 1, 2020 12:46:47 PM

Scott –

Runa referred your email to me as we are trying to consolidate our state communication to the extent possible to help expedite responses.

When you say you haven't heard any summaries of private provider calls directly to CDC, I am not sure if you referring to getting testing results from PUIs or knowing that a provider has called to inquire about a patient potentially meeting criteria to be a PUI.

For the former, we have identified that there is an issue with the eLIMS automatic reporting feature. In the interim, until the issue is resolved, we are emailing negative nCoV PCR results to the public health lab submitter email that is included with the specimen. Official reports will follow when the eLIMS issue is resolved. The lab is testing throughout the weekend and we email the negative results out as soon as we get them.

If your question is about providers that might have called about a potential PUI, when that occurs, the provider is being instructed to contact the health department.

If I have not answered your question or if you have additional questions, don't hesitate to reach out.

Thanks,
Alicia Budd

EPI Task Force
2019 n-CoV Response
eocevent212@cdc.gov

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 11:40 AM
To: Budd, Alicia (CDC/DDID/NCIRD/ID) <acp4@cdc.gov>
Subject: FW: EOC PUI team Questions

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 10:42 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>

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Subject: Re: EOC PUI team Questions

Thanks. We still haven't heard any summaries of private provider calls directly to CDC. We really need to have the is information.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 10:26:59 AM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: RE: EOC PUI team Questions

Hi Scott,

We are staffed 24/7. I apologize for the delay, we are looking into why it occurred. I believe our on-call staff spoke with your department this morning. Please let me know if any questions or concerns remain.

Sincerely,
Runa

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 8:29 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: EOC PUI team Questions

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

Scott Pritchard, MPH
Interim Director

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Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

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From:	Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
To:	McGough, John (HHS/IEA); Weir, Charles (OS/ASPR/IO); scott.rivkees@flhealth.gov; Koneff, Douglas A; Roberson, Shamarial (CDC flhealth.gov)
Cc:	Butler, Jay C. (CDC/DDID/OD); Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); Cetron, Marty (CDC/DDID/NCEZID/DGMQ); Knutson, Donna (CDC/DDNID/NCEH/OD)
Subject:	RE: Florida Cruise Ship Summary 3.17.20 4 pm
Date:	Tuesday, March 17, 2020 11:45:42 PM
Attachments:	Chile (37.2 KB).msg

Hi Mr. McGough,

I wanted to update you about the situation with Royal Caribbean and the flights from Chile and Brazil

1. There has been no movement on any flights from Brazil
2. AT 6:30 PM EST, Ms. Kalisch from Royal Caribbean emailed us to tell us that the Government of Chile had put a hold on their flights
3. At around 6:44 PM, I received a call from Dr. Rivkees, the Florida Surgeon General who told me that the Governor was not going to allow any flights to land and disembark passengers in Miami until there was a solid plan articulated by the Cruise company.
4. Right after that call we notified the State Department and copied DHS. We also notified Eleni Kalisch and told her to contact the State of Florida to coordinate a plan(we gave her the relevant phone numbers)
5. At approximately 7:30 Eleni Kalisch emailed that the flight from Chile was going to proceed, but she never responded about contacting Florida state or local authorities despite multiple emails from CDC telling her to do so
6. At 10:07 she told us that the flight would be departing Chile at 12:10 AM local time and arriving in Miami at 9:10 AM EST

Attached is the last email chain starting at 10:20 when Eleni told us there is a slight change of plans which states that CDC will be screening her passengers. We have told her multiple times that CDC will not be screening passengers. We asked her to contact us by phone right away (11PM), but she has not done so. We believe that the flight may have already departed and we are concerned that no one has signed off on this from Florida and that a clear and reasonable plan has not been sent any of us.

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Sent: Tuesday, March 17, 2020 4:23 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles

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(OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: RE: Florida Cruise Ship Summary 3.17.20 4 pm

Enormously helpful, thank you.

John G. McGough
Regional Director
U.S. Department of Health & Human Services
Region 1 - New England - (CT, ME, MA, NH, RI, & VT)
Region 4 - Southeast - (AL, FL, GA, KY, MS, NC, SC, & TN)
JFK Federal Building, Suite 2100
Boston, MA 02203

Tel (617) 565-1500
Fax (617) 565-1491
John.McGough@hhs.gov

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 4:08 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: Florida Cruise Ship Summary 3.17.20 4 pm

Dear Mr. McGough,

Attached please find a summary of our phone call with the Florida Governor's Deputy Chief of Staff regarding two Royal Caribbean cruise ships and pending charter flights to Miami from both Brazil and Chile. Please let me know if you have any other questions.

Kind regards,
Cindy

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

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From: Mooney, Dayle

To: Rivkees, Scott A; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org

Cc: Boswell, Patricia; James-Glasgow, Olivia N.; Moffses, Thomas P; Villalta, Yesenia D; Wegener-Vitani, Carol A; Myers, Paul D; Lander, Mark S; Vick, Stephanie; Waldron, Kerry S; Hawker, Miranda C; Durden, Tammy M; Danyluk, Gregory M; Harvey, James D; Snyder, Robert E; Conklin, Kelly H; Grabelle, Dorothy A; Singer, Keith A; Ming, Randy S; Jergens, Christy M; Duncan, Sherry L; Pepe, Joseph D; Speedling, Sandon S.; Johnson, Karen S (HolmesCHD); Smith, Angela M; Hess, Erin E; Cooksey, Adrian; Pino, Raul; Danielle Sorrentino-Brightman; Park-O"Hara, Sandra L; Johns, Amie G; Bill VanHelden; Amy Perez; CERULLO, TIMOTHY; HAWLEY, WILLIAM; WILLIAMS, RAYMOND; Martin, Sandy K; Henry, Charles H; Stahl, Maria A; Pierce, Bruce; Street, Karen K; Inman, Barry; Medlin, Helen K; Choe, Ulyee; Prosser, Kimberly; DL CHD46 ICSR; Chapman, Karen A; Allbritton, Kimberly; Napier, Mike J.; Baker, Lisa A; Nicholson, Garik A; Zelnick, Sanford D; Jena Glantz; Winn, Jason Esq ; Matt Jordan; "William Hightower"; Robinson, Lynn; Wadsworth, Lynn; Curt Sommerhoff; nmcdonald@uwf.edu; Courson, Sandi C; Foster, Kena K; Fleischman, Jennifer; Gray, Jennifer; Syfrett, Christine M; Bohaboy-Walby, Madalaine I; Byrge, Treasure L; Carmichael, Megan; Crumpton, Greg T; Etzel, Patricia L; Exline, Timothy; Hensley, Deborah S; Maguire, Ken G; Mullens, Donna J; Pavone, David; Pell, Jennie B; Snead, Jordan A; Watson, George F; Watts, Melissa E; alexandergolden@comcast.net; Sandoval, Randi C; Bailey, William H; Hodges, Zachary L; Cook, Helen M; Hogan, Lisa C; Hinds, Sarah JQ; Rolle, Pauline J; Sentman, Michael L; Sperber, Clint J.; Rubio, Tito G.; Central Florida Disaster Medical Coalition; Eric.Alberts@orlandohealth.com; Rogers, Jon; Rodrigues, Ruth; Phillipine, Kristin; Holt, Holly; Barley, Kathryn C; Portis, Alan L; Locke, Barbara L; Alonso, Alina M; Kissler, Aaron X; Medved, Daniel T; Matos, Nathaly; Cherry, Georgianne M; Juarez, Padraic R; Holtzclaw, Rhonda; Janet Kinney; jannamatautia@calhounlibertyhospital.com; BAKER, JOANN; jennifer.cloud@doctorsmemorialhospital.com; Sarah Catalanotto; Janet Smith; Long, Tracey; FREEBURG, RICHARD; David Abercombe; Debbie Stanger; Denise Grimsley; Rosalie Oliver; Cathy Jaco; matthew.l.smith@adventhealht.com; David Walker; Bill Storck; Rebecca Springer; Heath Huron; jbeltz@hhrmc.us; Temiela Blackman; Madeline Corbo; Pam Howard; Paula Webb; Jennifer Thomas; Jill Fulgham; Brett McClung; Martha Oakley; heidi.schaffer@hcahealthcare.com; Dan Hogan; Teresa Conerly; STONE, THOMAS; Doug Faircloth; david.ottati@fhms.org; Jermaine Bucknor; J.H. 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Bonilla; Randy Truette; Allen Parrish; Eddie Hand; swilliams@panhandleareahealthnetwork.com; Susan Grich; melissa.thibodeau@hrhn.org; Lynn Witt; garyowens@nwfrhn.com; Rpearson@rhnmc.org; HALL, ROGER; Reich, Debbie A; Dunn, Nathan P; Beedie, Katherine A; psparks@uwf.edu; Kirsch, Holly S; Stewart, Gail; DAlessio, Rebecca; Smith, Kathy J; Oliver, Rosalie; Walsh, Donna; PLATT, CARROL; Moscoso, Alberto; SHERROD, RHONDA; Brown, Richard; Perez, Ellis E; Asim Jani; Struble,Wayne Gordon; Matt Meyers; peterpappas52@gmail.com; Crowe, David R; Jonathan Lord; Baker, Kevin M; Bencie, Jennifer L; Poniatowski, Michael; Klein, Jason L.; Rutledge, Laura X; Napier, Robin; Ziegler, Carolyn H; McDaniel, Allison L; Smith, Rita M; Ashley Beigle; Melyssa Callahan; DiFede, Matthew; MacDonell, Sam; Blevins, Allison M; Jenkins Kelley; Burns, Mary K; Lewis, Susan M.; Welter, Bonnie J; Stewart, Lewis Shayne; rhambrick@ncf.edu; Brafford, Melba G.; Loftin, Edwin; Schuffert, Michael; Andrews, Phil; Jo.Alverson@Steward.org; REED, PAMELA; Mann, William; Johns, Paul M.; Abbasi, Muhammad J; Harder, Terri A; Hollingsworth, Kristine M; Marr, Kathleen J; Mercado, Carlos A.; Pedigo, Ryan J.; Miller, Brian L.; Gordon, Leslene E.; Lanza, John J; Bolton, Beate H; Georgine Kruedelbach; Marcia Catania; Hendershot, Jeri; Albert, Michele M; Burns, David; Clincea, Radu; Moore, Valarie E; Roberson, Candice S; Smith, Bret A; Whitston, Shannon M; Combs, Sue S; Kimberly Sample; Jackson, Joy L; Joseph, Ashley; Claire Sutherland; Scott, Katie E; Beauchamp, Brittany J; Larkin, Emerald A; Simmons, Deanna T; Pippin, Jessie W; Richards, Shelby D; Fugate, Betty K; Fisher, Ashley; Stalnaker,Jeffrey C., MD; Reagan Husong; Langston, Taylor; Eadie, Bob; Senyshyn, William; Richards, Patricia; McMillan, Emily A; Reese, Suzette W; DL DEPCS00 BPR HCCTF; Wilsey, Leigh; Allicock, Dawn; Caldwell, Jamie S; Caitlyn Eck; Campbell, Sieglinde D; Dr. Corin DeChirico; Schenk, Terry; Rashena Clark; John James; Koncelik,Denise Lavern; Carhart, Ty; Collins, Tiffany L; Hardacre, Tod B; Shipley, Valerie D; Kelly Keys; Michele Jones; Cabrera, Mary Ann; Clifton, Nicholas L; Bradley, Edward; McKay, Leslie W; Tuero, Kim L; Bryant, Rachel W; Marilia VanKeeken; Eric Anderson; Ackerman, Craig; Crowley, Meaghan K; Bjelke, David; DL CHD13 SENIOR LEADERSHIP TEAM; Nickola-Williams, Noreen B; Dorans, Christopher; Bailey, Bobby; Rowe, Ann; Kelley, Debbie A; Stenberg, Christina; James, Susan; Alonso, Zuzel; Ngo-Seidel, Eugenia J; Zayas, Maribel A; Keyes, Becky (County Health Systems); Smith, Thomas M; Alison Doeing; Foerster, Lisa R.; Peggy Brown; Quigley, Jacob B; Harris, Nicole E.; Morris, Cindy K.; Hill, Ann; Weller, Karen; Yow, Annmarie; Bielling, Jeffery; acburke8@gmail.com; Luce, Christie; Nelson, Joanna; Robinson, Eriko M; Davis, Ashley; Vaughn, Freda G; Shedlock, Andrew (AndrewShedlock@fdle.state.fl.us); Woodlief, Douglas; Jackson, Iris F; Tracey Vause; Ciereck, Christina M.; HSU MD, Vincent; Taryn Kryzda; Steve Wolfberg; ddyess@ci.stuart.fl.us; commissioners@ci.stuart.fl.us; William Schobel; Gaylord, Laurie; comish@martin.fl.us; wdsnyder@sheriff.martin.fl.us; jtummine@ci.stuart.fl.us; Michelle Miller; Rouse, Renay C; Bowzer, Leah F; Powell, Sheryl L; Doug Smith; Watkins, Shirley; Kevin Herndon; Don Donaldson; Domenica Labbate; George Stokus; Meier, Mike; Katelyn White; Reinhold, Todd A; County Health Systems; Mich Mongel; Ronnie Daves; David Whalen; Darrel Welborn; Matthew D. Abbott (mabbott@sheriff-okaloosa.org); BonicaLauren; SummersDan; ShawMichael; Kevin Gingras; Astrid Ramirez; Scuteri, Ana C; EmergencyManagementEmployees; Manuel Cela; Connor, Olga; Zach Annett; Eneida Roldan; Ashley Krutz; Smoak, Kimberly; Best, Jay; William Johnston - Northbay; Brian T. Cook; Ray Downs; Becky Washler; Louis Lamarche; Adrian Damms; Morell, Venita

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W; YOUNG, Brenna; Dominguez, Orlando J; Debra Boyce; Clark, Heath; Pokryfke, John; Glass Leighton, Kelli; Harold Jenkins; Amy Aiken

Subject: RE: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
Date: Wednesday, March 4, 2020 1:24:12 PM
Attachments: 030402020 Agenda COVID-19 All Public Health and Heathcare Stakeholders.pdf

Please see the attached Agenda for this afternoon's call.

Sincerely,

Dayle D. Mooney, Manager
Community Preparedness Section
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support

-----Original Appointment-----
From: Rivkees, Scott A
Sent: Wednesday, February 12, 2020 10:50 AM
To: Rivkees, Scott A; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
Cc: Boswell, Patricia; James-Glasgow, Olivia N.; Moffses, Thomas P; Villalta, Yesenia D; Wegener-Vitani, Carol A; Myers, Paul D; Lander, Mark S; Vick, Stephanie; Waldron, Kerry S; Hawker, Miranda C; Durden, Tammy M; Danyluk, Gregory M; Harvey, James D; Snyder, Robert E; Conklin, Kelly H; Grabelle, Dorothy A; Singer, Keith A; Ming, Randy S; Jergens, Christy M; Duncan, Sherry L; Pepe, Joseph D; Speedling, Sandon S.; Johnson, Karen S (HolmesCHD); Smith, Angela M; Hess, Erin E; Cooksey, Adrian; Pino, Raul; Danielle Sorrentino-Brightman; Park-O'Hara, Sandra L; Johns, Amie G; Bill VanHelden; Amy Perez; CERULLO, TIMOTHY; HAWLEY, WILLIAM; WILLIAMS, RAYMOND; Martin, Sandy K; Henry, Charles H; Stahl, Maria A; Pierce, Bruce; Street, Karen K; Inman, Barry; Medlin, Helen K; Choe, Ulyee; Prosser, Kimberly; DL CHD46 ICSR; Chapman, Karen A; Allbritton, Kimberly; Napier, Mike J.; Baker, Lisa A; Nicholson, Garik A; Zelnick, Sanford D; Jena Glantz; Winn, Jason Esq ; Matt Jordan; 'William Hightower'; Robinson, Lynn; Wadsworth, Lynn; Curt Sommerhoff; nmcdonald@uwf.edu; Courson, Sandi C; Foster, Kena K; Fleischman, Jennifer; Gray, Jennifer; Syfrett, Christine M; Bohaboy-Walby, Madalaine I; Byrge, Treasure L; Carmichael, Megan; Crumpton, Greg T; Etzel, Patricia L; Exline, Timothy; Hensley, Deborah S; Maguire, Ken G; Mullens, Donna J; Pavone, David; Pell, Jennie B; Snead, Jordan A; Watson, George F; Watts, Melissa E; alexandergolden@comcast.net; Sandoval, Randi C; Bailey, William H; Hodges, Zachary L; Cook, Helen M; Hogan, Lisa C; Hinds, Sarah JQ; Rolle, Pauline J; Sentman, Michael L; Sperber, Clint J.; Rubio, Tito G.; Central Florida Disaster Medical Coalition; Eric.Alberts@orlandohealth.com; Rogers, Jon;

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Rodrigues, Ruth; Phillipine, Kristin; Holt, Holly; Barley, Kathryn C; Portis, Alan L; Locke, Barbara L; Alonso, Alina M; Kissler, Aaron X; Medved, Daniel T; Matos, Nathaly; Cherry, Georgianne M; Juarez, Padraic R; Holtzclaw, Rhonda; janetkinney@calhounlibertyhospital.com; jannamatautia@calhounlibertyhospital.com; BAKER, JOANN; jennifer.cloud@doctorsmemorialhospital.com; Sarah Catalanotto; janet.smith@doctorsmemorial.org; Long, Tracey; FREEBURG, RICHARD; davidab@baptisthealth.net; dstanger@baptisthealth.net; denise.grimsley@ahss.org; rosalie.oliver@ahss.org; cathy.jaco@ahss.org; matthew.l.smith@adventhealht.com; dwalker@emmsmemorial.com; bstorck@weemsmemorial.com; rspringer@hrmc.us; hhuron@weemsmemorial.com; jbeltz@hhrmc.us; tblackman@hrmc.us; mcorbo@hrmc.us; Pam Howard; pwebb@lakebutlerhospital.com; jthomas@lakebutlerhospital.com; jfulgham@lakebutlerhospital.com; brett.mcclung@bmcjax.com; martha.oakley@bmcjax.com; heidi.schaffer@hcahealthcare.com; dhogan@dmh.org; tconerly@dmh.org; STONE, THOMAS; doug.faircloth@doctorsmemorial.com; david.ottati@fhms.org; jermaine.bucknor@ahss.org; jthompson@healthmarkregional.com; lmeese@jackhosp.org; Krovito@jackhosp.org; HUTCHINS, MICHAEL; keith.strickling@bhcpns.org; brandy.call@bhcpns.org; rroche@lmcpbc.org; briley@lmcpbc.org; dan.mcLean@lpnt.net; debra.noyes@lpnt.net; MELEAR, P; robin.arrieta@hcahealthcare.com; rhall@shhpens.org; christy.rizza@shhpens.org; robin.godwin@ascension.org; rhonda.sherrod@hma.com; cdavidjay@aol.com; jsmsith@aol.com; awiman@bigbendahec.org; aingram@bigbendahec.org; support@hrhn.org; jfeller@wellflorida.org; Abarca, Chris; Moderie, Julie; astephenson@lorhn.org; tparrish@hcsef.org; ecallwood@lorhn.org; lholmes@lorhn.org; mrangel@lorhn.org; vgauze@healthcareswfl.org; sconnell@holmescountyfl.org; hendricksa@ci.marathon.fl.us; mwalters@mywakulla.com; rblewis1107@gmail.com; pburkel@union-ems.net; Fireco@madisoncountyfl.com; flakeysambulance@gmail.com; randytruette@gmail.com; allen_parrish@bradfordcountyfl.gov; eddieh@suwgov.org; swilliams@panhandleareahealthnetwork.com; Susan Grich; melissa.thibodeau@hrhn.org; lynn.witt@hma.com; garyowens@nwfrhn.com; Rpearson@rhnmc.org; HALL, ROGER; Reich, Debbie A; Dunn, Nathan P; Beedie, Katherine A; psparks@uwf.edu; Kirsch, Holly S; Stewart, Gail; DAlessio, Rebecca; Smith, Kathy J; Oliver, Rosalie; Walsh, Donna; PLATT, CARROL; Moscoso, Alberto; SHERROD, RHONDA; Brown, Richard; Perez, Ellis E; Asim Jani; Struble,Wayne Gordon; Matt Meyers; peterpappas52@gmail.com; Crowe, David R; Jonathan Lord; Baker, Kevin M; Bencie, Jennifer L; Poniatowski, Michael; Klein, Jason L.; Rutledge, Laura X; Napier, Robin; Ziegler, Carolyn H; McDaniel, Allison L; Smith, Rita M; Ashley Beigle; Melyssa Callahan; DiFede, Matthew; MacDonell, Sam; Blevins, Allison M; Jenkins Kelley; Burns, Mary K; Lewis, Susan M.; Welter, Bonnie J; Stewart, Lewis Shayne; rhambrick@ncf.edu; Brafford, Melba G.; Loftin, Edwin; Schuffert, Michael; Andrews, Phil; Jo.Alverson@Steward.org; REED, PAMELA; Mann, William; Johns, Paul M.; Abbasi, Muhammad J; Harder, Terri A; Hollingsworth, Kristine M; Marr, Kathleen J; Mercado, Carlos A.; Pedigo, Ryan J.; Miller, Brian L.; Gordon, Leslene E.; Lanza, John J; Bolton, Beate H; Georgine Kruedelbach; Marcia Catania; Hendershot, Jeri; Albert, Michele M; Burns, David; Clincea, Radu; Moore, Valarie E; Roberson, Candice S; Smith, Bret A; Whitston, Shannon M; Combs, Sue S; Kimberly Sample; Jackson, Joy L; Joseph, Ashley; Claire Sutherland; Scott, Katie E; Beauchamp, Brittany J; Larkin, Emerald A; Simmons, Deanna T; Pippin, Jessie W; Richards, Shelby D; Fugate, Betty K; Fisher, Ashley; Stalnaker,Jeffrey C., MD; Reagan Husong; Langston, Taylor; Eadie, Bob; Senyshyn, William; Richards, Patricia; McMillan, Emily A; Reese, Suzette W; DL DEPCS00 BPR HCCTF; Wilsey, Leigh; Allicock, Dawn; Caldwell, Jamie S; Caitlyn Eck; Campbell, Sieglinde D; Dr. Corin DeChirico; Schenk, Terry; Mooney,

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Dayle; Rashena Clark; John James; Koncelik,Denise Lavern; Carhart, Ty; Collins, Tiffany L; Hardacre, Tod B; Shipley, Valerie D; Kelly Keys; Michele Jones; Cabrera, Mary Ann; Clifton, Nicholas L; Bradley, Edward; McKay, Leslie W; Tuero, Kim L; Bryant, Rachel W; Marilia VanKeeken; Eric Anderson; Ackerman, Craig; Crowley, Meaghan K; Bjelke, David; DL CHD13 SENIOR LEADERSHIP TEAM; Nickola-Williams, Noreen B; Dorans, Christopher; Bailey, Bobby; Rowe, Ann; Kelley, Debbie A; Stenberg, Christina; James, Susan; Alonso, Zuzel; Ngo-Seidel, Eugenia J; Zayas, Maribel A; Keyes, Becky (County Health Systems); Smith, Thomas M; Alison Doeing; Foerster, Lisa R.; Peggy Brown; Quigley, Jacob B; Harris, Nicole E.; Morris, Cindy K.; Hill, Ann; Weller, Karen; Yow, Annmarie; Bielling, Jeffery; acburke8@gmail.com; Luce, Christie; Nelson, Joanna; Robinson, Eriko M; Davis, Ashley; Vaughn, Freda G; Shedlock, Andrew (AndrewShedlock@fdle.state.fl.us); Woodlief, Douglas; Jackson, Iris F; Tracey Vause; Ciereck, Christina M.; HSU MD, Vincent; Taryn Kryzda; Steve Wolfberg; ddyess@ci.stuart.fl.us; commissioners@ci.stuart.fl.us; William Schobel; Gaylord, Laurie; comish@martin.fl.us; wdsnyder@sheriff.martin.fl.us; jtummine@ci.stuart.fl.us; Michelle Miller; Rouse, Renay C; Bowzer, Leah F; Powell, Sheryl L; Doug Smith; Watkins, Shirley; Kevin Herndon; Don Donaldson; Domenica Labbate; George Stokus; Meier, Mike; Katelyn White; Reinhold, Todd A; County Health Systems; Mich Mongel; Ronnie Daves; David Whalen; Darrel Welborn; Matthew D. Abbott (mabbott@sheriff-okaloosa.org); BonicaLauren; SummersDan; ShawMichael; Kevin Gingras; Astrid Ramirez; Scuteri, Ana C; EmergencyManagementEmployees; Manuel Cela; Connor, Olga; zannett@thearpc.com; Eneida Roldan; Ashley Krutz; Smoak, Kimberly; Best, Jay; William Johnston - Northbay; brian.cook@hcahealthcare.com; ray@healthmarkregional.com; becky.washler@ascension.org; llamarche@mywakulla.com; adamms@hendryfla.net; Morell, Venita W; YOUNG, Brenna; Dominguez, Orlando J; Debra Boyce; Clark, Heath; Pokryfke, John; Glass Leighton, Kelli; Harold Jenkins; Amy Aiken
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Wednesday, March 4, 2020 2:00 PM-3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

FYI

-----Original Appointment-----
From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Tuesday, February 11, 2020 2:36 PM
To: Rivkees, Scott A; DL DOH CHD Administrators_Directors; Molly.McKinstry@ahca.myflorida.com; Laura MacLafferty; Kinsley, Chris; mary.mayhew@ahca.myflorida.com; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; jeanetta.stalcup@uhsinc.com; steve winn; michelle@foma.org; andrew@foma.org; govaffairs@foma.org; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; MThomas@flmedical.org; CPrine@flmedical.org
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call

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we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

AMERICAN OVERSIGHT

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS); Wallace, Marla D.
Cc: Blackmore, Carina (CDC flhealth.gov); DSLRCrisisCoag (CDC)
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project
Date: Friday, February 14, 2020 1:13:28 PM

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing LA's vector project needs and are proposing some alternative use of funds.

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

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Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
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Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager

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Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

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From: Wallace, Marla D.
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS); Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Cc: Blackmore, Carina; DSLRCrisisCoag (CDC); Clark, Marah; Stanek, Danielle R; Morrison, Andrea
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project
Date: Friday, February 14, 2020 1:49:13 PM

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

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From:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
To:	Wallace, Marla D.; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Cc:	Blackmore, Carina (CDC flhealth.gov); DSLRCrisisCoag (CDC); Clark, Marah; Stanek, Danielle (CDC flhealth.gov); Morrison, Andrea
Subject:	RE: Florida Hurricane Crisis CoAg Vector Control Project
Date:	Friday, February 14, 2020 2:20:31 PM

Thank you, Marla. I appreciate the additional details. I believe both activities for **FL** are allowable, trailers and educational material, but because it is equipment, it will have to have prior approval in GMM. That is why I am I requesting the additional information/quotes now rather than later in the review process. Finally, as you are probably aware- FL's budget narrative and workplan will also have to reflect these new activities and should also be submitted accordingly. I hope that helps clarify. Please don't hesitate to reach out with any questions.

Thanks again and hope you have a great weekend.

Warm regards,

Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
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Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

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AMERICAN OVERSIGHT

From:	Clark, Marah
To:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS); Wallace, Marla D.; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Cc:	Carina Blackmore; DSLRCrisisCoag (CDC); Danielle Stanek; Andrea Morrison
Subject:	RE: Florida Hurricane Crisis CoAg Vector Control Project
Date:	Tuesday, February 18, 2020 1:11:10 PM

Good afternoon All,

The following is a breakdown and information from the two programs requesting to purchase a trailer. I was misinformed on the purpose for one of the trailers as they are not both for outreach/education. One plans to use the trailer to move equipment around the county, increasing their capacity in post storm treatment response. The other is interested in using the trailer to educate their constituents. Please see the information below for cost approximations, size, and use details.

Hernando:
The trailer would be used to transport ATV's equipped with larviciding/adulticiding equipment as the A1 was purchased last year is loaded on their 6 x 12 trailer now. Therefore, they need another transport trailer. They're looking at a 6 x 14 or so, estimated cost from $1300-$1900 without a side gate. If they go for a side gate it could go up to $2500. The cost is certainly within their 10k allotment from year two distribution.

Pasco:
The cost for the trailer alone was $9363. Designing the trailer and customizing it to meet their needs is something they will be working on in the upcoming months. Estimates could be another $4000 in order for them to design the interior (adding shelving, cabinets, flooring, etc.), customize the exterior paint/wrap, add a generator, and finally, purchasing the educational material (microscope, TV, artwork, banners, etc.). So, overall, the total cost of the education trailer is approximately $14000.

The education trailer will be used to showcase how Pasco County Mosquito Control District proactively uses integrated mosquito management strategies to reduce pestiferous mosquito populations and protect residents from mosquito-borne diseases. This educational tool will be fun and interactive, designed to educate children and adult audiences by providing outreach services to area school districts, libraries, civic organizations, and other community groups.

The specs on the trailer;

- 8.5' x 24' V-nose, enclosed trailer
- 2 – 7000lb axels
- 84" interior height
- Rear and side ramps (instead of full doors)
- 4" x 4" concession window

I hope this information helps in obtaining needed approval and amending the current workplan.

Marah

Marah Clark
Environmental Administrator
Entomology and Pest Control Section
Bureau of Scientific Evaluation and Technical Assistance
Division of Agricultural Environmental Services
Florida Department of Agriculture and Consumer Services

(850) 617-7918 – Office
Marah.Clark@FDACS.gov

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NOTE: New email address and website

The Conner Building, Lab 6
3125 Conner Boulevard
Tallahassee, FL 32399

www.FDACS.gov

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida

---

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Friday, February 14, 2020 2:20 PM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Carina Blackmore <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@fdacs.gov>; Danielle Stanek <Danielle.Stanek@flhealth.gov>; Andrea Morrison <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Thank you, Marla. I appreciate the additional details. I believe both activities for **FL** are allowable, trailers and educational material, but because it is equipment, it will have to have prior approval in GMM. That is why I am I requesting the additional information/quotes now rather than later in the review process. Finally, as you are probably aware- FL's budget narrative and workplan will also have to reflect these new activities and should also be submitted accordingly. I hope that helps clarify. Please don't hesitate to reach out with any questions.

Thanks again and hope you have a great weekend.

Warm regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@freshfromflorida.com>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

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The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) [mailto:ydh1@cdc.gov]
Sent: Friday, February 14, 2020 1:13 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing **LA**'s vector project needs and are proposing some alternative use of funds. **Do you means FL?**

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

In other words, we need to see clearly see what the money was originally approved for, and how much, and where the money is going toward now, how much, justifications, and associated quotes… Based on that, we will review and get the necessary prior approval, and if approved, have the appropriate changes documented in GMM.

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Please let me know if this makes sense. Thank you!

Kind regards,

Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

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A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From:	Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
To:	Wallace, Marla D.; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
Cc:	Blackmore, Carina (CDC flhealth.gov)
Subject:	RE: Florida Hurricane Crisis CoAg Vector Control Project
Date:	Friday, February 14, 2020 7:11:23 AM

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

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Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: Roberson, Shamarial
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
Subject: RE: Florida
Date: Wednesday, March 25, 2020 5:57:15 PM

Thank you!

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Wednesday, March 25, 2020 5:57 PM
To: Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>
Subject: RE: Florida

Just sent you an email

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>
Sent: Wednesday, March 25, 2020 5:55 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Subject: Florida

Good Afternoon,

Please send correspondence about the two cruises. Thanks for your assistance, it is greatly appreciated.

Best Regards,

Shamarial Roberson, DrPH, MPH
Deputy Secretary for Health
Florida Department of Health
4052 Bald Cypress Way, Bin A-13
Tallahassee, FL 32399-1721
Phone: 850-245-4391
Email: shamarial.roberson@flhealth.gov
****

pha

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts. Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media on request. Your e-mail communications may therefore be subject to public disclosure.

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	RE: Follow-up Call
Date:	Friday, March 20, 2020 7:22:43 AM

Absolutely. I will send out a call line. Feel free to forward as needed.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 7:21 AM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
Subject: Re: Follow-up Call

Would 930 am work?

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From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 7:20:00 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
Subject: Follow-up Call

Hello Dr. Blackmore,

We were alerted that you would like to schedule a follow-up call regarding the LTC facility. The healthcare infection control team is happy to chat. Let us know what time works best.

Thanks,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Pritchard, Scott; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Kuhar, David T. (CDC/DDID/NCEZID/DHQP); Perz, Joseph (CDC/DDID/NCEZID/DHQP); CDC IMS 2019 NCOV Healthcare Infection Control; mangordillo@gmail.com
Subject:	RE: Follow-up from call with facility
Date:	Tuesday, March 3, 2020 12:50:19 PM

We will put the hospital in contact with our emergency management team to discuss the facility capacity related issues.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:45 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

Thank you for reaching out and providing the summary.
Regarding lab testing, our current state lab turn around time is within 24 hours of receipt.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 03, 2020 12:40 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Subject: Follow-up from call with facility

Hi Scott,

A quick summary of today's call with Dr. Gordillo (cc'd here)

1. The facility is rapidly running out of AIIR capacity given their high suspicion for COVID-19 in

AMERICAN OVERSIGHT

the community. They have some limited ability to create some negative pressure rooms in their ICU and ER but these rooms will have a shared air space among them which not allow them to mix PUIs with true cases. They also asked about the option of portable isolation units such as a tent. Our CDC NIOSH colleagues would know the most about this option. I have emailed them to request a call with the facility hopefully later today.

2. The other concern the facility had was regarding the speed of testing. Scott-I will defer that question to you. However, they did wonder if CDC lab technical support would be an option to help them build up their own in-house test. Again I defer this totally to FL, and I don't know if this would even be an option from the CDC side. However, I am happy to inquire on our side if you are interested.

Happy to chat.

Best,
Elizabeth

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Blackmore, Carina
Cc:	Cooksey, Samantha; Otis, Aaron
Subject:	RE: Follow-up from call with facility
Date:	Tuesday, March 3, 2020 1:36:37 PM

Yes, thank you!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 03, 2020 1:23 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Follow-up from call with facility

Okay. NIOSH can meet at 3:30 today. I am happy to set up a call line. Scott would that be okay with you?

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 1:16 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>; Aaron Otis (CDC flhealth.gov) <aaron.otis@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Follow-up from call with facility

Yes.
I am copying Sam and Aaron who will coordinate
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From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 3, 2020 12:56:26 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

Thanks, Carina. To make I understand, would a call with NIOSH still be appropriate then from your perspective?

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:50 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)

AMERICAN OVERSIGHT

<lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com
Subject: RE: Follow-up from call with facility

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:45 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 03, 2020 12:40 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Subject: Follow-up from call with facility

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AMERICAN OVERSIGHT

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Happy to chat.

Best,
Elizabeth

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Kuhar, David T. (CDC/DDID/NCEZID/DHQP); Perz, Joseph (CDC/DDID/NCEZID/DHQP); CDC IMS 2019 NCOV Healthcare Infection Control; mangordillo@gmail.com; Blackmore, Carina
Subject:	RE: Follow-up from call with facility
Date:	Tuesday, March 3, 2020 12:44:42 PM

Thank you for reaching out and providing the summary.
Regarding lab testing, our current state lab turn around time is within 24 hours of receipt.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Sent: Tuesday, March 03, 2020 12:40 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Subject: Follow-up from call with facility

Hi Scott,

A quick summary of today's call with Dr. Gordillo (cc'd here)

1. The facility is rapidly running out of AIIR capacity given their high suspicion for COVID-19 in the community. They have some limited ability to create some negative pressure rooms in their ICU and ER but these rooms will have a shared air space among them which not allow them to mix PUIs with true cases. They also asked about the option of portable isolation units such as a tent. Our CDC NIOSH colleagues would know the most about this option. I have emailed them to request a call with the facility hopefully later today.
2. The other concern the facility had was regarding the speed of testing. Scott-I will defer that question to you. However, they did wonder if CDC lab technical support would be an option to help them build up their own in-house test. Again I defer this totally to FL, and I don't know if this would even be an option from the CDC side. However, I am happy to inquire on our side if you are interested.

Happy to chat.

Best,

AMERICAN OVERSIGHT

Elizabeth

AMERICAN OVERSIGHT

From:	Bresee, Joseph (CDC/DDID/NCIRD/ID)
To:	Rivkees, Scott A
Cc:	Meltzer, Martin I. (CDC/DDID/NCEZID/DPEI)
Subject:	RE: Follow-up on modeling and social distancing
Date:	Tuesday, March 24, 2020 11:03:16 PM

Sorry about that. Cc'here
joe

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Tuesday, March 24, 2020 10:57 PM
To: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>
Subject: Re: Follow-up on modeling and social distancing

Dear Joe

Many thanks for your note and your time.

Can you also pass along Martin's contact information?

All the best,

Scott

Scott Rivkees, M.D.
State Surgeon General

From: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>
Sent: Tuesday, March 24, 2020 10:51:20 PM
To: hwalke1@gmail.com <hfw3@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: RE: Follow-up on modeling and social distancing

Thanks, Henry and nice to talk with you Scott. As promised, I want to introduce you to Dr, Martin Meltzer.

Martin – Scott is the State Surgeon General of Florida and interested in planning for medical surge needs, I talked about your current plans to create tools for supporting this work. Wonder if you might have time to talk with him, as you are much more eloquent on your work than me!

Thanks

AMERICAN OVERSIGHT

Joe

Joseph Bresee, MD
Dep. Incident Manager
2020 CDC nCoV Response

From: Walke, Henry (CDC/DDID/NCEZID/DPEI) <hfw3@cdc.gov>
Sent: Tuesday, March 24, 2020 9:53 AM
To: scott.rivkees@flhealth.gov
Cc: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>; Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: Follow-up on modeling and social distancing

Scott,

Jay said you have a couple of questions.

- I am connecting you to Joe Bresee, 404 421 5648, who has wide visibility on the modeling activities at CDC and can help answer your questions.

- The evidence base for social distancing is best found in the 2017 Community Mitigation Guidelines to Prevent Pandemic Influenza.
  https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

Best, Henry

Henry Walke, MD, MPH
Deupty Incident Manager
Jurisdiction Support
CDC COVID-19 Response
+1-404-639-3582 (office)
+1-404-452-9624 (mobile)
hwalke@cdc.gov

AMERICAN OVERSIGHT

From: Bresee, Joseph (CDC/DDID/NCIRD/ID)
To: Walke, Henry (CDC/DDID/NCEZID/DPEI); scott.rivkees@flhealth.gov
Cc: Butler, Jay C. (CDC/DDID/OD)
Subject: RE: Follow-up on modeling and social distancing
Date: Tuesday, March 24, 2020 10:51:22 PM

Thanks, Henry and nice to talk with you Scott. As promised, I want to introduce you to Dr, Martin Meltzer.

Martin – Scott is the State Surgeon General of Florida and interested in planning for medical surge needs, I talked about your current plans to create tools for supporting this work. Wonder if you might have time to talk with him, as you are much more eloquent on your work than me!

Thanks
Joe

Joseph Bresee, MD
Dep. Incident Manager
2020 CDC nCoV Response

From: Walke, Henry (CDC/DDID/NCEZID/DPEI) <hfw3@cdc.gov>
Sent: Tuesday, March 24, 2020 9:53 AM
To: scott.rivkees@flhealth.gov
Cc: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>; Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: Follow-up on modeling and social distancing

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  https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

Best, Henry

Henry Walke, MD, MPH
Deupty Incident Manager
Jurisdiction Support
CDC COVID-19 Response
+1-404-639-3582 (office)
+1-404-452-9624 (mobile)

AMERICAN OVERSIGHT

hwalke@cdc.gov

AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	eocsctfmccmlno@cdc.gov
Cc:	Blackmore, Carina
Subject:	RE: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Tuesday, March 3, 2020 4:13:34 PM

Florida would request that supply chain issues be communicated to:

Primary
Florida Department of Health Incident Management Team
Email: StateESF8.Planning@flhealth.gov
Phone: 850-245-4012

Secondary
Samantha Cooksey, Deputy Incident Commander
Email: Samantha.Cooksey@flhealth.gov
Phone: 850-251-2553

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 3:23 PM
To: Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>
Subject: Fwd: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Get Outlook for iOS

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Tuesday, March 3, 2020 3:08:57 PM
To: Mullins, Andy <Andy.Mullins@adph.state.al.us>; Christopher.Shields@cityofchicago.org <Christopher.Shields@cityofchicago.org>; Provenzano, Francesca <Francesca.Provenzano@ct.gov>; patrick.ashley@dc.gov <patrick.ashley@dc.gov>; Luce, Christie <Christie.Luce@flhealth.gov>; Scott.Minarcine@dph.ga.gov <Scott.Minarcine@dph.ga.gov>; Dudley, Matthew - EMS <Matthew.Dudley@dhw.idaho.gov>; Lytle, Megan <MLytle@isdh.IN.gov>; Denise L. Kelly [KDHE] <Denise.L.Kelly@ks.gov>; RickD.Johnson@ky.gov <RickD.Johnson@ky.gov>; Stella Fogleman <sfogleman@ph.lacounty.gov>; Doris Brown <Doris.Brown@LA.GOV>; Sherry.adams@maryland.gov <Sherry.adams@maryland.gov>; kerin.milesky@state.ma.us <kerin.milesky@state.ma.us>; Macqueen, Mary (DHHS) <MacqueenM@michigan.gov>; RPongliyab@fsmhealth.fm <RPongliyab@fsmhealth.fm>; cheryl.petersen-kroeber@state.mn.us <cheryl.petersen-kroeber@state.mn.us>; Nickelson, Paula <Paula.Nickelson@health.mo.gov>; O'Loughlin, Kevin

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<KOLoughlin@mt.gov>; warren.villagomez@dph.gov.mp <warren.villagomez@dph.gov.mp>; eric.sergeant@nebraska.gov <eric.sergeant@nebraska.gov>; Malinda Southard <msouthard@health.nv.gov>; Daly, Elizabeth <Elizabeth.Daly@dhhs.nh.gov>; Dana.johnson@doh.nj.gov <Dana.johnson@doh.nj.gov>; Christopher.emory@state.nm.us <Christopher.emory@state.nm.us>; Primeau, Michael J (HEALTH) <michael.primeau@health.ny.gov>; bmaldin@health.nyc.gov <bmaldin@health.nyc.gov>; jsickler@nd.gov <jsickler@nd.gov>; scotts@health.ok.gov <scotts@health.ok.gov>; ritter.udui@palauhealth.org <ritter.udui@palauhealth.org>; jcabrera@salud.gov.pr <jcabrera@salud.gov.pr>; Paul Petersen <paul.petersen@tn.gov>; jeff.hoogheem@dshs.state.tx.us <jeff.hoogheem@dshs.state.tx.us>; Kevin Mcculley <kmcculley@utah.gov>; Francine.lang@doh.vi.gov <Francine.lang@doh.vi.gov>; Halvorson, Clark (CDC doh.wa.gov) <Clark.Halvorson@DOH.WA.GOV>; donnie.w.haynes@wv.gov <donnie.w.haynes@wv.gov>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; Aifili Tufa <a.tufa@doh.as>; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Abdo, Mark (HHS/) <Mark.Abdo@hhs.gov>; Rachel-Philip, Disney (IHS/ABR/BCH) <Disney.Rachel-Philip@ihs.gov>; Davies-Cole, John (CDC dc.gov) <john.davies-cole@dc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; ann.pobutksy@dphss.guam.gov <ann.pobutksy@dphss.guam.gov>; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Hahn, Christine G. <ID> (CDC dhw.idaho.gov) <hahnc@dhw.idaho.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; farah.ahmed@ks.gov <farah.ahmed@ks.gov>; Ratard, Raoult (CDC la.gov) <raoult.ratard@la.gov>; Abdo, Mark (HHS/) <Mark.Abdo@hhs.gov>; Brown, Catherine (DPH) <catherine.brown@state.ma.us>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Eliaser Johnson <ejohnson@fsmhealth.fm>; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; Tan, Christina (CDC doh.state.nj.us) <Christina.Tan@doh.state.nj.us>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; Layton, Marci (CDC health.nyc.gov) <mlayton@health.nyc.gov>; Burnsed, Laurence (CDC health.ok.gov) <Laurence@health.ok.gov>; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; Dudley, Matthew - EMS <Matthew.Dudley@dhw.idaho.gov>; Francine.lang@doh.vi.gov <Francine.lang@doh.vi.gov>; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Eliaser Johnson <ejohnson@fsmhealth.fm>; Williamson, Laura (CDC mt.gov) <lwilliamson@mt.gov>

Cc: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>

Subject: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Good Afternoon, We are following up with you on the request below. This is a gentle reminder to provide the outlined information by COB today, March 3, 2020. You can send all responses to **eocsctfmccmlno@cdc.gov .**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at

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eocsctfmccmlno@cdc.gov .

We appreciate all you are doing to support COVID-19!

Thank you, Devi Hawkins-Prather
State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

404-232-0480

From: Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
Sent: Friday, February 28, 2020 1:31 PM
To: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Greetings PHEP Directors & State Epidemiologists –

The outbreak of COVID-19 in China has led to a disruption in the global supply chain of personal protective equipment (PPE). CDC recognizes that healthcare facilities may experience temporary shortages even if they do not care for patients with COVID-19. CDC has released guidance for optimizing the use of N95 respirators, which includes some recommendations that may be applicable to other types of PPE, including surgical masks. CDC also has guidance regarding who needs and does not need PPE to help prevent excessive use of PPE.

As you are aware, this is a delicate system with many factors. When CDC receives notifications from healthcare systems about supply chain shortages, we encourage the Healthcare Coalition Partners to work together to problem solve within the coalition and/or wider state system. Further we encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

We have heard from the healthcare system partners that have contacted us that they are unsure whom to contact in the state health department about supply chain shortages in their facilities. As a way to help mitigate this, **we are asking you to reply to eocsctfmccmlno@cdc.gov no later than March 3, 2020, with an identified primary and secondary point of contact for any supply chain issues within your state.**

Please provide the following information:

AMERICAN OVERSIGHT

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	CDC IMS State Coordination Task Force (SCTF) MCCM LNO
Cc:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	RE: Gentle Reminder-Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Monday, March 2, 2020 8:45:36 PM

Good evening,

Thanks so much to all of you who have submitted the requested information below!

For those of you who have no returned the requested information, this is a gentle reminder that we are asking for the information outlined below by COB tomorrow, March 3, 2020.

We appreciate all you are doing to support COVID-19!

Kimberly

Kimberly Cantrell
State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

From: Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
Sent: Friday, February 28, 2020 1:31 PM
To: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

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encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

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Please provide the following information:

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

AMERICAN OVERSIGHT

From:	Schmitz, Ann
To:	Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Cc:	Thaqi, Paula M; Jenkins, Patrick H
Subject:	RE: High Priority: Norwegian Bliss
Date:	Thursday, March 19, 2020 4:07:17 PM

Thank you for the advance notification. I am cc'ing Broward CHD for their awareness.

From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Sent: Thursday, March 19, 2020 4:03 PM
To: Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: FW: High Priority: Norwegian Bliss

Hi Ann,

FYI—regarding a ship arriving tomorrow. Let me know if any additional questions.

Michelle

From: Aboukheir, Mahmoud (CDC/DDID/NCEZID/DGMQ) <npa0@cdc.gov>
Sent: Thursday, March 19, 2020 3:47 PM
To: Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Cc: Adams, Regina E CDR <Regina.E.Adams@uscg.mil>
Subject: RE: High Priority: Norwegian Bliss

Greetings Kara

Correct, the Bliss had a case on the voyage of 03/01 to 03/08. Regarding the current voyage, we do not have any reported illness, death or influenza like illness for the ship.

Gracias
Mahmoud K.
404-435-9624

From: Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>
Sent: Thursday, March 19, 2020 2:21 PM
To: Aboukheir, Mahmoud (CDC/DDID/NCEZID/DGMQ) <npa0@cdc.gov>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Cc: Adams, Regina E CDR <Regina.E.Adams@uscg.mil>
Subject: High Priority: Norwegian Bliss

Good Afternoon Mahmoud,

Pls take a look at Norwegian Bliss; they were denied entry to Norfolk, VA so are requesting to enter Miami tomorrow, March 20. Supposedly they have a COVID case onboard, a 2 YOM. Can you

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confirm? Also, what other reporting do you have on this ship?

I'm aware per the EpiX dtd 13 March that the Bliss had a case from 1 March following debarkation.

Thank you for your time.

V/R,
Kara

AMERICAN OVERSIGHT

From:	Coppola, Courtney
To:	Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE)
Subject:	RE: Letters from Princess Cruise Line to passengers and crew of Sky Princess
Date:	Saturday, March 14, 2020 7:30:46 PM

Received, thank you!

Courtney F. Coppola
Chief of Staff
& Marijuana Coordinator
Florida Department of Health

Florida Department of Health | 4052 Bald Cypress Way | Tallahassee, FL 32399




Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>
Sent: Saturday, March 14, 2020 6:58 PM
To: Coppola, Courtney <Courtney.Coppola@flhealth.gov>
Cc: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Subject: Letters from Princess Cruise Line to passengers and crew of Sky Princess

Good evening Ms. Coppola,

Dr. Rivkees gave me your name and email to forward these letters sent by Princess Cruise Line to passengers and crew of the Sky Princess voyages on 2/22 and 2/29. Alberto Moscoso (cc'd here) was involved with the crafting of the letters.

Thank you and please acknowledge receipt.

On Detail to COVID-19 Response

Paul J. Weidle, PharmD, MPH, CAPT USPHS
Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30329
404-639-6155
pweidle@cdc.gov

From: Peyton, Dennis (PCL) <dpeyton@hagroup.com>
Sent: Saturday, March 14, 2020 6:14 PM
To: Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; alberto.moscoso@flhealth.gov

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Cc: Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; White, Stefanie B. (CDC/DDID/NCEZID/DGMQ) <ixy3@cdc.gov>; Poser, Sarah (CDC/DDID/NCEZID/OD) <wzk8@cdc.gov>; Rinker, Robin (CDC/OD/OADPS) <vqb2@cdc.gov>; Brooks, Ashley (CDC/DDID/NCIRD/OD) <ylo5@cdc.gov>; Tarling, Grant (PCL) <gtarling@hagroup.com>; Howard, Daniel (PCL) <dhoward@hagroup.com>; Drumalds, Aleks (PCL) <adrumalds@hagroup.com>
Subject: RE: Connection - Princess with State of Florida Comms

Good Day Paul and Kara,

Thank you kindly for reaching out today.

As per telephonic guidance received the evening of 12 March 2020 from Alberto Moscoso and team at Florida Department of Health, as well as Cindy Friedman and Paul Weidle from US CDC, it was recommended that an email notification to be sent to individuals with travel history aboard Sky Princess voyage A [22-29 February 2020] and voyage B [29 February – 7 March]. Attached are the email notifications sent on 13 March 2020.

Thanks,

Dennis Peyton Jr., MPH, CIC
Epidemiologist | Health Services
Holland America Group | Princess Cruises, Holland America Line, Seabourn, P&O Australia, & HAP Alaska
+1 (661) 753-2353 office | +1 (661) 645-4013 mobile | dpeyton@hagroup.com
24/7 Emergency Line: +1-661-753-2355

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR
Subject:	RE: MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 6:30:50 PM

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Subject: MS Marina (Oceania) - awareness???

AMERICAN OVERSIGHT

Sam/Ashley

This is the string I got below and why I asked if you had this ship on the radar. Let me know if you find something out. HHS has no ask….we just want to make sure you are aware this may be headed to Miami.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM

AMERICAN OVERSIGHT

To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

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AMERICAN OVERSIGHT

From: Fitzgerald, John M CDR
To: "Eckes, Jeanne (OS/ASPR/EMMO)"; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject: RE: MS Marina (Oceania) - awareness???
Date: Friday, March 20, 2020 7:30:18 AM

Jeanne,

Passed yesterday to Ashley and ESF-8 that vessel is off Panama and is tentative for arrival in Miami on March 23. Will keep tracking this one.

v/r,

John

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Sent: Thursday, March 19, 2020 6:31 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Subject: [Non-DoD Source] RE: MS Marina (Oceania) - awareness???

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
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Subject:	RE: MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 6:30:40 PM

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AMERICAN OVERSIGHT

From:	Karl Ensign
To:	Esther Muna; Livinson Taulung (LTaulung2@fsmhealth.fm); Laurent Duenas, MPH, BSN, RN; Emais Roberts; Catherine de la Cruz Duran; Bruce Bilimon; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com); Nate Smith; Angell, Sonia Y@CDPH; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; Howard Zucker; John Wiesman; Motusa Nua
Cc:	Subroto Banerji; lauri.ogumoro@dph.gov.mp; Reva Ferguson; Rachelle Ashe; Peggy Ullom; linda.fullem@flhealth.gov; Tangonan, Sharon S.; Jacqueline Silvia; Terry Bergener; Eti Uiagalelei; Janet Guerrero; Fancy Soloman; Suzanne Kaneshiro; Lalie Ikluk; Marline Loeak; Louise Baa; Aniah John; Danny Staley; Carolyn McCoy; Carolyn Mullen; Michael Fraser; Cendra Clarke; Christi Mackie; Mark Mioduski; Joe Davis; Emi Chutaro (emic@pihoa.org); Taveras, Sam (CDC/OSTLTS/DPHCD); Gallo, Bill (CDC/OSTLTS/DPHCD); Jose T. Montero, MD, MPH; Ottley, Basil C
Subject:	RE: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date:	Monday, February 24, 2020 11:59:34 AM
Attachments:	image001.png

Dear Subcommittee on Insular Affairs Members & Meeting Participants –

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

Apologies for multiple emails.

Thanks,
Karl

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

AMERICAN OVERSIGHT

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

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

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

Tuesday, February 25th, 2020
4:00 – 5:30 pm ET
Madison Hotel – Adams B
1177 15th Street, NW
Washington, DC 20005

A calendar invite will follow.

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

https://naturalresources.house.gov/imo/media/doc/Insular%20Fact%20Sheet_ks.pdf
https://scholarlycommons.pacific.edu/pjh/vol2/iss1/1/

The Insular Affairs Subcommittee to the ASTHO Government Affairs Policy Committee was formed in 2018 to identify the unique policy needs and priorities of the Pacific and Atlantic jurisdictions. The subcommittee provides a forum for ASTHO's members to exchange information on policy challenges and solutions within the insular areas. Additionally, the subcommittee provides recommendations to the full committee on policy priorities.

See you soon!
Karl

Karl Ensign, Chief
Territorial Support

AMERICAN OVERSIGHT

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308

Tel: (571) 527-3143 | astho.org
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AMERICAN OVERSIGHT

From:	Rubino, Heather
To:	Pritchard, Scott; Blackmore, Carina; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Subject:	RE: Next week
Date:	Thursday, February 27, 2020 8:36:02 AM

Completely agree!

From: Pritchard, Scott
Sent: Wednesday, February 26, 2020 6:50 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Next week

Can't wait to have you Tim!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 26, 2020 6:23:53 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Next week

We are excited to have you on site next week. Coronavirus is the first item on the menu as you can imagine. But we are also engaged in hep A and legionella response. Not to forget flu.
What time do you think you will be in the office? We would like to sit down sometimes early in the day to discuss scientific on boarding. Carina

Get Outlook for iOS

AMERICAN OVERSIGHT

From:	Reich, Andrew
To:	Roberts, Virginia (CDC/OID/NCEZID); Veytsel, Gabriella (CDC/DDID/NCEZID/DFWED)
Cc:	Clark, Rick; Goff, Kendra F; Mitchell, Michael S; Ursin, Elke; Wade, Tracy L
Subject:	RE: OHHABS Data Transfer
Date:	Friday, February 7, 2020 9:10:57 AM
Attachments:	OHHABS Environmental Form Data Dictionary 2-7-2020.xlsx

Virginia, Gabriella

We made some great progress on the OHHABS data dictionary descriptions and identifying ways to facilitate uploads to OHHABS. Please see attachment for the latest revisions. Elke has done a great job updating the spreadsheet since the last discussion including adding a couple of columns: CDC Follow-up questions and remaining DOH Action Items.

We would like to have another conference call to finish the review. I will send out a Doodle poll soon for us to pick a day and time that work.

Thanks.

Andy
Andrew Reich MS, MSPH, RRT
Scientific Advisor
Bureau of Environmental Health
Florida Department of Health
813.559.4370
andy.reich@flhealth.gov
floridahealth.gov/environmental-health/

AMERICAN OVERSIGHT

From:	Yoon, Paula (CDC/DDPHSS/CSELS/DHIS)
To:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Rivkees, Scott A
Cc:	Blackmore, Carina (CDC flhealth.gov)
Subject:	RE: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Tuesday, March 10, 2020 11:07:33 AM

Our team has already reached out to colleagues in FL with instructions for turning on data access but if you have questions, I would be happy to take them.

Paula

Paula W. Yoon, ScD, MPH
Director
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS E-97, Atlanta, GA 30333
404-498-6298 Office | pyoon@cdc.gov
Assistant: Bessie Holland | 404-498-6346 | vbb3@cdc.gov

From: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Sent: Tuesday, March 10, 2020 11:06 AM
To: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS) <pay3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Outreach: COVID-19 Collaborative Syndromic Surveillance

Hi Scott

Dr Paula Yoon will follow up directly with Dr Balckmore.

Thanks

JT

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Monday, March 9, 2020 7:59 PM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

AMERICAN OVERSIGHT

Thank you,
Scott

AMERICAN OVERSIGHT

From:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD)
To:	Rivkees, Scott A; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS)
Cc:	Blackmore, Carina (CDC flhealth.gov)
Subject:	RE: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Tuesday, March 10, 2020 11:05:57 AM

Hi Scott

Dr Paula Yoon will follow up directly with Dr Balckmore.

Thanks

JT

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Monday, March 9, 2020 7:59 PM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

Thank you,
Scott

AMERICAN OVERSIGHT

From:	Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
To:	Chapman, Jennifer Rose; Stanek, Danielle (CDC flhealth.gov); Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); Cohen, Jonathan
Cc:	Blackmore, Carina (CDC flhealth.gov); Jones, Patricia Denise; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); CGH DPDM DPDx Web Inquiries (CDC); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); White, Stephen L; Holland, Aubrey; Quaye, Elesi A; Rico, Edhelene; Noya-Chaveco, Pedro A; Mejia-Echeverry, Alvaro
Subject:	RE: Possible Leishmaniasis Patient: FL 29 yo F Miami
Date:	Monday, February 10, 2020 3:40:51 PM
Attachments:	image001.png image002.png
Sensitivity:	Confidential

Dr. Chapman,

We will need the entire FFPE block. The block will be returned to the submitter after the case is finalized but please note, the block may be depleted during testing. For evaluation of Leishmania, the infectious diseases pathology branch (IDPB) performs immunohistochemistry. The DNA is extracted here (at IDPB) and then sent to the Div. of Parasitic Diseases (DPD) for PCR analysis.

Thank you for your understanding.

Regards,
Eddy

Eduard Matkovic, M.D.
Associate fellow | National Center for Emerging and Zoonotic Infectious Diseases | Division of High-Consequence Pathogens and Pathology | Infectious Disease Pathology Branch | Centers for Disease Control and Prevention | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 | Tel: (404) 626-8119 | lua6@cdc.gov

From: Chapman, Jennifer Rose <JChapman@med.miami.edu>
Sent: Monday, February 10, 2020 3:24 PM
To: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
Subject: Re: Possible Leishmaniasis Patient: FL 29 yo F Miami
Sensitivity: Confidential

AMERICAN OVERSIGHT

Dear all,

We plan to cut tissue scrolls from a FFPE block of bone marrow aspirate that has not been decaled.

I will send the scrolls to the Florida Department of Public Health with the CDC requisition.

I assume that the Florida Dept of Health will then send them to the infectious disease pathology branch within the CDC.

Please confirm that this is appropriate.

Thank you.

Jennifer Chapman, MD
Associate Professor
Acting Director, Hematopathology Division
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowships
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

University of Miami Hospital
Department of Pathology
4th floor, room 4076
1400 NW 12th Ave.
Miami, Florida 33138
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From: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>
Sent: Monday, February 10, 2020 12:40 PM
To: 'Benoit, Tina (CDC/DDID/NCEZID/DHCPP)' <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>;

AMERICAN OVERSIGHT

Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami

---

You've received an encrypted message from Danielle.Stanek@flhealth.gov
To view your message
Save and open the attachment (message.html), and follow the instructions.
Sign in using the following email address: JChapman@med.miami.edu

This email message and its attachments are for the sole use of the intended recipient or recipients and may contain confidential information. If you have received this email in error, please notify the sender and delete this message.

Message encryption by Microsoft Office 365



AMERICAN OVERSIGHT

From:	Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
To:	Pathology (CDC); Cohen, Jonathan
Cc:	Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Chapman, Jennifer Rose; Jones, Patricia Denise; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); CGH DPDM DPDx Web Inquiries (CDC); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP)
Subject:	RE: Possible Leishmaniasis Patient: FL 29 yo F Miami
Date:	Monday, February 10, 2020 11:58:32 AM
Attachments:	image001.png
Sensitivity:	Confidential

Good morning Dr. Cohen

The FL Department of Public Health prefers that specimens for leishmaniasis are routed through their state Public Health Laboratory for shipment to CDC. I'm connecting you with Drs. Danielle Stanek (Danielle.Stanek@flhealth.gov) and Carina Blackmore (carina.blackmore@flhealth.gov) from the FL Department of Health who will provide additional guidance on how to submit the specimen to their state public health lab.

This email serves as approval to submit fixed tissue to IDPB (***through your state health department***) for testing. Please enclose with your submission:

- A copy of the path report
- Recent ID consult note or other similar clinical note on the patient that might include information on presentation, course, testing performed, treatment provided and any medical history
- Information on travel history and/or country of birth
- History of insect bites

Regards,

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
Centers for Disease Control and Prevention
1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027
MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc.gov

From: Pathology (CDC) <Pathology@cdc.gov>
Sent: Monday, February 10, 2020 7:30 AM
To: Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>
Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami
Sensitivity: Confidential

Hi Dr. Cohen,

The pathologist on service this week (Dr. Eduard Matkovic) and epidemiologist (Tina Benoit) have been cc'd on your query and should be responding to you.

Note: this email and it's attachments are specific only to paraffin block(s) or wet formalin-fixed tissues intended for testing by our branch (IDPB) and do not apply to any unfixed tissues or other specimens being submitted to Dr. Yvonne Qvarnstrom's Leishmania lab.

AMERICAN OVERSIGHT

WARNING (per CDC's Mail Services): After September 30th, 2019, mail received with an incorrect or outdated mailstop will be returned to the sender with no exceptions. For our branch (IDPB), the new mailstop is "**MS: H18-SB**" as shown in section D of the attached guidelines.
If approved, please see the attached IDPB General Guidelines for Specimen Submission PDF and submit one hardcopy (per case) of the attached required electronically completed pre-populated CDC 50.34 form with the formalin-fixed wet tissues and/or formalin-fixed paraffin-embedded tissue blocks at ambient temperature. Paraffin-embedded tissue blocks are preferred if formalin-fixation of the wet tissues has exceeded 2 weeks; and, tissue scrolls or unstained slides are not accepted for PCR testing per IDPB's protocols. Select Test Order Code CDC-10365. Enter any test specifics in the Comments section on page 2.
Note, for human cases from the USA, the attached CDC 50.34 form has been pre-populated for your convenience with the correct Test Order Code and Public Health Lab contact information. Do not change or delete this information. Receipt of incorrect information in these sections can lead to a delay in testing.

Testing subject to CLIA regulations requires two primary patient identifiers (i.e., patient first and last name, date of birth, unique patient identifier from time of collection, such as medical record number) on the specimen container and on the test requisition

The course of testing will be determined by the clinical history, the histopathology observed, and the availability of specimens. Scant tissue is subject to depletion during the course of testing.
Please first inform/consult your City/State Health Department about this case, as specimens are normally required to be routed through them http://www.cdc.gov/laboratory/specimen-submission/who-may-submit-specimens.html. Dr. Danielle Stanek has been cc'd.
Thank you,
Pathology Team

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Sunday, February 9, 2020 9:04 AM
To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Pathology (CDC) <Pathology@cdc.gov>
Subject: Re: Possible Leishmaniasis Patient

Excellent
I will speak with our pathologists
Patient will see Dr Jones from the Hepatology service on Monday; consideration of liver biospy
Thanks
Jonathan Cohen

From: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Sent: Friday, February 7, 2020 5:09 PM
To: Cohen, Jonathan <j.cohen11@miami.edu>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Pathology (CDC) <Pathology@cdc.gov>
Subject: RE: Possible Leishmaniasis Patient

Ok, if we are going to proceed with fixed tissue, that will actually have to be submitted through our Infectious Diseases Pathology Branch, because they have the protocol for extracting DNA from tissue blocks. I've cc'ed our colleagues over there, they can provide guidance for their submission process, which differs from ours.

If you are able to get fresh tissue, that specimen can be sent to us. If so, let me know and I'll ship you some vials of our transport/culture medium prior to the procedure.

Sorry for the complexity, this is one of our most complicated diseases to test, particularly because it can arise in so many tissue types.

Best,
DPDx

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Friday, February 07, 2020 5:05 PM

AMERICAN OVERSIGHT

To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>
Subject: RE: Possible Leishmaniasis Patient

Will ask Dr Chapman to send fixed tissue
Dr. Jones will evaluate for possible liver biopsy, to send fresh tissue
Thanks
Jonathan Cohen

From: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Sent: Friday, February 7, 2020 5:02 PM
To: Cohen, Jonathan <j.cohen11@miami.edu>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>
Subject: RE: Possible Leishmaniasis Patient

Ok thanks! We can do PCR from fixed tissue, though that's not optimal because the time in formalin reduces our chance of success. If we can get fresh tissue, that lets us attempt culture, PCR and microscopy as described below.

- DPDx

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Friday, February 07, 2020 4:58 PM
To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>
Subject: RE: Possible Leishmaniasis Patient

I will talk with my pathologist on Monday, but the bone marrow specimen is fixed in blocks with stained slides
If a liver biopsy is done I assume tissue can also be sent
I will give you more information Monday or Tuesday
Thanks

From: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Sent: Friday, February 7, 2020 4:46 PM
To: Cohen, Jonathan <j.cohen11@miami.edu>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Leishmania (CDC) <leishmania@cdc.gov>
Subject: RE: Possible Leishmaniasis Patient

Hello Dr. Cohen,

If possible, please send an aliquot of the bone marrow (0.5mL or more would be ideal). We can prepare a stained smear for microscopic analysis, perform PCR for Leishmania detection and species identification, and attempt to culture the parasites if they are present. The bone marrow should be sent chilled but not frozen, for weekday delivery, to the address below. Please also complete and print the attached specimen submission form, and send it with the patient sample.

CDC STAT Lab
Attn Unit 52
1600 Clifton Rd NE
Atlanta GA 30329

Best regards,
The DPDx Team

From: Cohen, Jonathan <j.cohen11@miami.edu>

AMERICAN OVERSIGHT

Sent: Friday, February 07, 2020 4:38 PM
To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Subject: Possible Leishmaniasis Patient

I am seeing a 29 yo female at the University of Miami with massive splenomegaly documented since 2017, hepatomegaly, cutaneous lesions, neutropenia and thrombocytopenia
Her leishmania antibody IgG was positive 1.79 (greater than 1.00 is considered positive at Quest)
Bone marrow biopsy appears normal, but will be reexamined Monday for parasites now that I have this serology.
The patient will also be seen by our hepatology service on Monday.
What other test should I do confirm or rule out this diagnosis?
Thanks
Jonathan Cohen

AMERICAN OVERSIGHT

From:	Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED)
To:	Pritchard, Scott; Oh, David (CDC/DDID/NCEZID/DFWED); Blackmore, Carina (CDC flhealth.gov)
Cc:	Stanek, Danielle (CDC flhealth.gov); Tomson, Kelly F; Rowlinson, Marie-Claire; Lockhart, Shawn (CDC/DDID/NCEZID/DFWED); Natarajan, Pavithra (CDC/DDID/NCEZID/DFWED)
Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Wednesday, February 12, 2020 4:54:24 PM

Hi Scott,

That's great to know you learn about C. gattii meningitis cases through your reportable disease system. I know Shawn Lockhart would be glad to receive any isolates (he may get them already?).

I'd be happy to set up a conference call on C. gattii… would tomorrow, Friday, or the week of the 24th work for you? I'm sure you're busy with COVID work these days. Please let us know if any particular dates/times work well for you.

Danielle, to answer your question, our information on these cases is so anecdotal at this point, but Pete Pappas at UAB says he sees quite a bit of pulmonary disease from the southern part of the state. Hard to know at this point.

Thanks,
Brendan

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Wednesday, February 12, 2020 4:45 PM
To: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

Thank you!
Please proceed as is routine for your BOOTS investigation and keep us in the loop.
As for *C. gattii* in FL, we primarily detect cases through our mycotic and bacterial meningitis reportable disease category. Therefore we are missing the other clinical manifestations, which are likely more common. The numbers of reported *C. gattii* meningitis are small, single digits per year, but we too have detected a small increase over the past 5 years or so. We do have all of our available *C. gattii* isolates send to your lab for reference.
Perhaps we should have a discussion about how best we could contribute to understanding this potentially emerging fungal disease in Florida.

Sincerely,

Scott Pritchard, MPH

AMERICAN OVERSIGHT

Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>
Sent: Wednesday, February 12, 2020 4:36 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

Thanks Scott.

I wanted to mention a few quick follow-up items to David's email.

You all might know already, but our experience varies by state, so I thought I'd say that CDC's Blood, Organ, and Other Tissue Safety (BOOTS) office asks us to investigate potential donor-derived investigations caused by fungi under an agreement with the United Network for Organ Sharing. They ask us to contact transplant centers directly, which is not something we'd do for any other type of investigation. If you all would prefer we proceed differently, please let us know.

I also wanted to mention that we've been hearing from ID docs in the South that they seem to be seeing a recent increase in *Cryptococcus gattii* infections, including in people without severe immunocompromise. Most Cryptococcus infections in the South are typically caused by *C. neoformans*, although *C. gattii* is known to be endemic at low levels. We're lacking hard data on the subject, but their impressions are that most recent cases have occurred in people from the coastal plain, specifically south Alabama, south Georgia, and Florida. We're not sure why that would be, but this fungus lives in the environment, so there could be something new going on. For example, a specific strain of C. gattii emerged in the Pacific Northwest about 10-20 years ago. I know this disease isn't reportable in your state but I thought I'd give you a heads up in case you hear of anything. We'll certainly do the same.

Please don't hesitate to reach out if we can provide further info.

Best,
Brendan

Brendan Jackson, MD, MPH
Epidemiology Team Lead
CDC Mycotic Diseases Branch
CDR, U.S. Public Health Service
brjackson1@cdc.gov | Phone: 404-639-0536

AMERICAN OVERSIGHT

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Wednesday, February 12, 2020 4:24 PM
To: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

Hi David, Our process is to submit the isolate the our Bureau of Public Health Laboratories to be forwarded to CDC.
Our Jacksonville location has experience receiving *C. gattii* isolates to CDCs mycotics lab.
The submitter will need to complete our lab form. http://www.floridahealth.gov/programs-and-services/public-health-laboratories/forms-publications/_documents/DH1847--rev-5-13.pdf

The submitter can reach out to Kelly Tomson or Marie-Claire Rowlinson at 904-791-1500 for more information.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>
Sent: Wednesday, February 12, 2020 4:19 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

Hi Dr. Blackmore,

I hope you are well.

I wanted to get in touch with you with a follow-up of this case. We will be requesting the hospital that took care of the deceased recipient to send us a sample of the cultured isolate of the cryptococcus species. Different states have different regulations for how samples such as this can be sent to the CDC, and I wanted to touch base with you before I ask the hospital to send the sample. Would it be okay for the hospital to send the sample to CDC directly, or would it be better for the sample to be routed through the FL state laboratory?

Thank you.

AMERICAN OVERSIGHT

David Oh

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Thursday, February 6, 2020 9:33 AM
To: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

Thanks a lot David for the heads up. Let us know how we can assist.

Carina

From: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>
Sent: Thursday, February 6, 2020 8:07 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>
Subject: Potential Donor Derived Infection Investigation

Hello Dr. Blackmore,

This is David Oh from CDC Mycotics Branch. I wanted to send you a brief email to let you know that we were made aware of a kidney transplant recipient in Florida who suddenly expired about 3 months post-transplant, with Cryptococcus Gattii identified. I wanted to make sure to keep you in the loop. I do not know much about this case yet, but we work with DTAC and will help investigate this case and put together a report. I will update you as I learn more.

Please do not hesitate to let me know if you have any questions.

Thank you.

David Hyung Won Oh
Epidemiology Elective Student
Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases
Division of Foodborne, Waterborne, and Environmental Diseases
Mycotic Diseases Branch
qbr7@cdc.gov

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Oh, David (CDC/DDID/NCEZID/DFWED); Blackmore, Carina
Cc:	Stanek, Danielle R; Tomson, Kelly F; Rowlinson, Marie-Claire; Lockhart, Shawn (CDC/DDID/NCEZID/DFWED); Natarajan, Pavithra (CDC/DDID/NCEZID/DFWED)
Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Wednesday, February 12, 2020 4:58:31 PM

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Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>
Sent: Wednesday, February 12, 2020 4:54 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>; Lockhart, Shawn (CDC/DDID/NCEZID/DFWED) <gyi2@cdc.gov>; Natarajan, Pavithra (CDC/DDID/NCEZID/DFWED) <qdb5@cdc.gov>
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Danielle, to answer your question, our information on these cases is so anecdotal at this point, but Pete Pappas at UAB says he sees quite a bit of pulmonary disease from the southern part of the state. Hard to know at this point.

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CDR, U.S. Public Health Service
brjackson1@cdc.gov | Phone: 404-639-0536

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Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Thursday, February 13, 2020 1:06:44 PM

Thank you Scott for your response. When I ask the L kidney recipient's cultured isolate sample to be sent to the CDC, I'll make sure to forward them the directions you've provided here.

Thank you.

David

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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Cc: Tomson, Kelly F
Subject: RE: Potential Donor Derived Infection Investigation
Date: Friday, February 14, 2020 7:53:26 AM
Attachments: form-50-34.pdf

Hi Marie-Claire,

Thanks again for all your help with this potential DDI investigation! As we discussed, here are the instructions for sending the sample to CDC once you receive the sample from the hospital.

--Please complete one 50.34 form (attached), as completely as possible, and include in the shipment. We use this form's barcode to accession isolates into our LIMS system.

--Under Lab examination Requested, please fill in:
Test order code: CDC-10179
Suspected agent: Cryptococcus Gattii
At CDC, bring to the attention of: Elizabeth Berkow

--Please mention MLST and WGS in the comments

--As for the actual isolate, we require 2 identifiers on the isolate. These can be things like patient information (DOB, patient last name), medical record number, or a unique number that you've created to distinguish between isolates. These 2 identifiers must also be present on the 50.34 form. Failure to meet our 2 identifier requirement may result in testing delays or rejection of submission.

--Shipments should be addressed to the following:
Centers for Disease Control and Prevention
1600 Clifton Road
DASH Unit 37
Attn: ELIZABETH BERKOW -- MDB Fungal Diseases Laboratory
Atlanta, GA 30329

Again, thanks so much for your help and please feel free to reach out to me with any questions (650 669 7292).

David

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To: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
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Please let me know how I may assist in coordination from the laboratory.

Kind regards,

Marie-Claire

Marie-Claire Rowlinson, PhD, D(ABMM)
Assistant Laboratory Director/CLIA Laboratory Director

AMERICAN OVERSIGHT

Bureau of Public Health Laboratories - Jacksonville
Tel: 904-791-1562 | Cell: 904-271-1823 | Fax: 904-791-1567
Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
****
Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request.
Your e-mail communications may therefore be subject to public disclosure.

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Subject: Re: Potential Donor Derived Infection Investigation

Do you have information about clinical presentation from the IDs? Pulmonary primarily?

Danielle Stanek, DVM, DACVPM
State Public Health Veterinarian
Florida Department of Health
850-245-4117 work
850-294-1087 cell

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Hi David, Our process is to submit the isolate the our Bureau of Public Health Laboratories to be forwarded to CDC. Our Jacksonville location has experience receiving *C. gattii* isolates to CDCs mycotics lab.
The submitter will need to complete our lab form. http://www.floridahealth.gov/programs-and-services/public-health-laboratories/forms-publications/_documents/DH1847--rev-5-13.pdf

The submitter can reach out to Kelly Tomson or Marie-Claire Rowlinson at 904-791-1500 for more information.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>
Sent: Wednesday, February 12, 2020 4:19 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <ivn0@cdc.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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I hope you are well.

I wanted to get in touch with you with a follow-up of this case. We will be requesting the hospital that took care of the deceased recipient to send us a sample of the cultured isolate of the cryptococcus species. Different states have different regulations for how samples such as this can be sent to the CDC, and I wanted to touch base with you before I ask the hospital to send the sample. Would it be okay for the hospital to send the sample to CDC directly, or would it be better for the sample to be routed through the FL state laboratory?

Thank you.

David Oh

AMERICAN OVERSIGHT

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Thursday, February 6, 2020 9:33 AM
To: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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Thanks a lot David for the heads up. Let us know how we can assist.

Carina

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Subject: Potential Donor Derived Infection Investigation

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Please do not hesitate to let me know if you have any questions.

Thank you.

David Hyung Won Oh
Epidemiology Elective Student
Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases
Division of Foodborne, Waterborne, and Environmental Diseases
Mycotic Diseases Branch
qbr7@cdc.gov

AMERICAN OVERSIGHT

From: Rowlinson, Marie-Claire
To: Stanek, Danielle R; Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Pritchard, Scott; Oh, David (CDC/DDID/NCEZID/DFWED); Blackmore, Carina
Cc: Tomson, Kelly F
Subject: RE: Potential Donor Derived Infection Investigation
Date: Wednesday, February 12, 2020 4:45:16 PM

Please let me know how I may assist in coordination from the laboratory.

Kind regards,

Marie-Claire

Marie-Claire Rowlinson, PhD, D(ABMM)
Assistant Laboratory Director/CLIA Laboratory Director
Bureau of Public Health Laboratories - Jacksonville
Tel: 904-791-1562 | Cell: 904-271-1823 | Fax: 904-791-1567
Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request.
Your e-mail communications may therefore be subject to public disclosure.

From: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>
Sent: Wednesday, February 12, 2020 4:42 PM
To: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
Subject: Re: Potential Donor Derived Infection Investigation

Do you have information about clinical presentation from the IDs? Pulmonary primarily?

Danielle Stanek, DVM, DACVPM
State Public Health Veterinarian
Florida Department of Health
850-245-4117 work
850-294-1087 cell

From: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>
Sent: Wednesday, February 12, 2020 3:35:43 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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Subject: RE: Potential Donor Derived Infection Investigation

Thanks Scott.

I wanted to mention a few quick follow-up items to David's email.

You all might know already, but our experience varies by state, so I thought I'd say that CDC's Blood, Organ, and Other Tissue Safety (BOOTS) office asks us to investigate potential donor-derived investigations caused by fungi under an agreement with the United Network for Organ Sharing. They ask us to contact transplant centers directly, which is not something we'd do for any other type of investigation. If you all would prefer we proceed differently, please let us know.

I also wanted to mention that we've been hearing from ID docs in the South that they seem to be seeing a recent

AMERICAN OVERSIGHT

increase in *Cryptococcus gattii* infections, including in people without severe immunocompromise. Most Cryptococcus infections in the South are typically caused by *C. neoformans*, although *C. gattii* is known to be endemic at low levels. We're lacking hard data on the subject, but their impressions are that most recent cases have occurred in people from the coastal plain, specifically south Alabama, south Georgia, and Florida. We're not sure why that would be, but this fungus lives in the environment, so there could be something new going on. For example, a specific strain of C. gattii emerged in the Pacific Northwest about 10-20 years ago. I know this disease isn't reportable in your state but I thought I'd give you a heads up in case you hear of anything. We'll certainly do the same.

Please don't hesitate to reach out if we can provide further info.

Best,
Brendan

Brendan Jackson, MD, MPH
Epidemiology Team Lead
CDC Mycotic Diseases Branch
CDR, U.S. Public Health Service
brjackson1@cdc.gov | Phone: 404-639-0536

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Wednesday, February 12, 2020 4:24 PM
To: Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
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Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases
Division of Foodborne, Waterborne, and Environmental Diseases
Mycotic Diseases Branch
qbr7@cdc.gov

AMERICAN OVERSIGHT

From:	Burns, Erin (CDC/DDID/NCIRD/ID)
To:	Moscoso, Alberto; Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject:	RE: Press release planning for Florida
Date:	Sunday, March 1, 2020 2:14:49 PM

I am not actually seeing an announcement about your presumptive-positive. Are you waiting for CDC confirmation? We won't report until you do.
All our press releases are online: https://www.cdc.gov/media/dpk/diseases-and-conditions/coronavirus/coronavirus-2020.html#tabz
Thanks,
Erin

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 1:20 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks, Scott.

Kristen,

I really appreciate your reaching out. We have updated our website to reflect Florida test results and PUIs: www.FloridaHealth.gov/COVID-19

I would certainly be grateful for whatever information you are able to share. Situational awareness is always a priority.

Is there anything else I can provide on my end to support your mission?

Thanks,

Alberto Moscoso
Communications Director
Florida Department of Health
(850) 408-7687 (cell)

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AMERICAN OVERSIGHT

<Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

Hi Alberto,

Happy to chat anytime. Illinois announced a community case today and as I mentioned, we expect at least one other than you guys this week.

Thanks,
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404-956-0336 (cell)

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To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
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Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>
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I can also let you know that other states will be putting out communication this weekend about cases they've identified through testing.

AMERICAN OVERSIGHT

Thanks,
Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

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Quick summaries are:
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63 year old male with unknown exposure who is in the ICU.

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29 year old female with travel to Europe who is at home in isolation.

Best,
Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Burns, Erin (CDC/DDID/NCIRD/ID)
To:	Moscoso, Alberto; Nordlund, Kristen (CDC/DDID/NCIRD/OD); CDC IMS JIC Lead -2; LaRocque, Marcie (CDC/DDID/NCIRD/OD) (CTR)
Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject:	RE: Press release planning for Florida
Date:	Sunday, March 1, 2020 3:15:38 PM

We absolutely will NOT light up FL on the map until you announce.

Thanks,

Erin

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 3:04 PM
To: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

Would it be possible for you to hold on lighting up Florida on your map until we announce?

We will be moving very expeditiously.

Thank you,

Alberto

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Subject: Re: Press release planning for Florida

That's exactly right. Thanks!

From: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>
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To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
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Subject:	RE: Press release planning for Florida
Date:	Saturday, February 29, 2020 9:35:22 PM

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Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

Hi Kristen, Conne, and Erin,

Scott Pritchard at the DOH in Florida will be coordinating the press for their two presumptive positive COVID-19 cases. Can you please coordinate with Scott regarding press? They will likely wait until CDC confirmation, but want to plan ahead in case they need to go public earlier as contacts and HCWs will be notified before CDC confirmation. Can you connect with Scott about this?

Quick summaries are:
NCoVID: FL 2785091
63 year old male with unknown exposure who is in the ICU.

NCoVID: FL 2785125
29 year old female with travel to Europe who is at home in isolation.

Best,
Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Vinson, Alonna; ASPR Region 4 (HHS/ASPR/OEM); Bowman, Thomas (OS/ASPR/EMMO); gwen.keenan@fema.dhs.gov; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Manny.Toro@fema.dhs.gov; Logs Command; Davis, Ashley; Guthrie, Kevin
Subject:	RE: Request for USS Hope & USS Mercy
Date:	Tuesday, March 17, 2020 2:25:29 PM
Attachments:	CDC HAN 430 Info and Guidance about Global Travel on Cruise Ships due to COVID-19 Updated 03 17 2020.pdf

FDOH ESF 8

I am passing this back to you as well for further information. I will call again.
I am also attaching the CDC guidance about global travel and cruise ships for your reference.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Vinson, Alonna <Alonna.Vinson@em.myflorida.com>
Sent: Tuesday, March 17, 2020 7:10 AM
To: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Bowman, Thomas (OS/ASPR/EMMO) <Thomas.Bowman@hhs.gov>; gwen.keenan@fema.dhs.gov; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Cc: Manny.Toro@fema.dhs.gov; Logs Command <Logs_Command@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Subject: Request for USS Hope & USS Mercy

Good morning all,

Attached is an RRF for the USS Hope & USS Mercy. This request has been approved by Kevin Guthrie, SERT Chief.

AMERICAN OVERSIGHT

Please acknowledge receipt of this request.

Respectfully,

Alonna E. Vinson
Mutual Aid Branch Director & EMAC Coordinator
Florida Division of Emergency Management
Bureau of Response | Logistics Section
Alonna.Vinson@em.myflorida.com
Office: 850-815-4280 | Mobile: 850-901-8456

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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To:	Vinson, Alonna; ASPR Region 4 (HHS/ASPR/OEM); Bowman, Thomas (OS/ASPR/EMMO); gwen.keenan@fema.dhs.gov; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Manny.Toro@fema.dhs.gov; Logs Command; Davis, Ashley; Guthrie, Kevin
Subject:	RE: Request for USS Hope & USS Mercy
Date:	Tuesday, March 17, 2020 2:25:15 PM
Attachments:	CDC HAN 430 Info and Guidance about Global Travel on Cruise Ships due to COVID-19 Updated 03 17 2020.pdf

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Cc: Manny.Toro@fema.dhs.gov; Logs Command <Logs_Command@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
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AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane
Date: Wednesday, February 5, 2020 10:08:18 AM

I am

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>
Sent: Wednesday, February 5, 2020 10:03 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane

Morning, team –
I'm back and relatively alive after a bout of the flu. I wanted to check in with the team – who all from FL DOH will be attending Vector Week? I think that'll be a good way for us to get together and chat in person about funding strategy for ELC BP2. We can call in folks that will not be in attendance in person.

Nga

From: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>
Sent: Tuesday, January 28, 2020 8:08 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD) <csz5@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: Request for reschedule : FL DOH - ELC/Hurricane

Good morning,

Our apologies for the late notice but we have a couple of folks out sick today. We would like to reschedule the call when we have everyone back and healthy. Do you mind if we try later the week or early next?

(Winter colds...not corona!)

Thank you,

Chris

AMERICAN OVERSIGHT

DVBD - Arboviral Disease Branch
(970) 219-8034

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
Sent: Friday, January 17, 2020 7:54:45 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD) <csz5@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Subject: Spenddown discussion: FL DOH - ELC/Hurricane
When: Tuesday, January 28, 2020 11:00 AM-12:00 PM.
Where: Skype line 855-348-8390 / 2855050

FL DOH has funding in the following buckets:

1. ELC BP1 (19-20) PMS: $40,233.07
    a. ELC Yellow Fever PMS: _____
2. ELC Zika NCE PMS: $105,790.75
3. Hurricane PMS: $921,483.93 REDCap: $1,750,512

Let's focus the conversation on…

- Progress of spenddown
- Key challenges in spenddown
- At-risk activities or projects
- Priorities for any redirection

Blocked off an hour in case we need the full time.

Join Skype Meeting

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AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD); Stanek, Danielle R; Wallace, Marla D.; Morrison, Andrea
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane
Date: Friday, February 7, 2020 4:45:23 PM

I am sorry but I am not sure any of these times will work great for me. I am traveling and have several extra CoV calls. The best time is probably Friday at 2. I could reschedule the meeting I have then. Marah is the lead for the hurricane vector funds so if we are to talk about that funding she should be on the line.
Carina

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>
Sent: Thursday, February 6, 2020 9:47 AM
To: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane

Good morning,
Looks like the CDC team would like to have a brief call prior to vector week, and then follow it up with a brief 30 min 1:1 meeting during vector week later. Would you all be available during one of the following dates/times? I'll block it off for a full hour, but we may not use all of it.

- Monday, Feb 10 2 pm – 3 pm ET
- Tuesday, Feb 11 11 am – 1 pm ET*
- Tuesday, Feb 11 2 pm – 3 pm ET*
- Wednesday, Feb 12 4 pm – 5 pm ET
- Thursday, Feb 13 2 pm – 3 pm ET
- Friday, Feb 14 2 pm – 3 pm ET

*There is a standing monthly FL hurricane call on Feb 11th between 1 pm – 2 pm. We just want to go over the funding streams in depth with the FL DOH team without FDACS on the line and to give us adequate room to talk about funding strategy for FL DOH within the ELC for BP2.

Let us know what will work best for you all. Thanks!
Nga

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>
Sent: Wednesday, February 05, 2020 10:03 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane

Morning, team –

AMERICAN OVERSIGHT

I'm back and relatively alive after a bout of the flu. I wanted to check in with the team – who all from FL DOH will be attending Vector Week? I think that'll be a good way for us to get together and chat in person about funding strategy for ELC BP2. We can call in folks that will not be in attendance in person.

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Sent: Tuesday, January 28, 2020 8:08 AM
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Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
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(Winter colds...not corona!)

Thank you,

Chris

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(970) 219-8034

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AMERICAN OVERSIGHT

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From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
To: Blackmore, Carina (CDC flhealth.gov); Stanek, Danielle (CDC flhealth.gov); Morrison, Andrea; Wallace, Marla D.
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD)
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane
Date: Wednesday, February 5, 2020 10:02:50 AM

Morning, team –
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AMERICAN OVERSIGHT

<Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
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AMERICAN OVERSIGHT

From:	Wallace, Marla D.
To:	Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Blackmore, Carina; ONeill, Mark; Framingham, Julie L
Subject:	RE: Second Quarter PMS Report
Date:	Tuesday, February 25, 2020 4:00:36 PM

De'Lisa

Thanks we will review. We do have a few vacancies at this time in the Lab, Surveillance Systems, Epi Food & Water and Vector Borne. On added note I am preparing out budget request from Project E to help assist with our COVID-19 response. Ad indicated we are applying for the 874K that was approved but unfunded.

To clarify we just need a cover letter signed by Dr. Blackmore and the detailed budget. These documents will be emailed to the ELC Mailbox and a courtesy copy to you. Should the letter be addressed to you, Angelica or the Grants Management (OGS) Official.

Thanks

Marla

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

From: Simpson, De'Lisa D. (CDC/DDID/NCEZID/DPEI) [mailto:ion9@cdc.gov]
Sent: Tuesday, February 25, 2020 3:28 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; ONeill, Mark <Mark.ONeill@flhealth.gov>; Framingham, Julie L <Julie.Framingham@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Subject: Second Quarter PMS Report
Importance: High

Good afternoon,

AMERICAN OVERSIGHT

I am sending you the attached PDF file, which is your jurisdiction's Payment Management System (PMS) Quarter 2 (Q2) Report. This Q2 report covers transactions reported from August 1 through October 31 (Q1), and expenditures from November 1 through January 31, 2020 (Q2). The intent of sharing these quarterly reports is to increase your awareness and provide you with resources to have informed conversations with your financial office.

A few things to point out when reviewing the attached PMS report:

1. PMS does track charges and spending but is only as accurate as the data being entered, as well as the frequency.

2. The attached report shows base funding as well as special funding (Ebola & Hurricane). If you received special funding, you will see suffixes in the document number.
    a. '-19EBLA' is the designation for Ebola funds.
    b. '-19HURR' is the designation for Hurricane funds.

3. Columns to focus on when reviewing:
    a. 'Percentage of Total Charged Against Account' column shows the percentage of funds charged against what was awarded.
    b. 'Percentage of Total Paid Out' column shows the percentage of funds paid out against what was awarded.
    c. Given that we are 50% into Budget Period 1, the charged &/or disbursement should be showing relative spending progress.
        i. On average, ELC awards are comprised of over 70% personnel costs so, if all positions are filled, then a good portion of Q2 funding should be charged &/or disbursed.
        ii. Things like contracts may not be invoiced until work is completed which could result in an artificially lower amount being expended.

Again, the intent of sharing this information is to help with the monitoring and managing of ELC funds.

Feel free to contact me with any questions or concerns.

De'Lisa

De'Lisa D. Simpson, MBA
Program Advisor/Project Officer
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)
Division of Preparedness and Emerging Infections
National Center for Emerging & Zoonotic Infectious Diseases (NCEZID)
Centers for Disease Control and Prevention
1600 Clifton Rd, Mailstop C-12
Atlanta, GA 30333
Office: 404-639-3629
Blackberry: 404-372-5928
Fax: 404-718-1874
ion9@cdc.gov

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From: Clark, Marah

To: Castaneda, Maribel; agentes@clarke.com; alopez@clarke.com; sschneider@clarke.com; jamesclauson@comcast.net; leeduke1@live.com; cindymulla@comcast.net; michael.riles@comcast.net; summerseddie@comcast.net; Joe.Faella@brevardcounty.us; Inman, Barry; lacy.kittles@brevardfl.gov; Beth.Carey-Kovach@charlottecountyfl.gov; Rebecca.owers@charlottecountyfl.gov; Turner, Edna L; Scott.Schermerhorn@charlottecountyfl.gov; Bagley, Rebecca L; gdeskins@citrusmosquito.org; Dunn, Freta K; bkellner@citrusmosquito.org; Poirier, Thomas P; Rashley, Merton J; BenjaminA@coj.net; Rwishard@coj.net; lrosie1965@gmail.com; matthew_mello@co.escambia.fl.us; bill@flaglermosquito.com; markefmcd@outlook.com; fmbmctd@gmail.com; mcothran@gulfcounty-fl.gov; Legg, Keith O; Prowant, Brian K; sfisher@co.hernando.fl.us; JWhitehurst@co.hernando.fl.us; BurnsL@HillsboroughCounty.org; McFaulN@hillsboroughcounty.org; MontgomeryR@hillsboroughcounty.org; shafers@HillsboroughCounty.org; s.artman@irmosquito2.org; s.burroughs@irmosquito2.org; d.pelley@irmosquito2.org; h.whitehead@irmosquito2.org; m.kartzinel@irmosquito2.org; sterling@lcmcd.org; Lloyd@lcmcd.org; Roth, Jennifer; kbaker@lcmcd.org; Armstrong, Angela N; colvinh@leoncountyfl.gov; forda@leoncountyfl.gov; PourciauG@leoncountyfl.gov; CDBaum@manateemosquito.com; Barbara.Bayer@manateemosquito.com; max.dersch@manateemosquito.com; gduesterbeck@martin.fl.us; amcgowan@martin.fl.us; Reinhold, Todd A; snoe@martin.fl.us; Kylie Zirbel; Cason, Emily; connerla@msn.com; Geib, Kim N; Godwin, Michael D; Beedie, Katherine A; eevers@co.okaloosa.fl.us; carin.harrison@us.af.mil; srhenson@myokaloosa.com; Steve.Harrison@ocfl.net; susan.durand@ocfl.net; Jeremy.Brown@ocfl.net; Rafael.Melendez@ocfl.net; dpenson@rcid.org; kpeters@rcid.org; asolis@rcid.org; Rick.Baird@osceola.org; Fricano, Pat; ajanus@pascomosquito.org; Arogers@pascomosquito.org; Dennis Moore; Bohinc, Becky; GEdson@co.pinellas.fl.us; blawton@pinellascounty.org; dnovich@pinellascounty.org; LSmith@pinellascounty.org; Lamb, JoAnne; jstuck@co.pinellas.fl.us; Carlboohene@polk-county.net; hugoortiz@polk-county.net; wynonah.little@putnam-fl.com; sanitation@putnam-fl.com; aprilm@santarosa.fl.gov; nosborn@scgov.net; geby@seminolecountyfl.gov; tjones03@seminolecountyfl.gov; snieves@seminolecountyfl.gov; lreaves@seminolecountyfl.gov; quallsamcd@bellsouth.net; gainesamcd@bellsouth.net; mfarooqamcd@gmail.com; ssmoleroffamcd@gmail.com; xueamcd@gmail.com; jacksons@stlucieco.org; JacobsenR@stlucieco.org; Harts@stlucieco.org; hendersong@stlucieco.org; Koerner, David J; Kossler, Kimberly; minceyt@stlucieco.org; Jared.Stokes@sumtercountyfl.gov; SBartlett@volusia.org; jdillon@volusia.org; DFalcon@volusia.org; mlauth@volusia.org; lraymaley@volusia.org; rlucas@volusia.org; tmachardy@volusia.org; CEfstathion@volusia.org; TVasconcellosByrd@volusia.org; Mosquito Control-North; nwmosquito4@gmail.com; lab@swcmcd.org; director@swcmcd.org; reception@swcmcd.org; mcteche@swcmcd.org; operations@swcmcd.org; mctechb@swcmcd.org; supervisor@swcmcd.org; supervisor@swcmcd.org; Bryant, Glenn W; Andrew Cannons; Choe, Ulyee; Dennis, Anthony D; Dunn, Freta K; Godwin, Michael D; Gregos, Eliot M.; Guidash, Gayle; Hensley, Deborah S; Koerner, David J; Legg, Keith O; Matthias, James M; Miller, Brian L.; Mock, Valerie; Lewandowski, Patty A; Morris, Cindy K.; Myers, Paul D; Pierce, Bruce; Prowant, Brian K; Rashley, Merton J; Reinhold, Todd A; Roth, Jennifer; Rowlinson, Marie-Claire; Scuteri, Ana C; Seaton, Lylah J; Smith, Bret A; Steele, Crystal C; Turner, Scott M; Ulery, Sheryl P; Walsh, Donna; Williams, Diana J; Young, Zelda J; Zipperer, Angela; dwayne.carbonneau@fwc.state.fl.us; seth.britch@ars.usda.gov; JFDay@mail.ifas.ufl.edu; jrey@ufl.edu; crr@mail.ifas.ufl.edu; docmx8@gmail.com; dbowers@unf.edu; hhassan@health.usf.edu; tunnasch@health.usf.edu; pvanderkelen@gmail.com; lstarkm@aol.com; taytaylor518@gmail.com; ciadams@fsu.edu; stacey.k.booker.mil@mail.mil; Rachel.Beck@adph.state.al.us; Joshua.Coleman@adph.state.al.us; PEfird@mchd.org; dlee@mchd.org; antrimm@chathamcounty.org; lfpeaty@chathamcounty.org; keith@mosquitocs.com; Jayna@mosquitocs.net; william.schommer@rentokil.com; cwaldron@la.gov

Cc: Heberlein-Larson, Lea A.; Andrew Cannons; Lewandowski, Patty A; LaCrue, Alexis N; Kopp, Edgar W; Danielle Stanek; Lamberg, Frieda; Pierre-Saint, Ashley; Andrea Morrison; Carina Blackmore; Gill, Caitlin; Welch, Johanna; Nicely, Bruce; Ber, Jessica

Subject: RE: Sentinel Chicken Program Important Update

Date: Thursday, March 12, 2020 1:05:07 PM

Good afternoon Mosquito Control Arboviral Surveillance Coordinators and Directors,

After speaking with Dr. Stanek, the following is suggested for mosquito control programs currently and planning to start their sentinel chicken surveillance programs for the year based on the email from the FDOH Tampa Laboratory:

1. If you have already started your program, do not continue bleeding chickens, but maintain your flocks. Once the FDOH lab is able to start testing samples, they will contact you to start back up again. At that point, the chickens will be considered NEW birds and tested as such.
2. If you are only in the planning stages and preparing to launch the program in the upcoming months, hold off until you receive the go ahead from the lab or FDOH arbovirus coordinators to implement your program for the year.

Having been responsible for arboviral surveillance previously, I truly understand the significance of the data this testing provides and the impacts this can have on your program's proactive response.

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The FDOH laboratories understands the importance of sentinel sera testing for endemic mosquito borne viruses and this was not an easy decision for them to make. ***Please trust that they are doing everything possible to increase lab capacity and will be providing more guidance as they move forward. Your support of this decision is appreciated.***

As always,

Marah Clark
Environmental Administrator
Entomology and Pest Control Section
Bureau of Scientific Evaluation and Technical Assistance
Division of Agricultural Environmental Services
Florida Department of Agriculture and Consumer Services

(850) 617-7918 – Office
Marah.Clark@FDACS.gov

NOTE: New email address and website

The Conner Building, Lab 6
3125 Conner Boulevard
Tallahassee, FL 32399

www.FDACS.gov

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida

---

From: Castaneda, Maribel <Maribel.Castaneda@flhealth.gov>
Sent: Thursday, March 12, 2020 12:06 PM
To: agentes@clarke.com; alopez@clarke.com; sschneider@clarke.com; jamesclauson@comcast.net; leeduke1@live.com; cindymulla@comcast.net; michael.riles@comcast.net; summerseddie@comcast.net; Joe.Faella@brevardcounty.us; Inman, Barry <Barry.Inman@flhealth.gov>; lacy.kittles@brevardfl.gov; Beth.Carey-Kovach@charlottecountyfl.gov; Rebecca.owers@charlottecountyfl.gov; Turner, Edna L <Edna.Turner@flhealth.gov>; Scott.Schermerhorn@charlottecountyfl.gov; Bagley, Rebecca L <Rebecca.Bagley@flhealth.gov>; gdeskins@citrusmosquito.org; Dunn, Freta K <Freta.Dunn@flhealth.gov>; bkellner@citrusmosquito.org; Poirier, Thomas P <Thomas.Poirier@flhealth.gov>; Rashley, Merton J <Merton.Rashley@flhealth.gov>; BenjaminA@coj.net; Rwishard@coj.net; lrosie1965@gmail.com <RWSMITH@coj.net>; matthew_mello@co.escambia.fl.us; bill@flaglermosquito.com; markefmcd@outlook.com; fmbmctd@gmail.com; mcothran@gulfcounty-fl.gov; Legg, Keith O <Keith.Legg@flhealth.gov>; Prowant, Brian K <Brian.Prowant@flhealth.gov>; sfisher@co.hernando.fl.us; JWhitehurst@co.hernando.fl.us; BurnsL@HillsboroughCounty.org; McFaulN@hillsboroughcounty.org; MontgomeryR@hillsboroughcounty.org; shafers@HillsboroughCounty.org; s.artman@irmosquito2.org; s.burroughs@irmosquito2.org;

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d.pelley@irmosquito2.org; h.whitehead@irmosquito2.org; m.kartzinel@irmosquito2.org; sterling@lcmcd.org; Lloyd@lcmcd.org; Roth, Jennifer <Jennifer.Roth@flhealth.gov>; kbaker@lcmcd.org; Armstrong, Angela N <Angela.Armstrong@flhealth.gov>; colvinh@leoncountyfl.gov; forda@leoncountyfl.gov; PourciauG@leoncountyfl.gov; CDBaum@manateemosquito.com; Barbara.Bayer@manateemosquito.com; max.dersch@manateemosquito.com; gduesterbeck@martin.fl.us; amcgowan@martin.fl.us; Reinhold, Todd A <Todd.Reinhold@flhealth.gov>; snoe@martin.fl.us; Kylie Zirbel <kzirbel@martin.fl.us>; Cason, Emily <Emily.Cason@flhealth.gov>; connerla@msn.com; Geib, Kim N <Kim.Geib@flhealth.gov>; Godwin, Michael D <Michael.Godwin@flhealth.gov>; Beedie, Katherine A <Katherine.Beedie@flhealth.gov>; eevers@co.okaloosa.fl.us; carin.harrison@us.af.mil; srhenson@myokaloosa.com; Steve.Harrison@ocfl.net; susan.durand@ocfl.net; Jeremy.Brown@ocfl.net; Rafael.Melendez@ocfl.net; dpenson@rcid.org; kpeters@rcid.org; asolis@rcid.org; Rick.Baird@osceola.org; Fricano, Pat <Pasquale.Fricano@flhealth.gov>; ajanus@pascomosquito.org; Arogers@pascomosquito.org; Dennis Moore <dmoore@pascomosquito.org>; Bohinc, Becky <Rebecca.Bohinc@flhealth.gov>; GEdson@co.pinellas.fl.us; blawton@pinellascounty.org; dnovich@pinellascounty.org; LSmith@pinellascounty.org; Lamb, JoAnne <JoAnne.Lamb@flhealth.gov>; jstuck@co.pinellas.fl.us; Carlboohene@polk-county.net; hugoortiz@polk-county.net; wynonah.little@putnam-fl.com; sanitation@putnam-fl.com; aprilm@santarosa.fl.gov; nosborn@scgov.net; geby@seminolecountyfl.gov; tjones03@seminolecountyfl.gov; snieves@seminolecountyfl.gov; lreaves@seminolecountyfl.gov; quallsamcd@bellsouth.net; gainesamcd@bellsouth.net; mfarooqamcd@gmail.com; ssmoleroffamcd@gmail.com; xueamcd@gmail.com; jacksons@stlucieco.org; JacobsenR@stlucieco.org; Harts@stlucieco.org; hendersong@stlucieco.org; Koerner, David J <David.Koerner@flhealth.gov>; Kossler, Kimberly <Kimberly.Kossler@flhealth.gov>; minceyt@stlucieco.org; Jared.Stokes@sumtercountyfl.gov; SBartlett@volusia.org; jdillon@volusia.org; DFalcon@volusia.org; mlauth@volusia.org; lraymaley@volusia.org; rlucas@volusia.org; tmachardy@volusia.org; CEfstathion@volusia.org; TVasconcellosByrd@volusia.org; Mosquito Control-North <hunbrenda@co.walton.fl.us>; nwmosquito4@gmail.com; lab@swcmcd.org; director@swcmcd.org; reception@swcmcd.org; mcteche@swcmcd.org; operations@swcmcd.org; mctechb@swcmcd.org; supervisor@swcmcd.org; supervisor@swcmcd.org; Andrea Morrison <Andrea.Morrison@flhealth.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>; Bryant, Glenn W <Glenn.Bryant@flhealth.gov>; Andrew Cannons <Andrew.Cannons@flhealth.gov>; Choe, Ulyee <Ulyee.Choe@flhealth.gov>; Dennis, Anthony D <Anthony.Dennis@flhealth.gov>; Dunn, Freta K <Freta.Dunn@flhealth.gov>; Godwin, Michael D <Michael.Godwin@flhealth.gov>; Gregos, Eliot M. <Eliot.Gregos@flhealth.gov>; Guidash, Gayle <Gayle.Guidash@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>; Hensley, Deborah S <Deborah.Hensley@flhealth.gov>; Koerner, David J <David.Koerner@flhealth.gov>; Legg, Keith O <Keith.Legg@flhealth.gov>; Matthias, James M <James.Matthias@flhealth.gov>; Miller, Brian L. <Brian.Miller@flhealth.gov>; Mock, Valerie <Valerie.Mock@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Morris, Cindy K. <Cindy.Morris@flhealth.gov>; Myers, Paul D <Paul.Myers@flhealth.gov>; Pierce, Bruce <Bruce.Pierce@flhealth.gov>; Prowant, Brian K <Brian.Prowant@flhealth.gov>; Rashley, Merton J <Merton.Rashley@flhealth.gov>; Reinhold, Todd A <Todd.Reinhold@flhealth.gov>; Roth, Jennifer <Jennifer.Roth@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>; Scuteri, Ana C <Ana.Scuteri@flhealth.gov>; Seaton, Lylah J <Lylah.Seaton@flhealth.gov>; Smith, Bret

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A <Bret.Smith@flhealth.gov>; Danielle Stanek <Danielle.Stanek@flhealth.gov>; Steele, Crystal C <Crystal.Steele@flhealth.gov>; Turner, Scott M <Scott.Turner@flhealth.gov>; Ulery, Sheryl P <Sheryl.Ulery@flhealth.gov>; Walsh, Donna <Donna.Walsh@flhealth.gov>; Williams, Diana J <Diana.Williams2@flhealth.gov>; Young, Zelda J <Zelda.Young@flhealth.gov>; Zipperer, Angela <Angela.Zipperer@flhealth.gov>; Clark, Marah <Marah.Clark@fdacs.gov>; dwayne.carbonneau@fwc.state.fl.us; seth.britch@ars.usda.gov; JFDay@mail.ifas.ufl.edu; jrey@ufl.edu; crr@mail.ifas.ufl.edu; docmx8@gmail.com; dbowers@unf.edu; hhassan@health.usf.edu; tunnasch@health.usf.edu; pvanderkelen@gmail.com; lstarkm@aol.com; taytaylor518@gmail.com; ciadams@fsu.edu; Pierre-Saint, Ashley <Ashley.Pierre-Saint@fdacs.gov>; Lamberg, Frieda <Frieda.Lamberg@fdacs.gov>; stacey.k.booker.mil@mail.mil; Rachel.Beck@adph.state.al.us; Joshua.Coleman@adph.state.al.us; PEfird@mchd.org; dlee@mchd.org; antrimm@chathamcounty.org; lfpeaty@chathamcounty.org; keith@mosquitocs.com; Jayna@mosquitocs.net; william.schommer@rentokil.com; cwaldron@la.gov
Cc: Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>; Andrew Cannons <Andrew.Cannons@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; LaCrue, Alexis N <Alexis.LaCrue@flhealth.gov>; Kopp, Edgar W <Edgar.Kopp@flhealth.gov>; Castaneda, Maribel <Maribel.Castaneda@flhealth.gov>
Subject: Sentinel Chicken Program Important Update

Good Morning Sentinel Chicken Program Participants,

Our laboratory and epidemiology leadership have decided to suspend Sentinel Chicken Testing effective immediately. At this time, all personnel are need to help perform COVID-19 testing. For the next seven weeks or until further notice, we will not be performing HAI, ELISA, PRNT, and mosquito pool testing. Specimens received today or tomorrow will not be processed. Please send me an e-mail so that I know what you would like us to do with those specimens. We will notify you when we are able to resume testing.

Reports:

1. This Friday, March 13, 2020 the regular HAI report will be e-mailed.
2. Tuesday, March 17, 2020 the IgM ELISA report will be e-mailed.
3. Wednesday, March 18, 2020 the PRNT report (for February specimens) will be e-mailed.

Please understand that we are doing what is best to promote, protect, and improve the health of all people in the state. Please contact me, if you have any questions or concerns.

Thank you,

Maribel

Maribel Castaneda
Lead Scientist

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Sentinel Chicken Program Coordinator
Bureau of Public Health Laboratories – Tampa
Division of Disease Control and Health Protection
Florida Department of Health
3602 Spectrum Blvd.
Tampa, FL 33612
Phone: 813-233-2342

Division of Disease Control and Health Protection
Florida Department of Health

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From: Cohen, Jonathan
To: Chapman, Jennifer Rose; Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); BPHL13FL@flhealth.gov
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC/flhealth.gov); Blackmore, Carina (CDC/flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC/flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Date: Thursday, February 13, 2020 9:40:09 AM
Sensitivity: Confidential

All,
The patient was born in [redacted]
She has traveled to the Caribbean and Central America but not South America.
All of us in South Florida have history of insect bites.
January 29, 2020 positive leishmaniasis IgG
Testing negative for hepatitis B, hepatitis C, HIV

Jonathan Cohen

From: Chapman, Jennifer Rose <JChapman@med miami edu>
Sent: Wednesday, February 12, 2020 3:18 PM
To: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc gov>; Pathology (CDC) <Pathology@cdc gov>; BPHL13FL@flhealth gov; Cohen, Jonathan <j cohen11@miami edu>
Cc: Elesi Quaye@flhealth gov; Stanek, Danielle (CDC flhealth gov) <Danielle Stanek@flhealth gov>; Blackmore, Carina (CDC flhealth gov) <carina blackmore@flhealth gov>; Edhelene Rico@flhealth gov; Alvaro Mejia-Echeverry@flhealth gov; pedro noya-chaveco@flhealth gov; Schmitz, Ann (CDC flhealth gov) <ann schmitz@flhealth gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc gov>; Leishmania (CDC) <leishmania@cdc gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc gov>
Subject: Re: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

Adding Dr Cohen, treating physician, to answer the questions below

Jennifer Chapman, MD
Associate Professor
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowship Program
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc gov>
Sent: Wednesday, February 12, 2020 3:03:35 PM
To: Pathology (CDC) <Pathology@cdc gov>; BPHL13FL@flhealth gov <BPHL13FL@flhealth gov>
Cc: Chapman, Jennifer Rose <JChapman@med miami edu>; Elesi Quaye@flhealth gov <Elesi Quaye@flhealth gov>; Stanek, Danielle (CDC flhealth gov) <Danielle Stanek@flhealth gov>; Blackmore, Carina (CDC flhealth gov) <carina blackmore@flhealth gov>; Edhelene Rico@flhealth gov <Edhelene Rico@flhealth gov>; Alvaro Mejia-Echeverry@flhealth gov <Alvaro Mejia-Echeverry@flhealth gov>; pedro noya-chaveco@flhealth gov <pedro noya-chaveco@flhealth gov>; Schmitz, Ann (CDC flhealth gov) <ann schmitz@flhealth gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc gov>; Leishmania (CDC) <leishmania@cdc gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc gov>
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171

Good afternoon

We are requesting additional information regarding this case:

- Travel history and/or country of birth
- History of insect bites
- Leish testing date
- Results of any other microbiologic evaluation

Tina Benoit MPH
Clinical Epidemiology Coordinator Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
Centers for Disease Control and Prevention
1600 Clifton Rd NE MS H18-SB | Atlanta GA 30329-4027
MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc gov

From: Pathology (CDC) <Pathology@cdc gov>
Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth gov
Cc: jchapman@med miami edu; Elesi Quaye@flhealth gov; Stanek, Danielle (CDC flhealth gov) <Danielle Stanek@flhealth gov>; Blackmore, Carina (CDC flhealth gov) <carina blackmore@flhealth gov>; Edhelene Rico@flhealth gov; Alvaro Mejia-Echeverry@flhealth gov; pedro noya-chaveco@flhealth gov; Schmitz, Ann (CDC flhealth gov) <ann schmitz@flhealth gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc gov>; Leishmania (CDC) <leishmania@cdc gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc gov>
Subject: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence.
Dr. Stephen White,
This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.
If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

Eduard Matkovic, M.D. | Pathology Fellow | Tel 404-639-0549 | Fax 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS H18-SB | Atlanta, GA 30329-4027 |

Report Password: the password to open the password protected Pathology Report PDF (Preliminary/Final/Addendum) for this case will be provided in a separate email after you receive the Final Pathology Report Email and will be a unique 12 digit number. If additional specimens are subsequently received on the same case by IDPB, the password will remain unchanged. Animal case reports will not have password protection.

Specimen Receipt Notice: the official contact(s) at the Health Departments (if known) will be cc'd on IDPB's Specimen Receipt Notice emails, in addition to cc'ing other case specific relevant parties. The same official contact(s) at the Health Departments (if known) will continue to receive IDPB's Final Pathology Reports once finalized.

ePathology Service: IDPB now offers telepathology consultation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http://www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
To: Cohen, Jonathan; Chapman, Jennifer Rose; Pathology (CDC); BPHL13FL@flhealth.gov
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Date: Thursday, February 13, 2020 9:41:45 AM
Sensitivity: Confidential

Noted
Thanks for the update Dr. Cohen

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
Centers for Disease Control and Prevention
1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027
MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc.gov

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Thursday, February 13, 2020 9:40 AM
To: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

All,
The patient was born in [redacted]
She has traveled to the Caribbean and Central America but not South America.
All of us in South Florida have history of insect bites.
January 29, 2020 positive leishmaniasis IgG
Testing negative for hepatitis B, hepatitis C, HIV

Jonathan Cohen

From: Chapman, Jennifer Rose <JChapman@med.miami.edu>
Sent: Wednesday, February 12, 2020 3:18 PM
To: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
Subject: Re: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

Adding Dr Cohen, treating physician, to answer the questions below.

Jennifer Chapman, MD
Associate Professor
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowship Program
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Sent: Wednesday, February 12, 2020 3:03:35 PM
To: Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov <BPHL13FL@flhealth.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Elesi.Quaye@flhealth.gov <Elesi.Quaye@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov <Edhelene.Rico@flhealth.gov>; Alvaro.Mejia-Echeverry@flhealth.gov <Alvaro.Mejia-Echeverry@flhealth.gov>; pedro.noya-chaveco@flhealth.gov <pedro.noya-chaveco@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171

Good afternoon

We are requesting additional information regarding this case:

- Travel history and/or country of birth
- History of insect bites
- Leish testing date
- Results of any other microbiologic evaluation

Tina Benoit, MPH
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AMERICAN OVERSIGHT

From: Pathology (CDC) <Pathology@cdc.gov>
Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.nova-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Subject: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence.
Dr. Stephen White,
This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.
If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

****

Report Password: the password to open the password protected Pathology Report PDF (Preliminary/Final/Addendum) for this case will be provided in a separate email after you receive the Final Pathology Report Email and will be a unique 12 digit number. If additional specimens are subsequently received on the same case by IDPB, the password will remain unchanged. Animal case reports will not have password protection.

Specimen Receipt Notice: the official contact(s) at the Health Departments (if known) will be cc'd on IDPB's Specimen Receipt Notice emails, in addition to cc'ing other case specific relevant parties. The same official contact(s) at the Health Departments (if known) will continue to receive IDPB's Final Pathology Reports once finalized.

ePathology Service: IDPB now offers telepathology consultation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http://www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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AMERICAN OVERSIGHT

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
To: Pathology (CDC); BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Date: Wednesday, February 12, 2020 3:03:37 PM
Sensitivity: Confidential

Good afternoon

We are requesting additional information regarding this case:

- Travel history and/or country of birth
- History of insect bites
- Leish testing date
- Results of any other microbiologic evaluation

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
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From: Pathology (CDC) <Pathology@cdc.gov>
Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Subject: Specimen Receipt Notice: IDPB 2020-0171
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Dr. Stephen White,
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If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

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ePathology Service: IDPB now offers telepathology consultation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http://www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) Operations
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	RE: State Health Official & State Epi Touchbase
Date:	Thursday, February 27, 2020 7:29:40 PM
Attachments:	DRAFT - Home Q or Iso Considerations v5.4_2.27.20.pdf

Good Evening Colleagues,

As a follow-up to today's state health official and state epidemiologist touchbase, please find the **DRAFT** "Home Containment for Persons Exposed to (Quarantine) or Infected with (Isolation) COVID-19 Coronavirus" guidance attached to this email. In addition, please be mindful this is a working document. As we learn more through science and the duration of the COVID-19 response, we anticipate adjusting the guidance accordingly.

Lastly, please take a moment to review the guidance and provide feedback to preparedness@cdc.gov. We are aware many jurisdictions are currently doing home containment planning. Subject matter experts at CDC wanted to provide draft guidance to assist you with your planning efforts. At this time, we are only sharing this guidance with the participants of state health official and state epidemiologist touchbase. Please let us know if you have any questions. Thank you.

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

(Sent by BCC to state health officials and State epidemiologists)

AMERICAN OVERSIGHT

From: India Bowman
To: John Dunn; Carina Blackmore
Cc: Craig Hedberg; Donald Sharp
Subject: RE: Third Edition CIFOR Guidelines for Foodborne Outbreak Response Final Draft for Association Approval
Date: Wednesday, February 12, 2020 4:55:19 PM
Attachments: image001.png
3rd edition CIFOR Guidelines Final Draft.docx.pdf

Dear NASPHV Colleagues,

I would like to follow up on the status of your leadership review and approval of the 3rd edition *CIFOR Guidelines*. If your leadership has not yet completed their review, Craig and I welcome any comments or edits that you may have compiled up to this point. As CDC is very keen on obtaining our printing goal below, we ask that you provide these comments or edits as soon as possible and to keep us informed of your internal approval status.

Once more, I have provided you with a copy for review. Please let me know if you have any questions or need any assistance!

Sincerely,

India

From: India Bowman
Sent: Tuesday, December 31, 2019 1:13 PM
Cc: Craig Hedberg <hedbe005@umn.edu>; India Bowman <ibowman@cste.org>
Subject: Third Edition CIFOR Guidelines for Foodborne Outbreak Response Final Draft for Association Approval
Importance: High

Sent to Members of the CIFOR Council

Dear CIFOR Colleagues,

We are happy to announce the final draft of *The CIFOR Guidelines for Foodborne Outbreak Response* (3rd. Edition) is now available for CIFOR member association approvals!

As an update, the Guidelines were available on the CIFOR website for public commenting from November 6th through December 1st, 2019. In total, we received comments from five individuals. These comments primarily consisted of format changes, graphics requests and minor technical edits. Currently, we are working with a graphic design firm to produce a cover and modify the visual aspects of the Guidelines. The firm estimates that the design work will take 3-4 weeks to complete and our publishing timeline is as follows:

- We expect to have cover designs produced by **mid to late January** and will ask CIFOR Council members to vote. If you have any suggestions for design ideas, we welcome your input.
    - In **early January**, we will be reaching out to obtain high-resolution versions of your agency's graphics placed throughout the Guidelines.
- This design firm also has printing capabilities and estimates that printing will take approximately 3 weeks to complete. Depending on how quickly approvals are obtained, this has our final printing taking place in **late February.**

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- Our overall goal is to have books in hand at InFORM in **Early March** or shortly thereafter.

In the interim, we are asking that members provide their organizations with a copy of the draft (attached) to obtain appropriate leadership approvals prior to publication. Once obtained, please provide CSTE with a confirmation of approval. We are asking that approvals be obtained no later than **Friday, February 7th, 2020**. *Please note: This draft does not contain the foreword nor any appendices.*

To better assist with organizational approvals, we have listed below the most significant, high-level changes to the Guidelines:

- Content:
  - WGS and CIDT issues are discussed.
  - Integration of consumer complaint systems with pathogen-specific surveillance are discussed.
  - Importance of sub-cluster investigations and epidemiologic tracebacks are emphasized.
  - Importance of environmental assessments are emphasized.
  - Importance of after-action reviews are emphasized.
  - More coordinated inclusion of communications sections.
  - Elimination of CIFOR metrics, better referencing of existing program metrics.
- Format:
  - More functional, easier-to-use format.
  - Reorganization of chapters into foundational (1-3) and operational (4-8).
  - Streamlined organization of chapters and less redundancy between chapters.
  - Chapter summary points to highlight content of each chapter.

As always, please let us know if you have any questions. Thank you all for your hard work! Please have a safe and happy New Year!

Sincerely,
India

India Bowman, MPH
Program Analyst

Council of State and Territorial Epidemiologists
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Documents with personal data and/or confidential information must be sent to CSTE's national office only through a secure ShareFile request and not through regular email.

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR)
Cc: Pritchard, Scott; Rubino, Heather
Subject: RE: Tim"s email
Date: Monday, February 17, 2020 6:20:40 PM

Thanks Hugh. Hope you had a good trip.

Carina

From: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR) <hmm2@cdc.gov>
Sent: Monday, February 17, 2020 6:17 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Tim's email

Hi Carina
Just coming back from leave. My understanding is that Tim is starting a few transition weeks with our FSB team getting oriented to the CEFO program and also supporting the corona virus state coordination task force. When I departed on Feb 10, He was still slated to start with you on March 1- but will hopefully have a good understanding of State issues and priorities related to recent corona virus events.
Hugh

Get Outlook for iOS

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Monday, February 17, 2020 8:40:43 AM
To: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR) <hmm2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: FW: Tim's email

Hi Hugh, is Tim deployed? Will that affect his start date with us?

From: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Sent: Monday, February 17, 2020 8:38 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: Tim's email

I will be out of the office indefinitely, on response related issues.
For DGHP ADS clearance related issues, please contact Curtis Blanton (cgb9@cdc.gov) or David Scharf (zuc1@cdc.gov).

AMERICAN OVERSIGHT

From: Cooksey, Samantha
To: eocsctftfcoord@cdc.gov
Cc: Coulter, Jennifer; Luce, Christie; Blackmore, Carina; Rubino, Heather
Subject: RE: Time Sensitive Request – Verification for DCIPHER User Access for 2019-nCoV (Florida)
Date: Friday, February 7, 2020 3:54:33 PM

No Florida DCIPHER users need access to the 2019-nCov reporting database.

Please refer any additional questions regarding reporting of Movement & Monitoring data to Heather Rubino in our Bureau of Epidemiology. She is copied on this email. Her phone number is (850) 901-6940.

Thank you.

Samantha Cooksey Strickland
State ESF8 Planning & Operations Section Manager
Bureau of Preparedness & Response
Florida Department of Health
Office | 850.617.1506
Mobile | 850.251.2553
Email| Samantha.Cooksey@flhealth.gov

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Thursday, February 6, 2020 1:14 PM
To: Luce, Christie <Christie.Luce@flhealth.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>; Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>
Subject: Time Sensitive Request – Verification for DCIPHER User Access for 2019-nCoV (Florida)

Good Morning,

In preparation for data entry regarding 2019-nCoV Movement and Monitoring for EpiX notification of travelers, we are providing you a list of people currently credentialed for DCIPHER in your jurisdiction.

Please review the names below and indicate in the column labeled **Grant access to 2019-nCoV** those people you want to access the 2019 nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

Current DCIPHER Users

OrgState	First Name	Last Name	Email Address	OrgName	Grant access to 2019-nCoV
Florida	Ruth	Adams	Ruth.Adams@flhealth.gov	Florida Department of Health	
Florida	Stephanie	Anspaugh-Naples	stephanie.anspaugh-naples@flhealth.gov	Florida Department of Health	
Florida	Sebastian	Arenas	Sebastian.Arenas@flhealth.gov	Florida Department of Health	
Florida	Elizabeth	Beshearse	elizabeth.beshearse@flhealth.gov	Florida Department of Health	
Florida	Dean	Bodager	Dean.Bodager@flhealth.gov	Florida Department of Health	
Florida	Laura	Castro	laura.castro@flhealth.gov	Florida Department of Health	
Florida	Oscar	Celorio	Oscar.Celorio@flhealth.gov	Florida Department of Health	
Florida	Georgianne	Cherry	Georgianne.Cherry@flhealth.gov	Florida Department of Health	
Florida	Peter	Chirinos	peter.chirinos@flhealth.gov	Florida Department of Health in Palm Beach County	
Florida	Deborah	Collinge	deborah.collinge@FLHealth.gov	Orange County Health Department	
Florida	Kevan	Cook	Kevan.Cook@flhealth.gov	Florida Department of Health	
Florida	Jennifer	Coulter	jennifer.coulter@flhealth.gov	Florida Department of Health, Bureau of Preparedness and	

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				Resposne	
Florida	Jenny	Crain	jenny.crain@flhealth.gov	Florida State Department of Health	
Florida	Jason	Crowe	jason.crowe@fdacs.gov	Florida Department of Agriculture and Consumer Services	
Florida	Jamie	DeMent	Jamie.DeMent@flhealth.gov	Florida Department of Health	
Florida	Nychie	Dotson	nychie.dotson@flhealth.gov	Florida Department of Health	
Florida	Philip	Dulmage	philip.dulmage@flhealth.gov	Florida Department of Health	
Florida	Timothy	Exline	timothy.exline@flhealth.gov	Florida Department of Health	
Florida	Paul	Fiorella	paul.fiorella@flhealth.gov	Florida Dept of Health	
Florida	Scott	Fryberger	scott.fryberger@flhealth.gov	Florida Department of Health-Seminole County	
Florida	Teresa	Gorden	Teresa.Gorden@flhealth.gov	Florida Department of Health	
Florida	Gayle	Guidash	Gayle.Guidash@flhealth.gov	Department of Health in Pinellas	
Florida	Ashley	Hoskins	Ashley.Hoskins@flhealth.gov	Florida Department of Health	
Florida	Brandi	Keels	brandi.keels@flhealth.gov	Florida Department of Health	
Florida	Nicole	Kikuchi	Nicole.Kikuchi@flhealth.gov	Florida Department of Health	
Florida	Kamal	King	Kamal.King@flhealth.gov	Broward Department of Health	
Florida	Lea	Knezevich	Lea.knezevich@flhealth.gov	Florida Department of Health In Hernando County	
Florida	Shamilla	Lutchman	shamilla.lutchman@flhealth.gov	Florida Department of Health	
Florida	Christie	Mathison	Christie.Mathison@flhealth.gov	Florida Department of Health	
Florida	Nina	Mattei	nina.mattei@flhealth.gov	Florida Department of Health in Hernando County	
Florida	Katherine	McCombs	katherine.mccombs@vdh.virginia.gov	FL Department of Health	
Florida	Rafael	Mendoza	Rafael.Mendoza@flhealth.gov	Florida Department of Health - Broward County	
Florida	Megan	Milanese	Megan.Milanese@flhealth.gov	Florida Department of Health in Lake County	
Florida	Denita	Mitchell	denita.mitchell@flhealth.gov	Florida Department of Health	
Florida	Sasha	Nelson	Sasha.Nelson@flhealth.gov	Florida Department of Health	
Florida	Ihab	Osman	Ihab.Osman@FLHealth.gov	Florida Department of Health	
Florida	Aaron	Otis	aaron.otis@flhealth.gov	Centers for Disease Control and Prevention	
Florida	Noemi	Padro	Noemi.Padro@flhealth.gov	Florida Department of Health - Hillsborough	
Florida	Ryan	Pedigo	Ryan.Pedigo@flhealth.gov	FL DOH - Hillsborough	
Florida	William	Ritten	William.Ritten@flhealth.gov	Department of Health in Lake County	
Florida	Jordan	Snead	Jordan.Snead@flhealth.gov	Florida Department of Health Pasco County	
Florida	Kimberly	Stockdale	Kimberly.Stockdale@flhealth.gov	FL Department of Health	
Florida	Natasha	Strokin	Natasha.Strokin@flhealth.gov	Florida Department of Health in Miami-Dade	
Florida	Terri	Sudden	Terri.Sudden@flhealth.gov	Florida Department of Health in Broward	
Florida	Gastrude	Tassy Toussaint	Gastrude.Tassy-Toussaint@flhealth.gov	Florida Department of Health in Miami-Dade	
				Florida Department of Health	

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Florida	Samantha	Taylor	samantha.taylor@flhealth.gov	- Seminole County	
Florida	Mackenzie	Tewell	Mackenzie.Tewell@azdhs.gov	Florida Department of Health in Hillsborough County	
Florida	James	Turchetta	James.Turchetta@flhealth.gov	Florida Department of Health in Broward County	
Florida	Ana	Urueta	Ana.Urueta@flhealth.gov	Florida Department of Health in Pinellas County	
Florida	Kaila	Yeager	Kaila.Yeager@flhealth.gov	Florida Department of Health in Pinellas County	

If you would like to add additional designees to access 2019-nCoV data, we need to know **ASAP**. At present, staff who are not currently credentialed would have to go through the verification process, in order to be granted access to the system. **Provide the names and emails (in the table below) that you would like to add, and we will initiate the process with our IT team**. Correspondence will follow providing a timeline for the verification process for all new designees.

Staff that need to be added to DCIPHER		
First Name	**Last Name**	**Email Address**

More information will be shared on today's 1:00 p.m. EST call, to discuss "Data Reporting to CDC & Supply Conservation Strategies for PHEP Directors & State Epidemiologists".

For additional questions, please email the State Coordination Task Force (SCTF) regional desk at eocsctftfcoord@cdc.gov.

Thank you for expeditiously fulfilling this time-sensitive request.

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

404-232-0480

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; Luce, Christie
Cc:	Coulter, Jennifer; Rubino, Heather
Subject:	RE: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Tuesday, February 18, 2020 4:25:48 PM

Per previous conversations, we will not be using DCIPHER. Case data will be sent through NNDSS. We can discuss how to send monitoring data in an aggregate form.

Carina

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Saturday, February 15, 2020 11:24 AM
To: Luce, Christie <Christie.Luce@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

We are following up with the request below. Once we have received your submission access will be granted for 2019-nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

As a reminder, please consult with your state Epi and state Lab counterparts to ensure we provide access to all staff in your jurisdiction that might need to enter data for various aspects of the response.

If you have any questions please contact eocsctftfcoord@cdc.gov.

Thank you,

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

AMERICAN OVERSIGHT

404-232-0480

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Sent: Wednesday, February 12, 2020 4:41 PM
To: Christie.Luce@flhealth.gov <Christie.Luce@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: jennifer.coulter@flhealth.gov <jennifer.coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

As we prepare to use DCIPHER for the 2019-nCoV response (e.g., data collection, transmission, and data sharing), we are seeking additional information about the type of access for the users you previously identified for the nCoV 2019 DCIPHER platform.

The "access group" options are described here:

1. **Access to DCIPHER to VIEW (only) data**. Role allows individual to see a view of different reports and analyses for their jurisdiction's information and any aggregate national report that may be created.
2. **Access to DCIPHER for DATA ENTRY and EDITING**. Role allows individual to directly enter information into DCIPHER, edit data, see all data associated with the jurisdiction, in addition to viewing/creating different reports and analyses.

In the attachment, please complete information in the last two columns (epi and monitoring), select either **view** or **data entry/editing** for each user.

Please return your response to eocsctftfcoord@cdc.gov as soon as possible so we can configure the platform to support your jurisdictions' access requests.

Warm Regards,

State Coordination Task Force (SCTF)

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Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

404-232-0480

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Vallabhaneni, Snigdha (CDC/DDID/NCEZID/DHQP); Blackmore, Carina; Dotson, Nychie
Subject:	RE: Updated IPC Guidance
Date:	Tuesday, March 10, 2020 5:03:54 PM

Thanks for the update!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 10, 2020 4:42 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Vallabhaneni, Snigdha (CDC/DDID/NCEZID/DHQP) <fco6@cdc.gov>
Subject: Updated IPC Guidance

Hi Scott,

The new **Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings** has been released and can be found at this link: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Biggest changes to highlight:

1. **PPE recommendations:**
    a. Based upon local and regional supplies, facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to healthcare personnel (HCP). When the supply chain has been restored, facilities should return to the use of respirators.
    b. Eye protection, gloves, and gowns continue to be recommended. If gown shortages are experienced, they should be for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Additional guidance is given regarding how to extend the use of respirators, facemasks, and eye protection as well on PPE shortages.
    c. Increased emphasis on the implementation of early source control measures such as putting a facemask on patients presenting with symptoms of respiratory infection.
2. **Rooming:**

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a. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.
b. Patients with known or suspected COVID-19 can be cared for in a single-person room with the door closed.
c. Facilities could consider designating entire units with dedicated HCP to care for those with known or suspected HCP which will also help facilitate the extended use of respirators, facemasks, and eye protection.

3. **Additional consideration during times of wide spread community transmission:** Additional language regarding this has been added under the minimizing exposure and visitor sections.

Always happy to chat.

Best,
Elizabeth

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From: Lalie Ikluk
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; Patricia Vinson (CDC adph.state.al.us); heidi.hedberg@alaska.gov; Uiagalelei, Eti (CDC doh.as); Snyder, Wendy (CDC azdhs.gov); Ferguson, Reva (CDC arkansas.gov); rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC.cdph.ca.gov); aislinn.barnett@state.co.us; Jensen, Dana (CDC ct.gov); richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@flhealth.gov; angelica.mcgrier@dph.ga.gov; fanny.vazquez@dph.ga.gov; Solomon, Fancy (CDC fsmhealth.fm); Kaneshiro, Suzanne (CDC dphss.guam.gov); Sharon.Tangonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Oluwaseun.Oyeniran@illinois.gov; Musgrave, Shirely (CDC illinois.gov); Barrett, Tami (CDC isdh.in.gov); Caskey, Jennifer (CDC idph.iowa.gov); Denise.Schimmel@ks.gov; ccanfieldsmither@ky.gov; Jane.Killen2@La.gov; Lawrence, Peggie (CDC maine.gov); lacey.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benvenga@maryland.gov; rebecca.white@state.ma.us; Egelskil@michigan.gov; Pizzuti, Sandy (CDC state.mn.us); Griffin, Jenny (CDC msdh.ms.gov); jwebruer@health.mo.gov; kacech@mt.gov; Kellie.Richett@mt.gov; Engel, Bonnie (CDC nebraska.gov); Magen.Schachta@nebraska.gov; jpfillppi@health.nv.gov; Bogert, Kelly (CDC dhhs.nh.gov); White, Barbara (CDC dhhs.nh.gov); deanna.morris@doh.nj.gov; Soliz, Angela (CDC state.nm.us); jacki.silvia@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guerrero, Janet (CDC dph.gov.mp); cabyrnes@pa.gov; Lalie Ikluk; marlineloeak@gmail.com; Menard, Rita (CDC health.ri.gov); Higgins, Teresa (CDC dhec.sc.gov); Harding, Monica (CDC state.sd.us); Stanton, Tammy (CDC tn.gov); carolyn.geter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idhelleh@doh.vi.gov; McFarlane, Lesa (CDC doh.vi.gov); tesha.plunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC vermont.gov); Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC doh.wa.gov); Fisher, Andrea (CDC wv.gov); tara.vasby@dhs.wisconsin.gov
Cc: Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Motusa Tuileama (CDC doh.as); Christ, Cara (CDC azdhs.gov); Smith, Nathaniel (CDC arkansas.gov); Sonia.angel@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC ct.gov); karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC dc.gov); scott.rivkees@flhealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; Linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Clabaugh, Gerd (CDC idph.iowa.gov); lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; nirav.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC state.ma.us); Khalduni@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; shellahogan@mt.gov; Gholzman@mt.gov; dannette.smith@nebraska.gov; gary.anthone@nebraska.gov; l.sherych@health.nv.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC health.ny.gov); mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; mylynntufte@nd.gov; Muña, Esther (CDC doh.gov.mp); esther.muna@doh.gov.mp; amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC state.or.us); ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; Emais Roberts; bblilmon@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov); rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC state.sd.us); Lisa.Piercey@tn.gov; Hellerstedt, John (CDC dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC doh.wa.gov); cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); marcus.plesia@ASTHO.com.
Subject: RE: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)
Date: Monday, March 2, 2020 11:42:32 PM

Attention: CDC IMS State Coordination Task Force (SCTF):

Submitting information of the top health official for Replublic of Palau. Please see high-lighted information.

Thank you.

Lalie Ikluk
Administrative Manager
BHASS-Ministry of Health
Republic of Palau
Ph: (680) 488-2552/3
Alt. Email: lalsikluk@gmail.com

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocscftfcoord@cdc.gov>
Sent: Tuesday, March 3, 2020 1:40 AM
To: Patricia Vinson (CDC adph.state.al.us) <Patricia.Vinson@adph.state.al.us>; heidi.hedberg@alaska.gov; Uiagalelei, Eti (CDC doh.as) <euiagalelei@doh.as>; Snyder, Wendy (CDC azdhs.gov) <Wendy.Snyder@azdhs.gov>; Ferguson, Reva (CDC arkansas.gov) <Reva.Ferguson@arkansas.gov>; rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC.cdph.ca.gov) <peggy.ullom@cdph.ca.gov>; aislinn.barnett@state.co.us; Jensen, Dana (CDC ct.gov) <dana.Jensen@ct.gov>; richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@flhealth.gov; angelica.mcgrier@dph.ga.gov; fanny.vazquez@dph.ga.gov; Solomon, Fancy (CDC fsmhealth.fm) <fsolomon@fsmhealth.fm>; Kaneshiro, Suzanne (CDC dphss.guam.gov) <suzanne.kaneshiro@dphss.guam.gov>; Sharon.Tangonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Oluwaseun.Oyeniran@illinois.gov; Musgrave, Shirely (CDC illinois.gov) <shirley.musgrave@illinois.gov>; Barrett, Tami (CDC isdh.in.gov) <tbarrett@isdh.in.gov>; Caskey, Jennifer (CDC idph.iowa.gov) <jennifer.caskey@idph.iowa.gov>; Denise.Schimmel@ks.gov; ccanfieldsmither@ky.gov; Jane.Killen2@La.gov; Lawrence, Peggie (CDC maine.gov) <peggie.d.lawrence@maine.gov>; lacey.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benvenga@maryland.gov; rebecca.white@state.ma.us; Egelskil@michigan.gov; Pizzuti, Sandy (CDC state.mn.us) <sandy.pizzuti@state.mn.us>; Griffin, Jenny (CDC msdh.ms.gov) <jenny.griffin@msdh.ms.gov>; Mebruer, Debbie (CDC health.mo.gov) <debbie.mebruer@health.mo.gov>; kacech@mt.gov; Kellie.Richett@mt.gov; Engel, Bonnie (CDC nebraska.gov) <bonnie.engel@nebraska.gov>; Magen.Schachta@nebraska.gov; jpfillppi@health.nv.gov; Bogert, Kelly (CDC dhhs.nh.gov) <kelly.bogert@dhhs.nh.gov>; White, Barbara (CDC dhhs.nh.gov) <barbara.white@dhhs.nh.gov>; deanna.morris@doh.nj.gov; Soliz, Angela (CDC state.nm.us) <angela.soliz@state.nm.us>; jacki.silvia@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guerrero, Janet (CDC dph.gov.mp) <janet.guerrero@dph.gov.mp>; Ashley.Wilson@odh.ohio.gov; mdianeh@health.ok.gov; Nest, Patricia (CDC state.or.us) <patricia.nest@state.or.us>; tbarnettno@pa.gov; pbeene@pa.gov; Byrnes, Carolyn (CDC pa.gov) <cabyrnes@pa.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; marlineloeak@gmail.com; Menard, Rita (CDC health.ri.gov) <rita.menard@health.ri.gov>; Higgins, Teresa (CDC dhec.sc.gov) <higgint@dhec.sc.gov>; Harding, Monica (CDC state.sd.us) <monica.harding@state.sd.us>; Stanton, Tammy (CDC tn.gov) <tammy.stanton2@tn.gov>; carolyn.geter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idhelleh@doh.vi.gov; McFarlane, Lesa (CDC doh.vi.gov) <lesa.mcfarlane@doh.vi.gov>; tesha.plunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC vermont.gov) <sarah.gregorek@vermont.gov>; Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC doh.wa.gov) <terry.bergener@doh.wa.gov>; Fisher, Andrea (CDC wv.gov) <Andrea.L.Fisher@wv.gov>; tara.vasby@dhs.wisconsin.gov
Cc: Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Motusa Tuileama (CDC doh.as) <tuinua@doh.as>; Christ, Cara (CDC azdhs.gov) <cara.christ@azdhs.gov>; Smith, Nathaniel (CDC arkansas.gov) <nathaniel.smith@arkansas.gov>; Sonia.angel@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC ct.gov) <renee.coleman-mitchell@ct.gov>; karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC dc.gov) <laquandra.nesbitt@dc.gov>; scott.rivkees@flhealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; Linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Clabaugh, Gerd (CDC idph.iowa.gov) <gerd.clabaugh@idph.iowa.gov>; lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; nirav.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC state.ma.us) <monica.bharel@state.ma.us>; Khalduni@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; shellahogan@mt.gov; Gholzman@mt.gov; dannette.smith@nebraska.gov; gary.anthone@nebraska.gov; l.sherych@health.nv.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC health.ny.gov) <howard.zucker@health.ny.gov>; mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; mylynntufte@nd.gov; Muña, Esther (CDC doh.gov.mp) <esther.muna@doh.gov.mp>; amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC state.or.us) <lillian.shirley@state.or.us>; ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; Emais Roberts <emais.roberts@palauhealth.org>; bblilmon@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov) <Nicole.alexanderscott@health.ri.gov>; rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC state.sd.us) <kim.malsam-rysdon@state.sd.us>; Lisa.Piercey@tn.gov; Hellerstedt, John (CDC dshs.texas.gov) <John.Hellerstedt@dshs.texas.gov>; justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC utah.gov) <joeminer@utah.gov>; mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC doh.wa.gov) <jmwiesman@doh.wa.gov>; cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>; Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>; marcus.plesia@ASTHO.com.
Subject: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)

Good Morning,

CDC Incident Management has asked the State Coordination Task Force for contact information of the **top health official** in each jurisdiction to expedite outreach in the event of an emergencies and to provide COVID-19 updates as expeditiously as possible. To accomplish this task, I am reaching out to the SHO/THO Assistant with a cc to the SHO/THO. This information will be used in tandem with the information we have for the SHO/THO maintained by ASTHO. You all are in a great position to assist us!

We know that in many cases the top health official is the SHO/THO. If that case is , just **reply** to this email that they are the **same**.

For those where there is a person who is more senior to the SHO/THO (as a reminder, we are looking for the most senior health official), please complete the following information:

State/Territory	Highest Health Official (I.e. Commissioner/ Minister/Secretary) Name (including degrees as appropriate)	Title	Phone Number (Please provide a **number or** numbers where we can reach out ***after hour*** should the need arise for COVID-19)	Email	Executive Assistant Name	Phone Number	Email
Republic of Palau	Emais Roberts, MD, FACS Ministry of Health Degrees: BS-Visual Science MD-Medicine Medical Training: General Surgery Residency Integrated Surgical Residency Trauma-Burns Resident Surgeon	Minister of Health	680 488-2552/3 680 775-4321	emais.roberts@palauhealth.org	Lalie Ikluk Omengkar D. Wally	680 775-5257 680 775-0000	lalie.ikluk@palauhealth.org omengkar.wally@palauhealth.org

Due to the nature of this **urgent request**, respond by **COB today**.

Thank you so much for your assistance.

If you have questions or concerns, please contact me.

Kimberly
Kimberly Cantrell
State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

Read about the Palau Health disclaimer

AMERICAN OVERSIGHT

From:	Chris Johnstone
To:	Blackmore, Carina
Cc:	Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 1:14:03 AM
Attachments:	image002.png Carina Blackmore - Emergency Mosquito Control in FL.pdf Carina Blackmore - FDACS Mosquito Control Incident Response Teams.pptx

Hi Carina – This is the 3rd slide deck I have for you. Is this presentation intended to replace one of the attached? Also this slide deck has a DRAFT watermark.

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692



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Alaka`ina Foundation Family of Companies Email Privacy Policy.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 19, 2020 3:33 PM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

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VECTOR WEEK 2020: SPEAKER GUIDANCE

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Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 10:08:52 AM
Attachments:	image001.png dengue slides for blackmore VV20final.pptx

The dengue file. Let me know if you need anything else

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Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 10:31:45 AM
Attachments:	image001.png Adam J Clinician Survey Texas Am J Trop Med Hyg 2014.pdf DengueCliniciansurveyAZ2015VectorborneZoonoticDis.pdf

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Date:	Friday, February 21, 2020 10:38:57 AM
Attachments:	image001.png Floridaphysiciandengue2016.pdf

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From: Chris Johnstone <cjohnstone@alakaina.com>
Sent: Friday, February 21, 2020 1:13 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Hi Carina – This is the 3rd slide deck I have for you. Is this presentation intended to replace one of the attached? Also this slide deck has a DRAFT watermark.

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692

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One Team with **One Mission** | www.alakainafoundation.com
Alaka`ina Foundation Family of Companies Email Privacy Policy.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 19, 2020 3:33 PM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

CAUTION: This email originated from outside of the Alakaina FOC organization. DO NOT click links or open attachments unless you recognize the sender.

Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Sent: Wednesday, February 19, 2020 2:03 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Landry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: FW: Vector Week Presentation slides

Hi Carina
I hope you're doing well.

AMERICAN OVERSIGHT

Just a friendly reminder if you could at your earliest convenience send the slides for your presentation for Vector Week's Tuesday afternoon's session on dengue to cjohnstone@alakaina.com (so she can load them ahead of time) with a copy to me along with a short bio, we'd much appreciate it.

See you next week.

Best regards,
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Thursday, February 13, 2020 12:09 PM
To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: RE: Vector Week Speaker Guidance

Hello Speakers for the Dengue Prevention and Control Session on Tuesday afternoon, February 25, 2020–

I want to thank you all again for agreeing to participate in this session. I think the audience will be excited about and learn a lot from what you all have to say!

Below is what we currently have you planning to talk about --- if your content is significantly different, please let us know as soon as possible!

1. *World Mosquito Program, Wolbachia replacement intervention trials (Steven Kern) ~20 min*

2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela*

AMERICAN OVERSIGHT

Paz-Bailey) ~20 min

3. Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name
b. Job title
c. Credentials
d. Name of organization

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Looking forward to seeing you all in a couple of weeks.

Thanks again ~
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Sent: Friday, January 31, 2020 12:26 PM
To: Ciota, Alexander T (HEALTH) <alexander.ciota@health.ny.gov>; Rebecca.Osborn@dhs.wisconsin.gov; bcreiner@uw.edu
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; Powers, Ann (CDC/DDID/NCEZID/DVBD) <akp7@cdc.gov>; CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

AMERICAN OVERSIGHT

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #8, Emerging Issues in Mosquito Borne Diseases**. The session is scheduled for Wednesday February 26, 2020, 10:00-11:15am in Salon II & III at the University Hilton in Fort Collins, CO.

Presentation time: 20 minutes
Speakers in session: 3
Moderator(s) (cc'd here): Ann Powers, Steve Waterman

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

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Sincerely,
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AMERICAN OVERSIGHT

From: Blackmore, Carina
To: cjohnstone@alakaina.com
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date: Wednesday, February 19, 2020 3:32:39 PM
Attachments: dengue slides for blackmore VV20.pptx

Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

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Division of Vector-Borne Diseases, CDC
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To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
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2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela Paz-Bailey) ~20 min*

3. *Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min*

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name
b. Job title

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c. Credentials
d. Name of organization

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Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; Powers, Ann (CDC/DDID/NCEZID/DVBD) <akp7@cdc.gov>; CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

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Moderator(s) (cc'd here): Ann Powers, Steve Waterman

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Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
To: Robinson,Laura (DSHS); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD)
Cc: Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject: RE: Vector Week Speaker Guidance
Date: Tuesday, February 11, 2020 10:56:52 AM

Morning, team –
Thanks again for joining Angi and I on the speakers call yesterday. Here's the outline/flow of presentations for Session 16:

Name	Presentation
Erin Staples	Title: CDC-developed Arboviral Response Plans Focus: Overview of the CDC response plans – possible review of future plans in development too.
Carina Blackmore	Title: Emergency Mosquito Control in FL Focus: Structure of FL for emergency response to mosq disaster and outbreak.
Laura Robinson	Title: Hurricane and Flooding Mosquito Response in Texas Focus: Structure of TX for emergency response focused on hurricane and flooding events.
Kathy Dolan	Title: Resources and Tools to Enhance State Capacity for Vector-Borne Disease Response Focus: Overview of tools and resources for SHDs – Highlight of ASTHO developed tools incl. PH Confronts the Mosquito.
Jennifer Li	Title: Vector-Borne Diseases Preparedness for Locals Focus: Resources and tools to vector programs – being more prepared to detect VBD threats/respond to outbreaks. Recommendations to integrate overall prep structure. NACCHO toolbox.

Notes:

- Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.**
- Send your name, occupation title, organization to Molly, Angi, and I as soon as possible. We'll use this to assist Molly in introducing the speakers.
- Arrive 10 minutes before the presentation. Sit at the front of the room.

Please reach out to Molly, Angi, and I if you have any further questions. See you all in Fort Collins in 2 weeks!

Thanks,
Nga

From: Robinson,Laura (DSHS) <Laura.Robinson@dshs.texas.gov>
Sent: Monday, February 10, 2020 11:23 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Harris, Angela (CDC/DDID/NCEZID/DVBD) <lwl3@cdc.gov>; Baker, Molly <Molly.Baker@health.mo.gov>;

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Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; jli@naccho.org (CDC naccho.org) <jli@naccho.org>; Chelsea Gridley-Smith <cgridley-smith@naccho.org>; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD) <auv1@cdc.gov>
Cc: Garcia,Imelda M (DSHS) <ImeldaM.Garcia@dshs.texas.gov>; Aldridge,Tiffany (DSHS) <Tiffany.Aldridge@dshs.texas.gov>
Subject: RE: Vector Week Speaker Guidance

Hello, everyone -
I wanted to send you my name, contact information, and credentials. Due to novel coronavirus activities, Associate Commissioner Imelda Garcia will not be attending the CDC Vector Week conference. She asked that I present "Hurricane and Flooding Mosquito Response in Texas."

Thank you,
LER

Laura E. Robinson, DVM, MS
Acting State Public Health Veterinarian
Zoonosis Control Branch
Department of State Health Services
Phone: 512-776-3306 Fax: 512-776-7454
Laura.Robinson@dshs.texas.gov

Mailing Address:
P.O. Box 149347, MC1956
Austin, Texas 78714-9347

https://www.dshs.texas.gov/idcu/health/zoonosis/

-----Original Appointment-----
From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) [mailto:ypg2@cdc.gov]
Sent: Friday, February 7, 2020 3:57 PM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD); Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject: Vector Week Speaker Guidance
When: Monday, February 10, 2020 11:00 AM-11:30 AM (UTC-07:00) Mountain Time (US & Canada).
Where: Skype line / 855-348-8390 / 2855050

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

AMERICAN OVERSIGHT

Your presentation is included in **Session #16, Emergency Response Plans**. The session is scheduled for Thursday February 27, 2020, 8:30-9:45am in Breakout Room A (Salon III, IV & VI) at the University Hilton in Fort Collins, CO.

Presentation time: 10-12 minutes
Speakers in session: 5
Moderator(s) (cc'd here): Angela Harris, Nga Vuong, Molly Baker

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Sincerely,
The Vector Week Steering Committee

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(404) 553-8912,,2855050# (Ft. Collins Dial-in Conference Region)	English (United States)
(855) 348-8390,,2855050# (Ft. Collins Dial-in Conference Region)	English (United States)

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Conference ID: 2855050
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From:	Vuong, Nga (CDC/DDID/NCEZID/DVBD)
To:	Robinson,Laura (DSHS); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD)
Cc:	Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject:	RE: Vector Week Speaker Guidance
Date:	Friday, February 14, 2020 9:12:13 AM
Importance:	High

Good morning, everyone –
Please send your slides to cjohnstone@alakaina.com as soon as possible. Reach out to Kimi Landry at nrn8@cdc.gov for any questions or concerns.

Thank you,
Nga

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
Sent: Tuesday, February 11, 2020 8:57 AM
To: Robinson,Laura (DSHS) <Laura.Robinson@dshs.texas.gov>; Harris, Angela (CDC/DDID/NCEZID/DVBD) <lwl3@cdc.gov>; Baker, Molly <Molly.Baker@health.mo.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; jli@naccho.org (CDC naccho.org) <jli@naccho.org>; Chelsea Gridley-Smith <cgridley-smith@naccho.org>; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD) <auv1@cdc.gov>
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Conference ID: 2855050

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Cc:	Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject:	RE: Vector Week Speaker Guidance
Date:	Monday, February 10, 2020 1:22:32 PM

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VECTOR WEEK 2020: SPEAKER GUIDANCE

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Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #16, Emergency Response Plans**. The session is scheduled

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for Thursday February 27, 2020, 8:30-9:45am in Breakout Room A (Salon III, IV & VI) at the University Hilton in Fort Collins, CO.

Presentation time: 12 minutes
Speakers in session: 5
Moderator(s) (cc'd here): Angela Harris, Nga Vuong, Molly Baker

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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From: MAXWELL, LAUREN

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Subject:	RE: WHO/CDC ZIKV IPD Consortium Presentation
Date:	Friday, February 28, 2020 6:14:30 AM
Attachments:	ZIKV IPD-MA Protocol_BMJ Open.pdf LOA_ZIKV IPD Consortium_IPD-MA_UPDATED March 2019_CDC SPECIFIC.docx

Dear USZPIR partners,

Many thanks to everyone who was able to attend the presentation on the ZIKV IPD Consortium-led individual participant data meta-analysis (IPD-MA) of cohorts of pregnant women and their infants and children.

Please find the protocol for the ZIKV IPD-MA and the Letter of Agreement (LoA) for data sharing and authorship, which includes the amendments that were requested by US-CDC and DHHS.

Please let us know if there are any follow-up questions. We would also be happy to host a presentation with your specific team if that would be useful.

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Because the ZIKV IPD-MA will use de-identified data for the same objectives for which that data was collected, the IPD-MA was deemed exempt from ethical review by the WHO Ethics Review Committee. As mentioned on the call, USZPIR sites that wish to participate in the IPD-MA would need to review and sign the LoA for data sharing and authorship, but the de-identified data for that specific site would be uploaded to the WHO e-Archive system from the existing USZPIR dataset rather than the participating site.

Thank you again!

Lauren Maxwell

Lauren Maxwell, PhD, MPH
Project Manager
ZIKV IPD Consortium
WHO Department of Sexual and Reproductive Health and Research
Human Reproduction Programme

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-----Original Appointment-----
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Sent: Thursday, February 13, 2020 3:10 PM
To: ZIKApregnancy (CDC); lauren.maxwell@emory.edu; lauren.maxwell@uni-heidelberg.de; MAXWELL, LAUREN; Davidson, Sherri (CDC adph.state.al.us); McIntyre, Mary (CDC adph.state.al.us); Rachael.Montgomery@adph.state.al.us; tobytha.powell@adph.state.al.us; Brenda.Ryals@adph.state.al.us; janice.smiley@adph.state.al.us; Stevens, Kelly (CDC adph.state.al.us); amy.stratton@adph.state.al.us; grace.thomas@adph.state.al.us; tammie.yeldell@adph.state.al.us; mirwais.zhuben@adph.state.al.us; evelyn.geeter@adph.state.al.us; Castrodale, Louisa (CDC alaska.gov); Fearey, Donna (CDC alaska.gov); r.ropeti@doh.as; Iugafono, Sunia (CDC doh.as); a.tufa@doh.as; Dianna.contreras@azdhs.gov; Timothy.Flood@azdhs.gov; Lora.Andrikopoulos@azdhs.gov; Rigler, Jessica (CDC azdhs.gov); irene.ruberto@azdhs.gov; Joseph.Spadafino@azdhs.gov; Tarter, Kara (CDC azdhs.gov); Venkat, Heather (CDC azdhs.gov); Villarroel, Lisa (CDC azdhs.gov); Joli.Weiss@azdhs.gov; RangelCF@archildrens.org; Rupa.Sharma@arkansas.gov; Lori.Simmons@arkansas.gov; SmithHL@archildrens.org; brandi.stricklin@arkansas.gov; catherine.waters@arkansas.gov; harit.agroia@cdph.ca.gov; Olga.Barer@cdph.ca.gov; Valorie.Eckert@cdph.ca.gov; Similoluwa.Sowunmi@cdph.ca.gov; Richard.Olney@cdph.ca.gov; Charsey.Porse@cdph.ca.gov; Barbara.Warmerdam@cdph.ca.gov; Watt, James (CDC cdph.ca.gov); Eileen.Yamada@cdph.ca.gov; ccroker@ph.lacounty.gov; MIbrahim@ph.lacounty.gov; along@ph.lacounty.gov; clyu@ph.lacounty.gov; Mascola, Laurene (CDC ph.lacounty.gov); vngo@ph.lacounty.gov; SReynaldo@ph.lacounty.gov; cvincent-jones@ph.lacounty.gov; Cchang@ph.lacounty.gov; House, Jennifer (CDC state.co.us); Natalie.Marzec@state.co.us; Cartter, Matthew (CDC ct.gov); karin.davis@ct.gov; abdi.elmi@ct.gov; brenda.esponda-morrison@ct.gov; tabitha.fox@ct.gov; zack.Fraser@ct.gov; Claudia.gutierrez@ct.gov; paula.eggers@state.de.us; Davies-Cole, John (CDC dc.gov); Iyengar, Preetha (CDC dc.gov); PRAMS District of Columbia (CDC dc.gov);

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Cc: Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID); BROUTET, Nathalie Jeanne Nicole; KIM, Caron Rahn; Kara, Edna; SAYERS, Janet; THWIN, Soe Soe
Subject: WHO/CDC ZIKV IPD Consortium Presentation
When: Wednesday, February 26, 2020 2:00 PM-2:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Skype Meeting

***Updated to include presentation slides (attached).**

Dear USZPIR partners,

We invite you to attend a presentation by Lauren Maxwell, Project Manager for the ZIKV IPD Consortium with WHO. Dr. Maxwell will be discussing the current and future efforts of the Individual Participant Data Meta-Analysis (IPD-MA) lead by WHO. This project involves plans to pool data on various cohorts to do a series of analyses related to Zika and pregnancy and could be of interest to jurisdictions who participated in the USZPIR at any time.

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From: Clark, Marah
To: Schramm, Danielle; Carina Blackmore
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD)
Subject: RE: Y2Q2 Submission Reminder, Request
Date: Friday, February 7, 2020 8:04:25 AM
Attachments: image001.png

Vector Week Update:

SIT: Florida has two programs implementing Sterile Insect Technique targeting the *Aedes aegypti* mosquito with assistance from the CDC grant funding. Despite the delay in receiving funding, both programs have made progress to start releasing sterile males in cities in both the northeast and southwest regions of the state.

Insecticide Resistance: In the past few years, insecticide resistance testing for disease vectoring mosquitoes has become an important part of Florida's mosquito control programs. Funding has allowed the Florida Medical Entomology Laboratory to not only continue testing Aedes aegypti and Aedes albopictus mosquitoes, but to expand testing to a Culex species mosquito. Since July 2019, mosquito control programs have been submitted eggs and testing for both pyrethroid and organophosphate mosquito adulticides.

I am working on the spreadsheet and hope to have it in by COB. I have been in training this week and several programs have been slow in providing requested info.

Thanks!

Marah

From: Schramm, Danielle <Danielle.Schramm@icf.com>
Sent: Thursday, February 6, 2020 12:21 PM
To: Clark, Marah <Marah.Clark@fdacs.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: RE: Y2Q2 Submission Reminder, Request

Hi Marah,

Just a note to check on your Y2Q2 submission and success story highlight. Do you anticipate sending to us by tomorrow?

I am going to be out of the office Feb. 10-19, so I just wanted to see where things are and finalize what I can before being out.

Thanks!
Danielle

From: Schramm, Danielle
Sent: Tuesday, January 28, 2020 3:38 PM
To: 'Clark, Marah' <Marah.Clark@fdacs.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>

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Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: RE: Y2Q2 Submission Reminder, Request

Hey Marah,

Great to hear that! Feel free to send separate ones and we'll try to fit them both in.

Thank you! Let me know if you need anything from me!
Danielle

From: Clark, Marah <Marah.Clark@fdacs.gov>
Sent: Tuesday, January 28, 2020 3:33 PM
To: Schramm, Danielle <Danielle.Schramm@icf.com>; Carina Blackmore <Carina.Blackmore@flhealth.gov>
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: RE: Y2Q2 Submission Reminder, Request

Good afternoon!

I am working to get the information assembled. I am hoping to have everything together by the end of the week, but some of my programs are slow in sending me the requested information.

As for highlights, I will try to send you a quick blurb on the SIT and possibly mosquito resistance testing. Would these be separate or should they be in the same blurb? (We finally have some forward action on our Novel MC project!)

Marah

From: Schramm, Danielle <Danielle.Schramm@icf.com>
Sent: Tuesday, January 28, 2020 3:29 PM
To: Clark, Marah <Marah.Clark@fdacs.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: Y2Q2 Submission Reminder, Request

Hi Marah & Carina!

This is a friendly reminder to submit your completed Y2Q2 quarterly performance measure data collection tool by Friday January 31, 2020. If you need additional time, please submit no later than Friday February 7, 2020. Please email your completed Excel template as well as any relevant attachments to me and cc KCZ2@cdc.gov and Jeff Borchert gqx1@cdc.gov when submitting.

In addition, ICF will be developing a poster for Vector Week highlighting the accomplishments of the Hurricane Supplemental Funding thus far. We will be presenting data at the aggregate level with the exception of success stories that we would like to highlight from each state/territory. If there is a specific accomplishment you would like to highlight, we are asking that you develop a 3-4 sentence blurb summarizing the accomplishment along with the specific activity in your workplan to which it aligns. If you are unable to develop a blurb, we can pull from your progress submissions and develop a summary

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and share with you for approval. Feel free to provide this information when sending in your Y2Q2 data submission. If you would like us to develop a summary for you, please let us know by COB this Friday January 31, 2020.

If you have any questions or need any assistance completing your data collection tool, please don't hesitate to contact me.

Thank you,
Danielle

Danielle Schramm, MSPH | Senior Research Scientist | 404-592-2299 direct or 404-321-3211 main | danielle.schramm@icf.com | icf.com
ICF | 3 Corporate Blvd. NE, Suite 370, Atlanta, GA 30329 USA |

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From:	Schramm, Danielle
To:	Clark, Marah; Carina Blackmore
Cc:	Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD)
Subject:	RE: Y2Q2 Submission Reminder, Request
Date:	Thursday, February 6, 2020 12:20:41 PM
Attachments:	image001.png

Hi Marah,

Just a note to check on your Y2Q2 submission and success story highlight. Do you anticipate sending to us by tomorrow?

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Subject: RE: Y2Q2 Submission Reminder, Request

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Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: RE: Y2Q2 Submission Reminder, Request

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If you have any questions or need any assistance completing your data collection tool, please don't hesitate to contact me.

Thank you,
Danielle

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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow
Date:	Tuesday, March 17, 2020 3:25:03 PM

Hi Michelle –

Apologies for the delay. Here is the information on the 6 guests and 2 crew members who are experiencing mild flu-like symptoms and will be traveling via air ambulance to Miami:

Mrs Meredith Bess Amon (GUEST)
1700 Southwest Broadway Drive, Portland, Oregon, 97201 (wheelchair)

Mr. Harvey Norman Levitt (GUESTS)
Mrs. Mara Ellen Levitt
58 Sheridan Drive #22, Atlanta, Georgia 30305

Mr. Bruce Vincent Rodgers (GUESTS)
Mrs. Jeanne Alice Farley Rodgers
4356 2nd Street, Pleasanton, California, 904566

Mrs. Patricia Petrich (GUEST)
33 Shady Bend, Fort Myers, Florida

Ms. Amanda Charland (CREW):
1510 Pine Street, Apartment 3r, Philadelphia, Pennsylvania, USA 19102

Mr. Daniel Leflore (CREW):
1937 Hauser Boulevard, Los Angeles, California, 90016

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:59 AM
To: Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

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EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Dear Eleni,
2 questions and 2 points:

Among the 8 persons who will come on air ambulance,

1. Are any moderately or severe ill, or are they all with mild influenza-like illness?
2. What is their final destination/state of residence?

We are working on specific guidance for you – coming after we clear some items with Florida Health authorities, including Yesenia.

A couple of things for your awareness:

1. We strongly advise that the charter flights have clinicians (doctor/nurse) on board for safe travel and to assist with the arrival process in Miami in case anyone is ill.
2. We request that you distribute this infographic to the American passengers who will be traveling by charter (attached).

Best,
Michelle

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 9:22 AM
To: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>
Cc: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

Good morning, Rachel –

Is CDC able to provide the list of recommended quarantine locations in Miami?

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations

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Royal Caribbean Cruises Ltd.|1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799|Cell: 786.253.5305|ekalisch@rccl.com

From: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>
Sent: Tuesday, March 17, 2020 7:24 AM
To: Eleni Kalisch <ekalisch@rccl.com>; Koneff, Douglas A <KoneffD@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>
Cc: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

+ Andy Klevos from the Miami Quarantine station.
Thanks,
Rachel

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 7:22 AM
To: Koneff, Douglas A <KoneffD@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

Good Morning, Doug –

I will provide an update on Silver Shadow later this morning but, as of late last night, she was prepared to debark guests for charter flights home later today. I will provide an updated timeline after our internal calls this morning.

Thanks,

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Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Koneff, Douglas A <KoneffD@state.gov>
Sent: Tuesday, March 17, 2020 6:37 AM
To: Eleni Kalisch <ekalisch@rccl.com>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

All - good morning. I have broken the Brazil and Chile ships into separate threads, for ease of tracking.

When able, if someone could provide a short status update on the Silver Shadow and any pending asks (for USG or Brazil) that would be very helpful, thanks. Doug

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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 8:17:33 PM
To: (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Re: Question for CBP

Hi Abdias –

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Thanks for the email. Below is the breakdown of guests by nationality:

NATIONALITY	COUNT
ARGENTINA	60
AUSTRALIA	55
AUSTRIA	2
BELGIUM	18
BOLIVIA	7
BRAZIL	45
BULGARIA	17
CANADA	456
CHILE	65
CHINA	1
COLOMBIA	25
CROATIA	2
DENMARK	6
ECUADOR	1
FINLAND	15
FRANCE	18
GERMANY	117
HONG KONG	1
ICELAND	1
INDIA	3
INDONESIA	1
IRELAND	18
ISRAEL	6
ITALY	1
MALAYSIA	2
MALTA	6
MEXICO	102
NETHERLANDS	11
NEW ZEALAND	13
NORWAY	6
PERU	2
POLAND	4
PORTUGAL	2
ROMANIA	5
RUSSIA	8
SERBIA	1
SINGAPORE	5
SOUTH AFRICA	4
SPAIN	43
SWEDEN	10
SWITZERLAND	8
UKRAINE	6
UNITED KINGDOM	253
UNITED STATES	1165

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URUGUAY	13
VENEZUELA	3
Grand Total	**2613**

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Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: ORTIZ, ABDIAS <ABDIAS.ORTIZ@cbp.dhs.gov>
Sent: Monday, March 16, 2020 8:06 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Question for CBP

Hi, Eleni. I am seeking guidance from HQ to your question.

Thanks.

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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 6:22:44 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; ORTIZ, ABDIAS <ABDIAS.ORTIZ@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)

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<yqj1@cdc.gov>
Subject: Question for CBP

CAUTION: This email originated from outside of DHS. DO NOT click links or open attachments unless you recognize and/or trust the sender. Contact theCBP Security Operations Center with questions or concerns.

Hello Abdias –

I had reached out earlier today to your colleague, Chris Ashe. As mentioned in my earlier email, Azamara Pursuit has decided to abandon its efforts to dock and debark in South America and is instead en route to Miami.

Similarly, Celebrity Eclipse continues to have issues docking in Chile and is now considering a 10+ day trip to San Diego. If that is the course chosen, can you please provide guidance as to visa issues that will arise with the South American and Mexican guests onboard? I will send you a manifest by nationality shortly.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell:786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make

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determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road

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Atlanta, GA 30329

470-487-4373

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 2:20 PM
To: Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC

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SparksTk@state.gov

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From: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM)
To: Eleni Kalisch; Rosenfarb, Charles H; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth (CDC state.gov); Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow
Date: Monday, March 16, 2020 12:22:31 PM

Hi Eleni,

Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.

Thank you,
Leah

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 12:17 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

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I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
Thanks for speaking just now. To reiterate CDC's recommendation:

- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
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Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

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U.S. Department of State
Room HST 5323
Office: 202-647-2908
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From:	Barrett, John M (Recife)
To:	Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Rosenfarb, Charles H; Yesenia.Villalta@flhealth.gov
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 12:45:26 PM

All -

To streamline this process with Royal Caribbean, Mission Brazil is initiating a conf call with a smaller group. We will report out shortly. Thank you.

Sent from Workspace ONE Boxer

On 16 March 2020 12:23:13 PM EDT, Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov> wrote:

> Hi Eleni,
>
> Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.
>
> Thank you,
> Leah
>
> ---
>
> **From:** Eleni Kalisch <ekalisch@rccl.com>
> **Sent:** Monday, March 16, 2020 12:17 PM
> **To:** Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
> **Cc:** Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted

AMERICAN OVERSIGHT

(OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
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Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd.|1050 Caribbean Way, Miami FL 33132
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From:	Rosenfarb, Charles H
To:	Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Yesenia.Villalta@flhealth.gov; CBPCoronaVirusTaskForce@cbp.dhs.gov; Ashe, Christopher
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 1:18:20 PM

Eleni, Yesenia,
Directly linking you with CBP on how the arrival of the repatriated passengers would be handled is certainly the best way to get you the answers you need. Christopher Ashe from CBP's Latin America and Caribbean Division has been our primary contact at CBP (CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov). A second contact is to the CBPCoronaVirusTaskForce@cbp.dhs.gov.

Regards,
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To: Eleni Kalisch <ekalisch@rccl.com>; Rosenfarb, Charles H <rosenfarbch@state.gov>; Yesenia.Villalta@flhealth.gov
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AMERICAN OVERSIGHT

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Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 2:03:59 PM

Thank you Dr. Rosenfarb –

The smaller group just convened and addressed all pending issues.

Yesenia, I will be I touch to discuss.

Thanks everyone.

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
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Sent: Monday, March 16, 2020 12:22 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Rosenfarb, Charles H <rosenfarbch@state.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Eleni,

Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.

Thank you,

AMERICAN OVERSIGHT

Leah

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 12:17 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

AMERICAN OVERSIGHT

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
Thanks for speaking just now. To reiterate CDC's recommendation:

- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
- Health screening of passengers would be done by the cruise line company prior to boarding in Recife, with no additional screening performed at the funneling airport (unless the individual has become obviously ill on the initial flight).
- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

AMERICAN OVERSIGHT

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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AMERICAN OVERSIGHT

From:	Eleni Kalisch
To:	Rosenfarb, Charles H; wvp4@cdc.gov; Yesenia.Villalta@flhealth.gov
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ; Regan, Joanna (CDC/DDID/NCEZID/DGMQ; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE; Walters, William; Charles, Julia (CDC/OD/OCS; WHA-FO; Marty Cetron (CDC); Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD; Kennedy, Ted (OS/ASPR/SPPR; Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal
Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 12:16:52 PM

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

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Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD

AMERICAN OVERSIGHT

<dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

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Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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AMERICAN OVERSIGHT

From:	Grow, Stefan
To:	Sayler, Erik; St Laurent, Louise R
Cc:	Larson, Bradford U (Brad) Col USAF NG FLANG (USA); Deleon, Melissa (FLNG)
Subject:	RE: [EXTERNAL] FW: MOA for CST testing lab (UNCLASSIFIED)
Date:	Wednesday, March 25, 2020 5:42:26 PM

I'll have someone look at it.

AHCA certified CLIA, so to the extent there are certification requirements, then we would need to be at least part of that process. Not sure if that warrants being part of the agreement though.

From: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Sent: Wednesday, March 25, 2020 5:19 PM
To: St Laurent, Louise R <Louise.StLaurent@flhealth.gov>; Grow, Stefan <Stefan.Grow@ahca.myflorida.com>
Cc: Larson, Bradford U (Brad) Col USAF NG FLANG (USA) <bradford.u.larson.mil@mail.mil>; Deleon, Melissa (FLNG) <Melissa.e.deleon.mil@mail.mil>
Subject: [External] FW: [EXTERNAL] FW: MOA for CST testing lab (UNCLASSIFIED)

Louise & Stefan,
Attached is the FLNG MOA for the testing machine between DOH and FLNG. Col. Bradford's team drafted it. Are these the right state parties to the MOA? The Colonel said the lab comes with some NG personnel, but they are not currently CLIA certified. Also, supplies and wrap-around services will need to be procured. Do you have any edits? If you have any questions, please let me know.

All,
Some logistics items to be addressed/questions to be answered about the lab, but don't necessarily need to be addressed in the MOA. These are logs/finc/management questions but worth noting and sharing internally.

1. Staffing the lab
    a. How many lab techs are needed to operate the lab at full capacity.
    b. The Colonel says the lab can test 500 samples per day, but is that in an 8, 12, or 24 hour period?
    c. Currently the NG personnel are not CLIA certified; so lab techs will need to be procured – who pays for the lab techs (DOH, AHCA, DEM)
2. Testing materials
    a. What materials are included with the lab (what not included)
    b. What materials are needed to operate the lab at full capacity
    c. Procuring those material that help the lab operate – who procures/pays for these material
3. Wrap-around services
    a. What services are needed (ie, 24-hr security, food for staff, maintenance of lab, etc.)
    b. Who pays for the wrap-around services (DOH, AHCA, DEM)?
4. Timing – It will take at least a week to get the lab.
5. Location – where to stage the lab – that's a logs/mgt decision

AMERICAN OVERSIGHT

6. Other items??

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

Florida has a very broad public records law. Written communications to or from state officials regarding state business constitute public records. Public records are available to the public and media upon request, unless the information is subject to a specific statutory exemption. Therefore, any information that you send to this address, including your contact information, may be subject to public disclosure.

-----Original Message-----
From: Larson, Bradford U (Brad) Col USAF NG FLANG (USA) <bradford.u.larson.mil@mail.mil>
Sent: Wednesday, March 25, 2020 4:25 PM
To: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: [EXTERNAL] FW: MOA for CST and DOH (UNCLASSIFIED)

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

CLASSIFICATION: UNCLASSIFIED

Erik

Attached is the draft MOA we discussed. Please let me know if you have any suggestions. I contacted LTC Eastman and asked what we would need and what we may receive to run this machine. The National Guard Bureau is still working those details as far as what PPE, pipets, kits, etc. may come with the machine. He will get back with me. NGB is sending 2 to NY, so we will have a good idea of what to expect based on what they receive. He did say this would not get to us for about a week even if we do get one.

V/R
Brad

BRADFORD U. LARSON, Col, FLANG
Command Judge Advocate
Florida National Guard
Work: 904-823-0683

AMERICAN OVERSIGHT

Cell: 850-774-3000

CLASSIFICATION: UNCLASSIFIED

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Guthrie, Kevin
To:	Fitzgerald, John M CDR; Davis, Ashley
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:08:10 PM

10=4

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Subject: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald
D7 LNO to the FL EOC

AMERICAN OVERSIGHT

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Fitzgerald, John M CDR; Davis, Ashley
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan
Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:28:20 PM

Good news here for the MS Marina

Here are the next two ship that I just got info in (good timing here)

Costa Magica and Costa Favolosa:

- The Costa Magica is currently close to the Martinique with 930 crew members, 50 of which may have symptoms of Covid-19 (one crew member have been brought inland by helicopter to get urgent care).

- The Costa Favolosa is currently close to Guadeloupe with 1030 crew members, among which 50 may also present symptoms of Covid-19

Perhaps USCG can track these vessels? I have no idea where home port is but in the thread of email sent me they are talking Miami as a landing place.
Sorry for the good news. ☺

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Saturday, March 21, 2020 2:08 PM
To: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Davis, Ashley <Ashley.Davis@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Subject: RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

10=4

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Subject: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

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Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

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Please let me know if you need further.

v/r,

CDR Fitzgerald

AMERICAN OVERSIGHT

D7 LNO to the FL EOC

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
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Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:29:09 PM

Good news here for the MS Marina

Here are the next two ship that I just got info in (good timing here)

Costa Magica and Costa Favolosa:

- The Costa Magica is currently close to the Martinique with 930 crew members, 50 of which may have symptoms of Covid-19 (one crew member have been brought inland by helicopter to get urgent care).

- The Costa Favolosa is currently close to Guadeloupe with 1030 crew members, among which 50 may also present symptoms of Covid-19

Perhaps USCG can track these vessels? I have no idea where home port is but in the thread of email sent me they are talking Miami as a landing place.
Sorry for the good news. ☺

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Saturday, March 21, 2020 2:08 PM
To: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Davis, Ashley <Ashley.Davis@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Subject: RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

10=4

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Subject: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

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Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald

AMERICAN OVERSIGHT

D7 LNO to the FL EOC

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

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AMERICAN OVERSIGHT

From:	Guthrie, Kevin
To:	Fitzgerald, John M CDR; Davis, Ashley
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:07:59 PM

10=4

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
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D7 LNO to the FL EOC

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Emily Davenport, MPH
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Cc:	SWO COMMAND; Lock, Ryan; Guthrie, Kevin; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:28:34 PM

I have no SA on this vessel.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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Sam/Ashley

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Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

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From:	Guthrie, Kevin
To:	Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:36:30 AM

We discussed at the 1800 briefing last night. Ryan Lock has a little info Jared M and I will work this morning.

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
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Kevin.Guthrie@em.myflorida.com

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Cc: SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Rosenstein, Jared <Jared.Rosenstein@em.myflorida.com>; fdot-emoncall@dot.state.fl.us
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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To:	Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:36:39 AM

We discussed at the 1800 briefing last night. Ryan Lock has a little info Jared M and I will work this morning.

Kevin Guthrie | Deputy Director

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Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
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AMERICAN OVERSIGHT

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To:	"Guthrie, Kevin"; Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:40:56 AM

Kevin,

Tracking this one. It was off Panama yesterday with tentative arrival in Miami on March 23, 2020.

Advised Ashley and ESF-8 yesterday.

Let me know if you need further.

v/r,

John

CDR John Fitzgerald
D7 LNO to the FLEOC

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Friday, March 20, 2020 7:37 AM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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Subject: [Non-DoD Source] RE: [EXTERNAL] MS Marina (Oceania) - awareness???

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Kevin Guthrie | Deputy Director
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AMERICAN OVERSIGHT

Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	Fitzgerald, John M CDR
To:	"Guthrie, Kevin"; Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:41:06 AM

Kevin,

Tracking this one. It was off Panama yesterday with tentative arrival in Miami on March 23, 2020.

Advised Ashley and ESF-8 yesterday.

Let me know if you need further.

v/r,

John

CDR John Fitzgerald
D7 LNO to the FLEOC

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Friday, March 20, 2020 7:37 AM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Cc: SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Rosenstein, Jared <Jared.Rosenstein@em.myflorida.com>; fdot-emoncall@dot.state.fl.us
Subject: [Non-DoD Source] RE: [EXTERNAL] MS Marina (Oceania) - awareness???

We discussed at the 1800 briefing last night. Ryan Lock has a little info Jared M and I will work this morning.

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, March 19, 2020 3:28 PM
To: Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees,

AMERICAN OVERSIGHT

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Cc: SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Rosenstein, Jared <Jared.Rosenstein@em.myflorida.com>; fdot-emoncall@dot.state.fl.us
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Sam/Ashley

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Respectfully,
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Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

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To:	Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO COMMAND; Lock, Ryan; Guthrie, Kevin; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:28:23 PM

I have no SA on this vessel.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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AMERICAN OVERSIGHT

From: Sayler, Erik
To: Deleon, Melissa (FLNG)
Cc: Grow, Stefan; St Laurent, Louise R
Subject: RE: [EXTERNAL] RE: National Guard Civil Support Team Mobile COVID-19 testing lab
Date: Wednesday, March 25, 2020 3:38:18 PM

Major DeLeon,
Do you have an ETA on the MOU for the CST mobile testing lab? Do you need anything from legal?

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

Florida has a very broad public records law. Written communications to or from state officials regarding state business constitute public records. Public records are available to the public and media upon request, unless the information is subject to a specific statutory exemption. Therefore, any information that you send to this address, including your contact information, may be subject to public disclosure.

From: Grow, Stefan <Stefan.Grow@ahca.myflorida.com>
Sent: Tuesday, March 24, 2020 6:29 PM
To: Sayler, Erik <Erik.Sayler@em.myflorida.com>; St Laurent, Louise R <Louise.StLaurent@flhealth.gov>
Cc: Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>; Ernst, Colleen <Colleen.Ernst@eog.myflorida.com>
Subject: [EXTERNAL] RE: National Guard Civil Support Team Mobile COVID-19 testing lab

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Erik,

Correct, AHCA certifies CLIA, so we would need to be part of the MOU. I sent the CMS 116 attachment to our field supervisor to begin approval and to make sure there are no hiccups with getting this expedited. They are working on it now.

Thanks,

From: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Sent: Tuesday, March 24, 2020 6:05 PM
To: St Laurent, Louise R <Louise.StLaurent@flhealth.gov>; Grow, Stefan <Stefan.Grow@ahca.myflorida.com>
Cc: Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>; Ernst, Colleen <Colleen.Ernst@eog.myflorida.com>
Subject: [External] National Guard Civil Support Team Mobile COVID-19 testing lab

Louise and Stefan,

AMERICAN OVERSIGHT

Our national guard liaison officer Maj. DeLeon is working to help secure a mobile testing lab resource from the National Guard Bureau (NGB) from the Civil Support Team (CST). The Major says there are 10 such mobile labs in the NGB. To secure it, we need an MOU for the equipment (the Guard is drafting that) and the DOH will need to authorize the CST members to work under their Clinical Laboratory Improvement Amendments (CLIA) certification.

Kevin Guthrie asked me to help facilitate this. I believe this touches on both DOH and AHCA jurisdiction. The attached emails include background information and the CLIA application. I'll let you know when I receive the NGB MOU for the equipment.

Sincerely,

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, Florida 32399-2100
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

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AMERICAN OVERSIGHT

From:	Davis, Ashley
To:	Jeanne Eckes; Fitzgerald, John M CDR
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian
Subject:	RE: [EXTERNAL] Re: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 8:30:46 AM

I have copied in Ops (Ian) to assist us. Thank you, Ash

From: Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Sent: Friday, March 20, 2020 8:28 AM
To: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Cc: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] Re: MS Marina (Oceania) - awareness???

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Thanks

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Jeanne

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Emergency Management & Medical Operations (EMMO)
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AMERICAN OVERSIGHT

On Mar 20, 2020, at 7:30 AM, Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil> wrote:

Jeanne,

Passed yesterday to Ashley and ESF-8 that vessel is off Panama and is tentative for arrival in Miami on March 23. Will keep tracking this one.

v/r,

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 6:31 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Subject: [Non-DoD Source] RE: MS Marina (Oceania) - awareness???

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
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Subject:	RE: [EXTERNAL] Re: MS Marina (Oceania) - awareness???
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Cc: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

AMERICAN OVERSIGHT

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Subject: MS Marina (Oceania) - awareness???

Sam/Ashley

This is the string I got below and why I asked if you had this ship on the radar. Let me know if you find something out. HHS has no ask….we just want to make sure you are aware this may be headed to Miami.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

18MAR: Indications that an Oceania cruise ship will be arriving at Port of Miami sometime next week with various COVID-19 positives on it. Consular Affairs from the Australian Embassy contacted to say they had been notified overnight that the MS Marina (Oceania) is returning to Miami from South America via the Panama Canal after it was denied docking by several countries. The latest advice the Embassy has is that it is passing through the Canal could take 5 or 6 days. Australian Embassy in Mexico and Honorary Consul in Panama are trying to assist at least 49 Australians on board - some of whom are starting to run short of medications etc. - but are having difficulty contacting the crew and Oceania's agents in Panama. CONS provided them with the contact for Norwegian cruise lines which is a parent company of Oceania. OFM indicates Port of Miami is not aware of the ship coming to Miami and questioned where it would even dock as all available ports are occupied. OFM in touch with Norwegian.

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Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:16:49 PM
Attachments:	SOP for disembarking international cruise ships with passengers arriving in charter flights (ver 3_17_2020).docx

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.

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a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

    i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

    ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 1:57 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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AMERICAN OVERSIGHT

<PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
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Tyler

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

AMERICAN OVERSIGHT

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

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> All -

AMERICAN OVERSIGHT

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
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WHA/BSC
SparksTk@state.gov

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 8:16:27 PM

The flight will be arriving at Terminal J, Gate TBD at MIA tomorrow morning at 9:10am.

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The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 10:19:50 PM

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

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Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

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> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
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> Centers for Disease Control and Prevention
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> 1600 Clifton Road
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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 10:36:03 PM

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to

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fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

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At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:20:41 PM

Also – forgot to add that the Florida Surgeon General, Dr Scott Rivkees, who is now included on the emails, has asked CDC to pass on his request that passengers wear surgical masks, if available, on the charter flight, arriving in Miami.

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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.

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4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf
    b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>

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Sent: Monday, March 16, 2020 2:20 PM
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All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

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U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:22:37 PM

Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

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Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC

AMERICAN OVERSIGHT

c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.

d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.

2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
   a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking

   b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.

3. Passengers without any symptoms can board charter flights.

4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US

5. Upon arrival at airport in US
   a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.

   b. CDC Quarantine Station staff are available for illness response, as per protocol.

   c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.

   d. Passengers who are not ill will be allowed to continue their travel on commercial flights.

6. After arrival
   a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.

   b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.

7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
   a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

      i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

      ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

   b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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Sorry - now with Eleni from RC. Again, due-outs are:

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Cindy R. Friedman, MD

Centers for Disease Control and Prevention

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Atlanta, GA 30329

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Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:26:34 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png

Thanks Michelle.

Can I share this with ANVISA, for their awareness?

Is there anything else you need from ANVISA at this point? Is RC in contact with them for the ground logistics?

Just making sure all the loops are closed.

Amy

Amy DuBois MD MPH FACS
CAPT, US Public Health Service
Health Attaché | U.S. Department of Health and Human Services (HHS)
U.S. Embassy | Brasilia
☎ +55 61 3312-7569 | +55 61 982248700 | ✉ duboisae@state.gov

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5. Upon arrival at airport in US
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Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send

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manifests for four ships

Tyler

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329

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470-487-4373

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All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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Tyler

Tyler Sparks
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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Dubois, Amy E; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:39:51 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png

Most definitely!

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 2:29 PM
To: Dubois, Amy E <DuboisAE@state.gov>; Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: Re: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Yes, feel free to share. I don't think anything else is needed in terms of our collaboration with Brazilian health colleagues.

Eleni - could you kindly confirm that RC is in touch with Brazilian authorities for on the ground issues?

From: Dubois, Amy E <DuboisAE@state.gov>
Sent: Tuesday, March 17, 2020 2:26:28 PM

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To: Eleni Kalisch <ekalisch@rccl.com>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Thanks Michelle.

Can I share this with ANVISA, for their awareness?

Is there anything else you need from ANVISA at this point? Is RC in contact with them for the ground logistics?

Just making sure all the loops are closed.

Amy

Amy DuBois MD MPH FACS
CAPT, US Public Health Service
Health Attaché | U.S. Department of Health and Human Services (HHS)
U.S. Embassy | Brasilia
☎ +55 61 3312-7569 | +55 61 982248700 | ✉ duboisae@state.gov

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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
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Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire

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completed

a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking

b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.

3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf
    b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>

Sent: Tuesday, March 17, 2020 1:57 PM

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+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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Senior Brazil Desk Officer
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Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:25:03 PM

Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

Until then, I will arrange for Dr. Green to receive 60 Quest Novel Coronavirus (2019-nCoV)/COVID-19 test kits from my office, so that he can make final determinations on those who are ill. Ms. Stephanie Buchler will follow Quest collection instructions and will ensure courier specimen pickup, if necessary.

Dr. Green will direct his Medical staff to triage the arrival of these patients to either Jackson Memorial Hospital or Hotel St. Michel in Coral Gables, depending on their physical condition.

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To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

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Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
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    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at

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https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Senior Brazil Desk Officer
WHA/BSC

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AMERICAN OVERSIGHT

added Rachel , Michelle and Shannon

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329

470-487-4373

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All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

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Tyler Sparks
U.S. Department of State
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SparksTk@state.gov

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To:	Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:32:27 PM

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
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> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:50:56 PM

Dear Eleni,
Could you kindly clarify Dr. Green at CDC? Is that CDC as in Centers for Disease Control and Prevention or is that a typo? If yes, we do not know him – could you kindly share his contact information?

Most importantly, you need to work with and have the approval of the Florida State and Local Health Departments – Dr. Rivkees, the Florida Surgeon General and Dr. Roberson, the Deputy Surgeon General are on this email.

Best,
Michelle

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Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

Until then, I will arrange for Dr. Green to receive 60 Quest Novel Coronavirus (2019-nCoV)/COVID-19 test kits from my office, so that he can make final determinations on those who are ill. Ms. Stephanie Buchler will follow Quest collection instructions and will ensure courier specimen pickup, if necessary.

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Dr. Green will direct his Medical staff to triage the arrival of these patients to either Jackson Memorial Hospital or Hotel St. Michel in Coral Gables, depending on their physical condition.

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any passengers who become ill during travel and to assist at arrival in US

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7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
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<Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Sent: Monday, March 16, 2020 3:27 PM
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Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
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Tyler

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM

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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Roberson, Shamarial (CDC flhealth.gov); scott.rivkees@flhealth.gov
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM)
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:56:07 PM

Here is his background. The reference to CDC was provided by the Royal Caribbean doctor who shared his information with me.

https://doctors.umiamihealth.org/provider/Barth+Armand+Green/525094

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From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 7:51 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Dubois, Amy E <DuboisAE@state.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; scott.rivkees@flhealth.gov
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Dear Eleni,
Could you kindly clarify Dr. Green at CDC? Is that CDC as in Centers for Disease Control and Prevention or is that a typo? If yes, we do not know him – could you kindly share his contact information?

Most importantly, you need to work with and have the approval of the Florida State and Local Health Departments – Dr. Rivkees, the Florida Surgeon General and Dr. Roberson, the Deputy Surgeon General are on this email.

Best,
Michelle

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 7:25 PM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E

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<DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

Until then, I will arrange for Dr. Green to receive 60 Quest Novel Coronavirus (2019-nCoV)/COVID-19 test kits from my office, so that he can make final determinations on those who are ill. Ms. Stephanie Buchler will follow Quest collection instructions and will ensure courier specimen pickup, if necessary.

Dr. Green will direct his Medical staff to triage the arrival of these patients to either Jackson Memorial Hospital or Hotel St. Michel in Coral Gables, depending on their physical condition.

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EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

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ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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Tyler Sparks
Senior Brazil Desk Officer
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AMERICAN OVERSIGHT

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>
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>
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>
> I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller

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group of folks working on the Brazil/Chile RC ships.

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 1:57:31 PM

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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From: Sparks, Tyler K

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Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
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> Centers for Disease Control and Prevention
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> Atlanta, GA 30329
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> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
> **To:** Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife)

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<BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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Subject: RE: [External] Re: communications test
Date: Friday, March 13, 2020 2:19:35 PM

Can everyone please STOP replying all? Please and thank you!

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Contact OSH's Compliance Hotline: 866-244-0486 to anonymously report possible illegal, unethical, or improper conduct.

From: Deborah Anderson <deanderson@signaturehomenow.com>
Sent: Friday, March 13, 2020 1:11 PM
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Subject: [External] Re: communications test

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~ Passion to Service ~

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Douglas
Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Subject: RE: [External] Re: communications test
Date: Friday, March 13, 2020 1:19:00 PM

Can everyone please STOP replying all? Please and thank you!

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Contact OSH's Compliance Hotline: 866-244-0486 to anonymously report possible illegal, unethical, or improper conduct.

From: Deborah Anderson <deanderson@signaturehomenow.com>
Sent: Friday, March 13, 2020 1:11 PM
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Subject: [External] Re: communications test

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yes

TOMMY JOHNSON, Maintenance Supervisor

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~ Passion to Service ~

From: Ann Hill <ann.echcc@gmail.com>
Sent: Friday, March 13, 2020 12:31:22 PM
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Douglas
Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Kennedy, Ellen
To:	"Sudden, Terri M"; Anderton, David; "Burdian, JoAnn F CAPT"; Wiltshire, Glenn; Jones, Dan C CAPT; KRALICK, DEANNA M; Thaqi, Paula M; fdecenteceo@cdc.gov
Cc:	D07-SMB-SECMIAPreventionsArrivals; Lavan, Ken; Neiman, Jason A. LCDR; Silva, Anna; Henbest, Harris; Montfort, Alinda; Rossman, Richard; Lewis, David; Jenkins, Robert; D07-DG-SECMIAMI-IMT-SITL; Perez, Jose A CDR; Lavin, Kara M CDR; Papas, Christopher D LT; Briggs, Christopher M LCDR; White, Jeff; Pennypacker, William; "Cathcart, Christopher"
Subject:	RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20
Date:	Tuesday, March 24, 2020 12:06:37 PM

This is a developing situation. Here is what Holland America posted on their website yesteday.

ZAANDAM: This morning aboard Zaandam, 13 guests and 29 crew reported to the ship's medical center with influenza-like symptoms. Out of an abundance of caution, we have now asked all guests to remain in their staterooms until we have more information. There are 1,243 guests and 586 crew on board.

Zaandam is following the response protocols that have been developed in coordination with the U.S. Centers for Disease Control and Prevention (CDC). Since it is flu season, and COVID-19 testing is not available on board, it is difficult to determine the cause of these elevated cases at this time.

The safety and well-being of our guests and crew is one of our highest priorities. The ship has activated these precautionary measures out of an abundance of caution:

As is our standard practice, all ill persons have been isolated and their close contacts placed in quarantine.
Guests have been asked to remain in their staterooms and monitor their health. If they become symptomatic, they are asked to call the medical center for an evaluation and care from the ship's medical professionals (at no charge).
Effective today, meal service will be provided by room service until further notice. All public areas are closed.
The entire ship is operating at maximum sanitation levels, including rigorous cleaning and disinfecting of public and crew areas.
Crew who are not required for the safe operation of the ship are being quarantined. Those that are needed to maintain the ship's operation are being asked to self-isolate when not performing essential functions, practice social distancing, self-monitor and report any illness to the Medical Center.
Both internet and guest stateroom telephone services remain complimentary so that guests may stay in touch with their families.
Zaandam was sailing a South America voyage that departed Buenos Aires, Argentina, on March 7 and was originally scheduled to end in San Antonio, Chile, on March 21. However, due to global health concerns, Holland America Line made the decision to suspend its global cruise operations for 30 days and end its current cruises in progress as quickly as possible and return guests home. Despite previous confirmations that guests could disembark in Punta Arenas, Chile, for flights, we were not permitted to do so. No one has been off the ship since March 14 in Punta Arenas.

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Zaandam then sailed to Valparaiso, Chile, where it remained at anchor March 20-21 while taking on provisions and fuel, including regular medications for those that needed them. Zaandam departed Valparaiso on March 21 and is currently sailing north. Our intention is to proceed to Fort Lauderdale, Florida, for arrival on March 30, however we are still working on securing a reservation to transit the Panama Canal. Alternative options are also being developed.

From: Sudden, Terri M <Terri.Sudden@flhealth.gov>
Sent: Tuesday, March 24, 2020 11:13 AM
To: Anderton, David <DANDERTON@broward.org>; 'Burdian, JoAnn F CAPT' <JoAnn.F.Burdian@uscg.mil>; Wiltshire, Glenn <GWILTSHIRE@broward.org>; Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>; KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; fdecenteceo@cdc.gov
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Subject: RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

External Email

Well this is what we are seeing:

https://wgntv.com/news/a-cruise-ship-with-42-people-experiencing-flu-like-symptoms-is-headed-to-florida/

Terri Sudden, Director
Public Health Preparedness
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Florida Health; the first accredited public health system in the U.S.

Mission: To protect, promote & improve the health of all people in Florida through integrated

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state, county, & community efforts.

Vision: To be the Healthiest State in the Nation

Values: (ICARE)

I nnovation: We search for creative solutions and manage resources wisely.

C ollaboration: We use teamwork to achieve common goals & solve problems.

A ccountability: We perform with integrity & respect.

R esponsiveness: We achieve our mission by serving our customers & engaging our partners.

E xcellence: We promote quality outcomes through learning & continuous performance improvement.

From: Anderton, David <DANDERTON@broward.org>
Sent: Tuesday, March 24, 2020 10:26 AM
To: 'Burdian, JoAnn F CAPT' <JoAnn.F.Burdian@uscg.mil>; Wiltshire, Glenn <GWILTSHIRE@broward.org>; Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>; KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; fdecenteceo@cdc.gov
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>; Sudden, Terri M <Terri.Sudden@flhealth.gov>; Lavan, Ken <KLAVAN@broward.org>; Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>; Silva, Anna <ansilva@broward.org>; Henbest, Harris <Harris_Henbest@sheriff.org>; Montfort, Alinda <AMONTFORT@broward.org>; Rossman, Richard <Richard_Rossman@sheriff.org>; Lewis, David <David_Lewis@sheriff.org>; Jenkins, Robert <rojenkins@broward.org>; Kennedy, Ellen <EKENNEDY@broward.org>; D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>; Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>; Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>; Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>; White, Jeff <JEWHITE@broward.org>; Pennypacker, William <William_Pennypacker@sheriff.org>; 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>
Subject: RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

Port Everglades concurs.

J. David Anderton II, AICP, PPM
Assistant Director of Port Everglades
Port Everglades Department
1850 Eller Drive, Suite 604
Fort Lauderdale, Florida 33316-4201
(954) 468-0144

From: Burdian, JoAnn F CAPT <JoAnn.F.Burdian@uscg.mil>
Sent: Tuesday, March 24, 2020 10:17 AM
To: Wiltshire, Glenn <GWILTSHIRE@broward.org>; Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>;

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KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>; paula.thaqi@flhealth.gov; fdecenteceo@cdc.gov
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>; terri.sudden@flhealth.gov; Lavan, Ken <KLAVAN@broward.org>; Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>; Anderton, David <DANDERTON@broward.org>; Silva, Anna <ansilva@broward.org>; Henbest, Harris <Harris_Henbest@sheriff.org>; Montfort, Alinda <AMONTFORT@broward.org>; Rossman, Richard <Richard_Rossman@sheriff.org>; Lewis, David <David_Lewis@sheriff.org>; Jenkins, Robert <rojenkins@broward.org>; Kennedy, Ellen <EKENNEDY@broward.org>; D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>; Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>; Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>; Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>; White, Jeff <JEWHITE@broward.org>; Pennypacker, William <William_Pennypacker@sheriff.org>; 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>
Subject: RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

External Email

All,
I propose we add PEV Pilots to the UC. Please provide concurrence; CG will execute.

Thank you,
JFB

From: Wiltshire, Glenn <GWILTSHIRE@broward.org>
Date: Thursday, Mar 19, 2020, 18:28
To: Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>, KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>, paula.thaqi@flhealth.gov <paula.thaqi@flhealth.gov>, fdecenteceo@cdc.gov <fdecenteceo@cdc.gov>
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>, terri.sudden@flhealth.gov <terri.sudden@flhealth.gov>, Lavan, Ken <KLAVAN@broward.org>, Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>, Anderton, David <DANDERTON@broward.org>, Silva, Anna <ansilva@broward.org>, Henbest, Harris <Harris_Henbest@sheriff.org>, Montfort, Alinda <AMONTFORT@broward.org>, Rossman, Richard <Richard_Rossman@sheriff.org>, Lewis, David <David_Lewis@sheriff.org>, Jenkins, Robert <rojenkins@broward.org>, Kennedy, Ellen <EKENNEDY@broward.org>, D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>, Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>, Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>, Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>, Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>, White, Jeff <JEWHITE@broward.org>, Pennypacker, William <William_Pennypacker@sheriff.org>, 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>, Burdian, JoAnn F CAPT <JoAnn.F.Burdian@uscg.mil>
Subject: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

As discussed briefly during Wednesday morning's Unified Command meeting, attached is the Port Everglades Harbormaster report of vessels currently in Port Everglades and those that have

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submitted berth applications to enter the port on March 20th. Would appreciate a review against any USCG, CDC, CBP, and FDOH data to verify that all of the ships currently in port or scheduled to arrive tomorrow have no open health issues.

Regards,

Glenn

Glenn A Wiltshire

Acting Chief Executive & Port Director
Broward County Port Everglades Department
954-468-3504
954-895-5442 (cell)
954-523-8713 (fax)

Under Florida law, most e-mail messages to or from Broward County employees or officials are public records, available to any person upon request, absent an exemption. Therefore, any e-mail message to or from the County, inclusive of e-mail addresses contained therein, may be subject to public disclosure.

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

To: CDC IMS State Coordination Task Force (SCTF) Operations; Abinash.Achrekar@state.nm.us; adearinger@ky.gov; alexander.billioux@la.gov; Alexander-Scott, Nicole (CDC health.ri.gov); amy.acton@odh.ohio.gov; anne.zink@alaska.gov; Betsey.Tilson@dhhs.nc.gov; Bharel, Monica (CDC state.ma.us); bruce.s.anderson@doh.hawaii.gov; cathy.c.slemp@wv.gov; Christ, Cara (CDC azdhs.gov); Clabaugh, Gerd (CDC idph.iowa.gov); Coleman, Renee (CDC ct.gov); dannette.smith@nebraska.gov; elke.shaw-tulloch@dhw.idaho.gov; Jennifer Dillaha, MD; fran.phillips@maryland.gov; Gary.Anthone@nebraska.gov; GaryC@health.ok.gov; Gholzman@mt.gov; Harrist, Alexia (CDC wyo.gov); Hellerstedt, John (CDC dshs.texas.gov); jan.malcolm@state.mn.us; jeanne.ayers@dhs.wisconsin.gov; jill.hunsakerryan@state.co.us; Judith.Persichilli@doh.nj.gov; Kalani Kaneko, Honorable (CDC gmail.com); kathleen.toomey@dph.ga.gov; kathy.kunkel@state.nm.us; kbox@isdh.in.gov; KhaldunJ@michigan.gov; l.sherych@health.ny.gov; lee.norman@ks.gov; lisa.morris@dhhs.nh.gov; Lisa.Piercey@tn.gov; Malsam-Rysdon, Kim (CDC state.sd.us); mark.benton@dhhs.nc.gov; mark.levine@vermont.gov; Miner, Joseph (CDC utah.gov); mylynntufte@nd.gov; Nesbitt, LaQuandra (CDC dc.gov); Ngozi.Ezike@illinois.gov; nirav.shah@Maine.Gov; norm.oliver@vdh.virginia.gov; ralevine@pa.gov; Randall.williams@health.mo.gov; Rattay, Karyl (CDC state.de.us); rick.toomey@dhec.sc.gov; robert.neall@maryland.gov; Scott.Harris@adph.state.al.us; scott.rivkees@flhealth.gov; sheilahogan@mt.gov; Shirley, Lillian (CDC state.or.us); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; Thomas.Dobbs@msdh.ms.gov; Wiesman, John (CDC doh.wa.gov); Zucker, Howard (CDC health.ny.gov); Catherine.delacruz@salud.pr.gov; DrRafael.Rodriguez@salud.pr.gov; emais.roberts@palauhealth.org; justa.encarnacion@doh.vi.gov; linda.denorcey@dphss.guam.gov; msamo@fsmhealth.fm; Muña, Esther (CDC dph.gov.mp); Nua, Motusa Tuileama (CDC doh.as); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Dreyzehner, John (CDC/DDPHSIS/CPR/OD); Williams, Ian (CDC/DDID/NCEZID/DFWED); CDC IMS State Coordination Task Force (SCTF) Policy & Comm; CDC IMS State Coordination Task Force (SCTF) Lead; Fry, Alicia (CDC/DDID/NCIRD/ID); Weinbaum, Cindy (CDC/DDID/NCIRD/ISD); a.tufa@doh.as; Dunn, Angela (CDC utah.gov); ann.pobutsky@dphss.guam.gov; Bandy, Utpala (CDC health.ri.gov); Bell, Linda (CDC dhec.sc.gov); benjamin.chan@dhhs.nh.gov; Bennett, Siiri (CDC maine.gov); Blackmore, Carina (CDC flhealth.gov); Blog, Debra (CDC health.ny.gov); Blythe, David (CDC maryland.gov); Burnsed, Laurence (CDC health.ok.gov); caitlin.pedati@idph.iowa.gov; carmen.deseda@salud.pr.gov; Cartter, Matthew (CDC ct.gov); catherine.brown@state.ma.us; Chavez, Gilbert (CDC cdph.ca.gov); Clayton, Joshua (CDC state.sd.us); Cragin, Lori (CDC vermont.gov); Davidson, Sherri (CDC adph.state.al.us); Davies-Cole, John (CDC dc.gov); deFijter, Sietske (CDC odh.ohio.gov); Del Rosario, Maria (CDC wv.gov); Thoroughman, Douglas (CDC ky.gov); Drenzek, Cherie (CDC dph.ga.gov); Ellis, Esther (CDC doh.vi.gov); farah.ahmed@ks.gov; george.turabelidze@health.mo.gov; Herlihy, Rachel (CDC state.co.us); James.Rajotte@health.ri.gov; jonathan.meiman@dhs.wisconsin.gov; Jones, Tim F. (CDC tn.gov); Kelso, Patsy (CDC vermont.gov); Komatsu, Kenneth (CDC azdhs.gov); Landen, Michael (CDC state.nm.us); Larson, Sandra (CDC health.nv.gov); Layden, Jennifer (CDC cityofchicago.org); lilian.peake@vdh.virginia.gov; Lynfield, Ruth (CDC state.mn.us); lyoncallos@michigan.gov; McLaughlin, Joseph (CDC alaska.gov); Miller, Tracy (CDC nd.gov); Moore, Zackary (CDC dhhs.nc.gov); mpeekbullock@health.nv.gov; paul.byers@msdh.ms.gov; paul.white@dph.gov.mp; Pontones, Pamela (CDC isdh.in.gov); Ratard, Raoult (CDC la.gov); sarah.park@doh.hawaii.gov; Watkins, Sharon; Skilling, Vita A. (CDC fsmhealth.fm); tabatha.offutt-powell@state.de.us; Tan, Christina (CDC doh.state.nj.us); thomas.l.jeanne@state.or.us; Tolliver, Rickey (CDC state.co.us); Wasserman, Cathy (CDC doh.wa.gov); Shah, Dhara (CDC cste.org); Marcus Plescia; Blumenstock, Jim (CDC astho.org); Elizabeth.Daly@dhhs.nh.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; CDC IMS State Coordination Task Force (SCTF) EPI LNO; Engel, Jeff (CDC cste.org); Lichtenstein, Meredith (CDC cste.org); CDC IMS State Coordination Task Force (SCTF) GMTF LNO; Bowman, Thomas (OS/ASPR/EMMO); Gold, Rebecca (CDC/DDID/NCEZID/OD); "Daniel.huff@state.mn.us"; Daniel, Katherine Lyon (CDC/DDPHSIS/OD); CDC IMS 2019 NCOV Response Policy; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); "steven.stack@ky.gov"; Burns, Erin (CDC/DDID/NCIRD/ID); "MELISSA.E.POWELL@dhsoha.state.or.us"; CDC IMS State Coordination Task Force (SCTF) EOC Desk; "Stephen.Pont@dshs.texas.gov"; Weir, Charles (OS/ASPR/IO); Yeskey, Kevin (OS/ASPR/IO); Greene, Jonathan (OS/ASPR/EMMO); Baker, Michael (OS/IEA); Watson, John (CDC/DDID/NCIRD/DVD); "karyl.rattay@delaware.gov"; "bbilimon@hotmail.com"; Louie, Shirley (CDC arkansas.gov); "im.lno@hhs.gov"; Caceres, Victor (CDC/DDPHSIS/CPR/DSLR); McCarty, Colleen (CDC/OD/OADPS); Sloan, Katrina (CDC/OD/OCS)

Cc: Randolph, Jean (CDC/DDPHSIS/CPR/DSLR); Gallo, Bill (CDC/DDPHSIS/CSTLTS/OD); CDC IMS State Coordination Task Force (SCTF) Partner Share; Hawkins-Prather, Devi I. (CDC/DDPHSIS/CSTLTS/DPPS); CDC IMS State Coordination Task Force (SCTF) MCCM LNO; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD); Lindquist, Scott SL (CDC doh.wa.gov); Williamson, Laura (CDC mt.gov); Peart, Jordan (CDC cste.org); Hamilton, Janet (CDC cste.org); Roush, Sandra (CDC/DDID/NCIRD/OD); Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR); Friday, James (CDC/DDPHSIS/CPR/DSLR)

Subject: RE: **Extended** State Health Official & State Epi Touchbase

Date: Thursday, March 19, 2020 5:24:53 PM

Attachments: Scarce Resource Management and Crisis Standards of Care Overview and Materials 2020-3-16.pdf
COVID19 PPT Healthsystems preparedness two weeks 3.19.2020 final.pdf

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Dear Colleagues:

As a follow-up to today's Crisis Standards of Care in Response to COVID-19 webinar, please see the attached slide deck and the Washington State Department of Health Crisis Standard of Care packet.

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Please send any additional questions to preparedness@cdc.gov.

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

-----Original Appointment-----
From: CDC IMS State Coordination Task Force (SCTF) Operations <eocsctfops@cdc.gov>
Sent: Monday, February 3, 2020 6:15 PM
To: CDC IMS State Coordination Task Force (SCTF) Operations; Abinash.Achrekar@state.nm.us; adearinger@ky.gov; alexander.billioux@la.gov; Alexander-Scott, Nicole (CDC health.ri.gov); amy.acton@odh.ohio.gov; anne.zink@alaska.gov; Betsey.Tilson@dhhs.nc.gov; Bharel, Monica (CDC state.ma.us); bruce.s.anderson@doh.hawaii.gov; cathy.c.slemp@wv.gov; Christ, Cara (CDC azdhs.gov); Clabaugh, Gerd (CDC idph.iowa.gov); Coleman, Renee (CDC ct.gov); dannette.smith@nebraska.gov; elke.shaw-tulloch@dhw.idaho.gov; Jennifer Dillaha, MD; fran.phillips@maryland.gov; Gary.Anthone@nebraska.gov; GaryC@health.ok.gov; Gholzman@mt.gov; Harrist, Alexia (CDC wyo.gov); Hellerstedt, John (CDC dshs.texas.gov); jan.malcolm@state.mn.us; jeanne.ayers@dhs.wisconsin.gov; jill.hunsakerryan@state.co.us; Judith.Persichilli@doh.nj.gov; Kalani Kaneko, Honorable (CDC gmail.com); kathleen.toomey@dph.ga.gov; kathy.kunkel@state.nm.us; kbox@isdh.in.gov; KhaldunJ@michigan.gov; l.sherych@health.nv.gov; lee.norman@ks.gov; lisa.morris@dhhs.nh.gov; Lisa.Piercey@tn.gov; Malsam-Rysdon, Kim (CDC state.sd.us); mark.benton@dhhs.nc.gov; mark.levine@vermont.gov; Miner, Joseph (CDC utah.gov); mylynntufte@nd.gov; Nesbitt, LaQuandra (CDC dc.gov); Ngozi.Ezike@illinois.gov; nirav.shah@Maine.Gov; norm.oliver@vdh.virginia.gov; ralevine@pa.gov; Randall.williams@health.mo.gov; Rattay, Karyl (CDC state.de.us); rick.toomey@dhec.sc.gov; robert.neall@maryland.gov; Scott.Harris@adph.state.al.us; scott.rivkees@flhealth.gov; sheilahogan@mt.gov; Shirley, Lillian (CDC state.or.us); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; Thomas.Dobbs@msdh.ms.gov; Wiesman, John (CDC doh.wa.gov); Zucker, Howard (CDC health.ny.gov); Catherine.delacruz@salud.pr.gov; DrRafael.Rodriguez@salud.pr.gov; emais.roberts@palauhealth.org; justa.encarnacion@doh.vi.gov; linda.denorcey@dphss.guam.gov; msamo@fsmhealth.fm; Muña, Esther (CDC dph.gov.mp); Nua, Motusa Tuileama (CDC doh.as); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Dreyzehner, John (CDC/DDPHSIS/CPR/OD); Williams, Ian (CDC/DDID/NCEZID/DFWED); CDC IMS State Coordination Task Force (SCTF) Policy & Comm; CDC IMS State Coordination Task Force (SCTF) Lead; Fry, Alicia (CDC/DDID/NCIRD/ID); Weinbaum, Cindy (CDC/DDID/NCIRD/ISD); a.tufa@doh.as; Dunn, Angela (CDC utah.gov); ann.pobutsky@dphss.guam.gov; Bandy, Utpala (CDC health.ri.gov); Bell, Linda (CDC

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dhec.sc.gov); benjamin.chan@dhhs.nh.gov; Bennett, Siiri (CDC maine.gov); Blackmore, Carina (CDC flhealth.gov); Blog, Debra (CDC health.ny.gov); Blythe, David (CDC maryland.gov); Burnsed, Laurence (CDC health.ok.gov); caitlin.pedati@idph.iowa.gov; carmen.deseda@salud.pr.gov; Cartter, Matthew (CDC ct.gov); catherine.brown@state.ma.us; Chavez, Gilbert (CDC cdph.ca.gov); Clayton, Joshua (CDC state.sd.us); Cragin, Lori (CDC vermont.gov); Davidson, Sherri (CDC adph.state.al.us); Davies-Cole, John (CDC dc.gov); deFijter, Sietske (CDC odh.ohio.gov); Del Rosario, Maria (CDC wv.gov); Thoroughman, Douglas (CDC ky.gov); Drenzek, Cherie (CDC dph.ga.gov); Ellis, Esther (CDC doh.vi.gov); farah.ahmed@ks.gov; george.turabelidze@health.mo.gov; Herlihy, Rachel (CDC state.co.us); James.Rajotte@health.ri.gov; jonathan.meiman@dhs.wisconsin.gov; Jones, Tim F. (CDC tn.gov); Kelso, Patsy (CDC vermont.gov); Komatsu, Kenneth (CDC azdhs.gov); Landen, Michael (CDC state.nm.us); Larson, Sandra (CDC health.nv.gov); Layden, Jennifer (CDC cityofchicago.org); lilian.peake@vdh.virginia.gov; Lynfield, Ruth (CDC state.mn.us); lyoncallos@michigan.gov; McLaughlin, Joseph (CDC alaska.gov); Miller, Tracy (CDC nd.gov); Moore, Zackary (CDC dhhs.nc.gov); mpeekbullock@health.nv.gov; paul.byers@msdh.ms.gov; paul.white@dph.gov.mp; Pontones, Pamela (CDC isdh.in.gov); Ratard, Raoult (CDC la.gov); sarah.park@doh.hawaii.gov; Watkins, Sharon; Skilling, Vita A. (CDC fsmhealth.fm); tabatha.offutt-powell@state.de.us; Tan, Christina (CDC doh.state.nj.us); thomas.l.jeanne@state.or.us; Tolliver, Rickey (CDC state.co.us); Wasserman, Cathy (CDC doh.wa.gov); Shah, Dhara (CDC cste.org); Marcus Plescia; Blumenstock, Jim (CDC astho.org); Elizabeth.Daly@dhhs.nh.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; CDC IMS State Coordination Task Force (SCTF) EPI LNO; Engel, Jeff (CDC cste.org); Lichtenstein, Meredith (CDC cste.org); CDC IMS State Coordination Task Force (SCTF) GMTF LNO; Bowman, Thomas (OS/ASPR/EMMO); Gold, Rebecca (CDC/DDID/NCEZID/OD); 'Daniel.huff@state.mn.us'; Daniel, Katherine Lyon (CDC/DDPHSIS/OD); CDC IMS 2019 NCOV Response Policy; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); 'steven.stack@ky.gov'; Burns, Erin (CDC/DDID/NCIRD/ID); 'MELISSA.E.POWELL@dhsoha.state.or.us'; CDC IMS State Coordination Task Force (SCTF) EOC Desk; 'Stephen.Pont@dshs.texas.gov'; Weir, Charles (OS/ASPR/IO); Yeskey, Kevin (OS/ASPR/IO); Greene, Jonathan (OS/ASPR/EMMO); Baker, Michael (OS/IEA); Watson, John (CDC/DDID/NCIRD/DVD); 'karyl.rattay@delaware.gov'; 'bbilimon@hotmail.com'; Louie, Shirley (CDC arkansas.gov); 'im.lno@hhs.gov'; Caceres, Victor (CDC/DDPHSIS/CPR/DSLR); McCarty, Colleen (CDC/OD/OADPS); Sloan, Katrina (CDC/OD/OCS)

Cc: Randolph, Jean (CDC/DDPHSIS/CPR/DSLR); Gallo, Bill (CDC/DDPHSIS/CSTLTS/OD); CDC IMS State Coordination Task Force (SCTF) Partner Share; Hawkins-Prather, Devi I. (CDC/DDPHSIS/CSTLTS/DPPS); CDC IMS State Coordination Task Force (SCTF) MCCM LNO; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD); Lindquist, Scott SL (CDC doh.wa.gov); Williamson, Laura (CDC mt.gov); Peart, Jordan (CDC cste.org); Hamilton, Janet (CDC cste.org); Roush, Sandra (CDC/DDID/NCIRD/OD); Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR); Friday, James (CDC/DDPHSIS/CPR/DSLR)

Subject: **Extended**State Health Official & State Epi Touchbase

When: Thursday, March 19, 2020 4:30 PM-5:30 PM (UTC-05:00) Eastern Time (US & Canada).

Where: Building 21, 5th Fl. 5116 OR Bridgeline: 1(888)455-7719 Participant Passcode: 1232930

****Please note – During today's touchbase we will cover the following, via webinar (link provided below):**

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Crisis Standards of Care in Response to COVID-19: Background and tools - Satish Pillai
- Legal Considerations for Crisis Standards of Care- Gregory Sunshine
- Washington State Experience with Crisis Standards of Care to COVID-19 - Kathy Lofy

CDC's 2019 Novel Coronavirus (2019-nCoV) IM leadership team will host a recurring weekly call series, twice a week (Tuesday's and Thursday's), from 4:30 p.m. to 5:00 p.m., to provide a platform to discuss relevant response matters with state health officials and state epidemiologists. Please extend this invite to other core members of your team.

Bridgeline: 1(888)455-7719
Participant Passcode: 1232930

For Participants:
URL: https://www.mymeetings.com/nc/join/
Conference number: PWXW1022793
Audience passcode: 1232930

Participants can join the event directly at:
https://www.mymeetings.com/nc/join.php?i=PWXW1022793&p=1232930&t=c

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

(Sent by BCC to state health officials and State epidemiologists)

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
To: Blackmore, Carina (CDC flhealth.gov)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: RE: cdc consult
Date: Wednesday, March 11, 2020 9:17:47 PM

Dr. Blackmore:

Caroline is not working tonight, but I'm happy to work with you and discuss any questions. I think our cruise ship team is likely the best group to involve with this. I can see if they are able to discuss tonight, but it might be tomorrow AM before we are able to pull everyone together. Would that be OK? I'm also happy to have a call with you to clarify the questions as well before we set up the larger conference call. Let me know what would be best-

Thanks-

Sara Oliver, MD, MSPH
LCDR, U.S. Public Health Service
Medical Director, CDC COVID Clinical Call Unit
email: yxo4@cdc.gov

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:15 PM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi Caroline. We would be interested in a consult to discuss the port situation and your recommendations to minimize exposure to employees and passengers. Are u still willing to set this up? Thanks Carina

Get Outlook for iOS

From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

I communicated to our morning team that there was follow up needed with you all.

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Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: Re: cdc consult

Did you not hear from anyone today?

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

Caroline Schrodt

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
To: Blackmore, Carina (CDC flhealth.gov)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: RE: cdc consult
Date: Wednesday, March 11, 2020 9:23:43 PM

Great- thanks will do!

Sara

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 9:19 PM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Tomorrow sounds great!

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Wednesday, March 11, 2020 9:17:45 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

Caroline is not working tonight, but I'm happy to work with you and discuss any questions. I think our cruise ship team is likely the best group to involve with this. I can see if they are able to discuss tonight, but it might be tomorrow AM before we are able to pull everyone together. Would that be OK? I'm also happy to have a call with you to clarify the questions as well before we set up the larger conference call. Let me know what would be best-

Thanks-

Sara Oliver, MD, MSPH
LCDR, U.S. Public Health Service
Medical Director, CDC COVID Clinical Call Unit
email: yxo4@cdc.gov

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:15 PM

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To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi Caroline. We would be interested in a consult to discuss the port situation and your recommendations to minimize exposure to employees and passengers. Are u still willing to set this up? Thanks Carina

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Subject: RE: cdc consult

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
To: Blackmore, Carina (CDC flhealth.gov)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: RE: cdc consult
Date: Tuesday, March 10, 2020 11:30:48 PM

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Thank you.

Caroline Schrodt

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From: Jenna McElvea

To: Johnson, Tommy; Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Barlow; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: RE: communications test
Date: Friday, March 13, 2020 6:25:59 PM

yes



Healthy **O**ptions for **P**ersonal **E**mpowerment

Jenna McElyea, MBA, LPN
Behavioral Wellness Clinic Program Manager
Bridgeway Center, Inc
137 Hospital Dr.
Ft. Walton Beach FL 32548
850-833-7500 ext 211
850-419-6921 (C)

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From: Johnson, Tommy <bfmaint@SOUTHERNLTC.COM>
Sent: Friday, March 13, 2020 11:39 AM
To: Ann Hill <ann.echcc@gmail.com>; 21st Century Oncology Inc. <aspurlock@nwcancerclinic.com>; A & J Transport <sandmanwes152003@yahoo.com>; Aaron Otis <Aaron.Otis@flhealth.gov>; Abby Burdeshaw <jcsenior@bellsouth.net>; Adam Principe <aprincipe@selectmedical.com>; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray <agray@bereadyalliance.org>; ajolly@brookdaleliving.com; Alberta Granger <alberta@fala.org>; Alexandra.collins@kindredhospicecare.com; Allison Blevins <Allison.Blevins@flhealth.gov>; Amanda Baker <WashingtonCHD@flhealth.gov>; Amanda Rae Bower <abower03@hotmail.com>; Amber <agant@d-s-i.com>; Amber Smith <Amber.smith16@hcahealthcare.com>; Ami <amireaddy@gmail.com>; Amy Johnson <Amy.Johnson@flhealth.gov>; Angel Barber <angel.barber@azuracare.com>; Angie Bowen <angiebowenlcsw@yahoo.com>; Anita T <AnitaTotten@bereadyalliance.org>; Ann Brown <nonnibrown@bellsouth.net>; Anna Pope <apope@bereadyalliance.org>; Anthony Booth <anthony.booth@doctorsmemorial.org>; Anthony Brown <anbrown@gchc.com>; Aric Porter <aric.porter@flhealth.gov>; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO <michele.asberry@us.af.mil>; Aubrey <southernfamilyh@gmail.com>; Avery, Emily <Emily.Avery@medxcelfm.com>; Batts, Howell T <Howell.Batts@flhealth.gov>; Beasley, Karla <Karla.Beasley@ahca.myflorida.com>; Belie Williams <thevillasgb@cs.com>; Bernard Restrepo <Bernard.restrepo@dph.ga.gov>; Berryhill Manor <berryhillmanor@aim.com>; Bethany.Sanders@angmarcompanies.com; Betsy Schatti <bschatti@pensacolacare.org>; Betty Scott <bscott@holmescountyfl.org>; Bill Storck <BStorck@weemsmemorial.com>; Blitch, Brenda J <Brenda.Blitch@flhealth.gov>; Blood, Joshua <Joshua.Blood@flhealth.gov>; Bonnie Barlow

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~ Passion to Service ~

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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners

Please respond to me only - do not copy all

Please send email answering YES that you received my communication for this test

Thank you

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Subject: RE: communications test
Date: Friday, March 13, 2020 6:25:24 PM

yes



Healthy **O**ptions for **P**ersonal **E**mpowerment

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~ Passion to Service ~

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Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; ~Bell, Jeffrey FA; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Blakely, Danny; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ferland, Ross; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
To:	Roberson, Shamarial (CDC flhealth.gov)
Cc:	White, Stefanie B. (CDC/DDID/NCEZID/DGMQ); Brown, Clive (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject:	RE: costa favalosa and magica
Date:	Wednesday, March 25, 2020 6:11:34 PM

Adding colleagues for awareness

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
Sent: Wednesday, March 25, 2020 5:57 PM
To: Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>
Subject: costa favalosa and magica

9 severely ill crew need medivac; 1 critically ill with RR 30 on O2 with increasing O2 demand and b/l pneumonia in yellow
These are the nine seriously ill crew. Plan being arranged with Cruise company (Carnival/ costa), Coast Guard and Miami regarding medivac of these severely ill 9 patients

Favolosa

Age	Gender
53	M
33	M
47	M
49	M
36	M

Magica

32	MALE
31	MALE
53	MALE
56	MALE

COSTA MAGICA Total crew - 932

- **ILI with flu-like symptoms**

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Total 35

- **Critically ill/unstable**

Total – 4

- March 14 - two positive Covid-19 (1 guest , 1 crew) tested in Martinique
- After positives and guests off ship spread out and isolated except for essential staff
- Isolated sick and positives
- Capacity – has PPE, 2 ICU beds, 2 vents, Oxygen concentrator, CPAP
- Medical staff: 3 MDs /3 RNs (1 was ill and has recovered but still isolated)

COSTA FAVALOSA Total crew - 1010

- **ILI with COVID-19-like symptoms**

Total 53

- **Critically ill/unstable**

Total – 5

- March 15 – 3 positive crew COVID-19 tested in Martinique
  March 18 -1 crew medivac to Guadelupe when out at sea for worsening illness
- After positives and guests off ship spread out and isolated except for essential staff
- Isolated sick and positives
- Capacity – has PPE, 2 ICU beds, 2 vents, Oxygen concentrator, CPAP
- Medical staff: 3 MDs and 4 RNS (1 MD was sick – COVID negative by SCREEN IgG/IgM and returned to work)

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

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From:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To:	Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M; Schmitz, Ann (CDC flhealth.gov)
Subject:	RE: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 12:09:45 PM

Thanks Scott. Lets hold 4-5 pm EST for now. Will follow up with a confirmation once I lock down CDC SMEs.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Anytime between 2-5 could work for me.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Thursday, March 12, 2020 11:29 AM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: Re: remote TA call from CDC - COVID-19

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From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 8:24:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: remote TA call from CDC - COVID-19

Hi Dr. Blackmore,

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Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

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From:	Pritchard, Scott
To:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Blackmore, Carina; Thaqi, Paula M; Jenkins, Patrick H
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Schmitz, Ann
Subject:	RE: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 12:10:42 PM

Dr. Thaqi and Patrick, does this time work for you?

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 12:10 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

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To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Anytime between 2-5 could work for me.

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Bureau of Epidemiology
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Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>

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Subject: Re: remote TA call from CDC - COVID-19

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National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

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From: Schmitz, Ann
To: Pritchard, Scott; Blackmore, Carina; Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M
Subject: RE: remote TA call from CDC - COVID-19
Date: Thursday, March 12, 2020 12:12:46 PM

That window works for me as well.

Ann Schmitz, DVM, AM
CDR, USPHS
Career Epidemiology Field Officer
Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Epidemiology
1325 NW 14th Avenue
Miami, FL 33125
Tel: (305) 325-2547
Fax: (305) 325-2560
Cell: (850) 251-4502
24/7 EPI Hotline: (850) 245-4401
Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Anytime between 2-5 could work for me.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott

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<Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
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O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

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From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To: Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov)
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M; Schmitz, Ann (CDC flhealth.gov)
Subject: RE: remote TA call from CDC - COVID-19
Date: Thursday, March 12, 2020 1:26:49 PM

We are locked in for 4pm EST. Will send out an invite.

Chris

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

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E: fjr0@cdc.gov

AMERICAN OVERSIGHT

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To:	Blackmore, Carina; Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M; Schmitz, Ann
Subject:	RE: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 11:30:22 AM

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Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Sent: Thursday, March 12, 2020 11:29 AM
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Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
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Centers for Disease Control and Prevention

AMERICAN OVERSIGHT

O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From: Amores, Norma A.
To: Gilliard, Deric (HHS/IEA)
Cc: Villalta, Yesenia D
Subject: RE: request for Dr. Yesinia"s cell #
Date: Thursday, March 12, 2020 3:03:38 PM
Attachments: image001.png

Good afternoon Mr. Gilliard,
Thank you for providing the attached and contact information, I shall save this to her Outlook directory. Dr. Villalta's mobile contact as you request is (305) 423-5247

Norma Amores
Florida Department of Health in Miami-Dade County
Administrative Assistant II
Email: Norma.Amores@flhealth.gov
Phone: (786) 336-1259
Mailing Address: 8323 NW 12 STREET Floor: 02 Room: 212 Bin : 212
MIAMI, FL 33126

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From: Gilliard, Deric (HHS/IEA) <deric.gilliard@hhs.gov>
Sent: Thursday, March 12, 2020 2:38 PM
To: Amores, Norma A. <Norma.Amores@flhealth.gov>
Cc: yesinia.villalta@flhealth.gov
Subject: request for Dr. Yesinia's cell #
Importance: High

Hello Norma.

You may recall, your office and I held a call with Dr. Yesinia and her staff late last year to discuss secretarial priorities.
Please accept this cell # for regional director John McGough, (202) 774-7692, in the event she may need to reach him on a pressing matter regarding the coronavirus. Also, I am requesting her cell, in the event we need to do the same, for the spreadsheet we are developing. We will not bother her, otherwise.

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Thanks,

Deric

DERIC GILLIARD, MA
Public Affairs Specialist
U.S. Department of Health and Human Services
Atlanta Federal Center
61 Forsyth St, SW Suite 5B95
Atlanta, GA 30303-8909
Deric.Gilliard@hhs.gov
Twitter: @HHSRegion4
404-562-7910 Office
202-868-9202 Cell

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Torres, Yari; Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Stanek, Danielle R
Subject: Re: Action Required: COVID-19 impact on your polio TDY
Date: Friday, March 13, 2020 5:28:25 AM

Looking forward to seeing yiu

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From: Torres, Yari <Yari.Torres@flhealth.gov>
Sent: Friday, March 13, 2020 3:13:35 AM
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Fwd: Action Required: COVID-19 impact on your polio TDY

FYI- At the moment my new return date is March 24th which is within that time frame, I will let you know if that changes.

Thank you and see you soon!

Yari
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From: Vertefeuille, John F. (CDC/DDPHSIS/CGH/GID) <dki4@cdc.gov>
Sent: Friday, March 13, 2020 3:23:29 AM
To: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP) <pja5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>
Cc: Frank, Daniel (CDC/DDPHSIS/CGH/GID) <fcd3@cdc.gov>; Rouse, Edward N. (CDC/DDPHSIS/CPR/DEO) <dmz0@cdc.gov>; Taylor, Bryan (CDC/DDPHSIS/CPR/DEO) <yzi8@cdc.gov>; Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>; Wiesen, Eric (CDC/DDPHSIS/CGH/GID) <ejw2@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>
Subject: Action Required: COVID-19 impact on your polio TDY

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If you believe that anything may impact your date for return to work at your home office, please let us know and we can reach out to your supervisory chain. New agency guidance regarding post-

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deployment telework and monitoring policies should be coming out by the end of the week and will be sent to you.

Please continue to monitor all information you receive from the post where you are located which may impact your travel, as well as any guidance you receive from the EOC. Thank you for your contributions to polio eradication, the contributions you may be being asked to make regarding COVID-19 in your TDY location, and your commitments to CDC's mission.

John F. Vertefeuille, PhD, MHS
Incident Manager
CDC Polio Activation

AMERICAN OVERSIGHT

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Subject: Re: Action Required: COVID-19 impact on your polio TDY
Date: Friday, March 13, 2020 3:19:45 AM

It is early in the morning... I will let you know my new date of arrival as I am expected to return sooner than the 24th :)

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Sent: Friday, March 13, 2020 7:13:35 AM
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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Incident Manager
CDC Polio Activation

AMERICAN OVERSIGHT

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Blackmore, Carina (CDC flhealth.gov)
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject: Re: CDC Infection Prevention and Control Assistance
Date: Friday, March 20, 2020 3:07:15 PM

Also, please let me know if it is better if I flew in to Fort-Lauderdale airport, given that this is Broward county.
Thanks,
Srinivas

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Sent: Friday, March 20, 2020 2:55 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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Sent: Friday, March 20, 2020 1:59 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>

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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

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Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

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From:	Blackmore, Carina
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial; Pritchard, Scott; Schmitz, Ann; Dotson, Nychie; McCoy, Steve
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 3:45:50 PM

It probably would be better to go to Ft Lauderdale airport
Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051
Agency for Health Care Administration 561-573-5968.

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To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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AMERICAN OVERSIGHT

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Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 3:55:07 PM

Thanks.

Dr. Thaqi - the number doesn't seem to work for me. Could you advise me the address and time where I need to get to tomorrow?
Thanks,
Srinivas

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 2:45:50 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
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AMERICAN OVERSIGHT

From:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
To:	Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial (CDC flhealth.gov); Schmitz, Ann (CDC flhealth.gov); Dotson, Nychie; McCoy, Steve
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 4:00:13 PM

Thanks!

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, March 20, 2020 2:56:18 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

Small correction. Dr. Thaqi's cell is 954-295-9051.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:55 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks.

Dr. Thaqi - the number doesn't seem to work for me. Could you advise me the address and time where I need to get to tomorrow?
Thanks,
Srinivas

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 2:45:50 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

It probably would be better to go to Ft Lauderdale airport
Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051
Agency for Health Care Administration 561-573-5968.

Get Outlook for iOS

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:07:12 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Also, please let me know if it is better if I flew in to Fort-Lauderdale airport, given that this is Broward county.
Thanks,
Srinivas

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Subject: Re: CDC Infection Prevention and Control Assistance

Hi Dr. Blackmore,
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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

Thank you-that sounds like a great plan. Sri should be able to start work with you tomorrow. We are still sorting through the logistics.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 1:59 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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AMERICAN OVERSIGHT

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1. To provide targeted infection control assessment and observation of the affected healthcare facility to included hand hygiene, transmission based precaution use, and environmental cleaning.
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3. Provide technical support on healthcare worker and patient/resident monitoring during this time
4. To build internal capacity within the health departments for these types of assessments moving forward through mechanisms such as tele-infection control assessments (ICAR) or focused onsite ICARs
5. If times allows, to conduct preparedness assessment at other healthcare facilities

We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

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From:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Blackmore, Carina (CDC flhealth.gov)
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 2:55:10 PM

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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

AMERICAN OVERSIGHT

From: McWhorter, Linda
To: Peterson, Amy; LogisticsDesk2; Deleon, Melissa (FLNG); Bequer, Samantha; Guidicelli, Ian; Dumas, Wendell; EOC-Plans; Mahon, Jason; Anspaugh-Naples, Stephanie; courtney.coppola@flhealth.gov; Kincaid, Brooke
Subject: Re: Community Based Testing Sites- SitRep from 3-23-20
Date: Tuesday, March 24, 2020 3:05:03 PM

Change Orlando report - they have one opening.
Add critical need statement: need test kits otherwise testing becomes nonexistent

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On Tue, Mar 24, 2020 at 9:43 AM -0400, "Kincaid, Brooke" <Brooke.Kincaid@em.myflorida.com> wrote:

> All,
>
> Please see the attached SitRep, for personnel and potential burn rates for the Community Based Testing Sites. However, new numbers came in during the morning briefing on tests conducted. The most up to date numbers can be found in below:
>
> Jacksonville- TIAA Stadium
> Federal Tests- 254
> Not Meeting Criteria- 184
>
> Orlando- Convention Center
> First Responder Testing- 3/25
> General Public Testing- 3/26
>
> Broward- CB Smith Park
> Tested- 799
> Not Meeting Criteria- 272
>
> Miami- Hard Rock
> Federal Tests- 200
> State Testing- 575
> Not Meeting Criteria- 187
>
> **Brooke Kincaid, MPA | Recovery Regional Manager and Region 2**
> Bureau of Recovery
> Florida Division of Emergency Management
> *Rebuilding Together*
> (850)-567-6197 (c)
> (850) 815-4437 (o)
> Email: Brooke.Kincaid@em.myflorida.com
>
> *Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.*
>
> Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made

AMERICAN OVERSIGHT

available upon request.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Green, Gary; Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Cc:	Pritchard, Scott
Subject:	Re: Coronavirus Guidance
Date:	Friday, February 28, 2020 6:16:42 PM

Happy to review. Carina

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From: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ) <fba8@cdc.gov>
Sent: Friday, February 28, 2020 5:07:42 PM
To: Green, Gary <Gary.Green@mlb.com>; Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: Coronavirus Guidance

Hi Jon, Gary— Great to hear from you both. Regarding contacts in FL, you may reachbout to Scott and Carina.

Scott.Pritchard@flhealth.gov
carina.blackmore@flhealth.gov

Checking on resource to assist with guidance. What topics were you addressing?
Francisco

From: Green, Gary <Gary.Green@mlb.com>
Sent: Friday, February 28, 2020 5:24 PM
To: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Subject: Re: Coronavirus Guidance

Hi and I'm sure you are inundated with calls. First, thanks for all of your help in the past and appreciate your help on the coronavirus. I have been in contact with the Maricopa and Pima County health departments regarding our teams that are training in Arizona. Florida is much more complicated as our teams are spread out throughout the state. I was wondering if you have a contact at the Florida Public Health for me to reach out to regarding our teams training in Florida? Thanks so much,
Gary Green, MD
Medical Director, MLB

From: Coyles, Jon <jon.coyles@mlb.com>
Sent: Wednesday, February 26, 2020 10:51 AM
To: fba8@cdc.gov <fba8@cdc.gov>; fba8@cdc.gov <fba8@cdc.gov>; shw2@cdc.gov <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>

AMERICAN OVERSIGHT

Cc: Green, Gary <Gary.Green@mlb.com>
Subject: Coronavirus Guidance

Hello Francisco and CDC colleagues – I hope all is well with you. As you can imagine, we have received a number of inquiries from MLB Clubs and Players with respect to the coronavirus and we are planning to disseminate guidance that is based on CDC recommendations. Prior to dissemination of this guidance, is there someone at CDC that you could recommend that we could briefly coordinate with to ensure that our guidance is 100% accurate and consistent with current CDC guidelines? CDC was incredibly helpful to us on the Zika situation a few years ago and it would be very much appreciated if CDC could provide similar guidance and support to our industry on this current public health topic as well.

Thank you in advance and I look forward to hearing back from you.

Sincerely,
Jon Coyles

Jonathan D. Coyles | MLB | Vice President • Drug, Health & Safety Programs
1271 Avenue of the Americas • New York, NY 10020
W: 212-931-7859 | C: 917-494-1256

AMERICAN OVERSIGHT

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To:	Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Cc:	Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Subject:	Re: Coronavirus Guidance
Date:	Friday, February 28, 2020 6:20:20 PM
Attachments:	Memo re Coronavirus.pdf

Scott and Carina,
Francisco kindly forwarded me your contact information. I'm the medical director for Major League Baseball and just wanted to establish contact with the Florida public health in case the need arises for increased measure with our 15 teams currently doing spring training in Florida. I have distributed the enclosed memo to all of our teams and in close contact with them regarding any potential exposures. I have made similar contacts in Arizona with our teams training there and is much easier because they are all in one county. Florida is a bit more challenging with our team all spread out. Our teams are being very cautious with respect to screening people with potential travel risks. If you have any recommendations for MLB over the next month, please reach out to me and we will implement them. Also, I wanted to ensure that there are testing facilities throughout Florida that have the capability to test for coronavirus if needed and how to refer patients for testing.
Thank you in advance and let me know if there is anything we can do to assist Florida public health.
Gary Green, MD
Medical Director, MLB
cell: 310-740-7322

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To: Green, Gary <Gary.Green@mlb.com>; Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>
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Cc:	Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
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AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	Jeanne Eckes-Roper; Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	Re: DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:31:02 PM

We are on a call with them now. I'll provide briwf when the call ends.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 1:28 PM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Luce, Christie <Christie.Luce@flhealth.gov>; Jeanne Eckes-Roper <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>
Cc: Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Manny J. Toro (manny.toro@fema.dhs.gov) <manny.toro@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; robert.p.ashe.mil@mail.mil <robert.p.ashe.mil@mail.mil>; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov) <Stacy.Gunnin@fema.dhs.gov>; IMT2 Administration and Finance (OS/ASPR) <IMT2.ANF@hhs.gov>; Barton, Jessie-Kate (OS/ASPR/EMMO) <Jessie-kate.Barton@hhs.gov>; Ramirez, Gabriela (OS/ASPR/EMMO) <Gabriela.Ramirez@hhs.gov>; R4 PHUL (FEMA.DHS.GOV) <r4-phul@fema.dhs.gov>; FEMA-R4-RRCC-SITL <R04-rrcc-sitl@fema.dhs.gov>; FEMA-R4-WatchUnit (fema.dhs.gov) <FEMA-R4-WatchUnit@fema.dhs.gov>; Maiden, Shawn <shawn.maiden@fema.dhs.gov>; Teague, Brian <Brian.Teague@fema.dhs.gov>
Subject: DoS update on cruise ships

Received the following from our LNO with DoS for your awareness
I am thinking they may be medivac'd to FL?

Costa Magica and Costa Favolosa are north of Cuba heading north toward the U.S. Costa Magica has a crew member in critical condition (male, 32, Philippines, bilateral pneumonia)and in is need of urgent medical evacuation. The Company is coordinating with USCG to perform a medivac (details being worked). Magica has an additional 3 crew members who need medical support ashore and Favolosa has 5 crew members who need medical support ashore. The Company is also working a plan to repatriate ~300 EU, ~600 Philippine and ~250 Indonesia asymptomatic crew members later this week.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov

AMERICAN OVERSIGHT

(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From:	Cooksey, Samantha
To:	Jeanne Eckes-Roper; Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	Re: DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:30:50 PM

We are on a call with them now. I'll provide briwf when the call ends.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 1:28 PM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Luce, Christie <Christie.Luce@flhealth.gov>; Jeanne Eckes-Roper <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>
Cc: Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Manny J. Toro (manny.toro@fema.dhs.gov) <manny.toro@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; robert.p.ashe.mil@mail.mil <robert.p.ashe.mil@mail.mil>; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov) <Stacy.Gunnin@fema.dhs.gov>; IMT2 Administration and Finance (OS/ASPR) <IMT2.ANF@hhs.gov>; Barton, Jessie-Kate (OS/ASPR/EMMO) <Jessie-kate.Barton@hhs.gov>; Ramirez, Gabriela (OS/ASPR/EMMO) <Gabriela.Ramirez@hhs.gov>; R4 PHUL (FEMA.DHS.GOV) <r4-phul@fema.dhs.gov>; FEMA-R4-RRCC-SITL <R04-rrcc-sitl@fema.dhs.gov>; FEMA-R4-WatchUnit (fema.dhs.gov) <FEMA-R4-WatchUnit@fema.dhs.gov>; Maiden, Shawn <shawn.maiden@fema.dhs.gov>; Teague, Brian <Brian.Teague@fema.dhs.gov>
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Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov

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(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
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cell: 404.772.9701
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email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From: Pritchard, Scott
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP)
Cc: Blackmore, Carina; Leapley, Andrea C
Subject: Re: EOC PUI team Questions
Date: Saturday, February 1, 2020 10:42:11 AM

Thanks. We still haven't heard any summaries of private provider calls directly to CDC. We really need to have the is information.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 10:26:59 AM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: RE: EOC PUI team Questions

Hi Scott,

We are staffed 24/7. I apologize for the delay, we are looking into why it occurred. I believe our on-call staff spoke with your department this morning. Please let me know if any questions or concerns remain.

Sincerely,
Runa

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 8:29 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: EOC PUI team Questions

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Pritchard, Scott; yet7@cdc.gov
Cc: Leapley, Andrea C
Subject: Re: EOC PUI team Questions
Date: Saturday, February 1, 2020 8:58:33 AM

Can you resend Broward info. I don't think I have it.

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 8:28:44 AM
To: yet7@cdc.gov <yet7@cdc.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: EOC PUI team Questions

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Sincerely

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

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From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; Jacobs Slifka, Kara (CDC/DDID/NCEZID/DHQP); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Subject:	Re: FL Call Follow-up
Date:	Tuesday, March 17, 2020 11:55:35 AM

Thanks a lot. Very much appreciated.

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From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 17, 2020 11:35:21 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; Jacobs Slifka, Kara (CDC/DDID/NCEZID/DHQP) <ipf8@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Subject: FL Call Follow-up

Hello Everyone,

Thank you for chatting with us today.

As I mentioned the CDC Healthcare Infection Control can be reached for further TA via eocevent141@cdc.gov or via phone at 404-414-8385

I think your biggest challenge is going to be figuring out the contracted staff and how they have interacted with other facilities. It would be reasonable to apply many of the below listed concepts to other at risk facilities based upon how these staff moved to detect cases earlier among residents and staff. If helpful someone from our team developed a rapid facility phone assessment which could be deployed (attached).

Here are some good links:
LTC guidance which can apply to AL: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
General IPC guidance: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
Criteria for return to work for HCP (healthcare personnel): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Please remember many of the docs I have attached are not CDC cleared. Some were created as tools by our field team or by other jurisdictions so feel free to modify to your own needs.

A couple important points and lessons learned from other states:

1. Ensure a good active monitoring system for residents (at least once a day although more often if possible). They should be mindful (as you know) the elderly may present in other and

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potentially less dramatic fashion especially if they have baseline lung disease. I have attached a symptom/temp checking that we created for HCP but could be modified for use with residents.

2. Likewise a good monitoring system for all HCP is key. They should be self-monitoring with delegation (i.e., they know who to call with symptoms) when at home and then have a symptom/temp check before starting their shift. This pre-shift check could happen upon facility arrival or via something like facetime before leaving for work. Just make sure they take their temp and show while on facetime.
3. Implement universal masking for HCP while in the facility. Attached is a PPE strategy for LTC which accounts for shortages in gowns and extend use of masks and eye protection. In addition, I have attached some docs about general PPE for all HCF which we do expect to be posted to the web soon.
4. Ideally gowns, gloves, mask/respirator, eye should be used for all cases, PUIs, and anyone with unknown respiratory illness. Again may need to refer to the PPE strategy doc if not doable. NTEC has a good video that helps with donning and doffing: https://repository.netecweb.org/items/show/688
5. Restrict visitors. Any visitor that must enter should have symptom/temp check, masked, and controlled movement in and out of resident rooms. I have attached an example letter to families that can be modified.
6. Restrict resident movements, no congregate settings.
7. I have attached some cleaning consideration as well to include the use of nursing/CNAs to wipe high touch surfaces for cases or PUIs instead of EVS.
8. I have also attached a line list if you want it.
9. Contact tracing and risk assessment is not practical in this setting and ideally time should be spent in the above activities plus IPC. We understand that work restricting staff may shutter the entire facility and thus the emphasis of the good monitoring of HCP. We discuss this in the new risk assessment at the very bottom of the page: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
10. You and other PH staff should be wearing a facemask when you enter the facility and institute self-monitoring as well.

Please feel free to reach out with questions.

Best,
Elizabeth and Nicola

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From: Blackmore, Carina
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM)
Subject: Re: FL request for CDC assistance
Date: Wednesday, March 11, 2020 8:35:17 PM

Workplace exposure

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 8:31:02 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: FL request for CDC assistance

This info I got was confusing. It sounded like there were two different chains of communication and I wanted to make sure we hadn't left anything undone. What are your thoughts on the cases among the cruise port workers? Does it seem like a common workplace exposure or community transmission?
Thank you,
Stephanie

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:09:14 PM
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Subject: Re: FL request for CDC assistance

Ok. I am not familiar with that request. What we are interested in is a consult. We had a call the other night and had discussed a follow up call. I was working with someone else on that. Who made the request. Do you know.

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 7:17:35 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: FL request for CDC assistance

Dr. Blackmore,
I wanted to follow up on a call we had received through our EOC that Florida may have questions or possibly want assistance in investigating recent reports of cases of COVID-19 in Florida related to cruise port workers in Broward County. Please call me when it's convenient for you.
Thank you,
Stephanie
404-617-6374

Stephanie R. Bialek MD MPH

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Epidemiology Task Force Lead
CDC COVID-19 Response

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From: Blackmore, Carina
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM)
Subject: Re: FL request for CDC assistance
Date: Wednesday, March 11, 2020 8:09:14 PM

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Get Outlook for iOS

From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 7:17:35 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: FL request for CDC assistance

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Thank you,
Stephanie
404-617-6374

Stephanie R. Bialek MD MPH
Epidemiology Task Force Lead
CDC COVID-19 Response

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Budd, Alicia (CDC/DDID/NCIRD/ID)
Cc:	Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Blackmore, Carina; Leapley, Andrea C; CDC IMS 2019 NCOV Response EPI Task Force
Subject:	Re: FL: EOC PUI team Questions
Date:	Saturday, February 1, 2020 1:00:43 PM

Would be easier to chat. Could you call my cell?
8502515558

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Budd, Alicia (CDC/DDID/NCIRD/ID) <acp4@cdc.gov>
Sent: Saturday, February 1, 2020 12:46:45 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; CDC IMS 2019 NCOV Response EPI Task Force <eocevent212@cdc.gov>
Subject: RE: FL: EOC PUI team Questions

Scott –

Runa referred your email to me as we are trying to consolidate our state communication to the extent possible to help expedite responses.

When you say you haven't heard any summaries of private provider calls directly to CDC, I am not sure if you referring to getting testing results from PUIs or knowing that a provider has called to inquire about a patient potentially meeting criteria to be a PUI.

For the former, we have identified that there is an issue with the eLIMS automatic reporting feature. In the interim, until the issue is resolved, we are emailing negative nCoV PCR results to the public health lab submitter email that is included with the specimen. Official reports will follow when the eLIMS issue is resolved. The lab is testing throughout the weekend and we email the negative results out as soon as we get them.

If your question is about providers that might have called about a potential PUI, when that occurs, the provider is being instructed to contact the health department.

If I have not answered your question or if you have additional questions, don't hesitate to reach out.

Thanks,
Alicia Budd

AMERICAN OVERSIGHT

EPI Task Force
2019 n-CoV Response
eocevent212@cdc.gov

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 11:40 AM
To: Budd, Alicia (CDC/DDID/NCIRD/ID) <acp4@cdc.gov>
Subject: FW: EOC PUI team Questions

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 10:42 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: Re: EOC PUI team Questions

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Sent: Saturday, February 1, 2020 10:26:59 AM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: RE: EOC PUI team Questions

Hi Scott,

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Sincerely,
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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>

AMERICAN OVERSIGHT

Sent: Saturday, February 1, 2020 8:29 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
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Sincerely

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

AMERICAN OVERSIGHT

From:	Koneff, Douglas A
To:	Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); McGough, John (HHS/IEA); Weir, Charles (OS/ASPR/IO); scott.rivkees@flhealth.gov; Roberson, Shamarial (CDC flhealth.gov)
Cc:	Butler, Jay C. (CDC/DDID/OD); Eidex, Rachel B (Dar es Salaam - CDC); Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); Marty Cetron (CDC); Knutson, Donna (CDC/DDNID/NCEH/OD)
Subject:	Re: Florida Cruise Ship Summary 3.17.20 4 pm
Date:	Wednesday, March 18, 2020 6:41:18 AM

I saw an email from Eleni this morning - the charter departed 0300 local fr Chile and ETA Miami is between 1200-1300 EDT. I asked whether coordinations had been completed with state of FL and DHS, but have not heard back yet.

Get Outlook for iOS

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 11:45:40 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; Koneff, Douglas A <KoneffD@state.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Knutson, Donna (CDC/DDNID/NCEH/OD) <dbk2@cdc.gov>
Subject: RE: Florida Cruise Ship Summary 3.17.20 4 pm

Hi Mr. McGough,
I wanted to update you about the situation with Royal Caribbean and the flights from Chile and Brazil

1. There has been no movement on any flights from Brazil
2. AT 6:30 PM EST, Ms. Kalisch from Royal Caribbean emailed us to tell us that the Government of Chile had put a hold on their flights
3. At around 6:44 PM, I received a call from Dr. Rivkees, the Florida Surgeon General who told me that the Governor was not going to allow any flights to land and disembark passengers in Miami until there was a solid plan articulated by the Cruise company.
4. Right after that call we notified the State Department and copied DHS. We also notified Eleni Kalisch and told her to contact the State of Florida to coordinate a plan(we gave her the relevant phone numbers)
5. At approximately 7:30 Eleni Kalisch emailed that the flight from Chile was going to proceed, but she never responded about contacting Florida state or local authorities despite multiple emails from CDC telling her to do so
6. At 10:07 she told us that the flight would be departing Chile at 12:10 AM local time and arriving in Miami at 9:10 AM EST

Attached is the last email chain starting at 10:20 when Eleni told us there is a slight change of plans which states that CDC will be screening her passengers. We have told her multiple times that CDC will not be screening passengers. We asked her to contact us by phone right away (11PM), but she has not done so. We believe that the flight may have already departed and we are concerned that

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no one has signed off on this from Florida and that a clear and reasonable plan has not been sent any of us.

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Sent: Tuesday, March 17, 2020 4:23 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: RE: Florida Cruise Ship Summary 3.17.20 4 pm

Enormously helpful, thank you.

John G. McGough
Regional Director
U.S. Department of Health & Human Services
Region 1 - New England - (CT, ME, MA, NH, RI, & VT)
Region 4 - Southeast - (AL, FL, GA, KY, MS, NC, SC, & TN)
JFK Federal Building, Suite 2100
Boston, MA 02203

Tel (617) 565-1500
Fax (617) 565-1491
John.McGough@hhs.gov

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 4:08 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles

AMERICAN OVERSIGHT

(OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: Florida Cruise Ship Summary 3.17.20 4 pm

Dear Mr. McGough,

Attached please find a summary of our phone call with the Florida Governor's Deputy Chief of Staff regarding two Royal Caribbean cruise ships and pending charter flights to Miami from both Brazil and Chile. Please let me know if you have any other questions.

Kind regards,
Cindy

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

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From: Jean, Reynald
To: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Cc: Villalta, Yesenia D; Rico, Edhelene
Subject: Re: Follow up to Illness in Passenger
Date: Wednesday, February 26, 2020 10:39:14 AM

Thank you so much, Michelle.

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From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Sent: Wednesday, February 26, 2020 10:36 AM
To: Jean, Reynald
Subject: Fwd: Follow up to Illness in Passenger

Good morning Dr. Jean,

See below regarding the report of ill passenger transported to Jackson. I also sent to Ann Schmitz.

Michelle

Get Outlook for iOS

From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Sent: Wednesday, February 26, 2020 10:35:47 AM
To: Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: Fwd: Follow up to Illness in Passenger

Ann, please see below regarding ill passenger who was taken to Jackson this morning.

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From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Sent: Wednesday, February 26, 2020 10:33:36 AM
To: Hatfield Jr., Mark O. (Aviation) <mhatfield@miami-airport.com>; Christopher Maston <christopher.d.maston@cbp.dhs.gov>; RODRIGUEZ, MICHELLE <michelle.rodriguez@cbp.dhs.gov>; John Gardner (gardnerj@miamidade.gov) <gardnerj@miamidade.gov>
Cc: Davenport, Emily Patricia (CDC/DDID/NCEZID/DGMQ) <xkh2@cdc.gov>; Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ) <ikb0@cdc.gov>; Aboukheir, Mahmoud (CDC/DDID/NCEZID/DGMQ) <npa0@cdc.gov>
Subject: Follow up to Illness in Passenger

Good morning,

Based on the travel history and a lack of epidemiological risk for the passenger who was transported to the hospital this morning, and per a consultation with our Quarantine Medical Officer, this is NOT considered a patient under investigation for COVID-19.

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Our current guidelines require both symptoms AND either travel to China in the past 14 days OR close contact with a laboratory-confirmed COVID-19 patient. Additionally, the passenger has only been to Argentina, which currently does not have known community spread of COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html)

To ensure that this does not need additional public health intervention, and because there are other illnesses of public health concern, such as influenza, the passenger is being assessed at the hospital, and we will follow up in coordination with the Florida Department of Health.

If there are any changes to the above information, we will communicate this to you as soon as possible.

Thank you,

Michelle
Michelle Decenteceo
CDC Miami Quarantine Station

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Re: Follow-up Call
Date:	Friday, March 20, 2020 7:21:08 AM

And THANKS

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From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 7:20:00 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
Subject: Follow-up Call

Hello Dr. Blackmore,

We were alerted that you would like to schedule a follow-up call regarding the LTC facility. The healthcare infection control team is happy to chat. Let us know what time works best.

Thanks,
Elizabeth Soda

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From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Re: Follow-up Call
Date:	Friday, March 20, 2020 7:20:58 AM

Would 930 am work?

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From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 7:20:00 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
Subject: Follow-up Call

Hello Dr. Blackmore,

We were alerted that you would like to schedule a follow-up call regarding the LTC facility. The healthcare infection control team is happy to chat. Let us know what time works best.

Thanks,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response PUI
To:	EOC Report (CDC)
Cc:	CDC IMS 2019 NCOV Response PUI; Blackmore, Carina (CDC flhealth.gov); CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Follow-up email concerningJorge Trujillo-Concentra Urgent Care-2019 Novel Coronavirus–FL
Date:	Friday, February 7, 2020 3:25:05 PM

Closed, not PUI.

Summary of call:

Concentra clinician call (Tampa airport, Jorge Trujillo) about a flight attendant who had contact with an ill passenger on 2/2/20. The passenger had arrived from China on 12/21. Not ill. On 2/2 they shared a flight during which the traveler (with history of December travel from China) developed some dizziness and almost lost consciousness, and was attended to by the flight attendant. Upon arrival she was better. The flight attendant developed chills, cough, with mucous on 2/3 with hot feeling (no temp taken). On 2/5 he also developed dizziness, continued cough. On 2/6 had some nausea, with continued cough. On 2/7 no further cough; was recommended to see contractor health clinic in the Tampa airport (Concentra).

Dr Trujillo contacted the FL HD.

Discussed PUI definition and current unknowns of possible asymptomatic carriage., FL

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

From: EOC Report (CDC) <eocreport@cdc.gov>
Sent: Friday, February 7, 2020 2:54 PM
To: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Cc: EOC Report (CDC) <eocreport@cdc.gov>
Subject: Follow-up email concerningJorge Trujillo-Concentra Urgent Care-2019 Novel Coronavirus–FL

Call Information

Call/Journal ID:	322584
Date/Time:	02/07/2020 2:38PM
Shift:	A - 0700-1500
Officer:	Chandra Lewis

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Caller Contact Information

Agency: Clinician/RN
Title: N/A **Email Address:** N/A
Name: Jorge Trujillo
Phone #: 813-476-5484 **Alternate Phone #:** N/A
Contact Person Name: N/A
Facility Name: Concentra Urgent Care
Country: United States **State/Province:** Florida **City:** Tampa

Event Location Information

Street Address: N/A
Country: United States **State/Province:** N/A **City:** N/A

NNC Information

Disease being reported: N/A **NNC Category:** N/A
Unique NNC Id: N/A **Time SME Contacted:**
CDC Info Call: No

Category

Primary:
Event: 2019 Novel Coronavirus
Known As: 2019 Novel Coronavirus
Secondary:
Known As: N/A

Resolution & Notification

Resolution: Local 911/ PMD **Notification Method:**Clinician Line **SME Name:**Koumans Emilia **SME Contact:**770-488-6233

Call Information

Brief Summary: Division of Viral Diseases and Respiratory Virus Branch provided a consultation to a clinician in FL regarding 2019 Novel Coronavirus
Notes: PUI recent exposure to potential patient presenting with headache and running nose

Time Of Resolution: 02/07/2020 2:41PM
Time SME Contacted Agency:

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From: Blackmore, Carina
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc: Cooksey, Samantha; Otis, Aaron; Pritchard, Scott
Subject: Re: Follow-up from call with facility
Date: Tuesday, March 3, 2020 1:15:43 PM

Yes.
I am copying Sam and Aaron who will coordinate
Get Outlook for iOS

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 3, 2020 12:56:26 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

Thanks, Carina. To make I understand, would a call with NIOSH still be appropriate then from your perspective?

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:50 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com
Subject: RE: Follow-up from call with facility

We will put the hospital in contact with our emergency management team to discuss the facility capacity related issues.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:45 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

Thank you for reaching out and providing the summary.
Regarding lab testing, our current state lab turn around time is within 24 hours of receipt.

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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 03, 2020 12:40 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Subject: Follow-up from call with facility

Hi Scott,

A quick summary of today's call with Dr. Gordillo (cc'd here)

1. The facility is rapidly running out of AIIR capacity given their high suspicion for COVID-19 in the community. They have some limited ability to create some negative pressure rooms in their ICU and ER but these rooms will have a shared air space among them which not allow them to mix PUIs with true cases. They also asked about the option of portable isolation units such as a tent. Our CDC NIOSH colleagues would know the most about this option. I have emailed them to request a call with the facility hopefully later today.
2. The other concern the facility had was regarding the speed of testing. Scott-I will defer that question to you. However, they did wonder if CDC lab technical support would be an option to help them build up their own in-house test. Again I defer this totally to FL, and I don't know if this would even be an option from the CDC side. However, I am happy to inquire on our side if you are interested.

Happy to chat.

Best,
Elizabeth

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From: Rivkees, Scott A
To: Bresee, Joseph (CDC/DDID/NCIRD/ID)
Subject: Re: Follow-up on modeling and social distancing
Date: Tuesday, March 24, 2020 10:57:18 PM

Dear Joe

Many thanks for your note and your time.

Can you also pass along Martin's contact information?

All the best,

Scott

Scott Rivkees, M.D.
State Surgeon General

From: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>
Sent: Tuesday, March 24, 2020 10:51:20 PM
To: hwalke1@gmail.com <hfw3@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: RE: Follow-up on modeling and social distancing

Thanks, Henry and nice to talk with you Scott. As promised, I want to introduce you to Dr, Martin Meltzer.

Martin – Scott is the State Surgeon General of Florida and interested in planning for medical surge needs, I talked about your current plans to create tools for supporting this work. Wonder if you might have time to talk with him, as you are much more eloquent on your work than me!

Thanks
Joe

Joseph Bresee, MD
Dep. Incident Manager
2020 CDC nCoV Response

From: Walke, Henry (CDC/DDID/NCEZID/DPEI) <hfw3@cdc.gov>
Sent: Tuesday, March 24, 2020 9:53 AM
To: scott.rivkees@flhealth.gov

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Cc: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>; Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: Follow-up on modeling and social distancing

Scott,

Jay said you have a couple of questions.

- I am connecting you to Joe Bresee, 404 421 5648, who has wide visibility on the modeling activities at CDC and can help answer your questions.

- The evidence base for social distancing is best found in the 2017 Community Mitigation Guidelines to Prevent Pandemic Influenza.
  https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

Best, Henry

Henry Walke, MD, MPH
Deupty Incident Manager
Jurisdiction Support
CDC COVID-19 Response
+1-404-639-3582 (office)
+1-404-452-9624 (mobile)
hwalke@cdc.gov

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From: Moulton, Diane
To: Eifert, James
Cc: Strum, Shane; Moskowitz, Jared; Rivkees, Scott
Subject: Re: Guardsmen in isolation
Date: Wednesday, March 18, 2020 9:03:39 PM

Sir,

Can you please send us the draft letter for Shane and the Governor's review?

Sent from my iPhone

> On Mar 18, 2020, at 9:00 PM, Eifert, James O Maj Gen USAF NG FLARNG (USA) <james.o.eifert.mil@mail.mil> wrote:
>
> Teammates,
> I was just notified that we currently have 4 FLNG Soldiers in isolation due to either exposure to COVID-positive patients prior to being activated to State Active Duty, or due to exhibiting COVID symptoms since they were activated.
>
> We're working through the details, but this is a scenario we have been preparing for, and is not unexpected. If we were able to activate them under 502(f) authority, they would be eligible for federal benefits instead of the state's Workman's Comp, which would be a better scenario for the Soldier and the State of Florida. If they get ill from the virus and require extensive treatment, the federal benefits afforded by a 502(f) activation could be substantial. The attached info paper discusses the issue in greater detail.
>
> Every TAG in the nation is pushing to get the Feds to authorize 502(f) since this situation is only going to get worse with time. I encourage Governor DeSantis to continue to support this initiative and will be presenting him with a letter tomorrow requesting his endorsement for this as well.
>
> As an aside, there are 30 Broward County 1st responders in quarantine due to exposure to COVID-positive patients. Our Drive-thru team will be testing them with collection and sampling kits tomorrow as part of their practice for opening the lanes on Friday.
>
> I'm available to answer any questions you may have...
>
> Thanks!
>
> V/R,
>
> Eif
>
> JAMES O. EIFERT
> Major General
> Florida National Guard
> The Adjutant General
>
> DSN: 822-0101, Comm: (904) 823-0101
> Work Cell: (904) 481-6387
> SIPR: james.o.eifert.mil@mail.smil.mil
>
>
> <Talking points regarding need for 502f authority IRT COVID emergency final.docx>

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

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From:	Torres, Yari
To:	Sikka, Neha (CDC/DDPHSIS/CGH/GID); Abebe, Fikru (CDC taskforce.org)
Cc:	Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR); Greene, Sharon (CDC/DDPHSIS/CGH/GID); Polio Surge (CDC); Durry, Elias (CDC/DDPHSIS/CGH/GID); Datta, Deblina (CDC/DDPHSIS/CGH/GID)
Subject:	Re: ITF NCOV Daily Update - 02-12-2020
Date:	Thursday, February 13, 2020 9:58:37 AM

Good morning team,

Thank you for this information. This is a good opportunity to let everyone know that while deployed my primary email will be my CDC account HVB0@cdc.gov, please send all further correspondence to that account.

Thank you for your support.

Yari

Please

Yaritbel Torres-Mendoza, DVM, MPH
CDC Epidemic Intelligence Service Officer
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Phone: 850 -901-6933
Mobile: 850 -815-0059
E-mail: Yari.Torres@flhealth.gov | hvb0@cdc.gov
DOH Mission: To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.
Please Note: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

Sent from Outlook for iOS

From: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>
Sent: Thursday, February 13, 2020 8:21:28 AM
To: Abebe, Fikru (CDC taskforce.org) <fabebe-c@taskforce.org>; axmadgedi2@hotmail.com <axmadgedi2@hotmail.com>; hamudismail99@gmail.com <hamudismail99@gmail.com>; tilahuntafeseafele@yahoo.com <tilahuntafeseafele@yahoo.com>; mesitase2003@gmail.com <mesitase2003@gmail.com>; Blau, Erin (CDC/DDPHSS/CSELS/DSEPD) <okl2@cdc.gov>; dagnachewalemu7@gmail.com <dagnachewalemu7@gmail.com>; Jones, Sydney (CDC/DDPHSS/CSELS/DSEPD) <okn7@cdc.gov>; McMichael, Temet (CDC/DDPHSS/CSELS/DSEPD) <pgv4@cdc.gov>; Oakley, Lisa P. (CDC/DDPHSS/CSELS/DSEPD) <vru2@cdc.gov>; Owusu, Daniel (CDC/DDID/NCIRD/ID) <pgv7@cdc.gov>; Rispens, Jared (CDC/DDNID/NCEH/DEHSP) <okq6@cdc.gov>; Tompkins, Lindsay (CDC/DDNID/NCEH/DEHSP) <pgx9@cdc.gov>; Varela, Kate (CDC/NIOSH/RHD/FSB) <nwn2@cdc.gov>; Wansaula, Zimy (CDC/DDPHSIS/CGH/GID) <lxq5@cdc.gov>; Kanu, Florence (CDC/DDNID/NCCDPHP/DNPAO) <VKW7@cdc.gov>; Wu, Alexander (CDC/DDPHSS/CSELS/DSEPD) <ohh5@cdc.gov>; Mooring, Eric (CDC/DDPHSS/CSELS/DSEPD)

AMERICAN OVERSIGHT

<pgv5@cdc.gov>; Myers, Tanya R. (CDC/DDID/NCEZID/DHQP) <vje9@cdc.gov>; Bugli, Dante (CDC/DDPHSIS/CGH/DGHP) <kpt7@cdc.gov>; Feder, Kenneth (CDC/DDPHSS/CSELS/DSEPD) <phv3@cdc.gov>; Ortiz, Nancy (CDC/DDPHSS/CSELS/DSEPD) <hqo5@cdc.gov>; Nielsen, Carrie F. (CDC/DDPHSIS/CGH/GID) <hgo6@cdc.gov>; Patel, Jaymin (CDC/DDPHSIS/CGH/GID) <isr0@cdc.gov>; Talwar, Amish (CDC/DDID/NCHHSTP/DTE) <nvr0@cdc.gov>; Rubenstein, Beth (CDC/DDPHSIS/CGH/DPDM) <pgx2@cdc.gov>; Rao, Carol (CDC/DDPHSIS/CGH/DGHP) <cnr3@cdc.gov>; Araujo, Aufra (CDC/DDPHSS/CSELS/DLS) <aka8@cdc.gov>; Bustamante, Nirma (CDC/DDPHSS/CSELS/DSEPD) <okl6@cdc.gov>; Espinosa, Catherine Couper (CDC/DDPHSIS/CPR/DEO) <xwn7@cdc.gov>; Sreevatsava, Meghana (CDC taskforce.org) <msreevatsava-c@taskforce.org>; Pao, Leah (CDC/DDPHSIS/CGH/DGHP) <UZY8@cdc.gov>; Ghiselli, Margherita (CDC/DDPHSIS/CGH/GID) <wkz8@cdc.gov>; Gourmanon, Djebo (CDC/DDPHSIS/CGH/GID) <lrk6@cdc.gov>; Regan, Kelly Ann (CDC/DDPHSIS/CSTLTS/OD) <ngi6@cdc.gov>; Karmarkar, Ellora (CDC cdph.ca.gov) <Ellora.Karmarkar@cdph.ca.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Whitehouse, Erin (CDC/DDID/NCEZID/DHCPP) <okp7@cdc.gov>
Cc: Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Greene, Sharon (CDC/DDPHSIS/CGH/GID) <fny9@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>
Subject: FW: ITF NCOV Daily Update - 02-12-2020

Dear Polio deployers,

We have heard from many of you that nCOV/COVID-19 has become a concern in many of the countries where you are deployed. I wanted to forward the below email to you so that you may stay informed. Please note the final section of the email below, containing information that is public and may be shared with partners.

Kind regards
Neha Sikka

From: CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>
Sent: Wednesday, February 12, 2020 6:47 PM
To: CDC CGH Non-Atlanta Based *Non-Emp <NTBDLORGCGHNonAtlanta-BasedNonEmp@cdc.gov>
Cc: CDC IMS 2019 nCoV Response International TF DL <IMS2019nCoVResponseInternationalTFDL@cdc.gov>
Subject: ITF NCOV Daily Update - 02-12-2020

Greetings colleagues: This is the nCoV ITF Daily Update for February 12, 2020.

If you have questions that you would like to have answered in these Daily Updates, please send them to the International Task Force at eocevent223@cdc.gov.

> ***PLEASE NOTE:*** *The nCoV outbreak is a rapidly evolving situation. We are sharing information with you as we receive it, but remain mindful that known information may*

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change quickly.

Information shared on these updates will come from a variety of sources. We will endeavor to ensure that the source and 'sharability' of each document is noted. Any document that is located on a public website (i.e. it is a link in this email) can be shared freely as long as properly attributed. Any document cleared for distribution by the CDC JIC will be so labeled and can be shared as official CDC guidance. There will, however, be some documents that are for internal CDC use only. Please be mindful not to disseminate uncleared and internal-use materials. ***Please do not forward this entire email to non-CDC recipients.***

We are maintaining a repository of all materials disseminated through the Daily Update on a **ITF SharePoint site**, found **here**. The **COVID-19 Communications SharePoint Site** with CDC Response Key Messages/Key Points is available **here**.

Talking Points

- No updates today

News & Updates

- The WHO has issued an official name of the 2019 novel coronavirus, COVID-19, which CDC has adopted and will implement on all guidance and websites.
- The Lancet has published a retrospective review of nine pregnant women with COVID-19 pneumonia; in his small group, there was no evidence of vertical transmission of COVID-19 , attached (PDF document, **Public**)
- The following social media links have gone live, and will be maintained in real-time with the most up-to-date information
    - Facebook: https://www.facebook.com/CDC/videos/794433791055151/
    - Twitter handle: @CDCgov: https://twitter.com/CDCgov/status/1227615594163449856
    - Instagram: https://www.instagram.com/p/B8eMt2uHZod/
- WHO's SitRep for February 12, 2020 is attached (PDF document, **Public**)
- Today's communication surveillance report is attached (PDF document, **CDC-Internal**)

Guidance Documents

Response Planning

- State Department guidance on foreign engagement for COVID-19 was sent out earlier today for your situational awareness.

Surveillance and Case/Contact Investigation

- No updates today

Traveler Screening & Travel Notices

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- WHO published today "Key considerations for repatriation and quarantine of travelers in relation to the outbreak of novel coronavirus 2019-nCoV" at: https://www.who.int/ith/Repatriation_Quarantine_nCoV-key-considerations_HQ-final11Feb.pdf?ua=1

PPE & Infection Control

- The CDC has released a **DRAFT** version of the "Interim guidance for public health personnel evaluating persons under investigation (PUIs) and asymptomatic close contacts of confirmed cases at their home". This document lays out the precautions that public health professionals must take when evaluating PUIs in their own homes (PDF document, **CDC-Internal**)
- The CDC has centralized all information pertaining to the PPE recommended for healthcare workers, including "Strategies for Optimizing Supply of N95 Respirators", at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html

Laboratory Support

- Update on the status of the CDC 2019-nCoV Real-Time RT-PCR test kit:
  - We have learned that one of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel reagents, N3, is not performing as expected.
  - All CDC reagent kit orders are now on a quality hold until the new N3 reagent can be manufactured, validated, and distributed to the IRR. We appreciate your patience during this time.
  - If you have urgent need, we encourage you to consider other diagnostic options until this issue is resolved and your order is received. Please contact us if you have further questions or concerns.

Risk Communications

- No updates today

Communication to your Country Office Staff

- No updates today

Management & Operations

- No updates today

Standing list of Important links to share with partners – all public:

- CDC's 2019-nCoV page: https://www.cdc.gov/coronavirus/2019-ncov/index.html
- CDC Risk Assessment Summary page: https://www.cdc.gov/coronavirus/2019-nCoV/summary.html#risk-assessment
- CDC Health Advisory Network (HAN): https://emergency.cdc.gov/han/index.asp
- WHO's Novel Coronavirus (2019-nCoV) technical guidance: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

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- WHO SitReps: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports
- WHO's Training portal pertinent to nCoV: https://openwho.org
- Several major journals have created nCoV portals:
    - The Lancet https://www.thelancet.com/coronavirus
    - NEJM https://www.nejm.org/coronavirus?query=main_nav_lg
    - JAMA https://jamanetwork.com/journals/jama/pages/coronavirus-alert
    - Elsevier https://www.elsevier.com/connect/coronavirus-information-center

International Task Force

2019 Novel Coronavirus Response

eocevent223@cdc.gov

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Fitzgerald, John M CDR
Cc:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Re: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 8:28:54 AM

Thanks

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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> On Mar 20, 2020, at 7:30 AM, Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil> wrote:
>
> Jeanne,
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> Passed yesterday to Ashley and ESF-8 that vessel is off Panama and is tentative for arrival in Miami on March 23. Will keep tracking this one.
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> v/r,

AMERICAN OVERSIGHT

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 6:31 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Subject: [Non-DoD Source] RE: MS Marina (Oceania) - awareness???

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

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From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM

AMERICAN OVERSIGHT

To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
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Jeanne,

AMERICAN OVERSIGHT

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

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From:	Catherine de la Cruz Duran
To:	Karl Ensign; Esther Muna; Livinson Taulung (LTaulung2@fsmhealth.fm); Laurent Duenas, MPH, BSN, RN; Emais Roberts; Bruce Bilimon; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com); Nate Smith; Angell, Sonia Y@CDPH; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; Howard Zucker; John Wiesman; Motusa Nua
Cc:	Reva Ferguson; Rachelle Ashe; Peggy Ullom; linda.fullem@flhealth.gov; Tangonan, Sharon S.; Jacqueline Silvia; Terry Bergener; Eti Uiagalelei; Janet Guerrero; Fancy Soloman; Suzanne Kaneshiro; Lalie Ikluk; Marline Loeak; Louise Baa; Aniah John; Carolyn Mullen; Michael Fraser; Joe Davis; Taveras, Sam (CDC/OSTLTS/DPHCD); Jose T. Montero, MD, MPH; Subroto Banerji; lauri.ogumoro@dph.gov.mp; Danny Staley; Carolyn McCoy; Cendra Clarke; Christi Mackie; Mark Mioduski; Emi Chutaro (emic@pihoa.org); Gallo, Bill (CDC/OSTLTS/DPHCD); Ottley, Basil C
Subject:	Re: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date:	Monday, February 24, 2020 1:10:37 PM
Attachments:	image001.png

Thank you Karl for keeping us updated. Yes, change is the only constant.
Catherine

From: Karl Ensign <kensign@astho.org>
Sent: Monday, February 24, 2020 1:06 PM
To: Esther Muna <esther.muna@dph.gov.mp>; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <Laurent.Duenas@dphss.guam.gov>; Emais Roberts <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon <rmiminister.mohhs@gmail.com>; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com) <justa.elisa@gmail.com>; Nate Smith <nathaniel.smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; bruce.s.anderson@doh.hawaii.gov <bruce.s.anderson@doh.hawaii.gov>; Howard Zucker <howard.zucker@health.ny.gov>; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Reva Ferguson <Reva.Ferguson@arkansas.gov>; Rachelle Ashe <rachelle.ashe@arkansas.gov>; Peggy Ullom <peggy.ullom@cdph.ca.gov>; linda.fullem@flhealth.gov <linda.fullem@flhealth.gov>; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak <marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Joe Davis <jdavis@astho.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Jose T. Montero, MD, MPH <znn3@cdc.gov>; Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp <lauri.ogumoro@dph.gov.mp>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Canceled: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
When: Tuesday, February 25, 2020 5:00 PM-6:30 PM.
Where: Madison Hotel – Adams B, 1177 15th Street, NW, Washington, DC 20005

Dear Subcommittee on Insular Affairs Members & Meeting Participants –

AMERICAN OVERSIGHT

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

Apologies for multiple emails.

Thanks,
Karl

From: Karl Ensign
Sent: Sunday, February 23, 2020 3:35 PM
To: esther.muna@dph.gov.mp; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov>; Emais Roberts MD (emais.roberts@palauhealth.org) <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon <rmiminister.mohhs@gmail.com>; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com) <justa.elisa@gmail.com>; Nate Smith, MD <Nathaniel.Smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; howard.zucker@health.ny.gov; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp; Reva Ferguson <Reva.Ferguson@arkansas.gov>; 'Rachelle Ashe' <rachelle.ashe@arkansas.gov>; Peggy Ullom <Peggy.Ullom@cdph.ca.gov>; linda.fullem@flhealth.gov; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak <marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov) <znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

On behalf of Subcommittee Chair Esther Muna, CNMI and ASTHO CEO Mike Fraser, we welcome you

AMERICAN OVERSIGHT

to Washington Week and thank you for your active engagement and participation! Please note our meeting has been changed to the following date and time:

Tuesday, February 25th, 2020
4:00 – 5:30 pm ET
Madison Hotel – Adams B
1177 15th Street, NW
Washington, DC 20005

A calendar invite will follow.

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

https://naturalresources.house.gov/imo/media/doc/Insular%20Fact%20Sheet_ks.pdf
https://scholarlycommons.pacific.edu/pjh/vol2/iss1/1/

The Insular Affairs Subcommittee to the ASTHO Government Affairs Policy Committee was formed in 2018 to identify the unique policy needs and priorities of the Pacific and Atlantic jurisdictions. The subcommittee provides a forum for ASTHO's members to exchange information on policy challenges and solutions within the insular areas. Additionally, the subcommittee provides recommendations to the full committee on policy priorities.

See you soon!
Karl

Karl Ensign, Chief
Territorial Support
Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450,
Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000,
Atlanta, GA 30308

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AMERICAN OVERSIGHT

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From:	Justa Encarnacion
To:	Karl Ensign
Cc:	Angell, Sonia Y@CDPH; Aniah John; Bruce Bilimon; Carolyn McCoy; Carolyn Mullen; Catherine de la Cruz Duran; Cendra Clarke; Christi Mackie; Danny Staley; Emais Roberts; Emi Chutaro (emic@pihoa.org); Esther Muna; Eti Uiagalelei; Fancy Soloman; Gallo, Bill (CDC/OSTLTS/DPHCD); Howard Zucker; Jacqueline Silvia; Janet Guerrero; Joe Davis; John Wiesman; Jose T. Montero, MD, MPH; Lalie Ikluk; Laurent Duenas, MPH, BSN, RN; Livinson Taulung (LTaulung2@fsmhealth.fm); Louise Baa; Mark Mioduski; Marline Loeak; Michael Fraser; Motusa Nua; Nate Smith; Ottley, Basil C; Peggy Ullom; Rachelle Ashe; Reva Ferguson; Subroto Banerji; Suzanne Kaneshiro; Tangonan, Sharon S.; Taveras, Sam (CDC/OSTLTS/DPHCD); Terry Bergener; bruce.s.anderson@doh.hawaii.gov; lauri.ogumoro@dph.gov.mp; linda.fullem@flhealth.gov; scott.rivkees@flhealth.gov
Subject:	Re: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date:	Monday, February 24, 2020 12:01:03 PM
Attachments:	image001.png

Thank you for the update. I'll be available to meet.

Kind regards.

On Mon, Feb 24, 2020 at 11:59 AM Karl Ensign <kensign@astho.org> wrote:

> *Dear Subcommittee on Insular Affairs Members & Meeting Participants –*
>
> Well, change is a constant!! Given that we have a last minute request from the White House for our members to brief officials on COVID-19 while they are in town, the meeting of the Subcommittee on Insular Affairs held during Washington Week will be cancelled this year. However, in the absence of the full committee meeting, Cendra and I would still appreciate having a working session with our partners and staff not traveling to the White House tomorrow to further our priorities and action steps for the coming year. It is critical that we keep this work moving. I have emailed these individuals separately.
>
> Apologies for multiple emails.
>
> Thanks,
>
> Karl
>
> ---
>
> **From:** Karl Ensign
> **Sent:** Sunday, February 23, 2020 3:35 PM
> **To:** esther.muna@dph.gov.mp; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov>; Emais Roberts MD (emais.roberts@palauhealth.org) <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon <rmiminister.mohhs@gmail.com>; RN

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BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com) <justa.elisa@gmail.com>; Nate Smith, MD <Nathaniel.Smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; howard.zucker@health.ny.gov; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp; Reva Ferguson <Reva.Ferguson@arkansas.gov>; 'Rachelle Ashe' <rachelle.ashe@arkansas.gov>; Peggy Ullom <Peggy.Ullom@cdph.ca.gov>; linda.fullem@flhealth.gov; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak <marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov) <znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

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

Tuesday, February 25th, 2020

4:00 – 5:30 pm ET

Madison Hotel – Adams B

1177 15th Street, NW

Washington, DC 20005

A calendar invite will follow.

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

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

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

The Insular Affairs Subcommittee to the ASTHO Government Affairs Policy Committee was formed in 2018 to identify the unique policy needs and priorities of the Pacific and Atlantic jurisdictions. The subcommittee provides a forum for ASTHO's members to exchange information on policy challenges and solutions within the insular areas. Additionally, the subcommittee provides recommendations to the full committee on policy priorities.

See you soon!

Karl

Karl Ensign, Chief
Territorial Support

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials

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

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--

Warm regards,

Justa "Tita" Encarnacion, RN, BSN, MBA/HCM

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From: Mejia-Echeverry, Alvaro
To: Dobson, Jolie T; Burger, Ron; Cicerrella, Richard; Connor, Olga; Cyrille, Charles; Davis, Joanna; Disbrow, Scott; Jeanne Eckes-Roper; Elmir, Samir; Erase, Romualde X; Franco, Benjamin; Frost, Matthew; Garcia, Maikel; Gomez, Tatiana ; Hernandez, Richard; Horner, Alicia; Jean, Reynald; Kelly Keys; Lara, William; Lewandowski, Patty A; Loo, Georgina; Lopez, Jose M; Milian, Victor ; Nunez, R. Jaime; Presmanes, Cristina; Quaye, Elesi A; Rafky, Brian; Schmitz, Ann; Senyshyn, William; Serrano, Maria; Steele, Michelle; Sudden, Terri M; Toñanez, Alvaro Lt.; Trim, Anthony Capt.; Vaughn, Freda G; Villalta, Yesenia D; White, Stephen L; Chao Morales, Christina A; Castillo, Klelia S; Celorio, Oscar; Villamil, Vanessa
Cc: Suarez, Ana; Pognon, Monica; Jaime Hernandez; jzambella@icerif.com; John Antapasis; Chambliss, James; James Russo; Franco, Benhamin; Davis, Joanna S - APHIS; Lara, William (RER); Bello, Joel; vmmilian@gmail.com; Zambella, Joseph; Serrano, Maria (ASD); Oliphant, Mark C; Yereb, Daniel
Subject: Re: Miami-area BAC Quarterly Meeting
Date: Thursday, March 12, 2020 9:58:15 PM

Thanks to all who attended the BAC meeting/ conference call today. It was important to maintain continuity even in these difficult times! Glad we were able to debrief about the Super Bowl LIV and learn or review basics about COVID-19. Also, it's great to know that BioWatch has offered its assets to assist with COVID-19 testing. We are very thankful about that offer!

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From: Dobson, Jolie T <Jolie.Dobson@flhealth.gov>
Sent: Thursday, March 12, 2020 11:40:33 AM
To: Burger, Ron <Ron.Burger@flhealth.gov>; Cicerrella, Richard <rwcicerrella@fbi.gov>; Connor, Olga <Olga.Connor@flhealth.gov>; Cyrille, Charles <charles.cyrille@miamidade.gov>; Davis, Joanna <joanna.s.davis@aphis.usda.gov>; Disbrow, Scott <sdisbrow@hialeahfl.gov>; Jeanne Eckes-Roper <Jeanne.Eckes@hhs.gov>; Elmir, Samir <Samir.Elmir@flhealth.gov>; Erase, Romualde X <Romualde.Erase@flhealth.gov>; Franco, Benjamin <Franco.Benjamin@epamail.epa.gov>; Frost, Matthew <matthew.frost@hq.dhs.gov>; Garcia, Maikel <hazmat@miamigov.com>; Gomez, Tatiana <tgomez@hialeahfl.gov>; Hernandez, Richard <rfhernandez@mdpd.com>; Horner, Alicia <ahorner@miamidade.gov>; Jean, Reynald <Reynald.Jean@flhealth.gov>; Kelly Keys <Kkeys@browardhealth.org>; Lara, William <laraw@miamidade.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Loo, Georgina <Georgina.Loo@miamidade.gov>; Lopez, Jose M <Jose.Lopez@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>; Milian, Victor <vmmilian@mdpd.com>; Nunez, R. Jaime <rjnunez@mdpd.com>; Presmanes, Cristina <cristina.presmanes@miamidade.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rafky, Brian <blrafky@mdpd.com>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Senyshyn, William <William.Senyshyn@flhealth.gov>; Serrano, Maria <serranm@miamidade.gov>; Steele, Michelle <Michelle.Steele@miamidade.gov>; Sudden, Terri M <Terri.Sudden@flhealth.gov>; Toñanez, Alvaro Lt. <Tonanez@miamidade.gov>; Trim, Anthony Capt. <ttrim@miamidade.gov>; Vaughn, Freda G <Freda.Vaughn@flhealth.gov>; Villalta, Yesenia D <Yesenia.Villalta@flhealth.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Chao Morales, Christina A <Christina.ChaoMorales@flhealth.gov>; Castillo, Klelia S <Klelia.Castillo@flhealth.gov>; Celorio, Oscar <Oscar.Celorio@flhealth.gov>; Villamil, Vanessa <Vanessa.Villamil@flhealth.gov>
Cc: Suarez, Ana <ASUAREZ@broward.org>; Pognon, Monica <mpognon@Broward.org>; Jaime Hernandez <jahernandez@hollywoodfl.org>; jzambella@icerif.com <jzambella@icerif.com>; John Antapasis <John_Antapasis@davie-fl.gov>; Chambliss, James <Jim_Chambliss@bsosid.org>; James Russo <JRusso@hollywoodfl.org>; Franco, Benhamin <franco.benjamin@epa.gov>; Davis, Joanna S - APHIS <joanna.s.davis@usda.gov>; Lara, William (RER) <William.Lara@miamidade.gov>; Bello, Joel

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<jbello@mdpd.com>; vmmilian@gmail.com <vmmilian@gmail.com>; Zambella, Joseph <jzambella@gmail.com>; Serrano, Maria (ASD) <Maria.Serrano@miamidade.gov>
Subject: Miami-area BAC Quarterly Meeting
When: Thursday, March 12, 2020 10:00 AM-12:00 PM.
Where: 8175 NW 12 Street (Suite 300); Doral, FL 33126. Dial-in# 888-585-9008; Conference Room# 219-046-121

Please find the updated COVID-19 ppt.

Thank you.

Jolie Dobson
Biological Scientist IV
Florida Department of Health in Miami-Dade County
Email: Jolie.Dobson@flhealth.gov
Phone: (305) 470-5558



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From:	Blackmore, Carina
To:	Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); Balda, Michael
Cc:	Pritchard, Scott; Rubino, Heather
Subject:	Re: Monday
Date:	Monday, March 2, 2020 7:57:52 AM

Michael should get you shortly

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From: Doyle, Tim (CDC/DDPHSIS/CPR/DSLR) <tcd2@cdc.gov>
Sent: Monday, March 2, 2020 7:56:17 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Monday

Ok, I am in lobby

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Monday, March 2, 2020 6:17:03 AM
To: Doyle, Tim (CDC/DDPHSIS/CPR/DSLR) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Monday

Change of plans. We can meet first thing this morning.

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From: Blackmore, Carina
Sent: Sunday, March 1, 2020 10:26:23 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Monday

Hi Tim, The good news is you are coming right at the best time. Expect to be plugged into the Coronavirus response from day one. The bad news is that tomorrow morning will likely be a tad chaotic. We may have our two first cases confirmed tomorrow and we have just declared an emergency. I have a meeting between 830-9 am. It may drag out a little. I will try to meet you at 8 and we will get your badge and computer etc set up started. Then we will all get together as soon as we have a chance. Hopefully shortly after 9. Just wanted to give you a heads up and wish you a warm welcome :). Carina

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From:	Blackmore, Carina
To:	Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc:	Pritchard, Scott; Rubino, Heather
Subject:	Re: Monday
Date:	Monday, March 2, 2020 6:17:03 AM

Change of plans. We can meet first thing this morning.

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From: Blackmore, Carina
Sent: Sunday, March 1, 2020 10:26:23 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Monday

Hi Tim, The good news is you are coming right at the best time. Expect to be plugged into the Coronavirus response from day one. The bad news is that tomorrow morning will likely be a tad chaotic. We may have our two first cases confirmed tomorrow and we have just declared an emergency. I have a meeting between 830-9 am. It may drag out a little. I will try to meet you at 8 and we will get your badge and computer etc set up started. Then we will all get together as soon as we have a chance. Hopefully shortly after 9. Just wanted to give you a heads up and wish you a warm welcome :). Carina

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From:	Traci, Meg
To:	Lushbaugh, Justin (CDC/DDNID/NCBDDD/DHDD); Claudia.Johnson@ky.gov; Pier, Kristi (CDC maryland.gov); Cramer, Steve (CDC health.mo.gov); Paras, Kathy (CDC utah.gov); Kamp, Susan (CDC vermont.gov); Laurie.Eldridge-Auffant@adph.state.al.us; Roberson, Shamarial (CDC flhealth.gov); bryan.russell@flhealth.gov; maggie.ferguson@idph.iowa.gov; jhall@ku.edu; Kbruns@ku.edu; hoffmana5@michigan.gov; Manning, Mary (CDC state.mn.us); Bluhm, Jim JB (CDC state.mn.us); Susan.havercamp@osumc.edu; vanessas@uark.edu; Rodrigo.Monterrey@MassMail.State.MA.US; Barbara.wallace@health.ny.gov; weaverro@ohsu.edu; SMCDERMO@mailbox.sc.edu; devlinj@mailbox.sc.edu; Barb.Locker@ky.gov; Allison.perline@vermont.gov; Wimberley, Richard (CDC michigan.gov); HWelch@mt.gov; erin.ashinghurst@maryland.gov; bdkilpat@uark.edu; ann.robinson@osumc.edu; Kimberly.Phillips@unh.edu; holly.teal@health.ny.gov; Brenda.Maley@health.mo.gov; Kimberley.Warsett@state.ma.us; hornerjo@ohsu.edu; nettie.romanzo-smith@health.ny.gov; Evan.England@unh.edu; nassira.d.nicola@state.ma.us; aBraner@utah.gov; ctamayo@phhp.ufl.edu; Rachael.Austin@health.ny.gov; Patrick.Hodge@flhealth.gov; Casey, Margaret MC (CDC health.ny.gov); maureen.spence@health.ny.gov; rodrigo.monterrey@state.ma.us; LeeC@michigan.gov; anna.fuller@uky.edu; lindsey.c.mullis@uky.edu; chithra.adams@uky.edu; David.Ellsworth@odh.ohio.gov; Edward.Clark@flhealth.gov; FrameA@michigan.gov; Bishop, Susan (CDC state.mn.us); emily.smoak@state.mn.us; Mackenzie.Jones@mt.gov; Schulte, Ann (MDH); Crotty, Anne E
Cc:	Tilahun, Selam (MDH); Erin Taylor; Vincent-Mark, Arlene (CDC/DDNID/NCBDDD/DHDD)
Subject:	Re: NCHPAD Home workout toolkit
Date:	Friday, March 20, 2020 12:27:20 PM

Thanks, Justin.

We have added the NCHPAD toolkit to the MTDH website with other information and resources that partners have been sharing related to COVID-19 and People with Disabilities at: https://mtdh.ruralinstitute.umt.edu/?p=7763

Justin and others-- please let us know of additional information and resources to add and share with partners and people with Montana.

Thank you,
Meg

Meg Ann Traci, PhD
Pronouns: she, her, hers
Research Associate Professor
Montana Disability and Health Program
The Rural Institute for Inclusive Communities
University of Montana
Office: 245 Corbin Hall
Phone: 406-243-4956
Email: meg.traci@mso.umt.edu
Websites:
UM RIIC http://ruralinstitute.umt.edu/
MTDH https://mtdh.ruralinstitute.umt.edu/

The University of Montana acknowledges that we are in the aboriginal territories of the Salish and Kalispel people. We honor the path they have always shown us in caring for this place for the generations to come.

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Subject: NCHPAD Home workout toolkit

Good morning, all:

Please find attached NCHPAD's Inclusive Home Workout Toolkit, and please feel free to share the content with your networks.

Thanks, and please let me know if you have any questions.

Stay happy and healthy!

-Justin

Justin Lushbaugh
Public Health Analyst
Disability Science and Program Team ¦ Disability & Health Promotion Branch
Division of Human Development and Disability
National Center on Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
4770 Buford Hwy MS-S101-3
Chamblee, GA 30341-3717
Xko0@cdc.gov
(404) 498-3036 Office
(470) 421-0183 Mobile
(770) 488-0270 Fax

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From:	Pritchard, Scott
To:	Blackmore, Carina; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc:	Rubino, Heather
Subject:	Re: Next week
Date:	Wednesday, February 26, 2020 6:49:45 PM

Can't wait to have you Tim!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 26, 2020 6:23:53 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Next week

We are excited to have you on site next week. Coronavirus is the first item on the menu as you can imagine. But we are also engaged in hep A and legionella response. Not to forget flu. What time do you think you will be in the office? We would like to sit down sometimes early in the day to discuss scientific on boarding. Carina

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From:	Blackmore, Carina
To:	Yoon, Paula (CDC/DDPHSS/CSELS/DHIS); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Rivkees, Scott A
Subject:	Re: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Tuesday, March 10, 2020 11:10:57 AM

we appreciate the partnership.

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From: Yoon, Paula (CDC/DDPHSS/CSELS/DHIS) <pay3@cdc.gov>
Sent: Tuesday, March 10, 2020 11:07:31 AM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Outreach: COVID-19 Collaborative Syndromic Surveillance

Our team has already reached out to colleagues in FL with instructions for turning on data access but if you have questions, I would be happy to take them.

Paula

Paula W. Yoon, ScD, MPH
Director
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS E-97, Atlanta, GA 30333
404-498-6298 Office | pyoon@cdc.gov
Assistant: Bessie Holland | 404-498-6346 | vbb3@cdc.gov

From: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Sent: Tuesday, March 10, 2020 11:06 AM
To: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS) <pay3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Outreach: COVID-19 Collaborative Syndromic Surveillance

Hi Scott

Dr Paula Yoon will follow up directly with Dr Balckmore.

Thanks

JT

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>

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Sent: Monday, March 9, 2020 7:59 PM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

Thank you,
Scott

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From:	Rivkees, Scott A
To:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD)
Cc:	Blackmore, Carina
Subject:	Re: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Monday, March 9, 2020 7:58:40 PM

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

Thank you,
Scott

From: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Sent: Monday, March 9, 2020 3:34:41 PM
To: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Subject: FW: Outreach: COVID-19 Collaborative Syndromic Surveillance

Scott

I know you are buried under a lot of COVID 19 related work, but I wanted to bring back to your attention our request for your participation on syndromic surveillance.
We raised this topic at SHP call a few weeks back and I highlighted again when I had the chance to address the SHO in DC.
I know ASTHO sent you a couple of weeks an email with a specific request on this topic. Hopefully you will be able to join the other 30 that already agreed

I would be happy to connect you to NSSP team doing the work if you need more detail

Here are a few bullets describing the work to date:

1. **Community Outreach**: Twenty-nine jurisdictions are currently sharing syndromic data with CDC for COVID-19 surveillance. NSSP staff are actively engaged with staff from other states who are interested but have questions, concerns, or need a new DUA.

2. **Developing queries** to identify potentially relevant visits from the emergency department data: NSSP staff are developing two COVID-19 queries, one focused on chief complaint narratives and one focused on discharge diagnosis codes. Queries are shared with the community of practice via Slack and discussed on calls among community partners. The discharge-diagnosis based query has been developed and incorporated into ESSENCE. The chief-complaint query is being refined using site specific data shared with NSSP and the team is exploring the utility of including triage notes as part of this effort.

3. **Methods for tracking trends** of persons exhibiting symptoms consistent with COVID-19:

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Development effort is focused on reducing the effect of influenza and other non-coronavirus etiologies. The influenza query using discharge diagnosis has been developed to help negate confirmed influenza in the COVID-19 query using site-specific data that has been shared with NSSP.

4. **Developing approaches for querying emergency department data** to analyze records for persons under isolation and with infectious disease. A query was shared with the Community of Practice via Slack and was revised. The community is using the query. Some noted a large increase in patients under isolation, and others noted a small increase. The community said this is helpful for identifying severe illness.

5. **Developing reports and dashboards** that can be shared in ESSENCE to aid state and local users in tracking trends and active case finding. The dashboard will update in real-time with the level of data accessible to each user. Development is dependent on completion of queries/syndromes identified above. The addition of newly shared data will accelerate development of this ESSENCE dashboard by enabling NSSP staff to test functionality that will be accessible to state and local jurisdictions.

6. **Developing reports for the CDC EOC** on national and HHS-region-level syndromic summaries. Also working on state-level summaries for sites sharing data. The report will be shared with participating states for approval before sharing with the CDC EOC.

Thanks

JT
José T. Montero, MD, MHCDS
Director, Center for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention
Century Center, Atlanta GA
Tel: 404-498-0300
E-mail:znn3@cdc.gov
MS: E70

AMERICAN OVERSIGHT

From:	Chapman, Jennifer Rose
To:	Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP); Stanek, Danielle (CDC flhealth.gov); Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); Cohen, Jonathan
Cc:	Blackmore, Carina (CDC flhealth.gov); Jones, Patricia Denise; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); CGH DPDM DPDx Web Inquiries (CDC); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); White, Stephen L; Holland, Aubrey; Quaye, Elesi A; Rico, Edhelene; Noya-Chaveco, Pedro A; Mejia-Echeverry, Alvaro
Subject:	Re: Possible Leishmaniasis Patient: FL 29 yo F Miami
Date:	Monday, February 10, 2020 4:57:14 PM
Attachments:	image001.png image002.png
Sensitivity:	Confidential

Okay. We will send the FFPE clot section, which has not been decalcified.

Jennifer Chapman, MD
Associate Professor
Acting Director, Hematopathology Division
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowships
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

University of Miami Hospital
Department of Pathology
4th floor, room 4076
1400 NW 12th Ave.
Miami, Florida 33138
The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

From: Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
Sent: Monday, February 10, 2020 3:40 PM
To: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami

Dr. Chapman,

AMERICAN OVERSIGHT

We will need the entire FFPE block. The block will be returned to the submitter after the case is finalized but please note, the block may be depleted during testing. For evaluation of Leishmania, the infectious diseases pathology branch (IDPB) performs immunohistochemistry. The DNA is extracted here (at IDPB) and then sent to the Div. of Parasitic Diseases (DPD) for PCR analysis.

Thank you for your understanding.

Regards,
Eddy

Eduard Matkovic, M.D.
Associate fellow | National Center for Emerging and Zoonotic Infectious Diseases | Division of High-Consequence Pathogens and Pathology | Infectious Disease Pathology Branch | Centers for Disease Control and Prevention | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 | Tel: (404) 626-8119 | lua6@cdc.gov

---

From: Chapman, Jennifer Rose <JChapman@med.miami.edu>
Sent: Monday, February 10, 2020 3:24 PM
To: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
Subject: Re: Possible Leishmaniasis Patient: FL 29 yo F Miami
Sensitivity: Confidential

Dear all,

We plan to cut tissue scrolls from a FFPE block of bone marrow aspirate that has not been decaled.

I will send the scrolls to the Florida Department of Public Health with the CDC requisition.

I assume that the Florida Dept of Health will then send them to the infectious disease pathology branch within the CDC.

AMERICAN OVERSIGHT

Please confirm that this is appropriate.

Thank you.

Jennifer Chapman, MD
Associate Professor
Acting Director, Hematopathology Division
Director of Anatomic Pathology Operations @UHealth
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Department of Pathology and Laboratory Medicine
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Sent: Monday, February 10, 2020 12:40 PM
To: 'Benoit, Tina (CDC/DDID/NCEZID/DHCPP)' <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami

---

You've received an encrypted message from **Danielle.Stanek@flhealth.gov**
To view your message
Save and open the attachment (message.html), and follow the instructions.
Sign in using the following email address: **JChapman@med.miami.edu**

This email message and its attachments are for the sole use of the intended recipient or recipients and may contain confidential information. If you have received this email in error, please notify the sender and delete this message.

AMERICAN OVERSIGHT

Message encryption by Microsoft Office 365



AMERICAN OVERSIGHT

From:	Moscoso, Alberto
To:	Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Cc:	Burns, Erin (CDC/DDID/NCIRD/ID); Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Pritchard, Scott
Subject:	Re: Press release planning for Florida
Date:	Sunday, March 1, 2020 1:20:20 PM

Thanks, Scott.

Kristen,

I really appreciate your reaching out. We have updated our website to reflect Florida test results and PUIs: www.FloridaHealth.gov/COVID-19

I would certainly be grateful for whatever information you are able to share. Situational awareness is always a priority.

Is there anything else I can provide on my end to support your mission?

Thanks,

Alberto Moscoso
Communications Director
Florida Department of Health
(850) 408-7687 (cell)

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
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Hi Alberto,

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Thanks,
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404-956-0336 (cell)

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AMERICAN OVERSIGHT

Alberto <Alberto.Moscoso@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

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I can also let you know that other states will be putting out communication this weekend about cases they've identified through testing.

Thanks,
Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

AMERICAN OVERSIGHT

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Scott Pritchard at the DOH in Florida will be coordinating the press for their two presumptive positive COVID-19 cases. Can you please coordinate with Scott regarding press? They will likely wait until CDC confirmation, but want to plan ahead in case they need to go public earlier as contacts and HCWs will be notified before CDC confirmation. Can you connect with Scott about this?

Quick summaries are:
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63 year old male with unknown exposure who is in the ICU.

NCoVID: FL 2785125
29 year old female with travel to Europe who is at home in isolation.

Best,
Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Moscoso, Alberto
To:	Burns, Erin (CDC/DDID/NCIRD/ID); Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Pritchard, Scott
Subject:	Re: Press release planning for Florida
Date:	Sunday, March 1, 2020 2:16:45 PM

That's exactly right. Thanks!

From: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>
Sent: Sunday, March 1, 2020 2:14 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

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Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Pritchard, Scott
Subject:	Re: Press release planning for Florida
Date:	Sunday, March 1, 2020 3:03:50 PM

Would it be possible for you to hold on lighting up Florida on your map until we announce?

We will be moving very expeditiously.

Thank you,

Alberto

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 2:16 PM
To: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

Hi Kristen, Conne, and Erin,

AMERICAN OVERSIGHT

Scott Pritchard at the DOH in Florida will be coordinating the press for their two presumptive positive COVID-19 cases. Can you please coordinate with Scott regarding press? They will likely wait until CDC confirmation, but want to plan ahead in case they need to go public earlier as contacts and HCWs will be notified before CDC confirmation. Can you connect with Scott about this?

Quick summaries are:
NCoVID: FL 2785091
63 year old male with unknown exposure who is in the ICU.

NCoVID: FL 2785125
29 year old female with travel to Europe who is at home in isolation.

Best,
Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Moscoso, Alberto
To:	Nordlund, Kristen (CDC/DDID/NCIRD/OD); CDC IMS JIC Lead -2; LaRocque, Marcie (CDC/DDID/NCIRD/OD) (CTR); Burns, Erin (CDC/DDID/NCIRD/ID)
Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Pritchard, Scott
Subject:	Re: Press release planning for Florida
Date:	Sunday, March 1, 2020 3:16:13 PM

Thank you.

Alberto Moscoso
Communications Director
Florida Department of Health
(850) 408-7687

From: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>
Sent: Sunday, March 1, 2020 3:15:36 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; CDC IMS JIC Lead -2 <eocjiclead2@cdc.gov>; LaRocque, Marcie (CDC/DDID/NCIRD/OD) (CTR) <lox3@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

We absolutely will NOT light up FL on the map until you announce.

Thanks,

Erin

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 3:04 PM
To: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

Would it be possible for you to hold on lighting up Florida on your map until we announce?

We will be moving very expeditiously.

Thank you,

Alberto

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>

AMERICAN OVERSIGHT

Sent: Sunday, March 1, 2020 2:16 PM
To: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

That's exactly right. Thanks!

From: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>
Sent: Sunday, March 1, 2020 2:14 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

I am not actually seeing an announcement about your presumptive-positive. Are you waiting for CDC confirmation? We won't report until you do.
All our press releases are online: https://www.cdc.gov/media/dpk/diseases-and-conditions/coronavirus/coronavirus-2020.html#tabz
Thanks,
Erin

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 1:20 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks, Scott.

Kristen,

I really appreciate your reaching out. We have updated our website to reflect Florida test results and PUIs: www.FloridaHealth.gov/COVID-19

I would certainly be grateful for whatever information you are able to share. Situational awareness is always a priority.

Is there anything else I can provide on my end to support your mission?

AMERICAN OVERSIGHT

Thanks,

Alberto Moscoso
Communications Director
Florida Department of Health
(850) 408-7687 (cell)

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:35:19 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

Hi Alberto,

Happy to chat anytime. Illinois announced a community case today and as I mentioned, we expect at least one other than you guys this week.

Thanks,
Kristen
404-956-0336 (cell)

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 29, 2020 9:16 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:11:11 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>

AMERICAN OVERSIGHT

Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>
Subject: RE: Press release planning for Florida

Hi Scott,

Sorry if others have reached out, but wanted to make sure we followed up. CDC and other states have put out a lot of communication in the last few days about both travel and unknown exposure related COVID-19 cases that I'm happy to share.

I can also let you know that other states will be putting out communication this weekend about cases they've identified through testing.

Thanks,
Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
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Best,
Katherine

AMERICAN OVERSIGHT

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Cc:	Burns, Erin (CDC/DDID/NCIRD/ID); Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Moscoso, Alberto
Subject:	Re: Press release planning for Florida
Date:	Saturday, February 29, 2020 9:15:44 PM

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:11:11 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>
Subject: RE: Press release planning for Florida

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Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

AMERICAN OVERSIGHT

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Best,
Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From: Chapman, Jennifer Rose
To: Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); BPHL13FL@flhealth.gov; Cohen, Jonathan
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: Re: Specimen Receipt Notice: IDPB 2020-0171
Date: Wednesday, February 12, 2020 3:18:03 PM
Sensitivity: Confidential

Adding Dr Cohen, treating physician, to answer the questions below.

Jennifer Chapman, MD
Associate Professor
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowship Program
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Sent: Wednesday, February 12, 2020 3:03:35 PM
To: Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov <BPHL13FL@flhealth.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Elesi.Quaye@flhealth.gov <Elesi.Quaye@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov <Edhelene.Rico@flhealth.gov>; Alvaro.Mejia-Echeverry@flhealth.gov <Alvaro.Mejia-Echeverry@flhealth.gov>; pedro.noya-chaveco@flhealth.gov <pedro.noya-chaveco@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171

Good afternoon

We are requesting additional information regarding this case:

- Travel history and/or country of birth
- History of insect bites
- Leish testing date
- Results of any other microbiologic evaluation

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
Centers for Disease Control and Prevention
1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027
MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 **(Tuesdays ONLY)**
TBenoit@cdc.gov

From: Pathology (CDC) <Pathology@cdc.gov>
Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Subject: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence.
Dr. Stephen White,
This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.
If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

****

Report Password: the password to open the password protected Pathology Report PDF (Preliminary/Final/Addendum) for this case will be provided in a separate email after you receive the Final Pathology Report Email and will be a unique 12 digit number. If additional specimens are subsequently received on the same case by IDPB, the password will remain unchanged. Animal case reports will not have password protection.

Specimen Receipt Notice: the official contact(s) at the Health Departments (if known) will be cc'd on IDPB's Specimen Receipt Notice emails, in addition to cc'ing other case specific relevant parties. The same official contact(s) at the Health Departments (if known) will continue to receive IDPB's Final Pathology Reports once finalized.

ePathology Service: IDPB now offers telepathology consultation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http://www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Kopp, Edgar W; sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Cannons, Andrew C; Heberlein-Larson, Lea A.
Subject:	Re: Specimen Submission for COVID-19 PUI ID# 0001287
Date:	Thursday, February 20, 2020 8:08:33 PM

Thanks

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Kopp, Edgar W <Edgar.Kopp@flhealth.gov>
Sent: Thursday, February 20, 2020 7:43:16 PM
To: sgk5@cdc.gov <sgk5@cdc.gov>; eocevent177@cdc.gov <eocevent177@cdc.gov>; eocevent185@cdc.gov <eocevent185@cdc.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Cannons, Andrew C <Andrew.Cannons@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>
Subject: Specimen Submission for COVID-19 PUI ID# 0001287

FedEx tracking number 777820256263
Sender's name: Edgar Kopp

From: Pritchard, Scott
Sent: Wednesday, February 19, 2020 3:41 PM
To: Cannons, Andrew C <Andrew.Cannons@flhealth.gov>; Kopp, Edgar W <Edgar.Kopp@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Specimen Submission COVID-19 PUI ID# 0001287

Here are the details for an incoming PUI from Hillsborough county.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Sent: Wednesday, February 19, 2020 3:37 PM
To: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; CDC IMS Logistics Transportation <eocevent306@cdc.gov>; Hyde, Allen W. (CDC/DDPHSIS/CPR/DEO) <fnb4@cdc.gov>; Schneider, Eileen (CDC/DDID/NCIRD/DVD) <ees2@cdc.gov>; CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Subject: PUI ID# 0001287

Hello Scott:

Thank you for contacting CDC about the patient under investigation (PUI) for novel coronavirus (COVID-19). Please find summary information below to help assist in the PUI evaluation and specimen referral.

Summary

38 yo male who resides in China (Guangzhou City) came to US on 2/3. on 2/15 he developed cough, congestion, rash and subjective fever. Patient presented to ED for evaluation. Decision made to admit patient but patient signed himself out AMA. Specimen x 3 were collected prior to his signing himself out. Denied other risk factors (travel to Wuhan or Hubei province; contacts to a known case).

CDC COVID-19 ID #0001287

POC Details

Name: Scott Pritchard

Location: Florida

Phone: 850-251-5558

Email: scott.pritchard@flhealth.gov

Additional information

Guidance for health departments to submit PUI information to CDC can be found here.

AMERICAN OVERSIGHT

Include the CDC COVID-19 ID issued to you by CDC in the top right box and on all specimen forms. The PUI form should be submitted as soon as able and need not wait for specimen shipping. Instructions on how to submit the PUI form are located at the top of the form.

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

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

Please see the attached *2019 Novel Coronavirus (nCoV) Specimen Submission Guidelines* for detailed guidance on specimen shipment, packaging, and documentation. Please ensure that the patient information on the specimen tube exactly matches the 50.34 DASH Form, or the CDC may have to reject the specimen or testing may be delayed.

For questions about specimen collection or completing the 50.34 Form, please see https://www.cdc.gov/laboratory/specimen-submission/help-faqs.html.

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

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

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

Thank you,

CDC IMS 2019 NCOV Response PUI Team

2019 Novel Coronavirus Response

eocevent185@cdc.gov

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From:	Koneff, Douglas A
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Eleni Kalisch; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); CGRCU-Internal; O"Reilly, Kevin M; WHA-BSC-only; CGRCU-CAReps
Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject:	Re: Status of Chile charter (Silver Express pax)
Date:	Wednesday, March 18, 2020 9:13:17 AM

From Eleni:

The Latam charter from Chile is scheduled to arrive MIA at 11:30AM. We are arranging charters for this afternoon for non-Floridians to return them to airports closer to their homes. I have reached out to DOT to see if we can continue the Latam charter aircraft on to another airport and am awaiting guidance.

Get Outlook for iOS

From: Koneff, Douglas A <KoneffD@state.gov>
Sent: Wednesday, March 18, 2020 8:59:09 AM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; O'Reilly, Kevin M <OReillyKM@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Subject: Status of Chile charter (Silver Express pax)

I am slimming the chain to take our overseas colleagues off for right now. Please add DHS and others in the US as needed. Adding the State Department COVID coordination unit and consular reps.

Eleni - we understand the charter from Chile is scheduled to land in MIA between 1200-1300 EDT, and that FL state authorities have said non FL residents will not be allowed to continue onward to home unless moved to another charter.

Can you give us the latest? We are concerned both about Amcits on this flight as well as future charters by RC or other charters seeking to land in FL.

Thanks - Doug

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From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:37 PM

AMERICAN OVERSIGHT

To: Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc: Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 10:20 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

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Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Eleni Kalisch
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM

AMERICAN OVERSIGHT

To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

AMERICAN OVERSIGHT

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
> **To:** Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
> **Subject:** Royal Caribbean Ships off Brazil/Chile
>
> All -

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Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From: Blackmore, Carina
To: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR)
Subject: Re: Tim Doyle will be on Board with CPR/DSLR effective Sunday and should be reporting to FL next week
Date: Thursday, February 27, 2020 3:26:37 PM

Hi Hugh. Delighted to see the news about Dr Philip. Have great respect for her. Drs B and D also seem to be skilled, thoughtful, practical and personable people.
Yes We are very excited to have Tim on boa d next week and expect to immediately plug him in to our Corona response effort. Not a day too soon! Carina

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From: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR) <hmm2@cdc.gov>
Sent: Thursday, February 27, 2020 1:20:54 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Tim Doyle will be on Board with CPR/DSLR effective Sunday and should be reporting to FL next week

Hi Carina-
Tim is on his way to you.
On the information exchange side and not related to COVID 19- we just received the following note from Dr Redfield….
With the addition of Dr Philip, there are an increasing number of former senior state health officials joining CDC at executive ranks. This now includes Dr Butler from Alaska, Dr Dreyzhner from Tennessee, Dr Montero from New Hampshire. This may mark a new trend toward increased responsiveness to the public health issues and priorities of SLTT jurisdictions.
Cheers

Hugh

I am pleased to announce that **Celeste Philip, MD, MPH**, has been selected as CDC's Deputy Director for Non-Infectious Diseases.

Dr. Philip brings a wealth of public health management, knowledge, and experience as a physician to the agency. She most recently served as Health Officer for the Sonoma County Department of Health Services in Santa Rosa, California, where she oversaw the public health division during a period of unprecedented response efforts, including the Kincade Fire, numerous public safety power shut-offs, and health service provisions for a large number of people experiencing homelessness. Previously, she was appointed by the Governor of Florida to serve as Florida's Surgeon General and Secretary of Health from 2016-2018. In this role, she managed a $3 billion budget and more than 13,000 full-time employees. She led the state-wide response to the Zika virus; directed the state's Emergency Support Function—Public Health and Medical Services (ESF8)—during five hurricanes, including Irma (2017) and Michael (2018); and guided the redesign of the state's HIV program to provide pre-exposure prophylaxis (PrEP) in all 67 counties. From 2013-2016, Dr. Philip served as Florida's Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services. During her tenure, she brokered the negotiation of settlement terms to end 10 years of litigation

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against the State of Florida over Title XIX; the settlement helped to build bridges and led to statewide collaborations on immunizations, mental health, adverse childhood experiences, and opioid policy with clinician groups.

Her professional training includes serving as an EIS Officer from 2006-2008, with the Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion; and completing CDC's Preventive Medicine Residency as a Lieutenant Commander in the US Public Health Service with the Florida Department of Health in Polk County (Bartow, Florida).

Dr. Philip received a bachelor's degree from Howard University (magna cum laude), and both a Master of Public Health degree in maternal and child health and a Doctor of Medicine degree from Loma Linda University in California. She is certified by the American Board of Preventive Medicine and the American Board of Family Medicine and holds medical licenses in both Florida and California.

Dr. Philip has been recognized as the Loma Linda University School of Public Health Alumnus of the Year, the Florida Outstanding Woman in Public Health by the University of South Florida, and as a Trustee Scholar by Howard University. She has also received the American Cancer Society's Southeast Region Impact Award, an Outstanding Unit Citation for CDC's H1N1 response, the MacKenzie Foundation Award, the Selma Andrews Award in Public Health, and both the Special Act or Service Award and the On the Spot Award from the National Library of Medicine.

She has also given numerous public health presentations, published medical journal articles, and served on many boards, advisory councils, and volunteer positions over the course of her career.

Please join me in welcoming Dr. Philip as she returns to CDC in her new role, starting March 30, 2020, as Deputy Director for Non-Infectious Diseases.

I would also like to express my gratitude to both Anne Schuchat, MD (RADM, USPHS, RET) and Ileana Arias, PhD for serving as Acting Deputy Director for Non-Infectious Diseases. Thank you both for supporting our mission to see the possible in public health.

Sincerely,

Robert R. Redfield, MD
Director, CDC, and
Administrator, ATSDR

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Blackmore, Carina (CDC flhealth.gov); Luce, Christie
Cc:	Coulter, Jennifer; Rubino, Heather; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Tuesday, February 18, 2020 5:37:02 PM

Thanks. We are still gathering information from each state, and will reach out to you soon to discuss how you could send the data in an aggregate form.

Thanks again!

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

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, February 18, 2020 4:25 PM
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>; Luce, Christie <Christie.Luce@flhealth.gov>
Cc: Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: RE: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Per previous conversations, we will not be using DCIPHER. Case data will be sent through NNDSS. We can discuss how to send monitoring data in an aggregate form.

Carina

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Saturday, February 15, 2020 11:24 AM
To: Luce, Christie <Christie.Luce@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

We are following up with the request below. Once we have received your submission access will be granted for 2019-nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

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As a reminder, please consult with your state Epi and state Lab counterparts to ensure we provide access to all staff in your jurisdiction that might need to enter data for various aspects of the response.

If you have any questions please contact eocsctftfcoord@cdc.gov.

Thank you,

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

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Sent: Wednesday, February 12, 2020 4:41 PM
To: Christie.Luce@flhealth.gov <Christie.Luce@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: jennifer.coulter@flhealth.gov <jennifer.coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

As we prepare to use DCIPHER for the 2019-nCoV response (e.g., data collection, transmission, and data sharing), we are seeking additional information about the type of access for the users you previously identified for the nCoV 2019 DCIPHER platform.

The "access group" options are described here:

1. **Access to DCIPHER to VIEW (only) data**. Role allows individual to see a view of different reports and analyses for their jurisdiction's information and any aggregate national report that may be created.
2. **Access to DCIPHER for DATA ENTRY and EDITING**. Role allows individual to directly enter information into DCIPHER, edit data, see all data associated with the jurisdiction, in addition to viewing/creating different reports and analyses.

In the attachment, please complete information in the last two columns (epi and monitoring), select either **view** or **data entry/editing** for each user.

Please return your response to eocsctftfcoord@cdc.gov as soon as possible so we can configure the platform to support your jurisdictions' access requests.

Warm Regards,
State Coordination Task Force (SCTF)
Regional Coordination Team - eocsctftfcoord@cdc.gov

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Center for Preparedness and Response (CPR)
404-232-0480

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Christie.Luce@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Cc:	jennifer.coulter@flhealth.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Saturday, February 15, 2020 11:24:11 AM
Attachments:	Florida.xlsx

Greetings PHEP Directors and State Epidemiologists,

We are following up with the request below. Once we have received your submission access will be granted for 2019-nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

As a reminder, please consult with your state Epi and state Lab counterparts to ensure we provide access to all staff in your jurisdiction that might need to enter data for various aspects of the response.

If you have any questions please contact eocsctftfcoord@cdc.gov.

Thank you,

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

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Sent: Wednesday, February 12, 2020 4:41 PM
To: Christie.Luce@flhealth.gov <Christie.Luce@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: jennifer.coulter@flhealth.gov <jennifer.coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

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1. **Access to DCIPHER to <u>VIEW</u> (only) data**. Role allows individual to see a view of different reports and analyses for their jurisdiction's information and any aggregate national report that may be created.
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In the attachment, please complete information in the last two columns (epi and monitoring), select either **view** or **data entry/editing** for each user.

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Warm Regards,

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

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From: Barnett - CDPHE, Aislinn
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Cc: Patricia Vinsen (CDC/ddph/state/al.us); heidi.hatcher@alaska.gov; Utagaleli, Eli (CDC/doh.as); Snyder, Wendy (CDC/azdhs.gov); Ferguson, Reva (CDC/arkansas.gov); rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC/cdph.ca.gov); Jensen, Dana (CDC/ct.gov); richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@flhealth.gov; angelica.magnan@doh.ga.gov; fanny.vasquez@doh.ga.gov; Solonion, Fanoy (CDC/fsmhealth.fm); Kaneshiro, Suzanne (CDC/dohss.guam.gov); Sharon.Tanonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Olugasegun.Oyeniran@illinois.gov; Musgrave, Sherry (CDC/illinois.gov); Barrett, Tarni (CDC/isdh.in.gov); Gaskey, Jennifer (CDC/idph.iowa.gov); Denise.Schimmel@ks.gov; joanfieldsmither@ky.gov; Jane.Killen2@la.gov; Lawrence, Peggie (CDC/maine.gov); jacey.barry1@maryland.gov; Michelle.Pingree@maryland.gov; Eva.benyenga@maryland.gov; rebecca.white@state.ma.us; Fierstein@michigan.gov; Pozun, Sandy (CDC/state.mn.us); Griffin, Jenny (CDC/msdh.ms.gov); Mebruer, Debbie (CDC/health.mo.gov); kacesh@mt.gov; Kelly, Richard@mt.gov; Engel, Bonnie (CDC/nebraska.gov); Mapen.Schacht@nebraska.gov; pdiloreto@health.nv.gov; Bozent, Kelly (CDC/dhhs.nh.gov); White, Barbara (CDC/dhhs.nh.gov); deanna.morris@doh.nj.gov; Bolz, Angela (CDC/state.nm.us); jade.silva@health.ny.gov; portia.moore@dohhs.ne.gov; phomsen@nd.gov; Petersen, Jandi (CDC/doh.gov.mp); Ashley.Wilson@odh.ohio.gov; mdanish@health.ok.gov; Best, Patricia (CDC/state.or.us); tbarrettno@pa.gov; pbeene@pa.gov; Byrnes, Carolyn (CDC/pa.gov); julie.klute@palauhealth.org; marinelopeak@gmail.com; Menard, Rita (CDC/health.ri.gov); Higgins, Teresa (CDC/dhec.sc.gov); Harding, Monica (CDC/state.sd.us); Stanton, Tammy (CDC/tn.gov); carolyn.peter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idhelleh@doh.vi.gov; McFarlane, Lesa (CDC/doh.vi.gov); tasha.clunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC/vermont.gov); Maryanna.wollman@vdh.virginia.gov; Bergener, Terry (CDC/doh.wa.gov); Fisher, Andrea (CDC/wv.gov); tara.vasby@dhs.wisconsin.gov; Scott.Harris@kdheks.gov; anne.rick@alaska.gov; Nua, Mokusa Tuileama (CDC/doh.as); Ghrist, Cara (CDC/azdhs.gov); Smith, Nathaniel (CDC/arkansas.gov); Sonia.gnall@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC/ct.gov); tracy.cattau@delaware.gov; Nesbitt, LaQuanita (CDC/dc.gov); scott.rivkees@flhealth.gov; kathleen.toomey@doh.ga.gov; miamm@fsmhealth.fm; Linda.cinoncio@dohss.guam.gov; bruce.s.anderson@doh.hawaii.gov; ike.ehaw-tulloch@dhw.idaho.gov; Nagy,Elke@illinois.gov; jpox@isdh.in.gov; Dalbaugh, Carol (CDC/idph.iowa.gov); jay.norman@ks.gov; adearinger@ky.gov; alexander.billoux@la.gov; niray.shah@Maine.Gov; robert.neal@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC/state.ma.us); Khalouh@michigan.gov; ian.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; aheilbrodt@mt.gov; Cholman@mt.gov; danielle.smith@nebraska.gov; gary.anthone@nebraska.gov; Lenevich@health.ny.gov; jazarn@health.ny.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC/health.ny.gov); mark.benton@dhhs.ne.gov; Betsey.Tilson@dhhs.nd.gov; maryenbuffle@nd.gov; Muña, Esther (CDC/doh.gov.mp); amy.acton@odh.ohio.gov; GaryG@health.ok.gov; Stanley, Lillian (CDC/state.or.us); ralevine@sa.gov; Dr.Rafael.Rodriguez@salud.pr.gov; Catherine.delarosa@salud.pr.gov; emais.roberts@palauhealth.org; tbillman@hotmail.com; Alexander-Scott, Nicole (CDC/health.ri.gov); rick.toomey@dhec.sc.gov; Malsam-Reydon, Kim (CDC/state.ad.us); Lisa.Piercey@tn.gov; Hellerstedt, John (CDC/dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC/utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC/doh.wa.gov); cathy.s.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harriet, Alexis (CDC/cwus.gov); Montero, Jose (CDC/DDNID/NSIOD/STLTS/OD); marcus.rivera@ASTHO.com;
Subject: Re: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)
Date: Monday, March 2, 2020 4:33:30 PM

Hello,
Our top health official remains the same.

We do have our Chief Medical Officer on board now.
CO, Eric France, MD, Chief Medical Officer, 720-651-1137, eric.france@state.co.us, Amber Beren, 303-692-2614, amber.beren@state.co.us.

Aislinn Barnett, MS
Executive Assistant, Jill Hunsaker Ryan - Executive Director
Executive Assistant, Karin McGowan - Deputy Executive Director/Director of Community Relations

4300 Cherry Creek Drive South, Denver, CO 80246 | Ph: 303-880-0764
aislinn.barnett@state.co.us | www.colorado.gov/cdphe
Your feedback is important to us! Please let us know how I am doing.

On Mon, Mar 2, 2020 at 9:39 AM CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov> wrote:

Good Morning,

CDC Incident Management has asked the State Coordination Task Force for contact information of the **top health official** in each jurisdiction to expedite outreach in the event of an emergencies and to provide COVID-19 updates as expeditiously as possible. To accomplish this task, I am reaching out to the SHO/THO Assistant with a cc to the SHO/THO. This information will be used in tandem with the information we have for the SHO/THO maintained by ASTHO. You all are in a great position to assist us!

We know that in many cases the top health official is the SHO/THO. If that case is , just **reply** to this email that they are the **same**.

For those where there is a person who is more senior to the SHO/THO (as a reminder, we are looking for the most senior health official), please complete the following information:

State/Territory	Highest Health Official (i.e. Commissioner/ Minister/Secretary) Name (including degrees as appropriate)	Title	Phone Number (Please provide a **number or** numbers where we can reach out ***after hour*** should the need arise for COVID-19)	Email	Executive Assistant Name	Phone Number	Email

Due to the nature of this **urgent request**, respond by **COB today**.

Thank you so much for your assistance.

If you have questions or concerns, please contact me.

Kimberly

Kimberly Cantrell

State Coordination Task Force

c: 404-232-0480

SCTF: eomssctftfcoord@cdc.gov

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Pritchard, Scott
Cc:	Blackmore, Carina (CDC flhealth.gov); Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD); CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers
Date:	Saturday, February 15, 2020 8:27:10 AM

Thank you for your response. SCTF confirm receipt.

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

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, February 14, 2020 10:21 PM
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Florida: 850-245-4401

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 14, 2020 5:05 PM
To: Pritchard, Scott
Subject: FW: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Did you respond

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Friday, February 14, 2020 11:57 AM
To: Stevens, Kelly (CDC adph.state.al.us) <kelly.stevens@adph.state.al.us>; McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; eugene.livar@azdhs.gov; Smith, Nathaniel (CDC arkansas.gov) <nathaniel.smith@arkansas.gov>; catherine.waters@arkansas.gov;

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sonia.angell@cdph.ca.gov; Black, Stephanie SB (CDC cityofchicago.org) <stephanie.black@cityofchicago.org>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Coleman, Renee (CDC ct.gov) <renee.coleman-mitchell@ct.gov>; Heather.Aaron@ct.gov; doh.epi@dc.gov; karyl.rattay@delaware.gov; Paula.Eggers@delaware.gov; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Elke.Shaw-Tulloch@dhw.idaho.gov; Katherine.Turner@dhw.idaho.gov; molly.lamb@illinois.gov; kbox@isdh.in.gov; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; farah.ahmed@ks.gov; White, Connie (CDC ky.gov) <connie.white@ky.gov>; Nirav.shah@maine.gov; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; fran.phillips@maryland.gov; catherine.brown@state.ma.us; lyoncallos@michigan.gov; jsarofalpiy@fsmhealth.fm; jan.malcolm@state.mn.us; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; Thomas.Dobbs@msdh.ms.gov; Randall.Williams@health.mo.gov; Anderson, Stacey (CDC mt.gov) <sanderson2@mt.gov>; eric.sergeant@nebraska.gov; mpeekbullock@health.nv.gov; iazzam@health.nv.gov; benjamin.chan@dhhs.nh.gov; christopher.neuwirth@doh.nj.gov; chelsea.mcmullen@state.nm.us; ddaskalakis@health.nyc.gov; Zucker, Howard (CDC health.ny.gov) <howard.zucker@health.ny.gov>; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; Moore, Zackary (CDC dhhs.nc.gov) <zack.moore@dhhs.nc.gov>; mylynntufte@nd.gov; Muña, Esther (CDC dph.gov.mp) <esther.muna@dph.gov.mp>; Amy.Acton@odh.ohio.gov; GaryC@health.ok.gov; MELISSA.E.POWELL@dhsoha.state.or.us; desedamd@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov) <Nicole.alexanderscott@health.ri.gov>; Jamie Blair <BlairJD@dhec.sc.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; josh.clayton@state.sd.us; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Dunn, Angela (CDC utah.gov) <angeladunn@utah.gov>; Kelso, Patsy (CDC vermont.gov) <patsy.kelso@vermont.gov>; lilian.peake@vdh.virginia.gov; cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>; jennifer.shuford@dshs.texas.gov; joy.zimmermanbodi@dshs.texas.gov; Linda.denorcey@dphss.guam.gov; alexander.billioux@la.gov; ralevine@pa.gov; bbilimon@hotmail.com; emais.roberts@palauhealth.org; Nua, Motusa Tuileama (CDC doh.as) <tuinua@doh.as>; Arwady, Allison AA (CDC cityofchicago.org) <allison.arwady@cityofchicago.org>; BFerrer@ph.lacounty.gov

Cc: McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; a.tufa@doh.as; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Tolliver, Rickey (CDC state.co.us) <rickey.tolliver@state.co.us>; Cartter, Matthew (CDC ct.gov) <matt.cartter@ct.gov>; Davies-Cole, John (CDC dc.gov) <john.davies-cole@dc.gov>; Tabatha.Offutt-Powell@state.de.us; Skilling, Vita A. (CDC fsmhealth.fm) <Vskilling@fsmhealth.fm>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Ann.Pobutsky@dphss.guam.gov; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; Hahn, Christine G. <ID> (CDC dhw.idaho.gov) <hahnc@dhw.idaho.gov>; Layden, Jennifer (CDC illinois.gov) <jennifer.layden@illinois.gov>; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; farah.ahmed@ks.gov; Thoroughman,

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Douglas (CDC ky.gov) <douglas.thoroughman@ky.gov>; Ratard, Raoult (CDC la.gov) <raoult.ratard@la.gov>; catherine.brown@state.ma.us; Blythe, David (CDC maryland.gov) <david.blythe@maryland.gov>; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; lyoncallos@michigan.gov; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; george.turabelidze@health.mo.gov; paul.byers@msdh.ms.gov; Williamson, Laura (CDC mt.gov) <lwilliamson@mt.gov>; Moore, Zackary (CDC dhhs.nc.gov) <zack.moore@dhhs.nc.gov>; Miller, Tracy (CDC nd.gov) <tkmiller@nd.gov>; Safranek, Thomas <NE> (CDC nebraska.gov) <tom.safranek@nebraska.gov>; benjamin.chan@dhhs.nh.gov; Tan, Christina (CDC doh.state.nj.us) <Christina.Tan@doh.state.nj.us>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; paul.white@dph.gov.mp; mpeekbullock@health.nv.gov; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; deFijter, Sietske (CDC odh.ohio.gov) <Sietske.deFijter@odh.ohio.gov>; Burnsed, Laurence (CDC health.ok.gov) <Laurence@health.ok.gov>; dean.e.sidelinger@dhsoha.state.or.us; shawatkins@pa.gov; carmen.deseda@salud.pr.gov; Bandy, Utpala (CDC health.ri.gov) <utpala.bandy@health.ri.gov>; Bell, Linda (CDC dhec.sc.gov) <belllw@dhec.sc.gov>; Clayton, Joshua (CDC state.sd.us) <joshua.clayton@state.sd.us>; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Dunn, Angela (CDC utah.gov) <angeladunn@utah.gov>; lilian.peake@vdh.virginia.gov; Kelso, Patsy (CDC vermont.gov) <patsy.kelso@vermont.gov>; Cragin, Lori (CDC vermont.gov) <lori.cragin@vermont.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; Wasserman, Cathy (CDC doh.wa.gov) <cathy.wasserman@doh.wa.gov>; jonathan.meiman@dhs.wisconsin.gov; Ryan.Westergaard@dhs.wisconsin.gov; Del Rosario, Maria (CDC wv.gov) <Maria.C.delRosario@wv.gov>; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>
Subject: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Good Morning,

We need your help, please.

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

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

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

Thank you
State Coordination Task Force
Regional Desk

State Coordination Task Force (SCTF)

AMERICAN OVERSIGHT

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

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From: Pritchard, Scott
To: eocsctftfcoord@cdc.gov
Cc: Blackmore, Carina
Subject: Re: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers
Date: Friday, February 14, 2020 10:21:00 PM

Florida: 850-245-4401

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 14, 2020 5:05 PM
To: Pritchard, Scott
Subject: FW: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Did you respond

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Friday, February 14, 2020 11:57 AM
To: Stevens, Kelly (CDC adph.state.al.us) <kelly.stevens@adph.state.al.us>; McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; eugene.livar@azdhs.gov; Smith, Nathaniel (CDC arkansas.gov) <nathaniel.smith@arkansas.gov>; catherine.waters@arkansas.gov; sonia.angell@cdph.ca.gov; Black, Stephanie SB (CDC cityofchicago.org) <stephanie.black@cityofchicago.org>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Coleman, Renee (CDC ct.gov) <renee.coleman-mitchell@ct.gov>; Heather.Aaron@ct.gov; doh.epi@dc.gov; karyl.rattay@delaware.gov; Paula.Eggers@delaware.gov; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Elke.Shaw-Tulloch@dhw.idaho.gov; Katherine.Turner@dhw.idaho.gov; molly.lamb@illinois.gov; kbox@isdh.in.gov; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; farah.ahmed@ks.gov; White, Connie (CDC ky.gov) <connie.white@ky.gov>; Nirav.shah@maine.gov; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; fran.phillips@maryland.gov; catherine.brown@state.ma.us; lyoncallos@michigan.gov; jsarofalpiy@fsmhealth.fm; jan.malcolm@state.mn.us; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; Thomas.Dobbs@msdh.ms.gov; Randall.Williams@health.mo.gov; Anderson, Stacey (CDC mt.gov) <sanderson2@mt.gov>; eric.sergeant@nebraska.gov; mpeekbullock@health.nv.gov; iazzam@health.nv.gov; benjamin.chan@dhhs.nh.gov; christopher.neuwirth@doh.nj.gov; chelsea.mcmullen@state.nm.us;

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Cc: McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; a.tufa@doh.as; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Tolliver, Rickey (CDC state.co.us) <rickey.tolliver@state.co.us>; Cartter, Matthew (CDC ct.gov) <matt.cartter@ct.gov>; Davies-Cole, John (CDC dc.gov) <john.davies-cole@dc.gov>; Tabatha.Offutt-Powell@state.de.us; Skilling, Vita A. (CDC fsmhealth.fm) <Vskilling@fsmhealth.fm>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Ann.Pobutsky@dphss.guam.gov; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; Hahn, Christine G. <ID> (CDC dhw.idaho.gov) <hahnc@dhw.idaho.gov>; Layden, Jennifer (CDC illinois.gov) <jennifer.layden@illinois.gov>; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; farah.ahmed@ks.gov; Thoroughman, Douglas (CDC ky.gov) <douglas.thoroughman@ky.gov>; Ratard, Raoult (CDC la.gov) <raoult.ratard@la.gov>; catherine.brown@state.ma.us; Blythe, David (CDC maryland.gov) <david.blythe@maryland.gov>; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; lyoncallos@michigan.gov; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; george.turabelidze@health.mo.gov; paul.byers@msdh.ms.gov; Williamson, Laura (CDC mt.gov) <lwilliamson@mt.gov>; Moore, Zackary (CDC dhhs.nc.gov) <zack.moore@dhhs.nc.gov>; Miller, Tracy (CDC nd.gov) <tkmiller@nd.gov>; Safranek, Thomas <NE> (CDC nebraska.gov) <tom.safranek@nebraska.gov>; benjamin.chan@dhhs.nh.gov; Tan, Christina (CDC doh.state.nj.us) <Christina.Tan@doh.state.nj.us>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; paul.white@dph.gov.mp; mpeekbullock@health.nv.gov; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; deFijter, Sietske (CDC odh.ohio.gov) <Sietske.deFijter@odh.ohio.gov>; Burnsed, Laurence (CDC health.ok.gov) <Laurence@health.ok.gov>; dean.e.sidelinger@dhsoha.state.or.us; shawatkins@pa.gov; carmen.deseda@salud.pr.gov; Bandy, Utpala (CDC health.ri.gov) <utpala.bandy@health.ri.gov>; Bell, Linda (CDC dhec.sc.gov) <belllw@dhec.sc.gov>; Clayton, Joshua (CDC state.sd.us) <joshua.clayton@state.sd.us>; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Gaul, Linda (CDC

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dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Dunn, Angela (CDC utah.gov) <angeladunn@utah.gov>; lilian.peake@vdh.virginia.gov; Kelso, Patsy (CDC vermont.gov) <patsy.kelso@vermont.gov>; Cragin, Lori (CDC vermont.gov) <lori.cragin@vermont.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; Wasserman, Cathy (CDC doh.wa.gov) <cathy.wasserman@doh.wa.gov>; jonathan.meiman@dhs.wisconsin.gov; Ryan.Westergaard@dhs.wisconsin.gov; Del Rosario, Maria (CDC wv.gov) <Maria.C.delRosario@wv.gov>; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>
Subject: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Good Morning,

We need your help, please.

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

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

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

Thank you

State Coordination Task Force

Regional Desk

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

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404-232-0480

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From:	Abelardo Moncayo
To:	Ashley Vineyard; Catherine Brown; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID); Carina Blackmore; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc:	Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject:	Re: [EXTERNAL] RE: 2020 CSTE VBD Workshop Planning
Date:	Wednesday, February 12, 2020 2:44:01 PM
Attachments:	pntd.0007831.pdf

Hi All – I was made aware of this article by Tom Scott and others. It contains a nice history of vector control and a call for renewed political will and investment in VBDs and VBD control as a public health priority. Just wanted to throw this out there in case you think this topic may be of interest to the workshop participants.

Talk to you soon,
Abelardo

From: Ashley Vineyard <avineyard@cste.org>
Date: Wednesday, February 12, 2020 at 7:57 AM
To: Katie Brown <catherine.brown@state.ma.us>, Abelardo Moncayo <Abelardo.Moncayo@tn.gov>, "elizabeth.schiffman@state.mn.us" <elizabeth.schiffman@state.mn.us>, "Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD)" <bio1@cdc.gov>, "Marc (CDC/CCID/NCZVED) Fischer" <mxf2@cdc.gov>, Carina Blackmore <Carina.Blackmore@flhealth.gov>, "Elizabeth.Dykstra@DOH.WA.GOV" <elizabeth.dykstra@doh.wa.gov>, "Mayes,Bonny (DSHS)" <Bonny.Mayes@dshs.texas.gov>, "Broussard,Kelly (DSHS)" <Kelly.Broussard@dshs.texas.gov>, "Armstrong, Paige A (CDC/DDID/NCEZID/DVBD)" <yzu9@cdc.gov>, "Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)" <kzy2@cdc.gov>
Cc: "Alison F. Hinckley" <cue0@cdc.gov>
Subject: [EXTERNAL] RE: 2020 CSTE VBD Workshop Planning

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Good morning all,

Some materials that may be helpful for our workshop planning call this afternoon:

Workshop description:

Title: Improving Public Health Practice for Vector-Borne Diseases

This workshop will highlight a range of vectors and vector-borne diseases. There will be a series of presentations on vector ecology, surveillance, and emerging VBD issues. The final list of

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speakers/topics will be made when we have the draft agenda for the CSTE conference to ensure the workshop complements presentations and roundtables happening later in the week. The workshop will provide ample time for discussion and sharing of best practices.

Notes from last call:

- Discuss a breadth of VBD topics
- Texas suggested flea-borne and Chagas
- TBRF—Job Lopez from TX as potential speaker
- Vector ecology—similar to tick ecology last year
- Sociopolitical drivers of VBDs/Climate change etc. (article linked below)
- Mosquitoes!
- Note: include more interactive time based on comments from last year's evaluation
- Kiersten suggested a couple titles: "Improving Public Health Practice for Vector-Borne Diseases" and "Improving Knowledge of the Bugs We're Fighting"

This is the article Liz referenced about dengue and the various things impacting its resurgence in Honduras.
https://www.nytimes.com/2019/12/29/world/americas/honduras-dengue-epidemic.html

Thanks and looking forward to chatting soon!
Ashley

-----Original Appointment-----
From: Ashley Vineyard
Sent: Tuesday, February 4, 2020 9:28 AM
To: Ashley Vineyard; Brown, Catherine (DPH); Abelardo Moncayo; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID); Blackmore, Carina; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc: Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject: 2020 CSTE VBD Workshop Planning
When: Wednesday, February 12, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: RingCentral Meetings (see below)

Please save this date and time for our 2020 CSTE Annual Conference VBD Workshop planning calls.

To join and view screen: https://meetings.ringcentral.com/j/1493671493

Or Telephone:
Dial: US: +1 (773) 231 9226
Meeting ID: 149 367 1493

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From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Dubois, Amy E; Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	Re: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:29:07 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png

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Yes, feel free to share. I don't think anything else is needed in terms of our collaboration with Brazilian health colleagues.

Eleni - could you kindly confirm that RC is in touch with Brazilian authorities for on the ground issues?

From: Dubois, Amy E <DuboisAE@state.gov>
Sent: Tuesday, March 17, 2020 2:26:28 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Thanks Michelle.

Can I share this with ANVISA, for their awareness?

Is there anything else you need from ANVISA at this point? Is RC in contact with them for the ground logistics?

Just making sure all the loops are closed.

Amy

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Health Attaché | U.S. Department of Health and Human Services (HHS)
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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 3:23 PM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 2:17 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago)

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<HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>

Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov

Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.

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a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

    i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

    ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 1:57 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W

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<PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

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Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
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> **Subject:** Royal Caribbean Ships off Brazil/Chile
>
> All -

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Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
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Subject: Re: [External] Re: communications test
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yes

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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
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From: Deborah Anderson

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Subject: Re: [External] Re: communications test
Date: Friday, March 13, 2020 1:10:39 PM

yes

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Subject: [External] Re: communications test

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yes

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PH: 850-547-9289 Fax: 850-547-2575
e-mail: bfmaint@southernltc.com
~ Passion to Service ~

From: Ann Hill <ann.echcc@gmail.com>
Sent: Friday, March 13, 2020 12:31:22 PM
To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray;

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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Subject:	Re: cdc consult
Date:	Tuesday, March 10, 2020 10:54:17 PM

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

Caroline Schrodt

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From: Blackmore, Carina
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: Re: cdc consult
Date: Wednesday, March 11, 2020 6:43:43 AM

Yes I believe we do need to circle back. What you describe didn't address the issues at the port itself. Let me check with the health officer first thing

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

I communicated to our morning team that there was follow up needed with you all. Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

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Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
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Caroline Schrodt

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From:	Blackmore, Carina
To:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Cc:	Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject:	Re: cdc consult
Date:	Wednesday, March 11, 2020 8:14:55 PM

Hi Caroline. We would be interested in a consult to discuss the port situation and your recommendations to minimize exposure to employees and passengers. Are u still willing to set this up? Thanks Carina

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

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Subject: Re: cdc consult

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Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

Caroline Schrodt

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Cc:	Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject:	Re: cdc consult
Date:	Wednesday, March 11, 2020 9:18:55 PM

Tomorrow sounds great!

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Wednesday, March 11, 2020 9:17:45 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

Caroline is not working tonight, but I'm happy to work with you and discuss any questions. I think our cruise ship team is likely the best group to involve with this. I can see if they are able to discuss tonight, but it might be tomorrow AM before we are able to pull everyone together. Would that be OK? I'm also happy to have a call with you to clarify the questions as well before we set up the larger conference call. Let me know what would be best-

Thanks-

Sara Oliver, MD, MSPH
LCDR, U.S. Public Health Service
Medical Director, CDC COVID Clinical Call Unit
email: yxo4@cdc.gov

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:15 PM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi Caroline. We would be interested in a consult to discuss the port situation and your recommendations to minimize exposure to employees and passengers. Are u still willing to set this up? Thanks Carina

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>

AMERICAN OVERSIGHT

Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

I communicated to our morning team that there was follow up needed with you all. Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: Re: cdc consult

Did you not hear from anyone today?

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

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AMERICAN OVERSIGHT

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Thank you.

Caroline Schrodt

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Thank you.

Caroline Schrodt

AMERICAN OVERSIGHT

From: Jen Sulack

To: Ann Hill

Cc: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

	Douglas
Subject:	Re: communications test
Date:	Friday, March 13, 2020 12:51:51 PM

YES

On Fri, Mar 13, 2020 at 11:32 AM Ann Hill <ann.echcc@gmail.com> wrote:

> Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
> Please respond to me only - do not copy all
> Please send email answering YES that you received my communication for this test
> Thank you
>
> --
>
> Ann Hill, Executive Director
> Emerald Coast Healthcare Coalition
> 850-585-1679

--

Jen Sulack
Emerald Coast Healthcare Coalition

AMERICAN OVERSIGHT

From: Jen Sulack

To: Ann Hill

Cc: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Jen Sulack
Emerald Coast Healthcare Coalition

AMERICAN OVERSIGHT

From: Johnson, Tommy

To: Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

Subject: Re: communications test
Date: Friday, March 13, 2020 1:21:22 PM

yes

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~ Passion to Service ~

From: Ann Hill <ann.echcc@gmail.com>
Sent: Friday, March 13, 2020 12:31:22 PM
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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Johnson, Tommy

To: Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Re: communications test
Date: Friday, March 13, 2020 12:46:41 PM

yes

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From: Ann Hill <ann.echcc@gmail.com>
Sent: Friday, March 13, 2020 12:31:22 PM
To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Johnson, Tommy; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; Dahill, Gerard; David Morrison; Bell, Blake; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org;

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evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; Thomas, Jim; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Brooke, Keith; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; ~Bell, Jeffrey FA; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Blakely, Danny; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ferland, Ross; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina

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Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

NOTICE: This e-mail message and any attachment to this e-mail message contains confidential information that may be legally privileged. If you are not the intended recipient, you must not review, retransmit, convert to hard copy, copy, use or disseminate this e-mail or any attachments to it. If you received this e-mail in error, please notify us immediately by return e-mail or by telephone and delete this message. Please note that if this e-mail message contains a forwarded message or is a reply to a prior message, some or all of the contents of this message or any attachments may not have been produced by SHC.

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Funk, Renee (CDC/DDNID/NCEH/OD)
Subject:	Re: disinfection of PPE
Date:	Sunday, March 22, 2020 3:13:17 PM

Super thanks

Get Outlook for iOS

From: Funk, Renee (CDC/DDNID/NCEH/OD) <rjf8@cdc.gov>
Sent: Sunday, March 22, 2020 3:06:13 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: disinfection of PPE

Hi Carina,

I know everyone is swamped these days! I don't know the answer but will send to NIOSH EOC desk. I am sure they get this question a lot.

Hope you are doing as well as you can.

Take care,

Renée

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Sunday, March 22, 2020 2:22:14 PM
To: Funk, Renee (CDC/DDNID/NCEH/OD) <rjf8@cdc.gov>
Subject: disinfection of PPE

Howdy,
I am assuming you, like me, are knee deep in the COVID response.
Do you by any chance know who I could talk to about using UV light to disinfect PPE? I am guessing that hard surfaces (plastic) might work but what about cloth ? (masks/ gowns)
Any intel on this would be helpful

Thanks a lot. Thankful to have wise friends
Carina

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ)
Cc:	Quarantine Station - Miami (CDC); Smith, Christy (CDC/DDID/NCEZID/DGMQ); Jungerman, M. Robynne (CDC/DDID/NCEZID/DGMQ); Gulati, Reena (CDC/DDID/NCEZID/DGMQ); Blackmore, Carina; Drennon, Michael T
Subject:	Re: fee waiver
Date:	Sunday, March 1, 2020 7:43:15 PM

Thank you For the response Andrew. It is disappointing that CDC can leverage their partnership with airlines to contribute to the public health goal of limiting the spread of this growing outbreak. We will inform the family.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ) <ikb0@cdc.gov>
Sent: Sunday, March 1, 2020 7:36 PM
To: Pritchard, Scott
Cc: Quarantine Station - Miami (CDC); Smith, Christy (CDC/DDID/NCEZID/DGMQ); Jungerman, M. Robynne (CDC/DDID/NCEZID/DGMQ); Gulati, Reena (CDC/DDID/NCEZID/DGMQ)
Subject: RE: fee waiver

Good Evening Scott,

Thank you for reporting this CoVID-19 contact *and* for your patience with all the calls. After discussing the case with our medical officer and Travel Restriction officer, the "Fee Waiver" letter would not be applicable for this contact case.

Hope you have quiet evening.

Best,
Andrew

From: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ)
Sent: Sunday, March 1, 2020 5:55 PM
To: Scott Prichard - FL DOH Bureau of Epidemiology Laboratory Liaison (Tampa) (Scott.Pritchard@flhealth.gov) <Scott.Pritchard@flhealth.gov>
Cc: Quarantine Station - Miami (CDC) <QS-Miami@cdc.gov>; Smith, Christy (CDC/DDID/NCEZID/DGMQ) <ktp2@cdc.gov>; Jungerman, M. Robynne (CDC/DDID/NCEZID/DGMQ) <guk8@cdc.gov>; Gulati, Reena (CDC/DDID/NCEZID/DGMQ) <ffa0@cdc.gov>
Subject: RE: fee waiver

Hello Scott,

AMERICAN OVERSIGHT

Thank you for providing the update on the CoVID 19 case for the contacts who are currently in Reno, NV. We are in discussions regarding the return travel for the contacts.

Thank you for your patience.

Best,
Andrew

From: Quarantine Station - Miami (CDC) <QS-Miami@cdc.gov>
Sent: Sunday, March 1, 2020 4:47 PM
To: CDC DDID NCEZID DGMQ QBHSB Miami QS <DDIDNCEZIDDGMQQBHSBMiamiQS@cdc.gov>
Subject: FW: fee waiver

From: Pritchard, Scott
Sent: Sunday, March 1, 2020 4:46:16 PM (UTC-05:00) Eastern Time (US & Canada)
To: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ)
Cc: Quarantine Station - Miami (CDC)
Subject: RE: fee waiver

Andrew,
Call me back when you can receive all the requested information.
Thanks,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ) <ikb0@cdc.gov>
Sent: Sunday, March 01, 2020 12:21 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Quarantine Station - Miami (CDC) <QS-Miami@cdc.gov>
Subject: fee waiver

Hello Scott,

Please provide the case information for the airline fee waiver request. Thanks!

Best,

Andrew

Andrew Ganzon, MPH
Quarantine Public Health Officer

AMERICAN OVERSIGHT

CDC Miami Quarantine Station
Ph: 305-526-2910
Fax: 305-869-1495

AMERICAN OVERSIGHT

From:	Thaqi, Paula M
To:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Blackmore, Carina; Jenkins, Patrick H; Pritchard, Scott
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Schmitz, Ann
Subject:	Re: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 12:13:16 PM

We will becon the call. Thx.

Sent from my Verizon, Samsung Galaxy smartphone
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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 12:10:42 PM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Jenkins, Patrick H <Patrick.Jenkins@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Dr. Thaqi and Patrick, does this time work for you?

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 12:10 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Thanks Scott. Lets hold 4-5 pm EST for now. Will follow up with a confirmation once I lock down CDC SMEs.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

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Anytime between 2-5 could work for me.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Thursday, March 12, 2020 11:29 AM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: Re: remote TA call from CDC - COVID-19

The most important people who need to be on is not me although will try my hardest but it is Dr Thaqi and her team from Broward CHD and Scott Pritchard and his team. I will defer to them about an ideal time. Thanks so much.
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From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 8:24:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: remote TA call from CDC - COVID-19

Hi Dr. Blackmore,

I am working to set up a follow up TA call to assist with your questions related to the cruise ship port. Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Pritchard, Scott; Thaqi, Paula M
Subject:	Re: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 11:28:59 AM

The most important people who need to be on is not me although will try my hardest but it is Dr Thaqi and her team from Broward CHD and Scott Pritchard and his team. I will defer to them about an ideal time. Thanks so much.
Get Outlook for iOS

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 8:24:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: remote TA call from CDC - COVID-19

Hi Dr. Blackmore,

I am working to set up a follow up TA call to assist with your questions related to the cruise ship port. Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From:	DNPAO Comm TA (CDC)
To:	DNPAO Comm TA (CDC)
Subject:	Reminder -- Register for Feb 13 Comm Networking Call: Using Audience Research to Inform Communication Activities
Date:	Tuesday, February 11, 2020 2:49:01 PM

Dear State and Community Health Media/Communication Contacts,

This is a reminder of our next communication networking call on **Thursday, February 13 at 2:00pm ET**. We will share new audience research and discuss how you can use in your communication activities.

You must register using the link provided below to get the webinar log-on details. Details on how to join will come in a separate email.

Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

Please join CDC's Division of Nutrition, Physical Activity, and Obesity for the following Networking Call:

"Using Audience Research to Inform Communication Activities"

Thursday, February 13, 2020
2:00-3:30 pm EDT

Who should participate?

Principal Investigators, Program Managers, communication staff, and other interested staff
**Principal Investigators – please forward this invitation to other staff working on communication activities.*

How do I connect?

Participants must register for this event.

Let us know if you have any accessibility accommodations (e.g., captioning) by February 11.

What will the networking call cover?

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The networking call will cover:

- Audience research findings conducted by CDC's Division of Nutrition, Physical Activity, and Obesity
- Ways state and local public health programs can apply the audience research to their work

Who are the presenters and panelists?

Presenters and panelists will include recipients along with staff and contractors from CDC/DNPAO's Strategic Communication Team.

- Suzi Gates, DNPAO Strategic Communication Team
- Shea Van Horn, FHI 360 Contractor, DNPAO Strategic Communication Team
- Rebecca Ledsky, FHI 360 Contractor, DNPAO Strategic Communication Team
- Thomas Lehman, FHI 360 Contractor, DNPAO Strategic Communication Team
- Maureen Spence, New York State Department of Health
- Jasmine Deskins, Marion County Public Health Department
- Emily DeWitt, University of Kentucky

Hints and reminders for the event

1. Register to get event login details.
2. Check your connection and Adobe Connect access the day before the session.
3. Contact your organization's IT staff if you have trouble accessing Adobe Connect.
4. Visit Adobe Connect Support if you need help.
5. Log onto **Adobe Connect (website)** and **phone** line 10 minutes before the start time.

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Reminder: COVID-19 Call Today, 1:45 PM EST
Date: Friday, February 14, 2020 12:37:47 PM

Just a reminder if you haven't registered for today's COVID-19 federal update call:

Please join us for a national briefing call **TODAY, Friday, February 14 at 1:45 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Additional Information

- You can find more information and resources at the CDC website here: https://www.cdc.gov/coronavirus/.
- **NEW: Excerpts from Secretary Azar's interviews with CNN and CNBC**

Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

What The Admin Is Saying | HHS Secretary Alex Azar Discusses the Coronavirus on CNN and CNBC

Secretary Azar provided an update on the coronavirus and the administration's aggressive efforts to protect the health and safety of Americans.

PROTECTING THE HEALTH AND SAFETY OF THE AMERICAN PEOPLE

AZAR: "We're working aggressively across the whole of government to protect the health and safety of the American people and using the time that we have bought through our very aggressive, multilayered approaches of public health to prepare."

AZAR: "This is about protecting America's borders and allowing us the time to continue our proactive preparations."

AZAR: "People who are not U.S. citizens or permanent residents of the United States may not enter the United States if they have been in China in the previous 14 days.

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Once they've been out of China for that 14-day incubation period, they are welcome as always into the United States."

AZAR: "Americans coming back who have been in China in the previous 14 days, we ask them to both funnel to 11 airport ports of entry where they can be inspected, surveilled, and we ask them voluntarily to isolate themselves at home for 14 days. If they've been in the hot zone, which is an increasingly diminishing number of people who've been in Hubei province in the previous 14 days, we will actually quarantine them for that 14-day period."

IDENTIFYING AND MONITORING CASES

AZAR: "We are proactively planning now to prevent further spread in the U.S., but also to conduct aggressive surveillance, to have an early warning system. Our public health system's the best in the world, and it's working. That system is what identified the 15 cases that we have."

AZAR: "The 15 cases that we have were identified by our public health system. We immediately alerted our hospitals, our doctors, our public health departments, of the symptoms and of the connection to China. And so we have been scanning and surveilling from day one on this."

AZAR: "One of the things that we did – the CDC – within a week of getting the genetic sequencing, developed a test, we had a diagnostic there at CDC. We've now deployed that around the country in over 170 public health labs."

AZAR: "We're taking an important measure that we announced yesterday, which is we are using our flu surveillance network in Seattle, San Francisco, L.A., Chicago and New York, where individuals who present with flu-like, or China coronavirus-like symptoms will be tested not just for flu, but also tested for China coronavirus. That way we have an early warning system."

IMPACT WITHIN THE UNITED STATES

AZAR: "The risk to the average American is very low right now. Let's remember, we have 15 confirmed cases here in the United States – all of whom were either traveling in Hubei province, where Wuhan is, or had a direct intimate personal contact with an individual who was there."

AZAR: "They should be more worried about flu and regular cold season, in terms of taking precautions like washing their hands, coughing into their arms, and not touching their face."

AZAR: "So far, we're seeing very limited impact here in the United States, but that could change at any time. We're working to prevent that from happening, to keep that risk low, and we're working to proactively prepare with states, local governments, and the private sector."

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COOPERATION WITH CHINA

AZAR: "The World Health Organization must insist that China be transparent and fully cooperative, as they would insist on the United States or any other country."

AZAR: "It is very important that the World Health Organization hold China to account for transparency and cooperation, as they would any other country, including the United States."

AZAR: "The World Health Organization, we believe, has secured agreement to deploy a W.H.O. team with our U.S. public health experts as part of that team. We are ready to go. And we are waiting for final clearance from the Chinese government to make that happen."

AZAR: "We need to get this team that I have offered now for 39 days of CDC experts. We've got to get them into China and they've got to be given access to data, genetic sequences, run the studies to get answers to the key questions."

AZAR: "They have got to be able to work shoulder to shoulder with their Chinese scientific colleagues – looking at raw data, running the studies, looking at genetic sequences, doing the virology and epidemiology that is their mission – or it won't be a useful mission."

###

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject: Reminder: COVID-19 Call Today, 1:45 PM EST
Date: Friday, February 14, 2020 12:33:31 PM

Just a reminder if you haven't registered for today's COVID-19 federal update call:

Please join us for a national briefing call **TODAY, Friday, February 14 at 1:45 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Additional Information

- You can find more information and resources at the CDC website here: https://www.cdc.gov/coronavirus/.
- **NEW: Excerpts from Secretary Azar's interviews with CNN and CNBC**

Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

What The Admin Is Saying | HHS Secretary Alex Azar Discusses the Coronavirus on CNN and CNBC

Secretary Azar provided an update on the coronavirus and the administration's aggressive efforts to protect the health and safety of Americans.

PROTECTING THE HEALTH AND SAFETY OF THE AMERICAN PEOPLE

AZAR: "We're working aggressively across the whole of government to protect the health and safety of the American people and using the time that we have bought through our very aggressive, multilayered approaches of public health to prepare."

AZAR: "This is about protecting America's borders and allowing us the time to continue our proactive preparations."

AZAR: "People who are not U.S. citizens or permanent residents of the United States may not enter the United States if they have been in China in the previous 14 days.

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Once they've been out of China for that 14-day incubation period, they are welcome as always into the United States."

AZAR: "Americans coming back who have been in China in the previous 14 days, we ask them to both funnel to 11 airport ports of entry where they can be inspected, surveilled, and we ask them voluntarily to isolate themselves at home for 14 days. If they've been in the hot zone, which is an increasingly diminishing number of people who've been in Hubei province in the previous 14 days, we will actually quarantine them for that 14-day period."

IDENTIFYING AND MONITORING CASES

AZAR: "We are proactively planning now to prevent further spread in the U.S., but also to conduct aggressive surveillance, to have an early warning system. Our public health system's the best in the world, and it's working. That system is what identified the 15 cases that we have."

AZAR: "The 15 cases that we have were identified by our public health system. We immediately alerted our hospitals, our doctors, our public health departments, of the symptoms and of the connection to China. And so we have been scanning and surveilling from day one on this."

AZAR: "One of the things that we did – the CDC – within a week of getting the genetic sequencing, developed a test, we had a diagnostic there at CDC. We've now deployed that around the country in over 170 public health labs."

AZAR: "We're taking an important measure that we announced yesterday, which is we are using our flu surveillance network in Seattle, San Francisco, L.A., Chicago and New York, where individuals who present with flu-like, or China coronavirus-like symptoms will be tested not just for flu, but also tested for China coronavirus. That way we have an early warning system."

IMPACT WITHIN THE UNITED STATES

AZAR: "The risk to the average American is very low right now. Let's remember, we have 15 confirmed cases here in the United States – all of whom were either traveling in Hubei province, where Wuhan is, or had a direct intimate personal contact with an individual who was there."

AZAR: "They should be more worried about flu and regular cold season, in terms of taking precautions like washing their hands, coughing into their arms, and not touching their face."

AZAR: "So far, we're seeing very limited impact here in the United States, but that could change at any time. We're working to prevent that from happening, to keep that risk low, and we're working to proactively prepare with states, local governments, and the private sector."

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COOPERATION WITH CHINA

AZAR: "The World Health Organization must insist that China be transparent and fully cooperative, as they would insist on the United States or any other country."

AZAR: "It is very important that the World Health Organization hold China to account for transparency and cooperation, as they would any other country, including the United States."

AZAR: "The World Health Organization, we believe, has secured agreement to deploy a W.H.O. team with our U.S. public health experts as part of that team. We are ready to go. And we are waiting for final clearance from the Chinese government to make that happen."

AZAR: "We need to get this team that I have offered now for 39 days of CDC experts. We've got to get them into China and they've got to be given access to data, genetic sequences, run the studies to get answers to the key questions."

AZAR: "They have got to be able to work shoulder to shoulder with their Chinese scientific colleagues – looking at raw data, running the studies, looking at genetic sequences, doing the virology and epidemiology that is their mission – or it won't be a useful mission."

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Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Reminder: EPIC Webinar @ 1 PM TODAY (3-18-20)
Date:	Wednesday, March 18, 2020 12:22:09 PM

Dear Colleagues:

We wanted to provide a quick reminder that there is an EPIC Webinar @ 1 PM TODAY. Please pass this information along to your partners if you feel like they might be interested. The topic is **"Answering 20 Questions About COVID-19" and is geared towards the general public**. It will be broadcast on Facebook live and will have closed captioning.

https://emergency.cdc.gov/epic/learn/2020/webinar_20200318.asp

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	ASTHO Executive Office
To:	ASTHO Executive Office
Cc:	Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD); Research and Evaluation
Subject:	Reminder: Help CDC Improve its Project Officer Support
Date:	Wednesday, February 5, 2020 10:26:35 AM
Attachments:	Survey Distribution Instructions.pdf

Dear Senior Deputies,

This email is another request for action and a follow-up to the survey launched on Tuesday, January 14th (announcement email is attached). For those of you who have already distributed this evaluation to the appropriate points of contact within your agency, we appreciate your support. At this time we ask that you remind your staff about this survey by simply forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department.

As a reminder, ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements and grants. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

This survey should be completed by health agency staff who work on and serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements or grants (full list of selected cooperative agreements/grants is attached).

Our ask of you: Please remind your staff about this survey by forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department for their response. The invitation content to request participation is provided below the signature on this email. Feel free to directly forward this email to the intended recipients or create a new outreach message using the content below.

Thank you for your assistance.

Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308
www.astho.org | Twitter | Facebook | Blog

EMAIL FOR SURVEY RESPONDENT:

Instructions for survey respondent: The Association of State and Territorial Health Officials

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(ASTHO), in partnership with the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support is administering an assessment to health departments in all 50 states and the District of Columbia related to satisfaction with the services and support provided by CDC project officers.

Results from the assessment will be used by CDC to improve project officer support to state health agencies. Participation is voluntary, and your feedback will inform continued project officer development and training.

In order to participate in this voluntary assessment, please click the hyperlink provided in this email to be redirected to the web-based assessment. The assessment should take no longer than 25 minutes to complete. All responses are immediately saved and can be changed at any time. However, once the assessment is submitted, you will be unable to modify any responses. Also, you are not required to complete the assessment in one sitting. When finished responding to all relevant questions, click the **SUBMIT** button at the end of the assessment to submit your responses.

Information collected will be kept on secure, password protected servers accessible only to ASTHO project team members. All information you provided will be analyzed and reported in the aggregate with no identifying information attached.

Follow this link to the Assessment: Take the Assessment

Please submit responses to this assessment no later than February 27, 2020.

Note: The survey is designed for respondents to consider only one project officer within each selected cooperative agreement and grant. If your agency has more than one project officer for the Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations (DP17-1701), we invite your agency's appropriate point of contact to complete separate survey entries for each project officer.

Additionally, a few of the HIV, Viral Hepatitis, TB, and STD cooperative agreements have been updated with the current cooperative agreement numbers. The updated names and numbers are in the attached survey distribution instructions. If you already submitted responses under a prior cooperative agreement number you do not need to re-submit.

If you experience problems with the web-based assessment or have any questions, please contact Allen Rakotoniaina at researchandevaluation@astho.org for technical assistance.

Thank you in advance for your participation.

Disclaimer

The information contained in this communication from the sender is confidential. It is intended solely for use by the recipient and others authorized to receive it. If you are not the recipient, you are hereby notified that

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	scott.rivkees@flhealth.gov
Cc:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Cantrell, Russell (CDC/DDPHSIS/CSTLTS/DPIFS)
Subject:	Response to: Request on Cleaning Guidance at hotels sent to Dr. Montero
Date:	Wednesday, February 19, 2020 12:56:14 PM
Attachments:	20200208 Enviro Cleaning Recs Final.docx SCTF Talking Points from GMTF 02142020.docx public-health-management-decision-making.pdf

Good Afternoon Dr. Rivkees,

I am following up on a message you recently sent Dr. Montero.

Attached are two documents to address your request. The Global Migration Task Force provided the cleaning guidance. They also provided quarantine-related talking points. Please feel free to use the talking points in conjunction with the hotel cleaning guidance as appropriate.

I have also included a document that was recently added to the CDC guidance documents that helps in the assessment of a travelers risk for developing infection. The newest guidance documents are highlighted in the "What's New" section at the following CDC website https://www.cdc.gov/coronavirus/2019-ncov/index.html .

Please let me know if we can be of further assistance.

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

AMERICAN OVERSIGHT

From: Scott, Katie E

To: Hill, Ann; 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Sandoval, Randi C; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Talbert, Rick; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Martin, Sandy K; Sarah Demotto; DONALD H RIPLEY; Scott Vickers; Shandra Jenkins; Shannon Murray; Sharon Wise; Stewart, Lewis Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Knox, Thomas; Thomas McDaniel; Smith, Thomas M; Verlaan, Thomas D; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Long, Tracey; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kianison, RN, RM; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; BRENDA J BASFORD; Woodlief, Douglas; Wyatt Barton

Subject: Revised Agenda: ECHCC General Coalition Meeting

AMERICAN OVERSIGHT

Date:	Wednesday, February 12, 2020 9:47:26 AM
Attachments:	AGENDA 2 13 2020.docx
Importance:	High

On behalf of Ann Hill, please see the revised agenda for the ECHCC General Coalition Meeting.

From: Ann Hill <ann.echcc@gmail.com>
Sent: Wednesday, February 12, 2020 8:28 AM
Subject: ECHCC General Coalition Meeting

Good morning
this will serve as a reminder that there is NO general coalition meeting today in Washington County
The meeting is scheduled for tomorrow THURSDAY FEBRUARY 13 at the coalition offices located at 755 Lovejoy Road, Ft Walton Beach, FL atm 10:00 am CST

We will have items on display to view, a board to suggest requested trainings, an inventory list that the coalition has on hand for distribution during disasters or affiliated events, speakers on Cyber Security, Lean on Me Project, Training and Exercises, report on Influenza and coronavirus, and more

Please make every attempt to appear in person or send someone from your agency if you are busy. Come see the new training room improvements and learn how to use this facility for your meetings.

Agenda is attached for the meeting - at the top, there is the call-in information
Also, remember that this Friday is the deadline for submitting your project ideas to the coalition

Thank you

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Scott, Katie E

To: Hill, Ann; 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; Ard, John; John Dosh; John Gainous; John Hatfield; Ottesen, John P; John.Hatfield; Lanza, John J; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Milligan, Joseph D; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Chapman, Karen A; Karen Urquhart; Beedie, Katherine A; Kathlyn Campbell White; Kathrine Lee; Kayla Henderson; Kay Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Lonas, Kim; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Webb, Robert K; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Bridgeway Center, Inc.; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Kent, Linda H; Linda Langley; Linda Villanova; RENEE HAMILTON; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Svehla, Louis; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Winn, Mary; MATT H BALTZ; Dobson, Roger M; Douglass, Matt; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Dang, Meo T; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; StateESF8.Planning; Nancy Walls; Johnson, Natalie N; Nathan Monk; nhall@srso.net; Kimbrel, Nicole H; nicolette Bennett; Oscar Williams; Patricia Krimminga; Roberts, Patricia J; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; 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Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Long, Tracey; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kianison, RN, RM; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; BRENDA J BASFORD; Woodlief, Douglas; Wyatt Barton

Subject: Revised Agenda: ECHCC General Coalition Meeting

AMERICAN OVERSIGHT

Date:	Wednesday, February 12, 2020 9:47:21 AM
Attachments:	AGENDA 2 13 2020.docx
Importance:	High

On behalf of Ann Hill, please see the revised agenda for the ECHCC General Coalition Meeting.

From: Ann Hill <ann.echcc@gmail.com>
Sent: Wednesday, February 12, 2020 8:28 AM
Subject: ECHCC General Coalition Meeting

Good morning
this will serve as a reminder that there is NO general coalition meeting today in Washington County
The meeting is scheduled for tomorrow THURSDAY FEBRUARY 13 at the coalition offices located at 755 Lovejoy Road, Ft Walton Beach, FL atm 10:00 am CST

We will have items on display to view, a board to suggest requested trainings, an inventory list that the coalition has on hand for distribution during disasters or affiliated events, speakers on Cyber Security, Lean on Me Project, Training and Exercises, report on Influenza and coronavirus, and more

Please make every attempt to appear in person or send someone from your agency if you are busy. Come see the new training room improvements and learn how to use this facility for your meetings.

Agenda is attached for the meeting - at the top, there is the call-in information
Also, remember that this Friday is the deadline for submitting your project ideas to the coalition

Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From:	Perry, Kaylynn
To:	Miller, Carly; chris@waltoncountyem.org; Courtney.Coppola@flhealth.gov; EduardoBustillo@semtribe.com; EOC-Plans; Bussey, Jon; Guthrie, Kevin; Waterman, Laura; Cintron, Morgan; espe0001@shands.ufl.edu; edward.f.toombs2.mil@mail.mil; twillrick@daytonainternationalspeedway.com; County Emergency Management Directors
Subject:	Revised Situation Report #22
Date:	Tuesday, March 24, 2020 2:53:27 PM
Attachments:	COVID-19 Sit Rep 22.pdf

Please see attached for a revised Situation Report.

Kaylynn Perry
All-Hazard Preparedness Unit / SERT ESF 5
Florida Division of Emergency Mangement
Kaylynn.perry@em.myflorida.com
Office: (850) 815-4337
Mobile: (850) 254-5657

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	EOC-Plans
To:	Rosenstein, Jared; Andrew.Love@flhealth.gov; Mooney, Dayle; Kimbrel, Nicole H; Madeleine Nobles; McKinstry, Molly; Hagan, Karen (ARC-TLH); Melanie Motiska; Bob Asztalos; Emmett Reed; Nick Van Der Linden; Steve Bahmer; Gail Matillo; COVID-19@flhealth.gov; Rivkees, Scott A; Blackmore, Carina; Roberson, Shamarial; Coppola, Courtney; Mary.Mayhew@ahca.myflorida.com; Prudom, Richard
Cc:	Perry, Kaylynn; lgriffin@floridaseniorliving.org; Tiffani Hart; Delgado, Austin; Sokoloski, Kristin; Catherine McGrath; Dori Landsberg; Jeanne Curtin; Derinda Kirkland; Anne Chansler; Godfrey, Diane; Givens, Michelle; ungrug@elderaffairs.org; Alberta Granger; Ginnifer Barber; McClendon, Alexander; MacLafferty, Laura; Kimberly Stewart (Agency for Health Care Administration); Register, Joshua (Elder Affairs); Carr,Carol (Elder Affairs); Dobbs, David; Michael Phillips; Carhart, Ty; Yow, Annmarie; Peggy Brown; Eck, Caitlyn; Zach Annett; Tracey Vause; Anderson, Eric; Jeanne Eckes; Wilgis, John (FL Hospital Assoc); Kelley, Debbie A; Denise Imbler; Keys, Kelly R; hunter.zager@tampabayhmpc.org; Moscoso, Alberto; LGTeam@eog.myflorida.com; Tommy Cleversy; Clarence Lewis; Melanie Etters; Lynne Daw; Jeannette Estes; Leslie Richards; Erin Romeiser; Barbara Palmer; Kevin Bailey; Francis Carbone; Amanda Smith; Robin Keller; Wagner, Maureen; Leigh Wilsey; Otis, Aaron; Marilia Van Keeken; Jaime Caldwell; Lorena Fulcher; Stacie Cleveland; Nicole Miller; Kristin Korinko; CFDMC; Matt Meyers; Salinas, Rose; Lisa Robertson; Hillary Jackson; Linda Donar; Marguerite Morgan; Michael Mayfield; Rebecca Roberts; Barbara Matthews; Martha Mason; Kim Barnes; Heather Battista; Lynelle Smith; Sharon Taber; Rita Castor; Jeff Ivey; Musgrave, Lisa; Thomas Holcomb; Nathan Koch; Harris, Shevaun; Henley, Victoria; Kirk Hall; Rivas, Erin; McCleary, Denise; Janice Phillips (jphillips@hmsfl.com); Smith, Cary (ACC); Jenny Rojas; Smith, Brandi; annmarie.winter@aaapp.org; Kristen Griffis; Lisa Bretz; karla.radka@sraflorida.org; Linda Levin; Barbara Suarez; Lt.John.Longacre@districtgov.org; mathertaylorc@adrcbroward.org; Josh Jensen; Marsha Lorenz; Elizabeth Lombardo; Nancy Tufts; Kim Streit; Cheryl Love
Subject:	SEOC Aging and Vulnerable Populations Call

UPDATE: This Call is now only on Tuesday and Thursday. Please distribute to your applicable partners.

Aging and Vulnerable Populations Call

Tuesday and Thursday

4:15 PM to 4:45 PM

Call-In Information

Call-In Number: 888-585-9008

Conference Room ID: 208-305-233

Join the State Emergency Operations Center for a call concerning updates on the State's response to COVID-19.

Standing Agenda

* Situation Updates from the Florida Department of Health
* Briefing from the Agency for Healthcare Administration
* Updates from other State Agencies
* Questions from Partners

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From:	EOC-Plans
To:	Rosenstein, Jared; Andrew.Love@flhealth.gov; Mooney, Dayle; Kimbrel, Nicole H; Madeleine Nobles; McKinstry, Molly; Hagan, Karen (ARC-TLH); Melanie Motiska; Bob Asztalos; Emmett Reed; Nick Van Der Linden; Steve Bahmer; Gail Matillo; COVID-19@flhealth.gov; Rivkees, Scott A; Blackmore, Carina; Roberson, Shamarial; Coppola, Courtney; Mary.Mayhew@ahca.myflorida.com
Cc:	Perry, Kaylynn; lgriffin@floridaseniorliving.org; Tiffani Hart; Delgado, Austin; Sokoloski, Kristin; Catherine McGrath; Dori Landsberg; Jeanne Curtin; Derinda Kirkland; Anne Chansler; Godfrey, Diane; Givens, Michelle; ungrug@elderaffairs.org; Alberta Granger; Ginnifer Barber; McClendon, Alexander; MacLafferty, Laura; Kimberly Stewart (Agency for Health Care Administration); Register, Joshua (Elder Affairs); Carr,Carol (Elder Affairs); Dobbs, David; Michael Phillips; Carhart, Ty; Yow, Annmarie; Peggy Brown; Eck, Caitlyn; Zach Annett; Tracey Vause; Anderson, Eric; Jeanne Eckes; Wilgis, John (FL Hospital Assoc); Kelley, Debbie A; Denise Imbler; Keys, Kelly R; hunter.zager@tampabayhmpc.org; Moscoso, Alberto; LGTeam@eog.myflorida.com; Tommy Cleversy; Clarence Lewis; Melanie Etters; Lynne Daw; Jeannette Estes; Leslie Richards; Erin Romeiser; Barbara Palmer; Kevin Bailey; Francis Carbone; Amanda Smith
Subject:	SEOC Aging and Vulnerable Populations Call

UPDATE: This call is now daily at 4:15 PM. Call-In Information has changed.

Aging and Vulnerable Populations Call

Daily

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Conference Room ID: 208-305-233

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AMERICAN OVERSIGHT

From:	EOC-Plans
To:	Rosenstein, Jared; Andrew.Love@flhealth.gov; Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; Stalcup, Jeanetta; TKnox@fachc.org; abehrman@fachc.org; winnsr@earthlink.net; michelle@foma.org; andrew@foma.org; govaffairs@foma.org; mcarter@flmedical.org; MThomas@flmedical.org; CPrine@flmedical.org; COVID-19@flhealth.gov; StateESF8.Planning@flhealth.gov; Molly.McKinstry@ahca.myflorida.com; AHCAEOC@ahca.myflorida.com; Mary.Mayhew@ahca.myflorida.com
Cc:	Faustin, Marilyne; Kriebel, Devon; Kerry.waldron@flhealth.gov; Morgan, Cindy D; Aliene Harris; Buhrow, Rena; St Laurent, Louise R; Wenhold, Jennifer; Yow, Annmarie; Peggy Brown; Eck, Caitlyn; Zach Annett; Anderson, Eric; Tracey Vause; Denise Imbler; Jeanne Eckes; Carhart, Ty; Marilia Van Keeken; Jaime Caldwell; Wilgis, John (FL Hospital Assoc); Matt Meyers; Hale, Rebecca; AnnMarie.Kleczkowski@ocfl.net; Klein, Jason L.; Perez, Ellis E; Lauren Possinger; Litton, Bill (Osceola Co EM); Manuel Soto; Kelley, Debbie A; hunter.zager@tampabayhmpc.org; Maldonado, Carmelo; Johns, Paul M.; Judge II, James (Volusia Co EM); Doyle, Philip; Royer, Melissa; John Maze; Crowe, David R
Subject:	SEOC Healthcare Provider Call

UPDATE: The Call time and number has been updated. Please see updates below.

SEOC Healthcare Provider Call

Hosted by the Florida Department of Health

Every Tuesday

6:30 PM to 7:30 PM

Call-In Information

Call-In Number: 888-585-9008

Conference Room ID: 208-305-233

Join the State Emergency Operations Center for a call concerning updates on the State's response to COVID-19.

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AMERICAN OVERSIGHT

From:	EOC-Plans
To:	Rosenstein, Jared; Love, Andrew; Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; Stalcup, Jeanetta; Knox, Thomas; Behrman, Andrew; steve winn; michelle@foma.org; andrew@foma.org; govaffairs@foma.org; mcarter@flmedical.org; MThomas@flmedical.org; CPrine@flmedical.org; COVID-19; StateESF8.Planning; Molly.McKinstry@ahca.myflorida.com; AHCAEOC@ahca.myflorida.com; Mary.Mayhew@ahca.myflorida.com
Cc:	Faustin, Marilyne; Kriebel, Devon; Waldron, Kerry S; Morgan, Cindy D; Aliene Harris; Buhrow, Rena; St Laurent, Louise R; Wenhold, Jennifer; Yow, Annmarie; Peggy Brown; Caitlyn Eck; Zach Annett; Eric Anderson; Tracey Vause; Denise Imbler; Jeanne Eckes-Roper; Carhart, Ty; Marilia VanKeeken; Caldwell, Jamie S; Wilgis, John; Matt Meyers; Hale, Rebecca; AnnMarie.Kleczkowski@ocfl.net; Klein, Jason L.; Perez, Ellis E; Lauren Possinger; Litton, Bill (Osceola Co EM); Manuel Soto; Kelley, Debbie A; hunter.zager@tampabayhmpc.org; Maldonado, Carmelo; Johns, Paul M.; Judge, Jim; Philip Doyle; Royer, Melissa; John Maze; Crowe, David R
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AMERICAN OVERSIGHT

From:	Flakes, Krystal
To:	arturo.lopez@coffo.org; birypa@cs.com; brodriguez@med.miami.edu; Britney.Moore@dep.state.fl.us; Charla@frpa.org; Mitchem, Emily; jgordon1@health.usf.edu; kpagan@ufl.edu; kwilliams@flimpact.org; lynn.b.brannon.ctr@mail.mil; Robert.Hill@heart.org; tami@fdha.org; Tonya.Ehrhardt@heart.org; adamsw@hhcs.com; Cambridge, Amber K; Odeh, Asma; Russell, Bryan M; Hanson, Elvira J; Zayas, Fatima A.; Davis, Janiece N; Johnson, Jennifer S; Weller, Karen; Jackson, Rhonda G; Collins, Sade X; Isaac, Sean; Harp, Shannon; Chapman, Shay; Bane, Summer; Lee, Valerie
Subject:	Save-The-Date: PHHSBG Advisory Committee Meeting / Webinar

Greetings Preventive Health and Health Services Block Grant Advisory Committee Members,

Please Save-The-Date on your calendars for the next Advisory Committee Meeting to be held Friday, April 24, 2020 from 10:00 A.M – 11:30 A.M. Agenda forthcoming.

The purpose of this meeting is to:

- Discuss the FY 2019-2020 workplan (Public Health Dental Program, Violence and Injury Prevention Program and Chronic Disease Prevention).
- Share updates from the Centers for Disease Control and Prevention

The Florida Department of Health is required to keep record of external membership annually.

For external partners, if you have not done so, please complete the application for membership at this link:
https://apps.floridahealth.gov/bcquestionnaire/

Please do not hesitate to contact our office if you have any questions.

Please be advised, meeting date and time are subject to change based on Covid-19 response efforts. We will keep you updated should any changes occur.

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United States: +1 (786) 535-3119 <tel:+17865353119,,508577157>

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Krystal Flakes, MPH

Preventive Health and Health Services Block Grant Coordinator

Bureau of Chronic Disease Prevention

Florida Department of Health

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AMERICAN OVERSIGHT

Sadé Collins, MPH, CHES ®

Environmental Approaches Section Administrator

Bureau of Chronic Disease Prevention

Florida Department of Health

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Fax: 850-414-6625

sade.collins@flhealth.gov <mailto:sade.collins@flhealth.gov>

AMERICAN OVERSIGHT

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

To: Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Motusa Tuileama (CDC doh.as); Christ, Cara (CDC azdhs.gov); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC ct.gov); karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC dc.gov); scott.rivkees@flhealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Clabaugh, Gerd (CDC idph.iowa.gov); lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; nirav.shah@Maine.Gov; robert.neall@maryland.gov; Bharel, Monica (CDC state.ma.us); KhaldunJ@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; sheilahogan@mt.gov; dannette.smith@nebraska.gov; l.sherych@health.nv.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC health.ny.gov); mark.benton@dhhs.nc.gov; mylynntufte@nd.gov; Muña, Esther (CDC dph.gov.mp); amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC state.or.us); ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; emais.roberts@palauhealth.org; Alexander-Scott, Nicole (CDC health.ri.gov); rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC state.sd.us); Lisa.Piercey@tn.gov; Hellerstedt, John (CDC dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC doh.wa.gov); cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov); steven.stack@ky.gov; bbilimon@hotmail.com; Betsey.Tilson@dhhs.nc.gov; fran.phillips@maryland.gov; Gary.Anthone@nebraska.gov; Gholzman@mt.gov; Catherine.delacruz@salud.pr.gov; andy.mullins@adph.state.al.us; brian.ritchie@alaska.gov; bensili@doh.as; teresa.ehnert@azdhs.gov; Tricia.Blocher@cdph.ca.gov; Christopher.Shields@cityofchicago.org; scott.bookman@state.co.us; Francesca.Provenzano@ct.gov; timothy.cooper@state.de.us; patrick.ashley@dc.gov; Christie.Luce@flhealth.gov; Scott.Minarcine@dph.ga.gov; Kaneshiro, Suzanne (CDC dphss.guam.gov); judy.kern@doh.hawaii.gov; matthew.dudley@dhw.idaho.gov; Keturah.Tracy@illinois.gov; Mlytle@isdh.IN.gov; rebecca.curtiss@idph.iowa.gov; Denise.L.Kelly@ks.gov; robbie.hume@ky.gov; sfogleman@ph.lacounty.gov; doris.brown@la.gov; william.jenkins@maine.gov; wasejacklick@gmail.com; Sherry.adams@maryland.gov; kerin.milesky@state.ma.us; macqueenm@michigan.gov; RPongliyab@fsmhealth.fm; Cheryl.Petersen-Kroeber@state.mn.us; wayne.vaughn@msdh.ms.gov; paula.nickelson@health.mo.gov; KOLoughlin@mt.gov; warren.villagomez@dph.gov.mp; eric.sergeant@nebraska.gov; msouthard@health.nv.gov; elizabeth.daly@dhhs.nh.gov; Dana.johnson@doh.nj.gov; Christopher.emory@state.nm.us; michael.primeau@health.ny.gov; bmaldin@health.nyc.gov; Combs, Brian (CDC dhhs.nc.gov); jsickler@nd.gov; tamara.mcbride@odh.ohio.gov; scotts@health.ok.gov; akiko.saito@state.or.us; 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Subject:	Senior Administration Officials Briefing Call on COVID-19 // Regarding President Trump issuing proclamation under section 212(f) of the Immigration and Nationality Act (INA), restricting travel
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png

State and Local Leaders,

On Thursday, March 12, at 2:00 p.m. Eastern Time, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

* Date: Today, Thursday, March 12
* Time: 2:00 PM ET (please note time zone)
* Call-In Registration: CLICK HERE <https://ems9.intellor.com/?do=register&t=1&p=901287>
* Note: You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,

Zach

The White House Office of Intergovernmental Affairs

Zach Swint

Office of Intergovernmental Affairs

The White House

C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov <mailto:Zachariah.D.Swint2@who.eop.gov>

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

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"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

* President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.

* Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.

* The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
* Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
* There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

* The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.
* President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.

* These loans will help overcome disruptions caused by the coronavirus.
* The President is calling on Congress to increase funding for this program by an additional $50 billion.

* The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.

* This action will provide more than $200 billion of additional liquidity to the economy.

* President Trump is calling on Congress to immediately pass payroll tax relief.
* The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.

* The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

* The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
* The Trump Administration declared a public health emergency in January to bolster response efforts.
* President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.

* In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
* In February, the President restricted travel for individuals recently traveling from Iran.
* The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
* Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.

* Today, the President directed his Administration to make general-use face masks available to our healthcare workers.

* The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.

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* President Trump signed into law more than $8 billion to fund response efforts.
* The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
* Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.

* More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
* Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.

* The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.

* From the start, President Trump has made keeping the public informed a top priority.

* The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

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Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

WATCH HERE. <https://grabien.com/getmedia.php?id=856365&key=8a068e0e7ba2ceda6bd6ed7452ddb3de>

From very early on, President Trump took decisive action to put the health of the American people first.

"We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

"The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE <https://grabien.com/getmedia.php?id=856357&key=57d8648a9738379794d8d7cc05271db7> .

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no higher priority than the health, safety and well-being of the American people.

"The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country.

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You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS

WATCH HERE <https://grabien.com/getmedia.php?id=856379&key=cb1ba3743718e73a552d06d4ad66a617> AND HERE <https://grabien.com/getmedia.php?id=856383&key=9e8d30fd728e132040b652f01534deb4> .

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

"The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

"Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

WATCH HERE <https://grabien.com/getmedia.php?id=856387&key=11a16cd41a35ed71b5740a5915232784> AND HERE <https://grabien.com/getmedia.php?id=856391&key=8c259b68ce8df48e55ad39eaae2c0b4a> .

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

"We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

"Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

"But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

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ON CBS This Morning

WATCH HERE <https://grabien.com/getmedia.php?id=856403&key=076e051c5bee0accd97969ffc61e1e8a> .

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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

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(CDC/DDPHSIS/CPR/DSLR); Sakyi, Stephanie (CDC/DDPHSIS/CPR/DSLR); McHugh, Katherine (CDC/DDPHSIS/CPR/DSLR); Schultz, Lindsay (CDC/DDPHSIS/CPR/DSLR); Polk, Jennifer (CDC/DDPHSIS/CPR/DSLR); Bemisdarfer, Sara (CDC/DDPHSIS/CPR/DSLR); McCardle, Candice (CDC/DDPHSIS/CPR/DSLR); Kroessler, Elizabeth (CDC/DDPHSIS/CPR/DSLR); Cabato, Erika (CDC/DDPHSIS/CPR/DSLR); Trapp, Haley (CDC/DDPHSIS/CPR/DSLR); Kopania, Kathryn (CDC/DDPHSIS/CPR/DSLR); Daniels, Marissa (CDC/DDPHSIS/CPR/DSLR); Johnson, Jennifer (CDC/DDPHSIS/CPR/DSLR); Herreros, Celia (CDC/DDPHSIS/CPR/DSLR); Skewes, Andrea (CDC/DDPHSIS/CPR/DSLR); Ho, Lauren (CDC/DDPHSIS/CPR/DSLR); Stark, Kristina (CDC/DDPHSIS/CPR/DSLR); Gorgen, Lindsay (CDC/DDPHSIS/CPR/DSLR); Lira, Rosa (CDC azdhs.gov); stephanie.sakyi@arkansas.gov; kate.mchugh@cdph.ca.gov; jennifer.polk@dph.ga.gov; sara.bemisdarfer@dhw.idaho.gov; Candice.McCardle@state.mn.us; danielm@dhec.sc.gov; Jennifer.N.Johnson@tn.gov; lauren.ho@partner.vermont.gov; lindsay.gorgen@wa.gov; askewes@utah.gov; CDC IMS State Coordination Task Force (SCTF) Lead; CDC IMS State Coordination Task Force (SCTF) Science Advisor; CDC IMS State Coordination Task Force (SCTF) Chief of Staff; CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) EOC Desk; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; CDC IMS State Coordination Task Force (SCTF) Policy & Comm; CDC IMS State Coordination Task Force (SCTF) Partner Share; CDC IMS State Coordination Task Force (SCTF) Eval & Analysis; CDC IMS State Coordination Task Force (SCTF) Prog Services Unit; CDC IMS State Coordination Task Force (SCTF) Field Services Unit; eocsctftfcoord2@cdc.gov; CDC IMS State Coordination Task Force (SCTF) MCCM LNO; CDC IMS State Coordination Task Force (SCTF) Lab LNO; CDC IMS State Coordination Task Force (SCTF) EPI LNO; CDC IMS State Coordination Task Force (SCTF) GMTF LNO; CDC IMS State Coordination Task Force (SCTF) Funding Programs LNO; mplescia@astho.org; barbara.blake@alaska.gov; donna.steward@alaska.gov; lynn.trujillo@state.nm.us; morgan.ferris@state.co.us; CommOffice@michigan.gov; dawn.vick@wisconsin.gov; tribalnations@mt.gov; Jim.Suennen@chhs.ca.gov; nahc@nahc.ca.gov; jill.avery@iowa.gov; linda.scott@iowa.gov; Kathy.Aplan@state.sd.us; scott.w.shafer@nebraska.gov; sjdavis@nd.gov; aiac@att.net; benjamin.hermerding@governor.virginia.gov; burne.stanley-peters@mass.gov; daphne.pinto@doa.nc.gov; eddietullis@yahoo.com; Feedback@sos.nj.gov; GOCI.info@Maryland.gov; soo.koo@maryland.gov; info@cfma.sc.gov; info@fgcia.org; info@georgiaindiancouncil.org; info@ocfs.ny.gov; john.peters@mass.gov; MelWilliams@icrc.in.gov; mitsced@roadrunner.com; nhcnativeamericanaffairs@gmail.com; pat.arnould@la.gov; Brian.Hendrix@sos.ok.gov; KNAA@ks.gov; gotrinfo@az.gov; ssilversmith@utah.gov; craig.bill@goia.wa.gov; inquiry@ihrc.idaho.gov; jguthrie@senate.idaho.gov; LCIS@oregonlegislature.gov; mystique.hurtado@goia.wa.gov; tamara.fulwyler@doh.wa.gov; afninfo@NativeFederation.org; Vboerner@anhb.org; anthcwebsite@anthc.org; apiai@apiai.org; Cindy@ancsaceos.org; info@beringstraits.com; rclark@bbahc.org; Chitina_village@outlook.com; scott.davis@chugachgov.com; info@CITCI.org; info@crnative.org; charleen.fisher@catg.org; communications@doyon.com; kejaw@eatribes.net; info@fairbanksnative.org; tvanderhoop@kictribe.org; info@kodiakhealthcare.org; info@mstc.org; news@nana.com; nve@eklutna-nsn.gov; Kerin@eyak-nsn.gov; ntc@ninilchiktribe-nsn.gov; cpiscoya@nshcorp.org; corpcomm@sealaska.com; KGottlieb@SouthcentralFoundation.com; TACdirectors@aleutcorp.com; info@ykhc.org; nmalonzo@aaihb.org; russel.pederson@ihs.gov; Debra.Grabowski@ihs.gov; info@aihschgo.org; ATuomi@aihfs.org; LaPlaunt, Tyler (CDC glitc.org); info@ihb-mpls.org; kellumm@juelfairbanks.org; m.a.s.t@frontiernet.net; vsandoval@helenaindianalliance.com; Snell, Bill (CDC rmtlc.org); admin@aihscorp.org; dadtatum@aol.com; info@friendshiphousesf.org; awscott@ihcscv.org; intertribal.ca@itccinc.org; rvaladez@nativedirections.org; info@snahc.org; info@sdaihc.com; info@tasin.org; info@uaii.org; mark.lebeau@crihb.net; jerilyn.church@gptchb.org; ColonialEraTribes@gmail.com; info@nativelifelines.org; sking@newyorkindiancouncil.org; kcarroll@usetinc.org; jill.jim@nndoh.org; information@kcindiancenter.org; angie.c@okcic.com; nwahpepah@spthb.org; info@itcaonline.com; info@itcn.org; outreach@nacainc.org; jreeves@nvui.org; Maria.dadgar@itcaonline.com; info@naranorthwest.org; NPInfo@nativeproject.org; info@sihb.org; atni@atnitribes.org; jfinkbonner@npaihb.org; Bernal, Jacob (CDC ticenter.org); Provost, Ellen (CDC anthc.org); English, Kevin (CDC aaihb.org); Cresci, Vanesscia (CDC crihb.org); Gonzalez, German (CDC glitc.org); Beaudry, PJ (CDC gptchb.org); Ritchey, Jamie (CDC itcaonline.com); ramona.nez@nndoh.org; Warren-Mears, Victoria (CDC npaihb.org); Prather, Tracy (CDC spthb.org); Andreini,

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Subject:	Senior Administration Officials Briefing Call on COVID-19 // Regarding President Trump issuing proclamation under section 212(f) of the Immigration and Nationality Act (INA), restricting travel
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png

State and Local Leaders,

On Thursday, March 12, at 2:00 p.m. Eastern Time, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

* Date: Today, Thursday, March 12
* Time: 2:00 PM ET (please note time zone)
* Call-In Registration: CLICK HERE <https://ems9.intellor.com/?do=register&t=1&p=901287>
* Note: You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,

Zach

The White House Office of Intergovernmental Affairs

Zach Swint

Office of Intergovernmental Affairs

The White House

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President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

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"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

* President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.

* Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.

* The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
* Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
* There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

* The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.
* President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.

* These loans will help overcome disruptions caused by the coronavirus.
* The President is calling on Congress to increase funding for this program by an additional $50 billion.

* The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.

* This action will provide more than $200 billion of additional liquidity to the economy.

* President Trump is calling on Congress to immediately pass payroll tax relief.
* The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.

* The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

* The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
* The Trump Administration declared a public health emergency in January to bolster response efforts.
* President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.

* In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
* In February, the President restricted travel for individuals recently traveling from Iran.
* The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
* Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.

* Today, the President directed his Administration to make general-use face masks available to our healthcare workers.

* The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.

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* President Trump signed into law more than $8 billion to fund response efforts.
* The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
* Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.

* More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
* Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.

* The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.

* From the start, President Trump has made keeping the public informed a top priority.

* The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

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Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

WATCH HERE. <https://grabien.com/getmedia.php?id=856365&key=8a068e0e7ba2ceda6bd6ed7452ddb3de>

From very early on, President Trump took decisive action to put the health of the American people first.

"We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

"The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE <https://grabien.com/getmedia.php?id=856357&key=57d8648a9738379794d8d7cc05271db7> .

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no higher priority than the health, safety and well-being of the American people.

"The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country.

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You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS

WATCH HERE <https://grabien.com/getmedia.php?id=856379&key=cb1ba3743718e73a552d06d4ad66a617> AND HERE <https://grabien.com/getmedia.php?id=856383&key=9e8d30fd728e132040b652f01534deb4> .

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

"The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

"Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

WATCH HERE <https://grabien.com/getmedia.php?id=856387&key=11a16cd41a35ed71b5740a5915232784> AND HERE <https://grabien.com/getmedia.php?id=856391&key=8c259b68ce8df48e55ad39eaae2c0b4a> .

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

"We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

"Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

"But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

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ON CBS This Morning

WATCH HERE <https://grabien.com/getmedia.php?id=856403&key=076e051c5bee0accd97969ffc61e1e8a> .

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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AMERICAN OVERSIGHT

From: Castaneda, Maribel

To: agentes@clarke.com; alopez@clarke.com; sschneider@clarke.com; jamesclauson@comcast.net; leeduke1@live.com; cindymulla@comcast.net; michael.riles@comcast.net; summerseddie@comcast.net; Joe.Faella@brevardcounty.us; Inman, Barry; lacy.kittles@brevardfl.gov; Beth.Carey-Kovach@charlottecountyfl.gov; Rebecca.owers@charlottecountyfl.gov; Turner, Edna L; Scott.Schermerhorn@charlottecountyfl.gov; Bagley, Rebecca L; gdeskins@citrusmosquito.org; Dunn, Freta K; bkellner@citrusmosquito.org; Poirier, Thomas P; Rashley, Merton J; BenjaminA@coj.net; Rwishard@coj.net; lrosie1965@gmail.com; matthew_mello@co.escambia.fl.us; bill@flaglermosquito.com; markefmcd@outlook.com; fmbmctd@gmail.com; mcothran@gulfcounty-fl.gov; Legg, Keith O; Prowant, Brian K; sfisher@co.hernando.fl.us; JWhitehurst@co.hernando.fl.us; BurnsL@HillsboroughCounty.org; McFaulN@hillsboroughcounty.org; MontgomeryR@hillsboroughcounty.org; shafers@HillsboroughCounty.org; s.artman@irmosquito2.org; s.burroughs@irmosquito2.org; d.pelley@irmosquito2.org; h.whitehead@irmosquito2.org; m.kartzinel@irmosquito2.org; sterling@lcmcd.org; Lloyd@lcmcd.org; Roth, Jennifer; kbaker@lcmcd.org; Armstrong, Angela N; colvinh@leoncountyfl.gov; forda@leoncountyfl.gov; PourciauG@leoncountyfl.gov; CDBaum@manateemosquito.com; Barbara.Bayer@manateemosquito.com; max.dersch@manateemosquito.com; gduesterbeck@martin.fl.us; amcgowan@martin.fl.us; Reinhold, Todd A; snoe@martin.fl.us; Kylie Zirbel; Cason, Emily; connerla@msn.com; Geib, Kim N; Godwin, Michael D; Beedie, Katherine A; eevers@co.okaloosa.fl.us; carin.harrison@us.af.mil; srhenson@myokaloosa.com; Steve.Harrison@ocfl.net; susan.durand@ocfl.net; Jeremy.Brown@ocfl.net; Rafael.Melendez@ocfl.net; dpenson@rcid.org; kpeters@rcid.org; asolis@rcid.org; Rick.Baird@osceola.org; Fricano, Pat; ajanus@pascomosquito.org; Arogers@pascomosquito.org; Dennis Moore; Bohinc, Becky; GEdson@co.pinellas.fl.us; blawton@pinellascounty.org; dnovich@pinellascounty.org; LSmith@pinellascounty.org; Lamb, JoAnne; jstuck@co.pinellas.fl.us; Carlboohene@polk-county.net; hugoortiz@polk-county.net; wynonah.little@putnam-fl.com; sanitation@putnam-fl.com; aprilm@santarosa.fl.gov; nosborn@scgov.net; geby@seminolecountyfl.gov; tjones03@seminolecountyfl.gov; snieves@seminolecountyfl.gov; lreaves@seminolecountyfl.gov; quallsamcd@bellsouth.net; gainesamcd@bellsouth.net; mfarooqamcd@gmail.com; ssmoleroffamcd@gmail.com; xueamcd@gmail.com; jacksons@stlucieco.org; JacobsenR@stlucieco.org; Harts@stlucieco.org; hendersong@stlucieco.org; Koerner, David J; Kossler, Kimberly; minceyt@stlucieco.org; Jared.Stokes@sumtercountyfl.gov; SBartlett@volusia.org; jdillon@volusia.org; DFalcon@volusia.org; mlauth@volusia.org; lraymaley@volusia.org; rlucas@volusia.org; tmachardy@volusia.org; CEfstathion@volusia.org; TVasconcellosByrd@volusia.org; Mosquito Control-North; nwmosquito4@gmail.com; lab@swcmcd.org; director@swcmcd.org; reception@swcmcd.org; mcteche@swcmcd.org; operations@swcmcd.org; mctechb@swcmcd.org; supervisor@swcmcd.org; supervisor@swcmcd.org; Morrison, Andrea; Blackmore, Carina; Bryant, Glenn W; Cannons, Andrew C; Choe, Ulyee; Dennis, Anthony D; Dunn, Freta K; Godwin, Michael D; Gregos, Eliot M.; Guidash, Gayle; Heberlein-Larson, Lea A.; Hensley, Deborah S; Koerner, David J; Legg, Keith O; Matthias, James M; Miller, Brian L.; Mock, Valerie; Lewandowski, Patty A; Morris, Cindy K.; Myers, Paul D; Pierce, Bruce; Prowant, Brian K; Rashley, Merton J; Reinhold, Todd A; Roth, Jennifer; Rowlinson, Marie-Claire; Scuteri, Ana C; Seaton, Lylah J; Smith, Bret A; Stanek, Danielle R; Steele, Crystal C; Turner, Scott M; Ulery, Sheryl P; Walsh, Donna; Williams, Diana J; Young, Zelda J; Zipperer, Angela; Marah.Clark@freshfromflorida.com; dwayne.carbonneau@fwc.state.fl.us; seth.britch@ars.usda.gov; JFDay@mail.ifas.ufl.edu; jrey@ufl.edu; crr@mail.ifas.ufl.edu; docmx8@gmail.com; dbowers@unf.edu; hhassan@health.usf.edu; tunnasch@health.usf.edu; pvanderkelen@gmail.com; lstarkm@aol.com; taytaylor518@gmail.com; ciadams@fsu.edu; Ashley.pierre-saint@freshfromflorida.com; Frieda.Lamberg@FreshFromFlorida.com; stacey.k.booker.mil@mail.mil; Rachel.Beck@adph.state.al.us; Joshua.Coleman@adph.state.al.us; PEfird@mchd.org; dlee@mchd.org; antrimm@chathamcounty.org; lfpeaty@chathamcounty.org; keith@mosquitocs.com; Jayna@mosquitocs.net; william.schommer@rentokil.com; cwaldron@la.gov

Cc: Heberlein-Larson, Lea A.; Cannons, Andrew C; Lewandowski, Patty A; LaCrue, Alexis N; Kopp, Edgar W; Castaneda, Maribel

Subject: Sentinel Chicken Program Important Update

Date: Thursday, March 12, 2020 12:05:45 PM

Good Morning Sentinel Chicken Program Participants,

Our laboratory and epidemiology leadership have decided to suspend Sentinel Chicken Testing effective immediately. At this time, all personnel are need to help perform COVID-19 testing. For the next seven weeks or until further notice, we will not be performing HAI, ELISA, PRNT, and mosquito pool testing. Specimens received today or tomorrow will not be processed. Please send me an e-mail so that I know what you would like us to do with those specimens. We will notify you when we are able to resume testing.

Reports:

1. This Friday, March 13, 2020 the regular HAI report will be e-mailed.
2. Tuesday, March 17, 2020 the IgM ELISA report will be e-mailed.
3. Wednesday, March 18, 2020 the PRNT report (for February specimens) will be e-mailed.

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Please understand that we are doing what is best to promote, protect, and improve the health of all people in the state. Please contact me, if you have any questions or concerns.

Thank you,

Maribel

Maribel Castaneda
Lead Scientist
Sentinel Chicken Program Coordinator
Bureau of Public Health Laboratories – Tampa
Division of Disease Control and Health Protection
Florida Department of Health
3602 Spectrum Blvd.
Tampa, FL 33612
Phone: 813-233-2342

Division of Disease Control and Health Protection
Florida Department of Health

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Rico, Edhelene; Mejia-Echeverry, Alvaro; Jean, Reynald
Cc:	Schmitz, Ann; Villalta, Yesenia D; Blackmore, Carina; Moran, Susan O Col USAF SOUTHCOM SC-CC (USA)
Subject:	SouthCom COVID Exposures
Date:	Thursday, March 12, 2020 5:46:24 PM

Good Afternoon,
Dr. Susan Moran (305-437-1327 and copied) from Southcom reached out to me. She is leading a contact investigation of a reportedly positive COVID-19 case that visited the facility on Sunday. She is currently stratifying risk for around 97 persons. Est 10-20 may be medium risk. During our discussion we developed a plan that I think meets all of our needs.

- Southcom will plan to monitor all medium risk enlisted persons and only reach out if they have persons that need testing.
- They will also, develop a list of medium risk civilians with contact information, and provide to Miami-Dade CHD and you can notify other counties as needed by residence to monitor those folks.
- They will educate all low risk and ask that they call them if they develop illness they will triage and report as needed.

Her colleague Dr. Alexis Bowers(sp?) is also involved and can be reached at 305-437-3916.

Thank you!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
Division of Disease Control and Health Protection

Phone: 850-245-4406
Cell: 850-251-5558
Fax: 850-414-6894
24/7 EPI Hotline: (850) 245-4401
Email: scott.pritchard@flhealth.gov

Physical Address:
4025 Esplanade Way, Room 240-H
Tallahassee, FL 32399-1720

Mailing Address:
4052 Bald Cypress Way, Bin A-12
Tallahassee, FL 32399-1720

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From: SNRegistry

To: Carly.Swartz@em.myflorida.com; Colby.Maxwell@em.myflorida.com; DEM_Regional_Coordinators@em.myflorida.com; mjones@martin.fl.us; ELoPresti@ircgov.com; aharris@seminolecountyfl.gov; wpecci@martin.fl.us; wmayo@holmescountyem.org; richard.halquist@osceola.org; Lauren Possinger; Rhonda Lewis; tashondawhaley@tds.net; scott.garner@dixie.fl.gov; shawnw@tds.net; shayne_morgan@columbiacountyfla.com; donna@waltoncountyem.org; kwolfe@myokaloosa.com; danielh@santarosa.fl.gov; BCHATTAW@co.escambia.fl.us; jaalexander@sjcfl.us; mashuler@fairpoint.net; MShivers@myglades.com; Gerard.Mallet@charlottecountyfl.gov; Scott Canaday; David Casto; cevan@sheriffcitrus.org; jerri.kaplan@hardeecounty.net; johnmacdonald@levydisaster.com; jill.newman@hardeecounty.net; bek.parker@bakerso.com; lnelson@flaglercounty.org; emgmgnt@sjcfl.us; MLOberdorfer@NassauSO.com; rsmith@gcfr.org; Cooksey, Samantha; paulwomble@polk-county.net; parrishr@stlucieco.org; slerner@seminolecountyfl.gov; Rachel Jackson; emiller@marionso.com; lwilcoxen@pascocountyfl.net; TCanelli@scgov.net; vilchezg@stlucieco.org; jbowlin@marionso.com; patrick.fuller@charlottecountyfl.gov; brandi.frame@hendryfla.net; lmarker@bakerso.com; bhardin@baycountyfl.gov; sherschenhorn@broward.org; swyllie@sheriffcitrus.org; maria.haney@claycountygov.com; Lauren.Bonica@colliercountyfl.gov; ZGainer@coj.net; TDTOMPKINS@myescambia.com; em1frank@fairpoint.net; DSantana@co.hernando.fl.us; williamst@HCFLGov.net; Hawker, Miranda C; jgussler@lakecountyfl.gov; dquimby@leegov.com; nagyj@leoncountyfl.gov; leathakeene@levydisaster.com; pstefanski@marionso.com; Roberto.Cepeda@miamidade.gov; haskins-anna@monroecounty-fl.gov; ahoward@co.okeechobee.fl.us; Carmen Weatherford; SpecialNeeds@osceola.org; kwall@pbcgov.org; ema@pinellascounty.org; JudyRobinson@polk-county.net; mazle.holder@putnam-fl.com; GinnyP@santarosa.fl.gov; grahamj@unionsheriff.us; lkuzma@volusia.org; marving@miccosukeetribe.com; Eve Rainey; Jeanne Eckes-Roper; wendy_russell@bradfordsheriff.org; Luis.hernandez@brevardfl.gov; bjordan@sheriffcitrus.org; RRussell@co.hernando.fl.us; Pedigo, Ryan J.; brittany.lozada@miamidade.gov; kalson-vince@monroecounty-fl.gov; Todd Stalbaum; mserfustini@pinellascounty.org; LaTosha Reiss; debg@santarosa.fl.gov; ParrisR@hcflgov.net; john.scott@brevardcounty.us; bpickering@flaglercounty.org; wjohnson@martin.fl.us; myersk@stlucieco.org; jlord@flaglercounty.org; Schaudel, James; Scott, Katie E; TSMEAD@myescambia.com; Sharon.Hingson@suwanneesheriff.com; bill.litton@osceola.org; Massoud-Matt@MonroeCounty-FL.Gov; robin.peiffer@suwanneesheriff.com; Sison, Allyson R.; ahassell@lakecountyfl.gov; Renee Lowe; madisoncoem2@embarqmail.com; lafayem@windstream.net; Pelletier, Dan; Sussman, Andrew; Williams, Ted; director@holmescountyem.net; Laurie, Christine; Roberts, James; Margaret S Hart; Fiske, Jodie; Lambert, Gina; Titus, Tasha S; EMA, EMA; Creech, Denise R; EmergencyManagementEmployees; Serfustini, Mecca R; bryan.otoole@putnam-fl.com; April.McQuaig@hardeecounty.net; Brad C. Hattaway; Sullivan, Robert; Scott, John; Reiss, Latosha; Lisa Poziomek; calhounemc@gmail.com; Perea, Aurelio O; DL DEPCS00 BPR Regional-County Planners; DL DOH CHD Administrators_Directors; Kimbrel, Nicole H; Silverstein, Judith L; McCray, Debra; Risher, Valerie J; Levings, Margaret A; Paula Carroll; Connie Welch; Demott, Monica; Long, Jessica L; Krista Ditoro; Frankie Lumm; Snead, Jordan A; Marr, Kathleen J; Chmiel, J David; Vick, Stephanie; Garcia, Mary L; Hoskins, Ashley J; Strokin, Natasha M; Gifford, Jeremy X; Stewart, Lewis Shayne; Street, Karen K; Ming, Randy S; Hess, Erin E; DuBois, Adam J; Courson, Sandi C; Exline, Timothy; Smith, Kathy J; Hamlett, Elizabeth(Chd48); Sykes, Michael R; Cook, Kevan D; Lanza, John J; Crain, Pamela A; Chirinos, Peter P; Milanese, Megan; Miller, Jason S; Mooney, Dayle; Vaughn, Freda G; Paterniti, Beth A; Horner, Jennifer E; Sudden, Terri M; Gountas, Ioannis; Smith, Jennifer M; Williams, Lydia K; Zelnick, Sanford D; Huard, Gerald S.; Webb, Robert K; Bencie, Jennifer L; Rich, Don; Fey, Eric S; Baird, Angela T.; Collinge, Deborah; Bartels, Amy; Skau, David M; Day, Patricia; Medved, Daniel T; Rubio, Tito G.; Laucevicius, Rachell A; SantanaReyes, Yamilet; Lopez, Jose M; Mattei, Nina L; Stahl, Maria A; Nickola-Williams, Noreen B; Crowe, David R; Rutledge, Laura X; Turchetta, James P; Walsh, Donna; Paula J. Sellek; Baltzley, Edwin W; Snyder, Robert E; Welter, Bonnie J; Reese, Suzette W; Nealon Joseph; Butler, Lola J; Herrera, Luis; Bartha, Caroline T; Hardacre, Tod B; Eichler, Fred V; Pepe, Joseph D; Martin, Sandy K; Batts, Howell T; Roberts, Kyle B; Davis, Terri C; Clark, Tricia L; Johns, Amie G; Joseph, Jerry A.; Vreeland, Lisa M; Rolle, Pauline J; Meyers, Matt D; Jeffers, Carol R; Austin, James E; Osman, Ihab N; Long, Jason E; Barnes, Brenda L; Leigh Webb; Huffman, Heather E; Morales, Jose A; Blevins, Allison M; Sewell, Susie W; Waldron, Kerry S; Boswell, Patricia; Moffses, Thomas P; Sandoval, Randi C; Wright, Cyna; Allicock, Dawn; Veneman, Robert J; Quigley, Jacob B; Cobb, Joseph L; Pietrangelo, Joseph; Combs, Sue S; Duncan, Jordan D; Holt, Douglas A. (Doug); Verlaan, Thomas D; McMillion, Barbara J; Rodriguez, Genevie N; Park-O"Hara, Sandra L; Locke, Barbara L; Kallay, Ruth; Howe, Albert L; McCluskey, Vianca; Yeager, Kaila E; Mitchell, Halle M; Brad Baker; Powell, Joseph M; Kelly, Christine L; McBride, Laura J; Bracken, Jennifer C; Owen, Kristina J; swarner@baycountyfl.gov; Kayla Kinsey; James, Nasseam McPherson; Andre, Lisa A; Kirsch, Holly S; Kevin Peters; Bielling, Jeffery; Van Alstine, Randy L.; Ritten, William T; Roberts, Eric P; Sumner, Samuel M; Bechtel, Stephanie R; Campbell, Sieglinde D; Hartwell, Paige M; Newhouse, Brandi; Arant, Jennifer S; Senyshyn, William; Jackson, Iris F; Brandow, Jennifer; Hartzell, Vivian; Casey, Kristin; Johnson, Adam C; Lane, Susan M; Flaherty, Terrie; Foster, Kena K; Lutchman, Shamilla N; Office of Emergency Management; Olson, Jan E; Courtney C. Wildes; Hobby, Tonya X; Wiser, Robert H; Dulmage, Philip; Black, Melanie A; Kossler, Kimberly; Roberson, Angela C; Beck, Pam; Otis, Aaron; Barley, Kathryn C; Warren, Skyler C; Luce, Christie; Benefield, Dustin B; O"Rourke, Christopher P; Elkins, Vickie; Linnens, Robert L; Rodriguez, Carolyn; Guerrero, Rangel; Higginbotham, William T; Baumgardner, Kedra S; Blood, Joshua; Padro, Noemi; kbAUMGARDNER@ISF.COM; Harkrider, Tommy G; Bailey, William H; Hodges, Zachary L; Hinds, Sarah JQ; Choe, Ulyee; Myers, Paul D; Bradley, Edward; Hazel, Richard C; Eadie, Bob; Mehta, Udgit P; Valentine, Kathryn; McDonald, Linda A; Kissler, Aaron X; Adams, Ruth C

Subject: Special Needs Registry

Attachments: 2020-02-11 Registry Workgroup Agenda.doc

Good Afternoon All,

AMERICAN OVERSIGHT

Please find attached the agenda for tomorrow's call. There will not be any webinar information as there is no demonstrations to show the workgroup.

Monthly SNR Workgroup Conference Call

888-585-9008

Participant(Conf. Rm#): 269-597-735

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From: Pathology (CDC)
To: BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quave@flhealth.gov; Stanek, Danielle (CDC/flhealth.gov); Blackmore, Carina (CDC/flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.nova-chaveco@flhealth.gov; Schmitz, Ann (CDC/flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP); Benpit, Tina (CDC/DDID/NCEZID/DHCPP)
Subject: Specimen Receipt Notice: IDPB 2020-0171
Date: Wednesday, February 12, 2020 2:07:00 PM
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence.

Dr. Stephen White,

This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.

If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

****

Report Password: the password to open the password protected Pathology Report PDF (Preliminary/Final/Addendum) for this case will be provided in a separate email after you receive the Final Pathology Report Email and will be a unique 12 digit number. If additional specimens are subsequently received on the same case by IDPB, the password will remain unchanged. Animal case reports will not have password protection.

Specimen Receipt Notice: the official contact(s) at the Health Departments (if known) will be cc'd on IDPB's Specimen Receipt Notice emails, in addition to cc'ing other case specific relevant parties. The same official contact(s) at the Health Departments (if known) will continue to receive IDPB's Final Pathology Reports once finalized.

ePathology Service: IDPB now offers telepathology consultation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http://www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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From:	Kopp, Edgar W
To:	sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Pritchard, Scott; Cannons, Andrew C; Heberlein-Larson, Lea A.
Subject:	Specimen Submission for COVID-19 PUI ID# 0001287
Date:	Thursday, February 20, 2020 7:43:16 PM

FedEx tracking number 777820256263
Sender's name: Edgar Kopp

From: Pritchard, Scott
Sent: Wednesday, February 19, 2020 3:41 PM
To: Cannons, Andrew C <Andrew.Cannons@flhealth.gov>; Kopp, Edgar W <Edgar.Kopp@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Specimen Submission COVID-19 PUI ID# 0001287

Here are the details for an incoming PUI from Hillsborough county.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Sent: Wednesday, February 19, 2020 3:37 PM
To: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; CDC IMS Logistics Transportation <eocevent306@cdc.gov>; Hyde, Allen W. (CDC/DDPHSIS/CPR/DEO) <fnb4@cdc.gov>; Schneider, Eileen (CDC/DDID/NCIRD/DVD) <ees2@cdc.gov>; CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Subject: PUI ID# 0001287

Hello Scott:

Thank you for contacting CDC about the patient under investigation (PUI) for novel coronavirus (COVID-19). Please find summary information below to help assist in the PUI evaluation and specimen referral.

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Summary

38 yo male who resides in China (Guangzhou City) came to US on 2/3. on 2/15 he developed cough, congestion, rash and subjective fever. Patient presented to ED for evaluation. Decision made to admit patient but patient signed himself out AMA. Specimen x 3 were collected prior to his signing himself out. Denied other risk factors (travel to Wuhan or Hubei province; contacts to a known case).

CDC COVID-19 ID #0001287

POC Details

Name: Scott Pritchard

Location: Florida

Phone: 850-251-5558

Email: scott.pritchard@flhealth.gov

Additional information

Guidance for health departments to submit PUI information to CDC can be found here. Include the CDC COVID-19 ID issued to you by CDC in the top right box and on all specimen forms. The PUI form should be submitted as soon as able and need not wait for specimen shipping. Instructions on how to submit the PUI form are located at the top of the form.

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

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

Please see the attached *2019 Novel Coronavirus (nCoV) Specimen Submission Guidelines* for detailed guidance on specimen shipment, packaging, and documentation. Please ensure that the patient information on the specimen tube exactly matches the 50.34 DASH Form, or the

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CDC may have to reject the specimen or testing may be delayed.

For questions about specimen collection or completing the 50.34 Form, please see https://www.cdc.gov/laboratory/specimen-submission/help-faqs.html.

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

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

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

Thank you,

CDC IMS 2019 NCOV Response PUI Team

2019 Novel Coronavirus Response

eocevent185@cdc.gov

AMERICAN OVERSIGHT

From:	Cannons, Andrew C
To:	sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Pritchard, Scott; Heberlein-Larson, Lea A.; Kopp, Edgar W
Subject:	Specimen Submission for COVID-19 PUI ID# FL2783039 & FL2783057
Date:	Thursday, February 27, 2020 3:35:58 PM

Senders Name: Edgar Kopp
FedEx Tracking Number: 777882281733

Andrew C. Cannons, Ph.D., HCLD(ABB)
Laboratory Director, Bureau of Public Health Laboratories -Tampa
Division of Disease Control and Health Protection
Florida Department of Health
E-mail: andrew.cannons@flhealth.gov

Phone: (813) 233-2277
Fax: (813) 233-2379
Cell: (813) 956-8850

How am I doing? Please let me know by taking this short survey. Thank you!

Bureau of Public Health Laboratories

AMERICAN OVERSIGHT

From:	Kopp, Edgar W
To:	sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Pritchard, Scott; Heberlein-Larson, Lea A.; Herriman, Robert E; Cannons, Andrew C
Subject:	Specimen Submission for COVID-19 PUI ID# FL2785091
Date:	Thursday, March 12, 2020 5:09:51 PM

FedEx tracking number 770005225073
Sender's name: Edgar Kopp

Andrew C. Cannons, Ph.D., HCLD(ABB)
Laboratory Director, Bureau of Public Health Laboratories -Tampa
Division of Disease Control and Health Protection
Florida Department of Health
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Cell: (813) 956-8850

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Bureau of Public Health Laboratories

AMERICAN OVERSIGHT

From:	Cannons, Andrew C
To:	Kopp, Edgar W; sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Pritchard, Scott; Heberlein-Larson, Lea A.
Subject:	Specimen Submission for COVID-19 PUI ID# FL2786318
Date:	Tuesday, March 3, 2020 11:55:17 AM

FedEx tracking number 777911072788
Sender's name: Edgar Kopp

Andrew C. Cannons, Ph.D., HCLD(ABB)
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Bureau of Public Health Laboratories

AMERICAN OVERSIGHT

From:	Cannons, Andrew C
To:	Kopp, Edgar W; sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Pritchard, Scott; Heberlein-Larson, Lea A.; Herriman, Robert E
Subject:	Specimen Submission for COVID-19 PUI ID# FL2792318: FL2792316: FL2785125: FL2786318: FL2792718
Date:	Wednesday, March 11, 2020 3:55:18 PM

FedEx tracking number 777994873679
Sender's name: Edgar Kopp

Andrew C. Cannons, Ph.D., HCLD(ABB)
Laboratory Director, Bureau of Public Health Laboratories -Tampa
Division of Disease Control and Health Protection
Florida Department of Health
E-mail: andrew.cannons@flhealth.gov

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Fax: (813) 233-2379
Cell: (813) 956-8850

How am I doing? Please let me know by taking this short survey. Thank you!

Bureau of Public Health Laboratories

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	State Health Official & State Epi Touchbase
Date:	Thursday, March 12, 2020 5:32:53 PM
Attachments:	Considerations for school closure Draft 031220 Updated.pdf
Importance:	High

Dear Colleagues:

Thank you for your participation in today's state health official and state epidemiologist touch base. Please see the attached "**Interim Considerations for School Closures**" guidance. Feel free to send any questions to preparedness@cdc.gov.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Koneff, Douglas A
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Eleni Kalisch; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); CGRCU-Internal; O"Reilly, Kevin M; WHA-BSC-only; CGRCU-CAReps
Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject:	Status of Chile charter (Silver Express pax)
Date:	Wednesday, March 18, 2020 8:59:14 AM

I am slimming the chain to take our overseas colleagues off for right now. Please add DHS and others in the US as needed. Adding the State Department COVID coordination unit and consular reps.

Eleni - we understand the charter from Chile is scheduled to land in MIA between 1200-1300 EDT, and that FL state authorities have said non FL residents will not be allowed to continue onward to home unless moved to another charter.

Can you give us the latest? We are concerned both about Amcits on this flight as well as future charters by RC or other charters seeking to land in FL.

Thanks - Doug

Get Outlook for iOS

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:37 PM
To: Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc: Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

AMERICAN OVERSIGHT

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 10:20 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Eleni Kalisch
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>;

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Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship

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Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329

AMERICAN OVERSIGHT

470-487-4373

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 2:20 PM
To: Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From: Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD)
To: Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD)
Cc: ExecutiveOffice@astho.org; Montero, Jose (CDC/DDPHSIS/CSTLTS/OD)
Subject: Survey Extension until March 3rd: Help CDC Improve its Project Officer Support
Date: Monday, February 24, 2020 3:17:24 PM
Attachments: Survey Distribution Instructions.pdf

Dear Colleagues,

I wanted to personally thank you for your participation in this process.

I recognize that many of you are involved with the COVID-19 response and your time is very valuable. Please take this last opportunity to forward this survey on to the appropriate program contacts and encourage your colleagues to provide their honest feedback.

- The assessment should take no longer than 25 minutes to complete.
- Information collected will be kept on secure, password protected servers accessible only to ASTHO project team members. All information you provided will be analyzed and reported in the aggregate with no identifying information attached. So CDC will NOT know the individual State source.

With your programs' input we will better understand which project officer services are successful and those that need improvement. We will use the aggregate data to create best practices and provide training to support CDC efforts to provide outstanding technical assistance to our funding recipients in the future.

Assessment Link: Take the Assessment

I look forward to seeing you in Colorado in July!

Sincerely,

Steve

Steven L Reynolds, MPH
Deputy Director
Center for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention
404-394-9159

From: ASTHO Executive Office <g>
Sent: Monday, February 24, 2020 10:01 AM
To: ASTHO Executive Office <ExecutiveOffice@astho.org>
Cc: Research and Evaluation <ResearchandEvaluation@astho.org>; Suja Shunmugavelu

AMERICAN OVERSIGHT

<sshunmugavelu@astho.org>; Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD) <slr6@cdc.gov>
Subject: Survey Extension until March 3rd: Help CDC Improve its Project Officer Support

Dear Senior Deputies,

This email is another request for action and a follow-up to the CDC Project Officer survey launched in January (announcement email is attached). **Please note the survey has been extended until Tuesday, March 3rd.**

For those of you who have already distributed this evaluation to the appropriate points of contact within your agency, we appreciate your support. At this time we ask that you remind your staff about this survey by simply forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department.

As a reminder, ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements and grants. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

This survey should be completed by health agency staff who work on and serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements or grants (full list of selected cooperative agreements/grants is attached).

Our ask of you: Please remind your staff about this survey by forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department for their response. The invitation content to request participation is provided below the signature on this email. Feel free to directly forward this email to the intended recipients or create a new outreach message using the content below.

Thank you for your assistance.

Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308
www.astho.org | Twitter | Facebook | Blog

EMAIL FOR SURVEY RESPONDENT:

Instructions for survey respondent: The Association of State and Territorial Health Officials

AMERICAN OVERSIGHT

(ASTHO), in partnership with the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support is administering an assessment to health departments in all 50 states and the District of Columbia related to satisfaction with the services and support provided by CDC project officers.

Results from the assessment will be used by CDC to improve project officer support to state health agencies. Participation is voluntary, and your feedback will inform continued project officer development and training.

In order to participate in this voluntary assessment, please click the hyperlink provided in this email to be redirected to the web-based assessment. The assessment should take no longer than 25 minutes to complete. All responses are immediately saved and can be changed at any time. However, once the assessment is submitted, you will be unable to modify any responses. Also, you are not required to complete the assessment in one sitting. When finished responding to all relevant questions, click the **SUBMIT** button at the end of the assessment to submit your responses.

Information collected will be kept on secure, password protected servers accessible only to ASTHO project team members. All information you provided will be analyzed and reported in the aggregate with no identifying information attached.

Follow this link to the Assessment: Take the Assessment

Please submit responses to this assessment no later than March 3, 2020.

Note: The survey is designed for respondents to consider only one project officer within each selected cooperative agreement and grant. If your agency has more than one project officer for the Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations (DP17-1701), we invite your agency's appropriate point of contact to complete separate survey entries for each project officer.

Additionally, a few of the HIV, Viral Hepatitis, TB, and STD cooperative agreements have been updated with the current cooperative agreement numbers. The updated names and numbers are in the attached survey distribution instructions. If you already submitted responses under a prior cooperative agreement number you do not need to re-submit.

If you experience problems with the web-based assessment or have any questions, please contact Allen Rakotoniaina at researchandevaluation@astho.org for technical assistance.

Thank you in advance for your participation.

Disclaimer

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From:	ASTHO Executive Office
To:	ASTHO Executive Office
Cc:	Research and Evaluation; Suja Shunmugavelu; Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD)
Subject:	Survey Extension until March 3rd: Help CDC Improve its Project Officer Support
Date:	Monday, February 24, 2020 10:02:56 AM
Attachments:	Survey Distribution Instructions.pdf

Dear Senior Deputies,

This email is another request for action and a follow-up to the CDC Project Officer survey launched in January (announcement email is attached). **Please note the survey has been extended until Tuesday, March 3rd.**

For those of you who have already distributed this evaluation to the appropriate points of contact within your agency, we appreciate your support. At this time we ask that you remind your staff about this survey by simply forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department.

As a reminder, ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements and grants. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

This survey should be completed by health agency staff who work on and serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements or grants (full list of selected cooperative agreements/grants is attached).

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Thank you for your assistance.

Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308
www.astho.org | Twitter | Facebook | Blog

AMERICAN OVERSIGHT

EMAIL FOR SURVEY RESPONDENT:

Instructions for survey respondent: The Association of State and Territorial Health Officials (ASTHO), in partnership with the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support is administering an assessment to health departments in all 50 states and the District of Columbia related to satisfaction with the services and support provided by CDC project officers.

Results from the assessment will be used by CDC to improve project officer support to state health agencies. Participation is voluntary, and your feedback will inform continued project officer development and training.

In order to participate in this voluntary assessment, please click the hyperlink provided in this email to be redirected to the web-based assessment. The assessment should take no longer than 25 minutes to complete. All responses are immediately saved and can be changed at any time. However, once the assessment is submitted, you will be unable to modify any responses. Also, you are not required to complete the assessment in one sitting. When finished responding to all relevant questions, click the **SUBMIT** button at the end of the assessment to submit your responses.

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Follow this link to the Assessment: Take the Assessment

Please submit responses to this assessment no later than March 3, 2020.

Note: The survey is designed for respondents to consider only one project officer within each selected cooperative agreement and grant. If your agency has more than one project officer for the Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations (DP17-1701), we invite your agency's appropriate point of contact to complete separate survey entries for each project officer.

Additionally, a few of the HIV, Viral Hepatitis, TB, and STD cooperative agreements have been updated with the current cooperative agreement numbers. The updated names and numbers are in the attached survey distribution instructions. If you already submitted responses under a prior cooperative agreement number you do not need to re-submit.

If you experience problems with the web-based assessment or have any questions, please contact Allen Rakotoniaina at researchandevaluation@astho.org for technical assistance.

Thank you in advance for your participation.

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AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: TELE-TOWN HALL TONIGHT WITH SEC. AZAR
Date: Sunday, March 15, 2020 4:06:54 PM

The HHS Office of Intergovernmental and External Affairs would like to invite you to join a tele-town hall with Secretary Alex Azar **TODAY** at **7:00 PM ET** regarding the testing for COVID-19 in the United States. The call will provide information to state public health officials, clinical laboratories, and healthcare systems to best serve the public health interests of the American public during the COVID-19 emergency. The Secretary will be joined by additional officials who are leading the Administration's efforts to combat COVID-19's spread in the United States.

THIS INVITE SHOULD NOT BE FORWARDED OUTSIDE OF YOUR ORGANIZATION. But, to provide for a robust call, please ensure that the appropriate person from your organization is on the call. Ideally this person will have a grasp of the technical and operational issues of testing for the organization or jurisdiction. If there is an organization that you work with that you believe should receive this invite, please reply directly with that suggestion.

CLICK HERE to register for the call.

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: TELE-TOWN HALL TONIGHT WITH SEC. AZAR
Date: Sunday, March 15, 2020 4:08:48 PM

The HHS Office of Intergovernmental and External Affairs would like to invite you to join a tele-town hall with Secretary Alex Azar **TODAY** at **7:00 PM ET** regarding the testing for COVID-19 in the United States. The call will provide information to state public health officials, clinical laboratories, and healthcare systems to best serve the public health interests of the American public during the COVID-19 emergency. The Secretary will be joined by additional officials who are leading the Administration's efforts to combat COVID-19's spread in the United States.

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CLICK HERE to register for the call.

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: TELE-TOWN HALL TONIGHT WITH SEC. AZAR
Date: Sunday, March 15, 2020 4:06:27 PM

The HHS Office of Intergovernmental and External Affairs would like to invite you to join a tele-town hall with Secretary Alex Azar **TODAY** at **7:00 PM ET** regarding the testing for COVID-19 in the United States. The call will provide information to state public health officials, clinical laboratories, and healthcare systems to best serve the public health interests of the American public during the COVID-19 emergency. The Secretary will be joined by additional officials who are leading the Administration's efforts to combat COVID-19's spread in the United States.

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CLICK HERE to register for the call.

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

From: TMS Mailbox (CDC)

To: CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD); CDC EISO Class 2018; Carroll, Dianna D. (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD); Robinson, Byron (CDC/DDPHSS/CSELS/DSEPD); Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD); Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD); Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Liang, Jennifer (FDA/CDER); Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD); Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD); CDC EISO EAC Roster 2018; Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Henning, Tara C. (CDC/DDPHSS/CSELS/DSEPD); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Kennedy, Cynthia (CDC/DDPHSS/CSELS/DSEPD); Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD); Teresa and John Horan; Ralph H. Henderson,M.D.; Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Amos, Renee J. (CDC/DDPHSS/CSELS/DSEPD) (CTR); Bradley, Seliscia A. (CDC/DDPHSS/CSELS/DSEPD); Cordeira, Kelly (CDC/DDPHSS/CSELS/DSEPD); Wiese, Nicholas (CDC/DDID/NCEZID/DHCPP); Mayer, Oren (CDC/DDID/NCEZID/DHCPP); York, Shannon (CDC/DDPHSS/CSELS/DSEPD); Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP); Hott, Amanda (CDC/DDID/NCHHSTP/DTE); Woodson, Evonne (CDC/DDID/NCHHSTP/DSTDP); Stokes, Kindra (CDC/DDPHSS/CSELS/DLS); Scherer, Erin (CDC/DDID/NCIRD/DBD); Jacobs, Jesica (CDC/DDPHSS/CSELS/DSEPD); Buono, Sean (CDC/DDID/NCIRD/DBD); Carlson, Christina (CDC/DDPHSIS/CGH/DPDM); Freeman, Brandi (CDC/DDID/NCIRD/DVD); Levinson, Kara (CDC/DDPHSS/CSELS/DSEPD); Wadhwa, Ashutosh (CDC/DDID/NCEZID/DHQP); Barkley, Joi (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC LLS Class 2018; CDC LLS Class 2019; CDC EISO Class 2019

Subject: THIS SEMINAR HAS BEEN CANCELLED: TMS Presents: Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

Attachments: image003.jpg

AS A RESULT OF THE COVID-19 RESPONSE, THIS SEMINAR HAS BEEN CANCELLED.

Maureen will be asked to present her work at a later date.

Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

SPEAKER

Maureen Miller, MD MPH

EIS officer in the National Center for Chronic Disease Prevention and Health Promotion

Attendance Options and Continuing Education

* Remote options: • IPTV <http://cdciptv.cdc.gov/> • Envision <http://crss.cdc.gov/EnvisionList.aspx> • Adobe webinar <https://virtualsepd.adobeconnect.com/tms2/>

• Audio conference (1-866-761-5101, passcode "8445480#")

* Continuing education (CE) is available; see the TMS CE instructions <http://intranet.cdc.gov/csels/dsepd/pdfs/HowToGetContinuingEd.pdf> .

* See the TMS schedule and CE statements <http://intranet.cdc.gov/csels/dsepd/ewb/tuesday-monthly-seminars.html> .

* There is no cost for this activity.

AMERICAN OVERSIGHT

From:	Adedeji, Cleopatra Y. (CDC/DDPHSIS/CSTLTS/DPPS) on behalf of DSLRCrisisCoag (CDC)
To:	Fleming, John (CDC houstontx.gov); Smith, Marquis - HHD; Schultz,Lisa (DSHS); Osborne,Lisette (DSHS); Anna Eisenberg - TX; Blackmore, Carina (CDC flhealth.gov); Catherine Brown - MA; Rustin, Chrs (CDC dph.ga.gov); Doris Brown - LA; Joann Schulte - Houston; Kara Loewe - FL; Katrina Plummer - MA; Mahsa Yazdy - MA; Mardrah Starks-Robinson - LA; Marla Wallace - FL; Kelly, Rosmarie (CDC dph.ga.gov); Sandra Harris - LA; Tifany Nguyen - GA; Varnado, Wendy (CDC msdh.ms.gov)
Cc:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS); Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS); VanMaldeghem, Kelley (CDC/DDPHSIS/CSTLTS/OD) (CTR); Dacuan, Lindsay Barr (CDC/DDPHSIS/CSTLTS/OD) (CTR); Regan, Kelly Ann (CDC/DDPHSIS/CSTLTS/DPPS); Crockett, James B. (CDC/DDPHSIS/CSTLTS/DPPS)
Subject:	TP18-1802 Crisis CoAg: Hurricane Recovery Update
Date:	Monday, March 23, 2020 4:31:52 PM

Dear Colleagues,

CDC is aware that the public health system response to COVID-19 has resulted in many changes that impact hurricane-related projects funded under the TP18-1802 Crisis Cooperative Agreement.

Provided below is additional guidance to ensure maximum flexibility as you navigate necessary modifications to project activities:

1. **Canceling Convenings:** CDC, in accordance with the President's Coronavirus Guidelines for America -- 15 Days to Slow the Spread of Coronavirus (COVID-19), recommends that individuals and organizations cancel or postpone in-person events that consist of 10 people or more throughout the United States for the next 15 days. When feasible, organizers may modify events to be virtual. Please note that this interim guidance is based on what is currently known about the Coronavirus Disease 2019 (COVID-19). CDC will update this interim guidance as needed and as additional information becomes available.
    a. **Costs Incurred for Canceled or Postponed Convenings:** Recipients will be permitted to drawdown funds to cover nonrefundable costs incurred for previously approved Hurricane recovery related activities now canceled or postponed due to COVID-19. Recipients should make every effort to minimize costs associated with activities (i.e., seek reimbursement for flights, negotiate postponing meetings vs canceling, etc.).
    b. **Redirection of Funds:** To accommodate alterations to project activities, recipients may submit a request to redirect funds as needed. Please follow the steps outlined in the attachment *"Redirection of Funds Guidance"* to submit your request and receive prior written approval from CDC. As a reminder:
        i. Redirections that *exceed* 25% or $250,000 (or whichever is less) of the total approved budget should be submitted through GrantSolutions as a ***Budget Redirection Amendment*** which is a formal prior approval action completed by the Grants Management Specialist (GMS).
        ii. Redirections that are *less than* 25% or $250,000 (or whichever is less) of the total approved budget should be submitted in GrantSolutions as

AMERICAN OVERSIGHT

a ***Grant Note*** which should include written prior approval received from relevant Technical Monitor(s).

It is important to note that you <u>may not</u> redirect 1802 Hurricane Crisis funds to COVID-19 response activities. Funds may only be redirected to support other Hurricane recovery related activities and projects that are within scope of the award.

2. **No Cost Extension (NCE) Requests:** Per OMB's memorandum *"Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations"* released on March 19th, TP18-1802 Hurricane recipients are eligible for a 'No Cost Extension' *up to* twelve (12) months for activities scheduled to end by or before December 31, 2020. Financial and performance reports will be due 90 days following the *end date of the extension*. For guidance on how to submit your request through GrantSolutions, please refer to the attached job aid.

   Along with the required components of NCE request(s), we ask that you also include a statement of how COVID-19 response has impacted the Hurricane-related projects for which extension is being sought. This will serve as formal documentation of the need for an NCE.

Thank you for your continued partnership and all that your organization does to protect our nation's public health. We encourage you to monitor this dynamic situation by visiting www.cdc.gov/COVID19 for the latest information and guidance. Please do not hesitate to reach out to your respective Project Officers with any questions or concerns.

Kind Regards,
Hurricane Crisis Cooperative Agreement Team

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, Atlanta, GA 30329

AMERICAN OVERSIGHT

From: Otis, Aaron
To: Bowman, Thomas; Mann, Travis (OS/ASPR/EMMO)
Cc: McCoy, Steve; Blackmore, Carina
Subject: Testing of Florida Resident
Date: Saturday, March 14, 2020 5:30:33 PM

Tom,

I confirmed with our State Epidemiologist and Deputy Secretary for Health we will NOT be requesting testing of the 53 Floridians prior to transport.

Aaron

CDR Aaron B. Otis
Public Health Advisor
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support
Florida Department of Health

United States Public Health Service
CDC Public Health Advisor

4052 Bald Cypress Way Bin A23
Tallahassee, Florida 32399

aaron.otis@flhealth.gov
850-617-1534
850-445-1380 Mobile
850-245-4580 Fax

DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

PLEASE NOTE: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

How am I doing? Please let me know by taking this short survey. Thank you!
http://survey.doh.state.fl.us/survey/entry.jsp?id=1389303062486

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Cc:	Trent-Adams, Sylvia (HHS/OASH)
Subject:	Thank you - and follow-up email
Date:	Tuesday, March 17, 2020 6:58:19 PM

Dear State Health Officials –

Thank you so much for listening to HHS on the ASTHO call earlier this evening. As we mentioned, our goal is to increase the synergy between the testing operations that have stood up and the rollout of the HHS testing sites across the country. We hope to highlight locations for testing for COVID-19 everywhere in the nation. If you are willing and able to share the information from testing sites in your states, we would greatly appreciate it. Please find below some of the key pieces of information that we are seeking.

- Facility Name
- Facility Address
    - Street Address
    - City
    - County
    - State
    - Zip code
- Phone Number (if applicable)
- Days/Hours of Operation
- Requirements for Testing, *if any* (i.e. note from physician, age, symptoms, travel)
- Drive-thru, walk-in, or other? (If other, please specify.)

We thank you for your continued partnership and support. ASTHO and its members have always been a key partner of HHS, and we appreciate everything that you do. Please don't hesitate to reach out to me if there are any questions. I can be reached via email or my phone number below.

Thank you!
Michael

Michael Baker
Office of Intergovernmental and External Affairs
Office of the Secretary
U.S. Department of Health and Human Services
202-439-7829

AMERICAN OVERSIGHT

From:	Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
To:	CDC IMS State Coordination Task Force (SCTF) MCCM LNO
Cc:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Friday, February 28, 2020 1:30:41 PM

Greetings PHEP Directors & State Epidemiologists –

The outbreak of COVID-19 in China has led to a disruption in the global supply chain of personal protective equipment (PPE). CDC recognizes that healthcare facilities may experience temporary shortages even if they do not care for patients with COVID-19. CDC has released guidance for optimizing the use of N95 respirators, which includes some recommendations that may be applicable to other types of PPE, including surgical masks. CDC also has guidance regarding who needs and does not need PPE to help prevent excessive use of PPE.

As you are aware, this is a delicate system with many factors. When CDC receives notifications from healthcare systems about supply chain shortages, we encourage the Healthcare Coalition Partners to work together to problem solve within the coalition and/or wider state system. Further we encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

We have heard from the healthcare system partners that have contacted us that they are unsure whom to contact in the state health department about supply chain shortages in their facilities. As a way to help mitigate this, **we are asking you to reply to eocsctfmccmlno@cdc.gov no later than March 3, 2020, with an identified primary and secondary point of contact for any supply chain issues within your state.**

Please provide the following information:

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Christie.Luce@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Cc:	jennifer.coulter@flhealth.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Wednesday, February 12, 2020 4:41:31 PM
Attachments:	Florida.xlsx

Greetings PHEP Directors and State Epidemiologists,

As we prepare to use DCIPHER for the 2019-nCoV response (e.g., data collection, transmission, and data sharing), we are seeking additional information about the type of access for the users you previously identified for the nCoV 2019 DCIPHER platform.

The "access group" options are described here:

1. **Access to DCIPHER to VIEW (only) data**. Role allows individual to see a view of different reports and analyses for their jurisdiction's information and any aggregate national report that may be created.
2. **Access to DCIPHER for DATA ENTRY and EDITING**. Role allows individual to directly enter information into DCIPHER, edit data, see all data associated with the jurisdiction, in addition to viewing/creating different reports and analyses.

In the attachment, please complete information in the last two columns (epi and monitoring), select either **view** or **data entry/editing** for each user.

Please return your response to eocsctftfcoord@cdc.gov as soon as possible so we can configure the platform to support your jurisdictions' access requests.

Warm Regards,

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

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); CDC IMS State Coordination Task Force (SCTF) Operations; Byrd, Shirley K. (CDC/OCOO/OFR/OGS); Roush, Sandra (CDC/DDID/NCIRD/OD); Brammer, Lynnette (CDC/DDID/NCIRD/ID); Gross, Melanie S. (CDC/DDID/NCIRD/ID)
Subject:	Today at 2pm EST_All state call hosted by SCTF re: 2019-nCoV
Date:	Monday, February 10, 2020 11:55:57 AM

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

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

Participant Information

Bridgeline: 1(800)-857-6697
Participant Passcode: 1324420

For your convenience, call series dates are provided below.

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

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); CDC IMS State Coordination Task Force (SCTF) Operations; Byrd, Shirley K. (CDC/OCOO/OFR/OGS); Roush, Sandra (CDC/DDID/NCIRD/OD)
Subject:	Today at 2pm EST_All state call hosted by SCTF re: 2019-nCoV
Date:	Monday, February 3, 2020 11:41:53 AM
Importance:	High

Greetings,
We were just made aware of an all-state call that will be held today at 2pm EST and the topic is the Novel Coronavirus (2019-nCoV). The call is hosted by the CDC State Coordination Task Force (SCTF) and not the ELC; however, the content may be of interest.

The ELC role in our agency's response to this effort is still evolving but we will keep you posted with any information that is relevant to your program and ELC activities.

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

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

Participant Information

Bridgeline: 1(800)-857-6697
Participant Passcode: 1324420

For your convenience, call series dates are provided below.

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

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Tools to Support Medicaid and CHIP - COVID-19
Date: Monday, March 23, 2020 1:18:46 PM

Dear Governors and State Health Officials:

The Trump Administration has released new tools to strip away regulatory red tape and unleash new resources to support state Medicaid and Children's Health Insurance Programs (CHIP) during the 2019 Novel Coronavirus (COVID-19) outbreak. Because of the President's bold action in declaring COVID-19 a national emergency, CMS now has a full suite of tools available to maximize responsiveness to state needs. The agency has created four checklists that together will make up a comprehensive Medicaid COVID-19 federal authority checklist to make it easier for states to receive federal waivers and implement flexibilities in their program.

The tools include:

- **1115 Waiver Opportunity and Application Checklist**
- **1135 Waiver Opportunity and Application Checklist**
- **1915(c) Appendix K Template**
- **Medicaid Disaster State Plan Amendment Template**

You can find a copy of the press release here: **https://www.cms.gov/newsroom/press-releases/trump-administration-releases-covid-19-checklists-and-tools-accelerate-relief-state-medicaid-chip**

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit **www.coronavirus.gov.** For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the, please visit the **Current Emergencies Website.**

Sincerely,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Touch base with FL

Please feel free to forward

.....

Join Skype Meeting <https://webconf.cdc.gov/lxn9/YRCSB0K8>

Trouble Joining? Try Skype Web App <https://webconf.cdc.gov/lxn9/YRCSB0K8?sl=1>

Join by phone

(404) 553-8912,,6336505# (Atlanta Dial-in Conference Region)	English (United States)
(855) 348-8390,,6336505# (Atlanta Dial-in Conference Region)	English (United States)

Find a local number <https://webaudio.cdc.gov?id=6336505>

Conference ID: 6336505

Forgot your dial-in PIN? <https://webaudio.cdc.gov> |Help <https://o15.officeredir.microsoft.com/r/rlidLync15?clid=1033&p1=5&p2=2009>

[!OC([1033])!]

.....

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Tuesday, March 10 - CDC COVID-19 Key Points & Updated Interim Infection Prevention & Control Guidance
Date:	Wednesday, March 11, 2020 1:06:02 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_10_2020 FINAL.pdf

Dear Colleagues,

Please see the attached CDC COVID-19 daily key points from Tuesday, March 10.

We would also like to draw your attention to the **"Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings"**. You can reference the guidance here. For your convenience, a summary of the changes are provided below:

- Updated PPE recommendations for the care of patients with known or suspected COVID-19
- Considerations for designating entire units within the facility, with dedicated healthcare personnel (HCP), to care for known or suspected COVID-19 patients and options for extended use of respirators, facemasks, and eye protection on such units.
- Updated recommendations regarding need for an airborne infection isolation room (AIIR).

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Tuesday, March 10 - CDC COVID-19 Key Points & Updated Interim Infection Prevention & Control Guidance
Date:	Wednesday, March 11, 2020 1:13:59 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_10_2020 FINAL.pdf

Dear Colleagues,

Please see the attached CDC COVID-19 daily key points from Tuesday, March 10.

We would also like to draw your attention to the **"Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings"**. You can reference the guidance here. For your convenience, a summary of the changes are provided below:

- Updated PPE recommendations for the care of patients with known or suspected COVID-19
- Considerations for designating entire units within the facility, with dedicated healthcare personnel (HCP), to care for known or suspected COVID-19 patients and options for extended use of respirators, facemasks, and eye protection on such units.
- Updated recommendations regarding need for an airborne infection isolation room (AIIR).

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Tuesday, March 10 - CDC COVID-19 Key Points & Updated Interim Infection Prevention & Control Guidance
Date:	Wednesday, March 11, 2020 1:03:13 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_10_2020 FINAL.pdf

Dear Colleagues,

Please see the attached CDC COVID-19 daily key points from Tuesday, March 10.

We would also like to draw your attention to the **"Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings"**. You can reference the guidance here. For your convenience, a summary of the changes are provided below:

- Updated PPE recommendations for the care of patients with known or suspected COVID-19
- Considerations for designating entire units within the facility, with dedicated healthcare personnel (HCP), to care for known or suspected COVID-19 patients and options for extended use of respirators, facemasks, and eye protection on such units.
- Updated recommendations regarding need for an airborne infection isolation room (AIIR).

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: UPDATED Risk Assessment and Management Guidance
Date: Thursday, March 5, 2020 11:10:42 PM

Dear Colleagues:

CDC's "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures" has been updated and is now available online. You can find the guidance here. This link includes a summary of updates to the guidance. Please let us know if you have any questions.

State Coordination Task Force (SCTF)
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Center for Preparedness and Response (CPR)

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: UPDATE: Grand Princess Quarantine Orders Lifted
Date: Wednesday, March 25, 2020 9:09:43 PM

Dear Colleagues:

This week, CDC will lift quarantine orders for more than 1,300 people who have been quarantined from the Grand Princess cruise ship. As a top priority, CDC's COVID-19 response team will begin transmitting data to states of individuals who tested positive, including the following: contact information, date of test, date of result, and date of release. Many were asymptomatic and chose to be tested voluntarily. In addition, most were released from isolation based on the release of new clinical criteria. However, due to delayed test results from various laboratories processing the samples, some individuals had test results returned after they were released from quarantine. Lastly, following this notification you will begin to receive data on individuals with pending tests or extended quarantine periods. We are working with HHS/ASPR to transmit the results of pending tests to all departed passengers and any additional positive tests to the states.

Feel free to send any questions to preparedness@cdc.gov. Thank you!

State Coordination Task Force (SCTF)
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CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Cc: Butler, Jay C. (CDC/DDID/OD)
Subject: URGENT State Health Official Message
Date: Tuesday, March 17, 2020 9:10:23 AM

Dear Colleagues:

As we continue to explore avenues to increase state access to COVID-19 testing, we would like for each state to provide the name of one institution in your jurisdiction that could perform high through-put testing if adequate reagents produced by Roche could be made available. In most instances, this will likely be an academic institution or a large medical center with advance diagnostic testing capacity. Please provide this information to Jay Butler (jcb3@cdc.gov) and Hilary Eiring (vte0@cdc.gov) in the CDC EOC as soon as possible. Thank you!

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to state health officials)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: URGENT WEB UPDATE: CDC Mass Gathering Statement
Date: Sunday, March 15, 2020 9:05:46 PM
Importance: High

Dear Colleagues:

Large events and mass gatherings can contribute to the spread of COVID-19 in the United States via travelers who attend these events and introduce the virus to new communities. Examples of large events and mass gatherings include conferences, festivals, parades, concerts, sporting events, weddings, and other types of assemblies. These events can be planned not only by organizations and communities but also by individuals.

Therefore, CDC, in accordance with its guidance for large events and mass gatherings, recommends that for the next 8 weeks, organizers (whether groups or individuals) cancel or postpone in-person events that consist of 50 people or more throughout the United States.

Events of any size should only be continued if they can be carried out with adherence to guidelines for protecting vulnerable populations, hand hygiene, and social distancing. When feasible, organizers could modify events to be virtual.

This recommendation does not apply to the day to day operation of organizations such as schools, institutes of higher learning, or businesses. This recommendation is made in an attempt to reduce introduction of the virus into new communities and to slow the spread of infection in communities already affected by the virus. This recommendation is not intended to supersede the advice of local public health officials.

Please let us know if you have any questions. Thank you.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: Lushbaugh, Justin (CDC/DDNID/NCBDDD/DHDD)
To: Claudia.Johnson@ky.gov; Pier, Kristi (CDC maryland.gov); Cramer, Steve (CDC health.mo.gov); Paras, Kathy (CDC utah.gov); Kamp, Susan (CDC vermont.gov); Laurie.Eldridge-Auffant@adph.state.al.us; Roberson, Shamarial (CDC flhealth.gov); bryan.russell@flhealth.gov; maggie.ferguson@idph.iowa.gov; jhall@ku.edu; Kbruns@ku.edu; hoffmana5@michigan.gov; Manning, Mary (CDC state.mn.us); Bluhm, Jim JB (CDC state.mn.us); Meg.Traci@mso.umt.edu; Susan.havercamp@osumc.edu; vanessas@uark.edu; Rodrigo.Monterrey@MassMail.State.MA.US; Barbara.wallace@health.ny.gov; weaverro@ohsu.edu; SMCDERMO@mailbox.sc.edu; devlinj@mailbox.sc.edu; Barb.Locker@ky.gov; Allison.perline@vermont.gov; Wimberley, Richard (CDC michigan.gov); HWelch@mt.gov; erin.ashinghurst@maryland.gov; bdkilpat@uark.edu; ann.robinson@osumc.edu; Kimberly.Phillips@unh.edu; holly.teal@health.ny.gov; Brenda.Maley@health.mo.gov; Kimberley.Warsett@state.ma.us; hornerio@ohsu.edu; nettie.romanzo-smith@health.ny.gov; Evan.England@unh.edu; nassira.d.nicola@state.ma.us; aBraner@utah.gov; ctamayo@phhp.ufl.edu; Rachael.Austin@health.ny.gov; Patrick.Hodge@flhealth.gov; Casey, Margaret MC (CDC health.ny.gov); maureen.spence@health.ny.gov; rodrigo.monterrey@state.ma.us; LeeC@michigan.gov; anna.fuller@uky.edu; lindsey.c.mullis@uky.edu; chithra.adams@uky.edu; David.Ellsworth@odh.ohio.gov; Edward.Clark@flhealth.gov; FrameA@michigan.gov; Bishop, Susan (CDC state.mn.us); emily.smoak@state.mn.us; Mackenzie.Jones@mt.gov; Schulte, Ann (MDH); Crotty, Anne E
Cc: Tilahun, Selam (MDH); Erin Taylor; Owens, Jasmine R. (CDC/DDNID/NCBDDD/DHDD)
Subject: Upcoming COCA Call
Date: Monday, March 23, 2020 10:30:35 AM

Good morning, all:

I hope this message finds each of you doing well.

Please see the below message:

Information for partners

Updated website content now available:

- Are you at higher risk for severe illness: This is an updated landing page.
- People who are at higher risk for severe illness. Based on the data we are seeing, this is the updated list of risk factors for severe illness.

COCA call tomorrow:

COCA Call - CDC Clinician Outreach and Communication Activity

Underlying Medical Conditions and People at Higher Risk for Coronavirus Disease 2019 (COVID-19)

AMERICAN OVERSIGHT

Overview

During this COCA call, presenters will focus on current information about people who are higher risk for COVID-19 complications because of their age or underlying medical conditions, particularly those that are not well-controlled.

Due to the high demand we anticipate for this COCA Call, we encourage participants to consider viewing on Facebook. To see the call live, please click on COCA's Facebook Page.

There will only be a few slides for this COCA Call. Slides will not advance during the presentation portion of this webinar. You can find the slides under the "Call Materials" tab here.

Advanced registration is not required.

If you are unable to attend the live COCA Call, it will be available for viewing on the COCA website a few hours after the live event ends. It will be available for viewing **immediately after** the live event ends at 3:00 P.M. ET on COCA's Facebook page.

Continuing Education will not be offered for this COCA Call.



Date: Tuesday, March 24, 2020
Time: 2:00pm–3:00pm (ET)

You may participate in this COCA Call via the Zoom platform or via Facebook Live.

Please note, the Zoom access links and dial-in information for this COCA Call have been changed. The corrected information is below:

https://www.zoomgov.com/j/1613416798

Or iPhone one-tap:
US: +16692545252,,1613416798# or +16468287666,,1613416798#

Or Telephone:
US: +1 669 254 5252 or +1 646 828 7666

Webinar ID: 161 341 6798

International numbers available:
https://www.zoomgov.com/u/acMT9czZKu

Presenters

John T. Brooks, MD
Chief Medical Officer, COVID-19 Response
Centers for Disease Control and Prevention

Georgina Peacock, MD, MPH, FAAP
COVID-19 Response, At Risk Task Force Lead

AMERICAN OVERSIGHT

Centers for Disease Control and Prevention

Sapna Bamrah Morris MD, MBA, FIDSA CAPT, U.S. Public Health Service
COVID-19 Response Health Systems Worker Safety Task Force, Clinical Team
Centers for Disease Control and Prevention

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

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

- CDC Clinician Outreach and Communication Activity Facebook page—connect with COCA on Facebook
- Clinician Outreach and Communication Activity—resources for healthcare providers
- COCA RSS Feed—subscribe to be notified of conference calls, updates, and CDC guidance for health providers
- Crisis & Emergency Risk Communication Training—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication
- Health Alert Network—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories

CDC Logo

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Links to non-federal organizations are provided solely as a service to our users. Links do not constitute an endorsement of any organization by CDC or the federal government, and none should be inferred. CDC is not responsible for the content of the individual organizations.

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Centers for Disease Control and Prevention
1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348
Questions or Problems | Unsubscribe

Justin Lushbaugh
Public Health Analyst
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Division of Human Development and Disability
National Center on Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
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Xko0@cdc.gov
(404) 498-3036 Office
(470) 421-0183 Mobile
(770) 488-0270 Fax

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Updated CDC COVID-19 Guidance: Evaluating and Reporting Persons Under Investigation (PUI)
Date:	Thursday, February 27, 2020 4:26:05 PM
Importance:	High

Dear Colleagues:

CDC has posted updated Criteria to Guide Evaluation of PUI for COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Revisions were made on February 27, 2020, to reflect the following:

Information updated in the "Criteria to Guide Evaluation of PUI for COVID-19" section.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Updated CDC COVID-19 Guidance: Evaluating and Reporting Persons Under Investigation (PUI)
Date:	Thursday, February 27, 2020 4:27:57 PM

Dear Colleagues:

CDC has posted updated Criteria to Guide Evaluation of PUI for COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Revisions were made on February 27, 2020, to reflect the following:

Information updated in the "Criteria to Guide Evaluation of PUI for COVID-19" section.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Updated CDC COVID-19 Guidance: Evaluating and Reporting Persons Under Investigation (PUI)
Date:	Thursday, February 27, 2020 4:23:34 PM
Importance:	High

Dear Colleagues:

CDC has posted updated Criteria to Guide Evaluation of PUI for COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Revisions were made on February 27, 2020, to reflect the following:

Information updated in the "Criteria to Guide Evaluation of PUI for COVID-19" section.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	Epi Aid (CDC); LLS (CDC); CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Subject:	Updated Guidance for Returning CDC Staff from 2019-nCoV Domestic Field Deployments
Date:	Friday, February 7, 2020 2:44:49 PM

Hello EIS/LLS,

OSSAM, after consulting with infection prevention and control subject matter experts, has updated the February 1, 2020, Guidance for Returning CDC Staff from 2019-nCoV Domestic Field Deployments with more detailed instructions based on new public guidance released by CDC this week.

Please use the new Guidance for Returning CDC Staff from 2019-nCoV Domestic Field Deployments to better understand requirements of CDC staff returning from 2019-nCoV domestic deployments. CDC is currently developing guidance for those returning from overseas deployments.

For all employees returning from China (e.g., on leave), supervisors should follow published CDC guidance found in the new public guidance. This provides important information regarding returning to work for employees who recently arrived in the U.S. from China (e.g., employees categorized as Medium or High risk).

Please contact your Management Officer if you have questions regarding telework or other workplace flexibilities.

Please direct health and safety questions to OSSAM at EOCevent300@cdc.gov.

Distributed by:
Brent Joyner
CDC EOC Duty Officer
eocreport@cdc.gov
Primary: 770.488.7100
Alternate: *404.444.2638*

Michael Gronostaj, MD, MPH, FACPM
CDR, United States Public Health Service
Epi-Aid/Lab-Aid Response Team Lead | EIS/LLS Deployment Coordinator

Fellowship Response and Support Team | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services

Centers for Disease Control and Prevention (CDC)
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Work Phone: 404-498-6167 / Fax: 404-498-6535
vie0@cdc.gov

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Updated Summary Key Points 2019-nCoV, January 31, 2020
Date:	Saturday, February 1, 2020 7:36:14 PM
Attachments:	CDC_2019-nCoV Daily Key Points__1_31_2020_corrected.pdf

Good Evening,

Please note - A correction was made to the 2019-nCoV summary key points from yesterday. Attached, you will find the latest **UPDATED** version. Feel free to share amongst your staff and appropriate parties.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
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CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	Updated: Community Based Testing Site (CBTS) Concept of Operations and Operating Criteria
Date:	Wednesday, March 25, 2020 6:20:01 PM
Attachments:	COVID-19 Community-Based Testing Sites CONOP 2020.03.24 v5.pptx FEMA CBTS Flyer_2_Web.pdf FEMA CBTS Flyer_2_Print.pdf

May be dupe to some.....apologies

*****The CBTS Task Force updated its guidance for community-based testing sites. Please review and disseminate the attached guidance and fact sheet to help support questions from your state/local health partners.*****

Please see included the criteria and ConOps for operating a Community Based Testing Site. The Criteria outlines simple requirements for remaining in compliance with the program. This step was necessary due to a number of State modifications to the program that introduced compliances issues causing sites to be put on pause or taking off line. The updated ConOp streamlines the CBTS process and reduces potential exposure to the operators.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
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email: ASPR.R4@hhs.gov
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Alternate phone numbers

AMERICAN OVERSIGHT

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cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	Updated: Community Based Testing Site (CBTS) Concept of Operations and Operating Criteria
Date:	Wednesday, March 25, 2020 6:17:31 PM
Attachments:	COVID-19 Community-Based Testing Sites CONOP 2020.03.24 v5.pptx FEMA CBTS Flyer_2_Web.pdf FEMA CBTS Flyer_2_Print.pdf

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May be dupe to some.....apologies

*****The CBTS Task Force updated its guidance for community-based testing sites. Please review and disseminate the attached guidance and fact sheet to help support questions from your state/local health partners.*****

Please see included the criteria and ConOps for operating a Community Based Testing Site. The Criteria outlines simple requirements for remaining in compliance with the program. This step was necessary due to a number of State modifications to the program that introduced compliances issues causing sites to be put on pause or taking off line. The updated ConOp streamlines the CBTS process and reduces potential exposure to the operators.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
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Alternate phone numbers

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AMERICAN OVERSIGHT

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

To: Patricia Vinson (CDC adph.state.al.us); heidi.hedges@alaska.gov; Lagaisio, Eli (CDC doh.as); Snyder, Wendy (CDC.azdhs.gov); Ferguson, Reva (CDC.arkansas.gov); rachelle.seha@arkansas.gov; Lilcrn, Peggy (CDC.cdph.ca.gov); aielon.barnett@state.co.us; Jensen, Dana (CDC.ct.gov); richard.little@delaware.gov; tanya.bethe@dc.gov; Jade.Tindle@ihealth.gov; angelicia.morgan@doh.ga.gov; tammy.vasquez@doh.ga.gov; Solomon, Fanoy (CDC.femhealth.fm); Kaneshiro, Suzanne (CDC.dphss.guam.gov); Sharon.Tanoman@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Molly.Daniels@dhw.idaho.gov; Oluwaseun.Oyerinde@illinois.gov; Musgrave, Shirley (CDC.illinois.gov); Barrett, Tami (CDC.isdh.in.gov); Oakley, Jennifer (CDC.idph.iowa.gov); Denise.Schimmel@ks.gov; scantlebberther@ky.gov; Jane.Killen2@ky.gov; Lawrence, Peggie (CDC.maine.gov); jacky.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benyenga@maryland.gov; rebecca.white@state.ma.us; Espleiu@michigan.gov; Pizzuti, Sandy (CDC.state.mn.us); Griffin, Jenny (CDC.msdh.ms.gov); Mebruer, Debbie (CDC.health.mo.gov); jacobj@mt.gov; Kellie.Richett@mt.gov; Engel, Bonnie (CDC.nebraska.gov); Magen.Schachta@nebraska.gov; jstilos@health.ny.gov; Bissell, Kelly (CDC.dhhs.nh.gov); Whale, Barbara (CDC.dhhs.nh.gov); deanna.morris@doh.nj.gov; Sola, Angela (CDC.state.nm.us); jacki.sikula@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guevara, Janet (CDC.doh.gov.mp); Ashley.Wilson@odh.ohio.gov; mdigrazia@health.ok.gov; Nast, Patricia (CDC.state.or.us); thornetton@pa.gov; pbeers@pa.gov; Byrnes, Carolyn (CDC.pa.gov); Jale.Kiuki@pauhealth.org; marianelopez@gmail.com; Menard, Rita (CDC.health.ri.gov); Higgins, Teresa (CDC.dhec.sc.gov); Harding, Monica (CDC.state.sd.us); Stanton, Tammy (CDC.tn.gov); carolyn.peter@dshs.texas.gov; sadia.al@doh.vi.gov; louise.bap@doh.vi.gov; amaal.idhaleh@doh.vi.gov; McFarlane, Lesa (CDC.doh.vi.gov); tesha.plunkett@doh.vi.gov; betsy.coleman@utah.gov; Gregorek, Sarah (CDC.vermont.gov); Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC.doh.wa.gov); Fisher, Andrea (CDC.wv.gov); tara.vasby@dhs.wisconsin.gov

Cc: Scott.Harris@doh.state.al.us; anne.zink@alaska.gov; Nua, Mohusa Tuileama (CDC.doh.as); Christ, Cara (CDC.azdhs.gov); Smith, Nathaniel (CDC.arkansas.gov); Sonia.angell@cdph.ca.gov; jill.burgakervan@state.co.us; Coleman, Renee (CDC.ct.gov); kaval.rattay@delaware.gov; Nesbitt, LaQuandra (CDC.dc.gov); scott.dykes@ihealth.gov; kathleen.toomey@doh.ga.gov; msams@femhealth.fm; Linda.denorey@dphss.guam.gov; bruce.sanderson@doh.hawaii.gov; alice.shaw-tulloch@dhw.idaho.gov; Nora.Fiske@illinois.gov; stex@isdh.in.gov; Oatmeyer, Gerd (CDC.idph.iowa.gov); lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; niray.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Rinzel, Monica (CDC.state.ma.us); KhaldunJ@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; sheilahogan@mt.gov; Cholman@mt.gov; dannette.smith@nebraska.gov; gary.anthone@nebraska.gov; Lehenych@health.ny.gov; jasram@health.ny.gov; lisa.morrie@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC.health.ny.gov); mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; mavinnuttle@nd.gov; Mutia, Esther (CDC.doh.gov.mp); amy.acton@odh.ohio.gov; CaryC@health.ok.gov; Shirley, Lillian (CDC.state.or.us); rraevine@pa.gov; Drrafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; amais.roberts@pauhealth.org; bblimon@hotmail.com; Alexander-Scott, Nicole (CDC.health.ri.gov); rich.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC.state.sd.us); Lisa.Piercey@tn.gov; Helgerstedt, John (CDC.dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC.utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC.doh.wa.gov); cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harvist, Alexa (CDC.wvo.gov); Montero, Jose (CDC DOH-S) S (CTR) TS OD); marcus.plescia@ASTHO.com;

Subject: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)

Date: Monday, March 2, 2020 11:39:34 AM

Good Morning,

CDC Incident Management has asked the State Coordination Task Force for contact information of the **top health official** in each jurisdiction to expedite outreach in the event of an emergencies and to provide COVID-19 updates as expeditiously as possible. To accomplish this task, I am reaching out to the SHO/THO Assistant with a cc to the SHO/THO. This information will be used in tandem with the information we have for the SHO/THO maintained by ASTHO. You all are in a great position to assist us!

We know that in many cases the top health official is the SHO/THO. If that case is , just **reply** to this email that they are the **same**.

For those where there is a person who is more senior to the SHO/THO (as a reminder, we are looking for the most senior health official), please complete the following information:

State/Territory	Highest Health Official (i.e. Commissioner/ Minister/Secretary) Name (including degrees as appropriate)	Title	Phone Number (Please provide a **number or** numbers where we can reach out ***after hour*** should the need arise for COVID-19)	Email	Executive Assistant Name	Phone Number	Email

Due to the nature of this **urgent request**, respond by **COB today**.

Thank you so much for your assistance.

If you have questions or concerns, please contact me.

Kimberly

Kimberly Cantrell
State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	scott.rivkees@flhealth.gov
Cc:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Viral swabs request
Date:	Saturday, March 14, 2020 5:07:53 PM

Hi Dr. Rivkees, thank you for reaching out about viral swabs. CDC is aware of the low inventory and is working quickly to increase supplies and support to the States and Locals. With a limited supply everywhere, we'll be in contact soon on submitted orders. We apologize for the delay but will contact you soon. Please don't hesitate to contact us with any other questions or needs.

Thanks, Wendy

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

Wendy Holmes: 404-452-9792

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AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 10, 2020 Florida Flu Review
Date:	Wednesday, March 11, 2020 4:18:04 PM
Attachments:	Week 10, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the week 10, Florida Flu Review.

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

Ten outbreaks were reported, up from nine outbreaks in the previous week. Of the ten outbreaks reported, four were influenza-associated and six were ILI.

Two new influenza-associated pediatric deaths were reported, both in vaccinated individuals with known underlying medical conditions. Twelve influenza-associated pediatric deaths have been reported so far this season; only three children were vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection

AMERICAN OVERSIGHT

Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

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AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
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Thank you!

Amy E. Bogucki, MPH
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Two new influenza-associated pediatric deaths were reported, both in vaccinated individuals with known underlying medical conditions. Twelve influenza-associated pediatric deaths have been reported so far this season; only three children were vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

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Subject:	Week 11, 2020 Florida Flu Review
Date:	Wednesday, March 18, 2020 4:23:20 PM
Attachments:	Week 11, 2020 Florida Flu Review.pdf

Good afternoon!

Please find attached the week 11 Florida Flu Review.

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

For questions regarding COVID-19 in Florida please email COVID-19@FLHealth.gov or call 1-866-779-6121.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, one was influenza-associated and ten were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take

AMERICAN OVERSIGHT

everyday precautions to prevent the spread of influenza:

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- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Best,

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
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Date:	Wednesday, March 25, 2020 3:52:43 PM
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Subject:	Week 5, 2020 Florida Flu Review
Date:	Wednesday, February 5, 2020 3:40:25 PM
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Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Eighteen outbreaks were reported, down from 24 outbreaks in the previous week. Of the 18 outbreaks reported, 12 were influenza-associated and six were ILI.

No new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On February 21, 2020, CDC issued interim vaccine effectiveness (VE) estimates for the 2019-20 influenza season. For all ages, the VE was 45% (95% confidence interval [CI] = 36-53%) against any influenza virus illness and was 55% (95% CI = 42-65%) among children six months to 17 years (www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6907a1-H.pdf).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
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Florida Department of Health
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Phone: (850) 901 - 6938

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AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 9, 2020 Florida Flu Review
Date:	Wednesday, March 4, 2020 2:45:57 PM
Attachments:	Week 9, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 9, 2020 Florida Flu Review.

Week 9 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 9 but remained above peak levels observed in the 2016-17 season. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Nine outbreaks were reported, down from 18 outbreaks in the previous week. Of the nine outbreaks reported, two were influenza-associated and seven were ILI.
One new influenza-associated pediatric death was reported in an unvaccinated child with underlying medical conditions. Ten influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

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- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

AMERICAN OVERSIGHT

Thank you!

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Subject:	Week 9, 2020 Florida Flu Review
Date:	Wednesday, March 4, 2020 2:46:03 PM
Attachments:	Week 9, 2020 Florida Flu Review.pdf

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Activity decreased in week 9 but remained above peak levels observed in the 2016-17 season. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

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One new influenza-associated pediatric death was reported in an unvaccinated child with underlying medical conditions. Ten influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

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AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	What Governors Need to Know - HHS Issues New COVID-19 Resources
Date:	Wednesday, March 11, 2020 1:12:31 PM
Attachments:	PRELIMINARY - NOT FOR FURTHER DISCLOSURE Initial State and Local Funding.pdf

Dear Governor:

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19.

As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

Funding for States to Address COVID-19

Perhaps of keenest interest to you and your health officials is an update on funding for states and communities to address mitigation of COVID-19.

Today, at 1 PM EST HHS will be announcing that more than $560 million will be made available to the 62 entities which have existing cooperative agreements with the CDC through its Public Health Emergency Program, known as "PHEP."

The $8.3 billion dollar Supplemental passed by Congress included statutory language which prescribed the exact formula for disbursing the money: states will receive 90% of their 2019 CDC PHEP grants. So that you know what your state will receive, we have attached a document identifying the amounts going to states, territories, or cities. This marks the first tranche of funding to states from the $8.3 billion supplemental. Your state health officers are receiving a letter today from CDC outlining what is needed to receive the funding, essentially they need to submit a spend plan and they will receive guidance on what that spend plan should contain.

Helping Communities Know Mitigation Strategies

Yesterday, CDC released their "Implementation." Essentially, this is a guide for communities describing possible mitigation strategies for communities dealing with transmission at three different levels: (1) None/Minimal, (2) Moderate, or (3) Substantial. Community mitigation strategies, which are non-pharmaceutical interventions, are often the most available interventions to help slow the transmission of COVID-19 in communities. The Mitigation Plans include a set of actions that persons and communities can take to slow the spread of respiratory virus infections. The Community Mitigation Plan can be found here.

Guidance on Infection Control For Healthcare Workers

Yesterday, CDC released updated guidance on infection prevention and control recommendations. Healthcare workers are fighting this outbreak on the front lines, and this guidance is intended to provide assistance to healthcare settings that are handling suspected or confirmed cases of COVID-19. This guidance is applicable to all U.S. healthcare settings, but not for non-healthcare settings. There is separate guidance for that. The new guidance on infection control can be found here.

AMERICAN OVERSIGHT

OMB Flexibilities
On March 9, 2020, OMB issued a memo that provides administrative relief for recipients and applicants of Federal financial assistance who are directly impacted by COVID-19. The grant flexibilities include 10 actions that HHS can take to provide short-term administrative and financial management relief, allowing funds to be awarded quicker and giving grantees the ability to focus on their critical response, research, or services. More information can be found here.

General Preparation Information: On March 9, 2020, the White House Coronavirus Task Force released practical steps that we recommend posting and sharing to keep workplaces, school, home and commercial establishments safe. This information can be found here.

CMS Specific Guidance:

- **CMS Guidance on Masks:** On March 10, 2020, CMS released guidance updating recommendations to expand the type of facemasks healthcare workers can use in situations involving COVID-19. This guidance aligns with the information by CDC regarding personal protective equipment as well. The memo sent to State Survey Agency Directors can be found here.

- **CMS FAQs on Suspension of Non-Emergency Survey Inspections**: On March 10, 2020, CMS released a frequently asked questions document to further explain the changes in guidance issued on March 4 that suspends all non-emergency survey inspections. This guidance and FAQ will help to enable State Inspectors to address the spread of COVID-19. The FAQ document can be found here.

- **CMS Nursing Home Guidance:** As you know, nursing homes and their residents are vulnerable populations for COVID-19. This week, CMS released updated guidance for infection control and prevention of COVID-19 in Nursing Homes which can be found here (3/9). The Press Release can be found here and all CMS guidance related to COVID-19 can be found here.

If you have any questions on these items or other issues, please feel free to reach out.

Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	[IMPORTANT UPDATE] FDA Issues New Policy to Help Expedite Availability of Diagnostics
Date:	Saturday, February 29, 2020 6:57:03 PM

Dear Partner –

Today, as part of the U.S. Food and Drug Administration's ongoing and aggressive commitment to address the coronavirus outbreak, the agency issued a new policy for certain laboratories seeking to develop diagnostic tests for coronavirus in order to achieve more rapid testing capacity in the U.S.

The new policy is for certain laboratories that develop and begin to use validated COVID-19 diagnostics before the FDA has completed review of their Emergency Use Authorization (EUA) requests. The immediately in effect guidance issued today describes the circumstances where the FDA does not intend to object to the use of these tests for clinical testing while the laboratories are pursuing an EUA with the FDA. Importantly, this policy only applies to laboratories that are certified to perform high-complexity testing consistent with requirements under Clinical Laboratory Improvement Amendments.

The FDA guidance provides recommendations for test developers, including information regarding test validation, FDA notification and interim confirmatory clinical testing. Following the completion of their test validation, laboratories should communicate with the FDA, via email, in order to notify the agency that the test has been validated. Laboratories should submit a completed EUA request within 15 business days of notification.

The link to the full press release is here.

Related Information

- Novel Coronavirus
- Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency - Immediately in Effect Guidance for Clinical Laboratories and Food and Drug Administration Staff

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
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AMERICAN OVERSIGHT

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To:	Baker, Michael (OS/IEA)
Subject:	[IMPORTANT UPDATE] FDA Issues New Policy to Help Expedite Availability of Diagnostics
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Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: [RELEASE] - HHS Awards $117 Million to End the HIV Epidemic in the United States
Date: Wednesday, February 26, 2020 10:59:31 AM

Dear Partner –

Today, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), awarded approximately $117 million to expand access to HIV care, treatment, medication, and prevention services. This investment is a critical component of the Administration's *Ending the HIV Epidemic: A Plan for America (EHE)* initiative, which aims to reduce the number of new HIV infections in the United States by 90 percent by 2030.

The EHE initiative and today's awards focus on 48 counties, Washington, D.C., and San Juan, Puerto Rico, geographic areas where more than 50 percent of new HIV diagnoses occurred in 2016 and 2017, as well as the seven states with a substantial rural HIV burden.

"HRSA is a leader in working to end the HIV epidemic in the U.S.," said HHS Secretary Alex Azar. "These investments will support partnerships between organizations that are on the front lines of preventing and reducing HIV transmission, as well as improving the overall health outcomes for people with HIV."

HRSA's Health Center Program awards will be used to identify at-risk individuals and engage in preventive services, test for HIV, and prescribe pre-exposure prophylaxis (PrEP) when appropriate. Awards made to HRSA's Ryan White HIV/AIDS Program recipients will be used to link people who are either newly diagnosed with HIV, or diagnosed but currently not in care, to essential HIV care, treatment, and support services, helping them reach viral suppression and reduce HIV transmission.

For further discussion on this announcement, we invite you to a stakeholder call TODAY, February 26, 2020 with HRSA Administrator Tom Engels. Details can be found below:

Date: February 26, 2020
Time: 4:00 PM EST
Number: 888-790-3548
Passcode: 2511315

For a list of award recipients, visit:

- Health Center Program: https://bphc.hrsa.gov/program-opportunities/primary-care-hiv-prevention/fy2020-awards
- Ryan White HIV/AIDS Program: https://hab.hrsa.gov/about-ryan-white-hivaids-program/fy2020-ending-hiv-epidemic-awards

For more information about HRSA's role in the Ending the HIV Epidemic initiative, visit: www.hrsa.gov/ending-hiv-epidemic.

Sincerely,

AMERICAN OVERSIGHT

Darcie

Darcie Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC LLS Class 2019; CDC LLS Class 2018; CDC LLS Class 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Cc:	Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Coronado, Fatima (CDC/DDPHSS/CSELS/DSEPD); Black, Erin (CDC/DDPHSS/CSELS/DSEPD); Jee, Ina (CDC/DDPHSS/CSELS/DSEPD)
Subject:	cancellation of EIS and LLS regional trainings - EIS and LLS needed for COVID-19 response
Date:	Thursday, March 5, 2020 12:15:58 PM

EIS and LLS,

The top priority for CDC right now is supporting the response to COVID-19. As EIS officers and LLS fellows, you are essential for the response. About 75% of EIS officers and LLS fellows have already or are currently deployed to support an EOC activation (COVID-19, Ebola, and polio). EIS officers and LLS alumni from both programs are fully engaged and making major contributions at all levels of these activations.

We are **canceling the EIS Regional trainings in Atlanta and Phoenix** given the prioritization of COVID-19 and the number of EIS officers and LLS fellows, supervisors, and EWB staff currently deployed and likely to be deployed in the coming weeks.

Our top priority is the COVID-19 response and other essential duties related to your assignments. At this time, we do not have the luxury of taking you away from your assignments for a week of training. Please note the following:

- In times of urgent need, the EIS and LLS Programs reserve the right to unilaterally assign an EISO or LLS fellow to a field team or other emergency response activity without first seeking supervisory approval. At this time, we expect all EIS officers and LLS fellows to support the COVID-19 response and some of you may be asked to deploy repeatedly. **We are asking all supervisors to support the need for EIS and LLS to deploy**.

- If you are deploying, you should NOT be concerned about CAL completion or EIS conference presentations – if COVID-19 interferes with CAL completion we will work with you on a case by case basis. EIS or LLS program requirements should not interfere with your availability to deploy.

- Field officers who are already working on the response in your assigned jurisdiction are not expected to deploy elsewhere.

- EIS conference is currently scheduled as originally planned. We will notify you as soon as possible if we expect any changes to the conference.

- We will identify alternatives to allow you to practice and get feedback on your EIS conference presentations. We will also determine alternatives for EIS and LLS rounds.

We understand that many of you will be disappointed Regional Trainings are cancelled. We also know that many of you are pushing yourselves (including EIS and LLS supervisors) to support the

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response and keep up with your regular duties. We hope we have alleviated any concerns about needing to focus on EIS conference presentations for the time being. We encourage you to reach out for support from your classmates, supervisors, and staff within EWB should you need it. We also encourage you to speak with EOC resiliency coordinators, be aware of deployment resources, and take advantage of the Employee Assistance Program (EAP).

You were all selected for EIS or LLS because of your ability to thrive in a response environment. Your contributions are recognized and valued by CDC leadership. Thank you for your selflessness and service to CDC and our local, state, and international partners.

Respectfully,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.



please consider the environment before printing this e-mail.

AMERICAN OVERSIGHT

From:	Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)
To:	Heinzerling, Amy (CDC cdph.ca.gov); Blau, Erin (CDC ky.gov); Blau, Erin (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo (CDC adph.state.al.us); Heinzerling, Amy Patricia (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo Vincent (CDC/DDPHSS/CSELS/DSEPD); Szablewski, Christine (CDC dph.ga.gov); Szablewski, Christine (CDC/DDPHSS/CSELS/DSEPD); Torres, Yaritbel (CDC flhealth.gov); Torres-Mendoza, Yaritbel (CDC/DDPHSS/CSELS/DSEPD); James, Allison (CDC arkansas.gov); James, Allison (CDC/DDPHSS/CSELS/DSEPD); Ghinai, Isaac; Ghinai, Isaac (CDC/DDPHSS/CSELS/DSEPD); Steinberg, Jonathan (CDC state.sd.us); Feder, Kenneth (CDC/DDPHSS/CSELS/DSEPD); Kenneth Feder -MDH-; Steinberg, Jonathan (CDC/DDPHSS/CSELS/DSEPD)
Cc:	jennifer.layden@cityofchicago.org; Blackmore, Carina (CDC flhealth.gov); Davidson, Sherri (CDC adph.state.al.us); Drenzek, Cherie (CDC dhr.state.ga.us); Edison, Laura (CDC dph.ga.gov); Materna, Barbara (CDC cdph.ca.gov); Robeson, Sara (CDC ky.gov); Stanek, Danielle (CDC flhealth.gov); Thoroughman, Douglas (CDC/DDPHSIS/CPR/DSLR); Wilken, Jason (CDC cdph.ca.gov); Wortley, Pascale (CDC dph.ga.gov); Balamurugan, Appathurai (CDC arkansas.gov); Clayton, Joshua (CDC state.sd.us); Austin, Connie (CDC illinois.gov); Blythe, David (CDC maryland.gov); Crum, David (CDC maryland.gov); Soda, Elizabeth (CDC illinois.gov); Layden, Jennifer (CDC illinois.gov); Duwell, Monique MD (CDC maryland.gov); Rothfeldt, Laura (CDC arkansas.gov); Tarkhashvili, Nato (CDC state.sd.us)
Subject:	checking in
Date:	Monday, March 16, 2020 9:19:25 AM
Attachments:	Alroy_COVID_HSR.docx okn7_0900f3eb81aea13c.docx

Hi everyone,

I hope you are doing well in what is undoubtedly a stressful and busy time for all of you. I know you are all working hard, and I'd like to thank you for all you're doing for the health of residents in your state and the country.

I wanted to ask you to check in when you can by phone or email and let me know how you're doing. Right now we are assuming you are in full response mode and don't have time to work on other activities, so I won't be contacting you to ask how your CALs are going. Of course, if you do need assistance with anything or are planning any coronavirus-related products such as MMWRs or manuscripts, please let me know.

I'm attaching a sample project determination for coronavirus. When time permits if you haven't already (I know public health response takes precedence and that you might not have time to do this right now), please submit a project determination for your activities.

Hang in there, everyone, and stay safe and healthy.

Suzanne

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)

Epidemic Intelligence Service | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

Subject: communications test
Date: Friday, March 13, 2020 12:32:53 PM

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Funk, Renee (CDC/NIOSH/OD)
Subject: disinfection of PPE
Date: Sunday, March 22, 2020 2:22:15 PM

Howdy,
I am assuming you, like me, are knee deep in the COVID response.
Do you by any chance know who I could talk to about using UV light to disinfect PPE? I am guessing that hard surfaces (plastic) might work but what about cloth ? (masks/ gowns)
Any intel on this would be helpful

Thanks a lot. Thankful to have wise friends
Carina

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	"Vuong, Nga (CDC/OID/NCEZID) <ypg2@cdc.gov>"
Subject:	emergency presentation
Date:	Tuesday, February 18, 2020 6:34:25 PM
Attachments:	MCIRT_SART_vectorweek.pdf

For vector week for your review.

Thanks
CB

AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019; Brower, Melissa (CDC/DDPHSS/CSELS/OD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Duggan, Natalie (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Olivares, Dagny (CDC/DDPHSIS/CPR/DEO)
Subject:	how to handle any COVID-19 speaking requests
Date:	Friday, February 28, 2020 5:04:54 PM
Attachments:	Dr Schuchat_COVID-19_2020.jpg

Dear EISOs and LLS Fellows,

As the response to COVID-19 continues to evolve, it is increasingly likely that many of you (especially EISOs and LLS assigned to states) will be approached to participate in media interviews. During any emergency response that requires the activation of CDC's EOC, all communication functions are handed through the Joint Information Center (JIC) in the EOC. Decisions about who may serve as a CDC spokesperson with regard to media interviews are made by the public affairs specialists working in the JIC in collaboration with the Indecent Manager and CDC leadership. Those decisions are also guided by HHS's Office of the Assistant Secretary for Public Affairs (ASPA).

During EOC-led responses, a very limited number of spokespeople are approved to speak to media on behalf of CDC. In a rapidly evolving emergency response, it is critical that our messages remain as consistent as possible, are based on the most current information, and include important framing and nuances. The staff best positioned to deliver these nuanced messages are on all the calls, involved in all the conversations, and briefed on every aspect of the response = senior leaders at CDC (picture attached of EIS alum delivering key messages).

Please understand we want you to have as many opportunities as possible to talk with media about your work. This is a time when it's in the best interest of the agency and the public to limit the number of people talking to media for the reasons described above. This is also in your best interest, as it helps ensure that you will not be put in the position of being asked to speak and comment about things that are beyond the scope of your specific work. When media quote a CDC employee, that employee is invariably presented as speaking on behalf of the entire agency. Asking you to speak now offers far more risk than benefit given the fast-moving and politically complicated nature of the response.

Guidance is being developed and will be issued soon for all staff deployed to the field. **Any requests to speak about COVID-19 should be directed to the following address** eocjicmedia2@cdc.gov. Thanks for your cooperation and contributions to a complicated and ever evolving response.

For those of you that get a good weekend, have a good weekend. For those of you working – thanks for your service on behalf of EIS/LLS and CDC.

Regards,
Eric

Eric Pevzner, PhD, MPH

AMERICAN OVERSIGHT

CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.


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From: Ann Hill

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AMERICAN OVERSIGHT

Subject: information received from one of our SME"s
Date: Monday, March 16, 2020 9:53:58 AM

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; D"Angelo, Joseph ; Dellamura, Joseph ; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; RRCC LOGS Supply Box
Subject:	public health lab reagent
Date:	Wednesday, March 25, 2020 7:56:25 PM

All

Many of our states are asking about the reagents and why are they not available to the public health lab **it is a supply and demand issue.**
Supply is low and demand is high - here is some info on an alternate reagent recipe for public health labs. Also including a FAQs sheet from FDA.

Here is the FDA FAQ site with alternative extraction reagents: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#whatif

If they want to use alternate reagents not already accepted by FDA, that would be considered a "Laboratory Developed Test", FDA guidance is at www.fda.gov/regulatory-information/search-fda-guidance-documents/policy-diagnostic-tests-coronavirus-disease-2019-during-public-health-emergency, and

FAQ's at https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#clinicallaboratories

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov

AMERICAN OVERSIGHT

HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Subject:	remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 8:24:49 AM

Hi Dr. Blackmore,

I am working to set up a follow up TA call to assist with your questions related to the cruise ship port. Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
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Subject: second shipment
Date: Sunday, March 22, 2020 9:24:31 AM

All

It appears in the second shipment that will be off loaded today this is what is in the trucks. See the second line "high intensity" for the shipment from last night

Florida

	Date Directed	Status	N95 Respirators	Surgical Masks	Face Shield	Surgical Gowns	Coveralls	Gloves	First Shipment Est. Delivery Date	Last Shipment Est. Delivery Date
Pro Rata			180,868	430,860	82,043	66,892	342	238,179		3/14/2020
High Intensity	3/20/2020		180,868	430,860	82,043	66,892	342	238,179		

Regards,
Jeanne

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Subject: second shipment
Date: Sunday, March 22, 2020 9:24:15 AM

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Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
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HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)
To:	Blackmore, Carina (CDC flhealth.gov); Stanek, Danielle (CDC flhealth.gov)
Cc:	Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD)
Subject:	site visit report
Date:	Thursday, February 27, 2020 1:59:34 PM
Attachments:	Site Visit External 2020 Florida_Torres.docx

Dear Dr. Blackmore and Dr. Stanek,

Thank you very much for hosting me for my site visit to FDOH last month to discuss Yari's EIS experience and how the Epidemiology Workforce Branch and FDOH can continue to work together to provide an excellent experience for future EISOs. I really appreciate you spending the day with me and enjoyed meeting you and FDOH staff in person.

Attached is an site visit report summarizing my meetings and the visit. The report is essentially the same as the internal report (I removed the logistics section pertaining to lodging and transportation and revised the wording in several spaces to improve clarity). One item we didn't discuss during the meeting but that has come up internally afterwards was the potential involvement of local health departments to improve field investigation opportunities. Would staff in Miami or Orlando, for example, have interest in setting up an arrangement to host an EISO to assist with field investigations?

Thank you again for meeting me, and please don't hesitate to contact me with questions or comments about the site visit report or any other concerns you have.

Regards,

Suzanne Beavers

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)

Epidemic Intelligence Service | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Tim.Hatch@adph.state.al.us; (Andy.Mullins@adph.state.al.us); (john.hopper@adph.state.al.us; Jim.Craig@msdh.ms.gov; wayne.vaughn@msdh.ms.gov; christy.craft@msdh.ms.gov; Combs, Brian (CDC/dhhs.nc.gov); Stephanie Anspaugh Naples (Stephanie.Anspaugh.Naples@tnhealth.gov); Clement, Kimberly D; amanda.b.willford@dhhs.nc.gov; Blair, Jamie D.; Harbison, Dave A.; peter.koonz@tn.gov; paul.petersen@tn.gov; sean.i.kice@tn.gov; Christie Luce - Florida Department of Health (Christie.Luce@tnhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHS/SCPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@tnhealth.gov; Gillis, Rebecca L (CHES/DPH/EPB); jamez.house@ky.gov; Hume, Robbie ; Jasie Loodson (Jasie.Loodson@ky.gov); Johnson, Rick D (CHES/DPH/EPB); Kik, Angela M.; White, Connie (CDC/ky.gov); K.T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.radeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Cc: Sczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.o.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; D'Angelo, Joseph ; Dellamura, Joseph ; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; RRCC LOGS Supply Box
Subject: swab delivery
Date: Wednesday, March 25, 2020 8:01:05 PM

Good evening,
I received word that the following locations have received the following states received 4000 swabs today. The locations are listed below.

Swab delivery info from today

Organization Name	Testing Status	State/Local	Primary E-Mail	Primary Phone	Address	City	State	Zip	Shipping POC	Email	Phone	Tracking information for swab shipments from PBM/LifeSign	Status
Alabama Bureau of Clinical Laboratories	Testing	State	sharon.massingale@adph.state.al.us	334.260.3400 (3493)	1637 Mitchell Young Road	Montgomery	AL	36108				170397531128	delivered 3/24/2020
Georgia Public Health Laboratory	Testing	State	efranko@dhr.state.ga.us	404.327.7900	1749 Clairmont Road	Decatur	GA	30032				170397531209	delivered 3/24/2020
Kentucky Division of Laboratory Service	Testing	State	vaneet.arora@ky.gov	502.564.4446	100 Sower Blvd.	Frankfort	KY	40601				170397531264	delivered 3/24/2020
Mississippi Public Health Laboratory	Testing	State	daphne.ware@msdh.ms.gov	601.576.7582	570 East Woodrow Wilson Blvd	Jackson	MS	39216				170397531323	delivered 3/24/2020
North Carolina State Laboratory of Public Health	Testing	State	Scott.Shone@dhhs.nc.gov	919.807.8940	306 N Wilmington Street	Raleigh	NC	27611				170397531367	delivered 3/24/2020
South Carolina Public Health Laboratory	Testing	State	kanh@dhec.sc.gov	803.896.0965	8231 Parklane Road	Columbia	SC	29223				170397531448	delivered 3/24/2020
Tennessee Department of Health: Laboratory Services	Testing	State	richard.steece@tn.gov	615.262.6301	630 Hart Lane	Nashville	TN	37243				170397531610 170397531621 170397531632 170397531643	delivered 3/24/2020

Regards,
Jeanne

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Subject: swab delivery
Date: Wednesday, March 25, 2020 8:00:48 PM

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AMERICAN OVERSIGHT

From: Rivkees, Scott A
To: jsb6@cdc.gov
Subject: test data by state
Date: Wednesday, March 25, 2020 8:00:18 AM

Dear Joe

Please let me know when the # of tests performed per state data will be available.

Thanks

Scott

Scott A. Rivkees, M.D.
Surgeon General
Florida Department of Health

Scott.Rivkees@flhealth.gov
Office: 850-245-4210
Cell: 850-408-9735



Please note that under Florida law correspondence, which is not confidential or exempt pursuant to the Florida Statutes, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	CDC IMS 2019 NCOV Response Epi TF Case Tracking Team; Bowen, Virginia B. (CDC/DDID/NCHHSTP/DSTDP); Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Wen, John (CDC/DDPHSIS/CGH/DGHT); Wiese, Michael T.; Blackmore, Carina
Subject:	#2 FL Health Care Contact Invest

Please join us to discuss a small HCP provider contact investigation at a urgent care for presumptive positive case #2.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC COVID-19 Key Points
Date:	Wednesday, March 4, 2020 10:47:51 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_3_2020_final.pdf

Dear Colleagues:

Attached are the **CDC COVID-19 Key Points for March 3rd, 2020**. Feel free to share with partners and appropriate parties.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

March 03, 2020

Updated text is shown in colored text.

SNAPSHOT

CDC has reported:

- 60 confirmed and presumptive positive cases of COVID-19
- 6 COVID-19 related deaths
- 12 states reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 60 reported U.S. cases of COVID-19 from 12 states.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently they are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- On March 3, a *Morbidity and Mortality Weekly Report* (*MMWR*) Update was published titled "Active Monitoring of Persons Exposed to Patients with Confirmed COVID-19 — United States, January–February 2020." (See Section "MMWR Update.")

AMERICAN OVERSIGHT

- As of March 3, 2020, 68 international locations (including the U.S.) have reported confirmed cases of COVID-19.
- 60 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York, New Hampshire, Oregon, Rhode Island, Washington and Wisconsin.
    - 11 of these cases occurred through person-to-person spread.
    - 22 cases all were in persons who had travel to China.
    - 27 cases where the source of exposure is still under investigation.
- As of March 3, CDC issued Travel Health Notices for the following locations:
    - Level 3 Travel Health Notice (avoid non-essential travel): China, Iran, South Korea, and Italy
    - Level 2 Travel Health Notices (Practice Enhanced Precautions): Japan
    - Level 1 (practice usual precautions): Hong Kong
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.
- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- Because states are reporting publicly directly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
- If there are discrepancies between case counts reported by state or local officials versus CDC reported numbers, the numbers provided by states will be the most up-to-date.
- State health laboratories are reporting their results to CDC.
- CDC is consolidating state reports and combining them with CDC confirmed test results and presenting a national aggregated case count daily from Monday through Friday.
- Case counts submitted to CDC by 4pm the prior day will be posted at noon.
- CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.
- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan) in a separate chart available on the CDC website.
- CDC has discontinued reporting of the numbers of persons under investigation (PUIs) tested and those that tested negative.
- Now that states are testing and reporting their own results, CDC's numbers will not be representative of all the testing being done nationwide.

AMERICAN OVERSIGHT

MMWR UPDATE:

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- CDC supported state/local public health officials as they tracked 445 close contacts of the first U.S. cases.

WHAT YOU CAN DO

- Everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.

AMERICAN OVERSIGHT

- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:**
  - Preparing first responders, healthcare providers, and health systems
  - Reinforcing state, territorial, and local public health readiness
  - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
  - Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC COVID-19 Key Points
Date:	Wednesday, March 4, 2020 10:43:53 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_3_2020_final.pdf

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- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.

AMERICAN OVERSIGHT

- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:**
  - Preparing first responders, healthcare providers, and health systems
  - Reinforcing state, territorial, and local public health readiness
  - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
  - Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 03-03-2020 CDC Media Statement: CDC Announces Additional COVID-19 Infections
Date: Tuesday, March 3, 2020 6:16:59 PM

Media Statement

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Announces Additional COVID-19 Infections

At noon on Tuesday, March 3 the Centers for Disease Control and Prevention (CDC) reported 60 cases of COVID-19 from 12 states. Twenty-two of these cases are travel-related; 11 are believed to be person-to-person spread; and for the remaining 27 the source of exposure is still under investigation. Noteworthy developments in recent days include:

- Florida announced its first and second presumptive positive cases of COVID-19, one in a person with recent travel history (to Italy), the other with no currently known travel or contact history.
- Georgia announced its first and second confirmed cases of COVID-19, one is a person with recent travel history (to Italy), the other in a close contact of the first patient.
- New Hampshire also reported its first presumptive positive case of COVID-19 in a person with recent travel history (to Italy).
- New York state announced its first case of COVID-19 in a person with recent travel history (to Iran).
- Rhode Island announced its first presumptive positive case of COVID-19 in a person with recent travel history (to Italy).
- Washington state announced more cases of COVID-19 associated with an outbreak in a long-term care facility. Washington has announced it now has 14 cases of COVID-19, including 6 COVID-19 deaths.

The 12 states that have reported cases include: Arizona, California, Florida, Georgia, Illinois, Massachusetts, New Hampshire, New York, Oregon, Rhode Island, Washington, and Wisconsin.

As the outbreak of COVID-19 continues to expand and as testing capacity in the U.S. increases, CDC expects more cases to be detected across the country, including more instances of person-to-person spread in more states. While information so far suggests that most COVID-19 illness is mild, a report out of China suggests serious illness occurs in 16% of cases. Older people and people with certain underlying health conditions like heart disease, lung disease and diabetes, for example, seem to be at greater risk of serious illness.

The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health

AMERICAN OVERSIGHT

emergency. CDC expects additional instances of person-to-person spread in the coming days and weeks.

Cases reported to CDC include those confirmed by CDC as well as presumptive positive cases reported by states. A presumptive positive result is when a patient has tested positive by a public health laboratory, but results are pending confirmation at CDC. For public health purposes, a presumptive positive result using the CDC test is treated as a positive.

CDC will report total presumptive and confirmed cases weekdays at noon. This number is based on all state reports received by 4 p.m. the previous day. CDC is no longer reporting number of persons-under-investigation (PUIs) nor those PUIs that test negative because now that states are testing and reporting their own results, these numbers would not be representative of the testing being done nationally. States are reporting results quickly and in the event of a discrepancy between CDC and state case counts, the state case counts should always be considered more up-to-date.

For more information about COVID-19 visit www.cdc.gov/covid19.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 03-03-2020 CDC Media Statement: CDC Announces Additional COVID-19 Infections
Date: Tuesday, March 3, 2020 6:20:39 PM

Media Statement

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

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For more information about COVID-19 visit www.cdc.gov/covid19.

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Statement: CDC Announces Additional COVID-19 Infections
Date:	Tuesday, March 3, 2020 6:13:07 PM

Media Statement

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Announces Additional COVID-19 Infections

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Tuesday, March 3, 2020 10:29:42 AM

Media Advisory

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 1:00 p.m. ET Tuesday, March 3, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-517-308-9127
PASSCODE: 4603973

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Tuesday, March 3, 2020 10:32:53 AM

Media Advisory

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	03-03-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Tuesday, March 3, 2020 10:23:04 AM

Media Advisory

For Immediate Release
Tuesday, March 3, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Cc:	Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019; CDC CSELS DSEPD EWB
Subject:	100% of EIS officers and LLS fellows are needed for the COVID-19 response
Date:	Wednesday, March 18, 2020 2:46:15 PM

EIS and LLS supervisors,

I am writing again, asking for your support in having EIS officers and LLS fellows deploy or take on other roles for CDC's response to COVID-19. I want to emphasize that **completing CALs (graduation requirements) should NOT factor into whether an EIS officer or LLS fellow deploys**. Supervisors should not be asking to review deployment roles or objectives before approving a deployment. In the past we wanted to ensure deployments aligned with our training objectives. We no longer have that luxury, the primary responsibility of the EIS and LLS programs needs to be supporting the response until we are informed otherwise.

We will deal with CAL completion and how COVID-19 might impact graduation on a case-by-case basis. I want to assure you we will be very understanding in finding ways to compensate if involvement with the COVID-19 response prevented anyone from fulfilling the requirements to graduate.

We understand that some EISOs or LLS fellows may not be able to deploy to the field because of obligations to care for family members or themselves. There are response roles that can be completed while teleworking and do not require travel. We are available to assist in finding deployment roles – contact us at EpiAid@cdc.gov and we can discuss their particular circumstance. In addition, any fellows who are not currently deployed can volunteer by:

1. Emailing us at EpiAid@cdc.gov
2. Volunteer for a Go Team by submitting name in ReADI
3. Responding directly to any calls for volunteers they receive through other communication channels

Thank you for your support of the EIS and LLS programs and of your officers or fellows. We know a lot is being asked of you as well and CDC leadership appreciates all you are doing with respect to your individual contributions and your support of the EIS officers and LLS fellows.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

AMERICAN OVERSIGHT

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.


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From:	ARLN Health
To:	Darryl.Pendergrass@adph.state.al.us; Darryl.Pendergrass@adph.state.al.us; ramandeep.kaur@adph.state.al.us; Melanie.Chervony@adph.state.al.us; Sharon.Massingale@adph.state.al.us; Aretha.Williams@adph.state.al.us; uzo0@cdc.gov; qpf1@cdc.gov; nub7@cdc.gov; pwi4@cdc.gov; qov3@cdc.gov; vqq9@cdc.gov; ARLN@cdc.gov; ibesser@cdc.gov; Jwp6@cdc.gov; ekersh@cdc.gov; vsrinivasan@cdc.gov; qvi2@cdc.gov; idz4@cdc.gov; iyk6@cdc.gov; Tammy.Jernigan@flhealth.gov; Carina.Blackmore@flhealth.gov; nychie.dotson@flhealth.gov; Susanne.Crowe@flhealth.gov; Kendra.Edwards@flhealth.gov; Patty.Lewandowski@flhealth.gov; Sasha.Nelson@flhealth.gov; Sarah.Schmedes@flhealth.gov; Nicole.Castro@flhealth.gov; Jason.Blanton@flhealth.gov; Mary.Connelly@dph.ga.gov; Tonia.Parrott@dph.ga.gov; cherie.drenzek@dph.ga.gov; Michael.Anderson@dph.ga.gov; Joanna.Wagner@dph.ga.gov; amanda.jara@dph.ga.gov; Jeanne.Negley@dph.ga.gov; Doug.Blomberg@dph.ga.gov; Tiffany.Rivers@dph.ga.gov; Theresa.Sokol@LA.GOV; Lauren.Kleamenakis@la.gov; Stephanie.Kleinpeter@LA.GOV; Ashley.Terry@la.gov; alexa.ramirez@la.gov; Jean-Jacques.Aucoin@LA.GOV; Erica.Washington@LA.gov; Fatima.Brakta@la.gov; raoult.ratard@la.gov; Kirbie.StJames@la.gov; Theresa.Sokol@la.gov; paul.byers@msdh.ms.gov; Cynthia.Allard@msdh.ms.gov; Daphne.Ware@msdh.ms.gov; ilsa.villegas@salud.pr.gov; Militza.Echevarria@salud.pr.gov; inelia.otero@salud.pr.gov; Norma.Diaz@salud.pr.gov; Sara Belknap; Linda Thomas; Dorothy Baynham; Tracy McLemore; Jessica Barnes; Tabatha East; Daniel Golson; Henrietta Hardin; Richard Steece; Albert Burks; Randall Morris; Matthew Estes; Katie Thure; Paula L. Gibbs; Xiaorong Qian; Amelia A. Keaton; Carol Rauch; Robin M. Rasnic; Natasha Lindahl; Victoria Stone; lhsmith@utah.gov; arossi@utah.gov
Cc:	Allison Chan; Carolyn Stover
Subject:	2019 SE Regional AR Lab Network Report and Newsletter
Date:	Thursday, February 27, 2020 10:47:51 AM
Attachments:	image001.png image002.png AR Lab Network SE Regional Newsletter Vol2_Iss4.pdf 2019 SE AR Lab Network Report.pdf

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Please see the attached 2019 report and Q4 2019 newsletter. This report includes the aggregate numbers for the SE Region for the calendar year 2019.
We look forward to continue working with you all.

Thanks and please let us know if you have questions.

Allison Chan, MPH | Epidemiologist
Healthcare Associated Infections and Antimicrobial Resistance Program
Communicable and Environmental Diseases and Emergency Preparedness
Andrew Johnson Tower, 3rd Floor, 3.317C
710 James Robertson Parkway, Nashville, TN 37243
p. 615-532-6401 | allison.chan@tn.gov
tn.gov/health
Connect with TDH on Facebook and Twitter @TNDeptofHealth!

Our Mission – To protect, promote and improve the health and prosperity of people in Tennessee.

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Southeast Antibiotic Resistance Lab Network (AR Lab Network) Report

About the report:

The Southeast AR Lab Network report is a compilation of testing performed within 2019*.

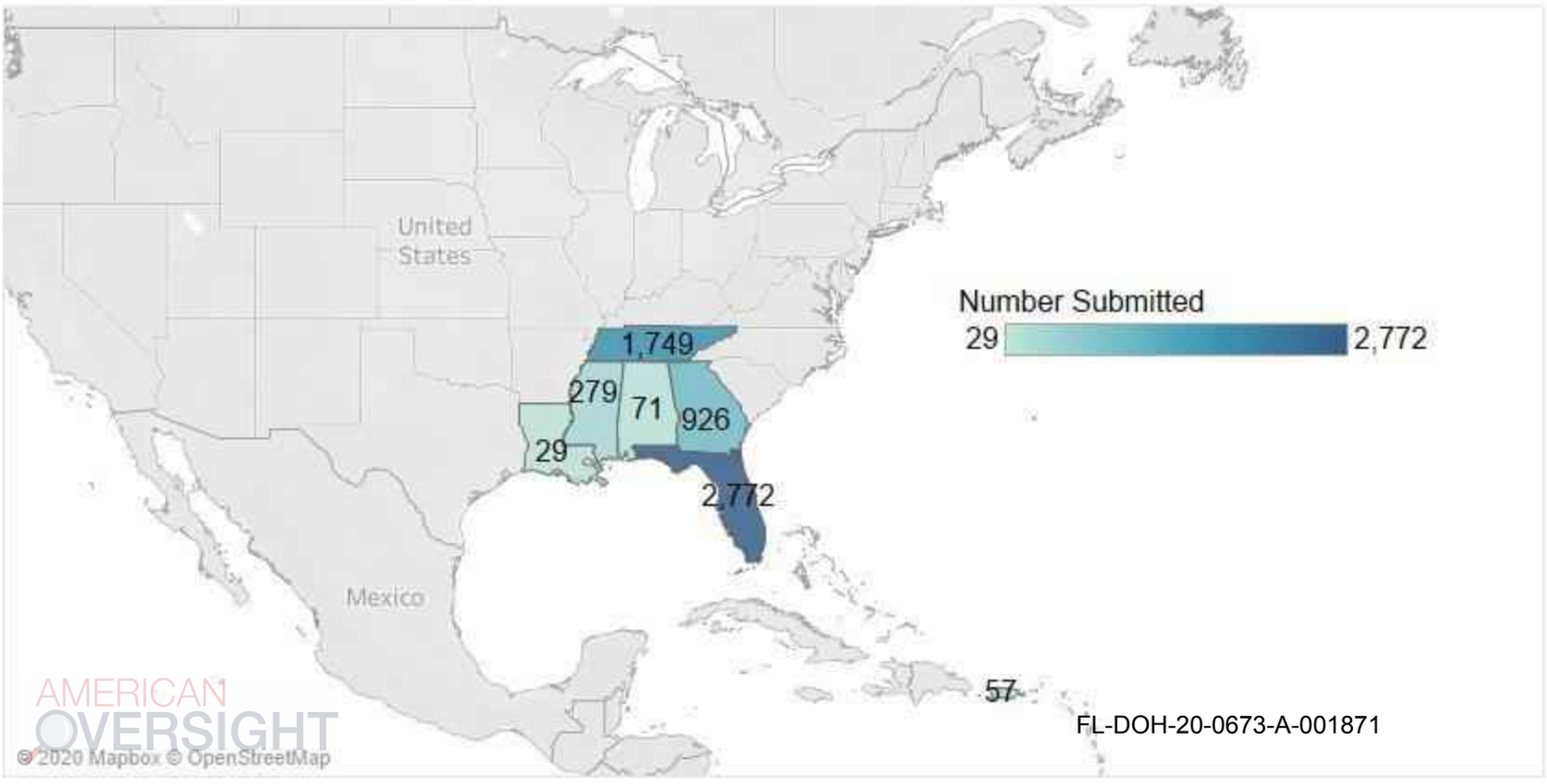
Summary tables and maps have been generated to characterize:

CRE/CRPA confirmatory testing
Acinetobacter baumannii testing
Colonization screening
Alert Values

*Data are from Jan 2019 thru Dec 2019 based on date received at the regional lab

Isolate submission by activity

		2019			
		Q1	Q2	Q3	Q4
AL	CRAB		2		
	CRE	12	14	20	8
	CRPA	12	1	1	1
FL	COLONIZATION	607	1,323	588	198
	CRAB	1	1	5	5
	CRE		6	14	4
	CRPA	2	10	1	4
GA	COLONIZATION	65	365	135	30
	CRAB	22	10	13	20
	CRE	4	4	8	6
	CRPA	5	1	1	8
LA	CRAB	5		6	2
	CRE	2	1	2	3
	CRPA	1	5	1	1
MS	COLONIZATION		38	168	33
	CRAB		2		1
	CRE		4	4	1
	CRPA		2		
PR	CRE	14	10	16	10
	CRPA		2	2	3
TN	COLONIZATION	333	371	275	297
	CRAB	36	44	38	47
	CRE	12	7	13	9
	CRPA	7	4	1	2
Grand Total		1,140	2,227	1,312	693



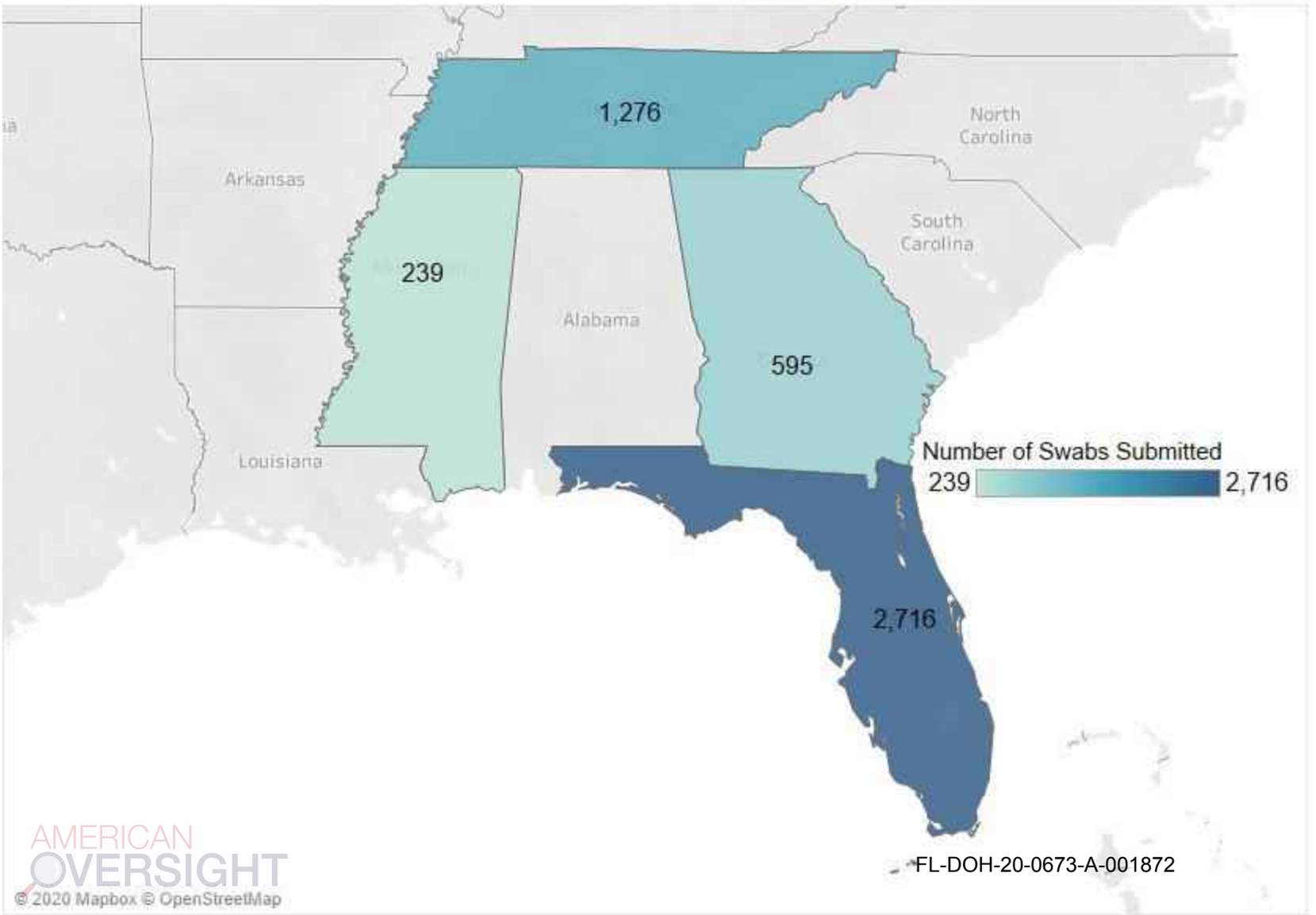
AMERICAN OVERSIGHT

Colonization Screening Summary

Colonization screenings were conducted in response to identification of novel resistance mechanisms (NDM, VIM, NDM/OXA-48-like) as well as clusters of KPC and CRAB.

Total number of genes detected from screens

FL	KPC	96
	NDM	8
	NDM_KPC	1
	OXA23	1
	OXA48_NDM	1
	VIM	32
	VIM_KPC	1
	VIM_NDM	1
GA	KPC	70
	NDM	8
	NDM_KPC	1
	OXA23	3
MS	NDM	3
	OXA23	8
TN	KPC	9
	NDM	1
	OXA23	9
	OXA24/40	1
	OXA48	1
	VIM	2



AMERICAN OVERSIGHT

"Alert" Values

"Alert" values reported include:

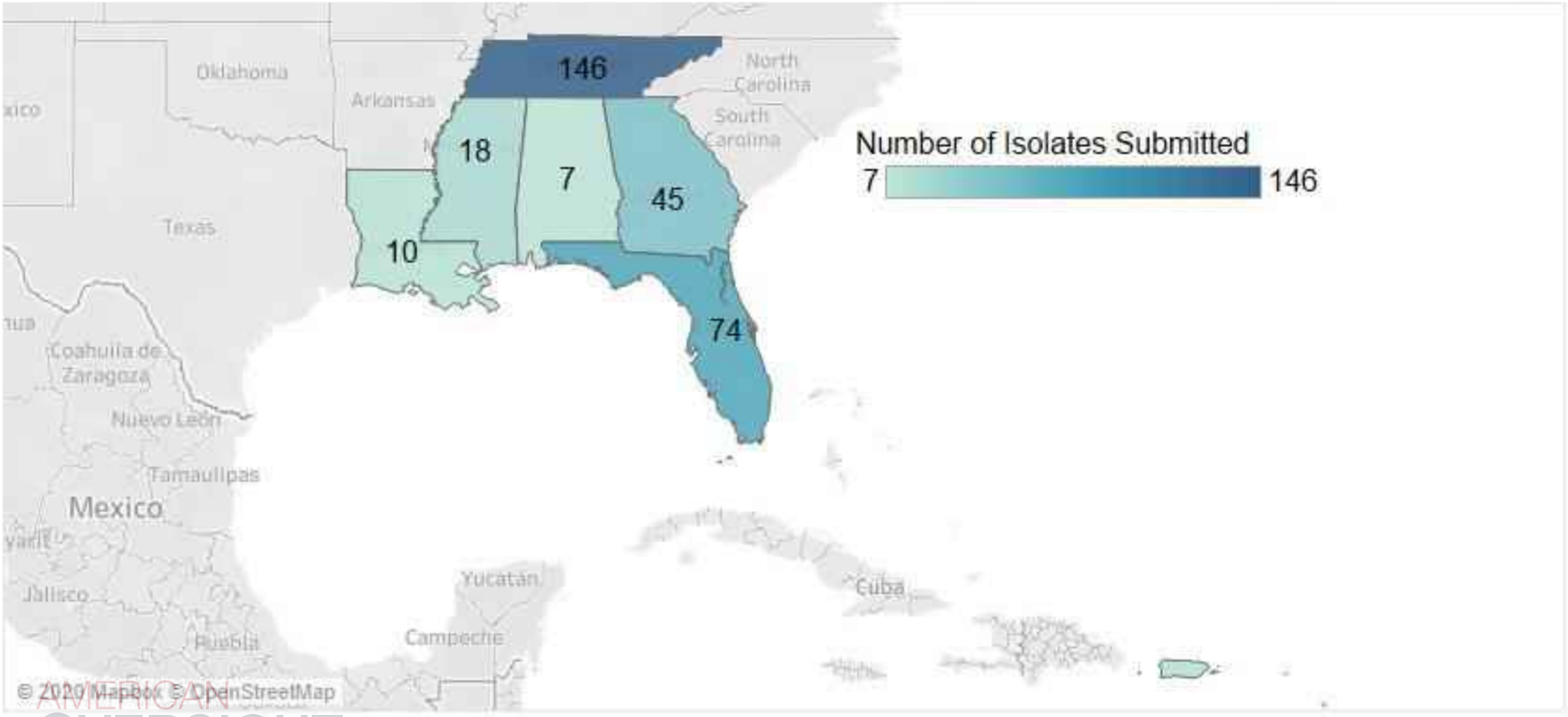
CP-CRPA
Non-KPC CRE
OXA-23
OXA-24/40
OXA-58
Discordant mCIM*

Alert Type

PHL	Alert	
AL	DISCORDANT MCIM	1
	NON-KPC CRE	4
	OXA23	2
FL	CP-CRPA	27
	DISCORDANT MCIM	5
	MCR-1	1
	NON-KPC CRE	32
	OXA23	8
	OXA24_40	1
GA	CP-CRPA	2
	DISCORDANT MCIM	1
	NON-KPC CRE	17
	OXA23	25
LA	DISCORDANT MCIM	1
	NON-KPC CRE	2
	OXA23	1
	OXA24_40	6
MS	NON-KPC CRE	8
	OXA23	9
	OXA24_40	1
PR	CP-CRPA	6
	NON-KPC CRE	3
TN	CP-CRPA	9
	DISCORDANT MCIM	10
	NON-KPC CRE	41
	OXA23	65
	OXA24_40	21

AR Genes

PHL	Alert	AR Gene	
AL	NON-KPC CRE	NDM	1
		OXA48	3
FL	CP-CRPA	KPC	5
		VIM	22
	NON-KPC CRE	IMP	2
		KPC	3
		NDM	10
		NDM_KPC	1
		OXA48_NDM	2
		VIM	12
		VIM_KPC	1
		VIM_NDM	1
GA	CP-CRPA	KPC	1
		VIM	1
	NON-KPC CRE	IMP	2
		NDM	10
		NDM_KPC	1
		OXA48_NDM	4
LA	NON-KPC CRE	IMP	1
		NDM	1
MS	NON-KPC CRE	IMP	1
		NDM	7
PR	CP-CRPA	KPC	6
	NON-KPC CRE	NDM	1
		NDM_KPC	2
TN	CP-CRPA	IMP	1
		KPC	3
		VIM	3
		VIM_NDM	2
	NON-KPC CRE	IMP	4
		NDM	20
		OXA48	13
		VIM	4



*mCIM is a phenotypic laboratory test to identify the prodution of a protein called carbapenemase. Carbapenemase breaks down the class of antibiotics called carbapenems.

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CRE Characterization

CRE Characterization summarizes CRE isolates submitted to the AR Lab Network for further or full characterization

mCIM Test Result*

		NEGATIVE	POSITIVE
MCG**	AL	34	16
	FL	9	10
	GA	6	11
	MS		5
	PR	4	45
	TN		33
LCG***	AL	1	3
	FL	2	1
	GA		1
	LA	4	4
	MS		3
	TN		8

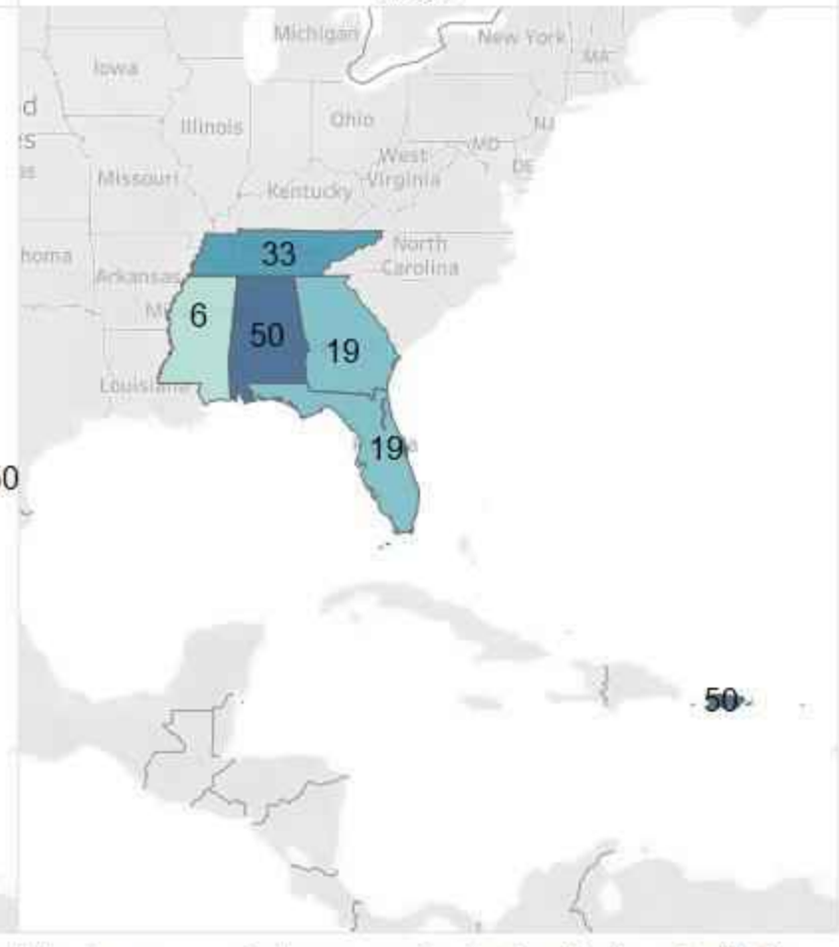
Carbapenemases Genes

MCG**	IMP	1
	KPC	65
	NDM	27
	NDM_KPC	2
	OXA48	13
	OXA48_NDM	5
	VIM	3
LCG***	IMP	8
	KPC	3
	NDM	3
	OXA48	2

LCG***



MCG**



*mCIM is a phenotypic laboratory test to identify the prodution of a protein called carbapenemase. Carbapenemase breaks down the class of antibiotics called carbapenems.

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** MCG- Most common genera of the Enterobacteriaceae family. This includes *Escherichia*, *Klebsiella*, and *Enterobacter*.
***LCG - Less common genera of the Enterobacteriaceae family. This includes all other Enterobacteriaceae genera.

Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)

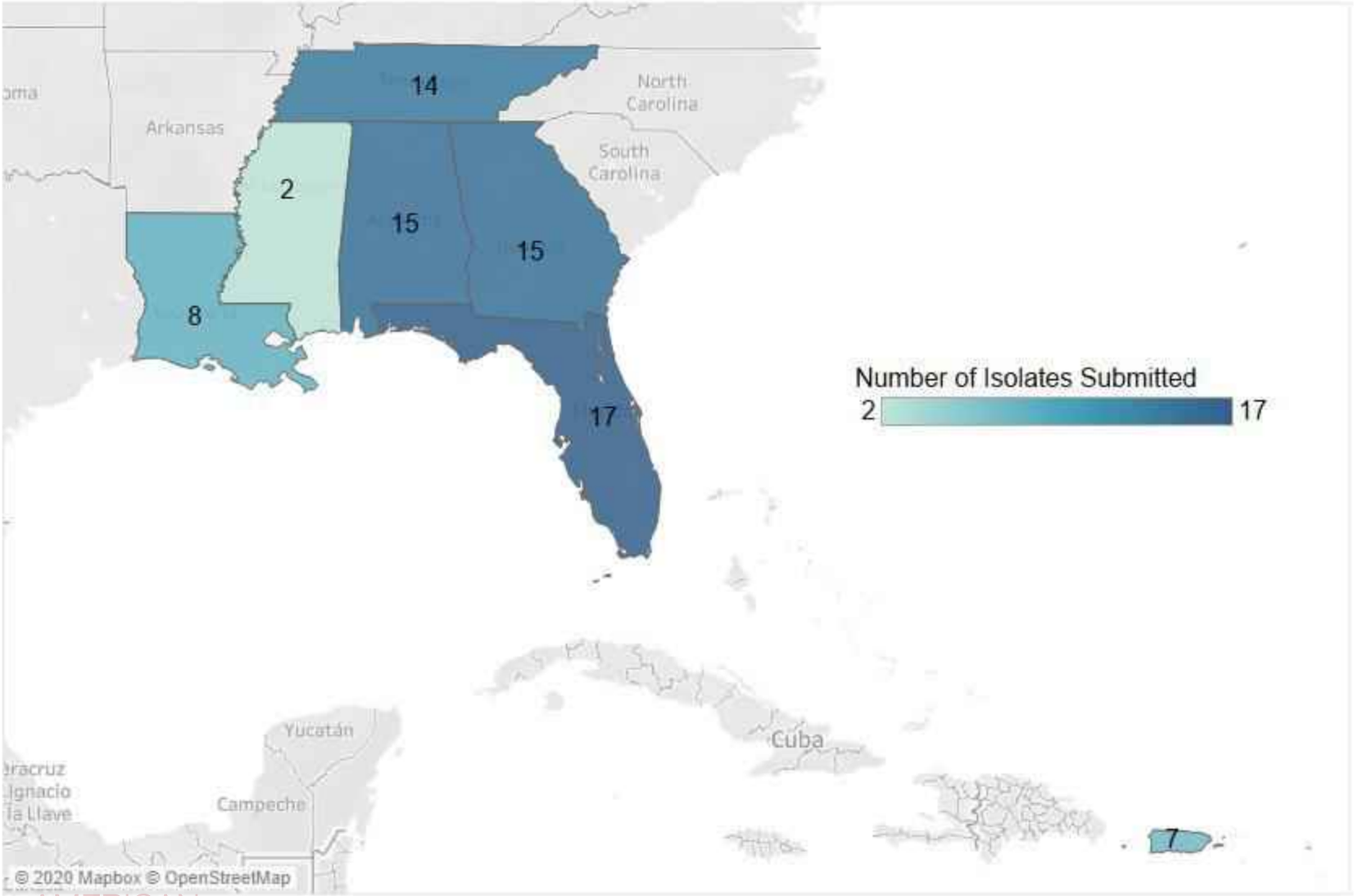
CRPA characterization sumarizes isolates submitted to the AR Lab Network for further characterization or full characterization.

Carbapenemase Production Test

PHL	mCIM Test Result*	
AL	NEGATIVE	15
FL	NEGATIVE	9
	POSITIVE	7
GA	NEGATIVE	15
LA	NEGATIVE	8
MS	NEGATIVE	2
PR	NEGATIVE	1
	POSITIVE	6
TN	POSITIVE	14

Carbapenemase Genes Detected

PHL	Alert	AR Gene	
FL	CP-CRPA	VIM	2
	DISCORDANT MCIM	N/A	5
PR	CP-CRPA	KPC	6
TN	CP-CRPA	IMP	1
		KPC	2
		VIM	2
		VIM_NDM	2
	DISCORDANT MCIM	N/A	7



*mCIM is a phenotypic laboratory test to identify the prodution of a protein called carbapenemase. Carbapenemase breaks down the class of antibiotics called carbapenems.

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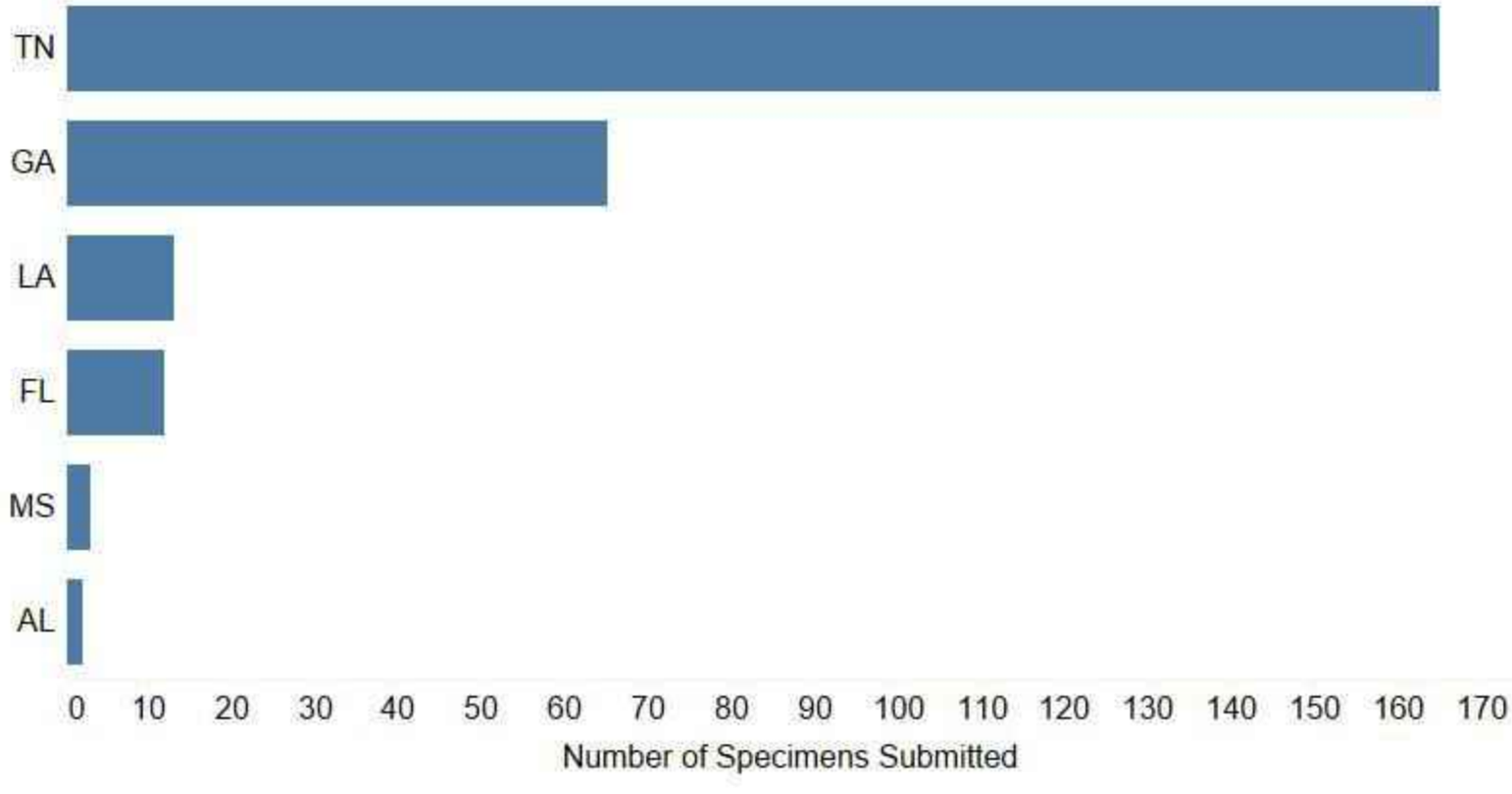
Carbapenem-resistant *Acinetobacter baumannii* (CRAB)

Acinetobacter baumannii characterization includes PCR testing for the carbapenemase genes, OXA-23, OXA-24/40, and OXA-58*

Isolate Submissions



PHL	Oxa 23 Gene	Oxa 24 40 Gene	Oxa 58 Gene	
AL	DETECTED	DETECTED	NOT DETECTED	1
		NOT DETECTED	NOT DETECTED	1
FL	DETECTED	NOT DETECTED	NOT DETECTED	7
	NOT DETECTED	DETECTED	NOT DETECTED	1
		NOT DETECTED	NOT DETECTED	2
GA	DETECTED	NOT DETECTED	NOT DETECTED	21
	NOT DETECTED	NOT DETECTED	NOT DETECTED	17
LA	DETECTED	NOT DETECTED	NOT DETECTED	1
	NOT DETECTED	DETECTED	NOT DETECTED	6
MS	DETECTED	NOT DETECTED	NOT DETECTED	1
	NOT DETECTED	DETECTED	NOT DETECTED	1
		NOT DETECTED	NOT DETECTED	1
TN	DETECTED	DETECTED	NOT DETECTED	2
		NOT DETECTED	NOT DETECTED	54
	NOT DETECTED	DETECTED	NOT DETECTED	20
		NOT DETECTED	NOT DETECTED	25

*The PCR assay for OXA-23, OXA-24/40, and OXA-58 was not validated until 5/22/2019. Therefore, not all CRAB isolates were tested in 2019 for these genes.

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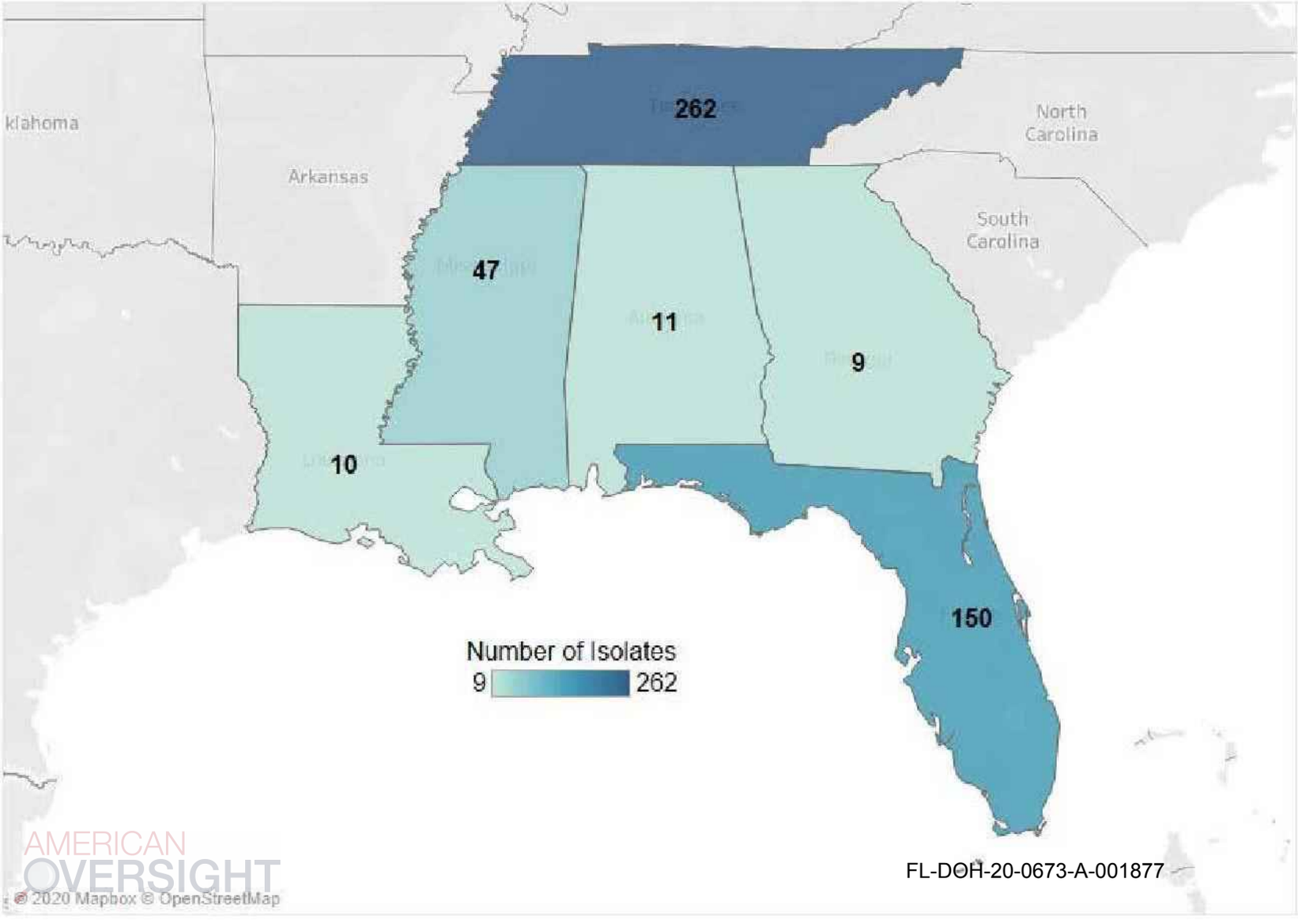
Southeast AR Lab Network
Candida Report

The Southeast AR Lab Network *Candida* quarterly report is a compilation of AR Lab Network testing performed year-to-date. Summary tables, graphs, and maps have been generated to characterize the number of isolates submitted, isolate submission by state, clinical lab species identification compared to AR Lab Network species identification, and specimen source.

Isolates Submitted by State PHL

	2019				
PHL	Q1	Q2	Q3	Q4	Grand Total
AL		3	2	6	11
FL	41	48	29	32	150
GA		3	3	3	9
LA		3	4	3	10
MS		4	7	37	48
TN	54	81	62	67	264
Grand Total	95	142	107	148	492

Isolate Submission by State Public Health Lab



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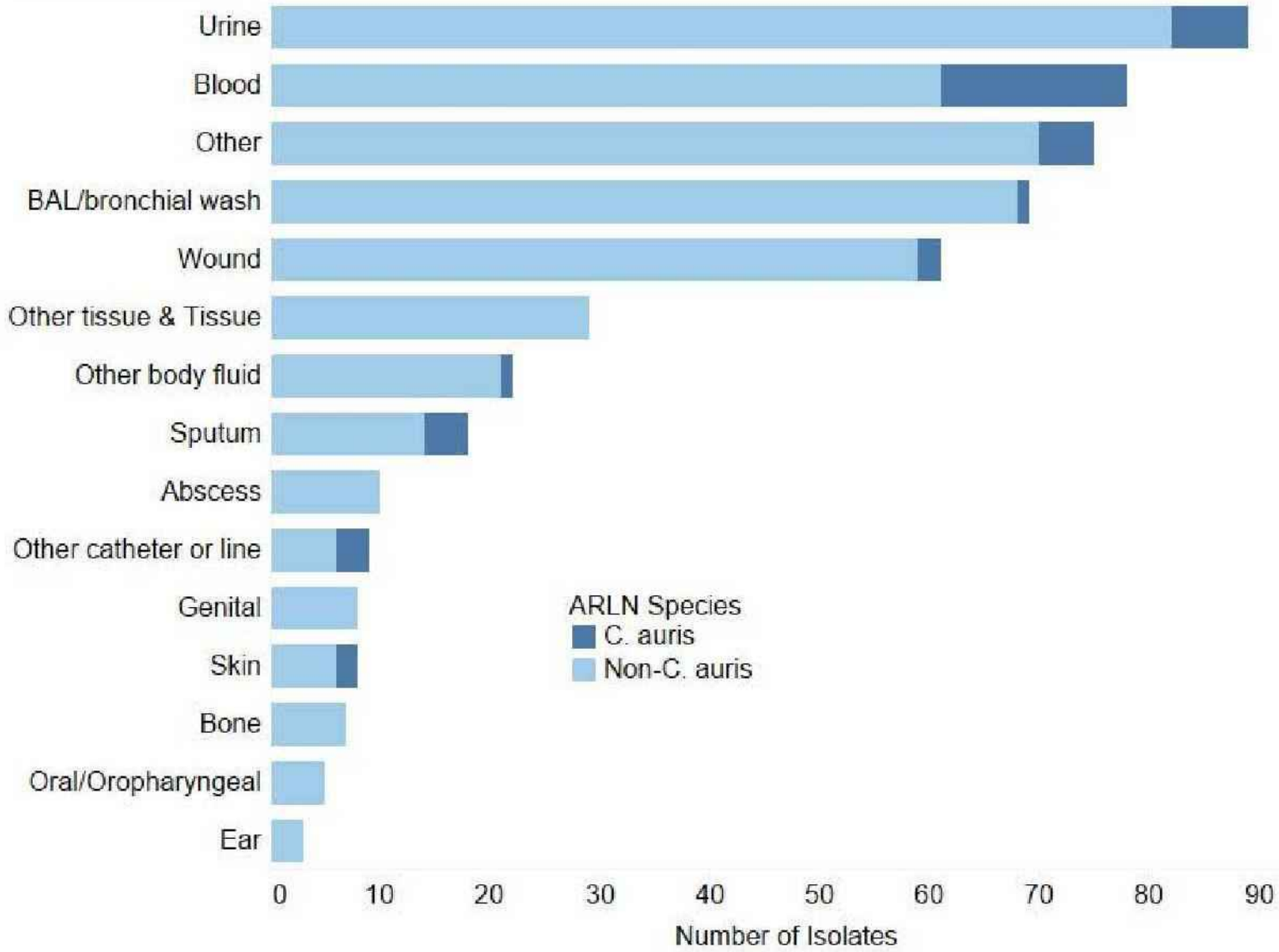
Specimen Sources



Specimen sources for all isolates, from most common to least. Some patients had multiple isolates. Categories 'Other catheter or line,' 'Other body fluid,' 'Other tissue,' and 'Other' were used when specimen source was nonspecific. Data shown is from Q3 2019.

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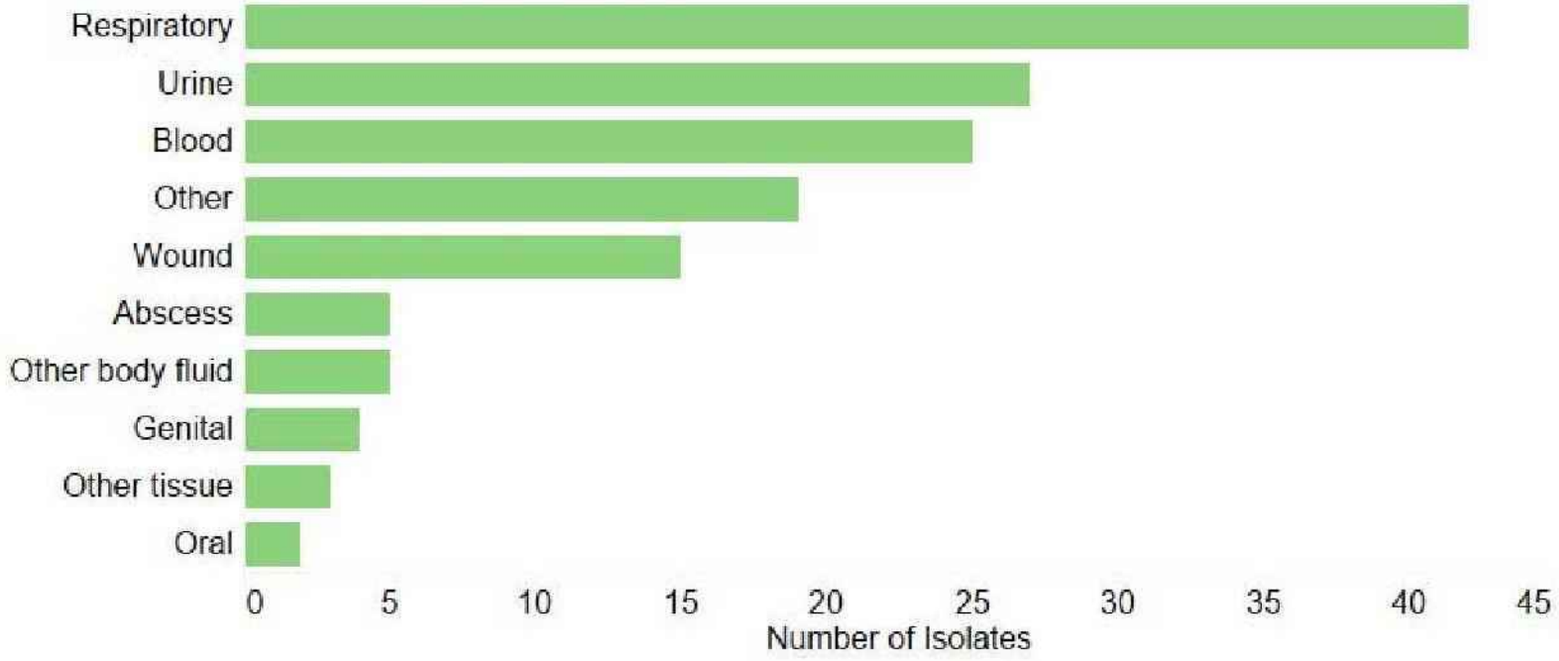
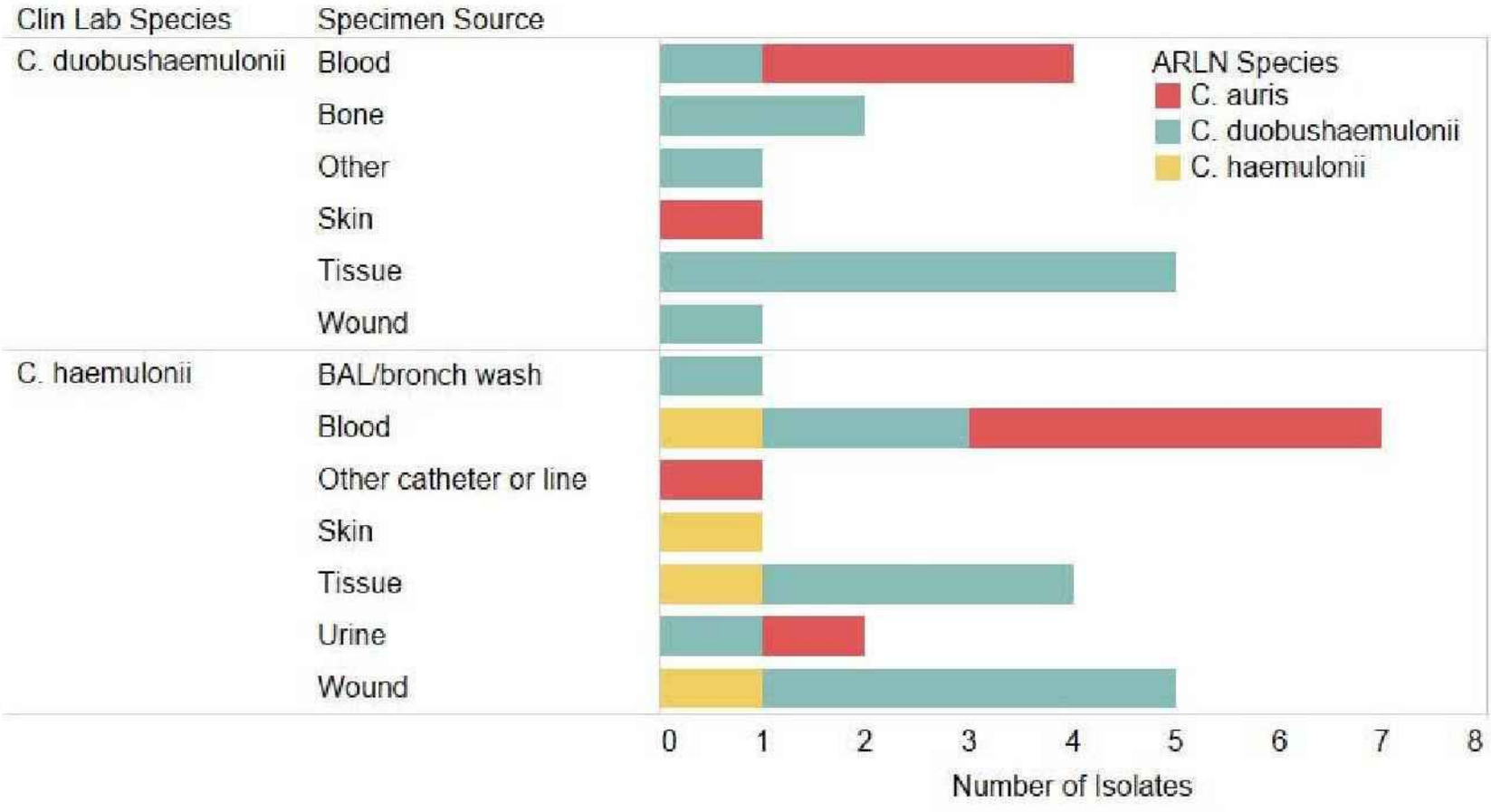
Specimen Source of *C. glabrata* Isolates



Specimen source of isolates submitted as *C. haemulonii* or *C. duobushaemulonii*



C. auris can be misidentified as *C. haemulonii* or *C. duobushaemulonii*. Four (4) *C. auris* isolates were misidentified by the submitting lab as *C. duobushaemulonii, and* six (6) were misidentified as *C. haemulonii*.

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VOLUME 2, ISSUE 4

Winter 2019

ARLABnetwork

Southeast Regional Newsletter

This newsletter will be distributed on a quarterly basis to all Southeast Antibiotic Resistance Lab Network sentinel sites, public health epidemiologists and labs. Articles will include regional updates, lab protocols, surveillance updates and staff introductions. Please email ARLN.Health@TN.gov if you are interested in submitting an article for the next newsletter. We are excited to use this newsletter as a means for the SE region to stay updated and connected!

Inside this issue:

Lab Web Portal	2
2019 AR Threat Report	3
Meet the Staff	4
Candida Updates & Recipe	5
Sudoku	6



TN Department of Health

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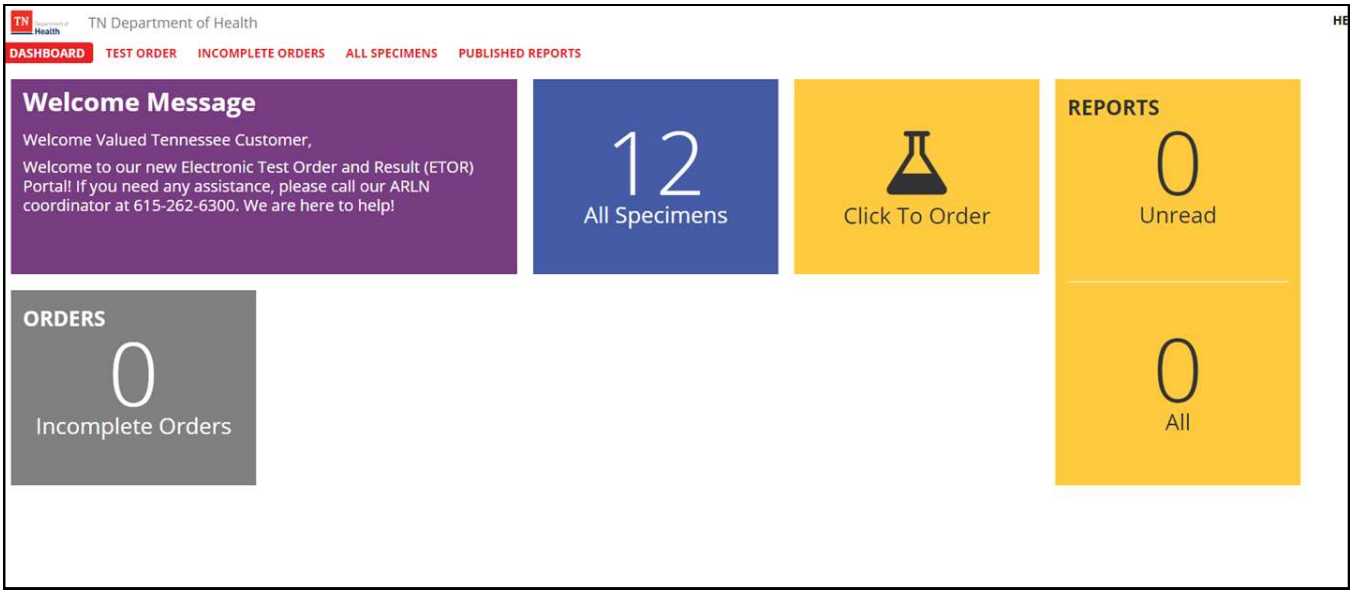
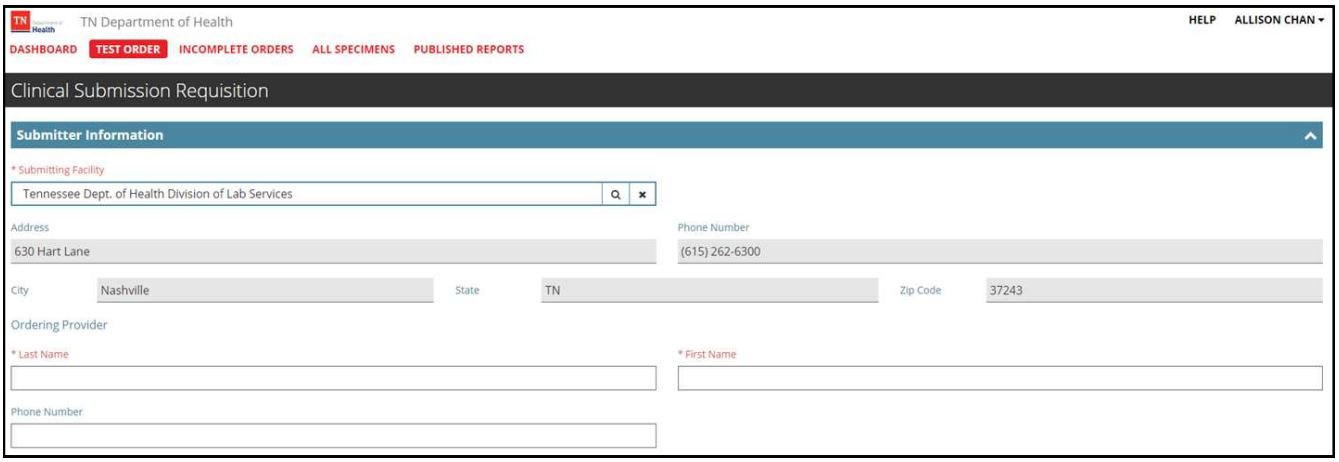
CRE Colonization Lab Web Portal

The Tennessee laboratory informatics team is recruiting pilot sites for the lab web portal, LWP. Users with access to the LWP can request CRE colonization screenings with a point-and-click user interface. Final lab results will be available through the LWP and downloaded as PDFs.





The LWP will be available for everyone to request CRE colonization screenings after the initial pilot phase.

If you are interested in being a pilot site or have a site interested in your jurisdiction then please contact ARLN.Health@tn.gov

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CDC's AR Threat Report 2019



In November 2019, CDC released an updated AR Threats Report. The updated report utilized electronic health data that was not available when the first report was released in 2013 and contains an updated threat list, a watch list and infection and death trends.

Sections of the updated report include the threat of antibiotic resistance, challenges and opportunities in detection and treatment for antibiotic-resistant infections, national action plan to combat antibiotic resistance and pathogen summaries.

The full report can be found here: www.cdc.gov/DrugResistance/Biggest-Threats.html

Highlights

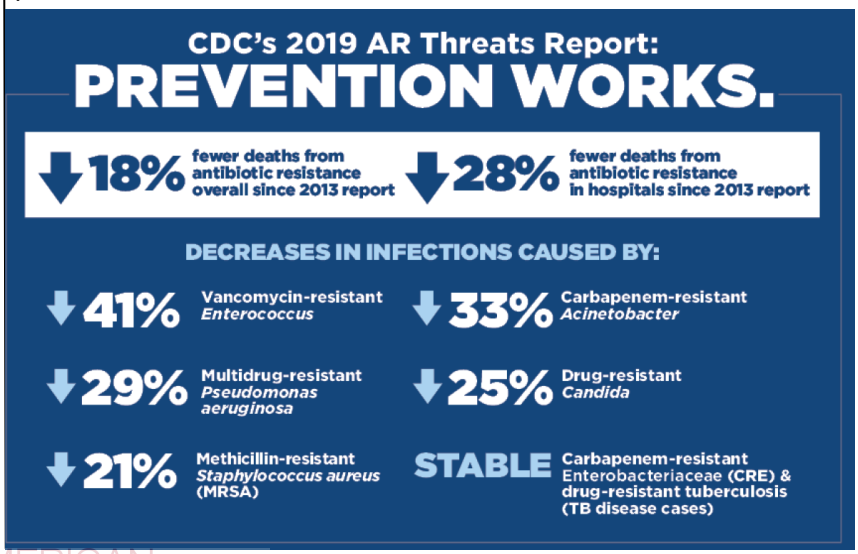
Updated Numbers

Each year, antibiotic resistant bacteria and fungi cause more than **2.8 million infections** and **35,000 deaths**. In addition, *C. difficile* sent almost **223,900 people to the hospital** in 2017 and caused at least **12,800 deaths**.

The estimates from the 2013 report were that two million people were infected with resistant bacteria and fungi and that 23,000 people died each year. However, with the new data sources available, such as electronic health data, the CDC recalculated the 2013 estimates. The updated 2013 estimates were 2.6 million infections and 44,000 deaths. Based on these new numbers, the number of deaths attributable to antibiotic resistant infections has decreased 18 percent in the past six years.

The **Urgent Threat** list has been updated to included carbapenem-resistant *Acinetobacter* and *Candida auris*, which was unknown when the first report was released.

A **Watch List** was added which includes antibiotic resistant threats that are not yet common in the United States and have the potential to spread or become a challenge. Currently on the watch list are azole-resistant *Aspergillus fumigatus*, drug-resistant *Mycoplasma genitalium* and drug-resistant *Bordetella pertussis*.



The publication of the 2013 report led to the release of the National Action Plan for Combating Antibiotic Resistant Bacteria, CARB, which in turn led to the creation of the AR Solutions Initiative and in 2016, the **AR Lab Network**.

As of 2018, the AR Lab Network has detected a resistant pathogen that required a public health investigation **every four hours**. When this report was released in November 2019 the AR Lab Network had tested nearly 13,000 swabs, over **106,000** bacteria and sent more than **2,200** alerts on unusual resistance.

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Meet the Staff



Sarah Schmedes, PhD is a bioinformatician with the Florida Bureau of Public Health Laboratories, BPHL in Jacksonville, Fla. and serves as the bioinformatics regional resource, BRR lead for the Southeast Region. As the BRR, Schmedes provides bioinformatics support for next-generation sequencing data analysis, bioinformatics pipeline development and support to improve bioinformatics infrastructure and capabilities for public health labs in the region. Prior to joining FL BPHL, she was an APHL/CDC bioinformatics fellow in the Malaria Branch at the Centers for Disease Control and Prevention in Atlanta, Ga. Schmedes received her PhD in molecular genetics from the University of North Texas Health Science Center in Fort Worth, Texas and has previous molecular biology and bioinformatics research
experience in the areas of paleopathology, tick-borne diseases, human and microbial forensic genetics, microbiome genomics and malaria genomics. In her free time, she enjoys baking, knitting and traveling with her family. Schmedes can be reached by email at Sarah.Schmedes@flhealth.gov or by phone at (904) 791-1788 for all your bioinformatics needs.



Carol A. Rauch, MD, PhD is new to the Antimicrobial Resistance Laboratory Network as part of CDC's AR Lab Network Coordination and Strategy Unit, where she serves as technical laboratory liaison. She is based in Nashville with the Southeast Region, although she will work with the program as a whole. Most recently from Vanderbilt University Medical Center, Rauch has had a career in clinical microbiology where she has worked to optimize the interface with public health. She has extensive experience in laboratory quality, outbreak management, emergency and BT preparedness and healthcare-associated infections. Rauch enjoys gardening, cooking and spending time with her miniature schnauzer, Holly.

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Candida Updates

***Candida auris* PCR**

C. auris PCR for colonization screening is validated and running at the SE Regional Lab. Please be aware that swab capacity under PCR is greatly reduced, and only a small number of swabs can be tested in a day. As a result, we ask that all swab submissions are coordinated with the lab prior to submission to ensure timely testing and results.

No Retest on Known *C. auris* Positives

Based on CDC recommendations, the SE Regional lab will NOT retest swabs from patients who previously tested positive for *C. auris* if the prior positive was collected within the last three months. These swabs will be marked unsatisfactory and not tested. If the prior positive was collected more than three months ago, then the swab will be tested.

***Candida* AST Interpretations**

Lab reports for all *Candida* species do not include interpretations with the AST results as the susceptibility testing is for surveillance use only, and should not be used to inform treatment decisions.

Recipe: Melted Snowman Cookies



Recipe from allrecipes.com

Cookies

- 24 sugar cookies
- 24 large marshmallows
- 1 (.75 ounce) tube black decorating gel
- 1 (.75 ounce) tube orange decorating gel
- 75 silver nonpareils, or as desired (optional)
- 1 (.75 ounce) tube red decorating gel (optional)
- 1 (.75 ounce) tube green decorating gel (optional)

Icing

- 4 egg whites
- 8 cups confectioners' sugar, or as needed
- 1/4 cup lemon juice, or as needed

Directions

1. Beat egg whites lightly in a large bowl using an electric mixer until frothy. Slowly beat enough confectioners' sugar into egg whites to make icing that will hold shape; blend in lemon juice until desired consistency is reached.
2. Arrange cookies about one inch apart on a large sheet of waxed paper. Spread icing onto each cookie, allowing icing to drip over edges to look like melting snow.
3. Grease a microwave-safe plate. Place one marshmallow onto plate.
4. Microwave marshmallow until it starts to puff up, 20 to 30 seconds. Immediately place marshmallow on the edge of one cookie while the icing is still wet to look like a melted snowman. Repeat with remaining marshmallows and iced cookies.
5. Decorate 'melted snowmen' by piping 'twig-like arms' using black decorating gel on the icing. Make 'coal eyes' and a 'mouth' on the marshmallow using black decorating gel. Make a 'carrot nose' under the 'coal eyes' using orange decorating gel. Make 'coat buttons' by arranging silver nonpareils down the middle of the icing. Make 'scarves' or 'bow-ties' using red decorating gel or green decorating gel.
6. Allow cookies to fully dry before removing from waxed paper, at least one hour.

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TN Department of Health

TENNESSEE DEPARTMENT OF HEALTH - COMMUNICABLE AND ENVIRONMENTAL DISEASES AND EMERGENCY PREPAREDNESS

TN Laboratory Services
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Nashville, TN 37216

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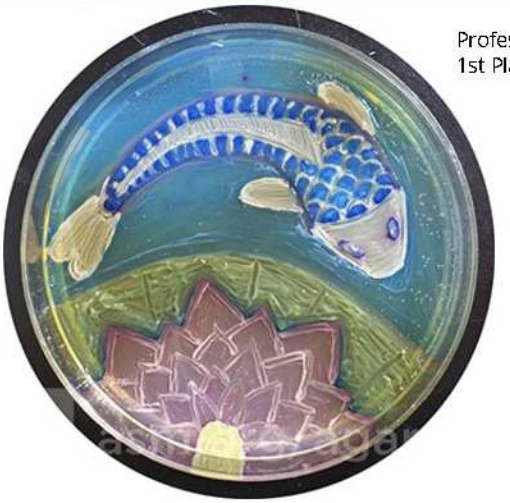
E-mail: ARLN.Health@TN.gov

If you would like to unsubscribe from our newsletter or submit an article for the next issue, please email ARLN.Health@TN.gov

2019 American Society for Microbiology Agar Art Contest



Professional Category, 1st Place

"Seemingly Simple Elegance," Arwa Hadid, Undergraduate MLS Student, Oakland University, Rochester Hills, MI, United States.

The winners of the 2019 American Society for Microbiology Agar Art Contest winners have been announced. Check out the press release HERE for more pictures of the winners and runners-up as well as write-ups on each piece and instructions if you'd like to enter the contest next year.

Sudoku

9	4		1	7	8			
		1			3		9	
5					6		3	
8						2	7	5
3		5	6		7	8		1
7	1	4						3
	6		5					7
	5		4			3		
			7	6	1		2	9

WEB SUDOKU
www.websudoku.com

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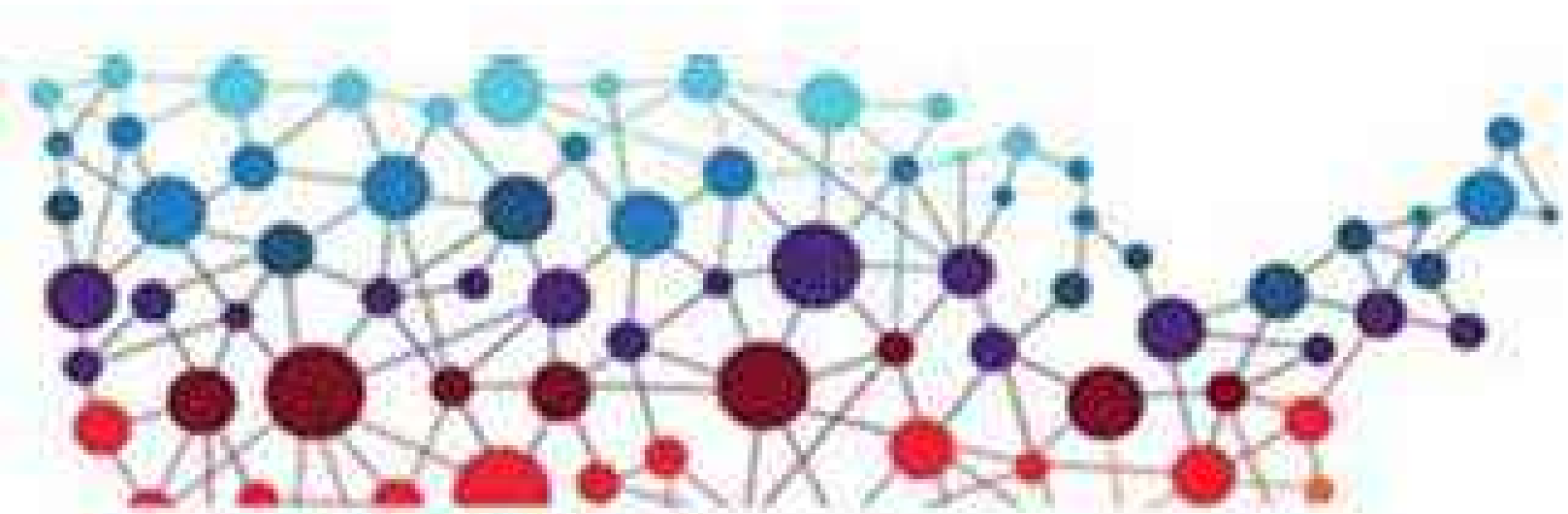
Tennessee Department of Health Authorization Number 343200. FL-DOH-20-0673-A-001885

Electronic only publication produced at no cost. October 2019



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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	2019-nCoV Key Points and Updated Guidance Documents
Date:	Monday, February 10, 2020 7:15:51 PM
Attachments:	CDC_2019-nCoV Daily Key Points__2_10_2020_final.pdf

Dear Colleagues,

Please find today's 2019-nCoV key points attached. Feel free to share amongst your staff and appropriate parties.

In addition, several guidance documents have been posted/updated on the CDC 2019-nCoV website.

Updated Guidance Documents

Information for Businesses and Employers: Interim guidance that may help prevent workplace exposures to acute respirator illness, including nCoV, in non-healthcare settings.

Information for Travelers: This page includes information about 2019 novel coronavirus (2019-nCoV) for travelers going to and returning from China, and information for aircrew and resources ship industry.

- Travelers from China arriving in the US
- Interim Recommendations for Airlines and Airline Crew: Novel Coronavirus in China
- Interim Guidance for Ships on Managing 2019 Novel Coronavirus

Interim Guidance of Emergency Medical Services (EMS) and 911 Public Safety Answering Points (PASPs) for 2019-nCoV in the US: Interim guidance for EMS including recommendations for 911 PSAPs, clinician practices, PUI/Patient transport, cleaning EMS vehicles, follow-up/reporting measures, and EMS employer responsibilities.

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV): This interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV.

Interim Considerations for Disposition of Hospitalized Patients with 2019-nCoV Infection: The following is intended to serve as a framework for patient disposition. All patients should be evaluated on a case-by-case basis and their disposition discussed with health care providers and public health departments.

Healthcare Supply of Personal Protective Equipment: CDC specific PPE recommendations based on the current 2019-nCoV situation and availability of PPE.

Frequently Asked Questions about Respirators and their Use: This document is intended to address frequently asked questions about respirators and their use.

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CDC Daily Key Points
2019 Novel Coronavirus (2019-nCoV)

February 10, 2020

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus abbreviated "2019-nCoV."
- This virus is able to spread from person-to-person and cause severe disease and death.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- Most cases are still limited to mainland China.
- Right now, this virus is not spreading in the community in the United States and the vast majority of Americans have a low risk of exposure. The greater risk is for people who have recently traveled to China or their close contacts.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.
- The U.S. public health system also is on high alert to detect cases of 2019-nCoV infection and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread.
- Extensive work has been done over the past 15 years to prepare for an influenza pandemic.
- Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current 2019-nCoV outbreak triggers a pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans. Selected materials are available from www.cdc.gov/ncov.

SITUATION UPDATE

- To date, 27 international locations (in addition to the U.S.) have reported confirmed cases of 2019-nCoV infection.
- As of February 10, 2020, at 7pm, 12 infections with 2019-nCoV have been reported in the U.S. in six states – Arizona, California, Illinois, Massachusetts, Washington, and Wisconsin.
    - To date, there have been 398 "persons under investigation" (PUIs) for possible 2019-nCoV infection reported to CDC, with 318 persons ruled

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Text in red new or updated.

out as negative. These data are updated regularly at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.

- Two instances of person-to-person spread with this virus in the United States have been detected, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- Over the weekend, the U.S. Embassy in China announced the death of the first American citizen from 2019-nCoV occurring in that country.
- CDC established a 2019-nCoV Incident Management System on January 7, 2020. On January 21, 2020, CDC activated its Emergency Operations Center to better provide ongoing support to the 2019-nCoV response.
    - As of February 7, 2020, more than 800 CDC staff members had been deployed to the 2019-nCoV Response.
- The CDC-established International Reagent Resource (IRR) is taking orders for real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) tests that can diagnose 2019-nCoV in respiratory and serum samples from clinical specimens.
- Over the coming days and weeks, state and local public health departments will begin to test for 2019-nCoV in their laboratories. Test results will be validated at CDC for a period of time, after which states will perform their own testing and report results to CDC. CDC will continue to report case counts in aggregate.
- On February 1, 2020, CDC issued a Health Alert Network (HAN) update with some updates to previously posted guidance and, for the first time, guidance on clinical care of 2019-nCoV patients.
- On February 3, CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to 2019-nCoV and implementing public health actions based on a person's risk level and clinical presentation.
- CDC is working with healthcare and industry partners to understand the supply chain for personal protective equipment (PPE) in order to adjust response actions appropriately. Based on the current 2019-nCoV situation and availability of PPE, on February 8, 2020, CDC posted:
    - "Healthcare Supply of Personal Protective Equipment" which outlines who needs PPE and who does not. (See section Use of Facemasks in U.S. below.)
    - "Strategies for Optimizing Supply of N-95 Respirators" which was posted in the face of potential ongoing 2019-nCoV transmission in the United States.
- CDC isolated the virus and sent it to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. 2019-nCoV patients to detect person-to-person spread.

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- CDC is preparing senior staff to support the WHO international senior technical mission being formed to work with Chinese public health counterparts to help improve understanding of this new disease, including learning more about transmissibility and severity.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
  - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
  - If you are a healthcare provider, be on the look-out for people who recently traveled from China and who have fever and respiratory symptoms.
  - If you are a healthcare provider caring for a 2019-nCoV patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
  - For people who have had close contact with someone infected with 2019-nCoV who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a 2019-nCoV patient.
  - For people who are ill with 2019-nCoV, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

USE OF FACEMASKS IN THE U.S.

- At this time, CDC does not recommend the use of facemasks or respirators among the general public. While limited person-to-person spread of 2019-nCoV among close contacts has been detected, this virus is not currently spreading in the community in the United States.
- In the United States, person-to-person spread has been seen only among people in close and prolonged contact with someone who has become infected with 2019-nCoV in China.
- If you are not sick:
  - Members of the general public in the United States DO NOT need to use facemasks. CDC does NOT recommend that people who are well wear a facemask to protect themselves from respiratory viruses, including 2019-nCoV.
  - Masks should be reserved for people who are sick, so they can protect others from getting infected.
- If you are sick (i.e., people with confirmed or possible 2019-nCoV infection, including patients under investigation who do not need to be hospitalized; and people with confirmed 2019-nCoV infection who were hospitalized and determined to be medically stable to go home):

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    - You should wear a facemask when you are around other people (e.g., sharing a room or vehicle) and before you enter a healthcare provider's office. This will help protect the people around from getting infected.
    - If you are not able to wear a facemask (for example, because it causes trouble breathing), then people who are in the same room with you should wear a facemask, but they should also limit the amount of time they spend in the same room with you.
- If worn properly, a facemask helps block the spread of respiratory viruses by the wearer from spreading to other people and surfaces.
- People with increased risk of exposure to 2019-nCoV, for example household contacts and caregivers of people with known or suspected 2019-nCoV, should wear a facemask if the patient is not able to wear a facemask (for example, due to difficulty breathing while wearing a facemask)
- Facemasks should be used once and then thrown away in the trash.
- Healthcare personnel should wear personal protective equipment (PPE), including respirators, when caring for confirmed or possible 2019-nCoV patients because they are in direct contact with patients, which increases their risk of exposure.
    - Respirators worn by healthcare personnel are not the same as facemasks sold in retail stores, online, etc. for public use.
    - For respirators to work effectively, they must fit snugly against the user's face to make sure particles don't pass through and infect the wearer; healthcare personnel are fit-tested for their respirators and trained to use them to be sure they work correctly.
    - Without proper training, respirators are likely to be worn incorrectly and used ineffectively.
    - Respirators and facemasks designed for general consumer use are not subject to the same regulations required for respirators in workplaces.
- There are everyday preventive actions that EVERYONE can take to prevent the spread of respiratory illnesses, including 2019-nCoV:
    - Avoid close contact with people who are sick.
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
    - Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.
    - Hands should be cleaned after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.

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TRAVEL

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to 2019 novel coronavirus.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus." The declaration became effective beginning 5 p.m. EST, Sunday, February 2, 2020.
    - Foreign nationals who have visited China in the past 14 days may not enter the United States.
    - Special precautions are required of U.S. citizens, immediate family members of U.S. citizens, and legal permanent residents entering the United States who have been in China during the past 14 days, including up to a 14-day quarantine.
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 U.S. airports.
        - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
            - If asymptomatic, American citizens and exempted persons will be subject to a mandatory 14-day quarantine at or near that location. (They will not be able to complete their itinerary.)
        - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
            - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be monitored under self-quarantine for 14 days.
    - CDC is working with public health partners to support the implementation of the travel policies detailed in the presidential proclamation (above).
    - As of February 10, about 30,000 people have been screened at U.S. airports.
    - On February 3, CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Persons with Potential

AMERICAN OVERSIGHT

2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to 2019-nCoV and implementing public health actions based on a person's risk level and clinical presentation.

Repatriated Flights & Quarantine Orders

- CDC supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents from Wuhan, China on five chartered flights.
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all the passengers (891 people) entering the United States on these planes.
- The quarantine period is for 14 days, starting from the day the passengers left Wuhan, China.
- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also will protect the health of the repatriated persons, their families, and their communities.
- Medical staff will monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC will work with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- The first group of returning passengers will complete their 14-day quarantine period on February 11. No cases of 2019-nCoV infection were detected among this group of passengers. Another 600+ persons remain under quarantine.

For more information please visit the 2019 Novel Coronavirus Outbreak Page at: https://www.cdc.gov/coronavirus/2019-ncov/index.html

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	2019-nCoV Key Points, Business and Employers Guidance, Information for Travelers
Date:	Friday, February 7, 2020 7:42:46 PM
Attachments:	CDC_2019-nCoV Daily Key Points__2_7_2020_final.pdf

Please find today's 2019-nCoV key points attached. Feel free to share amongst your staff and appropriate parities.

In addition, several guidance documents have been posted/updated on the CDC 2019-nCoV website.

Information for Businesses and Employers

Information for Travelers

AMERICAN OVERSIGHT

CDC Daily Key Points
2019 Novel Coronavirus (2019-nCoV)

February 7, 2020

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus abbreviated "2019-nCoV."
- This virus is able to spread from person-to-person and cause severe disease and death.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- Most cases are still limited to mainland China.
- Right now, this virus is not spreading in the community in the United States and the vast majority of Americans have a low risk of exposure. The greater risk is for people who have recently traveled to China or their close contacts.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.
- The U.S. public health system also is on high alert to detect cases of 2019-nCoV infection and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread.
- Extensive work has been done over the past 15 years to prepare for an influenza pandemic.
- Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current 2019-nCoV outbreak triggers a pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans. Selected materials are available from www.cdc.gov/ncov.

SITUATION UPDATE

- To date, 27 international locations (in addition to the U.S.) have reported confirmed cases of 2019-nCoV infection.
- As of February 6, 2020, at 7 pm, 12 infections with 2019-nCoV have been reported in the U.S. in six states — Arizona, California, Illinois, Massachusetts, Washington, and Wisconsin.
    - To date, there have been 337 "persons under investigation" (PUIs) for possible 2019-nCoV infection reported to CDC, with 225 persons ruled

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  - out as negative. These data are updated regularly at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
  - As part of efforts to detect cases of 2019-nCoV in the United States, CDC's laboratory had tested more than 2,000 samples as of February 6, 2020.
- Two instances of person-to-person spread with this virus in the United States have been detected, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- CDC established a 2019-nCoV Incident Management System on January 7, 2020. On January 21, 2020, CDC activated its Emergency Operations Center to better provide ongoing support to the 2019-nCoV response.
  - As of February 7, 2020, more than 800 CDC staff members had been deployed to the 2019-nCoV Response.
- The CDC-established International Reagent Resource (IRR) is taking orders for real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) tests that can diagnose 2019-nCoV in respiratory and serum samples from clinical specimens.
  - As of February 6, 2020, test kits had been sent to 33 states and 70 labs in 66 countries.
- On February 1, 2020, CDC issued a Health Alert Network (HAN) update with some updates to previously posted guidance and, for the first time, guidance on clinical care of 2019-nCoV patients.
- On February 3, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to 2019-nCoV and implementing public health actions based on a person's risk level and clinical presentation.
- CDC isolated the virus and sent it to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. 2019-nCoV patients to detect person-to-person spread.
- Also, on February 6, 2020, CDC and Customs and Border (CBP) personnel had screened about 20,000 people with recent travel history to China at U.S. airports.
- CDC is preparing senior staff to support the WHO international senior technical mission being formed to work with Chinese public health counterparts to help improve understanding of this new disease, including learning more about transmissibility and severity.

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WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people who recently traveled from China and who have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a 2019-nCoV patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - For people who have had close contact with someone infected with 2019-nCoV who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a 2019-nCoV patient.
    - For people who are ill with 2019-nCoV, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TRAVEL

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to 2019 novel coronavirus.
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    - Foreign nationals who have visited China in the past 14 days may not enter the United States.
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    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 U.S. airports.
        - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
            - If asymptomatic, American citizens and exempted persons will be subject to a mandatory 14-day quarantine

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at or near that location. (They will not be able to complete their itinerary.)

- American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
  - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
  - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be monitored under self-quarantine for 14 days.

- CDC is working with public health partners to support the implementation of the travel policies detailed in the presidential proclamation (above).
- On February 3, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to 2019-nCoV and implementing public health actions based on a person's risk level and clinical presentation.

Repatriated Flights & Quarantine Orders

- CDC supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents from Wuhan, China on five chartered flights.
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all the passengers (891 people) entering the United States on these planes.
- The quarantine period is for 14 days, starting from the day the passengers left Wuhan, China.
- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also will protect the health of the repatriated persons, their families, and their communities.
- Medical staff will monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC will work with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.

For more information please visit the 2019 Novel Coronavirus Outbreak Page at: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 CDC Media Telebriefing: Update on COVID-19 AND 2-20-20 COVID-19 CDC Key Points
Date:	Friday, February 21, 2020 11:11:26 AM
Attachments:	CDC_COVID-19_Daily Key Points_2.20.20.pdf

2-20-20 CDC COVID-19 Key Points are attached. Feel free to share with partners. See media advisory below.

Media Advisory

For Immediate Release
Friday, Feb. 21, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

Ian Brownlee, Principal Deputy Assistant Secretary,
Bureau of Consular Affairs, Department of State

When 12:15 p.m. ET Friday, February 21, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT

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A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

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U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 20, 2020

All content updated since February 19 is shown in colored text.

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2."
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- This virus that causes COVID-19 is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
- Most COVID-19 cases outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
    - Other destinations with apparent community spread of COVID-19 have been identified—Singapore, Thailand, Vietnam, South Korea, and Taiwan. Information about COVID-19 was added to the CDC destination pages for these locations on February 19.
- CDC issued a Level 1 Travel Notice (Practice Usual Precautions) for Hong Kong and Japan on February 19.
- On February 20, the State Department updated their travel guidance for Hubei Province, China to recommend that U.S. citizens reconsider travel by cruise ship to or within East Asia and the Asia-Pacific Region.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.

AMERICAN OVERSIGHT

- These measures are likely to cause some disruption.
- CDC has worked with Department of State to support the safe return of Americans overseas affected by the ongoing outbreaks of COVID-19, including most recently passengers from the *Diamond Princess* cruise ship. (See Section: "*Diamond Princess*")
- The U.S. public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
    - Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 30 international locations (in addition to the U.S.) have reported confirmed cases of COVID-19.
- As of February 19, 15 cases of COVID-19 have been reported in the U.S. in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
    - To date, there have been 479 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 412 persons ruled out as negative. These data are updated regularly at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - These numbers do not include passengers from the *Diamond Princess* cruise ship, including presumptive-positive cases, who were returned to the U.S. via State Department-chartered flights.
    - It is likely that additional cases of COVID-19 will be detected in the United States.
- On February 20, 263 people were released from federal quarantine after being returned to the U.S. from Wuhan, China via State Department-chartered flights.
    - People released from quarantine pose no health risk to their communities.
- CDC established a COVID-19 Incident Management System on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.
- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.
- CDC isolated the virus and shared this material with NIH's BEI Resources Repository for use by the broad scientific community.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

AMERICAN OVERSIGHT

- On February 3, CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. COVID-19 patients to detect person-to-person spread.
- As of February 19, CDC and Customs and Border (CBP) personnel had screened about 43,000 people with recent travel history to China at U.S. airports.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
    - Five chartered flights returned passengers from Wuhan City, China.

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    - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
    - Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
    - CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
    - At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.
- On February 18, 347 people who were under federal quarantine were released.
- On February 20, 263 people who were under federal quarantine were released.

DIAMOND PRINCESS

- CDC is supporting the Department of State-led mission to repatriate U.S. citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the U.S. government recommended that U.S. citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and have been monitored and evaluated by medical and public health personnel during the trip and after arrival.
    - Those passengers who returned from Japan are being housed separately from the people already in quarantine who returned on previous U.S. Government repatriation flights from Wuhan.
- There are more than 100 American citizens still onboard the *Diamond Princess* cruise ship or in hospitals in Japan. These citizens have been placed under travel restrictions, as have the ship's other passengers and crew.
    - After disembarkation from the *Diamond Princess*, these passengers and crew will be required to wait at least 14 days without having symptoms or a positive coronavirus test result before they are permitted to board flights to the United States.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

AMERICAN OVERSIGHT

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-21-20 CDC Media Telebriefing: Update on COVID-19 AND 2-20-20 COVID-19 CDC Key Points
Date:	Friday, February 21, 2020 11:02:40 AM
Attachments:	CDC_COVID-19_Daily Key Points_2.20.20.pdf

2-20-20 CDC COVID-19 Key Points are attached. Feel free to share with partners. See media advisory below.

Media Advisory

For Immediate Release
Friday, Feb. 21, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

Ian Brownlee, Principal Deputy Assistant Secretary,
Bureau of Consular Affairs, Department of State

When 12:15 p.m. ET Friday, February 21, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

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TRANSCRIPT

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###

U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

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February 20, 2020

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MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2."
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- This virus that causes COVID-19 is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
- Most COVID-19 cases outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
    - Other destinations with apparent community spread of COVID-19 have been identified—Singapore, Thailand, Vietnam, South Korea, and Taiwan. Information about COVID-19 was added to the CDC destination pages for these locations on February 19.
- CDC issued a Level 1 Travel Notice (Practice Usual Precautions) for Hong Kong and Japan on February 19.
- On February 20, the State Department updated their travel guidance for Hubei Province, China to recommend that U.S. citizens reconsider travel by cruise ship to or within East Asia and the Asia-Pacific Region.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.

AMERICAN OVERSIGHT

- These measures are likely to cause some disruption.
- CDC has worked with Department of State to support the safe return of Americans overseas affected by the ongoing outbreaks of COVID-19, including most recently passengers from the *Diamond Princess* cruise ship. (See Section: "*Diamond Princess*")
- The U.S. public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
    - Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 30 international locations (in addition to the U.S.) have reported confirmed cases of COVID-19.
- As of February 19, 15 cases of COVID-19 have been reported in the U.S. in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
    - To date, there have been 479 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 412 persons ruled out as negative. These data are updated regularly at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - These numbers do not include passengers from the *Diamond Princess* cruise ship, including presumptive-positive cases, who were returned to the U.S. via State Department-chartered flights.
    - It is likely that additional cases of COVID-19 will be detected in the United States.
- On February 20, 263 people were released from federal quarantine after being returned to the U.S. from Wuhan, China via State Department-chartered flights.
    - People released from quarantine pose no health risk to their communities.
- CDC established a COVID-19 Incident Management System on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.
- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.
- CDC isolated the virus and shared this material with NIH's BEI Resources Repository for use by the broad scientific community.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

AMERICAN OVERSIGHT

- On February 3, CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. COVID-19 patients to detect person-to-person spread.
- As of February 19, CDC and Customs and Border (CBP) personnel had screened about 43,000 people with recent travel history to China at U.S. airports.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
    - Five chartered flights returned passengers from Wuhan City, China.

AMERICAN OVERSIGHT

    - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
    - Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
    - CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
    - At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.
- On February 18, 347 people who were under federal quarantine were released.
- On February 20, 263 people who were under federal quarantine were released.

DIAMOND PRINCESS

- CDC is supporting the Department of State-led mission to repatriate U.S. citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the U.S. government recommended that U.S. citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and have been monitored and evaluated by medical and public health personnel during the trip and after arrival.
    - Those passengers who returned from Japan are being housed separately from the people already in quarantine who returned on previous U.S. Government repatriation flights from Wuhan.
- There are more than 100 American citizens still onboard the *Diamond Princess* cruise ship or in hospitals in Japan. These citizens have been placed under travel restrictions, as have the ship's other passengers and crew.
    - After disembarkation from the *Diamond Princess*, these passengers and crew will be required to wait at least 14 days without having symptoms or a positive coronavirus test result before they are permitted to board flights to the United States.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

AMERICAN OVERSIGHT

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

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To:	State and Local Readiness (CDC)
Subject:	2-21-20 Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19
Date:	Friday, February 21, 2020 5:26:24 PM
Attachments:	COVID-19_GuidanceList_21FEB20.pdf

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Last updated: February 21, 2020

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AMERICAN OVERSIGHT

Last updated: February 21, 2020

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AMERICAN OVERSIGHT

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- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

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AMERICAN OVERSIGHT

Last updated: February 21, 2020

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Last updated: February 21, 2020

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AMERICAN OVERSIGHT

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- Interim guidance from the CDC and Federal Aviation Administration for Air Carriers and Crewmembers

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- This guidance provides cabin crew with practical methods to protect themselves, passengers, and other crew members when someone onboard is sick with a possible contagious disease.

Businesses, Employers, and Schools

Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19), February 2020

- Interim guidance that may help prevent workplace exposures to acute respiratory illness, including COVID-19, in non-healthcare settings.

Healthcare Professionals

Evaluating and Reporting Persons Under Investigation (PUI)

- The Centers for Disease Control and Prevention (CDC) clinical criteria for a COVID-19 person under investigation (PUI). Subject to change as additional information becomes available.

Flowchart to Identify and Assess 2019 Novel Coronavirus

- Flowchart for the evaluation of patients who may be ill with or who may have been exposed to COVID-19.

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or Persons Under Investigation for SARS-CoV-2 in Healthcare Settings

- Interim infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.**

AMERICAN OVERSIGHT

Last updated: February 21, 2020

Interim Guidance of Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PASPs) for COVID-19 in the United States

- Interim guidance for all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work

Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020

- Interim guidance for the collection and submission of postmortem specimens from deceased persons under investigation (PUI) for COVID-19. This document also provides recommendations for biosafety and infection control practices during specimen collection and handling, including during autopsy procedures. The guidance can be utilized by medical examiners, coroners, pathologists, other workers involved in the postmortem care of deceased PUI, and local and state health departments.

Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- Interim guidance for healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) to help prevent the spread of COVID-19 in healthcare facilities.

Interim Clinical Guidance for Management of Patients with Confirmed COVID-19

- Interim guidance for clinicians caring for patients with confirmed COVID-19

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance for staff at local and state health departments, infection prevention and control professionals, and healthcare personnel who are coordinating the home care and isolation[1] of people with confirmed or suspected 2019-nCoV infection, including persons under investigation (see Criteria to Guide Evaluation of Persons Under Investigation (PUI) for 2019-nCoV).

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV. For guidance on assessment and management of exposure risk in non-healthcare settings, refer to the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings.

Infection Control

Interim Guidance for Preventing the Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities

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- Interim guidance to help prevent COVID-19 from spreading among people in their homes and in other residential communities.

Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19

- Interim guidance to help healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation to help prevent the spread of COVID-19 in the community.

Maritime

Interim Guidance for Ships on Managing Suspected Coronavirus Disease 2019

- Interim guidance for ships originating from, or stopping in, the United States to help prevent, detect, and medically manage suspected 2019-nCoV infections.

Personal Protective Equipment (PPE)

Healthcare Supply of Personal Protective Equipment

- CDC specific PPE recommendations based on the current COVID-19 situation and availability of PPE.

Public Health Officials

Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).

Case Report Form for 2019 Novel Coronavirus

- The Case Report Form is intended for local and state health departments who have a laboratory confirmed case of 2019-nCoV to report to CDC.

Pandemic Preparedness Resources

- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

Pregnant Women and Children

Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19

- Interim guidance for women who are confirmed to have COVID-19 or are persons-under-investigation (PUI) for COVID-19 and are currently breastfeeding.

AMERICAN OVERSIGHT

Last updated: February 21, 2020

Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings

- Interim for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings.

Travelers

Information for Travelers

- This page includes information about 2019 novel coronavirus (COVID-19) for travelers going to and returning from China, and information for aircrew and resources ship industry.

Travelers to China

- Travel recommendations for travel to China

Travelers from China arriving in the U.S.

- Information for travelers from China arriving to the U.S.

Risk Assessment

Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-associated or Community Settings

- Interim guidance to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for healthcare providers with potential exposure to COVID-19.

Frequently Asked Questions (FAQs)

Frequently Asked Questions and Answers about COVID-19

- General FAQs

Healthcare Infection Prevention and Control FAQs for COVID-19

- **Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.
- **What is it for:** This creates FAQs to support the existing Healthcare Infection Prevention and Control Guidance for COVID-19.
- **How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

Frequently Asked Questions and Answers: Coronavirus Disease 2019 (COVID-19) and Pregnancy

AMERICAN OVERSIGHT

Last updated: February 21, 2020

- This is a list of frequently asked questions and answers for pregnant women, infants, and women who are breastfeeding.

Frequently Asked Questions about Respirators and their Use

Healthcare Professionals: Frequently Asked Questions and Answers

- FAQs for healthcare professionals

Information for Laboratories COVID-19 Requests for Diagnostic Panels and Virus

- FAQs for lab professionals

Travel: Frequently Asked Questions and Answers

- General travel-related FAQs

Additional Resources

2020 Health Alert (HAN) Messages: CDC's Health Alert Network (HAN) is CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, tribal, and local public health practitioner; clinicians; and public health laboratories.

CDC Newsroom: CDC Media Telebriefing: Update on COVID-19: CDC provides an update periodically to media on the COVID-19 response. Sign up for media announcements.

Clinician Outreach and Communication Activity (COCA) Calls/Webinars: During COCA Calls/Webinars, subject matter experts present key emergency preparedness and response topics, followed by meaningful Q&A with participants. The call or webinar will offer the most up to date information on guidance for clinicians.

Travel Health Notices: Travel Health Notices inform travelers and clinicians about current health issues that impact travelers' health, like disease outbreaks, special events or gatherings, and natural disasters, in specific international destinations.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-25-2020 CDC COVID-19 Daily Key Points and STLT Westerdam Information
Date:	Wednesday, February 26, 2020 1:10:07 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_25_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points for Tuesday, February 25, 2020.

Below you will find a CDC media statement regarding the Westerdam cruise ship.

> Westerdam Media Statement:
>
> No testing of passengers from the Westerdam Cruise Ship for SARS-CoV-2, the virus that causes COVID-19, has been done at CDC. CDC is aware that an American passenger on the Westerdam tested positive for infection with SARS-CoV-2 in Malaysia and that two sequential tests on samples from that same person were negative. CDC is aware that follow-up testing among more than 1,500 passengers from the Westerdam has all been negative.
>
> At this time, CDC considers passengers from the Westerdam to be at "low risk" of SARS-CoV-2 infection during the 14 days after their last exposure per the agency's Risk Assessment guidance at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html. Given this level of risk, testing of Westerdam passengers for SARS-CoV-2 is not recommended unless additional exposures are identified to warrant testing.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 25, 2020

All content updated since February 24 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with apparent community spread of COVID-19 include Hong Kong, Iran, Italy, Japan, Singapore, South Korea, Taiwan, and Thailand.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection. For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, risk assessment would be different.
- Global efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

AMERICAN OVERSIGHT

- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions would be the most important response strategy.

SITUATION UPDATE

- On February 25, a *Morbidity and Mortality Weekly Report* (*MMWR*) Update was published titled "Public Health Response to the Coronavirus Disease 2019 Outbreak — United States, February 24, 2020." (See Section "MMWR Update.")
- To date, 37 international locations (including the U.S.) have reported confirmed cases of COVID-19.
- On February 24, CDC issued a Level 2 Travel Notices (Practice Enhanced Precautions) for Iran and Italy.
- On February 24, CDC issued Level 3 Travel Alert Notices (Practice Usual Precautions) for South Korea.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- This is consistent with guidance by the U.S. State Department.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan).
- Fourteen cases of COVID-19 have been detected in California, Illinois, Massachusetts, Washington, and Wisconsin through U.S. public health surveillance.
- Two of these cases occurred through person-to-person spread. The remaining cases all were in persons who had travel to China.
- 43 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the Diamond Princess. (That includes 3 people repatriated from Wuhan and 40 people who were repatriated from the Diamond Princess, an increase of 4 since yesterday.)
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

***MMWR* UPDATE:**

- As of February 23, 2020, there were 76,936 reported cases in mainland China and 1,875 cases in locations outside mainland China.
- Fourteen cases have been diagnosed in the United States, and an additional 39 cases have occurred among repatriated persons from high-risk settings, for a current total of 53 cases within the United States.
    - No deaths have been reported in the United States.

AMERICAN OVERSIGHT

- CDC and partners are implementing aggressive measures to slow and contain the spread of COVID-19 in the United States.
    - Although these measures might not prevent widespread transmission of the virus in the United States, they are being implemented to
        1) slow the spread of illness;
        2) provide time to better prepare state and local health departments, health care systems, businesses, educational organizations, and the general public in the event that widespread transmission occurs; and
        3) better characterize COVID-19 to guide public health recommendations and the development and deployment of medical countermeasures, including diagnostics, therapeutics, and vaccines.
    - CDC's COVID-19 Response by the numbers:
        - As of February 24, 2020, a total of 1,336 CDC staff members have been involved in the COVID-19 response, including clinicians (i.e., physicians, nurses, and pharmacists), epidemiologists, veterinarians, laboratorians, communicators, data scientists and modelers, and coordination staff members.
        - CDC teams work with the Department of Homeland Security at 11 airports to screen all travelers from China who are returning to the United States.
        - As of February 23, 2020
            - A total of 46,016 air travelers have been screened at these 11 U.S. airports.
            - Eleven travelers were referred to a hospital and tested for infection; one tested positive and was isolated and managed medically.
            - Seventeen travelers were quarantined for 14 days because of travel from Hubei Province, China.
            - 479 persons for 43 states and territories had been or are being tested for COVID-19; 14 (3%) had a positive test, 412 (86%) had a negative test, and 53 (11%) test results are pending.
        - During January 18-Febrary 23, 2020, CDC laboratories used real-time reverse transcription–polymerase chain reaction (RT-PCR) to test 2,620 specimens from 1,007 persons for SARS-CoV-2.
        - During January 29-February 6, 2020, the U.S. government repatriated 808 U.S. citizens, residents, and their families from Hubei Province, China, on five chartered flights.
        - CDC posts travel notices to inform travelers and clinicians about current health issues that could affect travelers' health.
- CDC and partners are preparing for widespread transmission of COVID-19 in U.S. communities.
- The report is available online.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.

AMERICAN OVERSIGHT

- If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
- If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
- If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
- For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 400 specimens per day.
- CDC's testing capacity is more than adequate to meet current testing demands. (There is no backlog of tests at CDC.)
- A number of laboratories are able to test for the virus that causes COVID-19 using CDC's test.
- All confirmatory testing for COVID-19 continues to be performed at CDC. (All positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.)
- CDC continues to work on remanufacturing test kits to detect the virus that causes COVID-19, which will be distributed following rigorous quality control processes.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness.**
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.

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        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.
    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
- **Supporting communities, businesses, and schools:**
    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
    - **Developing guidance for childcare programs, K-12 schools, and colleges/universities** to help them plan and prepare for COVID-19 and respond if there is a local outbreak in their community.
        - Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
        - Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community mitigation strategies.
- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.

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- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. community NPIs (social distancing measures and school closures and dismissals); and
    3. environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-25-2020 CDC COVID-19 Daily Key Points and STLT Westerdam Information
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AMERICAN OVERSIGHT

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- The report is available online.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.

AMERICAN OVERSIGHT

- If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
- If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
- If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
- For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 400 specimens per day.
- CDC's testing capacity is more than adequate to meet current testing demands. (There is no backlog of tests at CDC.)
- A number of laboratories are able to test for the virus that causes COVID-19 using CDC's test.
- All confirmatory testing for COVID-19 continues to be performed at CDC. (All positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.)
- CDC continues to work on remanufacturing test kits to detect the virus that causes COVID-19, which will be distributed following rigorous quality control processes.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness.**
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.

AMERICAN OVERSIGHT

        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.
    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
- **Supporting communities, businesses, and schools:**
    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
    - **Developing guidance for childcare programs, K-12 schools, and colleges/universities** to help them plan and prepare for COVID-19 and respond if there is a local outbreak in their community.
        - Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
        - Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community mitigation strategies.
- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.

AMERICAN OVERSIGHT

- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. community NPIs (social distancing measures and school closures and dismissals); and
    3. environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-25-2020 CDC COVID-19 Daily Key Points and STLT Westerdam Information
Date:	Wednesday, February 26, 2020 1:06:57 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_25_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points for Tuesday, February 25, 2020.

Below you will find a CDC media statement regarding the Westerdam cruise ship.

> Westerdam Media Statement:
>
> No testing of passengers from the Westerdam Cruise Ship for SARS-CoV-2, the virus that causes COVID-19, has been done at CDC. CDC is aware that an American passenger on the Westerdam tested positive for infection with SARS-CoV-2 in Malaysia and that two sequential tests on samples from that same person were negative. CDC is aware that follow-up testing among more than 1,500 passengers from the Westerdam has all been negative.
>
> At this time, CDC considers passengers from the Westerdam to be at "low risk" of SARS-CoV-2 infection during the 14 days after their last exposure per the agency's Risk Assessment guidance at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html. Given this level of risk, testing of Westerdam passengers for SARS-CoV-2 is not recommended unless additional exposures are identified to warrant testing.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 25, 2020

All content updated since February 24 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with apparent community spread of COVID-19 include Hong Kong, Iran, Italy, Japan, Singapore, South Korea, Taiwan, and Thailand.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection. For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, risk assessment would be different.
- Global efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

AMERICAN OVERSIGHT

- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions would be the most important response strategy.

SITUATION UPDATE

- On February 25, a *Morbidity and Mortality Weekly Report* (*MMWR*) Update was published titled "Public Health Response to the Coronavirus Disease 2019 Outbreak — United States, February 24, 2020." (See Section "MMWR Update.")
- To date, 37 international locations (including the U.S.) have reported confirmed cases of COVID-19.
- On February 24, CDC issued a Level 2 Travel Notices (Practice Enhanced Precautions) for Iran and Italy.
- On February 24, CDC issued Level 3 Travel Alert Notices (Practice Usual Precautions) for South Korea.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- This is consistent with guidance by the U.S. State Department.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan).
- Fourteen cases of COVID-19 have been detected in California, Illinois, Massachusetts, Washington, and Wisconsin through U.S. public health surveillance.
- Two of these cases occurred through person-to-person spread. The remaining cases all were in persons who had travel to China.
- 43 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the Diamond Princess. (That includes 3 people repatriated from Wuhan and 40 people who were repatriated from the Diamond Princess, an increase of 4 since yesterday.)
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

***MMWR* UPDATE:**

- As of February 23, 2020, there were 76,936 reported cases in mainland China and 1,875 cases in locations outside mainland China.
- Fourteen cases have been diagnosed in the United States, and an additional 39 cases have occurred among repatriated persons from high-risk settings, for a current total of 53 cases within the United States.
    - No deaths have been reported in the United States.

AMERICAN OVERSIGHT

- CDC and partners are implementing aggressive measures to slow and contain the spread of COVID-19 in the United States.
    - Although these measures might not prevent widespread transmission of the virus in the United States, they are being implemented to
        1) slow the spread of illness;
        2) provide time to better prepare state and local health departments, health care systems, businesses, educational organizations, and the general public in the event that widespread transmission occurs; and
        3) better characterize COVID-19 to guide public health recommendations and the development and deployment of medical countermeasures, including diagnostics, therapeutics, and vaccines.
    - CDC's COVID-19 Response by the numbers:
        - As of February 24, 2020, a total of 1,336 CDC staff members have been involved in the COVID-19 response, including clinicians (i.e., physicians, nurses, and pharmacists), epidemiologists, veterinarians, laboratorians, communicators, data scientists and modelers, and coordination staff members.
        - CDC teams work with the Department of Homeland Security at 11 airports to screen all travelers from China who are returning to the United States.
        - As of February 23, 2020
            - A total of 46,016 air travelers have been screened at these 11 U.S. airports.
            - Eleven travelers were referred to a hospital and tested for infection; one tested positive and was isolated and managed medically.
            - Seventeen travelers were quarantined for 14 days because of travel from Hubei Province, China.
            - 479 persons for 43 states and territories had been or are being tested for COVID-19; 14 (3%) had a positive test, 412 (86%) had a negative test, and 53 (11%) test results are pending.
        - During January 18-Febrary 23, 2020, CDC laboratories used real-time reverse transcription–polymerase chain reaction (RT-PCR) to test 2,620 specimens from 1,007 persons for SARS-CoV-2.
        - During January 29-February 6, 2020, the U.S. government repatriated 808 U.S. citizens, residents, and their families from Hubei Province, China, on five chartered flights.
        - CDC posts travel notices to inform travelers and clinicians about current health issues that could affect travelers' health.
- CDC and partners are preparing for widespread transmission of COVID-19 in U.S. communities.
- The report is available online.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.

AMERICAN OVERSIGHT

- If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
- If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
- If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
- For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 400 specimens per day.
- CDC's testing capacity is more than adequate to meet current testing demands. (There is no backlog of tests at CDC.)
- A number of laboratories are able to test for the virus that causes COVID-19 using CDC's test.
- All confirmatory testing for COVID-19 continues to be performed at CDC. (All positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.)
- CDC continues to work on remanufacturing test kits to detect the virus that causes COVID-19, which will be distributed following rigorous quality control processes.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness.**
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.

AMERICAN OVERSIGHT

        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.
    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
- **Supporting communities, businesses, and schools:**
    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
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NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community mitigation strategies.
- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.

AMERICAN OVERSIGHT

- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. community NPIs (social distancing measures and school closures and dismissals); and
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- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 2-26-20 CDC COVID-19 Key Points and CDC"s New COVID-19 "What"s New Weekly Update"
Date: Thursday, February 27, 2020 8:20:22 AM
Attachments: CDC_COVID-19_Daily Key Points__2_26_2020.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Wednesday, February 26, 2020. Feel free to share among partners and appropriate parties.

Thank you,

State Coordination Task Force

EPIC Extra

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

Dear CDC EPIC Partners and Subscribers,

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

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

Sincerely,

CDC's EPIC Team

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 26, 2020

All content updated since February 25 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with widespread or sustained community spread of COVID-19 include China, Iran, Italy, Japan, and South Korea.
- Other destinations with instances of apparent community spread include Hong Kong, Singapore, Taiwan, Thailand, and Vietnam.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection.
    - For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- CDC expects that more cases will be reported in the United States, including person-to-person spread.
- Global efforts at this time are focused concurrently on containing spread of and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.

AMERICAN OVERSIGHT

- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions (NPIs) would be the most important response strategy. NPIs simultaneously help contain the spread of disease and reduce the impact of disease.

SITUATION UPDATE

- To date, 42 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Algeria, Austria, Brazil, Croatia, Switzerland.
- CDC is reviewing and updating their travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Iran, Italy, and Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 15 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Two of these cases occurred through person-to-person spread.
    - On February 26, CDC confirmed an infection with the virus that causes COVID-19 in a person who reportedly did not have relevant travel history or exposure to another COVID-19 patient.
    - It's possible this could be an instance of community spread of COVID-19, which would be the first time that has happened in the United States.
    - Community spread means spread of an illness for which the source of infection is unknown.
    - It's also possible, however, that the patient may have been exposed to a returned traveler who was infected.
    - All the remaining cases detected through the U.S. public health system were in persons who had travel to China.
- 45 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 42 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.

AMERICAN OVERSIGHT

- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- CDC and FDA have developed a protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
- By the end of this week, at least 40 public health laboratories should be able to begin testing using existing kits in their laboratories.
- Further, FDA and CDC have identified additional kits that will be evaluated and could be shipped to public health laboratories.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 400 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.

AMERICAN OVERSIGHT

- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness**.
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.
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- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
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    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
    - **Developing guidance for childcare programs, K-12 schools, and colleges/universities** to help them plan and prepare for COVID-19 and respond if there is a local outbreak in their community.

AMERICAN OVERSIGHT

- Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
- Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community mitigation strategies.
- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.
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- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 2-26-20 CDC COVID-19 Key Points and CDC"s New COVID-19 "What"s New Weekly Update"
Date: Thursday, February 27, 2020 8:23:04 AM
Attachments: CDC_COVID-19_Daily Key Points__2_26_2020.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Wednesday, February 26, 2020. Feel free to share among partners and appropriate parties.

Thank you,

State Coordination Task Force

EPIC Extra

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

Dear CDC EPIC Partners and Subscribers,

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

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

Sincerely,

CDC's EPIC Team

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 26, 2020

All content updated since February 25 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with widespread or sustained community spread of COVID-19 include China, Iran, Italy, Japan, and South Korea.
- Other destinations with instances of apparent community spread include Hong Kong, Singapore, Taiwan, Thailand, and Vietnam.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection.
    - For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- CDC expects that more cases will be reported in the United States, including person-to-person spread.
- Global efforts at this time are focused concurrently on containing spread of and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.

AMERICAN OVERSIGHT

- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions (NPIs) would be the most important response strategy. NPIs simultaneously help contain the spread of disease and reduce the impact of disease.

SITUATION UPDATE

- To date, 42 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Algeria, Austria, Brazil, Croatia, Switzerland.
- CDC is reviewing and updating their travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Iran, Italy, and Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 15 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Two of these cases occurred through person-to-person spread.
    - On February 26, CDC confirmed an infection with the virus that causes COVID-19 in a person who reportedly did not have relevant travel history or exposure to another COVID-19 patient.
    - It's possible this could be an instance of community spread of COVID-19, which would be the first time that has happened in the United States.
    - Community spread means spread of an illness for which the source of infection is unknown.
    - It's also possible, however, that the patient may have been exposed to a returned traveler who was infected.
    - All the remaining cases detected through the U.S. public health system were in persons who had travel to China.
- 45 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 42 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.

AMERICAN OVERSIGHT

- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- CDC and FDA have developed a protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
- By the end of this week, at least 40 public health laboratories should be able to begin testing using existing kits in their laboratories.
- Further, FDA and CDC have identified additional kits that will be evaluated and could be shipped to public health laboratories.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 400 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.

AMERICAN OVERSIGHT

- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
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    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
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    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.
    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
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    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
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    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
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AMERICAN OVERSIGHT

- Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
- Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
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To: State and Local Readiness (CDC)
Subject: 2-26-20 CDC COVID-19 Key Points and CDC"s New COVID-19 "What"s New Weekly Update"
Date: Thursday, February 27, 2020 8:17:36 AM
Attachments: CDC_COVID-19_Daily Key Points__2_26_2020.pdf

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February 26, 2020

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 2-28-2020 CDC Media Telebriefing: Update on COVID-19
Date: Friday, February 28, 2020 11:22:03 AM

Media Advisory

For Immediate Release
Friday Feb. 28, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Friday, Feb. 28, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 6656039

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

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

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 2-28-2020 CDC Media Telebriefing: Update on COVID-19
Date: Friday, February 28, 2020 11:24:29 AM

Media Advisory

For Immediate Release
Friday Feb. 28, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	2-28-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, February 28, 2020 11:19:19 AM

Media Advisory

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Friday Feb. 28, 2020

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AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: 3 PM EST TODAY- COVID-19 Press Briefing Livestream
Date: Tuesday, February 25, 2020 2:25:01 PM

Dear State and Local Partners,

Today, the Department of Health and Human Services (HHS) will host a press briefing to provide an update on the Administration's response to COVID-19.

You can join the briefing via livestream at https://www.hhs.gov/live/live-1/index.html#11607

As always, please do not hesitate to contact me if you have questions.
Darcie Johnston,
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-11-20 CDC COVID-19 Key Points, Grand Princess Movement and Monitoring Summary, and Community Intervention and PPE Guidance
Date:	Thursday, March 12, 2020 8:09:44 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_11_2020_FINAL.pdf GP movement monitoring Exec Sum FINAL 20200310.pdf

Dear Colleagues,

Attached please find the **CDC COVID-19 Key Points for March 11, 2020.** Feel free to share with partners and appropriate parties.

Also attached, is the **Grand Princess Movement and Public Health Monitoring executive summary**.

Finally, below are links to new/updated **CDC COVID-19 Community Intervention and PPE Guidance**.

Preventing COVID-19 Spread in Communities:
https://www.cdc.gov/coronavirus/2019-ncov/community/index.html

I**mplementation of mitigation strategies for communities:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf

Healthcare Supply of Personal Protective Equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 11, 2020 as of 9:55pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 938 confirmed and presumptive positive cases of COVID-19
  - 29 COVID-19 related deaths
  - 38 states and the District of Columbia.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of places, including in the states of California, Washington, and New York in the United States.
- There are 938 reported U.S. cases of COVID-19 from 38 states, New York City, and the District of Columbia. New states reporting cases since yesterday include South Dakota and Michigan.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- More cases of COVID-19 are expected in the United States in the coming days, including more instances of community spread.
- As the outbreak continues, at some point, widespread transmission of COVID-19 in the United States is expected occur.
- Many people will get sick, but based on what is known about this virus, most people will not develop serious illness.
- Based on data out of China, where this virus first emerged, older adults and persons of all ages who have serious long-term health problems seem to be at higher risk for more serious COVID-19 illness.
  - It's important that people who are at higher risk of serious COVID-19 illness take special precautions to reduce their risk of getting sick.
  - CDC has guidance for what people at higher risk should do at this time.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

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SITUATION UPDATE

- 938 reported cases of COVID-19 have been detected in Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York (and New York City), North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 75 of these cases occurred through close contact with another case.
    - 92 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
    - 771 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 10, 79 state and local public health labs in 50 states and the District of Columbia have verified they are successfully using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 10, 2020, CDC and local and state public health laboratories had tested a total of 11,079 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.
- CDC also recommends that older adults and travelers with underlying health issues avoid situations that put them at increased risk for more severe disease, including avoiding non-essential travel on long plane trips.
- On March 11, WHO made the assessment that COVID-19 can be characterized as a pandemic.

NEW GUIDANCE

- On March 10, CDC posted "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission."
- This document is a framework for actions which local and state health departments can recommend in their community to both prepare for and mitigate community transmission of COVID-19 in the United States.
- Selection and implementation of these actions should be guided by the local characteristics of disease transmission, local population demographics, and public health and healthcare system capacity.

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PANDEMIC DEFINITION:

- Pandemics happen when a disease emerges to infect people easily and spreads from person to person in an efficient and sustained way globally.
- In 2009, WHO declared the outbreak of the H1N1 influenza a global pandemic.
- The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health threat for months.
- CDC has been implementing its pandemic preparedness and response plans, working on multiple fronts, including providing specific guidance on measures to prepare communities to respond to local spread of the virus that causes COVID-19.
- On March 10, CDC posted "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission"

WHO KEY POINTS ON COVID-19 AS PANDEMIC:

- On March 11, WHO made the assessment that COVID-19 can be characterized as a pandemic.
    - WHO has been assessing this outbreak around the clock, since the news of this virus first emerged on December 31, 2019.
    - In the past two weeks, the number of cases of COVID-19 outside China has increased 13-fold, and the number of countries with cases has tripled.
    - There are now more than 118,000 cases in 114 countries, and 4,291 people have lost their lives.
    - The number of cases, the number of deaths, and the number of affected countries are all expected to increase.
    - WHO believes that what the world is seeing can be characterized as a pandemic.
    - All countries can still change the course of this pandemic with decisive action.
    - At this time, WHO does not have a formal process or criteria for defining an outbreak as a pandemic and this characterization does not change the scale or strategy of the WHO response.

INFECTION CONTROL/MASK GUIDANCE

- On March 10, CDC published updated Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings.
- Respiratory protection of healthcare workers is a priority and is especially important during aerosol-generating procedures for patients.
- Healthcare facilities are increasingly unable to procure reliable and sufficient infection control supplies, including N95 respirators.
- Because of supply demands associated with the COVID-19 response, CDC is updating its interim COVID-19 infection control guidance for the healthcare setting.
    - The aim of the revised interim guidance is to prioritize the use of N95 respirators and other respiratory protection devices during high-risk procedures, while still protecting healthcare personnel with facemasks and eye protection during other routine patient care activities in the setting of temporary respirator shortages.

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    - This interim guidance aims to support healthcare facilities in practical decision-making at the local level.
    - This guidance also outlines multiple interventions that can be used to enhance protection of healthcare personnel.
- The spread of COVID-19 can be stopped in many ways, such as prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- Employers and healthcare workers should remember the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
    - All healthcare facilities should be reviewing their infection control supply inventories and taking steps to optimize supplies. This is particularly true for facilities that perform aerosol-generating procedures, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
    - The anticipated timeline for return to routine levels of PPE is not known.
- CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available. CDC has also provided a companion checklist to help healthcare facilities prioritize the implementation of the strategies.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not currently have respiratory protection programs or fit-tested HCP.
    - These facilities would not be able to implement all of the recommended infection control interventions in the previous version of this guidance.
    - Without respiratory protection programs and fit testing, unnecessary transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.

PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- Right now, some people are at higher risk of exposure/infection, including:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of having been exposed.

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PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness.
- The people who are at greatest risk are those who are older and those who have serious long-term health conditions like diabetes, heart disease, or lung disease.
- This seems to be a disease that affects adults, and older adults, most seriously.
    - Starting at age 60, there is an increasing risk of severe disease and the risk increases with age.
    - The highest risk of serious illness and death is in people older than 80 years.
- People with serious underlying health conditions also are more likely to develop serious outcomes including death.
- Reports out of China that looked at more than 70,000 COVID-19 patients found that about 80% of illness was mild and people recovered. 15% to 20% developed serious illness.
- Of the more than 70,000 cases, only about 2% were in people younger than 19.
- These are early data and more information from countries outside of China, including experience here in the United States, will inform the public health response as time goes on. For now, data suggest that measures should be taken to protect America's oldest population, who are most vulnerable to severe COVID-19 illness.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and
        - People who have been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)

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        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
    - CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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The objectives of this plan are to ensure that all passengers disembark as quickly as possible; receive screening for health concerns and testing for COVID-19 if desired; and quickly travel to their home state if possible. HHS developed this plan to remove all ticketed passengers from the Grand Princess cruise ship moored in Oakland Harbor, CA, and transport them to their home states where they can continue to be monitored by State/Commonwealth and local public health authorities. HHS will organize and fund all physical movements, public health monitoring, and associated logistics between Oakland Harbor and every person's final destination in the United States.

Physical Movement

Coming off the ship, HHS medical teams will use CDC guidelines to screen all passengers and determine if any passengers require additional evaluation for COVID-19; and identify those who require immediate medical attention. Passengers will be transferred by bus to an air terminal and then flown by contract aircraft to one of several U.S. military installations outside of California. If preferred by the state, HHS can attempt to send passengers directly to their home states, though this must be balanced with the need to remove all passengers from the ship as quickly as possible. At the military installations, HHS medical teams will use CDC guidelines to screen passengers for symptoms again, assign risk strata, and initiate health monitoring as appropriate. Those who develop confirmed COVID-19 will be transported to an HHS care site or local health facility.

Other U.S. residents who are asymptomatic may travel to their home states regardless of their testing status (i.e., refused testing, test result pending, negative result, or positive result). If allowed to return to their home states, passengers will be flown as soon as possible by charter flight to an agreed upon airport, after which ground transportation will also be coordinated with state and local authorities. Upon arrival at their final destinations, travelers will fall under the authorities of state and local public health officials for additional monitoring (if needed) and other public health actions as determined by the state and local health authorities. State and local health officials may utilize any public health authority as directed by state policy, but are highly encouraged to follow CDC guidance.

All passengers will remain under federal health authority until responsibility for individual monitoring and supervision is transferred to a state or local health official. **State Executives and/or senior health officials may indicate that they are prepared to receive passengers through written communication (confirmatory email) with the Regional Emergency Coordinators.** State officials may also indicate a requirement for final SARS-CoV-2 test results prior to individual transfer, recognizing that passengers have the option to refuse testing. Those who are positive for SARS-COV-2 will travel separately from those who are negative or unknown.

Public Health Monitoring

Prior to leaving California, any person who has or develops significant symptoms of any kind will be taken to an HHS care site (if symptoms are mild to moderate) in Oakland Harbor or a local hospital if they require care beyond the local HHS capability. HHS health care teams will also assist passengers throughout their movements and monitoring periods with any acute medical conditions, management of chronic conditions, and coordinate with the patients' personal physicians as needed. Passengers who develop respiratory symptoms at any time will be taken to an HHS care site or local health facility until COVID-19 can be ruled out.

Following their arrival at one of the military installations (in California or elsewhere), HHS will coordinate with state and local health authorities to offer COVID-19 testing. HHS teams will conduct appropriate oropharyngeal/nasal swabs and send those samples to a local laboratory. Depending on

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individual location at the time that test results are available, the laboratory will send test results to CDC as required by protocol, to the HHS health monitoring team at the military installation, and/or the passenger's home state public health authority.

Passengers (patients) who remain under HHS care for COVID-19 will remain isolated until resolution of symptoms and negative SARS-CoV-2 PCR results from at least 2 consecutive sets of NP/OP swabs collected at least 24 hours apart. Other patients under HHS care who have non-COVID-19 health conditions will be released after 14 days of health monitoring and stabilization of other health conditions. As needed, patients will be transported to a community health center or hospital if their care needs are beyond the capabilities of the HHS medical team or if they require continued inpatient care, convalescence, or rehabilitation after 14 days.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-11-20 CDC COVID-19 Key Points, Grand Princess Movement and Monitoring Summary, and Community Intervention and PPE Guidance
Date:	Thursday, March 12, 2020 8:11:34 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_11_2020_FINAL.pdf GP movement monitoring Exec Sum FINAL 20200310.pdf

Dear Colleagues,

Attached please find the **CDC COVID-19 Key Points for March 11, 2020.** Feel free to share with partners and appropriate parties.

Also attached, is the **Grand Princess Movement and Public Health Monitoring executive summary**.

Finally, below are links to new/updated **CDC COVID-19 Community Intervention and PPE Guidance**.

Preventing COVID-19 Spread in Communities:
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        - People who have been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)

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        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
    - CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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The objectives of this plan are to ensure that all passengers disembark as quickly as possible; receive screening for health concerns and testing for COVID-19 if desired; and quickly travel to their home state if possible. HHS developed this plan to remove all ticketed passengers from the Grand Princess cruise ship moored in Oakland Harbor, CA, and transport them to their home states where they can continue to be monitored by State/Commonwealth and local public health authorities. HHS will organize and fund all physical movements, public health monitoring, and associated logistics between Oakland Harbor and every person's final destination in the United States.

Physical Movement

Coming off the ship, HHS medical teams will use CDC guidelines to screen all passengers and determine if any passengers require additional evaluation for COVID-19; and identify those who require immediate medical attention. Passengers will be transferred by bus to an air terminal and then flown by contract aircraft to one of several U.S. military installations outside of California. If preferred by the state, HHS can attempt to send passengers directly to their home states, though this must be balanced with the need to remove all passengers from the ship as quickly as possible. At the military installations, HHS medical teams will use CDC guidelines to screen passengers for symptoms again, assign risk strata, and initiate health monitoring as appropriate. Those who develop confirmed COVID-19 will be transported to an HHS care site or local health facility.

Other U.S. residents who are asymptomatic may travel to their home states regardless of their testing status (i.e., refused testing, test result pending, negative result, or positive result). If allowed to return to their home states, passengers will be flown as soon as possible by charter flight to an agreed upon airport, after which ground transportation will also be coordinated with state and local authorities. Upon arrival at their final destinations, travelers will fall under the authorities of state and local public health officials for additional monitoring (if needed) and other public health actions as determined by the state and local health authorities. State and local health officials may utilize any public health authority as directed by state policy, but are highly encouraged to follow CDC guidance.

All passengers will remain under federal health authority until responsibility for individual monitoring and supervision is transferred to a state or local health official. **State Executives and/or senior health officials may indicate that they are prepared to receive passengers through written communication (confirmatory email) with the Regional Emergency Coordinators.** State officials may also indicate a requirement for final SARS-CoV-2 test results prior to individual transfer, recognizing that passengers have the option to refuse testing. Those who are positive for SARS-COV-2 will travel separately from those who are negative or unknown.

Public Health Monitoring

Prior to leaving California, any person who has or develops significant symptoms of any kind will be taken to an HHS care site (if symptoms are mild to moderate) in Oakland Harbor or a local hospital if they require care beyond the local HHS capability. HHS health care teams will also assist passengers throughout their movements and monitoring periods with any acute medical conditions, management of chronic conditions, and coordinate with the patients' personal physicians as needed. Passengers who develop respiratory symptoms at any time will be taken to an HHS care site or local health facility until COVID-19 can be ruled out.

Following their arrival at one of the military installations (in California or elsewhere), HHS will coordinate with state and local health authorities to offer COVID-19 testing. HHS teams will conduct appropriate oropharyngeal/nasal swabs and send those samples to a local laboratory. Depending on

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individual location at the time that test results are available, the laboratory will send test results to CDC as required by protocol, to the HHS health monitoring team at the military installation, and/or the passenger's home state public health authority.

Passengers (patients) who remain under HHS care for COVID-19 will remain isolated until resolution of symptoms and negative SARS-CoV-2 PCR results from at least 2 consecutive sets of NP/OP swabs collected at least 24 hours apart. Other patients under HHS care who have non-COVID-19 health conditions will be released after 14 days of health monitoring and stabilization of other health conditions. As needed, patients will be transported to a community health center or hospital if their care needs are beyond the capabilities of the HHS medical team or if they require continued inpatient care, convalescence, or rehabilitation after 14 days.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-11-20 CDC COVID-19 Key Points, Grand Princess Movement and Monitoring Summary, and Community Intervention Guidance
Date:	Thursday, March 12, 2020 8:07:21 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_11_2020_FINAL.pdf GP movement monitoring Exec Sum FINAL 20200310.pdf

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Dear Colleagues,

Attached please find the **CDC COVID-19 Key Points for March 11, 2020.** Feel free to share with partners and appropriate parties.

Also attached, is the **Grand Princess Movement and Public Health Monitoring executive summary**.

Finally, below are links to new/updated **CDC COVID-19 Community Intervention and PPE Guidance**.

Preventing COVID-19 Spread in Communities:
https://www.cdc.gov/coronavirus/2019-ncov/community/index.html

I**mplementation of mitigation strategies for communities:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf

Healthcare Supply of Personal Protective Equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 11, 2020 as of 9:55pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 938 confirmed and presumptive positive cases of COVID-19
  - 29 COVID-19 related deaths
  - 38 states and the District of Columbia.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of places, including in the states of California, Washington, and New York in the United States.
- There are 938 reported U.S. cases of COVID-19 from 38 states, New York City, and the District of Columbia. New states reporting cases since yesterday include South Dakota and Michigan.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- More cases of COVID-19 are expected in the United States in the coming days, including more instances of community spread.
- As the outbreak continues, at some point, widespread transmission of COVID-19 in the United States is expected occur.
- Many people will get sick, but based on what is known about this virus, most people will not develop serious illness.
- Based on data out of China, where this virus first emerged, older adults and persons of all ages who have serious long-term health problems seem to be at higher risk for more serious COVID-19 illness.
  - It's important that people who are at higher risk of serious COVID-19 illness take special precautions to reduce their risk of getting sick.
  - CDC has guidance for what people at higher risk should do at this time.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

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SITUATION UPDATE

- 938 reported cases of COVID-19 have been detected in Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York (and New York City), North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 75 of these cases occurred through close contact with another case.
    - 92 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
    - 771 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 10, 79 state and local public health labs in 50 states and the District of Columbia have verified they are successfully using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 10, 2020, CDC and local and state public health laboratories had tested a total of 11,079 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.
- CDC also recommends that older adults and travelers with underlying health issues avoid situations that put them at increased risk for more severe disease, including avoiding non-essential travel on long plane trips.
- On March 11, WHO made the assessment that COVID-19 can be characterized as a pandemic.

NEW GUIDANCE

- On March 10, CDC posted "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission."
- This document is a framework for actions which local and state health departments can recommend in their community to both prepare for and mitigate community transmission of COVID-19 in the United States.
- Selection and implementation of these actions should be guided by the local characteristics of disease transmission, local population demographics, and public health and healthcare system capacity.

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PANDEMIC DEFINITION:

- Pandemics happen when a disease emerges to infect people easily and spreads from person to person in an efficient and sustained way globally.
- In 2009, WHO declared the outbreak of the H1N1 influenza a global pandemic.
- The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health threat for months.
- CDC has been implementing its pandemic preparedness and response plans, working on multiple fronts, including providing specific guidance on measures to prepare communities to respond to local spread of the virus that causes COVID-19.
- On March 10, CDC posted "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission"

WHO KEY POINTS ON COVID-19 AS PANDEMIC:

- On March 11, WHO made the assessment that COVID-19 can be characterized as a pandemic.
    - WHO has been assessing this outbreak around the clock, since the news of this virus first emerged on December 31, 2019.
    - In the past two weeks, the number of cases of COVID-19 outside China has increased 13-fold, and the number of countries with cases has tripled.
    - There are now more than 118,000 cases in 114 countries, and 4,291 people have lost their lives.
    - The number of cases, the number of deaths, and the number of affected countries are all expected to increase.
    - WHO believes that what the world is seeing can be characterized as a pandemic.
    - All countries can still change the course of this pandemic with decisive action.
    - At this time, WHO does not have a formal process or criteria for defining an outbreak as a pandemic and this characterization does not change the scale or strategy of the WHO response.

INFECTION CONTROL/MASK GUIDANCE

- On March 10, CDC published updated Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings.
- Respiratory protection of healthcare workers is a priority and is especially important during aerosol-generating procedures for patients.
- Healthcare facilities are increasingly unable to procure reliable and sufficient infection control supplies, including N95 respirators.
- Because of supply demands associated with the COVID-19 response, CDC is updating its interim COVID-19 infection control guidance for the healthcare setting.
    - The aim of the revised interim guidance is to prioritize the use of N95 respirators and other respiratory protection devices during high-risk procedures, while still protecting healthcare personnel with facemasks and eye protection during other routine patient care activities in the setting of temporary respirator shortages.

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    - This interim guidance aims to support healthcare facilities in practical decision-making at the local level.
    - This guidance also outlines multiple interventions that can be used to enhance protection of healthcare personnel.
- The spread of COVID-19 can be stopped in many ways, such as prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- Employers and healthcare workers should remember the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
    - All healthcare facilities should be reviewing their infection control supply inventories and taking steps to optimize supplies. This is particularly true for facilities that perform aerosol-generating procedures, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
    - The anticipated timeline for return to routine levels of PPE is not known.
- CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available. CDC has also provided a companion checklist to help healthcare facilities prioritize the implementation of the strategies.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not currently have respiratory protection programs or fit-tested HCP.
    - These facilities would not be able to implement all of the recommended infection control interventions in the previous version of this guidance.
    - Without respiratory protection programs and fit testing, unnecessary transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.

PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- Right now, some people are at higher risk of exposure/infection, including:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of having been exposed.

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PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness.
- The people who are at greatest risk are those who are older and those who have serious long-term health conditions like diabetes, heart disease, or lung disease.
- This seems to be a disease that affects adults, and older adults, most seriously.
    - Starting at age 60, there is an increasing risk of severe disease and the risk increases with age.
    - The highest risk of serious illness and death is in people older than 80 years.
- People with serious underlying health conditions also are more likely to develop serious outcomes including death.
- Reports out of China that looked at more than 70,000 COVID-19 patients found that about 80% of illness was mild and people recovered. 15% to 20% developed serious illness.
- Of the more than 70,000 cases, only about 2% were in people younger than 19.
- These are early data and more information from countries outside of China, including experience here in the United States, will inform the public health response as time goes on. For now, data suggest that measures should be taken to protect America's oldest population, who are most vulnerable to severe COVID-19 illness.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and
        - People who have been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
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- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
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        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
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    - CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

The objectives of this plan are to ensure that all passengers disembark as quickly as possible; receive screening for health concerns and testing for COVID-19 if desired; and quickly travel to their home state if possible. HHS developed this plan to remove all ticketed passengers from the Grand Princess cruise ship moored in Oakland Harbor, CA, and transport them to their home states where they can continue to be monitored by State/Commonwealth and local public health authorities. HHS will organize and fund all physical movements, public health monitoring, and associated logistics between Oakland Harbor and every person's final destination in the United States.

Physical Movement

Coming off the ship, HHS medical teams will use CDC guidelines to screen all passengers and determine if any passengers require additional evaluation for COVID-19; and identify those who require immediate medical attention. Passengers will be transferred by bus to an air terminal and then flown by contract aircraft to one of several U.S. military installations outside of California. If preferred by the state, HHS can attempt to send passengers directly to their home states, though this must be balanced with the need to remove all passengers from the ship as quickly as possible. At the military installations, HHS medical teams will use CDC guidelines to screen passengers for symptoms again, assign risk strata, and initiate health monitoring as appropriate. Those who develop confirmed COVID-19 will be transported to an HHS care site or local health facility.

Other U.S. residents who are asymptomatic may travel to their home states regardless of their testing status (i.e., refused testing, test result pending, negative result, or positive result). If allowed to return to their home states, passengers will be flown as soon as possible by charter flight to an agreed upon airport, after which ground transportation will also be coordinated with state and local authorities. Upon arrival at their final destinations, travelers will fall under the authorities of state and local public health officials for additional monitoring (if needed) and other public health actions as determined by the state and local health authorities. State and local health officials may utilize any public health authority as directed by state policy, but are highly encouraged to follow CDC guidance.

All passengers will remain under federal health authority until responsibility for individual monitoring and supervision is transferred to a state or local health official. **State Executives and/or senior health officials may indicate that they are prepared to receive passengers through written communication (confirmatory email) with the Regional Emergency Coordinators.** State officials may also indicate a requirement for final SARS-CoV-2 test results prior to individual transfer, recognizing that passengers have the option to refuse testing. Those who are positive for SARS-COV-2 will travel separately from those who are negative or unknown.

Public Health Monitoring

Prior to leaving California, any person who has or develops significant symptoms of any kind will be taken to an HHS care site (if symptoms are mild to moderate) in Oakland Harbor or a local hospital if they require care beyond the local HHS capability. HHS health care teams will also assist passengers throughout their movements and monitoring periods with any acute medical conditions, management of chronic conditions, and coordinate with the patients' personal physicians as needed. Passengers who develop respiratory symptoms at any time will be taken to an HHS care site or local health facility until COVID-19 can be ruled out.

Following their arrival at one of the military installations (in California or elsewhere), HHS will coordinate with state and local health authorities to offer COVID-19 testing. HHS teams will conduct appropriate oropharyngeal/nasal swabs and send those samples to a local laboratory. Depending on

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individual location at the time that test results are available, the laboratory will send test results to CDC as required by protocol, to the HHS health monitoring team at the military installation, and/or the passenger's home state public health authority.

Passengers (patients) who remain under HHS care for COVID-19 will remain isolated until resolution of symptoms and negative SARS-CoV-2 PCR results from at least 2 consecutive sets of NP/OP swabs collected at least 24 hours apart. Other patients under HHS care who have non-COVID-19 health conditions will be released after 14 days of health monitoring and stabilization of other health conditions. As needed, patients will be transported to a community health center or hospital if their care needs are beyond the capabilities of the HHS medical team or if they require continued inpatient care, convalescence, or rehabilitation after 14 days.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-12-20 CDC COVID-19 Key Points, Considerations for School Closures Guidance, and Force Health Protection Guidance
Date:	Friday, March 13, 2020 8:19:04 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_12_2020_FINAL.pdf Considerations for school closure Draft 031220 Updated.pdf Force Health Protection Guidance (Supplement 4) (002).pdf

Dear Colleagues:

Attached, please find

1. **CDC COVID-19 Key Points for Thursday, March 12, 2020. Please feel free to share with staff and appropriate parties.**
2. **CDC draft of Considerations for School closure guidance**. Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.
3. **Force Health Protection Guidance**

An additional note on U.S. Military guidance during the COVID-19 pandemic: Many of you have military bases and personnel in your states and communities. Attached for your information is the Department of Defense Force Protection Guidance, including a risk based table for global implementation of guidance for military members returning home from either CDC travel health notice (THN) Level 3 (Avoid non-essential travel) or Level 2(Special precautions for high-risk travelers) areas to stay home for 14 days, social distance and self-monitor.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 12, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 1,215 confirmed and presumptive positive cases of COVID-19
  - 36 COVID-19 related deaths
  - 42 states and the District of Columbia

MAIN KEY POINTS

- The global outbreak of respiratory illness caused by a new coronavirus that emerged from China has reached pandemic proportions, according to the World Health Organization.
- The United States is in the early phase of the outbreak.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19 and reduce the impact of that outbreak.
- School closures are one of a number of nonpharmaceutical interventions.
- On March 12, CDC posted "Considerations for school closures" which provides information about the appropriate timing of school closures.
- More cases of COVID-19 are expected in the United States in the coming days, including more instances of community spread.
- As the outbreak continues, at some point, widespread transmission of the virus that causes COVID-19 in the United States is expected occur.
- Many people will get sick, but based on what is known about this virus, most people will not develop serious illness.
- Based on data out of China, where this virus first emerged, older adults and persons of all ages who have serious long-term health problems seem to be at higher risk for more serious COVID-19 illness.
  - It's important that people who are at higher risk of serious COVID-19 illness take special precautions to reduce their risk of getting sick and that the people around them take action to help protect those who are most vulnerable.
  - CDC has guidance for what people at higher risk should do at this time.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 1,215 reported cases of COVID-19 have been detected in Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York (and New York City), North

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Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 102 of these cases occurred through close contact with another case.
    - 125 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
    - 988 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 11, 81 state and local public health labs in 50 states and the District of Columbia have verified they are successfully using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 11, 2020, CDC and local and state public health laboratories had tested a total of 13,624 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- U.S. citizens, residents, and their immediate family members who have been in China or Iran within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
- On March 11, President Trump issued a proclamation that foreign nationals who have been in one or more of 26 European countries within the past 14 days cannot enter the United States for a period of 30 days.
- On March 11, CDC issued a:
    - Level 3 Travel Health Notice recommending travelers avoid all nonessential travel to most of Europe.
    - Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.

CONSIDERATIONS FOR SCHOOL CLOSURES

- There is a role for school closures in response to school-based cases of COVID-19:
    - For decontamination and contact tracing (few days of closure)
    - In response to significant absenteeism of staff and students (short to medium length, i.e., 2–4 weeks of closure)
    - As part of a larger community mitigation strategy for jurisdictions with substantial community spread (medium to long length, i.e., 4–8 weeks or more of closure)
- Available modeling data indicate that short- to medium-length closures early in the outbreak will not impact the spread of COVID-19 or health care measures (e.g., hospitalizations). There

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may be some impact of much longer closures (8 or more weeks) further into the outbreak when there is more community spread.
- The same model shows other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures.
- In other countries, places that closed schools (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).
- In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. All of the following must be addressed:
    - Provision of academic support (e.g., tele-ed)
    - Alternatives for school-based meals and other services (e.g., behavioral and mental health services) for economically and physically vulnerable children
    - Support for families for whom telework and paid sick leave is not available
    - Continued protection for high risk individuals
- Special consideration must be given for healthcare workers so that school closures do not impact their ability to work.

PANDEMIC INFORMATION

- Pandemics happen when a disease emerges to infect people easily and spreads from person to person in an efficient and sustained way globally.
- This is the first pandemic known to be caused by the emergence of a new coronavirus.
- In the past century, there have been four pandemics caused by the emergence of novel influenza viruses.
    - Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health threat for months.
- CDC has been implementing its pandemic preparedness and response plans, working on multiple fronts, including providing specific guidance on measures to prepare communities to respond to local spread of the virus that causes COVID-19.
- Pandemics of respiratory disease follow a certain progression outlined in a "Pandemic Intervals Framework."
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.
    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
- Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
- Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
- The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

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PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- The immediate risk of being exposed to this virus is still low for most Americans, but as the outbreak expands, that risk will increase. Cases of COVID-19 and instances of community spread are being reported in a growing number of states.
- Right now, people are at higher risk of exposure/infection include:
    - People in communities where ongoing community spread of the virus that causes COVID-19 has been reported are at elevated risk of exposure, with level of risk dependent on the location.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure, with level of risk dependent on where they traveled.

PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness. This includes:
    - Older adults, with risk increasing by age
    - People who have serious chronic medical conditions like
        - Heart disease
        - Diabetes
        - Lung disease

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering

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nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

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School Decision Tree

All Schools Regardless of Community Spread

Confirmed person with COVID-19 in building? → Assess Risk → *Short (potential 2-5 Day) Building Dismissal to Clean/Disinfect/Contact Trace in consultation with local health officials*

No Community Spread

- Prepare
- Teach and reinforce healthy hygiene
- Develop information sharing systems
- Intensify cleaning and disinfection
- Monitor for absenteeism
- Assess group gatherings and events – consider postponing non-critical gatherings and events
- Require sick students and staff stay home
- Establish procedures for someone becoming sick at school

→ *Monitor changes in community spread*

Minimal to Moderate OR Substantial Community Spread

Is community spread Minimal to Moderate or Substantial?

M/M

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building.
- Consider ways to accommodate needs of children and families at high risk.

S

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building WITH EXTENDED SCHOOL DISMISSALS.
- Consider ways to accommodate needs of children and families at high risk.

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Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	• **Impact on disease** ○ Allows for decontamination ○ Allows time for epidemical evaluation and conact tracing; further action can be scaled based on epi investigation.	• **Impact on disease** ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students.	• May occur frequently during a wide-spread outbreak
Short-term (2 weeks closure)	• **Impact on disease** ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • **Impact on families** ○ Children may be less impacted by social isolation from their peers for shorter time frames • **Impact on school** ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Key services are interrupted for students (e.g., meals, other social,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

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	○ Given current timing, some schools may be able to take advantage of spring break closures ○ Provides protection for older staff and students and staff with underlying medical conditions	physical health, and mental health services, after school programs) ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Potential academic impact because of the disruption to the continuity of learning • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	
Medium-term (4 weeks closure)	• **Impact on disease** ○ Provides more protection for older staff and students and staff with underlying medical conditions • **Impact on schools** ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

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		after school programs) are put at greater risk ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Economic impact if school staff are not paid during school closure must be considered.
Long-term (8 weeks, 20 weeks closure)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have	• **Impact on disease** ○ Longer closures may result in more students congregating outside of	• Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried

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	higher disease impacts, suggests that longer closures are may have greater impact in terms of overall transmission. Provides substantial protection for older staff and students and staff with underlying medical conditions
	• **Impact on schools**
	  ○ Schools without distance learning may see closures of this length as reason to implement distance learning approaches they may not have previously had or used
		school (e.g., other students' homes, shopping malls)
		  ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage.
		• **Impact on families**
		  ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at substantial risk
		  ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs)
		  ○ Student engagement with schools and peers diminishes, which could increase anxiety and other mental health and emotional problems.
		  ○ High school seniors likely to lose ability to participate in their prom, graduation etc.
		• **Impact on schools**
		  ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements
			workers who may have more flexible leave and telework opportunities)
			• If a school closes for this length of time, schools must consider ways to continue key services
			• Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled.
			• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure.
			• Given current timing, 20 week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid June.
			• A 20 week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well
			• Economic impact if school staff are not paid during school closure must be considered.

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		○ Loss of educational progress, even having to add an extra semester or year to graduate or move up a grade ○ Staff within the schools may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ○ Maintaining communication with school staff, families, and students becomes substantially more difficult as the school closure lengthens. • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	

Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

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OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

MAR 1 1 2020

MEMORANDUM FOR CHIEF MANAGEMENT OFFICER OF THE DEPARTMENT OF DEFENSE
SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
CHIEF OF THE NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Force Health Protection Guidance (Supplement 4) – Department of Defense Guidance for Personnel Traveling During the Novel Coronavirus Outbreak

This memorandum supplements requirements in DoD Instruction 6200.03 "Public Health Emergency Management (PHEM) Within the DoD," March 28, 2019, with respect to coronavirus disease 2019 (COVID-19). The COVID-19 outbreak continues to spread globally and as a result, the Centers for Disease Control and Prevention (CDC) is rapidly issuing Travel Health Notices (THNs) and guidance for persons with travel in countries or areas with COVID-19 transmission. CDC THNs tier these locations as Level 3 (Widespread sustained (ongoing) transmission), Level 2 (Sustained (ongoing) community transmission) and Level 1 (Risk of limited community transmission), with associated monitoring guidance for returning travelers. The CDC THNs are at: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html. This guidance applies to all DoD Components, except that it does not apply to air crew of military aircraft.

All existing Novel Coronavirus Outbreak FHP guidance remains in effect and applies to all DoD Components, including the Reserves and National Guard, and, as appropriate, foreign military personnel who are under DoD authority. The FHP guidance for China travelers ("Force Health Protection Guidance (Supplement 1) – Department of Defense Guidance for Monitoring of Personnel Returning from China During the Novel Coronavirus Outbreak," dated February 7, 2020), remains in effect. FHP documents are at: https://www.defense.gov/Explore/Spotlight/Coronavirus. Individuals should continue to check the CDC COVID-19 website for additional updates at: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

This document provides pre- and post-travel health guidance for all DoD travelers to enable mission assurance and Force Health Protection (FHP), utilizing the CDC THNs for DoD Component considerations. DoD Components may be more restrictive based on local risk assessment in consultation with public health authorities. Command location, local community transmission, risk to mission, and risk to force are all key considerations in DoD Component decision making.

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Actions for all DoD travelers

Actions prior to official travel:

- DoD Components shall incorporate CDC guidance into the full scope of planning for official travel, to include the following:
    - Consider the risk profile of the traveler (e.g., older individuals or those with underlying diseases). Limit travel to those individuals who are healthy, to the greatest extent possible. For DoD civilian personnel, these considerations must be consistent with the requirements of the Rehabilitation Act of 1973, as amended.
    - Coordinate with the receiving installation to ensure the post-travel requirements in this document can be implemented at that location.

Actions upon departure/exit screening:

- DoD Components should emphasize each individual's responsibility to avoid travel when sick.
- For travel on military aircraft, DoD Components should ensure exit screening is conducted at the point of embarkation. At a minimum, this should consist of a questionnaire[1] to assess risk of exposure, temperature check (fever is >100.4°F or 38°C per CDC), and visual check for signs and symptoms (i.e., feeling feverish, coughing or shortness of breath per CDC) of COVID-19. If the screening yields concerns, a secondary medical evaluation by a health professional should be conducted. DoD Components should also be prepared to appropriately manage a patient under investigation if such a determination is made, to include referral to the appropriate medical authority per CDC guidance found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html.
- Travel on commercial air carriers may not include exit screening of travelers. Therefore, taking the appropriate action upon arrival is critical.

Actions for all Service members

Actions upon arrival from a CDC THN Level 3 or Level 2 location:

DoD Components should identify all Service members who travel or have traveled in the prior 14 days to, through, or from a CDC THN Level 3 or Level 2 country. This includes travel by military or commercial means, as well as private conveyance, and includes all forms of travel to include Permanent Change of Station, Temporary Duty, and leave. DoD Components should place these Service members under a 14-day restriction of movement (ROM). During the ROM (starting from the day of departure from the Level 3 or Level 2 country):

[1] Guidance to support questionnaire development is at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

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- Service members should be restricted to their residence or other appropriate domicile for 14 days and limit close contact (within 6 feet or 2 meters) with others during this 14-day period. Immediate supervisors will not require Service members to report to their duty location or otherwise disregard the ROM.

- Service members should self-monitor by taking their temperatures twice a day to check for fever, and remain alert for cough or difficulty breathing. If they feel feverish or develop a fever (>100.4°F or 38°C per CDC), cough, or difficulty breathing during the self-monitoring period, they should self-isolate, limit contact with others, notify their supervisor or chain of command, and seek advice by telephone from the appropriate healthcare provider to determine whether medical evaluation is needed.

- For any in-person assessments of Service members (including asymptomatic individuals), medical personnel should apply CDC guidance to include wearing appropriate personal protective equipment (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html).

- Service members living in open-bay settings, or rooms with shared bathrooms and/or kitchen facilities, should be placed in separate lodging to span the 14-day ROM period. The DoD Component to which the Service member is assigned will arrange and fund the separate lodging if needed.

- Service members should separate themselves from other people in the home or dwelling if residing with roommates or family members and avoid sharing personal items.

- Service members should not travel, visit public or crowded areas, or use public transportation and should avoid interaction with pets or other animals.

- Medical evaluation and care should be immediately arranged if the Service member displays fever or symptoms consistent with COVID-19, as per CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html).

    - The Service member should call ahead before going to a medical treatment facility, informing medical staff of his/her symptoms and travel history.

    - Medical staff should follow CDC guidance when assessing individuals displaying fever and symptoms consistent with COVID-19.

    - DoD Components should appropriately report an individual if identified as a patient under investigation, per previously published Under Secretary of Defense for Personnel and Readiness guidance, "Force Health Protection Guidance for the Novel Coronavirus Outbreak," dated January 30, 2020.

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Actions upon arrival from a non-CDC THN Level 2 or Level 3 CONUS or OCONUS location:

DoD Components should identify and track all Service members who travel or have a history of travel in the prior 14 days to, through, or from a non-CDC THN Level 2 or Level 3 CONUS or OCONUS location. This includes travel by military or commercial means as well as private conveyance and includes all forms of travel to include Permanent Change of Station, Temporary Duty, and leave. DoD Components should ensure that these Service members take the following actions for the next 14 days:

- Implement self-observation, i.e., remain alert for fever, cough, or difficulty breathing.
- To the extent possible, implement social distancing, e.g., remain out of congregate settings, avoid mass gatherings, and maintain 6 feet or 2 meter distance from others when possible.
- Immediately self-isolate, limit contact with others, and seek advice by telephone from the appropriate healthcare provider to determine whether medical evaluation is required, if individuals feel feverish or develop measured fever, cough, or difficulty breathing.

Actions for DoD civilian employees, contractor personnel, and family members

DoD strongly recommends that DoD civilian employees, contractor personnel, and family members who travel to, through, and from countries with a CDC THN for COVID-19 follow this DoD guidance, which is more stringent than CDC guidance. DoD Components should restrict DoD workplace access for 14 days for DoD civilian employees and contractor personnel whose travel has included THN Level 2 and Level 3 locations. If these civilian employees and contractor personnel feel feverish or develop a fever, cough, or difficulty breathing, they should notify their supervisor or chain of command. For all other travel, DoD Components will encourage self-observation and accommodation of social distancing. To restrict access from the DoD workplace and maximize telework options, DoD Components shall implement the Under Secretary of Defense for Personnel and Readiness memorandum, "Civilian Personnel Guidance for DoD Components in Responding to Coronavirus Disease 2019," dated March 8, 2020. For contractor personnel, DoD Components should implement measures in consultation with the appropriate contracting office.

This guidance is effective March 13, 2020. My point of contact is COL Jennifer M. Kishimori, who may be reached at (703) 681-8179 or jennifer.m.kishimori.mil@mail.mil.

Alexis Lasselle Ross
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Attachment:
Quick-Reference for Travel during the COVID-19 Outbreak

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Attachment 1. Quick Reference for Travel during the COVID-19 Outbreak.

CDC THN Level[1]	CDC Definitions	Actions Upon MIL AIR Departure	Actions Upon Arrival[2]
3	• Widespread sustained (ongoing) transmission • Avoid non-essential travel • Travelers should stay home for 14 days	Risk Assessment: • Questionnaire • Temperature Checks • Visual assessment for signs and symptoms Medical Team Assessment (if indicated): • Health evaluation • Transfer to command health authority if needed	• Stay at home for 14 days • Practice social distancing • Self-monitoring
2	• Sustained (ongoing) community transmission • Special Precautions for High-Risk Travelers		• Stay at home for 14 days • Practice social distancing • Self-monitoring
1	• Risk of Limited community transmission • Practice usual precautions		• Ensure personnel tracking • Practice social distancing for 14 days • Self-observation for 14 days
N/A	• All other countries/areas		• Ensure personnel tracking • Practice social distancing for 14 days • Self-observation for 14 days

[1]Travel Health Notice (THN), [2]Does not apply to air crew.

Actions prior to official travel:

- DoD Components shall incorporate CDC guidance into the full scope of planning for official travel to include the following:
    - Consider the risk profile of traveler (e.g., older individuals or those with underlying diseases). Limit travel to those individuals to those who are healthy, to the greatest extent possible. For DoD civilian personnel, these considerations must be consistent with the requirements of the Rehabilitation Act of 1973, as amended.
    - Coordinate with the receiving installation to ensure the post-travel requirements can be implemented at that location.

References:
DoD COVID-19 Homepage (includes all Force Health Protection Guidances):
https://www.defense.gov/Explore/Spotlight/Coronavirus

CDC COVID-19 Homepage (CDC authoritative information on COVID-19):
https://www.cdc.gov/coronavirus/2019-ncov/index.html

CDC Travel Health Notice Information (CDC Country Level Notifications):
https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

CDC Travel Precautions (includes COVID-19 symptoms such as fever, cough, shortness of breath):
https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

CDC Healthcare Provider Information (includes Infection Control information and Personal Protective Equipment Guidance):
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-12-20 CDC COVID-19 Key Points, Considerations for School Closures Guidance, and Force Health Protection Guidance
Date:	Friday, March 13, 2020 8:21:43 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_12_2020_FINAL.pdf Considerations for school closure Draft 031220 Updated.pdf Force Health Protection Guidance (Supplement 4) (002).pdf

Dear Colleagues:

Attached, please find

1. **CDC COVID-19 Key Points for Thursday, March 12, 2020. Please feel free to share with staff and appropriate parties.**
2. **CDC draft of Considerations for School closure guidance**. Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.
3. **Force Health Protection Guidance**

An additional note on U.S. Military guidance during the COVID-19 pandemic: Many of you have military bases and personnel in your states and communities. Attached for your information is the Department of Defense Force Protection Guidance, including a risk based table for global implementation of guidance for military members returning home from either CDC travel health notice (THN) Level 3 (Avoid non-essential travel) or Level 2(Special precautions for high-risk travelers) areas to stay home for 14 days, social distance and self-monitor.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 12, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 1,215 confirmed and presumptive positive cases of COVID-19
  - 36 COVID-19 related deaths
  - 42 states and the District of Columbia

MAIN KEY POINTS

- The global outbreak of respiratory illness caused by a new coronavirus that emerged from China has reached pandemic proportions, according to the World Health Organization.
- The United States is in the early phase of the outbreak.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19 and reduce the impact of that outbreak.
- School closures are one of a number of nonpharmaceutical interventions.
- On March 12, CDC posted "Considerations for school closures" which provides information about the appropriate timing of school closures.
- More cases of COVID-19 are expected in the United States in the coming days, including more instances of community spread.
- As the outbreak continues, at some point, widespread transmission of the virus that causes COVID-19 in the United States is expected occur.
- Many people will get sick, but based on what is known about this virus, most people will not develop serious illness.
- Based on data out of China, where this virus first emerged, older adults and persons of all ages who have serious long-term health problems seem to be at higher risk for more serious COVID-19 illness.
  - It's important that people who are at higher risk of serious COVID-19 illness take special precautions to reduce their risk of getting sick and that the people around them take action to help protect those who are most vulnerable.
  - CDC has guidance for what people at higher risk should do at this time.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 1,215 reported cases of COVID-19 have been detected in Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York (and New York City), North

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Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 102 of these cases occurred through close contact with another case.
    - 125 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
    - 988 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 11, 81 state and local public health labs in 50 states and the District of Columbia have verified they are successfully using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 11, 2020, CDC and local and state public health laboratories had tested a total of 13,624 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- U.S. citizens, residents, and their immediate family members who have been in China or Iran within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
- On March 11, President Trump issued a proclamation that foreign nationals who have been in one or more of 26 European countries within the past 14 days cannot enter the United States for a period of 30 days.
- On March 11, CDC issued a:
    - Level 3 Travel Health Notice recommending travelers avoid all nonessential travel to most of Europe.
    - Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.

CONSIDERATIONS FOR SCHOOL CLOSURES

- There is a role for school closures in response to school-based cases of COVID-19:
    - For decontamination and contact tracing (few days of closure)
    - In response to significant absenteeism of staff and students (short to medium length, i.e., 2–4 weeks of closure)
    - As part of a larger community mitigation strategy for jurisdictions with substantial community spread (medium to long length, i.e., 4–8 weeks or more of closure)
- Available modeling data indicate that short- to medium-length closures early in the outbreak will not impact the spread of COVID-19 or health care measures (e.g., hospitalizations). There

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may be some impact of much longer closures (8 or more weeks) further into the outbreak when there is more community spread.
- The same model shows other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures.
- In other countries, places that closed schools (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).
- In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. All of the following must be addressed:
    - Provision of academic support (e.g., tele-ed)
    - Alternatives for school-based meals and other services (e.g., behavioral and mental health services) for economically and physically vulnerable children
    - Support for families for whom telework and paid sick leave is not available
    - Continued protection for high risk individuals
- Special consideration must be given for healthcare workers so that school closures do not impact their ability to work.

PANDEMIC INFORMATION

- Pandemics happen when a disease emerges to infect people easily and spreads from person to person in an efficient and sustained way globally.
- This is the first pandemic known to be caused by the emergence of a new coronavirus.
- In the past century, there have been four pandemics caused by the emergence of novel influenza viruses.
    - Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health threat for months.
- CDC has been implementing its pandemic preparedness and response plans, working on multiple fronts, including providing specific guidance on measures to prepare communities to respond to local spread of the virus that causes COVID-19.
- Pandemics of respiratory disease follow a certain progression outlined in a "Pandemic Intervals Framework."
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.
    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
- Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
- Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
- The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

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PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- The immediate risk of being exposed to this virus is still low for most Americans, but as the outbreak expands, that risk will increase. Cases of COVID-19 and instances of community spread are being reported in a growing number of states.
- Right now, people are at higher risk of exposure/infection include:
    - People in communities where ongoing community spread of the virus that causes COVID-19 has been reported are at elevated risk of exposure, with level of risk dependent on the location.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure, with level of risk dependent on where they traveled.

PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness. This includes:
    - Older adults, with risk increasing by age
    - People who have serious chronic medical conditions like
        - Heart disease
        - Diabetes
        - Lung disease

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering

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nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

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School Decision Tree

All Schools Regardless of Community Spread

Confirmed person with COVID-19 in building? → Assess Risk → *Short (potential 2-5 Day) Building Dismissal to Clean/Disinfect/Contact Trace in consultation with local health officials*

No Community Spread

- Prepare
- Teach and reinforce healthy hygiene
- Develop information sharing systems
- Intensify cleaning and disinfection
- Monitor for absenteeism
- Assess group gatherings and events – consider postponing non-critical gatherings and events
- Require sick students and staff stay home
- Establish procedures for someone becoming sick at school

→ *Monitor changes in community spread*

Minimal to Moderate OR Substantial Community Spread

Is community spread Minimal to Moderate or Substantial?

M/M

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building.
- Consider ways to accommodate needs of children and families at high risk.

S

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building WITH EXTENDED SCHOOL DISMISSALS.
- Consider ways to accommodate needs of children and families at high risk.

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Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	• **Impact on disease** ○ Allows for decontamination ○ Allows time for epidemical evaluation and conact tracing; further action can be scaled based on epi investigation.	• **Impact on disease** ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students.	• May occur frequently during a wide-spread outbreak
Short-term (2 weeks closure)	• **Impact on disease** ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • **Impact on families** ○ Children may be less impacted by social isolation from their peers for shorter time frames • **Impact on school** ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Key services are interrupted for students (e.g., meals, other social,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

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	○ Given current timing, some schools may be able to take advantage of spring break closures ○ Provides protection for older staff and students and staff with underlying medical conditions	physical health, and mental health services, after school programs) ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Potential academic impact because of the disruption to the continuity of learning • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	
Medium-term (4 weeks closure)	• **Impact on disease** ○ Provides more protection for older staff and students and staff with underlying medical conditions • **Impact on schools** ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

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		after school programs) are put at greater risk ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Economic impact if school staff are not paid during school closure must be considered.
Long-term (8 weeks, 20 weeks closure)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have	• **Impact on disease** ○ Longer closures may result in more students congregating outside of	• Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried

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	higher disease impacts, suggests that longer closures are may have greater impact in terms of overall transmission. Provides substantial protection for older staff and students and staff with underlying medical conditions
	• **Impact on schools**
	  ○ Schools without distance learning may see closures of this length as reason to implement distance learning approaches they may not have previously had or used
		school (e.g., other students' homes, shopping malls)
		  ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage.
		• **Impact on families**
		  ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at substantial risk
		  ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs)
		  ○ Student engagement with schools and peers diminishes, which could increase anxiety and other mental health and emotional problems.
		  ○ High school seniors likely to lose ability to participate in their prom, graduation etc.
		• **Impact on schools**
		  ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements
			workers who may have more flexible leave and telework opportunities)
			• If a school closes for this length of time, schools must consider ways to continue key services
			• Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled.
			• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure.
			• Given current timing, 20 week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid June.
			• A 20 week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well
			• Economic impact if school staff are not paid during school closure must be considered.

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		○ Loss of educational progress, even having to add an extra semester or year to graduate or move up a grade ○ Staff within the schools may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ○ Maintaining communication with school staff, families, and students becomes substantially more difficult as the school closure lengthens. • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	

Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

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OFFICE OF THE UNDER SECRETARY OF DEFENSE
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PERSONNEL AND
READINESS

MAR 1 1 2020

MEMORANDUM FOR CHIEF MANAGEMENT OFFICER OF THE DEPARTMENT OF DEFENSE
SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
CHIEF OF THE NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Force Health Protection Guidance (Supplement 4) – Department of Defense Guidance for Personnel Traveling During the Novel Coronavirus Outbreak

This memorandum supplements requirements in DoD Instruction 6200.03 "Public Health Emergency Management (PHEM) Within the DoD," March 28, 2019, with respect to coronavirus disease 2019 (COVID-19). The COVID-19 outbreak continues to spread globally and as a result, the Centers for Disease Control and Prevention (CDC) is rapidly issuing Travel Health Notices (THNs) and guidance for persons with travel in countries or areas with COVID-19 transmission. CDC THNs tier these locations as Level 3 (Widespread sustained (ongoing) transmission), Level 2 (Sustained (ongoing) community transmission) and Level 1 (Risk of limited community transmission), with associated monitoring guidance for returning travelers. The CDC THNs are at: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html. This guidance applies to all DoD Components, except that it does not apply to air crew of military aircraft.

All existing Novel Coronavirus Outbreak FHP guidance remains in effect and applies to all DoD Components, including the Reserves and National Guard, and, as appropriate, foreign military personnel who are under DoD authority. The FHP guidance for China travelers ("Force Health Protection Guidance (Supplement 1) – Department of Defense Guidance for Monitoring of Personnel Returning from China During the Novel Coronavirus Outbreak," dated February 7, 2020), remains in effect. FHP documents are at: https://www.defense.gov/Explore/Spotlight/Coronavirus. Individuals should continue to check the CDC COVID-19 website for additional updates at: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

This document provides pre- and post-travel health guidance for all DoD travelers to enable mission assurance and Force Health Protection (FHP), utilizing the CDC THNs for DoD Component considerations. DoD Components may be more restrictive based on local risk assessment in consultation with public health authorities. Command location, local community transmission, risk to mission, and risk to force are all key considerations in DoD Component decision making.

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Actions for all DoD travelers

Actions prior to official travel:

- DoD Components shall incorporate CDC guidance into the full scope of planning for official travel, to include the following:
    - Consider the risk profile of the traveler (e.g., older individuals or those with underlying diseases). Limit travel to those individuals who are healthy, to the greatest extent possible. For DoD civilian personnel, these considerations must be consistent with the requirements of the Rehabilitation Act of 1973, as amended.
    - Coordinate with the receiving installation to ensure the post-travel requirements in this document can be implemented at that location.

Actions upon departure/exit screening:

- DoD Components should emphasize each individual's responsibility to avoid travel when sick.
- For travel on military aircraft, DoD Components should ensure exit screening is conducted at the point of embarkation. At a minimum, this should consist of a questionnaire[1] to assess risk of exposure, temperature check (fever is >100.4°F or 38°C per CDC), and visual check for signs and symptoms (i.e., feeling feverish, coughing or shortness of breath per CDC) of COVID-19. If the screening yields concerns, a secondary medical evaluation by a health professional should be conducted. DoD Components should also be prepared to appropriately manage a patient under investigation if such a determination is made, to include referral to the appropriate medical authority per CDC guidance found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html.
- Travel on commercial air carriers may not include exit screening of travelers. Therefore, taking the appropriate action upon arrival is critical.

Actions for all Service members

Actions upon arrival from a CDC THN Level 3 or Level 2 location:

DoD Components should identify all Service members who travel or have traveled in the prior 14 days to, through, or from a CDC THN Level 3 or Level 2 country. This includes travel by military or commercial means, as well as private conveyance, and includes all forms of travel to include Permanent Change of Station, Temporary Duty, and leave. DoD Components should place these Service members under a 14-day restriction of movement (ROM). During the ROM (starting from the day of departure from the Level 3 or Level 2 country):

[1] Guidance to support questionnaire development is at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

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- Service members should be restricted to their residence or other appropriate domicile for 14 days and limit close contact (within 6 feet or 2 meters) with others during this 14-day period. Immediate supervisors will not require Service members to report to their duty location or otherwise disregard the ROM.

- Service members should self-monitor by taking their temperatures twice a day to check for fever, and remain alert for cough or difficulty breathing. If they feel feverish or develop a fever (>100.4°F or 38°C per CDC), cough, or difficulty breathing during the self-monitoring period, they should self-isolate, limit contact with others, notify their supervisor or chain of command, and seek advice by telephone from the appropriate healthcare provider to determine whether medical evaluation is needed.

- For any in-person assessments of Service members (including asymptomatic individuals), medical personnel should apply CDC guidance to include wearing appropriate personal protective equipment (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html).

- Service members living in open-bay settings, or rooms with shared bathrooms and/or kitchen facilities, should be placed in separate lodging to span the 14-day ROM period. The DoD Component to which the Service member is assigned will arrange and fund the separate lodging if needed.

- Service members should separate themselves from other people in the home or dwelling if residing with roommates or family members and avoid sharing personal items.

- Service members should not travel, visit public or crowded areas, or use public transportation and should avoid interaction with pets or other animals.

- Medical evaluation and care should be immediately arranged if the Service member displays fever or symptoms consistent with COVID-19, as per CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html).

    - The Service member should call ahead before going to a medical treatment facility, informing medical staff of his/her symptoms and travel history.

    - Medical staff should follow CDC guidance when assessing individuals displaying fever and symptoms consistent with COVID-19.

    - DoD Components should appropriately report an individual if identified as a patient under investigation, per previously published Under Secretary of Defense for Personnel and Readiness guidance, "Force Health Protection Guidance for the Novel Coronavirus Outbreak," dated January 30, 2020.

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Actions upon arrival from a non-CDC THN Level 2 or Level 3 CONUS or OCONUS location:

DoD Components should identify and track all Service members who travel or have a history of travel in the prior 14 days to, through, or from a non-CDC THN Level 2 or Level 3 CONUS or OCONUS location. This includes travel by military or commercial means as well as private conveyance and includes all forms of travel to include Permanent Change of Station, Temporary Duty, and leave. DoD Components should ensure that these Service members take the following actions for the next 14 days:

- Implement self-observation, i.e., remain alert for fever, cough, or difficulty breathing.
- To the extent possible, implement social distancing, e.g., remain out of congregate settings, avoid mass gatherings, and maintain 6 feet or 2 meter distance from others when possible.
- Immediately self-isolate, limit contact with others, and seek advice by telephone from the appropriate healthcare provider to determine whether medical evaluation is required, if individuals feel feverish or develop measured fever, cough, or difficulty breathing.

Actions for DoD civilian employees, contractor personnel, and family members

DoD strongly recommends that DoD civilian employees, contractor personnel, and family members who travel to, through, and from countries with a CDC THN for COVID-19 follow this DoD guidance, which is more stringent than CDC guidance. DoD Components should restrict DoD workplace access for 14 days for DoD civilian employees and contractor personnel whose travel has included THN Level 2 and Level 3 locations. If these civilian employees and contractor personnel feel feverish or develop a fever, cough, or difficulty breathing, they should notify their supervisor or chain of command. For all other travel, DoD Components will encourage self-observation and accommodation of social distancing. To restrict access from the DoD workplace and maximize telework options, DoD Components shall implement the Under Secretary of Defense for Personnel and Readiness memorandum, "Civilian Personnel Guidance for DoD Components in Responding to Coronavirus Disease 2019," dated March 8, 2020. For contractor personnel, DoD Components should implement measures in consultation with the appropriate contracting office.

This guidance is effective March 13, 2020. My point of contact is COL Jennifer M. Kishimori, who may be reached at (703) 681-8179 or jennifer.m.kishimori.mil@mail.mil.

Alexis Lasselle Ross
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Attachment:
Quick-Reference for Travel during the COVID-19 Outbreak

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Attachment 1. Quick Reference for Travel during the COVID-19 Outbreak.

CDC THN Level[1]	CDC Definitions	Actions Upon MIL AIR Departure	Actions Upon Arrival[2]
3	• Widespread sustained (ongoing) transmission • Avoid non-essential travel • Travelers should stay home for 14 days	Risk Assessment: • Questionnaire • Temperature Checks • Visual assessment for signs and symptoms Medical Team Assessment (if indicated): • Health evaluation • Transfer to command health authority if needed	• Stay at home for 14 days • Practice social distancing • Self-monitoring
2	• Sustained (ongoing) community transmission • Special Precautions for High-Risk Travelers		• Stay at home for 14 days • Practice social distancing • Self-monitoring
1	• Risk of Limited community transmission • Practice usual precautions		• Ensure personnel tracking • Practice social distancing for 14 days • Self-observation for 14 days
N/A	• All other countries/areas		• Ensure personnel tracking • Practice social distancing for 14 days • Self-observation for 14 days

[1]Travel Health Notice (THN), [2]Does not apply to air crew.

Actions prior to official travel:

- DoD Components shall incorporate CDC guidance into the full scope of planning for official travel to include the following:
    - Consider the risk profile of traveler (e.g., older individuals or those with underlying diseases). Limit travel to those individuals to those who are healthy, to the greatest extent possible. For DoD civilian personnel, these considerations must be consistent with the requirements of the Rehabilitation Act of 1973, as amended.
    - Coordinate with the receiving installation to ensure the post-travel requirements can be implemented at that location.

References:
DoD COVID-19 Homepage (includes all Force Health Protection Guidances):
https://www.defense.gov/Explore/Spotlight/Coronavirus

CDC COVID-19 Homepage (CDC authoritative information on COVID-19):
https://www.cdc.gov/coronavirus/2019-ncov/index.html

CDC Travel Health Notice Information (CDC Country Level Notifications):
https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

CDC Travel Precautions (includes COVID-19 symptoms such as fever, cough, shortness of breath):
https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

CDC Healthcare Provider Information (includes Infection Control information and Personal Protective Equipment Guidance):
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-12-20 CDC COVID-19 Key Points, Considerations for School Closures Guidance, and Force Health Protection Guidance
Date:	Friday, March 13, 2020 8:16:11 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_12_2020_FINAL.pdf Considerations for school closure Draft 031220 Updated.pdf Force Health Protection Guidance (Supplement 4) (002).pdf

Dear Colleagues:

Attached, please find

1. **CDC COVID-19 Key Points for Thursday, March 12, 2020. Please feel free to share with staff and appropriate parties.**
2. **CDC draft of Considerations for School closure guidance**. Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.
3. **Force Health Protection Guidance**

An additional note on U.S. Military guidance during the COVID-19 pandemic: Many of you have military bases and personnel in your states and communities. Attached for your information is the Department of Defense Force Protection Guidance, including a risk based table for global implementation of guidance for military members returning home from either CDC travel health notice (THN) Level 3 (Avoid non-essential travel) or Level 2(Special precautions for high-risk travelers) areas to stay home for 14 days, social distance and self-monitor.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 12, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 1,215 confirmed and presumptive positive cases of COVID-19
  - 36 COVID-19 related deaths
  - 42 states and the District of Columbia

MAIN KEY POINTS

- The global outbreak of respiratory illness caused by a new coronavirus that emerged from China has reached pandemic proportions, according to the World Health Organization.
- The United States is in the early phase of the outbreak.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19 and reduce the impact of that outbreak.
- School closures are one of a number of nonpharmaceutical interventions.
- On March 12, CDC posted "Considerations for school closures" which provides information about the appropriate timing of school closures.
- More cases of COVID-19 are expected in the United States in the coming days, including more instances of community spread.
- As the outbreak continues, at some point, widespread transmission of the virus that causes COVID-19 in the United States is expected occur.
- Many people will get sick, but based on what is known about this virus, most people will not develop serious illness.
- Based on data out of China, where this virus first emerged, older adults and persons of all ages who have serious long-term health problems seem to be at higher risk for more serious COVID-19 illness.
  - It's important that people who are at higher risk of serious COVID-19 illness take special precautions to reduce their risk of getting sick and that the people around them take action to help protect those who are most vulnerable.
  - CDC has guidance for what people at higher risk should do at this time.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 1,215 reported cases of COVID-19 have been detected in Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York (and New York City), North

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Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 102 of these cases occurred through close contact with another case.
    - 125 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
    - 988 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 11, 81 state and local public health labs in 50 states and the District of Columbia have verified they are successfully using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 11, 2020, CDC and local and state public health laboratories had tested a total of 13,624 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- U.S. citizens, residents, and their immediate family members who have been in China or Iran within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
- On March 11, President Trump issued a proclamation that foreign nationals who have been in one or more of 26 European countries within the past 14 days cannot enter the United States for a period of 30 days.
- On March 11, CDC issued a:
    - Level 3 Travel Health Notice recommending travelers avoid all nonessential travel to most of Europe.
    - Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.

CONSIDERATIONS FOR SCHOOL CLOSURES

- There is a role for school closures in response to school-based cases of COVID-19:
    - For decontamination and contact tracing (few days of closure)
    - In response to significant absenteeism of staff and students (short to medium length, i.e., 2–4 weeks of closure)
    - As part of a larger community mitigation strategy for jurisdictions with substantial community spread (medium to long length, i.e., 4–8 weeks or more of closure)
- Available modeling data indicate that short- to medium-length closures early in the outbreak will not impact the spread of COVID-19 or health care measures (e.g., hospitalizations). There

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may be some impact of much longer closures (8 or more weeks) further into the outbreak when there is more community spread.
- The same model shows other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures.
- In other countries, places that closed schools (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).
- In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. All of the following must be addressed:
    - Provision of academic support (e.g., tele-ed)
    - Alternatives for school-based meals and other services (e.g., behavioral and mental health services) for economically and physically vulnerable children
    - Support for families for whom telework and paid sick leave is not available
    - Continued protection for high risk individuals
- Special consideration must be given for healthcare workers so that school closures do not impact their ability to work.

PANDEMIC INFORMATION

- Pandemics happen when a disease emerges to infect people easily and spreads from person to person in an efficient and sustained way globally.
- This is the first pandemic known to be caused by the emergence of a new coronavirus.
- In the past century, there have been four pandemics caused by the emergence of novel influenza viruses.
    - Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health threat for months.
- CDC has been implementing its pandemic preparedness and response plans, working on multiple fronts, including providing specific guidance on measures to prepare communities to respond to local spread of the virus that causes COVID-19.
- Pandemics of respiratory disease follow a certain progression outlined in a "Pandemic Intervals Framework."
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.
    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
- Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
- Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
- The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

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PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- The immediate risk of being exposed to this virus is still low for most Americans, but as the outbreak expands, that risk will increase. Cases of COVID-19 and instances of community spread are being reported in a growing number of states.
- Right now, people are at higher risk of exposure/infection include:
    - People in communities where ongoing community spread of the virus that causes COVID-19 has been reported are at elevated risk of exposure, with level of risk dependent on the location.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure, with level of risk dependent on where they traveled.

PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness. This includes:
    - Older adults, with risk increasing by age
    - People who have serious chronic medical conditions like
        - Heart disease
        - Diabetes
        - Lung disease

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering

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nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

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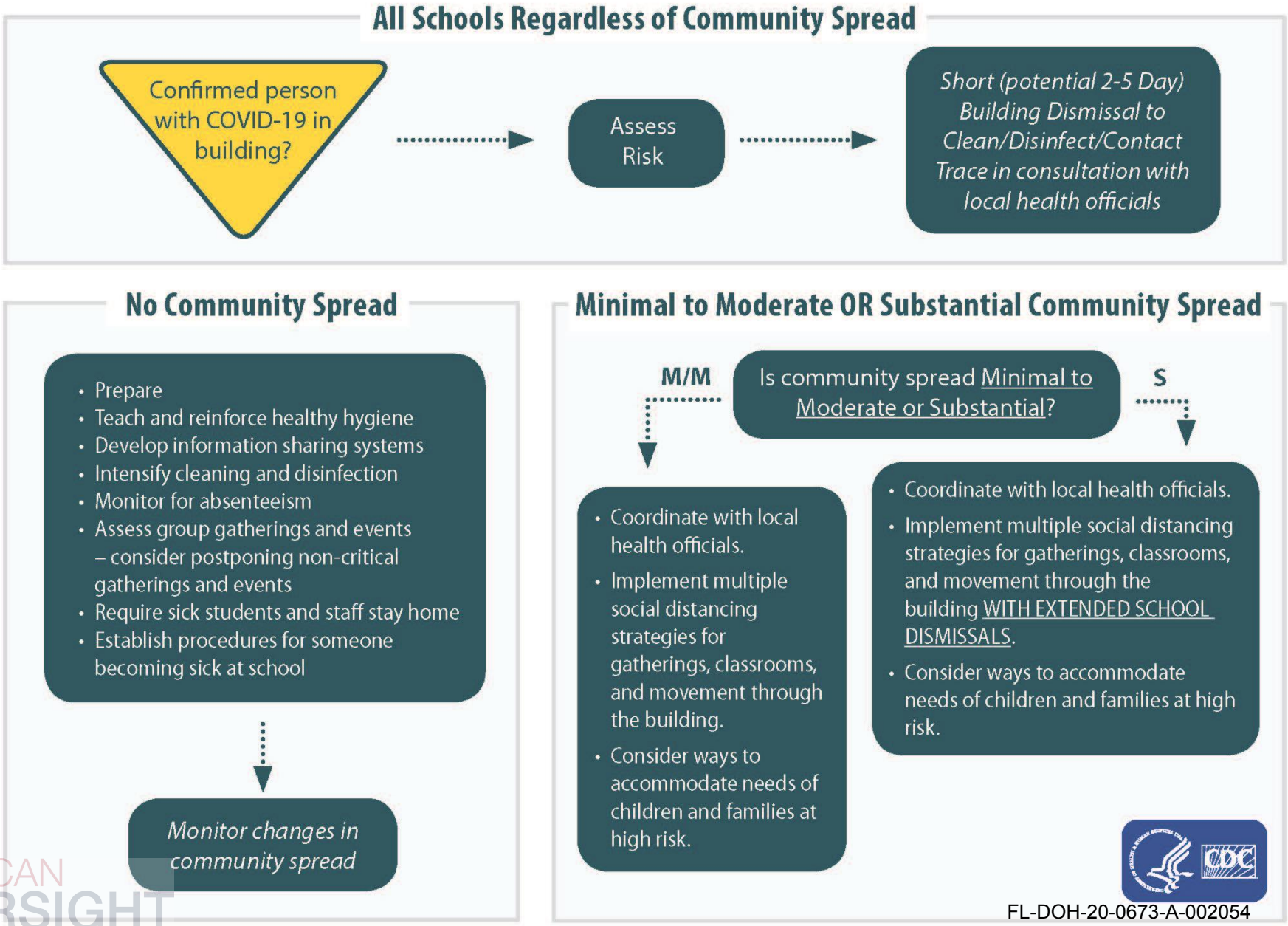
School Decision Tree



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Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	• **Impact on disease** ○ Allows for decontamination ○ Allows time for epidemical evaluation and conact tracing; further action can be scaled based on epi investigation.	• **Impact on disease** ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students.	• May occur frequently during a wide-spread outbreak
Short-term (2 weeks closure)	• **Impact on disease** ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • **Impact on families** ○ Children may be less impacted by social isolation from their peers for shorter time frames • **Impact on school** ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Key services are interrupted for students (e.g., meals, other social,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

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	○ Given current timing, some schools may be able to take advantage of spring break closures ○ Provides protection for older staff and students and staff with underlying medical conditions	physical health, and mental health services, after school programs) ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Potential academic impact because of the disruption to the continuity of learning • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	
Medium-term (4 weeks closure)	• **Impact on disease** ○ Provides more protection for older staff and students and staff with underlying medical conditions • **Impact on schools** ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

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		after school programs) are put at greater risk ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Economic impact if school staff are not paid during school closure must be considered.
Long-term (8 weeks, 20 weeks closure)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have	• **Impact on disease** ○ Longer closures may result in more students congregating outside of	• Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried

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	higher disease impacts, suggests that longer closures are may have greater impact in terms of overall transmission. Provides substantial protection for older staff and students and staff with underlying medical conditions
	• **Impact on schools**
	  ○ Schools without distance learning may see closures of this length as reason to implement distance learning approaches they may not have previously had or used
		school (e.g., other students' homes, shopping malls)
		  ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage.
		• **Impact on families**
		  ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at substantial risk
		  ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs)
		  ○ Student engagement with schools and peers diminishes, which could increase anxiety and other mental health and emotional problems.
		  ○ High school seniors likely to lose ability to participate in their prom, graduation etc.
		• **Impact on schools**
		  ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements
			workers who may have more flexible leave and telework opportunities)
			• If a school closes for this length of time, schools must consider ways to continue key services
			• Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled.
			• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure.
			• Given current timing, 20 week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid June.
			• A 20 week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well
			• Economic impact if school staff are not paid during school closure must be considered.

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		○ Loss of educational progress, even having to add an extra semester or year to graduate or move up a grade ○ Staff within the schools may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ○ Maintaining communication with school staff, families, and students becomes substantially more difficult as the school closure lengthens. • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	

Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

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OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

MAR 1 1 2020

MEMORANDUM FOR CHIEF MANAGEMENT OFFICER OF THE DEPARTMENT OF DEFENSE
SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
CHIEF OF THE NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Force Health Protection Guidance (Supplement 4) – Department of Defense Guidance for Personnel Traveling During the Novel Coronavirus Outbreak

This memorandum supplements requirements in DoD Instruction 6200.03 "Public Health Emergency Management (PHEM) Within the DoD," March 28, 2019, with respect to coronavirus disease 2019 (COVID-19). The COVID-19 outbreak continues to spread globally and as a result, the Centers for Disease Control and Prevention (CDC) is rapidly issuing Travel Health Notices (THNs) and guidance for persons with travel in countries or areas with COVID-19 transmission. CDC THNs tier these locations as Level 3 (Widespread sustained (ongoing) transmission), Level 2 (Sustained (ongoing) community transmission) and Level 1 (Risk of limited community transmission), with associated monitoring guidance for returning travelers. The CDC THNs are at: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html. This guidance applies to all DoD Components, except that it does not apply to air crew of military aircraft.

All existing Novel Coronavirus Outbreak FHP guidance remains in effect and applies to all DoD Components, including the Reserves and National Guard, and, as appropriate, foreign military personnel who are under DoD authority. The FHP guidance for China travelers ("Force Health Protection Guidance (Supplement 1) – Department of Defense Guidance for Monitoring of Personnel Returning from China During the Novel Coronavirus Outbreak," dated February 7, 2020), remains in effect. FHP documents are at: https://www.defense.gov/Explore/Spotlight/Coronavirus. Individuals should continue to check the CDC COVID-19 website for additional updates at: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

This document provides pre- and post-travel health guidance for all DoD travelers to enable mission assurance and Force Health Protection (FHP), utilizing the CDC THNs for DoD Component considerations. DoD Components may be more restrictive based on local risk assessment in consultation with public health authorities. Command location, local community transmission, risk to mission, and risk to force are all key considerations in DoD Component decision making.

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Actions for all DoD travelers

Actions prior to official travel:

- DoD Components shall incorporate CDC guidance into the full scope of planning for official travel, to include the following:
    - Consider the risk profile of the traveler (e.g., older individuals or those with underlying diseases). Limit travel to those individuals who are healthy, to the greatest extent possible. For DoD civilian personnel, these considerations must be consistent with the requirements of the Rehabilitation Act of 1973, as amended.
    - Coordinate with the receiving installation to ensure the post-travel requirements in this document can be implemented at that location.

Actions upon departure/exit screening:

- DoD Components should emphasize each individual's responsibility to avoid travel when sick.
- For travel on military aircraft, DoD Components should ensure exit screening is conducted at the point of embarkation. At a minimum, this should consist of a questionnaire[1] to assess risk of exposure, temperature check (fever is >100.4°F or 38°C per CDC), and visual check for signs and symptoms (i.e., feeling feverish, coughing or shortness of breath per CDC) of COVID-19. If the screening yields concerns, a secondary medical evaluation by a health professional should be conducted. DoD Components should also be prepared to appropriately manage a patient under investigation if such a determination is made, to include referral to the appropriate medical authority per CDC guidance found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html.
- Travel on commercial air carriers may not include exit screening of travelers. Therefore, taking the appropriate action upon arrival is critical.

Actions for all Service members

Actions upon arrival from a CDC THN Level 3 or Level 2 location:

DoD Components should identify all Service members who travel or have traveled in the prior 14 days to, through, or from a CDC THN Level 3 or Level 2 country. This includes travel by military or commercial means, as well as private conveyance, and includes all forms of travel to include Permanent Change of Station, Temporary Duty, and leave. DoD Components should place these Service members under a 14-day restriction of movement (ROM). During the ROM (starting from the day of departure from the Level 3 or Level 2 country):

[1] Guidance to support questionnaire development is at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

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- Service members should be restricted to their residence or other appropriate domicile for 14 days and limit close contact (within 6 feet or 2 meters) with others during this 14-day period. Immediate supervisors will not require Service members to report to their duty location or otherwise disregard the ROM.

- Service members should self-monitor by taking their temperatures twice a day to check for fever, and remain alert for cough or difficulty breathing. If they feel feverish or develop a fever (>100.4°F or 38°C per CDC), cough, or difficulty breathing during the self-monitoring period, they should self-isolate, limit contact with others, notify their supervisor or chain of command, and seek advice by telephone from the appropriate healthcare provider to determine whether medical evaluation is needed.

- For any in-person assessments of Service members (including asymptomatic individuals), medical personnel should apply CDC guidance to include wearing appropriate personal protective equipment (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html).

- Service members living in open-bay settings, or rooms with shared bathrooms and/or kitchen facilities, should be placed in separate lodging to span the 14-day ROM period. The DoD Component to which the Service member is assigned will arrange and fund the separate lodging if needed.

- Service members should separate themselves from other people in the home or dwelling if residing with roommates or family members and avoid sharing personal items.

- Service members should not travel, visit public or crowded areas, or use public transportation and should avoid interaction with pets or other animals.

- Medical evaluation and care should be immediately arranged if the Service member displays fever or symptoms consistent with COVID-19, as per CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html).

    - The Service member should call ahead before going to a medical treatment facility, informing medical staff of his/her symptoms and travel history.

    - Medical staff should follow CDC guidance when assessing individuals displaying fever and symptoms consistent with COVID-19.

    - DoD Components should appropriately report an individual if identified as a patient under investigation, per previously published Under Secretary of Defense for Personnel and Readiness guidance, "Force Health Protection Guidance for the Novel Coronavirus Outbreak," dated January 30, 2020.

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Actions upon arrival from a non-CDC THN Level 2 or Level 3 CONUS or OCONUS location:

DoD Components should identify and track all Service members who travel or have a history of travel in the prior 14 days to, through, or from a non-CDC THN Level 2 or Level 3 CONUS or OCONUS location. This includes travel by military or commercial means as well as private conveyance and includes all forms of travel to include Permanent Change of Station, Temporary Duty, and leave. DoD Components should ensure that these Service members take the following actions for the next 14 days:

- Implement self-observation, i.e., remain alert for fever, cough, or difficulty breathing.
- To the extent possible, implement social distancing, e.g., remain out of congregate settings, avoid mass gatherings, and maintain 6 feet or 2 meter distance from others when possible.
- Immediately self-isolate, limit contact with others, and seek advice by telephone from the appropriate healthcare provider to determine whether medical evaluation is required, if individuals feel feverish or develop measured fever, cough, or difficulty breathing.

Actions for DoD civilian employees, contractor personnel, and family members

DoD strongly recommends that DoD civilian employees, contractor personnel, and family members who travel to, through, and from countries with a CDC THN for COVID-19 follow this DoD guidance, which is more stringent than CDC guidance. DoD Components should restrict DoD workplace access for 14 days for DoD civilian employees and contractor personnel whose travel has included THN Level 2 and Level 3 locations. If these civilian employees and contractor personnel feel feverish or develop a fever, cough, or difficulty breathing, they should notify their supervisor or chain of command. For all other travel, DoD Components will encourage self-observation and accommodation of social distancing. To restrict access from the DoD workplace and maximize telework options, DoD Components shall implement the Under Secretary of Defense for Personnel and Readiness memorandum, "Civilian Personnel Guidance for DoD Components in Responding to Coronavirus Disease 2019," dated March 8, 2020. For contractor personnel, DoD Components should implement measures in consultation with the appropriate contracting office.

This guidance is effective March 13, 2020. My point of contact is COL Jennifer M. Kishimori, who may be reached at (703) 681-8179 or jennifer.m.kishimori.mil@mail.mil.

Alexis Lasselle Ross
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Attachment:
Quick-Reference for Travel during the COVID-19 Outbreak

AMERICAN OVERSIGHT

Attachment 1. Quick Reference for Travel during the COVID-19 Outbreak.

CDC THN Level[1]	CDC Definitions	Actions Upon MIL AIR Departure	Actions Upon Arrival[2]
3	• Widespread sustained (ongoing) transmission • Avoid non-essential travel • Travelers should stay home for 14 days	Risk Assessment: • Questionnaire • Temperature Checks • Visual assessment for signs and symptoms Medical Team Assessment (if indicated): • Health evaluation • Transfer to command health authority if needed	• Stay at home for 14 days • Practice social distancing • Self-monitoring
2	• Sustained (ongoing) community transmission • Special Precautions for High-Risk Travelers		• Stay at home for 14 days • Practice social distancing • Self-monitoring
1	• Risk of Limited community transmission • Practice usual precautions		• Ensure personnel tracking • Practice social distancing for 14 days • Self-observation for 14 days
N/A	• All other countries/areas		• Ensure personnel tracking • Practice social distancing for 14 days • Self-observation for 14 days

[1]Travel Health Notice (THN), [2]Does not apply to air crew.

Actions prior to official travel:

- DoD Components shall incorporate CDC guidance into the full scope of planning for official travel to include the following:
    - Consider the risk profile of traveler (e.g., older individuals or those with underlying diseases). Limit travel to those individuals to those who are healthy, to the greatest extent possible. For DoD civilian personnel, these considerations must be consistent with the requirements of the Rehabilitation Act of 1973, as amended.
    - Coordinate with the receiving installation to ensure the post-travel requirements can be implemented at that location.

References:
DoD COVID-19 Homepage (includes all Force Health Protection Guidances):
https://www.defense.gov/Explore/Spotlight/Coronavirus

CDC COVID-19 Homepage (CDC authoritative information on COVID-19):
https://www.cdc.gov/coronavirus/2019-ncov/index.html

CDC Travel Health Notice Information (CDC Country Level Notifications):
https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

CDC Travel Precautions (includes COVID-19 symptoms such as fever, cough, shortness of breath):
https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

CDC Healthcare Provider Information (includes Infection Control information and Personal Protective Equipment Guidance):
https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-13-20 CDC Media Telebriefing: Update on COVID-19 and updated Considerations for School Closure Guidance
Date: Friday, March 13, 2020 10:45:02 AM
Attachments: considerations-for-school-closure.pdf

Dear Colleagues:

Final CDC Considerations for School Closure Draft attached. See below for media briefing information.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 1:00 p.m. ET Friday, March 13, 2020

Dial-In

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

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U.S. Department of Health and Human Services

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

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

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School Decision Tree

All Schools Regardless of Community Spread

Confirmed person with COVID-19 in building?

→ Assess Risk

→ *Short (potential 2-5 Day) Building Dismissal to Clean/Disinfect/Contact Trace in consultation with local health officials*

No Community Spread

- Prepare
- Teach and reinforce healthy hygiene
- Develop information sharing systems
- Intensify cleaning and disinfection
- Monitor for absenteeism
- Assess group gatherings and events – consider postponing non-critical gatherings and events
- Require sick students and staff stay home
- Establish procedures for someone becoming sick at school

↓

Monitor changes in community spread

Minimal to Moderate OR Substantial Community Spread

Is community spread Minimal to Moderate or Substantial?

M/M

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building.
- Consider ways to accommodate needs of children and families at high risk.

S

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building WITH EXTENDED SCHOOL DISMISSALS.
- Consider ways to accommodate needs of children and families at high risk.

AMERICAN OVERSIGHT

Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	• **Impact on disease** ○ Allows for decontamination ○ Allows time for epidemical evaluation and contact tracing; further action can be scaled based on epi investigation.	• **Impact on disease** ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students.	• May occur frequently during a wide-spread outbreak
Short-term (2 weeks closure)	• **Impact on disease** ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • **Impact on families** ○ Children may be less impacted by social isolation from their peers for shorter time frames • **Impact on school** ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather) ○ Given current timing, some schools may be able to take advantage of spring break closures	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short-term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Key services are interrupted for students (e.g., meals, other social,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

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	○ Provides protection for older staff and students and staff with underlying medical conditions	physical health, and mental health services, after school programs) ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Potential academic impact because of the disruption to the continuity of learning • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	
Medium-term (4 weeks closure)	• **Impact on disease** ○ Provides more protection for older staff and students and staff with underlying medical conditions • **Impact on schools** ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at greater risk	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

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		○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Economic impact if school staff are not paid during school closure must be considered.
Long-term (8 weeks, 20 weeks closure)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that longer closures are may have greater impact in terms of overall	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls)	• Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried workers who may have more flexible leave and telework opportunities)

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	transmission. Provides substantial protection for older staff and students and staff with underlying medical conditions
	• **Impact on schools**
	  ○ Schools without distance learning may see closures of this length as reason to implement distance learning approaches they may not have previously had or used
		○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage.
		• **Impact on families**
		  ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at substantial risk
		  ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs)
		  ○ Student engagement with schools and peers diminishes, which could increase anxiety and other mental health and emotional problems.
		  ○ High school seniors likely to lose ability to participate in their prom, graduation etc.
		• **Impact on schools**
		  ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements
		  ○ Loss of educational progress, even having to add an extra semester or
			• If a school closes for this length of time, schools must consider ways to continue key services
			• Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled.
			• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure.
			• Given current timing, 20-week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid-June.
			• A 20-week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well
			• Economic impact if school staff are not paid during school closure must be considered.

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		year to graduate or move up a grade ○ Staff within the schools may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ○ Maintaining communication with school staff, families, and students becomes substantially more difficult as the school closure lengthens. • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	

Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-13-20 CDC Media Telebriefing: Update on COVID-19 and updated Considerations for School Closure Guidance
Date: Friday, March 13, 2020 10:46:44 AM
Attachments: considerations-for-school-closure.pdf

Dear Colleagues:

Final CDC Considerations for School Closure Draft attached. See below for media briefing information.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 1:00 p.m. ET Friday, March 13, 2020

Dial-In

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

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

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

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School Decision Tree

All Schools Regardless of Community Spread

Confirmed person with COVID-19 in building?

→ Assess Risk →

Short (potential 2-5 Day) Building Dismissal to Clean/Disinfect/Contact Trace in consultation with local health officials

No Community Spread

- Prepare
- Teach and reinforce healthy hygiene
- Develop information sharing systems
- Intensify cleaning and disinfection
- Monitor for absenteeism
- Assess group gatherings and events – consider postponing non-critical gatherings and events
- Require sick students and staff stay home
- Establish procedures for someone becoming sick at school

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Monitor changes in community spread

Minimal to Moderate OR Substantial Community Spread

Is community spread Minimal to Moderate or Substantial?

M/M

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building.
- Consider ways to accommodate needs of children and families at high risk.

S

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building WITH EXTENDED SCHOOL DISMISSALS.
- Consider ways to accommodate needs of children and families at high risk.

AMERICAN OVERSIGHT

Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	• **Impact on disease** ○ Allows for decontamination ○ Allows time for epidemical evaluation and contact tracing; further action can be scaled based on epi investigation.	• **Impact on disease** ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students.	• May occur frequently during a wide-spread outbreak
Short-term (2 weeks closure)	• **Impact on disease** ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • **Impact on families** ○ Children may be less impacted by social isolation from their peers for shorter time frames • **Impact on school** ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather) ○ Given current timing, some schools may be able to take advantage of spring break closures	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short-term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Key services are interrupted for students (e.g., meals, other social,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

AMERICAN OVERSIGHT

	○ Provides protection for older staff and students and staff with underlying medical conditions	physical health, and mental health services, after school programs) ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Potential academic impact because of the disruption to the continuity of learning • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	
Medium-term (4 weeks closure)	• **Impact on disease** ○ Provides more protection for older staff and students and staff with underlying medical conditions • **Impact on schools** ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at greater risk	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

AMERICAN OVERSIGHT

		○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Economic impact if school staff are not paid during school closure must be considered.
Long-term (8 weeks, 20 weeks closure)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that longer closures are may have greater impact in terms of overall	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls)	• Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried workers who may have more flexible leave and telework opportunities)

AMERICAN OVERSIGHT

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	• **Impact on schools**
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		  ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements
		  ○ Loss of educational progress, even having to add an extra semester or
			• If a school closes for this length of time, schools must consider ways to continue key services
			• Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled.
			• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure.
			• Given current timing, 20-week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid-June.
			• A 20-week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well
			• Economic impact if school staff are not paid during school closure must be considered.

AMERICAN OVERSIGHT

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Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-13-20 CDC Media Telebriefing: Update on COVID-19 and updated Considerations for School Closure Guidance
Date: Friday, March 13, 2020 10:43:20 AM
Attachments: considerations-for-school-closure.pdf

Dear Colleagues:
Final CDC Considerations for School Closure Draft attached. See below for media briefing information.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 1:00 p.m. ET Friday, March 13, 2020

Dial-In

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

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U.S. Department of Health and Human Services

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

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

AMERICAN OVERSIGHT

School Decision Tree

All Schools Regardless of Community Spread

Confirmed person with COVID-19 in building?

→ Assess Risk →

Short (potential 2-5 Day) Building Dismissal to Clean/Disinfect/Contact Trace in consultation with local health officials

No Community Spread

- Prepare
- Teach and reinforce healthy hygiene
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-14-20 OSHA Enforcement Memo on Respirator Annual Fit Testing
Date:	Sunday, March 15, 2020 7:50:08 AM

Dear Colleagues:

Yesterday the Occupational Safety and Health Administration (OSHA) released **Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak**. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit

A fit test is required for anyone wearing a respirator to protect against COVID-19. Annual fit test can be temporarily suspended if employee has already been fit tested to that respirator.

See relevant bullets from memo below:

- Perform initial fit tests for each HCP with the same model, style, and size respirator that the worker will be required to wear for protection against COVID-19 (initial fit testing is essential to determine if the respirator properly fits the worker and is capable of providing the expected level of protection);

- Inform workers that the employer is temporarily suspending the annual fit testing of N95 filtering facepiece respirators to preserve and prioritize the supply of respirators for use in situations where they are required to be worn.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-14-20 OSHA Enforcement Memo on Respirator Annual Fit Testing
Date:	Sunday, March 15, 2020 7:52:12 AM

Dear Colleagues:

Yesterday the Occupational Safety and Health Administration (OSHA) released **Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak**. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-14-20 OSHA Enforcement Memo on Respirator Annual Fit Testing
Date:	Sunday, March 15, 2020 7:47:10 AM
Importance:	High

Dear Colleagues:

Yesterday the Occupational Safety and Health Administration (OSHA) released **Temporary Enforcement Guidance - Healthcare Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak**. The guidance can be found here: https://www.osha.gov/memos/2020-03-14/temporary-enforcement-guidance-healthcare-respiratory-protection-annual-fit

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-17-20 CDC Weekly Key Messages, Daily Key Points, and Links to Updated COVID-19 Guidance
Date:	Wednesday, March 18, 2020 8:28:36 AM
Attachments:	CDC_COVID-19_Daily Key Points__3.17.2020_FINAL.pdf CDC_COVID-19 Weekly Key Messages__3.17.20_FINAL.pdf
Importance:	High

Dear Colleagues:

Attached please find the CDC COVID-19 weekly key messages (Week of 3/8) and CDC COVID-19 Key Points for Tuesday, March 17, 2020. Please feel free to share with your staff and other partners.

In addition, The CDC COVID-19 Website has been updated with several new/updated interim guidance documents. Click the links below to find the guidance.

- Updated **home isolation guidance**
- Updated information on when to end isolation on **What to do it you are sick**
- New Guidance – **Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected (COVID-19)**
- New Guidance – **Ending home isolation for people who are immunocompromised**

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AMERICAN OVERSIGHT

CDC Weekly Key Messages

Coronavirus Disease 2019 (COVID-19) Outbreak

March 17, 2020 as of 10:00pm

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.

All content updated since March 8 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use “the virus that causes COVID-19.”
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.

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    - The outbreak began in China but is spreading worldwide and is now considered a pandemic.
- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person-to-person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **March 16, more than 167,511** cases have been identified worldwide. More than **86,434** of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On March 11, 2020, WHO announced that the outbreak of COVID-19 can be characterized as a pandemic.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- Pandemics of respiratory disease follow a certain progression outlined in the Pandemic Intervals Framework, part of the National Pandemic Strategy.
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.

AMERICAN OVERSIGHT

    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
    - Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
    - Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
    - The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time. Selected pandemic preparedness materials are available online.
- On March 13, the President of the United States declared the COVID-19 outbreak a national emergency.
- On March 16, the White House announced a program called "15 Days to Slow the Spread." This is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **March 16, 2020**:

- **Travel-related: 205**
- **Close contact: 214**
- **Under investigation: 3,068**
- **Total cases: 3,487**
- **Deaths: 68**
- **Jurisdictions reporting cases: 53 (49 states and the District of Columbia)**

For global cases, please see the WHO daily situation reports.

SITUATION IN THE U.S.

- Different parts of the country are seeing different levels of COVID-19 activity. The United States nationally is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase. The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- CDC and state and local public health laboratories are testing for the virus that causes COVID-19.
- More and more states are reporting cases of COVID-19 to CDC.
- U.S. COVID-19 cases include:
    - Imported cases in travelers
    - Cases among close contacts of a known case
    - Community-acquired cases where the source of the infection is unknown.
- Three U.S. states are experiencing sustained community spread: Washington, California, and New York.

CLUSTER IN WASHINGTON STATE

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.

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- One of the patients died and was the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a healthcare worker.
    - This was the first reported case in a healthcare worker.
- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
- Circumstances suggest person-to-person spread, including in the long-term care facility.
- CDC has deployed a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.
- CDC infection control experts are assessing the risk of additional healthcare worker exposures and carefully reviewing infection control practices within the facility to protect residents and healthcare workers from further spread of COVID-19.
    - The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
    - All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- It is rare for animal coronaviruses to become capable of infecting humans and then spreading between people.
    - Severe acute respiratory syndrome (SARS-CoV) and Middle East respiratory syndrome (MERS-CoV) are examples of coronaviruses that originated in animals and spread to people.
    - That is what is suspected happened with the virus that causes the current outbreak of COVID-19.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.
    - At this time, there is no evidence that companion animals, including pets, can spread COVID-19. CDC has not received any reports of pets or other animals becoming sick with COVID-19.
    - There is no reason to think that any animals, including pets, in the United States might be a source of infection with this new coronavirus.

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- On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested "weak positive" to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19.
- CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
- It's important to remember that dogs have their own coronaviruses, which cannot spread to people.
    - *AFCD official report available*

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes or ticks.
    - Mosquitoes and ticks cannot spread all types of viruses. For a virus to pass to a person through a mosquito or tick bite, the virus must be able to replicate inside the mosquito or tick.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

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- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.
- On February 18, CDC stood up a new surge laboratory to support testing for COVID-19. This expanded capacity to 350 samples per day
- On February 20, CDC completed contracts with 2 large commercial manufacturers to ensure reagent availability for the public health laboratories
- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits include the two components (e.g., reagents) that are specific to novel coronavirus.
    - Before new test kits were available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner was able to move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand-carried to IRR for repackaging and distribution to additional public health labs.
- On February 29, IRR began to distribute new test kits to the additional 40 laboratories.
- As of the evening of March 16, at least one lab in all 50 states (and Washington, D.C.) is able to run the CDC assay. 89 public health labs are running the CDC test.
- Commercial manufacturers are now producing their own tests.
- As of March 16th, CDC has tested over 4255 samples.

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- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
    - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
    - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

PEOPLE AT RISK FOR SERIOUS ILLNESS

- Older adults and people who have severe underlying medical conditions seem to be at higher risk for more serious COVID-19 illness.
- Based upon available information to date, those most at risk include—
    - People 65 years and older
    - People who live in a nursing home or long-term care facility
    - People of any age with the following underlying medical conditions, particularly those that are not well controlled
        - Heart disease
        - Diabetes
        - Lung disease
- Early data suggest older people are twice as likely to have serious COVID-19 illness.
- If you are at increased risk for COVID-19 complications due to age or because you have a serious underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.
- If you are a person with a serious underlying medical condition that can put you at higher risk, stay home and away from other people.
    - Stock up on supplies
    - Make a plan with family members, friends, caregivers, and/or healthcare providers and consider including the following in your plan:

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- Alternate caregiver in case your caregiver is sick or paid service is limited or unavailable—it's a good idea to have at least three alternate caregivers
- A 30-day supply of medications and a checklist to monitor usage
- Nonperishable food items for at least 30 days
- Phone bank plan in case of quarantine (this reduces feelings of loneliness and isolation)

- If you feel sick, use these guidelines to reduce the risk of spread:
  - Stay home.
  - Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
  - If you need emergency help, call 911.
  - If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.

What people at higher risk can do to prepare

- Have supplies on hand
  - Contact your healthcare professional to ask about obtaining extra necessary medications to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home.
  - If you cannot get extra medications, consider using mail-order for medications.
  - Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
  - Have enough household items and groceries on hand so that you will be prepared to stay at home for at least 14 days.
- Take everyday precautions
  - Avoid close contact with people who are sick.
  - Take everyday preventive actions.
    - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
    - If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.
    - To the extent possible, avoid touching high-touch surfaces in public places – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
    - Wash your hands after touching surfaces in public places.
    - Avoid touching your face, nose, eyes, etc.
    - Clean and disinfect your home to remove germs. Practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks and cell phones).

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        - Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.
- If COVID-19 is spreading in your community, take extra measures to put distance between yourself and other people.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks.
- Have a plan for if you get sick.
    - **Consult with your healthcare provider for more information about** monitoring your health for symptoms suggestive of COVID-19**.**
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick.
    - Plan for how you will get more supplies if you need them before you recover.
- Watch for symptoms and emergency warning signs.
    - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
    - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:
        - Difficulty breathing or shortness of breath
        - Persistent pain or pressure in the chest
        - New confusion or inability to arouse
        - Bluish lips or face

          *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

What to do if you are at higher risk and get sick:

- Stay home and call your doctor.
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

Community Support for Older Adults

- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.

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- Many of these people live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.
- Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and Caregiver Support

- Know what medications your loved one is taking and see if you can help them have extra on hand.
- Monitor food and other medical supplies (hearing aid batteries, oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- Stock up on non-perishable food items to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

Coping for People at Risk for Serious Illness and Caregivers

- People at higher risk for COVID-19 (including older people and people with severe underlying medical conditions), as well as the people who care for and about them, may feel especially stressed, worried, or anxious.
    - Things you can do to take care of yourself and help the people you care for:
        - Take breaks from watching, reading, or listening to news stories, including social media. Remind others that you care for to do the same.
        - Stay connected to others through calls (audio or video), instant messaging, email, letters, or other forms of communication, even if you cannot be together in person.
        - Talk with people you trust about your concerns and how you are feeling.
- If you, or someone you care about, is feeling overwhelmed with emotions like sadness, depression, or anxiety, or if you are concerned about harming yourself or others, call 911 or the SAMHSA Disaster Distress Helpline: 1-800-985-5990 or text TalkWithUs to 66746 (TTY 1-800-846-8517).

Tribal Elders and Multi-generational Tribal Families

- Tribal communities and Urban American Indians and Alaska Natives are particularly vulnerable to COVID-19 because of unique characteristics of health that impact tribal members.
- Any exposure to COVID-19 can pose a threat to tribal and urban American Indian and Alaska Native communities.
- Many tribal communities are made up of interdependent multi-generational families that house many Elders. These families may be both geographically and socially close. For tribal families, avoiding sick children or Elders may not seem practical or desirable.
- Families can take steps to protect the health and safety of Elders.
    - Consider limiting visitation except for caregivers or healers.
    - Avoid communing at social tribal events or gatherings, supermarkets, or casinos.

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- Consider seeking out other partners in the community to help with housing accommodations or optional caregiving, in case of illness.

Rural Communities

- Rural communities face some COVID-19 challenges that are different from urban and suburban communities. These differences warrant additional guidance.
- Many rural communities have experienced multiple closings of hospitals and healthcare facilities. This can leave an already vulnerable population without immediate access to healthcare, should an outbreak occur in the community.
- People living in rural communities can take steps to prepare.
    - Identify the two closest healthcare facilities to contact in case of an outbreak
    - Create an information card with the numbers and addresses of healthcare facilities and the family and friends who are physically nearest to you.
    - Locate state, local, or tribal health centers in advance to identify available resources
    - Create a phone tree system (activating a group of people by telephone to get a message out quickly) with family, friends, and neighbors

People with Asthma

- People with asthma may be at higher risk of getting infected with COVID-19. COVID-19 can affect your respiratory tract (nose, throat, lungs), cause an asthma attack, and possibly lead to pneumonia and acute respiratory disease.
- If you have asthma, you should prepare for COVID-19 and follow your Asthma Action Plan.
    - Take your asthma medication exactly as prescribed.
        - Talk to your healthcare provider, insurer, and pharmacist about creating an emergency supply of prescription medications, such as asthma inhalers.
        - Make sure that you have 30 days of non-prescription medications and supplies on hand too, in case you need to stay home for a long time.
    - Know how to use your inhaler.
    - Avoid your asthma triggers.
    - Clean and disinfect frequently touched surfaces like tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks daily to protect yourself against COVID-19.
        - Avoid disinfectants that can cause an asthma attack.
    - As more cases of COVID-19 are discovered and our communities take action to combat the spread of disease, it is natural for some people to feel concerned or stressed. Strong emotions can trigger an asthma attack. Take steps to help yourself cope with stress and anxiety.
- If you have symptoms
    - Contact your health care provider to ask about your symptoms.

For Pregnant People:

- Pregnant people may be at higher risk for having severe illness from COVID-19.
- CDC has limited information on adverse pregnancy outcomes in pregnant people with COVID-19.

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- Pregnancy loss, including miscarriage and stillbirth, has been observed in cases of infection with other related coronaviruses [SARS-CoV and MERS-CoV] during pregnancy.
- There is limited information on infant outcomes of COVID-19 illness during pregnancy.
- Other respiratory viral infections during pregnancy, such as influenza, have been associated with adverse neonatal outcomes, including low birth weight and preterm birth.
- High fevers during the first trimester of pregnancy can increase the risk of certain birth defects.

- It is especially important for pregnant people to take actions to reduce their risk of exposure.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
  - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
  - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
  - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
  - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
    - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
  - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
  - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
  - Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
  - Share accurate information about how the virus spreads.
  - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
    - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
    - Engage with stigmatized groups in person and through media channels including news media and social media.

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- Share with others the need for social support for people who have returned from an area with ongoing spread or are worried about friends or relatives in the affected areas.

TRAVEL

Presidential Proclamations announcing travel restrictions for travelers from China, Iran, United Kingdom, Republic of Ireland, and most of Europe

- On January 31, President Trump issued the first Presidential Proclamation implementing temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
    - The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days.
- On March 2, a Presidential Proclamation suspended entry to the United States of foreign nationals who have been in Iran in the past 14 days.
    - For more information, consult the notice published in the Federal Register.
- On March 11, a Presidential Proclamation suspended entry to the United States of foreign nationals who have been in 26 countries in Europe (known as the Schengen Area) in the past 14 days.
    - The order suspends the entry of foreign nationals for 30 days from these European states: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland.
- On March 14, a Presidential proclamation suspended entry to the United States of foreign nationals who have been in the United Kingdom (excluding overseas territories outside of Europe) or the Republic of Ireland in the past 14 days.
- Exemptions to these travel restrictions include American citizens, legal permanent residents, and immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")

American Citizens and Exempted Persons:

- All American citizens and exempted persons coming from
    - **China, and Iran** will be directed to ("**funneled to"**) one of 11 US airports (the first 11 airports in the list below).
    - **Europe, the United Kingdom, and the Republic of Ireland** will be directed to ("funneled to") one of 13 US airports (including the last 2 airports in the list below).
- American citizens and exempted persons who have been in **Hubei province** in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
    - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)

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        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in **other parts of mainland China (outside of Hubei Province) or Iran** in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
    - American citizens and exempted persons who have been to the **Schengen area of Europe, UK and Ireland** in the previous 14 days will screened by Department of Homeland Security and receive a Travelers' Health Alert Notice.
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
    - The 13 airports where travelers are being funneled include:
        - John F. Kennedy International Airport (JFK), New York
        - Chicago O'Hare International Airport (ORD), Illinois
        - San Francisco International Airport (SFO), California
        - Seattle-Tacoma International Airport (SEA), Washington
        - Daniel K. Inouye International Airport (HNL), Hawaii
        - Los Angeles International Airport (LAX), California
        - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
        - Washington-Dulles International Airport (IAD), Virginia
        - Newark Liberty International Airport (EWR), New Jersey
        - Dallas/Fort Worth International Airport (DFW), Texas
        - Detroit Metropolitan Airport (DTW), Michigan
        - Boston Logan International Airport (BOS), Massachusetts
        - Miami International Airport (MIA), Florida
    - As of March 12, about 57,000 people have been screened at U.S. airports.

Travel Notices and Advisories:

- **CDC's most current travel notices:**
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, most of Europe (Schengen Area), the United Kingdom and the Republic of Ireland, South Korea, and cruise travel worldwide.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for the global outbreak

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- CDC has posted a webpage about COVID-19 and considerations for travel in the United States.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Chartered flights returned passengers from Wuhan City, China and passengers from a cruise ship docked in Japan. (See section: Diamond Princess).
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- As of March 6th, almost everyone from the repatriation flights who were quarantined has been released and returned home.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored by medical and public health personnel throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and were housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
    - All of these individuals completed their quarantine.
- No US citizens remain on the Diamond Princess.
- More than 25 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-19, including some who are reportedly severely ill.

Grand Princess*:

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- CDC has been working with the California Department of Public Health, other federal, state, and local partners and the Princess Cruise Line to investigate a possible cluster of COVID-19 cases connected with a Grand Princess voyage from February 11-21. Additionally, CDC worked with the same partners to assess the risk for passengers currently aboard the Grand Princess.
    - CDC notified states about the risk and management of passengers aboard the Grand Princess between February 11 and 21 who might have COVID-19 symptoms.
- At this time, the U.S. Department of Health and Human Services (HHS) is working with state and local partners in California to support the return of passengers currently aboard the Grand Princess.
- On March 8, HHS announced that the Grand Princess would dock in the Port of Oakland.
    - Passengers are being transferred to federal military installations for medical screening, COVID-19 testing, and a 14-day quarantine.
    - Nearly 1,000 passengers who are California residents are completing the mandatory quarantine at Travis Air Force Base.
    - Additional residents of California and residents of other states are completing the mandatory quarantine at Marine Corps Air Station Miramar in San Diego, Lackland Air Force Base in San Antonio, or Dobbins Air Reserve Base in Georgia.
    - Throughout the quarantine, passengers will be monitored for symptoms of COVID-19.
    - The Department of State is working closely with the home countries of several hundred passengers to arrange for repatriation to their countries.
    - If you were on the initial—February 11-21—Grand Princess cruise and have COVID-19 symptoms, please call your healthcare provider and explain your symptoms and potential exposure.
        - Your healthcare provider will advise you of how to move forward.
        - In the meantime, CDC always recommends everyday preventive actions to help prevent the spread of respiratory diseases.
    - CDC is monitoring a number of other cruises for potential and confirmed COVID-19 cases, including a cluster of cases among people who traveled on Nile River Cruises in Egypt in late February and early March.
        - CDC is notifying states of known returned travelers who may have been exposed.

**Please continue to look for updates in CDC's Daily Key Points and in next week's Key Messages document. The situation is rapidly evolving and CDC will provide updates as they become available.*

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.

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- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
    - The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - As of March 13, all American citizens and exempted persons coming from most of Europe (knows as the Schengen Area) will be funneled through 13 airports (listed in the above Travel section). As of March 16, all American citizens and exempted persons coming from the United Kingdom (excluding overseas territories outside of Europe) or the Republic of Ireland will also be funneled through those 13 airports.
        - CDC and partners will conduct enhanced illness response at these points of entry.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;
        - South Korea — Level 3, Avoid Nonessential Travel — updated February 24;
        - Most of Europe (Schengen Area) — Level 3, Avoid Nonessential Travel – updated March 12;
        - Global Outbreak — Level 2, Practice Enhanced Precautions — posted March 11.
        - United Kingdom and U.K. — Level 3, Avoid Nonessential Travel — posted March 15.
        - COVID-19 and Cruise Ship Travel – Level 3, Avoid Nonessential Travel — posted March 17.
    - CDC is issuing clinical guidance, including clinical care guidance and healthcare infection control guidance.
    - On March 2, FDA announced that commercial companies may sell test kits under CDC's EUA.
    - CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
    - CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure

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working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.

- State PHEP programs stand ready to address future developments in the outbreak.
- CDC has developed a fast-track approval method that enables jurisdictions to request the redirection of Public Health Emergency Preparedness (PHEP) cooperative agreement funds for the rapid procurement of services, supplies, and equipment needed during the COVID-19 response.
- CDC has reduced the normal 30-day request process to one to three business days for urgent requests.
- CDC has coordinated a funding strategy and developed guidance for awarding an initial $35 million to jurisdictions responding to COVID-19.
- The funding is being awarded through two mechanisms:
    - Component A of the Crisis Response Cooperative Agreement, and
    - The Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement to select state and local jurisdictions.
- These initial awards support activities such as monitoring of travelers, data management, laboratory equipment, supplies, staffing, shipping, infection control, surge staffing, and sentinel surveillance.
- Awards were issued March 6.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity. CDC developed a molecular test to detect COVID-19 from human clinical specimens and distributed this test to state and local health laboratories.
- After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test.
    - Further, newly manufactured kits were provided to the International Reagent Resource for distribution.

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        - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
        - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
        - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
        - As of March 16, 89 public-health labs are now testing samples with the CDC assay (50 states plus Washington DC and Guam).
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC is conducting laboratory testing in two of its laboratories at its headquarters in Atlanta. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
    - CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.
    - CDC has deployed staff to assist in local areas experiencing clusters of COVID-19.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- CDC is providing technical assistance to the Government of Italy for exit screening flights departing from Italy to the United States.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.

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        - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
        - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –

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        - By having direct contact with infectious secretions from a patient, such as being coughed on.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent International Travelers:

- If you have traveled internationally, watch your health, and limit interactions with others for 14 days after returning to the United States.
- If you feel sick with fever, cough, or difficulty breathing during this time, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
    - If you were in a country with widespread sustained (ongoing) transmission—China, Iran, South Korea, most of Europe (known as the Schengen Area), the United Kingdom, or the Republic of Ireland—stay home, monitor yourself, and practice social distancing for 14 days after you left that country.

People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

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On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- On March 16, the White House recommended that if someone in your household has tested positive for COVID-19, the entire household should stay home and you should contact your medical provider.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

Healthcare Professionals

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- As availability of diagnostic testing for COVID-19 increases, clinicians will be able to access laboratory tests for diagnosing COVID-19 through clinical laboratories performing tests authorized by FDA under an Emergency Use Authorization (EUA).
    - Clinicians will also be able to access laboratory testing through public health laboratories in their jurisdictions.
- This expands testing to a wider group of symptomatic patients. Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested.
    - Decisions on which patients receive testing should be based on the local epidemiology of COVID-19, as well as the clinical course of illness.
    - Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing).
    - Clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Epidemiologic factors that may help guide decisions on whether to test include: any persons, including healthcare workers, who have had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset, or a history of travel from affected geographic areas within 14 days of symptom onset.

Recommendations for Reporting, Testing, and Specimen Collection:

- Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19.
- State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website.
- State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays.
- Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.
- On March 13, CDC updated its guidance for specimen collection for testing for COVID-19to to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.

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- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019. Everyone has a role to play in getting ready and staying healthy.
    - For most people in the U.S., the immediate risk of being exposed to the virus that causes COVID-19 is thought to be low. The virus is not currently widespread in the U.S.
    - In places where ongoing community spread of the virus that causes COVID-19 has been reported, people are at elevated risk of exposure.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as temporary school dismissals, postponing or cancelling large events, social distancing (i.e. limiting face-to-face contact) can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for disease outbreaks, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local public health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs in their local communities.
- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, respiratory and cough etiquette, using facemasks in community settings when ill, practicing hand hygiene)
    - Community measures aimed at increasing social distancing (e.g., temporary school dismissals, social distancing in workplaces (like working remotely), postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched objects or surfaces)

Household/Personal Protective Measures

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- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, **stay home when you are sick** with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- **Mass gatherings:**
    - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
    - On March 16, the White House recommended avoiding social gatherings in groups of more than 10 people.
- **Community and faith-based organizations:**
    - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.
    - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before an outbreak can help provide your organization with the support and resources needed.
    - CDC has created interim guidance to help you create an emergency plan for your community and faith-based organization.
- **Administrators of U.S. childcare programs and K-12 schools:**
    - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
    - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be dismissed in the event of an outbreak. (NOTE: The U.S. Department of Education does not recommend using "school closure" terminology.)
    - School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
    - CDC has posted guidance for school settings on its website.
    - CDC has posted recommendations of considerations for school dismissals.

Information for Law Enforcement

- For law enforcement personnel performing daily routine activities, the immediate health risk is low.

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- CDC has developed recommendations for law enforcement to protect themselves from exposure.
    - Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS.
    - Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
    - Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Different styles of PPE may be necessary to perform operational duties.
    - These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.
- If close contact occurs during apprehension:
    - Clean and disinfect duty belt and gear prior to reuse. Use a household cleaning spray or wipe, according to the product label.
    - Follow standard operating procedures for the containment and disposal of used PPE.
    - Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:
    1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
    2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
    3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
    4. Rinse your hands well under clean, running water.
    5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

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- Healthcare facilities are increasingly unable to procure reliable and sufficient supplies for infection control, including N95 respirators.
- Because of demands associated with the COVID-19 response, CDC has updated the current national COVID-19 infection control guidance for healthcare in the midst of supply realities and growing insight about the spread of COVID-19.
- Protection of healthcare personnel is a priority. CDC's updated guidance on infection control aims to prioritize the use of N95 respirators and other respiratory protection devices for use during high-risk procedures while still protecting health care personnel with facemasks and eye protection during other routine patient care activities, in the setting of respirator shortages.
- CDC's updated, interim IPC guidance also aims to support health care facilities in practical decision-making at the local level to maintain a functional health care system while protecting healthcare workers.
- The guidance also outlines multiple interventions that can be implemented to enhance protection of health care personnel
- CDC has updated guidance on the PPE healthcare personnel should use when caring for patients with known or suspected COVID-19:
    - Eye protection, gown, and gloves continue to be recommended.
    - While respirators remain preferred, facemasks are an acceptable alternative until the supply chain is restored.
        - Facemasks protect the wearer from splashes and sprays.
        - Respirators, which filter inspired air, offer respiratory protection.
    - Respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to healthcare professionals.
- The risk of transmission can be reduced by several types of actions, like prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- CDC reminds all employers and healthcare personnel about the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
- All healthcare facilities should continuously review their infection control supply inventories and taking steps to optimize supplies.
    - This is particularly true for areas in facilities where aerosol-generating procedures are performed, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
- The anticipated timeline for return to routine levels of PPE is not known.

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    - CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available.
    - CDC has also posted a companion checklist to help healthcare facilities prioritize the implementation of the strategies is available.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not typically procure N-95 respirators, currently have respiratory protection programs, nor fit-tested HCP. Therefore, they would not be able to implement all the recommended infection control interventions for care of COVID-19 patients.
    - Without respiratory protection programs and fit testing, unnecessary transfer of stable patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.
- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other strategies to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage of patients and limiting the numbers of healthcare personnel entering the patient room.
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel, visitors, and other patients who may be exposed to a patient with COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Care for patients with known or suspected COVID-19 in a single-person room with the door closed. Reserve Airborne Infection Isolation Rooms (AIIRs) for patients undergoing aerosol-generating procedures.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious materials, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.

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    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are not considered aerosol generating procedures. These procedures should take place in an examination room with the door closed.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
    - CDC has created Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their healthcare personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available), prior to leaving the facility.

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.

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- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:
    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- The first report of an infected healthcare provider occurred on February 29 in a long-term care facility in Washington.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining the need for appropriate work restrictions.

OPTIMIZING THE SUPPLY OF N95 RESPIRATORS

- Protection of healthcare workers is a priority. CDC's Strategies for Optimizing the Supply of N95 Respirators offers a series of strategies or options to optimize supplies of disposable N95 filtering facepiece respirators (commonly called "N95 respirators") in healthcare settings where there is limited supply.

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- It also includes considerations for use by federal, state, and local public health officials, respiratory protection program managers, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.
- CDC has provided additional resources related to these strategies:
    - Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response is intended to help healthcare facilities prioritize the implementation of the strategies presented in the Strategies for Optimizing the Supply for N95 Respirators guidance.
    - Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response
        - In times of increased demand and decreased supply, consideration can be made to use the N95s listed in the guidance past their manufacturer-designated shelf life when responding to COVID-19.
        - This preliminary information from the NIOSH study suggests certain N95 models beyond their manufacturer-designated shelf life will be protective. CDC recommends that N95s that have exceeded their manufacturer-designated shelf life should be used only as outlined in the Strategies for Optimizing the Supply of N95 Respirators.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and people of any age with underlying chronic medical conditions such as heart disease, lung disease and diabetes.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

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- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Remdesivir is an investigational antiviral drug that is being studied in patients with COVID-19.
    - There are two clinical trials available for patients with COVID-19 in the United States, one for patients with severe coronavirus disease and one for patients with moderate coronavirus disease.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure. Recommendations released March 16 state that if someone in a household has tested positive, keep the entire household at home.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to

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a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.

- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 (COVID-19) Outbreak
March 17, 2020 as of 10:00pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 4,226 confirmed and presumptive positive cases of COVID-19
  - 75 COVID-19 related deaths
  - 49 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called "15 Days to Slow the Spread," lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
- The Centers for Medicare & Medicaid Services (CMS) has taken new measures to keep America's nursing home residents safe from COVID-19. These measures are based on the newest CDC recommendations.
  - Those who are sick are asked to stay home and follow the new guidance for when it's OK for them to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be possible to extend these recommended measures for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 (COVID-19) Outbreak
March 17, 2020 as of 10:00pm

SITUATION UPDATE

- 4,226 reported cases of COVID-19 have been detected in all states except West Virginia.
- 245 of these cases occurred through close contact with another case.
- 229 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 3,752 cases are still being investigated to determine the source of exposure.
- As of the evening of March 15, 89 state and local public health labs in 50 states and the District of Columbia have verified they are successfully using COVID-19 diagnostic tests. This includes one or more PHL in 50 states plus D.C. and Guam. (See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.)
- As of the evening of March 16, 2020, CDC and local and state public health laboratories had tested a total of 31,878 specimens.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
- The agency will roll out a COVID-19 surveillance report in the coming days.
- On Monday, March 16 CDC reported the first confirmed case in a CDC employee.

CDC GUIDANCE UPDATES

- CDC is reviewing and updating travel notices almost on a daily basis.
    - U.S. citizens, residents, and their immediate family members who have been in China, Iran, the United Kingdom, Ireland or any one of 26 European countries within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - CDC also has a Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
    - On March 17, CDC posted a Level 3 Travel Health Notice for Cruise Ship Travel, recommending travelers defer all cruise ship travel worldwide.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in "Discontinuation of Home Isolation for Persons with COVID-19."
    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
        - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 (COVID-19) Outbreak
March 17, 2020 as of 10:00pm

PANDEMIC INFORMATION

- Pandemics happen when a disease emerges to infect people easily and spreads from person to person in an efficient and sustained way globally.
- This is the first pandemic known to be caused by the emergence of a new coronavirus.
- In the past century, there have been four pandemics caused by the emergence of novel influenza viruses.
    - Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to prepare for and respond to this public health threat for months.
- CDC has been implementing its pandemic preparedness and response plans, working on multiple fronts, including providing specific guidance on measures to prepare communities to respond to local spread of the virus that causes COVID-19.
- Pandemics of respiratory disease follow a certain progression outlined in a "Pandemic Intervals Framework."
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.
    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
- Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
- Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
- The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called "15 Days to Slow the Spread," which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?

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CDC Daily Key Points
Coronavirus Disease 2019 (COVID-19) Outbreak
March 17, 2020 as of 10:00pm

- If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
- If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: 3-18-20 CDC COVID-19 Key Points and New/Updated Guidance on Web
Date: Thursday, March 19, 2020 9:14:49 AM
Attachments: CDC_COVID-19_Daily Key Points__3_18_2020_FINAL.pdf

For the duplication……

Dear Colleagues,

Attached are the **CDC COVID-19 key points for Wednesday, March 18, 2020**. Please feel free to share with your staff and other partners.

Also, CDC has released/updated several COVID-19 interim guidance websites. Links below.

New/ Updated CDC COVID-19 Guidance:

- Prepare to Care for COVID-19: Get Your Practice Ready
- FAQs about Hand Hygiene for Healthcare Personnel Responding to COVID-2019
- New At-Risk landing page with new content:
  - Older Adults
  - People with Asthma and COVID-19
  - COVID-19: What people with HIV should know
  - Caring for someone at home

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
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AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 7,038 confirmed and presumptive positive cases of COVID-19
  - 97 COVID-19 related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19 (West Virginia confirmed their first case of COVID-19.)

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called "15 Days to Slow the Spread," lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
    - Two CDC Morbidity & Mortality Weekly Reports (MMWRs) published today underscore how vulnerable older people are to developing serious illness from COVID-19. (See section MMWR publications.)
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be possible to extend these recommended measures for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

SITUATION UPDATE

- 7,038 reported cases of COVID-19 have been detected in all 50 states.
- 276 of these cases occurred through close contact with another case.
- 269 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 6,493 cases are still being investigated to determine the source of exposure.
    - The number of cases of COVID-19 being reported in the United States is rising quickly.
    - With increasing laboratory testing and reporting across the country, CDC expected to see a rise in cases, but the growing number of cases also reflects a rapid spread of disease across communities
    - While these numbers are concerning, it's not unexpected and the more robust information will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- As of the evening of March 16, 89 state and local public health labs in 50 states, the District of Columbia, Guam, and Puerto Rico have verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of the evening of March 17, 2020, CDC and local and state public health laboratories had tested a total of 37,824 specimens.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
- The agency will roll out a COVID-19 surveillance report in the coming days.
- On Monday, March 16 CDC reported the first confirmed case in a CDC employee.

MMWR PUBLICATIONS

- On March 18, CDC published COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020 in the Morbidity & Mortality Weekly Report.
    - This report looked at an outbreak of COVID-19 in a long-term residential care facility in Washington state. During the outbreak, 81 residents of one facility were infected along with 34 staff members and 14 visitors. Twenty-three people died.
    - An investigation into the outbreak identified factors that likely contributed to the vulnerability of these facilities, including:
        1. Staff members who worked while symptomatic;
        2. Staff members who worked in more than one facility;
        3. Inadequate familiarity and adherence to standard, droplet, and contact precautions and eye protection recommendations;
        4. Challenges to implementing infection control practices including inadequate supplies of PPE and other items (e.g., alcohol-based hand sanitizer)
        5. Delayed recognition of cases because of low index of suspicion, limited testing availability, and difficulty identifying persons with COVID-19 based on signs and symptoms alone.
    - These findings underscore improvements that can be made across long-term care facilities in the United States to help protect residents from COVID-19 outbreaks as the pandemic continues to expand in the United States.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

- On March 18, CDC published Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020 in the Morbidity & Mortality Weekly Report.
    - This report looked at severity of disease—by age group—among 4,226 COVID-19 cases in the United States that occurred during February 12–March 16, 2020.
    - Overall, 31% of cases, 45% of hospitalizations, 53% of ICU admissions, and 80% of deaths associated with COVID-19 occurred among adults aged 65 years or older. The highest percentage of severe outcomes were among persons adults aged 85 years or older.
    - In contrast, no ICU admissions or deaths were reported among persons aged 19 years or younger.
    - Similar to reports from other countries, this finding suggests that the risk for serious disease and death from COVID-19 is higher in older age groups.
    - Approximately 49 million people in the United States are aged 65 years or older.
    - Data on other risk factors, including serious underlying health conditions that could increase risk for complications and severe illness, were unavailable at the time of this analysis.

CDC GUIDANCE UPDATES

- CDC is reviewing and updating travel notices almost on a daily basis.
    - On March 18, CDC posted a Level 3 Travel Health Notice (Avoid Nonessential Travel) for Malaysia. Malaysia is experiencing widespread ongoing transmission of respiratory illness caused by COVID-19.
    - U.S. citizens, residents, and their immediate family members who have been in China, Iran, the United Kingdom, Ireland or any one of 26 European countries within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - CDC also has a Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
    - On March 17, CDC posted a Level 3 Travel Health Notice for Cruise Ship Travel, recommending travelers defer all cruise ship travel worldwide.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.
    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
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AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
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- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called 15 Days to Slow the Spread which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
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For more information please visit CDC's Coronavirus Disease 2019 Outbreak page at www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-18-20 CDC COVID-19 Key Points and New/Updated Guidance on Web
Date:	Thursday, March 19, 2020 8:46:29 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_18_2020_FINAL.pdf

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- New At-Risk landing page with new content:
  - Older Adults
  - People with Asthma and COVID-19
  - COVID-19: What people with HIV should know
  - Caring for someone at home

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

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SNAPSHOT

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  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be possible to extend these recommended measures for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

SITUATION UPDATE

- 7,038 reported cases of COVID-19 have been detected in all 50 states.
- 276 of these cases occurred through close contact with another case.
- 269 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 6,493 cases are still being investigated to determine the source of exposure.
    - The number of cases of COVID-19 being reported in the United States is rising quickly.
    - With increasing laboratory testing and reporting across the country, CDC expected to see a rise in cases, but the growing number of cases also reflects a rapid spread of disease across communities
    - While these numbers are concerning, it's not unexpected and the more robust information will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- As of the evening of March 16, 89 state and local public health labs in 50 states, the District of Columbia, Guam, and Puerto Rico have verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of the evening of March 17, 2020, CDC and local and state public health laboratories had tested a total of 37,824 specimens.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
- The agency will roll out a COVID-19 surveillance report in the coming days.
- On Monday, March 16 CDC reported the first confirmed case in a CDC employee.

MMWR PUBLICATIONS

- On March 18, CDC published COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020 in the Morbidity & Mortality Weekly Report.
    - This report looked at an outbreak of COVID-19 in a long-term residential care facility in Washington state. During the outbreak, 81 residents of one facility were infected along with 34 staff members and 14 visitors. Twenty-three people died.
    - An investigation into the outbreak identified factors that likely contributed to the vulnerability of these facilities, including:
        1. Staff members who worked while symptomatic;
        2. Staff members who worked in more than one facility;
        3. Inadequate familiarity and adherence to standard, droplet, and contact precautions and eye protection recommendations;
        4. Challenges to implementing infection control practices including inadequate supplies of PPE and other items (e.g., alcohol-based hand sanitizer)
        5. Delayed recognition of cases because of low index of suspicion, limited testing availability, and difficulty identifying persons with COVID-19 based on signs and symptoms alone.
    - These findings underscore improvements that can be made across long-term care facilities in the United States to help protect residents from COVID-19 outbreaks as the pandemic continues to expand in the United States.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

- On March 18, CDC published Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020 in the Morbidity & Mortality Weekly Report.
    - This report looked at severity of disease—by age group—among 4,226 COVID-19 cases in the United States that occurred during February 12–March 16, 2020.
    - Overall, 31% of cases, 45% of hospitalizations, 53% of ICU admissions, and 80% of deaths associated with COVID-19 occurred among adults aged 65 years or older. The highest percentage of severe outcomes were among persons adults aged 85 years or older.
    - In contrast, no ICU admissions or deaths were reported among persons aged 19 years or younger.
    - Similar to reports from other countries, this finding suggests that the risk for serious disease and death from COVID-19 is higher in older age groups.
    - Approximately 49 million people in the United States are aged 65 years or older.
    - Data on other risk factors, including serious underlying health conditions that could increase risk for complications and severe illness, were unavailable at the time of this analysis.

CDC GUIDANCE UPDATES

- CDC is reviewing and updating travel notices almost on a daily basis.
    - On March 18, CDC posted a Level 3 Travel Health Notice (Avoid Nonessential Travel) for Malaysia. Malaysia is experiencing widespread ongoing transmission of respiratory illness caused by COVID-19.
    - U.S. citizens, residents, and their immediate family members who have been in China, Iran, the United Kingdom, Ireland or any one of 26 European countries within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - CDC also has a Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
    - On March 17, CDC posted a Level 3 Travel Health Notice for Cruise Ship Travel, recommending travelers defer all cruise ship travel worldwide.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.
    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
        - At least 7 days have passed since symptoms first appeared.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 18, 2020 as of 11:20pm

- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called 15 Days to Slow the Spread which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit CDC's Coronavirus Disease 2019 Outbreak page at www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-19-20 CDC COVID-19 Key Points and Updated CDC COVID-19 Guidance
Date:	Friday, March 20, 2020 8:57:51 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_19_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Thursday, March 19, 2020. Please feel free to share with your staff and other partners.

In addition, see below, for updates to several CDC COVID-19 guidance documents.

- Symptom self-checker on What To Do if You Are Sick
- New PDF "Protect Your Patients and Staff from COVID-19: CDC's Recommended Infection Control Procedures"
- Disinfecting Your Facility if Someone is Sick
- Interim Guidance for Administrators of US Institutions of Higher Education
- Institutes of Higher Education: FAQs for Administrators
- After travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 19, 2020 as of 10:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 10,442 confirmed and presumptive positive cases of COVID-19
  - 150 COVID-19 related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19.

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called 15 Days to Slow the Spread, lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
    - Two CDC Morbidity & Mortality Weekly Reports (MMWRs) published March 17 underscore how vulnerable older people are to developing serious illness from COVID-19. (See section MMWR publications.)
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified or extended for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.
- The White House Task Force on Coronavirus has established www.coronavirus.gov as the centralized website for the Federal government.
  - CDC continues to maintain www.cdc.gov/covid19.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 19, 2020 as of 10:30pm

SITUATION UPDATE

- 10,442 reported cases of COVID-19 have been detected in all 50 states.
- 310 of these cases occurred through close contact with another case.
- 290 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 9,842 cases are still being investigated to determine the source of exposure.
    - The number of cases of COVID-19 being reported in the US is rising quickly.
    - This increase was expected given an increase in testing and ongoing rapid spread of disease across communities in the United States.
    - While these numbers are concerning, the increase is not unexpected.
    - More robust data will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- A CDC study published March 17 shows that younger people can develop serious COVID-19 illness requiring hospitalization. This finding is different from the first reports from China. Younger people are still much less likely to die from COVID-19 than older people. (See MMWR Publications)
- As of the evening of March 18, 89 state and local public health labs in 50 states, the District of Columbia, Guam and Puerto Rico have verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of the evening of March 19, 2020, CDC and local and state public health laboratories had tested a total of 44,872 specimens.
- Private laboratories are increasing their testing capacity. In addition to the approximately 2,500 tests per day currently done nationally, it is projected that:
    - Roche will increase their capacity up to 10,000 tests per day by end of this week
    - BioReference will increase their capacity by an additional 3,000 tests per day.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
    - CDC plans to roll out a COVID-19 surveillance report next week.
- On Monday, March 16, CDC reported the first confirmed case in a CDC employee.

MMWR PUBLICATIONS

- On March 18, CDC published COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020 in the Morbidity & Mortality Weekly Report.
    - This report looked at an outbreak of COVID-19 in a long-term residential care facility in Washington state. During the outbreak, 81 residents of one facility were infected along with 34 staff members and 14 visitors. Twenty-three people died.
    - An investigation into the outbreak identified factors that likely contributed to the vulnerability of these facilities, including:
        1. Staff members who worked while symptomatic;
        2. Staff members who worked in more than one facility;
        3. Inadequate familiarity and adherence to standard, droplet, and contact precautions and eye protection recommendations;

AMERICAN OVERSIGHT

4. Challenges to implementing infection control practices including inadequate supplies of PPE and other items (e.g., alcohol-based hand sanitizer)
5. Delayed recognition of cases because of low index of suspicion, limited testing availability, and difficulty identifying persons with COVID-19 based on signs and symptoms alone.

- These findings underscore improvements that can be made across long-term care facilities in the United States to help protect residents from COVID-19 outbreaks as the pandemic continues to expand in the United States.

- On March 18, CDC published Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020 in the Morbidity & Mortality Weekly Report.
  - This report looked at severity of disease—by age group—among 4,226 COVID-19 cases in the United States that occurred during February 12–March 16, 2020.
  - Overall, 31% of cases, 45% of hospitalizations, 53% of ICU admissions, and 80% of deaths associated with COVID-19 occurred among adults aged 65 years or older. The highest percentage of severe outcomes were among persons adults aged 85 years or older.
  - Among 2,449 patients with known age, 6% were aged 85 years or older, 25% were aged 65–84 years, 18% each were aged 55–64 years and 45–54 years, and 29% were aged 20–44 years. Only 5% of cases occurred in persons aged 0–19 years.
  - Similar to reports from other countries, this finding suggests that the risk for serious disease and death from COVID-19 is higher in older age groups.
  - These preliminary data also demonstrate that severe illness leading to hospitalization, including ICU admission and death, can occur in adults of any age with COVID-19.
  - Approximately 49 million people in the United States are aged 65 years or older.
  - Data on other risk factors, including serious underlying health conditions that could increase risk for complications and severe illness, were unavailable at the time of this analysis.

CDC GUIDANCE UPDATES

- On March 17, 2020, CDC updated guidance, Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.
- CDC is reviewing and updating travel notices almost on a daily basis.
  - On March 18, CDC posted a Level 3 Travel Health Notice (Avoid Nonessential Travel) for Malaysia. Malaysia is experiencing widespread ongoing transmission of respiratory illness caused by COVID-19.
  - U.S. citizens, residents, and their immediate family members who have been in China, Iran, the United Kingdom, Ireland or any one of 26 European countries within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
  - CDC also has a Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
  - On March 17, CDC posted a Level 3 Travel Health Notice for Cruise Ship Travel, recommending travelers defer all cruise ship travel worldwide.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 19, 2020 as of 10:30pm

- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.
    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
        - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called 15 Days to Slow the Spread which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 19, 2020 as of 10:30pm

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: 3-20-20 CDC COVID-19 Key Points
Date: Saturday, March 21, 2020 3:02:59 PM
Attachments: CDC_COVID-19_Daily Key Points__3_20_2020_FINAL.pdf

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Attached please find the CDC COVID-19 daily key points for Thursday, March 20, 2020. Please feel free to share with your staff and other partners.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

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AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 20, 2020 as of 10:45pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 15,219 confirmed and presumptive positive cases of COVID-19
  - 201 COVID-19-related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19.

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called 15 Days to Slow the Spread, lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
    - Two CDC Morbidity & Mortality Weekly Reports (MMWRs) published March 17 underscore how vulnerable older people are to developing serious illness from COVID-19. (See section MMWR publications.)
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified or extended for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.
- The White House Task Force on Coronavirus has established www.coronavirus.gov as the centralized website for the Federal government.
  - CDC continues to maintain www.cdc.gov/covid19.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 20, 2020 as of 10:45pm

- CDC continues to maintain www.cdc.gov/covid19.

SITUATION UPDATE

- 15,219 reported cases of COVID-19 have been detected in all 50 states.
- 321 of these cases occurred through close contact with another case.
- 337 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 14,561 cases are still being investigated to determine the source of exposure.
    - The number of cases of COVID-19 being reported in the US is rising quickly.
    - This increase was expected given an increase in testing and ongoing rapid spread of disease across communities in the United States.
- While these numbers are concerning, the increase is not unexpected.
- More robust data will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- On March 20, 2020, new web content on the 15-Day Pause was posted. The 15-day pause recommended by the White House presents the entire country with an opportunity to implement actions designed to slow and limit the spread of COVID-19.
- On March 19, 2020, a new online interactive COVID-19 symptom self-checker was launched.
    - The self-checker helps users make decisions about seeking appropriate medical care. This system is not intended for diagnosis or treatment of COVID-19 or other diseases.
    - As of the morning of March 20, 2020, approximately 25,000 users per hour had used the self-checker. The self-checker is being used by people from the United States and other countries.
- On March 18, 2020, CDC posted a new webpage with guidance for colleges and universities including:
    - Interim Guidance for Administrators of US Institutions of Higher Education
        - FAQs for Administrators of Institutes of Higher Education
- On March 19, 2020, CDC posted additional guidance on COVID-19 for clinicians and health care facilities, including:
    - Protect Your Patients and Staff from COVID-19: CDC's Recommended Infection Control Procedures
    - Disinfecting Your Facility if Someone is Sick
    - Clinician Toolkit, which includes outdoor and indoor signs and patient handouts with tips for home care
- On March 18, 2020, CDC Principal Deputy Director Dr. Anne Schuchat did a Q&A on What to Expect When You're Expecting for an audience of 16 million new and expectant mothers. Dr. Schuchat answered questions related to COVID-19 and pregnancy, infant care, and breastfeeding.
- A CDC study published March 17 shows that younger people can develop serious COVID-19 illness requiring hospitalization. This finding is different from the first reports from China. Younger people are still much less likely to die from COVID-19 than older people. (See MMWR Publications)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 20, 2020 as of 10:45pm

- As of March 17, 2020, there are confirmed COVID-19 cases in corrections facilities in NY, WA and GA. Discussion of implementing releases of non-violent offenders to reduce populations incarcerated, decrease chance of spread.
- As March 19, 91 state and local public health labs in 50 states, the District of Columbia, Guam and Puerto Rico have verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of March 19, 2020, CDC and local and state public health laboratories had tested a total of 54,205 specimens.
- Private laboratories are increasing their testing capacity. In addition to the approximately 2,500 tests per day currently done nationally, it is projected that:
    - Roche will increase their capacity up to 10,000 tests per day by end of this week
    - BioReference will increase their capacity by an additional 3,000 tests per day.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
    - CDC plans to roll out a COVID-19 surveillance report next week.
- On Monday, March 16, CDC reported the first confirmed case in a CDC employee.

CDC GUIDANCE UPDATES

- On March 19, CDC updated technical guidance and consumer information about cleaning and disinfecting your home when someone is sick.
- On March 17, updates were made to CDC guidance on alternate non-95 PPE guidance: Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.
- CDC is reviewing and updating travel notices almost on a daily basis.
    - On March 19, the U.S. State Department posted a Level 4 Global Health Advisory, warning travelers Do Not Travel.
    - On March 19, CDC posted after-travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.
    - On March 18, CDC posted a Level 3 Travel Health Notice (Avoid Nonessential Travel) for Malaysia. Malaysia is experiencing widespread ongoing transmission of respiratory illness caused by COVID-19.
    - U.S. citizens, residents, and their immediate family members who have been in China, Iran, the United Kingdom, Ireland or any one of 26 European countries within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - CDC also has a Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
    - On March 17, CDC posted a Level 3 Travel Health Notice for Cruise Ship Travel, recommending travelers defer all cruise ship travel worldwide.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.

AMERICAN OVERSIGHT

    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
        - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called 15 Days to Slow the Spread which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-20-20 CDC COVID-19 Key Points
Date:	Saturday, March 21, 2020 2:40:32 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_20_2020_FINAL.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 daily key points for Thursday, March 20, 2020. Please feel free to share with your staff and other partners.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 20, 2020 as of 10:45pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 15,219 confirmed and presumptive positive cases of COVID-19
  - 201 COVID-19-related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19.

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called 15 Days to Slow the Spread, lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
    - Two CDC Morbidity & Mortality Weekly Reports (MMWRs) published March 17 underscore how vulnerable older people are to developing serious illness from COVID-19. (See section MMWR publications.)
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified or extended for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.
- The White House Task Force on Coronavirus has established www.coronavirus.gov as the centralized website for the Federal government.
  - CDC continues to maintain www.cdc.gov/covid19.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 20, 2020 as of 10:45pm

- CDC continues to maintain www.cdc.gov/covid19.

SITUATION UPDATE

- 15,219 reported cases of COVID-19 have been detected in all 50 states.
- 321 of these cases occurred through close contact with another case.
- 337 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 14,561 cases are still being investigated to determine the source of exposure.
    - The number of cases of COVID-19 being reported in the US is rising quickly.
    - This increase was expected given an increase in testing and ongoing rapid spread of disease across communities in the United States.
- While these numbers are concerning, the increase is not unexpected.
- More robust data will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- On March 20, 2020, new web content on the 15-Day Pause was posted. The 15-day pause recommended by the White House presents the entire country with an opportunity to implement actions designed to slow and limit the spread of COVID-19.
- On March 19, 2020, a new online interactive COVID-19 symptom self-checker was launched.
    - The self-checker helps users make decisions about seeking appropriate medical care. This system is not intended for diagnosis or treatment of COVID-19 or other diseases.
    - As of the morning of March 20, 2020, approximately 25,000 users per hour had used the self-checker. The self-checker is being used by people from the United States and other countries.
- On March 18, 2020, CDC posted a new webpage with guidance for colleges and universities including:
    - Interim Guidance for Administrators of US Institutions of Higher Education
        - FAQs for Administrators of Institutes of Higher Education
- On March 19, 2020, CDC posted additional guidance on COVID-19 for clinicians and health care facilities, including:
    - Protect Your Patients and Staff from COVID-19: CDC's Recommended Infection Control Procedures
    - Disinfecting Your Facility if Someone is Sick
    - Clinician Toolkit, which includes outdoor and indoor signs and patient handouts with tips for home care
- On March 18, 2020, CDC Principal Deputy Director Dr. Anne Schuchat did a Q&A on What to Expect When You're Expecting for an audience of 16 million new and expectant mothers. Dr. Schuchat answered questions related to COVID-19 and pregnancy, infant care, and breastfeeding.
- A CDC study published March 17 shows that younger people can develop serious COVID-19 illness requiring hospitalization. This finding is different from the first reports from China. Younger people are still much less likely to die from COVID-19 than older people. (See MMWR Publications)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 20, 2020 as of 10:45pm

- As of March 17, 2020, there are confirmed COVID-19 cases in corrections facilities in NY, WA and GA. Discussion of implementing releases of non-violent offenders to reduce populations incarcerated, decrease chance of spread.
- As March 19, 91 state and local public health labs in 50 states, the District of Columbia, Guam and Puerto Rico have verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of March 19, 2020, CDC and local and state public health laboratories had tested a total of 54,205 specimens.
- Private laboratories are increasing their testing capacity. In addition to the approximately 2,500 tests per day currently done nationally, it is projected that:
    - Roche will increase their capacity up to 10,000 tests per day by end of this week
    - BioReference will increase their capacity by an additional 3,000 tests per day.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
    - CDC plans to roll out a COVID-19 surveillance report next week.
- On Monday, March 16, CDC reported the first confirmed case in a CDC employee.

CDC GUIDANCE UPDATES

- On March 19, CDC updated technical guidance and consumer information about cleaning and disinfecting your home when someone is sick.
- On March 17, updates were made to CDC guidance on alternate non-95 PPE guidance: Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.
- CDC is reviewing and updating travel notices almost on a daily basis.
    - On March 19, the U.S. State Department posted a Level 4 Global Health Advisory, warning travelers Do Not Travel.
    - On March 19, CDC posted after-travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.
    - On March 18, CDC posted a Level 3 Travel Health Notice (Avoid Nonessential Travel) for Malaysia. Malaysia is experiencing widespread ongoing transmission of respiratory illness caused by COVID-19.
    - U.S. citizens, residents, and their immediate family members who have been in China, Iran, the United Kingdom, Ireland or any one of 26 European countries within in the past 14 days can enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - CDC also has a Global Level 2 Travel Health Notice recommending older adults and those who have chronic medical conditions consider postponing nonessential travel.
    - On March 17, CDC posted a Level 3 Travel Health Notice for Cruise Ship Travel, recommending travelers defer all cruise ship travel worldwide.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.

AMERICAN OVERSIGHT

    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
        - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called 15 Days to Slow the Spread which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-2-2020 CDC Media Telebriefing: Update on COVID-19
Date: Monday, March 2, 2020 11:11:42 AM

Media Advisory

For Immediate Release
Monday March 2, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

Stephen M. Hahn, M.D., Food and Drug Administration
Commissioner

When 12 p.m. ET Monday, March 2, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

AMERICAN OVERSIGHT

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U.S. Department of Health and Human Services

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

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: 3-2-2020 CDC Media Telebriefing: Update on COVID-19
Date: Monday, March 2, 2020 11:13:42 AM

Media Advisory

For Immediate Release
Monday March 2, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-2-2020 CDC Media Telebriefing: Update on COVID-19
Date:	Monday, March 2, 2020 11:09:03 AM

Media Advisory

For Immediate Release
Monday March 2, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

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AMERICAN OVERSIGHT

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-23-20 CDC COVID-19 Key Points and Summary of Updated Guidance Documents
Date:	Monday, March 23, 2020 11:20:42 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_23_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Monday, March 23, 2020. Please feel free to share with your staff and other partners.

Below is a summary of CDC COVID-19 new/updated guidance documents as of Monday, March 23, 2020.

New Guidance= Highlighted
All others, updated since March 21, 2020.

At-Risk

- Children and Coronavirus Disease 2019 (COVID-19)
- Interim Guidance for responding to coronavirus disease 2019 (COVID-19) among people experiencing unsheltered homelessness
- List of underlying medical Conditions (updated)

Communication Resources:

- Print Resources: Stay at home if you are sick!

Community Mitigation:

- Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities
- Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19)

Cruise Ships

- Cruise Passengers returning via charter flights

Healthcare

- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)
- Interim Infection Control Guidance on COVID-19 for Personnel at Blood and Plasma Collection Facilities

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- Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020
- Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

Infection Control

- Environmental Cleaning Guidance for community facilities and households

Risk Assessment

- Risk Assessment and Management Guidance (updated)

Travel Notices:

- Level 3 Travel Health Notices: Chile, Pakistan, Thailand, Turkey

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

CDC State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 23, 2020 as of 10:45pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 33,404 confirmed and presumptive positive cases of COVID-19
  - 400 COVID-19-related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19.

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called 15 Days to Slow the Spread, lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
    - Two CDC Morbidity & Mortality Weekly Reports (MMWRs) published March 17 underscore how vulnerable older people are to developing serious illness from COVID-19.
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the next 15 days, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified or extended for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.
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AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 23, 2020 as of 10:45pm

SITUATION UPDATE

- 33,404 reported cases of COVID-19 have been detected in all 50 states.
- 539 of these cases occurred through close contact with another case.
- 449 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 32,416 cases are still being investigated to determine the source of exposure.
    - The number of cases of COVID-19 being reported in the US is rising quickly.
    - This increase was expected given an increase in testing and ongoing rapid spread of disease across communities in the United States.
- While these numbers are concerning, the increase is not unexpected.
- More robust data will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- On March 20, new web content on the 15-Day Pause was posted. The 15-day pause recommended by the White House presents the entire country with an opportunity to implement actions designed to slow and limit the spread of COVID-19.
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    - Disinfecting Your Facility if Someone is Sick; and
    - A Clinician Toolkit, which includes outdoor and indoor signs and patient handouts with tips for home care.
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- As of March 17, 2020, there are confirmed COVID-19 cases in corrections facilities in NY, WA and GA. Discussion of implementing releases of non-violent offenders to reduce populations incarcerated, decrease chance of spread.
- As of March 22, 91 state and local public health labs in 50 states, the District of Columbia, Guam, and Puerto Rico have verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 23, 2020 as of 10:45pm

- As of March 22, CDC and local and state public health laboratories had tested a total of 61,847 specimens.
- Private laboratories are increasing their testing capacity. In addition to the approximately 2,500 tests per day currently done nationally, it is projected that:
    - Roche will increase their capacity up to 10,000 tests per day by end of this week
    - BioReference will increase their capacity by an additional 3,000 tests per day.
- CDC is adapting some of the agency's existing surveillance systems to better track COVID-19.
    - CDC plans to roll out a COVID-19 surveillance report next week.
- On Monday, March 16, CDC reported the first confirmed case in a CDC employee.

CDC GUIDANCE UPDATES

- On March 22, CDC posted COVID-19 information specific to children including:
    - Tips for parents during school dismissal,
    - Guidance for Schools and Childcare Programs, and
    - Updated FAQs related to children and COVID-19
- On March 22, CDC posted Guidance for Retirement Communities and Independent Living to help them plan, prepare, and respond to COVID-19.
- On March 19, CDC updated technical guidance and consumer information about cleaning and disinfecting your home when someone is sick.
- On March 17, updates were made to CDC guidance on alternate non-95 PPE guidance: Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.
- CDC is reviewing and updating travel notices almost on a daily basis.
    - As of March 23, CDC has issued 9 additional Level 3 Travel notices for Australia, Brazil, Canada, Chile, Israel, Japan, Pakistan, Thailand, and Turkey.
    - On March 19, the U.S. State Department posted a Level 4 Global Health Advisory, warning travelers Do Not Travel.
    - On March 19, CDC posted after-travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.
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AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 23, 2020 as of 10:45pm

- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.
    - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
        - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
        - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - On March 16, the White House announced a program called 15 Days to Slow the Spread which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
        - Does the patient have recent travel from an affected area?
        - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
        - Does the patient reside in an area where there has been community spread of COVID-19?
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - People who get a fever or cough should consider whether they might have COVID-19, depending on where they live, their travel history or other exposures.
        - More than half of the United States is seeing some level of community spread of COVID-19.
        - Testing for COVID-19 may be accessed through medical providers or public health departments, but there is no treatment for this virus.
        - Most people have mild illness and are able to recover at home without medical care.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement

AMERICAN OVERSIGHT

and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-23-20 CDC COVID-19 Weekly Key Messages and Updated Website Guidance
Date:	Monday, March 23, 2020 8:45:28 AM
Attachments:	CDC_COVID-19 Weekly Key Messages__3.22.2020_FINAL.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 weekly key messages for Sunday, March 22, 2020. Feel free to share with your staff and other partners.

In addition, CDC released/updated several guidance documents on the CDC COVID-19 webpage.

- New People who are at higher risk for severe illness (consumer page)
- New COVID-19 and Underlying Medical Conditions (healthcare professional page)
- New Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness
- Updates to Information for Health Departments on Reporting Cases of COVID-19
    - COVID-19 Case Report Form Instructions
    - Completing a CRF and Specimen guidance
- New FAQs for consumers on Higher Risk & Underlying Conditions

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Pandemic

March 22, 2020 as of 11:40pm

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.

All content updated since March 17 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use “the virus that causes COVID-19.”
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is now considered a pandemic.

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- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly-emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person to person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **March 21, 292,142** cases have been confirmed worldwide. More than **210,644** of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On March 11, 2020, WHO announced that the outbreak of COVID-19 can be characterized as a pandemic.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- Pandemics of respiratory disease follow a certain progression outlined in the Pandemic Intervals Framework, part of the National Pandemic Strategy.
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.

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    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
    - Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
    - Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
    - The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time. Selected pandemic preparedness materials are available online.
- On March 13, the President of the United States declared the COVID-19 outbreak a national emergency.
- On March 16, the White House announced a program called "15 Days to Slow the Spread." This is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **March 20, 2020:**

- **Travel-related: 337**
- **Close contact: 321**
- **Under investigation: 14,561**
- **Total cases: 15,219**
- **Deaths: 201**
- **Jurisdictions reporting cases: All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19**

For global cases, please see the WHO daily situation reports.

SITUATION IN THE U.S.

- The number of cases of COVID-19 being reported in the United States is rising quickly.
    - This increase is expected given an increase in testing and ongoing rapid spread of disease across communities in the United States.
    - While these numbers are concerning, the increase is not unexpected.
    - More robust data will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- Different parts of the country are seeing different levels of COVID-19 activity. The United States nationally is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase. The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- CDC and state and local public health laboratories are testing for the virus that causes COVID-19.
- More and more states are reporting cases of COVID-19 to CDC.
- U.S. COVID-19 cases include:
    - Imported cases in travelers
    - Cases among close contacts of a known case

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    - Community-acquired cases where the source of the infection is unknown.
- Twenty-seven U.S. states are reporting some community spread of COVID-19.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- It is rare for animal coronaviruses to become capable of infecting humans and then spreading between people.
    - Severe acute respiratory syndrome (SARS-CoV) and Middle East respiratory syndrome (MERS-CoV) are examples of coronaviruses that originated in animals and spread to people.
    - That is what is suspected happened with the virus that causes the current outbreak of COVID-19.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- There is no reason at this time to think that any animals, including pets, in the United States might be a source of infection with the new coronavirus that causes COVID-19.

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    - On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested "weak positive" to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19.
        - CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
        - It's important to remember that dogs have their own coronaviruses, which cannot spread to people.
            - *AFCD official report available*
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes or ticks.
    - Mosquitoes and ticks cannot spread all types of viruses. For a virus to pass to a person through a mosquito or tick bite, the virus must be able to replicate inside the mosquito or tick.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

Diagnostics

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.
- On February 18, CDC stood up a new surge laboratory to support testing for COVID-19. This expanded capacity to 350 samples per day
- On February 20, CDC completed contracts with 2 large commercial manufacturers to ensure reagent availability for the public health laboratories

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- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits include the two components (e.g., reagents) that are specific to novel coronavirus.
    - Before new test kits were available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner was able to move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand-carried to IRR for repackaging and distribution to additional public health labs.
- On February 29, IRR began to distribute new test kits to the additional 40 laboratories.
- On March 16, FDA reauthorized the EUA for the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel.
- As of March 21, 91 public health labs are running the CDC test, representing all 50 states, as well as the District of Columbia, Guam, and Puerto Rico.
- Commercial manufacturers are now producing their own tests.
- As of March 22, CDC has tested over 4,607 samples.
- Overall, CDC and public health labs have tested 71,870 samples as of March 22.

Treatment

- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- Most people have mild illness and are able to recover at home.
- For severe cases, treatment should include care to support vital organ functions.
- *See more in Management of Patients Guidance for Healthcare Providers section*

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.

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- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

PEOPLE AT RISK FOR SERIOUS ILLNESS

- Older adults and people who have severe underlying medical conditions are at higher risk for more serious COVID-19 illness.
- Eight out of 10 deaths reported in the United States have been in adults aged 65 years or older.
- Based upon available information to date, those most at risk include—
    - People 65 years and older
    - People who live in a nursing home or long-term care facility
    - People of any age with the following underlying medical conditions, particularly those that are not well controlled
        - Heart disease
        - Diabetes
        - Lung disease
- Severe illness leading to hospitalization, including ICU admission and death, can occur in adults of any age with COVID-19.
- The risk for serious disease and death from COVID-19 in the United States increases with age.
- Preliminary data in the United States indicate fatality is highest among persons aged 85 years or older, ranging from 10% to 27%.
- Early data suggest older people are twice as likely to have serious COVID-19 illness.
- If you are at increased risk for COVID-19 complications due to age or because you have a serious underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.
- If you are a person with a serious underlying medical condition that can put you at higher risk, stay home and away from other people.
    - Stock up on supplies.
    - Make a plan with family members, friends, caregivers, and/or healthcare providers and consider including the following in your plan:
        - Alternate caregiver in case your caregiver is sick or paid service is limited or unavailable—it's a good idea to have at least three alternate caregivers
        - A 30-day supply of medications and a checklist to monitor usage
        - Nonperishable food items for at least 14 days

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        - Phone bank plan in case of quarantine (this reduces feelings of loneliness and isolation)
    - If you feel sick, use these guidelines to reduce the risk of spread:
        - Stay home.
        - Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
        - If you need emergency help, call 911.
        - If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.

What people at higher risk can do to prepare

- Have supplies on hand
    - Contact your healthcare professional to ask about obtaining extra necessary medications to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home.
    - If you cannot get extra medications, consider using mail-order for medications.
    - Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
    - Have enough household items and groceries on hand so that you will be prepared to stay at home for at least 14 days.
- Take everyday precautions
    - Avoid close contact with people who are sick.
    - Take everyday preventive actions.
        - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
        - If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.
        - To the extent possible, avoid touching high-touch surfaces in public places – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
        - Wash your hands after touching surfaces in public places.
        - Avoid touching your face, nose, eyes, etc.
        - Clean and disinfect your home to remove germs. Practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks and cell phones).
        - Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.

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- If COVID-19 is spreading in your community, take extra measures to put distance between yourself and other people.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks.
- Have a plan for if you get sick.
    - **Consult with your healthcare provider for more information about** monitoring your health for symptoms suggestive of COVID-19**.**
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick.
    - Plan for how you will get more supplies if you need them before you recover.
- Watch for symptoms and emergency warning signs.
    - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
    - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:
        - Difficulty breathing or shortness of breath
        - Persistent pain or pressure in the chest
        - New confusion or inability to arouse
        - Bluish lips or face

          *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

What to do if you are at higher risk and get sick

- Stay home and call your doctor.
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

Community Support for Older Adults

- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.
    - Many of these people live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.

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- Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and Caregiver Support

- Know what medications your loved one is taking and see if you can help them have extra on hand.
- Monitor food and other medical supplies (hearing aid batteries, oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- Stock up on non-perishable food items to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

Coping for People at Risk for Serious Illness and Caregivers

- People at higher risk for COVID-19 (including older people and people with severe underlying medical conditions), as well as the people who care for and about them, may feel especially stressed, worried, or anxious.
    - Things you can do to take care of yourself and help the people you care for:
        - Take breaks from watching, reading, or listening to news stories, including social media. Remind others that you care for to do the same.
        - Stay connected to others through calls (audio or video), instant messaging, email, letters, or other forms of communication, even if you cannot be together in person.
        - Talk with people you trust about your concerns and how you are feeling.
- If you, or someone you care about, is feeling overwhelmed with emotions like sadness, depression, or anxiety, or if you are concerned about harming yourself or others, call 911 or the SAMHSA Disaster Distress Helpline: 1-800-985-5990 or text TalkWithUs to 66746 (TTY 1-800-846-8517).

Tribal Elders and Multi-generational Tribal Families

- Tribal communities and Urban American Indians and Alaska Natives are particularly vulnerable to COVID-19 because of unique characteristics of health that impact tribal members.
- Any exposure to COVID-19 can pose a threat to tribal and urban American Indian and Alaska Native communities.
- Many tribal communities are made up of interdependent multi-generational families that house many Elders. These families may be both geographically and socially close. For tribal families, avoiding sick children or Elders may not seem practical or desirable.
- Families can take steps to protect the health and safety of Elders.
    - Consider limiting visitation except for caregivers or healers.
    - Avoid communing at social tribal events or gatherings, supermarkets, or casinos.

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- Consider seeking out other partners in the community to help with housing accommodations or optional caregiving, in case of illness.

Rural Communities

- Rural communities face some COVID-19 challenges that are different from urban and suburban communities. These differences warrant additional guidance.
- Many rural communities have experienced multiple closings of hospitals and healthcare facilities. This can leave an already vulnerable population without immediate access to healthcare, should an outbreak occur in the community.
- People living in rural communities can take steps to prepare.
    - Identify the two closest healthcare facilities to contact in case of an outbreak
    - Create an information card with the numbers and addresses of healthcare facilities and the family and friends who are physically nearest to you.
    - Locate state, local, or tribal health centers in advance to identify available resources
    - Create a phone tree system (activating a group of people by telephone to get a message out quickly) with family, friends, and neighbors

People with Asthma

- People with asthma may be at higher risk of getting infected with COVID-19. COVID-19 can affect your respiratory tract (nose, throat, lungs), cause an asthma attack, and possibly lead to pneumonia and acute respiratory disease.
- If you have asthma, you should prepare for COVID-19 and follow your Asthma Action Plan.
    - Take your asthma medication exactly as prescribed.
        - Talk to your healthcare provider, insurer, and pharmacist about creating an emergency supply of prescription medications, such as asthma inhalers.
        - Make sure that you have 30 days of non-prescription medications and supplies on hand too, in case you need to stay home for a long time.
    - Know how to use your inhaler.
    - Avoid your asthma triggers.
    - Clean and disinfect frequently touched surfaces like tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks daily to protect yourself against COVID-19.
        - Avoid disinfectants that can cause an asthma attack.
    - As more cases of COVID-19 are discovered and our communities take action to combat the spread of disease, it is natural for some people to feel concerned or stressed. Strong emotions can trigger an asthma attack. Take steps to help yourself cope with stress and anxiety.
- If you have symptoms
    - Contact your health care provider to ask about your symptoms.

Pregnant People

- Pregnant people may be at higher risk for having severe illness from COVID-19.

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- CDC has limited information on adverse pregnancy outcomes in pregnant people with COVID-19.
    - Pregnancy loss, including miscarriage and stillbirth, has been observed in cases of infection with other related coronaviruses [SARS-CoV and MERS-CoV] during pregnancy.
    - There is limited information on infant outcomes of COVID-19 illness during pregnancy.
    - Other respiratory viral infections during pregnancy, such as influenza, have been associated with adverse neonatal outcomes, including low birth weight and preterm birth.
    - High fevers during the first trimester of pregnancy can increase the risk of certain birth defects.
- It is especially important for pregnant people to take actions to reduce their risk of exposure.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.

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- Share with others the need for social support for people who have returned from an area with ongoing spread or are worried about friends or relatives in the affected areas.

TRAVEL

Presidential Proclamations announcing travel restrictions for travelers from China, Iran, United Kingdom, Republic of Ireland, and most of Europe

- On January 31, President Trump issued the first Presidential Proclamation implementing temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
    - The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days.
- On March 2, a Presidential Proclamation suspended entry to the United States of foreign nationals who have been in Iran in the past 14 days.
    - For more information, consult the notice published in the Federal Register.
- On March 11, a Presidential Proclamation suspended entry to the United States of foreign nationals who have been in 26 countries in Europe (known as the Schengen Area) in the past 14 days.
    - The order suspends the entry of foreign nationals for 30 days from these European states: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland.
- On March 14, a Presidential proclamation suspended entry to the United States of foreign nationals who have been in the United Kingdom (excluding overseas territories outside of Europe) or the Republic of Ireland in the past 14 days.
- Exemptions to these travel restrictions include American citizens, legal permanent residents, and immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- **Under the Presidential Proclamations:** All American citizens and exempted persons coming from
    - **China, and Iran** will be directed to ("**funneled to"**) one of 11 US airports (the first 11 airports in the list below).
    - **Europe, the United Kingdom, and the Republic of Ireland** will be directed to ("funneled to") one of 13 US airports (including the last 2 airports in the list below).
- American citizens and exempted persons who have been in **China or Iran** in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
    - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
    - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.

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- American citizens and exempted persons who have been to the **Schengen area of Europe, UK and Ireland** in the previous 14 days will screened by Department of Homeland Security and receive a Travelers' Health Alert Notice.
    - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
    - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
- The 13 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
    - Boston Logan International Airport (BOS), Massachusetts
    - Miami International Airport (MIA), Florida
- As of March 18, about 60,000 people have been screened at U.S. airports.

CDC Travel Health Notices and Other Travel Guidance

- CDC has issued Level 3 Travel Health Notices (Avoid Nonessential Travel) for Australia, Brazil, Canada, China, Iran, Israel, Japan, most of Europe (Schengen Area), the United Kingdom and the Republic of Ireland, Malaysia, South Korea, and cruise travel worldwide.
- CDC has issued Level 2 Travel Health Notices (Practice Enhanced Precautions) for the global outbreak.
- CDC has posted after-travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.
- CDC has posted a webpage about COVID-19 and considerations for travel in the United States.
- On March 19, the U.S. State Department posted a Level 4 Global Health Advisory, warning travelers Do Not Travel.

Repatriation flights and quarantine orders

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Chartered flights returned passengers from Wuhan City, China and passengers from a cruise ship docked in Japan. (See section: Diamond Princess).

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- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- As of March 18th, everyone from the Wuhan and Diamond Princess repatriation flights who were quarantined or isolated under federal orders has been released and returned home.
    - A small number of people are still isolated or quarantined under state orders

Cruise Ships and River Cruises*

- The U.S. Government's priority is to protect the health of passengers and crew, their loved ones, the traveling public, and communities within the US.
- CDC recommends all persons defer any travel on cruise ships, including river cruises, worldwide because of the increased risk of COVID-19 on board ships.
- CDC is continuously tracking cruise ships that are coming into domestic ports that may have confirmed, suspected, or no cases of COVID-19.
    - Cruise ships, both domestic and international, carrying American citizens are being assessed and documented.
    - The situation in the United States is evolving, both with increasing community transmission and an increasing number of cruise ships coming into port. CDC is continuing to reevaluate its approach to returning cruise ships.
    - As CDC reevaluates the approach to returning cruise ships, CDC's priority is to protect passengers' and crews' health while helping them get home as quickly and safely as possible.
- On March 13, the Cruise Lines International Association voluntarily suspended cruise travel out of U.S. ports.
    - Many cruise ships will soon be ending their voyages and coming into port in the U.S. and other countries. New cruise voyages will be postponed.
- On March 15, CDC released a Health Alert Network (HAN) Update providing information and guidance about global travel on cruise ships, including river cruises, due to COVID-19.
    - The HAN provides broad information and recommendations for clinicians seeing patients who have recently traveled by cruise ship or river cruise.
    - State and local health departments should check the Epidemic Information Exchange (Epi-X) notification system for information on COVID-19 cases on cruise ships and river cruises. If a ship has one or more confirmed COVID-19 cases on board, CDC will send an Epi-X alert to state health departments alerting them to these cases.

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- On March 17, CDC posted a Global Level 3 Travel Health Notice for Cruise Ship Travel recommending travelers defer all cruise ship travel worldwide.
    - Cruise travelers should stay home for 14 days after returning from travel, monitor their health, and practice social distancing.
- In an effort to make sure returning passengers and crew members without symptoms can get home as quickly and safely as possible, CDC will not hold ships in port and will not prevent disembarking passengers and crew from onward travel. They will be treated like other travelers returning from areas with widespread ongoing transmission, such as Europe.
    - Passengers without symptoms will be allowed to travel home immediately via commercial carrier.
    - Cruise line passengers and crew members are advised to stay home for 14 days, monitor their health, and practice social distancing.
        - Social distancing means staying out of crowded places and keeping a distance of about 6 feet (2 meters) from others as much as possible.
        - Cruise lines will give disembarking passengers details about how to monitor themselves at home and practice social distancing.
        - These recommendations are consistent with CDC recommendations for travelers returning from countries with widespread ongoing transmission.
    - Any passengers who get sick with fever, new or worsening cough, or shortness of breath during their cruise should isolate themselves in their cabin and notify the onboard medical center immediately.
        - Crew members who get sick should follow any instructions from the cruise line.
    - If an ill passenger or crew member is identified on board the ship, the cruise line will report to the CDC Quarantine Station responsible for the port. CDC staff will determine if further action is needed.
- If a ship has one or more confirmed COVID-19 cases on board, CDC will send an Epi-X alert to state health departments alerting them to these cases.
- CDC will also alert WHO per the International Health Regulations to ensure non-US citizen travelers are aware of their risk.

Diamond Princess

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and were housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They were monitored by medical and public health personnel throughout the 14-day quarantine period. All of these individuals completed their quarantine.

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- 11 Americans who were on board the *Diamond Princess* remain in Japan, including some who are still hospitalized.

Grand Princess*

- CDC has been working with the California Department of Public Health, other federal, state, and local partners and the Princess Cruise Line to investigate a cluster of COVID-19 cases connected with a Grand Princess voyage from February 11-21. Additionally, CDC worked with the same partners to assess the risk for passengers currently aboard the Grand Princess.
    - CDC notified states about the risk and management of passengers aboard the Grand Princess between February 11 and 21 who might have COVID-19 symptoms.
- The U.S. Department of Health and Human Services (HHS) is continuing to work with state and local partners in California to support the return of passengers from the Grand Princess.
- On March 9, the Grand Princess docked in the Port of Oakland.
    - Passengers were transferred to federal military installations across the United States for medical screening, COVID-19 testing, and a 14-day quarantine.
    - Nearly 1,000 passengers who are California residents are completing the mandatory quarantine at Travis Air Force Base.
    - Additional residents of California and residents of other states are completing the mandatory quarantine at Marine Corps Air Station Miramar in San Diego, Lackland Air Force Base in San Antonio, or Dobbins Air Reserve Base in Georgia.
    - Throughout the quarantine, passengers will be monitored for symptoms of COVID-19.
    - The Department of State is working closely with the home countries of several hundred foreign national passengers to arrange for repatriation to their countries.

**Please continue to look for updates in CDC's Daily Key Points and in next week's Key Messages document. The situation is rapidly evolving and CDC will provide updates as they become available.*

Nile River Cruises

- As of March 14, 2020, 16 state health departments have notified CDC of **62** COVID-19 cases and **42** patients under investigation (PUIs) associated with cruise boats on the Nile River in Egypt. Those 16 states are California, Colorado, Delaware, Florida, Iowa, Illinois, Maryland, North Carolina, New Mexico, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin.
    - Most of these American citizens have returned to the United States.
    - Three American citizens remain in Egypt, 1 of whom is in the hospital.
- The affected cruise boats on the Nile River include at least the following ships:
    - M/S A'sara
    - M.S. Esplanade
    - M.S. Queen of Hansa
    - M.S. Sun Goddess
    - Crown Empress
    - M.S. Mayfair
- As of March 12, the Pilgrim tour agency suspended all Egyptian river cruise tours.

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- On March 19, Cairo, Egypt temporarily halted all flights to its airports as a further measure against the spread of COVID-19. The suspension of air traffic will continue until March 31.
- The M/S A'sara took at least four voyages.
    - Cruise 1 had 9 confirmed cases among American passengers and was associated with a cluster of cases in Texas.
    - Cruise 2 had 2 confirmed cases among American passengers.
    - Cruise 3 had 6 confirmed cases among American passengers.
    - Cruise 4 had 29 confirmed cases among American passengers.
- The M.S/ Queen Hansa sailed February 28–March 2. It had at least 1 confirmed case among American passengers.
- The M.S. Esplanade sailed February 24–February 27. As of March 11, it had 7 cases among American passengers and was associated with a cluster in Iowa.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
    - The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in mainland China are allowed to enter the United States, but they are subject to health monitoring for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - As of March 13, all American citizens and exempted persons coming from most of Europe (knows as the Schengen Area) will be funneled through 13 airports (listed in the above Travel section). As of March 16, all American citizens and exempted persons coming from the United Kingdom (excluding overseas territories outside of Europe) or the Republic of Ireland will also be funneled through those 13 airports.
        - CDC and partners will conduct enhanced illness response at these points of entry.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;

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    - South Korea — Level 3, Avoid Nonessential Travel — updated February 24;
    - Most of Europe (Schengen Area) — Level 3, Avoid Nonessential Travel – updated March 12;
    - Global Outbreak — Level 2, Practice Enhanced Precautions — posted March 11.
    - United Kingdom and Ireland — Level 3, Avoid Nonessential Travel — posted March 15.
    - COVID-19 and Cruise Ship Travel — Level 3, Avoid Nonessential Travel — posted March 17.
    - Malaysia — Level 3, Avoid Nonessential Travel — posted March 18.
    - Australia— Level 3, Avoid Nonessential Travel — posted March 21.
    - Brazil— Level 3, Avoid Nonessential Travel — posted March 21.
    - Canada — Level 3, Avoid Nonessential Travel — posted March 21.
    - Israel — Level 3, Avoid Nonessential Travel — posted March 21.
    - Japan — Level 3, Avoid Nonessential Travel — posted March 21.
- CDC is issuing clinical guidance, including clinical care guidance and healthcare infection control guidance.
- On March 2, FDA announced that commercial companies may sell test kits under CDC's EUA.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
- Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
- On March 16, CDC awarded nearly $570 million in funding to 65 state, local, territorial, and tribal jurisdictions to provide resources to prevent, prepare for, and respond to the COVID-19 outbreak.
    1. CDC made these awards 10 days after the President signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123)
    2. CDC has authorized recipients to begin spending their funds immediately.
- CDC activated the Cooperative Agreement for Emergency Response: Public Health Crisis Response (CDC-RFA-TP18-1802) to award a total of $569,822,380 to the 65 eligible jurisdictions on the approved but unfunded (ABU) list for the cooperative agreement.
    1. The 65 jurisdictions include the 50 states; eight U.S. territories and freely associated states; six directly funded localities (Chicago, Houston, Los Angeles County, New York City, Philadelphia, and the District of Columbia); and one tribal nation (Cherokee Nation).

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- This funding gives state and local health departments the flexibility to implement response actions based on the disease characteristics and priorities in their communities.
- The funding supports two required activities:
    1. Accelerated laboratory testing, data collection, and real-time reporting to CDC for identification and tracking of COVID-19 cases in the community; and
    2. Implementation of COVID-19 community intervention plans.
- The supplemental funding is in addition to funding in the amount of $35 million to 21 jurisdictions for immediate COVID-19 response activities.
    - CDC awarded that initial funding on March 6.
    - For the 21 jurisdictions that received the initial funding, CDC has combined their initial funding with the new supplemental funding to reduce the administrative burden of managing two awards.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity. CDC developed a molecular test to detect COVID-19 from human clinical specimens and distributed this test to state and local health laboratories.
- After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC worked with FDA to amend the existing Emergency Use Authorization (EUA) for the test.
    - Further, newly manufactured kits were provided to the International Reagent Resource for distribution.
        - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
        - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.

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        - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
        - As of March 19th, 91 public health labs are running the CDC test, representing all 50 states, as well as the District of Columbia, Guam, and Puerto Rico.
        - Commercial manufacturers are now producing their own tests.
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC is conducting laboratory testing in two of its laboratories at its headquarters in Atlanta. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
    - CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.
    - CDC has deployed staff to assist in local areas experiencing clusters of COVID-19.

CDC International Response

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- CDC is providing technical assistance to the Government of Italy for exit screening flights departing from Italy to the United States.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.

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- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

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- If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
- If you have symptoms of COVID-19 and want to get tested, try calling your state or local health department or a medical provider. While supplies of these tests are increasing, it may still be difficult to find a place to get tested.
- Most people have mild illness and are able to recover at home.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent International Travelers

- If you have traveled internationally, watch your health, and limit interactions with others for 14 days after returning to the United States.
- If you feel sick with fever, cough, or difficulty breathing during this time, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
    - If you were in a country with widespread sustained (ongoing) transmission—China, Iran, South Korea, most of Europe (known as the Schengen Area), the United Kingdom, or the Republic of Ireland—stay home, monitor yourself, and practice social distancing for 14 days after you left that country.

People Confirmed to Have, or Being Evaluated for, COVID-19

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.

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- Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
- Wash your hands often with soap and water for at least 20 seconds.
- Avoid sharing household items like eating utensils, cups, or linens.
- Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- On March 16, the White House recommended that if someone in your household has tested positive for COVID-19, the entire household should stay home and you should contact your medical provider.

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- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

Healthcare Professionals

- As availability of diagnostic testing for COVID-19 increases, clinicians will be able to access laboratory tests for diagnosing COVID-19 through clinical laboratories performing tests authorized by FDA under an Emergency Use Authorization (EUA).
    - Clinicians will also be able to access laboratory testing through public health laboratories in their jurisdictions.
- This expands testing to a wider group of symptomatic patients. Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested.
    - Decisions on which patients receive testing should be based on the local epidemiology of COVID-19, as well as the clinical course of illness.
    - Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing).
    - Clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Epidemiologic factors that may help guide decisions on whether to test include: any persons, including healthcare workers, who have had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset, or a history of travel from affected geographic areas within 14 days of symptom onset.

Recommendations for Reporting, Testing, and Specimen Collection

- Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19.
- State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website.
- State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays.
- Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.
- On March 13, CDC updated its guidance for specimen collection for testing for COVID-19to to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).

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- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019. Everyone has a role to play in getting ready and staying healthy.
    - For most people in the U.S., the immediate risk of being exposed to the virus that causes COVID-19 is thought to be low. The virus is not currently widespread in the U.S.
    - In places where ongoing community spread of the virus that causes COVID-19 has been reported, people are at elevated risk of exposure.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as temporary school dismissals, postponing or cancelling large events, social distancing (i.e. limiting face-to-face contact) can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for disease outbreaks, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local public health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs in their local communities.
- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, respiratory and cough etiquette, using facemasks in community settings when ill, practicing hand hygiene)

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- Community measures aimed at increasing social distancing (e.g., temporary school dismissals, social distancing in workplaces (like working remotely), postponing or cancelling mass gatherings)
- Environmental measures (e.g., routine cleaning of frequently touched objects or surfaces)

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, **stay home when you are sick** with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- **Mass gatherings:**
  - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
  - On March 16, the White House recommended avoiding social gatherings in groups of more than 10 people.
- **Community and faith-based organizations:**
  - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.
  - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before an outbreak can help provide your organization with the support and resources needed.
  - CDC has created interim guidance to help you create an emergency plan for your community and faith-based organization.
- **Administrators of U.S. childcare programs and K-12 schools and administrators of institutions of higher education:**
  - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
  - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be

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dismissed in the event of an outbreak. (NOTE: The U.S. Department of Education does not recommend using "school closure" terminology.)

- School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
- CDC has posted guidance for childcare and K-12 school settings on its website.
- CDC has posted recommendations of considerations for school dismissals.
- CDC has posted guidance for institutions of higher education (IHE) on its website.
    - This guidance includes considerations about addressing campus housing. Guidance for IHE with students participating in international travel or study abroad programs is also available.

- **Homeless shelters:**
    - People experiencing homelessness may be at risk for infection during an outbreak of COVID-19.
        - CDC has created interim guidance for homeless shelters that address planning for and responding to COVID-19 in these settings.
        - CDC has also posted Interim Guidance for Responding to COVID-19 among People Experiencing Unsheltered Homelessnessv.

Information for Law Enforcement

- For law enforcement personnel performing daily routine activities, the immediate health risk is low.
- CDC has developed recommendations for law enforcement to protect themselves from exposure.
    - Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS.
    - Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
    - Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Different styles of PPE may be necessary to perform operational duties.
    - These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.
- If close contact occurs during apprehension:
    - Clean and disinfect duty belt and gear prior to reuse. Use a household cleaning spray or wipe, according to the product label.
    - Follow standard operating procedures for the containment and disposal of used PPE.
    - Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

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HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:
    1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
    2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
    3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
    4. Rinse your hands well under clean, running water.
    5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare facilities are increasingly unable to procure reliable and sufficient supplies for infection control, including N95 respirators.
- Because of demands associated with the COVID-19 response, CDC has updated the current national COVID-19 infection control guidance for healthcare in the midst of supply realities and growing insight about the spread of COVID-19.
- Protection of healthcare personnel is a priority. CDC's updated guidance on infection control aims to prioritize the use of N95 respirators and other respiratory protection devices for use during high-risk procedures while still protecting health care personnel with facemasks and eye protection during other routine patient care activities, in the setting of respirator shortages.
- CDC's updated, interim IPC guidance also aims to support health care facilities in practical decision-making at the local level to maintain a functional health care system while protecting healthcare workers.
- The guidance also outlines multiple interventions that can be implemented to enhance protection of health care personnel
- CDC has updated guidance on the PPE healthcare personnel should use when caring for patients with known or suspected COVID-19:
    - Eye protection, gown, and gloves continue to be recommended.
    - While respirators remain preferred, facemasks are an acceptable alternative until the supply chain is restored.
        - Facemasks protect the wearer from splashes and sprays.

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        - Respirators, which filter inspired air, offer respiratory protection.
    - Respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to healthcare professionals.
- The risk of transmission can be reduced by several types of actions, like prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- CDC reminds all employers and healthcare personnel about the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
- All healthcare facilities should continuously review their infection control supply inventories and taking steps to optimize supplies.
    - This is particularly true for areas in facilities where aerosol-generating procedures are performed, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
- The anticipated timeline for return to routine levels of PPE is not known.
    - CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available.
    - CDC has also posted a companion checklist to help healthcare facilities prioritize the implementation of the strategies is available.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not typically procure N-95 respirators, currently have respiratory protection programs, nor fit-tested HCP. Therefore, they would not be able to implement all the recommended infection control interventions for care of COVID-19 patients.
    - Without respiratory protection programs and fit testing, unnecessary transfer of stable patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.
- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.

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    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other strategies to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage of patients and limiting the numbers of healthcare personnel entering the patient room.
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel, visitors, and other patients who may be exposed to a patient with COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Care for patients with known or suspected COVID-19 in a single-person room with the door closed. Reserve Airborne Infection Isolation Rooms (AIIRs) for patients undergoing aerosol-generating procedures.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious materials, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are not considered aerosol generating procedures. These procedures should take place in an examination room with the door closed.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
    - CDC has created Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their healthcare personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.

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- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available), prior to leaving the facility.

Long-term care facilities

- The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
- All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.
- In late February, there was an outbreak of COVID-19 in a long-term care facility in Washington state infecting patients and a healthcare professionals.
- CDC deployed a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:

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    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- The first report of an infected healthcare provider occurred on February 29 in a long-term care facility in Washington.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining the need for appropriate work restrictions.

OPTIMIZING THE SUPPLY OF N95 RESPIRATORS

- Protection of healthcare workers is a priority. CDC's Strategies for Optimizing the Supply of N95 Respirators offers a series of strategies or options to optimize supplies of disposable N95 filtering facepiece respirators (commonly called "N95 respirators") in healthcare settings where there is limited supply.
- It also includes considerations for use by federal, state, and local public health officials, respiratory protection program managers, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.
- CDC has provided additional resources related to these strategies:
    - Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response is intended to help healthcare facilities

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prioritize the implementation of the strategies presented in the Strategies for Optimizing the Supply for N95 Respirators guidance.

- Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response
    - In times of increased demand and decreased supply, consideration can be made to use the N95s listed in the guidance past their manufacturer-designated shelf life when responding to COVID-19.
    - This preliminary information from the NIOSH study suggests certain N95 models beyond their manufacturer-designated shelf life will be protective. CDC recommends that N95s that have exceeded their manufacturer-designated shelf life should be used only as outlined in the Strategies for Optimizing the Supply of N95 Respirators.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and people of any age with underlying chronic medical conditions such as heart disease, lung disease and diabetes.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

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- There are no U.S. Food and Drug Administration (FDA)-approved drugs specifically for the treatment of patients with COVID-19.
- At present, clinical management includes infection prevention and control measures and supportive care, including supplementary oxygen and mechanical ventilatory support when indicated.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

Therapeutic Options for COVID-19 Patients

- There are two approved drugs (chloroquine and hydroxychloroquine) and one investigational agent (remdesivir) currently in use in the United States.
    - The two approved drugs have not been approved specifically for the treatment of patients with COVID-19.
    - For full information on therapeutic options and obtaining these drugs, visit Information for Clinicians on Therapeutic Options for COVID-19 Patients.
- Remdesivir is an investigational intravenous drug with broad antiviral activity that inhibits viral replication through premature termination of RNA transcription. It has in-vitro activity against SARS-CoV-2 and in-vitro and in-vivo activity against related betacoronaviruses.
    - It is available through three clinical trials or on an uncontrolled compassionate use basis.
- Hydroxychloroquine and chloroquine are oral prescription drugs that have been used for treatment of malaria and certain inflammatory conditions.
    - Based upon limited in-vitro and anecdotal data, chloroquine or hydroxychloroquine are currently recommended for treatment of hospitalized COVID-19 patients in several countries.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.

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    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure. Recommendations released March 16 state that if someone in a household has tested positive, keep the entire household at home.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.
    - Determine how you will operate if absenteeism spikes from increases in sick employees, those who stay home to care for sick family members, and those who must stay home to watch their children dismissed from childcare programs and K-12 schools.

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	3-24-2020 CDC COVID-19 Key Points, Telehealth Expansion Notice, and Updated CDC Guidance
Date:	Wednesday, March 25, 2020 8:17:11 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_24_2020_FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 key points for Tuesday, March 24, 2020. Please feel free to share with your staff and other partners.

Please see below for updated CDC COVID-19 guidance posted on the CDC COVID-19 webpage.

- **New Tool**: Coronavirus Disease 2019 (COVID-19) Outpatient Dialysis Facility Preparedness Assessment Tool
- **Level 3 Travel Health Notices** for: Ecuador, Singapore, Indonesia, Romania, Saudi Arabia, Qatar, Philippines, India, South Africa

Secretary Azar Announces Historic Expansion of Telehealth Access to Combat COVID-19

On Tuesday, the President and the Department of Health and Human Services (HHS) announced unprecedented steps to expand Americans' access to telehealth services during the COVID-19 outbreak. The Centers for Medicare & and Medicaid Services (CMS) expanded Medicare coverage for telehealth visits, the HHS Office for Civil Rights (OCR) announced it will waive potential HIPAA penalties for good faith use of telehealth during the emergency, and the HHS Office of Inspector General (OIG) provided flexibility for healthcare providers to reduce or waive beneficiary cost-sharing for telehealth visits paid by federal healthcare programs.

This includes major shifts in various laws that makes telehealth more accessible:

- See CMS's press release: https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak
- See OCR's guidance: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
- See OIG's policy statement: https://oig.hhs.gov/compliance/alerts/index.asp

Kind Regards,

CDC State Coordination Task Force

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 24, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 44,183 confirmed and presumptive positive cases of COVID-19
  - 544 COVID-19-related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19.

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called 15 Days to Slow the Spread, lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the 15-day period ending March 30, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified or extended for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.
- The White House Task Force on Coronavirus has established www.coronavirus.gov as the centralized website for the Federal government.
  - CDC continues to maintain www.cdc.gov/covid19.

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 24, 2020 as of 9:30pm

SITUATION UPDATE

- 44,183 reported cases of COVID-19 have been detected in all 50 states.
- 569 of these cases occurred through close contact with another case.
- 479 cases occurred in people who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 43,135 cases are either still being investigated to determine the source of exposure, or have an unknown source of exposure and are therefore assumed to be a result of community spread.
- The number of cases of COVID-19 being reported in the United States is rising quickly.
    - Early on, most cases in the United States were among travelers returning from affected countries or close contacts of people who had COVID-19.
    - Now, more and more cases are resulting from community spread where the source of the exposure is unknown.
- As COVID-19 activity continues to increase, it will be possible to track activity using some existing surveillance systems that track respiratory illnesses, including flu.
- CDC's most recent FluView showed that the percent of specimens testing positive for influenza at clinical laboratories is decreasing. At the same time, levels of influenza-like-illness (ILI)—as measured by people seeking care for fever, cough, and sore throat—increased for the second week in a row after declining for three weeks.
    - This means that more people are seeking care for respiratory illness than usual at this time of year and that the increase is not due to increasing influenza activity.
    - There are likely multiple factors that contribute to this increase. These may include concern over COVID-19 causing people to seek treatment for respiratory illness when they otherwise would not have, delayed or cancelled visits for routine healthcare, and the ILI surveillance system picking up COVID-19 illness activity.
- CDC and partners that collaborate on surveillance are adapting many of the surveillance systems that routinely collect information on viruses, illnesses, hospitalizations and deaths to better track COVID-19.
    - They are additionally creating new systems to track COVID-19.
    - All sources of information will be made available in one place on the web to facilitate tracking of COVID-19
    - The agency plans to roll out COVID-19 surveillance data on the website this week.
- As of March 23, 91 state and local public health labs in 50 states, the District of Columbia, Guam, and Puerto Rico verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of March 23, 2020, CDC and local and state public health laboratories had tested a total of 88,042 specimens.
- Private laboratories are increasing their testing capacity. In addition to the approximately 2,500 tests per day currently done nationally, it is projected that:
    - Roche will increase their capacity up to 10,000 tests per day by end of this week
    - BioReference will increase their capacity by an additional 3,000 tests per day.

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 24, 2020 as of 9:30pm

- In addition, the Food and Drug Administration has issued a number of Emergency Use Authorizations for commercial manufacturers to develop other COVID-19 tests, including a point-of-care test that could deliver results in as short as 30 minutes.,

CDC GUIDANCE UPDATES

- On March 23, 2020 CDC posted additional guidance for specific community settings including:
  - Management of COVID-19 in Correctional and Detention Facilities,
  - Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings, and
  - Infection Control Guidance for Personnel at Blood and Plasma Collection Facilities.
- On March 22, CDC posted COVID-19 information specific to children including:
  - Tips for parents during school dismissal,
  - Guidance for Schools and Childcare Programs, and
  - Updated FAQs related to children and COVID-19
- On March 22, CDC posted Guidance for Retirement Communities and Independent Living to help them plan, prepare, and respond to COVID-19.
- On March 19, CDC updated technical guidance and consumer information about cleaning and disinfecting your home when someone is sick.
- On March 17, updates were made to CDC guidance on alternate non-95 PPE guidance: Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.
- CDC is reviewing and updating travel notices almost on a daily basis.
  - On March 23, CDC issued 9 additional Level 3 Travel notices for Ecuador, India, Indonesia, Philippines, Qatar, Romania, Saudi Arabia, Singapore, and South Africa.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.
  - People with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
    - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
    - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
  - On March 16, the White House announced a program called 15 Days to Slow the Spread, which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.

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    - CDC developed print resources to promote this message, including a Stay at home if you are sick! poster.
- Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
- If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
    - Does the patient have recent travel from an affected area?
    - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
    - Does the patient reside in an area where there has been community spread of COVID-19?
- If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
- CDC and federal partners recommend that people postpone routine medical or dental care at this time. This will help to reduce the burden on the healthcare system.
    - If you cannot postpone medical treatment, call your provider before visiting to see if they offer consultations by phone or telemedicine.
- People who get a fever or cough should consider whether they might have COVID-19, depending on where they live, their travel history, or other exposures.
    - More than half of the United States is seeing some level of community spread of COVID-19.
    - Testing for COVID-19 may be accessed through medical providers or public health departments, but there is no treatment for this virus.
    - Most people have mild illness and are able to recover at home without medical care.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-4-2020 CDC COVID-19 Key Points and Travel Health Alert Notice (THAN) Cards
Date:	Thursday, March 5, 2020 11:52:37 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf 03-03-2020_COVID-19_THAN_Level 3s.pdf

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Dear Colleagues:

Attached, please find **CDC COVID-19 Key Points from 03-04-2020**. Feel free to share with partners and appropriate parties.

In addition, CDC has updated **COVID-19 Travel Health Alert Notice (THAN) Cards** for travelers, a PDF version is attached.

CDC has launched a new webpage for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.

The full link is: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html
The shortened link is: www.cdc.gov/COVIDTravel

The shortened link is printed on the back of the updated Travel Health Alert Notice (THAN) card, which is attached. The THAN cards will be distributed to all travelers from countries with a Level 3 travel notice. Travelers from China will continue to receive the **Check and Record Everyday (CARE) booklet, available here:** https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

The launch of the above webpage corresponds with changes to travel notice language. Level 3 travel notices can be accessed from the above page and advise travelers to "stay home and monitor their health during travel and for 14 days after returning to the United States."

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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COVID 19 CORONAVIRUS DISEASE

Health Alert: Coronavirus Disease 2019 (COVID-19)

You have traveled to a country with an outbreak of COVID-19 and are at higher risk.

COVID-19 is a respiratory illness that can spread from person to person.

Stay Home

Stay home for the next 14 days and monitor your health. Take your temperature with a thermometer two times a day and watch for symptoms.

If you feel sick and have symptoms:

- Call ahead before you go to a doctor's office or emergency room.
- Tell the doctor about your recent travel and your symptoms.
- Avoid contact with others.
- Do not travel while sick.

Symptoms

Illnesses have ranged from mild symptoms to severe illness and death. Symptoms may appear 2–14 days after exposure.

Symptoms can include:



Fever (100.4°F/38°C or higher)



Cough



Shortness of breath

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Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

FL-DOH-20-0673-A-002214

CDC

CS 315649-B February 29, 2020 4:15 PM

For information about COVID-19 and how to monitor your health after travel, open your cell phone camera and scan this code:

Для получения информации о COVID-19 и о том, как контролировать состояние вашего здоровья после путешествия, включите камеру на вашем мобильном телефоне и отсканируйте этот код:

Pour obtenir des informations relatives à COVID-19 et à la manière de surveiller votre santé après un voyage, ouvrez la caméra de votre téléphone portable et scannez le code suivant :

للحصول على معلومات حول فيروس كورونا المستجد COVID-19 وكيفية مراقبة حالتك الصحية بعد السفر، افتح كاميرا هاتفك الخلوي وامسح هذا الرمز ضوئيًا:

新型コロナウイルス感染症（COVID-19）に関する情報、および旅行後の自身の健康状態を観察する方法については、携帯電話のカメラを起動して、このコードをスキャンしてください：

Para obter informações sobre o COVID-19 e como monitorar sua saúde após a viagem, abra a câmera do seu celular e digitalize este código:

코로나바이러스감염증-19(COVID-19) 및 여행 후 건강 상태를 모니터링하는 방법에 대한 정보를 보려면, 휴대폰 카메라로 이 코드를 스캔하십시오:

COVID-19 के बारे मे और यात्रा के बाद अपने स्ास्य को मॉनीटर कैसे करे, के बारे मे जानकारी के लिए, अपने सेि फोन का कैमरा चालिए और इस कोड को स्कैन करे:

สำหรับข้อมูลเพิ่มเติมเกี่ยวกับ COVID-19 และวิธีการตรวจเช็คสุขภาพของคุณหลังจากการเดินทาง โปรดเปิดกล้องมือถือของคุณและสแกนรหัสนี้:

Untuk mendapatkan maklumat mengenai COVID-19 dan cara mengawasi kesihatan anda selepas perjalanan, buka kamera telefon bimbit anda dan imbas kod ini:

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AMERICAN OVERSIGHT

FL-DOH-20-0673-A-002215

www.cdc.gov/COVIDTravel

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

March 04, 2020

Updated text is shown in colored text.

SNAPSHOT

CDC has reported:

- 80 confirmed and presumptive positive cases of COVID-19
- 9 COVID-19 related deaths
- 13 states reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 80 reported U.S. cases of COVID-19 from 13 states.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- As of March 2, 2020, 85 international locations (including the U.S.) have reported confirmed cases of COVID-19, including most recently Argentina, Chile, Poland and Ukraine.

AMERICAN OVERSIGHT

- 80 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York, New Hampshire, North Carolina, Oregon, Rhode Island, Washington and Wisconsin.
    - 16 of these cases occurred through person-to-person spread.
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    - 40 cases are still being investigated to determine the source of exposure.
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    - Level 1 (practice usual precautions): Hong Kong
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REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- As of March 4, 42 state and local public health laboratories are able to test for COVID-19.
    - CDC has developed a map showing the states that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list of states currently testing for COVID-19 is provided by the Association of Public Health Laboratories (APHL).
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may differ from what states, local authorities, or media are reporting.
    - If there are discrepancies between case counts reported by state or local officials and CDC-reported numbers, the numbers provided by states will be the most up to date.
- State health laboratories are reporting their results to CDC.
    - CDC is consolidating state reports and combining them with CDC-confirmed test results to present a national aggregated case count daily from Monday through Friday.
    - CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.

AMERICAN OVERSIGHT

    - CDC will post case counts submitted to CDC by 4pm the prior day on the COVID-19 response website at noon.
- As of March 2, 2020, 1,235 patients had been tested at CDC. This does not include testing being done at state and local public health laboratories, which began this week.
- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan) in a separate chart available on the CDC website.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.

AMERICAN OVERSIGHT

- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
  - Preparing first responders, healthcare providers, and health systems
  - Reinforcing state, territorial, and local public health readiness
  - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will need to prepare for and coordinate response to an outbreak, if it occurs.
  - Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-4-2020 CDC COVID-19 Key Points and Travel Health Alert Notice (THAN) Cards
Date:	Thursday, March 5, 2020 11:54:37 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf 03-03-2020_COVID-19_THAN_Level 3s.pdf

---

Dear Colleagues:

Attached, please find **CDC COVID-19 Key Points from 03-04-2020**. Feel free to share with partners and appropriate parties.

In addition, CDC has updated **COVID-19 Travel Health Alert Notice (THAN) Cards** for travelers, a PDF version is attached.

CDC has launched a new webpage for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.

The full link is: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html
The shortened link is: www.cdc.gov/COVIDTravel

The shortened link is printed on the back of the updated Travel Health Alert Notice (THAN) card, which is attached. The THAN cards will be distributed to all travelers from countries with a Level 3 travel notice. Travelers from China will continue to receive the **Check and Record Everyday (CARE) booklet, available here:** https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

The launch of the above webpage corresponds with changes to travel notice language. Level 3 travel notices can be accessed from the above page and advise travelers to "stay home and monitor their health during travel and for 14 days after returning to the United States."

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

COVID 19 CORONAVIRUS DISEASE

Health Alert: Coronavirus Disease 2019 (COVID-19)

You have traveled to a country with an outbreak of COVID-19 and are at higher risk.

COVID-19 is a respiratory illness that can spread from person to person.

Stay Home

Stay home for the next 14 days and monitor your health. Take your temperature with a thermometer two times a day and watch for symptoms.

If you feel sick and have symptoms:

- Call ahead before you go to a doctor's office or emergency room.
- Tell the doctor about your recent travel and your symptoms.
- Avoid contact with others.
- Do not travel while sick.

Symptoms

Illnesses have ranged from mild symptoms to severe illness and death. Symptoms may appear 2–14 days after exposure.

Symptoms can include:



Fever (100.4°F/38°C or higher)



Cough



Shortness of breath

AMERICAN OVERSIGHT

Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

FL-DOH-20-0673-A-002221

CDC

CS 315649-B February 29, 2020 4:15 PM

For information about COVID-19 and how to monitor your health after travel, open your cell phone camera and scan this code:

Для получения информации о COVID-19 и о том, как контролировать состояние вашего здоровья после путешествия, включите камеру на вашем мобильном телефоне и отсканируйте этот код:

Pour obtenir des informations relatives à COVID-19 et à la manière de surveiller votre santé après un voyage, ouvrez la caméra de votre téléphone portable et scannez le code suivant :

للحصول على معلومات حول فيروس كورونا المستجد COVID-19 وكيفية مراقبة حالتك الصحية بعد السفر، افتح كاميرا هاتفك الخلوي وامسح هذا الرمز ضوئيًا:

新型コロナウイルス感染症（COVID-19）に関する情報、および旅行後の自身の健康状態を観察する方法については、携帯電話のカメラを起動して、このコードをスキャンしてください：

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COVID-19 के बारे मे और यात्रा के बाद अपने स्ास्य को मॉनीटर कैसे करे, के बारे मे जानकारी के लिए, अपने सेि फोन का कैमरा चालिए और इस कोड को स्कैन करे:

สำหรับข้อมูลเพิ่มเติมเกี่ยวกับ COVID-19 และวิธีการตรวจเช็คสุขภาพของคุณหลังจากการเดินทาง โปรดเปิดกล้องมือถือของคุณและสแกนรหัสนี้:

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AMERICAN OVERSIGHT

FL-DOH-20-0673-A-002222

www.cdc.gov/COVIDTravel

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

March 04, 2020

Updated text is shown in colored text.

SNAPSHOT

CDC has reported:

- 80 confirmed and presumptive positive cases of COVID-19
- 9 COVID-19 related deaths
- 13 states reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 80 reported U.S. cases of COVID-19 from 13 states.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
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    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
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- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
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SITUATION UPDATE

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

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For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	3-4-2020 CDC COVID-19 Key Points and Travel Health Alert Notice (THAN) Cards
Date:	Thursday, March 5, 2020 11:49:57 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf 03-03-2020_COVID-19_THAN_Level 3s.pdf

---

Dear Colleagues:

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Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

COVID 19 CORONAVIRUS DISEASE

Health Alert: Coronavirus Disease 2019 (COVID-19)

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COVID-19 is a respiratory illness that can spread from person to person.

Stay Home

Stay home for the next 14 days and monitor your health. Take your temperature with a thermometer two times a day and watch for symptoms.

If you feel sick and have symptoms:

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- Avoid contact with others.
- Do not travel while sick.

Symptoms

Illnesses have ranged from mild symptoms to severe illness and death. Symptoms may appear 2–14 days after exposure.

Symptoms can include:



Fever (100.4°F/38°C or higher)



Cough



Shortness of breath

AMERICAN OVERSIGHT

Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

FL-DOH-20-0673-A-002228

CDC

CS 315649-B February 29, 2020 4:15 PM

For information about COVID-19 and how to monitor your health after travel, open your cell phone camera and scan this code:

Для получения информации о COVID-19 и о том, как контролировать состояние вашего здоровья после путешествия, включите камеру на вашем мобильном телефоне и отсканируйте этот код:

Pour obtenir des informations relatives à COVID-19 et à la manière de surveiller votre santé après un voyage, ouvrez la caméra de votre téléphone portable et scannez le code suivant :

للحصول على معلومات حول فيروس كورونا المستجد COVID-19 وكيفية مراقبة حالتك الصحية بعد السفر، افتح كاميرا هاتفك الخلوي وامسح هذا الرمز ضوئيًا:

新型コロナウイルス感染症（COVID-19）に関する情報、および旅行後の自身の健康状態を観察する方法については、携帯電話のカメラを起動して、このコードをスキャンしてください：

Para obter informações sobre o COVID-19 e como monitorar sua saúde após a viagem, abra a câmera do seu celular e digitalize este código:

코로나바이러스감염증-19(COVID-19) 및 여행 후 건강 상태를 모니터링하는 방법에 대한 정보를 보려면, 휴대폰 카메라로 이 코드를 스캔하십시오:

COVID-19 के बारे मे और यात्रा के बाद अपने स्ास्य को मॉनीटर कैसे करे, के बारे मे जानकारी के लिए, अपने सेि फोन का कैमरा चालिए और इस कोड को स्कैन करे:

สำหรับข้อมูลเพิ่มเติมเกี่ยวกับ COVID-19 และวิธีการตรวจเช็คสุขภาพของคุณหลังจากการเดินทาง โปรดเปิดกล้องมือถือของคุณและสแกนรหัสนี้:

Untuk mendapatkan maklumat mengenai COVID-19 dan cara mengawasi kesihatan anda selepas perjalanan, buka kamera telefon bimbit anda dan imbas kod ini:

Para obtener información sobre el COVID-19 y cómo monitorear su salud después de un viaje, abra la cámara de su teléfono y escanee este código:

有关COVID-19 的信息以及如何在旅行后监测您的健康状况，请打开手机摄像头并扫描此二维码：

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FL-DOH-20-0673-A-002229

www.cdc.gov/COVIDTravel

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

March 04, 2020

Updated text is shown in colored text.

SNAPSHOT

CDC has reported:

- 80 confirmed and presumptive positive cases of COVID-19
- 9 COVID-19 related deaths
- 13 states reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 80 reported U.S. cases of COVID-19 from 13 states.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- As of March 2, 2020, 85 international locations (including the U.S.) have reported confirmed cases of COVID-19, including most recently Argentina, Chile, Poland and Ukraine.

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- 80 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York, New Hampshire, North Carolina, Oregon, Rhode Island, Washington and Wisconsin.
    - 16 of these cases occurred through person-to-person spread.
    - 24 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.
    - 40 cases are still being investigated to determine the source of exposure.
- On March 4, CDC updated its guidance for "Evaluating and Reporting Persons Under Investigation (PUI)."
    - Criteria for evaluation of Persons Under Investigation (PUI) were expanded to a wider group of symptomatic patients.
    - On Thursday, March 5, CDC will host a clinician education call on the topic of COVID-19. Visit CDC's website for information on how to join this call.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- As of March 4, 2020, CDC had issued the following Travel Health Notices:
    - Level 3 Travel Health Notice (avoid non-essential travel): China, Iran, South Korea, and Italy
    - Level 2 Travel Health Notices (Practice Enhanced Precautions): Japan
    - Level 1 (practice usual precautions): Hong Kong
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.
- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- As of March 4, 42 state and local public health laboratories are able to test for COVID-19.
    - CDC has developed a map showing the states that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list of states currently testing for COVID-19 is provided by the Association of Public Health Laboratories (APHL).
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may differ from what states, local authorities, or media are reporting.
    - If there are discrepancies between case counts reported by state or local officials and CDC-reported numbers, the numbers provided by states will be the most up to date.
- State health laboratories are reporting their results to CDC.
    - CDC is consolidating state reports and combining them with CDC-confirmed test results to present a national aggregated case count daily from Monday through Friday.
    - CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.

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    - CDC will post case counts submitted to CDC by 4pm the prior day on the COVID-19 response website at noon.
- As of March 2, 2020, 1,235 patients had been tested at CDC. This does not include testing being done at state and local public health laboratories, which began this week.
- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan) in a separate chart available on the CDC website.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.

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- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
  - Preparing first responders, healthcare providers, and health systems
  - Reinforcing state, territorial, and local public health readiness
  - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will need to prepare for and coordinate response to an outbreak, if it occurs.
  - Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	[IMPORTANT UPDATE] FDA Issues New Policy to Help Expedite Availability of Diagnostics
Date:	Saturday, February 29, 2020 6:57:03 PM

Dear Partner –

Today, as part of the U.S. Food and Drug Administration's ongoing and aggressive commitment to address the coronavirus outbreak, the agency issued a new policy for certain laboratories seeking to develop diagnostic tests for coronavirus in order to achieve more rapid testing capacity in the U.S.

The new policy is for certain laboratories that develop and begin to use validated COVID-19 diagnostics before the FDA has completed review of their Emergency Use Authorization (EUA) requests. The immediately in effect guidance issued today describes the circumstances where the FDA does not intend to object to the use of these tests for clinical testing while the laboratories are pursuing an EUA with the FDA. Importantly, this policy only applies to laboratories that are certified to perform high-complexity testing consistent with requirements under Clinical Laboratory Improvement Amendments.

The FDA guidance provides recommendations for test developers, including information regarding test validation, FDA notification and interim confirmatory clinical testing. Following the completion of their test validation, laboratories should communicate with the FDA, via email, in order to notify the agency that the test has been validated. Laboratories should submit a completed EUA request within 15 business days of notification.

The link to the full press release is here.

Related Information

- Novel Coronavirus
- Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency - Immediately in Effect Guidance for Clinical Laboratories and Food and Drug Administration Staff

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	[IMPORTANT UPDATE] FDA Issues New Policy to Help Expedite Availability of Diagnostics
Date:	Saturday, February 29, 2020 6:56:10 PM

Dear Partner –

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Related Information

- Novel Coronavirus
- Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency - Immediately in Effect Guidance for Clinical Laboratories and Food and Drug Administration Staff

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: [RELEASE] - HHS Awards $117 Million to End the HIV Epidemic in the United States
Date: Wednesday, February 26, 2020 10:59:31 AM

Dear Partner –

Today, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), awarded approximately $117 million to expand access to HIV care, treatment, medication, and prevention services. This investment is a critical component of the Administration's *Ending the HIV Epidemic: A Plan for America (EHE)* initiative, which aims to reduce the number of new HIV infections in the United States by 90 percent by 2030.

The EHE initiative and today's awards focus on 48 counties, Washington, D.C., and San Juan, Puerto Rico, geographic areas where more than 50 percent of new HIV diagnoses occurred in 2016 and 2017, as well as the seven states with a substantial rural HIV burden.

"HRSA is a leader in working to end the HIV epidemic in the U.S.," said HHS Secretary Alex Azar. "These investments will support partnerships between organizations that are on the front lines of preventing and reducing HIV transmission, as well as improving the overall health outcomes for people with HIV."

HRSA's Health Center Program awards will be used to identify at-risk individuals and engage in preventive services, test for HIV, and prescribe pre-exposure prophylaxis (PrEP) when appropriate. Awards made to HRSA's Ryan White HIV/AIDS Program recipients will be used to link people who are either newly diagnosed with HIV, or diagnosed but currently not in care, to essential HIV care, treatment, and support services, helping them reach viral suppression and reduce HIV transmission.

For further discussion on this announcement, we invite you to a stakeholder call TODAY, February 26, 2020 with HRSA Administrator Tom Engels. Details can be found below:

Date: February 26, 2020
Time: 4:00 PM EST
Number: 888-790-3548
Passcode: 2511315

For a list of award recipients, visit:

- Health Center Program: https://bphc.hrsa.gov/program-opportunities/primary-care-hiv-prevention/fy2020-awards
- Ryan White HIV/AIDS Program: https://hab.hrsa.gov/about-ryan-white-hivaids-program/fy2020-ending-hiv-epidemic-awards

For more information about HRSA's role in the Ending the HIV Epidemic initiative, visit: www.hrsa.gov/ending-hiv-epidemic.

Sincerely,

AMERICAN OVERSIGHT

Darcie

Darcie Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

Washington, Kendra

From: Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Sent: Thursday, March 12, 2020 2:11 PM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Subject: Accepted: Call with Florida COVID-19

AMERICAN OVERSIGHT

From: Fullem, Linda R on behalf of Rivkees, Scott A
To: Poser, Sarah (CDC/DDID/NCEZID/OD)
Subject: Accepted: Plans to Notify COVID-19 Exposed Persons in Florida Port

AMERICAN OVERSIGHT

From: Villalta, Yesenia D
To: CDC IMS State Coordination Task Force (SCTF) Operations
Subject: Accepted: Senior Administration Officials Briefing Call on COVID-19 // Regarding President Trump issuing proclamation under section 212(f) of the Immigration and Nationality Act (INA), restricting travel

AMERICAN OVERSIGHT

From: ASTHO President

To: amy.acton@odh.ohio.gov; Nicole Alexanderscott; sadia.ali@doh.vi.gov; bruce.s.anderson@doh.hawaii.gov; Sonia.angell@cdph.ca.gov; gary.anthone@nebraska.gov; Rachelle Ashe; jeanne.ayers@dhs.wisconsin.gov; iazzam@health.nv.gov; louise.baa@doh.vi.gov; aislinn.barnett@state.co.us; tbarnettno@pa.gov; Tami Barrett; lacey.barry1@maryland.gov; pbeene@pa.gov; mark.benton@dhhs.nc.gov; Eva.benvenga@maryland.gov; Terry Bergener; tanya.bethel@dc.gov; Monica Bharel; alexander.billioux@la.gov; Kelly Bogert; kbox@isdh.in.gov; Carolyn Byrnes; Jennifer Caskey; kacech@mt.gov; Cara M. Christ; Gerd Clabaugh; betsycoleman@utah.gov; Renee.Coleman-Mitchell@ct.gov; GaryC@health.ok.gov; Misty.Daniels@dhw.idaho.gov; Catherine.delacruz@salud.pr.gov; adearinger@ky.gov; Linda.denorcey@dphss.guam.gov; Odette Desgeorges; Thomas Dobbs; Egelskil@michigan.gov; justa.encarnacion@doh.vi.gov; Bonnie Engel; Ngozi.Ezike@illinois.gov; Reva Ferguson; jpfilippi@health.nv.gov; Andrea Fisher; Linda.Fullem@flhealth.gov; carolyn.geter@dshs.texas.gov; Sarah Gregorek; Jenny Griffin; Janet Guerrero; Diane M. Hanley; Monica Harding; ScottHarris; Alexia Harrist; heidi.hedberg@alaska.gov; John Hellerstedt; Teresa Higgins; Sheila Hogan; Gholzman@mt.gov; amaal.idheileh@doh.vi.gov; lalie.ikluk@palauhealth.org; Dana Jensen; Kalani Kaneko; Suzanne Kaneshiro; KhaldunJ@michigan.gov; Jane.Killen2@La.gov; Mailynn Konelios-Langinlur; kathy.kunkel@state.nm.us; Peggie Lawrence; Mark Levine; Rachel Levine; Peggy.Lindley@dhw.idaho.gov; richard.little@delaware.gov; marlineloeak@gmail.com; jan.malcolm@state.mn.us; Kim Malsam-Rysdon; Lesa McFarlane; angelica.mcgrier@dph.ga.gov; Debbie Mebruer; Rita Menard; Joe Miner; Carla Moore; Deanna Morris; Lisa Morris; Esther Muna; Shirley Musgrave; robert.neall@maryland.gov; LaQuandra Nesbitt; lee.norman@ks.gov; norm.oliver@vdh.virginia.gov; Oluwaseun.Oyeniran@illinois.gov; Judith.Persichilli@doh.nj.gov; fran.phillips@maryland.gov; Lisa.Piercey@tn.gov; Sandy Pizzuti; tesha.plunkett@doh.vi.gov; Michelle.Pringle@maryland.gov; dawn.l.quitugua@state.or.us; karyl.rattay@delaware.gov; Kellie.Richetti@mt.gov; scott.rivkees@flhealth.gov; Emais Roberts; Rafael Rodriguez; jill.hunsakerryan@state.co.us; Marcus H. Samo, MPH; Magen.Schachta@nebraska.gov; Denise.Schimmel@ks.gov; nirav.shah@maine.gov; elke.shaw-tulloch@dhw.idaho.gov; l.sherych@health.nv.gov; lillian.shirley@state.or.us; Jacqueline Silvia; Catherine Slemp, MD, MPH; dannette.smith@nebraska.gov; Nate Smith; Wendy Snyder; Angela Soliz; Fancy Soloman; Tammy Stanton; Sharon.Tangonan@doh.hawaii.gov; pthompson@nd.gov; Betsey.Tilson@dhhs.nc.gov; Motusa Nua; kathleen.toomey@dph.ga.gov; rick.toomey@dhec.sc.gov; Mylynn Tufte; Eti Uiagalelei; Peggy Ullom; tara.vasby@dhs.wisconsin.gov; fanny.vazquez@dph.ga.gov; kyrad.vermillion@ky.gov; Patricia Vinson; Barbara White; Rebecca White; John Wiesman; Randall Williams; Ashley.Wilson@odh.ohio.gov; Maryanne.wollman@vdh.virginia.gov; anne.zink@alaska.gov; Howard Zucker; Deb Colston; idalmi90@gmail.com; KFarrell@hrsa.gov; bhandler@health.nv.gov; Lance Himes; IngersollJ2@michigan.gov; ngl1@cdc.gov; Jose T. Montero, MD, MPH; ppontones@isdh.in.gov; Mark.Pyle@nebraska.gov; Stephanie Pyle; Connie White; Stephanie Williams; ASTHO-All-Staff; LTaulung2@fsmhealth.fm; eric.france@state.co.us; Jennifer.dillaha@arkansas.gov; joel.tumlison@arkansas.gov; Shirley.louie@arkansas.gov; laurie.forlano@vdh.virginia.gov; steven.stack@ky.gov; Margaret.kelly@state.mn.us; mbecker@nga.org; eric.chenier@state.nm.us; Kellie.Giefer@state.mn.us; gary.wheeler@arkansas.gov

Cc: carolyn.mccoy@gmail.com

Subject: ASTHO All S/THO Call (COVID-19-focused)

Agenda forthcoming

One-tap dialing: 6468769923,,185680719#

Phone Number: 646-876-9923

Meeting ID: 185 680 719

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AMERICAN OVERSIGHT

From: ASTHO President

To: fran.phillips@maryland.gov; jill.hunsakerryan@state.co.us; joel.tumlison@arkansas.gov; Shirley.louie@arkansas.gov; Jennifer.dillaha@arkansas.gov; amy.acton@odh.ohio.gov; Nicole Alexanderscott; sadia.ali@doh.vi.gov; bruce.s.anderson@doh.hawaii.gov; Sonia.angell@cdph.ca.gov; gary.anthone@nebraska.gov; Rachelle Ashe; jeanne.ayers@dhs.wisconsin.gov; jazzam@health.nv.gov; louise.baa@doh.vi.gov; aislinn.barnett@state.co.us; tbarnettno@pa.gov; Tami Barrett; lacey.barry1@maryland.gov; pbeene@pa.gov; mark.benton@dhhs.nc.gov; Eva.benvenga@maryland.gov; Terry Bergener; tanya.bethel@dc.gov; Monica Bharel; bbilimon@hotmail.com; alexander.billioux@la.gov; Kelly Bogert; kbox@isdh.in.gov; Carolyn Byrnes; ccanfieldsmither@ky.gov; Jennifer Caskey; kacech@mt.gov; Cara M. Christ; Gerd Clabaugh; betsycoleman@utah.gov; Renee.Coleman-Mitchell@ct.gov; GaryC@health.ok.gov; Misty.Daniels@dhw.idaho.gov; Catherine.delacruz@salud.pr.gov; adearinger@ky.gov; Linda.denorcey@dphss.guam.gov; Odette Desgeorges; Thomas Dobbs; Egelskil@michigan.gov; justa.encarnacion@doh.vi.gov; Bonnie Engel; Ngozi.Ezike@illinois.gov; Reva Ferguson; jpfilippi@health.nv.gov; Andrea Fisher; carolyn.geter@dshs.texas.gov; Sarah Gregorek; Jenny Griffin; Janet Guerrero; Diane M. Hanley; Monica Harding; ScottHarris; Alexia Harrist; heidi.hedberg@alaska.gov; John Hellerstedt; Teresa Higgins; Sheila Hogan; Gholzman@mt.gov; amaal.idheileh@doh.vi.gov; lalie.ikluk@palauhealth.org; Dana Jensen; Suzanne Kaneshiro; KhaldunJ@michigan.gov; Jane.Killen2@La.gov; Mailynn Konelios-Langinlur; kathy.kunkel@state.nm.us; Peggie Lawrence; Mark Levine; Rachel Levine; Peggy.Lindley@dhw.idaho.gov; richard.little@delaware.gov; marlineloeak@gmail.com; jan.malcolm@state.mn.us; Kim Malsam-Rysdon; Lesa McFarlane; angelica.mcgrier@dph.ga.gov; Debbie Mebruer; Rita Menard; Joe Miner; Carla Moore; Deanna Morris; Lisa Morris; Esther Muna; Shirley Musgrave; robert.neall@maryland.gov; LaQuandra Nesbitt; patricia.nest@state.or.us; lee.norman@ks.gov; norm.oliver@vdh.virginia.gov; Oluwaseun.Oyeniran@illinois.gov; Judith.Persichilli@doh.nj.gov; Lisa.Piercey@tn.gov; Sandy Pizzuti; tesha.plunkett@doh.vi.gov; Michelle.Pringle@maryland.gov; karyl.rattay@delaware.gov; Kellie.Richetti@mt.gov; scott.rivkees@flhealth.gov; Emais Roberts; Rafael Rodriguez; Marcus H. Samo, MPH; Magen.Schachta@nebraska.gov; Denise.Schimmel@ks.gov; nirav.shah@maine.gov; elke.shaw-tulloch@dhw.idaho.gov; l.sherych@health.nv.gov; lillian.shirley@state.or.us; Jacqueline Silvia; Catherine Slemp, MD, MPH; dannette.smith@nebraska.gov; Nate Smith; Wendy Snyder; Angela Soliz; Fancy Soloman; Tammy Stanton; Sharon.Tangonan@doh.hawaii.gov; pthompson@nd.gov; Betsey.Tilson@dhhs.nc.gov; Jade.Tindle@flhealth.gov; Motusa Nua; kathleen.toomey@dph.ga.gov; rick.toomey@dhec.sc.gov; Mylynn Tufte; Eti Uiagalelei; Peggy Ullom; tara.vasby@dhs.wisconsin.gov; fanny.vazquez@dph.ga.gov; Patricia Vinson; Barbara White; Rebecca White; John Wiesman; Randall Williams; Ashley.Wilson@odh.ohio.gov; Maryanne.wollman@vdh.virginia.gov; anne.zink@alaska.gov; Howard Zucker; James Blumenstock; Gerrit Bakker; Regina Hawkins; Jerry Rhodes; Lisa Peterson; Sharon Miller; LTaulung2@fsmhealth.fm; eric.france@state.co.us; gary.wheeler@arkansas.gov; sstack2@utk.edu; steven.stack@ky.gov; Andy Baker-White; Margaret.kelly@state.mn.us; Kellie.giefer@state.mn.us

Cc: Lillian Shirley; EMT; Danny Staley; Michael Fraser; Mary A. Cooney; John Mericsko; Boateng, Sarah; Jane Esworthy; Zarnaaz Bashir; Amber Williams; Meredith Allen; Melissa Peek-Bullock; Carolyn Mullen; Luna-Pinto, S. Carolina (CDC/DDPHSIS/CSTLTS/DPPS); Ashleigh Faulstich; Marcus Plescia

Subject: ASTHO All S/THO Call: 2019-nCoV

Agenda materials forthcoming

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From: ASTHO President

To: amy.acton@odh.ohio.gov; Nicole Alexanderscott; sadia.ali@doh.vi.gov; bruce.s.anderson@doh.hawaii.gov; Sonia.angell@cdph.ca.gov; gary.anthone@nebraska.gov; Rachelle Ashe; jeanne.ayers@dhs.wisconsin.gov; iazzam@health.nv.gov; louise.baa@doh.vi.gov; aislinn.barnett@state.co.us; tbarnettno@pa.gov; Tami Barrett; lacey.barry1@maryland.gov; pbeene@pa.gov; mark.benton@dhhs.nc.gov; Eva.benvenga@maryland.gov; Terry Bergener; tanya.bethel@dc.gov; Monica Bharel; bbilimon@hotmail.com; alexander.billioux@la.gov; Kelly Bogert; kbox@isdh.in.gov; Carolyn Byrnes; ccanfieldsmither@ky.gov; Jennifer Caskey; kacech@mt.gov; Cara M. Christ; Gerd Clabaugh; betsycoleman@utah.gov; Renee.Coleman-Mitchell@ct.gov; GaryC@health.ok.gov; Misty.Daniels@dhw.idaho.gov; Catherine.delacruz@salud.pr.gov; adearinger@ky.gov; Linda.denorcey@dphss.guam.gov; Odette Desgeorges; Thomas Dobbs; Egelskil@michigan.gov; justa.encarnacion@doh.vi.gov; Bonnie Engel; Ngozi.Ezike@illinois.gov; Reva Ferguson; jpfilippi@health.nv.gov; Andrea Fisher; carolyn.geter@dshs.texas.gov; Sarah Gregorek; Jenny Griffin; Janet Guerrero; Diane M. Hanley; Monica Harding; ScottHarris; Alexia Harrist; heidi.hedberg@alaska.gov; John Hellerstedt; Teresa Higgins; Sheila Hogan; Gholzman@mt.gov; amaal.idheileh@doh.vi.gov; lalie.ikluk@palauhealth.org; Dana Jensen; Suzanne Kaneshiro; KhaldunJ@michigan.gov; Jane.Killen2@La.gov; Mailynn Konelios-Langinlur; kathy.kunkel@state.nm.us; Peggie Lawrence; Mark Levine; Rachel Levine; Peggy.Lindley@dhw.idaho.gov; richard.little@delaware.gov; marlineloeak@gmail.com; jan.malcolm@state.mn.us; Kim Malsam-Rysdon; Lesa McFarlane; angelica.mcgrier@dph.ga.gov; Debbie Mebruer; Rita Menard; Joe Miner; Carla Moore; Deanna Morris; Lisa Morris; Esther Muna; Shirley Musgrave; robert.neall@maryland.gov; LaQuandra Nesbitt; patricia.nest@state.or.us; lee.norman@ks.gov; norm.oliver@vdh.virginia.gov; Oluwaseun.Oyeniran@illinois.gov; Judith.Persichilli@doh.nj.gov; fran.phillips@maryland.gov; Lisa.Piercey@tn.gov; Sandy Pizzuti; tesha.plunkett@doh.vi.gov; Michelle.Pringle@maryland.gov; karyl.rattay@delaware.gov; Kellie.Richetti@mt.gov; scott.rivkees@flhealth.gov; Emais Roberts; Rafael Rodriguez; jill.hunsakerryan@state.co.us; Marcus H. Samo, MPH; Magen.Schachta@nebraska.gov; Denise.Schimmel@ks.gov; nirav.shah@maine.gov; elke.shaw-tulloch@dhw.idaho.gov; l.sherych@health.nv.gov; lillian.shirley@state.or.us; Jacqueline Silvia; Catherine Slemp, MD, MPH; dannette.smith@nebraska.gov; Nate Smith; Wendy Snyder; Angela Soliz; Fancy Soloman; Tammy Stanton; Sharon.Tangonan@doh.hawaii.gov; pthompson@nd.gov; Betsey.Tilson@dhhs.nc.gov; Jade.Tindle@flhealth.gov; Motusa Nua; kathleen.toomey@dph.ga.gov; rick.toomey@dhec.sc.gov; Mylynn Tufte; Eti Uiagalelei; Peggy Ullom; tara.vasby@dhs.wisconsin.gov; fanny.vazquez@dph.ga.gov; Patricia Vinson; Barbara White; Rebecca White; John Wiesman; Randall Williams; Ashley.Wilson@odh.ohio.gov; Maryanne.wollman@vdh.virginia.gov; anne.zink@alaska.gov; Howard Zucker; James Blumenstock; Gerrit Bakker; Regina Hawkins; Jerry Rhodes; Lisa Peterson; Sharon Miller; LTaulung2@fsmhealth.fm; eric.france@state.co.us; gary.wheeler@arkansas.gov; Jennifer.dillaha@arkansas.gov; joel.tumlison@arkansas.gov; Shirley.louie@arkansas.gov; sstack2@utk.edu; steven.stack@ky.gov; Andy Baker-White; Margaret.kelly@state.mn.us; Kellie.giefer@state.mn.us

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Subject: ASTHO All S/THO Call: 2019-nCoV

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Attached: Update on COVID-19 response to Governors (2-20-2020 COVID-19 SHO & State Epi Call)
Date:	Thursday, February 20, 2020 5:28:23 PM
Attachments:	02 20 2020 MEMO AMA call with governors on COVID-19.docx

Dear Colleagues,

Attached is the "Update on COVID-19 response to Governors" document mentioned on today's CDC COVID-19 SHO & State Epi Call.

Thank you,

State Coordination Task Force

Sent by BCC to State Health Officials and State Epidemiologists

AMERICAN OVERSIGHT

DATE: February 19, 2020

TO: The Secretary

THROUGH: Judy Stecker, Deputy Chief of Staff
Ann C. Agnew, Executive Secretary

FROM: Laura Trueman, Director, IEA

SUBJECT: Meeting with U.S. Governors – BRIEFING MEMO

Details:
Date: Thursday, February 20, 2020
Time: 2:30 PM – 3:30 PM
Location: 615-F
HHS Staff: Brian Harrison (IOS), Judy Stecker (IOS), Laura Trueman (IEA), Darcie Johnston (IEA), Dr. Robert Redfield (CDC), Dr. Robert Kadlec (ASPR), Dr. Anthony Fauci (NIAID), Michael Baker (IEA)
External Attendees: Acting Deputy Secretary Ken Cuccinelli (DHS)
Press: No

Who requested this meeting?: White House Intergovernmental Affairs

Topic: Update on COVID-19 response to Governors

Secretary's Role: Provide high-level overview on the Administration's action plan and next steps and answer questions the Governors may have.

Background:
The purpose of this call is to update Governors on the Administration's recent actions in the ongoing COVID-19 response, encourage Governors to begin planning for a more intensive response, and answer questions that the Governors may have on HHS and Administration actions. The Governors may be staffed by state health and emergency response individuals from their states on this call.

Additionally, National Governor Association Executive Director Bill McBride and Association of State and Territorial Health Officials CEO Mike Fraser have been invited to listen on the call.

In addition to HHS subject matter experts, Acting Deputy Secretary Ken Cuccinelli of the Department of Homeland Security will provide a brief DHS update.

After these updates, Governors will be able to ask questions.

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Proposed Run of Show:

2:30 PM	Welcome and introductions by Laura Trueman
2:31 PM – 2:35 PM	High-Level Overview by Secretary Azar
2:35 PM – 2:38 PM	CDC updates with Dr. Bob Redfield
2:38 PM – 2:41 PM	DHS Updates with Acting Deputy Secretary Cuccinelli
2:41 PM – Call end	Discussion and Q&A
	Close Call by Laura Trueman

Discussion Points

Discussion on Prudent Planning for State, Local, and Tribal Governments

i. What would your roles and responsibilities be if a pandemic impacted your state/communities?
ii. What are your authorities at the state level? What are the authorities of your local officials?
iii. How will you communicate with key stakeholders in the health care system and critical industries?
iv. Discussion of available planning resources.

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Coronavirus TPs:

Thank you all for joining today's call.

- We appreciate you talking with us so we can provide you a status update on the Administration's COVID-19 response.
- While the immediate risk to the American public is still currently low, we wanted to update you all on recent Departmental and Administration actions, and answer questions that you may have.

First, let me provide you with a brief status update on the current case count. This data is current as of last night, though as you all know this is a rapidly changing situation and we are constantly monitoring developments to update our response.

- As of February 19, there are 74,185 cases in China and 2,004 deaths. Outside of China, we are tracking 991 cases, 542 with Diamond Princess. Other countries of concern include Singapore, Hong Kong, Japan (29 non-Diamond Princess cases out of 66), and South Korea.
- In the U.S., we currently stand at 15 cases, plus 28 presumptive cases in process of being confirmed at CDC from Diamond Princess; total would give the US 43 cases.
- Those 15 confirmed cases have been reported in the U.S. in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
- Of the 15 original cases, 3 have been released, 4 remain in the hospital, and 4 are in home isolation; there are 58 POI pending, 6 from Diamond Princess.
- Our scientists and public health experts are trying to learn more about the virus using the data we have from China and the cases we have here. And we are working with Chinese counterparts and other international experts on the ground in China.

We want to continue to assure you that protecting the public health and preparing for events like this is what we do, and we are proud to work with state and local health departments to do it. As we continue our federal response planning, we look towards a realistic phase 2 that may require a transition from containment to mitigation.

- We sincerely appreciate the partnership that you, our nation's Governors, and the mayors in your states have worked with us on.
- Though there has been limited transmission in the U.S. so far, we are preparing for the possibility that there may be increased person to person transmission.

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- In a situation where we move from containment to mitigation of disease spread in an affected community, we know that there will need to be some adjustments to our current posture.
- In preparation for this transition, we strongly recommend that you, your public health teams, and your emergency management teams to review your emergency response plans. We suggest you explore and confirm the authorities that you possess to aid in the response to wide-spread transmission in U.S. jurisdictions.
- Confer and collaborate with your Attorneys General and legislature leaders to confirm and identify what authorities that you have and any that you may need to be granted.
- State and local officials will be responsible for three major pieces of a response:
    - Transportation;
    - Housing; and
    - Coordinating with locals and private sector
- Most importantly, we encourage you to lean in and be ready to execute on any necessary actions. We all know that in emergency response, time is of the utmost importance.
- When we talk about having the world's finest public health system, that is talking about the high quality coordination that occurs from HHS on down to your health departments and local hospitals.

Finally, a few additional actions we've taken that I'd like to highlight:

- As of February 17, CDC and Customs and Border (CBP) personnel had screened about 41,000 people with recent travel history to China at U.S. airports.
- Both the NIH and the Biomedical Advanced Research Development Authority (BARDA) in ASPR have entered into partnerships with industry partners to accelerate the development of a COVID-19 vaccine candidate.
- CDC has links and planning resources widely available, including some that focus on public health law, some that focus on preparedness standards, and some that discuss funding. Our staff will be highlighting those for you, and we encourage you to review them to help answer any questions that you may have.

Across the government, we continue to value our partnership with you as we respond to this outbreak. I'll now turn this over to Dr. Bob Redfield for a further update on recent CDC actions.

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Recent Update on the Situation Involving the Diamond Princess

- CDC is supporting the Department of State-led mission to repatriate U.S. citizens returning to the United States from Japan who were aboard the Diamond Princess cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the U.S. government recommended that U.S. citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and have been monitored and evaluated by medical and public health personnel during the trip and after arrival.
    - Those passengers who returned from Japan are being housed separately from the people already in quarantine who returned on previous U.S. Government repatriation flights from Wuhan.
- There are more than 100 American citizens still onboard the Diamond Princess cruise ship or in hospitals in Japan. These citizens have been placed under travel restrictions, as have the ship's other passengers and crew.
    - After disembarkation from the Diamond Princess, these passengers and crew will be required to wait at least 14 days without having symptoms or a positive coronavirus test result before they are permitted to board flights to the United States.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

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From: Coppola, Courtney
To: Deleon, Melissa E MAJ USARMY NG FLARNG (USA)
Subject: Automatic reply: Airport Personnel
Date: Wednesday, March 25, 2020 1:54:39 PM

Thank you for your email. I am currently activated in the State Emergency Operations Center for COVID-19. During this time I will be delayed in replying to email. If you need immediate assistance, please contact Jade Tindle at Jade.Tindle@FLHealth.gov

Thank you

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Pesik, Nicki (CDC/DDID/NCEZID/OD)
Subject: Automatic reply: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington
Date: Tuesday, February 25, 2020 12:58:16 PM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: State and Local Readiness (CDC)
Subject: Automatic reply: CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date: Monday, February 24, 2020 4:40:08 PM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

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From: Blackmore, Carina
To: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ)
Subject: Automatic reply: Coronavirus Guidance
Date: Friday, February 28, 2020 6:07:51 PM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

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From: Blackmore, Carina
To: EPIXUpdate@cdc.gov
Subject: Automatic reply: Important: DGMQ 2019-nCoV Entry Screening: Contact List for Flight DL 0026 on 02/24/2020 for FL
Date: Monday, February 24, 2020 9:10:10 AM

I am in the field. If you need immediate assistance please call my cell phone at 850-528-1595. I will return to the office Mar 2.
Best regards,

Dr. Carina Blackmore

AMERICAN OVERSIGHT

From: Coppola, Courtney
To: Gilliard, Deric (HHS/IEA)
Subject: Automatic reply: Please give me a call when you can
Date: Tuesday, March 24, 2020 2:03:28 PM

Thank you for your email. I am currently activated in the State Emergency Operations Center for COVID-19. During this time I will be delayed in replying to email. If you need immediate assistance, please contact Jade Tindle at Jade.Tindle@FLHealth.gov

Thank you

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From:	Schedule, Gov
To:	Lukis, Adrian; Strum, Shane; FDLE, Mansion; Swearingen, Rick; Rivkees, Scott; Moskowitz, Jared; Eifert, James; Mayhew, Mary; Corcoran, Richard
Subject:	Briefing regarding Coronavirus

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Subject:	Briefing with Agency Heads regarding Coronavirus

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From:	Schedule, Gov
To:	Lukis, Adrian; Rivkees, Scott; Eifert, James; Mayhew, Mary; Corcoran, Richard; Spencer, Chris; Moulton, Diane
Subject:	Briefing with Agency Heads regarding Coronavirus

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Subject:	Briefing with Agency Heads regarding Coronavirus

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From:	Tiara Smith
To:	India Bowman; Jesse C. Bliss; Robert Casey; apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Moyer, Ben	APHL; Hainstock, Lisa (MDARD; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro; Sharp, Donald (CDC/DDID/NCEZID/DFWED; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID; Scott E. Holmes; christina.ferguson@dph.ga.gov; Collaro, Thomas - FSIS; Laura Wildey; Amy Chang; Tiara Smith
Subject:	Canceled: CIFOR Promote DT Meeting
Importance:	High

Meeting Cancellation

Due to response efforts around COVID-19, this meeting is being canceled. In lieu of the scheduled meeting, an email with updates and action items is forthcoming.

Thanks,

Tiara

Dear All,

Please save the date, the 3rd Monday of each month, for the CIFOR Promote DT Meeting.

Regards,

Tiara

tsmith@naccho.org <mailto:tsmith@naccho.org> is inviting you to a scheduled Zoom meeting.

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Meeting ID: 871 476 261

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Meeting ID: 871 476 261
Find your local number: https://naccho.zoom.us/u/acel60w87R

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From:	Tomas Guilarte
To:	bhayden@banyanhealth.org; smarcus@hfsf.org; MFundora@HCNetwork.org; tjames@hcnetwork.org; ptorres@hcnetwork.org; aaafflitto@alz.org; charlesm@allianceforaging.org; Karen.Weller@flhealth.gov; eriko.grover@flhealth.gov; Yesenia.Villalta@flhealth.gov; bkubilus@projectaccessfoundation.net; Trivel.Mckire@flhealth.gov; Edhelene.rico@flhealth.gov; Juan.Suarez@flhealth.gov; Virginia.Munoz@flhealth.gov; MargaretSo@baptisthealth.net; vqi8@cdc.gov; Barbara.Moliere@miamidade.gov; Robinson, Eriko M; hfernandez@camillus.org; cwigutow@entrinsichealth.com; arodr137@fiu.edu; pmartinez@gamechangertec.com; rene@nchdevelopment.com; Ailin Rodriguez-Atia; Janisse Schoepp; cmccoy@med.miami.edu; renee.podolsky@fhealth.gov; kgkimg@gmail.com; Soto, Alina; Mark Macgowan; Yasenka Peterson; Paola Moreno; Miladys Martinez Palacios; Pedro Greer; Tomas Guilarte
Cc:	Hilda Fernandez
Subject:	Canceled: Community Advisory Board Meeting
Attachments:	image001.png Accreditation celebration.png Directions to the FIU Modesto Maidique Campus-Virtual Parking Pass.doc
Importance:	High

Good morning,

In an effort to follow the recommendations of experts for social distancing due to the coronavirus outbreak, the Dean decided to cancel this meeting for now.

We will inform you as soon as a new date has been selected for this meeting.

Thank you!

Kind regards,

Miladys (Milly) Martínez

Senior Executive Assistant to Dean Tomás R. Guilarte

Robert Stempel College of Public Health & Social Work

Florida International University
MMC, AHC5 506

(305) 348-5344| milmarti@fiu.edu <mailto:milmarti@fiu.edu>

To learn more about Stempel College, please click here <https://issuu.com/fiupublications/docs/rob_stempel_brag_booklet?e=1346729/65085629>

AMERICAN OVERSIGHT

PLEASE JOIN US!

The Robert Stempel College
of Public Health and Social Work
is celebrating

the Reaffirmation of its Accreditation

April 3, 2020
3 P.M. - 5:00 P.M.
AHC-5 ATRIUM
RSVP to Milly Martinez (milmarti@fiu.edu)

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Directions to the FIU Modesto Maidique Campus

Address:
Florida International University
11200 SW 8th St
Miami, FL 33199

Parking Garage 5 - PG5
SW 8th St and 109th Ave

From Miami International Airport:
Take the SR 836 (Dolphin Expressway) WEST exit from the Airport
Follow SR 836 (Dolphin Expressway) to the Florida Turnpike
Take the Florida Turnpike SOUTH exit
Follow the Florida Turnpike to the Tamiami Trail exit (SW 8th Street)

From I-95, Downtown Miami, Ft. Lauderdale, and West Palm Beach:
Take I-95 to SR 836 (Dolphin Expressway) WEST
Follow SR 836 (Dolphin Expressway) to the Florida Turnpike
Take the Florida Turnpike SOUTH exit
Follow the Florida Turnpike to the Tamiami Trail exit (SW 8th Street)

From western Palm Beach / Broward County or the Florida Turnpike north:
Take the Florida Turnpike SOUTH
Follow the Florida Turnpike to the Tamiami Trail exit (SW 8th Street)

From above:

1. Enter FIU on 8th St and SW 109th Ave
2. You will see, on your right, the Red Parking Garage (PGR), and on your left **Parking Garage 5 (PG5). Please use PG5 as this garage is adjacent to the AHC5 building**
3. If your vehicle has already been registered online, you are able to park at any "student" parking space, located on floors 3 – rooftop.



Academic Health Center 5 **(AHC5)** is located directly in front of **PG5**. Please take the elevator to the 5th floor and exit to the left, where you will see the entrance to the Office of the Dean.

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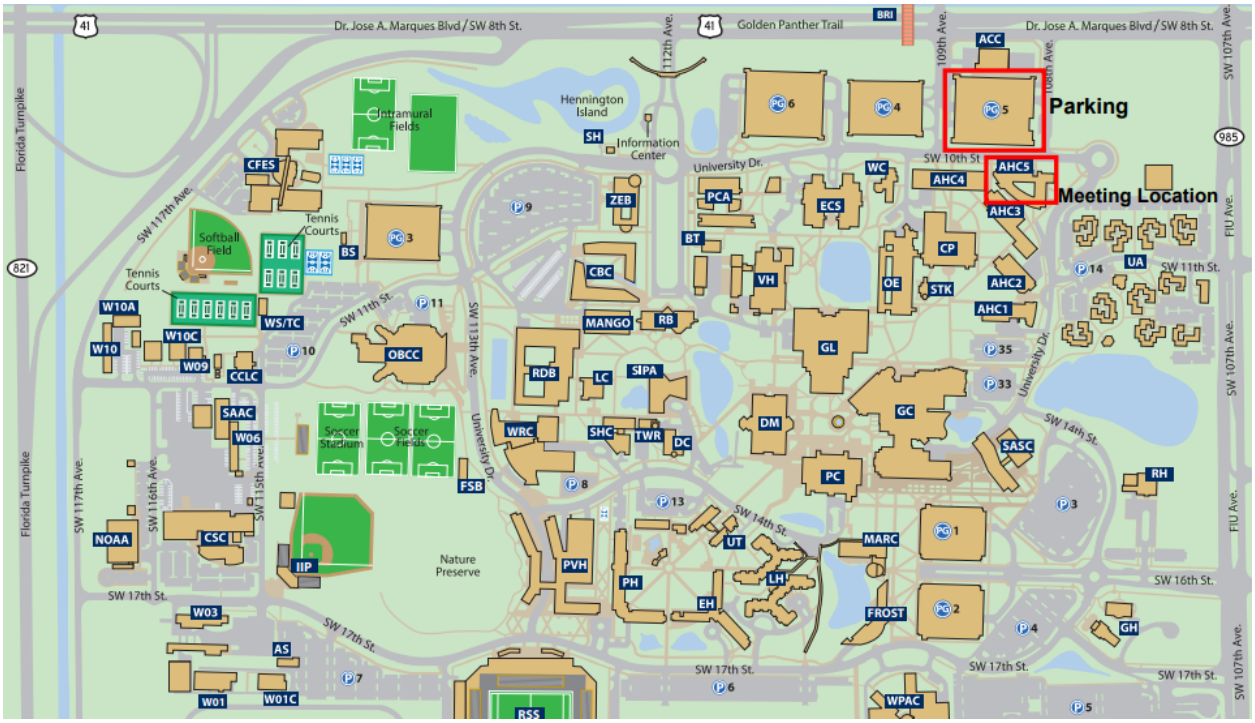

For any questions and concerns, please call Milly Martinez at 305-348-5344.

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

From: COVID-19

To: Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; DL DOH CHD Administrators_Directors; DL DOH CHD Nursing Directors; COVID-19

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Subject: Canceled: COVID-19 Weekly Clinician Call

Attachments: Healthcare Provider Agenda W 1130.docx

Importance: High

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Healthcare Provider Call

Hosted by the Florida Department of Health

Every Wednesday
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Call-In Information

Call-In Number: 888-585-9008
Participant Code: 872-128-152

Description

This is a weekly conference call hosted by the Florida Department of Health to disseminate the most up-to-date information regarding COVID-19 to healthcare provider partners. All medical professionals are invited to participate on the call. There will be an opportunity for questions as time permits.

Standing Agenda

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Attachments: Healthcare Provider Agenda W 1130.docx

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Subject: Canceled: COVID-19 Weekly Clinician Call

Attachments: Healthcare Provider Agenda W 1130.docx

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Call-In Number: 888-585-9008
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Attachments: Healthcare Provider Agenda W 1130.docx

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From: COVID-19

To: Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; DL DOH CHD Administrators_Directors; DL DOH CHD Nursing Directors; COVID-19

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Subject: Canceled: COVID-19 Weekly Clinician Call

Attachments: Healthcare Provider Agenda W 1130.docx

Importance: High

The weekly conference call for healthcare practitioners is moving from Wednesdays, 11:30-12:00 to Wednesdays, 2:00-2:30. A meeting invitation for the new call was distributed yesterday afternoon from EOC-Plans@em.myflorida.com <mailto:EOC-Plans@em.myflorida.com> . Please accept that new invite and remove this one from your calendars. Please share the new invite with your partners as appropriate.

AMERICAN OVERSIGHT

Healthcare Provider Call

Hosted by the Florida Department of Health

Every Wednesday
11:30 AM to 12:00 PM

Call-In Information

Call-In Number: 888-585-9008
Participant Code: 872-128-152

Description

This is a weekly conference call hosted by the Florida Department of Health to disseminate the most up-to-date information regarding COVID-19 to healthcare provider partners. All medical professionals are invited to participate on the call. There will be an opportunity for questions as time permits.

Standing Agenda

- Situation Updates from the Florida Department of Health
- Briefing from the Florida Agency for Healthcare Administration
- Updates from other State Agencies
- Questions from Partners

Intended Audience

This call is intended solely for healthcare provider partners in Florida. Other partners should relay any questions or concerns to their local county health department.

Contact the Joint Information Center at JIC-Reports@em.myflorida.com for help with any technical issues with the Conference Call.

AMERICAN OVERSIGHT

From: Rivkees, Scott A

To: Shepard, Lela; "mcarter@flmedical.org"; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; MThomas@flmedical.org; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; "Molly.McKinstry@ahca.myflorida.com"; "mary.mayhew@ahca.myflorida.com"; "jeanetta.stalcup@uhsinc.com"; "michelle@foma.org"; "andrew@foma.org"; "govaffairs@foma.org"; "CPrine@flmedical.org"; MThomas@flmedical.org; Rivkees, Scott A

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

AMERICAN OVERSIGHT

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

AMERICAN OVERSIGHT

From: Rivkees, Scott A

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

AMERICAN OVERSIGHT

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

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When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From: Rivkees, Scott A

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When: Each Wednesday at 2:00 p.m. EST

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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

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Duquette"; "Capezzuto, Kenneth P."; "Jessica Banks L."; "Joseph Nelson"; "Sean Pamplona"; "Mallette, Victoria (HT)"; "King, Sammy L."; "Bridget Pelaez"; "Lincoln, Deborah"; "Laidys Alfonso"; Moore, Larry; "Nate Ortiz"; "Talledo, George"; "Rodriguez, Isabel (Medley)"; Tanya Tatum; "Joseph, Weddary"; "Cathy Brockman"; "Susan Kreuter"; "Cruzsoler, Mayda"; "Wu-Ballis, Melody P., M.P.H., CIC"; Roberts, Patricia J; Steele, Crystal C; "Tracey Adams"; "Gifts, Kimberley B."; "O"Leary, Terence"; Kim Streit; "Jorge, Robert"; "Sarah McBrearty"; "bbowers@uwf.edu"; "Jeffrey Tsai"; Golden, Percy; Nichols, Antonio C; Ward, Richard E; Murphy, Jacqueline; Washington, Tawanda S; Turner, Scott M; Taylor, Lisa G; Demott, Monica; Day, Patricia; Levings, Margaret A; lalgarin@crossseniorcare.com; susanlynn.ffwc@gmail.com; jparrish@gchc.com; "libertychc@fairpoint.net"; janice.bennett@pepsico.com; Wesley Marsh; mrill@ergjax.com; silvia.lopez@communitygrp.com; ce@flasianservices.org; "Maura Belette"; "Gonzalez, Alina M. 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Subject: Canceled: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

Importance: High

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

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When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From:	Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH)
To:	Lesinger, Cindy (CDC adph.state.al.us); Nakema.Moss@adph.state.al.us; Michael.Cima@arkansas.gov; McCartney, Kellye (CDC arkansas.gov); Aaron Otis (CDC flhealth.gov); Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); Mark.ONeill@flhealth.gov; Andrea.Leapley@flhealth.gov; Wendy.Sweigert@flhealth.gov; Amy.Riggen@flhealth.gov; Ben.Sloat@dph.ga.gov; Ami.Gandhi@dph.ga.gov; Tracy.Kavanaugh@dph.ga.gov; Lovett, Sheila (CDC dph.ga.gov); Thoroughman, Douglas (CDC ky.gov); Robeson, Sara (CDC ky.gov); Amanda.Hunt@ky.gov; Johnson, Tisha (CDC ky.gov); jennifer.khoury@ky.gov; Schweitzer, Jody (CDC ky.gov); Anderson, Emily A. (CDC ky.gov); Sokol, Theresa (CDC la.gov); stacy.hall@la.gov; Jenna.IbergJohnson@la.gov; Frank Welch; Paul.Byers@msdh.ms.gov; Jannifer.Anderson@msdh.ms.gov; Kittle, Theresa (CDC msdh.ms.gov); Shipp, Rebecca; erica.wilson@dhhs.nc.gov; christina.caputo@dhhs.nc.gov; natalie.bontrager@dhhs.nc.gov; justin.albertson@dhhs.nc.gov; susan.sullivan@dhhs.nc.gov; Holmes, Wendy (CDC dhhs.nc.gov); Drociuk, Dan (CDC dhec.sc.gov); White, Stephen (CDC dhec.sc.gov); Cassandra.Jones@tn.gov; SHOC.Epidemiologist@tn.gov; Michelle.Fiscus@tn.gov; Haralson, Catherine (CDC tn.gov); Latoya.Antoine@tn.gov; John.Benitez@tn.gov; SHOC.Planning@tn.gov; Amy.Cox@tn.gov; Shavetta.Conner@tn.gov; Sean.J.Kice@tn.gov; Peter Koonz; Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Montgomery, Martha (CDC/DDID/NCHHSTP/DVH); Weng, Mark (CDC/DDID/NCHHSTP/DVH); Augustine, Ryan (CDC/DDID/NCHHSTP/DVH); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Teshale, Eyasu H. (CDC/DDID/NCHHSTP/DVH); Cooley, Laura A. (CDC/DDID/NCHHSTP/DVH); Chappell, Shauntrelle L. (CDC/DDID/NCIRD/ISD); Awwad, Hanan (CDC/DDID/NCIRD/ISD); Schwartz-Kitchens, Tricia (CDC/DDID/NCIRD/ISD); Crawford, Nathan E. (CDC/DDID/NCIRD/ISD); mschroeder@cste.org; Hamilton, Janet (CDC cste.org); Shah, Dhara (CDC cste.org); Danila, Richard (CDC state.mn.us); traxlelb@dhec.sc.gov; Sanders.Kelsey (DSHS); Leos.Greg (DSHS); Salinas.Andrea (DSHS); Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH)
Cc:	william.ledford@arkansas.gov
Subject:	Canceled: Hepatitis A Regional Call - HHS Regions 4 & 6
Importance:	High

Hi All,

We know you're busy either responding to COVID-19 or covering for colleagues who are responding, so out of respect for the competing demands on your time we're going to cancel this round of hepatitis A regional calls. Please don't hesitate to reach out or email viralhepatitisoutbreak@cdc.gov <mailto:viralhepatitisoutbreak@cdc.gov> with any questions or concerns. We're still available to help in any way we can.

Thanks,

Megan

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From:	Karl Ensign
To:	Esther Muna; Livinson Taulung (LTaulung2@fsmhealth.fm); Laurent Duenas, MPH, BSN, RN; Emais Roberts; Catherine de la Cruz Duran; Bruce Bilimon; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com); Nate Smith; Angell, Sonia Y@CDPH; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; Howard Zucker; John Wiesman; Motusa Nua; Karl Ensign
Cc:	Reva Ferguson; Rachelle Ashe; Peggy Ullom; linda.fullem@flhealth.gov; Tangonan, Sharon S.; Jacqueline Silvia; Terry Bergener; Eti Uiagalelei; Janet Guerrero; Fancy Soloman; Suzanne Kaneshiro; Lalie Ikluk; Marline Loeak; Louise Baa; Aniah John; Carolyn Mullen; Michael Fraser; Joe Davis; Taveras, Sam (CDC/OSTLTS/DPHCD); Jose T. Montero, MD, MPH; Subroto Banerji; lauri.ogumoro@dph.gov.mp; Danny Staley; Carolyn McCoy; Cendra Clarke; Christi Mackie; Mark Mioduski; Emi Chutaro (emic@pihoa.org); Gallo, Bill (CDC/OSTLTS/DPHCD); Ottley, Basil C
Subject:	Canceled: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Attachments:	image001.png Agenda-Insular Affairs Subcommittee Dinner Convening.Final Agenda.docx ASTHO Insular Areas Background.Short.docx Insular Areas Subcommittee Priorities Identified to Date.2.2020.docx
Importance:	High

Dear Subcommittee on Insular Affairs Members & Meeting Participants –

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

Apologies for multiple emails.

Thanks,

Karl

From: Karl Ensign
Sent: Sunday, February 23, 2020 3:35 PM
To: esther.muna@dph.gov.mp <mailto:esther.muna@dph.gov.mp> ; Livinson Taulung (LTaulung2@fsmhealth.fm <mailto:LTaulung2@fsmhealth.fm>) <LTaulung2@fsmhealth.fm <mailto:LTaulung2@fsmhealth.fm> >; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov <mailto:laurent.duenas@dphss.guam.gov> >; Emais Roberts MD (emais.roberts@palauhealth.org <mailto:emais.roberts@palauhealth.org>) <emais.roberts@palauhealth.org <mailto:emais.roberts@palauhealth.org> >; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov <mailto:catherine.delacruz@salud.pr.gov> >; Bruce Bilimon <rmiminister.mohhs@gmail.com <mailto:rmiminister.mohhs@gmail.com> >; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com <mailto:justa.elisa@gmail.com>) <justa.elisa@gmail.com <mailto:justa.elisa@gmail.com> >; Nate Smith, MD <Nathaniel.Smith@arkansas.gov <mailto:Nathaniel.Smith@arkansas.gov> >; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov <mailto:Sonia.Angell@cdph.ca.gov> >; scott.rivkees@flhealth.gov <mailto:scott.rivkees@flhealth.gov> ; bruce.s.anderson@doh.hawaii.gov <mailto:bruce.s.anderson@doh.hawaii.gov> ; howard.zucker@health.ny.gov <mailto:howard.zucker@health.ny.gov> ; John Wiesman <jmwiesman@doh.wa.gov <mailto:jmwiesman@doh.wa.gov> >; Motusa Nua <tuinua@doh.as <mailto:tuinua@doh.as> >
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Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

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

Tuesday, February 25th, 2020

4:00 – 5:30 pm ET

Madison Hotel – Adams B

1177 15th Street, NW

Washington, DC 20005

A calendar invite will follow.

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

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

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

The Insular Affairs Subcommittee to the ASTHO Government Affairs Policy Committee was formed in 2018 to identify the unique policy needs and priorities of the Pacific and Atlantic jurisdictions. The subcommittee provides a forum for ASTHO's members to exchange information on policy challenges and solutions within the insular areas. Additionally, the subcommittee provides recommendations to the full committee on policy priorities.

See you soon!

Karl

_____

Karl Ensign, Chief
Territorial Support

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials

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Association of State and Territorial Health Officials **Subcommittee on Insular Affairs Subcommittee Meeting**

Tuesday, February 25, 2020

4:00 – 5:30 PM

The Madison Hotel | 1177 15th St. NW Washington, DC 20005 | Room Name: Adams B

Welcome and Introductions – Esther Muna (Chair, CNMI), Michael Fraser (CEO, ASTHO), Karl Ensign (Territorial Support ASTHO)
Overview of the Compact of Free Association – Bill Gallo, CDC
Overview of the Insular Affairs Subcommittee Priorities – Karl Ensign, ASTHO
Legislative Overview of the Past Year – Carolyn McCoy, ASTHO
Addressing Subcommittee Priorities – Priority Setting & Action Steps • *Improve Funding for Public Health & Related Services* • *Improve Data on Health Status & Outcomes* • *Strategize on Ways to Advocate for Improving Support to Veterans*
Next Steps and Adjourn – Karl Ensign (ASTHO), and Esther Muna (Chair CNMI)

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ASTHO Insular Areas – Priorities & Needs

ASTHO Insular Area members represent territories and freely associated states in the Pacific and Atlantic oceans:

- **Territories:** American Samoa, Commonwealth of the Northern Marianna Islands, and Guam in the Pacific, and Puerto Rico and the US Virgin Islands in the Atlantic.

- **Freely Associated States:** Federated States of Micronesia, Palau, and the Republic of the Marshall Islands in the Pacific.

Providing public health services in remote islands in the Pacific and the Atlantic is often costlier than in the states. Moreover, the policy needs of these jurisdictions are complex and often substantially different than those of the states. Largely, this stems from differences in the following areas:

- **Service configuration.** Pacific health officials oversee a broad array of services including emergency and hospital services in addition to the more traditional array of public health services within states. Officials also oversee behavioral health, environmental services, outpatient clinics and primary care. Health officials are also concerned with food and pharma safety, given the general dependency on imports. This dependency is heightened when food and pharmaceuticals are not readily available following a disaster.

- **Eligibility for federal funding and program participation.** Typically, territories are eligible for the same programs as states but have a lower reimbursement rate for entitlement programs such as Medicaid and a cap on the amount they can receive. This leads to frequent gaps in coverage. Until recently they have been able to close some of this gap through special appropriations but those are set to expire at the end of calendar year 2019 resulting in the "Medicaid Cliff" (https://www.npr.org/sections/health-shots/2019/11/20/780452645/americas-shame-medicaid-funding-slashed-in-u-s-territories). The freely associated states operate under a Compact of Free Association (COFA) with the United States, making them generally ineligible for entitlement funding. Instead, they must rely on other sources of funding including those administered to these jurisdictions under COFA through the Department of the Interior. COFA is set for renewal in 2023.

- **Population health needs.** Insular areas have challenges often associated with the developing world (such as dysentery, Dengue, Zika, and Hansen's Disease) along with those related to westernization (such as souring obesity rates and Diabetes). Mental health needs are also acute and treatment options are extremely limited. Given their need, all islands have facilities that meet the Health Professional Shortage Area (HPSA) designation, meaning there is limited access to primary care.

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- **Increased susceptibility to extreme weather events.** Within the past few years alone, extreme weather events on a scale not seen before wrecked havoc in both the Pacific (typoons Soudelor and Yutu) and the Atlantic (hurricanes Maria and Irma). This and other events associated with changing climates and rising sea levels place all Insular Areas at ongoing risk.

Insular Areas Strategic Priorities. Profile data and strategic plans facilitated in four jurisdictions (CNMI, Guam, FSM, Puerto Rico) revealed the following strategic priorities.

- Preventing and treating NCDs by addressing cancer, respiratory diseases, heart disease, stroke, and diabetes; lessening major risk factors for NCDs; and improving nutrition and physical activity.
- Lessening the prevalence and spread of communicable diseases: preventing and controlling Zika; addressing tuberculosis (TB), including multi-drug resistant TB; decreasing vaccine preventable diseases; treating and preventing sexually transmitted diseases including HIV; and eradicating leprosy.
- Meeting the needs of specialized populations, including efforts focused on maternal, infant, and child health; veterans; mental health and substance abuse prevention; and older adults.

Capacity-Building Assistance (CBA) Needs. To address these priorities, THA leaders and ASTHO identified the following as CBA needs within their agencies:

- Improving information technology and the collection and use of data: implementing electronic health records; strengthening data collection and linking; using data to inform decisionmaking; and strengthening surveillance capabilities.
- Better equipping and training the workforce: undertaking recruitment and retention planning; improving training; placing qualified students in health and medical fields; and addressing the aging health workforce.
- Improving key business processes: improving grants and contracts management; streamlining procurement and recruitment and onboarding processes.
- Entering into strategic partnerships: forging and strengthening collaborations with peer agencies, as well as local and community agencies and groups.
- Developing sustainable funding: planning for COFA funding replacement; achieving parity with state Medicare and Medicaid funding; meeting the needs of the un- and underinsured; applying for funding for nurses and prevention programs.
- Developing effective policies: implementing sugar-sweetened beverage taxes; establishing import taxes on unhealthy food.
- Improving education and outreach activities: engaging remote communities, indigent, and high-risk groups; improving education programs for family planning and other programs.

Policy Priorities. The newly-formed Insular Affairs Subcommittee to the ASTHO Government Affairs Committee has formulated the following policy priorities:

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- **Provide Long-term, Stable Medicaid Financing for the Territories.** Territorial health care is largely dependent on federal Medicaid funding. Yet despite immense need and relatively high eligibility rates, funding for territories' Medicaid expenses is capped and appropriations frequently expire. Severe and devastating hurricanes in the Atlantic and typhoons in the Pacific have further challenged the economies of the territories, impacting their ability to provide the necessary matching payments. For these reasons, long term, stable funding for Medicaid should be provided by raising or eliminating the cap, or through increased appropriation levels as a back-up. Additionally, the Federal Medical Assistance Percentage (FMAP) should be based on the same formula used to determine states' FMAP.

- **Working Capital.** Currently, jurisdictions with limited funding need to advance large amounts of capital to fund programs and services. Goal is to continue to hold jurisdictions accountable through their fiduciary responsibility while easing cash flow issues. Discussions with OGS, PIHOA etc. are underway. More background can be found here.

- **Strategize on ways to Advocate for improving support to Veterans.** The Insular Areas have some of the highest induction rates on a per capita basis and the military actively recruits on the islands. Yet access to health and supportive services are often not provided in the Insular Areas, particularly in the Freely-Associated States. Strategic meetings need to be held with the VA.

- **Improve the Inclusion of both Territories and Freely associated States (T/FAS) in Grant Announcements and Funding Eligibility Similar to American Indian and Alaskan Native (AI/AN).** Insular Area are often not explicitly included in eligibility criteria or are excluded from participating.

- **Improve Data on Health Status and Outcomes.** The Insular Areas are known to suffer from both first and third world public health challenges and existing data show relatively high rates of morbidity and mortality for a wide range of infectious and chronic disease. Access to health care and preventive services is often a challenge and there are workforce shortages of key health care specialists. Yet especially in the Pacific, reliable and consistent data on these challenges is not consistently available, challenging strategic planning, program development and implementation, and advocacy efforts.

  a. **Advocate for undertaking a new National Academy of Sciences (NAS) Health Assessment**
     - The last comprehensive assessment of health status in the Pacific -- the Pacific Partnerships for Health ("the Blue Book") -- was completed in 1998 and is out-of-date.
     - Monitor legislation into which funding for this could be inserted to fund a second assessment.
     - Include language to this effect in testimony as it was for Nate Smith's testimony before the House Labor, Health and Human Services and Education Appropriations Subcommittee.
     - Included request in outside testimony to the Senate Labor, HHS, Education and Related agencies requesting this assessment.

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- Included in comments to the Senate HELP Committee on The Lowering Healthcare Act of 2019 bill a request to include this assessment in the authorizing legislation.

b. Advocate that the insular areas fully participate in the National Electronic Disease Surveillance System (NEDS)

- Funding eligibility for NEDS and public health programs mandate states report into NEDS but these same requirements do not apply to the Insular Areas.
- Insular Areas are provided capitated rather than entitlement funding and those that do submit data are reported “below the line” in data reported out.
- As a result, Insular Area data is not included in public health data sets and reports (e.g., NCHS Data Store, HP2020).
- Catalogue key data that are – and are not – available on the Insular Areas in comparison to states.
- Team with PIHOA, TFAH, CSTE and other partners on strategy.
- Meet with key federal departmental (HHS, DOI) staff to better-understand the issue (e.g., funding, capacity) and strategize on needed improvements (could be done in conjunction with Hill Week).

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Insular Areas Subcommittee Priorities Identified to Date
December 2019

Improve Funding for Public Health & Related Services

1. **Provide Long-term, Stable Medicaid Financing for the Territories**
    - Territorial health care is largely dependent on federal Medicaid funding.
    - Yet despite immense need and relatively high eligibility rates, funding for territories' Medicaid expenses is capped and appropriations frequently expire.
    - Severe and devastating hurricanes in the Atlantic and typhoons in the Pacific have further challenged the economies of the territories, impacting their ability to provide the necessary matching payments.
    - For these reasons, long term, stable funding for Medicaid should be provided by raising or eliminating the cap, or through increased appropriation levels as a back-up.
    - Additionally, the Federal Medical Assistance Percentage (FMAP) should be based on the same formula used to determine states' FMAP.

2. **Support Re-Negotiation of the Compacts of Free Association**
    - The freely associated states in the Pacific (Federated States of Micronesia, Republic of the Marshall Islands, and Palau) operate under Compacts of Free Association (COFA) with the United States.
    - COFA enables citizens of these jurisdiction to travel to the United States without visa restrictions.
    - Additionally, COFA provides funding important to a number of activities and functions, including public health, administered through the Department of the Interior.
    - COFA is set for renewal in 2023.

3. **Working Capital**
    - Address the issue of the need for jurisdictions with limited funding needing to advance large amounts of capital to fund programs and services.
    - Discussions with OGS, PIHOA etc. are underway.
    - Goal is to hold jurisdictions accountable (fiduciary responsibility) while easing cash flow issues.
    - More on the subject can be found here.

4. **Improve the Inclusion of both Territories and Freely associated States (T/FAS) in Grant Announcements and Funding Eligibility Similar to American Indian and Alaskan Native (AI/AN)**
    - Insular Area are often not explicitly included in eligibility criteria or are excluded from participating.

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Improve Data on Health Status and Outcomes

- Access to health care and preventive services is often a challenge and there are workforce shortages of key health care specialists. Yet especially in the Pacific, reliable and consistent data on these challenges is not consistently available, challenging strategic planning, program development and implementation, and advocacy efforts.

5. **Advocate for undertaking a new National Academy of Sciences (NAS) Health Assessment**
    - The last comprehensive assessment of health status in the Pacific -- the Pacific Partnerships for Health ("the Blue Book") -- was completed in 1998 and is out-of-date.
    - Monitor legislation into which funding for this could be inserted to fund a second assessment.
    - Include language to this effect in testimony as it was for Nate Smith's testimony before the House Labor, Health and Human Services and Education Appropriations Subcommittee.
    - Included request in outside testimony to the Senate Labor, HHS, Education and Related agencies requesting this assessment.
    - Included in comments to the Senate HELP Committee on The Lowering Healthcare Act of 2019 bill a request to include this assessment in the authorizing legislation.

6. **Advocate that the insular areas fully participate in the National Electronic Disease Surveillance System (NEDS)**
    - Funding eligibility for NEDS and public health programs mandate states report into NEDS but these same requirements do not apply to the Insular Areas.
    - Insular Areas are provided capitated rather than entitlement funding and those that do submit data are reported "below the line" in data reported out.
    - As a result, Insular Area data is not included in public health data sets and reports (e.g., NCHS Data Store, HP2020).

Strategize on ways to Advocate for Improving Support to Veterans

- The Insular Areas have very high induction rates on a per capita basis and the military actively recruits on the islands.
- Yet access to health and supportive services are often not provided in the Insular Areas, particularly in the Freely-Associated States.

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From: omni

To: abross@acog.org; achaudhry@amchp.org; Aflagg@aphsa.org; ailis.clyne@health.ri.gov; Alane.oconnor@mainegeneral.org; Alda.Osinaga@health.ny.gov; Alexia Harrist; alexis.tucey@dhcfp.nv.gov; amanda.c.bennett@illinois.gov; Amy Koslick; amy.acton@odh.ohio.gov; amy@pachc.org; ann.zerr@fssa.in.gov; Anna Bartels; antraneise.jackson@ahca.myflorida.com; ANussbaum@marchofdimes.org; apeterson2@roseman.edu; april_henry@mednax.com; ashley.berliner@vermont.gov; ashley.busacker@wyo.gov; Ashley.Jeans@tn.gov; Ashley.Swarowski@uhc.com; aushry@acog.org; beverly.mason@dcfs.nv.gov; Breena.Holmes@vermont.gov; brenda.barker@tipqc.org; buffingtona@unce.unr.edu; catherine.friedman@bhddh.ri.gov; Catherine Slemp, MD, MPH; c-dakelley@pa.gov; cdf1@cdc.gov; chamilton@hsc.wvu.edu; charissa.fotinos@hca.wa.gov; choots@iphca.org; Christi Mackie; cio8@cdc.gov; cjohn@hsc.wvu.edu; ckendell@kyha.com; ckroelinger@cdc.gov; cmclachlan@dhcfp.nv.gov; coloradobabydoc@gmail.com; Connie White; cpaoli@washoecounty.us; cphinney@dhcfp.nv.gov; 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Jennifer.Johnson@flhealth.gov; jevins@dhcfp.nv.gov; Jill Rigsby; jill.marano@clarkcountynv.gov; jim.walsh@swedish.org; Joanna.Bacon@uhsinc.com; johnfirestone@tlccreno.org; jpatton@dhcfp.nv.gov; jschoolmeester@dhcfp.nv.gov; jsteinberg@hrsa.gov; jtonkin@dhcfp.nv.gov; jwo4@cdc.gov; jwolf@lacsn.org; kariearle@gmail.com; Kat Patterson; kathryn.chapman@alaska.gov; katie.eilers@doh.wa.gov; Katie.Letcher@uhc.com; kcraig2@renown.org; KDavis-Coelho@renown.org; kelly.boyle@dcyf.wa.gov; KFarrell@hrsa.gov; kharris997@aol.com; khx2@cdc.gov; kim.connolly@centerforbehavioralhealth.com; klayosa@step2reno.org; kmarschall@socialent.com; kmoran3@thehealthplan.com; kristi.pebley@centerforbehavioralhealth.com; Kristina.West@hhs.gov; kristine@symplexityconsulting.com; ktrocin@hrsa.gov; kuesugi@uic.edu; lamalinalovell@dhhs.nv.gov; laura.rooney@odh.ohio.gov; Lauren.Tobias@health.ny.gov; lhale@socialent.com; LHorlamus@hrsa.gov; libby.bunzli@ohhs.ri.gov; Lily.lou@alaska.gov; linda.mahoney@bhddh.ri.gov; linda.mccorkle@tn.gov; 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Pauley Wilson, Donna L; Goyal, Arvind; Morgan McDonald; llee@forrecovery.org; Kelly H Webber; Stalberg, Ilisa; Zink, Anne B (HSS); Jordan, Melissa Murray; Kasehagen, Laurin; Theriot, Judy (CHFS DMS); Nancy Merriman; KARA.MILLER@medicaid.ohio.gov; elizabeth.conrey@odh.ohio.gov; joyce.starr@mha.ohio.gov; Jennifer Somdahl; Ko, Jean Y. (CDC/DDNID/NCCDPHP/DRH); Nancy Bowen; Fox, Renee E. (CMS/CMCS); Cross-Barnet, Caitlin (CMS/CMMI); Chappell, Joan E. (HCA); Betancourt, Javier; Ezhuthachan, Rutu S; Schroeder, Maggie (BHDID/Frankfort); Corritore, Dena; Hayley Jarolimek; Strenio, Scott; Candice McDaniel; Terri Sabella; Romero, Lisa (CDC/DDNID/NCCDPHP/DRH); Monica Clouse; Parsons, Cynthia A; Roth, Rebecca E; Norberg, Natalie M (HSS); laura.dobler@wyo.gov; Melissa Campbell; Bowman, Sarah (RIDOH); Blank, Peter; Velonis, Alisa Joy; maria.delrio@ascension.org; Brenzel, Allen (BHDID/Frankfort); Payne, Shirley I; cduarte@socialent.com; Walsh,

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Cc:	Barker, Brenda; Debra Hibbard; Karen Meyer; Candice Frude; Rodack, Kristen; Kari Earle; Early, Kimberly; Mauldin, Lindsey; Anne R Lindsay; Daskalov, Rachel; Schrode, Dianne; Karanda, Kimberly; Jill Gresham; Yaryna Onufrey; Kelly H Webber; Berube, Jayne (HRSA); Deanna.Herold@jfs.ohio.gov
Subject:	Canceled: OMNI ASTHOConnects: Plans of Safe Care
Attachments:	image001.png
Importance:	High

Due to ASTHO's heightened response to COVID-19 and our priority to support our members, we are indefinitely postponing this ASTHOConnects on Plans of Safe Care. Please let the ASTHO team know if you have any questions.

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From: Allison Chan

To: Darryl.Pendergrass@adph.state.al.us; ramandeep.kaur@adph.state.al.us; Melanie.Chervony@adph.state.al.us; Sharon.Massingale@adph.state.al.us; Aretha.Williams@adph.state.al.us; uzo0@cdc.gov; gpf1@cdc.gov; pwj4@cdc.gov; nub7@cdc.gov; goy3@cdc.gov; iyk6@cdc.gov; vgg9@cdc.gov; ARLN@cdc.gov; jbesser@cdc.gov; Jwp6@cdc.gov; ekersh@cdc.gov; vsrinivasan@cdc.gov; gyi2@cdc.gov; idz4@cdc.gov; Tammy.Jernigan@flhealth.gov; nychie.dotson@flhealth.gov; Susanne.Crowe@flhealth.gov; Kendra.Edwards@flhealth.gov; Patty.Lewandowski@flhealth.gov; Carina.Blackmore@flhealth.gov; Sasha.Nelson@flhealth.gov; Jason.Blanton@flhealth.gov; Nicole.Castro@flhealth.gov; Sarah.Schmedes@flhealth.gov; Jeanne.Negley@dph.ga.gov; Mary.Connelly@dph.ga.gov; Tiffany.Rivers@dph.ga.gov; cherie.drenzek@dph.ga.gov; amanda.jara@dph.ga.gov; Michael.Anderson@dph.ga.gov; Tonia.Parrott@dph.ga.gov; Joanna.Wagner@dph.ga.gov; Doug.Blomberg@dph.ga.gov; Erica.Washington@LA.gov; Lauren.Kleamenakis@la.gov; Ashley.Terry@la.gov; Jean-Jacques.Aucoin@LA.GOV; Stephanie.Kleinpeter@LA.GOV; Theresa.Sokol@LA.GOV; raoult.ratard@la.gov; Fatima.Brakta@la.gov; alexa.ramirez@la.gov; Kirbie.StJames@la.gov; Cynthia.Allard@msdh.ms.gov; Daphne.Ware@msdh.ms.gov; paul.byers@msdh.ms.gov; Militza.Echevarria@salud.pr.gov; inelia.otero@salud.pr.gov; ilsa.villegas@salud.pr.gov; Norma.Diaz@salud.pr.gov; Tabatha East; Linda Thomas; Dorothy Baynham; Richard Steece; Matthew Estes; Jessica Barnes; Henrietta Hardin; Daniel Golson; Amelia A. Keaton; Tracy McLemore; Victoria Stone; Katie Thure; Paula L. Gibbs; Xiaorong Qian; Kara Levinson; Carol Rauch; Sara Belknap; Robin M. Rasnic; Natasha Lindahl; Randall Morris; Albert Burks; lhsmith@utah.gov; arossi@utah.gov; Allison Chan

Subject: Canceled: Q1 SE Regional AR Lab Network Call

Attachments: ATT23545 1.jpg

Importance: High

COVID-19 is an emerging, rapidly evolving situation and we recognize that AR Lab Network lab staff and epidemiologists are being asked to shift their focus away from regular duties to the COVID-19 response. We have decided to postpone our next SE Regional call after receiving feedback from the jurisdictions in the SE Region.

We plan to choose an alternative date for our next regional call and will keep you all updated.

Thanks!

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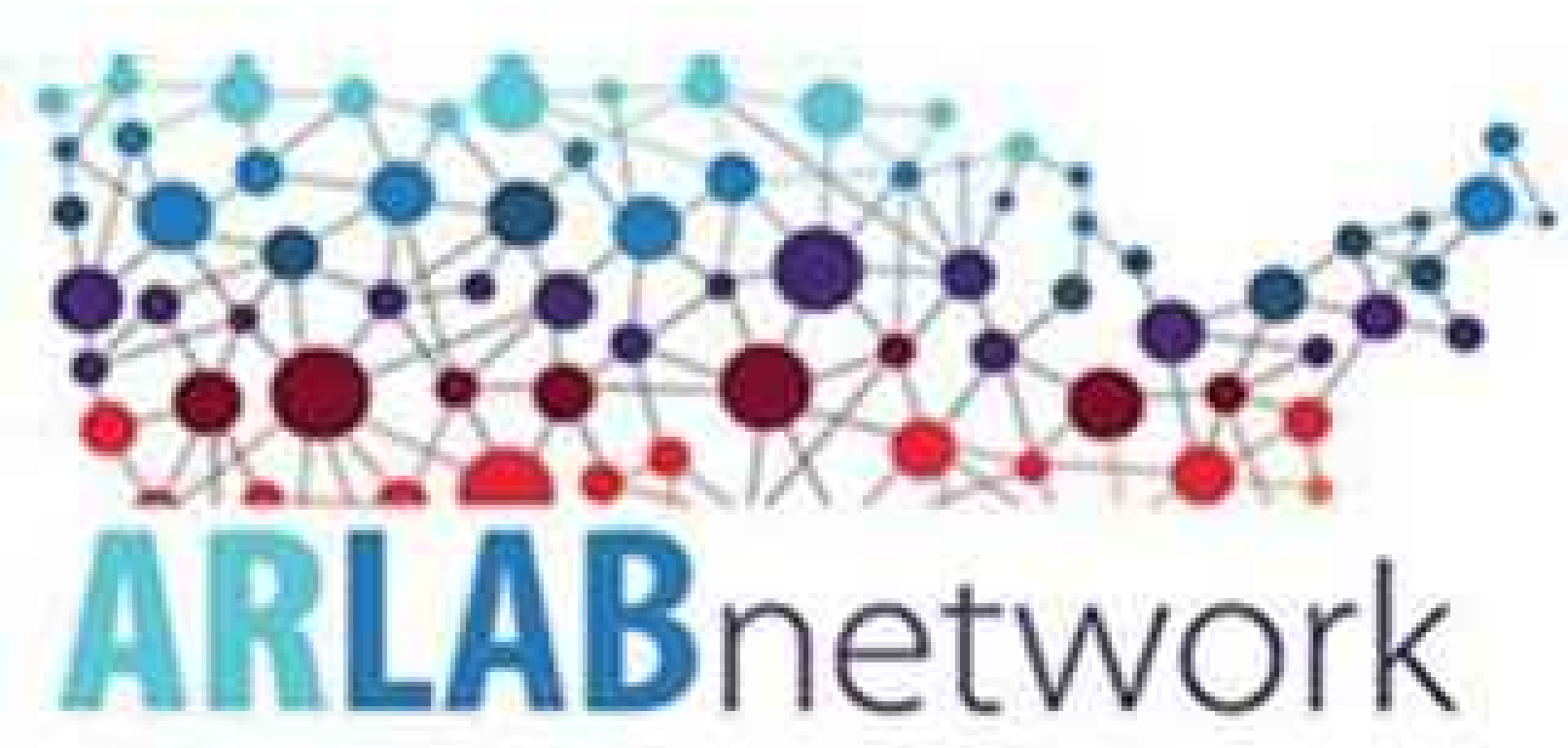

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From: TMS Mailbox (CDC)

To: CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD); CDC EISO Class 2018; Carroll, Dianna D. (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD); Robinson, Byron (CDC/DDPHSS/CSELS/DSEPD); Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD); Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD); Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Liang, Jennifer (FDA/CDER); Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD); Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD); CDC EISO EAC Roster 2018; Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Henning, Tara C. (CDC/DDPHSS/CSELS/DSEPD); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Kennedy, Cynthia (CDC/DDPHSS/CSELS/DSEPD); Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD); Teresa and John Horan; Ralph H. Henderson,M.D.; Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Amos, Renee J. (CDC/DDPHSS/CSELS/DSEPD) (CTR); Bradley, Seliscia A. (CDC/DDPHSS/CSELS/DSEPD); Cordeira, Kelly (CDC/DDPHSS/CSELS/DSEPD); Wiese, Nicholas (CDC/DDID/NCEZID/DHCPP); Mayer, Oren (CDC/DDID/NCEZID/DHCPP); York, Shannon (CDC/DDPHSS/CSELS/DSEPD); Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP); Hott, Amanda (CDC/DDID/NCHHSTP/DTE); Woodson, Evonne (CDC/DDID/NCHHSTP/DSTDP); Stokes, Kindra (CDC/DDPHSS/CSELS/DLS); Scherer, Erin (CDC/DDID/NCIRD/DBD); Jacobs, Jesica (CDC/DDPHSS/CSELS/DSEPD); Buono, Sean (CDC/DDID/NCIRD/DBD); Carlson, Christina (CDC/DDPHSIS/CGH/DPDM); Freeman, Brandi (CDC/DDID/NCIRD/DVD); Levinson, Kara (CDC/DDPHSS/CSELS/DSEPD); Wadhwa, Ashutosh (CDC/DDID/NCEZID/DHQP); Barkley, Joi (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC LLS Class 2018; CDC LLS Class 2019; CDC EISO Class 2019; TMS Mailbox (CDC)

Subject: Canceled: THIS SEMINAR HAS BEEN CANCELLED: TMS Presents: Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

Attachments: image003.jpg

Importance: High

AS A RESULT OF THE COVID-19 RESPONSE, THIS SEMINAR HAS BEEN CANCELLED.

Maureen will be asked to present her work at a later date.

Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

SPEAKER

Maureen Miller, MD MPH

EIS officer in the National Center for Chronic Disease Prevention and Health Promotion

Attendance Options and Continuing Education

* Remote options: • IPTV <http://cdciptv.cdc.gov/> • Envision <http://crss.cdc.gov/EnvisionList.aspx> • Adobe webinar <https://virtualsepd.adobeconnect.com/tms2/>

• Audio conference (1-866-761-5101, passcode “8445480#”)

* Continuing education (CE) is available; see the TMS CE instructions <http://intranet.cdc.gov/csels/dsepd/pdfs/HowToGetContinuingEd.pdf> .

* See the TMS schedule and CE statements <http://intranet.cdc.gov/csels/dsepd/ewb/tuesday-monthly-seminars.html> .

* There is no cost for this activity.

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From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC LLS Class 2019; CDC LLS Class 2018; CDC LLS Class 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Cc:	Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Coronado, Fatima (CDC/DDPHSS/CSELS/DSEPD); Black, Erin (CDC/DDPHSS/CSELS/DSEPD); Jee, Ina (CDC/DDPHSS/CSELS/DSEPD)
Subject:	cancellation of EIS and LLS regional trainings - EIS and LLS needed for COVID-19 response
Date:	Thursday, March 5, 2020 12:15:58 PM

EIS and LLS,

The top priority for CDC right now is supporting the response to COVID-19. As EIS officers and LLS fellows, you are essential for the response. About 75% of EIS officers and LLS fellows have already or are currently deployed to support an EOC activation (COVID-19, Ebola, and polio). EIS officers and LLS alumni from both programs are fully engaged and making major contributions at all levels of these activations.

We are **canceling the EIS Regional trainings in Atlanta and Phoenix** given the prioritization of COVID-19 and the number of EIS officers and LLS fellows, supervisors, and EWB staff currently deployed and likely to be deployed in the coming weeks.

Our top priority is the COVID-19 response and other essential duties related to your assignments. At this time, we do not have the luxury of taking you away from your assignments for a week of training. Please note the following:

- In times of urgent need, the EIS and LLS Programs reserve the right to unilaterally assign an EISO or LLS fellow to a field team or other emergency response activity without first seeking supervisory approval. At this time, we expect all EIS officers and LLS fellows to support the COVID-19 response and some of you may be asked to deploy repeatedly. **We are asking all supervisors to support the need for EIS and LLS to deploy**.

- If you are deploying, you should NOT be concerned about CAL completion or EIS conference presentations – if COVID-19 interferes with CAL completion we will work with you on a case by case basis. EIS or LLS program requirements should not interfere with your availability to deploy.

- Field officers who are already working on the response in your assigned jurisdiction are not expected to deploy elsewhere.

- EIS conference is currently scheduled as originally planned. We will notify you as soon as possible if we expect any changes to the conference.

- We will identify alternatives to allow you to practice and get feedback on your EIS conference presentations. We will also determine alternatives for EIS and LLS rounds.

We understand that many of you will be disappointed Regional Trainings are cancelled. We also know that many of you are pushing yourselves (including EIS and LLS supervisors) to support the

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response and keep up with your regular duties. We hope we have alleviated any concerns about needing to focus on EIS conference presentations for the time being. We encourage you to reach out for support from your classmates, supervisors, and staff within EWB should you need it. We also encourage you to speak with EOC resiliency coordinators, be aware of deployment resources, and take advantage of the Employee Assistance Program (EAP).

You were all selected for EIS or LLS because of your ability to thrive in a response environment. Your contributions are recognized and valued by CDC leadership. Thank you for your selflessness and service to CDC and our local, state, and international partners.

Respectfully,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.



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From:	EIS (CDC)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019
Cc:	CDC CSELS DSEPD EWB; Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Black, Erin (CDC/DDPHSS/CSELS/DSEPD)
Subject:	Cancellation of EIS conference – next steps
Date:	Monday, March 16, 2020 12:40:45 PM

EISOs,

I am writing to inform you of the cancellation of the EIS conference scheduled for May 4–7th. As of March 15, 2020, CDC is recommending the cancellation or postponement of in-person events consisting of 50 people or more throughout the U.S. We have been working on contingency planning for weeks and we determined that even a virtual conference is not feasible given the presenters and audience are needed for the COVID-19 response. During this time, response priorities take precedence over developing presentations for EIS Conference.

We understand that cancelling conference has broad implications for all of you, especially the 2nd year EISOs. We are cognizant of the potential impacts on CAL completion, job searching, graduation, and other elements that are important to all of you and the program. We want you to know the following:

- The match for the incoming class will be conducted virtually with an extended recruitment period starting on March 23, 2020 and an extended period for virtual interviewing from April 20 – May 8.
- We will work with 2nd year officers on a case-by-case basis if your COVID-19 response involvement might compromise your ability to complete your CALs. We do not want CAL completion to be a deterrent to your involvement. If you have concerns, please reach out to your EWB supervisor or CIO liaison to discuss your situation.
- We are working to plan a 2-day EIS presentation and graduation event for June. The event would include presentations from 2nd year EISOs who needed conference to fulfill the CAL requirement, a graduation ceremony, and the EIS satirical review.
- We know that EIS conference is a time when many of you were planning to network and interview for jobs. We are working to identify alternative ways to support your search for CDC jobs.

For all of you currently or preparing to deploy, we hope that the cancellation of the conference alleviates any tension you might have been experiencing regarding how to prepare your presentation in the midst of COVID-19, Ebola, and polio responses.

EISO's are playing a vital role in supporting this nation's public health response, at the local, state, and federal level. Thank you for your service. Your dedication and contributions are valued and appreciated. At this time, we expect every EISO to contribute to the response in some way. We expect most field EISOs are supporting the response within their assigned jurisdiction and do not expect you to deploy elsewhere. If you are not already involved in response activities, please volunteer now. If you need guidance on how to find a deployment role, please contact us at EpiAid@cdc.gov. If you have had difficulty obtaining supervisory approval to support the response,

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please contact your CIO liaison or EWB supervisor so that we can assist.

Please reserve time on your schedules for a **call on March 18, 2020 at 12 pm EST** to answer your questions and discuss planning for an EIS presentation and graduation event for all EISOs tentatively scheduled for June. We will be sending the link for the Skype Meeting ASAP.

Respectfully,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.



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From:	ASHE, CHRISTOPHER
To:	Rosenfarb, Charles H; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force; CBP HQ EOC
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); BAZILL, MARK; CONCOLATO, ELIZABETH; ALVEZ, CHRISTINA
Subject:	CBP POC Required - Coordination/Information for Royal Caribbean/Silver Shadow Disembarkation and Return to CONUS via Recife, Brazil
Date:	Monday, March 16, 2020 1:33:50 PM

Non-CBP Addressees: strangely – even as a CBP employee – my e-mail to the CBP Corona Virus TF got kicked back indicating I do not have permission to send to that address. If you experience a similar issue - please use the cbphqeoc@cbp.dhs.gov e-mail address (which was copied on my message) – which did go through.

CBP EOC Personnel: please see request below.

Christopher C. Ashe
Latin America and Caribbean Division
Office of International Affairs
U.S. Customs and Border Protection
Phone: (202) 538-1062
Department of State Detailee

From: ASHE, CHRISTOPHER
Sent: Monday, March 16, 2020 1:29 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force <CBPCoronaVirusTaskForce@cbp.dhs.gov>; CBP HQ EOC <cbphqeoc@cbp.dhs.gov>
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; BAZILL, MARK <MARK.BAZILL@cbp.dhs.gov>; CONCOLATO, ELIZABETH <ELIZABETH.CONCOLATO@cbp.dhs.gov>; ALVEZ, CHRISTINA <CHRISTINA.ALVEZ@CBP.DHS.GOV>
Subject: CBP POC Required - Coordination/Information for Royal Caribbean/Silver Shadow Disembarkation and Return to CONUS via Recife, Brazil

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Thank you Charles and Hello Eleni and Yesenia,

The CBP Coronavirus Task Force will serve as your CBP Lead as they are working with CBP's Office of Field Operations and coordinating with CDC on screening and quarantine issues at Ports of Entry (land, sea, air), as well as adherence to current travel restrictions.

Please let me know if I can provide any additional help – or if you do not receive a response from my Task Force colleagues.

Thanks,

Chris

Christopher C. Ashe
Latin America and Caribbean Division
Office of International Affairs
U.S. Customs and Border Protection
Phone: (202) 538-1062
Department of State Detailee

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 1:18 PM
To: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force <CBPCoronaVirusTaskForce@cbp.dhs.gov>; ASHE, CHRISTOPHER <CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov>
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

CAUTION: This email originated from outside of DHS. DO NOT click links or open attachments unless you recognize and/or trust the sender. Contact the CBP Security Operations Center with questions or concerns.

Eleni, Yesenia,
Directly linking you with CBP on how the arrival of the repatriated passengers would be handled is

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certainly the best way to get you the answers you need. Christopher Ashe from CBP's Latin America and Caribbean Division has been our primary contact at CBP (CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov). A second contact is to the CBPCoronaVirusTaskForce@cbp.dhs.gov.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

From: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>
Sent: Monday, March 16, 2020 12:22 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Rosenfarb, Charles H <rosenfarbch@state.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Eleni,

Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.

Thank you,
Leah

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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 12:17 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM

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To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
Thanks for speaking just now. To reiterate CDC's recommendation:

- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
- Health screening of passengers would be done by the cruise line company prior to boarding in Recife, with no additional screening performed at the funneling airport (unless the individual has become obviously ill on the initial flight).
- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)

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U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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From:	ASHE, CHRISTOPHER
To:	Rosenfarb, Charles H; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force; CBP HQ EOC
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); BAZILL, MARK; CONCOLATO, ELIZABETH; ALVEZ, CHRISTINA
Subject:	CBP POC Required - Coordination/Information for Royal Caribbean/Silver Shadow Disembarkation and Return to CONUS via Recife, Brazil
Date:	Monday, March 16, 2020 1:29:21 PM

Thank you Charles and Hello Eleni and Yesenia,

The CBP Coronavirus Task Force will serve as your CBP Lead as they are working with CBP's Office of Field Operations and coordinating with CDC on screening and quarantine issues at Ports of Entry (land, sea, air), as well as adherence to current travel restrictions.

Please let me know if I can provide any additional help – or if you do not receive a response from my Task Force colleagues.

Thanks,

Chris

Christopher C. Ashe
Latin America and Caribbean Division
Office of International Affairs
U.S. Customs and Border Protection
Phone: (202) 538-1062
Department of State Detailee

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Sent: Monday, March 16, 2020 1:18 PM
To: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Yesenia.Villalta@flhealth.gov; CBP Corona Virus Task Force <CBPCoronaVirusTaskForce@cbp.dhs.gov>; ASHE, CHRISTOPHER <CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov>
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J

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<ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

CAUTION: This email originated from outside of DHS. DO NOT click links or open attachments unless you recognize and/or trust the sender. Contact the CBP Security Operations Center with questions or concerns.

Eleni, Yesenia,
Directly linking you with CBP on how the arrival of the repatriated passengers would be handled is certainly the best way to get you the answers you need. Christopher Ashe from CBP's Latin America and Caribbean Division has been our primary contact at CBP (CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov). A second contact is to the CBPCoronaVirusTaskForce@cbp.dhs.gov.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

From: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>
Sent: Monday, March 16, 2020 12:22 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Rosenfarb, Charles H <rosenfarbch@state.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

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Hi Eleni,

Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.

Thank you,
Leah

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 12:17 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

Thanks,

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Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
Thanks for speaking just now. To reiterate CDC's recommendation:

- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
- Health screening of passengers would be done by the cruise line company prior to boarding in Recife, with no additional screening performed at the funneling airport (unless the individual has become obviously ill on the initial flight).
- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already

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told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
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Cell: 202-374-4128

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Schwartz, Erica (HHS/OASH); Horahan, Kevin (OS/ASPR/EMMO); Greene, Jonathan (OS/ASPR/EMMO); Yeskey, Kevin (OS/ASPR/IO); Cote, Mick (OS/ASPR/EMMO); Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV)
Subject:	CBTS test specimen daily limit
Date:	Monday, March 23, 2020 9:13:06 AM

All

I have heard your concerns regarding the CBTS 250 specimens per day. I refer you to RADM Schwartz who is heading up that program as I have no authority to change any parameters. Dr. Schwartz and team are leading that program. Her contact information is as follows

RADM Erica Schwartz, MD, JD, MPH
Deputy Surgeon General
Office of the Surgeon General
United States Public Health Service
U.S. Department of Health and Human Services
200 Independence Ave SW, Suite 701-H
Washington, DC 20201
Office Phone: 202-401-4660
Email: erica.schwartz@hhs.gov

Thank you

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov

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email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Schwartz, Erica (HHS/OASH); Horahan, Kevin (OS/ASPR/EMMO); Greene, Jonathan (OS/ASPR/EMMO); Yeskey, Kevin (OS/ASPR/IO); Cote, Mick (OS/ASPR/EMMO); Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV)
Subject:	CBTS test specimen daily limit
Date:	Monday, March 23, 2020 9:12:53 AM

All

I have heard your concerns regarding the CBTS 250 specimens per day. I refer you to RADM Schwartz who is heading up that program as I have no authority to change any parameters. Dr. Schwartz and team are leading that program. Her contact information is as follows

RADM Erica Schwartz, MD, JD, MPH
Deputy Surgeon General
Office of the Surgeon General
United States Public Health Service
U.S. Department of Health and Human Services
200 Independence Ave SW, Suite 701-H
Washington, DC 20201
Office Phone: 202-401-4660
Email: erica.schwartz@hhs.gov

Thank you

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
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cell: 404.772.9701
email: Jeanne.eckes@hhs.gov

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email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC 2019-nCoV Guidance
Date:	Wednesday, February 5, 2020 7:54:20 PM
Attachments:	TIM_factsheet-FAQ_forPH_02.02.2020.pdf 2019nCoV_InterimHousingGuidance_CDC_02012020.pdf CDC_2019-nCoV Daily Key Points__2_5_2020_final.pdf CDC_2019-nCoV Weekly Key Messages_2-4-2020_Final_Corrected.pdf 314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-English.jpg 314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-Mandarin.jpg

Dear Partners,

On Monday, February 3, the Centers for Disease Control and Prevention (CDC) released new movement and monitoring guidelines, "**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings"**. For your convenience, you can find it here.

In addition, please see the following attachments:

- CDC Interim Housing Guidance
- CDC Daily Key Points
- CDC Weekly Key Messages
- Text Illness Monitoring (T.I.M.) Fact Sheet
- Updated Travel Cards

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

Interim Recommendations regarding Shelter Characteristics for the 2019 Novel Coronavirus Outbreak United States Government Repatriation Operation
1 February 2020

Background:

In the setting of the expanding outbreak associated with a novel coronavirus from Wuhan, the United States Government has arranged for evacuation of US personnel in affected areas. Because these individuals will be evacuating from an outbreak zone, health screening and exposure risk assessments will be required to determine presence of illness or history of high-risk exposures upon entry to the US. Upon entry into the United States, these individuals will be placed under a quarantine order for 14 days after their last potential exposure to allow for illness detection and health monitoring. Individuals within the group will have different antecedent exposure risks. They should not be housed together in congregate settings, where an individual who becomes symptomatic could expose the rest of the evacuees.

Shelter requirements:

1) Separate quarters with separate bathroom facilities for each individual or family group are preferred.
   a. Cleaning supplies, e.g. household cleaning wipes, must be provided in any shared bathroom.
   b. If an individual sharing a bathroom becomes symptomatic, all others sharing the bathroom should be considered PUI contacts until the symptomatic person is appropriately evaluated and cleared.
2) No close congregation for social or dining activities. Food should be delivered to the individual quarters.
3) Overhead announcements and group SMS should be used instead of physical gatherings to share information.
4) Quarters should have a supply of face masks for individuals to put on if they become symptomatic.
5) Other support services (e.g. laundry, prescription medication refills, telephone/wifi/communication capability) will need to be provided.
6) Garbage should be bagged and left outside by the door of each of the quarters for routine pick up. Special handling is not required.
7) Appropriate infection control capabilities to manage initial clinical assessment of individuals who become ill should include a designated room(s) with a door that can be closed. The room(s) should be separate from residential facilities. Symptomatic individuals should be promptly evaluated and, if appropriate, await transfer to a medical facility in the room keeping the door closed. The room should be supplied with disposable facemasks for the ill individual to wear throughout the evaluation and

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transport process. Cleaning supplies e.g., hospital disinfectant spray or wipes, should be stocked in each evaluation room to clean and disinfect the room's surfaces after it's vacated by the ill individual. Current CDC healthcare guidance is here: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html

8) Each residential space, all common areas for staff members, and each clinical evaluation room must have supplies of alcohol-based hand rubs, as well as sinks with soap and water, and paper towels.
9) PPE supplies (disposable face shields, N95 disposable respirators, disposable gowns and gloves) should be maintained in each clinical assessment area to allow for response and assessment of individuals who become ill.
10) A system for temperature and symptom monitoring should provide assessment in-place for the individuals/family groups in their separate quarters.
11) Nearby medical facilities should have the capability to manage the assessment and treatment of ill persons (to include normal airborne infection isolation rooms)
12) The location should be secure against unauthorized access and be appropriate for enforcing quarantine, if enacted.



Michael Bell, MD
Deputy Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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CDC Daily Key Points
2019 Novel Coronavirus (2019-nCoV)

February 5, 2020

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus abbreviated "2019-nCoV."
- This virus is able to spread from person-to-person and cause severe disease and death.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- Most cases are still limited to mainland China.
- Right now, this virus is not spreading in the community in the United States and the vast majority of Americans have a low risk of exposure. The greater risk is for people who have recently traveled to China or their close contacts.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- The U.S. public health system also is on high alert to detect cases of 2019-nCoV infection and prevent further spread in the community.
- These measures are likely to cause some disruption.
- The success of response efforts now will determine what the coming days, weeks and months will bring here in the United States.
- While leaning forward aggressively, with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread.
- Extensive work has been done over the past 15 years to prepare for an influenza pandemic.
- Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current 2019-nCoV outbreak triggers a pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans. Selected materials are available from www.cdc.gov/ncov.

SITUATION UPDATE

- To date, 27 international locations (in addition to the U.S.) have reported confirmed cases of 2019-nCoV infection.
- As of February 5, 2020, 11 infections with 2019-nCoV have been reported in the U.S. in five states – Arizona, California, Illinois, Massachusetts, and Washington.

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FL-DOH-20-0673-A-002346

- Two instances of person-to-person spread with this virus in the United States have been detected, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- On Monday, February 3, 2020, CDC submitted an Emergency Use Authorization (EUA) package to the Food and Drug Administration (FDA) for its real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose 2019-nCoV in respiratory and serum samples from clinical specimens. FDA approved the EUA on February 4, 2020.
- The International Reagent Resource (IRR) is taking orders for diagnostic test kits and will begin shipping them to qualified laboratories. Only registered users will be able to order and obtain the diagnostic panel. (See section on "Testing" below.)
- On February 1, 2020, CDC issued a Health Alert Network (HAN) update to previously posted guidance and, for the first time, guidance on clinical care of 2019—nCoV patients.
- On February 3, 2020, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to 2019-nCoV and implementing public health actions based on a person's risk level and clinical presentation.
- CDC has isolated the virus and sent it to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. 2019-nCoV patients to detect person-to-person spread.
- CDC is preparing senior staff to support the WHO international senior technical mission being formed to work with Chinese public health counterparts to help improve understanding of this new disease, including learning more about transmissibility and severity.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people who recently traveled from China and who have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a 2019-nCoV patient or a public health responder, please take care of yourself and follow recommended infection control procedures.

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- For people who have had close contact with someone infected with 2019-nCoV and who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a 2019-nCoV patient.
- For people who are ill with 2019-nCoV, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- CDC developed a new laboratory test kit for use in testing patient specimens for 2019-nCoV.
- The test kit is called the "Centers for Disease Control and Prevention (CDC) 2019-Novel Coronavirus (2019-nCoV) Real-Time Reverse Transcriptase (RT)-PCR Diagnostic Panel." It is intended for use with the Applied Biosystems 7500 Fast DX Real-Time PCR Instrument with SDS 1.4 software.
  - Each test kit can test approximately 700–800 patient specimens.
  - The test utilizes a technology that can provide results in 4 hours from initial sample processing to result. (Note: Other steps involved in management of patient specimens, laboratory testing, and reporting may require additional time to perform.)
- CDC's test kit is intended for use by laboratories designated by CDC as qualified, and in the United States, certified under the Clinical Laboratory Improvement Amendments (CLIA) to perform high complexity tests. This include:
  - 115 qualified U.S. laboratories, including U.S. state and local public health laboratories and Department of Defense (DoD) laboratories
  - 191 qualified international laboratories, such as World Health Organization (WHO) Global Influenza Surveillance Response System (GISRS) laboratories
    - Laboratories will place orders via the IRR Website. All the laboratories that will be placing orders are already registered and have active accounts with the IRR.
    - Each laboratory that places an order will receive one test kit initially.
- The test will not be available in U.S. hospitals or other primary care settings.
- This test is intended for use with upper and lower respiratory specimens collected from individuals who meet CDC criteria for 2019-nCoV testing.
- At this time, CDC only recommends diagnostic testing of patients who meet the clinical criteria for a 2019-nCoV patient under investigation (PUI), per Interim Guidelines for Collecting, Handling and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV).
- On Monday, February 3, 2020, CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration (FDA) in order to expedite FDA permitted use of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel in the United States. For more information, see FDA EUA

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website: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.

- The EUA process enables FDA to consider and authorize the use of unapproved, but potentially life-saving medical or diagnostic products during a public health emergency. The U.S. Secretary of Health and Human Services declared the 2019-nCoV virus a U.S. public health emergency on Friday, January 31, 2020.
- FDA approved the EUA on February 4, 2020.

Interpretation of test results from CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel:

Positive Result:

- A positive test result means that 2019-nCoV was found in your sample. If you have a positive test result, it is very likely that you are infected with 2019-nCoV. Your healthcare provider will work with you to determine how best to care for you based on the test results along with other factors of your medical history and symptoms.

Negative Result:

- A negative test result means that 2019-nCoV was not found in your sample. However, negative results do not necessarily preclude 2019-nCoV infection and should not be used as the sole basis for treatment or other patient management decisions. Other risk factors such as travel history or contact with 2019-nCoV infected individuals should be considered.

Negative result if you are symptomatic:

- For 2019-nCoV, a negative test result for a sample collected while a person has symptoms likely means that 2019-nCoV is not causing your current illness.

Negative result if you are asymptomatic:

- While a negative test most likely means you do not have 2019-nCoV infection, patients who have no symptoms may:
  1) in fact, not be infected with nCoV, or
  2) have an infection that has not developed enough to be detected by the test.
  Optimum specimen types and timing for peak viral levels during infections caused by 2019-nCoV have not been determined so collection of multiple specimens (types and time points) may be necessary to definitively rule out 2019-nCoV viral presence in asymptomatic PUI's.

TRAVEL

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to 2019 novel coronavirus.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."

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- Foreign nationals who have visited China in the past 14 days may not enter the United States.
- Special precautions are required of U.S. citizens, immediate family members of U.S. citizens, and legal permanent residents entering the United States who have been in China during the past 14 days, including up to a 14-day quarantine.
- All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 U.S. airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory 14-day quarantine at or near that location. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be monitored under self-quarantine for 14 days.
- CDC is working with public health partners to support the implementation of the travel policies detailed in the presidential proclamation (above).
- On February 3, 2020, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to 2019-nCoV and implementing public health actions based on a person's risk level and clinical presentation.

The declaration became effective beginning 5 p.m. EST, Sunday, February 2, 2020.

The 11 airports where flights are being funneled to include:

- John F. Kennedy International Airport (JFK), New York
- Chicago O'Hare International Airport (ORD), Illinois

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- San Francisco International Airport (SFO), California
- Seattle-Tacoma International Airport (SEA), Washington
- Daniel K. Inouye International Airport (HNL), Hawaii
- Los Angeles International Airport (LAX), California
- Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
- Washington-Dulles International Airport (IAD), Virginia
- Newark Liberty International Airport (EWR), New Jersey
- Dallas/Fort Worth International Airport (DFW), Texas
- Detroit Metropolitan Airport (DTW), Michigan

Travel to China:

On January 30, 2020, the U.S. State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by the novel coronavirus.

CDC has issued a level 3 Travel Health Notice for China (its highest level) recommending that all travelers avoid non-essential travel.

First Repatriated Flight Plus Quarantine Order:

- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to 195 United States citizens who repatriated to the U.S. from Wuhan, China on January 29, 2020.
- The quarantine will last 14 days from when the plane left Wuhan, China.
- This action is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also will protect the health of the repatriated citizens, their families, and their communities.
- These individuals will continue to be housed at the March Air Reserve Base in Riverside, California.
- Medical staff will monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.

Additional Repatriation Flights:

- CDC will continue to support the Department of State in the safe and expedient ordered departure of all U.S. citizens and residents from Wuhan, China.
- This week, four planes carrying U.S. citizens from Wuhan, China will arrive at Air Force bases in several states. Two of these flights arrived on February 5, 2020.
- These planes will be met by a team of CDC personnel deployed there to assess the health of the passengers. The passengers have been screened, monitored, and evaluated by medical and public health personnel every step

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of the way, including before takeoff, during the flight, during a refueling in and now post-arrival which will be at several other locations.
- CDC staff will conduct risk assessments to ensure the health of each traveler, including temperature checks and observing for respiratory symptoms.
- These repatriated passengers will be issued quarantine orders upon arrival at their designated quarantine location.
- CDC will work with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.

For more information please visit the 2019 Novel Coronavirus Outbreak Page at: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

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CDC WEEKLY KEY MESSAGES

2019 Novel Coronavirus (2019-nCoV) Outbreak, Wuhan, China

February 4, 2020

This document summarizes key messages about the 2019-nCoV outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/ncov.

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OUTBREAK SUMMARY

- There is an expanding outbreak, centered in China, of respiratory illness caused by a novel (new) coronavirus abbreviated "2019-nCoV."
- The 2019 novel coronavirus (2019-nCoV) is a new respiratory virus that can cause illness varying from mild to severe, including potentially resulting in death. It can spread from person-to-person.
- This virus is spreading from person-to-person in China. A growing number of countries are reporting cases in travelers from China and some limited person-to-person spread has been reported in countries outside of China, including in the United States.
- As of **February 3, 2020, 17,385** cases have been identified worldwide, including **11** in the United States.
- On January 30, 2020, the World Health Organization (WHO) declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.

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- On January 31, 2020, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to 2019 novel coronavirus.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- The situation is rapidly changing, and we are monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners as well as public health partners to respond to this public health threat.
- The goal of the ongoing U.S. public health response is to detect new cases quickly and prevent community spread of 2019-nCoV in this country.
- The coming days and weeks are likely to bring more confirmed cases of 2019-nCoV in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic.

OUTBREAK STATISTICS

As of **February 3, 2020**:

U.S. cases: 11
U.S. deaths: 0
Total patients under investigation (PUI): 260
- Positive: 11
- Negative: 167
- Pending: 82

States with patients under investigation: 36

Global cases: 17,385
- Mainland China: 17,205
- Outside mainland China: 180 in 26 locations, including the United States

Global deaths: 362
- China: 361
- Outside China: 1

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OUTBREAK BACKGROUND

- In early January 2020, Chinese health officials identified a novel (new) coronavirus linked to an outbreak of respiratory illness in Wuhan, Hubei Province, China.
- Most cases have been detected in China, but some cases have been detected in more than two dozen other locations. Most infections outside of China have occurred in travelers coming from Wuhan City.
- Initially, many of the patients in the Wuhan outbreak reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread.
- Since then, Chinese officials report that sustained person-to-person spread in the community is occurring in China.
- Most cases in the U.S. have been associated with travel to Wuhan, China; however, person-to-person spread has also been seen in close (household) contacts of confirmed 2019-nCoV cases.
- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness in humans. But two coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS).

TRANSMISSION

Much is unknown about how 2019-nCoV can be spread. Current knowledge is largely based on what is known about other coronaviruses.

- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- It's also possible that a person may be able to get 2019-nCoV by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- There is much more to learn about the transmissibility, severity, and other features associated with 2019-nCoV and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose 2019-nCoV in respiratory and serum samples from clinical specimens. On

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January 24, 2020, CDC publicly posted the assay protocol for this test. Currently, testing for this virus must take place at CDC.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drugs Administration on February 3, 2020.
- Once FDA approves the EUA, the CDC test kits will distributed to domestic and international partners through the agency's International Reagent Resource.
- There is no specific antiviral treatment for 2019-nCoV infection. People infected with 2019-nCoV should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

There is currently no vaccine to prevent 2019-nCoV infection. The best way to prevent infection is to avoid being exposed to this virus.

CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:

- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

TRAVEL

Travel from China:

President Trump issued a Presidential Proclamation January 31, 2020, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.

The proclamation:

- Suspends entry to the United States to foreign nationals who have visited China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of U.S. citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")

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In addition:

- All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 U.S. airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory 14-day quarantine at or near that location. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be monitored under self-quarantine for 14 days.

The declaration took effect at 5 p.m. EST, Sunday, February 2, 2020.

The 11 airports where flights are being funneled to include:

- John F. Kennedy International Airport (JFK), New York
- Chicago O'Hare International Airport (ORD), Illinois
- San Francisco International Airport (SFO), California
- Seattle-Tacoma International Airport (SEA), Washington
- Daniel K. Inouye International Airport (HNL), Hawaii
- Los Angeles International Airport, (LAX), California
- Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
- Washington-Dulles International Airport (IAD), Virginia
- Newark Liberty International Airport (EWR), New Jersey
- Dallas/Fort Worth International Airport (DFW), Texas
- Detroit Metropolitan Airport (DTW), Michigan

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Travel to China:

- On January 30, 2020, the U.S. State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by the new coronavirus.
- CDC has issued a level 3 Travel Health Notice for Wuhan, China recommending that all travelers avoid non-essential travel.

First Repatriated Flight Plus Quarantine Order:

- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to 195 evacuees who came to the U.S. from Wuhan, China on January 29, 2020.
- The quarantine will last 14 days from when the plane left Wuhan, China.
- This action is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also will protect the health of the evacuees, their families, and their communities.
- These individuals will continue to be housed at the March Air Reserve Base in Riverside, California.
- Medical staff will monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.

Additional Repatriation Flights:

- On January 23, 2020, the Department of State ordered the departure of all U.S. Consulate General Wuhan personnel and their family members.
- The Department of State is working with the U.S. Government interagency and People's Republic of China counterparts on staging additional evacuation flights to the U.S. from Wuhan.
- CDC will continue to support the Department of State in the safe and expedient ordered departure of all evacuees from Wuhan, China.

CDC LABORATORY TEST FOR 2019 NOVEL CORONAVIRUS

- CDC has developed a new laboratory test kit for use in testing patient specimens for 2019 novel coronavirus (2019-nCoV).
- The test kit is called the "Centers for Disease Control and Prevention (CDC) 2019-Novel Coronavirus (2019-nCoV) Real-Time Reverse Transcriptase (RT)-PCR Diagnostic Panel." It is intended for use with the Applied Biosystems 7500 Fast DX Real-Time PCR Instrument with SDS 1.4 software.
    - Each test kit is enough for conducting 1,000 tests.

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    - The test utilizes a technology that can provide results in 4 hours from initial sample processing to result. (Note: Other steps involved in management of patient specimens, laboratory testing, and reporting may require additional time to perform.)

- CDC's test kit is intended for use by laboratories designated by CDC as qualified, and in the United States, certified under the Clinical Laboratory Improvement Amendments (CLIA) to perform high complexity tests.
    - This includes U.S. state and local public health laboratories and Department of Defense (DoD) laboratories.
    - The test kits also will be shipped to qualified international laboratories, such as WHO Global Influenza Surveillance Response System (GISRS) laboratories. For more information, see the section labeled CDC Laboratory Test Kit Distribution (general audiences).
- The test will not be available in U.S. hospitals or other primary care settings.
- This test is intended for use with upper and lower respiratory specimens collected from individuals who meet CDC criteria for 2019-nCoV testing.
- At this time, CDC only recommends diagnostic testing of patients who meet the clinical criteria for a 2019-nCoV patient under investigation (PUI), per Interim Guidelines for Collecting, Handling and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV).
    - For more information about interpreting test results, see section labeled "Interpretation of test results from CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel."

Emergency Use Authorization Package Submittal:

- On Monday, February 3, 2020, CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration (FDA) in order to expedite FDA permitted use of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel in the United States. For more information, see FDA EUA Website: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- The EUA process enables FDA to consider and authorize the use of unapproved, but potentially life-saving medical or diagnostic products during a public health emergency. The U.S. Secretary of Health and Human Services declared the 2019-nCoV virus a U.S. public health emergency on Friday, January 31, 2020. (For more information, see the Emergency Use Authorization Background section below).
- Criteria upon which CDC's 2019-nCoV test is being submitted for EUA authorization, include the following:
    - The 2019-nCoV can cause a serious or life-threatening disease or condition, including severe respiratory illness, to humans infected by this virus;
    - There is no adequate, approved, and available alternative to the emergency use of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel for diagnosing 2019-nCoV infection.

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- Based on the totality of scientific evidence available to FDA, it is reasonable to believe that the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel may be effective in diagnosing 2019-nCoV infection, and that the known and potential benefits of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel, when used for diagnosing 2019-nCoV infection, outweigh the known and potential risks.

- CDC has provided guidance on specimen collection, storage and shipping at "Interim Guidelines for Collecting, Handling and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV)."
- Public health officials anticipate that distribution of the tests will improve 2019-nCoV laboratory testing capacity in the United States.

CDC Laboratory Test Kit Distribution:

- Once CDC's diagnostic test is authorized by FDA under the EUA , the International Reagent Resource (IRR) will begin distributing the test to the following laboratories:
  - 115 qualified U.S. laboratories; this includes U.S. state and local public health laboratories and Department of Defense (DoD) laboratories.
  - 191 qualified international laboratories, such as WHO Global Influenza Surveillance Response System (GISRS) laboratories.
  - Laboratories will place orders via the IRR Website. All the laboratories that will be placing orders are already registered and have active accounts with the IRR.
  - Each laboratory that places an order will receive one test kit initially, and each test kit is enough for approximately 1,000 patient specimens.

Background: Emergency Use Authorization:

- The FDA is responsible for reviewing and approving medical products for use in the United States. This usually is a lengthy process.
- However, when the U.S. Secretary of Health and Human Services (HHS) determines that there is a significant potential for a public health emergency that has a significant potential to affect national security or the health and security of United States citizens living abroad and that circumstances exist justifying the authorization of an emergency use of a product pursuant to section 564 of the Federal Food, Drug and Cosmetic Act, the commissioner of the FDA can use an EUA to permit use of certain unapproved medical products or unapproved uses of approved medical products. There are several criteria necessary for the FDA Commissioner to issue an EUA, including:
  - The agent or agents specified in the declaration can cause a serious or life-threatening disease or condition;
  - Based on the scientific information available, it is reasonable to believe that the medical countermeasure may be effective in diagnosing, treating, or preventing the disease or caused by a CBRN (chemical, biological, radiological, nuclear) agent. The exact type and amount of data needed to support an EUA may vary depending on the nature of the circumstances giving rise to the declaration and the type of the candidate product;

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- The known and potential benefits outweigh the known and potential risks of the product when used to diagnose, prevent, or treat the serious or life-threatening disease or condition; AND
- There is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating the serious or life-threatening disease or condition. A potential alternative product may be considered "unavailable" if there are insufficient supplies to fully meet the emergency need. A potential alternative product may be considered "inadequate" if there are contradicting data for special circumstances or populations (e.g., immunocompromised individuals, individuals with drug allergies).

Information for Laboratory Professionals:

- The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel contains the following:
  - 2019-nCoV_N1, 2019-nCoV_N2 and 2019-nCoV_N3 primers and probes that target the nucleocapsid (N) gene and are designed for both universal detection of SARS-like coronavirus as well as specific detection of the 2019-nCoV. CDC has published the primers and probes sequences for 2019-nCoV online: https://www.cdc.gov/coronavirus/2019-ncov/lab/rt-pcr-panel-primer-probes.html
  - RP primers and probes that target the Human RNase P gene
  - nCoVPC, the 2019-nCoV positive control used in the assay
- The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel also requires the use of additional authorized materials and authorized ancillary reagents that are not included with the test but are commonly used in clinical laboratories and are described in the authorized CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use Package Insert.
- The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel requires the following control materials, or other authorized control materials; all controls listed below must generate expected results in order for a test to be considered valid, as outlined in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use:
  - Human Specimen Control (HSC): A human cell culture preparation used as an extraction control and positive control for the RNase P primer and probe set that is extracted and tested concurrently with each specimen extraction run.
  - Positive Control for 2019-nCoV (nCoVPC): Run with each batch of specimens. Monitors for failures of rRT-PCR reagents and reaction conditions.
  - No Template Control (NTC): Nuclease-free water included in each run. Monitors for reagent and system contamination.
- Contact your state and/or local public health laboratory for a consultation for testing of a patient under investigation (PUI).
- Use appropriate personal protective equipment when collecting and handling specimens from individuals suspected of being infected with 2019-nCoV as outlined in the CDC Interim Guidelines for Collecting, Handling and Testing Clinical Specimens from Patients Under

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Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV). Other specimens not listed in this guidance will not be accepted for testing.

Interpretation of test results from CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel:

Note: *these are consistent with but not identical to the package insert and were synthesized from input from lab and epi teams.

Positive Result:

A positive test result means that 2019-nCoV was found in your sample. If you have a positive test result, it is very likely that you are infected with 2019-nCoV. Your healthcare professional will work with you to determine how best to care for you based on the test results along with other factors of your medical history and symptoms.

Negative Result:

A negative test result means that 2019-nCoV was not found in your sample. However, negative results do not necessarily preclude 2019-nCoV infection and should not be used as the sole basis for treatment or other patient management decisions. Other risk factors such as travel history or contact with 2019-nCoV infected individuals should be considered.

Negative result if you are symptomatic:

For 2019-nCoV, a negative test result for a sample collected while a person has symptoms likely means that 2019-nCoV is not causing your current illness.

Negative result if you are asymptomatic:

While a negative test most likely means you do not have 2019-nCoV infection, patients who have no symptoms may:

1) in fact, not be infected with nCoV, or
2) have an infection that has not developed enough to be detected by the test. Optimum specimen types and timing for peak viral levels during infections caused by 2019-nCoV have not been determined so collection of multiple specimens (types and time points) may be necessary to definitively rule out 2019-nCoV viral presence in asymptomatic PUI's.

WHAT CDC IS DOING

CDC Response in the United States:

- The federal government is working closely with state, local, tribal, and territorial partners as well as public health partners to respond to this public health threat.
- The goal of the ongoing U.S. public health response is to detect new cases quickly and prevent further spread of 2019-nCoV in this country.
- CDC established a 2019-nCoV Incident Management Structure on January 7, 2020. On January 21, 2020, CDC activated its Emergency Operations Center to better provide ongoing support to the 2019-nCoV response.

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- On January 27, 2020, CDC issued updated travel guidance for China, recommending that travelers avoid all nonessential travel to all of the country (Level 3 Travel Health Notice).
- The U.S. government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, 2020, at 5pm, the U.S. government suspended entry of foreign nationals who have been in China within the past 14 days.
    - U.S. citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - See more at: "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus"
- CDC issued an updated interim Health Alert Notice (HAN) Update to inform state and local health departments and healthcare professionals about this outbreak on February 1, 2020.
- On January 30, 2020, CDC published guidance for healthcare professionals on the clinical care of 2019-nCoV patients.
- CDC has deployed multidisciplinary teams to Washington, Illinois, California, and Arizona to assist health departments with clinical management, contact tracing, and communications.
- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose 2019-nCoV in respiratory and serum samples from clinical specimens. On January 24, 2020, CDC publicly posted the assay protocol for this test. Currently, testing for this virus must take place at CDC.
- CDC submitted an Emergency Use Authorization package to the FDA on February 3, 2020.
- Once FDA approves the EUA, the CDC test kits will distributed to domestic and international partners through the agency's International Reagent Resource.
- CDC uploaded to GenBank the entire genome of the virus from reported cases in the United States as sequencing was completed.
- CDC also is growing the virus in cell culture, which is necessary for further studies, including for additional genetic characterization.

Internationally:

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC will work through WHO's China country office to support Chinese public health counterparts and help improve understanding of this new disease, including learning more about transmissibility and severity.
- One Beijing-based CDC expert is currently working with WHO in China and additional CDC headquarters experts are being identified and prepared for deployment.
- CDC staff based in 60+ countries around the world are working closely with ministries of health and other health partners to prepare and respond to the novel coronavirus.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within U.S. embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.

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- CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the U.S., China, and the world.
- CDC works closely with countries to establish Field Epidemiology Training Programs (FETPs) that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
- In China, CDC is the primary technical partner for the Chinese FETP. Using classroom and hands-on experience, this program has graduated 279 epidemiologists who conducted more than 2,000 outbreak investigations as part of their training.
- Specialized training tracks are now being established in non-communicable diseases and tuberculosis.
- With technical guidance from CDC, 71 graduates completed training for the new Western FETP that supports 13 under-served provinces of China — remote areas more vulnerable to novel infections and with increasing transport corridors.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between U.S. and China influenza experts

RECOMMENDATIONS

CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.

Recent Travelers to China:

If you were in China and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:

- Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
- Avoid contact with others.
- Not travel while sick.
- Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.

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- Wash your hands often with soap and water for at least 20 seconds to avoid spreading the virus to others. Use an alcohol-based hand sanitizer if soap and water are not available.

People Confirmed to Have, or Being Evaluated for, 2019-nCoV:
Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing 2019 Novel Coronavirus (2019-nCoV) from Spreading to Others in Homes and Communities.

- Stay home except to get medical care.
- Separate yourself from other people in your home.
- Call ahead before visiting your doctor.
- Wear a facemask.
- Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
- Wash your hands often with soap and water for at least 20 seconds.
- Avoid sharing household items like eating utensils, cups, or linens.
- Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 3, 2020, CDC published interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to the 2019-nCoV virus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in China during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:
People who have had close contact with someone who is confirmed to have, or being evaluated for, 2019-nCoV infection, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.

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    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, 2019-nCoV infection. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.

Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing 2019 Novel Coronavirus (2019-nCoV) from Spreading to Others in Homes and Communities web page.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of 2019-nCoV in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed 2019-nCoV patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

Note: Fever may be subjective or confirmed. The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

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Recommendations for Reporting, Testing, and Specimen Collection:

- Healthcare professionals should **immediately** notify both infection control personnel at their healthcare facility AND their local or state health department in the event of a PUI for 2019-nCoV.
- State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a 2019-nCoV PUI case investigation form available on CDC's Interim Guidance for Healthcare Professionals.
- At this time, diagnostic testing for 2019-nCoV can be conducted only at CDC.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected from 2019-nCoV PUIs.
- Testing for other respiratory pathogens should not delay specimen shipping to CDC.
- **For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for 2019-nCoV.**
- To increase the likelihood of detecting 2019-nCoV infection, CDC recommends collecting and testing multiple clinical specimens from different sites, including all three specimen types—lower respiratory, upper respiratory, and serum specimens. Additional specimen types (e.g., stool, urine) may be collected and stored initially until decision is made by CDC whether additional specimen sources should be tested. Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset. Maintain proper infection control when collecting specimens.

Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website. Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

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Text Illness Monitoring (T.I.M.)

A mobile text platform designed to help public health with monitoring

Using T.I.M. for 2019 Novel Coronavirus Monitoring

Monitoring conducted by public health officials has traditionally been conducted via telephone calls, which can be a time-consuming process requiring staff resources. CDC has developed the Text Illness Monitoring (T.I.M.) system, a nationally-centralized option utilizing two-way Short Message Service (SMS)/text messaging to aid in the process. Text messaging is an efficient method to elicit, manage, and act on any 2019-nCoV symptoms among those who are exposed or potentially exposed to the virus. The T.I.M. system was utilized to monitor for influenza symptoms in Michigan[1] with success.

How it works

Participation in the text monitoring program is voluntary for both the state/local health departments. Consenting persons in participating state and local municipalities will receive 2-5 text messages a day for up to14 days asking if they have symptoms consistent with 2019-nCoV. State/local health officials will immediately be alerted to any person that responds that they are experiencing symptoms and to any persons who fail to respond to two consecutive messages. State/local health officials would then follow up with individuals who are reporting symptoms or those that have been unresponsive.

Key benefits

- Reduces the resource burden on public health for illness monitoring, for contract tracing and monitoring of asymptomatic individuals
- Facilitates reporting through an online dashboard
- Compliant to regulations set by industry standards, telecom authorities and government policy
- Information is protected

1 Stewart RJ, Rossow J, Eckel S, et al. Text-Based Illness Monitoring for Detection of Novel Influenza A Virus Infections During an Influenza A (H3N2)v Virus Outbreak in Michigan, 2016: Surveillance and Survey. JMIR Public Health Surveill. 2019;5(2):e10842. Published 2019 Apr 26. doi:10.2196/10842 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6658270/

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FL-DOH-20-0673-A-002368

Frequently Asked Questions

How do I get access to T.I.M.?

State or local public health departments may request access by sending an email to **eocevent340@cdc.gov.** The public health department will need to provide a primary and secondary point of contact to act as an administrator in T.I.M. After registration, the public health administrators will receive an email with information on how to log in and access the system.

Is there a dashboard and what information can be seen?

The system access includes a dashboard with summary information on number of persons being monitored, and information related to the alerts/notifications that public health needs to take action on (i.e., those that reply YES to a text indicating symptoms, those that have not responded to two consecutive texts).

Who will be able to access the information in T.I.M.?

Public health administrators and their designees will have access to data within their jurisdiction. CDC will only have access to the deidentified aggregate data for monitoring campaigns.

Can I request access for other people in my jurisdiction?

The administrators may add users for their state.

How will I know if someone responds that they have symptoms?

If someone in your jurisdiction replies YES to a text message indicating symptoms you will receive an email notification. An email notification will also be sent if a person does not respond to two consecutive texts sent. These alerts/notifications are also captured on the dashboard.

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FL-DOH-20-0673-A-002369

From:	Munroe, Julia
To:	Rubino, Heather; Pritchard, Scott; Stanek, Danielle R; Riggen, Amy; Blackmore, Carina; Kendrick, Katie; Torres, Yari; Bogucki, Amy; Troelstrup, Thomas
Cc:	Gumke, Megan R; Schmitz, Ann; Leapley, Andrea C; Foster, Tricia; Higgins, Sue M; Atrubin, David L.; Elliott, Karen E; Samuel, Ashley N; Fawaz, Shelby R; Mahler, Erin; Doyle, Tim; Eisenstein, Leah; Mtenga, Mwedu; Prahlow, Samuel; Matthias, Laura P; Kite Powell, Aaron (CDC/DDPHSS/CSELS/DHIS)
Subject:	CDC Conference Call: COVID-19

CDC's 2019 Novel Coronavirus (COVID-19) response team will continue to host a national call series from 2 p.m. to 2:45 p.m. EST every Monday, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)921-9091

Participant Passcode: 1324420

For your convenience, call series dates are provided below.

* Monday, March 9 --> Room 105E
* Monday, March 16 --> Room 220P
* Monday, March 23 --> None booked
* Monday, March 30 --> None booked

CDC State Coordination Task Force (SCTF) - Operations

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

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

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From:	Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019; LLS (CDC); Epi Aid (CDC)
Subject:	CDC COVID-19 airport screener volunteers wanted
Date:	Friday, February 28, 2020 9:44:40 AM

Hello EIS/LLS,

The Global Migration Task Force (GMTF) in the CDC Emergency Operations Center is currently seeking available FTEs to deploy to the 11 US airports to serve as tertiary screeners and medical officers.

> **Tertiary screeners** are responsible for conducting and documenting passenger screening interviews/triage case reviews; distributing communication materials and health information updates; conducting data entry and transport coordination activities; and providing basic quarantine station support, including purchasing, property management, document processing, timekeeping, and answering inquiries, etc.
>
> **Medical officers** are responsible for reviewing the clinical information collected at the quarantine stations, evaluating the history and presenting symptoms, assessing available laboratory data, consulting with specialists, and making a clinical recommendation for disposition of ill travelers. We are accepting licensed medical physicians, physician assistants, and nurse practitioners for this role.

We are also looking for deployers who are fluent in Mandarin to fill both the tertiary screener and medical officer roles.

All positions above require that you pass a medical clearance exam and are respiratory fit tested. You will be required to interact with travelers and wear personal protective equipment that includes respiratory protection. Upon return to your duty stations you will be advised to self-monitor for 14 days while you go about your normal activities of daily living. Additional information is available on DeployCDC.

Deployments are 29 days in length and we have vacancies at all 11 station locations for March and April. The station locations include:

- Los Angeles
- New York
- San Francisco
- Atlanta
- Chicago
- Newark
- Seattle
- Honolulu
- Detroit
- Washington DC
- Dallas

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If you are interested in a deployment opportunity with GMTF, please respond to eocdgmqsrldaid@cdc.gov with your supervisory approval and answer the following.

Supervisor approval (please attach an email from your supervisor)
Dates of Availability (29 days):
Current duty location (e.g. Atlanta, GA):
Mobile number:

Many thanks for your consideration,

Michael Gronostaj, MD, MPH, FACPM
CDR, United States Public Health Service
Epi-Aid/Lab-Aid Response Team Lead | EIS/LLS Deployment Coordinator

Fellowship Response and Support Team | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE, MS V24-5, Atlanta, GA 30329-4027
Work Phone: 404-498-6167 / Fax: 404-498-6535
vie0@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/03/2020
Date: Tuesday, March 3, 2020 8:10:10 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported Cases.msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent today from the CSTE COVID-19 Leadership Team (attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction. We are doing this in order to coordinate consistent public messaging and improve data visualization on CDC's public-facing website for the COVID-19 response. **Currently, this will be a daily process (Monday–Friday)**. As the response evolves, the frequency of these requests will likely decrease.

At the bottom of this email, you will find a table with the current preliminary case counts for each jurisdiction **as of 4 pm ET on Tuesday, March 3, 2020**. These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the U.S. via State Department-chartered flights.

This email is being sent to the State Epidemiologist for each jurisdiction. Please, **by 9 am ET Wednesday, March 4**, reply to this email and provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:

- confirm the case count information provided (cases as of 4 pm ET), or,
- if incorrect, provide updated values by using the table shell below

	Value as of 4pm ET
Jurisdiction Name	
Presumptive Cases	
Lab-confirmed Cases*	
Total Cases (Presumptive + Lab-confirmed Cases)	
Total Deaths among Cases (Presumptive + Lab-confirmed Cases)	

**Currently, all confirmatory testing occurs at CDC*
Note: These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. It does not include people who returned to the U.S. via State Department-chartered flights.

Per discussion with the CSTE COVID-19 Leadership Team, CDC will post **only the total case count [presumptive + lab-confirmed] on the CDC website, which will be updated daily at 12 pm ET. Jurisdictions with one to five cases will be depicted as having "1–5 cases"; others will be listed as having "0 cases" or their actual number of cases (e.g. "6").** The other information collected (e.g. number of deaths) will be used for internal awareness and will not be shared publicly at this time. **We ask that the preliminary information shared in this email not be distributed**.

DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Thank you for your partnership,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	**Code**	**Lab Category***			**Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0

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Arkansas	AR	0	0	0	0
California	CA	19	10	29	0
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	2	2	4	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	0	0	0	0
New Hampshire	NH	1	0	1	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York	NY	0	0	0	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	0	0	0	0
Texas	TX	0	0	0	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA	25	2	27	9
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0

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Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	2	0	2	0
Northern Marianas Islands	MP	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC
website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; and 6) major avoidable issues we hope to overcome with your assistance. We plan for the noted changes to go into effect at **5 pm ET, Sunday, March 1.**

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **we anticipate that all jurisdictions will be onboarded to 'Phase 2' during the week of March 2.** As soon as your jurisdiction is able to confirm its 'Phase 2' status, please email eocevent118@cdc.gov.

As part of the 'Phase 2' rollout, CDC needs to better understand each jurisdiction's plan for providing data to CDC for the PUI and Case Report Form via DCIPHER, an electronic PUI and case reporting system. We request that each jurisdiction provides a list of ≤5 DCIPHER users before **Monday, March 2 at 5pm ET,** if they have not already done so. In addition, we ask that jurisdictions confirm their intent to input data on PUI and case-patients directly into the DCIPHER platform (preferred option) or if alternative arrangements need to be made to send data to CDC. Please email eocevent118@cdc.gov with the requested information by **March 2 at 5pm ET**.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

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- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings

For reporting jurisdictions that have the capacity to do their own testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs or Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.

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2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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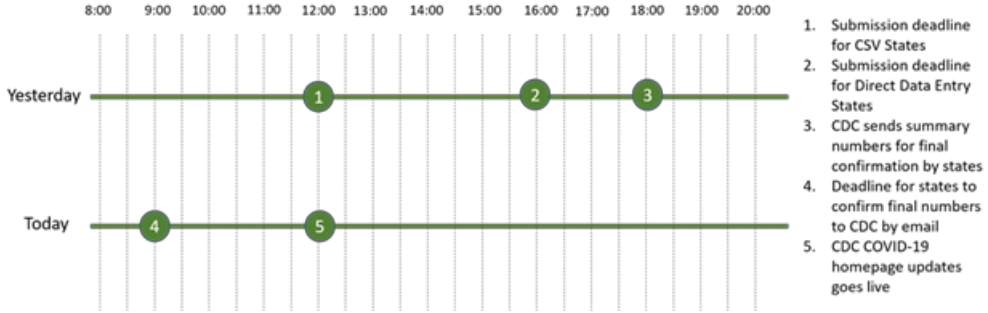
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
>
>
> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/04/2020
Date: Wednesday, March 4, 2020 6:43:38 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 4**.
- By **9 am ET Thursday, March 5**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET today)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	23	14	37	0
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0

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Idaho	ID	0	0	0	0
Illinois	IL	2	2	4	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	0	0	0	0
New Hampshire	NH	1	1	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	1	0	1	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	2	1	3	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	0	0	0	0
Texas	TX	0	0	0	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA	32	7	39	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	0	1	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0

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Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC
website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; and 6) major avoidable issues we hope to overcome with your assistance. We plan for the noted changes to go into effect at **5 pm ET, Sunday, March 1.**

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **we anticipate that all jurisdictions will be onboarded to 'Phase 2' during the week of March 2.** As soon as your jurisdiction is able to confirm its 'Phase 2' status, please email eocevent118@cdc.gov.

As part of the 'Phase 2' rollout, CDC needs to better understand each jurisdiction's plan for providing data to CDC for the PUI and Case Report Form via DCIPHER, an electronic PUI and case reporting system. We request that each jurisdiction provides a list of ≤5 DCIPHER users before **Monday, March 2 at 5pm ET,** if they have not already done so. In addition, we ask that jurisdictions confirm their intent to input data on PUI and case-patients directly into the DCIPHER platform (preferred option) or if alternative arrangements need to be made to send data to CDC. Please email eocevent118@cdc.gov with the requested information by **March 2 at 5pm ET**.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

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- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings

For reporting jurisdictions that have the capacity to do their own testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs or Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.

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2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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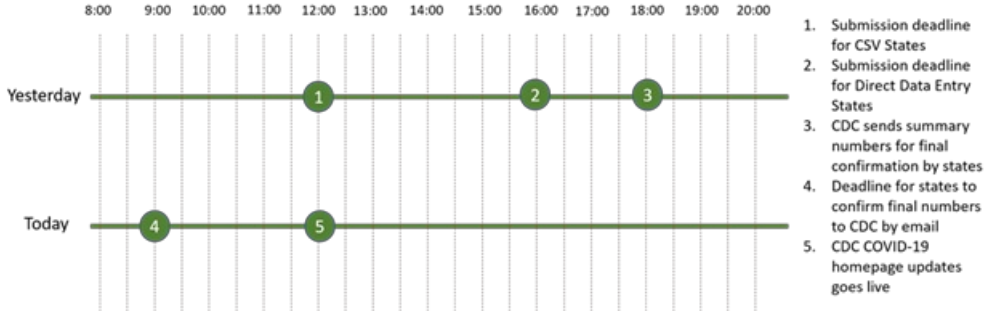
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
>
>
> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Thursday, March 5, 2020 7:21:59 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
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Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0

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Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

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***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **we anticipate that all jurisdictions will be onboarded to 'Phase 2' during the week of March 2.** As soon as your jurisdiction is able to confirm its 'Phase 2' status, please email eocevent118@cdc.gov.

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1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
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For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

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2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
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Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

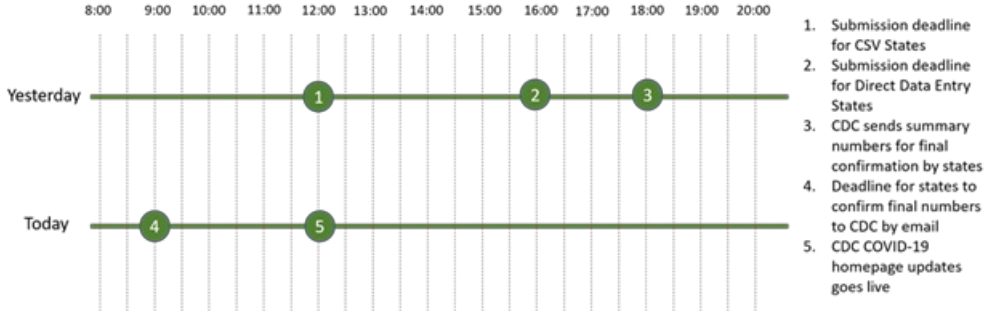
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
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> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
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> Sincerely,
> CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/08/2020
Date: Sunday, March 8, 2020 7:43:38 PM
Attachments: Attachment1_ReportingUpdates_2020March8.docx
CSTE COVID-19 Response New CDC Standard Process for Displaying Reported Cases.msg

---

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 8**.
- By **9 am ET Monday, March 9**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 8)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	3	2	5	0
Arkansas	AR	0	0	0	0
California	CA			110	1
Colorado	CO	8	1	9	0
Connecticut	CT	1	0	1	0
Delaware	DE	0	0	0	0
Florida	FL	3	3	6	0
Georgia	GA	2	5	7	0
Hawaii	HI	2	0	2	0
Idaho	ID	0	0	0	0

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Illinois	IL	3	4	7	0
Indiana	IN	2	0	2	0
Iowa	IA	0	0	0	0
Kansas	KS	1	0	1	0
Kentucky	KY	1	0	1	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	3	0	3	0
Massachusetts	MA	13	1	14	0
Michigan	MI	0	0	0	0
Minnesota	MN	1	0	1	0
Mississippi	MS	0	0	0	0
Missouri	MO	1	0	1	0
Montana	MT	0	0	0	0
Nebraska	NE	2	0	2	0
Nevada	NV	3	0	3	0
New Hampshire	NH	0	2	2	0
New Jersey	NJ	6	0	6	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	28	0	28	0
North Carolina	NC	2	0	2	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	1	1	0
Oregon	OR	13	1	14	0
Pennsylvania	PA	6	0	6	0
Rhode Island	RI	1	2	3	0
South Carolina	SC	6	0	6	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	3	3	6	0
Utah	UT	1	0	1	0
Vermont	VT	1	0	1	0
Virginia	VA	1	0	1	0
Washington	WA			136	18
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	1	0	1	0
Guam	GU	0	0	0	0
New York City	NYC	11	1	12	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

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**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Updated Sunday, March 8 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th and a CSTE email sent Friday, March 6th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) grouping of the PUI/Case Report variables into 3 tiers; and 7) major avoidable issues we hope to overcome with your assistance.

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

As of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report presumptive positive and confirmed positive cases to CDC**.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2'.** If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab (public health, commercial or hospital lab) or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.

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- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case (presumptive or confirmed) or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    b. Update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

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For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Grouping of the PUI/Case Report variables into 3 tiers

To support jurisdictions in providing timely case information, the variables included in the Persons Under Investigation (PUI) and Case Report Form have been grouped into 3 tiers. While all the information being collected is important to inform the response, Tier 1 variables are key in understanding the current burden within communities and are typically more readily available. CDC asks that Tier 1 variables be entered/submitted within 24 hours of being collected. The remaining variables should be submitted as soon as possible.

- Tier 1 Variables (to be reported directly into DCIPHER or via *csv* file upload)
  - CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
  - Reporting jurisdiction (state) (required field)
  - Current status of the person (current_status) (required field)
  - State of residence (res_state)
  - County of residence (res_county)
  - Sex (sex)
  - Age (age)
  - Age Units (ageunit)
  - Symptoms present during course of illness (sympstatus)
  - If symptomatic, onset date (onset_dt)
  - Hospitalization status (hosp_yn)
  - Death (death_yn)

- Tier 2 Variables
  - Report date of case to CDC (case_cdcreport_dt)
  - ICU Admission status (icu_yn)
  - If female, currently pregnant (pregnant_yn)
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)

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- Travel to other non-US country, specify (exp_othcountry_spec)
- Household contact with a COVID-19 case patient (exp_house)
- Community contact with a COVID-19 case patient (exp_community)
- Any healthcare contact with a COVID-19 case patient (exp_health)
- Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
- Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen type (see series on specimen type)
- Specimen ID (see series on specimen ID)
- Specimen sent to CDC (see series on specimen sent to CDC)

- Tier 3 Variables
  - The remaining variables collected on the PUI and Case Report Form

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

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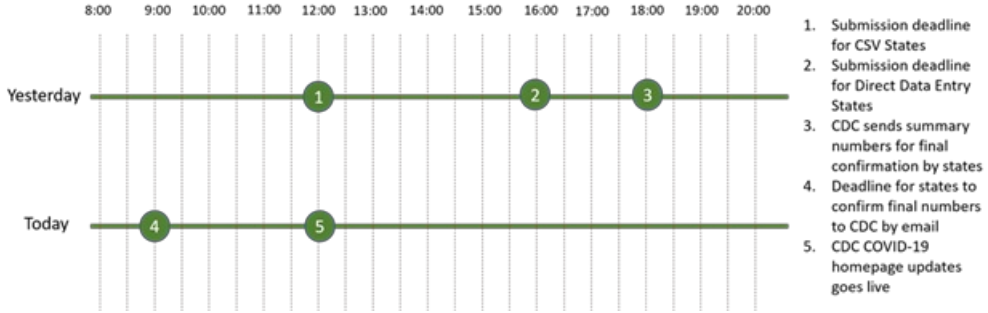
> 
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AMERICAN OVERSIGHT

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To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/10/2020
Date: Tuesday, March 10, 2020 9:20:36 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
Attachment1_ReportingUpdates_2020March8.docx

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As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Tuesday, March 10**.
- By **9 am ET Wednesday, March 11**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Tuesday, March 10**) using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

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What you need to do/know later:

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Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	6	2	8	0
Arkansas	AR	0	0	0	0
California	CA			135	2
Colorado	CO	17	0	17	0
Connecticut	CT	1	0	1	0
Delaware	DE	0	0	0	0
Florida	FL	12	7	19	2
Georgia	GA	11	8	19	0
Hawaii	HI	2	0	2	0
Idaho	ID	0	0	0	0

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Illinois	IL	15	4	19	0
Indiana	IN	5	0	5	0
Iowa	IA	8	0	8	0
Kansas	KS	1	0	1	0
Kentucky	KY	4	0	4	2
Louisiana	LA	1	0	1	0
Maine	ME	0	0	0	0
Maryland	MD	6	3	9	0
Massachusetts	MA	38	1	39	0
Michigan	MI	0	0	0	0
Minnesota	MN	2	0	2	0
Mississippi	MS	0	0	0	0
Missouri	MO	1	0	1	0
Montana	MT	0	0	0	0
Nebraska	NE	3	1	4	0
Nevada	NV	3	1	4	0
New Hampshire	NH	2	2	4	0
New Jersey	NJ	13	0	13	4
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY			125	0
North Carolina	NC	7	0	7	0
North Dakota	ND	0	0	0	0
Ohio	OH	3	0	3	0
Oklahoma	OK	1	1	2	0
Oregon	OR	13	1	14	0
Pennsylvania	PA	12	0	12	1
Rhode Island	RI	2	2	4	0
South Carolina	SC	7	1	8	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	11	4	15	0
Utah	UT	2	0	2	0
Vermont	VT	1	0	1	0
Virginia	VA	4	1	5	0
Washington	WA			207	25
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	32	1	33	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0

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Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Updated Sunday, March 8 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th and a CSTE email sent Friday, March 6th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) grouping of the PUI/Case Report variables into 3 tiers; and 7) major avoidable issues we hope to overcome with your assistance.

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1. PUI, testing pending*
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**Testing conducted by local lab (public health, commercial or hospital lab) or CDC lab*
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We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

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- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

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As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

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For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case (presumptive or confirmed) or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"
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    a. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
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1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
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For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

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Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Grouping of the PUI/Case Report variables into 3 tiers

To support jurisdictions in providing timely case information, the variables included in the Persons Under Investigation (PUI) and Case Report Form have been grouped into 3 tiers. While all the information being collected is important to inform the response, Tier 1 variables are key in understanding the current burden within communities and are typically more readily available. CDC asks that Tier 1 variables be entered/submitted within 24 hours of being collected. The remaining variables should be submitted as soon as possible.

- Tier 1 Variables (to be reported directly into DCIPHER or via *csv* file upload)
  - CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
  - Reporting jurisdiction (state) (required field)
  - Current status of the person (current_status) (required field)
  - State of residence (res_state)
  - County of residence (res_county)
  - Sex (sex)
  - Age (age)
  - Age Units (ageunit)
  - Symptoms present during course of illness (sympstatus)
  - If symptomatic, onset date (onset_dt)
  - Hospitalization status (hosp_yn)
  - Death (death_yn)

- Tier 2 Variables
  - Report date of case to CDC (case_cdcreport_dt)
  - ICU Admission status (icu_yn)
  - If female, currently pregnant (pregnant_yn)
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)

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- Travel to other non-US country, specify (exp_othcountry_spec)
- Household contact with a COVID-19 case patient (exp_house)
- Community contact with a COVID-19 case patient (exp_community)
- Any healthcare contact with a COVID-19 case patient (exp_health)
- Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
- Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen type (see series on specimen type)
- Specimen ID (see series on specimen ID)
- Specimen sent to CDC (see series on specimen sent to CDC)

- Tier 3 Variables
  - The remaining variables collected on the PUI and Case Report Form

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

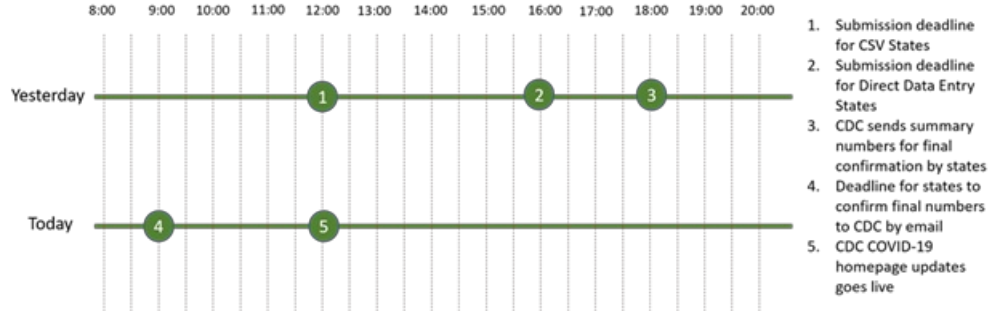
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases

CSTE Emergency Preparedness & Response
Coronavirus Disease (COVID-19)

Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
>
>
> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/11/2020
Date: Wednesday, March 11, 2020 6:54:03 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
Attachment1_ReportingUpdates_2020March8.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 11**.
- By **9 am ET Thursday, March 12**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Wednesday, March 11)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	7	2	9	0
Arkansas	AR	2	0	2	0
California	CA			152	3
Colorado	CO	17	0	17	0
Connecticut	CT	2	0	2	0
Delaware	DE	2	0	2	0
Florida	FL	19	7	26	2
Georgia	GA	14	9	23	0
Hawaii	HI	1	0	1	0
Idaho	ID	0	0	0	0

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Illinois	IL	23	4	27	0
Indiana	IN	9	0	9	0
Iowa	IA	13	0	13	0
Kansas	KS	1	0	1	0
Kentucky	KY	4	0	4	0
Louisiana	LA	6	0	6	0
Maine	ME	0	0	0	0
Maryland	MD	6	3	9	0
Massachusetts	MA	85	6	91	0
Michigan	MI	3	0	3	0
Minnesota	MN	4	1	5	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	1	1	0
Montana	MT	0	0	0	0
Nebraska	NE	4	1	5	0
Nevada	NV	4	1	5	0
New Hampshire	NH	3	2	5	0
New Jersey	NJ	17	0	17	1
New Mexico	NM	3	0	3	0
New York (excluding New York City)	NY			164	0
North Carolina	NC	7	0	7	0
North Dakota	ND	0	0	0	0
Ohio	OH	3	0	3	0
Oklahoma	OK	1	1	2	0
Oregon	OR	14	1	15	0
Pennsylvania	PA	16	0	16	0
Rhode Island	RI	3	2	5	0
South Carolina	SC	5	4	9	0
South Dakota	SD	5	0	5	1
Tennessee	TN	7	0	7	0
Texas	TX	18	5	23	0
Utah	UT	3	0	3	0
Vermont	VT	1	0	1	0
Virginia	VA	7	1	8	0
Washington	WA			366	29
West Virginia	WV	0	0	0	0
Wisconsin	WI	2	1	3	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	32	1	33	0
Northern Marianas Islands	MP	0	0	0	0
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  - If female, currently pregnant (pregnant_yn)
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)

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- Travel to other non-US country, specify (exp_othcountry_spec)
- Household contact with a COVID-19 case patient (exp_house)
- Community contact with a COVID-19 case patient (exp_community)
- Any healthcare contact with a COVID-19 case patient (exp_health)
- Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
- Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen type (see series on specimen type)
- Specimen ID (see series on specimen ID)
- Specimen sent to CDC (see series on specimen sent to CDC)

- Tier 3 Variables
  - The remaining variables collected on the PUI and Case Report Form

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
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> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
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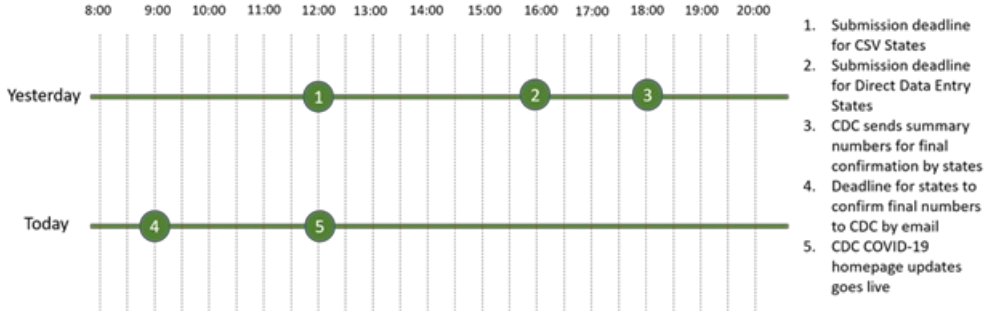
> 
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>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
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>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/12/2020
Date: Thursday, March 12, 2020 6:18:16 PM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
Attachment1_ReportingUpdates_2020March8.docx

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 12**.
- By **9 am ET Friday, March 13**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 12)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	7	2	9	0
Arkansas	AR	4	0	4	0
California	CA			175	3
Colorado	CO	33	1	34	0
Connecticut	CT	3	0	3	0
Delaware	DE	4	0	4	0
Florida	FL	24	7	31	2
Georgia	GA	0	31	31	1
Hawaii	HI	1	0	1	0
Idaho	ID	0	0	0	0
Illinois	IL	28	4	32	0
Indiana	IN	10	0	10	0
Iowa	IA	14	0	14	0
Kansas	KS	4	0	4	0
Kentucky	KY	5	0	5	0

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Louisiana	LA	14	0	14	0
Maine	ME	1	0	1	0
Maryland	MD	9	3	12	0
Massachusetts	MA	90	6	96	0
Michigan	MI	3	0	3	0
Minnesota	MN	5	1	6	0
Mississippi	MS	1	0	1	0
Missouri	MO	0	1	1	0
Montana	MT	1	0	1	0
Nebraska	NE	4	1	5	0
Nevada	NV	5	2	7	0
New Hampshire	NH	3	2	5	0
New Jersey	NJ	25	0	25	1
New Mexico	NM	5	0	5	0
New York (excluding New York City)	NY			230	0
North Carolina	NC	10	1	11	0
North Dakota	ND	1	0	1	0
Ohio	OH	5	0	5	0
Oklahoma	OK	2	1	3	0
Oregon	OR	17	2	19	0
Pennsylvania	PA	21	2	23	0
Rhode Island	RI	2	3	5	0
South Carolina	SC	8	2	10	0
South Dakota	SD	8	0	8	1
Tennessee	TN	9	0	9	0
Texas	TX	17	7	24	0
Utah	UT	4	0	4	0
Vermont	VT	2	0	2	0
Virginia	VA	15	0	15	0
Washington	WA			366	29
West Virginia	WV	0	0	0	0
Wisconsin	WI	7	1	8	0
Wyoming	WY	1	0	1	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	52	2	54	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Updated Sunday, March 8 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th and a CSTE email sent Friday, March 6th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) grouping of the PUI/Case Report variables into 3 tiers; and 7) major avoidable issues we hope to overcome with your assistance.

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

As of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report presumptive positive and confirmed positive cases to CDC**.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2'.** If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab (public health, commercial or hospital lab) or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.

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- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case (presumptive or confirmed) or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    b. Update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

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For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Grouping of the PUI/Case Report variables into 3 tiers

To support jurisdictions in providing timely case information, the variables included in the Persons Under Investigation (PUI) and Case Report Form have been grouped into 3 tiers. While all the information being collected is important to inform the response, Tier 1 variables are key in understanding the current burden within communities and are typically more readily available. CDC asks that Tier 1 variables be entered/submitted within 24 hours of being collected. The remaining variables should be submitted as soon as possible.

- Tier 1 Variables (to be reported directly into DCIPHER or via *csv* file upload)
  - CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
  - Reporting jurisdiction (state) (required field)
  - Current status of the person (current_status) (required field)
  - State of residence (res_state)
  - County of residence (res_county)
  - Sex (sex)
  - Age (age)
  - Age Units (ageunit)
  - Symptoms present during course of illness (sympstatus)
  - If symptomatic, onset date (onset_dt)
  - Hospitalization status (hosp_yn)
  - Death (death_yn)

- Tier 2 Variables
  - Report date of case to CDC (case_cdcreport_dt)
  - ICU Admission status (icu_yn)
  - If female, currently pregnant (pregnant_yn)
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)

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    - Travel to other non-US country, specify (exp_othcountry_spec)
    - Household contact with a COVID-19 case patient (exp_house)
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    - Any healthcare contact with a COVID-19 case patient (exp_health)
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    - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
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- Tier 3 Variables
    - The remaining variables collected on the PUI and Case Report Form

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CSTE Emergency Preparedness & Response
Coronavirus Disease (COVID-19)

Sent to State Epidemiologists and the CSTE Executive Board

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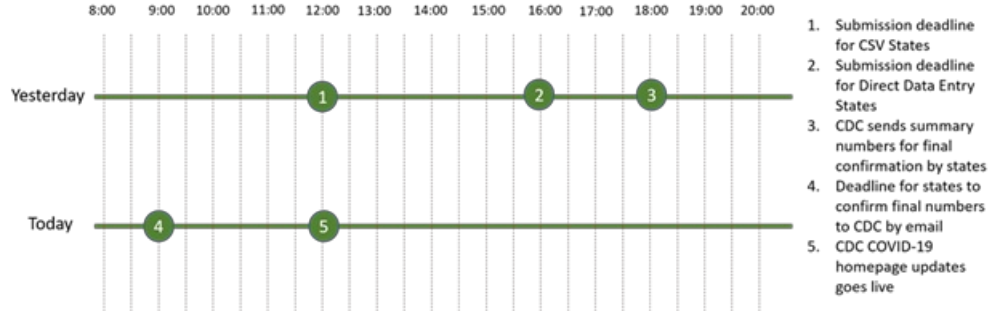

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To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/15/2020
Date: Sunday, March 15, 2020 7:18:45 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
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Updated guidance: See Attachment 1 that addresses commonly asked questions and the effects of new laboratory testing guidance on use of the National Case Report Form. Key changes are highlighted in yellow. These updates are reflected in the National Case Report Form Instruction Guide (attachment: 2019nCoV_PUICRF instructions_2020Mar15_final), which will be posted to the CDC website later this week.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**
Alabama	AL	11	0
Alaska	AK	1	0
Arizona	AZ	12	0
Arkansas	AR	14	0
California	CA	369	5
Colorado	CO	86	1
Connecticut	CT	20	0
Delaware	DE	8	0

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Florida	FL	108	4
Georgia	GA	66	1
Hawaii	HI	4	0
Idaho	ID	5	0
Illinois	IL	64	0
Indiana	IN	15	0
Iowa	IA	18	0
Kansas	KS	8	1
Kentucky	KY	17	0
Louisiana	LA	77	1
Maine	ME	15	0
Maryland	MD	26	0
Massachusetts	MA	144	0
Michigan	MI	36	0
Minnesota	MN	21	0
Mississippi	MS	6	0
Missouri	MO	5	0
Montana	MT	7	0
Nebraska	NE	17	0
Nevada	NV	16	0
New Hampshire	NH	7	0
New Jersey	NJ	90	2
New Mexico	NM	13	0
New York (excluding New York City)	NY	400	1
North Carolina	NC	23	0
North Dakota	ND	1	0
Ohio	OH	26	0
Oklahoma	OK	9	0
Oregon	OR	36	0
Pennsylvania	PA	48	0
Rhode Island	RI	20	0
South Carolina	SC	19	0
South Dakota	SD	9	1
Tennessee	TN	32	0
Texas	TX	51	0
Utah	UT	19	0
Vermont	VT	4	0
Virginia	VA	41	1
Washington	WA	642	40
West Virginia	WV	0	0
Wisconsin	WI	27	0
Wyoming	WY	3	0
American Samoa	AS	0	0
District of Columbia	DC	16	0
Guam	GU	0	0
New York City	NYC	269	1
Northern Marianas Islands	MP	0	0
Palau	PW	0	0

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Puerto Rico	PR	1	0
U.S. Virgin Islands	VI	1	0
Federated States of Micronesia	FSM	0	0
Republic of Marshall Islands	RMI	0	0

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of “presumptive positive”).

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual’s change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an “X” to mark boxes. Make sure to carefully mark boxes so that the “X” does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case’s first (given) name.
Patient last name: Enter case’s last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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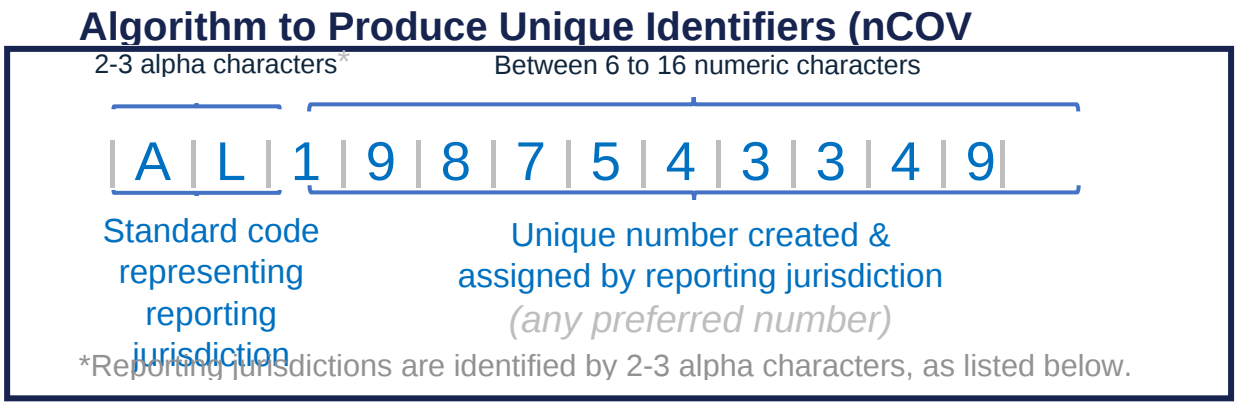
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Updates to the CRF instructions were made available in an email to all jurisdictions sent on March 16, 2020; these changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.

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4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the

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variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. <u>Major avoidable challenges we hope to overcome with your assistance</u>

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We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/16/2020
Date: Monday, March 16, 2020 6:49:58 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Monday, March 16**.
  - general community level transmission characterization (current options: Yes [community transmission is occurring], Undetermined, N/A)
- By **9 am ET Tuesday, March 17**, please use the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Monday, March 16)**
  - if needed, modify your "community level transmission characterization" by using the "additional information" field in the link below

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - General community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Resending updated guidance [initially sent on 3/15]: See Attachment 1 that addresses commonly asked questions and the effects of new laboratory testing guidance on use of the National Case Report Form. Key changes are highlighted in yellow. These updates are reflected in the National Case Report Form Instruction Guide (attachment: 2019nCoV_PUICRF instructions_2020Mar15_final), which will be posted to the CDC website later this week.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission
Alabama	AL	22	0	Undetermined
Alaska	AK	1	0	Undetermined
Arizona	AZ	18	0	Undetermined

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Arkansas	AR	22	0	Undetermined
California	CA	369	5	Yes
Colorado	CO	144	1	Undetermined
Connecticut	CT	26	0	Undetermined
Delaware	DE	8	0	Undetermined
Florida	FL	136	4	Undetermined
Georgia	GA	119	1	Undetermined
Hawaii	HI	7	0	Undetermined
Idaho	ID	5	0	Undetermined
Illinois	IL	103	0	Yes
Indiana	IN	19	0	Undetermined
Iowa	IA	22	0	Undetermined
Kansas	KS	11	1	Undetermined
Kentucky	KY	21	0	Undetermined
Louisiana	LA	101	2	Undetermined
Maine	ME	19	0	Undetermined
Maryland	MD	37	0	Undetermined
Massachusetts	MA	169	0	Undetermined
Michigan	MI	54	0	Undetermined
Minnesota	MN	54	0	Undetermined
Mississippi	MS	10	0	Undetermined
Missouri	MO	6	0	Undetermined
Montana	MT	7	0	Undetermined
Nebraska	NE	18	0	Undetermined
Nevada	NV	16	0	Undetermined
New Hampshire	NH	13	0	Undetermined
New Jersey	NJ	171	2	Undetermined
New Mexico	NM	22	0	Undetermined
New York (excluding New York City)	NY	487	2	Yes
North Carolina	NC	40	0	Undetermined
North Dakota	ND	1	0	Undetermined
Ohio	OH	37	0	Undetermined
Oklahoma	OK	11	0	Undetermined
Oregon	OR	39	1	Undetermined
Pennsylvania	PA	68	0	Undetermined
Rhode Island	RI	22	0	Undetermined
South Carolina	SC	28	0	Undetermined
South Dakota	SD	9	1	Undetermined
Tennessee	TN	39	0	Undetermined
Texas	TX	67	0	Undetermined
Utah	UT	21	0	Undetermined
Vermont	VT	9	0	Undetermined
Virginia	VA	51	1	Undetermined
Washington	WA	769	42	Yes
West Virginia	WV	0	0	N/A
Wisconsin	WI	27	0	Undetermined
Wyoming	WY	3	0	Undetermined
American Samoa	AS	0	0	N/A
District of Columbia	DC	17	0	Undetermined
Guam	GU	3	0	Undetermined
New York City	NYC	463	5	Yes
Northern Marianas Islands	MP	0	0	N/A

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Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	1	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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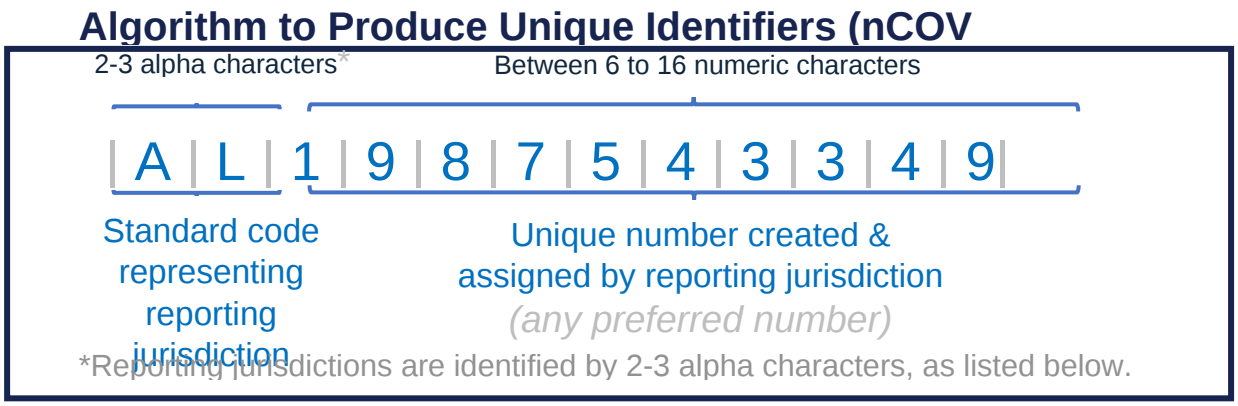
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code	State	Code	State	Code	Territory/Jurisdiction	Code
Alabama	AL	Louisiana	LA	Ohio	OH	American Samoa	AS
Alaska	AK	Maine	ME	Oklahoma	OK	District of Columbia	DC
Arizona	AZ	Maryland	MD	Oregon	OR	Guam	GU
Arkansas	AR	Massachusetts	MA	Pennsylvania	PA	New York City	NYC
California	CA	Michigan	MI	Rhode Island	RI	Northern Mariana Islands	MP
Colorado	CO	Minnesota	MN	South Carolina	SC	Puerto Rico	PR
Connecticut	CT	Mississippi	MS	South Dakota	SD	U.S. Virgin Islands	VI
Delaware	DE	Missouri	MO	Tennessee	TN	Federated States of Micronesia	FSM
Florida	FL	Montana	MT	Texas	TX	Republic of Marshall Islands	RMI
Georgia	GA	Nebraska	NE	Utah	UT	Republic of Palau	ROP
Hawaii	HI	Nevada	NV	Vermont	VT		
Idaho	ID	New Hampshire	NH	Virginia	VA		
Illinois	IL	New Jersey	NJ	Washington	WA		
Indiana	IN	New Mexico	NM	West Virginia	WV		
Iowa	IA	New York	NY	Wisconsin	WI		
Kansas	KS	North Carolina	NC	Wyoming	WY		
Kentucky	KY	North Dakota	ND				

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

--

CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/17/2020
Date: Tuesday, March 17, 2020 7:26:12 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Tuesday, March 17**.
  - general community level transmission characterization
- By **9 am ET Wednesday, March 18**, **please use the CDC Case Confirmation Portal** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Tuesday, March 17)**
  - if needed, modify your "community level transmission characterization"

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission
Alabama	AL	29	0	Undetermined
Alaska	AK	1	0	Undetermined
Arizona	AZ	18	0	Undetermined
Arkansas	AR	22	0	Undetermined
California	CA	447	7	Yes
Colorado	CO	160	1	Undetermined
Connecticut	CT	41	0	Undetermined
Delaware	DE	9	0	Undetermined
Florida	FL	145	5	Undetermined
Georgia	GA	143	1	Undetermined
Hawaii	HI	10	0	Undetermined

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Idaho	ID	5	0	Undetermined
Illinois	IL	105	0	Yes
Indiana	IN	24	1	Undetermined
Iowa	IA	23	0	Undetermined
Kansas	KS	16	1	Undetermined
Kentucky	KY	22	0	Undetermined
Louisiana	LA	137	3	Undetermined
Maine	ME	19	0	Undetermined
Maryland	MD	57	0	Undetermined
Massachusetts	MA	202	0	Undetermined
Michigan	MI	65	0	Undetermined
Minnesota	MN	60	0	Yes
Mississippi	MS	19	0	Undetermined
Missouri	MO	8	0	Undetermined
Montana	MT	7	0	Undetermined
Nebraska	NE	18	0	Undetermined
Nevada	NV	45	1	Undetermined
New Hampshire	NH	17	0	Undetermined
New Jersey	NJ	193	2	Undetermined
New Mexico	NM	22	0	Undetermined
New York (excluding New York City)	NY	730	1	Yes
North Carolina	NC	47	0	Undetermined
North Dakota	ND	1	0	Undetermined
Ohio	OH	63	0	Undetermined
Oklahoma	OK	19	0	Undetermined
Oregon	OR	47	1	Undetermined
Pennsylvania	PA	76	0	Undetermined
Rhode Island	RI	23	0	Undetermined
South Carolina	SC	33	1	Undetermined
South Dakota	SD	11	1	Undetermined
Tennessee	TN	52	0	Undetermined
Texas	TX	57	0	Undetermined
Utah	UT	29	0	Undetermined
Vermont	VT	10	0	Undetermined
Virginia	VA	67	2	Undetermined
Washington	WA	904	48	Yes
West Virginia	WV	0	0	N/A
Wisconsin	WI	53	0	Undetermined
Wyoming	WY	3	0	Undetermined
American Samoa	AS	0	0	N/A
District of Columbia	DC	22	0	Undetermined
Guam	GU	5	0	Undetermined
New York City	NYC	670	6	Yes
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	2	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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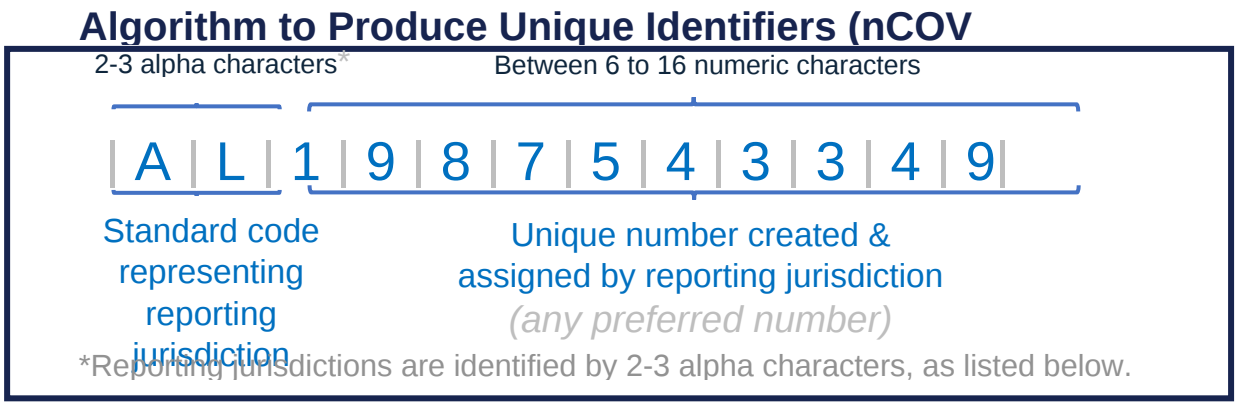
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. <u>Major avoidable challenges we hope to overcome with your assistance</u>
We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/18/2020
Date: Wednesday, March 18, 2020 8:39:15 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 18**.
  - general community level transmission characterization
- By **9 am ET Thursday, March 19**, **please use the CDC Case Confirmation Portal** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Wednesday, March 18)**
  - if needed, modify your "community level transmission characterization"

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission
Alabama	AL	29	0	Undetermined
Alaska	AK	1	0	Undetermined
Arizona	AZ	18	0	Undetermined
Arkansas	AR	22	0	Undetermined
California	CA	652	14	Yes
Colorado	CO	160	1	Undetermined
Connecticut	CT	41	0	Undetermined
Delaware	DE	9	0	Undetermined
Florida	FL	145	5	Undetermined
Georgia	GA	143	1	Undetermined
Hawaii	HI	10	0	Undetermined

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Idaho	ID	5	0	Undetermined
Illinois	IL	105	0	Yes
Indiana	IN	24	1	Undetermined
Iowa	IA	23	0	Undetermined
Kansas	KS	16	1	Undetermined
Kentucky	KY	22	0	Undetermined
Louisiana	LA	137	3	Undetermined
Maine	ME	19	0	Undetermined
Maryland	MD	57	0	Undetermined
Massachusetts	MA	202	0	Undetermined
Michigan	MI	65	0	Undetermined
Minnesota	MN	60	0	Yes
Mississippi	MS	19	0	Undetermined
Missouri	MO	8	0	Undetermined
Montana	MT	7	0	Undetermined
Nebraska	NE	18	0	Undetermined
Nevada	NV	45	1	Undetermined
New Hampshire	NH	17	0	Undetermined
New Jersey	NJ	193	2	Undetermined
New Mexico	NM	22	0	Undetermined
New York (excluding New York City)	NY	730	1	Yes
North Carolina	NC	47	0	Undetermined
North Dakota	ND	1	0	Undetermined
Ohio	OH	63	0	Undetermined
Oklahoma	OK	19	0	Undetermined
Oregon	OR	47	1	Undetermined
Pennsylvania	PA	76	0	Undetermined
Rhode Island	RI	23	0	Undetermined
South Carolina	SC	33	1	Undetermined
South Dakota	SD	11	1	Undetermined
Tennessee	TN	52	0	Undetermined
Texas	TX	57	0	Undetermined
Utah	UT	29	0	Undetermined
Vermont	VT	10	0	Undetermined
Virginia	VA	67	2	Undetermined
Washington	WA	904	48	Yes
West Virginia	WV	0	0	N/A
Wisconsin	WI	53	0	Undetermined
Wyoming	WY	3	0	Undetermined
American Samoa	AS	0	0	N/A
District of Columbia	DC	22	0	Undetermined
Guam	GU	5	0	Undetermined
New York City	NYC	670	6	Yes
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	2	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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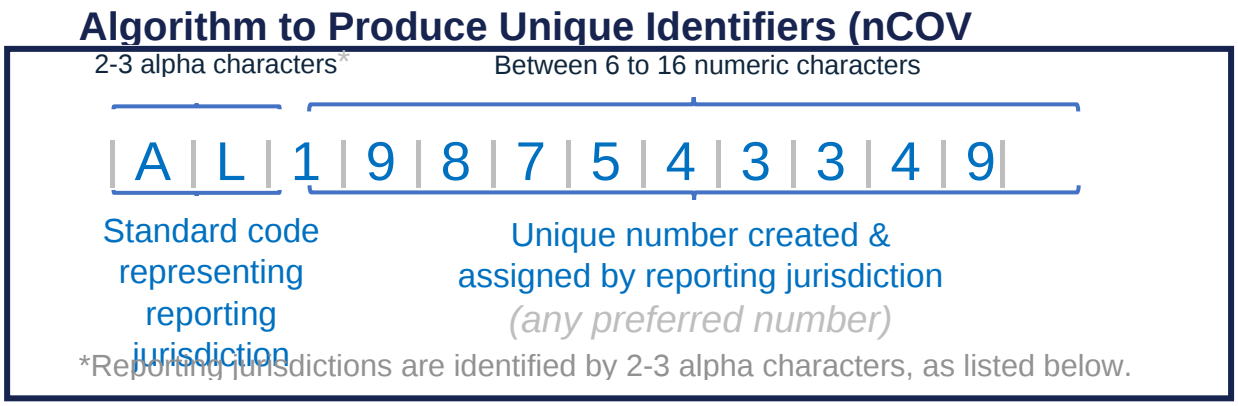
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. <u>Major avoidable challenges we hope to overcome with your assistance</u>
We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/19/2020
Date: Thursday, March 19, 2020 7:25:34 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
FW CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no longer required.msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 19**.
  - general community level transmission characterization
- By **9 am ET Friday, March 20**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 19)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	51	0	Undetermined
Alaska	AK	9	0	Undetermined
Arizona	AZ	27	0	Undetermined
Arkansas	AR	45	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	652	14	Yes, distinct clusters or widespread (please specify)

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Colorado	CO	216	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	96	1	Undetermined
Delaware	DE	26	0	Undetermined
Florida	FL	299	8	Undetermined
Georgia	GA	262	6	Yes, widespread community transmission across several geographical areas
Hawaii	HI	11	0	Undetermined
Idaho	ID	10	0	Undetermined
Illinois	IL	288	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	39	2	Undetermined
Iowa	IA	38	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	35	1	Undetermined
Kentucky	KY	35	1	Undetermined
Louisiana	LA	261	7	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	52	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	107	1	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	262	0	Yes, widespread community transmission across several geographical areas
Michigan	MI	91	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	89	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	50	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	24	1	Undetermined
Montana	MT	12	0	Undetermined
Nebraska	NE	27	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	63	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	39	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

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New Jersey	NJ	698	9	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	35	0	Undetermined
New York (excluding New York City)	NY	1683	1	Yes, distinct clusters or widespread (please specify)
North Carolina	NC	108	0	Undetermined
North Dakota	ND	7	0	Undetermined
Ohio	OH	98	0	Undetermined
Oklahoma	OK	33	0	Undetermined
Oregon	OR	75	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	186	1	Undetermined
Rhode Island	RI	33	0	Undetermined
South Carolina	SC	60	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	11	1	Undetermined
Tennessee	TN	98	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	83	2	Undetermined
Utah	UT	40	0	Undetermined
Vermont	VT	16	2	Undetermined
Virginia	VA	94	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	1376	74	Yes, distinct clusters or widespread (please specify)
West Virginia	WV	2	0	Undetermined
Wisconsin	WI	106	0	Undetermined
Wyoming	WY	16	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	39	0	Undetermined
Guam	GU	8	0	Undetermined
New York City	NYC	3555	21	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	2	0	Undetermined
U.S. Virgin Islands	VI	3	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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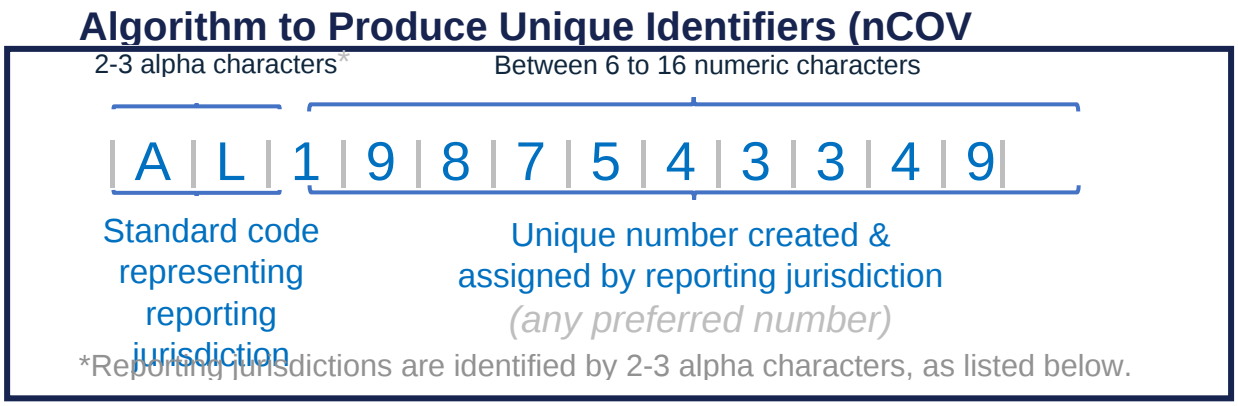
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	CDC COVID-19 Case Count Confirmation 03/23/2020
Date:	Monday, March 23, 2020 7:01:58 PM
Attachments:	CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg 2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx Attachment1_ReportingUpdates_2020March15_final.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Monday, March 23**.
  - general community level transmission characterization
- By **9 am ET Tuesday, March 24**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Monday, March 23)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	157	0	Undetermined
Alaska	AK	22	0	Undetermined
Arizona	AZ	152	2	Yes, widespread community transmission across several geographical areas
				Yes, distinct clusters of cases in a, or a few, defined geographical

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Arkansas	AR	195	0	area(s)
California	CA	1709	32	Yes, widespread community transmission across several geographical areas
Colorado	CO	591	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	327	8	Undetermined
Delaware	DE	56	0	Undetermined
Florida	FL	937	13	Undetermined
Georgia	GA	757	25	Yes, widespread community transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	47	0	Undetermined
Illinois	IL	1049	9	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	201	6	Undetermined
Iowa	IA	90	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	65	2	Undetermined
Kentucky	KY	103	3	Undetermined
Louisiana	LA	1035	29	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	110	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	288	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	5	Yes, widespread community transmission across several geographical areas
Michigan	MI	1035	8	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	236	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	249	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	106	3	Undetermined
Montana	MT	34	0	Undetermined
Nebraska	NE	50	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
				Yes, distinct clusters of cases in a,

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Nevada	NV	190	2	or a few, defined geographical area(s)
New Hampshire	NH	78	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	2751	25	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	75	0	Undetermined
New York (excluding New York City)	NY	8570	24	Yes, distinct clusters or widespread
North Carolina	NC	255	0	Undetermined
North Dakota	ND	30	0	Undetermined
Ohio	OH	351	3	Undetermined
Oklahoma	OK	67	2	Yes, widespread community transmission across several geographical areas
Oregon	OR	161	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	645	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Rhode Island	RI	97	0	Undetermined
South Carolina	SC	195	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	23	1	Undetermined
Tennessee	TN	505	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	5	Undetermined
Utah	UT	169	1	Undetermined
Vermont	VT	75	2	Undetermined
Virginia	VA	254	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	2221	110	Yes (defined area or widespread)
West Virginia	WV	16	0	Undetermined
Wisconsin	WI	381	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	116	2	Undetermined
Guam	GU	27	1	Undetermined
New York City	NYC	12110	99	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A

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Palau	PW	0	0	N/A
Puerto Rico	PR	23	1	Undetermined
U.S. Virgin Islands	VI	17	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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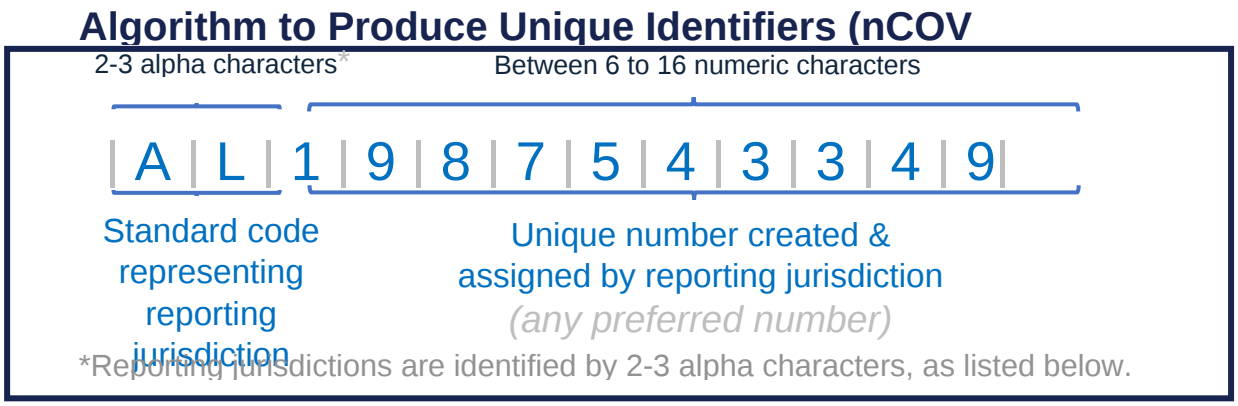
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

--

CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 03/24/2020
Date: Tuesday, March 24, 2020 6:59:51 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Tuesday, March 24**.
  - general community level transmission characterization
- By **9 am ET Wednesday, March 25**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Tuesday, March 24)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	196	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Alaska	AK	36	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
				Yes, widespread community transmission across several

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Arizona	AZ	253	2	geographical areas
Arkansas	AR	227	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	1931	35	Yes, widespread community transmission across several geographical areas
Colorado	CO	720	7	Yes, widespread community transmission across several geographical areas
Connecticut	CT	415	10	Yes, widespread community transmission across several geographical areas
Delaware	DE	87	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Florida	FL	1141	17	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Georgia	GA	1015	31	Yes, widespread community transmission across several geographical areas
Hawaii	HI	66	0	Undetermined
Idaho	ID	51	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Illinois	IL	1285	12	Yes, widespread community transmission across several geographical areas
Indiana	IN	259	7	Undetermined
Iowa	IA	105	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	82	2	Undetermined
Kentucky	KY	124	4	Undetermined
Louisiana	LA	1172	34	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	120	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	288	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	777	9	Yes, widespread community transmission across several geographical areas
Michigan	MI	1328	15	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
				Yes, distinct clusters of cases in a, or a few, defined geographical

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Minnesota	MN	262	1	area(s)
Mississippi	MS	320	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	183	3	Undetermined
Montana	MT	37	0	Undetermined
Nebraska	NE	52	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	245	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	101	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	3649	44	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	87	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York (excluding New York City)	NY	10761	31	Yes, distinct clusters or widespread
North Carolina	NC	398	0	Undetermined
North Dakota	ND	37	0	Undetermined
Ohio	OH	442	6	Undetermined
Oklahoma	OK	81	2	Yes, widespread community transmission across several geographical areas
Oregon	OR	191	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	852	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Rhode Island	RI	106	0	Undetermined
South Carolina	SC	298	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	28	1	Undetermined
Tennessee	TN	615	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	8	Undetermined
Utah	UT	280	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Vermont	VT	75	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Virginia	VA	290	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

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Washington	WA	2221	110	Yes (defined area or widespread)
West Virginia	WV	20	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wisconsin	WI	416	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wyoming	WY	26	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	137	2	Undetermined
Guam	GU	30	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York City	NYC	14511	131	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	31	2	Undetermined
U.S. Virgin Islands	VI	17	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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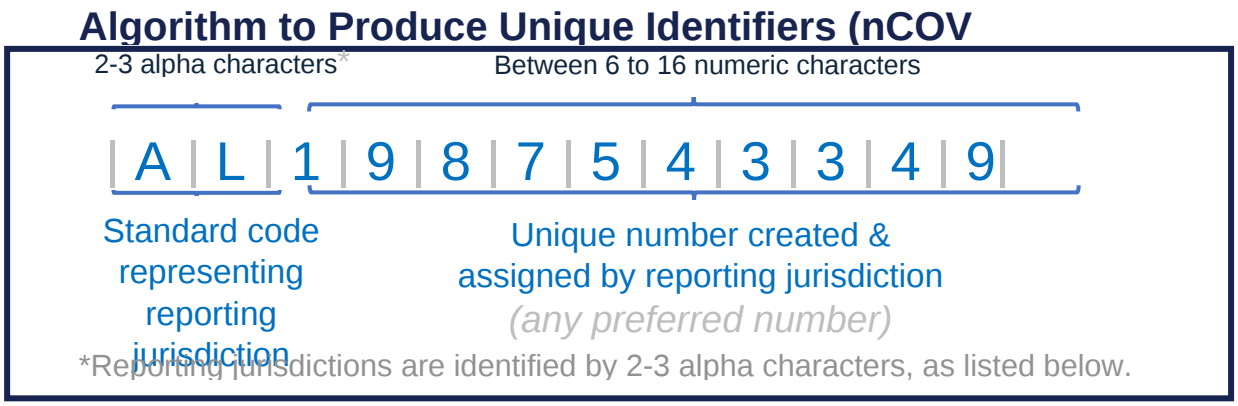
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	CDC COVID-19 Case Count Confirmation 03/25/2020
Date:	Wednesday, March 25, 2020 8:03:48 PM
Attachments:	2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx Attachment1_ReportingUpdates_2020March15_final.docx CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no... (77.6 KB).msg

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 25**.
  - general community level transmission characterization
- By **9 am ET Thursday, March 26**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Wednesday, March 25)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
				Yes, distinct clusters of cases in a,

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Alabama	AL	242	0	or a few, defined geographical area(s)
Alaska	AK	42	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Arizona	AZ	326	5	Yes, widespread community transmission across several geographical areas
Arkansas	AR	290	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	2511	44	Yes, widespread community transmission across several geographical areas
Colorado	CO	921	11	Yes, widespread community transmission across several geographical areas
Connecticut	CT	618	12	Yes, widespread community transmission across several geographical areas
Delaware	DE	104	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Florida	FL	1373	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Georgia	GA	1119	38	Yes, widespread community transmission across several geographical areas
Hawaii	HI	70	0	Undetermined
Idaho	ID	71	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Illinois	IL	1535	16	Yes, widespread community transmission across several geographical areas
Indiana	IN	365	12	Undetermined
Iowa	IA	124	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	98	2	Undetermined
Kentucky	KY	163	4	Undetermined
Louisiana	LA	1388	46	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	145	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	349	4	Yes, widespread community transmission across several geographical areas
				Yes, widespread community

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Massachusetts	MA	1224	12	transmission across several geographical areas
Michigan	MI	1791	24	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	287	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	377	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	255	5	Undetermined
Montana	MT	48	0	Undetermined
Nebraska	NE	53	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	278	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	108	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	4376	62	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	101	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York (excluding New York City)	NY	12955	39	Yes, distinct clusters or widespread
North Carolina	NC	504	0	Yes, widespread community transmission across several geographical areas
North Dakota	ND	38	0	Undetermined
Ohio	OH	564	8	Undetermined
Oklahoma	OK	106	3	Yes, widespread community transmission across several geographical areas
Oregon	OR	209	8	Yes, widespread community transmission across several geographical areas
Pennsylvania	PA	1128	10	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Rhode Island	RI	124	0	Yes, widespread community transmission across several geographical areas
South Carolina	SC	342	7	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	35	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

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Tennessee	TN	789	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	715	11	Undetermined
Utah	UT	298	1	Yes, widespread community transmission across several geographical areas
Vermont	VT	121	7	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Virginia	VA	391	9	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	2469	123	Yes (defined area or widespread)
West Virginia	WV	39	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wisconsin	WI	457	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Wyoming	WY	30	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	183	2	Undetermined
Guam	GU	30	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New York City	NYC	16585	199	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	39	2	Undetermined
U.S. Virgin Islands	VI	17	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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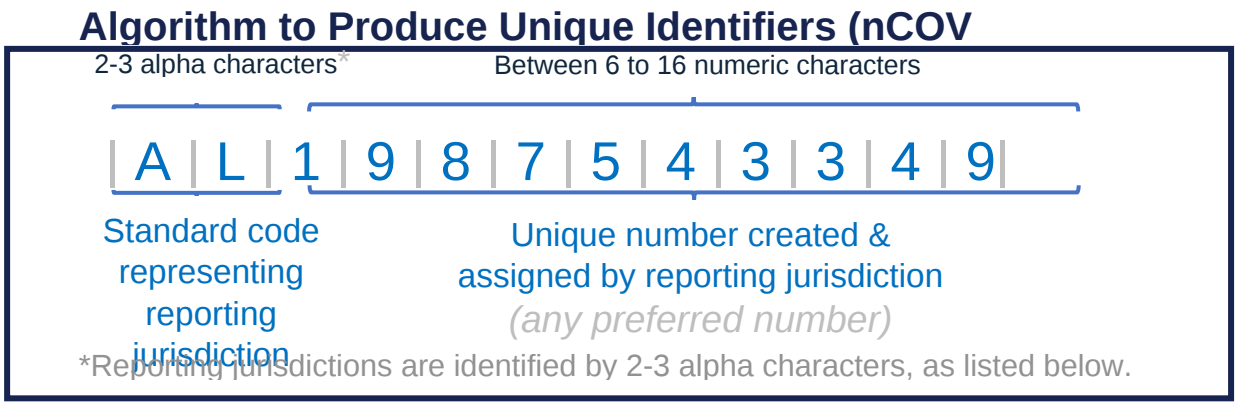
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
Currently assigned to CDC Coronavirus Response as Deputy Incident Manager
garmstrong@cdc.gov

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: CDC COVID-19 Case Count Confirmation 3/22/2020
Date: Sunday, March 22, 2020 6:20:27 PM
Attachments: Attachment1_ReportingUpdates_2020March15_final.docx
FW CSTE COVID-19 Response Confirmatory testing of COVID-19 samples is no longer required.msg
2019nCoV_PUICRF instructions_2020Mar15_final_clean.docx

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
  - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 22**.
  - general community level transmission characterization
- By **9 am ET Monday, March 23**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
  - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 22)**
  - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
  - Community level transmission characterization
  - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	131	0	Undetermined
Alaska	AK	14	0	Undetermined
Arizona	AZ	104	1	Undetermined
Arkansas	AR	168	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

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California	CA	1534	27	Yes, distinct clusters or widespread
Colorado	CO	475	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	223	5	Undetermined
Delaware	DE	45	0	Undetermined
Florida	FL	706	12	Undetermined
Georgia	GA	555	20	Yes, widespread community transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	42	0	Undetermined
Illinois	IL	753	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	126	4	Undetermined
Iowa	IA	68	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	55	2	Undetermined
Kentucky	KY	87	3	Undetermined
Louisiana	LA	763	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	94	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	190	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	4	Yes, widespread community transmission across several geographical areas
Michigan	MI	787	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	137	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	140	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	90	3	Undetermined
Montana	MT	27	0	Undetermined
Nebraska	NE	42	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	154	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	65	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	1831	19	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	75	0	Undetermined
New York (excluding New York City)	NY	6123	21	Yes, distinct clusters or widespread
North Carolina	NC	227	0	Undetermined
North Dakota	ND	28	1	Undetermined
Ohio	OH	247	3	Undetermined

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Oklahoma	OK	53	1	Undetermined
Oregon	OR	137	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	482	2	Undetermined
Rhode Island	RI	66	0	Undetermined
South Carolina	SC	173	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	21	1	Undetermined
Tennessee	TN	371	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	5	Undetermined
Utah	UT	125	0	Undetermined
Vermont	VT	49	2	Undetermined
Virginia	VA	152	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	1793	95	Undetermined
West Virginia	WV	12	0	Undetermined
Wisconsin	WI	281	4	Undetermined
Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	98	1	Undetermined
Guam	GU	14	0	Undetermined
New York City	NYC	6211	43	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	21	0	Undetermined
U.S. Virgin Islands	VI	6	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

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Version 13 Mar 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for persons under investigation who are being tested or have been tested for the virus that causes COVID-19.

- PUI: Any person who is currently under investigation for having the virus that causes COVID-19, or who was under investigation but tested negative for the virus.
- Laboratory-confirmed case of COVID-19: Individual who has tested positive for the virus that causes COVID-19 in at least one respiratory specimen (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

If a sample from a PUI tests positive for the virus that causes COVID-19, the form should be updated to indicate an individual's change in status from a PUI to being a laboratory-confirmed case.

The form should be completed if a person has a positive laboratory result for the virus that causes COVID-19, even when not previously identified as a PUI.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the case was already identified as a PUI in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have

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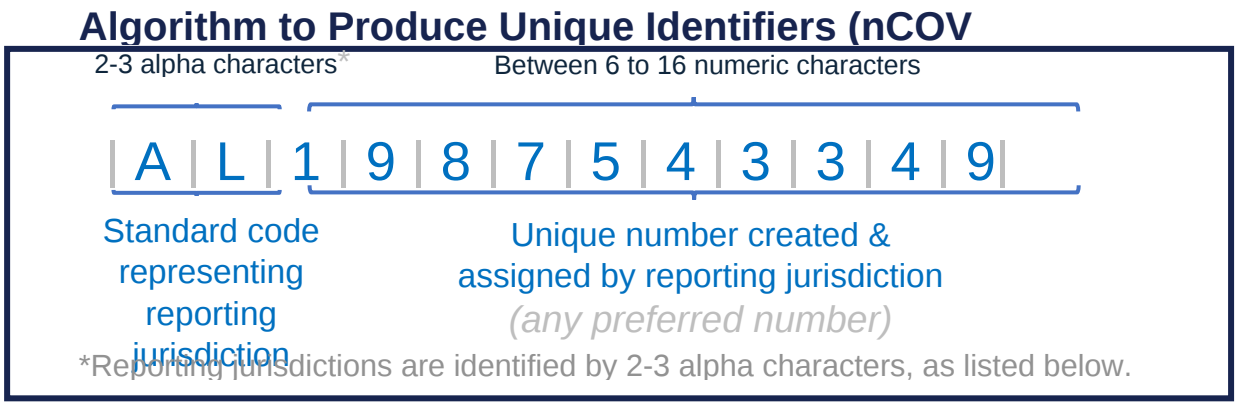
already been assigned and the CDC 2019-nCoV ID that was already provided by CDC should be entered. The CDC 2019 nCoV ID should be a part of the state or local health departments records; please check with the reporting jurisdiction. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI
Republic of Palau	ROP

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been

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assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person?

- Select "PUI, testing pending" if a PUI has been identified but the initial laboratory testing has not yet been completed.
- Select "PUI, tested negative" if a PUI was previously identified, but the laboratory testing for the virus that causes COVID-19 was negative.
- Select "laboratory-confirmed case" if a person has at least one respiratory specimen that tested positive for the virus that causes COVID-19 by a CDC laboratory, state or local public health laboratory, or commercial laboratory using FDA-validated COVID 19 NAA. (Note: effective 3/14/2020 there is no longer the designation of "presumptive positive").

Please update this field each time the individual's status changes.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being either a laboratory-confirmed case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

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Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

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Did the patient receive mechanical ventilation (MV)/intubation? Select “Yes” if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select “unknown” if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select “unknown” if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select “Unknown date of death.” (In DCIPHER, this is phrased as “Check if date of death unknown.”)

Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field. If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or had work-related exposures to large groups (e.g. airport screeners, port workers), please include details in the free text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select “N/A.”

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

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Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select “patient interview” or “medical record review.” If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select “Yes,” “No,” or “Unknown” for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after “Other”.

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark “No.” If not collected during interview and medical chart is missing, mark “Unknown.” After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If “Yes” to neurologic/neurodevelopment/intellectual disability or Other Chronic Diseases, please specify. The pregnancy question should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). If combined NP/OP swabs are collected, record results in the field for NP swabs. Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. For specimens tested at a local or state public health laboratory or at a commercial laboratory, select ”State Lab Tested.” For specimens tested at CDC, select “Sent to CDC.” For each test performed, indicate the result: positive, negative, pending, not done, or indeterminate.

Please update these test results as they become available.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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Updated Sunday, March 15 (major updates are highlighted in yellow)

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th, a CSTE email sent Friday, March 6th, and in a CSTE email sent during the weekend of March 14 regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) additional guidance on using the current PUI and Case Report Form, including classification of all positive laboratory tests as confirmed cases; 3) update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; 6) prioritization of the PUI/Case Report variables; and 7) major avoidable issues we hope to overcome with your assistance.

1. Jurisdictional 'Phase 2' Status

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for testing, **all jurisdictions should now be, or actively working towards being, onboarded to 'Phase 2',** which includes being able to assign unique identifiers to PUI/cases at the reporting jurisdiction level. If your jurisdiction has not yet confirmed its 'Phase 2' status, including how you will be inputting data into DCIPHER (preferred method: direct entry), please email eocevent118@cdc.gov.

Reminder: as of March 6th, CDC made the reporting of PUI to CDC through DCIPHER optional for jurisdictions in Phase 2. Jurisdictions **should continue to report positive cases to CDC** using the combined PUI/Case Report Form.

2. Updates to PUI and Case Report Form (CRF) on CDC's Website

Please continue to use the 5 status classifications below when completing a CRF. However, note the changes in how to apply the classifications.

1. PUI, testing pending
2. PUI, tested negative
3. Presumptive case (positive test by state or local health department lab*), confirmatory testing pending
4. Presumptive case (positive test by state or local health department lab*), confirmatory testing negative
5. Laboratory-confirmed case†

**These designations are no longer applicable on or after 3/14/2020*

†Now includes positive tests conducted by the CDC laboratory, commercial lab using FDA-validated COVID 19 NAA, or state or local health department lab.

These changes reflect FDA's acceptance of CDC's request for "enforcement discretion" to allow state and local public-health laboratories to consider positive samples to be interpreted as "positive" with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. **These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive.** CDC is still interested in receiving any specimens for which testing was "inconclusive" and which could not be resolved by repeat testing. For reporting purposes, these persons can be classified as "PUI, testing pending" until resulted by the CDC Laboratory. For epidemiologists, this will have little impact operationally, since the policy from the beginning was to act on "presumptive positives" as though they have already been confirmed. This means that the cases that previously were considered "presumptive" will all now be considered "confirmed". **For CDC analyses, presumptive and confirmed positive cases will be treated the same. Jurisdictions do not need to make changes to the historical data previously reported to CDC.**

Critical laboratory testing result fields are included at the end of the CRF to reflect COVID-19 laboratory test results. To minimize the need for making changes to the CRF at this time, **please use the same fields to report**

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specimens tested at the local level whether the testing laboratory was the state or jurisdiction public health laboratory or commercial laboratory. Further, **if the specimen was from a combined nasopharyngeal (NP) and oropharyngeal (OP) swab, record the results in the NP swab field**. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions. To support this matching process and to ensure the specimen is tested, please make sure to include an nCoV ID when submitting the specimen(s) to CDC.

If the PUI or case-patient had traveled on a cruise, had exposure to large social gatherings (e.g. conference, concert), or work-related exposures to large groups (e.g. airport screeners, port workers), please indicate in the free text field available with the "Other, specify:" option for the question: "In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply)."

Changes will also be reflected in the material made available on CDC's website.

3. Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, cases of COVID-19.

4. CDC Reporting Process for PUI/Case Reports and Lab Findings – Revised March 6th

CDC laboratory has received several specimens that were not assigned an nCoV ID. **Please note that all specimens need an nCoV ID for submission to CDC laboratory.** In the event that a sample is missing an nCoV ID, the specimen will be frozen, our staff will reach out to the point-of-contact listed on the submission form, and we will test the specimen once the nCoV ID has been submitted. Please provide an nCoV ID with all specimens to avoid delays in testing.

As of March 6, information for PUIs no longer needs to be entered into DCIPHER. However, jurisdictions may use NNDSS or DCIPHER to manage their PUIs.

For reporting jurisdictions that have the capacity to do their own testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter cases into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. If the person is already in DCIPHER, please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally, is **POSITIVE,** and is **the jurisdiction's first case or is part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
4. If a specimen is tested locally, is **POSITIVE,** and is **from a jurisdiction with existing presumptive or confirmed cases and is not part of a unique event (e.g., part of a large cluster of potential cases within a group at high risk**):
    a. Update the person's disposition in DCIPHER to "Confirmed Case"

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For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**, no further action is needed unless the person has already been reported to CDC as a PUI; if so:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:
For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.
2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

5. Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message has been made available via APHL starting at the bottom of Page 4 (https://www.aphl.org/Materials/02.12.2020_Informatics_FAQs_and_Guidance.pdf).

6. Prioritization of PUI/Case Report variables

To support improved data reporting, CDC has employed the Data Collation & Integration for Public Health Event Response (DCIPHER) platform that jurisdictions can use to directly enter or import and view their data. As of Friday, March 13, all 50 states and 3 jurisdictions (New York City, Washington DC, and U.S. Virgin Islands) are using DCIPHER for the COVID-19 response. Previously, to support jurisdictions in providing timely case information, CDC group the variables included in the National Case Report into 3 tiers to help jurisdictions prioritize what data are collected and reported. While all the information being collected is important, the variables that were included on CDC's list of Tier 1 and Tier 2 variables [**High Priority Variables**] are key to understanding the current burden of disease and its transmission within communities. Further, it is important that this information be entered/submitted within 24 hours of the case being identified to provide adequate situational awareness. The remaining variables (previously referred to as Tier 3 variables) should be submitted as soon as possible, some, of which, may require following up with cases over time.

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High Priority Variables
Timeline: entered/submitted within 24 hours of being collected.

- CDC 2019-nCoV ID (cdc_ncov2019_id) (required field)
- Reporting jurisdiction (state) (required field)
- Current status of the person (current_status) (required field)
- State of residence (res_state)
- County of residence (res_county)
- Sex (sex)
- Age (age)
- Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU admission status (icu_yn): may not be readily available during initial interview; update as soon as possible
- Death (death_yn): may not be readily available during initial interview; update as soon as possible
- If female, currently pregnant (pregnant_yn)
- Health care worker in the United States (hc_work_yn)
- Exposure data
  - Travel to mainland China (exp_China)
  - Travel to other non-US country (exp_othcountry)
  - Travel to other non-US country, specify (exp_othcountry_spec)
  - Household contact with a COVID-19 case patient (exp_house)
  - Community contact with a COVID-19 case patient (exp_community)
  - Any healthcare contact with a COVID-19 case patient (exp_health)
  - Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
  - Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen information
  - Specimen type (see series on specimen type)
  - Specimen ID (see series on specimen ID)
  - Specimen sent to CDC (see series on specimen sent to CDC)
- Report date of case to CDC (case_cdcreport_dt)

Other Variables of Importance
Timeline: submitted as soon as possible or available.

- Specific information on the hospitalization, including admission and discharge dates and ventilation status
- Information on signs and symptoms
- Information on pre-existing conditions
- The remaining variables collected on the PUI and Case Report Form

7. <u>Major avoidable challenges we hope to overcome with your assistance</u>
We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden, as well as descriptive statistics about the population impacted

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We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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Subject: FW: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Saturday, March 14, 2020 8:27 PM
To: CSTE Emergency Response
Cc: CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | Confirmatory testing of COVID-19 samples is no longer required



Sent to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good evening,

The message below regarding confirmatory testing of COVID-19 samples has been shared by Greg Armstrong, Deputy Incident Manager, CDC COVID-19 response.

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

Dear CSTE Colleagues,

Summary: State and local public health laboratories are no longer required to send “presumptive positive” samples to CDC for confirmation. From now on, respiratory samples positive for SARS-CoV2 in a state and public-health laboratory will be considered “positive” with no need for further testing.

More details: Last night, FDA accepted CDC’s request for “enforcement discretion” to allow state and local public-health laboratories to consider positive samples to be interpreted as “positive” with no need for confirmatory testing. This action was supported by data submitted by CDC showing agreement between results in state and local public health labs with corresponding results from CDC. CDC was asked to submit an amendment to its emergency-use authorization (EUA) for formal review.

For epidemiologists, this means that the cases that previously were considered “presumptive” will all now be considered “confirmed.”

Your laboratories should have received notification of this change already through APHL. These changes are retrospective such that samples already submitted to CDC for confirmation and had been awaiting confirmation may now be considered to be positive. CDC is still interested in receiving any specimens for which testing was “inconclusive” and which could not be resolved by repeat testing.

Sincerely,

Gregory Armstrong, MD
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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020
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Dear Colleagues,

Attached are the CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020. Feel free to share with your colleagues and other partners.

Thank you!

State Coordination Task Force

Sent by BCC to PHEP Directors, State Health Officials, State Epidemiologists, and Non-governmental partners

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

February 16, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 3 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING UPDATES

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

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OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19, centered in China, caused by a novel (new) coronavirus.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death. It can spread from person-to-person.
- This virus is spreading from person-to-person in China. A growing number of countries are reporting cases in travelers from China and some limited person-to-person spread has been reported in countries outside of China, including in the United States.
- Global case numbers are reported by the World Health Organization in their Coronavirus Disease 2019 (COVID-19) situation reports.
    - As of **February 16, more than 50,000** cases have been identified worldwide, including **15** in the United States. Fewer than 700 cases have occurred outside China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- The situation is rapidly changing, and CDC is monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.

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- The newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu.
- Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
- Selected pandemic preparedness materials are available online.

OUTBREAK STATISTICS

As of **February 14, 2020**:

- US cases: **15**
- US deaths: 0
- Total patients under investigation (PUI): **443**
  - Positive: **15**
  - Negative: **347**
  - Pending: **81**
- States with patients under investigation: **42**
- The US Embassy in China announced the death of the first American citizen from COVID-19 occurring in that country on February 7.

For global cases, please see the daily situation reports from the World Health Organization.

OUTBREAK BACKGROUND

- In early January 2020, Chinese health officials identified a novel (new) coronavirus (now named SARS-CoV-2) linked to an outbreak of respiratory illness in Wuhan, Hubei Province, China.
- Most cases have been detected in China, but some cases have been detected in more than two dozen other locations. Most infections outside of China have occurred in travelers coming from Wuhan City.
- Initially, many of the patients in the Wuhan outbreak reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread.
- Since then, Chinese officials report that sustained person-to-person spread in the community is occurring in China.
- Most cases in the US have been associated with travel to Wuhan, China; however, person-to-person spread also has been seen in close (household) contacts of confirmed COVID-19 cases.
- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

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TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- Based on our current knowledge, it is unclear whether a person may become infected with the new coronavirus by touching a surface or object contaminated with the virus and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to diagnose COVID-19 in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The kits are distributed through the International Reagent Resource (IRR).
- IRR began distribution of the test kits to states, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents which led to laboratories not being able to verify the test performance.

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- CDC is remanufacturing the kits using more robust quality control measures. New tests will be distributed once this issue has been addressed.
- CDC continues to perform initial and confirmatory testing.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
    - Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
    - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma and fear by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Help fight fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.

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- People who returned more than 14 days ago from areas where COVID-19 is active and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 without increasing fear.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel from China:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)

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        - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
            - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 14, about 38,000 people have been screened at US airports.

Travel to China:

- On January 27, CDC issued a level 3 Travel Health Notice for China recommending that all travelers avoid non-essential travel (this does not include the Special Administrative Regions of Hong Kong and Macau, or the island of Taiwan).
- On January 30, the US State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by COVID-19.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan were in the process of being repatriated. (See section: Diamond Princess)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- The quarantine period is for 14 days.

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- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.

Diamond Princess:

- CDC is supporting the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the Diamond Princess cruise ship.
- There are approximately 400 US citizens onboard the Diamond Princess cruise ship.
- Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- Americans returned by flights chartered by the State Department will be subject to a 14-day federal quarantine and be housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- Those passengers returning from Japan will be housed separately from people already in quarantine from previous Wuhan repatriation flights.
- These planes will be met by a team of US Government personnel deployed at these bases to assess the health of the passengers.
- The passengers were screened before leaving the ship and will be monitored and evaluated by medical and public health personnel during the trip and after arrival.
- Anyone who becomes ill on the flight will be sent directly to a local hospital for medical evaluation.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.

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- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- On January 27, CDC issued updated travel guidance for China, recommending that travelers avoid all nonessential travel to all of the country (Level 3 Travel Health Notice).
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
    - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - See more at: "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus".
- CDC issued an interim Health Alert Network (HAN) Update to inform state and local health departments and healthcare professionals about this outbreak on February 1.
- On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
- On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory and serum samples from clinical specimens. On January 24, CDC publicly posted the assay protocol for this test.
- CDC's International Reagent Resource began distributing test kits domestically on February 6. However, CDC identified a problem in the manufacturing of one of the three controls used in the verification process of the test.
    - To address this issue, CDC is remanufacturing the test kits, out of an abundance of caution, to ensure that laboratories have effective and reliable kits. This process is being expedited. The new kits will be made available to both domestic and international laboratories as soon as possible.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP).
    - Using classroom and hands-on experience, the China FETP program has graduated 279 epidemiologists who conducted more than 2,000 outbreak investigations as part of their training.
    - Specialized training tracks are now being established in non-communicable diseases and tuberculosis.
    - With technical guidance from CDC, 71 graduates completed training for the new Western FETP that supports 13 under-served provinces of China — remote areas more vulnerable to novel infections and with increasing transport corridors.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)

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    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility
          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

Recent Travelers to China:

- If you were in China and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Wash your hands often with soap and water for at least 20 seconds to avoid spreading the virus to others. Use an alcohol-based hand sanitizer if soap and water are not available.

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People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 3, CDC published interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in China during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.

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- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19 in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

Note: Fever may be subjective or confirmed. The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

Recommendations for Reporting, Testing, and Specimen Collection:

- Healthcare professionals should **immediately** notify both infection control personnel at their healthcare facility AND their local or state health department in the event of a PUI for COVID-19.
- State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a COVID-19 PUI case investigation form available on CDC's Interim Guidance for Healthcare Professionals.

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- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected from COVID-19 PUIs.
- **For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for COVID-19.**
- To increase the likelihood of detecting the virus, CDC recommends collecting and testing multiple clinical specimens from different sites, including both lower and upper respiratory. Additional specimen types (e.g., stool, urine) may be collected and stored initially until decision is made by CDC whether additional specimen sources should be tested. Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset. Maintain proper infection control when collecting specimens. Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website. Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of SARS-CoV-2 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of SARS-CoV-2 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolating them in an AIIR, if available.

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    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick

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during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.

- If facemasks are not available, sick HCPs should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.

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- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on the CDC website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks of COVID-19.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness, such as:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.

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- An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak

February 16, 2020

All content updated since February 13 is shown in colored text.

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2." The World Health Organization has named the disease associated with this virus coronavirus disease 2019 or "COVID-19."
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- This virus that causes COVID-19 is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
- Most COVID-19 cases outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- The vast majority of Americans have a low risk of exposure at this time.
- The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners as well as public health partners to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.
- CDC has been working with the Department of State, supporting the safe return of Americans overseas impacted by the ongoing outbreaks of COVID-19, including most recently passengers from the Diamond Princess cruise ship. (See Section: "Diamond Princess")

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- The US public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
- Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 28 international locations (in addition to the US) have reported confirmed cases of COVID-19.
- As of February 14, 2020, 15 cases of COVID-19 have been reported in the US in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
    - To date, there have been 443 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 347 persons ruled out as negative. These data are updated regularly at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - As part of efforts to detect cases of COVID-19 in the United States, CDC's laboratory had tested more than 2,000 samples as of February 12.
- The three most recent cases of COVID-19 in the United States were identified in people who had recently returned from Wuhan, China on US State Department chartered flights.
- They had been under federal quarantine for 14 days because of their recent exposure to widespread COVID-19 activity in Wuhan.
- No additional cases of COVID-19 have been detected among quarantined persons at this time.
- On February 12, 195 people who were on the first (of five) chartered flight from Wuhan were released from quarantine.
- More than 600 people remain under quarantine.
- It is likely that additional cases of COVID-19 will be detected in the United States.
- Two instances of person-to-person spread with this virus in the United States have been detected, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- CDC established a COVID-19 Incident Management System on January 7, 2020. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.

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  - As of February 7, more than 800 CDC staff members had been deployed to the response.
- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) tests that can diagnose COVID-19 in respiratory samples from clinical specimens.
- On February 1, CDC issued a Health Alert Network (HAN) update with some updates to previously posted guidance and, for the first time, guidance on clinical care of COVID-19 patients.
- On February 3, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide US public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC isolated the virus and sent to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
- CDC is working with state and local health departments on investigations to trace contacts of the US COVID-19 patients to detect person-to-person spread.
- As of February 14, CDC and Customs and Border (CBP) personnel had screened about 38,000 people with recent travel history to China at US airports.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
  - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
  - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
  - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
  - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
  - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.

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- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for infection with SARS-CoV-2 continues to be performed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan were in the process of being repatriated. (See section: Diamond Princess)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- The quarantine period is for 14 days.
- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.

DIAMOND PRINCESS

- CDC is supporting the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the Diamond Princess cruise ship.
- There are approximately 400 US citizens onboard the Diamond Princess cruise ship.
- Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- Americans returned by flights chartered by the State Department will be subject to a 14-day federal quarantine and be housed at two existing federal quarantine sites for repatriated travelers:
  - Travis Air Force Base in California
  - Joint Base San Antonio-Lackland in Texas

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- Those passengers returning from Japan will be housed separately from people already in quarantined from previous US Government repatriation flights from Wuhan.
- These planes will be met by a team of US Government personnel deployed at these bases to assess the health of the passengers.
- The passengers were screened before leaving the ship and will be monitored and evaluated by medical and public health personnel during the trip and after arrival.
- Anyone who becomes ill on the flight will be sent directly to a local hospital for medical evaluation.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date:	Monday, February 24, 2020 4:37:27 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_24_2020 FINAL.pdf CDC_COVID-19 Weekly Key Messages_2-24-20 FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points **AND** weekly key messages for Monday, February 24, 2020.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

February 24, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 16 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

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OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19, centered in China, caused by a novel (new) coronavirus.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death. It can spread from person-to-person.
- This virus is spreading from person-to-person in China. A growing number of countries are reporting cases in travelers from China and person-to-person spread has been reported in countries outside of China, including in the United States.
- Chinese officials report that sustained person-to-person spread in the community is occurring in China. In addition, other destinations have apparent community spread, meaning some people have been infected who are not sure how or where they became infected.
- Global case numbers are reported by the World Health Organization in their Coronavirus Disease 2019 (COVID-19) situation reports.
    - As of **February 23, more than 78,800** cases have been identified worldwide. Fewer than 1,800 cases have occurred outside China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- The situation is rapidly changing, and CDC is monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.

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- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.
- The newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu.

U.S. OUTBREAK STATISTICS

Confirmed cases in the United States as of **February 21, 2020**:

- Travel-related: **12**
- Person-to-person spread: **2**
- Total confirmed cases: **14**
- Total tested: **426**
- Deaths: 0

Persons repatriated to the United States and tested positive by CDC, as of **February 21, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **36**

For global cases, please see the daily situation reports from the World Health Organization.

OUTBREAK BACKGROUND

- In early January 2020, Chinese health officials identified a novel (new) coronavirus (now named SARS-CoV-2) linked to an outbreak of respiratory illness in Wuhan, Hubei Province, China.
- Most cases have been detected in China, but some cases have been detected in more than thirty other locations. Most infections outside of China have occurred in travelers coming from Wuhan City.
- Initially, many of the patients in the Wuhan outbreak reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread.
- Since then, Chinese officials report that sustained person-to-person spread in the community is occurring in China.
- Most cases in the US have been associated with travel to Wuhan, China; however, person-to-person spread also has been seen in close (household) contacts of confirmed COVID-19 cases.
- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.

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- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- Based on our current knowledge, it is unclear whether a person may become infected with the new coronavirus by touching a surface or object contaminated with the virus and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.

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- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states. CDC is looking into this situation further.
- To address this issue, CDC is remanufacturing the complete test kits to ensure that laboratories have effective and reliable kits.
- The new kits are being manufactured as quickly as possible and will be made available to domestic and international laboratories immediately thereafter.
- At this time:
    - CDC continues to perform initial and confirmatory testing.
    - Laboratories that have verified the assay are able to test.
        - All positive results from testing conducted in non-CDC laboratories must be confirmed at CDC.
    - Laboratories that have encountered problems verifying the assay should not continue testing.
    - CDC understands that 2-3 states are currently using the CDC diagnostic test for patient care. Many are not testing due to the current reagent issues.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.

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- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma and fear by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Help fight fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from areas where COVID-19 is active and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 without increasing fear.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

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TRAVEL

Travel from China:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey

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    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 23, about 45,000 people have been screened at US airports.

Travel Notices and Advisories:

- On January 27, CDC issued a level 3 Travel Health Notice for China recommending that all travelers avoid non-essential travel (this does not include the Special Administrative Regions of Hong Kong and Macau, or the island of Taiwan).
- On January 30, the US State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by COVID-19.
- On February 19, CDC issued a travel notice for Hong Kong, recommending that travelers practice usual precautions (Level 1).
- On February 22, CDC issued travel notices for Japan and South Korea, recommending that travelers practice enhanced precautions (Level 2). Older adults and those with chronic medical conditions should consider postponing nonessential travel to these countries.
- On February 23, CDC issued travel notices for Iran and Italy, recommending that travelers practice usual precautions (Level 1).
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan are in the process of being repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with state and local public health departments and/or HHS's Incident Management Team (IMT) to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.

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- Almost all people from the Wuhan flights who were quarantined have fulfilled their 14-day quarantine period and have been released.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- Passengers who elected not to return on the repatriation flights remain in Japan under a 14-day travel restriction.
    - CDC, in partnership with the US Embassy in Tokyo, is monitoring their health during the 14-day travel restriction in order to ensure they are healthy prior to their return to the United States.
- More than 60 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-2, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.

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- On January 27, CDC issued updated travel guidance for China, recommending that travelers avoid all nonessential travel to all of the country (Level 3 Travel Health Notice).
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
    - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - See more at: "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus".
- CDC issued an interim Health Alert Network (HAN) Update to inform state and local health departments and healthcare professionals about this outbreak on February 1.
- On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
- On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
    - CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory and serum samples from clinical specimens. On January 24, CDC publicly posted the assay protocol for this test.
- CDC's International Reagent Resource began distributing test kits domestically on February 6. However, CDC identified a problem in the manufacturing of one of the three controls used in the verification process of the test.
    - To address this issue, CDC is remanufacturing the complete test kits, to ensure that laboratories have effective and reliable kits. This process is being expedited. The new kits will be made available to both domestic and international laboratories as soon as possible.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP).
    - Using classroom and hands-on experience, the China FETP program has graduated 279 epidemiologists who conducted more than 2,000 outbreak investigations as part of their training.
    - Specialized training tracks are now being established in non-communicable diseases and tuberculosis.
    - With technical guidance from CDC, 71 graduates completed training for the new Western FETP that supports 13 under-served provinces of China — remote areas more vulnerable to novel infections and with increasing transport corridors.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)

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    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility
          - *or* –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

Recent Travelers to China:

- If you were in China and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Wash your hands often with soap and water for at least 20 seconds to avoid spreading the virus to others. Use an alcohol-based hand sanitizer if soap and water are not available.

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People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 3, CDC published interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in China during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.

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- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19 in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

Note: Fever may be subjective or confirmed. The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

Recommendations for Reporting, Testing, and Specimen Collection:

- Healthcare professionals should **immediately** notify both infection control personnel at their healthcare facility AND their local or state health department in the event of a PUI for COVID-19.
- State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a COVID-19 PUI case investigation form available on CDC's Interim Guidance for Healthcare Professionals.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected from COVID-19 PUIs.

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- **For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for COVID-19.**
- For initial diagnostic testing for COVID-19, CDC recommends collecting and testing upper respiratory (nasopharyngeal AND oropharyngeal swabs), and lower respiratory (sputum, if possible) for those patients with productive coughs.
    - Induction of sputum is not recommended.
- Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of SARS-CoV-2 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of SARS-CoV-2 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolating them in an AIIR, if available.

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    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick

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during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.

- If facemasks are not available, sick HCPs should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.

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- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on the CDC website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks of COVID-19.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness, such as:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.

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- An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 24, 2020

All content updated since February 21 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with apparent community spread of COVID-19 include Hong Kong, Iran, Italy, Japan, Singapore, South Korea, Taiwan, and Thailand.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection. For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, risk assessment would be different.
- Global efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

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- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions would be the most important response strategy.
- CDC launched a new weekly email newsletter with updates on the agency's COVID-19 outbreak response. Sign up for the newsletter.

SITUATION UPDATE

- To date, 35 international locations (including the U.S.) have reported confirmed cases of COVID-19.
- More than 77,000 cases have been confirmed on mainland China, with more than 2,500 deaths.
- On February 22, 2020, CDC issued a Level 2 Travel Notice (Practice Enhanced Precautions) for Japan and South Korea.
- On February 23, 2020 CDC issued Level 1 Travel Alert Notices (Practice Usual Precautions) for Iran and Italy.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- This is consistent with guidance by the U.S. State Department.
- For the latest travel guidance, visit COVID-19 Information for Travel.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan).
- Fourteen cases of COVID-19 have been detected in California, Illinois, Massachusetts, Washington, and Wisconsin through U.S. public health surveillance.
- Two of these cases occurred through person-to-person spread. The remaining cases all were in persons who had travel to China.
- 39 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the Diamond Princess. (That includes 3 people repatriated from Wuhan and 36 people who were repatriated from the Diamond Princes.)
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.

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- If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
- If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
- If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
- For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
  - Five chartered flights returned passengers from Wuhan City, China.
  - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- Almost all of the people from the Wuhan flights who were quarantined fulfilled their 14-day quarantine period and been released.
  - On February 12, 195 people from the first chartered flight were discharged from quarantine.
  - On February 18, 347 people who were under federal quarantine were released.
  - On February 20, 263 people who were under federal quarantine were released.
- People released from quarantine pose no health risk to their communities.

DIAMOND PRINCESS

- On February 16, 329 American citizens returned by flights chartered by the State Department.
- Persons who are not sick are being kept in quarantine.
- Persons who are sick with COVID-19 are in isolation and receiving medical care as needed.

AMERICAN OVERSIGHT

- All American passengers have disembarked from the *Diamond Princess* cruise ship. These people have been placed under travel restrictions, as have the ship's other passengers and crew.
- Some American crew members of the Diamond Princess remain aboard the ship.
- More than 60 Americans who were on board the Diamond Princess remain in Japan, hospitalized with COVID-2, including some who are reportedly severely ill.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WESTERDAM

- No testing of passengers from the Westerdam Cruise Ship for SARS-CoV-2, the virus that causes COVID-19, has been done at CDC.
- CDC is aware that an American passenger on the Westerdam tested positive for infection with SARS-CoV-2 in Malaysia and that two subsequent and sequential tests on samples from that same person were negative.
- CDC is aware that follow-up testing among more than 1,500 passengers from the Westerdam has all been negative.
- CDC considers passengers from the Westerdam to be at "low risk" of SARS-CoV-2 infection during the 14 days after their last exposure per the agency's Risk Assessment guidance.
- Given this level of risk, testing of Westerdam passengers for SARS-CoV-2 is not recommended unless additional exposures are identified to warrant testing.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness.**
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.

AMERICAN OVERSIGHT

    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
- **Supporting communities, businesses, and schools:**
    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
    - **Developing guidance for childcare programs, K-12 schools, and colleges/universities** to help them plan and prepare for COVID-19 and respond if there is a local outbreak in their community.
    - Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
    - Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

For more information, please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date:	Monday, February 24, 2020 4:39:57 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_24_2020 FINAL.pdf CDC_COVID-19 Weekly Key Messages_2-24-20 FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points **AND** weekly key messages for Monday, February 24, 2020.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

February 24, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 16 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

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OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19, centered in China, caused by a novel (new) coronavirus.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death. It can spread from person-to-person.
- This virus is spreading from person-to-person in China. A growing number of countries are reporting cases in travelers from China and person-to-person spread has been reported in countries outside of China, including in the United States.
- Chinese officials report that sustained person-to-person spread in the community is occurring in China. In addition, other destinations have apparent community spread, meaning some people have been infected who are not sure how or where they became infected.
- Global case numbers are reported by the World Health Organization in their Coronavirus Disease 2019 (COVID-19) situation reports.
    - As of **February 23, more than 78,800** cases have been identified worldwide. Fewer than 1,800 cases have occurred outside China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- The situation is rapidly changing, and CDC is monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.

AMERICAN OVERSIGHT

- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.
- The newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu.

U.S. OUTBREAK STATISTICS

Confirmed cases in the United States as of **February 21, 2020**:

- Travel-related: **12**
- Person-to-person spread: **2**
- Total confirmed cases: **14**
- Total tested: **426**
- Deaths: 0

Persons repatriated to the United States and tested positive by CDC, as of **February 21, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **36**

For global cases, please see the daily situation reports from the World Health Organization.

OUTBREAK BACKGROUND

- In early January 2020, Chinese health officials identified a novel (new) coronavirus (now named SARS-CoV-2) linked to an outbreak of respiratory illness in Wuhan, Hubei Province, China.
- Most cases have been detected in China, but some cases have been detected in more than thirty other locations. Most infections outside of China have occurred in travelers coming from Wuhan City.
- Initially, many of the patients in the Wuhan outbreak reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread.
- Since then, Chinese officials report that sustained person-to-person spread in the community is occurring in China.
- Most cases in the US have been associated with travel to Wuhan, China; however, person-to-person spread also has been seen in close (household) contacts of confirmed COVID-19 cases.
- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.

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- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- Based on our current knowledge, it is unclear whether a person may become infected with the new coronavirus by touching a surface or object contaminated with the virus and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.

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- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states. CDC is looking into this situation further.
- To address this issue, CDC is remanufacturing the complete test kits to ensure that laboratories have effective and reliable kits.
- The new kits are being manufactured as quickly as possible and will be made available to domestic and international laboratories immediately thereafter.
- At this time:
    - CDC continues to perform initial and confirmatory testing.
    - Laboratories that have verified the assay are able to test.
        - All positive results from testing conducted in non-CDC laboratories must be confirmed at CDC.
    - Laboratories that have encountered problems verifying the assay should not continue testing.
    - CDC understands that 2-3 states are currently using the CDC diagnostic test for patient care. Many are not testing due to the current reagent issues.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.

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- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma and fear by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Help fight fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from areas where COVID-19 is active and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 without increasing fear.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

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TRAVEL

Travel from China:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey

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    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 23, about 45,000 people have been screened at US airports.

Travel Notices and Advisories:

- On January 27, CDC issued a level 3 Travel Health Notice for China recommending that all travelers avoid non-essential travel (this does not include the Special Administrative Regions of Hong Kong and Macau, or the island of Taiwan).
- On January 30, the US State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by COVID-19.
- On February 19, CDC issued a travel notice for Hong Kong, recommending that travelers practice usual precautions (Level 1).
- On February 22, CDC issued travel notices for Japan and South Korea, recommending that travelers practice enhanced precautions (Level 2). Older adults and those with chronic medical conditions should consider postponing nonessential travel to these countries.
- On February 23, CDC issued travel notices for Iran and Italy, recommending that travelers practice usual precautions (Level 1).
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan are in the process of being repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with state and local public health departments and/or HHS's Incident Management Team (IMT) to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.

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- Almost all people from the Wuhan flights who were quarantined have fulfilled their 14-day quarantine period and have been released.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- Passengers who elected not to return on the repatriation flights remain in Japan under a 14-day travel restriction.
    - CDC, in partnership with the US Embassy in Tokyo, is monitoring their health during the 14-day travel restriction in order to ensure they are healthy prior to their return to the United States.
- More than 60 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-2, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.

AMERICAN OVERSIGHT

- On January 27, CDC issued updated travel guidance for China, recommending that travelers avoid all nonessential travel to all of the country (Level 3 Travel Health Notice).
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
    - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - See more at: "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus".
- CDC issued an interim Health Alert Network (HAN) Update to inform state and local health departments and healthcare professionals about this outbreak on February 1.
- On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
- On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
    - CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory and serum samples from clinical specimens. On January 24, CDC publicly posted the assay protocol for this test.
- CDC's International Reagent Resource began distributing test kits domestically on February 6. However, CDC identified a problem in the manufacturing of one of the three controls used in the verification process of the test.
    - To address this issue, CDC is remanufacturing the complete test kits, to ensure that laboratories have effective and reliable kits. This process is being expedited. The new kits will be made available to both domestic and international laboratories as soon as possible.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP).
    - Using classroom and hands-on experience, the China FETP program has graduated 279 epidemiologists who conducted more than 2,000 outbreak investigations as part of their training.
    - Specialized training tracks are now being established in non-communicable diseases and tuberculosis.
    - With technical guidance from CDC, 71 graduates completed training for the new Western FETP that supports 13 under-served provinces of China — remote areas more vulnerable to novel infections and with increasing transport corridors.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)

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    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility
          - *or* –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

Recent Travelers to China:

- If you were in China and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Wash your hands often with soap and water for at least 20 seconds to avoid spreading the virus to others. Use an alcohol-based hand sanitizer if soap and water are not available.

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People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 3, CDC published interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in China during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.

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- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19 in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

Note: Fever may be subjective or confirmed. The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

Recommendations for Reporting, Testing, and Specimen Collection:

- Healthcare professionals should **immediately** notify both infection control personnel at their healthcare facility AND their local or state health department in the event of a PUI for COVID-19.
- State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a COVID-19 PUI case investigation form available on CDC's Interim Guidance for Healthcare Professionals.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected from COVID-19 PUIs.

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- **For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for COVID-19.**
- For initial diagnostic testing for COVID-19, CDC recommends collecting and testing upper respiratory (nasopharyngeal AND oropharyngeal swabs), and lower respiratory (sputum, if possible) for those patients with productive coughs.
    - Induction of sputum is not recommended.
- Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of SARS-CoV-2 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of SARS-CoV-2 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolating them in an AIIR, if available.

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    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick

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during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.

- If facemasks are not available, sick HCPs should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.

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- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on the CDC website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks of COVID-19.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness, such as:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.

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- An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 24, 2020

All content updated since February 21 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with apparent community spread of COVID-19 include Hong Kong, Iran, Italy, Japan, Singapore, South Korea, Taiwan, and Thailand.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection. For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, risk assessment would be different.
- Global efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

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- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions would be the most important response strategy.
- CDC launched a new weekly email newsletter with updates on the agency's COVID-19 outbreak response. Sign up for the newsletter.

SITUATION UPDATE

- To date, 35 international locations (including the U.S.) have reported confirmed cases of COVID-19.
- More than 77,000 cases have been confirmed on mainland China, with more than 2,500 deaths.
- On February 22, 2020, CDC issued a Level 2 Travel Notice (Practice Enhanced Precautions) for Japan and South Korea.
- On February 23, 2020 CDC issued Level 1 Travel Alert Notices (Practice Usual Precautions) for Iran and Italy.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- This is consistent with guidance by the U.S. State Department.
- For the latest travel guidance, visit COVID-19 Information for Travel.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan).
- Fourteen cases of COVID-19 have been detected in California, Illinois, Massachusetts, Washington, and Wisconsin through U.S. public health surveillance.
- Two of these cases occurred through person-to-person spread. The remaining cases all were in persons who had travel to China.
- 39 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the Diamond Princess. (That includes 3 people repatriated from Wuhan and 36 people who were repatriated from the Diamond Princes.)
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.

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- If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
- If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
- If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
- For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
  - Five chartered flights returned passengers from Wuhan City, China.
  - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- Almost all of the people from the Wuhan flights who were quarantined fulfilled their 14-day quarantine period and been released.
  - On February 12, 195 people from the first chartered flight were discharged from quarantine.
  - On February 18, 347 people who were under federal quarantine were released.
  - On February 20, 263 people who were under federal quarantine were released.
- People released from quarantine pose no health risk to their communities.

DIAMOND PRINCESS

- On February 16, 329 American citizens returned by flights chartered by the State Department.
- Persons who are not sick are being kept in quarantine.
- Persons who are sick with COVID-19 are in isolation and receiving medical care as needed.

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- All American passengers have disembarked from the *Diamond Princess* cruise ship. These people have been placed under travel restrictions, as have the ship's other passengers and crew.
- Some American crew members of the Diamond Princess remain aboard the ship.
- More than 60 Americans who were on board the Diamond Princess remain in Japan, hospitalized with COVID-2, including some who are reportedly severely ill.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WESTERDAM

- No testing of passengers from the Westerdam Cruise Ship for SARS-CoV-2, the virus that causes COVID-19, has been done at CDC.
- CDC is aware that an American passenger on the Westerdam tested positive for infection with SARS-CoV-2 in Malaysia and that two subsequent and sequential tests on samples from that same person were negative.
- CDC is aware that follow-up testing among more than 1,500 passengers from the Westerdam has all been negative.
- CDC considers passengers from the Westerdam to be at "low risk" of SARS-CoV-2 infection during the 14 days after their last exposure per the agency's Risk Assessment guidance.
- Given this level of risk, testing of Westerdam passengers for SARS-CoV-2 is not recommended unless additional exposures are identified to warrant testing.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness.**
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.

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    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
- **Supporting communities, businesses, and schools:**
    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
    - **Developing guidance for childcare programs, K-12 schools, and colleges/universities** to help them plan and prepare for COVID-19 and respond if there is a local outbreak in their community.
    - Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
    - Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

For more information, please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 24, 2020
Date:	Monday, February 24, 2020 4:42:41 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_24_2020 FINAL.pdf CDC_COVID-19 Weekly Key Messages_2-24-20 FINAL.pdf

Dear Colleagues:

Attached please find the CDC COVID-19 daily key points **AND** weekly key messages for Monday, February 24, 2020.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

February 24, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 16 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

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OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19, centered in China, caused by a novel (new) coronavirus.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death. It can spread from person-to-person.
- This virus is spreading from person-to-person in China. A growing number of countries are reporting cases in travelers from China and person-to-person spread has been reported in countries outside of China, including in the United States.
- Chinese officials report that sustained person-to-person spread in the community is occurring in China. In addition, other destinations have apparent community spread, meaning some people have been infected who are not sure how or where they became infected.
- Global case numbers are reported by the World Health Organization in their Coronavirus Disease 2019 (COVID-19) situation reports.
    - As of **February 23, more than 78,800** cases have been identified worldwide. Fewer than 1,800 cases have occurred outside China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- The situation is rapidly changing, and CDC is monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.

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- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.
- The newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu.

U.S. OUTBREAK STATISTICS

Confirmed cases in the United States as of **February 21, 2020**:

- Travel-related: **12**
- Person-to-person spread: **2**
- Total confirmed cases: **14**
- Total tested: **426**
- Deaths: 0

Persons repatriated to the United States and tested positive by CDC, as of **February 21, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **36**

For global cases, please see the daily situation reports from the World Health Organization.

OUTBREAK BACKGROUND

- In early January 2020, Chinese health officials identified a novel (new) coronavirus (now named SARS-CoV-2) linked to an outbreak of respiratory illness in Wuhan, Hubei Province, China.
- Most cases have been detected in China, but some cases have been detected in more than thirty other locations. Most infections outside of China have occurred in travelers coming from Wuhan City.
- Initially, many of the patients in the Wuhan outbreak reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread.
- Since then, Chinese officials report that sustained person-to-person spread in the community is occurring in China.
- Most cases in the US have been associated with travel to Wuhan, China; however, person-to-person spread also has been seen in close (household) contacts of confirmed COVID-19 cases.
- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.

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- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- Based on our current knowledge, it is unclear whether a person may become infected with the new coronavirus by touching a surface or object contaminated with the virus and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.

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- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states. CDC is looking into this situation further.
- To address this issue, CDC is remanufacturing the complete test kits to ensure that laboratories have effective and reliable kits.
- The new kits are being manufactured as quickly as possible and will be made available to domestic and international laboratories immediately thereafter.
- At this time:
    - CDC continues to perform initial and confirmatory testing.
    - Laboratories that have verified the assay are able to test.
        - All positive results from testing conducted in non-CDC laboratories must be confirmed at CDC.
    - Laboratories that have encountered problems verifying the assay should not continue testing.
    - CDC understands that 2-3 states are currently using the CDC diagnostic test for patient care. Many are not testing due to the current reagent issues.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.

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- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma and fear by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Help fight fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from areas where COVID-19 is active and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 without increasing fear.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

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TRAVEL

Travel from China:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey

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    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 23, about 45,000 people have been screened at US airports.

Travel Notices and Advisories:

- On January 27, CDC issued a level 3 Travel Health Notice for China recommending that all travelers avoid non-essential travel (this does not include the Special Administrative Regions of Hong Kong and Macau, or the island of Taiwan).
- On January 30, the US State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by COVID-19.
- On February 19, CDC issued a travel notice for Hong Kong, recommending that travelers practice usual precautions (Level 1).
- On February 22, CDC issued travel notices for Japan and South Korea, recommending that travelers practice enhanced precautions (Level 2). Older adults and those with chronic medical conditions should consider postponing nonessential travel to these countries.
- On February 23, CDC issued travel notices for Iran and Italy, recommending that travelers practice usual precautions (Level 1).
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan are in the process of being repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with state and local public health departments and/or HHS's Incident Management Team (IMT) to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.

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- Almost all people from the Wuhan flights who were quarantined have fulfilled their 14-day quarantine period and have been released.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- Passengers who elected not to return on the repatriation flights remain in Japan under a 14-day travel restriction.
    - CDC, in partnership with the US Embassy in Tokyo, is monitoring their health during the 14-day travel restriction in order to ensure they are healthy prior to their return to the United States.
- More than 60 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-2, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.

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- On January 27, CDC issued updated travel guidance for China, recommending that travelers avoid all nonessential travel to all of the country (Level 3 Travel Health Notice).
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
    - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - See more at: "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus".
- CDC issued an interim Health Alert Network (HAN) Update to inform state and local health departments and healthcare professionals about this outbreak on February 1.
- On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
- On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
    - CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory and serum samples from clinical specimens. On January 24, CDC publicly posted the assay protocol for this test.
- CDC's International Reagent Resource began distributing test kits domestically on February 6. However, CDC identified a problem in the manufacturing of one of the three controls used in the verification process of the test.
    - To address this issue, CDC is remanufacturing the complete test kits, to ensure that laboratories have effective and reliable kits. This process is being expedited. The new kits will be made available to both domestic and international laboratories as soon as possible.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP).
    - Using classroom and hands-on experience, the China FETP program has graduated 279 epidemiologists who conducted more than 2,000 outbreak investigations as part of their training.
    - Specialized training tracks are now being established in non-communicable diseases and tuberculosis.
    - With technical guidance from CDC, 71 graduates completed training for the new Western FETP that supports 13 under-served provinces of China — remote areas more vulnerable to novel infections and with increasing transport corridors.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)

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    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility
          - *or* –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

Recent Travelers to China:

- If you were in China and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Wash your hands often with soap and water for at least 20 seconds to avoid spreading the virus to others. Use an alcohol-based hand sanitizer if soap and water are not available.

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People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 3, CDC published interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in China during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.

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- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19 in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

Note: Fever may be subjective or confirmed. The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

Recommendations for Reporting, Testing, and Specimen Collection:

- Healthcare professionals should **immediately** notify both infection control personnel at their healthcare facility AND their local or state health department in the event of a PUI for COVID-19.
- State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a COVID-19 PUI case investigation form available on CDC's Interim Guidance for Healthcare Professionals.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected from COVID-19 PUIs.

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- **For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for COVID-19.**
- For initial diagnostic testing for COVID-19, CDC recommends collecting and testing upper respiratory (nasopharyngeal AND oropharyngeal swabs), and lower respiratory (sputum, if possible) for those patients with productive coughs.
    - Induction of sputum is not recommended.
- Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of SARS-CoV-2 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of SARS-CoV-2 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolating them in an AIIR, if available.

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    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick

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during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.

- If facemasks are not available, sick HCPs should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.

AMERICAN OVERSIGHT

- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on the CDC website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks of COVID-19.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness, such as:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.

AMERICAN OVERSIGHT

- An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 24, 2020

All content updated since February 21 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness caused by a novel (new) coronavirus.
- This virus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- While most COVID-19 cases outside of China have been associated with travel to or from China, community spread is being detected in a growing number of countries.
- Destinations with apparent community spread of COVID-19 include Hong Kong, Iran, Italy, Japan, Singapore, South Korea, Taiwan, and Thailand.
- The fact that COVID-19 has caused illness, including illness resulting in death, and sustained person-to-person spread is concerning. These factors meet two of the criteria of a pandemic.
- As community spread is detected in more and more countries, the world moves closer toward meeting the third criteria, worldwide spread of the new virus.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- But individual risk is dependent on exposure.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is low.
- Under current circumstances, certain people will have an increased risk of infection. For example, healthcare workers caring for patients with COVID-19 and other close contacts of persons with COVID-19. CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- However, it's important to note that current global circumstances suggest it is likely that this virus will cause a pandemic. In that case, risk assessment would be different.
- Global efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

AMERICAN OVERSIGHT

- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions would be the most important response strategy.
- CDC launched a new weekly email newsletter with updates on the agency's COVID-19 outbreak response. Sign up for the newsletter.

SITUATION UPDATE

- To date, 35 international locations (including the U.S.) have reported confirmed cases of COVID-19.
- More than 77,000 cases have been confirmed on mainland China, with more than 2,500 deaths.
- On February 22, 2020, CDC issued a Level 2 Travel Notice (Practice Enhanced Precautions) for Japan and South Korea.
- On February 23, 2020 CDC issued Level 1 Travel Alert Notices (Practice Usual Precautions) for Iran and Italy.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- This is consistent with guidance by the U.S. State Department.
- For the latest travel guidance, visit COVID-19 Information for Travel.
- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.
- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan).
- Fourteen cases of COVID-19 have been detected in California, Illinois, Massachusetts, Washington, and Wisconsin through U.S. public health surveillance.
- Two of these cases occurred through person-to-person spread. The remaining cases all were in persons who had travel to China.
- 39 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the Diamond Princess. (That includes 3 people repatriated from Wuhan and 36 people who were repatriated from the Diamond Princes.)
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- Because the passengers on the Diamond Princess were in a close setting where there was significant spread of COVID-19, they are considered at high-risk for infection. CDC expects to see additional confirmed cases of among those passengers.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.

AMERICAN OVERSIGHT

- If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
- If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
- If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
- For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
  - Five chartered flights returned passengers from Wuhan City, China.
  - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- Almost all of the people from the Wuhan flights who were quarantined fulfilled their 14-day quarantine period and been released.
  - On February 12, 195 people from the first chartered flight were discharged from quarantine.
  - On February 18, 347 people who were under federal quarantine were released.
  - On February 20, 263 people who were under federal quarantine were released.
- People released from quarantine pose no health risk to their communities.

DIAMOND PRINCESS

- On February 16, 329 American citizens returned by flights chartered by the State Department.
- Persons who are not sick are being kept in quarantine.
- Persons who are sick with COVID-19 are in isolation and receiving medical care as needed.

AMERICAN OVERSIGHT

- All American passengers have disembarked from the *Diamond Princess* cruise ship. These people have been placed under travel restrictions, as have the ship's other passengers and crew.
- Some American crew members of the Diamond Princess remain aboard the ship.
- More than 60 Americans who were on board the Diamond Princess remain in Japan, hospitalized with COVID-2, including some who are reportedly severely ill.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WESTERDAM

- No testing of passengers from the Westerdam Cruise Ship for SARS-CoV-2, the virus that causes COVID-19, has been done at CDC.
- CDC is aware that an American passenger on the Westerdam tested positive for infection with SARS-CoV-2 in Malaysia and that two subsequent and sequential tests on samples from that same person were negative.
- CDC is aware that follow-up testing among more than 1,500 passengers from the Westerdam has all been negative.
- CDC considers passengers from the Westerdam to be at "low risk" of SARS-CoV-2 infection during the 14 days after their last exposure per the agency's Risk Assessment guidance.
- Given this level of risk, testing of Westerdam passengers for SARS-CoV-2 is not recommended unless additional exposures are identified to warrant testing.

CDC ACTIONS

- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- **Preparing first responders, healthcare providers, and health systems:**
    - Establishing **visibility across healthcare systems** to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting **extensive outreach to clinical and hospital professional organizations** to ensure health system **preparedness.**
    - Producing more than **23 guidance documents** on infection control, hospital preparedness assessments, personal protective equipment (PPE) supply planning, and clinical evaluation and management (as of February 22, 2020).
        - Working closely with healthcare facilities and providers to **reinforce infection control principles** that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
        - **Developing a range of respirator conservation strategies**, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing **telehealth tools** to direct people to the right level of healthcare for their medical needs.

AMERICAN OVERSIGHT

    - **Working with supply chain partners** to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that healthcare workers at highest risk have access to PPE.
    - **Sharing information with stakeholders** to help them recognize when to shift the strategies they are using.
- **Reinforcing state, territorial, and local public health readiness:**
    - **Assessing state and local readiness** to implement community mitigation measures like home containment, including housing and transportation needs.
    - Coordinating with states to **identify and mitigate gaps in readiness** that will help reduce the spread of disease in the community while protecting workers, infrastructure, and institutions.
    - Linking public health agencies and healthcare systems to **identify and mitigate stressors to the health system**
    - **Tracking stockpiles of PPE** across jurisdictions.
    - Working with state and local public health to **use existing Public Health Emergency Preparedness (PHEP) funding** to support COVID-19 preparedness and response activities.
    - Leveraging funding mechanisms to help states **accelerate preparedness activities.**
    - Providing **technical assistance and guidance** to states to improve their ability to respond to the outbreak.
- **Supporting communities, businesses, and schools:**
    - **Creating business guidance** to help the public and private sectors ensure they are able to operate with adaptations like telework and flexible sick leave policies, as well as how to respond if an employee gets sick.
    - **Developing guidance for childcare programs, K-12 schools, and colleges/universities** to help them plan and prepare for COVID-19 and respond if there is a local outbreak in their community.
    - Providing **planning guides for COVID-19** that households, community- and faith-based organizations, event planners of mass gatherings, and public health communicators can use.
    - Educating communities about **nonpharmaceutical interventions (NPIs)** that help slow the spread of illness, like COVID-19.

For more information, please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020
Date:	Monday, February 17, 2020 9:12:02 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_2-16-20 final.pdf CDC_COVID-19_Daily Key Points__2_16_2020_final.pdf

Dear Colleagues,

Attached are the CDC COVID-19 Daily Key Points and Weekly Key Messages for February 16, 2020. Feel free to share with your colleagues and other partners.

Thank you!

State Coordination Task Force

Sent by BCC to PHEP Directors, State Health Officials, State Epidemiologists, and Non-governmental partners

AMERICAN OVERSIGHT

CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

February 16, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 3 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING UPDATES

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

AMERICAN OVERSIGHT

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19, centered in China, caused by a novel (new) coronavirus.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death. It can spread from person-to-person.
- This virus is spreading from person-to-person in China. A growing number of countries are reporting cases in travelers from China and some limited person-to-person spread has been reported in countries outside of China, including in the United States.
- Global case numbers are reported by the World Health Organization in their Coronavirus Disease 2019 (COVID-19) situation reports.
    - As of **February 16, more than 50,000** cases have been identified worldwide, including **15** in the United States. Fewer than 700 cases have occurred outside China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- The situation is rapidly changing, and CDC is monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.

AMERICAN OVERSIGHT

- The newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu.
- Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
- Selected pandemic preparedness materials are available online.

OUTBREAK STATISTICS

As of **February 14, 2020**:

- US cases: **15**
- US deaths: 0
- Total patients under investigation (PUI): **443**
    - Positive: **15**
    - Negative: **347**
    - Pending: **81**
- States with patients under investigation: **42**
- The US Embassy in China announced the death of the first American citizen from COVID-19 occurring in that country on February 7.

For global cases, please see the daily situation reports from the World Health Organization.

OUTBREAK BACKGROUND

- In early January 2020, Chinese health officials identified a novel (new) coronavirus (now named SARS-CoV-2) linked to an outbreak of respiratory illness in Wuhan, Hubei Province, China.
- Most cases have been detected in China, but some cases have been detected in more than two dozen other locations. Most infections outside of China have occurred in travelers coming from Wuhan City.
- Initially, many of the patients in the Wuhan outbreak reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread.
- Since then, Chinese officials report that sustained person-to-person spread in the community is occurring in China.
- Most cases in the US have been associated with travel to Wuhan, China; however, person-to-person spread also has been seen in close (household) contacts of confirmed COVID-19 cases.
- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

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TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- Based on our current knowledge, it is unclear whether a person may become infected with the new coronavirus by touching a surface or object contaminated with the virus and then touching their own mouth, nose, or possibly their eyes.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to diagnose COVID-19 in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The kits are distributed through the International Reagent Resource (IRR).
- IRR began distribution of the test kits to states, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents which led to laboratories not being able to verify the test performance.

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- CDC is remanufacturing the kits using more robust quality control measures. New tests will be distributed once this issue has been addressed.
- CDC continues to perform initial and confirmatory testing.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
    - Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
    - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma and fear by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Help fight fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.

AMERICAN OVERSIGHT

- People who returned more than 14 days ago from areas where COVID-19 is active and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 without increasing fear.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel from China:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)

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        - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
            - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 14, about 38,000 people have been screened at US airports.

Travel to China:

- On January 27, CDC issued a level 3 Travel Health Notice for China recommending that all travelers avoid non-essential travel (this does not include the Special Administrative Regions of Hong Kong and Macau, or the island of Taiwan).
- On January 30, the US State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by COVID-19.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan were in the process of being repatriated. (See section: Diamond Princess)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- The quarantine period is for 14 days.

AMERICAN OVERSIGHT

- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.

Diamond Princess:

- CDC is supporting the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the Diamond Princess cruise ship.
- There are approximately 400 US citizens onboard the Diamond Princess cruise ship.
- Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- Americans returned by flights chartered by the State Department will be subject to a 14-day federal quarantine and be housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- Those passengers returning from Japan will be housed separately from people already in quarantine from previous Wuhan repatriation flights.
- These planes will be met by a team of US Government personnel deployed at these bases to assess the health of the passengers.
- The passengers were screened before leaving the ship and will be monitored and evaluated by medical and public health personnel during the trip and after arrival.
- Anyone who becomes ill on the flight will be sent directly to a local hospital for medical evaluation.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.

AMERICAN OVERSIGHT

- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- On January 27, CDC issued updated travel guidance for China, recommending that travelers avoid all nonessential travel to all of the country (Level 3 Travel Health Notice).
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
    - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - See more at: "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus".
- CDC issued an interim Health Alert Network (HAN) Update to inform state and local health departments and healthcare professionals about this outbreak on February 1.
- On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
- On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory and serum samples from clinical specimens. On January 24, CDC publicly posted the assay protocol for this test.
- CDC's International Reagent Resource began distributing test kits domestically on February 6. However, CDC identified a problem in the manufacturing of one of the three controls used in the verification process of the test.
    - To address this issue, CDC is remanufacturing the test kits, out of an abundance of caution, to ensure that laboratories have effective and reliable kits. This process is being expedited. The new kits will be made available to both domestic and international laboratories as soon as possible.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP).
    - Using classroom and hands-on experience, the China FETP program has graduated 279 epidemiologists who conducted more than 2,000 outbreak investigations as part of their training.
    - Specialized training tracks are now being established in non-communicable diseases and tuberculosis.
    - With technical guidance from CDC, 71 graduates completed training for the new Western FETP that supports 13 under-served provinces of China — remote areas more vulnerable to novel infections and with increasing transport corridors.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)

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    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility
          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

Recent Travelers to China:

- If you were in China and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Wash your hands often with soap and water for at least 20 seconds to avoid spreading the virus to others. Use an alcohol-based hand sanitizer if soap and water are not available.

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People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 3, CDC published interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in China during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.

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- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19 in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

Note: Fever may be subjective or confirmed. The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure).The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

Recommendations for Reporting, Testing, and Specimen Collection:

- Healthcare professionals should **immediately** notify both infection control personnel at their healthcare facility AND their local or state health department in the event of a PUI for COVID-19.
- State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a COVID-19 PUI case investigation form available on CDC's Interim Guidance for Healthcare Professionals.

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- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected from COVID-19 PUIs.
- **For biosafety reasons, it is not recommended to perform virus isolation in cell culture or initial characterization of viral agents recovered in cultures of specimens from a PUI for COVID-19.**
- To increase the likelihood of detecting the virus, CDC recommends collecting and testing multiple clinical specimens from different sites, including both lower and upper respiratory. Additional specimen types (e.g., stool, urine) may be collected and stored initially until decision is made by CDC whether additional specimen sources should be tested. Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset. Maintain proper infection control when collecting specimens. Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website. Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of SARS-CoV-2 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of SARS-CoV-2 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolating them in an AIIR, if available.

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    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick

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during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.

- If facemasks are not available, sick HCPs should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.

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- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on the CDC website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks of COVID-19.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness, such as:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.

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- An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak

February 16, 2020

All content updated since February 13 is shown in colored text.

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2." The World Health Organization has named the disease associated with this virus coronavirus disease 2019 or "COVID-19."
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- This virus that causes COVID-19 is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
- Most COVID-19 cases outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- The vast majority of Americans have a low risk of exposure at this time.
- The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners as well as public health partners to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.
- CDC has been working with the Department of State, supporting the safe return of Americans overseas impacted by the ongoing outbreaks of COVID-19, including most recently passengers from the Diamond Princess cruise ship. (See Section: "Diamond Princess")

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- The US public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
- Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 28 international locations (in addition to the US) have reported confirmed cases of COVID-19.
- As of February 14, 2020, 15 cases of COVID-19 have been reported in the US in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
    - To date, there have been 443 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 347 persons ruled out as negative. These data are updated regularly at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - As part of efforts to detect cases of COVID-19 in the United States, CDC's laboratory had tested more than 2,000 samples as of February 12.
- The three most recent cases of COVID-19 in the United States were identified in people who had recently returned from Wuhan, China on US State Department chartered flights.
- They had been under federal quarantine for 14 days because of their recent exposure to widespread COVID-19 activity in Wuhan.
- No additional cases of COVID-19 have been detected among quarantined persons at this time.
- On February 12, 195 people who were on the first (of five) chartered flight from Wuhan were released from quarantine.
- More than 600 people remain under quarantine.
- It is likely that additional cases of COVID-19 will be detected in the United States.
- Two instances of person-to-person spread with this virus in the United States have been detected, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- CDC established a COVID-19 Incident Management System on January 7, 2020. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.

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    - As of February 7, more than 800 CDC staff members had been deployed to the response.
- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) tests that can diagnose COVID-19 in respiratory samples from clinical specimens.
- On February 1, CDC issued a Health Alert Network (HAN) update with some updates to previously posted guidance and, for the first time, guidance on clinical care of COVID-19 patients.
- On February 3, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide US public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC isolated the virus and sent to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
- CDC is working with state and local health departments on investigations to trace contacts of the US COVID-19 patients to detect person-to-person spread.
- As of February 14, CDC and Customs and Border (CBP) personnel had screened about 38,000 people with recent travel history to China at US airports.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.

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- For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for infection with SARS-CoV-2 continues to be performed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan were in the process of being repatriated. (See section: Diamond Princess)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
- The quarantine period is for 14 days.
- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.

DIAMOND PRINCESS

- CDC is supporting the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the Diamond Princess cruise ship.
- There are approximately 400 US citizens onboard the Diamond Princess cruise ship.
- Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- Americans returned by flights chartered by the State Department will be subject to a 14-day federal quarantine and be housed at two existing federal quarantine sites for repatriated travelers:
  - Travis Air Force Base in California
  - Joint Base San Antonio-Lackland in Texas

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- Those passengers returning from Japan will be housed separately from people already in quarantined from previous US Government repatriation flights from Wuhan.
- These planes will be met by a team of US Government personnel deployed at these bases to assess the health of the passengers.
- The passengers were screened before leaving the ship and will be monitored and evaluated by medical and public health personnel during the trip and after arrival.
- Anyone who becomes ill on the flight will be sent directly to a local hospital for medical evaluation.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: CDC COVID-19 Daily Key Points for February 13, 2020
Date: Thursday, February 13, 2020 5:32:51 PM
Attachments: CDC_COVID-19 Daily Key Points__2_13_2020_final.pdf

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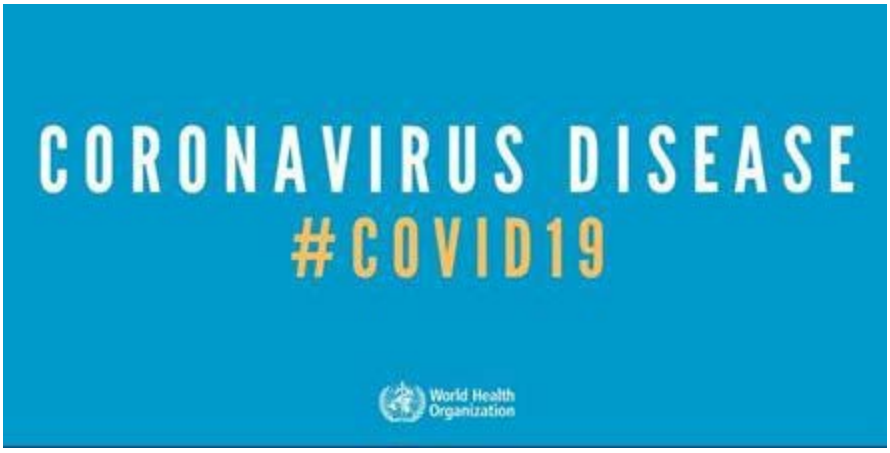
Dear Colleagues,

CDC COVID-19 Daily Key Points for February 13, 2020 are attached.

Additionally, on February 11, 2020 the World Health Organization announced an official name for the novel (new) coronavirus outbreak, **COVID-19**. CDC will be updating our website and other CDC materials to reflect the official disease name. For the most up to date information on Coronavirus Disease-2019, please visit cdc.gov.



Thank you,

State Coordination Task Force

AMERICAN OVERSIGHT

CDC Key Points
Coronavirus Disease 2019 ("COVID-19")

February 13, 2020

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2." The World Health Organization has named the disease associated with this virus coronavirus disease 2019 or "COVID-19."
- This virus is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
- Most COVID-19 outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- The vast majority of Americans have a low risk of exposure at this time.
- The greater risk is for people who have recently traveled to China or their close contacts.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners as well as public health partners to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.
- The U.S. public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside in China, this will increase the likelihood that a global pandemic will result.

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New content is in red.

- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
- Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 27 international locations (in addition to the U.S.) have reported confirmed cases of SARS-CoV-2 infection.
- As of February 13, 2020, 15 infections with SARS-CoV-2 have been reported in the U.S. in seven states – Arizona, California, Illinois, Massachusetts, Texas, Washington and Wisconsin.
    - To date, there have been 427 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 347 persons ruled out as negative. These data are updated regularly at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - As part of efforts to detect cases of COVID-19 in the United States, CDC's laboratory had tested more than 2,000 samples as of February 12.
- The two most recent cases of COVID-19 in the United States were identified in people who had recently returned from Wuhan, China on U.S. State Department chartered flights.
- They had been under federal quarantine for 14 days because of their recent exposure to widespread COVID-19 activity in Wuhan.
- No additional cases of COVID-19 have been detected among quarantined persons at this time.
- Yesterday, February 12, 195 people who were on the first (of five)chartered flight from Wuhan were released from quarantine.
- More than 600 people remain under quarantine.
- It is likely that additional cases of SARS-CoV-2 infection will be detected in the United States.
- Two instances of person-to-person spread with this virus in the United States have been detected, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- CDC established a COVID-19 Incident Management System on January 7, 2020. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.
    - As of February 7, more than 800 CDC staff members had been deployed to the response.
- CDC developed for real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) tests that can diagnose COVID-19 in respiratory samples from clinical specimens and began shipping those to U.S. states. During the initial verification of the test, performance issues were identified by some states.
- CDC has identified a problem in the manufacturing of one of the three controls used in the verification process of the test. This leads to an

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inconclusive test result. CDC is remanufacturing the reagents that are not performing consistently. (See: "Laboratory Issues" for more information.)

- On February 1, CDC issued a Health Alert Network (HAN) update with some updates to previously posted guidance and, for the first time, guidance on clinical care of COVID-19 patients.
- On February 3, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide US public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC isolated the virus and sent to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. COVID-19 patients to detect person-to-person spread.
- As of February 12, CDC and Customs and Border (CBP) personnel had screened about 35,000 people with recent travel history to China at U.S. airports.
- CDC is preparing senior staff to support the WHO international senior technical mission being formed to work with Chinese public health counterparts to help improve understanding of this new disease, including learning more about transmissibility and severity.

DIAMOND PRINCESS

Background

- The Diamond Princess cruise ship with 3,711 persons, of which over 400 are American citizens, was quarantined at the port of Yokohama, Japan.
- This action was taken following the laboratory confirmation of COVID-19 in a passenger who had disembarked on January 25.
- As of February 12, 174 passengers on the ship have been confirmed as having the virus.

Government of Japan Disembarkation Plan

- Over the next several days, Japanese health officials will begin a voluntary disembarkation of passengers.
- It is CDC's understanding that this will be a phased approach, with the most medically vulnerable passengers in the first phase, including older adults with pre-existing health conditions.
- Passengers in this phase 1 group will be tested for SARS-CoV-2.
    - If the test is positive, the passenger will be transported to a local hospital for further evaluation and isolation.
    - If the test is negative, the passenger will be given the option to leave the ship and be transported to a quarantine housing facility. If a passenger does not want to go to the quarantine facilities, they must remain on the ship.

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- This process will take time, and not everyone may be offered a chance to disembark before the end of the quarantine period.
- The Government of Japan has stated that the disembarkation will conform to CDC-approved protocols to prevent spread, and if this is effective, transfer to these facilities will not affect the original quarantine time frame.

What is CDC / USG doing?

- CDC is working in close collaboration with Japanese health authorities to ensure precautions are being taken to prevent the spread of illness on the Diamond Princess cruise ship.
- CDC has deployed a subject matter expert to assist the Japanese Ministry of Health, Labor, and Welfare. Four CDC experts are deployed to Japan to assist the U.S. Embassy in Tokyo.
- The US Government is in contact with American passengers and crew members and is providing ongoing recommendations to help protect their health.
- On February 11, CDC organized multidisciplinary interagency working group, comprised of epidemiology, infection prevention control, and quarantine procedures, to engage with the Government of Japan.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
  - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
  - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
  - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
  - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
  - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

LABORATORY ISSUES

Background:

- CDC has developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to diagnose COVID-19 in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.

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- On February 5, CDC test kits were available for ordering by domestic and international partners through the agency's International Reagent Resource.
- Upon arrival at public health laboratories, it is necessary to verify the assay before beginning to test specimens from persons under investigation (PUIs).
- A number of laboratories have reported issues when conducting initial verification of the test.
- Specifically, some laboratories are reporting sporadic reactivity in the negative controls of one of the three components of the assay.
- This can cause an inconclusive test result.
- CDC believes that this is a manufacturing issue.
- On February 9, APHL sent a message to their member laboratories, notifying them of this issue; CDC sent the message to the FDA and to Department of Defense colleagues on the same day.
- CDC is remanufacturing the reagents that are not performing consistently. This process is being expedited.
- At this time:
    - Laboratories that have verified the assay are able to test.
    - Laboratories that have encountered problems verifying the assay should not continue testing.
- FDA has concurred with this action plan.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue. CDC is looking into this situation further.
- The verification process is another critical QC step and, in this case, detected the problem.

TRAVEL

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to this novel coronavirus.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
    - Foreign nationals who have visited China in the past 14 days may not enter the United States.
    - Special precautions are required of U.S. citizens, immediate family members of U.S. citizens, and legal permanent residents entering the United States who have been in China during the past 14 days, including up to a 14-day quarantine.
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 U.S. airports.
        - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)

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        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory 14-day quarantine at or near that location. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be monitored under self-quarantine for 14 days.
  - CDC is working with public health partners to support the implementation of the travel policies detailed in the presidential proclamation (above).
  - On February 3, CDC issued "Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide US public health authorities and other partners with a framework for assessing and managing risk of potential exposures to SARS-CoV-2 and implementing public health actions based on a person's risk level and clinical presentation.
- The proclamation became effective beginning 5 p.m. EST, February 2.

Repatriated Flights & Quarantine Orders

- CDC supported the Department of State in the safe and expedient ordered departure of US citizens and residents from Wuhan, China, on five chartered flights.
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all the passengers (891 people) entering the United States on these planes.
- The quarantine period is for 14 days, starting from the day the passengers left Wuhan, China.
- The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also will protect the health of the repatriated persons, their families, and their communities.
- Medical staff will monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC will work with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms will be free to leave.

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- On February 12, 195 people from the first chartered flight were discharged from quarantine.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Daily Key Points for Friday, March 6, 2020
Date: Saturday, March 7, 2020 3:18:40 PM
Attachments: CDC_COVID-19_Daily Key Points__3_6_2020.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 daily key points from Friday, March 6.

Respectfully,

Jade Anderson, MPA
Special Advisor/Public Health Analyst
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
404-718-5723 Office | 470-747-9289 Cell | 404-639-2847 fax
e-mail: Jade.Anderson@cdc.hhs.gov

CDC 24-7 Logo__EMAIL_Small



AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 06, 2020 as of 9:00p

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 164 confirmed and presumptive positive cases of COVID-19
  - 11 COVID-19 related deaths
  - 19 states and New York City are reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 164 reported U.S. cases of COVID-19 from 19 states and New York City. New states reporting cases since yesterday include Nevada, Tennessee, and Texas.
- California reported their first death. This is the 11th COVID-19 death officially reported to CDC; the first to be reported outside the state of Washington.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
  - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
  - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
  - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
  - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of having been exposed.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 164 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, Nevada, New York (and New York City), New Hampshire, North Carolina, Oregon, Rhode Island, Tennessee, Texas, Washington, and Wisconsin.

AMERICAN OVERSIGHT

    - 36 of these cases occurred through person-to-person spread.
    - 18 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.
    - 110 cases are still being investigated to determine the source of exposure.
- On March 4, CDC updated its guidance for "Evaluating and Reporting Persons Under Investigation (PUI)."
    - Criteria for evaluation of PUIs were expanded to a wider group of symptomatic patients.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- As of March 5, CDC has issued the following Travel Health Notices:
    - Level 3 Travel Health Notice (avoid non-essential travel): China, Iran, South Korea, and Italy
    - Level 2 Travel Health Notices (practice enhanced precautions): Japan
    - Level 1 (practice usual precautions): Hong Kong
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

PEOPLE AT HIGH RISK OF SERIOUS COVID-19 ILLNESS

- Older adults and persons of all ages who have severe chronic medical conditions seem to be at higher risk for more serious COVID-19 illness.
- Early data suggest older people are twice as likely to have serious COVID-19 illness. This may be because:
    - As people age, their immune systems change, making it harder for their body to fight off diseases and infection.
    - Many older adults are also more likely to have underlying health conditions that make it harder to cope with and recover from illness.
- If you are at increased risk for COVID-19 complications due to age or a severe underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.

REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- As of the evening of March 5, there were 69 state and local public health labs in 45 states and the District of Columbia that have successfully verified and are currently using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- This list is provided by the Association of Public Health Laboratories (APHL).
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.

AMERICAN OVERSIGHT

    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC reported numbers, the numbers reported by states should be considered the most up to date.
- State health laboratories are reporting their results to CDC.
    - CDC is consolidating state reports and combining them with CDC-confirmed test results to present a national aggregated case count daily from Monday through Friday.
    - CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.
    - CDC will post case counts submitted to CDC by 4pm the prior day on the COVID-19 response website at noon.
- As of March 5, 2020, 1,583 patients had been tested at CDC. This does not include testing being done at state and local public health laboratories, which began this week.

- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan) in a separate chart.

WHAT YOU CAN DO

- Everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.

AMERICAN OVERSIGHT

- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

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AMERICAN OVERSIGHT

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To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points for Friday, March 6, 2020
Date:	Saturday, March 7, 2020 3:20:28 PM
Attachments:	CDC_COVID-19_Daily Key Points__3_6_2020.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 daily key points from Friday, March 6.

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

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- Everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.

AMERICAN OVERSIGHT

- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: CDC COVID-19 Daily Key Points for Friday, March 6, 2020
Date: Saturday, March 7, 2020 3:17:03 PM
Attachments: CDC_COVID-19_Daily Key Points__3_6_2020.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 daily key points from Friday, March 6.

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 06, 2020 as of 9:00p

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 164 confirmed and presumptive positive cases of COVID-19
  - 11 COVID-19 related deaths
  - 19 states and New York City are reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 164 reported U.S. cases of COVID-19 from 19 states and New York City. New states reporting cases since yesterday include Nevada, Tennessee, and Texas.
- California reported their first death. This is the 11th COVID-19 death officially reported to CDC; the first to be reported outside the state of Washington.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
  - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
  - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
  - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
  - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of having been exposed.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 164 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, Nevada, New York (and New York City), New Hampshire, North Carolina, Oregon, Rhode Island, Tennessee, Texas, Washington, and Wisconsin.

AMERICAN OVERSIGHT

    - 36 of these cases occurred through person-to-person spread.
    - 18 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.
    - 110 cases are still being investigated to determine the source of exposure.
- On March 4, CDC updated its guidance for "Evaluating and Reporting Persons Under Investigation (PUI)."
    - Criteria for evaluation of PUIs were expanded to a wider group of symptomatic patients.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- As of March 5, CDC has issued the following Travel Health Notices:
    - Level 3 Travel Health Notice (avoid non-essential travel): China, Iran, South Korea, and Italy
    - Level 2 Travel Health Notices (practice enhanced precautions): Japan
    - Level 1 (practice usual precautions): Hong Kong
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

PEOPLE AT HIGH RISK OF SERIOUS COVID-19 ILLNESS

- Older adults and persons of all ages who have severe chronic medical conditions seem to be at higher risk for more serious COVID-19 illness.
- Early data suggest older people are twice as likely to have serious COVID-19 illness. This may be because:
    - As people age, their immune systems change, making it harder for their body to fight off diseases and infection.
    - Many older adults are also more likely to have underlying health conditions that make it harder to cope with and recover from illness.
- If you are at increased risk for COVID-19 complications due to age or a severe underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.

REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- As of the evening of March 5, there were 69 state and local public health labs in 45 states and the District of Columbia that have successfully verified and are currently using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- This list is provided by the Association of Public Health Laboratories (APHL).
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.

AMERICAN OVERSIGHT

    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC reported numbers, the numbers reported by states should be considered the most up to date.
- State health laboratories are reporting their results to CDC.
    - CDC is consolidating state reports and combining them with CDC-confirmed test results to present a national aggregated case count daily from Monday through Friday.
    - CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.
    - CDC will post case counts submitted to CDC by 4pm the prior day on the COVID-19 response website at noon.
- As of March 5, 2020, 1,583 patients had been tested at CDC. This does not include testing being done at state and local public health laboratories, which began this week.

- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan) in a separate chart.

WHAT YOU CAN DO

- Everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.

AMERICAN OVERSIGHT

- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	CDC COVID-19 Daily Key Points for March 4, 2020
Date:	Thursday, March 5, 2020 8:34:18 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_4_2020_FINAL.pdf

FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
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AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

March 04, 2020

Updated text is shown in colored text.

SNAPSHOT

CDC has reported:

- 80 confirmed and presumptive positive cases of COVID-19
- 9 COVID-19 related deaths
- 13 states reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 80 reported U.S. cases of COVID-19 from 13 states.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- As of March 2, 2020, 85 international locations (including the U.S.) have reported confirmed cases of COVID-19, including most recently Argentina, Chile, Poland and Ukraine.

AMERICAN OVERSIGHT

- 80 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York, New Hampshire, North Carolina, Oregon, Rhode Island, Washington and Wisconsin.
    - 16 of these cases occurred through person-to-person spread.
    - 24 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.
    - 40 cases are still being investigated to determine the source of exposure.
- On March 4, CDC updated its guidance for "Evaluating and Reporting Persons Under Investigation (PUI)."
    - Criteria for evaluation of Persons Under Investigation (PUI) were expanded to a wider group of symptomatic patients.
    - On Thursday, March 5, CDC will host a clinician education call on the topic of COVID-19. Visit CDC's website for information on how to join this call.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- As of March 4, 2020, CDC had issued the following Travel Health Notices:
    - Level 3 Travel Health Notice (avoid non-essential travel): China, Iran, South Korea, and Italy
    - Level 2 Travel Health Notices (Practice Enhanced Precautions): Japan
    - Level 1 (practice usual precautions): Hong Kong
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.
- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- As of March 4, 42 state and local public health laboratories are able to test for COVID-19.
    - CDC has developed a map showing the states that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list of states currently testing for COVID-19 is provided by the Association of Public Health Laboratories (APHL).
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may differ from what states, local authorities, or media are reporting.
    - If there are discrepancies between case counts reported by state or local officials and CDC-reported numbers, the numbers provided by states will be the most up to date.
- State health laboratories are reporting their results to CDC.
    - CDC is consolidating state reports and combining them with CDC-confirmed test results to present a national aggregated case count daily from Monday through Friday.
    - CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.

AMERICAN OVERSIGHT

    - CDC will post case counts submitted to CDC by 4pm the prior day on the COVID-19 response website at noon.
- As of March 2, 2020, 1,235 patients had been tested at CDC. This does not include testing being done at state and local public health laboratories, which began this week.
- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the Diamond Princess cruise ship (Japan) in a separate chart available on the CDC website.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.

AMERICAN OVERSIGHT

- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
  - Preparing first responders, healthcare providers, and health systems
  - Reinforcing state, territorial, and local public health readiness
  - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will need to prepare for and coordinate response to an outbreak, if it occurs.
  - Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Daily Key Points for March 5, 2020
Date: Thursday, March 5, 2020 10:54:17 PM
Attachments: CDC_COVID-19_Daily Key Points__3_5_2020.pdf

Dear Colleagues:

Please find CDC COVID-19 daily key points attached to this email.

Additionally, please take a moment to review video link below on proper nasopharyngeal swabbing techniques for lab samples.

- https://www.youtube.com/watch?v=hXohAo1d6tk

Thank you!

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 05, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 99 confirmed and presumptive positive cases of COVID-19
  - 10 COVID-19 related deaths
  - 13 states and New York City are reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 99 reported U.S. cases of COVID-19 from 13 states and New York City.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
  - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
  - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
  - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
  - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 99 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York (and New York City), New Hampshire, North Carolina, Oregon, Rhode Island, Washington, and Wisconsin.
  - 30 of these cases occurred through person-to-person spread.
  - 20 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.

AMERICAN OVERSIGHT

    - 49 cases are still being investigated to determine the source of exposure.
- On March 4, CDC updated its guidance for "Evaluating and Reporting Persons Under Investigation (PUI)."
    - Criteria for evaluation of PUIs were expanded to a wider group of symptomatic patients.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- As of March 5, CDC has issued the following Travel Health Notices:
    - Level 3 Travel Health Notice (avoid non-essential travel): China, Iran, South Korea, and Italy
    - Level 2 Travel Health Notices (practice enhanced precautions): Japan
    - Level 1 (practice usual precautions): Hong Kong
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.
- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

PEOPLE AT HIGH RISK OF SERIOUS COVID-19 ILLNESS

- Older adults and persons who have severe chronic medical conditions seem to be at higher risk for more serious COVID-19 illness.
- Early data suggest older people are twice as likely to have serious COVID-19 illness. This may be because:
    - As people age, their immune systems change, making it harder for their body to fight off diseases and infection.
    - Many older adults are also more likely to have underlying health conditions that make it harder to cope with and recover from illness.
- If you are at increased risk for COVID-19 complications due to age or a severe underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.

REPORTING

- More public health laboratories are able to test for the virus that causes COVID-19, and they are reporting their results publicly.
- As of the evening of March 4, there were 62 state and local public health labs in 44 states and the District of Columbia that have successfully verified and are currently using COVID-19 diagnostic tests.
    - CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC reported numbers, the numbers reported by states should be considered the most up to date.

AMERICAN OVERSIGHT

- State health laboratories are reporting their results to CDC.
    - CDC is consolidating state reports and combining them with CDC-confirmed test results to present a national aggregated case count daily from Monday through Friday.
    - CDC is reporting cumulative confirmed and presumptive positive cases of COVID-19 in the United States since January 21, 2020.
    - CDC will post case counts submitted to CDC by 4pm the prior day on the COVID-19 response website at noon.
- As of March 4, 2020, 1,526 patients had been tested at CDC. This does not include testing being done at state and local public health laboratories, which began this week.
- CDC is presenting data related to people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan) in a separate chart.

WHAT YOU CAN DO

- Everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
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    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.

AMERICAN OVERSIGHT

- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
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COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
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- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Daily Key Points for March 5, 2020
Date: Thursday, March 5, 2020 10:58:48 PM
Attachments: CDC_COVID-19_Daily Key Points__3_5_2020.pdf

Dear Colleagues:

Please find CDC COVID-19 daily key points attached to this email.

Additionally, please take a moment to review video link below on proper nasopharyngeal swabbing techniques for lab samples.

- https://www.youtube.com/watch?v=hXohAo1d6tk

Thank you!

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 05, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 99 confirmed and presumptive positive cases of COVID-19
  - 10 COVID-19 related deaths
  - 13 states and New York City are reporting cases of COVID-19

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of countries, including in parts of the United States.
- There are 99 reported U.S. cases of COVID-19 from 13 states and New York City.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States. Individual risk is dependent on exposure.
- Under current circumstances, certain people will have an increased risk of infection. For example:
  - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
  - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
  - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
  - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of exposure.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- At this time, there is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

SITUATION UPDATE

- 99 reported cases of COVID-19 have been detected in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New York (and New York City), New Hampshire, North Carolina, Oregon, Rhode Island, Washington, and Wisconsin.
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AMERICAN OVERSIGHT

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- The situation is rapidly evolving. CDC is constantly reviewing and updating its guidance as needed.

PEOPLE AT HIGH RISK OF SERIOUS COVID-19 ILLNESS

- Older adults and persons who have severe chronic medical conditions seem to be at higher risk for more serious COVID-19 illness.
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AMERICAN OVERSIGHT

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WHAT YOU CAN DO

- Everyone can do their part to help us respond to this emerging public health threat:
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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	CDC COVID-19 Daily Key Points for March 5, 2020
Date:	Friday, March 6, 2020 8:40:59 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_5_2020.pdf

FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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cell: 202.909.6950 Verizon (secondary)

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: CDC COVID-19 Daily Key Points for March 5, 2020
Date: Thursday, March 5, 2020 10:43:02 PM
Attachments: CDC_COVID-19_Daily Key Points__3_5_2020.pdf

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    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like coronavirus disease 2019.
    - If you are a healthcare provider, be on the look-out for people who have been in close contact with a person known to have COVID-19, and people who live in or have recently been in an area with ongoing spread, and have fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have recently been to an area with ongoing spread of COVID-19 or have been exposed to someone sick with COVID-19 in the last 14 days, you may face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.

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- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
- CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points, Updated Guidance List, Consular Notification, and Interim Cleaning Guidance
Date:	Sunday, March 1, 2020 2:47:36 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf COVID-19_GuidanceList_01MAR20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.pdf

Dear Colleagues:

Attached are several CDC COVID-19 related guidance documents and CDC COVID-19 Daily Key points.

Attached

- 2-29-2020 CDC COVID-19 Daily Key Points. Feel free to share with partners and appropriate parties.
- CDC Consular Notification Guidance (FAQs) regarding Foreign Nationals
- CDC COVID-19 Updated Guidance List (3-1-2020)
- Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

In addition, CDC has created several new landing pages for specific response groups on the CDC COVID-19 website (https://www.cdc.gov/coronavirus/2019-ncov/index.html)

- Resources for Health Departments (https://www.cdc.gov/coronavirus/2019-ncov/php/index.html)
- Resources for Healthcare Facilities(https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.htm)
- Laboratories (https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html)

Kind Regards,

State Coordination Task Force (SCTF)

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 29, 2020

All content updated since February 27 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness named "COVID-19" caused by a novel (new) coronavirus.
- The outbreak began in China but is spreading worldwide, including the United States.
- COVID-19 is threatening to cause a pandemic.
- The U.S. public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the potential spread and impact of this virus.
- This aggressive response has helped to limit the number of U.S. cases in the United States.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- This week, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure.
- These possible instances of community spread occurred in California, Washington and Oregon.
- In Washington three patients were reported who had tested presumptive-positive for the virus that causes COVID-19 at the state.
    - These included a person who died, an infected hospitalized health care worker and a potential outbreak in a long-term care facility.
    - *See Possible Washington Cluster section*
- The U.S. expects to detect more introductions of COVID-19 through travel, as well as more person-to-person spread and community transmission of this virus.
- Aggressive containment efforts will continue, including ongoing use of isolation and quarantine measures to decrease introductions and spread of the virus.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
- In affected communities, local authorities will implement other measures too, including Nonpharmaceutical Interventions (NPIs).
- Local authorities will determine which NPIs to implement, taking into account current circumstances in their communities.
- Nonpharmaceutical Interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- The purpose of most NPIs is to help reduce spread of illness by maintaining or increasing distance between people.
- Social distancing measures are an important weapon to fight the spread of this virus and also can reduce the impact of this virus on communities as a whole.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.

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- But individual risk is dependent on exposure.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
- Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
- Close contacts of persons with COVID-19 also are at elevated risk of exposure.
- Travelers returning from affected locations internationally where community spread is occurring also are at elevated risk of exposure.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- While still taking every effort to prevent a pandemic, CDC is operationalizing all of its pandemic preparedness and response plans.
- Guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for COVID-19.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.

International

- To date, 60 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Azerbaijan, Iceland, and Monaco.
- CDC is reviewing and updating its travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.

Domestic

- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 22 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Six of these cases occurred through person-to-person spread.

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- On February 26, CDC confirmed what is potentially the first instance of community spread with the virus that causes COVID in Sacramento, CA.
- Late on February 28, CDC announced three more possible instances of community-acquired COVID-19—one each in California, Oregon, and the state of Washington.
- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19. All of these are potential cases of community spread.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
    - *See Possible Washington Cluster section*
- Community spread means spread of an illness for which the source of infection is unknown.
- It's also possible, however, that these patients may have been exposed to a returned traveler who was infected.
- CDC is supporting investigations locations with possible community spread.
- People who were exposed to these patients during their infection are at some level of risk depending on their exposure.
- Based on what is known about how this virus behaves, additional cases among people who have had contact with these patients, especially those who have had close, prolonged contact, are expected.
- This could include family members and potentially healthcare workers who cared for the patients.
- All the remaining cases detected through the U.S. public health system were in persons who had travel to areas with ongoing community transmission.

- 47 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 44 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- On Monday, most of the passengers from the Diamond Princess will complete their 14-day quarantine period.
- Patients who tested positive during their quarantine will remain in isolation. A small number of close contacts of those patients (for instance, spouses who have been living with them) who are at increased risk will have their quarantines extended.

WHAT'S NEW:

- On February 28 CDC issued a health alert network update titled: "Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)."
- CDC has been watching the increased spread of this virus across the world and worked with partners on an updated PUI definition.

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- The updated PUI definition takes into account the new geographic spread of the virus and includes a list of affected areas with widespread or sustained community spread. This list is dynamic and will change as our travel guidance is revised.
- CDC has posted "Community Mitigation Guidance for COVID-19 Response in the United States: Nonpharmaceutical Interventions for Community Preparedness and Outbreak Response."

WHAT TO DO

- While the immediate risk of this new virus for most of the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and;
        - People who have been in close contact with someone with COVID-19 or pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity for up to 14 days. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

POSSIBLE WASHINGTON CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a health care worker. This is the first reported case in a healthcare worker.

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- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
    - Circumstances suggest person-to-person spread including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

TESTING

- An important part of CDC's role in testing during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with the capacity to test for this virus.
- Distribution of a CDC rRT-PCR test to diagnose COVID-19 began to state and local public health labs, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents, which led to laboratories not being able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
        - CDC established that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Public health laboratories can use the original CDC test kit to test for the virus that causes COVID-19 using the new protocol.
    - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
- Combined with other reagents that CDC has procured, this is enough testing kits to test more than 75,000 people.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.
- Learn more information about CDC's laboratory work.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community interventions.

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- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.
- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. Personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. Community NPIs (social distancing measures and school closures and dismissals); and
    3. Environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

BACKGROUND

- This new coronavirus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
- Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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Last updated: March 1, 2020

CDC Coronavirus Disease 2019 (COVID-19) Guidance for State, Local, and Territorial Partners and Local Health Departments

Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19

Highlighted Text= New since February 21, 2020

Aircraft

Interim Guidance for Airlines and Airline Crew: Coronavirus Disease 2019 (COVID-19)

- Interim guidance for the commercial airline industry about COVID-19

Preventing Spread of Disease on Commercial Aircraft: Guidance for Cabin Crew

- This guidance provides cabin crew with practical methods to protect themselves, passengers, and other crew members when someone onboard is sick with a possible contagious disease.

Safety Alert for Operators 20001: 2019 Novel Coronavirus: Interim Health Guidance for Air Carrier and Crews

- Interim guidance from the CDC and Federal Aviation Administration for Air Carriers and Crewmembers

Businesses, Employers, and Schools

Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- This interim guidance is intended to help administrators of public and private childcare programs and K-12 schools prevent the spread of COVID-19 among students and staff.

Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19), February 2020

- Interim guidance that may help prevent workplace exposures to acute respiratory illness, including COVID-19, in non-healthcare settings.

Community Infection Control

Interim Guidance for Preventing the Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities

- Interim guidance to help prevent COVID-19 from spreading among people in their homes and in other residential communities.

Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19

- Interim guidance to help healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation to help prevent the spread of COVID-19 in the community.

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Last updated: March 1, 2020

Community Mitigation

CDC in Action: Preparing Communities for Potential Spread of COVID-19

- Information on how CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.

Healthcare Facilities

Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States

- Outlines goals and strategies for all U.S. healthcare facilities to prepare for and respond to community spread of coronavirus disease-2019 (COVID-19).

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

- General strategies CDC recommends to prevent the spread of COVID-19 in LTCF

Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19)

Healthcare Professionals and Infection Control

Evaluating and Reporting Persons Under Investigation (PUI)

- The Centers for Disease Control and Prevention (CDC) clinical criteria for a COVID-19 person under investigation (PUI). Subject to change as additional information becomes available.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

- Flowchart for the evaluation of patients who may be ill with or who may have been exposed to COVID-19.

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or Persons Under Investigation for SARS-CoV-2 in Healthcare Settings

- Interim infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.**

Interim Guidance of Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PASPs) for COVID-19 in the United States

- Interim guidance for all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work

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Last updated: March 1, 2020

Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020

- Interim guidance for the collection and submission of postmortem specimens from deceased persons under investigation (PUI) for COVID-19. This document also provides recommendations for biosafety and infection control practices during specimen collection and handling, including during autopsy procedures. The guidance can be utilized by medical examiners, coroners, pathologists, other workers involved in the postmortem care of deceased PUI, and local and state health departments.

Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- Interim guidance for healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) to help prevent the spread of COVID-19 in healthcare facilities.

Interim Clinical Guidance for Management of Patients with Confirmed COVID-19

- Interim guidance for clinicians caring for patients with confirmed COVID-19

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance for staff at local and state health departments, infection prevention and control professionals, and healthcare personnel who are coordinating the home care and isolation[1] of people with confirmed or suspected 2019-nCoV infection, including persons under investigation (see Criteria to Guide Evaluation of Persons Under Investigation (PUI) for 2019- nCoV).

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV. For guidance on assessment and management of exposure risk in non-healthcare settings, refer to the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings.

Maritime

Interim Guidance for Ships on Managing Suspected Coronavirus Disease 2019

- Interim guidance for ships originating from, or stopping in, the United States to help prevent, detect, and medically manage suspected 2019-nCoV infections.

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Last updated: March 1, 2020

Laboratories

Research Use Only Real-Time RT-PCR Protocol for Identification of 2019-nCoV

- This document describes the use of real-time RT PCR (rRT-PCR) assays for the in vitro qualitative detection of SARS-CoV-2 in respiratory specimens and sera.

Research Use Only 2019-Novel Coronavirus (2019-nCoV) Real-time RT-PCR Primer and Probe Information

Personal Protective Equipment (PPE)

Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response

Healthcare Supply of Personal Protective Equipment

- CDC specific PPE recommendations based on the current COVID-19 situation and availability of PPE.

Optimizing N95 Strategies

- Strategies for Optimizing the Supply of N95 Respirators

- Strategies for Optimizing the Supply of N95 Respirators: Contingency Capacity Strategies
    - In the continuum of care, the following measures can be categorized as contingency capacity, which may change daily practices but may not have any significant impact on the care delivered to the patient or the safety of the HCP.

- Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies
    - These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are not commensurate with current U.S. standards of care.

Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

- U.S. Government decision makers are considering whether these products should be released for use during the COVID-19 response. Information is provided below that may be used to inform these product release decisions.

Public Health Officials

Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).
    - Case Report Form for 2019 Novel Coronavirus

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Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings

- Guidance is intended to address recommended infection prevention and control practices when public health interviews or assessments are performed at a home or non-home residential settings.

Pandemic Preparedness Resources

- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

Pregnant Women and Children

Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19

- Interim guidance for women who are confirmed to have COVID-19 or are persons-under- investigation (PUI) for COVID-19 and are currently breastfeeding.

Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings

- Interim for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings.

Travelers

Information for Travelers

- This page includes information about 2019 novel coronavirus (COVID-19) for travelers going to and returning from China, and information for aircrew and resources ship industry.

Travelers to China

- Travel recommendations for travel to China

Travelers from China arriving in the U.S.

- Information for travelers from China arriving to the U.S.

Risk Assessment

Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-associated or Community Settings

- Interim guidance to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.

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Last updated: March 1, 2020

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for healthcare providers with potential exposure to COVID-19.

Stigma

Stigma Related to COVID-19

- Information to combat stigma and discrimination associated with COVID-19.

Frequently Asked Questions (FAQs)

Frequently Asked Questions and Answers about COVID-19

- General FAQs

Healthcare Infection Prevention and Control FAQs for COVID-19

- **Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.
- **What is it for:** This creates FAQs to support the existing Healthcare Infection Prevention and Control Guidance for COVID-19.
- **How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children

- This is a list of frequently asked questions and answers for questions about COVID-19 relating to children.

Frequently Asked Questions and Answers: Coronavirus Disease 2019 (COVID-19) and Pregnancy

- This is a list of frequently asked questions and answers for pregnant women, infants, and women who are breastfeeding.

Frequently Asked Questions about Respirators and their Use

Healthcare Professionals: Frequently Asked Questions and Answers

- FAQs for healthcare professionals

Information for Laboratories COVID-19 Requests for Diagnostic Panels and Virus

- FAQs for lab professionals

Travel: Frequently Asked Questions and Answers

- General travel-related FAQs

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Last updated: March 1, 2020

Additional Resources

2020 Health Alert (HAN) Messages: CDC's Health Alert Network (HAN) is CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, tribal, and local public health practitioner; clinicians; and public health laboratories.

CDC Newsroom: CDC Media Telebriefing: Update on COVID-19: CDC provides an update periodically to media on the COVID-19 response. Sign up for media announcements.

Clinician Outreach and Communication Activity (COCA) Calls/Webinars: During COCA Calls/Webinars, subject matter experts present key emergency preparedness and response topics, followed by meaningful Q&A with participants. The call or webinar will offer the most up to date information on guidance for clinicians.

Travel Health Notices: Travel Health Notices inform travelers and clinicians about current health issues that impact travelers' health, like disease outbreaks, special events or gatherings, and natural disasters, in specific international destinations.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

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Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

Background

There is much to learn about the newly emerged coronavirus disease 2019 (COVID-19). Based on what is known about early cases of COVID-19, spread from person-to-person via the respiratory route and usually happens among close contacts (within about 6 feet).

People with certain types of exposure to cases of COVID-19 may be housed and quarantined for observation until 14 days after their exposure. The purpose of the observation period is to ensure they don't develop symptoms and infect others during this time. Some people stay at home for the observation period, but others may be housed either separately or in groups in other types of facilities.

In these facilities, individuals and families are provided separate quarters with separate bathroom facilities. They are instructed that congregation and shared public spaces are to be avoided. Because the people under quarantine are not ill, the risk to cleaning staff is inherently low.

Purpose

This guidance provides recommendation on the cleaning and disinfection of rooms of persons under quarantine, as well as associated worker protection practices according to expected job tasks. The goal is to minimize interactions between persons under quarantine and cleaning staff. These recommendations will be updated if additional information becomes available.

General Recommendations for Housing Facilities for Persons Under Quarantine

- Employers should develop policies for worker protection and provide training to all cleaning staff on-site prior to beginning work. Training should include:
    - An understanding of when to use personal protective equipment (PPE)
    - What PPE is necessary and why (see below for PPE recommendations)
    - How to properly don (put on), use, and doff (take off) PPE
    - How to properly dispose of PPE
- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard, 29 CFR 1910.1200.
- Employers must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste, and PPE (29 CFR 1910.132).
- Cleaning staff should perform hand hygiene often including immediately after removing PPE by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Cleaning staff should immediately report breaches in PPE (e.g., tear in gloves) or any potential exposures (e.g., contact with a quarantined individual without wearing appropriate PPE) to their supervisor.

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- Employers should educate workers to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms until 14 days after the last day they had possible exposure to the virus.
    - Cleaning staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Cleaning staff should follow normal preventive actions while at work and home including covering their mouth and nose with a tissue when coughing or sneezing and avoiding touching eyes, nose, or mouth with unwashed hands.
- If surfaces are dirty, they should be cleaned using a detergent and water prior to disinfection.
    - A list of products with EPA-approved emerging viral pathogens claims, maintained by the American Chemistry Council Center for Biocide Chemistries (CBC), is available at: https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf.
    - Products with EPA-approved emerging viral pathogens claims are expected to be effective against COVID-19 based on data for harder to kill viruses.
    - Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE) for use.

Cleaning Activities During the Quarantine Period

Because cleaning needs are limited during the quarantine period, CDC is recommending that cleaning staff do not clean occupied rooms in quarantine facilities. Instead, all rooms should be provisioned with personal cleaning supplies, e.g., tissues, paper towels, cleaners and disinfectants that are EPA-approved against emerging viral pathogens (see list above) for use by persons under quarantine as needed. Rooms and common areas occupied by persons under quarantine should not be cleaned by cleaning staff until all persons under quarantine have been released from quarantine and have vacated the area and no sooner than 24 hours after rooms and common areas have been vacated.

During the quarantine:

- Persons under quarantine should bag trash and place the closed bag outside their door for daily pick up.
- Similarly, persons under quarantine should bag soiled linens and place the closed bag outside their door for pick up.
- Cleaning, laundry, and trash removal staff should wear disposable gloves and gowns for all tasks in the cleaning process, including collection of closed bags.
    - Staff should remove gloves after cleaning a room or area occupied by persons under quarantine before moving to the next room.
    - After delivering bags to their final destination, staff should clean and disinfect any hard, cleanable surfaces where bags have been stored (such as on carts or on the floor).
    - Laundry and trash removal staff collecting the closed bags should remove their gloves promptly after bags are delivered to their destination and cleaning and disinfection has been performed.
    - Any time staff remove gloves, they should perform hand hygiene immediately by washing their hands with soap and water for 20 seconds. If hands are not visibly dirty and soap and water are not available, an alcohol-based hand sanitizer that contains

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60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

- If possible, for fabrics or other materials that can be laundered, use the warm water setting and dry items completely on high heat.
- If a person under quarantine has a special need for assisted cleaning (e.g., an elderly person who is unable to clean a spill such as vomiting in their quarters), public health staff will oversee the cleaning process as part of their evaluation of the individual.

Cleaning a Room Vacated by a Person under Quarantine <u>with</u> COVID-19 (Enhanced Cleaning)

Rooms that housed a person under quarantine with COVID-19 should remain closed to further use until cleaned and disinfected by appropriately trained cleaning staff. The room should not be entered by cleaning staff for at least for 24 hours.

- Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process.
    - These gloves and gowns should be compatible with the disinfectant products being used
    - Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk for splash.
    - Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area.
- Cleaning should be undertaken using products with EPA-approved emerging viral pathogens claims (https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf). All products should be used according to label instructions.
    - Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
    - Adhere to any safety precautions or other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE).
    - Avoid using product application methods that cause splashing or generate aerosols.
    - Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
    - After cleaning and removal and disposal of gloves, staff should perform hand hygiene by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.
- Clean and disinfect all frequently touched surfaces in quarantine locations (e.g., counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, remotes and bedside tables) according to instructions described for products with EPA-approved emerging viral pathogens claims.
- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present. Launder items as appropriate in accordance with the manufacturer's instructions. Porous materials that will be laundered can be transported to the laundry facility in the usual manner. If possible, launder items using the warm water setting and dry items completely on high heat.

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- When cleaning is completed, collect soiled material and PPE in a sturdy, leak-proof (e.g., plastic) bag that is tied shut and not reopened. This waste can go to the regular solid waste stream (e.g., municipal trash) as it is not biohazardous or regulated medical waste.
- If bulk material and spills containing blood or body substances are present, cleaning staff should use absorbent materials, such as towels, to remove the material. The area should then be cleaned and then disinfected with products with EPA-approved emerging viral pathogens claims used according to product label instructions.
- No additional cleaning is needed for supply and return ventilation registers or filtration systems for the building.
- No additional treatment of wastewater is needed before discharging to sanitary sewer.

Cleaning Recommendations for Quarantined Persons from Uncontrolled Sources (e.g. increased likelihood of many cases such as on cruise ships, etc.)

Cleaning for facilities housing persons under quarantine because of exposure from an uncontrolled source should be conducted following the Enhanced Cleaning procedures and include cleaning of common areas outlined above.

Cleaning a Room Vacated by persons under quarantine without COVID-19

After all persons under quarantine are released and assuming the quarantined persons are not from an uncontrolled source (see above):

- If all persons under quarantine have been released and vacated the housing area and no persons tested positive for COVID-19, the facility (e.g., rooms, common areas) should be cleaned according to standard procedures.
- No additional PPE is required beyond what is normally worn for regular housekeeping activities.

Cleaning of Common Areas of a Housing Facility (if used)

If common areas are used by persons under quarantine, those areas will require cleaning and disinfection during the quarantine period.

- Common areas of a facility should be cleaned on a daily basis, and as needed.
- Regardless of known COVID-19 status of persons under quarantine, common areas should be cleaned according to ***Cleaning a Room Vacated by a person under quarantine with COVID-19(Enhanced Cleaning)*** recommendations, since communication to cleaning staff about persons under quarantine who develop symptoms or test positive for COVID-19 may not be able to occur as quickly as cleaning services are required.
- No quarantined individuals should be present in a common area during cleaning. Common areas of a facility should be closed off to all persons except for cleaning staff before cleaning and disinfection activities take place.

Additional Resource:

OSHA COVID-19 Website:
https://www.osha.gov/SLTC/covid-19/

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points, Updated Guidance List, Consular Notification, and Interim Cleaning Guidance
Date:	Sunday, March 1, 2020 2:49:50 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf COVID-19_GuidanceList_01MAR20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.pdf

Dear Colleagues:

Attached are several CDC COVID-19 related guidance documents and CDC COVID-19 Daily Key points.

Attached

- 2-29-2020 CDC COVID-19 Daily Key Points. Feel free to share with partners and appropriate parties.
- CDC Consular Notification Guidance (FAQs) regarding Foreign Nationals
- CDC COVID-19 Updated Guidance List (3-1-2020)
- Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

In addition, CDC has created several new landing pages for specific response groups on the CDC COVID-19 website (https://www.cdc.gov/coronavirus/2019-ncov/index.html)

- Resources for Health Departments (https://www.cdc.gov/coronavirus/2019-ncov/php/index.html)
- Resources for Healthcare Facilities(https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.htm)
- Laboratories (https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html)

Kind Regards,

State Coordination Task Force (SCTF)

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 29, 2020

All content updated since February 27 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness named "COVID-19" caused by a novel (new) coronavirus.
- The outbreak began in China but is spreading worldwide, including the United States.
- COVID-19 is threatening to cause a pandemic.
- The U.S. public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the potential spread and impact of this virus.
- This aggressive response has helped to limit the number of U.S. cases in the United States.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- This week, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure.
- These possible instances of community spread occurred in California, Washington and Oregon.
- In Washington three patients were reported who had tested presumptive-positive for the virus that causes COVID-19 at the state.
    - These included a person who died, an infected hospitalized health care worker and a potential outbreak in a long-term care facility.
    - *See Possible Washington Cluster section*
- The U.S. expects to detect more introductions of COVID-19 through travel, as well as more person-to-person spread and community transmission of this virus.
- Aggressive containment efforts will continue, including ongoing use of isolation and quarantine measures to decrease introductions and spread of the virus.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
- In affected communities, local authorities will implement other measures too, including Nonpharmaceutical Interventions (NPIs).
- Local authorities will determine which NPIs to implement, taking into account current circumstances in their communities.
- Nonpharmaceutical Interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- The purpose of most NPIs is to help reduce spread of illness by maintaining or increasing distance between people.
- Social distancing measures are an important weapon to fight the spread of this virus and also can reduce the impact of this virus on communities as a whole.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.

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- But individual risk is dependent on exposure.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
- Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
- Close contacts of persons with COVID-19 also are at elevated risk of exposure.
- Travelers returning from affected locations internationally where community spread is occurring also are at elevated risk of exposure.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- While still taking every effort to prevent a pandemic, CDC is operationalizing all of its pandemic preparedness and response plans.
- Guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for COVID-19.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.

International

- To date, 60 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Azerbaijan, Iceland, and Monaco.
- CDC is reviewing and updating its travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.

Domestic

- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 22 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Six of these cases occurred through person-to-person spread.

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- On February 26, CDC confirmed what is potentially the first instance of community spread with the virus that causes COVID in Sacramento, CA.
- Late on February 28, CDC announced three more possible instances of community-acquired COVID-19—one each in California, Oregon, and the state of Washington.
- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19. All of these are potential cases of community spread.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
    - *See Possible Washington Cluster section*
- Community spread means spread of an illness for which the source of infection is unknown.
- It's also possible, however, that these patients may have been exposed to a returned traveler who was infected.
- CDC is supporting investigations locations with possible community spread.
- People who were exposed to these patients during their infection are at some level of risk depending on their exposure.
- Based on what is known about how this virus behaves, additional cases among people who have had contact with these patients, especially those who have had close, prolonged contact, are expected.
- This could include family members and potentially healthcare workers who cared for the patients.
- All the remaining cases detected through the U.S. public health system were in persons who had travel to areas with ongoing community transmission.

- 47 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 44 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- On Monday, most of the passengers from the Diamond Princess will complete their 14-day quarantine period.
- Patients who tested positive during their quarantine will remain in isolation. A small number of close contacts of those patients (for instance, spouses who have been living with them) who are at increased risk will have their quarantines extended.

WHAT'S NEW:

- On February 28 CDC issued a health alert network update titled: "Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)."
- CDC has been watching the increased spread of this virus across the world and worked with partners on an updated PUI definition.

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- The updated PUI definition takes into account the new geographic spread of the virus and includes a list of affected areas with widespread or sustained community spread. This list is dynamic and will change as our travel guidance is revised.
- CDC has posted "Community Mitigation Guidance for COVID-19 Response in the United States: Nonpharmaceutical Interventions for Community Preparedness and Outbreak Response."

WHAT TO DO

- While the immediate risk of this new virus for most of the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and;
        - People who have been in close contact with someone with COVID-19 or pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity for up to 14 days. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

POSSIBLE WASHINGTON CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a health care worker. This is the first reported case in a healthcare worker.

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- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
    - Circumstances suggest person-to-person spread including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

TESTING

- An important part of CDC's role in testing during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with the capacity to test for this virus.
- Distribution of a CDC rRT-PCR test to diagnose COVID-19 began to state and local public health labs, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents, which led to laboratories not being able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
        - CDC established that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Public health laboratories can use the original CDC test kit to test for the virus that causes COVID-19 using the new protocol.
    - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
- Combined with other reagents that CDC has procured, this is enough testing kits to test more than 75,000 people.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.
- Learn more information about CDC's laboratory work.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community interventions.

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- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.
- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. Personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. Community NPIs (social distancing measures and school closures and dismissals); and
    3. Environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

BACKGROUND

- This new coronavirus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
- Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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CDC Coronavirus Disease 2019 (COVID-19) Guidance for State, Local, and Territorial Partners and Local Health Departments

Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19

Highlighted Text= New since February 21, 2020

Aircraft

Interim Guidance for Airlines and Airline Crew: Coronavirus Disease 2019 (COVID-19)

- Interim guidance for the commercial airline industry about COVID-19

Preventing Spread of Disease on Commercial Aircraft: Guidance for Cabin Crew

- This guidance provides cabin crew with practical methods to protect themselves, passengers, and other crew members when someone onboard is sick with a possible contagious disease.

Safety Alert for Operators 20001: 2019 Novel Coronavirus: Interim Health Guidance for Air Carrier and Crews

- Interim guidance from the CDC and Federal Aviation Administration for Air Carriers and Crewmembers

Businesses, Employers, and Schools

Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- This interim guidance is intended to help administrators of public and private childcare programs and K-12 schools prevent the spread of COVID-19 among students and staff.

Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19), February 2020

- Interim guidance that may help prevent workplace exposures to acute respiratory illness, including COVID-19, in non-healthcare settings.

Community Infection Control

Interim Guidance for Preventing the Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities

- Interim guidance to help prevent COVID-19 from spreading among people in their homes and in other residential communities.

Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19

- Interim guidance to help healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation to help prevent the spread of COVID-19 in the community.

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Community Mitigation

CDC in Action: Preparing Communities for Potential Spread of COVID-19

- Information on how CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.

Healthcare Facilities

Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States

- Outlines goals and strategies for all U.S. healthcare facilities to prepare for and respond to community spread of coronavirus disease-2019 (COVID-19).

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

- General strategies CDC recommends to prevent the spread of COVID-19 in LTCF

Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19)

Healthcare Professionals and Infection Control

Evaluating and Reporting Persons Under Investigation (PUI)

- The Centers for Disease Control and Prevention (CDC) clinical criteria for a COVID-19 person under investigation (PUI). Subject to change as additional information becomes available.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

- Flowchart for the evaluation of patients who may be ill with or who may have been exposed to COVID-19.

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or Persons Under Investigation for SARS-CoV-2 in Healthcare Settings

- Interim infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.**

Interim Guidance of Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PASPs) for COVID-19 in the United States

- Interim guidance for all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work

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Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020

- Interim guidance for the collection and submission of postmortem specimens from deceased persons under investigation (PUI) for COVID-19. This document also provides recommendations for biosafety and infection control practices during specimen collection and handling, including during autopsy procedures. The guidance can be utilized by medical examiners, coroners, pathologists, other workers involved in the postmortem care of deceased PUI, and local and state health departments.

Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- Interim guidance for healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) to help prevent the spread of COVID-19 in healthcare facilities.

Interim Clinical Guidance for Management of Patients with Confirmed COVID-19

- Interim guidance for clinicians caring for patients with confirmed COVID-19

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance for staff at local and state health departments, infection prevention and control professionals, and healthcare personnel who are coordinating the home care and isolation[1] of people with confirmed or suspected 2019-nCoV infection, including persons under investigation (see Criteria to Guide Evaluation of Persons Under Investigation (PUI) for 2019- nCoV).

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV. For guidance on assessment and management of exposure risk in non-healthcare settings, refer to the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings.

Maritime

Interim Guidance for Ships on Managing Suspected Coronavirus Disease 2019

- Interim guidance for ships originating from, or stopping in, the United States to help prevent, detect, and medically manage suspected 2019-nCoV infections.

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Last updated: March 1, 2020

Laboratories

Research Use Only Real-Time RT-PCR Protocol for Identification of 2019-nCoV

- This document describes the use of real-time RT PCR (rRT-PCR) assays for the in vitro qualitative detection of SARS-CoV-2 in respiratory specimens and sera.

Research Use Only 2019-Novel Coronavirus (2019-nCoV) Real-time RT-PCR Primer and Probe Information

Personal Protective Equipment (PPE)

Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response

Healthcare Supply of Personal Protective Equipment

- CDC specific PPE recommendations based on the current COVID-19 situation and availability of PPE.

Optimizing N95 Strategies

- Strategies for Optimizing the Supply of N95 Respirators

- Strategies for Optimizing the Supply of N95 Respirators: Contingency Capacity Strategies
    - In the continuum of care, the following measures can be categorized as contingency capacity, which may change daily practices but may not have any significant impact on the care delivered to the patient or the safety of the HCP.

- Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies
    - These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are not commensurate with current U.S. standards of care.

Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

- U.S. Government decision makers are considering whether these products should be released for use during the COVID-19 response. Information is provided below that may be used to inform these product release decisions.

Public Health Officials

Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).
    - Case Report Form for 2019 Novel Coronavirus

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Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings

- Guidance is intended to address recommended infection prevention and control practices when public health interviews or assessments are performed at a home or non-home residential settings.

Pandemic Preparedness Resources

- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

Pregnant Women and Children

Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19

- Interim guidance for women who are confirmed to have COVID-19 or are persons-under- investigation (PUI) for COVID-19 and are currently breastfeeding.

Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings

- Interim for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings.

Travelers

Information for Travelers

- This page includes information about 2019 novel coronavirus (COVID-19) for travelers going to and returning from China, and information for aircrew and resources ship industry.

Travelers to China

- Travel recommendations for travel to China

Travelers from China arriving in the U.S.

- Information for travelers from China arriving to the U.S.

Risk Assessment

Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-associated or Community Settings

- Interim guidance to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.

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Last updated: March 1, 2020

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for healthcare providers with potential exposure to COVID-19.

Stigma

Stigma Related to COVID-19

- Information to combat stigma and discrimination associated with COVID-19.

Frequently Asked Questions (FAQs)

Frequently Asked Questions and Answers about COVID-19

- General FAQs

Healthcare Infection Prevention and Control FAQs for COVID-19

- **Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.
- **What is it for:** This creates FAQs to support the existing Healthcare Infection Prevention and Control Guidance for COVID-19.
- **How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children

- This is a list of frequently asked questions and answers for questions about COVID-19 relating to children.

Frequently Asked Questions and Answers: Coronavirus Disease 2019 (COVID-19) and Pregnancy

- This is a list of frequently asked questions and answers for pregnant women, infants, and women who are breastfeeding.

Frequently Asked Questions about Respirators and their Use

Healthcare Professionals: Frequently Asked Questions and Answers

- FAQs for healthcare professionals

Information for Laboratories COVID-19 Requests for Diagnostic Panels and Virus

- FAQs for lab professionals

Travel: Frequently Asked Questions and Answers

- General travel-related FAQs

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Additional Resources

2020 Health Alert (HAN) Messages: CDC's Health Alert Network (HAN) is CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, tribal, and local public health practitioner; clinicians; and public health laboratories.

CDC Newsroom: CDC Media Telebriefing: Update on COVID-19: CDC provides an update periodically to media on the COVID-19 response. Sign up for media announcements.

Clinician Outreach and Communication Activity (COCA) Calls/Webinars: During COCA Calls/Webinars, subject matter experts present key emergency preparedness and response topics, followed by meaningful Q&A with participants. The call or webinar will offer the most up to date information on guidance for clinicians.

Travel Health Notices: Travel Health Notices inform travelers and clinicians about current health issues that impact travelers' health, like disease outbreaks, special events or gatherings, and natural disasters, in specific international destinations.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

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Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

Background

There is much to learn about the newly emerged coronavirus disease 2019 (COVID-19). Based on what is known about early cases of COVID-19, spread from person-to-person via the respiratory route and usually happens among close contacts (within about 6 feet).

People with certain types of exposure to cases of COVID-19 may be housed and quarantined for observation until 14 days after their exposure. The purpose of the observation period is to ensure they don't develop symptoms and infect others during this time. Some people stay at home for the observation period, but others may be housed either separately or in groups in other types of facilities.

In these facilities, individuals and families are provided separate quarters with separate bathroom facilities. They are instructed that congregation and shared public spaces are to be avoided. Because the people under quarantine are not ill, the risk to cleaning staff is inherently low.

Purpose

This guidance provides recommendation on the cleaning and disinfection of rooms of persons under quarantine, as well as associated worker protection practices according to expected job tasks. The goal is to minimize interactions between persons under quarantine and cleaning staff. These recommendations will be updated if additional information becomes available.

General Recommendations for Housing Facilities for Persons Under Quarantine

- Employers should develop policies for worker protection and provide training to all cleaning staff on-site prior to beginning work. Training should include:
    - An understanding of when to use personal protective equipment (PPE)
    - What PPE is necessary and why (see below for PPE recommendations)
    - How to properly don (put on), use, and doff (take off) PPE
    - How to properly dispose of PPE
- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard, 29 CFR 1910.1200.
- Employers must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste, and PPE (29 CFR 1910.132).
- Cleaning staff should perform hand hygiene often including immediately after removing PPE by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Cleaning staff should immediately report breaches in PPE (e.g., tear in gloves) or any potential exposures (e.g., contact with a quarantined individual without wearing appropriate PPE) to their supervisor.

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- Employers should educate workers to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms until 14 days after the last day they had possible exposure to the virus.
    - Cleaning staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Cleaning staff should follow normal preventive actions while at work and home including covering their mouth and nose with a tissue when coughing or sneezing and avoiding touching eyes, nose, or mouth with unwashed hands.
- If surfaces are dirty, they should be cleaned using a detergent and water prior to disinfection.
    - A list of products with EPA-approved emerging viral pathogens claims, maintained by the American Chemistry Council Center for Biocide Chemistries (CBC), is available at: https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf.
    - Products with EPA-approved emerging viral pathogens claims are expected to be effective against COVID-19 based on data for harder to kill viruses.
    - Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE) for use.

Cleaning Activities During the Quarantine Period

Because cleaning needs are limited during the quarantine period, CDC is recommending that cleaning staff do not clean occupied rooms in quarantine facilities. Instead, all rooms should be provisioned with personal cleaning supplies, e.g., tissues, paper towels, cleaners and disinfectants that are EPA-approved against emerging viral pathogens (see list above) for use by persons under quarantine as needed. Rooms and common areas occupied by persons under quarantine should not be cleaned by cleaning staff until all persons under quarantine have been released from quarantine and have vacated the area and no sooner than 24 hours after rooms and common areas have been vacated.

During the quarantine:

- Persons under quarantine should bag trash and place the closed bag outside their door for daily pick up.
- Similarly, persons under quarantine should bag soiled linens and place the closed bag outside their door for pick up.
- Cleaning, laundry, and trash removal staff should wear disposable gloves and gowns for all tasks in the cleaning process, including collection of closed bags.
    - Staff should remove gloves after cleaning a room or area occupied by persons under quarantine before moving to the next room.
    - After delivering bags to their final destination, staff should clean and disinfect any hard, cleanable surfaces where bags have been stored (such as on carts or on the floor).
    - Laundry and trash removal staff collecting the closed bags should remove their gloves promptly after bags are delivered to their destination and cleaning and disinfection has been performed.
    - Any time staff remove gloves, they should perform hand hygiene immediately by washing their hands with soap and water for 20 seconds. If hands are not visibly dirty and soap and water are not available, an alcohol-based hand sanitizer that contains

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60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

- If possible, for fabrics or other materials that can be laundered, use the warm water setting and dry items completely on high heat.
- If a person under quarantine has a special need for assisted cleaning (e.g., an elderly person who is unable to clean a spill such as vomiting in their quarters), public health staff will oversee the cleaning process as part of their evaluation of the individual.

Cleaning a Room Vacated by a Person under Quarantine <u>with</u> COVID-19 (Enhanced Cleaning)

Rooms that housed a person under quarantine with COVID-19 should remain closed to further use until cleaned and disinfected by appropriately trained cleaning staff. The room should not be entered by cleaning staff for at least for 24 hours.

- Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process.
    - These gloves and gowns should be compatible with the disinfectant products being used
    - Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk for splash.
    - Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area.
- Cleaning should be undertaken using products with EPA-approved emerging viral pathogens claims (https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf). All products should be used according to label instructions.
    - Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
    - Adhere to any safety precautions or other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE).
    - Avoid using product application methods that cause splashing or generate aerosols.
    - Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
    - After cleaning and removal and disposal of gloves, staff should perform hand hygiene by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.
- Clean and disinfect all frequently touched surfaces in quarantine locations (e.g., counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, remotes and bedside tables) according to instructions described for products with EPA-approved emerging viral pathogens claims.
- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present. Launder items as appropriate in accordance with the manufacturer's instructions. Porous materials that will be laundered can be transported to the laundry facility in the usual manner. If possible, launder items using the warm water setting and dry items completely on high heat.

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- When cleaning is completed, collect soiled material and PPE in a sturdy, leak-proof (e.g., plastic) bag that is tied shut and not reopened. This waste can go to the regular solid waste stream (e.g., municipal trash) as it is not biohazardous or regulated medical waste.
- If bulk material and spills containing blood or body substances are present, cleaning staff should use absorbent materials, such as towels, to remove the material. The area should then be cleaned and then disinfected with products with EPA-approved emerging viral pathogens claims used according to product label instructions.
- No additional cleaning is needed for supply and return ventilation registers or filtration systems for the building.
- No additional treatment of wastewater is needed before discharging to sanitary sewer.

Cleaning Recommendations for Quarantined Persons from Uncontrolled Sources (e.g. increased likelihood of many cases such as on cruise ships, etc.)

Cleaning for facilities housing persons under quarantine because of exposure from an uncontrolled source should be conducted following the Enhanced Cleaning procedures and include cleaning of common areas outlined above.

Cleaning a Room Vacated by persons under quarantine without COVID-19

After all persons under quarantine are released and assuming the quarantined persons are not from an uncontrolled source (see above):

- If all persons under quarantine have been released and vacated the housing area and no persons tested positive for COVID-19, the facility (e.g., rooms, common areas) should be cleaned according to standard procedures.
- No additional PPE is required beyond what is normally worn for regular housekeeping activities.

Cleaning of Common Areas of a Housing Facility (if used)

If common areas are used by persons under quarantine, those areas will require cleaning and disinfection during the quarantine period.

- Common areas of a facility should be cleaned on a daily basis, and as needed.
- Regardless of known COVID-19 status of persons under quarantine, common areas should be cleaned according to ***Cleaning a Room Vacated by a person under quarantine with COVID-19(Enhanced Cleaning)*** recommendations, since communication to cleaning staff about persons under quarantine who develop symptoms or test positive for COVID-19 may not be able to occur as quickly as cleaning services are required.
- No quarantined individuals should be present in a common area during cleaning. Common areas of a facility should be closed off to all persons except for cleaning staff before cleaning and disinfection activities take place.

Additional Resource:

OSHA COVID-19 Website:
https://www.osha.gov/SLTC/covid-19/

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Daily Key Points, Updated Guidance List, Consular Notification, and Interim Cleaning Guidance
Date:	Sunday, March 1, 2020 2:44:38 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf COVID-19_GuidanceList_01MAR20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.pdf

Dear Colleagues:

Attached are several CDC COVID-19 related guidance documents and CDC COVID-19 Daily Key points.

Attached

- 2-29-2020 CDC COVID-19 Daily Key Points. Feel free to share with partners and appropriate parties.
- CDC Consular Notification Guidance (FAQs) regarding Foreign Nationals
- CDC COVID-19 Updated Guidance List (3-1-2020)
- Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

In addition, CDC has created several new landing pages for specific response groups on the CDC COVID-19 website (https://www.cdc.gov/coronavirus/2019-ncov/index.html)

- Resources for Health Departments (https://www.cdc.gov/coronavirus/2019-ncov/php/index.html)
- Resources for Healthcare Facilities(https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.htm)
- Laboratories (https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html)

Kind Regards,

State Coordination Task Force (SCTF)

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 29, 2020

All content updated since February 27 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness named "COVID-19" caused by a novel (new) coronavirus.
- The outbreak began in China but is spreading worldwide, including the United States.
- COVID-19 is threatening to cause a pandemic.
- The U.S. public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the potential spread and impact of this virus.
- This aggressive response has helped to limit the number of U.S. cases in the United States.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- This week, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure.
- These possible instances of community spread occurred in California, Washington and Oregon.
- In Washington three patients were reported who had tested presumptive-positive for the virus that causes COVID-19 at the state.
    - These included a person who died, an infected hospitalized health care worker and a potential outbreak in a long-term care facility.
    - *See Possible Washington Cluster section*
- The U.S. expects to detect more introductions of COVID-19 through travel, as well as more person-to-person spread and community transmission of this virus.
- Aggressive containment efforts will continue, including ongoing use of isolation and quarantine measures to decrease introductions and spread of the virus.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
- In affected communities, local authorities will implement other measures too, including Nonpharmaceutical Interventions (NPIs).
- Local authorities will determine which NPIs to implement, taking into account current circumstances in their communities.
- Nonpharmaceutical Interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- The purpose of most NPIs is to help reduce spread of illness by maintaining or increasing distance between people.
- Social distancing measures are an important weapon to fight the spread of this virus and also can reduce the impact of this virus on communities as a whole.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.

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- But individual risk is dependent on exposure.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
- Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
- Close contacts of persons with COVID-19 also are at elevated risk of exposure.
- Travelers returning from affected locations internationally where community spread is occurring also are at elevated risk of exposure.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- While still taking every effort to prevent a pandemic, CDC is operationalizing all of its pandemic preparedness and response plans.
- Guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for COVID-19.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.

International

- To date, 60 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Azerbaijan, Iceland, and Monaco.
- CDC is reviewing and updating its travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.

Domestic

- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 22 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Six of these cases occurred through person-to-person spread.

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- On February 26, CDC confirmed what is potentially the first instance of community spread with the virus that causes COVID in Sacramento, CA.
- Late on February 28, CDC announced three more possible instances of community-acquired COVID-19—one each in California, Oregon, and the state of Washington.
- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19. All of these are potential cases of community spread.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
    - *See Possible Washington Cluster section*
- Community spread means spread of an illness for which the source of infection is unknown.
- It's also possible, however, that these patients may have been exposed to a returned traveler who was infected.
- CDC is supporting investigations locations with possible community spread.
- People who were exposed to these patients during their infection are at some level of risk depending on their exposure.
- Based on what is known about how this virus behaves, additional cases among people who have had contact with these patients, especially those who have had close, prolonged contact, are expected.
- This could include family members and potentially healthcare workers who cared for the patients.
- All the remaining cases detected through the U.S. public health system were in persons who had travel to areas with ongoing community transmission.

- 47 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 44 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- On Monday, most of the passengers from the Diamond Princess will complete their 14-day quarantine period.
- Patients who tested positive during their quarantine will remain in isolation. A small number of close contacts of those patients (for instance, spouses who have been living with them) who are at increased risk will have their quarantines extended.

WHAT'S NEW:

- On February 28 CDC issued a health alert network update titled: "Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)."
- CDC has been watching the increased spread of this virus across the world and worked with partners on an updated PUI definition.

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- The updated PUI definition takes into account the new geographic spread of the virus and includes a list of affected areas with widespread or sustained community spread. This list is dynamic and will change as our travel guidance is revised.
- CDC has posted "Community Mitigation Guidance for COVID-19 Response in the United States: Nonpharmaceutical Interventions for Community Preparedness and Outbreak Response."

WHAT TO DO

- While the immediate risk of this new virus for most of the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and;
        - People who have been in close contact with someone with COVID-19 or pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity for up to 14 days. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

POSSIBLE WASHINGTON CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a health care worker. This is the first reported case in a healthcare worker.

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- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
    - Circumstances suggest person-to-person spread including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

TESTING

- An important part of CDC's role in testing during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with the capacity to test for this virus.
- Distribution of a CDC rRT-PCR test to diagnose COVID-19 began to state and local public health labs, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents, which led to laboratories not being able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
        - CDC established that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Public health laboratories can use the original CDC test kit to test for the virus that causes COVID-19 using the new protocol.
    - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
- Combined with other reagents that CDC has procured, this is enough testing kits to test more than 75,000 people.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.
- Learn more information about CDC's laboratory work.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community interventions.

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- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.
- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. Personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. Community NPIs (social distancing measures and school closures and dismissals); and
    3. Environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

BACKGROUND

- This new coronavirus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
- Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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Last updated: March 1, 2020

CDC Coronavirus Disease 2019 (COVID-19) Guidance for State, Local, and Territorial Partners and Local Health Departments

Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19

Highlighted Text= New since February 21, 2020

Aircraft

Interim Guidance for Airlines and Airline Crew: Coronavirus Disease 2019 (COVID-19)

- Interim guidance for the commercial airline industry about COVID-19

Preventing Spread of Disease on Commercial Aircraft: Guidance for Cabin Crew

- This guidance provides cabin crew with practical methods to protect themselves, passengers, and other crew members when someone onboard is sick with a possible contagious disease.

Safety Alert for Operators 20001: 2019 Novel Coronavirus: Interim Health Guidance for Air Carrier and Crews

- Interim guidance from the CDC and Federal Aviation Administration for Air Carriers and Crewmembers

Businesses, Employers, and Schools

Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- This interim guidance is intended to help administrators of public and private childcare programs and K-12 schools prevent the spread of COVID-19 among students and staff.

Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19), February 2020

- Interim guidance that may help prevent workplace exposures to acute respiratory illness, including COVID-19, in non-healthcare settings.

Community Infection Control

Interim Guidance for Preventing the Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities

- Interim guidance to help prevent COVID-19 from spreading among people in their homes and in other residential communities.

Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19

- Interim guidance to help healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation to help prevent the spread of COVID-19 in the community.

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Community Mitigation

CDC in Action: Preparing Communities for Potential Spread of COVID-19

- Information on how CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.

Healthcare Facilities

Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States

- Outlines goals and strategies for all U.S. healthcare facilities to prepare for and respond to community spread of coronavirus disease-2019 (COVID-19).

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

- General strategies CDC recommends to prevent the spread of COVID-19 in LTCF

Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19)

Healthcare Professionals and Infection Control

Evaluating and Reporting Persons Under Investigation (PUI)

- The Centers for Disease Control and Prevention (CDC) clinical criteria for a COVID-19 person under investigation (PUI). Subject to change as additional information becomes available.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

- Flowchart for the evaluation of patients who may be ill with or who may have been exposed to COVID-19.

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or Persons Under Investigation for SARS-CoV-2 in Healthcare Settings

- Interim infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.**

Interim Guidance of Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PASPs) for COVID-19 in the United States

- Interim guidance for all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work

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Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020

- Interim guidance for the collection and submission of postmortem specimens from deceased persons under investigation (PUI) for COVID-19. This document also provides recommendations for biosafety and infection control practices during specimen collection and handling, including during autopsy procedures. The guidance can be utilized by medical examiners, coroners, pathologists, other workers involved in the postmortem care of deceased PUI, and local and state health departments.

Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- Interim guidance for healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) to help prevent the spread of COVID-19 in healthcare facilities.

Interim Clinical Guidance for Management of Patients with Confirmed COVID-19

- Interim guidance for clinicians caring for patients with confirmed COVID-19

Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance for staff at local and state health departments, infection prevention and control professionals, and healthcare personnel who are coordinating the home care and isolation[1] of people with confirmed or suspected 2019-nCoV infection, including persons under investigation (see Criteria to Guide Evaluation of Persons Under Investigation (PUI) for 2019- nCoV).

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV. For guidance on assessment and management of exposure risk in non-healthcare settings, refer to the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings.

Maritime

Interim Guidance for Ships on Managing Suspected Coronavirus Disease 2019

- Interim guidance for ships originating from, or stopping in, the United States to help prevent, detect, and medically manage suspected 2019-nCoV infections.

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Laboratories

Research Use Only Real-Time RT-PCR Protocol for Identification of 2019-nCoV

- This document describes the use of real-time RT PCR (rRT-PCR) assays for the in vitro qualitative detection of SARS-CoV-2 in respiratory specimens and sera.

Research Use Only 2019-Novel Coronavirus (2019-nCoV) Real-time RT-PCR Primer and Probe Information

Personal Protective Equipment (PPE)

Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response

Healthcare Supply of Personal Protective Equipment

- CDC specific PPE recommendations based on the current COVID-19 situation and availability of PPE.

Optimizing N95 Strategies

- Strategies for Optimizing the Supply of N95 Respirators

- Strategies for Optimizing the Supply of N95 Respirators: Contingency Capacity Strategies
    - In the continuum of care, the following measures can be categorized as contingency capacity, which may change daily practices but may not have any significant impact on the care delivered to the patient or the safety of the HCP.

- Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies
    - These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are not commensurate with current U.S. standards of care.

Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

- U.S. Government decision makers are considering whether these products should be released for use during the COVID-19 response. Information is provided below that may be used to inform these product release decisions.

Public Health Officials

Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).
    - Case Report Form for 2019 Novel Coronavirus

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Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings

- Guidance is intended to address recommended infection prevention and control practices when public health interviews or assessments are performed at a home or non-home residential settings.

Pandemic Preparedness Resources

- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

Pregnant Women and Children

Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19

- Interim guidance for women who are confirmed to have COVID-19 or are persons-under- investigation (PUI) for COVID-19 and are currently breastfeeding.

Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings

- Interim for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings.

Travelers

Information for Travelers

- This page includes information about 2019 novel coronavirus (COVID-19) for travelers going to and returning from China, and information for aircrew and resources ship industry.

Travelers to China

- Travel recommendations for travel to China

Travelers from China arriving in the U.S.

- Information for travelers from China arriving to the U.S.

Risk Assessment

Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-associated or Community Settings

- Interim guidance to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.

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Last updated: March 1, 2020

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for healthcare providers with potential exposure to COVID-19.

Stigma

Stigma Related to COVID-19

- Information to combat stigma and discrimination associated with COVID-19.

Frequently Asked Questions (FAQs)

Frequently Asked Questions and Answers about COVID-19

- General FAQs

Healthcare Infection Prevention and Control FAQs for COVID-19

- **Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.
- **What is it for:** This creates FAQs to support the existing Healthcare Infection Prevention and Control Guidance for COVID-19.
- **How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children

- This is a list of frequently asked questions and answers for questions about COVID-19 relating to children.

Frequently Asked Questions and Answers: Coronavirus Disease 2019 (COVID-19) and Pregnancy

- This is a list of frequently asked questions and answers for pregnant women, infants, and women who are breastfeeding.

Frequently Asked Questions about Respirators and their Use

Healthcare Professionals: Frequently Asked Questions and Answers

- FAQs for healthcare professionals

Information for Laboratories COVID-19 Requests for Diagnostic Panels and Virus

- FAQs for lab professionals

Travel: Frequently Asked Questions and Answers

- General travel-related FAQs

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Last updated: March 1, 2020

Additional Resources

2020 Health Alert (HAN) Messages: CDC's Health Alert Network (HAN) is CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, tribal, and local public health practitioner; clinicians; and public health laboratories.

CDC Newsroom: CDC Media Telebriefing: Update on COVID-19: CDC provides an update periodically to media on the COVID-19 response. Sign up for media announcements.

Clinician Outreach and Communication Activity (COCA) Calls/Webinars: During COCA Calls/Webinars, subject matter experts present key emergency preparedness and response topics, followed by meaningful Q&A with participants. The call or webinar will offer the most up to date information on guidance for clinicians.

Travel Health Notices: Travel Health Notices inform travelers and clinicians about current health issues that impact travelers' health, like disease outbreaks, special events or gatherings, and natural disasters, in specific international destinations.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

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Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

Background

There is much to learn about the newly emerged coronavirus disease 2019 (COVID-19). Based on what is known about early cases of COVID-19, spread from person-to-person via the respiratory route and usually happens among close contacts (within about 6 feet).

People with certain types of exposure to cases of COVID-19 may be housed and quarantined for observation until 14 days after their exposure. The purpose of the observation period is to ensure they don't develop symptoms and infect others during this time. Some people stay at home for the observation period, but others may be housed either separately or in groups in other types of facilities.

In these facilities, individuals and families are provided separate quarters with separate bathroom facilities. They are instructed that congregation and shared public spaces are to be avoided. Because the people under quarantine are not ill, the risk to cleaning staff is inherently low.

Purpose

This guidance provides recommendation on the cleaning and disinfection of rooms of persons under quarantine, as well as associated worker protection practices according to expected job tasks. The goal is to minimize interactions between persons under quarantine and cleaning staff. These recommendations will be updated if additional information becomes available.

General Recommendations for Housing Facilities for Persons Under Quarantine

- Employers should develop policies for worker protection and provide training to all cleaning staff on-site prior to beginning work. Training should include:
    - An understanding of when to use personal protective equipment (PPE)
    - What PPE is necessary and why (see below for PPE recommendations)
    - How to properly don (put on), use, and doff (take off) PPE
    - How to properly dispose of PPE
- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard, 29 CFR 1910.1200.
- Employers must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste, and PPE (29 CFR 1910.132).
- Cleaning staff should perform hand hygiene often including immediately after removing PPE by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Cleaning staff should immediately report breaches in PPE (e.g., tear in gloves) or any potential exposures (e.g., contact with a quarantined individual without wearing appropriate PPE) to their supervisor.

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- Employers should educate workers to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms until 14 days after the last day they had possible exposure to the virus.
    - Cleaning staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Cleaning staff should follow normal preventive actions while at work and home including covering their mouth and nose with a tissue when coughing or sneezing and avoiding touching eyes, nose, or mouth with unwashed hands.
- If surfaces are dirty, they should be cleaned using a detergent and water prior to disinfection.
    - A list of products with EPA-approved emerging viral pathogens claims, maintained by the American Chemistry Council Center for Biocide Chemistries (CBC), is available at: https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf.
    - Products with EPA-approved emerging viral pathogens claims are expected to be effective against COVID-19 based on data for harder to kill viruses.
    - Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE) for use.

Cleaning Activities During the Quarantine Period

Because cleaning needs are limited during the quarantine period, CDC is recommending that cleaning staff do not clean occupied rooms in quarantine facilities. Instead, all rooms should be provisioned with personal cleaning supplies, e.g., tissues, paper towels, cleaners and disinfectants that are EPA-approved against emerging viral pathogens (see list above) for use by persons under quarantine as needed. Rooms and common areas occupied by persons under quarantine should not be cleaned by cleaning staff until all persons under quarantine have been released from quarantine and have vacated the area and no sooner than 24 hours after rooms and common areas have been vacated.

During the quarantine:

- Persons under quarantine should bag trash and place the closed bag outside their door for daily pick up.
- Similarly, persons under quarantine should bag soiled linens and place the closed bag outside their door for pick up.
- Cleaning, laundry, and trash removal staff should wear disposable gloves and gowns for all tasks in the cleaning process, including collection of closed bags.
    - Staff should remove gloves after cleaning a room or area occupied by persons under quarantine before moving to the next room.
    - After delivering bags to their final destination, staff should clean and disinfect any hard, cleanable surfaces where bags have been stored (such as on carts or on the floor).
    - Laundry and trash removal staff collecting the closed bags should remove their gloves promptly after bags are delivered to their destination and cleaning and disinfection has been performed.
    - Any time staff remove gloves, they should perform hand hygiene immediately by washing their hands with soap and water for 20 seconds. If hands are not visibly dirty and soap and water are not available, an alcohol-based hand sanitizer that contains

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60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

- If possible, for fabrics or other materials that can be laundered, use the warm water setting and dry items completely on high heat.
- If a person under quarantine has a special need for assisted cleaning (e.g., an elderly person who is unable to clean a spill such as vomiting in their quarters), public health staff will oversee the cleaning process as part of their evaluation of the individual.

Cleaning a Room Vacated by a Person under Quarantine <u>with</u> COVID-19 (Enhanced Cleaning)

Rooms that housed a person under quarantine with COVID-19 should remain closed to further use until cleaned and disinfected by appropriately trained cleaning staff. The room should not be entered by cleaning staff for at least for 24 hours.

- Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process.
    - These gloves and gowns should be compatible with the disinfectant products being used
    - Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk for splash.
    - Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area.
- Cleaning should be undertaken using products with EPA-approved emerging viral pathogens claims (https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf). All products should be used according to label instructions.
    - Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
    - Adhere to any safety precautions or other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE).
    - Avoid using product application methods that cause splashing or generate aerosols.
    - Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
    - After cleaning and removal and disposal of gloves, staff should perform hand hygiene by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.
- Clean and disinfect all frequently touched surfaces in quarantine locations (e.g., counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, remotes and bedside tables) according to instructions described for products with EPA-approved emerging viral pathogens claims.
- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present. Launder items as appropriate in accordance with the manufacturer's instructions. Porous materials that will be laundered can be transported to the laundry facility in the usual manner. If possible, launder items using the warm water setting and dry items completely on high heat.

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- When cleaning is completed, collect soiled material and PPE in a sturdy, leak-proof (e.g., plastic) bag that is tied shut and not reopened. This waste can go to the regular solid waste stream (e.g., municipal trash) as it is not biohazardous or regulated medical waste.
- If bulk material and spills containing blood or body substances are present, cleaning staff should use absorbent materials, such as towels, to remove the material. The area should then be cleaned and then disinfected with products with EPA-approved emerging viral pathogens claims used according to product label instructions.
- No additional cleaning is needed for supply and return ventilation registers or filtration systems for the building.
- No additional treatment of wastewater is needed before discharging to sanitary sewer.

Cleaning Recommendations for Quarantined Persons from Uncontrolled Sources (e.g. increased likelihood of many cases such as on cruise ships, etc.)

Cleaning for facilities housing persons under quarantine because of exposure from an uncontrolled source should be conducted following the Enhanced Cleaning procedures and include cleaning of common areas outlined above.

Cleaning a Room Vacated by persons under quarantine without COVID-19

After all persons under quarantine are released and assuming the quarantined persons are not from an uncontrolled source (see above):

- If all persons under quarantine have been released and vacated the housing area and no persons tested positive for COVID-19, the facility (e.g., rooms, common areas) should be cleaned according to standard procedures.
- No additional PPE is required beyond what is normally worn for regular housekeeping activities.

Cleaning of Common Areas of a Housing Facility (if used)

If common areas are used by persons under quarantine, those areas will require cleaning and disinfection during the quarantine period.

- Common areas of a facility should be cleaned on a daily basis, and as needed.
- Regardless of known COVID-19 status of persons under quarantine, common areas should be cleaned according to ***Cleaning a Room Vacated by a person under quarantine with COVID-19(Enhanced Cleaning)*** recommendations, since communication to cleaning staff about persons under quarantine who develop symptoms or test positive for COVID-19 may not be able to occur as quickly as cleaning services are required.
- No quarantined individuals should be present in a common area during cleaning. Common areas of a facility should be closed off to all persons except for cleaning staff before cleaning and disinfection activities take place.

Additional Resource:

OSHA COVID-19 Website:
https://www.osha.gov/SLTC/covid-19/

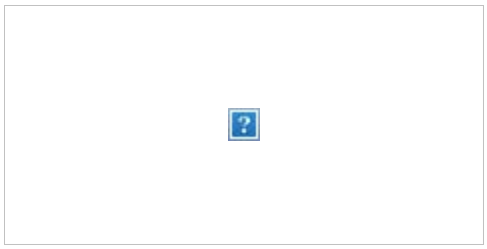
AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance)
Date: Monday, March 16, 2020 11:05:29 PM

Dear Colleagues:

Please see the link below for new **CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance).**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html



Disposition of Non-Hospitalized Patients with COVID-19 | CDC

Who this is for: Healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation. What this is for: To help prevent the spread of COVID-19 in the community. How to use: Reference to guide healthcare staff and

www.cdc.gov

Guidance as of March 16, 2020

- New guidance is added for a strategy to discontinue home isolation without testing.
- Updated guidance for a test-based strategy: The recommendation to collect both NP and OP swabs at each sampling has been changed so that only one swab is necessary, preferably NP, at each sampling.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance)
Date: Monday, March 16, 2020 11:07:25 PM

Dear Colleagues:

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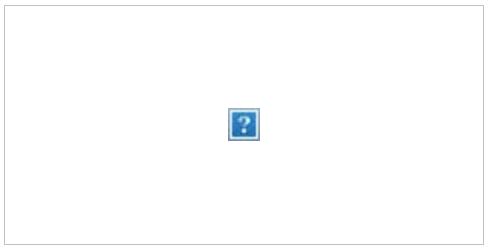
https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html



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To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Guidance for Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance)
Date: Monday, March 16, 2020 11:03:24 PM

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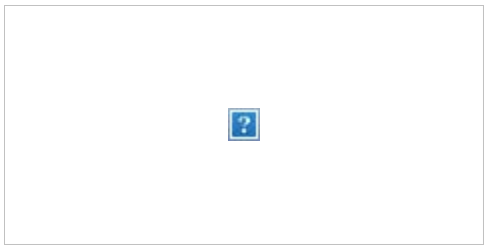

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AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: CDC COVID-19 guidance
Date: Sunday, March 1, 2020 11:49:40 AM

ALL

With so many new guidance documents being produced in the last few days, we wanted to make sure you had easy access to them.
This list also contains a document aimed at LTCs.

Healthcare Supply of Personal Protective Equipment

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html
- https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html

Resources for Healthcare Facilities

- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/steps-to-prepare.html
- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html
- https://wwwdev.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Optimizing N95 Strategies

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/conventional-capacity-strategies.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/contingency-capacity-strategies.html
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/crisis-alternate-strategies.html

Also pushed Lab pages

- https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/lab/tool-virus-requests.html
- https://www.cdc.gov/coronavirus/2019-ncov/lab/rt-pcr-detection-instructions.html
- https://www.cdc.gov/coronavirus/2019-ncov/lab/rt-pcr-panel-primer-probes.html

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)

AMERICAN OVERSIGHT

Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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cell: 202.909.6950 Verizon (secondary)

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Key Points (02-19-2020)
Date:	Thursday, February 20, 2020 8:23:32 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_19_2020_final.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 daily key points for Wednesday, February 19, 2020. Feel free to share with your staff and other partners.

Thank you,

State Coordination Task Force (SCTF)

Sent by BCC to State Health Officials, PHEP Directors, Non-governmental Partners, Lab Directors, State Epidemiologists, and STLT partners

AMERICAN OVERSIGHT

CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 19, 2020

All content updated since February 16 is shown in colored text.

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2."
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- This virus that causes COVID-19 is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
    - A Level 1 Travel Notice (Practice Usual Precautions) was issued for Hong Kong on February 18.
- Most COVID-19 cases outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
    - Other destinations with apparent community spread of COVID-19 have been identified—Japan, Singapore, Thailand, Vietnam, South Korea, and Taiwan. Information about COVID-19 was added to the destination pages for these locations on February 19.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.

AMERICAN OVERSIGHT

- CDC has worked with Department of State to support the safe return of Americans overseas affected by the ongoing outbreaks of COVID-19, including most recently passengers from the *Diamond Princess* cruise ship. (See Section: "*Diamond Princess*")
- The U.S. public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
    - Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 29 international locations (in addition to the U.S.) have reported confirmed cases of COVID-19.
- As of February 19, 15 cases of COVID-19 have been reported in the U.S. in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
    - To date, there have been 479 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 412 persons ruled out as negative. These data are updated regularly at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - These numbers do not include passengers from the *Diamond Princess* cruise ship, including presumptive-positive cases, who were returned to the U.S. via State Department-chartered flights.
    - It is likely that additional cases of COVID-19 will be detected in the United States.
- On February 18, 347 people who were under federal quarantine were released.
    - People released from quarantine pose no health risk to their communities.
- CDC established a COVID-19 Incident Management System on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.
- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.
- CDC isolated the virus and shared this material with NIH's BEI Resources Repository for use by the broad scientific community.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
- On February 3, CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a

AMERICAN OVERSIGHT

framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. COVID-19 patients to detect person-to-person spread.
- As of February 17, CDC and Customs and Border (CBP) personnel had screened about 41,000 people with recent travel history to China at U.S. airports.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
    - Five chartered flights returned passengers from Wuhan City, China.
    - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.

AMERICAN OVERSIGHT

    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
    - Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
    - CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
    - At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.
- On February 18, 347 people who were under federal quarantine were released.

DIAMOND PRINCESS

- CDC is supporting the Department of State-led mission to repatriate U.S. citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the U.S. government recommended that U.S. citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and have been monitored and evaluated by medical and public health personnel during the trip and after arrival.
    - Those passengers who returned from Japan are being housed separately from the people already in quarantine who returned on previous U.S. Government repatriation flights from Wuhan.
- There are more than 100 American citizens still onboard the *Diamond Princess* cruise ship or in hospitals in Japan. These citizens have been placed under travel restrictions, as have the ship's other passengers and crew.
    - After disembarkation from the *Diamond Princess*, these passengers and crew will be required to wait at least 14 days without having symptoms or a positive coronavirus test result before they are permitted to board flights to the United States.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Key Points (02-19-2020)
Date:	Thursday, February 20, 2020 10:15:55 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_19_2020_final.pdf

Dear Colleagues,

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
    - Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
    - CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
    - At the end of the 14-day period, people who have not developed symptoms will be free to leave.
- On February 12, 195 people from the first chartered flight were discharged from quarantine.
- On February 18, 347 people who were under federal quarantine were released.

DIAMOND PRINCESS

- CDC is supporting the Department of State-led mission to repatriate U.S. citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the U.S. government recommended that U.S. citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and have been monitored and evaluated by medical and public health personnel during the trip and after arrival.
    - Those passengers who returned from Japan are being housed separately from the people already in quarantine who returned on previous U.S. Government repatriation flights from Wuhan.
- There are more than 100 American citizens still onboard the *Diamond Princess* cruise ship or in hospitals in Japan. These citizens have been placed under travel restrictions, as have the ship's other passengers and crew.
    - After disembarkation from the *Diamond Princess*, these passengers and crew will be required to wait at least 14 days without having symptoms or a positive coronavirus test result before they are permitted to board flights to the United States.
- The U.S. Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Key Points (02-19-2020)
Date:	Thursday, February 20, 2020 8:19:46 AM
Attachments:	CDC_COVID-19_Daily Key Points_2_19_2020_final.pdf

Dear Colleagues,

Attached please find the CDC COVID-19 daily key points for Wednesday, February 19, 2020. Feel free to share with your staff and other partners.

Thank you,

State Coordination Task Force (SCTF)

Sent by BCC to State Health Officials, PHEP Directors, Non-governmental Partners, Lab Directors, State Epidemiologists, and STLT partners

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 19, 2020

All content updated since February 16 is shown in colored text.

MAIN KEY POINTS

- There is an expanding outbreak of respiratory illness centered in China caused by a novel (new) coronavirus.
- The International Committee on Taxonomy of Viruses (ICTV) has named this virus "SARS-CoV-2."
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- This virus that causes COVID-19 is able to spread from person-to-person and has caused disease ranging from mild to severe, including disease resulting in death.
- Most cases and most person-to-person spread with the new virus have occurred in mainland China, but outbreaks of COVID-19 have been detected outside of China too.
    - A Level 1 Travel Notice (Practice Usual Precautions) was issued for Hong Kong on February 18.
- Most COVID-19 cases outside of China have been associated with travel to or from China, but some person-to-person spread has been detected, including some community spread.
    - Other destinations with apparent community spread of COVID-19 have been identified—Japan, Singapore, Thailand, Vietnam, South Korea, and Taiwan. Information about COVID-19 was added to the destination pages for these locations on February 19.
- The potential global public health threat posed by this virus is high, but right now, the immediate risk to most Americans is low.
- The greater risk is for people who have recently traveled to China or been exposed to someone with COVID-19.
- Fifteen cases of COVID-19 have been reported in the United States. Most cases of COVID-19 in the United States have been associated with travel from China but some person-to-person spread among close contacts of travelers has been seen.
- It's important to note that this virus is not spreading in the community in the United States at this time.
- This is a rapidly evolving situation and the risk assessment for Americans may change.
- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States so as to reduce the spread and the impact of this virus.
- Strategies are in place to reduce the number of travelers from China and screen the remaining travelers from that country for illness, with people potentially being subject to a 14-day quarantine.
- These measures are likely to cause some disruption.

AMERICAN OVERSIGHT

- CDC has worked with Department of State to support the safe return of Americans overseas affected by the ongoing outbreaks of COVID-19, including most recently passengers from the *Diamond Princess* cruise ship. (See Section: "*Diamond Princess*")
- The U.S. public health system also is on high alert to detect cases of COVID-19 and prevent further spread in the community.
- The success of response efforts now will determine what the coming days, weeks, and months will bring here in the United States.
- While leaning forward aggressively with the hope that we will be able to prevent community spread, we also are preparing for the worst.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community takes hold outside China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Influenza pandemic preparedness platforms and plans would be appropriate in the event that the current COVID-19 outbreak triggers a pandemic.
    - Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- To date, 29 international locations (in addition to the U.S.) have reported confirmed cases of COVID-19.
- As of February 19, 15 cases of COVID-19 have been reported in the U.S. in seven states — Arizona, California, Illinois, Massachusetts, Texas, Washington, and Wisconsin.
    - To date, there have been 479 "persons under investigation" (PUIs) for possible COVID-19 reported to CDC, with 412 persons ruled out as negative. These data are updated regularly at www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.
    - These numbers do not include passengers from the *Diamond Princess* cruise ship, including presumptive-positive cases, who were returned to the U.S. via State Department-chartered flights.
    - It is likely that additional cases of COVID-19 will be detected in the United States.
- On February 18, 347 people who were under federal quarantine were released.
    - People released from quarantine pose no health risk to their communities.
- CDC established a COVID-19 Incident Management System on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the response.
- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose COVID-19 in respiratory samples from clinical specimens.
- CDC isolated the virus and shared this material with NIH's BEI Resources Repository for use by the broad scientific community.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
- On February 3, CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus Exposure in Travel-associated or Community Settings" to provide U.S. public health authorities and other partners with a

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framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. COVID-19 patients to detect person-to-person spread.
- As of February 17, CDC and Customs and Border (CBP) personnel had screened about 41,000 people with recent travel history to China at U.S. airports.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a COVID-19 patient or a public health responder, please take care of yourself and follow recommended infection control procedures.
    - If you have been in China or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus. If you develop COVID-19 symptoms, contact your healthcare provider, and tell them about your symptoms and your travel or exposure to a COVID-19 patient.
    - For people who have had close contact with someone with COVID-19 who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a COVID-19 patient.
    - For people who are ill with COVID-19, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

TESTING

- All testing for COVID-19 continues to be performed at CDC. At this time, all positive results from testing conducted in non-CDC, U.S. laboratories must be confirmed at CDC.
- CDC is remanufacturing test kits, which will be distributed following rigorous quality control processes.

REPATRIATED FLIGHTS & QUARANTINE ORDERS

- CDC has supported the Department of State in the safe and expedient ordered departure of U.S. citizens and residents affected by outbreaks of COVID-19.
    - Five chartered flights returned passengers from Wuhan City, China.
    - Most recently, passengers from a cruise ship docked in Japan were repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.

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    - The quarantine period is for 14 days.
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    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
    - Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
    - CDC works with the state and local public health departments to transport any passenger exhibiting symptoms to a hospital for further evaluation.
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DIAMOND PRINCESS

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    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and have been monitored and evaluated by medical and public health personnel during the trip and after arrival.
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- There are more than 100 American citizens still onboard the *Diamond Princess* cruise ship or in hospitals in Japan. These citizens have been placed under travel restrictions, as have the ship's other passengers and crew.
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- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Travel Health Alert Notice (THAN) Cards, Updated CARE Booklets, and Travel Alert Language
Date:	Tuesday, March 3, 2020 6:42:44 PM
Attachments:	03-03-2020_COVID-19_THAN_Level 3s.pdf

Dear Colleagues:

Attached is the updated Travel Health Alert Notice (THAN) card. The cards have a link to that a NEW traveler information webpage that has **not yet gone live, but will be live soon.**

In addition, the **updated Level 2 and Level 3 travel alert language will go live tomorrow.**

- When it does, it will be here: https://www.cdc.gov/coronavirus/2019-ncov/travelers.
- The language will instruct travelers from countries with a Level 3 alert to "stay home and monitor their health for 14 days after returning to the United States." It also instructs travelers from countries with a Level 2 alert to "monitor their health and limit interactions with others for 14 days after returning to the United States."

As was shared previously, the updated **CARE booklet for China travelers** is available here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

Kind Regards,

State Coordination Task Force

(Sent by BCC to state epidemiologists and state health officials)

AMERICAN OVERSIGHT

COVID 19 CORONAVIRUS DISEASE

Health Alert: Coronavirus Disease 2019 (COVID-19)

You have traveled to a country with an outbreak of COVID-19 and are at higher risk.

COVID-19 is a respiratory illness that can spread from person to person.

Stay Home

Stay home for the next 14 days and monitor your health. Take your temperature with a thermometer two times a day and watch for symptoms.

If you feel sick and have symptoms:

- Call ahead before you go to a doctor's office or emergency room.
- Tell the doctor about your recent travel and your symptoms.
- Avoid contact with others.
- Do not travel while sick.

Symptoms

Illnesses have ranged from mild symptoms to severe illness and death. Symptoms may appear 2–14 days after exposure.

Symptoms can include:



Fever (100.4°F/38°C or higher)



Cough



Shortness of breath

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Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

FL-DOH-20-0673-A-002821

CDC

CS 315649-B February 29, 2020 4:15 PM

For information about COVID-19 and how to monitor your health after travel, open your cell phone camera and scan this code:

Для получения информации о COVID-19 и о том, как контролировать состояние вашего здоровья после путешествия, включите камеру на вашем мобильном телефоне и отсканируйте этот код:

Pour obtenir des informations relatives à COVID-19 et à la manière de surveiller votre santé après un voyage, ouvrez la caméra de votre téléphone portable et scannez le code suivant :

للحصول على معلومات حول فيروس كورونا المستجد COVID-19 وكيفية مراقبة حالتك الصحية بعد السفر، افتح كاميرا هاتفك الخلوي وامسح هذا الرمز ضوئيًا:

新型コロナウイルス感染症（COVID-19）に関する情報、および旅行後の自身の健康状態を観察する方法については、携帯電話のカメラを起動して、このコードをスキャンしてください：

Para obter informações sobre o COVID-19 e como monitorar sua saúde após a viagem, abra a câmera do seu celular e digitalize este código:

코로나바이러스감염증-19(COVID-19) 및 여행 후 건강 상태를 모니터링하는 방법에 대한 정보를 보려면, 휴대폰 카메라로 이 코드를 스캔하십시오:

COVID-19 के बारे मे और यात्रा के बाद अपने स्ास्य को मॉनीटर कैसे करे, के बारे मे जानकारी के लिए, अपने सेि फोन का कैमरा चालिए और इस कोड को स्कैन करे:

สำหรับข้อมูลเพิ่มเติมเกี่ยวกับ COVID-19 และวิธีการตรวจเช็คสุขภาพของคุณหลังจากการเดินทาง โปรดเปิดกล้องมือถือของคุณและสแกนรหัสนี้:

Untuk mendapatkan maklumat mengenai COVID-19 dan cara mengawasi kesihatan anda selepas perjalanan, buka kamera telefon bimbit anda dan imbas kod ini:

Para obtener información sobre el COVID-19 y cómo monitorear su salud después de un viaje, abra la cámara de su teléfono y escanee este código:

有关COVID-19 的信息以及如何在旅行后监测您的健康状况，请打开手机摄像头并扫描此二维码：

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-002822

www.cdc.gov/COVIDTravel

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC COVID-19 Updated Guidance and CARE Booklets
Date: Tuesday, March 3, 2020 7:24:32 PM
Attachments: COVID-19_GuidanceList_03MAR20.pdf

Dear Colleagues:

Attached is the CDC COVID-19 Updated guidance list for 03-03-2020.

As was shared previously, the updated **CARE booklet for China travelers** is available here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/care-booklet.html.

Updated Guidance Includes:

Interim Guidance for Administrators of US Institutions of Higher Education (IHE) to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- Information for administrators of public and private institutions of higher education (IHE) prevent the spread of COVID-19 among students, staff, and faculty.

Guidance for Student Foreign Travel for Institutions of Higher Education

- This guidance is for Institutes of Higher Education with students participating in foreign exchange or study abroad programs.

Interim Guidance: Public Health Communicators Get Your Community Ready for Coronavirus Disease 2019 (COVID-19)

- Information for state and local public health information officers, health communication specialists, health educators, and other public health professionals responsible for planning communication strategies before, during, and after an outbreak of coronavirus disease (COVID-19).

Preventing COVID-19 Spread in Communities: Landing page for community mitigation guidance. How to prepare and take action for COVID-19

What Law Enforcement Personnel Need to Know about Coronavirus Disease 2019 (COVID-19)

- Interim guidance for Law Enforcement Personnel

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Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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Last updated: March 3, 2020

CDC Coronavirus Disease 2019 (COVID-19) Guidance for State, Local, and Territorial Partners and Local Health Departments

Interim guidance documents relevant to State, Local, and Territorial partners regarding COVID-19
CDC COVID-19 Website

Highlighted Text= New since March 1, 2020

Aircraft 2
Businesses, Employers, and Schools 2
Communications 2
Community Infection Control 3
Community Mitigation 3
Healthcare Facilities 3
Healthcare Professionals and Infection Control 4
Maritime 5
Laboratories 5
Law Enforcement Personnel 5
Personal Protective Equipment (PPE) 5
Public Health Officials 6
Pregnant Women and Children 7
Travelers 7
Risk Assessment 7
Stigma 7
Frequently Asked Questions (FAQs) 8
Additional Resources 9

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Last updated: March 3, 2020

Aircraft

Interim Guidance for Airlines and Airline Crew: Coronavirus Disease 2019 (COVID-19)

- Interim guidance for the commercial airline industry about COVID-19

Preventing Spread of Disease on Commercial Aircraft: Guidance for Cabin Crew

- This guidance provides cabin crew with practical methods to protect themselves, passengers, and other crew members when someone onboard is sick with a possible contagious disease.

Safety Alert for Operators 20001: 2019 Novel Coronavirus: Interim Health Guidance for Air Carrier and Crews

- Interim guidance from the CDC and Federal Aviation Administration for Air Carriers and Crewmembers

Businesses, Employers, and Schools

Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- This interim guidance is intended to help administrators of public and private childcare programs and K-12 schools prevent the spread of COVID-19 among students and staff.

Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19), February 2020

- Interim guidance that may help prevent workplace exposures to acute respiratory illness, including COVID-19, in non-healthcare settings.

Interim Guidance for Administrators of US Institutions of Higher Education (IHE) to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)

- Information for administrators of public and private institutions of higher education (IHE) prevent the spread of COVID-19 among students, staff, and faculty.

Guidance for Student Foreign Travel for Institutions of Higher Education

- This guidance is for Institutes of Higher Education with students participating in foreign exchange or study abroad programs.

Communications

Interim Guidance: Public Health Communicators Get Your Community Ready for Coronavirus Disease 2019 (COVID-19)

- Information for state and local public health information officers, health communication specialists, health educators, and other public health professionals responsible for planning communication strategies before, during, and after an outbreak of coronavirus disease (COVID-19).

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Last updated: March 3, 2020

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Community Infection Control

Interim Guidance for Preventing the Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities

- Interim guidance to help prevent COVID-19 from spreading among people in their homes and in other residential communities.

Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19

- Interim guidance to help healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) under in-home isolation to help prevent the spread of COVID-19 in the community.

Community Mitigation

Preventing COVID-19 Spread in Communities: Landing page for community mitigation guidance.
How to prepare and take action for COVID-19

- At home
- At childcare and K-12 schools
- At colleges and universities
- At work
- Healthcare settings
- Large community events/mass gatherings
- First responders

CDC in Action: Preparing Communities for Potential Spread of COVID-19

- Information on how CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the United States.

Healthcare Facilities

Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States

- Outlines goals and strategies for all U.S. healthcare facilities to prepare for and respond to community spread of coronavirus disease-2019 (COVID-19).

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF)

- General strategies CDC recommends to prevent the spread of COVID-19 in LTCF

Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19)

AMERICAN OVERSIGHT

Last updated: March 3, 2020

Healthcare Professionals and Infection Control

Evaluating and Reporting Persons Under Investigation (PUI)

- The Centers for Disease Control and Prevention (CDC) clinical criteria for a COVID-19 person under investigation (PUI). Subject to change as additional information becomes available.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

- Flowchart for the evaluation of patients who may be ill with or who may have been exposed to COVID-19.

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or Persons Under Investigation for SARS-CoV-2 in Healthcare Settings

- Interim infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of personal protective equipment (PPE) are all necessary to prevent infections from spreading during healthcare delivery. **This guidance is not intended for non-healthcare settings (e.g., schools) OR to persons outside of healthcare settings.**

Interim Guidance of Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PASPs) for COVID-19 in the United States

- Interim guidance for all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work

Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020

- Interim guidance for the collection and submission of postmortem specimens from deceased persons under investigation (PUI) for COVID-19. This document also provides recommendations for biosafety and infection control practices during specimen collection and handling, including during autopsy procedures. The guidance can be utilized by medical examiners, coroners, pathologists, other workers involved in the postmortem care of deceased PUI, and local and state health departments.

Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- Interim guidance for healthcare providers and public health officials managing patients with coronavirus disease (COVID-19) to help prevent the spread of COVID-19 in healthcare facilities.

Interim Clinical Guidance for Management of Patients with Confirmed COVID-19

- Interim guidance for clinicians caring for patients with confirmed COVID-19

AMERICAN OVERSIGHT

Last updated: March 3, 2020

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Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance for staff at local and state health departments, infection prevention and control professionals, and healthcare personnel who are coordinating the home care and isolation[1] of people with confirmed or suspected 2019-nCoV infection, including persons under investigation (see Criteria to Guide Evaluation of Persons Under Investigation (PUI) for 2019- nCoV).

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV. For guidance on assessment and management of exposure risk in non-healthcare settings, refer to the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings.

Maritime

Interim Guidance for Ships on Managing Suspected Coronavirus Disease 2019

- Interim guidance for ships originating from, or stopping in, the United States to help prevent, detect, and medically manage suspected 2019-nCoV infections.

Laboratories

Research Use Only Real-Time RT-PCR Protocol for Identification of 2019-nCoV

- This document describes the use of real-time RT PCR (rRT-PCR) assays for the in vitro qualitative detection of SARS-CoV-2 in respiratory specimens and sera.

Research Use Only 2019-Novel Coronavirus (2019-nCoV) Real-time RT-PCR Primer and Probe Information

Law Enforcement Personnel

What Law Enforcement Personnel Need to Know about Coronavirus Disease 2019 (COVID-19)

- Interim guidance for Law Enforcement Personnel

Personal Protective Equipment (PPE)

Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response

Healthcare Supply of Personal Protective Equipment

- CDC specific PPE recommendations based on the current COVID-19 situation and availability of PPE.

AMERICAN OVERSIGHT

Last updated: March 3, 2020

Optimizing N95 Strategies

- Strategies for Optimizing the Supply of N95 Respirators

- Strategies for Optimizing the Supply of N95 Respirators: Contingency Capacity Strategies
    - In the continuum of care, the following measures can be categorized as contingency capacity, which may change daily practices but may not have any significant impact on the care delivered to the patient or the safety of the HCP.

- Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies
    - These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are not commensurate with current U.S. standards of care.

Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

- U.S. Government decision makers are considering whether these products should be released for use during the COVID-19 response. Information is provided below that may be used to inform these product release decisions.

Public Health Officials

Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).
    - Case Report Form for 2019 Novel Coronavirus

Interim Guidance: Public Health Communicators Get Your Community Ready for Coronavirus Disease 2019 (COVID-19)

- Information for state and local public health information officers, health communication specialists, health educators, and other public health professionals responsible for planning communication strategies before, during, and after an outbreak of coronavirus disease (COVID-19).

Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings

- Guidance is intended to address recommended infection prevention and control practices when public health interviews or assessments are performed at a home or non-home residential settings.

Pandemic Preparedness Resources

- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

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Last updated: March 3, 2020

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- Interim guidance for women who are confirmed to have COVID-19 or are persons-under- investigation (PUI) for COVID-19 and are currently breastfeeding.

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Information for Travelers

- This page includes information about 2019 novel coronavirus (COVID-19) for travelers going to and returning from China, and information for aircrew and resources ship industry.

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- Travel recommendations for travel to China

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Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

AMERICAN OVERSIGHT

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To:	State and Local Readiness (CDC)
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What Law Enforcement Personnel Need to Know about Coronavirus Disease 2019 (COVID-19)

- Interim guidance for Law Enforcement Personnel

Kind Regards,

AMERICAN OVERSIGHT

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

Last updated: March 3, 2020

CDC Coronavirus Disease 2019 (COVID-19) Guidance for State, Local, and Territorial Partners and Local Health Departments

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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- Interim guidance for clinicians caring for patients with confirmed COVID-19

AMERICAN OVERSIGHT

Last updated: March 3, 2020

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AMERICAN OVERSIGHT

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- Strategies for Optimizing the Supply of N95 Respirators

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- Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies
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Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).
    - Case Report Form for 2019 Novel Coronavirus

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- Guidance is intended to address recommended infection prevention and control practices when public health interviews or assessments are performed at a home or non-home residential settings.

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    - These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are not commensurate with current U.S. standards of care.

Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response

- U.S. Government decision makers are considering whether these products should be released for use during the COVID-19 response. Information is provided below that may be used to inform these product release decisions.

Public Health Officials

Information for Health Departments on Reporting a Person Under Investigation (PUI) for 2019-nCoV

- Information for health departments on reporting and specimen referral for Persons Under Investigation (PUIs).
    - Case Report Form for 2019 Novel Coronavirus

Interim Guidance: Public Health Communicators Get Your Community Ready for Coronavirus Disease 2019 (COVID-19)

- Information for state and local public health information officers, health communication specialists, health educators, and other public health professionals responsible for planning communication strategies before, during, and after an outbreak of coronavirus disease (COVID-19).

Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings

- Guidance is intended to address recommended infection prevention and control practices when public health interviews or assessments are performed at a home or non-home residential settings.

Pandemic Preparedness Resources

- While the content at the links provided below was developed to prepare for, or respond to, an influenza ("flu") pandemic, the newly emerged coronavirus disease 2019 (COVID-19) is a respiratory disease that seems to be spreading much like flu. Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.

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Pregnant Women and Children

Interim Guidance on Breastfeeding for a Mother Confirmed or Under Investigation for COVID-19

- Interim guidance for women who are confirmed to have COVID-19 or are persons-under- investigation (PUI) for COVID-19 and are currently breastfeeding.

Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings

- Interim for healthcare facilities providing obstetric care for pregnant patients with confirmed coronavirus disease (COVID-19) or pregnant persons under investigation (PUI) in inpatient obstetric healthcare settings including obstetrical triage, labor and delivery, recovery and inpatient postpartum settings.

Travelers

Information for Travelers

- This page includes information about 2019 novel coronavirus (COVID-19) for travelers going to and returning from China, and information for aircrew and resources ship industry.

Travelers to China

- Travel recommendations for travel to China

Travelers from China arriving in the U.S.

- Information for travelers from China arriving to the U.S.

Risk Assessment

Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (COVID-19) Exposure in Travel-associated or Community Settings

- Interim guidance to provide U.S. public health authorities and other partners with a framework for assessing and managing risk of potential exposures to COVID-19 and implementing public health actions based on a person's risk level and clinical presentation.

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV)

- Interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for healthcare providers with potential exposure to COVID-19.

Stigma

Stigma Related to COVID-19

- Information to combat stigma and discrimination associated with COVID-19.

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Frequently Asked Questions (FAQs)

Frequently Asked Questions and Answers about COVID-19

- General FAQs

Healthcare Infection Prevention and Control FAQs for COVID-19

- **Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.
- **What is it for:** This creates FAQs to support the existing Healthcare Infection Prevention and Control Guidance for COVID-19.
- **How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children

- This is a list of frequently asked questions and answers for questions about COVID-19 relating to children.

Frequently Asked Questions and Answers: Coronavirus Disease 2019 (COVID-19) and Pregnancy

- This is a list of frequently asked questions and answers for pregnant women, infants, and women who are breastfeeding.

Frequently Asked Questions about Respirators and their Use

Healthcare Professionals: Frequently Asked Questions and Answers

- FAQs for healthcare professionals

Information for Laboratories COVID-19 Requests for Diagnostic Panels and Virus

- FAQs for lab professionals

Travel: Frequently Asked Questions and Answers

- General travel-related FAQs

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Additional Resources

2020 Health Alert (HAN) Messages: CDC's Health Alert Network (HAN) is CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, tribal, and local public health practitioner; clinicians; and public health laboratories.

CDC Newsroom: CDC Media Telebriefing: Update on COVID-19: CDC provides an update periodically to media on the COVID-19 response. Sign up for media announcements.

Clinician Outreach and Communication Activity (COCA) Calls/Webinars: During COCA Calls/Webinars, subject matter experts present key emergency preparedness and response topics, followed by meaningful Q&A with participants. The call or webinar will offer the most up to date information on guidance for clinicians.

Travel Health Notices: Travel Health Notices inform travelers and clinicians about current health issues that impact travelers' health, like disease outbreaks, special events or gatherings, and natural disasters, in specific international destinations.

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date:	Monday, March 9, 2020 11:49:15 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_3-8-20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 weekly key messages, Consular Notification Guidance, and the bridgeline for today's **CDC Media Telebriefing at 12:15 PM EDT provided below**.

Please reference the "Consular Notification Guidance for State and Local Authorities." This document was developed by the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained (i.e., a case when a quarantine order is issued because of possible exposure to COVID-19 disease).

Media Advisory

For Immediate Release
Monday, March 9, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Monday, March 9, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to

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indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

State Coordination Task Force (SCTF)
CDC COVID-19 Weekly Key Messages & Consular Notification Guidance for State and Local Authorities Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

March 8, 2020 as of 10:30pm

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since March 1 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).

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    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is threatening to cause a pandemic.
- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person-to-person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **March 8, more than 105,585** cases have been identified worldwide. More than **24,727** of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.

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- During the week of February 23, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure in multiple states. [See section "Possible U.S. cluster" below.]
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **March 6, 2020, 2020**:

- **Travel-related: 36**
- **Person-to-person spread: 18**
- **Under investigation: 110**
- **Total cases: 164**
- **Deaths: 11**
- **States reporting cases: 19**

Persons repatriated to the United States and tested positive by CDC, as of **March 6, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **46**

For global cases, please see the WHO daily situation reports.

CLUSTER IN WASHINGTON STATE

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
- One of the patients died and was the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a healthcare worker.

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    - This was the first reported case in a healthcare worker.
- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
- Circumstances suggest person-to-person spread, including in the long-term care facility.
- CDC has deployed a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.
- CDC infection control experts are assessing the risk of additional healthcare worker exposures and carefully reviewing infection control practices within the facility to protect residents and healthcare workers from further spread of COVID-19.
    - The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
    - All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- It is rare for animal coronaviruses to become capable of infecting humans and then spreading between people.
    - Severe acute respiratory syndrome (SARS-CoV) and Middle East respiratory syndrome (MERS-CoV) are examples of coronaviruses that originated in animals and spread to people.
    - That is what is suspected happened with the virus that causes the current outbreak of COVID-19.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.
    - At this time, there is no evidence that companion animals, including pets, can spread COVID-19. CDC has not received any reports of pets or other animals becoming sick with COVID-19.
    - There is no reason to think that any animals, including pets, in the United States might be a source of infection with this new coronavirus.
    - On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested “weak positive” to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19.

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- CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
- It's important to remember that dogs have their own coronaviruses, which cannot spread to people.
    - *AFCD official report available*

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.

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- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.
- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits will only include the two components (e.g., reagents) that are specific to novel coronavirus.
    - In the meantime, before new test kits are available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays. We anticipate this will increase testing capacity to about 40 state and local health departments.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner can move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
- On February 29, IRR began to distribute new test kits to the additional 40 laboratories.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.

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- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

PEOPLE AT RISK FOR SERIOUS ILLNESS

- Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease seem to be at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.
- If you are at increased risk for COVID-19 complications due to age or because you have a severe underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.
    - Stock up on supplies
    - Take everyday precautions to keep space between yourself and others
    - When you go out in public, keep away from others who are sick, limit close contact and wash your hands often.
    - Avoid crowds as much as possible
    - During a COVID-19 outbreak an outbreak in your community, stay home as much as possible

What people at higher risk can do to prepare

- Have supplies on hand
    - Contact your healthcare provider to ask about obtaining extra necessary medications to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home for a prolonged period of time.
    - If you cannot get extra medications, consider using mail-order for medications.
    - Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
    - Have enough household items and groceries on hand so that you will be prepared to stay at home for a period of time.
- Take everyday precautions
    - Avoid close contact with people who are sick.
    - Take everyday preventive actions.
        - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
        - If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.

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        - To the extent possible, avoid touching high-touch surfaces in public places – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
        - Wash your hands after touching surfaces in public places.
        - Avoid touching your face, nose, eyes, etc.
        - Clean and disinfect your home to remove germs: practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks and cell phones).
        - Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.
- If COVID-19 is spreading in your community, take extra measures to put distance between yourself and other people.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks.
- Have a plan for if you get sick:
    - **Consult with your healthcare provider for more information about** monitoring your health for symptoms suggestive of COVID-19**.**
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick
- Watch for symptoms and emergency warning signs.
    - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
    - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:
        - Difficulty breathing or shortness of breath
        - Persistent pain or pressure in the chest
        - New confusion or inability to arouse
        - Bluish lips or face

          *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

What to do if you are at higher risk and get sick:

- Stay home and call your doctor.
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

Community Support for Older Adults

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- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.
    - Many of these individuals live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.
- Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and Caregiver Support

- Know what medications your loved one is taking and see if you can help them have extra on hand.
- Monitor food and other medical supplies (oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- Stock up on non-perishable food items to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.

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- Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
- Share accurate information about how the virus spreads.
- Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
    - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
    - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel Restrictions from China and Iran:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- On March 2, a new Presidential Proclamation suspended entry to the United States of foreign nationals who have been in Iran in the past 14 days.
    - There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
    - For more information, consult the notice published in the Federal Register.
- **American Citizens and Exempted Persons:**
    - All American citizens and exempted persons coming from China and Iran will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)

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        - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) or Iran in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
            - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of March 2, about 52,000 people have been screened at US airports.
- On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.

Travel Notices and Advisories:

- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Chartered flights returned passengers from Wuhan City, China and passengers from a cruise ship docked in Japan. (See section: Diamond Princess).
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.

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        - The quarantine period is for 14 days.
        - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
        - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
    - Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.
    - At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
    - As of March 6th, almost everyone from the repatriation flights who were quarantined has been released and returned home.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored by medical and public health personnel throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
    - Many of these individuals completed their quarantine on March 2nd and were able to return home safely.
- No US citizens remain on the Diamond Princess.
- More than 35 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-19, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

Grand Princess*:

- CDC has been working with the California Department of Public Health, other federal, state, and local partners and the Princess Cruise Line to investigate a possible cluster of COVID-19 cases

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connected with a Grand Princess voyage from February 11-21. Additionally, CDC worked with the same partners to assess the risk for passengers currently aboard the Grand Princess.
    - CDC notified states about the risk and management of passengers aboard the Grand Princess between February 11 and 21 who might have COVID-19 symptoms.
- At this time, the U.S. Department of Health and Human Services (HHS) is working with state and local partners in California to support the return to the United States of passengers currently aboard the Grand Princess.
- On March 8, HHS announced that the Grand Princess would dock temporarily in a non-passenger port in San Francisco Bay.
    - Passengers will be transferred to federal military installations for medical screening, COVID-19 testing, and a 14-day quarantine.
    - Nearly 1,000 passengers who are California residents will complete the mandatory quarantine at Travis Air Force Base and Miramar Naval Air Station.
    - Residents of other states will complete the mandatory quarantine at Joint Base San Antonio Lackland in Texas or Dobbins Air Force Base in Georgia.
    - Throughout the quarantine, passengers will be monitored for symptoms of COVID-19.
    - The Department of State is working closely with the home countries of several hundred passengers to arrange for repatriation to their countries.
- If you were on the initial—February 11-21—Grand Princess cruise and have COVID-19 symptoms, please call your healthcare provider and explain your symptoms and potential exposure.
    - Your healthcare provider will advise you of how to move forward.
    - In the meantime, CDC always recommends everyday preventive actions to help prevent the spread of respiratory diseases.

**Please continue to look for updates in CDC's Daily Key Points and in next week's Key Messages document. The situation is rapidly evolving and CDC will provide updates as they become available.*

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the

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United States, but they are subject to health monitoring and possible quarantine for up to 14 days.

- On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
- CDC has issued the following travel guidance related to COVID-19:
  - China — Level 3, Avoid Nonessential Travel — updated February 22;
  - Hong Kong — Level 1, Practice Usual Precautions — issued February 19;
  - Iran — Level 3, Avoid Nonessential Travel — updated February 28;
  - Italy — Level 3, Avoid Nonessential Travel — updated February 28;
  - Japan — Level 2, Practice Enhanced Precautions — updated February 22;
  - South Korea — Level 3, Avoid Nonessential Travel — updated February 24.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.

- CDC is issuing clinical guidance, including:
  - On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
  - On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
  - On February 27, CDC updated its criteria to guide evaluation of persons under investigation for COVID-19.
  - On February 28, CDC issued a Health Alert Network (HAN): Update and Interim Guidance on Outbreak of COVID-19.
  - On March 2, FDA announced that commercial companies may sell test kits under CDC's EUA.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
  - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
  - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has developed a fast-track approval method that enables jurisdictions to request the redirection of Public Health Emergency Preparedness (PHEP) cooperative agreement funds for the rapid procurement of services, supplies, and equipment needed during the COVID-19 response.
  - CDC has reduced the normal 30-day request process to one to three business days for urgent requests.
- CDC has coordinated a funding strategy and developed guidance for awarding an initial $35 million to jurisdictions responding to COVID-19.
  - The funding is being awarded through two mechanisms:
    - Component A of the Crisis Response Cooperative Agreement, and

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        - The Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement to select state and local jurisdictions.
    - These initial awards support activities such as monitoring of travelers, data management, laboratory equipment, supplies, staffing, shipping, infection control, surge staffing, and sentinel surveillance.
    - Awards were issued March 6.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity.
    - After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
    - CDC worked on two potential resolutions to this problem.
        - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
            - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
            - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
            - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
            - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- CDC is providing technical assistance to the Government of Italy for exit screening flights departing from Italy to the United States.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China

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    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent International Travelers:

- If you have traveled internationally, watch your health for 14 days after returning to the United States.
- If you feel sick with fever, cough, or difficulty breathing during this time, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.

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- Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
- If you were in a country with widespread sustained (ongoing) transmission—China, Iran, Italy, South Korea—please stay home and monitor yourself for 14 days after you left that country.
- If you were in a country with sustained community transmission (Japan), please practice social distancing (e.g., avoid crowded places, keep distance from others).

People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

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Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Pregnant Persons:

- CDC does not currently know if pregnant women have increased chance of illness from COVID-19 than the general public.
    - Pregnant women experience changes in their bodies that might increase their risk of infections, including COVID-19.
- CDC has limited information on adverse pregnancy outcomes in pregnant persons with COVID-19.
    - Pregnancy loss, including miscarriage and stillbirth, has been observed in cases of infection with other related coronaviruses [SARS-CoV and MERS-CoV] during pregnancy.
    - There is limited information on infant outcomes of COVID-19 illness during pregnancy.
    - Other respiratory viral infections during pregnancy, such as influenza, have been associated with adverse neonatal outcomes, including low birth weight and preterm birth.
    - High fevers during the first trimester of pregnancy can increase the risk of certain birth defects.
- Pregnant women should do the same things as the general public to help avoid infection.
- Protect yourself and your baby from COVID-19 illness and its effects by taking these actions:
    - Wash your hands often with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.

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- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Avoid close contact with people who are sick.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **affected geographic areas** (i.e., countries with CDC Travel Health Notices at warning levels 2 or 3) within 14 days of symptom onset
Fever **and** signs/symptoms of acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)	**AND**	No source of exposure has been identified

Note: The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria. The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

- In addition to the above criteria, infants born to mothers with confirmed COVID-19 should be considered PUIs. As such, infants should be isolated according to the Infection Prevention and Control Guidance for PUIs.

Recommendations for Reporting, Testing, and Specimen Collection:

- Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19.
- State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website.
- State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays.

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- Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.
- For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available.
- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019. Everyone has a role to play in getting ready and staying healthy.
    - For most people in the U.S., the immediate risk of being exposed to the virus that causes COVID-19 is thought to be low. The virus is not currently widespread in the U.S.
    - In places where ongoing community spread of the virus that causes COVID-19 has been reported, people are at elevated risk of exposure.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as temporary school dismissals, postponing or cancelling large events, social distancing (i.e. limiting face-to-face contact) can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for disease outbreaks, like COVID-19 and have plans in place. Now is a good time for schools, businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local public health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs in their local communities.

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- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, respiratory and cough etiquette, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., temporary school dismissals, social distancing in workplaces (like working remotely), postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched objects or surfaces)

CDC'S Approach to Community-Based Interventions

- The federal guidance provided by CDC is intentionally broad to allow flexibility for states and local governments to tailor guidance to their circumstances. An intervention/ approach that is appropriate for one community with local transmission won't necessarily be appropriate for another community with no local transmission.
- Local health departments should evaluate and adapt CDC guidelines and recommendations based on local conditions and with input from community partners.
- Communities can take measures to reduce the spread of the COVID-19.
- CDC recommends working with the local public health department and community partners to determine options that make the most sense.
- If there is local transmission of COVID-19, potential measures include temporarily dismissing students from childcare programs and K-12 schools, social distancing of adults in the workplace (e.g., encouraging teleworking and alternate work schedules to limit face-to-face contact in the workplace), and postponing or cancelling large public (or mass) gatherings.

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, **stay home when you are sick** with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- **Mass gatherings:**
    - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
    - You may need to modify, postpone, or cancel your event. CDC recommends working with the emergency operations coordinator or planning team at your venue and staying informed about the local COVID-19 situation in your area.

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    - CDC has created interim guidance to help event organizers and staff plan and prevent the introduction of COVID-19 into their mass gathering or large events.
- **Community and faith-based organizations:**
    - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.
    - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before an outbreak can help provide your organization with the support and resources needed.
    - CDC has created interim guidance to help you create an emergency plan for your community and faith-based organization.
- **Administrators of U.S. childcare programs and K-12 schools:**
    - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
    - CDC recommends childcare and K-12 school officials:
        - Collaborate with local health departments and partners to review, update, and implement emergency operations plans.
        - Develop information-sharing systems with partners that can be used for day-to-day reporting and disease surveillance to identify unusual rates of absenteeism.
        - Review attendance and sick leave policies; encourage students and staff to stay home when sick and establish procedures to ensure student and staff who become sick at school or arrive at school sick are sent home as soon as possible.
        - Perform routine environmental cleaning.
        - Create communications plans for use with the school community.
    - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be dismissed in the event of an outbreak. (NOTE: The U.S. Department of Education does not recommend using “school closure” terminology.)
    - School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
    - CDC has created interim guidance for administrators of U.S. childcare programs and K-12 schools to help plan, prepare, and respond to COVID-19.

Information for Law Enforcement

- For law enforcement personnel performing daily routine activities, the immediate health risk is low.
- CDC has developed recommendations for law enforcement to protect themselves from exposure.

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    - Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS.
    - Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
    - Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Different styles of PPE may be necessary to perform operational duties.
    - These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.
- If close contact occurs during apprehension:
    - Clean and disinfect duty belt and gear prior to reuse. Use a household cleaning spray or wipe, according to the product label.
    - Follow standard operating procedures for the containment and disposal of used PPE.
    - Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:
    1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
    2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
    3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
    4. Rinse your hands well under clean, running water.
    5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.

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- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolate them in an AIIR, if available.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

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    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:
    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.

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- Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
- Producing guidance documents on infection control, hospital clinical evaluation and patient management.
- Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
- Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
- Leveraging existing telehealth tools to direct people to the right level of care.
- Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
- Sharing information with stakeholders to help them recognize when to shift the strategies they are using.

- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining appropriate work restrictions.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:

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- Acute respiratory distress syndrome (ARDS)
- Intensive care for respiratory support
- Pneumonia resulting in death
- Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Remdesivir is an investigational antiviral drug that is being studied in patients with COVID-19.
    - There are two clinical trials available for patients with COVID-19 in the United States, one for patients with severe coronavirus disease and one for patients with moderate coronavirus disease.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.

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    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date:	Monday, March 9, 2020 11:52:49 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_3-8-20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 weekly key messages, Consular Notification Guidance, and the bridgeline for today's **CDC Media Telebriefing at 12:15 PM EDT provided below**.

Please reference the "Consular Notification Guidance for State and Local Authorities." This document was developed by the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained (i.e., a case when a quarantine order is issued because of possible exposure to COVID-19 disease).

Media Advisory

For Immediate Release
Monday, March 9, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Monday, March 9, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to

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indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

State Coordination Task Force (SCTF)
CDC COVID-19 Weekly Key Messages & Consular Notification Guidance for State and Local Authorities Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

March 8, 2020 as of 10:30pm

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since March 1 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).

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    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is threatening to cause a pandemic.
- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person-to-person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **March 8, more than 105,585** cases have been identified worldwide. More than **24,727** of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.

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- During the week of February 23, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure in multiple states. [See section "Possible U.S. cluster" below.]
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **March 6, 2020, 2020**:

- **Travel-related: 36**
- **Person-to-person spread: 18**
- **Under investigation: 110**
- **Total cases: 164**
- **Deaths: 11**
- **States reporting cases: 19**

Persons repatriated to the United States and tested positive by CDC, as of **March 6, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **46**

For global cases, please see the WHO daily situation reports.

CLUSTER IN WASHINGTON STATE

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
- One of the patients died and was the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a healthcare worker.

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    - This was the first reported case in a healthcare worker.
- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
- Circumstances suggest person-to-person spread, including in the long-term care facility.
- CDC has deployed a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.
- CDC infection control experts are assessing the risk of additional healthcare worker exposures and carefully reviewing infection control practices within the facility to protect residents and healthcare workers from further spread of COVID-19.
    - The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
    - All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- It is rare for animal coronaviruses to become capable of infecting humans and then spreading between people.
    - Severe acute respiratory syndrome (SARS-CoV) and Middle East respiratory syndrome (MERS-CoV) are examples of coronaviruses that originated in animals and spread to people.
    - That is what is suspected happened with the virus that causes the current outbreak of COVID-19.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.
    - At this time, there is no evidence that companion animals, including pets, can spread COVID-19. CDC has not received any reports of pets or other animals becoming sick with COVID-19.
    - There is no reason to think that any animals, including pets, in the United States might be a source of infection with this new coronavirus.
    - On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested “weak positive” to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19.

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- CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
- It's important to remember that dogs have their own coronaviruses, which cannot spread to people.
  - *AFCD official report available*

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
  - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.

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- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.
- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits will only include the two components (e.g., reagents) that are specific to novel coronavirus.
    - In the meantime, before new test kits are available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays. We anticipate this will increase testing capacity to about 40 state and local health departments.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner can move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
- On February 29, IRR began to distribute new test kits to the additional 40 laboratories.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.

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- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

PEOPLE AT RISK FOR SERIOUS ILLNESS

- Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease seem to be at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.
- If you are at increased risk for COVID-19 complications due to age or because you have a severe underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.
    - Stock up on supplies
    - Take everyday precautions to keep space between yourself and others
    - When you go out in public, keep away from others who are sick, limit close contact and wash your hands often.
    - Avoid crowds as much as possible
    - During a COVID-19 outbreak an outbreak in your community, stay home as much as possible

What people at higher risk can do to prepare

- Have supplies on hand
    - Contact your healthcare provider to ask about obtaining extra necessary medications to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home for a prolonged period of time.
    - If you cannot get extra medications, consider using mail-order for medications.
    - Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
    - Have enough household items and groceries on hand so that you will be prepared to stay at home for a period of time.
- Take everyday precautions
    - Avoid close contact with people who are sick.
    - Take everyday preventive actions.
        - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
        - If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.

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        - To the extent possible, avoid touching high-touch surfaces in public places – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
        - Wash your hands after touching surfaces in public places.
        - Avoid touching your face, nose, eyes, etc.
        - Clean and disinfect your home to remove germs: practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks and cell phones).
        - Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.
- If COVID-19 is spreading in your community, take extra measures to put distance between yourself and other people.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks.
- Have a plan for if you get sick:
    - **Consult with your healthcare provider for more information about** monitoring your health for symptoms suggestive of COVID-19**.**
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick
- Watch for symptoms and emergency warning signs.
    - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
    - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:
        - Difficulty breathing or shortness of breath
        - Persistent pain or pressure in the chest
        - New confusion or inability to arouse
        - Bluish lips or face

          *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

What to do if you are at higher risk and get sick:

- Stay home and call your doctor.
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

Community Support for Older Adults

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- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.
    - Many of these individuals live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.
- Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and Caregiver Support

- Know what medications your loved one is taking and see if you can help them have extra on hand.
- Monitor food and other medical supplies (oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- Stock up on non-perishable food items to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.

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- Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
- Share accurate information about how the virus spreads.
- Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
    - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
    - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel Restrictions from China and Iran:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- On March 2, a new Presidential Proclamation suspended entry to the United States of foreign nationals who have been in Iran in the past 14 days.
    - There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
    - For more information, consult the notice published in the Federal Register.
- **American Citizens and Exempted Persons:**
    - All American citizens and exempted persons coming from China and Iran will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)

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        - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) or Iran in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
            - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of March 2, about 52,000 people have been screened at US airports.
- On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.

Travel Notices and Advisories:

- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Chartered flights returned passengers from Wuhan City, China and passengers from a cruise ship docked in Japan. (See section: Diamond Princess).
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.

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    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- As of March 6th, almost everyone from the repatriation flights who were quarantined has been released and returned home.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored by medical and public health personnel throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
    - Many of these individuals completed their quarantine on March 2nd and were able to return home safely.
- No US citizens remain on the Diamond Princess.
- More than 35 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-19, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

Grand Princess*:

- CDC has been working with the California Department of Public Health, other federal, state, and local partners and the Princess Cruise Line to investigate a possible cluster of COVID-19 cases

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connected with a Grand Princess voyage from February 11-21. Additionally, CDC worked with the same partners to assess the risk for passengers currently aboard the Grand Princess.
    - CDC notified states about the risk and management of passengers aboard the Grand Princess between February 11 and 21 who might have COVID-19 symptoms.
- At this time, the U.S. Department of Health and Human Services (HHS) is working with state and local partners in California to support the return to the United States of passengers currently aboard the Grand Princess.
- On March 8, HHS announced that the Grand Princess would dock temporarily in a non-passenger port in San Francisco Bay.
    - Passengers will be transferred to federal military installations for medical screening, COVID-19 testing, and a 14-day quarantine.
    - Nearly 1,000 passengers who are California residents will complete the mandatory quarantine at Travis Air Force Base and Miramar Naval Air Station.
    - Residents of other states will complete the mandatory quarantine at Joint Base San Antonio Lackland in Texas or Dobbins Air Force Base in Georgia.
    - Throughout the quarantine, passengers will be monitored for symptoms of COVID-19.
    - The Department of State is working closely with the home countries of several hundred passengers to arrange for repatriation to their countries.
- If you were on the initial—February 11-21—Grand Princess cruise and have COVID-19 symptoms, please call your healthcare provider and explain your symptoms and potential exposure.
    - Your healthcare provider will advise you of how to move forward.
    - In the meantime, CDC always recommends everyday preventive actions to help prevent the spread of respiratory diseases.

**Please continue to look for updates in CDC's Daily Key Points and in next week's Key Messages document. The situation is rapidly evolving and CDC will provide updates as they become available.*

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the

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United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Hong Kong — Level 1, Practice Usual Precautions — issued February 19;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;
        - Italy — Level 3, Avoid Nonessential Travel — updated February 28;
        - Japan — Level 2, Practice Enhanced Precautions — updated February 22;
        - South Korea — Level 3, Avoid Nonessential Travel — updated February 24.
    - CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- CDC is issuing clinical guidance, including:
    - On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
    - On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
    - On February 27, CDC updated its criteria to guide evaluation of persons under investigation for COVID-19.
    - On February 28, CDC issued a Health Alert Network (HAN): Update and Interim Guidance on Outbreak of COVID-19.
    - On March 2, FDA announced that commercial companies may sell test kits under CDC's EUA.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has developed a fast-track approval method that enables jurisdictions to request the redirection of Public Health Emergency Preparedness (PHEP) cooperative agreement funds for the rapid procurement of services, supplies, and equipment needed during the COVID-19 response.
    - CDC has reduced the normal 30-day request process to one to three business days for urgent requests.
- CDC has coordinated a funding strategy and developed guidance for awarding an initial $35 million to jurisdictions responding to COVID-19.
    - The funding is being awarded through two mechanisms:
        - Component A of the Crisis Response Cooperative Agreement, and

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        - The Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement to select state and local jurisdictions.
    - These initial awards support activities such as monitoring of travelers, data management, laboratory equipment, supplies, staffing, shipping, infection control, surge staffing, and sentinel surveillance.
    - Awards were issued March 6.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity.
    - After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
    - CDC worked on two potential resolutions to this problem.
        - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
            - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
            - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
            - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
            - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- CDC is providing technical assistance to the Government of Italy for exit screening flights departing from Italy to the United States.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China

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    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent International Travelers:

- If you have traveled internationally, watch your health for 14 days after returning to the United States.
- If you feel sick with fever, cough, or difficulty breathing during this time, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.

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- Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
- If you were in a country with widespread sustained (ongoing) transmission—China, Iran, Italy, South Korea—please stay home and monitor yourself for 14 days after you left that country.
- If you were in a country with sustained community transmission (Japan), please practice social distancing (e.g., avoid crowded places, keep distance from others).

People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

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Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Pregnant Persons:

- CDC does not currently know if pregnant women have increased chance of illness from COVID-19 than the general public.
    - Pregnant women experience changes in their bodies that might increase their risk of infections, including COVID-19.
- CDC has limited information on adverse pregnancy outcomes in pregnant persons with COVID-19.
    - Pregnancy loss, including miscarriage and stillbirth, has been observed in cases of infection with other related coronaviruses [SARS-CoV and MERS-CoV] during pregnancy.
    - There is limited information on infant outcomes of COVID-19 illness during pregnancy.
    - Other respiratory viral infections during pregnancy, such as influenza, have been associated with adverse neonatal outcomes, including low birth weight and preterm birth.
    - High fevers during the first trimester of pregnancy can increase the risk of certain birth defects.
- Pregnant women should do the same things as the general public to help avoid infection.
- Protect yourself and your baby from COVID-19 illness and its effects by taking these actions:
    - Wash your hands often with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.

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- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Avoid close contact with people who are sick.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **affected geographic areas** (i.e., countries with CDC Travel Health Notices at warning levels 2 or 3) within 14 days of symptom onset
Fever **and** signs/symptoms of acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)	**AND**	No source of exposure has been identified

Note: The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria. The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

- In addition to the above criteria, infants born to mothers with confirmed COVID-19 should be considered PUIs. As such, infants should be isolated according to the Infection Prevention and Control Guidance for PUIs.

Recommendations for Reporting, Testing, and Specimen Collection:

- Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19.
- State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website.
- State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays.

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- Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.
- For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available.
- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019. Everyone has a role to play in getting ready and staying healthy.
    - For most people in the U.S., the immediate risk of being exposed to the virus that causes COVID-19 is thought to be low. The virus is not currently widespread in the U.S.
    - In places where ongoing community spread of the virus that causes COVID-19 has been reported, people are at elevated risk of exposure.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as temporary school dismissals, postponing or cancelling large events, social distancing (i.e. limiting face-to-face contact) can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for disease outbreaks, like COVID-19 and have plans in place. Now is a good time for schools, businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local public health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs in their local communities.

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- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, respiratory and cough etiquette, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., temporary school dismissals, social distancing in workplaces (like working remotely), postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched objects or surfaces)

CDC'S Approach to Community-Based Interventions

- The federal guidance provided by CDC is intentionally broad to allow flexibility for states and local governments to tailor guidance to their circumstances. An intervention/ approach that is appropriate for one community with local transmission won't necessarily be appropriate for another community with no local transmission.
- Local health departments should evaluate and adapt CDC guidelines and recommendations based on local conditions and with input from community partners.
- Communities can take measures to reduce the spread of the COVID-19.
- CDC recommends working with the local public health department and community partners to determine options that make the most sense.
- If there is local transmission of COVID-19, potential measures include temporarily dismissing students from childcare programs and K-12 schools, social distancing of adults in the workplace (e.g., encouraging teleworking and alternate work schedules to limit face-to-face contact in the workplace), and postponing or cancelling large public (or mass) gatherings.

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, **stay home when you are sick** with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- **Mass gatherings:**
    - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
    - You may need to modify, postpone, or cancel your event. CDC recommends working with the emergency operations coordinator or planning team at your venue and staying informed about the local COVID-19 situation in your area.

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    - CDC has created interim guidance to help event organizers and staff plan and prevent the introduction of COVID-19 into their mass gathering or large events.
- **Community and faith-based organizations:**
    - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.
    - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before an outbreak can help provide your organization with the support and resources needed.
    - CDC has created interim guidance to help you create an emergency plan for your community and faith-based organization.
- **Administrators of U.S. childcare programs and K-12 schools:**
    - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
    - CDC recommends childcare and K-12 school officials:
        - Collaborate with local health departments and partners to review, update, and implement emergency operations plans.
        - Develop information-sharing systems with partners that can be used for day-to-day reporting and disease surveillance to identify unusual rates of absenteeism.
        - Review attendance and sick leave policies; encourage students and staff to stay home when sick and establish procedures to ensure student and staff who become sick at school or arrive at school sick are sent home as soon as possible.
        - Perform routine environmental cleaning.
        - Create communications plans for use with the school community.
    - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be dismissed in the event of an outbreak. (NOTE: The U.S. Department of Education does not recommend using “school closure” terminology.)
    - School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
    - CDC has created interim guidance for administrators of U.S. childcare programs and K-12 schools to help plan, prepare, and respond to COVID-19.

Information for Law Enforcement

- For law enforcement personnel performing daily routine activities, the immediate health risk is low.
- CDC has developed recommendations for law enforcement to protect themselves from exposure.

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    - Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS.
    - Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
    - Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Different styles of PPE may be necessary to perform operational duties.
    - These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.
- If close contact occurs during apprehension:
    - Clean and disinfect duty belt and gear prior to reuse. Use a household cleaning spray or wipe, according to the product label.
    - Follow standard operating procedures for the containment and disposal of used PPE.
    - Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:
    1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
    2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
    3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
    4. Rinse your hands well under clean, running water.
    5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.

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- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolate them in an AIIR, if available.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

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    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:
    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.

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    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining appropriate work restrictions.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:

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- Acute respiratory distress syndrome (ARDS)
- Intensive care for respiratory support
- Pneumonia resulting in death
- Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Remdesivir is an investigational antiviral drug that is being studied in patients with COVID-19.
    - There are two clinical trials available for patients with COVID-19 in the United States, one for patients with severe coronavirus disease and one for patients with moderate coronavirus disease.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.

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    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date:	Monday, March 9, 2020 11:46:44 AM
Attachments:	CDC_COVID-19 Weekly Key Messages_3-8-20.pdf CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please see the attached CDC COVID-19 weekly key messages, Consular Notification Guidance, and the bridgeline for today's **CDC Media Telebriefing at 12:15 PM EDT**.

Please reference the "Consular Notification Guidance for State and Local Authorities." This document was developed by the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained (i.e., a case when a quarantine order is issued because of possible exposure to COVID-19 disease).

Media Advisory

For Immediate Release
Monday, March 9, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Monday, March 9, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to

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indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

State Coordination Task Force (SCTF)
CDC COVID-19 Weekly Key Messages & Consular Notification Guidance for State and Local Authorities Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

March 8, 2020 as of 10:30pm

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since March 1 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).

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    - Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is threatening to cause a pandemic.
- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person-to-person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **March 8, more than 105,585** cases have been identified worldwide. More than **24,727** of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.

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- During the week of February 23, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure in multiple states. [See section "Possible U.S. cluster" below.]
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **March 6, 2020, 2020**:

- **Travel-related: 36**
- **Person-to-person spread: 18**
- **Under investigation: 110**
- **Total cases: 164**
- **Deaths: 11**
- **States reporting cases: 19**

Persons repatriated to the United States and tested positive by CDC, as of **March 6, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **46**

For global cases, please see the WHO daily situation reports.

CLUSTER IN WASHINGTON STATE

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
- One of the patients died and was the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a healthcare worker.

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    - This was the first reported case in a healthcare worker.
- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
- Circumstances suggest person-to-person spread, including in the long-term care facility.
- CDC has deployed a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.
- CDC infection control experts are assessing the risk of additional healthcare worker exposures and carefully reviewing infection control practices within the facility to protect residents and healthcare workers from further spread of COVID-19.
    - The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
    - All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- It is rare for animal coronaviruses to become capable of infecting humans and then spreading between people.
    - Severe acute respiratory syndrome (SARS-CoV) and Middle East respiratory syndrome (MERS-CoV) are examples of coronaviruses that originated in animals and spread to people.
    - That is what is suspected happened with the virus that causes the current outbreak of COVID-19.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.
    - At this time, there is no evidence that companion animals, including pets, can spread COVID-19. CDC has not received any reports of pets or other animals becoming sick with COVID-19.
    - There is no reason to think that any animals, including pets, in the United States might be a source of infection with this new coronavirus.
    - On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested “weak positive” to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19.

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- CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
- It's important to remember that dogs have their own coronaviruses, which cannot spread to people.
  - *AFCD official report available*

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
  - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.

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- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.
- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits will only include the two components (e.g., reagents) that are specific to novel coronavirus.
    - In the meantime, before new test kits are available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays. We anticipate this will increase testing capacity to about 40 state and local health departments.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner can move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
- On February 29, IRR began to distribute new test kits to the additional 40 laboratories.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.

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- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

PEOPLE AT RISK FOR SERIOUS ILLNESS

- Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease seem to be at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.
- If you are at increased risk for COVID-19 complications due to age or because you have a severe underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.
    - Stock up on supplies
    - Take everyday precautions to keep space between yourself and others
    - When you go out in public, keep away from others who are sick, limit close contact and wash your hands often.
    - Avoid crowds as much as possible
    - During a COVID-19 outbreak an outbreak in your community, stay home as much as possible

What people at higher risk can do to prepare

- Have supplies on hand
    - Contact your healthcare provider to ask about obtaining extra necessary medications to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home for a prolonged period of time.
    - If you cannot get extra medications, consider using mail-order for medications.
    - Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
    - Have enough household items and groceries on hand so that you will be prepared to stay at home for a period of time.
- Take everyday precautions
    - Avoid close contact with people who are sick.
    - Take everyday preventive actions.
        - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
        - If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.

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        - To the extent possible, avoid touching high-touch surfaces in public places – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
        - Wash your hands after touching surfaces in public places.
        - Avoid touching your face, nose, eyes, etc.
        - Clean and disinfect your home to remove germs: practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks and cell phones).
        - Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.
- If COVID-19 is spreading in your community, take extra measures to put distance between yourself and other people.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks.
- Have a plan for if you get sick:
    - **Consult with your healthcare provider for more information about** monitoring your health for symptoms suggestive of COVID-19**.**
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick
- Watch for symptoms and emergency warning signs.
    - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
    - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:
        - Difficulty breathing or shortness of breath
        - Persistent pain or pressure in the chest
        - New confusion or inability to arouse
        - Bluish lips or face

          *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

What to do if you are at higher risk and get sick:

- Stay home and call your doctor.
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

Community Support for Older Adults

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- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.
    - Many of these individuals live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.
- Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and Caregiver Support

- Know what medications your loved one is taking and see if you can help them have extra on hand.
- Monitor food and other medical supplies (oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- Stock up on non-perishable food items to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.

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- Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
- Share accurate information about how the virus spreads.
- Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
    - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
    - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel Restrictions from China and Iran:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- On March 2, a new Presidential Proclamation suspended entry to the United States of foreign nationals who have been in Iran in the past 14 days.
    - There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
    - For more information, consult the notice published in the Federal Register.
- **American Citizens and Exempted Persons:**
    - All American citizens and exempted persons coming from China and Iran will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)

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        - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) or Iran in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
            - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
            - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of March 2, about 52,000 people have been screened at US airports.
- On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.

Travel Notices and Advisories:

- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Chartered flights returned passengers from Wuhan City, China and passengers from a cruise ship docked in Japan. (See section: Diamond Princess).
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.

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    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- As of March 6th, almost everyone from the repatriation flights who were quarantined has been released and returned home.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They will continue to be monitored by medical and public health personnel throughout the 14-day quarantine period.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
    - Many of these individuals completed their quarantine on March 2nd and were able to return home safely.
- No US citizens remain on the Diamond Princess.
- More than 35 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-19, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

Grand Princess*:

- CDC has been working with the California Department of Public Health, other federal, state, and local partners and the Princess Cruise Line to investigate a possible cluster of COVID-19 cases

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connected with a Grand Princess voyage from February 11-21. Additionally, CDC worked with the same partners to assess the risk for passengers currently aboard the Grand Princess.
    - CDC notified states about the risk and management of passengers aboard the Grand Princess between February 11 and 21 who might have COVID-19 symptoms.
- At this time, the U.S. Department of Health and Human Services (HHS) is working with state and local partners in California to support the return to the United States of passengers currently aboard the Grand Princess.
- On March 8, HHS announced that the Grand Princess would dock temporarily in a non-passenger port in San Francisco Bay.
    - Passengers will be transferred to federal military installations for medical screening, COVID-19 testing, and a 14-day quarantine.
    - Nearly 1,000 passengers who are California residents will complete the mandatory quarantine at Travis Air Force Base and Miramar Naval Air Station.
    - Residents of other states will complete the mandatory quarantine at Joint Base San Antonio Lackland in Texas or Dobbins Air Force Base in Georgia.
    - Throughout the quarantine, passengers will be monitored for symptoms of COVID-19.
    - The Department of State is working closely with the home countries of several hundred passengers to arrange for repatriation to their countries.
- If you were on the initial—February 11-21—Grand Princess cruise and have COVID-19 symptoms, please call your healthcare provider and explain your symptoms and potential exposure.
    - Your healthcare provider will advise you of how to move forward.
    - In the meantime, CDC always recommends everyday preventive actions to help prevent the spread of respiratory diseases.

**Please continue to look for updates in CDC's Daily Key Points and in next week's Key Messages document. The situation is rapidly evolving and CDC will provide updates as they become available*.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the

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United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Hong Kong — Level 1, Practice Usual Precautions — issued February 19;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;
        - Italy — Level 3, Avoid Nonessential Travel — updated February 28;
        - Japan — Level 2, Practice Enhanced Precautions — updated February 22;
        - South Korea — Level 3, Avoid Nonessential Travel — updated February 24.
    - CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- CDC is issuing clinical guidance, including:
    - On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
    - On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
    - On February 27, CDC updated its criteria to guide evaluation of persons under investigation for COVID-19.
    - On February 28, CDC issued a Health Alert Network (HAN): Update and Interim Guidance on Outbreak of COVID-19.
    - On March 2, FDA announced that commercial companies may sell test kits under CDC's EUA.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has developed a fast-track approval method that enables jurisdictions to request the redirection of Public Health Emergency Preparedness (PHEP) cooperative agreement funds for the rapid procurement of services, supplies, and equipment needed during the COVID-19 response.
    - CDC has reduced the normal 30-day request process to one to three business days for urgent requests.
- CDC has coordinated a funding strategy and developed guidance for awarding an initial $35 million to jurisdictions responding to COVID-19.
    - The funding is being awarded through two mechanisms:
        - Component A of the Crisis Response Cooperative Agreement, and

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        - The Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement to select state and local jurisdictions.
    - These initial awards support activities such as monitoring of travelers, data management, laboratory equipment, supplies, staffing, shipping, infection control, surge staffing, and sentinel surveillance.
    - Awards were issued March 6.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity.
    - After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
    - CDC worked on two potential resolutions to this problem.
        - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
            - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
            - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
            - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
            - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.

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- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- CDC is providing technical assistance to the Government of Italy for exit screening flights departing from Italy to the United States.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China

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    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent International Travelers:

- If you have traveled internationally, watch your health for 14 days after returning to the United States.
- If you feel sick with fever, cough, or difficulty breathing during this time, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.

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- Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
- If you were in a country with widespread sustained (ongoing) transmission—China, Iran, Italy, South Korea—please stay home and monitor yourself for 14 days after you left that country.
- If you were in a country with sustained community transmission (Japan), please practice social distancing (e.g., avoid crowded places, keep distance from others).

People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.
    - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
    - Wash your hands often with soap and water for at least 20 seconds.
    - Avoid sharing household items like eating utensils, cups, or linens.
    - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

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Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

For Pregnant Persons:

- CDC does not currently know if pregnant women have increased chance of illness from COVID-19 than the general public.
    - Pregnant women experience changes in their bodies that might increase their risk of infections, including COVID-19.
- CDC has limited information on adverse pregnancy outcomes in pregnant persons with COVID-19.
    - Pregnancy loss, including miscarriage and stillbirth, has been observed in cases of infection with other related coronaviruses [SARS-CoV and MERS-CoV] during pregnancy.
    - There is limited information on infant outcomes of COVID-19 illness during pregnancy.
    - Other respiratory viral infections during pregnancy, such as influenza, have been associated with adverse neonatal outcomes, including low birth weight and preterm birth.
    - High fevers during the first trimester of pregnancy can increase the risk of certain birth defects.
- Pregnant women should do the same things as the general public to help avoid infection.
- Protect yourself and your baby from COVID-19 illness and its effects by taking these actions:
    - Wash your hands often with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.

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- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Avoid close contact with people who are sick.

For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **affected geographic areas** (i.e., countries with CDC Travel Health Notices at warning levels 2 or 3) within 14 days of symptom onset
Fever **and** signs/symptoms of acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)	**AND**	No source of exposure has been identified

Note: The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria. The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

- In addition to the above criteria, infants born to mothers with confirmed COVID-19 should be considered PUIs. As such, infants should be isolated according to the Infection Prevention and Control Guidance for PUIs.

Recommendations for Reporting, Testing, and Specimen Collection:

- Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19.
- State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website.
- State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays.

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- Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.
- For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available.
- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019. Everyone has a role to play in getting ready and staying healthy.
    - For most people in the U.S., the immediate risk of being exposed to the virus that causes COVID-19 is thought to be low. The virus is not currently widespread in the U.S.
    - In places where ongoing community spread of the virus that causes COVID-19 has been reported, people are at elevated risk of exposure.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as temporary school dismissals, postponing or cancelling large events, social distancing (i.e. limiting face-to-face contact) can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for disease outbreaks, like COVID-19 and have plans in place. Now is a good time for schools, businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local public health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs in their local communities.

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- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, respiratory and cough etiquette, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., temporary school dismissals, social distancing in workplaces (like working remotely), postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched objects or surfaces)

CDC'S Approach to Community-Based Interventions

- The federal guidance provided by CDC is intentionally broad to allow flexibility for states and local governments to tailor guidance to their circumstances. An intervention/ approach that is appropriate for one community with local transmission won't necessarily be appropriate for another community with no local transmission.
- Local health departments should evaluate and adapt CDC guidelines and recommendations based on local conditions and with input from community partners.
- Communities can take measures to reduce the spread of the COVID-19.
- CDC recommends working with the local public health department and community partners to determine options that make the most sense.
- If there is local transmission of COVID-19, potential measures include temporarily dismissing students from childcare programs and K-12 schools, social distancing of adults in the workplace (e.g., encouraging teleworking and alternate work schedules to limit face-to-face contact in the workplace), and postponing or cancelling large public (or mass) gatherings.

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, **stay home when you are sick** with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- **Mass gatherings:**
    - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
    - You may need to modify, postpone, or cancel your event. CDC recommends working with the emergency operations coordinator or planning team at your venue and staying informed about the local COVID-19 situation in your area.

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    - CDC has created interim guidance to help event organizers and staff plan and prevent the introduction of COVID-19 into their mass gathering or large events.
- **Community and faith-based organizations:**
    - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.
    - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before an outbreak can help provide your organization with the support and resources needed.
    - CDC has created interim guidance to help you create an emergency plan for your community and faith-based organization.
- **Administrators of U.S. childcare programs and K-12 schools:**
    - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
    - CDC recommends childcare and K-12 school officials:
        - Collaborate with local health departments and partners to review, update, and implement emergency operations plans.
        - Develop information-sharing systems with partners that can be used for day-to-day reporting and disease surveillance to identify unusual rates of absenteeism.
        - Review attendance and sick leave policies; encourage students and staff to stay home when sick and establish procedures to ensure student and staff who become sick at school or arrive at school sick are sent home as soon as possible.
        - Perform routine environmental cleaning.
        - Create communications plans for use with the school community.
    - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be dismissed in the event of an outbreak. (NOTE: The U.S. Department of Education does not recommend using “school closure” terminology.)
    - School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
    - CDC has created interim guidance for administrators of U.S. childcare programs and K-12 schools to help plan, prepare, and respond to COVID-19.

Information for Law Enforcement

- For law enforcement personnel performing daily routine activities, the immediate health risk is low.
- CDC has developed recommendations for law enforcement to protect themselves from exposure.

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    - Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS.
    - Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
    - Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Different styles of PPE may be necessary to perform operational duties.
    - These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.
- If close contact occurs during apprehension:
    - Clean and disinfect duty belt and gear prior to reuse. Use a household cleaning spray or wipe, according to the product label.
    - Follow standard operating procedures for the containment and disposal of used PPE.
    - Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:
    1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
    2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
    3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
    4. Rinse your hands well under clean, running water.
    5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.

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- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolate them in an AIIR, if available.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

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    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:
    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.

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    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining appropriate work restrictions.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:

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- Acute respiratory distress syndrome (ARDS)
- Intensive care for respiratory support
- Pneumonia resulting in death
- Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Remdesivir is an investigational antiviral drug that is being studied in patients with COVID-19.
    - There are two clinical trials available for patients with COVID-19 in the United States, one for patients with severe coronavirus disease and one for patients with moderate coronavirus disease.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.

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    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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Subject:	CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 10:52:06 PM
Attachments:	Cruise Ship SOP Talking Points_FINAL Cleared.pdf PH Recommendations for Cruise Ships Arriving at US Ports_FINAL Cleared.pdf 20_316043-A_FS_Guide_disembark_ship_March20.pdf Cruise Passengers returning charter flights_final_3.21.20.pdf

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Dr. Rivkees

As always it is a pleasure to speak with you. I spoke with our HHS Liaison to the Department of State and he is willing to work to set up a call with the Department of State. Based on your desire we can include CDC. I included the CDC guidance on cruise ships.

I should have a name of a Customs and Border Protection (CBP) representative for you shortly.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
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AMERICAN OVERSIGHT

Health Alert:
Coronavirus Disease 2019 (COVID-19)

You have recently been on a cruise ship or river cruise.

COVID-19 is a respiratory illness that can spread from person to person.

Stay home for 14 days from the time you left the cruise ship or river cruise and practice social distancing

Take these steps to monitor your health and practice social distancing:

1. Take your temperature with a thermometer two times a day and monitor for fever. Also watch for cough or trouble breathing.

2. Stay home and avoid contact with others. Do not go to work or school.

3. Keep your distance from others (about 6 feet or 2 meters).

What To Do If You Get Sick

If you get sick with fever (100.4°F/38°C or higher) or cough in the 14 days after you return from travel:

- Stay home. Avoid contact with others.
- You might have COVID-19; most people are able to recover at home without medical care.
- If you have trouble breathing or are worried about your symptoms, call or text a health care provider. Tell them about your recent travel and your symptoms.
- Call ahead before you go to a doctor's office or emergency room.

If you need to seek medical care for other reasons, such as dialysis, call ahead to your doctor and tell them about your recent travel on a cruise ship or river cruise.

Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-002956
CS 316043A March 20, 2020 11:16 AM

March 21, 2020

Public Health Management for Cruise Ship Passengers Returning to the United States via Charter Flights during COVID-19 Pandemic

Purpose: This document clarifies the roles and responsibilities of cruise ship/line if chartering flights for disembarking passengers back to the United States.

Phase	Recommendations
Preparing for departure	**Cruise ship/line** • Notifies CDC about any illness compatible with COVID-19 among any passengers or crew returning to the United States including the number of persons with confirmed or suspected COVID-19. • Obtains full approval from state and local authorities (including health authorities) for the arrival of the charter in the receiving state. • Provides full manifest with contact information to CDC. • Provides full itineraries to final destination for each passenger. • Travelers with confirmed COVID-19, or sick with symptoms compatible with COVID-19, must not board a non-medical charter flight or travel commercially to the United States, or within the US, unless they have met CDC's criteria for release from isolation (non-test-based criteria). ○ See information in https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html ○ Ill/infected travelers who are stable enough to travel should only travel by approved medical transport, to their state of residence, if possible. ○ Any transport of ill or infected travelers to the United States must be coordinated in advance with CDC and the health department of the receiving state. • Distribute general CDC COVID-19 health information to cruise ship passengers eligible to board the US flight. ○ Advise passengers to stay home, monitor their health, and practice social distancing for 14 days after they arrive in the United States. • Ensure air carrier has stocked sufficient personal protective equipment (PPE) for flight: ○ For cabin crew, PPE and supplies comparable to those on commercial airlines, i.e., Universal Precaution Kit. ○ Face masks for travelers who develop symptoms during travel are available onboard. **CDC Actions** • Addresses any concerns with the cruise line or air operator. • Provides guidance as needed (e.g., questions about screening procedures or protocols).
Before US passengers/crew disembark and boarding of charter flight	**Cruise ship/line** ○ Screen all US-bound passengers or crew who will board the US charter flight for fever (100.4°F or 38°C or higher) or new or worsening cough or shortness of breath. ○ Symptomatic travelers should not board the charter flight per instructions above.

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	• If space allows, passengers should spread out on the charter flight (e.g., six feet apart if possible) and travel companions should be seated together.
In Flight	**Cabin and Flight Crews** • Follow CDC guidance for managing and reporting illness or death during flight: https://www.cdc.gov/quarantine/air/index.html **CDC Actions** • Provides guidance as needed if an illness or death is reported during flight.
Arrival in the United States.	**Cruise ship/line** • Provides timely transport and appropriate arrangements for any passengers who have become ill in transit and have been evaluated at the port of entry but do not require hospitalization. These arrangements would depend on the clinical condition and diagnosis following evaluation. **US Government Actions** • Department of Homeland Security staff may perform screening of passengers, as per their protocols. • Passengers will receive health information. • CDC Quarantine Station staff are available for illness response, as per protocol. • Allows asymptomatic passengers to continue travel by either charter or commercial conveyance as arranged by the cruise line.

AMERICAN OVERSIGHT

Key Points—Incoming Cruise Ships

- The US Government's priority is to protect the health of passengers and crew, their loved ones, the traveling public, and communities within the United States.
- The Centers for Disease Control and Prevention (CDC) recommends all persons defer any travel on cruise ships, including river cruises, worldwide because of the increased risk of COVID-19 on board ships.
- On Friday, March 13th, the Cruise Lines International Association voluntarily suspended cruise travel out of US ports.
    - This means many cruise ships will soon be ending their voyages and coming into port in the US and other countries. This also means new cruise voyages will be postponed.
- The situation in the United States is evolving, both with increasing community transmission and an increasing number of cruise ships coming into port. CDC is continuing to reevaluate how we approach returning cruise ships.
    - As we reevaluate the approach to returning cruise ships, CDC's priority is to protect passengers' and crews' health while helping them get home as quickly and safely as possible.
- In an effort to make sure passengers and crew members without symptoms can get home as quickly and safely as possible, we will not hold ships in port and will not prevent disembarking passengers and crew from onward travel. All travelers returning to the United States who have been on cruise ships, including river cruises, in the past 14 days will be asked to follow the guidelines below.
    - Passengers without symptoms will be allowed to travel home immediately via commercial carrier.
    - Cruise line passengers and crew members are advised to stay home for 14 days, monitor their health, and practice social distancing. Social distancing means staying out of crowded places and keeping a distance of about 6 feet (2 meters) from others as much as possible. Cruise lines will give disembarking passengers details about how to monitor themselves at home and practice social distancing.
        - These recommendations are consistent with CDC recommendations for travelers returning from international travel, now that the CDC Global Level 3 Travel Health Notice is in effect.
    - Any passengers who get sick with fever, new or worsening cough, or trouble breathing during their cruise should isolate themselves in their cabin and notify the onboard medical center immediately.
        - Crew members who get sick should follow instructions of the cruise line.
    - If an ill passenger or crew member is identified on board the ship, the cruise line will report to the CDC Quarantine Station responsible for the port. CDC staff will determine if further action is needed.
- If a ship has one or more confirmed COVID-19 cases on board, CDC will send an alert to state health departments alerting them to these cases.

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- CDC will also alert the World Health Organization through the International Health Regulations to ensure non-US citizen travelers are aware of their risk.

We recognize this updated guidance on cruise ship passengers is concerning to passengers and crew from previous ships who have been quarantined upon their return to the United States. The COVID-19 situation in the United States and internationally is changing rapidly. We will continue to reevaluate how we approach returning cruise ships as the situation in the United States changes.

This update is in alignment with CDC's Level 3 Travel Health Warning for cruise ships (posted March 17) and CDC's Health Update regarding cruise ship travel (posted March 15).

AMERICAN OVERSIGHT

March 20, 2020

Public Health Management for Cruise Ships Arriving at a US Port during COVID-19 Pandemic

Follow Standard Protocols for Required Reporting of Sick Travelers: At present, CDC is requesting maritime partners to please follow standard required reporting of symptoms for any sick traveler on an international conveyance destined for the United States. Symptoms of COVID-19 may include fever, cough, and shortness of breath, which are included in CDC's regulatory definition of "ill person."

CDC has provided Interim Guidance for Ships on Managing Suspected Coronavirus Disease 2019 for preventing spread of COVID-19 during and after a voyage, including personal protective measures for crew members. www.cdc.gov/quarantine/maritime/recommendations-for-ships.html

Purpose: This document clarifies the roles and responsibilities of cruise ship/line, state and local health departments, and CDC if a confirmed case COVID-19 is identified on a current or a previous voyage.

Due to the current COVID-19 pandemic, CDC recommends that all US-based cruise ships currently at sea as of March 19, 2020:

1. cancel social gatherings on board ships, and
2. return to port early

As cruise ships return to US ports, the following scenarios and recommendations apply:

Scenario	Recommendations

1(a). Ship reports a confirmed case of COVID-19 on current voyage
 	
(e.g. a symptomatic person has medically disembarked and tests positive before end of voyage)
 	
OR
 	
1(b). Ship reports outbreak[1] of acute respiratory illness compatible with COVID-19 on current voyage
	Cruise ship/line – During Voyage Actions
	• Reports case to CDC quarantine station (QS) with jurisdiction for the port
	• Reports and isolates any additional travelers on board with acute respiratory illness compatible with COVID-19 per CDC guidance
	• Reports and quarantines travelers who the ship identifies as having close contact (e.g., cabin attendant, traveling companions) per CDC guidance
	• Cancels social gatherings
	• Cancels, or implements social distancing for, public dining to the extent possible
	• Advises passengers to remain in cabins to the extent possible and practice social distancing if out of cabin
	• Takes any additional actions per instructions of the QS
	
	Cruise ship/line– Disembarkation Actions
	• Coordinates movement of passengers or crew with laboratory-confirmed COVID-19 who are still considered infectious with QS and health department.
	  ○ Options include EMS transport and hospitalization (if clinically indicated), local isolation with transport by private vehicle, or air medical transport to final destination.
	  ○ Travelers known to be infectious with COVID-19 may not travel by commercial conveyance including charter flights with that are not approved air medical transport.
	• Arranges transfer of symptomatic travelers needing hospital evaluation
	  ○ Coordinates with QS and health department to identify receiving hospital
	  ○ Arranges EMS transport to receiving hospital
	• Allows disembarkation of mildly symptomatic (well enough to travel home) and asymptomatic travelers
	  ○ These travelers may return home by commercial transport *as long as no other communicable disease of public health concern is suspected based on QS assessment*
	• Informs disembarking travelers to stay home for the next 14 days and monitor their health
	• Provides CDC's COVID-19 letter to disembarking travelers and the subsequent voyage

[1]Outbreaks of ILI exceeding 1.380 cases per 1,000 traveler-days among passengers or crew members. See https://www.cdc.gov/quarantine/cruise/reporting-deaths-illness/how-calculate-influenza-influenza-like-illness-case-outbreak-threshold-cumulative-reports.html for more information.

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	CDC Actions
	Quarantine Station:
	• Serves as the point of contact for the cruise ship/line, local maritime partners, and local public health
	• Notifies seaport partners (e.g. CBP & US Coast Guard)
	
	Maritime Activity (MA):
	• MA obtains partial (close contacts of single confirmed case) or full (if outbreak identified) ship manifest to provide:
	  ○ Specific Epi-X notice to states for US residents
	  ○ Foreign public health notifications for those departing US

Scenario	**Recommendations**
2. Confirmed case of COVID-19 associated with a previous voyage* *(e.g. either case was a) infectious/had symptoms during the voyage, or b) infected/acquired the virus during the voyage)* **Assumes Scenario 1 does not apply*	If notified by any source other than the cruise ship/line, CDC Quarantine Station notifies cruise ship/line of a confirmed case of COVID-19 associated with a previous voyage **Cruise ship/line – Current Voyage Actions** • See above actions for ill travelers and close contacts **Cruise ship/line – Actions Related to Voyage with Confirmed Case** • Provides CDC's COVID-19 letter to passengers and crew from the voyage with the confirmed case and the voyage immediately after **CDC Actions** Quarantine Station: • Serves as the point of contact for the cruise ship/line, local maritime partners, and local public health • Notifies seaport partners (e.g. Customs and Border Protection & US Coast Guard)

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Guthrie, Kevin; Moskowitz, Jared; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Link, Paul (OS/ASPR/EMMO); Mann, Travis (OS/ASPR/EMMO); Sturrock, Lochlin (OS/ASPR/EMMO); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; Bowman, Thomas (OS/ASPR/EMMO); Dickinson, Jeanette (OS/ASPR/EMMO); Raspberry, Jenny (OS/ASPR/EMMO)
Subject:	CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 10:51:42 PM
Attachments:	Cruise Ship SOP Talking Points_FINAL Cleared.pdf PH Recommendations for Cruise Ships Arriving at US Ports_FINAL Cleared.pdf 20_316043-A_FS_Guide_disembark_ship_March20.pdf Cruise Passengers returning charter flights_final_3.21.20.pdf

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I should have a name of a Customs and Border Protection (CBP) representative for you shortly.

Regards,
Jeanne

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AMERICAN OVERSIGHT

Health Alert:
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Stay home for 14 days from the time you left the cruise ship or river cruise and practice social distancing

Take these steps to monitor your health and practice social distancing:

1. Take your temperature with a thermometer two times a day and monitor for fever. Also watch for cough or trouble breathing.

2. Stay home and avoid contact with others. Do not go to work or school.

3. Keep your distance from others (about 6 feet or 2 meters).

What To Do If You Get Sick

If you get sick with fever (100.4°F/38°C or higher) or cough in the 14 days after you return from travel:

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- You might have COVID-19; most people are able to recover at home without medical care.
- If you have trouble breathing or are worried about your symptoms, call or text a health care provider. Tell them about your recent travel and your symptoms.
- Call ahead before you go to a doctor's office or emergency room.

If you need to seek medical care for other reasons, such as dialysis, call ahead to your doctor and tell them about your recent travel on a cruise ship or river cruise.

Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-002964
CS 316043A March 20, 2020 11:16 AM

March 21, 2020

Public Health Management for Cruise Ship Passengers Returning to the United States via Charter Flights during COVID-19 Pandemic

Purpose: This document clarifies the roles and responsibilities of cruise ship/line if chartering flights for disembarking passengers back to the United States.

Phase	Recommendations
Preparing for departure	**Cruise ship/line** • Notifies CDC about any illness compatible with COVID-19 among any passengers or crew returning to the United States including the number of persons with confirmed or suspected COVID-19. • Obtains full approval from state and local authorities (including health authorities) for the arrival of the charter in the receiving state. • Provides full manifest with contact information to CDC. • Provides full itineraries to final destination for each passenger. • Travelers with confirmed COVID-19, or sick with symptoms compatible with COVID-19, must not board a non-medical charter flight or travel commercially to the United States, or within the US, unless they have met CDC's criteria for release from isolation (non-test-based criteria). ○ See information in https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html ○ Ill/infected travelers who are stable enough to travel should only travel by approved medical transport, to their state of residence, if possible. ○ Any transport of ill or infected travelers to the United States must be coordinated in advance with CDC and the health department of the receiving state. • Distribute general CDC COVID-19 health information to cruise ship passengers eligible to board the US flight. ○ Advise passengers to stay home, monitor their health, and practice social distancing for 14 days after they arrive in the United States. • Ensure air carrier has stocked sufficient personal protective equipment (PPE) for flight: ○ For cabin crew, PPE and supplies comparable to those on commercial airlines, i.e., Universal Precaution Kit. ○ Face masks for travelers who develop symptoms during travel are available onboard. **CDC Actions** • Addresses any concerns with the cruise line or air operator. • Provides guidance as needed (e.g., questions about screening procedures or protocols).
Before US passengers/crew disembark and boarding of charter flight	**Cruise ship/line** ○ Screen all US-bound passengers or crew who will board the US charter flight for fever (100.4°F or 38°C or higher) or new or worsening cough or shortness of breath. ○ Symptomatic travelers should not board the charter flight per instructions above.

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	• If space allows, passengers should spread out on the charter flight (e.g., six feet apart if possible) and travel companions should be seated together.
In Flight	**Cabin and Flight Crews** • Follow CDC guidance for managing and reporting illness or death during flight: https://www.cdc.gov/quarantine/air/index.html **CDC Actions** • Provides guidance as needed if an illness or death is reported during flight.
Arrival in the United States.	**Cruise ship/line** • Provides timely transport and appropriate arrangements for any passengers who have become ill in transit and have been evaluated at the port of entry but do not require hospitalization. These arrangements would depend on the clinical condition and diagnosis following evaluation. **US Government Actions** • Department of Homeland Security staff may perform screening of passengers, as per their protocols. • Passengers will receive health information. • CDC Quarantine Station staff are available for illness response, as per protocol. • Allows asymptomatic passengers to continue travel by either charter or commercial conveyance as arranged by the cruise line.

AMERICAN OVERSIGHT

Key Points—Incoming Cruise Ships

- The US Government's priority is to protect the health of passengers and crew, their loved ones, the traveling public, and communities within the United States.
- The Centers for Disease Control and Prevention (CDC) recommends all persons defer any travel on cruise ships, including river cruises, worldwide because of the increased risk of COVID-19 on board ships.
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- The situation in the United States is evolving, both with increasing community transmission and an increasing number of cruise ships coming into port. CDC is continuing to reevaluate how we approach returning cruise ships.
    - As we reevaluate the approach to returning cruise ships, CDC's priority is to protect passengers' and crews' health while helping them get home as quickly and safely as possible.
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    - If an ill passenger or crew member is identified on board the ship, the cruise line will report to the CDC Quarantine Station responsible for the port. CDC staff will determine if further action is needed.
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AMERICAN OVERSIGHT

- CDC will also alert the World Health Organization through the International Health Regulations to ensure non-US citizen travelers are aware of their risk.

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AMERICAN OVERSIGHT

March 20, 2020

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Purpose: This document clarifies the roles and responsibilities of cruise ship/line, state and local health departments, and CDC if a confirmed case COVID-19 is identified on a current or a previous voyage.

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As cruise ships return to US ports, the following scenarios and recommendations apply:

Scenario	Recommendations

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(e.g. a symptomatic person has medically disembarked and tests positive before end of voyage)
 	
OR
 	
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	Cruise ship/line – During Voyage Actions
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	• Reports and isolates any additional travelers on board with acute respiratory illness compatible with COVID-19 per CDC guidance
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	• Cancels social gatherings
	• Cancels, or implements social distancing for, public dining to the extent possible
	• Advises passengers to remain in cabins to the extent possible and practice social distancing if out of cabin
	• Takes any additional actions per instructions of the QS
	
	Cruise ship/line– Disembarkation Actions
	• Coordinates movement of passengers or crew with laboratory-confirmed COVID-19 who are still considered infectious with QS and health department.
	  ○ Options include EMS transport and hospitalization (if clinically indicated), local isolation with transport by private vehicle, or air medical transport to final destination.
	  ○ Travelers known to be infectious with COVID-19 may not travel by commercial conveyance including charter flights with that are not approved air medical transport.
	• Arranges transfer of symptomatic travelers needing hospital evaluation
	  ○ Coordinates with QS and health department to identify receiving hospital
	  ○ Arranges EMS transport to receiving hospital
	• Allows disembarkation of mildly symptomatic (well enough to travel home) and asymptomatic travelers
	  ○ These travelers may return home by commercial transport *as long as no other communicable disease of public health concern is suspected based on QS assessment*
	• Informs disembarking travelers to stay home for the next 14 days and monitor their health
	• Provides CDC's COVID-19 letter to disembarking travelers and the subsequent voyage

[1]Outbreaks of ILI exceeding 1.380 cases per 1,000 traveler-days among passengers or crew members. See https://www.cdc.gov/quarantine/cruise/reporting-deaths-illness/how-calculate-influenza-influenza-like-illness-case-outbreak-threshold-cumulative-reports.html for more information.

AMERICAN OVERSIGHT

	CDC Actions
	Quarantine Station:
	• Serves as the point of contact for the cruise ship/line, local maritime partners, and local public health
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	Maritime Activity (MA):
	• MA obtains partial (close contacts of single confirmed case) or full (if outbreak identified) ship manifest to provide:
	  ○ Specific Epi-X notice to states for US residents
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Scenario	**Recommendations**
2. Confirmed case of COVID-19 associated with a previous voyage* *(e.g. either case was a) infectious/had symptoms during the voyage, or b) infected/acquired the virus during the voyage)* **Assumes Scenario 1 does not apply*	If notified by any source other than the cruise ship/line, CDC Quarantine Station notifies cruise ship/line of a confirmed case of COVID-19 associated with a previous voyage **Cruise ship/line – Current Voyage Actions** • See above actions for ill travelers and close contacts **Cruise ship/line – Actions Related to Voyage with Confirmed Case** • Provides CDC's COVID-19 letter to passengers and crew from the voyage with the confirmed case and the voyage immediately after **CDC Actions** Quarantine Station: • Serves as the point of contact for the cruise ship/line, local maritime partners, and local public health • Notifies seaport partners (e.g. Customs and Border Protection & US Coast Guard)

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AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: CDC guidance updates
Date: Friday, March 6, 2020 8:24:52 AM

CDC guidance updates:

Evaluating and Reporting PUIs

Interim Guidance for Public Health Professionals Managing People with COVID-19 in Home Care and Isolation Who Have Pets or Other Animals

Interim Guidance: Get Your Community- and Faith-Based Organizations Ready for Coronavirus Disease 2019 (COVID-19)

"Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures" **:**
https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC HAN 427: (Correction to Link for PUI Case Investigation Form in this Version) Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)
Date:	Saturday, February 1, 2020 1:48:37 PM
Importance:	High

Correction: In the Recommendations for Reporting, Testing, and Specimen Collection section, the link for the 2019-nCoV PUI case investigation form has been corrected.

This is an official
CDC HEALTH UPDATE

Distributed via the CDC Health Alert Network
February 1, 2020, 0900 ET (9:00 AM ET)
CDCHAN-00427

Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)

Summary
The Centers for Disease Control and Prevention (CDC) continues to closely monitor an outbreak of respiratory illness caused by a novel coronavirus (2019-nCoV) that was initially detected in Wuhan City, Hubei Province, China in December 2019.

This CDC Health Alert Network (HAN) Update provides a situational update and interim guidance to state and local health departments that supersedes guidance in CDC's HAN 426 distributed on January 17, 2020. It also adds

- guidance for clinicians caring for patients with 2019-nCoV (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html),
- and for public health officials on the evaluation and testing of patients under investigation (PUIs) for 2019-nCoV (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html), and
- updated infection prevention and control guidance specific to 2019-nCoV (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html).

Early in the outbreak, many of the patients with respiratory illness caused by 2019-nCoV in China had exposure to a large seafood and live animal market, suggesting animal-to-human transmission. More recently, cases have been confirmed with no exposure to animal markets, indicating that person-to-person spread of the virus has occurred. Chinese officials report that sustained person-to-person spread in the community is occurring in China.

The first US case-patient was identified on January 21, 2020, and had recently traveled from Wuhan, China. Since that time, six additional cases have been confirmed in the United States, four among persons who traveled from Wuhan, and one a close contact of a confirmed case. Globally, reported illnesses in people with 2019-nCoV have ranged from mild (no or few signs and symptoms), to severe, including death. These findings are consistent with other coronaviruses, including Severe Acute Respiratory Syndrome (SARS) (https://www.cdc.gov/sars/) and Middle East Respiratory Syndrome (MERS) (https://www.cdc.gov/coronavirus/mers/index.html). Additional information about 2019-nCoV is needed to better understand transmission, disease severity, and risk to the general population. The goal of the ongoing US public health response is to identify and contain this outbreak and prevent sustained spread of 2019-nCoV in the United States.

Recommendations for Screening of Patients for 2019-nCoV in Healthcare Facilities

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Recommendations for screening of patients for possible 2019-nCoV infection are based on (1) current knowledge of the characteristics of clinical illness observed in early cases, and (2) the geographic distribution of current cases. They reflect the current public health goal of rapidly containing and preventing transmission of 2019-nCoV illness.

Patients presenting to healthcare facilities should be assessed for exposures associated with risk of 2019-nCoV infections (e.g., travel to China or close contact with a confirmed case) and for symptoms consistent with 2019-nCoV infection (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html). The assessment is intended to allow healthcare providers to make decisions about appropriate infection control and management of patients. Note that the signs and symptoms of 2019-nCoV overlap with those associated with other viral respiratory tract infections. Given the time of year, common respiratory illnesses, including influenza, should also be considered in patients who are screened. (Figure 1)

Clinicians should ask:

- Does the person have fever or symptoms of lower respiratory infection, such as cough or shortness of breath?

AND

- Has the patient traveled to mainland China within 14 days of symptom onset?

OR

- Has the patient had close contact[1] with a person confirmed with 2019-nCoV infection?

Figure 1.

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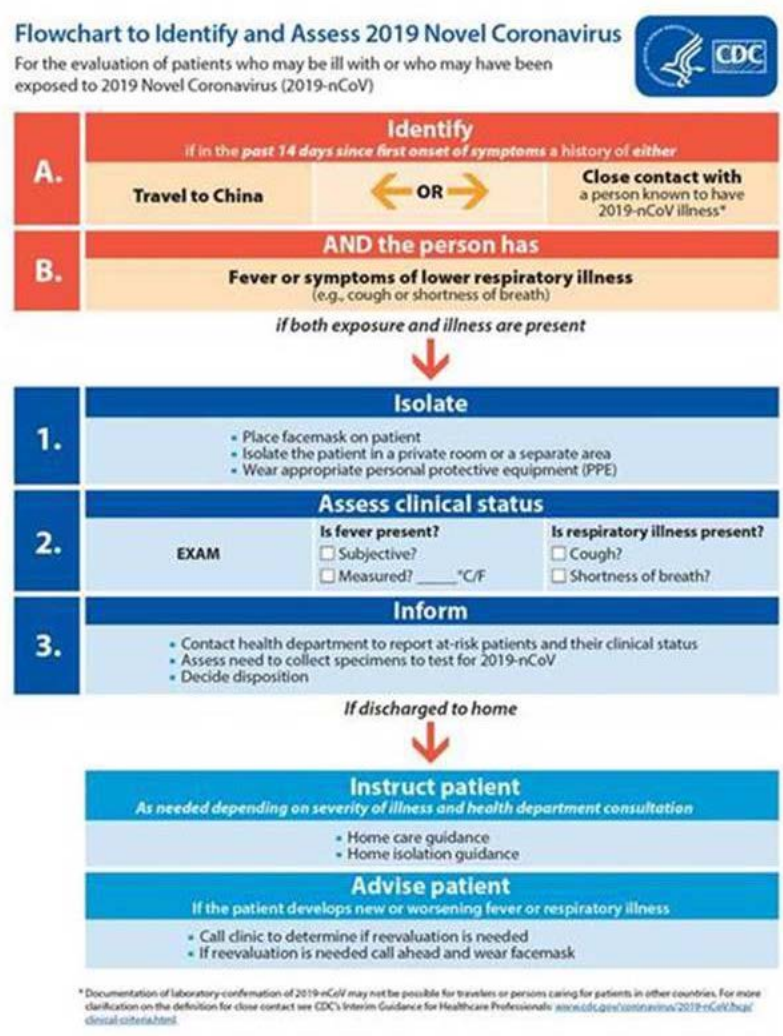

If a patient meets these criteria:

- To minimize the risk that other people will be exposed to individuals who may have 2019-nCoV, patients who report having these symptoms should be asked to wear a surgical mask as soon as they are identified and directed to a separate area, if possible, with at least 6 feet (2 meters) separation from other persons. Patients should be evaluated in a private room with the door closed, ideally an airborne infection isolation room (AIIR), if available. Healthcare personnel entering the room should use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., goggles or a face shield). For more information about this, see CDC's *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html).

Clinicians should immediately notify the healthcare facility's infection control personnel and local health department. The health department will determine if this patient needs to be considered a PUI for 2019-nCoV and be tested for infection.

Criteria to Guide Evaluation and Testing of Patients Under Investigation (PUI) for 2019-nCoV
Local health departments, in consultation with clinicians, should determine whether a patient is a PUI for 2019-nCoV. The CDC clinical criteria for 2019-nCoV PUIs have been developed based on available information about this novel virus, as well as what is known about SARS and MERS. These criteria are subject to change as additional information becomes available.

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Clinical Features	AND	Epidemiologic Risk
Fever[2] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers, who has had close contact[1] with a laboratory-confirmed[3] 2019-nCoV patient within 14 days of symptom onset
Fever[2] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever[2] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization[4]	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

These criteria are intended to serve as guidance for evaluation and testing. Patients should be evaluated and discussed with public health departments on a case-by-case basis for possible 2019-nCoV infection. Testing decisions might be further informed by the clinical presentation or exposure history (e.g., uncertain travel or exposure), and the presence of an alternative diagnosis that explains their clinical presentation .

Recommendations for Reporting, Testing, and Specimen Collection

Healthcare providers should **immediately** notify infection control personnel at their healthcare facility if a patient is classified a PUI for 2019-nCoV. State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a 2019-nCoV PUI case investigation form (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html#reporting-testing-specimen-collection). CDC's EOC will assist local and state health departments with obtaining, storing, and shipping appropriate specimens to CDC, including afterhours or on weekends or holidays. Currently, diagnostic testing for 2019-nCoV can be done only at CDC. Testing for other respiratory pathogens should not delay specimen shipping to CDC.

For initial diagnostic testing for 2019-nCoV, CDC recommends collecting and testing upper respiratory (nasopharyngeal AND oropharyngeal swabs), and lower respiratory (sputum, if possible)) for those patients with productive coughs. Induction of sputum is not indicated. Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See *Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV)* (https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html).

Recommendations for Healthcare Providers

No vaccine or specific treatment for 2019-nCoV infection is available. At present, medical care for patients with 2019-nCoV is supportive.

Persons with confirmed or suspected 2019-nCoV infection who are hospitalized should be evaluated and cared for in a private room with the door closed, ideally an airborne infection isolation room, if available.

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For more information, see *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html).

Home care and isolation may be an option, based on clinical and public health assessment, for some persons. Please see *Interim Guidance for Preventing the Spread of 2019 Novel Coronavirus (2019-nCoV) in Homes and Communities* (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html).

Those isolated at home should be monitored by public health officials to the extent possible. Refer to *Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)* (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html) for more information.

Notes

[1]Close contact is defined as:
a) being within approximately 6 feet (2 meters), or within the room or care area, of a 2019-nCoV case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a 2019-nCoV case
- or -
b) having direct contact with infectious secretions of a 2019-nCoV case (e.g., being coughed on) while not wearing recommended personal protective equipment.

[2]Fever may be subjective or confirmed
See CDC's updated *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (https://www.cdc.gov/coronavirus/2019-ncov/infection-control.html).
Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with 2019-nCoV (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

[3] Documentation of laboratory-confirmation of 2019-nCoV may not be possible for travelers or persons caring for patients in other countries.

[4] Category also includes any member of a cluster of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which 2019-nCoV is being considered that requires hospitalization. Such persons should be evaluated in consultation with state and local health departments regardless of travel history.

For More Information
More information is available at the 2019 Novel Coronavirus website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) or by calling 800-CDC-INFO | (800-232-4636) | TTY: (888) 232-6348

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:
Health Alert Requires immediate action or attention; highest level of importance
Health Advisory May not require immediate action; provides important information for a specific incident or situation
Health Update Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service Does not require immediate action; provides general public health information

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

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Distributed by:

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CDC EOC Duty Officer
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Respectfully,

Jade Anderson, MPA
Special Advisor/Public Health Analyst
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
404-718-5723 Office | 470-747-9289 Cell **|** 404-639-2847 fax
e-mail: Jade.Anderson@cdc.hhs.gov

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response Field Investigations Team; CDC IMS 2019 NCOV Response At Risk; CDC IMS 2019 NCOV Response Clinical On-Call Unit; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP); Fagan, Ryan (CDC/DDID/NCEZID/DHQP); Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 1:51:25 PM

Hello Dr. Blackmore,

I wanted to introduce you to Srinivas Nanduri who will help with the infection prevention and control aspects of this investigation. As we discussed on the phone today, his deployment will be about 5 days and will largely be focused on the following objectives:

1. To provide targeted infection control assessment and observation of the affected healthcare facility to included hand hygiene, transmission based precaution use, and environmental cleaning.
2. To provide training on essential infection control activities such as hand hygiene and PPE donning and doffing
3. Provide technical support on healthcare worker and patient/resident monitoring during this time
4. To build internal capacity within the health departments for these types of assessments moving forward through mechanisms such as tele-infection control assessments (ICAR) or focused onsite ICARs
5. If times allows, to conduct preparedness assessment at other healthcare facilities

We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

Please reach out to Sri directly to arrange further logistics.

Best,
Elizabeth Soda

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From:	Davis, Ashley
To:	Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	Roberts, James; Kincaid, Brooke; Scott, John; Siddall, Paul; Coppola, Courtney
Subject:	CDC links reference reusable materials
Date:	Saturday, March 21, 2020 10:06:55 AM

Samantha or Aaron, can you please share w/ your CHD's?

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Saturday, March 21, 2020 9:47 AM
To: Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] PPE RFI

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Below are the CDC links reference reusable materials that you requested.

The last paragraph of the pdf covers homemade masks.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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61 Forsyth Street, SW Suite 5B95
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fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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Cc:	Roberts, James; Kincaid, Brooke; Scott, John; Siddall, Paul; Coppola, Courtney
Subject:	CDC links reference reusable materials
Date:	Saturday, March 21, 2020 10:06:43 AM

Samantha or Aaron, can you please share w/ your CHD's?

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Saturday, March 21, 2020 9:47 AM
To: Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] PPE RFI

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Regards,
Jeanne

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Statement: CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.
Date:	Thursday, February 27, 2020 8:43:16 AM

Media Statement

For Immediate Release
Wednesday, February 26, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.

The Centers for Disease Control and Prevention (CDC) has confirmed an infection with the virus that causes COVID-19 in California in a person who reportedly did not have relevant travel history or exposure to another known patient with COVID-19.

At this time, the patient's exposure is unknown. It's possible this could be an instance of community spread of COVID-19, which would be the first time this has happened in the United States. Community spread means spread of an illness for which the source of infection is unknown. It's also possible, however, that the patient may have been exposed to a returned traveler who was infected.

This case was detected through the U.S. public health system — picked up by astute clinicians. This brings the total number of COVID-19 cases in the United States to 15.

The federal government has been working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat. Unprecedented, aggressive efforts have been taken to contain the spread and mitigate the impact of this virus.

This is a rapidly evolving situation. CDC will continue to update the public as circumstances warrant. For more information about COVID-19 visit www.cdc.gov/covid19.

###

U.S. Department of Health and Human Services

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

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Statement: CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.
Date:	Thursday, February 27, 2020 8:50:56 AM

Media Statement

For Immediate Release
Wednesday, February 26, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Statement: CDC Confirms Possible Instance of Community Spread of COVID-19 in U.S.
Date:	Thursday, February 27, 2020 8:40:52 AM

Media Statement

For Immediate Release
Wednesday, February 26, 2020

Contact: CDC Media Relations
(404) 639-3286

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Media Telebriefing: Update on 2019 Novel Coronavirus (2019-nCoV)
Date:	Wednesday, February 5, 2020 10:47:44 AM

Media Advisory

For Immediate Release
Wednesday, February 5, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on 2019 Novel Coronavirus (2019-nCoV)

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the 2019 Novel Coronavirus response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

RADM Denise Hinton, Chief Scientist
Food and Drug Administration

When 12:15 p.m. ET Wednesday, February 5, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 2684824

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site: www.cdc.gov/media.

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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC Media Telebriefing: Update on COVID-19 - Today at 3 P.M. EST
Date: Saturday, February 29, 2020 1:00:53 PM

Media Advisory

For Immediate Release
Saturday Feb. 29, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 3 p.m. ET Saturday, Feb. 29, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 4677929

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State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: CDC Media Telebriefing: Update on COVID-19 at 3 P.M. EST Today
Date: Saturday, February 29, 2020 12:56:54 PM

Media Advisory

For Immediate Release
Saturday Feb. 29, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 3 p.m. ET Saturday, Feb. 29, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 4677929

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

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U.S. Department of Health and Human Services

CDC works 24/7 protecting America's health, safety and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or

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deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: CDC Media Telebriefing: Update on COVID-19 at 3 P.M. EST
Date: Saturday, February 29, 2020 12:49:51 PM

Media Advisory

For Immediate Release
Saturday Feb. 29, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC Releases Interim Movement & Monitoring Guidance
Date:	Monday, February 3, 2020 8:29:35 PM
Attachments:	CDC_2019-nCoV Daily Key Points__2_3_2020_Final.pdf

Dear Partners,

Today, the Centers for Disease Control and Prevention (CDC) released new movement and monitoring guidelines, "**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings"**. For your convenience, you can find it here. In addition, summary key points are attached.

Feel free to send any questions to preparedness@cdc.gov. For the latest information on the 2019 Novel Coronavirus (2019-nCoV), please visit the response webpage.

Thank you,

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CDC Daily Key Points
2019 Novel Coronavirus (2019-nCoV)

February 3, 2020

MAIN KEY POINTS

- There is an expanding outbreak centered in China of respiratory illness caused by a novel (new) coronavirus abbreviated "2019-nCoV."
- This virus is spreading from person-to-person in China. A growing number of counties are reporting cases in travelers from China and some limited person-to-person spread has been reported in countries outside of China, including in the United States. Additionally, spread from an infected person who did not have symptoms to another person has been reported as well (i.e., asymptomatic spread).
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to 2019 novel coronavirus.
- Also on January 31, the President of the United States issued a "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus.
    - Foreign nationals who have visited China in the past 14 days may not enter the United States. Special precautions are required of U.S. citizens and certain other exempted persons entering the United States who have been in China during the past 14 days, including up to a 14-day quarantine. (See travel section for more information below.)
    - CDC is working with public health partners to support the implementation of the travel policies detailed in the presidential proclamation (above), including the quarantine of U.S. citizens and other exempted persons returning from China for up to 14 days.
    - Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick.
- The situation is rapidly changing, and we are monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this – when a new virus is emerging to infect people – are always concerning. Some people might be worried about this virus and how it may impact Americans.
    - While this situation poses a very serious public health threat, CDC believes the immediate risk to the U.S. public continues to be low at this time.
    - Risk also depends on exposure. People exposed to ill persons are at greater risk of infection. (For example, healthcare workers and family members caring for people with 2019-CoV.)
    - However, the situation is evolving, and risk will depend on how well the virus spreads, how widely it spreads, and how sick it makes people.
- CDC has activated its Emergency Operations Center and is implementing an aggressive public health response in collaboration with federal, state and local partners.
- The goal of the ongoing U.S. public health response is to detect and contain introductions of this virus with the goal of preventing sustained spread of

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2019-nCov in this country. Strong public health measures now may blunt the impact of the virus in the United States.

- The coming days and weeks are likely to bring more confirmed cases of 2019-nCoV in the United States and globally.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if were the next pandemic.

SITUATION UPDATE

- To date, 27 international locations (in addition to the U.S.) have reported confirmed cases of 2019-nCoV infection.
- As of February 2, 2020, 11 infections with 2019-nCoV have been reported in the U.S. in five states – Arizona, California, Illinois, Massachusetts and Washington.
- There have been two instances of person-to-person spread with this virus in the United States, in both cases after close, prolonged contact with a returned traveler from Wuhan.
- On Monday, February 3, 2020, CDC submitted an Emergency Use Authorization (EUA) package to the Food and Drug Administration (FDA) for its real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test that can diagnose 2019-nCoV in respiratory and serum samples from clinical specimens.
- The EUA process expedites the use of medical or diagnostic products during a public health emergency.
- Once CDC's diagnostic panel is FDA approved for use under EUA, the International Reagent Resource (IRR) will begin distributing the diagnostic panel to qualified laboratories. Only registered users will be able to order and obtain the diagnostic panel.
- On February 1, 2020, CDC issued a health alert network (HAN) update with some updates to previously posted guidance and, for the first time, guidance on clinical care of 2019—nCoV patients.
- CDC has isolated the virus and it is being sent to the NIH's BEI Resources Repository for use by the broad scientific community.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. 2019-nCoV patients to detect person-to-person spread.
- CDC will continue to lean forward on public health response efforts to protect Americans. We are working closely with state and local health departments and have teams on standby to deploy if needed. Our public health goal continues to be to protect the health of Americans by preventing community spread with this virus.
- CDC is preparing senior staff to support the WHO international senior technical mission being formed to work with Chinese public health counterparts to help improve understanding of this new disease, including learning more about transmissibility and severity.

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WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
  - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
  - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
  - If you are a healthcare provider caring for a 2019-nCoV patient, please take care of yourself and follow recommended infection control procedures.
  - For people who may have 2019-nCoV infection, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.
  - For people who have had close contact with someone infected with 2019-nCoV who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a 2019-nCoV patient.

TRAVEL

Travel from China:

President Trump issued a Presidential Proclamation January 31, 2020 to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.

The proclamation:

- Suspends entry into the United States to foreign nationals who have visited China (excluding Hong Kong and Macau) within the past 14 days. There are some exemptions, including for immediate family members of U.S. citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")

In addition:

- All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 U.S. airports.
  - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
    - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
    - If asymptomatic, American citizens and exempted persons will be subject to a mandatory 14-day quarantine

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at or near that location. (They will not be able to complete their itinerary.)

- American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
  - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
  - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be monitored under self-quarantine for 14 days.

The declaration will be effective beginning 5 p.m. EST, Sunday, February 2, 2020.

The 11 airports where flights are being funneled to include:

- John F. Kennedy International Airport (JFK), New York
- Chicago O'Hare International Airport (ORD), Illinois
- San Francisco International Airport (SFO), California
- Seattle-Tacoma International Airport (SEA), Washington
- Daniel K. Inouye International Airport (HNL), Hawaii
- Los Angeles International Airport, (LAX), California
- Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
- Washington-Dulles International Airport (IAD), Virginia
- Newark Liberty International Airport (EWR), New Jersey
- Dallas/Fort Worth International Airport (DFW), Texas
- Detroit Metropolitan Airport (DTW), Michigan

Travel to China:

On January 30, 2020 The US State Department issued a level 4 travel advisory, their highest threat level, requesting Americans not to travel to China because of the public health threat posed by the novel coronavirus.

CDC has issued a level 3 Travel Health Notice for China (its highest level) recommending that all travelers avoid non-essential travel.

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First Repatriated Flight Plus Quarantine Order

- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to 195 United States citizens who repatriated to the U.S. from Wuhan, China on January 29, 2020.
- The quarantine will last 14 days from when the plane left Wuhan, China.
- This action is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- This quarantine order also will protect the health of the repatriated citizens, their families, and their communities.
- These individuals will continue to be housed at the March Air Reserve Base in Riverside, California.
- Medical staff will monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.

Additional Repatriation Flights

- On January 23, 2020, the Department of State ordered the departure of all U.S. Consulate General Wuhan personnel and their family members.
- The Department of State is working with the U.S. Government interagency and PRC counterparts on staging additional flights for U.S. citizens to return to the United States from Wuhan.
- CDC will continue to support the Department of State in the safe and expedient ordered departure of all U.S. citizens and residents from Wuhan, China.

For more information please visit the 2019 Novel Coronavirus Outbreak Page at: https://www.cdc.gov/coronavirus/2019-ncov/index.html

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	CDC-- Taking Advantage of the 15-Day Pause to Slow the Spread of COVID-19
Date:	Friday, March 20, 2020 10:57:48 AM
Attachments:	15 Day Pause_Final_PDF.pdf
Importance:	High

Dear Colleagues,

Please find attached and hyperlinked the CDC Taking Advantage of the 15-day Pause to Slow the Spread of COVID-19 plan document. https://www.cdc.gov/coronavirus/2019-ncov/community/15-day-pause.html

What is the 15-day pause?

While every community is unique and experiencing varying levels of community transmission, the 15-day pause recommended by the White House presents the entire country with an opportunity to assess how prepared we are and take steps to implement actions designed to slow and limit the spread of COVID-19. We understand that the pause may last longer than 15 days.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors)

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Taking Advantage of the 15-Day Pause to Slow the Spread of COVID-19

Considerations for state and local community leaders

What is the 15-day pause?

While every community is unique and experiencing varying levels of community transmission, the 15-day pause recommended by the White House presents the entire country with an opportunity to assess how prepared we are and take steps to implement actions designed to slow and limit the spread of COVID-19. We understand that the pause may last longer than 15 days.

Thinking ahead

At some point, the recommended actions will change. Community leaders must come together to facilitate services and businesses re-opening in an orderly way. The resumption of activities needs planning so that it does not negatively affect ongoing mitigation efforts in local areas or the country as a whole.

Steps every sector can take during the 15-day pause to plan as One Community

Identify leaders from every sector who can join a task force to jointly plan for and implement a coordinated effort

- ✓ Communicate with the public to share considerations and decisions about when to start reopening – prepare them that 15 days may not be long enough and will depend on a variety of factors, which look different from community to community.
- ✓ Identify organizations serving at risk and underserved populations and help them prepare
- ✓ Access critical gaps in resources and supply chain
    - Medical equipment
    - Food supply
    - Cleaning and disinfection products
- ✓ Identify childcare for critical infrastructure workforce
    - Healthcare workers
    - First responders
    - Teachers and school administrators
    - Utility company staff
    - Mental health professionals
- ✓ Begin planning for an orderly return to daily life
    - Identify leaders from every sector who can join a task force to jointly plan for a coordinated effort
    - Work with public health authorities to determine which interventions should continue and identify local factors that might assist determining when and how to resume services.
        - Local factors to examine
            - Local spread
            - Strain on critical infrastructure
            - Supply chain relief
            - Public mood, tolerance and community resilience

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- For those interventions that should remain in place, consider how to lessen the adverse effects of them
- Prepare public communication materials to explain what people can do to alleviate the negative effects of interventions that remain in place.
    - Prepare the public that this may be a slow, staged progression back to normalcy
    - Restrictions will be lifted as soon as it is safe to do so
    - Communities need to stick together to help one another through these challenging times

Coordinate a community-wide strategy

Communities are interconnected systems. Actions taken in one sector may have a domino effect. It is critical that community plans account for this interconnection when the country begins a staged return to normal activity. Additional guidance is under development to help communities think through this process.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Text Illness Monitoring (T.I.M) System Update
Date:	Friday, February 28, 2020 2:54:53 PM
Attachments:	T.I.M. FAQ_forPH_02.27.2020.pdf

Dear Colleagues,

The Text Illness Monitoring (T.I.M.) system has recently been modified to allow county-level campaigns to be added under state campaigns. This allows for local use of T.I.M. for COVID-19 symptom monitoring.

If a state would like to add county-level users in T.I.M., they should provide the names of the counties that should be activated. Once the T.I.M. support team activates these counties, states may then add county-level users as appropriate.

Local jurisdictions will be assigned at the county level and will have access to the data for that county only, and states will have access to all data within the state.

Local jurisdictions should coordinate with their state for access. States may send the list of counties they wish to activate in T.I.M. to eocevent340@cdc.gov.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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Text Illness Monitoring (T.I.M.)

Frequently Asked Questions

About T.I.M.

What is T.I.M.?

Text Illness Monitoring (T.I.M.) is a mobile texting tool that facilitates symptom monitoring during an infectious disease outbreak. Monitoring conducted by public health officials has traditionally been conducted via telephone calls, which can be a time-consuming process requiring staff resources. CDC has developed T.I.M., a nationally-centralized option utilizing two-way Short Message Service (SMS)/text messaging to aid in the process. Text messaging is an efficient method to elicit, manage, and act on any coronavirus disease 2019 (COVID-19) symptoms among those who are exposed or potentially exposed to the virus. The T.I.M. system was utilized to monitor for influenza symptoms in Michigan[1] with success.

How is T.I.M. being used for the coronavirus disease 2019 response?

Use of T.I.M. is voluntary for health departments. Consenting persons in participating jurisdictions will receive 2-5 text messages a day for up to14 days asking if they have symptoms consistent with COVID-19. Health departments will immediately be alerted to any person in their jurisdiction that responds that they are experiencing symptoms and to any persons who fail to respond to two consecutive messages. Health departments would then follow up with individuals who are reporting symptoms or those that have been unresponsive.

Health Department Access

How do I get access to T.I.M.?

State and local public health departments may request access by sending an email to eocevent340@cdc.gov. Please provide a primary and secondary point of contact to act as an administrator in T.I.M. Instructions for adding users and assigning them to a campaign to receive notifications can be found in the "T.I.M. Adding a User and Alert Setup" guide available in the Resources section of T.I.M.

After registration, the public health administrators will receive an email with information on how to log in and access the system.

Can local public health jurisdictions use T.I.M.?

Yes, T.I.M. has recently been modified to allow county-level campaigns to be added under state campaigns. This allows for local use of T.I.M. for COVID-19 symptom monitoring. If a state would like to add county-level users in T.I.M., they should provide the names of the counties that should be activated. Once the T.I.M. support team activates these counties, states may then add county-level users as appropriate. Local jurisdictions will be assigned at the county level and will have access to the data for that county only. Local jurisdictions should coordinate with their state for access.

Who will be able to access the information in T.I.M.?

There are three levels of access to T.I.M.: CDC, state, and county. Public health administrators at the state level will have access to all data within their jurisdiction, including county level data. Local jurisdictions assigned at the county level

1 Stewart RJ, Rossow J, Eckel S, et al. Text-Based Illness Monitoring for Detection of Novel Influenza A Virus Infections During an Influenza A (H3N2)v Virus Outbreak in Michigan, 2016: Surveillance and Survey. JMIR Public Health Surveill. 2019;5(2):e10842. Published 2019 Apr 26. doi:10.2196/10842 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6658270/

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will only have access to the data for the county to which they are assigned. CDC will have access to the deidentified aggregate data for monitoring campaigns.

Can I add other people in my jurisdiction as users?

State users with the administrator role may add both state and county-level users for their state. County level users can add users to their assigned county only.

Dashboard and Notifications

Is there a dashboard and what information can be seen?

The T.I.M. system includes a dashboard with summary information on number of persons being monitored, and information related to the alerts/notifications that public health needs to take action on (i.e., those that reply YES to a text indicating symptoms, those that have not responded to two consecutive texts). Jurisdictions can view the mobile phone number of participating individuals being monitored through the T.I.M. system and the messages they sent.

How will I know if someone responds that they have symptoms?

If someone in your jurisdiction replies YES to a text message indicating symptoms you will receive an email notification. An email notification will also be sent if a person does not respond to two consecutive texts sent. You can also view a list of all users that responded they have symptoms on the dashboard and in reports.

What data is stored in T.I.M. for individuals being monitored?

Data stored in T.I.M. includes mobile phone number, any text message response provided by that mobile phone, and the date and time it was sent.

Are there any reports available in T.I.M.?

Yes. There are two reports in T.I.M. One report lists all of the text responses received from the previous day, with each response tied to a phone number. The other report lists all of the text responses received for the entire campaign, also tied to phone numbers. Both reports can be exported as a .csv or Excel file or can be reviewed and filtered using HTML.

How are families or head of household tracked in the system?

Each mobile phone enrolled in T.I.M. represents one household or family unit. A text reply of 'YES' or 'SYM' indicates that at least one person in the household/family has developed symptoms. A text reply of 'NO' indicates that no one in the household/family has developed symptoms.

Enrollment and Messaging

What messages will individuals enrolled in T.I.M. receive?

A diagram of the 14-day text message workflow is below. Individuals will immediately receive a welcome message notifying them they have been enrolled in the text symptom monitoring program after the jurisdiction adds their mobile phone number to T.I.M. Individuals will receive a daily message to reply 'Yes' or 'No' to symptoms of COVID-19. At the end of the 14-day monitoring period, individuals will receive a final message informing them that they have completed monitoring and will be unenrolled from T.I.M.

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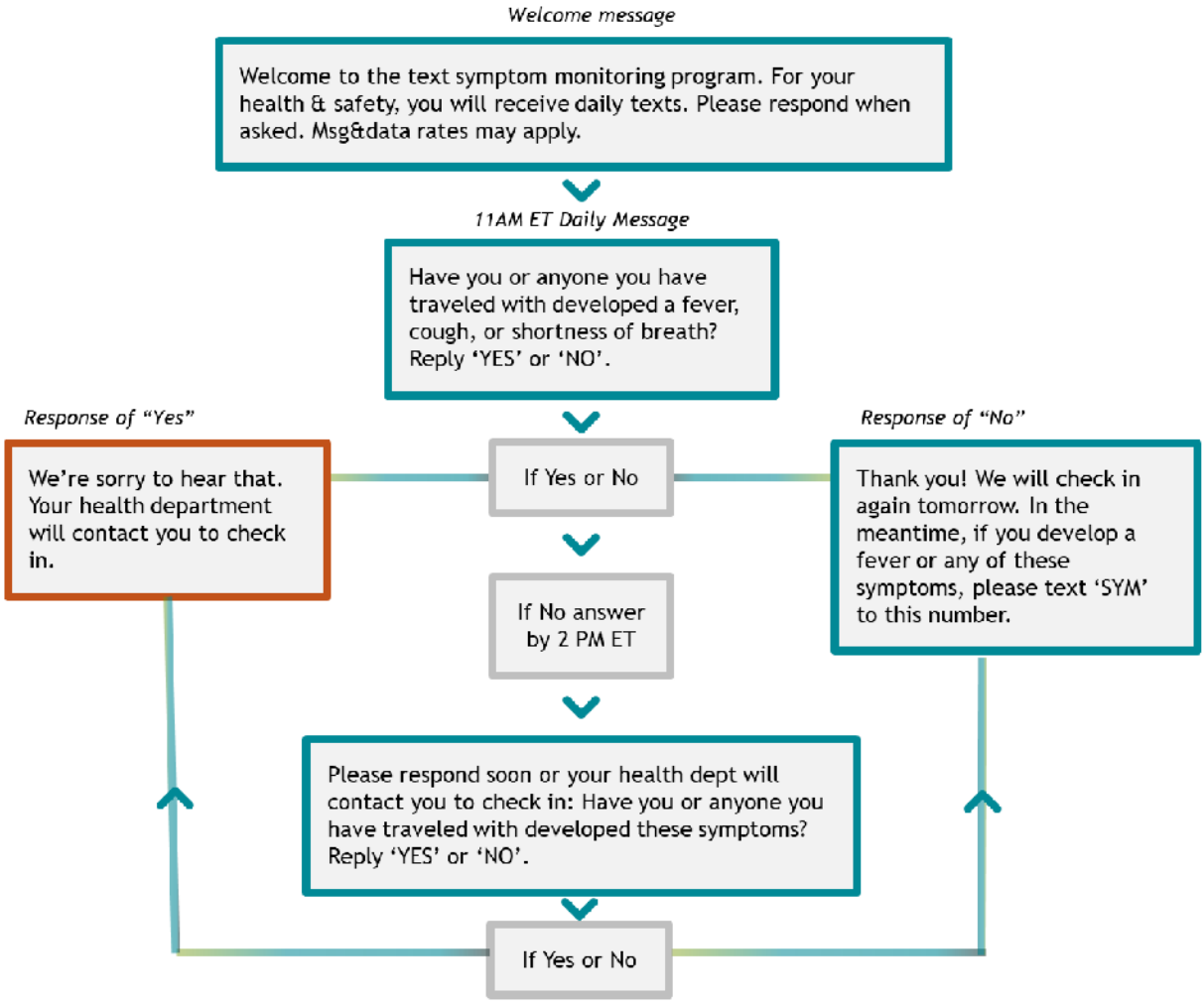

Figure 1. T.I.M. message flow

What information is needed to enroll individuals in T.I.M. for monitoring?

The only information needed to enroll an individual in T.I.M. is a U.S. mobile phone number. This mobile phone number is the only identifiable piece of information entered into T.I.M. Other personal information linked to the patient phone number should be maintained by the jurisdiction to cross-reference with the phone numbers in T.I.M. for any required follow up.

Infrastructure

Is there a cost to jurisdictions to implement T.I.M.?

T.I.M. is a web-based system that does not require additional hardware or software. The system is available at no cost to jurisdictions.

How is the data in T.I.M. secured?

T.I.M. is a secure, scalable, applications in alignment with HIPAA and HITECH compliance requirements. Please see Compliant Campaign's infrastructure security and compliance document for additional details:

What are the terms and conditions for using T.I.M.?

Terms and conditions are available here: https://www.tim-health.com/terms/.

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Other

Is there flexibility to change the duration of monitoring?

Monitoring for COVID-19 is for 14 days. If an individual does not want or need to be monitored for the full 14 days, they can text 'STOP' and they will no longer receive text messages from the system.

Can we remove or edit phone numbers entered into T.I.M.?

If a number is enrolled in T.I.M. and needs to be edited or an incorrect number needs to be removed, please contact timsupport@compliantcampaign.com.

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FL-DOH-20-0673-A-003009

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Can I add other people in my jurisdiction as users?

State users with the administrator role may add both state and county-level users for their state. County level users can add users to their assigned county only.

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Is there a dashboard and what information can be seen?

The T.I.M. system includes a dashboard with summary information on number of persons being monitored, and information related to the alerts/notifications that public health needs to take action on (i.e., those that reply YES to a text indicating symptoms, those that have not responded to two consecutive texts). Jurisdictions can view the mobile phone number of participating individuals being monitored through the T.I.M. system and the messages they sent.

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Yes. There are two reports in T.I.M. One report lists all of the text responses received from the previous day, with each response tied to a phone number. The other report lists all of the text responses received for the entire campaign, also tied to phone numbers. Both reports can be exported as a .csv or Excel file or can be reviewed and filtered using HTML.

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What messages will individuals enrolled in T.I.M. receive?

A diagram of the 14-day text message workflow is below. Individuals will immediately receive a welcome message notifying them they have been enrolled in the text symptom monitoring program after the jurisdiction adds their mobile phone number to T.I.M. Individuals will receive a daily message to reply 'Yes' or 'No' to symptoms of COVID-19. At the end of the 14-day monitoring period, individuals will receive a final message informing them that they have completed monitoring and will be unenrolled from T.I.M.

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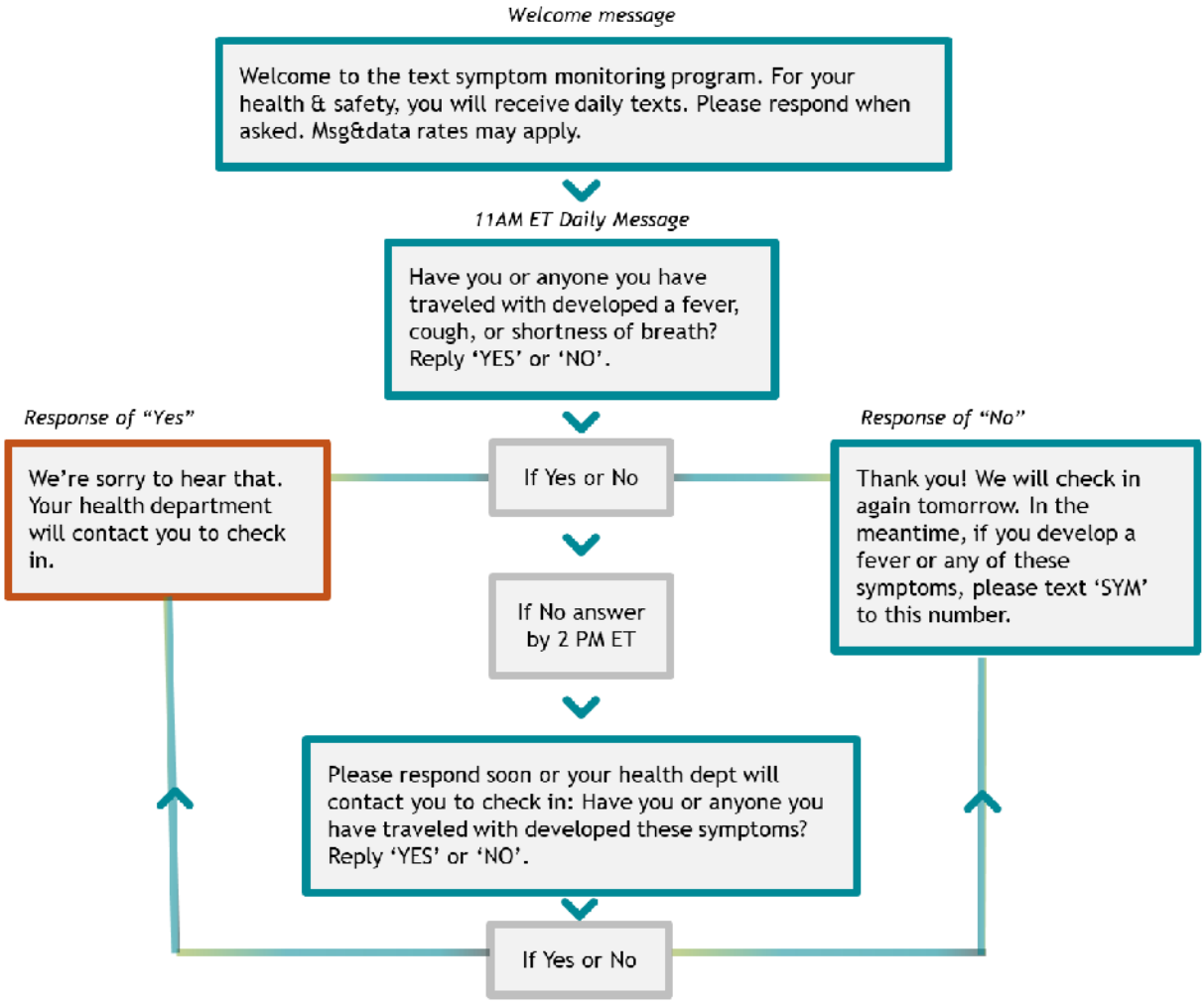

Figure 1. T.I.M. message flow

What information is needed to enroll individuals in T.I.M. for monitoring?

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Is there a cost to jurisdictions to implement T.I.M.?

T.I.M. is a web-based system that does not require additional hardware or software. The system is available at no cost to jurisdictions.

How is the data in T.I.M. secured?

T.I.M. is a secure, scalable, applications in alignment with HIPAA and HITECH compliance requirements. Please see Compliant Campaign's infrastructure security and compliance document for additional details:

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FL-DOH-20-0673-A-003011

Other

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	CDC Text Illness Monitoring (T.I.M) System Update
Date:	Friday, February 28, 2020 2:53:05 PM
Attachments:	T.I.M. FAQ_forPH_02.27.2020.pdf

Dear Colleagues,

The Text Illness Monitoring (T.I.M.) system has recently been modified to allow county-level campaigns to be added under state campaigns. This allows for local use of T.I.M. for COVID-19 symptom monitoring.

If a state would like to add county-level users in T.I.M., they should provide the names of the counties that should be activated. Once the T.I.M. support team activates these counties, states may then add county-level users as appropriate.

Local jurisdictions will be assigned at the county level and will have access to the data for that county only, and states will have access to all data within the state.

Local jurisdictions should coordinate with their state for access. States may send the list of counties they wish to activate in T.I.M. to eocevent340@cdc.gov.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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Text Illness Monitoring (T.I.M.)

Frequently Asked Questions

About T.I.M.

What is T.I.M.?

Text Illness Monitoring (T.I.M.) is a mobile texting tool that facilitates symptom monitoring during an infectious disease outbreak. Monitoring conducted by public health officials has traditionally been conducted via telephone calls, which can be a time-consuming process requiring staff resources. CDC has developed T.I.M., a nationally-centralized option utilizing two-way Short Message Service (SMS)/text messaging to aid in the process. Text messaging is an efficient method to elicit, manage, and act on any coronavirus disease 2019 (COVID-19) symptoms among those who are exposed or potentially exposed to the virus. The T.I.M. system was utilized to monitor for influenza symptoms in Michigan[1] with success.

How is T.I.M. being used for the coronavirus disease 2019 response?

Use of T.I.M. is voluntary for health departments. Consenting persons in participating jurisdictions will receive 2-5 text messages a day for up to14 days asking if they have symptoms consistent with COVID-19. Health departments will immediately be alerted to any person in their jurisdiction that responds that they are experiencing symptoms and to any persons who fail to respond to two consecutive messages. Health departments would then follow up with individuals who are reporting symptoms or those that have been unresponsive.

Health Department Access

How do I get access to T.I.M.?

State and local public health departments may request access by sending an email to eocevent340@cdc.gov. Please provide a primary and secondary point of contact to act as an administrator in T.I.M. Instructions for adding users and assigning them to a campaign to receive notifications can be found in the "T.I.M. Adding a User and Alert Setup" guide available in the Resources section of T.I.M.

After registration, the public health administrators will receive an email with information on how to log in and access the system.

Can local public health jurisdictions use T.I.M.?

Yes, T.I.M. has recently been modified to allow county-level campaigns to be added under state campaigns. This allows for local use of T.I.M. for COVID-19 symptom monitoring. If a state would like to add county-level users in T.I.M., they should provide the names of the counties that should be activated. Once the T.I.M. support team activates these counties, states may then add county-level users as appropriate. Local jurisdictions will be assigned at the county level and will have access to the data for that county only. Local jurisdictions should coordinate with their state for access.

Who will be able to access the information in T.I.M.?

There are three levels of access to T.I.M.: CDC, state, and county. Public health administrators at the state level will have access to all data within their jurisdiction, including county level data. Local jurisdictions assigned at the county level

1 Stewart RJ, Rossow J, Eckel S, et al. Text-Based Illness Monitoring for Detection of Novel Influenza A Virus Infections During an Influenza A (H3N2)v Virus Outbreak in Michigan, 2016: Surveillance and Survey. JMIR Public Health Surveill. 2019;5(2):e10842. Published 2019 Apr 26. doi:10.2196/10842 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6658270/

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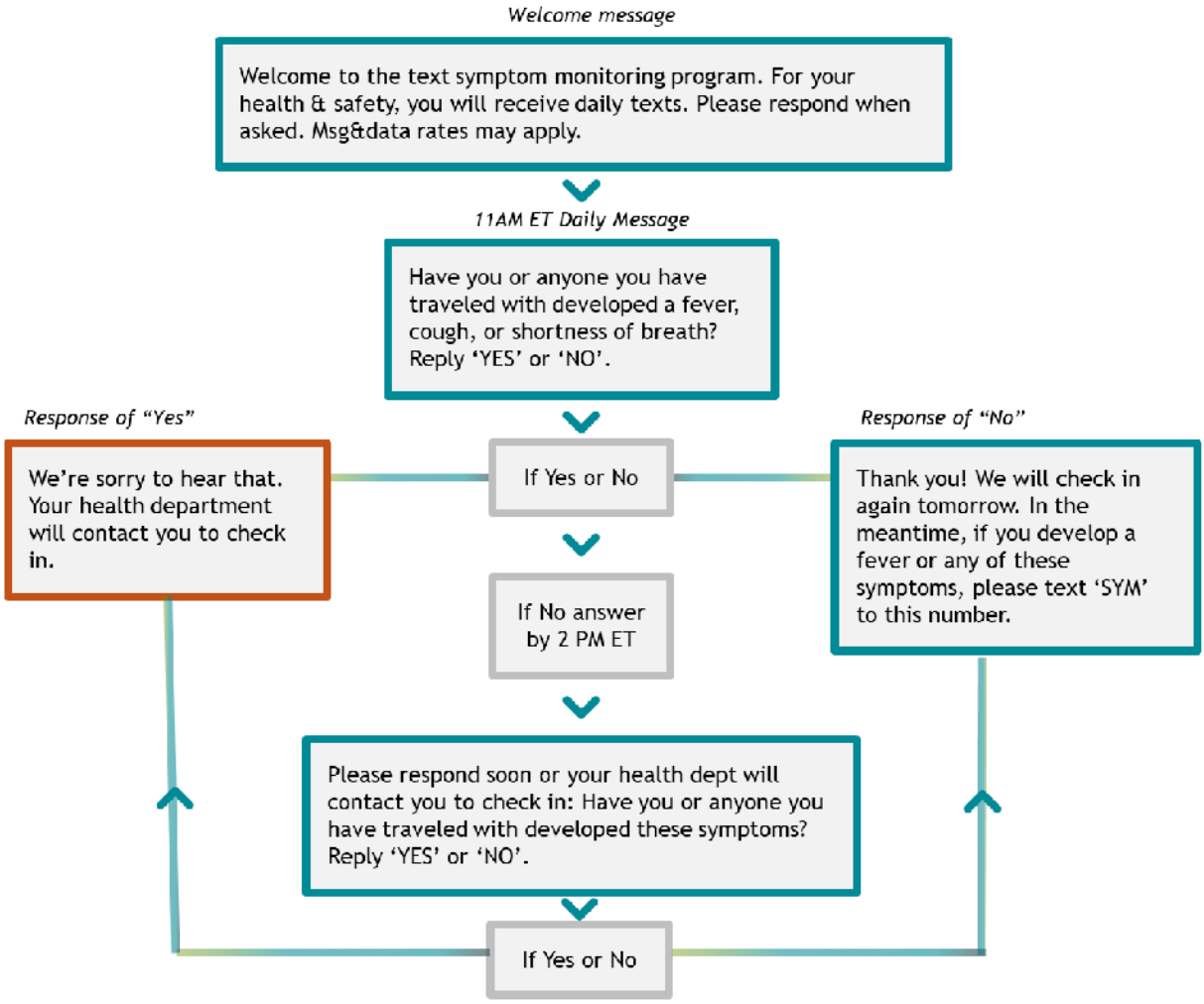

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: CDC Weekly Key Messages
Date: Monday, March 2, 2020 12:51:25 PM
Attachments: CDC_COVID-19 Weekly Key Messages__3-1-20_FINAL.pdf

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FYI

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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cell: 202.909.6950 Verizon (secondary)

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

March 1, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 24 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use “the virus that causes COVID-19.”

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- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is threatening to cause a pandemic.
- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person-to-person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **February 29, more than 85,000** cases have been identified worldwide. More than 6,000 of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- During the week of February 23, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure in multiple states. [See section "Possible U.S. cluster" below.]

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- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **February 29, 2020**:

- **Travel-related: 13** (12 confirmed, 1 presumptive positive)
- **Person-to-person spread: 9** (3 confirmed, 6 presumptive positive)
- **Total cases: 22** (15 confirmed, 7 presumptive positive)
- **Deaths: 1** (0 confirmed, 1 presumptive positive)

Persons repatriated to the United States and tested positive by CDC, as of **February 29, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **44**

For global cases, please see the WHO daily situation reports.

POSSIBLE U.S. CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
- One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a healthcare worker.
    - This is the first reported case in a healthcare worker.
- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.

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- While there is an ongoing investigation, the source of these infections is currently unknown.
- Circumstances suggest person-to-person spread, including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.
- CDC infection control experts are assessing the risk of additional healthcare worker exposures and carefully reviewing infection control practices within the facility to protect residents and healthcare workers from further spread of COVID-19.
    - The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
    - All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.
- On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested "weak positive" to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19. View the AFCD official report.
    - CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
    - It's important to remember dogs that have their own coronaviruses.
    - To date, CDC has not received any reports of pets or other animals becoming sick with COVID-19. At this time, there is no evidence that pets, including dogs, can spread COVID-19.
    - There is no reason to think that any animals, including pets, in the United States might be a source of infection with this new coronavirus.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory

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pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.

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- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits will only include the two components (e.g., reagents) that are specific to novel coronavirus.
    - In the meantime, before new test kits are available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays. We anticipate this will increase testing capacity to about 40 state and local health departments.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner can move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
- On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
    - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
    - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

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MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel Restrictions from China and Iran:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.

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- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 27, about 48,000 people have been screened at US airports.
- On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.

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Travel Notices and Advisories:

- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan are in the process of being repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with state and local public health departments and/or HHS's Incident Management Team (IMT) to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- Almost all people from the Wuhan flights who were quarantined have fulfilled their 14-day quarantine period and have been released.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They

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will continue to be monitored by medical and public health personnel throughout the 14-day quarantine period.

- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- No US citizens remain on the Diamond Princess.
- More than 50 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-19, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Hong Kong — Level 1, Practice Usual Precautions — issued February 19;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;
        - Italy — Level 3, Avoid Nonessential Travel — updated February 28;
        - Japan — Level 2, Practice Enhanced Precautions — updated February 22;

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        - South Korea — Level 3, Avoid Nonessential Travel — updated February 24.
    - CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- CDC is issuing clinical guidance, including:
    - On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
    - On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
    - On February 27, CDC updated its criteria to guide evaluation of persons under investigation for COVID-19.
    - On February 28, CDC issued a Health Alert Network (HAN): Update and Interim Guidance on Outbreak of COVID-19.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity.
    - After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
    - CDC worked on two potential resolutions to this problem.
        - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
            - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
            - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the

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assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
    - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
    - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
- Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
- CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
- CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.

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- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent Travelers to Geographic Areas with Sustained Spread:

- If you were in geographic areas with sustained spread (China, Iran, Italy, Japan, or South Korea) and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
  - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
  - Avoid contact with others.
  - Not travel while sick.
  - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
  - Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.

People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
  - Stay home except to get medical care.
  - Separate yourself from other people in your home.
  - Call ahead before visiting your doctor.
  - Wear a facemask.
  - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
  - Wash your hands often with soap and water for at least 20 seconds.
  - Avoid sharing household items like eating utensils, cups, or linens.
  - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.

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- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

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For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **affected geographic areas** (i.e., countries with CDC Travel Health Notices at warning levels 2 or 3) within 14 days of symptom onset
Fever **and** signs/symptoms of acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)	**AND**	No source of exposure has been identified

Note: The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria. The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

- In addition to the above criteria, infants born to mothers with confirmed COVID-19 should be considered PUIs. As such, infants should be isolated according to the Infection Prevention and Control Guidance for PUIs.

Recommendations for Reporting, Testing, and Specimen Collection:

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

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- For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available.
- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- The current risk to Americans for COVID-19 is low, but Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)

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CDC'S Approach to Community-Based Interventions

- The federal guidance provided by CDC is intentionally broad to allow flexibility for states and local health governments to tailor guidance to their circumstances. An intervention/ approach that is appropriate for one community with local transmission won't necessarily be appropriate for another community with no local transmission.
- Local health departments should evaluate and adapt CDC guidelines and recommendations based on local conditions and with input from community partners.
- The community can take measures to reduce the spread of the COVID-19. CDC recommends working with the local health department and community partners to determine options that make the most sense. Potential measures include dismissal of students from school and closure of childcare facilities, social distancing of adults in the community and workplace, which may include cancellation of large public (or mass) gatherings and encouraging teleworking and alternate work schedules to decrease social density.

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- Handwashing with soap and water is one of the best ways to protect against the virus.
- Creating a household emergency plan can help protect your health and the health of those you care about.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, stay home when you are sick with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- Mass gatherings:
    - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
    - You may need to modify, postpone, or cancel your event. CDC recommends working with the emergency operations coordinator or planning team at your venue and staying informed about the local COVID-19 situation in your area.
    - CDC is in the process of creating a planning guide to help event organizers and staff plan and prevent the introduction of COVID-19 into their mass gathering or event.
- Community and faith-based organizations:
    - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.

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        - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before a pandemic can help provide your organization with the support and resources needed.
        - CDC is in the process of a planning guide to help you create an emergency plan for your community and faith-based organization.
- Administrators of U.S. childcare programs and K-12 schools:
    - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
    - CDC recommends childcare and K-12 school officials:
        - Collaborate with local health departments and partners to review, update, and implement emergency operations plans.
        - Develop information-sharing systems with partners that can be used for day-to-day reporting and disease surveillance to identify unusual rates of absenteeism.
        - Review attendance and sick leave policies; encourage students and staff to stay home when sick and establish procedures to ensure student and staff who become sick at school or arrive at school sick are sent home as soon as possible.
        - Perform routine environmental cleaning.
        - Create communications plans for use with the school community.
    - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be dismissed in the event of an outbreak. (NOTE: DOE does not recommend using "school closure" terminology.)
    - School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
    - CDC has created interim guidance for administrators of U.S. childcare programs and K-12 schools to help plan, prepare, and respond to COVID-19.

HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:

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1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. Rinse your hands well under clean, running water.
5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolate them in an AIIR, if available.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before

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putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

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WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:
    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining appropriate work restrictions.

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MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:

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    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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From:	Brad Neal
To:	gabastouj@paho.org; infectiousdiseases@wustl.edu; ruth.lynfield@state.mn.us; jpatters@txbiomed.org; michael.macnaughton@swri.org; HSR7.COVID@dshs.texas.gov; lfrenkel@uw.edu; john.aitchison@seattlechildrens.org; kdl8@cdc.gov; april.davis@health.ny.gov; costas.danis@santepubliquefrance.fr; sjp97@medschl.cam.ac.uk; elke.mertens@niga.niedersachsen.de; globalhealth@hhs.gov; pi@usaid.gov; yadira.medrano@cdph.ca.gov; joseph.mclaughlin@alaska.gov; sherri.davidson@adph.state.al.us; a.tufa@doh.as; shirley.louie@arkansas.gov; ken.komatsu@azdhs.gov; James.watt@cdph.ca.gov; rachel.herlihy@state.co.us; rickey.tolliver@state.co.us; matt.cartter@ct.gov; john.davies-cole@dc.gov; Tabatha.Offutt-Powell@state.de.us; vskilling@fsmhealth.fm; Carina.Blackmore@flhealth.gov; Cherie.Drenzek@dph.ga.gov; Ann.Pobutsky@dphss.guam.gov; sarah.park@doh.hawaii.gov; caitlin.pedati@idph.iowa.gov; hahnc@dhw.idaho.gov; Craig.Conover@illinois.gov; ppontones@isdh.in.gov; farah.ahmed@ks.gov; Douglas.thoroughman@ky.gov; raoult.ratard@la.gov; catherine.brown@state.ma.us; david.blythe@maryland.gov; Siri.bennett@maine.gov; lyoncallos@michigan.gov; george.turabelidze@health.mo.gov; paul.byers@msdh.ms.gov; lwilliamson@mt.gov; Zack.Moore@dhhs.nc.gov; tkmiller@nd.gov; tom.safranek@nebraska.gov; Benjamin.Chan@dhhs.nh.gov; christina.tan@doh.state.nj.us; michael.landen@state.nm.us; paul.white@dph.gov.mp; mpeekbullock@health.nv.gov; debra.blog@health.ny.gov; Sietske.deFijter@odh.ohio.gov; Laurence@health.ok.gov; dean.e.sidelinger@dhsoha.state.or.us; shawatkins@pa.gov; carmen.deseda@salud.pr.gov; utpala.bandy@health.ri.gov; belllw@dhec.sc.gov; joshua.clayton@state.sd.us; john.dunn@tn.gov; Stephen.Pont@dshs.texas.gov; esther.ellis@doh.vi.gov; angeladunn@utah.gov; lilian.peake@vdh.virginia.gov; patsy.kelso@vermont.gov; Lori.Cragin@vermont.gov; scott.lindquist@doh.wa.gov; cathy.wasserman@doh.wa.gov; jonathan.meiman@dhs.wisconsin.gov; Ryan.Westergaard@dhs.wisconsin.gov; Maria.C.Delrosario@wv.gov; alexia.harrist1@wyo.gov
Subject:	Cheap and Possibly Effective Virucide for COVID-19
Date:	Wednesday, March 18, 2020 3:34:57 AM

Dear Distinguished Officials,

I write to you all - leaders in public health - asking that you please consider recommending Copper Sulfate (CuSO4) as a virucide against “SARS-CoV-2” .

I recently read that the COVID-19 virus dies much more quickly on copper/copper-alloy surfaces, than on other smooth (metal) or porous or fibrous materials. I found, in a 2015 article by the (US) NHS, that copper sulfate solutions were found to be particularly destructive to corona virus’ shells.
Therefore, given copper sulfate’s availability, low cost, low toxicity (to humans), and effectiveness as a virucide (against corona viruses), please consider recommending – at least testing – the use of a dilute, aqueous solution of this mineral in our collective fight against COVID-19.
Possible modes of employment:

- Disinfect surfaces – and leave a disinfecting residue – by spraying or wiping dilute solutions on them.
- Disinfect clothing and linens – and impregnating them with a disinfecting residue – by dipping them into dilute solutions…This could be effected in automatic washing machines by adding (dry) crystals during the rinse cycle. [Understand that, if employed in this latter method, biological wastewater treatment systems could be adversely affected, temporarily.]
- Disinfect skin and hair – and leave a disinfecting residue – by adding an appropriate amount to a body spray or a bath water.

I've no financial interest in the mining or sale of this mineral. I do have a financial interest in the global economy not grinding to a halt.
I'm approaching you all, rather than take my theory/idea to social media, so that you can vet the suggestion's viability and suitability.

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Sincerely,
Brad Neal
Houston, Texas

AMERICAN OVERSIGHT

From:	Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)
To:	Heinzerling, Amy (CDC cdph.ca.gov); Blau, Erin (CDC ky.gov); Blau, Erin (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo (CDC adph.state.al.us); Heinzerling, Amy Patricia (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo Vincent (CDC/DDPHSS/CSELS/DSEPD); Szablewski, Christine (CDC dph.ga.gov); Szablewski, Christine (CDC/DDPHSS/CSELS/DSEPD); Torres, Yaritbel (CDC flhealth.gov); Torres-Mendoza, Yaritbel (CDC/DDPHSS/CSELS/DSEPD); James, Allison (CDC arkansas.gov); James, Allison (CDC/DDPHSS/CSELS/DSEPD); Ghinai, Isaac; Ghinai, Isaac (CDC/DDPHSS/CSELS/DSEPD); Steinberg, Jonathan (CDC state.sd.us); Feder, Kenneth (CDC/DDPHSS/CSELS/DSEPD); Kenneth Feder -MDH-; Steinberg, Jonathan (CDC/DDPHSS/CSELS/DSEPD)
Cc:	jennifer.layden@cityofchicago.org; Blackmore, Carina (CDC flhealth.gov); Davidson, Sherri (CDC adph.state.al.us); Drenzek, Cherie (CDC dhr.state.ga.us); Edison, Laura (CDC dph.ga.gov); Materna, Barbara (CDC cdph.ca.gov); Robeson, Sara (CDC ky.gov); Stanek, Danielle (CDC flhealth.gov); Thoroughman, Douglas (CDC/DDPHSIS/CPR/DSLR); Wilken, Jason (CDC cdph.ca.gov); Wortley, Pascale (CDC dph.ga.gov); Balamurugan, Appathurai (CDC arkansas.gov); Clayton, Joshua (CDC state.sd.us); Austin, Connie (CDC illinois.gov); Blythe, David (CDC maryland.gov); Crum, David (CDC maryland.gov); Soda, Elizabeth (CDC illinois.gov); Layden, Jennifer (CDC illinois.gov); Duwell, Monique MD (CDC maryland.gov); Rothfeldt, Laura (CDC arkansas.gov); Tarkhashvili, Nato (CDC state.sd.us)
Subject:	checking in
Date:	Monday, March 16, 2020 9:19:25 AM
Attachments:	Alroy_COVID_HSR.docx okn7_0900f3eb81aea13c.docx

Hi everyone,

I hope you are doing well in what is undoubtedly a stressful and busy time for all of you. I know you are all working hard, and I'd like to thank you for all you're doing for the health of residents in your state and the country.

I wanted to ask you to check in when you can by phone or email and let me know how you're doing. Right now we are assuming you are in full response mode and don't have time to work on other activities, so I won't be contacting you to ask how your CALs are going. Of course, if you do need assistance with anything or are planning any coronavirus-related products such as MMWRs or manuscripts, please let me know.

I'm attaching a sample project determination for coronavirus. When time permits if you haven't already (I know public health response takes precedence and that you might not have time to do this right now), please submit a project determination for your activities.

Hang in there, everyone, and stay safe and healthy.

Suzanne

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)

Epidemic Intelligence Service | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

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Project Determination

New York City Preparedness and Response to COVID-19 outbreak

Project ID:	0900f3eb81ae0d17
Accession #:	CSELS-EWBG9-2/23/20-e0d17
Project Contact:	Alroy_Karen (nfu1)
Organization:	CSELS
Status:	Pending Clearance
Intended Use:	Project Determination
Estimated Start Date:	01/01/20
Estimated Completion Date:	06/30/20
CDC/ATSDR HRPO/IRB Protocol#:	The NYC DOHMH IRB has deemed this as public health activity and not research
OMB Control#:	NA

Description

Priority

Standard

Date Needed

02/24/20

Determination Start Date

02/23/20

Description

The Centers for Disease Control and Prevention (CDC) is closely monitoring developments around an outbreak of respiratory illness caused by a novel coronavirus first identified in Hubei Province, China. This novel coronavirus, named SARS-CoV-2 has resulted in in thousands of confirmed cases of the disease COVID-19 in China, with additional cases being identified in a growing number of countries internationally. Over 2000 deaths have been reported. The current CDC definition for a person under investigation (PUI) requires either travel to China, or exposure to a known COVID-19 case. However, if the virus is already circulating within the United States resulting in mild cases of COVID-19, it might be difficult to

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identify these cases if patients suspected of being infected do not meet the PUI case definition. A sentinel surveillance system is being developed in several sites across the United States to determine if community transmission of SARS-CoV-2 is already occurring.

Goals/Purpose

Provide support to the New York City (NYC) Department of Health and Mental Hygiene in preparedness and outbreak response to the COVID-19 outbreak.

Objective

Improve healthcare system readiness and establish and implement COVID-19 sentinel surveillance in NYC.

Activities or Tasks

New Collection of Information, Data, or Biospecimens

Target Population to be Included/Represented

General US Population

Tags/Keywords

nCoV: COVID-19: SARS-CoV-2: Surveillance: coronavirus

CDC's Role

Activity originated and designed by non-CDC staff (awardee or external collaborator): CDC is provider of technical assistance or staff time in the absence of CDC support

Method Categories

Outbreak Investigation: Surveillance Support

Methods

The EIS Officer assigned to the NYC Department of Health and Mental Hygiene under the supervision of the Bureau of Communicable Disease, will establish a sentinel surveillance system capable of detecting community transmission of COVID-19 in NYC. This will entail coordination with healthcare facilities and laboratories, seeking appropriate ethics approval, developing materials to provide informed consent, arranging for specimen collection, conducting data analysis, developing communication strategies, and coordination with CDC epidemiologists and laboratories.

Collection of Info, Data, or Bio specimens

Epidemiologic data and specimens will be collected by healthcare providers

Expected Use of Findings/Results and their impact

Findings will be used to inform public health actions to control the spread of COVID-19. Findings from this investigation could be used to generate abstracts and scientific manuscripts and products.

Could Individuals potentially be identified based on Information Collected?

Yes

Will PII be captured (including coded data)?

Yes

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Does CDC have access to the Identifiers (including coded data)?
No
Is an assurance of confidentiality in place or planned?
Yes
Is a certificate of confidentiality in place or planned?
Yes
Is there a formal written agreement prohibiting the release of identifiers?
No

Funding

Funding Type	Funding Title	Funding #	Original Fiscal Year	# of Years of Award
CDC Funding Intramural	EISO funded by CDC		2018	2

Regulation and Policy

Do you anticipate this project will be submitted to the IRB office:
No

Institutions

Institution	FWA #	FWA Exp. Date	IRB Title	IRB Exp. Date	Funding #
New York City Dept of Hlth & Mental Hygiene	FWA00009459	10/15/23	New York City Dept of Hlth & Mental Hygiene IRB #1	10/12/21	

Staff

Staff Member	SIQT Exp. Date	Citi Biomedical Exp. Date	Citi Social and Behavioral Exp. Date	Citi Good Clinical Exp. Date	Staff Role	Email	Phone #	Organization/ Institution
Karen Alroy	12/29/2021				Co-Investigator	nfu1@cdc.gov	347-396-2917	EWB Group 9

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DMP	
Proposed Data Collection Start Date	02/24/20
Proposed Data Collection End Date	05/31/20
Proposed Public Access Level	Non-Public
Reason for not Releasing the Data	Country/Jurisdiction owns the data with protections under their laws and regulations
Public Access justification	Data will be owned by the local public health district
How Access Will Be Provided for Data	De-identified data will be available upon request
Plans for archival and long-term preservation of the data	Data will be archived and stored using secure public health department servers

Spatiality (Geographic Location)

Country	State/Province	County/Region
United States	New York	

Determinations

Determination	Justification	Completed	Entered By & Role
HSC: Does NOT Require HRPO Review	Not Research	02/24/20	Sinha_Saswati (sds2) CIO HSC
PRA: PRA does not apply	**Qualifies for a regulatory exclusion:** Information collection not conducted or sponsored by Federal government *Justification:* NYC Department of Health and Mental Hygiene will be conducting data collections related to COVID-19.	02/24/20	Sinha_Saswati (sds2) OMB/PRA

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Project Determination

Investigation of a novel coronavirus outbreak, Connecticut - 2020

Project ID:	0900f3eb81aea13c
Accession #:	CSELS-EWBG3-2/28/20-ea13c
Project Contact:	Jones_Sydney (okn7)
Organization:	CSELS/DSEPD/EWBG3
Status:	Pending Clearance
Intended Use:	Project Determination
Estimated Start Date:	02/18/20
Estimated Completion Date:	07/01/20
CDC/ATSDR HRPO/IRB Protocol#:	
OMB Control#:	

Description

Priority

Standard

Date Needed

03/02/20

Determination Start Date

02/28/20

Description

The Centers for Disease Control and Prevention (CDC) is closely monitoring developments around an outbreak of respiratory illness caused by a novel coronavirus first identified in Wuhan, Hubei Province, China. Chinese authorities identified the new coronavirus, which has resulted in thousands of confirmed cases in China, including cases outside Wuhan City, with additional cases being identified in a growing number of countries internationally. Over 2,500 confirmed deaths have been reported. The first case in the United States was announced on January 21, 2020, after a

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patient from Snohomish County in Washington was confirmed with the virus. Little in know about the clinical and epidemiological manifestations of this novel virus in the US, and the potential scope of patients infected.

Goals/Purpose

Confirm cases of COVID-19 and identify potential exposed contacts in order to prevent further spread of this novel pathogen.

Objective

We investigate to identify and confirm cases, understand clinical features of the novel pathogen, and investigate epidemiologic links to serve the ultimate purpose of understanding the outbreak and stopping transmission of 2019-nCoV.

Activities or Tasks

New Collection of Information, Data, or Biospecimens

Target Population to be Included/Represented

General US Population

Tags/Keywords

Coronavirus: Communicable Diseases, Emerging: COVID-19

CDC's Role

Activity originated and designed by non-CDC staff (awardee or external collaborator)

Method Categories

Outbreak Investigation

Methods

The EIS officer assigned to CT Department of Public Health (DPH) will work under the supervision of Dr. Matthew Cartter, chief of the CT DPH Infectious Diseases Section, and Local Health Departments/Districts (LHDs) to investigate this outbreak. Under the supervision of CT DPH the EISO will participate in setting up case reporting, patient follow up interviews, disease surveillance and control activities, production of educational materials, and analysis of surveillance data. Under the supervision of CT DPH the EIS Officer will also work with facilities and clinicians to help prepare and support healthcare facilities in the screening of persons who are potentially ill with 2019-nCoV.

Collection of Info, Data, or Bio specimens

Data will be obtained from medical records and patient interviews.

Expected Use of Findings/Results and their impact

Findings will be used to inform public health actions to control the spread of 2019-nCoV. Findings from this investigation could be used to generate abstracts and scientific manuscripts and products.

Could Individuals potentially be identified based on Information Collected?

Yes

Will PII be captured (including coded data)?

Yes

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Does CDC have access to the Identifiers (including coded data)?
No
Is an assurance of confidentiality in place or planned?
No
Is a certificate of confidentiality in place or planned?
No
Is there a formal written agreement prohibiting the release of identifiers?
No

Funding

Funding Type	Funding Title	Funding #	Original Fiscal Year	# of Years of Award
CDC Funding Intramural	EISO funded by CDC		2018	2

Regulation and Policy

Do you anticipate this project will be submitted to the IRB office:
No

Institutions

Institution	FWA #	FWA Exp. Date	IRB Title	IRB Exp. Date	Funding #
Connecticut Department of Public Health	FWA00026243	11/21/22			

Staff

Staff Member	SIQT Exp. Date	Citi Biomedical Exp. Date	Citi Social and Behavioral Exp. Date	Citi Good Clinical Exp. Date	Staff Role	Email	Phone #	Organization/ Institution
Matthew Cartter	n/a	n/a	n/a	n/a	Principal Investigator	matt.cartter@ct.gov		Connecticut Department of Public Health

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DMP	
Proposed Data Collection Start Date	02/18/20
Proposed Data Collection End Date	07/01/20
Proposed Public Access Level	Non-Public
Reason for not Releasing the Data	Country/Jurisdiction owns the data with protections under their laws and regulations
Public Access justification	Data will be owned by the local public health district
How Access Will Be Provided for Data	De-identified data will be available upon request
Plans for archival and long-term preservation of the data	Data will be archived and stored using secure public health department servers

Spatiality (Geographic Location)		
Country	**State/Province**	**County/Region**
United States	Connecticut	

Determinations			
Determination	**Justification**	**Completed**	**Entered By & Role**
HSC: **HSC Determination - Pending**			
PRA: **PRA Determination - Pending**			

AMERICAN OVERSIGHT

From:	Amy Chang
To:	apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Robert Casey; Moyer, Ben	APHL; Hainstock, Lisa (MDARD); Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Collaro, Thomas - FSIS; Laura Wildey
Subject:	CIFOR Promote DT - February Meeting Notes and Action Items
Date:	Wednesday, February 19, 2020 11:24:18 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Guidelines Third Edition Postcard Draft 11Feb2020.pdf Promote DT Meeting_Notes_02-18-20 .docx

Good Morning,

Please see the attached notes from the meeting yesterday.

Immediate Action Items:

- 3rd Ed. Guidelines Promotion Plan
  - Promotion Plan
    - Newsletter blurb/couple social media - Michelle Shapiro will draft and send to group before she leaves at the end of February.
      - Postcard flyer (attached)
        - Action Item: If you have edits, send it to Michelle by 2/21.
      - Use Elizabeth's promotional plan 2020 - Amy posted updated copy post on Basecamp.
        - Action item: fill in and update the promotional plan where you can contribute.

Thank you,
Amy

Amy Chang
Senior Program Analyst
Environmental Health
National Association of County and City Health Officials ¦1201 Eye Street NW 4th Floor ¦ Washington, DC 20005
Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
www.naccho.org

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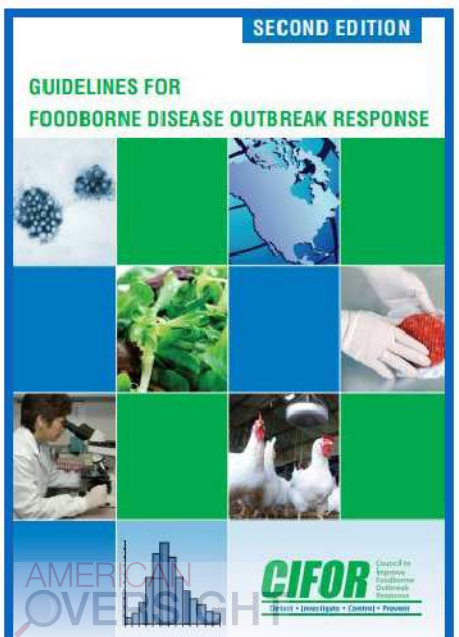
NEW!

Third Edition of the CIFOR

Guidelines for Foodborne Disease Outbreak Response



The CIFOR Guidelines are a comprehensive source of information on foodborne disease investigation and control for local, state and federal health agencies.

The Guidelines describe:

- the overall approach to addressing foodborne disease outbreaks, including preparation, detection, investigation, control and follow-up.
- the roles of key organizations in foodborne disease outbreaks.

Download the new Guidelines for free: https://cifor.us

FL-DOH-20-0673-A-003056

Flip to see what's new in the Third Edition

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NEW in the CIFOR Guidelines Third Edition

Extremely streamlined and easy to read

Provides information on the value and use of complaint systems

Highlights Whole Genome Sequencing and Culture-Independent Diagnostic Testing)

Highlights expanded importance of epi data:

- Recommends routine interviewing to collect detailed exposure information
- Expands effective models of sub-cluster investigations and product tracebacks

Better illustrates how epi, lab, and environmental data come together

Highlights importance of environmental assessments



CIFOR is a multidisciplinary collaboration of national associations and federal agencies working together since 2006 to improve methods to detect, investigate, control and prevent foodborne disease outbreaks. **Learn more at https://cifor.us.**

FDA OVERSIGHT

CIFOR Council to Improve Foodborne Outbreak Response

FL-DOH-20-0673-A-003057

Detect • Investigate • Control • Prevent

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CIFOR Promote Development Team Agenda
February 18, 2020 @ 3:00pm ET

Roll Call: Scott Holmes, Tom Collaro, Andre Pierce, Michelle Shapiro, Shari Shea, Katie Garmen, Don Sharp, India Bowman, Carina Blackmore, Lisa Hainstock, Jesse Bliss, Laura Wildey, Tiara Smith

Discussion Item(s)	Person Responsible	Due Date

Updates:
• Website updates and input/requests
• Website sign-ups
  • 146 sign-ups
• 3rd ed CIFOR Approval
  ○ Currently waiting for FDA approval and one CIFOR partner organization.
Revisiting the Guidelines Printing Needs survey
  ○ CSTE will put out a survey for printing needs from each CIFOR partner organizations and include a sign-up table at INFORM
  ○ Estimate that we will print 5000 print copies initially and will have a budget for 2nd printings
• Shipping options and number of Guidelines to order?
  ○ Some drop shipping will be available (printer publisher will ship from directly from warehouse) - no fees for person ordering copies. CSTE will work with NACCHO to put language on website to allow people to request copies.
• Cover page of new Guidelines
  ○ First draft cover mirrors the banner images. CSTE will ask for additional input or alternate graphic/layout.
• Promote DT Co-Chair Nominations
  ○ Postponed until after InFORM conference.
	NACCHO
	
	India
	All	

Upcoming Promotions:
• 3rd Ed. Guidelines Promotion Plan
  • Promotion Plan
  • Newsletter blurb/couple social media - Michelle Shapiro will draft and send to group before she leaves at the end of February.
  • Postcard flyer
  § If you have edits, send it to Michelle by 2/21.
	Scott Holmes	

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• Use Elizabeth's promotional plan 2020 - Amy posted updated copy post on Basecamp. • Action item: fill in and update the promotional plan where you can contribute. • Discussion: Chapter authors and coordinated effort to request info (learning modules and promotional outreach) • Scott has reached out to authors and items are still forthcoming. • CIFOR Banners • Banner status update (India) • Printers will provide CSTE the final images by COB 2/18. • Process to request banner at events • Two options 1. Request for banner can sent to India (CSTE) at least 2 weeks before date needed for shipment. Shipping costs - India will look into it on it. • 2. Promote DT can create a simple shared spreadsheet to request banner and view when banner is being used. Associations can communicate with each other to arrange shipping banners.		
Analytics & Tracking • Review from Michelle: ○ New analytics are available on Basecamp.	Michelle All	

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From:	Amy Chang
To:	chris.rustin@dph.ga.gov; apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Robert Casey; Moyer, Ben	APHL; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Kurylo, Elizabeth (CDC/OID/NCEZID); Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Collaro, Thomas - FSIS
Subject:	CIFOR Promote DT - February Meeting
Attachments:	Promote DT Meeting_Agenda_02-18-20.docx CIFOR Guidelines Third Edition Postcard Draft 11Feb2020.pdf

---

Achang@naccho.org <mailto:Achang@naccho.org> is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/507646459

Meeting ID: 507 646 459

One tap mobile
+19292056099,,507646459# US (New York)
+16699006833,,507646459# US (San Jose)

Dial by your location
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+1 669 900 6833 US (San Jose)
Meeting ID: 507 646 459
Find your local number: https://naccho.zoom.us/u/ahhDdSCQg

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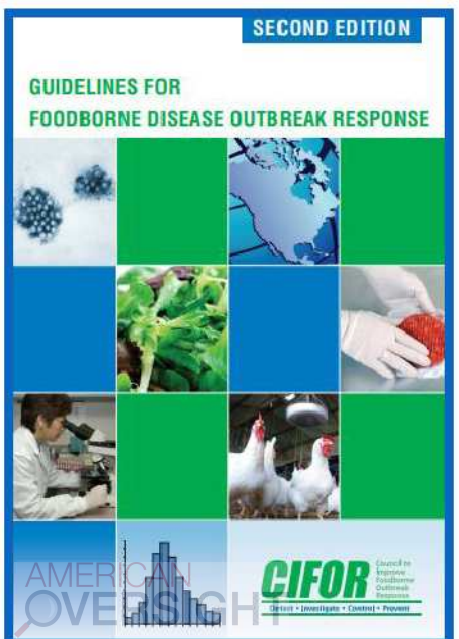
NEW!

Third Edition of the CIFOR

Guidelines for Foodborne Disease Outbreak Response



The CIFOR Guidelines are a comprehensive source of information on foodborne disease investigation and control for local, state and federal health agencies.

The Guidelines describe:

- the overall approach to addressing foodborne disease outbreaks, including preparation, detection, investigation, control and follow-up.
- the roles of key organizations in foodborne disease outbreaks.

Download the new Guidelines for free: https://cifor.us

FL-DOH-20-0673-A-003069

Flip to see what's new in the Third Edition

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NEW in the CIFOR Guidelines Third Edition

Extremely streamlined and easy to read

Provides information on the value and use of complaint systems

Highlights Whole Genome Sequencing and Culture-Independent Diagnostic Testing)

Highlights expanded importance of epi data:

- Recommends routine interviewing to collect detailed exposure information
- Expands effective models of sub-cluster investigations and product tracebacks

Better illustrates how epi, lab, and environmental data come together

Highlights importance of environmental assessments



CIFOR is a multidisciplinary collaboration of national associations and federal agencies working together since 2006 to improve methods to detect, investigate, control and prevent foodborne disease outbreaks. **Learn more at https://cifor.us.**

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CIFOR Council to Improve Foodborne Outbreak Response

FL-DOH-20-0673-A-003070

Detect • Investigate • Control • Prevent

CIFOR Promote Development Team Agenda
February 10, 2020 @ 3:00pm ET

Discussion Item(s)	Person Responsible	Due Date
Updates: • Website updates and input/requests • Website sign-ups • Revisiting the Guidelines Printing Needs survey • Shipping options and number of Guidelines to order? • Cover page of new Guidelines • Promote DT Co-Chair Nominations	NACCHO India All	

Upcoming Promotions:
• 3rd Ed. Guidelines Promotion Plan
  ○ Promotion Plan
  § National Conferences
  § Postcard Flyers
 	
• Discussion: Chapter authors and coordinated effort to request info (learning modules and promotional outreach)
 	
• CIFOR Banners
  ○ Banner status update (India)
  ○ Process to request banner at events
• Other Items?
	Scott Holmes	

Analytics & Tracking • Review from Michelle: ○ New analytics are available on Basecamp.	Michelle All	

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From:	Amy Chang
To:	apierce@wakegov.com; Shea, Shari	APHL; mcone@cste.org; Robert Casey; Moyer, Ben	APHL; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Kurylo, Elizabeth (CDC/OID/NCEZID); Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss; Collaro, Thomas - FSIS; Laura Wildey; Rustin, Chris; szimmerman@cste.org
Subject:	CIFOR Promote DT Updates and Action Items
Date:	Monday, March 16, 2020 9:01:44 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Guidelines Copy Request.pdf CIFOR Cover20_d5.pdf CIFOR Guidelines Third Edition Promotions LMW Suggestions 3-6-20.pdf CIFOR Third Edition Guidelines_Twitter.png CIFOR Third Edition Guidelines_Facebook.png

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Hi CIFOR Promote DT,

We hope everyone is well. In lieu of having our Promote DT meeting this month, please see below for updates and input needed.

1. **Spring Meeting Announcement**
   - Due to various employee travel bans at the state, local and federal levels, CSTE is developing alternative plans for the Spring meeting. More information will be shared in an all-Council email.

2. **3rd Ed Guidelines Updates**
   - 3rd Ed Guidelines Printing Needs survey – The printing needs survey at the following link: https://app.smartsheet.com/b/form/15cdaf107153491db9d67870d6699187. This form hosted on Smartsheet allows anyone with the link to fill out the form. Additionally, it allows us to maintain and track the number of guidelines requested as well as track the status of the request. Please see the three attached pdf files to see the form, the tracking sheet and the confirmation receipt. Please provide any feedback on the form to India.

   - Update on 3rd Ed Guidelines Printing Status – The Guidelines are nearing completion with graphic design and formatting. As of today, we've received Chapters 1-6, the table of contents and the acknowledgements. Following the completion, a full layout will be provide for review prior to sending to the printers. The printers are prepared to produce the guidelines in 4 weeks. In the interim, the pdf version will be available online on the CIFOR website.

   - New 3rd Ed Guidelines Cover - Please see the final cover attached (page 1). FSIS asked that we remove the live cattle and replace it with a burger.

   - Options for Guidelines promotion if some/all of the spring and summer conferences are postponed or cancelled. Any suggestions would be helpful (e.g. webinar series, etc.)

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- Postcard flyers – is there still a need for printed postcards since many upcoming in-person meetings/conferences are being cancelled?

-
- Promotional blurbs
    - Finalized blurbs for the 3rd Ed. Guidelines are forthcoming. Attached are draft blurbs and are currently being reviewed by CSTE's communications specialist. Once finalized, India will send the promotional blurbs to the Council to send out via respective communication channels prior to the digital copies being released onto the CIFOR website.

Let us know if you have any questions.

Thanks,
Amy

Amy Chang
Senior Program Analyst
Environmental Health
National Association of County and City Health Officials (NACCHO) ¦1201 Eye Street NW 4th Floor ¦ Washington, DC 20005
Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
www.naccho.org



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CIFOR Council to Improve Foodborne Outbreak Response

Detect • Investigate • Control • Prevent

GUIDELINES FOR FOODBORNE DISEASE OUTBREAK RESPONSE











THIRD EDITION

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FL-DOH-20-0673-A-003074

CIFOR Council to Improve Foodborne Outbreak Response

Detect • Investigate • Control • Prevent

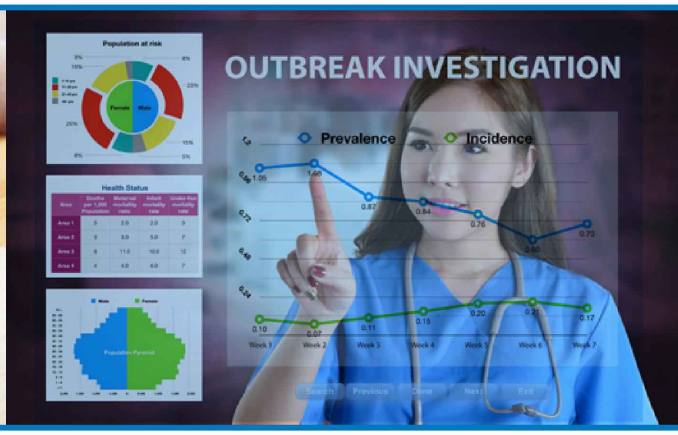
GUIDELINES FOR FOODBORNE DISEASE OUTBREAK RESPONSE











THIRD EDITION

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FL-DOH-20-0673-A-003075



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CIFOR Guidelines 3rd Edition Copy Request

Please use this form to sign up to receive a copy of the 3rd Edition CIFOR Guidelines For Foodborne Disease Outbreak Response. This sign up will assist the CIFOR member agencies with estimating printing needs and managing distributions.

Name *
Please provide your first and last name:

India Bowman

Email Address: *
Please provide your work email address.

ibowman@cste.org

Organization *
Please provide the full name of your organization. Ex: California Department of Health.

Council of State and Territorial Epidemiologists

Organization Mailing Address *
Please provide your work mailing address.
Ex: Division Name, 1234 Main Street, Anytown, FL, 12345

2635 Century Parkway NE, Atlanta, GA, 30345

How many copies of The 3rd Edition CIFOR Guidelines does your organization need? *
Please provide your best estimate.

10

Which job title best describes The 3rd Edition CIFOR Guidelines users at your organization?
Please select one.

Epidemiologist

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CIFOR Guidelines 3rd Edition Copy Request

smartsheet

	Row ID	Name	Form Field 2	Organization Mailing Address	Column8
1	1	India Bowman	Council of State and Territorial	2635 Century Parkway NE,	10

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Column9	Column10	Status
ibowman@cste.org	Epidemiologist	Reviewed

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Thank you. Your response has been added to my Smartsheet. CIFOR will review your request and follow up if any additional information is needed.

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Promotions for the Third Edition of the CIFOR Guidelines

Newsletter Blurb (Short)

Just Released: Third Edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response
The Council to Improve Foodborne Outbreak Response (CIFOR) released the streamlined and easy-to-read third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response. The CIFOR Guidelines are a comprehensive source of information on foodborne disease investigation and control for local, state and federal health agencies. Download the new Guidelines: https://cifor.us/products/guidelines.

Newsletter Blurb (Long)

Just Released: Third Edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response

The Council to Improve Foodborne Outbreak Response (CIFOR) released the streamlined and easy-to-read third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response. The CIFOR Guidelines are a comprehensive source of information on foodborne disease investigation and control for local, state and federal health agencies.

The Guidelines describe (a) the overall approach to addressing foodborne disease outbreaks, including preparation, detection, investigation, control and follow-up; and (b) the roles of key organizations in foodborne disease outbreaks.

These are a few of the updates in the new third edition:

- Provides information on the value and use of complaint systems
- Highlights Whole Genome Sequencing and Culture-Independent Diagnostic Testing
- Better illustrates how epidemiology, lab, and environmental health data come together
- Highlights importance of environmental assessments
- Recommends routine interviewing to collect detailed exposure information
- Expands effective models of sub-cluster investigations and product tracebacks

Download the new Guidelines: https://cifor.us/products/guidelines.

Social Media Posts

The highly anticipated third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response has arrived! Download your free copy today: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

The latest edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response is a streamlined and easy-to-read resource for local, state, and federal, agencies. Download your free copy today: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

Download the third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response, with all new information on Whole Genome Sequencing and Culture-Independent Diagnostic Testing: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

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Download the third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response, which highlights the expanded importance of epidemiology data and environmental assessments: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

Download the third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response, with new information on the importance of Foodborne Illness Complaint Systems: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

The Council to Improve Foodborne Outbreak Response (CIFOR) released new guidelines on foodborne disease investigation and control for local, state and federal health agencies: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

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JUST
RELEASED

THIRD EDITION: CIFOR GUIDELINES FOR FOODBORNE DISEASE OUTBREAK RESPONSE

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From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Cc:	Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD); Iademarco, Michael (CDC/DDPHSS/CSELS/OD); CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019; CDC CSELS DSEPD EWB
Subject:	CLARIFICATION RE: 100% of EIS officers and LLS fellows are needed for the COVID-19 response
Date:	Wednesday, March 18, 2020 2:55:48 PM

CLARIFICATION: We consider all EISOs and LLS fellows assigned to state and local health departments to be deployed working on COVID-19. This email is mostly intended for EIS and LLS assigned to CDC facilities. We did want field supervisors to know that we are NOT focused on CAL completion and fully support having EISOs and LLS dedicated to COVID-19 response.

Sorry for any confusion.

Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

please consider the environment before printing this e-mail.

From: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
Sent: Wednesday, March 18, 2020 2:46 PM
To: CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>; CDC LLS Supervisor 2018 <LLSSupervisor2018@cdc.gov>; CDC LLS Supervisors 2019 <DDPHSSCSELSDSEPDEWB2019LLSSupervisor@cdc.gov>
Cc: Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) <pms6@cdc.gov>; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) <mai9@cdc.gov>; CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC LLS Class 2018 <LLSClass2018@cdc.gov>; CDC LLS Class 2019 <LLSClass2019@cdc.gov>; CDC CSELS DSEPD EWB <OSELSSEPDPOEISStaff@cdc.gov>
Subject: 100% of EIS officers and LLS fellows are needed for the COVID-19 response

EIS and LLS supervisors,

I am writing again, asking for your support in having EIS officers and LLS fellows deploy or take on other roles for CDC's response to COVID-19. I want to emphasize that **completing CALs (graduation requirements) should NOT factor into whether an EIS officer or LLS fellow deploys**. Supervisors should not be asking to review deployment roles or objectives before approving a deployment. In the past we wanted to ensure deployments aligned with our training objectives. We no longer have that luxury, the primary responsibility of the EIS and LLS programs needs to be supporting the

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response until we are informed otherwise.

We will deal with CAL completion and how COVID-19 might impact graduation on a case-by-case basis. I want to assure you we will be very understanding in finding ways to compensate if involvement with the COVID-19 response prevented anyone from fulfilling the requirements to graduate.

We understand that some EISOs or LLS fellows may not be able to deploy to the field because of obligations to care for family members or themselves. There are response roles that can be completed while teleworking and do not require travel. We are available to assist in finding deployment roles – contact us at EpiAid@cdc.gov and we can discuss their particular circumstance. In addition, any fellows who are not currently deployed can volunteer by:

1. Emailing us at EpiAid@cdc.gov
2. Volunteer for a Go Team by submitting name in ReADI
3. Responding directly to any calls for volunteers they receive through other communication channels

Thank you for your support of the EIS and LLS programs and of your officers or fellows. We know a lot is being asked of you as well and CDC leadership appreciates all you are doing with respect to your individual contributions and your support of the EIS officers and LLS fellows.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

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From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019; Brower, Melissa (CDC/DDPHSS/CSELS/OD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Duggan, Natalie (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Olivares, Dagny (CDC/DDPHSIS/CPR/DEO)
Subject:	CLARIFICATION RE: how to handle any COVID-19 speaking requests
Date:	Tuesday, March 3, 2020 11:55:08 AM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf CDC_COVID-19 Weekly Key Messages__3-1-20_FINAL.pdf

EISOs and LLSers,

I know there have been a lot of questions following my email, “am I allowed to be part of a panel, I am supposed to speak at my graduate school, or, I was asked to speak about influenza and there will likely be questions about COVID-19.”

Please continue to fulfill planned speaking engagements at primary schools, universities, and lay audience presentations not specific to COVID-19. You should expect questions about COVID-19. You should redirect questions by letting people know “it is a constantly evolving situation and the most up-to-date information is available on CDC’s website.” What we are asking you to avoid are situations where you may be asked to speak on behalf of CDC re COVID-19 as all messaging is coming from CDC leadership given the seriousness, magnitude, and complexity of the situation.

I have attached for your reference “CDC’s Daily Key Points” and “Weekly Key Messages.” In the “Weekly Key Messages” document I would be familiar with the section “What CDC is Doing.” In general, it is best to avoid specifics and making any recommendations and again say the because it is a constantly evolving situation it is best to refer to CDC’s webpage for the latest recommendations.

If you have deployed for COVID-19 you can talk about your experience and the type of work you were doing to help protect the publics health. If you are asked to be part of any large meetings, press conferences, or COVID-19 specific sessions please reach out to the JIC eocjicmedia2@cdc.gov.

Thanks,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

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From: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
Sent: Friday, February 28, 2020 5:05 PM

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To: CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC LLS Class 2018 <LLSClass2018@cdc.gov>; CDC LLS Class 2019 <LLSClass2019@cdc.gov>
Cc: CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>; CDC LLS Supervisor 2018 <LLSSupervisor2018@cdc.gov>; CDC LLS Supervisors 2019 <DDPHSSCSELSDSEPDEWB2019LLSSupervisor@cdc.gov>; Brower, Melissa (CDC/DDPHSS/CSELS/OD) <ggk5@cdc.gov>; Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD) <tbn9@cdc.gov>; Duggan, Natalie (CDC/DDPHSS/CSELS/DSEPD) (CTR) <whv7@cdc.gov>; Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD) <ctg7@cdc.gov>; Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD) <aws8@cdc.gov>; Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD) <hld0@cdc.gov>; Olivares, Dagny (CDC/DDPHSIS/CPR/DEO) <dvp2@cdc.gov>
Subject: how to handle any COVID-19 speaking requests

Dear EISOs and LLS Fellows,

As the response to COVID-19 continues to evolve, it is increasingly likely that many of you (especially EISOs and LLS assigned to states) will be approached to participate in media interviews. During any emergency response that requires the activation of CDC's EOC, all communication functions are handed through the Joint Information Center (JIC) in the EOC. Decisions about who may serve as a CDC spokesperson with regard to media interviews are made by the public affairs specialists working in the JIC in collaboration with the Indecent Manager and CDC leadership. Those decisions are also guided by HHS's Office of the Assistant Secretary for Public Affairs (ASPA).

During EOC-led responses, a very limited number of spokespeople are approved to speak to media on behalf of CDC. In a rapidly evolving emergency response, it is critical that our messages remain as consistent as possible, are based on the most current information, and include important framing and nuances. The staff best positioned to deliver these nuanced messages are on all the calls, involved in all the conversations, and briefed on every aspect of the response = senior leaders at CDC (picture attached of EIS alum delivering key messages).

Please understand we want you to have as many opportunities as possible to talk with media about your work. This is a time when it's in the best interest of the agency and the public to limit the number of people talking to media for the reasons described above. This is also in your best interest, as it helps ensure that you will not be put in the position of being asked to speak and comment about things that are beyond the scope of your specific work. When media quote a CDC employee, that employee is invariably presented as speaking on behalf of the entire agency. Asking you to speak now offers far more risk than benefit given the fast-moving and politically complicated nature of the response.

Guidance is being developed and will be issued soon for all staff deployed to the field. **Any requests to speak about COVID-19 should be directed to the following address** eocjicmedia2@cdc.gov. Thanks for your cooperation and contributions to a complicated and ever evolving response.

For those of you that get a good weekend, have a good weekend. For those of you working – thanks

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for your service on behalf of EIS/LLS and CDC.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
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For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.


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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Outbreak

March 1, 2020

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since February 24 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use “the virus that causes COVID-19.”

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- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is threatening to cause a pandemic.
- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person-to-person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **February 29, more than 85,000** cases have been identified worldwide. More than 6,000 of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- During the week of February 23, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure in multiple states. [See section "Possible U.S. cluster" below.]

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- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- While it is unclear how this situation will evolve in the United States, CDC is preparing as if it were the next pandemic, while hoping it is not.
- The current outbreak meets two criteria for a pandemic. It is a new virus and it is capable of person-to-person spread. If sustained person-to-person spread in the community begins outside in China, this will increase the likelihood that a global pandemic will result.
- Extensive work has been done over the past 15 years in the United States to prepare for an influenza pandemic.
    - Guidance developed for influenza pandemic preparedness would be appropriate in the event the current COVID-19 outbreak triggers a pandemic.
    - Selected pandemic preparedness materials are available online.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **February 29, 2020**:

- **Travel-related: 13** (12 confirmed, 1 presumptive positive)
- **Person-to-person spread: 9** (3 confirmed, 6 presumptive positive)
- **Total cases: 22** (15 confirmed, 7 presumptive positive)
- **Deaths: 1** (0 confirmed, 1 presumptive positive)

Persons repatriated to the United States and tested positive by CDC, as of **February 29, 2020**:

- Wuhan, China: **3**
- *Diamond Princess* Cruise Ship: **44**

For global cases, please see the WHO daily situation reports.

POSSIBLE U.S. CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
- One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a healthcare worker.
    - This is the first reported case in a healthcare worker.
- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.

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- While there is an ongoing investigation, the source of these infections is currently unknown.
- Circumstances suggest person-to-person spread, including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.
- CDC infection control experts are assessing the risk of additional healthcare worker exposures and carefully reviewing infection control practices within the facility to protect residents and healthcare workers from further spread of COVID-19.
    - The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
    - All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.
- On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested "weak positive" to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19. View the AFCD official report.
    - CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
    - It's important to remember dogs that have their own coronaviruses.
    - To date, CDC has not received any reports of pets or other animals becoming sick with COVID-19. At this time, there is no evidence that pets, including dogs, can spread COVID-19.
    - There is no reason to think that any animals, including pets, in the United States might be a source of infection with this new coronavirus.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory

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pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- To date, CDC does not have any evidence to suggest that animals imported from China pose a risk for spreading the new coronavirus in the United States.
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes.
    - Mosquitoes cannot spread all types of viruses. For a virus to pass to a person through a mosquito bite, the virus must be able to replicate inside the mosquito.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.

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- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits will only include the two components (e.g., reagents) that are specific to novel coronavirus.
    - In the meantime, before new test kits are available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays. We anticipate this will increase testing capacity to about 40 state and local health departments.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner can move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
- On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- For severe cases, treatment should include care to support vital organ functions.

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.
    - Stay home when you are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
    - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
    - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

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MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region.

TRAVEL

Travel Restrictions from China and Iran:

- President Trump issued a Presidential Proclamation on January 31, to implement temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.

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- The proclamation took effect at 5 p.m. EST, Sunday, February 2.
- The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days. There are some exemptions, including for immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- In addition:
    - All American citizens and exempted persons coming from China will be directed to ("**funneled to"**) one of 11 US airports.
    - American citizens and exempted persons who have been in Hubei province in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for further medical evaluation. (They will not be able to complete their itinerary.)
        - If asymptomatic, American citizens and exempted persons will be subject to a mandatory quarantine at or near that location until 14 days after they left Hubei Province. (They will not be able to complete their itinerary.)
    - American citizens and exempted persons who have been in other parts of mainland China (outside of Hubei Province) in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
        - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
        - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will self-monitor under public health supervision for 14 days.
- The 11 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
- As of February 27, about 48,000 people have been screened at US airports.
- On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.

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Travel Notices and Advisories:

- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - CDC's recommendation is consistent with guidance from the U.S. Department of State.

Repatriation flights and quarantine orders:

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Five chartered flights returned passengers from Wuhan City, China.
- Most recently, passengers from a cruise ship docked in Japan are in the process of being repatriated. (See section: *Diamond Princess*)
- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Medical staff monitor the health of each traveler, including temperature checks and observation for respiratory symptoms.
- CDC works with state and local public health departments and/or HHS's Incident Management Team (IMT) to transport any passenger exhibiting symptoms to a hospital for further evaluation.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- Almost all people from the Wuhan flights who were quarantined have fulfilled their 14-day quarantine period and have been released.

***Diamond Princess*:**

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
    - Due to the dynamic nature of the ongoing outbreak, the US government recommended that US citizens disembark and return to the United States.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
    - The planes were met by a team of U.S. government personnel deployed at the bases to assess the health of the passengers.
    - The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They

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will continue to be monitored by medical and public health personnel throughout the 14-day quarantine period.

- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and are housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- No US citizens remain on the Diamond Princess.
- More than 50 Americans who were on board the *Diamond Princess* remain in Japan, hospitalized with COVID-19, including some who are reportedly severely ill.
- The US Government is taking measures to protect the health of the people under quarantine, their loved ones, and their communities, as well as the communities where they are being temporarily housed.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
- The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in Hubei province and other parts of mainland China are allowed to enter the United States, but they are subject to health monitoring and possible quarantine for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Hong Kong — Level 1, Practice Usual Precautions — issued February 19;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;
        - Italy — Level 3, Avoid Nonessential Travel — updated February 28;
        - Japan — Level 2, Practice Enhanced Precautions — updated February 22;

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        - South Korea — Level 3, Avoid Nonessential Travel — updated February 24.
    - CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
- CDC is issuing clinical guidance, including:
    - On January 30, CDC published guidance for healthcare professionals on the clinical care of COVID-19 patients.
    - On February 3, CDC posted guidance for assessing the potential risk for various exposures to COVID-19 and managing those people appropriately.
    - On February 27, CDC updated its criteria to guide evaluation of persons under investigation for COVID-19.
    - On February 28, CDC issued a Health Alert Network (HAN): Update and Interim Guidance on Outbreak of COVID-19.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
    - Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
    - State PHEP programs stand ready to address future developments in the outbreak.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity.
    - After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
    - CDC worked on two potential resolutions to this problem.
        - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
            - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
            - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the

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assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
        - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.
        - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
    - CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.

Internationally:

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.
- CDC has supported China CDC's national influenza laboratory for more than 20 years.

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- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent Travelers to Geographic Areas with Sustained Spread:

- If you were in geographic areas with sustained spread (China, Iran, Italy, Japan, or South Korea) and feel sick with fever, cough, or difficulty breathing, within 14 days after leaving the country, you should:
  - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
  - Avoid contact with others.
  - Not travel while sick.
  - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
  - Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.

People Confirmed to Have, or Being Evaluated for, COVID-19:

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
  - Stay home except to get medical care.
  - Separate yourself from other people in your home.
  - Call ahead before visiting your doctor.
  - Wear a facemask.
  - Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
  - Wash your hands often with soap and water for at least 20 seconds.
  - Avoid sharing household items like eating utensils, cups, or linens.
  - Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.

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- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation:

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
    - Fever—take your temperature twice a day.
    - Coughing.
    - Shortness of breath or difficulty breathing.
    - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
    - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- If you do not have any symptoms, you can continue with your daily activities, such as going to work, school, or other public areas.
- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

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For Healthcare Professionals:

Patients in the United States who meet the following criteria should be evaluated as a patient under investigation (PUI) in association with the outbreak of COVID-19.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	**AND**	Any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **affected geographic areas** (i.e., countries with CDC Travel Health Notices at warning levels 2 or 3) within 14 days of symptom onset
Fever **and** signs/symptoms of acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)	**AND**	No source of exposure has been identified

Note: The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria. The above criteria are available on the Interim Guidance for Healthcare Professionals web page.

- In addition to the above criteria, infants born to mothers with confirmed COVID-19 should be considered PUIs. As such, infants should be isolated according to the Infection Prevention and Control Guidance for PUIs.

Recommendations for Reporting, Testing, and Specimen Collection:

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

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- For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available.
- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page.

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- The current risk to Americans for COVID-19 is low, but Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, plans to work remotely can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)
    - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
    - Environmental measures (e.g., routine cleaning of frequently touched surfaces)

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CDC'S Approach to Community-Based Interventions

- The federal guidance provided by CDC is intentionally broad to allow flexibility for states and local health governments to tailor guidance to their circumstances. An intervention/ approach that is appropriate for one community with local transmission won't necessarily be appropriate for another community with no local transmission.
- Local health departments should evaluate and adapt CDC guidelines and recommendations based on local conditions and with input from community partners.
- The community can take measures to reduce the spread of the COVID-19. CDC recommends working with the local health department and community partners to determine options that make the most sense. Potential measures include dismissal of students from school and closure of childcare facilities, social distancing of adults in the community and workplace, which may include cancellation of large public (or mass) gatherings and encouraging teleworking and alternate work schedules to decrease social density.

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- Handwashing with soap and water is one of the best ways to protect against the virus.
- Creating a household emergency plan can help protect your health and the health of those you care about.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, stay home when you are sick with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- Mass gatherings:
    - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
    - You may need to modify, postpone, or cancel your event. CDC recommends working with the emergency operations coordinator or planning team at your venue and staying informed about the local COVID-19 situation in your area.
    - CDC is in the process of creating a planning guide to help event organizers and staff plan and prevent the introduction of COVID-19 into their mass gathering or event.
- Community and faith-based organizations:
    - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.

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        - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before a pandemic can help provide your organization with the support and resources needed.
        - CDC is in the process of a planning guide to help you create an emergency plan for your community and faith-based organization.
- Administrators of U.S. childcare programs and K-12 schools:
    - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
    - CDC recommends childcare and K-12 school officials:
        - Collaborate with local health departments and partners to review, update, and implement emergency operations plans.
        - Develop information-sharing systems with partners that can be used for day-to-day reporting and disease surveillance to identify unusual rates of absenteeism.
        - Review attendance and sick leave policies; encourage students and staff to stay home when sick and establish procedures to ensure student and staff who become sick at school or arrive at school sick are sent home as soon as possible.
        - Perform routine environmental cleaning.
        - Create communications plans for use with the school community.
    - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be dismissed in the event of an outbreak. (NOTE: DOE does not recommend using "school closure" terminology.)
    - School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
    - CDC has created interim guidance for administrators of U.S. childcare programs and K-12 schools to help plan, prepare, and respond to COVID-19.

HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:

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1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. Rinse your hands well under clean, running water.
5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Based on what CDC knows now related to severity, transmission efficiency, and shedding duration, CDC is currently recommending Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
- As CDC learns more about COVID-19, and as the needs of the response within US healthcare facilities change, CDC will refine and update this early and aggressive IPC approach.
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.
    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other pathways to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage, limiting personnel in the room, and using Airborne Infection Isolation Rooms (AIIR).
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel and other patients who may be exposed to a patient with confirmed or possible COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Place a facemask on the patient and isolate them in an AIIR, if available.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious material, and before

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putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are likely to induce coughing or sneezing. HCP collecting specimens for testing for COVID-19 from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection. These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.
- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- As a reminder, the role of face masks is for source control, and not to prevent exposure.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available).

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WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:
    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining appropriate work restrictions.

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MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and underlying chronic medical conditions such as lung disease, cancer, heart failure, cerebrovascular disease, renal disease, liver disease, diabetes, immunocompromising conditions, and pregnancy.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

- No specific treatment for COVID-19 is currently available. Prompt infection prevention and control measures and supportive management of complications is recommended.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings. The guidance also provides planning considerations if there are more widespread, community outbreaks.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:

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    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- For the general public, who are unlikely to be exposed to this virus, the immediate health risk from COVID-19 is considered low at this time. Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.
    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.

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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 29, 2020

All content updated since February 27 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness named "COVID-19" caused by a novel (new) coronavirus.
- The outbreak began in China but is spreading worldwide, including the United States.
- COVID-19 is threatening to cause a pandemic.
- The U.S. public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the potential spread and impact of this virus.
- This aggressive response has helped to limit the number of U.S. cases in the United States.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- This week, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure.
- These possible instances of community spread occurred in California, Washington and Oregon.
- In Washington three patients were reported who had tested presumptive-positive for the virus that causes COVID-19 at the state.
    - These included a person who died, an infected hospitalized health care worker and a potential outbreak in a long-term care facility.
    - *See Possible Washington Cluster section*
- The U.S. expects to detect more introductions of COVID-19 through travel, as well as more person-to-person spread and community transmission of this virus.
- Aggressive containment efforts will continue, including ongoing use of isolation and quarantine measures to decrease introductions and spread of the virus.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
- In affected communities, local authorities will implement other measures too, including Nonpharmaceutical Interventions (NPIs).
- Local authorities will determine which NPIs to implement, taking into account current circumstances in their communities.
- Nonpharmaceutical Interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- The purpose of most NPIs is to help reduce spread of illness by maintaining or increasing distance between people.
- Social distancing measures are an important weapon to fight the spread of this virus and also can reduce the impact of this virus on communities as a whole.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.

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- But individual risk is dependent on exposure.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
- Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
- Close contacts of persons with COVID-19 also are at elevated risk of exposure.
- Travelers returning from affected locations internationally where community spread is occurring also are at elevated risk of exposure.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- While still taking every effort to prevent a pandemic, CDC is operationalizing all of its pandemic preparedness and response plans.
- Guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for COVID-19.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.

International

- To date, 60 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Azerbaijan, Iceland, and Monaco.
- CDC is reviewing and updating its travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.

Domestic

- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 22 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Six of these cases occurred through person-to-person spread.

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- On February 26, CDC confirmed what is potentially the first instance of community spread with the virus that causes COVID in Sacramento, CA.
- Late on February 28, CDC announced three more possible instances of community-acquired COVID-19—one each in California, Oregon, and the state of Washington.
- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19. All of these are potential cases of community spread.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
    - *See Possible Washington Cluster section*
- Community spread means spread of an illness for which the source of infection is unknown.
- It's also possible, however, that these patients may have been exposed to a returned traveler who was infected.
- CDC is supporting investigations locations with possible community spread.
- People who were exposed to these patients during their infection are at some level of risk depending on their exposure.
- Based on what is known about how this virus behaves, additional cases among people who have had contact with these patients, especially those who have had close, prolonged contact, are expected.
- This could include family members and potentially healthcare workers who cared for the patients.
- All the remaining cases detected through the U.S. public health system were in persons who had travel to areas with ongoing community transmission.

- 47 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 44 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- On Monday, most of the passengers from the Diamond Princess will complete their 14-day quarantine period.
- Patients who tested positive during their quarantine will remain in isolation. A small number of close contacts of those patients (for instance, spouses who have been living with them) who are at increased risk will have their quarantines extended.

WHAT'S NEW:

- On February 28 CDC issued a health alert network update titled: "Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)."
- CDC has been watching the increased spread of this virus across the world and worked with partners on an updated PUI definition.

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- The updated PUI definition takes into account the new geographic spread of the virus and includes a list of affected areas with widespread or sustained community spread. This list is dynamic and will change as our travel guidance is revised.
- CDC has posted "Community Mitigation Guidance for COVID-19 Response in the United States: Nonpharmaceutical Interventions for Community Preparedness and Outbreak Response."

WHAT TO DO

- While the immediate risk of this new virus for most of the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and;
        - People who have been in close contact with someone with COVID-19 or pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity for up to 14 days. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

POSSIBLE WASHINGTON CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a health care worker. This is the first reported case in a healthcare worker.

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- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
    - Circumstances suggest person-to-person spread including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

TESTING

- An important part of CDC's role in testing during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with the capacity to test for this virus.
- Distribution of a CDC rRT-PCR test to diagnose COVID-19 began to state and local public health labs, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents, which led to laboratories not being able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
        - CDC established that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Public health laboratories can use the original CDC test kit to test for the virus that causes COVID-19 using the new protocol.
    - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
- Combined with other reagents that CDC has procured, this is enough testing kits to test more than 75,000 people.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.
- Learn more information about CDC's laboratory work.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community interventions.

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- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.
- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. Personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. Community NPIs (social distancing measures and school closures and dismissals); and
    3. Environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

BACKGROUND

- This new coronavirus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
- Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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AMERICAN OVERSIGHT

Subject: communications test
Date: Friday, March 13, 2020 12:32:53 PM

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Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

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850-585-1679

AMERICAN OVERSIGHT

From:	Kincaid, Brooke
To:	Peterson, Amy; LogisticsDesk2; Deleon, Melissa (FLNG); Bequer, Samantha; Guidicelli, Ian; McWhorter, Linda; Dumas, Wendell; EOC-Plans; Mahon, Jason; Anspaugh-Naples, Stephanie; courtney.coppola@flhealth.gov
Subject:	Community Based Testing Sites- SitRep from 3-23-20
Date:	Tuesday, March 24, 2020 9:43:33 AM
Attachments:	POC Sit Report 03232020.xlsx

All,

Please see the attached SitRep, for personnel and potential burn rates for the Community Based Testing Sites. However, new numbers came in during the morning briefing on tests conducted. The most up to date numbers can be found in below:

Jacksonville- TIAA Stadium
Federal Tests- 254
Not Meeting Criteria- 184

Orlando- Convention Center
First Responder Testing- 3/25
General Public Testing- 3/26

Broward- CB Smith Park
Tested- 799
Not Meeting Criteria- 272

Miami- Hard Rock
Federal Tests- 200
State Testing- 575
Not Meeting Criteria- 187

Brooke Kincaid, MPA | Recovery Regional Manager and Region 2
Bureau of Recovery
Florida Division of Emergency Management
Rebuilding Together
(850)-567-6197 (c)
(850) 815-4437 (o)
Email: Brooke.Kincaid@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

	A	B	C	D
1	**Daily Situation Report** **Point of Collection (POC) Roll-Up**			
2	3/23/2020 0:00			
3				
4	**Client Information**		**Number**	**Notes**
5	*Daily total number present:*		1256	
6	*Number of Vehicles thru POC:*		1431	
7	*Number of Swab/Tests Completed:*		1515	
8	*Number tested with appointment:*		0	
9	*Number tested without appointment:*		1568	
10	*Number not tested and reason:*		503	
11	*Average Test Per Hour:*		214	
12	*Maximum Test Per Hour:*		190	
13	*Minimum Test Per Hour:*		71	1828
14	*Total People Tested:*		1515	
15	*Total Not meeting Criteria:*		499	
16	*Total Number:*		8762	
17	**Supply Information**			
18	Daily count of supplies on hand at POC opening			
19	*Item:*	*Opening Count*		*Closing Count*
20	*N-95 Masks:*	13991		13294
21	*General Surgical Masks*	35990		12489
22	*Disposable Full-face Shields:*	820		432
23	*Goggles:*	2233		2282
24	*Nonsterile Gloves:*	113488		103764
25	*Medical Gowns:*	6664		6472
26	*Coverall/Suits:*	3620		3128
27	*COVID-19 Test Kits:*	11050		9506
28	Daily burn rate at POC closing (*order for five (5) days out*)			
29	*N-95 Masks:*	3%		
30	*General Surgical Masks*	2%		
31	*Disposable Full-face Shields:*	3%		
32	*Goggles:*	0%		
33	*Nonsterile Gloves:*	4%		
34	*Medical Gowns:*	0%		
35	*Coverall/Suits:*	0%		
36	*COVID-19 Test Kits:*	15%		
37	**Site Staff**			
38	Daily accountable of all site support personnel (*Attach ICS-214 Form*)			
39	*Command and General Staff:*	21		
40	*Clinical Staff:*	227		
41	*Non-Clinical Staff:*	28		
42	*Law Enforcement Staff:*	165		
43	*Dept. of Transportation*	11		
44	*Dept. of Health*	0		
45	*Fire Rescue/EMS Staff:*	32		

AMERICAN OVERSIGHT

	A	B	C	D
46	*National Guard Staff:*	577		
47	*Volunteer Staff:*	0		
48	*Volunteer Staff:*	16		

AMERICAN OVERSIGHT

Daily Situation Report
Point of Collection (POC) in Broward County, Florida

=NOW()		
To:	Community Base Testing Site State POC	
From:	Sharon Denton-Gow	POC Incident Commander

Client Information	Number	Notes
Daily total number present:	1071	
Number of Vehicles thru POC:	605	
Number of Swab/Tests Completed:	799	
Number tested with appointment:	0	n/a
Number tested without appointment:	799	
Number not tested and reason:	272	did not meet criteria
Average Test Per Hour:	92	
Maximum Test Per Hour:	151	
Minimum Test Per Hour:	64	
Total People Tested:	799	
Total Not meeting Criteria:	272	
Total Number:		

Operation Critical Information *(Please keep brief bullet points)*

Awaiting additional test kits

Supply Information

Daily count of supplies on hand at POC opening

Item:	*Opening Count*	*Closing Count*
N-95 Masks:	1541	1405
General Surgical Masks	2090	1990
Disposable Full-face Shields:	0	0
Goggles:	1493	1492
Nonsterile Gloves:	388	364
Medical Gowns:	0	0
Coverall/Suits:	1882	1866
COVID-19 Test Kits:	3050	2400

Daily burn rate at POC closing (*order for five (5) days out*)

N-95 Masks:	9%
General Surgical Masks	5%
Disposable Full-face Shields:	0%
Goggles:	1%

AMERICAN OVERSIGHT

	A	B	C	D
46	*Nonsterile Gloves:*	6%		
47	*Medical Gowns:*	0%		
48	*Coverall/Suits:*	1%		
49	*COVID-19 Test Kits:*	21%		
50	Site Staff			
51	Daily accountable of all site support personnel (*Attach ICS-214 Form*)			
52	*Command and General Staff:*	6		
53	*Clinical Staff:*	128		
54	*Non-Clinical Staff:*	26		
55	*Law Enforcement Staff:*	103		
56	*Dept. of Transportation*	8		
57	*Dept. of Health*	0		
58	*Fire Rescue/EMS Staff:*	2		
59	*National Guard Staff:*	198		
60	*Volunteer Staff:*	0		
61	*Unified Command*	14		
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AMERICAN OVERSIGHT

Daily Situation Report
Point of Collection (POC) in Duval County, Florida

March 21, 2020 at 1800

To:	Community Base Testing Site State POC
From:	James Bujeda — POC Incident Commander

Client Information	Number	Notes
Daily total number present:	185	
Number of Vehicles thru POC:	164	
Number of Swab/Tests Completed:	141	
Number tested with appointment:	0	
Number tested without appointment:	141	
Number not tested and reason:	44	Did not meet parameters
Average Test Per Hour:	18	
Maximum Test Per Hour:	39	
Minimum Test Per Hour:	7	
Total People Tested:	141	
Total Not meeting Criteria:	40	
Total Number:	389	

Operation Critical Information *(Please keep brief bullet points)*

Supply Information

Daily count of supplies on hand at POC opening

Item:	*Opening Count*	*Closing Count*
N-95 Masks:	4200	3800
General Surgical Masks	3000	3000
Disposable Full-face Shields:	112	48
Goggles:	200	200
Nonsterile Gloves:	38500	33000
Medical Gowns:	2472	2280
Coverall/Suits:	0	0
COVID-19 Test Kits:	2100	1959

Daily burn rate at POC closing (*order for five (5) days out*)

N-95 Masks:	0%
General Surgical Masks	0%
Disposable Full-face Shields:	0%
Goggles:	0%

AMERICAN OVERSIGHT

	A	B	C	D
46	*Nonsterile Gloves:*	0%		
47	*Medical Gowns:*	0%		
48	*Coverall/Suits:*	0%		
49	*COVID-19 Test Kits:*	7%		
50	Site Staff			
51	Daily accountable of all site support personnel (*Attach ICS-214 Form*)			
52	*Command and General Staff:*	10		
53	*Clinical Staff:*	47		
54	*Non-Clinical Staff:*	2		
55	*Law Enforcement Staff:*	61		
56	*Dept. of Transportation*	3		
57	*Dept. of Health*	0		
58	*Fire Rescue/EMS Staff:*	28		
59	*National Guard Staff:*	0		
60	*Volunteer Staff:*	0		
61	*DEM Staff*	2		
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AMERICAN OVERSIGHT

Daily Situation Report
Point of Collection (POC) in Miami-Dade County, Florida

	=NOW()		
To:	Community Base Testing Site State POC		
From:	Billy Estep	POC Incident Commander	

Client Information	Number	Notes
Daily total number present:		
Number of Vehicles thru POC:	662	
Number of Swab/Tests Completed:	575	
Number tested with appointment:	0	
Number tested without appointment:	628	
Number not tested and reason:	187	screening
Average Test Per Hour:	104	
Maximum Test Per Hour:		
Minimum Test Per Hour:		
Total People Tested:	575	
Total Not meeting Criteria:	187	
Total Number:	628	

Operation Critical Information *(Please keep brief bullet points)*

Supply Information

Daily count of supplies on hand at POC opening

Item:	*Opening Count*	*Closing Count*
N-95 Masks:	4260	4138
General Surgical Masks	30900	7499
Disposable Full-face Shields:	324	
Goggles:	540	590
Nonsterile Gloves:	44600	40400
Medical Gowns:	3826	3826
Coverall/Suits:	1388	912
COVID-19 Test Kits:	3500	2747

Daily burn rate at POC closing (*order for five (5) days out*)

N-95 Masks:	2%
General Surgical Masks	
Disposable Full-face Shields:	10%
Goggles:	

AMERICAN OVERSIGHT

	A	B	C	D
46	*Nonsterile Gloves:*	10%		
47	*Medical Gowns:*			
48	*Coverall/Suits:*			
49	*COVID-19 Test Kits:*	33%		
50	Site Staff			
51	Daily accountable of all site support personnel (*Attach ICS-214 Form*)			
52	*Command and General Staff:*			2
53	*Clinical Staff:*			
54	*Non-Clinical Staff:*			
55	*Law Enforcement Staff:*			
56	*Dept. of Transportation*			
57	*Dept. of Health*			
58	*Fire Rescue/EMS Staff:*			
59	*National Guard Staff:*			183
60	*Volunteer Staff:*			
61				
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AMERICAN OVERSIGHT

	A	B	C	D
1	**Daily Situation Report** **Point of Collection (POC) in Orange County, Florida**			
2	3/23/2020 18:35:00 PM			
3	To:	Community Base Testing Site State POC		
4	From:			Incident Commander/Planning Section Chief
5				
6	**Client Information**		**Number**	**Notes**
7	*Daily total number present:*		0	
8	*Number of Vehicles thru POC:*		0	
9	*Number of Swab/Tests Completed:*		0	
10	*Number tested with appointment:*		0	
11	*Number tested without appointment:*		0	
12	*Number not tested and reason:*		0	
13	*Average Test Per Hour:*		0	
14	*Maximum Test Per Hour:*		0	
15	*Minimum Test Per Hour:*		0	
16	*Total People Tested:*		0	
17	*Total Not meeting Criteria:*		0	
18	*Total Number:*		0	
19	**Operation Critical Information** *(Please keep brief bullet points)*			
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30	**Supply Information**			
31	Daily count of supplies on hand at POC opening			
32	*Item:*	*Opening Count*		*Closing Count*
33	*N-95 Masks:*	3990		3951
34	*General Surgical Masks*	0		0
35	*Disposable Full-face Shields:*	384		384
36	*Goggles:*	0		0
37	*Nonsterile Gloves:*	30000		30000
38	*Medical Gowns:*	366		366
39	*Coverall/Suits:*	350		350
40	*COVID-19 Test Kits:*	2400		2400
41	Daily burn rate at POC closing (*order for five (5) days out*)			
42	*N-95 Masks:*	0%		
43	*General Surgical Masks*	0%		
44	*Disposable Full-face Shields:*	0%		
45	*Goggles:*	0%		

AMERICAN OVERSIGHT

	A	B	C	D
46	*Nonsterile Gloves:*	0%		
47	*Medical Gowns:*	0%		
48	*Coverall/Suits:*	0%		
49	*COVID-19 Test Kits:*	0%		
50	Site Staff			
51	Daily accountable of all site support personnel (*Attach ICS-214 Form*)			
52	*Command and General Staff:*	3		
53	*Clinical Staff:*	52		
54	*Non-Clinical Staff:*	0		
55	*Law Enforcement Staff:*	1		
56	*Dept. of Transportation*	0		
57	*Dept. of Health*	0		
58	*Fire Rescue/EMS Staff:*	2		
59	*National Guard Staff:*	196		
60	*Volunteer Staff:*	0		
61				
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AMERICAN OVERSIGHT

From:	Kincaid, Brooke
To:	Guthrie, Kevin; courtney.coppola@flhealth.gov; Peterson, Amy; LogisticsDesk2; Deleon, Melissa (FLNG); Bequer, Samantha; Guidicelli, Ian; McWhorter, Linda; Dumas, Wendell; EOC-Plans; Mahon, Jason; Anspaugh-Naples, Stephanie; EOC Logistics Section
Subject:	Community Based Testing Sites- SitRep from 3-25-20
Date:	Wednesday, March 25, 2020 6:35:43 PM
Attachments:	CBTS Daily Master SitRep 032520.xlsx

Please find attached.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

	A	B	C	D
1			**Daily Situation Report CBTS Roll-Up**	
2	=NOW()			
3	**Client Information**		**Number**	**Notes**
4	*Number of Vehicles thru CBTS:*		1364	
5	*Number of Lanes*		21	
6	*Number of State Tested:*		977	
7	*Total not meeting State criteria*		74	
8	*Number of Federal Tested*		734	
9	*Total not meeting Federal criteria*		234	
10	*Average Test Per Hour:*		176.625	
11	*Maximum Test Per Hour:*		203	
12	*Minimum Test Per Hour:*		30	
13	*Combined Number Test Conducted Onsite (Federal/State):*		1717	
14	*Combined Number Not Meeting Criteria (Federal/State):*		315	
15	*Tests Conducted to Date (Cumulative Total):*		8098	
16	**Supply Information**			
17	Daily count of supplies on hand at POC opening			
18	*Item:*	*Opening Count*		*Closing Count*
19	*N-95 Masks:*	12065		11739
20	*General Surgical Masks*	17208		14898
21	*Disposable Full-face Shields:*	671		566
22	*Goggles:*	1636		1636
23	*Nonsterile Gloves:*	58280		76108
24	*Medical Gowns:*	4558		4347
25	*Coverall/Suits:*	10675		10518
26	*COVID-19 Test Kits:*	5495		4284
27	Daily burn rate at POC closing (*order for five (5) days out*)			
28	*N-95 Masks:*	5%		
29	*General Surgical Masks*	22%		
30	*Disposable Full-face Shields:*	8%		
31	*Goggles:*	0%		
32	*Nonsterile Gloves:*	5%		
33	*Medical Gowns:*	4%		
34	*Coverall/Suits:*	9%		
35	*COVID-19 Test Kits:*	15%		
36	**Site Staff**			
37	Daily accountable of all site support personnel (*Attach ICS-214 Form*)			
38	*Command and General Staff:*	37		
39	*Clinical Staff:*	279		
40	*Non-Clinical Staff:*	33		
41	*Law Enforcement Staff:*	188		
42	*Dept. of Transportation*	10		
43	*Dept. of Health*	0		
44	*Fire Rescue/EMS Staff:*	44		
45	*National Guard Staff:*	559		

AMERICAN OVERSIGHT

	A	B	C	D
46	*Volunteer Staff:*	3		
47				
48				
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AMERICAN OVERSIGHT

Daily Situation Report
CBTS in Broward County, Florida

Report Completed:	3/25/2020	POC Site Address:	900 N. Flamingo Road Pembroke Pines, FL	
		POC Site Telephone:	352-804-4689	
Day Total:	4/18/1901 0:00	Date Opened;	3/20/2020	
		Site Hours:	*5-Sep*	
Developed by:	Sharon Denton-Gow	Title:	SERT -IC	

Screening Criteria:

First responders: (essential personnel) police, fire -rescue and hospital workers who are symptomatic; 65 years or older with chronic conditions and symptomatic; individuals who meet the testing criteria (symptomatic, have travelled internattional by cruise or airor from an affected geographical area; immune compromised and symptomatic.

Client Information	Number	Notes
Number of Vehicles thru CBTS:	407	
Number of Lanes	5	
Number of State Tested:	474	
Total not meeting State criteria	6	
Number of Federal Tested	0	
Total not meeting Federal criteria	0	
Average Test Per Hour:	68	
Maximum Test Per Hour:	137	
Minimum Test Per Hour:	17	
Combined Number Test Conducted Onsite (Federal/State):	480	
Combined Number Not Meeting Criteria (Federal/State):	6	
Tests Conducted to Date (Cumulative Total):	3824	

Operation Critical Information *(Please keep brief bullet points)*

Limited the number of appointments based on low inventory of testing kits. Awaiting more kits to meet the need.

Supply Information

Daily count of supplies on hand at POC opening

Item:	*Opening Count*	*Closing Count*
N-95 Masks:	946	842
General Surgical Masks	1909	1859
Disposable Full-face Shields:	0	0
Goggles:	1492	1492
Nonsterile Gloves:	350	330
Medical Gowns:	0	0
Coverall/Suits:	1846	1829
COVID-19 Test Kits:	589	115

Daily burn rate at POC closing (*order for five (5) days out*)

AMERICAN OVERSIGHT

	A	B	C	D	E
45	*N-95 Masks:*	11%			
46	*General Surgical Masks*	50%			
47	*Disposable Full-face Shields:*	0%			
48	*Goggles:*	0%			
49	*Nonsterile Gloves:*	6%			
50	*Medical Gowns:*	0%			
51	*Coverall/Suits:*	1%			
52	*COVID-19 Test Kits:*	20%			
53	Site Staff				
54	Daily accountable of all site support personnel (*Attach ICS-214 Form*)				
55	*Command and General Staff:*	20			
56	*Clinical Staff:*	128			
57	*Non-Clinical Staff:*	26			
58	*Law Enforcement Staff:*	115			
59	*Dept. of Transportation*	8			
60	*Dept. of Health*	0			
61	*Fire Rescue/EMS Staff:*	2			
62	*National Guard Staff:*	198			
63	*Volunteer Staff:*	3			
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AMERICAN OVERSIGHT

	A	B	C	D	E
1	**Daily Situation Report** **CBTS in Duval County, Florida**				
2	Report Completed:	=TODAY()	POC Site Address:	1 TIAA Bank Drive	
3			POC Site Telephone:	850-296-5355	
4	Day Total:	237	Date Opened:	43911	
5			Site Hours:	*0900-1700*	
6	Developed by:	James Bujeda	Title:	CBTS POC	
7	**Screening Criteria:**				
8	any age with fever of 99.6 or higher and respiratory issues or HCP or first responder (Including expanding definition of that)				
9	**Client Information**		**Number**	**Notes**	
10	*Number of Vehicles thru CBTS:*		221		
11	*Number of Lanes*		9		
12	*Number of State Tested:*		0		
13	*Total not meeting State criteria*		0		
14	*Number of Federal Tested*		237		
15	*Total not meeting Federal criteria*		155		
16	*Average Test Per Hour:*		30		
17	*Maximum Test Per Hour:*		52		
18	*Minimum Test Per Hour:*		12		
19	*Combined Number Test Conducted Onsite (Federal/State):*		237		
20	*Combined Number Not Meeting Criteria (Federal/State):*		155		
21	*Tests Conducted to Date (Cumulative Total):*		1163		
22	**Operation Critical Information** *(Please keep brief bullet points)*				
23–32	*Thermometers are Critical.(Mission-06613), Facesheilds are critical (Mission-1764).*				
33	**Supply Information**				
34	Daily count of supplies on hand at POC opening				
35	*Item:*	*Opening Count*		*Closing Count*	
36	*N-95 Masks:*	3268		3150	
37	*General Surgical Masks*	7350		7350	
38	*Disposable Full-face Shields:*	0		0	
39	*Goggles:*	144		144	
40	*Nonsterile Gloves:*	25700		25300	
41	*Medical Gowns:*	366		366	
42	*Coverall/Suits:*	8150		8150	
43	*COVID-19 Test Kits:*	1444		1207	
44	Daily burn rate at POC closing (*order for five (5) days out*)				
45	*N-95 Masks:*	3.61%			

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	A	B	C	D	E
46	*General Surgical Masks*			0.00%	
47	*Disposable Full-face Shields:*			0.00%	
48	*Goggles:*			0.00%	
49	*Nonsterile Gloves:*			1.56%	
50	*Medical Gowns:*			0.00%	
51	*Coverall/Suits:*			0.00%	
52	*COVID-19 Test Kits:*			16.41%	
53	Site Staff				
54	Daily accountable of all site support personnel				
55	*Command and General Staff:*			10	
56	*Clinical Staff:*			57	
57	*Non-Clinical Staff:*			7	
58	*Law Enforcement Staff:*			41	
59	*Dept. of Transportation*			0	
60	*Dept. of Health*			0	
61	*Fire Rescue/EMS Staff:*			38	
62	*National Guard Staff:*			0	
63	*Volunteer Staff:*			0	
64	*HHS:*			1	
65	*DEM*			2	
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AMERICAN OVERSIGHT

Daily Situation Report
CBTS in Miami-Dade County, Florida

Report Completed:	3/25/2020	POC Site Address:	347 Don Shula Ave, Miami Gardens	
		POC Site Telephone:	(904) 813-3476	
Day Total:	250/331	Date Opened;	3/22/2020	
		Site Hours:	*0900-1700*	
Developed by:	Micheal Beha	Title:	Plans Section	

Screening Criteria:

criteria is over 65, and symptomatic, health care or law enforcement

Client Information	Number	Notes
Number of Vehicles thru CBTS:	534	
Number of Lanes	4	
Number of State Tested:	503	
Total not meeting State criteria	68	
Number of Federal Tested	250	
Total not meeting Federal criteria	79	
Average Test Per Hour:	79	
Maximum Test Per Hour:		
Minimum Test Per Hour:		
Combined Number Test Conducted Onsite (Federal/State):	753	
Combined Number Not Meeting Criteria (Federal/State):	147	
Tests Conducted to Date (Cumulative Total):	2864	

Operation Critical Information *(Please keep brief bullet points)*

Modified operations today; moved from using two lanes for fereal and two lanes for state to all four lanes for fed testing until 250 accomplished then transition to state testing. We have a limited supply of biohazard bags.

Supply Information

Daily count of supplies on hand at POC opening

Item:	*Opening Count*	*Closing Count*
N-95 Masks:	3900	3870
General Surgical Masks	6499	4335
Disposable Full-face Shields:	287	232
Goggles:		0
Nonsterile Gloves:	2230	21500
Medical Gowns:	3826	3666
Coverall/Suits:	329	205
COVID-19 Test Kits:	1062	812

Daily burn rate at POC closing (*order for five (5) days out*)

N-95 Masks:	*5%*

AMERICAN OVERSIGHT

	A	B	C	D	E
46	*General Surgical Masks*	30%			
47	*Disposable Full-face Shields:*	20%			
48	*Goggles:*				
49	*Nonsterile Gloves:*	10%			
50	*Medical Gowns:*	2%			
51	*Coverall/Suits:*	30%			
52	*COVID-19 Test Kits:*	13%			
53	Site Staff				
54	Daily accountable of all site support personnel (*Attach ICS-214 Form*)				
55	*Command and General Staff:*	5			
56	*Clinical Staff:*	24			
57	*Non-Clinical Staff:*				
58	*Law Enforcement Staff:*	31			
59	*Dept. of Transportation*	2			
60	*Dept. of Health*	0			
61	*Fire Rescue/EMS Staff:*	2			
62	*National Guard Staff:*	167			
63	*Volunteer Staff:*				
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AMERICAN OVERSIGHT

Daily Situation Report
CBTS in Orange County, Florida

Report Completed:	Mark Reali	POC Site Address:	5980 Destination PKWY	
		POC Site Telephone:	256-337-0872	
Day Total:		Date Opened;	3.25.20	
		Site Hours:	*0900-1700*	
Developed by:	Mark Reali	Title:	Planner	

Screening Criteria:

65+ and first responder

Client Information	Number	Notes
Number of Vehicles thru CBTS:	202	
Number of Lanes	3	
Number of State Tested:	0	
Total not meeting State criteria	0	
Number of Federal Tested	247	
Total not meeting Federal criteria	0	
Average Test Per Hour:	0	
Maximum Test Per Hour:	14	
Minimum Test Per Hour:	1	
Combined Number Test Conducted Onsite (Federal/State):	247	
Combined Number Not Meeting Criteria (Federal/State):	7	
Tests Conducted to Date (Cumulative Total):	247	

Operation Critical Information *(Please keep brief bullet points)*

Don't have a daily average. We opened 3 -swabbing lanes and switched to 5 swabbing lanes.

Supply Information

Daily count of supplies on hand at POC opening

Item:	*Opening Count*	*Closing Count*
N-95 Masks:	3951	3877
General Surgical Masks	1450	1354
Disposable Full-face Shields:	384	334
Goggles:	0	0
Nonsterile Gloves:	30000	28978
Medical Gowns:	366	315
Coverall/Suits:	350	334
COVID-19 Test Kits:	2400	2150

Daily burn rate at POC closing (*order for five (5) days out*)

N-95 Masks:	*2%*

AMERICAN OVERSIGHT

	A	B	C	D	E
46	*General Surgical Masks*	7%			
47	*Disposable Full-face Shields:*	13%			
48	*Goggles:*	0%			
49	*Nonsterile Gloves:*	3%			
50	*Medical Gowns:*	14%			
51	*Coverall/Suits:*	5%			
52	*COVID-19 Test Kits:*	10%			
53	Site Staff				
54	Daily accountable of all site support personnel (*Attach ICS-214 Form*)				
55	*Command and General Staff:*	2			
56	*Clinical Staff:*	70			
57	*Non-Clinical Staff:*				
58	*Law Enforcement Staff:*	1			
59	*Dept. of Transportation*	0			
60	*Dept. of Health*	0			
61	*Fire Rescue/EMS Staff:*	2			
62	*National Guard Staff:*	194			
63	*Volunteer Staff:*	0			
64					
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74					

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons
Date:	Tuesday, February 25, 2020 7:29:24 PM
Attachments:	CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

Dear Colleagues:

Please find attached a document that **summarizes important information for state and local health departments regarding the medical detention of foreign nationals.**

This document comes from the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained, such as in the case when a quarantine order is issued because of possible exposure to COVID-19 disease.

We hope this information will offer guidance and a timely summary of notification requirements whenever a jurisdiction deems it necessary to isolate, quarantine, or otherwise medically detain a foreign national.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

AMERICAN OVERSIGHT

national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons
Date:	Tuesday, February 25, 2020 7:31:22 PM
Attachments:	CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf

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AMERICAN OVERSIGHT

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If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

If a foreign national is from one of the 56 mandatory notification countries, notification of the detention *must* be made. In such cases, notifications to the consular officer must be made without delay, even if the foreign national objects. See the *List of Countries Requiring Mandatory Notification* at travel.state.gov/CNA.

For all other countries, authorities must inform the foreign national that he or she may have a consular officer notified of the detention and may communicate with that officer. The foreign national can accept or decline the offer of notification. If the foreign national accepts the offer, notification should be made, in coordination with CDC, without delay to the appropriate consular officer.

What is the Timeline for Notification?

Whether the case requires mandatory notification or the foreign national has requested consular notification, the notification to the foreign government's nearest embassy or consulate should be made within 24-72 hours.

Who Notifies?

In the United States, responsibility for consular notification rests with those officials, whether federal, state, or local, who are responsible for the legal action affecting the foreign national. Compliance with the notification requirements works best when it is undertaken by those government officials closest to the foreign national's situation and with direct responsibility for it. If you are a state or local official with a foreign national detained for medical reasons (e.g., isolation or quarantine), the list of points of contact for consular notification at foreign embassies in Washington can be found here. Please contact the CDC at dgmqpolicyoffice@cdc.gov and notify the foreign mission (embassy or consulate) associated with the foreign national's citizenship.

Guidance and Questions

Instructions for carrying out consular notification and access and detailed information on best practices can be found in the *Consular Notification and Access Manual* on travel.state.gov/CNA. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons
Date:	Tuesday, February 25, 2020 7:26:22 PM
Attachments:	CN -- Notification and Access for Persons Detained for Medical Reasons (2020) recd eh feb 24.pdf
Importance:	High

Dear Colleagues:

Please find attached a document that **summarizes important information for state and local health departments regarding the medical detention of foreign nationals.**

This document comes from the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained, such as in the case when a quarantine order is issued because of possible exposure to COVID-19 disease.

We hope this information will offer guidance and a timely summary of notification requirements whenever a jurisdiction deems it necessary to isolate, quarantine, or otherwise medically detain a foreign national.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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Consular Notification Guidance for State and Local Authorities Regarding Foreign Nationals Detained for Medical Reasons

SUMMARY: Given the scale and international scope of the novel coronavirus outbreak, the U.S. Department of State is providing this guidance to state and local authorities that are monitoring and treating individuals who are or are reasonably believed to be infected with the virus SARS-CoV-2 or COVID-19 disease. Since some individuals being monitored and/or treated may be foreign nationals, the U.S. Department of State would like to ensure that those individuals detained for medical reasons are advised that they may communicate with consular officers from their countries and, when requested or required, foreign embassies and consulates in the United States are informed. We ask that where notification is requested or required, state and local authorities, in coordination with the Centers for Disease Control and Prevention (CDC), notify foreign missions promptly. Consular notification obligations are reciprocal; your prompt action will support the Department of State's receipt of timely notification of U.S. citizens who are detained for medical reasons in foreign countries. Questions about obligations of state and local authorities or consular notification and access in general, should be directed to the Bureau of Consular Affairs, U.S. Department of State at consnot@state.gov.

Consular Notification and Access Obligations with Respect to Detained Foreign Nationals

Under the treaty obligations of the United States, federal, state, and local government officials are obligated to provide notification information to certain foreign consular officers and permit those officers to assist their nationals in the United States. When foreign nationals from most countries are detained, they must be advised without delay that they may, upon request, have their consular officers notified, and that they may communicate with the consular officers. If the foreign national requests notification, the nearest consulate or embassy must be notified without delay. For foreign nationals of some countries, consular officers must be notified of the detention, even if the foreign national does not request or want notification.

Who is a Foreign National?

For the purposes of consular notification, a foreign national is any person who is not a U.S. citizen. This includes lawful permanent resident aliens (LPRs), who have a resident alien registration card (Department of Homeland Security Form I-551), more commonly known as a "green card." They retain their foreign nationality and must be considered "foreign nationals" for the purposes of consular notification. Consular notification and access requirements apply regardless of immigration status. There is no reason, for purposes of consular notification, to inquire into a person's legal status in the United States. For purposes of consular notification, you should make no distinctions based on whether the foreign national is in the United States "legally" or "illegally."

If a U.S. citizen detained for medical reasons has more than one nationality and asks that his or her other country of nationality be notified, the U.S. Department of State encourages notification be made.

What is "detention for medical reasons" and why does it trigger consular notification?

Consular notification and access may be triggered for foreign nationals hospitalized, isolated, quarantined, or otherwise in circumstances in which the foreign national is detained *pursuant to governmental authority (law enforcement, judicial, or administrative)* and is not free to leave. Under the Vienna Convention on Consular Relations and most bilateral international agreements, a foreign

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national in such situations must usually be treated like a foreign national in detention, and appropriate consular notification must be provided. Further, in the case of the death of a foreign national in the United States, the nearest consulate of that national's country must be notified without delay.

As a general matter, even where an individual is not detained for medical reasons, the U.S. Department of State encourages medical facilities that are treating foreign nationals to inform those individuals that they may contact their embassy or consulate.

When is Notification Mandatory?

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Guidance and Questions

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	Corrected - CDC COVID-19 Daily Key Points for February 29th
Date:	Sunday, March 1, 2020 12:44:04 PM
Attachments:	CDC_COVID-19_Daily Key Points__2_29_2020_FINAL.pdf

FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
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CDC Daily Key Points

Coronavirus Disease 2019 ("COVID-19") Outbreak

February 29, 2020

All content updated since February 27 is shown in colored text.

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness named "COVID-19" caused by a novel (new) coronavirus.
- The outbreak began in China but is spreading worldwide, including the United States.
- COVID-19 is threatening to cause a pandemic.
- The U.S. public health response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States and reducing the potential spread and impact of this virus.
- This aggressive response has helped to limit the number of U.S. cases in the United States.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- This week, several instances of infection with the virus that causes COVID-19 occurred in people with no travel history and no known source of exposure.
- These possible instances of community spread occurred in California, Washington and Oregon.
- In Washington three patients were reported who had tested presumptive-positive for the virus that causes COVID-19 at the state.
    - These included a person who died, an infected hospitalized health care worker and a potential outbreak in a long-term care facility.
    - *See Possible Washington Cluster section*
- The U.S. expects to detect more introductions of COVID-19 through travel, as well as more person-to-person spread and community transmission of this virus.
- Aggressive containment efforts will continue, including ongoing use of isolation and quarantine measures to decrease introductions and spread of the virus.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
- In affected communities, local authorities will implement other measures too, including Nonpharmaceutical Interventions (NPIs).
- Local authorities will determine which NPIs to implement, taking into account current circumstances in their communities.
- Nonpharmaceutical Interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- The purpose of most NPIs is to help reduce spread of illness by maintaining or increasing distance between people.
- Social distancing measures are an important weapon to fight the spread of this virus and also can reduce the impact of this virus on communities as a whole.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.

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- But individual risk is dependent on exposure.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- For the general American public, who are unlikely to be exposed to this virus at this time, the immediate health risk from COVID-19 is considered low.
- People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
- Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
- Close contacts of persons with COVID-19 also are at elevated risk of exposure.
- Travelers returning from affected locations internationally where community spread is occurring also are at elevated risk of exposure.
- CDC has developed guidance to help in the risk assessment and management of people with potential exposures to COVID-19.
- While still taking every effort to prevent a pandemic, CDC is operationalizing all of its pandemic preparedness and response plans.
- Guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for COVID-19.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.

SITUATION UPDATE

- This is a rapidly evolving situation. CDC is constantly reviewing and updating its guidance as needed.

International

- To date, 60 international locations (including the U.S.) have reported confirmed cases of COVID-19, most recently Azerbaijan, Iceland, and Monaco.
- CDC is reviewing and updating its travel guidance daily.
- To date, CDC has issued:
    - Level 3 Travel Health Notices (Avoid Nonessential Travel) for China, Iran, Italy, and South Korea.
    - Level 2 Travel Health Notices (Practice Enhanced Precautions) for Japan.
    - Level 1 Travel Health Notices (Practice Usual Precautions) for Hong Kong.
- CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time.
    - This is consistent with guidance by the U.S. State Department.

Domestic

- CDC is reporting confirmed cases of COVID-19 in the United States in two categories:
    1. Cases detected through our domestic public health systems, and
    2. Cases among people who were repatriated via U.S. State Department flights from Wuhan, China and from the *Diamond Princess* cruise ship (Japan).
- 22 cases of COVID-19 have been detected through U.S. public health surveillance.
    - Six of these cases occurred through person-to-person spread.

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- On February 26, CDC confirmed what is potentially the first instance of community spread with the virus that causes COVID in Sacramento, CA.
- Late on February 28, CDC announced three more possible instances of community-acquired COVID-19—one each in California, Oregon, and the state of Washington.
- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19. All of these are potential cases of community spread.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
    - *See Possible Washington Cluster section*
- Community spread means spread of an illness for which the source of infection is unknown.
- It's also possible, however, that these patients may have been exposed to a returned traveler who was infected.
- CDC is supporting investigations locations with possible community spread.
- People who were exposed to these patients during their infection are at some level of risk depending on their exposure.
- Based on what is known about how this virus behaves, additional cases among people who have had contact with these patients, especially those who have had close, prolonged contact, are expected.
- This could include family members and potentially healthcare workers who cared for the patients.
- All the remaining cases detected through the U.S. public health system were in persons who had travel to areas with ongoing community transmission.

- 47 cases of COVID-19 have been detected among the 1,100+ people repatriated from Hubei Province, China and the *Diamond Princess*.
    - 3 people were repatriated from Wuhan.
    - 44 people were repatriated from the Diamond Princess, an increase of 2 since yesterday.
- Almost all of the people from the Wuhan flights who were quarantined have finished their 14-day quarantine period.
- On Monday, most of the passengers from the Diamond Princess will complete their 14-day quarantine period.
- Patients who tested positive during their quarantine will remain in isolation. A small number of close contacts of those patients (for instance, spouses who have been living with them) who are at increased risk will have their quarantines extended.

WHAT'S NEW:

- On February 28 CDC issued a health alert network update titled: "Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)."
- CDC has been watching the increased spread of this virus across the world and worked with partners on an updated PUI definition.

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- The updated PUI definition takes into account the new geographic spread of the virus and includes a list of affected areas with widespread or sustained community spread. This list is dynamic and will change as our travel guidance is revised.
- CDC has posted "Community Mitigation Guidance for COVID-19 Response in the United States: Nonpharmaceutical Interventions for Community Preparedness and Outbreak Response."

WHAT TO DO

- While the immediate risk of this new virus for most of the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and;
        - People who have been in close contact with someone with COVID-19 or pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure.
    - If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
    - For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
    - If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity for up to 14 days. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

POSSIBLE WASHINGTON CLUSTER

- On February 29, CDC and public health officials in the state of Washington reported three hospitalized patients who have tested presumptive-positive for the virus that causes COVID-19.
    - One of the patients has died. This is the first reported death in the United States from COVID-19.
- Two of the patients are from a long-term care facility where one is a health care worker. This is the first reported case in a healthcare worker.

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- Additional residents and staff of the long-term care facility who have not yet been tested for COVID-19 are reportedly either ill with respiratory symptoms or hospitalized with pneumonia of unknown cause.
- The patient who died was being treated in the same hospital as one of the other presumptive positive cases, but was not a resident of the long-term care facility.
- While there is an ongoing investigation, the source of these infections is currently unknown.
    - Circumstances suggest person-to-person spread including in the long-term care facility.
- CDC is deploying a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

TESTING

- An important part of CDC's role in testing during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with the capacity to test for this virus.
- Distribution of a CDC rRT-PCR test to diagnose COVID-19 began to state and local public health labs, but shortly thereafter performance issues were identified related to a problem in the manufacturing of one of the reagents, which led to laboratories not being able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19.
        - CDC established that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC is working with FDA to amend the existing Emergency Use Authorization (EUA) for the test, but in the meantime, FDA granted discretionary authority for the use of the original test kits.
        - Public health laboratories can use the original CDC test kit to test for the virus that causes COVID-19 using the new protocol.
    - Further, newly manufactured kits have been provided to the International Reagent Resource for distribution.
- Combined with other reagents that CDC has procured, this is enough testing kits to test more than 75,000 people.
- In addition, CDC has two laboratories conducting testing for the virus that causes COVID-19. CDC can test approximately 350 specimens per day.
- Commercial labs are working to develop their own tests and hopefully will be available soon. This will allow a greater number of tests to happen close to where potential cases are.
- Learn more information about CDC's laboratory work.

NONPHARMACEUTICAL INTERVENTIONS

- Nonpharmaceutical Interventions (NPIs) are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic flu or COVID-19.
- NPIs are also known as community interventions.

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- When a new virus spreads among people, causing illness worldwide, it is called a pandemic.
- Because the virus is new, the human population has little or no immunity against it. This allows the virus to spread quickly from person to person worldwide.
- NPIs are among the best ways of controlling a pandemic caused by a respiratory virus when vaccines are not yet available.
- NPIs are grouped in three categories:
    1. Personal NPIs (personal protective measures for everyday use and personal protective measures reserved for influenza pandemics);
    2. Community NPIs (social distancing measures and school closures and dismissals); and
    3. Environmental NPIs (surface cleaning measures)
- View information about NPIs and factors to consider before implementing nonpharmaceutical interventions.

BACKGROUND

- This new coronavirus has been named "SARS-CoV-2;" the disease it causes has been named COVID-19.
- Due to potential for confusion with SARS-CoV, where possible, public communications will use "the virus that causes COVID-19."

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Byrd, Shirley K. (CDC/OCOO/OFR/OGS); Roush, Sandra (CDC/DDID/NCIRD/OD); Brammer, Lynnette (CDC/DDID/NCIRD/ID); Gross, Melanie S. (CDC/DDID/NCIRD/ID); Lamont, Brock (CDC/DDID/NCIRD/ISD); CDC IMS State Coordination Task Force (SCTF) ELC LNO
Subject:	COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST
Date:	Sunday, February 16, 2020 9:55:36 PM

The CDC will be hosting an all-state COVID-19 call on Tuesday, February 18 from 2:00pm-2:45pm EST. The ELC is not coordinating this call; however, we wanted to share this information in the event you had not received it through other channels.

CDC's Coronavirus Disease-2019 (COVID-19) response team will host a national call from 2 p.m. to 2:45 p.m. EST on Tuesday, February 18, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)790-1880
Participant Passcode: 8138992

Please note, this update call is being held on a Tuesday, in lieu of President's Day observance. Future calls will be held on Mondays.

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 10:38:18 AM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

Dear Colleagues:

Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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COVID-19 Emergency Declaration
Health Care Providers Fact Sheet

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers combat and contain the spread of 2019 Novel Coronavirus Disease (COVID-19). In response to COVID-19, CMS is empowered to take proactive steps through 1135 waivers and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are available:

- **Skilled Nursing Facilities**
  CMS is waiving the requirement at Section 1812(f) of the Social Security Act for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of (SNF services without a qualifying hospital stay, for those people who need to be transferred as a result of the effect of a disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period.

  Second, CMS is waiving 42 CFR 483.20 to provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

- **Critical Access Hospitals**
  CMS is waiving the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

- **Housing Acute Care Patients In Excluded Distinct Part Units**
  CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

- **Durable Medical Equipment**
  Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.

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- **Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**
  CMS is waiving to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

- **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**
  CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

  CMS is waiving requirements to allow IRFs to exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

- **Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCH)s**
  Allows a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

- **Home Health Agencies**
  Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. Allows Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

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- **Provider Locations**
  Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.

- **Provider Enrollment**
  - Establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges
  - Waive the following screening requirements:
    - Application Fee - 42 C.F.R 424.514
    - Criminal background checks associated with FCBC - 42 C.F.R 424.518
    - Site visits - 42 C.F.R 424.517
  - Postpone all revalidation actions
  - Allow licensed providers to render services outside of their state of enrollment
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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 10:39:44 AM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

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Please see attached, the COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet.

The fact sheet discusses waivers and regulations in CMS purview.

Kind Regards,

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 2:28:23 PM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

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Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
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Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 2:30:00 PM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Centers for Medicaid and Medicare Services (CMS) Emergency Declaration Health Care Providers Fact Sheet
Date:	Tuesday, March 17, 2020 10:36:48 AM
Attachments:	covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

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  Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.

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- **Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**
  CMS is waiving to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

- **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**
  CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

  CMS is waiving requirements to allow IRFs to exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

- **Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCH)s**
  Allows a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

- **Home Health Agencies**
  Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. Allows Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

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- **Provider Locations**
  Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.

- **Provider Enrollment**
  - Establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges
  - Waive the following screening requirements:
    - Application Fee - 42 C.F.R 424.514
    - Criminal background checks associated with FCBC - 42 C.F.R 424.518
    - Site visits - 42 C.F.R 424.517
  - Postpone all revalidation actions
  - Allow licensed providers to render services outside of their state of enrollment
  - Expedite any pending or new applications from providers

- **Medicare appeals in Fee for Service, MA and Part D**
  - Extension to file an appeal
  - Waive timeliness for requests for additional information to adjudicate the appeal;
  - Processing the appeal even with incomplete Appointment of Representation forms but communicating only to the beneficiary;
  - Process requests for appeal that don't meet the required elements using information that is available.
  - Utilizing all flexibilities available in the appeal process as if good cause requirements are satisfied.

Medicaid and CHIP

When the President declares an emergency through the Stafford Act or National Emergency Act, and the Secretary declares a Public Health Emergency, the Secretary is authorized to waive certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) authorities under Section 1135 of the Social Security Act.

There is no specific form or format that is required to submit the request for a Section 1135 waiver, but the state should clearly state the scope of the issue and the impact. States and territories may submit a Section 1135 waiver request directly to Jackie Glaze, CMS Acting Director, Medicaid & CHIP Operations Group Center for Medicaid & CHIP Services by e-mail (Jackie.Glaze@cms.hhs.gov) or letter.

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The following are examples of flexibilities that states and territories may seek through a Section 1135 waiver request:

- Waive prior authorization requirements in fee-for-service programs
- Permits providers located out of state/territory to provide care to another state's Medicaid enrollees impacted by the emergency
- Temporarily suspend certain provider enrollment and revalidation requirements to increase access to care.
- Temporarily waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have an equivalent licensing in another state, and
- Temporarily suspend requirements for certain pre-admission and annual screenings for nursing home residents
- States and territories are encouraged to assess their needs and request these available flexibilities, which are more completely outlined in the Medicaid and CHIP Disaster Response Toolkit. For more information and to access the toolkit, visit: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html.

For questions please email: 1135waiver@cms.hhs.gov

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Guidance for Election Polling Locations, Community Actions, and Student Travel for Higher Education
Date:	Tuesday, March 3, 2020 8:32:45 AM
Attachments:	Guidance for Election Polling Locations_draft_3.2.20_Final.pdf

Dear Colleagues:

Attached is CDC COVID-19 Guidance for Election Polling Locations.

Please see the links below for updated community guidance and guidance for student travel for higher education.

Community guidance: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html
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Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

Recommended Precautions for Preventing Spread of COVID-19 in Election Polling Locations, including Cleaning and Disinfection

Background

There is much to learn about the novel coronavirus (SARS-CoV-2) that causes coronavirus disease 2019 (COVID-19). Based on what is currently known about SARS-CoV-2 and similar coronaviruses, spread from person-to-person with these viruses happens most frequently among close contacts (within about 6 feet). This type of transmission occurs via respiratory droplets. On the other hand, transmission of SARS-CoV-2 to persons from surfaces contaminated with the virus has not been documented. Transmission of coronavirus occurs much more commonly through respiratory droplets than through contact with contaminated surfaces. Current evidence suggests that SARS-CoV-2 may remain viable for hours to days on surfaces made from a variety of materials. Cleaning of visibly dirty surfaces followed by disinfection is a best practice measure for prevention of COVID-19 and other viral respiratory illnesses in election polling locations.

Purpose

This guidance provides recommendations on the routine cleaning and disinfection of polling location areas and associated electronic equipment (e.g., voting machines and computers). It suggests actions that polling station workers can take to reduce the risk of exposure to COVID-19 by limiting the survival of the virus in the environment. This guidance will be updated if additional information becomes available.

Definitions:

- *Community settings* (e.g. polling locations, households, schools, daycares, businesses) encompass most non-healthcare settings and are visited by the general public.

- *Cleaning* refers to the removal of dirt and impurities including germs from surfaces. Cleaning alone does not kill germs. But by removing them, it decreases the number of germs and therefore any risk of spreading infection.

- *Disinfecting* kills germs on surfaces. Disinfecting works by using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs. But killing germs remaining on a surface after cleaning further reduce any risk of spreading infection.

Preventive action polling workers can take

- **Stay at home if you have fever, respiratory symptoms, or believe you are sick**.
- **Practice routine cleaning of frequently touched surfaces:** including tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, etc.
- **Disinfect surfaces that may be contaminated with germs after cleaning:** a list of products with EPA-approved emerging viral pathogens claims, maintained by the

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- **Practice hand hygiene frequently**: wash hands often with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.
- **Clean and disinfect voting associated electronics (e.g., voting machines, laptops, tablets, keyboards) routinely using products with the EPA-approved emerging viral pathogens claims (examples can be found here: this link).** Follow the manufacturer's instructions for all cleaning and disinfection products.
    - Consult with the voting machine manufacturer about guidance on products appropriate for disinfecting voting machines and touch screens, and consider additional use of wipeable covers for machines if possible.
    - If no guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to clean voting machine buttons and touch screens. Use of alcohol-based products may reduce risk of damage to sensitive voting machine components.

Preventive action polling stations workers can take for themselves and the general public
Based on available data, the most important measures to prevent transmission of viruses in crowded public areas include careful and consistent cleaning of one's hands. Therefore:

- **Ensure bathrooms at the polling station are supplied adequately with soap, water, and drying materials so visitors and staff can wash their hands**.
- P**rovide an alcohol-based hand sanitizer with at least 60% alcohol** for use before or after using the voting machine or the final step in the voting process. Consider placing the alcohol-based hand sanitizer in visible, frequently used locations such as registration desks and exits.

References

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https://www.cdc.gov/handwashing/when-how-handwashing.html

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Guidance for Election Polling Locations, Community Actions, and Student Travel for Higher Education
Date:	Tuesday, March 3, 2020 8:36:03 AM
Attachments:	Guidance for Election Polling Locations_draft_3.2.20_Final.pdf

Dear Colleagues:

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Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

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Background

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Purpose

This guidance provides recommendations on the routine cleaning and disinfection of polling location areas and associated electronic equipment (e.g., voting machines and computers). It suggests actions that polling station workers can take to reduce the risk of exposure to COVID-19 by limiting the survival of the virus in the environment. This guidance will be updated if additional information becomes available.

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AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	COVID-19 Guidance for Election Polling Locations, Community Actions, and Student Travel for Higher Education
Date:	Tuesday, March 3, 2020 8:29:44 AM
Attachments:	Guidance for Election Polling Locations_draft_3.2.20_Final.pdf

Dear Colleagues:

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AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: COVID-19 Guidance/Response Updates - March 23, 2020
Date: Monday, March 23, 2020 9:14:20 PM
Attachments: COVID-19 Priority Testing Patients Graphic 03.23.2020.pdf

Dear Colleagues:

The Administration continues to place its full weight and resources behind the response to COVID-19. FEMA now leads federal operations on behalf of the White House Coronavirus Task Force which oversees the whole-of-government response to the pandemic. As part of the White House Coronavirus Task Force, HHS will continue to provide their subject matter expertise as the nation's pre-eminent public health responders.

Because there are so many updates coming out daily from across the divisions at HHS --FDA, CDC, CMS, ASPR, and others – I want to help you and your teams track what's issued. While my emails will not be a comprehensive list, it will certainly include important items for you to review relative to your industry.

Today's information and guidance includes:

Clear Recommendations: Who Should Get Tested?
Today, HHS provided recommendations for prioritizing COVID-19 testing for individuals. Given that we are still ramping of testing availability in the private sector, this uniform guidance is particularly important for states and private labs.

There are three categories for States and clinical laboratories to utilize as they develop strategies to prioritize COVID-19 testing in their communities:

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Priority 3 Testing for COVID-19

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

Non-Priority

- Individuals without symptoms

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Attached is a graphic with some additional details about the three categories and why we must prioritize these populations.

No Hoarding, Price Gouging, or Peddling of Fraudulent Products President Trump signed an Executive Order to prevent the hoarding and price gouging of critical supplies needed to combat the coronavirus. This action will help ensure that hospitals, first-responders, and doctors receive sufficient supplies of critical medical equipment and the Department of Justice will prosecute entities that violate this order.

What Types of Ventilators Can be Used to Expand Supply? The FDA issued guidance to expand the availability of ventilators as well as other respiratory devices and their accessories during this pandemic. Wherever possible, health care facilities should use FDA-cleared conventional/standard full featured ventilators when necessary to support patients with respiratory failure. However, to expand availability, FDA will not object to limited modifications to the *indications, claims, functionality, or to the hardware, software, or materials of FDA-cleared devices used* to support patients with respiratory failure or respiratory insufficiency. This policy applies only during the public health emergency.

How to Avoid Rumors and Fraudulent Products?: FEMA has released a website, FEMA Rumor Control, that lists common rumors and accurate information, while FDA also issued a notice warning consumers that there is not presently an approved home test kit.

How Can States Apply for COVID-19 Medicaid Waivers? The agency has made it easier for states to receive federal waivers and implement flexibilities in their Medicaid program by creating four checklists that together will make up a comprehensive Medicaid COVID-19 federal authority checklist. The tools include information on how to apply for an 1115 Waiver Opportunity and Application Checklist, 1135 Waiver Checklist, 1915(c) Appendix K Template, Medicaid Disaster State Plan Template.

How to Report COVID-19 Cases? CDC released information for state health departments on how to report COVID-19 cases to better track the impact of the outbreak and public health response.

Flexibility for Deadlines and Exceptions for Medicare Quality Reporting Requirements CMS announced it is providing relief for clinicians, providers, hospitals and facilities by granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The new deadlines and exceptions for reporting can be found here.

How has Nursing Home Inspection Guidance Changed? CMS released the findings from their inspection of Kirkland Nursing Home in Washington. As a result, nursing home guidance has changed and CMS has a new inspection process that will focus only on complaint inspections, targeted infection control inspections, and self-assessments.

What is the Latest Information for Individuals, Especially Those At-Risk and Older Individuals?

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CDC released a self-checker that helps users make decisions about seeking appropriate medical care. This system is not intended for diagnosis or treatment of COVID-19 or other diseases but can advise on next steps. CDC has updated their webpage that identifies the high risk populations including adults older than 65, residents of nursing homes or long-term care facilities, individuals with high risk conditions (asthma, heart disease or immunocompromised individuals), and monitoring for people who are pregnant. CDC has also released additional information for older adults as well. Additional guidance was released for local and state health departments, homelessness service systems, housing authorities, healthcare facilities and others on responding to COVID-19 among people experiencing unsheltered homelessness.

What is the Latest Information for Seniors' Facilities? CDC updated their guidance and information for retirement communities and independent living facilities to plan, prepare for, and respond to COVID-19 as well as how to prevent the spread of COVID-19 in facilities. This webpage provides information on how to disinfect your facility if someone is sick. This webpage provides guidance to personnel at blood and plasma collection facilities, a key support entity in the healthcare delivery system.

A Call for Hospitals to Delay Non-Essential Procedures: The Surgeon General published an op-ed in USA Today to encourage hospitals to cancel or delay non-essential planned medical and dental procedures to conserve resources for COVID-19 response.

What Is the Latest Information for Healthcare Professionals? CDC updated their frequently asked questions for healthcare professionals to include more information for pregnant healthcare workers. New information was released for clinicians on therapeutic options for COVID-19 patients that provides information on the current drugs being studied to treat the virus.

What is the Latest Information for Laboratories: CDC has updated their information for laboratories webpage with additional guidance, resources and FAQs.

Laura

Laura C. Trueman
Director, Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington D.C. 20201
Laura.Trueman@hhs.gov
202-690-6060 (main office)

AMERICAN OVERSIGHT

Coronavirus
COVID-19

PRIORITIES FOR TESTING PATIENTS WITH SUSPECTED COVID-19 INFECTION

COVID-19 Symptoms: Fever, Cough, and Shortness of Breath

PRIORITY 1

Ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system

- Hospitalized patients
- Healthcare facility workers with symptoms

PRIORITY 2

Ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

PRIORITY 3

As resources allow, test individuals in the surrounding community of rapidly increasing hospital cases to decrease community spread, and ensure health of essential workers

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

NON-PRIORITY

- Individuals without symptoms

AMERICAN OVERSIGHT

For more information visit: coronavirus.gov

FL-DOH-20-0673-A-003208

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Achim, John (CDC/DDID/NCEZID/DPEI); Bellis, Kimberly (CDC/DDID/NCEZID/DPEI); Borrelli, Aaron (CDC/DDID/NCEZID/DPEI); Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Chung, Christina L. (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Hall, Christopher (Jason) (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Light, Megan (CDC/DDID/NCEZID/DPEI); Montgomery, Meagan (CDC/DDID/NCEZID/DPEI) (CTR); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pappas, Danielle (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI)
Subject:	COVID-19 Jurisdictional call series (sending on behalf of State Coordination Task Force)
Date:	Monday, March 9, 2020 12:53:15 PM

Below is the dial in information for an 'all state' call today hosted by the COVID-19 CDC State Coordination Task Force. It is my understanding that this call information has been shared with SHOs and State Epis. In an effort to make sure that you receive the most current information, I encourage you to work with these POCs in your jurisdiction to receive information and updates about this series of calls (and any others) important to your current activities.

CDC's 2019 Novel Coronavirus (COVID-19) response team will continue to host a national call series from 2 p.m. to 2:45 p.m. EST every Monday, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)921-9091
Participant Passcode: 1324420

For your convenience, call series dates are provided below.

- Monday, March 9
- Monday, March 16
- Monday, March 23
- Monday, March 30

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	Perry, Kaylynn
To:	Miller, Carly; chris@waltoncountyem.org; Courtney.Coppola@flhealth.gov; EduardoBustillo@semtribe.com; EOC-Plans; Bussey, Jon; Guthrie, Kevin; Waterman, Laura; Cintron, Morgan; espe0001@shands.ufl.edu; edward.f.toombs2.mil@mail.mil; Chance, Betsy (Dept. of State); County Emergency Management Directors
Subject:	COVID-19 Situation Report #21
Date:	Monday, March 23, 2020 2:02:10 PM
Attachments:	COVID-19 Sit Rep 21.pdf

Good afternoon,

Attached is the latest COVID-19 Situation Report.

Kaylynn Perry
All-Hazard Preparedness Unit / SERT ESF 5
Florida Division of Emergency Mangement
Kaylynn.perry@em.myflorida.com
Office: (850) 815-4337
Mobile: (850) 254-5657

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

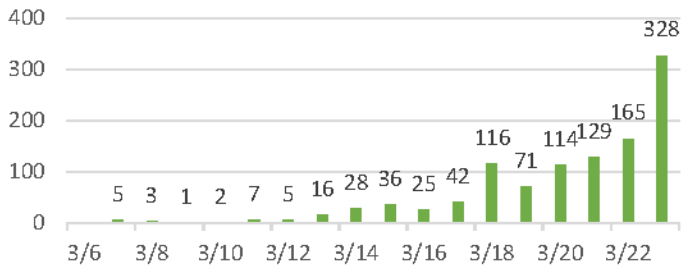
Florida SEOC Situation Report COVID-19

Published: 3-23-2020 @ 14:00 EDT | **Changes in Red** | **Situation Report #21**

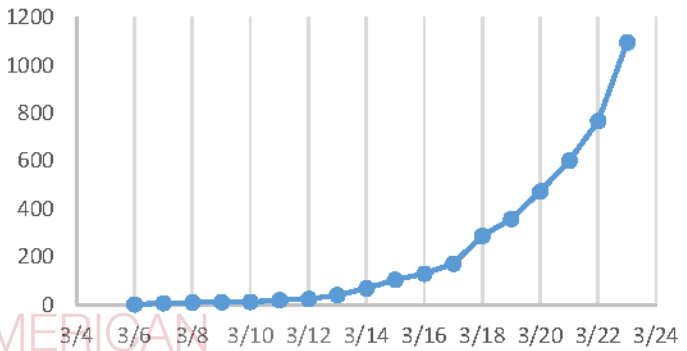
Cases in Florida

	Current	Change
Total Cases in Florida	1,171	+341
Florida Resident Cases	1,096	+328
Florida Fatalities	14	+1
Negative Tests	11,063	+4,484
# of Counties with Cases	47	+4

New Cases per Day

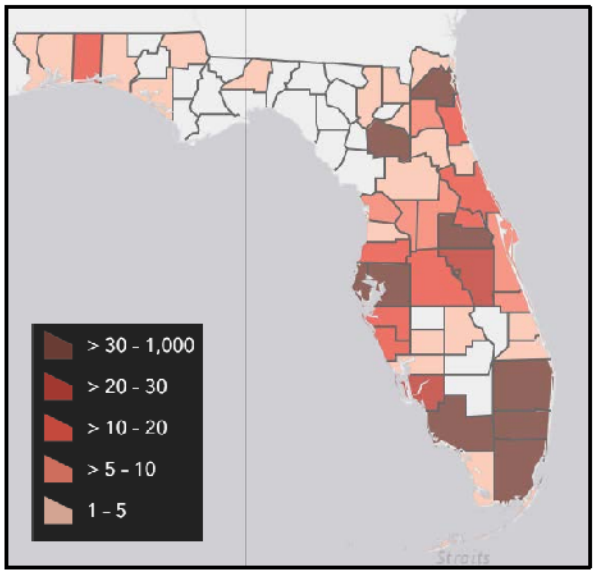


Resident Cases



County Summary

- Local State of Emergencies have been declared in 64 counties.
- Level 1 EOC in 1 county.
  - Alachua County
- Level 2 EOC in 47 counties.
- The SEOC is tracking 3,927 active resource requests from counties.
- All School districts are extending spring break.



State Actions

- State EOC has been activated to a Level 1 with Emergency Services and Human Services emergency support functions at full staffing.
- All Executive Orders are being uploaded to Information Message 433.
- All FDEM Emergency Orders uploaded to Information Message 454.
- Governor recommends that communities and organizers cancel large events. CDC recommends that all events with 10 or more people be cancelled or postponed.
- Governor of Florida has signed EO-68 with guidance on restaurants and bars. (Info Message 264).
- The SEOC is receiving and distributing resource mission orders.
- The Drive Through Plan can be found in Info Message 252.

Send any curfew notifications to eoc-plans@em.myflorida.com

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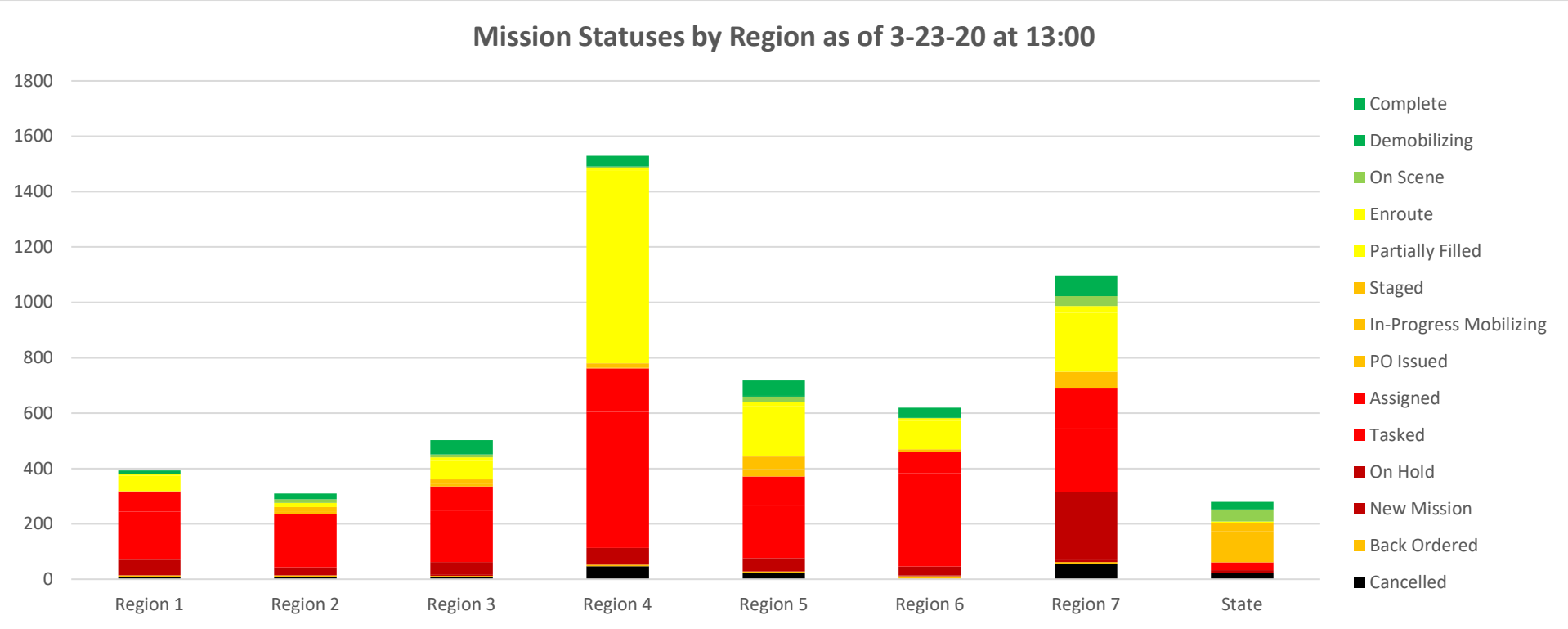

County	Cases	Fatalities	County	Cases	Fatalities	County	Cases	Fatalities	County	Cases	Fatalities
Alachua	37		**Franklin**	0		**Lee**	28	2	**Pinellas**	40	
Baker	3		**Gadsden**	1		**Leon**	5		**Polk**	13	
Bay	1		**Gilchrist**	0		**Levy**	0		**Putnam**	2	
Bradford	1		**Glades**	0		**Liberty**	0		**St. Johns**	18	
Brevard	7		**Gulf**	0		**Madison**	0		**St. Lucie**	3	
Broward	258	3	**Hamilton**	0		**Manatee**	15	1	**Santa Rosa**	3	1
Calhoun	0		**Hardee**	0		**Marion**	4		**Sarasota**	19	
Charlotte	3		**Hendry**	0		**Martin**	2		**Seminole**	20	
Citrus	9		**Hernando**	5		**Miami-Dade**	267		**Sumter**	8	
Clay	8	1	**Highlands**	2		**Monroe**	2		**Suwannee**	0	
Collier	34		**Hillsborough**	73		**Nassau**	1		**Taylor**	0	
Columbia	2		**Holmes**	0		**Okaloosa**	14		**Union**	0	
DeSoto	1		**Indian River**	8		**Okeechobee**	0		**Volusia**	15	
Dixie	0		**Jackson**	1		**Orange**	45	2	**Wakulla**	0	
Duval	46	2	**Jefferson**	0		**Osceola**	24		**Walton**	5	
Escambia	5		**Lafayette**	0		**Palm Beach**	89	2	**Washington**	0	
Flagler	3		**Lake**	7		**Pasco**	13		**Out of State**	6	1

AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject:	COVID-19 Testing Prioritization
Date:	Monday, March 23, 2020 6:58:02 PM
Attachments:	COVID-19 Priority Testing Patients Graphic 03.23.2020.pdf
Importance:	High

Dear Governors and State Health Officials,

The U.S. Department of Health and Human Services is writing to provide recommendations for prioritizing COVID-19 testing for individuals. We have developed three categories that we strongly recommend States and clinical laboratories utilize as they develop strategies to prioritize COVID-19 testing in their communities:

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Priority 3 Testing for COVID-19

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

Non-Priority

- Individuals without symptoms

Attached is a document with some additional details about the three categories and why we must prioritize these populations. Please share with partners and others in your community.

Thank you for your attention and help spreading this important communication.

Darcie Johnston, Director
Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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Coronavirus
COVID-19

PRIORITIES FOR TESTING PATIENTS WITH SUSPECTED COVID-19 INFECTION

COVID-19 Symptoms: Fever, Cough, and Shortness of Breath

PRIORITY 1

Ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system

- Hospitalized patients
- Healthcare facility workers with symptoms

PRIORITY 2

Ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

PRIORITY 3

As resources allow, test individuals in the surrounding community of rapidly increasing hospital cases to decrease community spread, and ensure health of essential workers

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- Healthcare facility workers and first responders
- Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

NON-PRIORITY

- Individuals without symptoms

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For more information visit: coronavirus.gov

FL-DOH-20-0673-A-003215

From:	Mejia-Echeverry, Alvaro
To:	Aguilar, Alexandra; Alexandre, Antonine; Alghawi, Wissam; Amores, Norma A.; Anderson, Erica C; Arseda, Nurya; Arshad, Amena; Barrera, Anne; Becerra, Ana; Bula, Evelyn A; Calle, Stephanie; Camacho, Walter; Cartaya, Gabriella W; Castillo, Klelia S; Celorio, Oscar; Charlot-Aladin, Mary; Coello, Erika X; Concepcion, Chaveli; Corzo-Sanchez, Elisa M; Cuevas, Carlos; Curbelo, Oswaldo; Cyril, Lorrie; Davidson, Khaleeq J; Dobson, Jolie T; Ejiofor, Ngozichukwuka; Eldanaf, Amal H; Estrada, Juan Jose; Etienne, Marie Ketty (Epi); FernandezdeCastro, Ana; Goldberg, Cynthia; Gonzalez, Irima V; Grajales, Janet; Jit, Mohnisha; Johnson, Venus; Joseph, Keren; Laine, Claudia B; Llau, Anthoni; Lopez, Jose M; Lopez, Victor J; Lyonel, Elsie; Martinez, Anita; Martinez, Yuray; Mauck, Daniel E; Mejia-Echeverry, Alvaro; Melus, Vickie; Menoscal, Paola C; Morales, Fernando X; Muse, Nicole J; Nowotny, Kyle; Noya-Chaveco, Pedro A; Oliver, Christine M; Paramo, Christian; Paul, Paulette J; Paulynice, Berthamise; Ramos, Vivian L; Rodriguez, Daniel; Rojas, Mercedes C; Salvador, Cristina G; Sandoval, Lydia; Schroeder, Wayne A; Stallworth, Barbara; Suarez, Juan; Suazo, Ingrid E; Summers, Debbie; Tassy-Toussaint, Gastrude; Torrecilla, Ana; Urbina, Angelica; Uribarri, Enrique S; Vera, Raul A; Veras, Braulio; Villamil, Vanessa; Webb, Jenna; Zhang, Guoyan
Cc:	Beaton, Heather L; Rico, Edhelene; Goldberg, Cynthia; Schmitz, Ann; White, Stephen L; Davenport, Emily Patricia (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Jean, Reynald; Caballero, Reinaldo; Casimir, Yanick; Lowe, Camille N; Munoz, Virginia E; Olguin, Lourdes; Ortega, Marisabel; Toledo, Marilyn X; Villalta, Yesenia D
Subject:	COVID-19 Training/TTX
Date:	Friday, February 14, 2020 5:51:04 PM
Attachments:	image001.png

Good afternoon.

I would like to thank all EpiRT members for attending the COVID-19 Training/TTX today. This was a great opportunity to review current public health protocols and actions in response to this outbreak! I appreciate your interest in the matter and your willingness to respond to a potential call for action.

I also want to thank speakers for taking the time to prepare and deliver their talks about the different fields covered in the training. I really appreciate your sharing your expertise with the team!

Alvaro Mejia-Echeverry, MD, MPH
Florida Department of Health in Miami-Dade County
Advanced Practice Registered Nurse
Email: Alvaro.Mejia-Echeverry@flhealth.gov
Phone: (305) 470-5660 x 6932
Mailing Address: 8600 NW 17TH STREET Floor: 02 Room: 2 Bin : Epi
MIAMI, FL 33126

How is my customer service? Please let me know by taking our survey at www.FDOHMDCares.com

Our Mission is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has very broad public records law. Most written communication to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

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AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: COVID-19 Updates for Friday, March 13, 2020
Date: Friday, March 13, 2020 9:14:46 PM

Dear State and Local Partners:

Every day brings new information and developments on COVID-19, many of which impact your efforts to address the Coronavirus. We value our strong partnership with you all as we continue to work on the COVID-19 response. We aim to ensure that you have access to the resources and information that you need for your communities.

Here are key highlights:

National Emergency Declaration: Today, President Trump signed a National Emergency Declaration in response to COVID-19. The Emergency Declaration will allow HHS to provide emergency funding to state and local entities (up to $50 billion) and specifically will enable HHS to waive provisions of certain laws and regulations to provide increased flexibility to healthcare providers. Additional flexibilities will be able to be exercised around the use of telehealth, state licensing requirements for providers to practice in areas of greatest need, increasing the supply of providers, loosening restrictions on where hospitals can care for patients within a hospital, and flexibilities on the number of beds and lengths of stay for Critical Access Hospitals.

Increasing Capacity for Testing: The Administration designated Assistant Secretary for Health, ADM Brett Giroir, M.D., to take the lead in coordinating testing efforts to ensure seamless access for patients, doctors, and hospitals. HHS is working to help expedite the availability of tests by utilizing the private sector and allowing states to offer and develop their own tests. Yesterday, the FDA authorized a diagnostic test developed by Roche, to rapidly expand the capacity and timeliness of testing for COVID-19 diagnostics. The FDA also approved the New York State Department of Health to directly authorize labs to begin patient testing. More information about these actions can be found here. For technical information on diagnostic testing, FDA posted frequently asked questions related to the development and performance of diagnostic testing.

With help from public-health and private-sector lab capabilities, HHS has also enabled states and healthcare providers to implement sample collection for pre-screened patients, similar to what is being done at the Mayo Clinic and Minnesota Department of Health, by the Colorado Health Department and by the University of Washington. CMS has also published the Medicare reimbursement amounts to providers for COVID-19 testing, which can be found here.

Lab Test Questions – As public and private testing labs continue to gear up capabilities and review the new options being created through the FDA, they may have questions. To help answer those questions that are technical in nature, the FDA has stood up a 24/7 hotline for things related to COVID-19: 1-888-INFO-FDA or 1-888-463-6332.

Essential Health Benefit Coverage of COVID-19: The FAQs released today, March 13, detail existing federal rules governing health coverage provided through the individual and small group insurance markets that apply to the diagnosis and treatment of COVID-19. The FAQs clarify which COVID-related services, including testing, isolation/quarantine, and vaccination, are generally currently covered as EHBs in these markets. The purpose of the FAQs is to provide guidance to Americans enrolled in individual or small group market health plans, including HealthCare.gov consumers. As questions and issues continue to come to CMS, they will be addressed and added to these FAQs. The document can be found here.

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Community Response: All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy. CDC has released updated information on Preventing the Spread of COVID-19 in Communities as well as issuing considerations for school closures.

Surgical Masks and Gowns: The FDA sent a letter to healthcare providers on conservation strategies for personal protective equipment. The recommendations include strategies for conventional, contingency and crisis level of supplies.

Cruise Advisory: CDC and the State Department recommend travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide. At this point, all passengers from the Grand Princess cruise have disembarked from the ship.

If there are any questions, please don't hesitate to reach out.

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	COVID-19, Supplemental Case Investigation Form
Date:	Sunday, March 22, 2020 12:37:16 PM
Attachments:	COVID-19_Case_Investigation_Form.pdf

Dear Partners,

Thank you for your collaboration in case reporting.

We are reaching out to you as CDC has developed a supplemental case investigation form (see attached) for an in-depth investigation of a sample of COVID-19 cases. CDC is looking to gather information from approximately 5-10 cases in each jurisdiction, from different age groups and of different severities. Pooling data from supplemental forms nationally will provide critically needed information on the relationship between severity of illness and transmissibility. This information can help inform state and national response efforts.

We know that you are very busy with this unprecedented response. CDC may be able to provide staff to assist in collecting these data. Please let us know if you could help in this effort by contacting the State Coordination Team directly (eocevent118@cdc.gov).

Sincerely,

Tom

Tom Shimabukuro, MD, MPH, MBA
Captain, U.S. Public Health Service
Deputy
COVID-19 Epidemiology Task Force
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, Atlanta, GA 30329

Phone: 404-498-0679, Fax: 404-498-0666
Email: TShimabukuro@cdc.gov

AMERICAN OVERSIGHT

nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): _____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

COVID-19 Case Investigation Form

Reporting jurisdiction: _____ Case state/local ID: _____

Reporting health department: _____ CDC 2019-nCoV ID: _____

Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. bFor NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____

Telephone _____ Email _____

Date of interview: _____(MM/DD/YYYY) Date of medical chart abstraction: _____ (MM/DD/YYYY)

Data sources used for this form?

☐ Case-patient interview ☐ Other interview, specify relationship to case:_____ ☐ Medical Chart Abstraction

Case-patient's primary language: _____ Was this form administered via a translator? ☐ Yes ☐ No ☐ Unknown

Case-patient demographic information

1. Report date to CDC (MM/DD/YYYY): _____
2. Under what process was the case first identified? (check all that apply): ☐ PUI/sought care for acute illness ☐ Contact tracing of case patient ☐ Surveillance system, please specify:_____
   ☐ EpiX notification of travelers; if checked, DGMQID_____ ☐ Unknown ☐ Other, specify:_____
3. Date of birth (MM/DD/YYYY): _____
4. Age: _____ Age units: ☐ Years ☐ Months ☐ Days
5. Sex: ☐ Male ☐ Female
6. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Not specified
7. Race (check all that apply): ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Black
   ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ Other, specify: _____
8. County of Residence:_____ State/territory?_____
9. Country of Residence: ☐ United States ☐ Other, specify_____
10. Occupation:_____
    If student, what grade level? _____
    If child, does s/he attend day care? ☐ Yes ☐ No ☐ Unknown

Travel history

11. In the 14 days prior to illness onset, were you traveling away from your home internationally?
    ☐ Yes ☐ No ☐ Unknown
12. In the 14 days prior to illness onset, were you traveling away from your home within the United States?
    ☐ Yes ☐ No ☐ Unknown

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

AMERICAN OVERSIGHT

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

COVID-19 Case Investigation Form

13. Where did you travel 14 days prior to illness onset (list **ALL** locations, including overnight transits and layovers)?

	Departure Date (MM/DD/YYYY)	Departure city, state/province/country	Arrival Date (MM/DD/YYYY)	Arrival city, state/province/country
Trip 1				
Trip 2				
Trip 3				
Trip 4				
Trip 5				

Exposure history

14. In the **14 DAYS prior to illness**, did you have close contact with another lab-confirmed COVID-19 case-patient?

☐ Yes ☐ No ☐ Unknown Date Range: Start Date (MM/DD/YYYY) _____ End Date (MM/DD/YYYY) _____

15. Relationship to COVID-19 **source** case (select all that apply):
☐ Spouse/Partner ☐ Child ☐ Parent ☐ Other Family ☐ Friend ☐ HCW ☐ Co-worker
☐ Classmate ☐ Roommate ☐ Contact only – no relationship ☐ Other (specify):_____

16. Exposure setting to the COVID-19 **source** case (select all that apply):
☐ Household ☐ Work ☐ Daycare ☐ School/University ☐ Transit ☐ Rideshare ☐ Hotel ☐ Cruise Ship
☐ Healthcare ☐ Other (specify): _____

17. In the **14 DAYS prior to illness onset,** did you:

Exposure	**Answer**	**Date Range**
…have any household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (e.g. cough, sore throat etc.)?	☐ Yes ☐ No ☐ Unknown	
…have close contact (e.g. caring for, speaking with, or touching) with any ill persons?	☐ Yes ☐ No ☐ Unknown	
…attend a mass gathering (e.g., religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?	☐ Yes ☐ No ☐ Unknown	
…use public transportation (bus, train, airplane)?	☐ Yes ☐ No ☐ Unknown	
…attend or work at a school or daycare?	☐ Yes ☐ No ☐ Unknown	
…have a household member who attended school or daycare?	☐ Yes ☐ No ☐ Unknown	
…have close contact (e.g. caring for, speaking with, or touching) with a sick person who had contact with a COVID-19 patient (i.e., secondary contact to confirmed case)?	☐ Yes ☐ No ☐ Unknown	
…have close contact (e.g. caring for, speaking with, or touching) with a person who had a fever and/or acute respiratory illness and international travel in the past 2 weeks?	☐ Yes ☐ No ☐ Unknown If yes where did the person travel:_____	

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

AMERICAN OVERSIGHT

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

COVID-19 Case Investigation Form

18. In the **14 DAYS prior to illness onset,** did you:

Exposure	Yes / No /Unknown	Facility type (Select all that apply)		Date(s) exposure occurred
Work in healthcare setting:	☐ Yes ☐ No ☐ Unknown If yes, what was your role: ☐ Physician ☐ Nurse ☐ Administration staff ☐ Housekeeping ☐ Patient transport ☐ Other, specify_____	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	
Volunteer in healthcare setting	☐ Yes ☐ No ☐ Unknown	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	
Have direct patient contact	☐ Yes ☐ No ☐ Unknown	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	
Visit healthcare setting as a patient (not just for this illness)	☐ Yes ☐ No ☐ Unknown	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	
Visit healthcare setting for any reason other than as a patient	☐ Yes ☐ No ☐ Unknown	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	
Contact with a known COVID-19 case-patient in a healthcare setting	☐ Yes ☐ No ☐ Unknown If yes, as a ☐ Patient ☐ Visitor ☐ HCW	☐ Hospital ☐ Urgent Care ☐ Doctor's office/clinic	☐ Dialysis unit/center ☐ Long Term Care Facility ☐ Other (specify)	

19. Do you reside in an institutional or group setting (e.g. long-term care facility/nursing home, boarding school, college dormitory, etc.)?
☐ Yes ☐ No ☐ Unknown

20. How many people in total resided in your household (HH) from the 14 days prior to illness through the date of this interview (excluding you)? _____. *A household member is anyone with at least one overnight stay during the 14 days prior to patient's illness onset to the date of this interview. If patient belongs to multiple HH, group HH members by identifying the 1st HH as A, the 2nd HH as B, etc.*

HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the ***14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness***?	Date of illness onset of household member (MM/DD/YYYY)
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

AMERICAN OVERSIGHT

CDC 2019-nCoV ID: ☐

Form Approved: OMB: 0920-1011 Exp. 4/23/2020

COVID-19 Case Investigation Form

HH (if case-patient belongs to >1 HH)	Relation to patient	Sex M/F	Age (specify unit as years, months, or days)	Did household member have fever or respiratory symptoms (e.g. cough, sore throat, etc.) in the ***14 days prior to patient's illness onset, during the patient's illness, or 14 days after patient's illness***?	Date of illness onset of household member (MM/DD/YYYY)
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	
☐ A ☐ B ☐ C				☐ Yes ☐ No ☐ Unknown	

Symptoms

21. If symptomatic, onset date of first symptom (MM/DD/YYYY): _____ ☐ Unknown ☐ Asymptomatic
22. If experienced symptoms, are you ☐ Still symptomatic ☐ Unknown symptom status ☐ Symptoms resolved
    If symptoms resolved, date of symptom resolution (MM/DD/YYYY): _____ ☐ Unknown date

23. During this illness, did you experience any of the following symptoms?

Symptom		**Symptom**	
Fever ≥100.4F (38C)	☐Yes ☐No ☐ Unknown	Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐ Unknown
Highest temp_____ °F		Dry	☐Yes ☐No ☐ Unknown
Date of onset (MM/DD/YYYY) _____		Productive	☐Yes ☐No ☐ Unknown
Duration of fever ≥100.4F (38C) (days) _____		Bloody sputum (hemoptysis)	☐Yes ☐No ☐ Unknown
Subjective fever (felt feverish)	☐Yes ☐No ☐ Unknown	Shortness of breath (dyspnea)	☐Yes ☐No ☐ Unknown
Chills	☐Yes ☐No ☐ Unknown	Wheezing	☐Yes ☐No ☐ Unknown
Fatigue	☐Yes ☐No ☐ Unknown	Chest Pain	☐Yes ☐No ☐ Unknown
Muscle aches (myalgia)	☐Yes ☐No ☐ Unknown	Abdominal pain	☐Yes ☐No ☐ Unknown
Rash	☐Yes ☐No ☐ Unknown	Vomiting	☐Yes ☐No ☐ Unknown
Headache	☐Yes ☐No ☐ Unknown	Nausea	☐Yes ☐No ☐ Unknown
Eye redness (conjunctivitis)	☐Yes ☐No ☐ Unknown	Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐ Unknown
Runny nose (rhinorrhea)	☐Yes ☐No ☐ Unknown	Poor Feeding/Poor appetite	☐Yes ☐No ☐ Unknown
Sore throat	☐Yes ☐No ☐Unknown	Seizures	☐Yes ☐No ☐ Unknown
Other, specify:	☐Yes ☐No ☐Unknown	Other, specify:	☐Yes ☐No ☐ Unknown

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CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

COVID-19 Case Investigation Form

Past medical history

24. Do you have any pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease	☐Yes ☐No ☐Unknown	
Asthma/reactive airway disease	☐Yes ☐No ☐Unknown	
Emphysema/COPD	☐Yes ☐No ☐Unknown	
Other chronic lung disease	☐Yes ☐No ☐Unknown	(If YES, specify) _____
Active tuberculosis	☐Yes ☐No ☐Unknown	
Diabetes Mellitus	☐Yes ☐No ☐Unknown	
Cardiovascular disease	☐Yes ☐No ☐Unknown	
Hypertension	☐Yes ☐No ☐Unknown	
Coronary artery disease	☐Yes ☐No ☐Unknown	
Heart failure/Congestive heart failure	☐Yes ☐No ☐Unknown	
Cerebrovascular accident/Stroke	☐Yes ☐No ☐Unknown	
Congenital heart disease	☐Yes ☐No ☐Unknown	
Other	☐Yes ☐No ☐Unknown	If YES, specify: _____
Renal disease	☐Yes ☐No ☐Unknown	
Chronic kidney disease/insufficiency	☐Yes ☐No ☐Unknown	
End-stage renal disease	☐Yes ☐No ☐Unknown	
Dialysis	☐Yes ☐No ☐Unknown	
Other	☐Yes ☐No ☐Unknown	If YES, specify: _____
Liver disease	☐Yes ☐No ☐Unknown	
Alcoholic hepatitis	☐Yes ☐No ☐Unknown	
Chronic liver disease	☐Yes ☐No ☐Unknown	
Cirrhosis/End stage liver disease	☐Yes ☐No ☐Unknown	
Hepatitis B, chronic	☐Yes ☐No ☐Unknown	
Hepatitis C, chronic	☐Yes ☐No ☐Unknown	
Non-alcoholic fatty liver disease (NAFLD)/NASH	☐Yes ☐No ☐Unknown	
Other	☐Yes ☐No ☐Unknown	If YES, specify: _____
Immunocompromised Condition	☐Yes ☐No ☐Unknown	
HIV infection	☐Yes ☐No ☐Unknown	
AIDS or CD4 count <200	☐Yes ☐No ☐Unknown	
Solid organ transplant	☐Yes ☐No ☐Unknown	
Stem cell transplant (e.g., bone marrow transplant)	☐Yes ☐No ☐Unknown	
Cancer: current/in treatment or diagnosed in last 12 months	☐Yes ☐No ☐Unknown	
Other	☐Yes ☐No ☐Unknown	If YES, specify: _____
Immunosuppressive therapy	☐Yes ☐No ☐Unknown	If YES, specify: _____ _____ For what condition: _____ _____
Neurologic/neurodevelopmental disorder	☐Yes ☐No ☐Unknown	If YES, specify: _____

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COVID-19 Case Investigation Form

Other chronic diseases	☐ Yes ☐ No ☐ Unknown	If YES, specify: _____

25. Current height: _____ (inches) OR _____ (cm)
26. Current weight: _____ (pounds) OR _____ (kg)
27. If female, are you currently pregnant? ☐ Yes Weeks pregnant at illness onset_____ ☐ No ☐ Unknown
28. If female, are you postpartum (≤6 weeks postpartum)? ☐ Yes ☐ No ☐ Unknown
29. If female, are you breastfeeding? ☐ Yes ☐ No ☐ Unknown
30. If child, is he/she being breastfed? ☐ Yes ☐ No ☐ Unknown

Social history

31. Do you currently smoke cigarettes? ☐ Yes ☐ No ☐ Unknown
    If yes, how many packs of cigarettes per day? _____ For how many years? _____
32. Have you ever smoked cigarettes? ☐ Yes ☐ No ☐ Unknown
    If yes, how many packs of cigarettes per day? _____ For how many years? _____ How long since you last smoked a cigarette? ___(m) ___(y)
33. Do you currently use e-cigarettes/vape-pen? ☐ Yes ☐ No ☐ Unknown
34. In the past year, how often did you have a drink containing alcohol?
    ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times per week ☐ 4 or more times per week

Course of Illness

35. Do you feel back to normal? ☐ Yes ☐ No ☐ Not applicable (patient deceased) ☐ Unknown ☐ Not applicable (patient never symptomatic)
    If yes, when did you feel back to normal? _____ (MM/DD/YYYY)
36. Did you miss work or school for this illness? ☐ Yes ☐ No ☐ Unknown
    If yes, how many days during illness? _____
37. Did you receive any medical care for the illness? ☐ Yes ☐ No ☐ Unknown
38. If yes, where and which dates did you seek care after this illness started (check all that apply)? [Please add extra visit dates in comments box]

☐ Doctor's office	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Emergency room	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Retail store/pharmacy	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Health department	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Urgent care	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Telephone triage line	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Other _____	Date 1: _____ (MM/DD/YYYY)	Date 2: _____ (MM/DD/YYYY)
☐ Unknown		

39. Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown **If YES, please fill out hospitalization section below If no, skip to Question #53**
    Purpose: ☐ Clinical indication ☐ No clinical indication (e.g., isolation for public health)

Hospitalization

40. Hospital name: _____ Hospital phone: _____
41. If yes, Admission date 1 _____ (MM/DD/YYYY) , discharge date 1 _____ (MM/DD/YYYY) ☐ Patient still hospitalized
42. To where was the patient discharged for hospital admission 1?
    ☐ Home ☐ Transferred to another hospital ☐ Nursing facility/rehab ☐ Hospice ☐ Other _____ ☐ Unknown
43. If hospitalized more than once, please enter the second hospitalization's admission and discharge dates:
    Hospital name: _____ Hospital phone: _____
    Admission date 2 _____ (MM/DD/YYYY) Discharge date 2_____ (MM/DD/YYYY)
    ☐ Patient still hospitalized
44. To where was the patient discharged from hospital admission 2?
    ☐ Home ☐ Transferred to another hospital ☐ Nursing facility/rehab ☐ Hospice ☐ Other _____ ☐ Unknown

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45. First recorded vital signs: Temp_____ (Unit: ☐ °F / ☐ °C) Blood pressure: _____ (systolic) /_____ (diastolic)

Heart rate: _____ Resp rate:_____

O2 Sat: _____ (Type of support required when O2 saturation was measured:

☐ Room Air ☐ Nasal Cannula ☐ Face Mask ☐ CPAP or BIPAP ☐ High Flow Nasal Cannula ☐ Invasive mechanical ventilation
☐ Other, specify: ☐ Unknown
Fraction of Inspired Oxygen/Flow _____ ☐ % ☐ Liters/minute (LPM) ☐ Unknown ☐ NA

46. First recorded laboratory values for:

	Date (MM/DD/YYYY)	Value	Unit
White blood cell (WBC) count			☐ Cells x 109/L ☐ x 1 000/µL ☐ Other
Absolute neutrophil count			☐ Cells x 109/L ☐ x 1 000/µL ☐ Other
Absolute lymphocyte count			☐ Cells x 109/L ☐ x 1 000/µL ☐ Other
Platelets (Plt)			☐ Cells x 109/L ☐ x 1 000/µL ☐ Other
Aspartate transaminase (AST)			☐ U/L ☐ IU/L ☐ Other
Alanine aminotransferase (ALT)			☐ U/L ☐ IU/L ☐ Other
Lactate dehydrogenase (LDH)			☐ U/L ☐ IU/L ☐ Other

47. Was the patient admitted to an intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown
ICU admission date 1 _____ (MM/DD/YYYY) ICU discharge date 1 _____ (MM/DD/YYYY)
ICU admission date 2 _____ (MM/DD/YYYY) ICU discharge date 2 _____ (MM/DD/YYYY)

48. During hospitalization, did the patient receive...

		Start Date (MM/DD/YYYY)	Last Date (MM/DD/YYYY)	Total Days
Supplemental Oxygen?	☐ Yes ☐ No ☐ Unknown			
BiPaP or CPAP use?	☐ Yes ☐ No ☐ Unknown			
High flow nasal cannula?	☐ Yes ☐ No ☐ Unknown			
Invasive mechanical ventilation?	☐ Yes ☐ No ☐ Unknown			
ECMO?	☐ Yes ☐ No ☐ Unknown			

49. Did the patient receive a discharge diagnosis of pneumonia (refer to clinical discharge summary)?
☐ Yes ☐ No ☐ Unknown

50. Did the patient receive a discharge diagnosis of acute respiratory distress syndrome (ARDS) (refer to clinical discharge summary)?
☐ Yes ☐ No ☐ Unknown

51. Clinical Discharge Diagnoses and ICD10 Discharge Codes

Clinical Discharge Diagnoses	**ICD-10-CM Code**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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52. Did the patient receive any antiviral medications during hospitalization for this illness:

Medication		Dose	Frequency	Start Date (MM/DD/YYYY)	Last Date (MM/DD/YYYY)	Total Days
Remdesivir	☐ PO ☐ IV ☐ IM					
Other:_____	☐ PO ☐ IV ☐ IM					
Other:_____	☐ PO ☐ IV ☐ IM					

Imaging

53. Was a chest x-ray taken? ☐ Yes ☐ No ☐ Unknown
54. Were any of these chest x-rays abnormal? ☐ Yes ☐ No ☐ Unknown
    Date of first abnormal chest x-ray: _____ (MM/DD/YYYY
55. For first abnormal chest x-ray, please check all that apply: Report not available: ☐

Air space density	☐	Cannot rule out pneumonia	☐	ARDS (acute respiratory distress syndrome)	☐	Other	☐
Air space opacity	☐	Consolidation	☐	Lung infiltrate	☐	Pleural Effusion	☐
Bronchopneumonia/pneumonia	☐	Cavitation	☐	Interstitial infiltrate	☐	Empyema	☐

56. Was a chest CT/MRI taken? ☐ Yes ☐ No ☐ Unknown
57. Were any of these chest CT/MRIs abnormal? ☐ Yes ☐ No ☐ Unknown
    Date of first abnormal CT/MRI: _____ (MM/DD/YYYY)
58. For first abnormal chest CT/MRI, please check all that apply: Report not available: ☐

Air space density	☐	ARDS (acute respiratory distress syndrome)	☐	Empyema	☐	Englarge epiglottis	☐
Air space opacity/opacification	☐	Lung infiltrate	☐	Pneumothorax	☐	Tracheal narrowing	☐
Bronchopneumonia/pneumonia	☐	Interstitial infiltrate	☐	Pneumomediastinum	☐	Ground glass opacities	☐
Consolidation	☐	Lobar infiltrate	☐	Widened mediastinum	☐	Other	☐
Cavitation	☐	Pleural effusion					

Lab Results

59. SARS-CoV-2 Testing (Please report further test results in comments)

Date of sample collection (MM/DD/YYYY)	Sample Type	Result
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: _____	☐ Pos ☐ Neg ☐ Inconclusive
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: _____	☐ Pos ☐ Neg ☐ Inconclusive
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: _____	☐ Pos ☐ Neg ☐ Inconclusive
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: _____	☐ Pos ☐ Neg ☐ Inconclusive
	☐ NP ☐ OP ☐ Sputum ☐ Other, specify: _____	☐ Pos ☐ Neg ☐ Inconclusive

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COVID-19 Case Investigation Form

60. Was patient tested for other viral respiratory pathogens during their illness? ☐Yes (report results below) ☐No ☐Unknown

	Positive	Negative	Not Tested Unknown	Collection Date (MM/DD/YYY)	Specimen Type
Flu A/H1	☐	☐	☐		
Flu A/H3	☐	☐	☐		
Flu B	☐	☐	☐		
Flu (no type)	☐	☐	☐		
Respiratory syncytial virus/RSV	☐	☐	☐		
Adenovirus	☐	☐	☐		
Parainfluenza virus 1	☐	☐	☐		
Parainfluenza virus 2	☐	☐	☐		
Parainfluenza virus 3	☐	☐	☐		
Parainfluenza virus 4	☐	☐	☐		
Human metapneumovirus	☐	☐	☐		
Rhinovirus/enterovirus	☐	☐	☐		
Human coronavirus 229E	☐	☐	☐		
Human coronavirus HKU1	☐	☐	☐		
Human coronavirus NL63	☐	☐	☐		
Human coronavirus OC43	☐	☐	☐		
Other, specify:	☐	☐	☐		

61. Were any bacterial culture tests performed during their illness? ☐ Yes ☐ No ☐ Unknown
If yes, was there a positive culture for a bacterial pathogen? ☐ Yes ☐ No ☐ Unknown

If yes, specify pathogen: _____

If yes, specify date of culture (MM/DD/YYYY): _____

If yes, site where pathogen identified: ☐Blood ☐Sputum ☐Bronchoalveolar lavage (BAL) ☐Endotracheal aspirate ☐Pleural fluid ☐ Cerebrospinal fluid (CSF) ☐Other, specify: _____

If more than one bacterial culture test was performed, please record in additional comments.

Outcome

62. Did the patient die as a result of this illness?
☐ Yes, Date: _____ (MM/DD/YYYY) ☐ No ☐ Unknown
Where did the death occur: ☐ Home ☐ Hospital ☐ ER ☐ Hospice ☐ Other, specify_____
(If the following information is not currently available, please send an update later using death certificate or death note in hospital record.)
Contribution of COVID-19 to death ☐ Underlying/primary ☐ Contributing/secondary ☐ No contribution to death ☐ Unknown
Was autopsy performed? ☐ Yes ☐ No ☐ Unknown
Primary Cause of death (death certificate/coroner) _____

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COVID-19 Case Investigation Form

Any additional comments or notes?

This is the end of the case investigation form. Thank you very much for your time. If you have any questions please feel free to contact the CDC at 770-488-7100 or eocevent330@cdc.gov

Reset Form

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Erin Morton; mlipsitc@hsph.harvard.edu; rek160@mail.harvard.edu; Perz, Joseph (CDC/DDID/NCEZID/DHQP)
Subject:	CSTE COVID-19 Response	Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST
Date:	Monday, February 24, 2020 2:13:16 PM
Attachments:	image001.png image002.png image003.png 00 pm EST (94.8 KB).msg



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

CSTE's ad hoc weekly COVID-19 All State Epi call is **TODAY at 4:00 pm EST**. These calls provide an open forum for discussion of emerging issues and response-related needs**.** Please see the call information highlighted below and note this call is intended for State Epidemiologists, CLUE, and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist
2. Washington Liaison Update, Erin Morton, CRD Associates, LLC
3. Presentation on COVID-19 Community Transmission Modeling, Marc Lipsitch and Rebecca Kahn, Harvard T.H. Chan School of Public Health
4. CDC COVID-19 Infection Prevention and Control Updates and Discussion, Joseph Perz, Healthcare Infection Control Team Lead, MCCM Task Force
5. Next Ad Hoc Call, Monday, March 2, 2020, 4:00-5:00 pm EST

Council of State and Territorial Epidemiologists · 2635 Century Parkway NE, Ste 700 · Atlanta, Georgia 30345 · 770.458.3811 · 770.458.8516

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

Please click the link below to see more information, or to start the session.

To start the session

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1. Go to https://cste.webex.com/cste/k2/j.php?MTID=tfebaa57e8bddcd420341120137d59a94
2. Log in to your account.
3. Click "Start Now".
4. Follow the instructions that appear on your screen.
To view in other time zones or languages, please click the link
https://cste.webex.com/cste/k2/j.php?MTID=tde7958b3ee30a95af0d6f666cb01aa2c

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To join the session by phone only

To receive a call back, provide your phone number when you join the training session, or call the number below and enter the access code.
Call-in toll-free number (US/Canada): 1-877-668-4490
Call-in toll number (US/Canada): 1-408-792-6300
Show toll-free dialing restrictions: https://www.webex.com/pdf/tollfree_restrictions.pdf
Access code: 794 313 782

For assistance

You can contact Matt Cone at:
mcone@cste.org
1-(678)-258-9582

To add this session to your calendar program (for example Microsoft Outlook), click this link:
https://cste.webex.com/cste/k2/j.php?MTID=tcc9fb0b421fd49aec52a9401586cc521

https://www.webex.com

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CSTE
Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945

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From: Jeremy Arieh <jarieh@cste.org>
Sent: Thursday, February 20, 2020 5:41 PM EST
To: Jeremy Arieh <jarieh@cste.org>
Subject: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - Monday, February 24 at 4:00 pm EST



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

The next CSTE ad hoc weekly COVID-19 All State Epi call is**TODAY at 4:00 pm EST**. These calls provide an open forum for discussion of emerging issues and response-related needs**.** Please see the call information below and note this call is intended for State Epidemiologists, City and Large Urban Area Epidemiologists (CLUE) and the CSTE Executive Board.

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Council of State and Territorial Epidemiologists · 2635 Century Parkway NE, Ste 700 · Atlanta, Georgia 30345 T 770.458.3811 F 770.458.8516

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
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Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

Please click the link below to see more information, or to start the session.

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To view in other time zones or languages, please click the link
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Emergency Preparedness & Response

Coronavirus Disease (COVID-19)

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Scott Becker; Scott Lindquist; Kathy Turner; O"Connor, Angelica (CDC/OID/NCEZID)
Subject:	CSTE COVID-19 Response	Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST
Date:	Monday, March 2, 2020 1:25:50 PM
Attachments:	image001.png image002.png image003.png



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – Today's CSTE ad hoc weekly COVID-19 All State Epi call is set for **4:00 pm EST**. Please see the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
    a. State Epidemiologist Transitions
        1. IL: Craig Conover, Acting
        2. TX: Stephen Pont, Acting
        3. TN: John Dunn, Permanent
2. COVID-19 Lab Testing Update, Scott Becker, APHL Chief Executive Officer
3. Notes from the Field: Washington State Update, Scott Lindquist, Washington State Epidemiologist
4. Update on SARS-CoV-2 Case Definition Discussions, Kathy Turner, Idaho Deputy State Epidemiologist
5. ELC Meeting Update, Angelica O'Connor, ELC Program Coordinator
6. ACIP Meeting Update, Chris Hahn, Idaho State Epidemiologist
7. Jurisdictional Experiences and Open Forum Discussion

Next Call, Monday, March 9, 2020, 4:00-5:00 pm EDT

Council of State and Territorial Epidemiologists · 2635 Century Parkway NE, Ste 700 · Atlanta, Georgia 30345 · 770.458.3811 · 770.458.8516

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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Access code: 794 313 782

For assistance

You can contact Matt Cone at:
mcone@cste.org
1-(678)-258-9582

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Coronavirus Disease (COVID-19)

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From: Jeremy Arieh

To: Aifili Tufa; Alesha Thompson; Alexia Harrist; Alexis Darden; Alyaa Altabbaa; Amanda Masters; Angela Dunn; Ann Pobutsky; Anna Likos; Ashley Vineyard; Becky Lampkins; Benjamin Chan; Beverly Christner; Brooke Beaulieu; Cailyn Lingwall; Caitlin Pedati; Carina Blackmore; Carmen Deseda; Catherine Brown; Cathy Wasserman; Charisse LaVell; Cherie Drenzek; Christina Tan; Christine Hahn; Craig Conover; Danielle Boyd; David Blythe; Dean Sidelinger; Debra Blog; Dhara Shah; Doug Thoroughman; Esther Ellis; Farah Ahmed; George Turabelidze; Hayleigh McCall; India Bowman; Ishan Azzam; James Watt; Janet Hamilton; Jeff Engel; Jennifer Lemmings; Jessica Arrazola; John Davies-Cole; John Dunn; Jonathan Meiman; Jordan Peart; Joseph McLaughlin; Joshua Clayton; Kathy Turner; Katrina Hedberg; Kenneth Komatsu; Kerry Pride; Laura Williamson; Laurence Burnsed; Laurene Mascola; Lilian Peake; Lilian Peake; Linda Gaul; Linda Bell; Lori Cragin; Maria del Rosario; Maria Patselikos; Matt Masiello; Matthew Cartter; Megan Irving; Megan Toe; Melissa Bullock; Meredith Lichtenstein; Mia Israel; Michelle Brown; Mike Landen; Mimi Huynh; Molly Howell; Mone Sharpe; Monica Schroeder; Nikka Sorrells; Pamela Pontones; Patsy Kelso; Paul Byers; Paul White; Puja Shah; Rachel Herlihy; Raoult Ratard; Rickey Tolliver; Ruth Lynfield; Ryan Westergaard; Sarah Lyon-Callo; Sarah Park; Sarah Zimmerman; Scott Lindquist; Shaily Krishan; Sharon Watkins; Shelby Lyons; Sherri Davidson; Shirley Louie; Shundra Clinton; Sietske de Fijter; Siiri Bennett; Song Xue; Stephen Ostroff; Stephen Pont; Symone Richardson; Tabatha Offutt-Powell; Thomas Jeanne; Tom Safranek; Tracy Miller; Utpala Bandy; Valerie Goodson; Vita Akapito Skilling; Zack Moore; Ada Huang; Alan Dorsinville; Alison Arwady; Anchalee Chillond; Andrew Hennenfent; Ann Winters; Annie Fine; Bernadette Albanese; Brian Reed; Caroline Johnson; Cora Hoover; David Stier; Dawn Terashita; Devin Raman; Don Weiss; Edhelene Rico; Ellen Lee; Emily Blake; Eric Bakota; Eric McDonald; Francisco Garcia; Heidi Threadgill Honza; Jacqueline Reuben; Jean Reynald; Jeffrey Duchin; Jenifer Jaeger; Jennifer Fiddner; Jessica Castorena; Joann Schulte; Julia Gunn; Julie Morita; Juliet Stoltey; Kathy Ritger; Kerry Chalkley; Kossia Dassie; Kristen Feemster; Kristen Mertz; Laeann Liu; Lauren Orkis; LuAnn Brink; Marcelle Layton; Mary Debry; Massimo Pacilli; Matthew Zahn; Meagan Kay; Melissa Ongpin; Peter Ruestow; Prabhu Gounder; Preetha Lyengar; Rachel Civen; Rebecca Sunenshine; Rita Espinoza; Roshan Reporter; Russ Jones; Sally Slavinski; Salma Khuwaja; Sarah Kemble; Sasha McGee; Scott Harper; Sharon Balter; Stephanie Black; Stephen Forest; Steve Alless; Susan Phillip; Susan Scheer; Taylor Pinsent; Wayne Enanoria; Wendy Chung; Barbara Gabella; Kate Goodin; Matt Cone; Melissa Jordan; Richard Danila; Shelia Scott; Stephanie Tucker; Berger, Sherri (CDC/OCOO/OD); Holloway, Rachel (CDC/OCOO/OD)

Subject: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - Monday, March 16

Attachments: image001.png
image002.png
image003.png

Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – The CSTE ad hoc weekly COVID-19 All State Epi call is Monday, March 16 at 4:00 pm EDT. See the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist

2. COVID-19 Jurisdictional Supplemental Funding Coordination via Crisis Cooperative Agreement, Sherri Berger, CDC Chief Operating Officer
3. COVID-19 CDC Response Update, Dan Jernigan, CDC IMS Incident Manager
4. COVID-19 Data Preparedness Update, Stephanie Bialek, CDC IMS Epi Task Force Lead
5. COVID-19 Bioinformatics Update, Greg Armstrong, CDC IMS Deputy Incident Manager
6. COVID-19 Nursing Home Preparedness, Satish Pillai, CDC IMS MCCM Task Force Lead
7. CSTE's COVID-19 Resource Repository Basecamp Demo, Meredith Lichtenstein Cone, CSTE
8. Open Forum Discussion

Next Call, Monday, March 23, 2020, 4:00 pm EDT

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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Call-in toll number (US/Canada):1-408-792-6300
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Access code: 794 313 782

For assistance

You can contact Matt Cone at:
mcone@cste.org <mailto:mcone@cste.org>
1-(678)-258-9582

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Coronavirus Disease (COVID-19)

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Sandra Roush; Yoon, Paula (CDC/OPHSS/CSELS/DHIS)
Subject:	CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST
Date:	Wednesday, February 19, 2020 12:57:18 PM
Attachments:	image001.png image002.png image004.png CSTE COVID-19 Response Ad Hoc Weekly All State Epi Call - Wednesday Feb... (80.1 KB).msg



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

CSTE's ad hoc weekly COVID-19 All State Epi call is **TODAY at 4:00 pm EST**. These calls provide an open forum for the discussion of emerging issues and response-related needs**.** Please see the WebEx info below, and note this call is intended for State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Introductory Remarks, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. Implementation Update for Phase 1 to Phase 2 Transition for COVID-19 Response, CDC IMS Response Staff for COVID-19 Response
   a. Introducing phased reporting and rationale for a staggered approach—Joseph Bresee and Marc Fischer
   b. Assigning unique identifiers (nCoV ID's)—Katherine Fleming-Dutra
   c. Persons under investigation (PUI) determination and reporting—Sara Oliver
   d. Reporting confirmed cases of COVID-19—Katherine Fleming-Dutra
   e. DCIPHER end-user experience and next steps—Katherine Fleming-Dutra
3. Syndromic Surveillance Data Sharing for COVID-19 Response, Paula Yoon, CDC/CSELS
4. Text Illness Monitoring (TIM) System Poll and Discussion

Please note the routine February All State Epi call scheduled for Monday, February 24, 2020 at 3:00 pm EST is cancelled in lieu of the next ad hoc weekly COVID-19 All State Epi call, which is Monday, February 24, 4:00-5:00 pm EST

Council of State and Territorial Epidemiologists · 2635 Century Parkway NE, Ste 700 · Atlanta, Georgia 30345 T 770.458.3811 F 770.458.8516

Topic: CSTE COVID-2019 Response Ad Hoc Weekly All State Epi Call
Host: Jeremy Arieh
Date: Wednesday, February 19, 2020

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Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)
Session number: 797 772 498
Session password: epi4321

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Access code: 797 772 498

For assistance

You can contact Jeremy Arieh at:
jarieh@cste.org

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From: Jeremy Arieh <jarieh@cste.org>
Sent: Thursday, February 13, 2020 3:37 PM EST
To: Jeremy Arieh <jarieh@cste.org>
Subject: CSTE COVID-19 Response Ad Hoc Weekly All State Epi Call - Wednesday, February 19 at 4 pm ET



Sent to State Epidemiologists, CLUE, and the CSTE Executive Board

The next CSTE ad hoc weekly COVID-19 All State Epi call is **Wednesday, February 19, 2020 at 4:00 pm EST**. These calls are intended to provide an open forum for discussion of emerging issues and response-related needs**.** Please see the call information below and note this call is intended State Epidemiologists, City and Large Urban Area Epidemiologists (CLUE) and the CSTE Executive Board. **Please limit participation to <u>one line per jurisdiction</u>.**

Thank you,

--

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Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
(Sent by Jeremy Arieh)

Topic: CSTE 2019-nCoV Response Ad Hoc Weekly All State Epi Call
Host: Jeremy Arieh
Date: Wednesday, February 19, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 797 772 498
Session password: epi4321

To join the training session
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2. Enter your name and email address.
3. Enter the session password: epi4321
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From: CSTE Emergency Response
To: CSTE Emergency Response
Cc: eocevent118@cdc.gov; CSTE Novel Coronavirus 2019
Subject: CSTE COVID-19 Response | CDC Phase 2 Rollout
Date: Wednesday, February 26, 2020 10:38:24 AM
Attachments: image001.png
image002.png
Attachment1_COVID19_Phase2Instructions_2020Feb25[1].docx
Attachment2_COVID19_PUI_Case_ReportForm_2020Feb24[1].pdf
Attachment3_COVID19_PUI_Case_Data Dictionary_2020Feb24[1].pdf
Attachment4_COVID19_PUI_Case_ReportForm_Instructions_2020Feb24[3].pdf
Attachment5_COVID19_SpecimenSubmission_2020Feb24[3].pdf



Forwarded to State Epidemiologists, Deputy State Epidemiologists, CLUE, Infectious Disease Points of Contact, and the CSTE Executive Board

Good morning,

Please see below for a message from the CDC COVID-19 Epi Task Force, regarding **Phase 2** of COVID-19 jurisdictional identification and reporting.

Colleagues,

Thank you for your continued partnership in the ongoing emergency response to the novel coronavirus, COVID-19. As we presented at the 50-state CSTE call on Wednesday, February 19th, we will begin to transition today, February 25th, to 'Phase 2' of jurisdictional identification and reporting of persons under investigation (PUI) and laboratory-confirmed cases of COVID-19.

This transition to Phase 2 will occur for all reporting jurisdictions that are able to do the following:

- Assess ill persons and determine PUI status
- Assign unique identifiers to PUI and cases using the specified format
- Report PUI and laboratory-confirmed cases to CDC using a brief, combined, report form

For the purposes of COVID-19 PUI and case reporting, a 'reporting jurisdiction' refers to any jurisdiction that submits data directly to the National Notifiable Disease Surveillance System. A complete list of the 59 jurisdictions included as reporting jurisdictions is contained in Attachment 1. Although COVID-19 is not a nationally notifiable disease, limiting reporting to only these jurisdictions will provide greater assurance of unique ID assignment and ensure higher data quality during this rapidly evolving outbreak.

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If your reporting jurisdiction is able to meet criteria to move to Phase 2, please email the State Coordination Unit of the CDC COVID-19 Epidemiology Task Force at eocevent118@cdc.gov to confirm your readiness.

Full details of the Phase 2 rollout are documented in the 5 attachments:

- Attachment 1: Clear description of Phase 2 implementation, including nCoV ID assignment
- Attachment 2: Combined PUI and Case Report Form
- Attachment 3: PUI and Case Report Form Data Dictionary
- Attachment 4: Instructions for completing the PUI and Case Report Form
- Attachment 5: Information on how to ship specimens to CDC

CDC is available to answer questions about the PUI and laboratory-confirmed case-reporting process. For inquiries, please email eocevent118@cdc.gov. We appreciate your continued efforts.

Best,
CDC COVID-19 Epidemiology Task Force

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Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to the novel coronavirus, COVID-19. As we presented at the 50-state CSTE call on Wednesday, February 19th, we will begin to transition today, February 25th, to 'Phase 2' of jurisdictional identification and reporting of persons under investigation (PUI) and laboratory-confirmed cases of COVID-19.

This transition to Phase 2 will occur for all reporting jurisdictions that are able to do the following:

- Assess ill persons and determine PUI status
- Assign unique identifiers to PUI and cases using the specified format (Figure 1, below)
- Report PUI and laboratory-confirmed cases to CDC using a brief, combined, report form

For the purposes of COVID-19 PUI and case reporting, a 'reporting jurisdiction' refers to any jurisdiction that submits data directly to the National Notifiable Disease Surveillance System. A complete list of the 59 jurisdictions included as reporting jurisdictions is contained below (Figure 2). Although COVID-19 is not a nationally notifiable disease, limiting reporting to only these jurisdictions will provide greater assurance of unique ID assignment and ensure higher data quality during this rapidly evolving outbreak.

If your reporting jurisdiction is able to meet criteria to move to Phase 2, please email the State Coordination Unit of the CDC COVID-19 Epidemiology Task Force at eocevent118@cdc.gov to confirm your readiness.

Jurisdictions in Phase 2:

Jurisdictions in Phase 2 will have processes in place to determine an individual person's PUI status without first contacting CDC. CDC staff remain available via the CDC EOC (770-488-7100) to consult on whether a person meets criteria for being a PUI. We recognize that many jurisdictions will choose to centralize this type of PUI assessment at the state level while others may develop systems that use a more decentralized approach.

Reporting jurisdictions will also assign unique identifiers (**nCoV IDs**) for each PUI and laboratory-confirmed case at the reporting jurisdiction level. To ensure that **nCoV IDs** are truly unique, reporting jurisdictions must use the ID format described in Figure 1, below.

As of Monday, February 24th, a single, combined form for reporting PUIs and Cases (PUI and Case Report Form) is available on CDC's novel coronavirus website. The data dictionary and instructions for completing the form are available on the same website. For convenience, we are attaching copies of the report form, the data dictionary, and the form instructions to this email. PDF copies of the PUI and Case Report Form remain available on CDC's website for local use but should not be used to transmit data to CDC.

Before shipping specimens to CDC, jurisdictions in Phase 2 should enter data on PUIs directly into the DCIPHER data platform, unless other arrangements have been made and approved by CDC. Data entered into DCIPHER will be used to identify laboratory samples for testing and to link specimens and their results back to individual PUIs and cases. Data must be entered into DCIPHER in order for laboratory specimens to be tested by CDC.

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While CDC encourages all reporting jurisdictions to provide updated information on PUIs and cases as it becomes available, the following variables are those considered minimally-acceptable for initial data submission to CDC:

- CDC 2019-nCoV ID (cdc_ncov2019_id) **(required field)**
- Reporting jurisdiction (state) **(required field)**
- Current status of the person as PUI or laboratory-confirmed case (current_status)
- Report date of PUI to CDC (pui_cdcreport_dt)
- Report date of case to CDC (case_cdcreport_dt)
- Sex (sex)
- Age (age) and Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU Admission status (icu_yn)
- Death (death_yn)
- If female, currently pregnant (pregnant_yn)
- Travel to mainland China (exp_China)
- Travel to other non-US country (exp_othcountry)
- Travel to other non-US country, specify (exp_othcountry_spec)
- Household contact with a COVID-19 case patient (exp_house)
- Community contact with a COVID-19 case patient (exp_community)
- Any healthcare contact with a COVID-19 case patient (exp_health)
- Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
- Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen type (see series on specimen type)
- Specimen ID (see series on specimen ID)
- Specimen sent to CDC (see series on specimen sent to CDC)

Variable names are contained in parentheses and can be found in the data dictionary (attached and on CDC's website).

Specimens should be packaged and shipped to CDC using the attached instructions for labelling and shipping novel coronavirus specimens. All specimens should include the CDC 2019-**nCoV ID** in the box specified in CDC's shipping instructions, which will facilitate timely testing of laboratory specimens.

Jurisdictions in Phase 1:
Jurisdictions that are not in Phase 2 should continue to follow previously established processes. This includes calling the CDC EOC (770-488-7100) to consult with CDC staff on determining whether a person meets criteria for being a PUI, receiving a CDC-issued CDC2019-**nCoV ID**, and working with CDC to complete the PUI and Case Report Form.

CDC is available to answer questions about the PUI and laboratory-confirmed case-reporting process. For inquiries, please email eocevent118@cdc.gov. We appreciate your continued efforts.

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Best,
CDC COVID-19 Epidemiology Task Force

Figure 1.

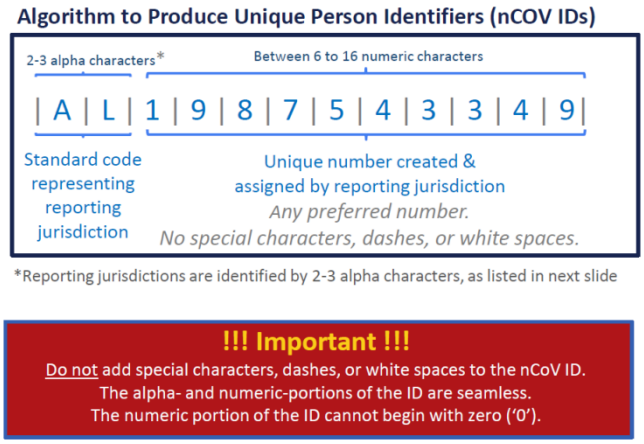

Figure 2.

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI

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CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person?
☐ Patient under investigation (PUI)
☐ Laboratory-confirmed case

Report date of PUI to CDC (MM/DD/YYYY):
____/_____/_____

Report date of case to CDC (MM/DD/YYYY):
____/_____/_____

County of residence: _____
State of residence: _____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/ Latino
☐ Not specified

Sex:
☐ Male
☐ Female
☐ Unknown
☐ Other

Race (check all that apply):
☐ Asian
☐ American Indian/Alaska Native
☐ Black
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Unknown
☐ Other, specify: _____

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____
Age units(yr/mo/day): _____

Date of first positive specimen collection (MM/DD/YYYY):
____/_____/_____
☐ Unknown ☐ N/A

Did the patient develop pneumonia?
☐ Yes ☐ Unknown
☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown
☐ No

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown
☐ No

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ Unknown
☐ No

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1
___/___/___ (MM/DD/YYYY)
If yes, discharge date 1
__/___/____ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days)
_____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY):
____/_____/_____
☐ Unknown date of death

Symptoms present during course of illness:
☐ Symptomatic
☐ Asymptomatic
☐ Unknown

If symptomatic, onset date (MM/DD/YYYY):
____/_____/_____
☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY):
____/_____/_____
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐ Yes ☐ No ☐ Unknown
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
☐ Travel to Wuhan
☐ Travel to Hubei
☐ Travel to mainland China
☐ Travel to other non-US country specify:_____
☐ Household contact with another lab-confirmed COVID-19 case-patient
☐ Community contact with another lab-confirmed COVID-19 case-patient
☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient
☐ Patient ☐ Visitor ☐ HCW
☐ Animal exposure
☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
☐ Other, specify:_____
☐ Unknown
If the patient had contact with another COVID-19 case, was this person a U.S. case? ☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A

Under what process was the PUI or case first identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX notification of travelers; if checked, DGMQID_____
☐ Unknown ☐ Other, specify:_____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

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CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C)[c]	☐Yes ☐No ☐Unk
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk
Chills	☐Yes ☐No ☐Unk
Muscle aches (myalgia)	☐Yes ☐No ☐Unk
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk
Sore throat	☐Yes ☐No ☐Unk
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk
Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk
Nausea or vomiting	☐Yes ☐No ☐Unk
Headache	☐Yes ☐No ☐Unk
Abdominal pain	☐Yes ☐No ☐Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unk
Other, specify:_____	

Pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unknown	
Diabetes Mellitus	☐Yes	☐No	☐Unknown	
Cardiovascular disease	☐Yes	☐No	☐Unknown	
Chronic Renal disease	☐Yes	☐No	☐Unknown	
Chronic Liver disease	☐Yes	☐No	☐Unknown	
Immunocompromised Condition	☐Yes	☐No	☐Unknown	
Neurologic/neurodevelopmental	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐No	☐Unknown	(If YES, specify) _____
If female, currently pregnant	☐Yes	☐No	☐Unknown	
Current smoker	☐Yes	☐No	☐Unknown	
Former smoker	☐Yes	☐No	☐Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify:_____	☐	☐	☐	☐

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	Sent to CDC	State Lab Tested
NP Swab			☐	☐
OP Swab			☐	☐
Sputum			☐	☐
Other, Specify: _____			☐	☐

Additional State/local Specimen IDs: _____ _____ _____ _____ _____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

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2019-nCoV PUI and CRF Data Dictionary
Form used: 03_2019-nCoV_PUI_Case ReportForm_2020Feb21.docx
Last updated 20200221_11.00am

Questions	Variable Name	Values, Labels	Type
Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form			
Reporting jurisdiction	state		Character
Reporting health department	healthdept		Character
Contact ID	contact_id		Character
Case state/local ID	local_id		Character
CDC 2019-nCoV ID	cdc_ncov2019_id		Character
NNDSS loc. Rec. ID/ Case ID	nndss_id		Character
Interviewer Information			
Last name of interviewer	interviewer_ln		Character
First name of interviewer	interviewer_fn		Character
Affilliation/ Organization	interviewer_org		Character
Telephone number	interviewer_tele		Character
Email	interviewer_email		Character
Basic Case Information			
What is the current status of this person?	current_status	1, Patient under investigation (PUI) 2, Laboratory-confirmed case	Number
Report date of PUI to CDC (MM/DD/YYYY)	pui_cdcreport_dt		Date (mm/dd/yyyy)
Report date of case to CDC (MM/DD/YYYY)	case_cdcreport_dt		Date (mm/dd/yyyy)
County of residence	res_county		Character
State of residence	res_state		Character
Ethnicity	ethnicity	1, Hispanic/Latino 0, Non-Hispanic/Latino 9, Not specified	Number
Sex	sex	1, Male 2, Female 9,Unknown 3, Other	Number
Race (Check all that apply)			
Asian	race_asian	1, Yes	Number
American Indian/ Alaska Native	race_aian	1, Yes	Number
Black	race_black	1, Yes	Number
Native Hawaiian/ Other Pacific Islander	race_nhpi	1, Yes	Number
White	race_white	1, Yes	Number
Unknown	race_unk	1, Yes	Number
Other	race_other	1, Yes	Number
Other specified race	race_spec		Character
Date of birth (MM/DD/YYYY)	dob		Date (mm/dd/yyyy)
Age	age		Number
Age units (yr/mo/days):	ageunit	1, Years 2, Months 3, Days	Number
Date of first positive specimen collection (MM/DD/YYYY)	pos_spec_dt		Date (mm/dd/yyyy)
Check if date unknown	pos_spec_unk	1, Yes	Number
Check if date not applicable	pos_spec_na	1, Yes	Number
Did the patient develop pneumonia?	pna_yn	1, Yes 0, No 9, Unknown	Number
Did the patient have acute respiratory distress syndrome?	acuterespdistress_yn	1, Yes 0, No 9, Unknown	Number
Did the patient have another diagnosis/etiology for their illness?	diagother	1, Yes 0, No 9, Unknown	Number
Did the patient have an abnormal chest X-ray?	abxchest_yn	1, Yes 0, No 9, Unknown	Number
Symptoms present during course of illness:	sympstatus	1, Symptomatic 0, Asymptomatic 9, Unknown	Number
If symptomatic, onset date (MM/DD/YYYY)	onset_dt		Date (mm/dd/yyyy)
If symptomatic, onset date - unknown	onset_unk	1, Yes	Number
If symptomatic, date of symptom resolution (MM/DD/YYYY)	symp_res_dt		Date (mm/dd/yyyy)
If symptomatic, state of resolution	symp_res_yn	1, Still symptomatic 0, Symptoms resolved, unknown date 9, Unknown symptom status	Number
Was the patient hospitalized?	hosp_yn	1, Yes 0, No 9, Unknown	Number
If yes, admission date 1 (MM/DD/YYYY)	adm1_dt		Date (mm/dd/yyyy)
If yes, discharge date 1 (MM/DD/YYYY)	dis1_dt		Date (mm/dd/yyyy)
Was the patient admitted to an intensive care unit (ICU)?	icu_yn	1, Yes 0, No 9, Unknown	Number
Did the patient receive mechanical ventilation (MV)/intubation?	mechvent_yn	1, Yes 0, No 9, Unknown	Number
If yes, total days with MV (days)	mechvent_dur		Number
Did the patient receive extracorporeal membrane oxygenation (ECMO)?	ecmo_yn	1, Yes 0, No 9, Unknown	Number
Did the patient die as a result of this illness?	death_yn	1, Yes 0, No 9, Unknown	Number
Date of Death (MM/DD/YYYY)	death_dt		Date (mm/dd/yyyy)
Date of Death Unknown	death_unk	1, Yes	Number
Is the patient a health care worker in the United States?	hc_work_yn	1, Yes 0, No 9, Unknown	Number
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China?	hc_work_china_yn	1, Yes 0, No 9, Unknown	Number
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):			
Travel to Wuhan	exp_wuhan	1, Yes	Number
Travel to Hubei	exp_hubei	1, Yes	Number
Travel to mainland China	exp_china	1, Yes	Number
Travel to other non-US country	exp_othcountry	1, Yes	Number
If yes, specify	exp_othcountry_spec		Character

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Household contact with another lab-confirmed COVID-19 case-patient	exp_house	1, Yes	Number
Community contact with another lab-confirmed COVID-19 case-patient	exp_community	1, Yes	Number
Any healthcare contact with another lab-confirmed COVID-19 case-patient	exp_health	1, Yes	Number
Healthcare contact with another lab-confirmed COVID-19 case-patient -- patient	exp_health_pt	1, Yes	Number
Healthcare contact with another lab-confirmed COVID-19 case-patient -- visitor	exp_health_vis	1, Yes	Number
Healthcare contact with another lab-confirmed COVID-19 case-patient -- healthcare worker	exp_health_hcw	1, Yes	Number
Animal exposure	exp_animal	1, Yes	Number
Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology	exp_cluster	1, Yes	Number
Other	exp_other	1, Yes	Number
If other, specify	exp_other_spec		Character
Unknown	exp_unk	1, Yes	Number
		1, Yes	
		0, No	
		9, Unknown	
If the patient had contact with another COVID-19 case, was this person a U.S. case?	cont_lab_us	5, NA	Number
If yes, specify nCoV ID of source case	cdc_ncov2019_sourceid_2		Character
Under what process was the PUI or case first identified? (check all that apply):			
Clinical evaluation leading to PUI determination	process_pui	1, Yes	Number
Contact tracing of case patient	process_cont	1, Yes	Number
Routine surveillance	process_surv	1, Yes	Number
EpiX notification of travelers	process_epix	1, Yes	Number
If checked, DGMQID	process_dgmqid		Character
Unknown	process_unk	1, Yes	Number
Other	process_other	1, Yes	Number
If other, specify	process_other_spec		Character
Symptoms, clinical course, past medical history and social history			
Collected from (check all that apply):			
Patient interview	collect_ptinterview	1, Yes	Number
Medical record review	collect_medchart	1, Yes	Number
During this illness, did the patient experience any of the following symptoms?			
		1, Yes	
		0, No	
Fever >100.4F (38C)	fever_yn	9, Unknown	Number
		1, Yes	
		0, No	
Subjective fever (felt feverish)	sfever_yn	9, Unknown	Number
		1, Yes	
		0, No	
Chills	chills_yn	9, Unknown	Number
		1, Yes	
		0, No	
Muscle aches (myalgia)	myalgia_yn	9, Unknown	Number
		1, Yes	
		0, No	
Runny nose (rhinorrhea)	runnose_yn	9, Unknown	Number
		1, Yes	
		0, No	
Sore throat	sthroat_yn	9, Unknown	Number
		1, Yes	
		0, No	
Cough (new onset or worsening of chronic cough)	cough_yn	9, Unknown	Number
		1, Yes	
		0, No	
Shortness of breath (dyspnea)	sob_yn	9, Unknown	Number
		1, Yes	
		0, No	
Nausea or Vomiting	nauseavomit_yn	9, Unknown	Number
		1, Yes	
		0, No	
Headache	headache_yn	9, Unknown	Number
		1, Yes	
		0, No	
Abdominal pain	abdom_yn	9, Unknown	Number
		1, Yes	
		0, No	
Diarrhea (≥3 loose/looser than normal stools/24hr period)	diarrhea_yn	9, Unknown	Number
Other symptoms - 1	othsym1_yn	1, Yes	Number
Other symptoms - 1, specify:	othsym1_spec		Character
Other symptoms - 2	othsym2_yn	1, Yes	Number
Other symptoms - 2, specify:	othsym2_spec		Character
Other symptoms - 3	othsym3_yn	1, Yes	Number
Other symptoms - 3, specify:	othsym3_spec		Character
		1, Yes	
		0, No	
Pre-existing medical conditions?	medcond_yn	9, Unknown	Number
		1, Yes	
		0, No	
Chronic lung disease (asthma/emphysema/COPD)	cld_yn	9, Unknown	Number
		1, Yes	
		0, No	
Diabetes Mellitus	diabetes_yn	9, Unknown	Number
		1, Yes	
		0, No	
Cardiovascular disease	cvd_yn	9, Unknown	Number
		1, Yes	
		0, No	
Chronic renal disease	renaldis_yn	9, Unknown	Number
		1, Yes	
		0, No	
Liver disease	liverdis_yn	9, Unknown	Number
		1, Yes	
		0, No	
Immunocompromised condition	immsupp_yn	9, Unknown	Number
		1, Yes	
		0, No	
Neurologic/neurodevelopmental	neuro_yn	9, Unknown	Number
If yes, specify	neuro_spec		Character
		1, Yes	
		0, No	
Other chronic diseases	otherdis_yn	9, Unknown	Number
If yes, specify	otherdis_spec		Character
		1, Yes	
		0, No	
If female, currently pregnant	pregnant_yn	9, Unknown	Number

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		1, Yes	
		0, No	
Current smoker	smoke_curr_yn	9, Unknown	Number
		1, Yes	
		0, No	
Former smoker	smoke_former_yn	9, Unknown	Number
Respiratory Diagnostic Testing			
		1, Positive	
		2, Negative	
		3, Pending	
Influenza A Rapid Ag	resp_flua_ag	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Influenza B Rapid Ag	resp_flub_ag	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Influenza A PCR	resp_flua_pcr	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Influenza B PCR	resp_flub_pcr	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
RSV	resp_rsv	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
H. metapneumovirus	resp_hm	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Parainfluenza (1-4)	resp_pi	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Adenovirus	resp_adv	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Rhinovirus/enterovirus	resp_rhino	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Coronavirus (OC43, 229E, HKU1, NL63)	resp_cov	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
M. pneumoniae	resp_mp	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
C. pneumoniae	resp_rcp	4, Not Done	Number
		1, Positive	
		2, Negative	
		3, Pending	
Other positive pathogens	othrp	4, Not Done	Number
If yes, specify	othrp_spec		Character
Specimens for COVID-19 Testing			
NP Swab: Local Specimen ID - 1	spec_npswab1id		Character
NP Swab: Collection date - 1	spec_npswab1_dt		Date (mm/dd/yyyy)
NP Swab: Sent to CDC - 1	spec_npswab1cdc	1, Yes	Number
NP Swab: State Lab Tested - 1	spec_npswab1state	1, Yes	Number
NP Swab: Local Specimen ID - 2	spec_npswab2id		Character
NP Swab: Collection date - 2	spec_npswab2_dt		Date (mm/dd/yyyy)
NP Swab: Sent to CDC - 2	spec_npswab2cdc	1, Yes	Number
NP Swab: State Lab Tested - 2	spec_npswab2state	1, Yes	Number
NP Swab: Local Specimen ID - 3	spec_npswab3id		Character
NP Swab: Collection date - 3	spec_npswab3_dt		Date (mm/dd/yyyy)
NP Swab: Sent to CDC - 3	spec_npswab3cdc	1, Yes	Number
NP Swab: State Lab Tested - 3	spec_npswab3state	1, Yes	Number
OP Swab: Local Specimen ID - 1	spec_opswab1id		Character
OP Swab: Collection date - 1	spec_opswab1_dt		Date (mm/dd/yyyy)
OP Swab: Sent to CDC - 1	spec_opswab1cdc	1, Yes	Number
OP Swab: State Lab Tested - 1	spec_opswab1state	1, Yes	Number
OP Swab: Local Specimen ID - 2	spec_opswab2id		Character
OP Swab: Collection date - 2	spec_opswab2_dt		Date (mm/dd/yyyy)
OP Swab: Sent to CDC - 2	spec_opswab2cdc	1, Yes	Number
OP Swab: State Lab Tested - 2	spec_opswab2state	1, Yes	Number
OP Swab: Local Specimen ID - 3	spec_opswab3id		Character
OP Swab: Collection date - 3	spec_opswab3_dt		Date (mm/dd/yyyy)
OP Swab: Sent to CDC - 3	spec_opswab3cdc	1, Yes	Number
OP Swab: State Lab Tested - 3	spec_opswab3state	1, Yes	Number
Sputum: Local Specimen ID - 1	spec_sputum1id		Character
Sputum: Collection date - 1	spec_sputum1_dt		Date (mm/dd/yyyy)
Sputum: Sent to CDC - 1	spec_sputum1cdc	1, Yes	Number
Sputum: State Lab Tested - 1	spec_sputum1state	1, Yes	Number
Sputum: Local Specimen ID - 2	spec_sputum2id		Character
Sputum: Collection date - 2	spec_sputum2_dt		Date (mm/dd/yyyy)
Sputum: Sent to CDC - 2	spec_sputum2cdc	1, Yes	Number
Sputum: State Lab Tested - 2	spec_sputum2state	1, Yes	Number
Sputum: Local Specimen ID - 3	spec_sputum3id		Character
Sputum: Collection date - 3	spec_sputum3_dt		Date (mm/dd/yyyy)
Sputum: Sent to CDC - 3	spec_sputum3cdc	1, Yes	Number
Sputum: State Lab Tested - 3	spec_sputum3state	1, Yes	Number
Other specimen type - 1	spec_otherspecimen1_yn	1, Yes	Number
If yes, specify type - 1	spec_otherspecimen1_spec		Character
Other: Local Specimen ID - 1	spec_otherspecimen1id		Character
Other: Collection date - 1	spec_otherspecimen1_dt		Date (mm/dd/yyyy)
Other: Sent to CDC - 1	spec_otherspecimen1cdc	1, Yes	Number
Other: State Lab Tested - 1	spec_otherspecimen1state	1, Yes	Number
Other specimen type - 2	spec_otherspecimen2_yn	1, Yes	Number
If yes, specify type - 2	spec_otherspecimen2_spec		Character

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Other: Local Specimen ID - 2	spec_otherspecimen2id		Character
Other: Collection date - 2	spec_otherspecimen2_dt		Date (mm/dd/yyyy)
Other: Sent to CDC - 2	spec_otherspecimen2cdc	1, Yes	Number
Other: State Lab Tested - 2	spec_otherspecimen2state	1, Yes	Number
Other specimen type - 3	spec_otherspecimen3_yn	1, Yes	Number
If yes, specify type - 3	spec_otherspecimen3_spec		Character
Other: Local Specimen ID - 3	spec_otherspecimen3id		Character
Other: Collection date - 3	spec_otherspecimen3_dt		Date (mm/dd/yyyy)
Other: Sent to CDC - 3	spec_otherspecimen3cdc	1, Yes	Number
Other: State Lab Tested - 3	spec_otherspecimen3state	1, Yes	Number
Additional State/local Specimen IDs:	lab_local_id1		Character
Any additional comments/notes?	final_notes		Character

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Version 19 FEB 2020

Instructions for Completing the Human Infection with 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form

Purpose: This document describes the procedures for completing the 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form (CRF) for reporting persons under investigation who are being tested for the virus that causes COVID-19 as well as laboratory-confirmed cases of COVID-19. If a person under investigation tests positive for the virus that causes COVID-19, the form should be updated to change the individual's status from a PUI to a laboratory-confirmed case. Other individuals may remain as PUI, and not become laboratory-confirmed cases if their laboratory samples test negative for the virus that causes COVID-19. If the person has a positive laboratory result for the virus that causes COVID-19, but was not previously a PUI, the form may be filled for the first time when a person is considered a laboratory-confirmed COVID-19 case.

General:

1. All dates should be formatted MM/DD/YYYY.
2. If completing the .pdf version of the form, use an "X" to mark boxes. Make sure to carefully mark boxes so that the "X" does not cross multiple boxes.

Header:

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC AND IS FOR LOCAL-USE ONLY:
Patient first name: Enter case's first (given) name.
Patient last name: Enter case's last (family) name.
Date of birth (MM/DD/YYYY): Enter date of birth in MM/DD/YYYY format.

ID information:

Reporting jurisdiction: Enter the reporting jurisdiction where the PUI or case was identified. The reporting jurisdiction must be a state/city/territory authorized to submit data through NNDSS.

Reporting health department: Enter the name of the health department completing the PUI or case report.

Case state/local ID: Enter a local-use ID assigned by the state or local health department if desired for patient tracking or matching.

CDC 2019-nCoV ID: Enter the CDC 2019-nCoV ID assigned to the PUI or case. If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with the state or local health department, this CDC 2019-nCoV ID should have already been assigned. This should be a part of the state or local health departments records; please check with the reporting jurisdiction. the If any of the above scenarios are true, enter the CDC 2019-nCoV ID that has been provided by CDC. This may have previously been called a PUI ID. **Do not assign a new 2019-nCoV ID for these individuals**.

If this is a new PUI or case that was not previously under investigation or reported, the CDC 2019-nCoV ID should be assigned by the jurisdiction. CDC 2019-nCoV IDs should be assigned for all PUIs and laboratory-confirmed cases so that this person can be tracked at the jurisdictional and national level. The reporting jurisdiction should

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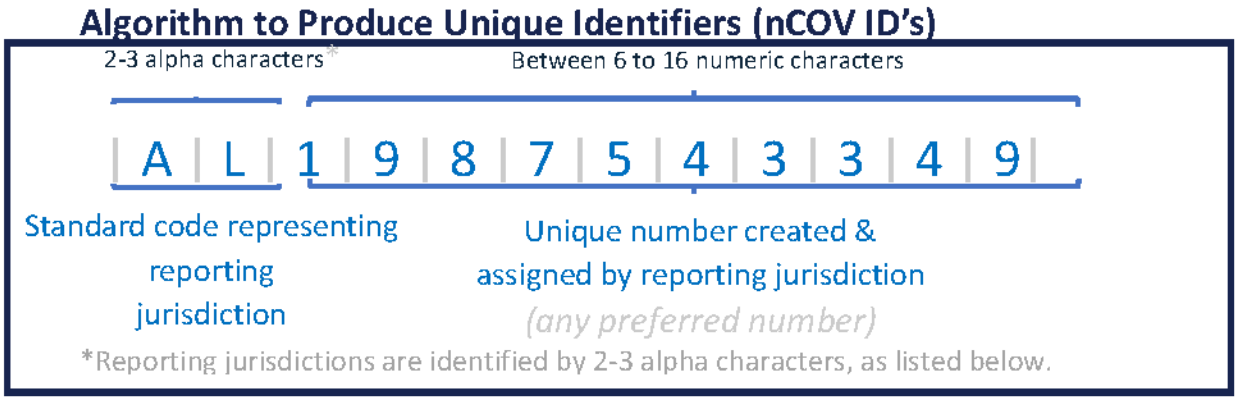
assign the CDC 2019-nCoV ID, and use this ID for all specimens and data transmitted to CDC for that person. The structure of the ID should be as follows:



!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID. The alpha- and numeric-portions of the ID are seamless. The numeric portion of the ID cannot begin with zero ('0').

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI

This ID will be used to track information about the PUI or case-patient in CDC data systems and **must** be provided on all forms or specimens related to this individual.

Contact ID: Only fill out this field if a PUI or case-patient is a known contact to another confirmed case of COVID-19. Contact IDs are assigned using the original (source) case-patient's nCoV ID followed by a hyphen and a sequential number indicating the order in which the contact was identified (e.g., Confirmed case CA102034567 may have contacts CA102034567 -01 and CA102034567 -02). If the person was previously under investigation in collaboration with CDC, or was part of a contact investigation in which CDC was collaborating with state/local health departments, this Contact ID may have been assigned previously. This should be a part of the state or local health departments records; please check with the reporting jurisdiction.

NNDSS loc. rec. ID/Case ID: For NNDSS reporters, enter the GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Enter the last name and first name of the person performing the interview.

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Affiliation/Organization: Enter the interviewer's affiliation/organization.

Telephone: Enter the interviewer's telephone number.

Email: Enter the interviewer's email address.

Basic case information

What is the current status of this person? Select "patient under investigation (PUI)" or "laboratory-confirmed case." If the person is being tested for the virus that causes COVID-19, but no positive test result has occurred, select "patient under investigation." If the person has had at least one respiratory specimen test positive for the virus that causes COVID-19, select "laboratory-confirmed case." Please update this field when applicable.

Report date of PUI to CDC: Enter the date the person was initially reported to CDC **as a PUI** in MM/DD/YYYY format.

Report date of case to CDC: Enter the date the case-patient was initially reported to CDC **as a case** in MM/DD/YYYY format. That is, please report the date at which the person changed from not being a case to being a case.

County of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired.

State of Residence: Please enter the individual's county of residence. Residence is typically defined by CSTE as the place of 'usual residence' at the time an infection is acquired. The state of residence and reporting jurisdiction may be two distinct places.

Ethnicity: Select appropriate response. If unknown, select not specified.

Sex: Select appropriate response.

Race: Check all race categories that apply. If other, please specify in free text.

Date of birth: Enter the PUI or case-patient's date of birth in MM/DD/YYYY format. Only enter data in this field if data can be transmitted to CDC per state/local policy.

Age: Enter the PUI or case-patient's age. Age may be entered in units of years, months, or days. Units will be specified later.

Age units (year/month/day): Select age units.

Date of first positive specimen collection: Enter the date of this person's first positive respiratory specimen collection, regardless of specimen type, in MM/DD/YYYY format. If the person tested positive, but the date is unknown, select "Unknown." If the person is a PUI and tested negative or is awaiting initial test results, select "N/A."

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Did the patient develop pneumonia?: Select the appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select 'unknown' if missing chart.

Did the patient have acute respiratory distress syndrome?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have another diagnosis/etiology for their illness?: Select appropriate response. Refer to the clinical discharge summary in the patient's medical chart. This should not be from ICD codes. Select "unknown" if missing chart.

Did the patient have an abnormal chest X-ray?: Select appropriate response. Select "unknown" if missing chart. Select 'yes' if—at any time—the person had an abnormal chest X-ray as part of this illness.

Symptoms present during course of illness?: This question refers to the PUI or case-patient's symptom status related to the entire duration of illness. If the PUI or case-patient was ever symptomatic as part of this illness with COVID-19, select "symptomatic." If the PUI or case-patient was asymptomatic (never experienced symptoms as part of this illness), please select "asymptomatic." If symptom status is unknown, select "unknown."

- If symptomatic, record symptom onset date in MM/DD/YYYY format or mark "unknown."
- If the PUI or case-patient was previously symptomatic and symptoms are currently resolved at the time of completing or updating this form, list date of symptom resolution in MM/DD/YYYY format. If exact dates of symptom resolution are not known, but there is a known approximate date, enter this in the date field. If still symptomatic at time of interview, mark "Still symptomatic." If the PUI or case-patient had symptoms, and the symptoms are resolved, but there is no information about the time frame of symptom resolution, mark "Symptoms resolved, unknown date." If the interviewer and patient do not know the symptom status, mark "Unknown symptom status."

Was the patient hospitalized? Select the appropriate response. If yes, provide dates of first hospital admission and first hospital discharge in MM/DD/YYYY format. If the patient is currently hospitalized, please leave the discharge date blank. This field can be revised at a later time.

Was the patient admitted to an intensive care unit (ICU)? Select the appropriate response. Select "unknown" if the medical chart is not available or ICU admission is not known.

Did the patient receive mechanical ventilation (MV)/intubation? Select "Yes" if the patient was mechanically ventilated during hospitalization via intubation *or* tracheostomy. If yes, count the total number of days with mechanical ventilation. Round up to whole number. Select "unknown" if the medical chart is not available.

Did the patient receive extracorporeal membrane oxygenation (ECMO)?: Select the appropriate response. Select "unknown" if the medical chart is not available.

Did the patient die as a result of this illness? Select appropriate response. If "Yes," then enter date of death in MM/DD/YYYY format. If unknown date of death, please select "Unknown date of death." (In DCIPHER, this is phrased as "Check if date of death unknown.")

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Is the patient a health care worker in the United States?: Select the appropriate response. HCP are defined as all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

Does the patient have a history of being in a healthcare facility (as a patient, worker, or visitor) in China?: Select the appropriate response.

In the 14 days prior to illness onset, did the patient have any of the following exposures: Check all that apply. For healthcare contact with another lab-confirmed COVID-19 case-patient, check if the PUI or case-patient identified in the current form was a patient, a visitor (e.g., accompanying family member who was seeking care), or a healthcare worker, when they contacted a lab-confirmed COVID-19 case-patient.

If the PUI or case-patient traveled to a non-US country that was not China, select all of the countries that the person traveled to within the past 14 days by selecting all relevant response options from the drop-down menu. If the country that the PUI or case-patient traveled to in the past 14 days is not listed, you may write the appropriate country in the text field.

If the patient had contact with another COVID-19 case, was this person a U.S. case?: Select the appropriate response. If yes, please provide the nCoV ID of the source case. If the patient did not have contact with another case, please select "N/A."

Under what process was the PUI or case first identified? Please check all that apply. If identified by the EpiX notification of travelers, please provide the DGMQID. If other, please specify.

Symptoms, clinical course, past medical history and social history:

Collected from (check all that apply): Please select "patient interview" or "medical record review." If both sources were used to collect information on symptoms, clinical course, past medical history, and social history, please select both response options.

During this illness, did you experience any of the following symptoms? Please select "Yes," "No," or "Unknown" for each specific symptom. Please indicate the symptoms that the PUI or case-patient has experienced to date, even if he/she is no longer experiencing these symptoms. All symptoms should have an answer. If other symptoms were experienced, then describe the symptom in the space after "Other".

Pre-existing medical conditions?: Mark the appropriate response based on whether the PUI or case-patient has *any* pre-existing medical conditions prior to investigation or confirmation of COVID-19. If PUI or case-patient has no pre-existing medical conditions, mark "No." If not collected during interview and medical chart is missing, mark "Unknown." After answering the initial (summary) question, please provide a response for *each* pre-existing condition. All questions—other than pregnancy—pertain to a *current* or *past* history of the condition. If "Yes" to neurologic/neurodevelopment or Other Chronic Diseases, please specify. The pregnancy question

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should be marked “Yes” if the PUI or case-patient is female and currently or recently pregnant (i.e., gave birth while ill with COVID-19).

Current smoker: Select the appropriate response.

Former smoker: Select the appropriate response.

Respiratory diagnostic testing: For each pathogen, indicate whether the test was positive, negative, pending, or not done. If the PUI or case-patient had a test performed for another pathogen, please check the appropriate test result and specify the name of the pathogen next to “Other, Specify.” (In DCIPHER, please specify additional tests/pathogens only if they are positive.) If multiple tests for the same pathogen were completed, mark “Positive” if any of the tests for that pathogen were positive during the course of the illness suspected to be COVID-19.

Specimens for COVID-19 testing: For each specimen tested for the virus that causes COVID-19, record if the specimen was from a nasopharyngeal swab (NP), oropharyngeal swab (OP), sputum, or other specimen (specify type). Jurisdictions can provide up to three results for each type of specimen; if additional specimens are collected, please provide information about these specimens in the “additional state/local specimen ID” fields below this question. If there are still additional specimens, please use the notes field following the specimen collection information to provide specimen IDs. Provide the local, state, or jurisdictional specimen ID associated with each specimen, as well as the date the specimen was collected in MM/DD/YYYY format. Mark for each specimen whether it was sent to CDC or was tested at the state or jurisdictional public health laboratory.

Additional state/local Specimen IDs: Provide additional specimen IDs from state/local laboratories for specimens tested for the virus that causes COVID-19. If needed, prioritize listing those specimens testing positive for the virus that causes COVID-19, regardless of specimen type.

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CDC RESPIRATORY VIRUSES DIAGNOSTIC LABORATORY

2019 NOVEL CORONAVIRUS (nCoV) SPECIMEN SUBMISSION GUIDELINES FOR PUIs

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

Prior to submitting any specimens, consultation is required

SAFETY NOTE

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

TIMING OF SPECIMEN COLLECTION

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

SPECIMEN TYPE

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

SPECIMEN COLLECTION AND STORAGE

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

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

SPECIMEN LABELING AND DOCUMENTATION

All specimens must be labeled with:

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

Please make sure that the information on the specimen tube matches exactly the information provided in the CDC Form 50.34 below. Otherwise, the specimen will be rejected or testing will be significantly delayed while the discordant information is rectified.

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

FORM:

Each specimen should be accompanied by a completed CDC Form 50.34 (also known as a DASH form). Please include the 50.34 in the package. A copy of the form is available at: https://www.cdc.gov/laboratory/specimen-submission/pdf/form-50-34.pdf

Complete all fields of the 50.34 electronically. **DO NOT fill it in by hand.**

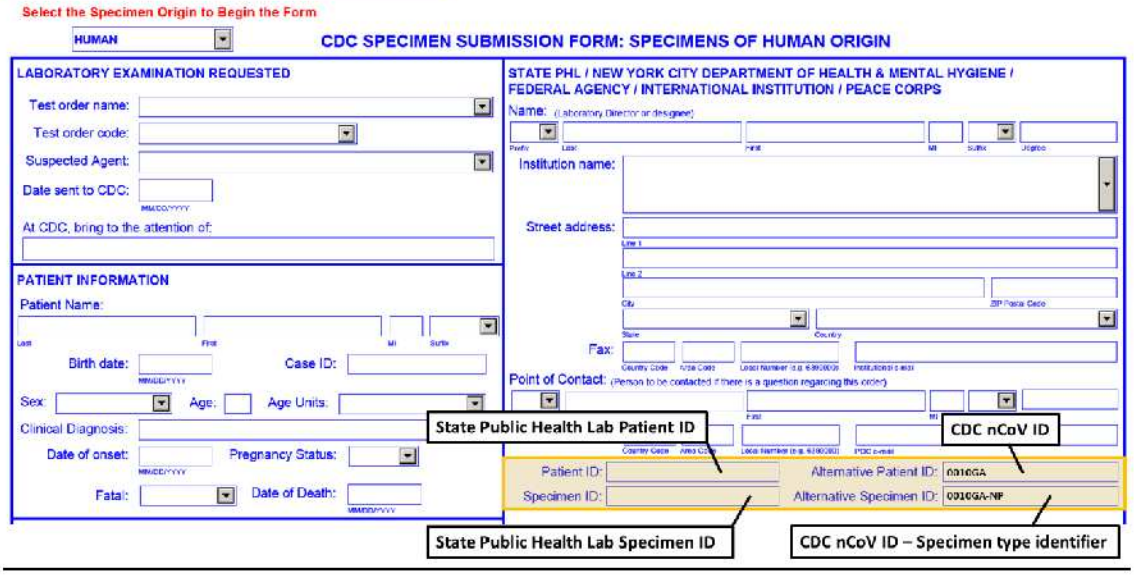
In particular, please make sure to include the following:

- Patient first name and last name
- Patient date of birth
- Original Submitter Patient ID
- Original Submitter Specimen ID
- State Public Health Laboratory contact information including full name, title, complete mailing address, email address, telephone, and fax number of the submitter
- State Public Health Lab Patient ID
- States Public Health Lab Specimen ID
- CDC nCoV ID (previously called CDC PUI ID e.g., 0010GA)
- CDC nCoV ID (previously called the CDC PUI ID) - two letter specimen type identifier (NP = nasopharyngeal swab, OP = oropharyngeal swab, SP = sputum, BAL = bronchoalveolar lavage)
    - If there are multiple of the same specimen type please label them sequentially (e.g. 0010GA-NP1, 0010GA-NP2)
- Specimen collected date
- Specimen source (type)

In the upper left-hand corner of the form, to ensure proper routing:

- For *test requested*, select "Respiratory virus molecular detection (non-influenza) CDC-10401"
- For *At CDC bring to the attention of*, put "Stephen Lindstrom: 2019-nCoV"

Please make sure the State Public Health Laboratory ID and CDC nCoV IDs (previously called the CDC PUI ID) are included in the fields indicated below.



If you need help completing the 50.34 DASH Form, please contact 404-639-2170 or cdcidlabinfo@cdc.gov

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SHIPPING GUIDELINES

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

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

All specimens must be prepacked to prevent breakage and spillage.

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

Some things ***not to do***:

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

When shipments are going out on Monday – Thursday:
Ship overnight using your usual courier such as FedEx or UPS to the following address
ATTN: STAT LAB - 2019 novel coronavirus **- PUI**
c/o Steve Lindstrom, Shifaq Kamili (Unit 84)
Respiratory Viruses Diagnostic Laboratory / DVD
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, Georgia, 30333
Telephone: 404-639-1587
Email: SQL5@CDC.GOV

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

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

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- Next, the shipping point of contact should email the above information to CDC IMS Logistics Transportation (eocevent306@cdc.gov) and CDC IMS Logistics Section Chief (CDC) (eoclogchief@cdc.gov)
- Then the shipping point of contact should call the CDC Emergency Operations Center (770-488-7100) to notify the EOC Logistics Section that a World Courier shipment needs to be arranged for coronavirus specimen shipping. Please have the PUI ID number and the information in bullet number 1 ready when you call.
- CDC EOC shipping staff will contact the person handing off the package to provide the details for how and when the courier will pick up the package.

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

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Emergency Preparedness & Response

Coronavirus Disease (COVID-19)

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Berger, Sherri (CDC/OCOO/OD); Holloway, Rachel (CDC/OCOO/OD); Jernigan, Daniel B. (CDC/DDID/NCIRD/ID); Stephanie Bialek; Armstrong, Gregory (CDC/DDID/NCEZID/OD); Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Meredith Lichtenstein
Subject:	CSTE COVID-19 Response | Reminder: Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EDT
Date:	Monday, March 16, 2020 11:20:24 AM
Attachments:	image001.png image002.png image003.png

A close up of a logo Description automatically generated

Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – Today's CSTE ad hoc weekly COVID-19 All State Epi call is set for 4:00 pm EDT. See the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board. ***Please note: Invitations for this call will only come from Preparedness@cste.org, jarieh@cste.org or mcone@cste.org.***

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. COVID-19 Jurisdictional Supplemental Funding Coordination via Crisis Cooperative Agreement, Sherri Berger, CDC Chief Operating Officer
3. COVID-19 CDC Response Update, Dan Jernigan, CDC IMS Incident Manager
4. COVID-19 Data Preparedness Update, Stephanie Bialek, CDC IMS Epi Task Force Lead
5. COVID-19 Bioinformatics Update, Greg Armstrong, CDC IMS Deputy Incident Manager
6. COVID-19 Nursing Home Preparedness, Satish Pillai, CDC IMS MCCM Task Force Lead
7. CSTE's COVID-19 Resource Repository Basecamp Demo, Meredith Lichtenstein Cone, CSTE
8. Open Forum Discussion

Next Call, Monday, March 23, 2020, 4:00-5:00 pm EDT. ***The previously scheduled March All State Epi call on Monday, March 23 at 3:00 pm EDT is replaced by this 4:00 pm EDT ad hoc call.***

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

Please click the link below to see more information, or to start the session.

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To start the session
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1. Go to https://cste.webex.com/cste/k2/j.php?MTID=tfebaa57e8bddcd420341120137d59a94
2. Log in to your account.
3. Click "Start Now".
4. Follow the instructions that appear on your screen.

To view in other time zones or languages, please click the link
https://cste.webex.com/cste/k2/j.php?MTID=tde7958b3ee30a95af0d6f666cb01aa2c

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To join the session by phone only

To receive a call back, provide your phone number when you join the training session, or call the number below and enter the access code.
Call-in toll-free number (US/Canada):1-877-668-4490
Call-in toll number (US/Canada):1-408-792-6300
Show toll-free dialing restrictions: https://www.webex.com/pdf/tollfree_restrictions.pdf
Access code: 794 313 782

For assistance

You can contact Matt Cone at:
mcone@cste.org

To add this session to your calendar program (for example Microsoft Outlook), click this link:
https://cste.webex.com/cste/k2/j.php?MTID=tcc9fb0b421fd49aec52a9401586cc521

https://www.webex.com

IMPORTANT NOTICE: This Webex service includes a feature that allows audio and any documents and other materials exchanged or viewed during the session to be recorded. By joining this session, you automatically consent to such recordings. If you do not consent to the recording, discuss your concerns with the meeting host prior to the start of the recording or do not join the session. Please note that any such recordings may be subject to discovery in the event of litigation.

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

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Emergency Preparedness & Response

Coronavirus Disease (COVID-19)

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Erin Morton; Jeff Engel; Patel, Anita (CDC/DDID/NCIRD/OD)
Subject:	CSTE COVID-19 Response	Reminder: Ad Hoc Weekly COVID-19 All State Epi Call - TODAY at 4:00 pm EDT
Date:	Monday, March 23, 2020 12:49:06 PM
Attachments:	image001.png image002.png image003.png

A close up of a logo Description automatically generated

Sent to State Epidemiologists, CLUE and the CSTE Executive Board

As a reminder, today's CSTE ad hoc weekly COVID-19 All State Epi call is set for 4:00 pm EDT. See the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. Washington Liaison Update, Erin Morton, CRD Associates
3. Update on 2020 CSTE Annual Conference, Jeff Engel, CSTE Executive Director
4. CDC COVID-19 Adult and Pediatric Online Self-Checker, Anita Patel, CDC IMS Deputy Incident Manager
5. Open Forum Discussion

Next Call, Monday, March 30, 2020, 4:00-5:00 pm EDT

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

Please click the link below to see more information, or to start the session.

To start the session
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1. Go to https://cste.webex.com/cste/k2/j.php?MTID=tfebaa57e8bddcd420341120137d59a94
2. Log in to your account.
3. Click "Start Now".
4. Follow the instructions that appear on your screen.

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To view in other time zones or languages, please click the link
https://cste.webex.com/cste/k2/j.php?MTID=tde7958b3ee30a95af0d6f666cb01aa2c

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To join the session by phone only

To receive a call back, provide your phone number when you join the training session, or call the number below and enter the access code.
Call-in toll-free number (US/Canada):1-877-668-4490
Call-in toll number (US/Canada):1-408-792-6300
Show toll-free dialing restrictions: https://www.webex.com/pdf/tollfree_restrictions.pdf
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mcone@cste.org

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Emergency Preparedness & Response

Coronavirus Disease (COVID-19)

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Wroblewski, Kelly	APHL; Chaitram, Jasmine; Kuhnert-Tallman, Wendi (CDC/DDID/NCEZID/OD); Scott Becker; Sandra Roush; Shult, Peter; Gautom, Romesh (DOH); Chandrasekera, Ruvani (OS/ASPR/SPPR)
Subject:	CSTE COVID-19 Response	Reminder: Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EDT
Date:	Monday, March 9, 2020 3:26:06 PM
Attachments:	image001.png image002.png image003.png

A close up of a logo Description automatically generated

Sent to State Epidemiologists, CLUE and the CSTE Executive Board

REMINDER – Today's CSTE ad hoc weekly COVID-19 All State Epi call is set for 4:00 pm EST. Please see the agenda and call information highlighted below, and note this call is limited to State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Announcements, Christine Hahn, Idaho State Epidemiologist
2. COVID-19 Diagnostic Laboratory Testing Updates and Discussion
    a. CDC Lab Testing Updates, Wendi Kuehnert, COVID-19 CDC IMS Response Lab Task Force Lead
    b. Public Health Reporting by Commercial Laboratories, Jasmine Chaitram, CDC CSELS/Division of Laboratory Services
    c. APHL Lab Testing Updates, Scott Becker, APHL Chief Executive Officer
    d. Notes from the Field: State Public Health Laboratory Experiences
        i. Washington State Public Health Lab, Romesh Gautom, Lab Director
        ii. Wisconsin State Public Health Lab, Pete Shult, Associate Lab Director
3. COVID-19 Sample Collection for Therapeutics and Vaccine R&D, Ruvani Chandrasekera, Executive Secretariat, HHS/ASPR USG Sample Sharing Working Group
4. Open Forum Discussion

Next Call, Monday, March 16, 2020, 4:00-5:00 pm EDT

Topic: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call
Host: Matt Cone
Date: Every Monday, from Monday, February 24, 2020 to Monday, May 4, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)

Session number: 794 313 782
Session password: epi4321

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Please click the link below to see more information, or to start the session.

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2. Log in to your account.
3. Click "Start Now".
4. Follow the instructions that appear on your screen.
To view in other time zones or languages, please click the link
https://cste.webex.com/cste/k2/j.php?MTID=tde7958b3ee30a95af0d6f666cb01aa2c

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Call-in toll number (US/Canada):1-408-792-6300
Show toll-free dialing restrictions: https://www.webex.com/pdf/tollfree_restrictions.pdf
Access code: 794 313 782

For assistance

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1-(678)-258-9582

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https://www.webex.com

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Coronavirus Disease (COVID-19)

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From:	CSTE Emergency Response
To:	CSTE Emergency Response
Cc:	CSTE Novel Coronavirus 2019; Sharon Watkins; Christine Hahn; Sandra Roush; Yoon, Paula (CDC/OPHSS/CSELS/DHIS)
Subject:	CSTE COVID-19 Response	Slides from Today"s Ad Hoc Weekly All State Epi Call
Date:	Wednesday, February 19, 2020 5:36:34 PM
Attachments:	image001.png image002.png image003.png COVID19_CSTE call_02.19.2020_for distribution.pdf



Sent to State Epidemiologists, CLUE and the CSTE Executive Board

Thank you to everyone who joined today's ad hoc All State Epi call. A PDF version of slides from the CDC IMS Response Staff COVID-19 presentation are attached. For questions pertaining to SyS data sharing for COVID-19 response, please email nssp@cdc.gov. The next ad hoc weekly All State Epi Call will be Monday, February 24 at 4 pm EST with call information coming soon.

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From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Wednesday, February 19, 2020 12:57 PM
To: CSTE Emergency Response <Preparedness@cste.org>
Cc: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>; Sharon Watkins <shawatkins@pa.gov>; Christine Hahn <Christine.Hahn@dhw.idaho.gov>; Sandra Roush <swr1@cdc.gov>; Yoon, Paula (CDC/OPHSS/CSELS/DHIS) <pay3@cdc.gov>
Subject: CSTE COVID-19 Response | Ad Hoc Weekly All State Epi Call - TODAY at 4:00 pm EST

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Sent to State Epidemiologists, CLUE and the CSTE Executive Board

CSTE's ad hoc weekly COVID-19 All State Epi call is **TODAY at 4:00 pm EST**. These calls provide an open forum for the discussion of emerging issues and response-related needs**.** Please see the WebEx info below, and note this call is intended for State Epidemiologists, CLUE and the CSTE Executive Board.

1. Welcome and Introductory Remarks, Sharon Watkins, CSTE President & Pennsylvania State Epidemiologist and Christine Hahn, Idaho State Epidemiologist
2. Implementation Update for Phase 1 to Phase 2 Transition for COVID-19 Response, CDC IMS Response Staff for COVID-19 Response
   a. Introducing phased reporting and rationale for a staggered approach—Joseph Bresee and Marc Fischer
   b. Assigning unique identifiers (nCoV ID's)—Katherine Fleming-Dutra
   c. Persons under investigation (PUI) determination and reporting—Sara Oliver
   d. Reporting confirmed cases of COVID-19—Katherine Fleming-Dutra
   e. DCIPHER end-user experience and next steps—Katherine Fleming-Dutra
3. Syndromic Surveillance Data Sharing for COVID-19 Response, Paula Yoon, CDC/CSELS
4. Text Illness Monitoring (TIM) System Poll and Discussion

Please note the routine February All State Epi call scheduled for Monday, February 24, 2020 at 3:00 pm EST is cancelled in lieu of the next ad hoc weekly COVID-19 All State Epi call, which is Monday, February 24, 4:00-5:00 pm EST

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Topic: CSTE COVID-2019 Response Ad Hoc Weekly All State Epi Call
Host: Jeremy Arieh
Date: Wednesday, February 19, 2020
Time: 4:00 pm, Eastern Standard Time (New York, GMT-05:00)
Session number: 797 772 498
Session password: epi4321

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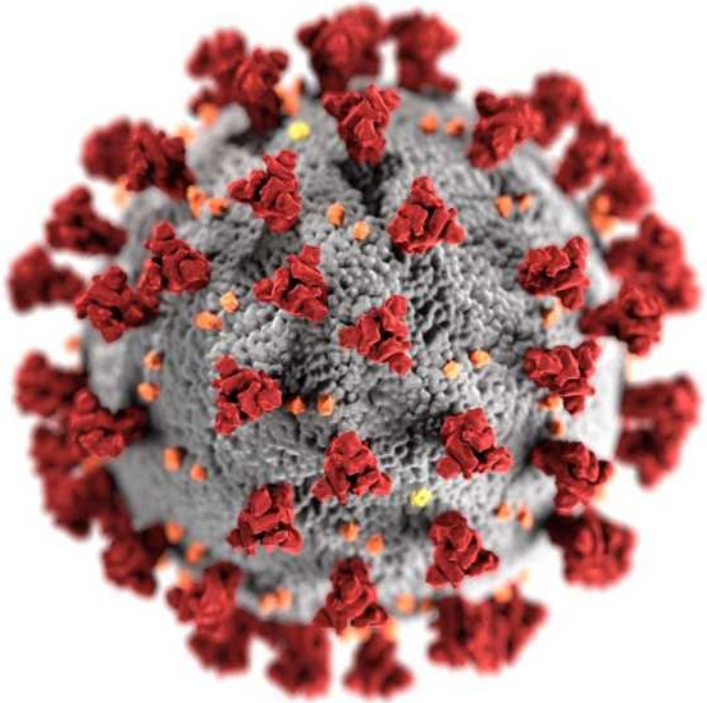
Tracking COVID-19 Persons Under Investigation & Cases

CSTE All-State Call
February 19, 2020

Speakers:
Dr. Marc Fischer, CDC COVID-19 Epi Task Force Lead
Dr. Katherine Fleming-Dutra, Case-Tracking Team Lead
Dr. Sara Oliver, Persons Under Investigation Team Lead



For more information: www.cdc.gov/COVID19

AMERICAN OVERSIGHT
FL-DOH-20-0673-A-003297

Agenda

- Introducing phased reporting and rationale for a staggered approach
- Assigning unique identifiers
- Determining and reporting Persons Under Investigation (PUI)
- Reporting confirmed cases of COVID-19
- DCIPHER end-user experience and next steps

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Phased Reporting: Rationale & Approach

Dr. Katherine Fleming-Dutra

AMERICAN OVERSIGHT

Last week, we introduced the idea of ‘Phase 1’ and ‘Phase 2’ reporting for COVID-19 cases & PUI.

Phase 1

CDC determines PUI status

CDC assigns unique PUI IDs

HDs submit PUI report forms

CDC tests specimens & returns results

HDs report confirmed cases

Phase 2

HDs determine PUI status

HDs assign unique PUI IDs

HDs submit aggregate PUI data

HDs test specimens

HDs report confirmed cases

‘Phase 2’ included a proposal for submitting **aggregate PUI data** and **individual data on lab-confirmed COVID-19 cases**.

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Due to delays in test kits, we need to move forward with case & PUI reporting in a redesigned 'Phase 2.'

Phase 1

CDC determines PUI status

CDC assigns unique PUI IDs

HDs submit PUI report forms

CDC tests specimens & returns results

HDs report confirmed cases



Redesigned Phase 2

HDs determine PUI status

HDs assign unique PUI IDs

HDs submit PUI report forms

CDC tests specimens & returns results

HDs report confirmed cases

Under this newly proposed 'Phase 2,' reporting jurisdictions will still have the independence and ability to **determine PUI status** and **assign IDs**.

We would like to continue individual PUI reporting for now, but **we can move to aggregate PUI reporting** once *most* state/local labs are testing.

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There are 4 main tasks requested of jurisdictions as they enter this redesigned 'Phase 2.'

- The 4 main tasks are:
  - Assessing ill persons and determining PUI status
  - Assigning unique identifiers to PUI and cases
  - Reporting PUI using a brief PUI form
  - Reporting lab-confirmed cases of COVID-19

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Assigning Unique Identifiers

Dr. Katherine Fleming-Dutra

AMERICAN OVERSIGHT

CDC requests that reporting jurisdictions create and assign unique identifiers for COVID-19 investigations.

- CDC will use unique individual-level identifiers, known as **nCoV IDs**, to track and link data for persons being tested for COVID-19 in the U.S.

- Reporting jurisdictions are asked to use the **nCoV ID Algorithm (next slide)** to directly assign a unique ID to **each person tested for COVID-19**.

- Reporting jurisdictions may *also* assign nCoV IDs for persons they are monitoring but *not* testing. This is optional.

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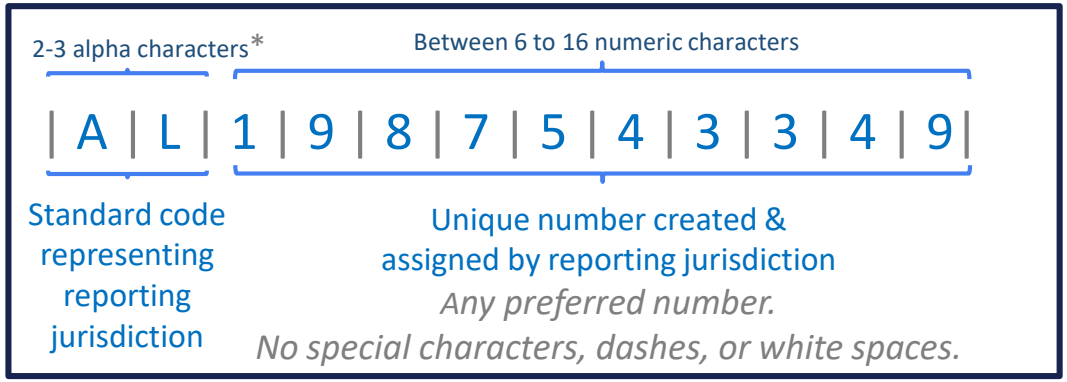
Assignment of unique identifiers (nCoV IDs) should adhere to a specified algorithm to ensure they are truly unique.

Algorithm to Produce Unique Person Identifiers (nCOV IDs)



*Reporting jurisdictions are identified by 2-3 alpha characters, as listed in next slide

Jurisdictions should include the unique nCoV ID:

- Laboratory specimens sent to CDC
- NNDSS/HL7 Case Notification messages
- PUI & Case Report Forms

!!! Important !!!

Do not add special characters, dashes, or white spaces to the nCoV ID.
The alpha- and numeric-portions of the ID are seamless.
The numeric portion of the ID cannot begin with zero ('0').

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Standard alpha-codes will be used to identify each of the 59 reporting jurisdictions.

State	Code
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY

State	Code
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND

State	Code
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Territory/Jurisdiction	Code
American Samoa	AS
District of Columbia	DC
Guam	GU
New York City	NYC
Northern Mariana Islands	MP
Puerto Rico	PR
U.S. Virgin Islands	VI
Federated States of Micronesia	FSM
Republic of Marshall Islands	RMI

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Determining and Reporting PUI

Dr. Sara Oliver

AMERICAN OVERSIGHT

In Phase 2, jurisdictions can independently assess ill persons and determine if they meet the PUI definition.

	Clinical Features	&	Epidemiologic Risk
1	Fever[1] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers, who has had close contact[2] with a laboratory-confirmed[3,4] 2019-nCoV patient within 14 days of symptom onset
2	Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China[5] within 14 days of symptom onset
3	Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization[4]	**AND**	A history of travel from mainland **China**[5] within 14 days of symptom onset

The criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health departments on a case-by-case basis. For severely ill individuals, testing can be considered when exposure history is equivocal (e.g., uncertain travel or exposure, or no known exposure) and another etiology has not been identified.

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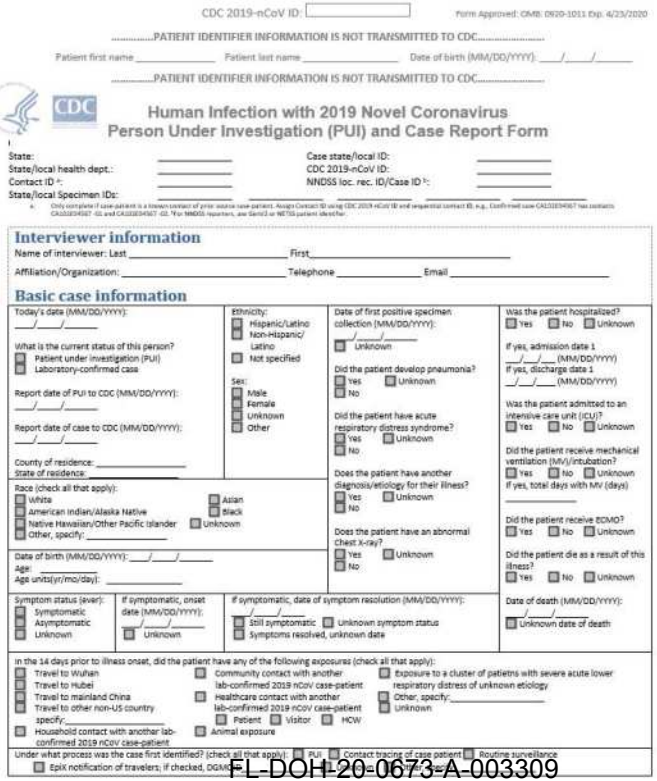
FL-DOH-20-0673-A-003308

Full details: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

CDC requests that reporting jurisdictions complete a brief form for each PUI identified.

- The PUI form will become available in electronic format.
- There are many advantages to completing the form electronically, because the PUI & case report forms have been merged.
- All lab testing procedures remain in place.



CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ___/___/_____

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

CDC

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

State: _____ Case state/local ID: _____
State/local health dept.: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____
State/local Specimen IDs: _____ _____ _____ _____

a. Only complete if case patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019 nCoV ID and sequential contact ID, e.g., Confirmed case CA10034567 has contacts CA10034567-01 and CA10034567-02. For NNDSS reporters, see Gen3 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic case information

Today's date (MM/DD/YYYY): ___/___/_____

What is the current status of this person?
☐ Patient under investigation (PUI)
☐ Laboratory-confirmed case

Report date of PUI to CDC (MM/DD/YYYY): ___/___/_____

Report date of case to CDC (MM/DD/YYYY): ___/___/_____

County of residence: _____
State of residence: _____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Not specified

Sex:
☐ Male
☐ Female
☐ Unknown
☐ Other

Date of first positive specimen collection (MM/DD/YYYY): ___/___/_____
☐ Unknown

Did the patient develop pneumonia?
☐ Yes ☐ Unknown
☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown
☐ No

Does the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown
☐ No

Does the patient have an abnormal Chest X-ray?
☐ Yes ☐ Unknown
☐ No

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1: ___/___/___ (MM/DD/YYYY)
If yes, discharge date 1: ___/___/___ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown

If yes, total days with MV (days): _____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY): ___/___/_____
☐ Unknown date of death

Race (check all that apply):
☐ White
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Other, specify: _____
☐ Asian
☐ Black
☐ Unknown

Date of birth (MM/DD/YYYY): ___/___/_____
Age:
Age units(yr/mo/day): _____

Symptom status (ever):
☐ Symptomatic
☐ Asymptomatic
☐ Unknown

If symptomatic, onset date (MM/DD/YYYY): ___/___/_____
☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY): ___/___/_____
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
☐ Travel to Wuhan
☐ Travel to Hubei
☐ Travel to mainland China
☐ Travel to other non-US country specify: _____
☐ Household contact with another lab-confirmed 2019 nCoV case-patient
☐ Community contact with another lab-confirmed 2019 nCoV case-patient
☐ Healthcare contact with another lab-confirmed 2019 nCoV case-patient
☐ Patient ☐ Visitor ☐ HCW
☐ Animal exposure
☐ Exposure to a cluster of patietns with severe acute lower respiratory distress of unknown etiology
☐ Other, specify: _____
☐ Unknown

Under what process was the case first identified? (check all that apply): ☐ PUI ☐ Contact tracing of case patient ☐ Routine surveillance
☐ EpiX notification of travelers; if checked, DGMQ

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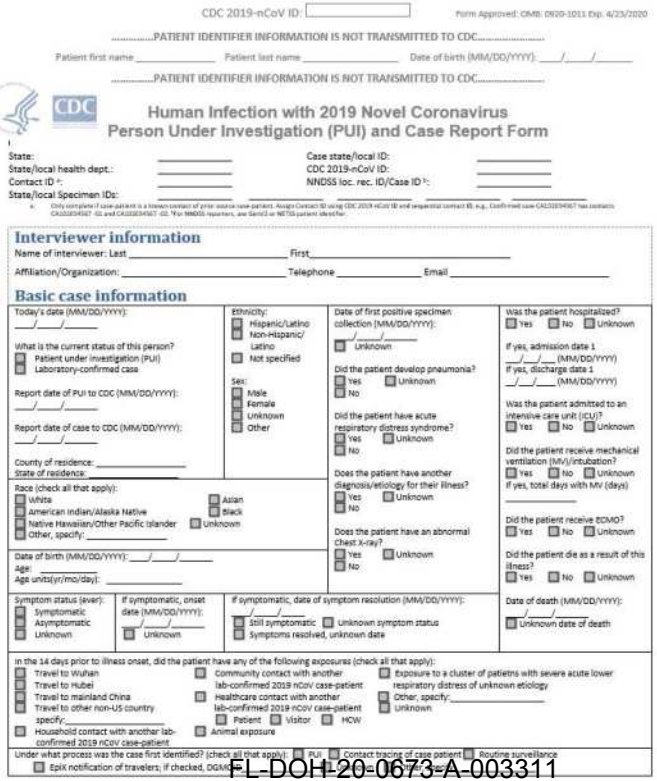
Case Reporting for Confirmed COVID-19

Dr. Katherine Fleming-Dutra

AMERICAN OVERSIGHT

If a respiratory specimen tests positive, CDC requests that reporting jurisdictions update the PUI's status.

- CDC has consolidated the PUI form with the case report form.
- Only lab-confirmed COVID-19 merits being labeled a 'case.'
- No additional form is needed. Jurisdictions are encouraged to assess whether updates to previously reported data are needed.



CDC 2019-nCoV ID: Form Approved: OMB: 0920-1011 Exp. 4/23/2020

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name Patient last name Date of birth (MM/DD/YYYY): ___/___/_____

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

CDC

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

State: Case state/local ID:
State/local health dept.: CDC 2019-nCoV ID:
Contact ID [a]: NNDSS loc. rec. ID/Case ID [b]:
State/local Specimen IDs:

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019 nCoV ID and sequential contact ID, e.g., Confirmed case CA10034567 has contacts CA10034567-01 and CA10034567-02. For NNDSS reporters, see Section 2 on NETSS patient identifier.

Interviewer information

Name of interviewer: Last First
Affiliation/Organization: Telephone Email

Basic case information

Today's date (MM/DD/YYYY): ___/___/_____

What is the current status of this person?
- Patient under investigation (PUI)
- Laboratory-confirmed case

Report date of PUI to CDC (MM/DD/YYYY): ___/___/_____

Report date of case to CDC (MM/DD/YYYY): ___/___/_____

County of residence:
State of residence:

Ethnicity:
- Hispanic/Latino
- Non-Hispanic/Latino
- Not specified

Sex:
- Male
- Female
- Unknown
- Other

Date of first positive specimen collection (MM/DD/YYYY): ___/___/_____ Unknown

Did the patient develop pneumonia? Yes Unknown No

Did the patient have acute respiratory distress syndrome? Yes Unknown No

Does the patient have another diagnosis/etiology for their illness? Yes Unknown No

Does the patient have an abnormal Chest X-ray? Yes Unknown No

Was the patient hospitalized? Yes No Unknown

If yes, admission date 1 ___/___/___ (MM/DD/YYYY)
If yes, discharge date 1 ___/___/___ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)? Yes No Unknown

Did the patient receive mechanical ventilation (MV)/intubation? Yes No Unknown
If yes, total days with MV (days)

Did the patient receive ECMO? Yes No Unknown

Did the patient die as a result of this illness? Yes No Unknown

Date of death (MM/DD/YYYY): ___/___/_____ Unknown date of death

Race (check all that apply):
- White
- American Indian/Alaska Native
- Native Hawaiian/Other Pacific Islander
- Other, specify:
- Asian
- Black
- Unknown

Date of birth (MM/DD/YYYY): ___/___/_____
Age:
Age units(yr/mo/day):

Symptom status (ever):
- Symptomatic
- Asymptomatic
- Unknown

If symptomatic, onset date (MM/DD/YYYY): ___/___/_____ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY): ___/___/_____
- Still symptomatic
- Unknown symptom status
- Symptoms resolved, unknown date

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
- Travel to Wuhan
- Travel to Hubei
- Travel to mainland China
- Travel to other non-US country specify:
- Household contact with another lab-confirmed 2019 nCoV case-patient
- Community contact with another lab-confirmed 2019 nCoV case-patient
- Healthcare contact with another lab-confirmed 2019 nCoV case-patient
  - Patient
  - Visitor
  - HCW
- Animal exposure
- Exposure to a cluster of patietns with severe acute lower respiratory distress of unknown etiology
- Other, specify:
- Unknown

Under what process was the case first identified? (check all that apply): PUI Contact tracing of case patient Routine surveillance
EpiX notification of travelers; if checked, DGMQ

FL-DOH-20-0673-A-003311

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DCIPHER

Dr. Katherine Fleming-Dutra

AMERICAN OVERSIGHT

DCIPHER is a web-based platform used to store, transmit, and visualize person-based data.

- The DCIPHER* platform is currently used in food- and waterborne outbreaks, as well as by partners in emergency preparedness.

- CDC will use DCIPHER for:
  - Reporting Persons Under Investigation (PUI) for COVID-19
  - Reporting lab-confirmed cases of COVID-19

- Jurisdictions should contact CDC (eocevent118@cdc.gov) if they cannot use DCIPHER to report PUI and cases.

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*DCIPHER stands for "Data Collation and Integration for Public Health Event Response"

Each reporting jurisdiction has been asked to provide a list of 2–4 DCIPHER users responsible for data-entry.

- Most jurisdictions have reported at least 2 users to CDC.
  - Once named, users will work through an 'authentication' process.
  - Users will need to complete 'Rules of Behavior' to gain access to COVID-19 forms.

- CDC will host a training for DCIPHER users during the **week of February 24** (date TBD).

- If you have not submitted the names of your DCIPHER users, please do so as soon as possible.

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articles - Dropbox | create new case

dcipher.cdc.gov/workspace/home

Imported From Fire... | DGHT | Duolingo | International Travel... | Files - Dropbox | GoToMeet.Me | Meeting Planner –... | Office 365 Login |... | Global Travel Office...

- Home
- Projects & files
- Recent
- Search... Ctrl + J

APPS · View all

- Object explorer
- Contour
- Reports

- Notifications
- Help & support
- Account

CDC

HELP & RESOURCES

- Palantir Foundry 101
- User Docs
- Contact Support



Hi JENNIFER, welcome to the CDC response for Coronoavirus Disease 2019

Entering Data

Add Core Responses for a New Case - CRF
Add core data for a new COVID-2019 case

Add Interview Responses - CRF
Add interview data for a COVID-2019 case

Add Exposure Responses - CRF
Add exposure data for a COVID-2019 case

Add Medical Chart Abstractions Responses - CRF
Add medical chart abstractions data for a COVID-2019 case

Add Laboratory Testing Responses - CRF
Add laboratory testing data for a COVID-2019 case

Edit and Search Data

Explore & Update Cases
Search across and edit all COVID-2019 cases

Review Analysis
View analysis created for the COVID-2019 response

Key Folders and Docs

2019-nCoV Folders
All project spaces for the COVID-2019 Response

2019-nCoV Data Pipeline
Full lineage for the entire data pipeline

Application Quick Links View all

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FL-DOH-20-0673-A-003315

1:53 PM 2/14/2020

Timeline

- CDC hopes to roll out Phase 2 during the week of February 24. We will email all State & Territorial Epidemiologists when the system is ready for use.
- In the meantime, please assess your jurisdiction's ability to perform the 4 main Phase 2 tasks:
  - Assessing ill persons and determining PUI status
  - Assigning unique identifiers (nCoV IDs) to PUI and cases
  - Reporting PUI using a brief PUI form
  - Reporting lab-confirmed cases of COVID-19
- Email eocevent118@cdc.gov to confirm your readiness for Phase 2.

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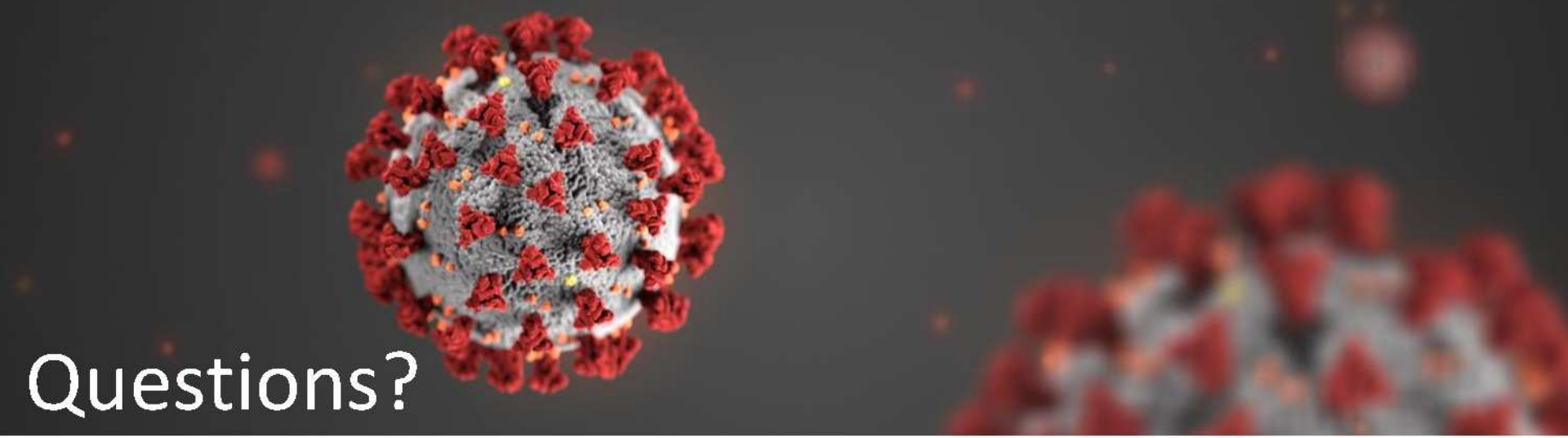

Questions?

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

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

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Emergency Preparedness & Response

Coronavirus Disease (COVID-19)

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

To: jacqueline@doh.as; bensili@doh.as; Nathan.Koffarnus@health.mo.gov; john.bos@health.mo.gov; Kelso, Patsy (CDC vermont.gov); Cook, Sally (CDC vermont.gov); William.Fritch@vermont.gov; Read, Jennifer (CDC vermont.gov); Turner, Kathryn (CDC dhw.idaho.gov); scott.hutton@dhw.idaho.gov; Iyengar, Preetha (CDC dc.gov); McGee, Sasha (CDC dc.gov); jennifer.myers@cdph.ca.gov; Lowenthal, Phil (CDC cdph.ca.gov); Ed.Powers@cdph.ca.gov; Charsey.Porse@cdph.ca.gov; Robert.Snyder@cdph.ca.gov; selam.Tecle@cdph.ca.gov; Charlotte.Girocco@cdph.ca.gov; jhmsablan@gmail.com; ginger.stringer@state.co.us; tasha.poissant@state.or.us; emilio.e.debess@state.or.us; alexia.y.zhang@state.or.us; amanda.e.faulkner@state.or.us; Linda.DeNorcey@dphss.guam.gov; Madeline.K.Levasseur@dhsoha.state.or.us; Powell, Melissa (CDC state.or.us); kelly.e.cogswell@state.or.us; Rekant, Steven (CDC dhsoha.state.or.us); Clayton, Joshua (CDC state.sd.us); Horan, Vickie (CDC state.sd.us); dustin.ortbahn@state.sd.us; Kipp.Stahl@state.sd.us; 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Shallyburton@isdh.in.gov; LMilroy@isdh.IN.gov; prevolt@isdh.in.gov; Gaub, Kathryn (CDC isdh.in.gov); rreporter@ph.lacounty.gov; mpulido@ph.lacounty.gov; Ward, Peter (CDC illinois.gov); Kauerauf, Judy (CDC illinois.gov); Austin, Connie (CDC illinois.gov); david.hennings@illinois.gov; michael.moore@illinois.gov; lori.saathoff@illinois.gov; Nims, Dawn (CDC illinois.gov); julie.dow@illinois.gov; rebecca.hambelton@illinois.gov; Lisa.McHugh@doh.nj.gov; kelly.miller-hood@doh.nj.gov; deepam.thomas@doh.nj.gov; rosemary.kidder@doh.nj.gov; Jill.Dinitz-Sklar@doh.nj.gov; barbara.carothers@doh.nj.gov; rebecca.greeley@doh.nj.gov; julia.wells@doh.nj.gov; Kathleen.Ross@doh.nj.gov; Robert.Sunkel@doh.nj.gov; annmarie.haldeman@doh.nj.gov; Pinar.Erdogdu@doh.nj.gov; Erica.Rauch@doh.nj.gov; alicia.sloughfy@doh.nj.gov; nicolette.wilson@doh.nj.gov; Tara.Fulton@doh.nj.gov; Perez, Stephan (CDC doh.nj.gov); cburnett@utah.gov; Chelsea.Mcmullen@state.nmus; Emma.stanislawski@state.nm.us; Daniel.sosin@state.nm.us; Joesph.Hicks@state.nm.us; 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Komatsu, Kenneth (CDC azdhs.gov); Watt, James (CDC cdph.ca.gov); Herlihy, Rachel (CDC state.co.us); Tolliver, Rickey (CDC state.co.us); Cartter, Matthew (CDC ct.gov); Tabatha.Offutt-Powell@state.de.us; Blackmore, Carina (CDC flhealth.gov); Ann.Pobutsky@dphss.guam.gov; Hahn, Christine G. <ID> (CDC dhw.idaho.gov); Layden, Jennifer (CDC illinois.gov); Pontones, Pamela (CDC isdh.in.gov); Thoroughman, Douglas (CDC ky.gov); Ratard, Raoult (CDC la.gov); catherine.brown@state.ma.us; ejohnson@fsmhealth.fm; Lynfield, Ruth (CDC state.mn.us); george.turabelidze@health.mo.gov; Williamson, Laura (CDC mt.gov); Safranek, Thomas <NE> (CDC nebraska.gov); Benjamin.Chan@dhhs.nh.gov; Tan, Christina (CDC doh.state.nj.us); Landen, Michael (CDC state.nm.us); Blog, Debra (CDC health.ny.gov); Layton, Marci (CDC health.nyc.gov); Moore, Zackary (CDC dhhs.nc.gov); Miller, Tracy (CDC nd.gov); paul.white@dph.gov.mp; deFijter, Sietske (CDC odh.ohio.gov); dean.e.sidelinger@dhsoha.state.or.us; shawatkins@pa.gov; carmen.deseda@salud.pr.gov; Bandy, Utpala (CDC health.ri.gov); Bell, Linda (CDC dhec.sc.gov); Dunn, John (CDC tn.gov); Stephen.Pont@dshs.texas.gov; lilian.peake@vdh.virginia.gov; Lindquist, Scott SL (CDC doh.wa.gov); Del Rosario, Maria (CDC wv.gov); Ryan.Westergaard@dhs.wisconsin.gov
Cc:	Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR); Hawkins-Prather, Devi I. (CDC/DDPHSIS/CSTLTS/DPPS); Patterson, Margaret (CDC/DDPHSIS/CSTLTS/DPIFS); Holmes, Wendy (CDC/DDPHSIS/CSTLTS/OD)
Subject:	DCIPHER DEMO: COVID-19 Traveler Health Screening Data
Attachments:	COVID-19 Response Travel Training Document.pdf

Please join us at the next demonstration of how to access COVID-19 Traveler Health Screening Data in the Data Collation & Integration for Public Health Event Response (DCIPHER) platform. This demo is similar to the first demo held last week, and appropriate for new DCIPHER users, or users who would like a refresher. Please forward to relevant members of your state teams, as necessary.

This demo will be facilitated by CDC DCIPHER technical staff, and CDC DGMQ staff.

Please note The demo will be live, however, participants are not required or expected to log into DCIPHER and follow along. If participants do not currently have access to DCIPHER, the demo is still a beneficial introduction to how the system is being utilized in the CDC COVID-19 Response.

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Join Skype Meeting <https://webconf.cdc.gov/kou3/M2P83N1H>

Trouble Joining? Try Skype Web App <https://webconf.cdc.gov/kou3/M2P83N1H?sl=1>

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[!OC([1033])!]

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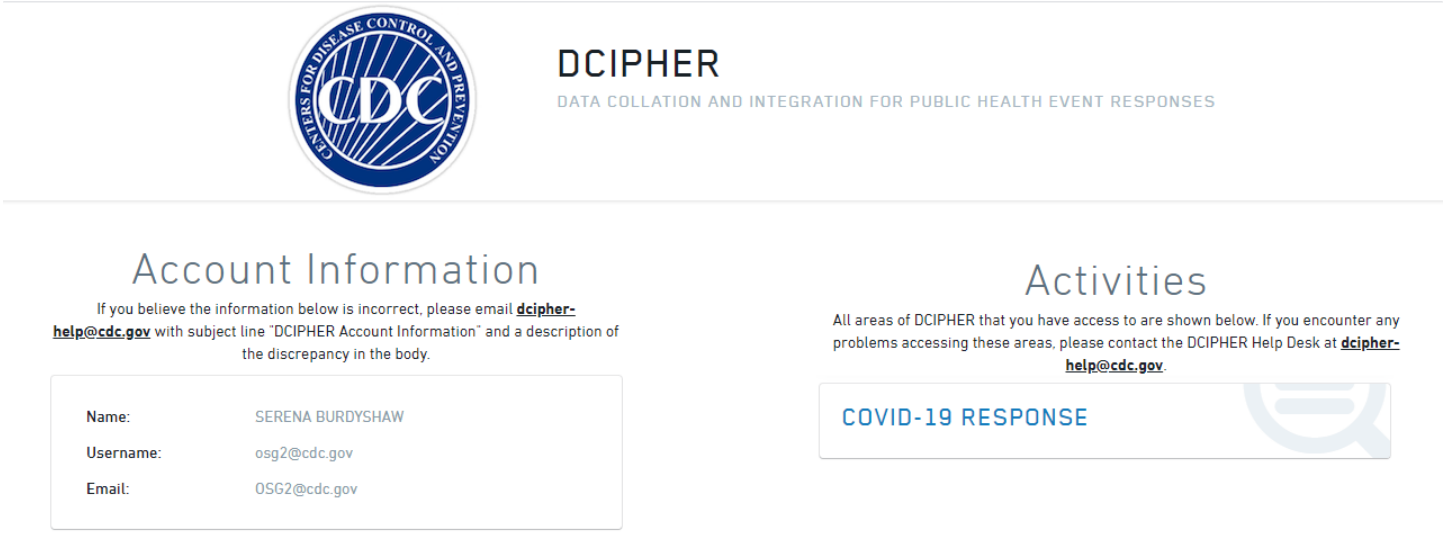
COVID-19 Response Travel Training Document

This training guide will take you through the process to enter data into DCIPHER, update data within DCIPHER and view Reports. This guide is intended for users that are viewing the EpiX travel data and completing the Aggregate State Monitoring Form for the 2019 Novel Coronavirus Response.

Platform Navigation

After logging into DCIPHER users will see the below DCIPHER Homepage. Under activities users can select the "COVID-19 Response" button.



After clicking the COVID-19 Response button, users will see the below landing page for the Coronavirus Disease 2019 Response. The key features are the "Entering Data" section and the "Edit and Search Data" button. The tutorial will focus on these two areas.

If the landing page does not load correctly (e.g., missing buttons), please reference the troubleshooting tips at the end of this tutorial)

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Entering data in the Aggregate State Monitoring form

To enter data into the aggregate state monitoring form, go to the 2019-nCoV Response landing page at

https://dcipher.cdc.gov/workspace/home

On the landing page click the "Add aggregate travel data" button (indicated by a green box below) to open the Aggregate State Monitoring form.

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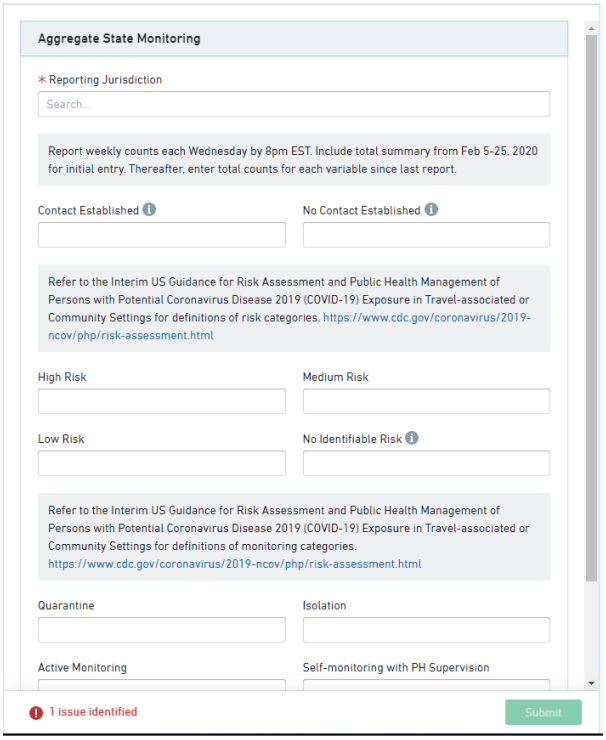
This will open the Aggregate State Monitoring form. Please enter all appropriate information and click the submit button. Fields that are required are indicated by a red asterisk.



Viewing EpiX Travel Data

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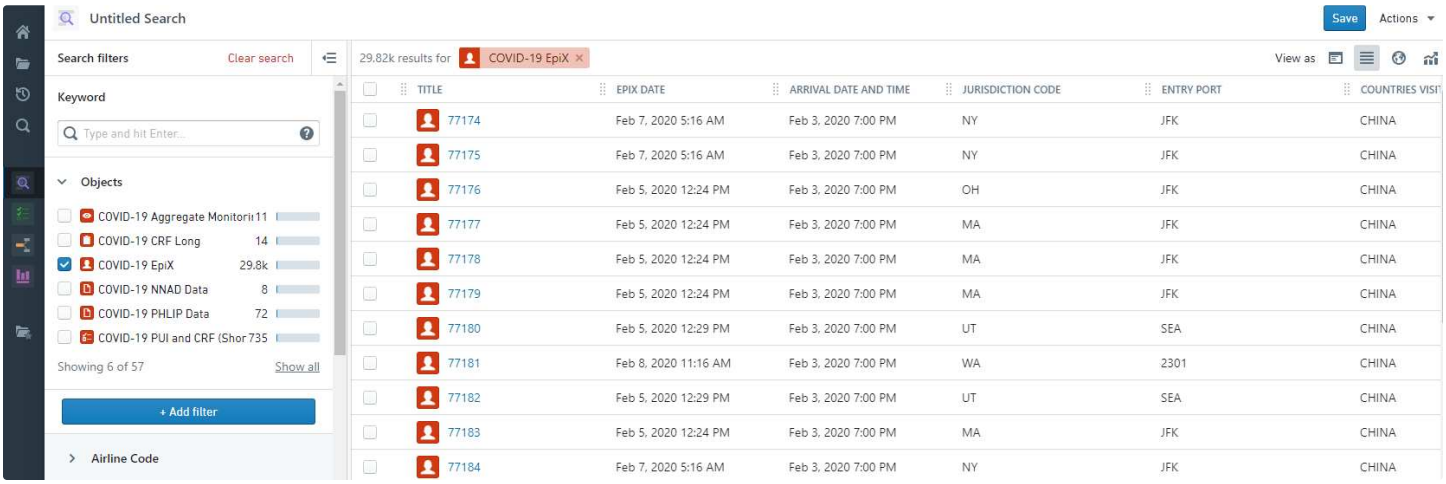
Data that was entered via EpiX can be viewed within the platform. To view this data navigate back to the landing page after



You will be taken to a list of travelers for your state that have been submitted. You can then search and click on the travelers of interest. The travelers are listed by their DGMQ ID.



After opening the traveler of interest, you will be shown the Traveler View. This provides summary information on the traveler including a timeline, personal information, temporary contact information, medical information, and travel information.

Troubleshooting Tips

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This sections covers a few troubleshooting steps for users to follow should they encounter an issue.

COVID-19 Landing Page does not load correctly:

If the landing page is missing the main buttons (Add a New Case, Explore & Update Cases, View National Report) please follow the steps below:

1. Clear your browser history including cookies and cached images/files and close your browser
2. Open Chrome and go to the following url: https://dcipher.cdc.gov/workspace/home
3. If you still do not see buttons to "Add aggregate travel data" and "Explore & Update Data," please restart your computer
4. Open Chrome and go to the following url: https://dcipher.cdc.gov/workspace/home

If the landing page still does not load, users can reach the main buttons using the below links:

1. Add Aggregate Data: https://dcipher.cdc.gov/workspace/fforms/f/new/ri.fforms.main.form.6e026126-e26d-4560-a69e-5cfebb981cae
2. Explore & Update Cases: https://dcipher.cdc.gov/workspace/hubble/search/N4Ig1gpgng7g9gJwCYgFwhAGhHARgKwgGMAXAFSgAcIBnNAbQF1sAzASwBsSIE7UmAvkA?searchId=a4aaf1b4-a6ac-4a51-b9b7-90367b9ec046

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https://dcipher.cdc.gov/workspace/report/ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae?searchId=a4aaf1b4-a6ac-4a51-b9b7-90367b9ec046&reportId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae&reportVersion=00000000-0000-0000-0000-000000000000&reportTab=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.tab.1&reportTabId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.tab.1&reportTabVersion=00000000-0000-0000-0000-000000000000&reportTabVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000&reportVersionTab=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.tab.1&reportVersionTabId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionTabVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000&reportVersionVersionTab=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1&reportVersionVersionTabId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionTabVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionTab=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1&reportVersionVersionVersionTabId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionTabVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionVersionTab=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1&reportVersionVersionVersionVersionTabId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionVersionTabVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionVersionVersionId=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000&reportVersionVersionVersionVersionVersionTab=ri.report.main.report.6e026126-e26d-4560-a69e-5cfebb981cae.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.version.00000000-0000-0000-0000-000000000000.tab.1&reportVersionVersionVersionVersionVersionTabId=ri.report.main.report.6e026126-e26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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Cc:	Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR)
Subject:	DCIPHER Users: CDC Aggregate Travel Module is due March 4 and there will be another Training March 6th- details below.
Date:	Tuesday, March 3, 2020 1:09:18 PM
Attachments:	DCIPHER QA Monitoring_03March2020.pdf

Good afternoon,

This email serves as a reminder that aggregate counts for monitoring of travelers in your jurisdiction are **due weekly each Wednesday by 8 p.m. ET.**

Jurisdictions that successfully entered initial information should submit aggregate counts for each variable for the period from **February 26, 2020, through March 3, 2020** by 8p.m. March 4, 2020**.**

Jurisdictions first entering information on March 4, 2020 should submit two entries. First, complete the form with aggregate counts **from February 5, 2020, through February 25, 2020.** Then submit a second form with aggregate counts from **February 26, 2020, through March 3, 2020.**

Refer to the attached Q/A if you have questions about the monitoring form.

Another DCIPHER training is planned for Friday, March 6, 2020 at 1:30pm. Below is the call in information. A calendar invitation for the training was also sent today.

Join Skype Meeting

Trouble Joining? Try Skype Web App

Join by phone

(770) 488-3600,,54801562# (Chamblee Dial-in Conference Region)	English (United States)
(855) 644-0229,,54801562# (Chamblee Dial-in Conference Region)	English (United States)

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Kimberly
Kimberly Cantrell

AMERICAN OVERSIGHT

State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

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Entering Aggregate Data in DCIPHER for Epi-X traveler notifications

1. **How do I access DCIPHER?**
   To access DCIPHER, you need Secure Access Management Services (SAMS) approval, and you must complete, sign, and return a Rules of Behavior form. Once access is granted, you can log into DCIPHER, https://dcipher.cdc.gov/. **If you already have SAMS and DCIPHER access (from other responses or routine business), see question #2 below.**

2. **How do I gain COVID-19 DCIPHER access or resolve system issues and error messages?**
   Send a message to DCIPHER@cdc.gov to **request COVID-19 access** (see question #1) or to resolve system issues. To expedite responses to issues, include a detailed description of the problem and attach a screenshot if possible.

3. **When are monitoring reports due?**
   Report weekly counts each Wednesday by 8 p.m. ET. Include total summary counts for notifications from February 5, 2020, through February 25, 2020, for initial data entry. Thereafter, enter total counts for each variable since the last report. Weekly summary counts represent estimates for new travelers since the last report.

   3a. What should jurisdictions first entering information on March 4, 2020 submit?
   Submit two entries. First, complete the form with aggregate counts **from February 5, 2020, through February 25, 2020.** Then submit a second form with aggregate counts from **February 26, 2020, through March 3, 2020.**

4. **Who should be included in monitoring reports?**
   Health departments have received traveler notifications via *Epi-X* since February 5, 2020. The DCIPHER aggregate monitoring is intended to primarily collect information about those travelers. However, it is acceptable to submit aggregate counts that include state identified travelers (e.g., travelers who have self-identified to the public health system or through some other source).

5. **What do I need to report?**
   Report aggregate counts about established **contacts, risk group, and monitoring type**. **Contact Established** means the health department made a connection with the traveler either actively (verbal confirmation) or passively (automated notification, text message, left a voicemail on a working number even if not returned, TIMS, etc.). **No Contact Established** includes travelers not reached due to nonworking phone numbers, no voicemail, etc.

   Refer to the *Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings (***https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) for definitions of risk category and monitoring types.**

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6. **Could you define the monitoring types?**
   Refer to the *Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings (*[**https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html)**](https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) **for definitions of risk category and monitoring types.**

7. **Will *Epi-X* notifications continue?**
   Epi-X traveler notifications will continue; DCIPHER is a secondary source for jurisdictions to ascertain the same information in a single, downloadable file.

8. **Is there a delay between *Epi-X* notifications and data in DCIPHER?**
   Yes, approximately an hour. *Epi-X* notifications are sent twice a day, at approximately 9 a.m. and 4 p.m. ET. Likewise, traveler information will be updated in DCIPHER twice a day, at approximately 10 a.m. and 5 p.m. ET.

9. **How long will monitoring reports be required?**
   We do not know. We understand the need to minimize burden on state staff. We will evaluate the information we receive and reassess reporting requirements as the response phase changes.

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

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Subject: DCIPHER Users: CDC Weekly Aggregate Travel Report due March 18

Date: Tuesday, March 24, 2020 1:40:02 PM

Attachments: DCIPHER QA Monitoring_03March2020.pdf

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Good afternoon,

This email serves as a reminder that aggregate counts for monitoring of travelers in your jurisdiction are **due weekly each Wednesday by 8 p.m. ET.**

A variable to indicate **Reporting Period** was added to the form. Submit one report for each time period that has passed; there is no need to update previously submitted information. Jurisdictions up to date on submissions, only need to submit aggregate counts by March 25, 2020 for each variable for the period from **March 18, 2020, through March 24, 2020.**

Refer to the attached Q/A if you have questions about the monitoring form.

Thank you, Devi

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

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Entering Aggregate Data in DCIPHER for Epi-X traveler notifications

1. **How do I access DCIPHER?**
   To access DCIPHER, you need Secure Access Management Services (SAMS) approval, and you must complete, sign, and return a Rules of Behavior form. Once access is granted, you can log into DCIPHER, https://dcipher.cdc.gov/. **If you already have SAMS and DCIPHER access (from other responses or routine business), see question #2 below.**

2. **How do I gain COVID-19 DCIPHER access or resolve system issues and error messages?**
   Send a message to DCIPHER@cdc.gov to **request COVID-19 access** (see question #1) or to resolve system issues. To expedite responses to issues, include a detailed description of the problem and attach a screenshot if possible.

3. **When are monitoring reports due?**
   Report weekly counts each Wednesday by 8 p.m. ET. Include total summary counts for notifications from February 5, 2020, through February 25, 2020, for initial data entry. Thereafter, enter total counts for each variable since the last report. Weekly summary counts represent estimates for new travelers since the last report.

   3a. What should jurisdictions first entering information on March 4, 2020 submit?
   Submit two entries. First, complete the form with aggregate counts **from February 5, 2020, through February 25, 2020.** Then submit a second form with aggregate counts from **February 26, 2020, through March 3, 2020.**

4. **Who should be included in monitoring reports?**
   Health departments have received traveler notifications via *Epi-X* since February 5, 2020. The DCIPHER aggregate monitoring is intended to primarily collect information about those travelers. However, it is acceptable to submit aggregate counts that include state identified travelers (e.g., travelers who have self-identified to the public health system or through some other source).

5. **What do I need to report?**
   Report aggregate counts about established **contacts, risk group, and monitoring type**. **Contact Established** means the health department made a connection with the traveler either actively (verbal confirmation) or passively (automated notification, text message, left a voicemail on a working number even if not returned, TIMS, etc.). **No Contact Established** includes travelers not reached due to nonworking phone numbers, no voicemail, etc.

   Refer to the *Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings (***https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) for definitions of risk category and monitoring types.**

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6. **Could you define the monitoring types?**
   Refer to the *Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings (*[**https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html)**](https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) **for definitions of risk category and monitoring types.**

7. **Will *Epi-X* notifications continue?**
   Epi-X traveler notifications will continue; DCIPHER is a secondary source for jurisdictions to ascertain the same information in a single, downloadable file.

8. **Is there a delay between *Epi-X* notifications and data in DCIPHER?**
   Yes, approximately an hour. *Epi-X* notifications are sent twice a day, at approximately 9 a.m. and 4 p.m. ET. Likewise, traveler information will be updated in DCIPHER twice a day, at approximately 10 a.m. and 5 p.m. ET.

9. **How long will monitoring reports be required?**
   We do not know. We understand the need to minimize burden on state staff. We will evaluate the information we receive and reassess reporting requirements as the response phase changes.

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

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Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR)

Subject: DCIPHER Users: CDC Weekly Aggregate Travel Report due March 18

Date: Tuesday, March 17, 2020 6:38:49 PM

Attachments: DCIPHER QA Monitoring_03March2020.pdf

Good afternoon,

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This email serves as a reminder that aggregate counts for monitoring of travelers in your jurisdiction are **due weekly each Wednesday by 8 p.m. ET.**

A variable to indicate **Reporting Period** was added to the form. Submit one report for each time period that has passed; there is no need to update previously submitted information. Jurisdictions up to date on submissions, only need to submit aggregate counts by March 18, 2020 for each variable for the period from **March 11, 2020, through March 17, 2020.**

Refer to the attached Q/A if you have questions about the monitoring form.

Thank you, Devi

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

Wendy Holmes: 404-452-9792

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Entering Aggregate Data in DCIPHER for Epi-X traveler notifications

1. **How do I access DCIPHER?**
   To access DCIPHER, you need Secure Access Management Services (SAMS) approval, and you must complete, sign, and return a Rules of Behavior form. Once access is granted, you can log into DCIPHER, https://dcipher.cdc.gov/. **If you already have SAMS and DCIPHER access (from other responses or routine business), see question #2 below.**

2. **How do I gain COVID-19 DCIPHER access or resolve system issues and error messages?**
   Send a message to DCIPHER@cdc.gov to **request COVID-19 access** (see question #1) or to resolve system issues. To expedite responses to issues, include a detailed description of the problem and attach a screenshot if possible.

3. **When are monitoring reports due?**
   Report weekly counts each Wednesday by 8 p.m. ET. Include total summary counts for notifications from February 5, 2020, through February 25, 2020, for initial data entry. Thereafter, enter total counts for each variable since the last report. Weekly summary counts represent estimates for new travelers since the last report.

   3a. What should jurisdictions first entering information on March 4, 2020 submit?
   Submit two entries. First, complete the form with aggregate counts **from February 5, 2020, through February 25, 2020.** Then submit a second form with aggregate counts from **February 26, 2020, through March 3, 2020.**

4. **Who should be included in monitoring reports?**
   Health departments have received traveler notifications via *Epi-X* since February 5, 2020. The DCIPHER aggregate monitoring is intended to primarily collect information about those travelers. However, it is acceptable to submit aggregate counts that include state identified travelers (e.g., travelers who have self-identified to the public health system or through some other source).

5. **What do I need to report?**
   Report aggregate counts about established **contacts, risk group, and monitoring type**. **Contact Established** means the health department made a connection with the traveler either actively (verbal confirmation) or passively (automated notification, text message, left a voicemail on a working number even if not returned, TIMS, etc.). **No Contact Established** includes travelers not reached due to nonworking phone numbers, no voicemail, etc.

   Refer to the *Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings (***https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) for definitions of risk category and monitoring types.**

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6. **Could you define the monitoring types?**
   Refer to the *Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposure in Travel-associated or Community Settings (*[**https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html)**](https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) **for definitions of risk category and monitoring types.**

7. **Will *Epi-X* notifications continue?**
   Epi-X traveler notifications will continue; DCIPHER is a secondary source for jurisdictions to ascertain the same information in a single, downloadable file.

8. **Is there a delay between *Epi-X* notifications and data in DCIPHER?**
   Yes, approximately an hour. *Epi-X* notifications are sent twice a day, at approximately 9 a.m. and 4 p.m. ET. Likewise, traveler information will be updated in DCIPHER twice a day, at approximately 10 a.m. and 5 p.m. ET.

9. **How long will monitoring reports be required?**
   We do not know. We understand the need to minimize burden on state staff. We will evaluate the information we receive and reassess reporting requirements as the response phase changes.

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From: Blackmore, Carina
To: Funk, Renee (CDC/NIOSH/OD)
Subject: disinfection of PPE
Date: Sunday, March 22, 2020 2:22:15 PM

Howdy,
I am assuming you, like me, are knee deep in the COVID response.
Do you by any chance know who I could talk to about using UV light to disinfect PPE? I am guessing that hard surfaces (plastic) might work but what about cloth ? (masks/ gowns)
Any intel on this would be helpful

Thanks a lot. Thankful to have wise friends
Carina

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From: DNPAO Program (CDC)

To: rlw0031@auburn.edu; llewis@thewellnesscoalition.org; jvincent@uaex.edu; llopezlove@uams.edu; erica.smith@pima.gov; Chesley.Blevins@sdcounty.ca.gov; Eugenio.Garcia@cdph.ca.gov; Priscila.Hegger@sdcounty.ca.gov; Cowling, Linda (CDC cdph.ca.gov); joan.brucha@state.co.us; smild001@hartford.gov; Marcia.Pessolano@ct.gov; alisoncberg@uga.edu; hgsouthall@uga.edu; carolyn.minter@dph.ga.gov; paula@healthysavannah.org; Toni.Nettles1@dph.ga.gov; janna.simon@iphionline.org; jedwards@marionhealth.org; alison.gustafson@uky.edu; jlian2@uky.edu; Brian.Boisseau@ky.gov; jfreightman@agcenter.lsu.edu; aguilart@worcesterma.gov; bolenc@worcesterma.gov; clarkke@worcesterma.gov; Msteve37@emich.edu; sshopinski@nkfm.org; cherylee.sherry@state.mn.us; Bishop, Susan (CDC state.mn.us); Cindy.Deblauw@health.mo.gov; Simmons, Pat (CDC health.mo.gov); msmith@ext.msstate.edu; jroach@msphi.org; tcollins@msphi.org; ACarmenia@raoassist.org; dave.gardner@dhhs.nc.gov; emilie@copeproject.org; npope@phs.org; smartin@caiglobal.org; daniel.french@health.ny.gov; mbenko@ccbh.net; nshaw@ccbh.net; Mildred Williamson (CDC aol.com); kelly.corfman@odh.ohio.gov; lacey.wallace@okstate.edu; charlene.a.mcgee@multco.us; aja.wilkerson@AlleghenyCounty.US; hannah.hardy@alleghenycounty.us; jzechman1@pennstatehealth.psu.edu; Bransteitter, Tiffany (CDC pa.gov); kedward@clemson.edu; bhinds@utk.edu; anna.macnak@sanantonio.gov; Denise.Benoit-Moctezuma@sanantonio.gov; Joan.Enderle@heart.org; valeria.jauregui@ag.tamu.edu; Fronberg, Rebecca (CDC utah.gov); jan.capps@kingcounty.gov; Ellings, Amy (CDC doh.wa.gov); ann.potempa@alaska.gov; tparker@thewellnesscoalition.org; cpalenske@uaex.edu; mmmeredith@uams.edu; Ptolliver@uams.edu; abigail.kesner@state.co.us; Chelsea.Cobb@dph.ga.gov; chambree.harris@dph.ga.gov; Kelly.Clay@dph.ga.gov; Jenna.frkovich@iphionline.org; Josh.Gryniewicz@iphionline.org; jdeskins@marionhealth.org; EllenH.Cartmell@ky.gov; RLosavio@agcenter.lsu.edu; cgiles@nkfm.org; mgerlach@nkfm.org; esensing@nkfm.org; jthompson@fcgworks.com; melissa.rockett@dhhs.nc.gov; mary.larson2@ndsu.edu; mcrousillat@caiglobal.org; Brett.spencer@dshs.texas.gov; dmecham@utah.gov; Lara.Sim@seattlechildrens.org; Douglas.Wagoner@doh.wa.gov; Killman, Molly (CDC adph.state.al.us); becky.adams2@arkansas.gov; bonnie.williams@azdhs.gov; stephanie.martinez@azdhs.gov; joann.jolly@dc.gov; Diggs, Robin (CDC dc.gov); Gatto, Fred (CDC state.de.us); shebra.hall@delaware.gov; Asma.Odeh@flhealth.gov; sade.collins@flhealth.gov; Roberson, Shamarial (CDC flhealth.gov); Hansen-Smith, Heidi (CDC doh.hawaii.gov); Irvin, Lola (CDC doh.hawaii.gov); ivie.smart@dhw.idaho.gov; Katie.Lamansky@dhw.idaho.gov; Miles, Cheryl (CDC illinois.gov); Jimenez, Paula (CDC illinois.gov); kbarrick@isdh.in.gov; Bouza, Lindsey (CDC isdh.in.gov); Olson, Erin (CDC idph.iowa.gov); sarah.taylorwatts@idph.iowa.gov; Jennifer.Church@ks.gov; Warren.Hays@ks.gov; Daisha.bonhomme@la.gov; Rhodes, Robin (CDC la.gov); kim.etingoff@state.ma.us; Pier, Kristi (CDC maryland.gov); Littlefield, Dawn (CDC maine.gov); DelatorreJ@michigan.gov; Imes, Gwen (CDC michigan.gov); maria.evora2@state.ma.us; James.Martin@msdh.ms.gov; Grant, Tiffani (CDC msdh.ms.gov); Hughes, Kara (CDC mt.gov); Zanto, Mandi (CDC mt.gov); jlpastir@nd.gov; Coyle, Brian BC (CDC nebraska.gov); Scholz, Tammie (CDC nebraska.gov); Janis.Mayer@doh.nj.gov; Melita.Jordan@doh.nj.gov; jaosalvo@health.nv.gov; stephanieu@health.ok.gov; JENNIFER.J.CHANDLER@dhsoha.state.or.us; carol.hallwalker@health.ri.gov; Sue.AnderBois@commerceri.com; Boykin, Erica EB (CDC dhec.sc.gov); Phillips, Lori (CDC dhec.sc.gov); Skjonsberg, Larissa (CDC state.sd.us); Alverson, Susan (CDC state.sd.us); Kamp, Susan (CDC vermont.gov); Gisel.Prado@sanantonio.gov; Sonia.Gonzales@sanantonio.gov; suzanne.kelley@vermont.gov; Lexi.Davis@dhs.wisconsin.gov; Pesik, Mary (CDC wisconsin.gov); Wright, Jessica (CDC wv.gov); CDC ONDIEH NCCDPHP NCCD DNPAO PDEB; Thomas, Christopher N. (CDC/DDNID/NCCDPHP/DNPAO); Tensuan, Lisa (CDC/DDNID/NCCDPHP/DNPAO) (CTR); DNPAO Program (CDC)

Subject: DNPAO Networking Call - What Makes a News Story?

Dear SPAN, HOP, and REACH program recipients,

Please join CDC's Division of Nutrition, Physical Activity, and Obesity for the following Networking Call:

"What Makes a News Story?"

Thursday, April 9, 2020

2:00-3:30 pm EDT

Who should participate?

Principal Investigators, Program Managers, communication staff, and other interested staff

*Principal Investigators – please forward this invitation to other staff working on communication activities.

How do I connect?

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Participants must register <https://fhi360smc.adobeconnect.com/sct_april2020/event/registration.html> for this event.

Let us know if you have any accessibility accommodations (e.g., captioning) by April 6.

What will the networking call cover?

The networking call will cover:

* Spokesperson tips to help with local media interviews
* Methods for connecting with local media to get news stories
* Successful local news stories on program efforts

Who are the presenters and panelists?

Presenters and panelists will include recipients along with staff and contractors from CDC/DNPAO's Strategic Communication Team.

* Chris Thomas, DNPAO Strategic Communication Team
* Lisa Tensuan, FHI 360 Contractor, DNPAO Strategic Communication Team
* Amy Elizer, University of Tennessee
* Carmen Heredia, California Department of Public Health
* Mike Johnson, The Institute for Family Health

Have example news stories to share?

Send two earned media news stories (e.g., newspaper, radio, TV, or digital media) to DNPAOCommTA@cdc.gov <mailto:DNPAOCommTA@cdc.gov> from the last 6-12 months by April 3. We will share examples during the networking call. Below are two examples:

* CDC: 28% of Georgia adults admit to being physically inactive <https://www.ajc.com/news/local/cdc-georgia-adults-admit-being-physically-inactive/rI44wWh0hzRlkX1mmJdilL> (Atlanta Journal Constitution)
* Where A Child Grows Up Plays A Major Role In Future Opportunities <https://www.npr.org/2019/12/18/789218060/where-a-child-grows-up-plays-a-major-role-in-future-opportunities> (NPR)

Hints and reminders for the event

1. Register <https://fhi360smc.adobeconnect.com/sct_april2020/event/registration.html> to get event login details.
2. Check your connection and Adobe Connect access the day before <http://admin.adobeconnect.com/common/help/en/support/meeting_test.htm> the session.
3. Contact your organization's IT staff if you have trouble accessing Adobe Connect.
4. Visit Adobe Connect Support <https://helpx.adobe.com/adobe-connect/connect-support.html> if you need help.
5. Log onto Adobe Connect (website) and phone line 10 minutes before the start time.

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:29:26 PM

Received the following from our LNO with DoS for your awareness
I am thinking they may be medivac'd to FL?

Costa Magica and Costa Favolosa are north of Cuba heading north toward the U.S. Costa Magica has a crew member in critical condition (male, 32, Philippines, bilateral pneumonia)and in is need of urgent medical evacuation. The Company is coordinating with USCG to perform a medivac (details being worked). Magica has an additional 3 crew members who need medical support ashore and Favolosa has 5 crew members who need medical support ashore. The Company is also working a plan to repatriate ~300 EU, ~600 Philippine and ~250 Indonesia asymptomatic crew members later this week.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:28:38 PM

Received the following from our LNO with DoS for your awareness
I am thinking they may be medivac'd to FL?

Costa Magica and Costa Favolosa are north of Cuba heading north toward the U.S. Costa Magica has a crew member in critical condition (male, 32, Philippines, bilateral pneumonia)and in is need of urgent medical evacuation. The Company is coordinating with USCG to perform a medivac (details being worked). Magica has an additional 3 crew members who need medical support ashore and Favolosa has 5 crew members who need medical support ashore. The Company is also working a plan to repatriate ~300 EU, ~600 Philippine and ~250 Indonesia asymptomatic crew members later this week.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

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FEMA RRCC Atlanta, GA
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cell: 202.909.6950 Verizon (secondary)

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From:	Pottebaum, Nic D. EOP/WHO
Cc:	Butler, Jay C. (CDC/DDID/OD); Darcie Johnston (darcie.johnston@hhs.gov)
Subject:	Draft PDF -- Community Mitigation Approach
Date:	Monday, March 9, 2020 9:11:24 PM
Attachments:	Community_Mitigation_Strategy_3_9_for_states.pdf

Governors' Senior Staff and State Health Officers,

Please send feedback or edits to Dr. Jay Butler (Deputy Director for Infectious Diseases at the CDC) by tomorrow (Tuesday, March 10) by late morning Eastern Time.

Email feedback to: jcb3@cdc.gov.

Thanks,
Nic

--
Nicholas D. Pottebaum
Special Assistant to the President and Deputy Director
White House Office of Intergovernmental Affairs
O: 202-456-2132 | C: 202-881-7803| E: Nicholas.D.Pottebaum@who.eop.gov

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Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission

Background

When a novel virus with pandemic potential emerges, nonpharmaceutical interventions, which will be called community mitigation strategies in this document, often are the most readily available interventions to help slow transmission of the virus in communities. Community mitigation is a set of actions that persons and communities can take to help slow the spread of respiratory virus infections. Community mitigation is especially important before a vaccine or drug becomes widely available.

The following is a proposed framework for actions which local and state health departments can implement as local spread of COVID-19 continues in the United States. Selection and implementation of these actions should be guided by the local characteristics of disease transmission, demographics, and public health and healthcare system capacity.

Goals

The goals for using mitigation strategies for communities with local COVID-19 transmission are to protect:

- Individuals at risk for severe illness, including older adults and persons of any age with underlying health conditions (See Appendix A).
- The healthcare workforce and critical infrastructure workforces

These approaches are used to minimize morbidity and mortality caused by COVID-19 and minimize social and economic impacts of COVID-19. Individuals, communities, businesses, and healthcare organizations are all part of a community mitigation strategy.

Implementation emphasizes:

- Emphasizing individual responsibility for implementation of recommended personal-level actions,
- Empowering businesses, schools, and community organizations to implement recommended actions, particularly in ways that protect persons at risk of severe illness
- Focusing on settings that provide critical services to implement recommended actions to protect critical infrastructure and individuals at risk of severe disease
- Minimizing disruptions to daily life to the extent possible

Guiding principles

- Each community is unique, and mitigation appropriate strategies will vary based on characteristics of the community and populations at risk of severe disease as well as the local capacity to implement strategies (Table 1).
- Consider all aspects of a community that might be impacted, including vulnerable populations that may be more impacted socially or economically, and select appropriate actions.
- Mitigation strategies can be scaled up or down depending on the evolving situation.
- When developing mitigation plans, communities should identify ways to ensure the safety and social well-being of groups that may be especially impacted by mitigation strategies, including individuals at risk for severe illness

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- Activation of community emergency plans is critical for the implementation of mitigation strategies. These plans may provide additional authorities and coordination needed for interventions to be implemented (Table 2).
- The level of activities implemented may vary across settings (ie. may be at moderate for one setting and at substantial for another setting at the same time in order to meet community response needs).
- Local and state public health departments may need to implement mitigation strategies for public health functions in the identification and contact tracing of cases depending on level of community spread (Table 3). When applied, community mitigation efforts may help implementation of public health activities like contact tracing.

Table 1. Local Factors to Consider for Determining Mitigation Strategies

Factor	Characteristics
Epidemiology	Level of community transmission Number of outbreaks COVID-19 cases impacting delivery of healthcare or impacting other critical infrastructure or services Epidemiology in surrounding jurisdictions
Community Characteristics	Size of community and population density Level of community engagement/support Size and characteristics of vulnerable populations Access to healthcare Transportation (public, walking) Planned large events
Healthcare capacity	Healthcare workforce Number of healthcare facilities Testing capacity Intensive care capacity PPE availability
Public health capacity	Public health workforce and availability of resources to implement strategies Available support from other state/local government agencies and partner organizations

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Table 2. Community mitigation strategies by setting and by level of community transmission or impact of COVID-19

Setting	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None/minimal	Moderate	Substantial

Individuals and Families at Home
 	
"What you can do to prepare, if you or a family member gets ill, or if your community experiences spread of COVID-19"
	• Know where to find local information on COVID-19 and local trends of COVID-19 cases.
	• Know the signs and symptoms of COVID-19 and what to do if symptomatic:
	  ○ Stay home when you are sick
	  ○ Call HCP office in advance of a visit
	  ○ Limit movement in the community
	  ○ Limit visitors
	• Know what additional measures those at high-risk and who are vulnerable should take
	• Implement personal protective measures (e.g., stay home when sick, handwashing, respiratory etiquette, clean frequently touched surfaces daily).
	• Create a household plan of action in case of illness in the household or disruption of daily activities due to COVID-19 in the community.
	  ○ Consider 2 week supply of prescription and OTC medications, food and other essentials. Know how to get food delivered if possible.
		• Continue to monitor local information about COVID-19 in your community.
		• Continue to practice personal protective measures.
		• Continue to put household plan into action.
		• Individuals at risk of severe illness should consider staying at home and avoiding gatherings or other situations of potential exposures, including travel
			• Continue to monitor local information
			• Continue to practice personal protective measures.
			• Continue to put household plan into place
			• All individuals should limit community movement and adapt to disruptions in routine activities (e.g., school and/or work closures) according to guidance from local officials

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	○ Establish ways to communicate with important others (e.g., family, friends, co-workers) ○ Establish plans to telework, what to do about childcare needs, how to adapt to cancellation of events. • Know about emergency operations plans for schools/workplaces of household members.		
Schools/childcare *"What childcare facilities, K-12 schools, and colleges and universities can do to prepare for COVID-19, if the school or facility has cases of COVID-19, or if the community is experiencing spread of COVID-19)"*	• Know where to find local information on COVID-19 and local trends of COVID-19 cases Know the signs and symptoms of COVID-19 and what to do if students or staff become symptomatic at school/childcare site. • Review and update emergency operations plan (including implementation of social distancing measures, distance learning if feasible) or develop plan if one is not available. • Evaluate whether there are students or staff who are at risk of severe illness and develop plans for them to continue to work or receive educational services if there is moderate levels of COVID-19 transmission or impact ○ Parents of children at risk for severe illness should discuss with their HCP whether those students should stay	• Implement social distancing measures, e.g.: ○ Reduce large gatherings (e.g., assemblies) ○ Alter schedules to reduce mixing (e.g., stagger recess, entry/dismissal times) ○ Limit inter-school interactions ○ Consider distance or e-learning in some settings • Regular health checks (e.g., temperature and respiratory symptom screening) of students, staff, and visitors. • Short-term dismissals for school and extracurricular activities as needed (e.g., if cases in staff/students) for cleaning and contact tracing • Students at risk of severe illness should consider implementing individual plans for distance learning, e-learning.	• Broader and/or longer-term school dismissals, either as a preventive measure or because of staff and/or student absenteeism • Cancellation of school-associated congregations, particularly those with participation of high-risk individuals. • Implement distance learning if feasible

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	home in case of school or community spread ○ High risk staff should have a plan to stay home if there are school-based cases or community spread. • Encourage staff and students to stay home when sick and notify school administrators of illness. • Encourage personal protective measures among staff/students (e.g., stay home when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in buildings.		
Assisted living facilities, Senior living facilities and adult day programs *"What facilities can do to prepare for COVID-19, if the facility has cases of COVID-19, or if the community is experiencing spread of COVID-19)"*	• Know where to find local information on COVID-19. • Know the signs and symptoms of COVID-19 and what to do if clients/residents or staff become symptomatic. • Review and update emergency operations plan (including implementation of social distancing measures) or develop plan if one is not available. • Encourage residents to stay in private quarters and staff and clients who live elsewhere to stay home when sick and notify program administrators of illness.	• Implement social distancing measures, e.g.: ○ Reduce large gatherings (e.g., group social events) ○ Alter schedules to reduce mixing (e.g., stagger meal, activity, arrival/departure times) ○ Limit programs with external staff ○ Consider having residents stay in facility ○ Limit visitors, implement screening	• Longer-term closure or quarantine of facility. • Restrict visitor access

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	• Encourage personal protective measures among staff, residents and clients who live elsewhere (e.g., stay home or in residences when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in buildings.	• Temperature and respiratory symptom screening of attendees, staff, and visitors. • Short-term closures as needed (e.g., if cases in staff, residents or clients who live elsewhere) for cleaning and contact tracing	

Workplace
 	
"What workplaces can do to prepare for COVID-19, if the workplace has cases of COVID-19, or if the community is experiencing spread of COVID-19)"
	• Know where to find local information on COVID-19 and local trends of COVID-19 cases.
	• Know the signs and symptoms of COVID-19 and what to do if staff become symptomatic at the worksite.
	• Review, update, or develop workplace plans to include:
	  ○ Liberal leave and telework policies
	  ○ 7-day leave policies for people with symptoms
	  ○ Consider alternate team approaches for work schedules.
	• Encourage employees to stay home and notify workplace administrators of illness when sick.
	• Encourage personal protective measures among staff (e.g., stay home when sick, handwashing, respiratory etiquette).
		• Encourage staff to telework (when feasible), particularly individuals at risk of severe disease
		• Implement social distancing measures, e.g.:
		  ○ Spacing workers at the worksite
		  ○ Staggering work schedules
		  ○ Decreasing social contacts in the workplace (limit in-person meetings)
		• Limit large work-related gatherings (e.g., staff meetings, after-work functions)
		• Limit non-essential work travel
		• Regular health checks (e.g., temperature and respiratory symptom screening) of staff and visitors entering buildings.
			• Implement extended telework arrangements (when feasible)
			• Ensure flexible leave policies for staff who need to stay home due to school/childcare dismissals
			• Cancel non-essential work travel
			• Cancel work-sponsored conferences, tradeshows, etc.

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	• Clean frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in building.		
Community and faith-based organizations *"What organizations can do to prepare for COVID-19, if the organizations has cases of COVID-19, or if the community is experiencing spread of COVID-19)"*	• Know where to find local information on COVID-19 and local trends of COVID-19 cases. • Know the signs and symptoms of COVID-19 and what to do if organization members/staff become symptomatic. • Identify safe ways to serve those that are at high risk or vulnerable (outreach, assistance, etc.) • Review, update, or develop emergency plans for the organization, especially consideration for individuals at risk of severe illness • Encourage staff and members to stay home and notify organization administrators of illness when sick. • Encourage personal protective measures among organization/members and staff (e.g., stay home when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces at organization gathering points daily. • Ensure hand hygiene supplies are readily available in building.	• Implement social distancing. Reduce activities (e.g., religious services, group congregation), especially for organizations with individuals at risk of severe illness. Consider offering video/audio of events. • Determine ways to continue providing support services to individuals at risk of severe disease (services, meals, checking in) while limiting group settings and exposures • Cancel large gatherings (e.g., >500 people) or move to smaller groupings. • For organizations that serve high-risk communities, cancel gatherings of more than 10 people.	• Cancel faith-based and community gatherings of any size

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Healthcare settings and healthcare provider (includes outpatient, nursing homes/long-term care facilities, inpatient, telehealth) *"What healthcare settings including nursing homes/long-term care facilities, can do to prepare for COVID-19, if the facilities has cases of COVID-19, or if the community is experiencing spread of COVID-19)"*	• Provide healthcare personnel (HCP, includes staff at nursing homes and long-term care), facilities, and systems with tools and guidance needed to support their decisions to care for patients at home (or in nursing homes/long-term care facility) • Assess facility infection control programs; assess personal protective equipment (PPE) supplies and optimize PPE use. • Assess plans for monitoring of HCP and plans for increasing numbers of HCP if needed. • Assess visitor policies • Assess HCP sick leave policies (healthcare facilities should provide non-punitive sick leave options to allow HCP to stay home when ill). • Encourage HCP to stay home and notify healthcare facility administrators of illness when sick. • In conjunction with local health department, identify exposed HCP, and implement recommended monitoring and work restrictions • Implement triage prior to entering facilities to rapidly identify and isolate patients with respiratory illness (e.g., phone triage before patient arrival, upon arrival)	• Implement changes to visitor policies to further reduce limit exposures to HCP, residents, and patients. Changes could include temperature/symptom checks for visitors, limiting visitor movement in the facility, etc. • Implement triage before entering facilities (e.g. parking lot triage, front door); phone triage and telemedicine; options to limit unnecessary healthcare visits • Actively monitor HCP absenteeism and respiratory illness among HCP and patients • Actively monitor PPE supplies • Establish processes to evaluate and test large numbers of patients and HCP with respiratory symptoms (e.g. designated clinic, surge tent) • Consider allowing asymptomatic exposed HCP to work while wearing a facemask • Begin to cross train HCP for working in other units in anticipation of staffing shortages	• Restrict all visitors from facility entry to reduce facility-based transmission. • Identify areas of operations that may be subject to alternative standards of care and implement necessary changes (e.g., allowing mildly symptomatic HCP to work while wearing a facemask) • Cancel elective and non-urgent procedures • Establish cohort units or facilities for large numbers of patients • Consider requiring all HCP to wear a facemask when in the facility depending on supply

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Table 3.

Public health control activities by level of COVID-19 community transmission		
None/Low (Evidence of limited community transmission, case investigations underway, no evidence of exposure in large communal setting, e.g., health care facility, school, mass gathering)	**Medium** (Widespread and/or sustained transmission with high likelihood or confirmed exposure within communal settings with potential for rapid increase in suspected cases)	**High** (Large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings like healthcare facilities, schools, mass gatherings etc.)
• Continue contact tracing, monitor and observe contacts as advised in guidance to maximize containment around cases • Isolation of confirmed COVID-19 cases until no longer considered infectious according to guidance • For asymptomatic close contacts exposed to a confirmed COVID-19 case, consideration of movement restrictions based on risk level, social distancing • Monitoring close contacts should be done by jurisdictions to the extent feasible based on local priorities and resources • Test symptomatic individuals for COVID-19 • Determine methods to streamline contact tracing through simplified data collection and surge if needed (resources including staffing through colleges, other first responder; technology etc.)	• May reduce contact tracing if needed, prioritizing to those in high-risk settings (e.g., healthcare professionals or high-risk settings based on vulnerable populations or critical infrastructure) infrastructure when necessary • Reduce at risk of spreading infection or exposures in (those with vulnerable populations or critical infrastructure) • Encourage HCP to more strictly implement phone triage and telemedicine practices • Continue routine COVID-19 testing; however, if testing capacity limited, prioritize testing of high-risk individuals	• May reduce or discontinue contact tracing, even in high-risk settings (e.g., healthcare professionals or high-risk settings further based on vulnerable populations or critical infrastructure) resource capacity. • Discontinue routine testing, continue testing of persons at high-risk of serious disease • Reinforce systems for phone triage and telemedicine to reduce unnecessary healthcare visits

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Appendix A: Underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age.

- **Blood disorders** (e.g., sickle cell disease or on blood thinners)
- **Chronic kidney disease as defined by your doctor**. Patient has been told to avoid or reduce the dose of medications because kidney disease, or is under treatment for kidney disease, including receiving dialysis
- **Chronic liver disease as defined by your doctor**. (e.g., cirrhosis, chronic hepatitis) Patient has been told to avoid or reduce the dose of medications because liver disease or is under treatment for liver disease.
- **Compromised immune system (immunosuppression)** (e.g., seeing a doctor for cancer and treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS)
- **Current or recent pregnancy** in the last two weeks
- **Endocrine disorders** (e.g., diabetes mellitus)
- **Metabolic disorders** (such as inherited metabolic disorders and mitochondrial disorders)
- **Heart disease** (such as congenital heart disease, congestive heart failure and coronary artery disease)
- **Lung disease including asthma or chronic obstructive pulmonary disease** (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
- **Neurological and neurologic and neurodevelopment conditions** [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury].

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From:	Newman, Sunny
To:	Domestic Security Oversight Council; "abecraft@miamigov.com"; "ashaw@hcso.tampa.fl.us"; "Benjamin.Burns@freshfromflorida.com"; Brenda Compton; "brent.wise@dhs.gov"; "CarolBishop@flhsmv.gov"; Christie Luce; Davenport, Jessica; "dbrand@flsheriffs.org"; Desguin, Shane; Diana Gryder; Donna Lusczynski; "douglas.goerke@cityoforlando.net"; Duffey, Mike; Ed Dwyer; "Elizabeth Ryon (Ryon.Elizabeth@flsenate.gov)"; "ElizabethDenmark@flhsmv.gov"; "Garrett.Wienckowski@ocfl. net"; "GeneSpaulding@flhsmv.gov"; Gordon, Kristi; "Jay.Etheridge@myfloridacfo.com"; "John.Kohnke@myfloridacfo.com"; "jrios@hcso.tampa.fl.us"; "Kevin.Johnson@ocfl.net"; "Larry.Zwieg@ocfl.net"; "lawrence.revell@talgov.com"; Lila Mestas; "linda.mcwhorter@em.myflorida.com"; "Lynne.Drawdy@flhealth.gov"; "Margaret.Medina@flhealth.gov"; Mark Pergola; "mdunagan@flsheriffs.org"; "meggsw@leoncountyfl.gov"; Mizell, Lori; Nicole Nelson; Rexroad, Samantha; Samantha Cooksey; "Sarah.Hofmeister@flhealth.gov"; Scott McAllister; "Sherry.hare@ocfl.net"; "Sue.Rantuccio@freshfromflorida.com"; "Tammy.Miller2@ocfl.net"
Cc:	Harvey, Robyn; Sasser, Billy E; Kelly, Damien; Wiggins, James; John Wilgis; Swearingen, Rick; Phillips, Mike; Ladd, Michael A COL USARMY NG FLARNG (USA); Burroughs, Joyce; Mark Dubina; Pollard, Vaden; Walker, Troy; Bradshaw, Ric L.; Vaughn, Thomas; Steve Casey; Thomas Storrar Jr - 0145; Halas, Julius; Burke, John; Lemma, Sheriff Dennis; Walt McNeil; Keenan, Gwen; Guthrie, Kevin; Lorin L. Mock; Daniels, Darryl; chiefdowneydc@gmail.com; quin romay; Brutnell, Mark; McPherson, Michael F. (TP) (FBI); Buccione, Charlene K. (TP) (FBI); Brad King; Burns, Ben; Rivkees, Scott A; Hevia, Robert; Luce, Christie; Steven.Thomas@ocfl.net; Moreland, Charles; Perez, Mark; Massie, Lee; Garry Lisiewski; Mandell, Milton; Bradley, Rose; McNeil, Beth; Foy, Tom; Brown, Chasity; Bucci, Joseph; "Yehuda.Green@ocfl.net"; CHRONISTER, CHAD; "Cintron, Morgan"
Subject:	DSOC Meeting Materials and Webinar Information
Attachments:	SCSO Budget change request FY18 Money.xlsx FY2018 Sustainment of Fusion Centers Budget Change Request.xlsx Miami_budget_change_request March 2020.xlsx 19-1119 DSOC draft minutes.docx 20-0325 DSOC Agenda.doc

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Good afternoon,

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Call in information:
US Dial In #: (888) 585-9008
Conference Room #: 215-384-938 then #
Webinar Link:
https://share.dhs.gov/dsoc_3252020/ <https://share.dhs.gov/dsoc_3252020/>

Please do not hesitate to contact me if you have any questions or concerns.

Thanks!
Sunny

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Florida Department of Law Enforcement
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AMERICAN OVERSIGHT

DOMESTIC SECURITY OVERSIGHT COUNCIL

November 19, 2019
Ocala, FL
Proceedings

Participants

Commissioner Richard Swearingen, Chairman

Director Jared Moskowitz, Vice Chairman
(represented by Kevin Guthrie)

Oversight Council Members (in attendance):

Director Ashley Moody
(represented by Emery Gainey)
Commissioner Nicole Fried
(represented by James Wiggins)
State Surgeon General Scott Rivkees
Commissioner Richard Corcoran
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Director Julius Halas
Thomas Vaughn
Sheriff Walt McNeil
(represented by Chris Summers)
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(represented by Joel Rios)
Sheriff Dennis Lemma
(represented by Mark Pergola)
Sheriff Kevin Rambosk
(represented by Tom Storrar)
Sheriff Ric Bradshaw
(represented by Robert Allen)
SAC Jack Massey
SAC Mark Perez
SAC John Burke
SAC Mark Brutnell
(represented by John Vecchio)
SAC Lee Massie
SAC Shane Pollard
SAC Troy Walker
Chief Lorin Mock
Chief Mark Oakes
Chief Quin Romay
Mark Dubina
Garry Lisiewski
Pete Gomez
Tammy Miller
(represented by Mitch Shaban)
FBI SAC Michael McPherson
Director Scott McAllister
Steve Casey
(represented by Matt Dunagan)
Executive Director Gene Spaulding

Commissioner Richard Swearingen, Florida Department of Law Enforcement (FDLE), called the meeting to order at 1:02 p.m.

Roll was taken and a quorum was present.

Commissioner Swearingen presented the minutes from the July 31, 2019 meeting for approval.

Julius Halas made a motion to accept the minutes; Emery Gainey seconded the motion. Motion approved by voice vote.

Information Items:

The Foreign Threat in American Business – Joe Morosco, National Counterintelligence and Security Center (NCSC)

Mr. Joe Morosco provided a presentation on the complex counterintelligence landscape. He discussed increasing threats, national counterintelligence priorities, Florida's geopolitical balance, economic espionage and China's strategy on acquiring technology. China's current strategy relies heavily upon technology research and investments within the U.S. Mr. Morosco discussed ways

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to mitigate the threat by maintaining connectivity on current threat intelligence, strengthening cyber security and hygiene, and implementing insider threat programs. Donna Uzzell asked if NCSC is speaking with the business community, and if they are available to provide presentations throughout the state. Mr. Morosco stated that there are versions of this message available online to provide to members of industry, and that they would be willing to provide presentations to community leaders and large groups.

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Marjory Stoneman Douglas High School Public Safety Commission—SAC Donna Uzzell, FDLE

SAC Donna Uzzell discussed The Marjory Stoneman Douglas High School Public Safety Commission's second report and its' findings and recommendations. She highlighted the need for policies and procedures on reunification and mass-casualty death notifications. She spoke to the chapter on threat assessments and what information is able to be shared. She spoke to the need for training on the Family Educational Rights and Privacy Act (FERPA). Commissioner Swearingen agreed and stated that training on both FERPA and the Health Insurance Portability and Accountability Act (HIPAA) is going to be critical.

Statewide Behavioral Threat Assessment Management Strategy—Commissioner Rick Swearingen, FDLE

Governor DeSantis charged FDLE to establish a statewide behavioral threat assessment strategy. Commissioner Swearingen discussed the composition of the work group and the four meetings that have taken place to develop the strategy. The strategy will reflect the Regional Domestic Security Task Force structure, to include mental health professionals. It is vital that information is being shared and we are not operating in silos. The draft will be finalized by the end of November. Training curriculum is being developed for basic recruits, a 40-hour course, and executive administrators.

Action Items:

State Cyber Disruption Plan – Molly Akins, FDLE

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Molly Akins, Cyber Terrorism Focus Group Chair, provided an overview of the State Cyber Disruption Plan for the Council. An exercise is planned in 2020 that will test the plan. She discussed the main changes; agency name changes, graphics, and where this plan sits within the Emergency Operation Center. It now sits under ESF-2 and they are deciding where it should be moved. Some other states have it under ESF 2 and some have a separate support function for it. The procurement process for the exercise has begun. After the exercise, an after action report will be provided and allow the group to update the plan based on gaps identified.

Tom Storrar made a motion to approve the State Cyber Disruption Plan; John Burke seconded the motion. Motion approved by voice vote.

FFY 2018 Miami UASI Budget Change Request – Pete Gomez, Miami Fire Rescue, FDLE

Pete Gomez presented eight Miami Urban Area Budget Change Request for a total of $483,804 that included cyber security equipment, EOC enhancements, access card readers, ballistic shields, portable license plate readers, and night vision goggles.

Julius Halas made a motion to accept the budget change request; Quin Romay seconded the motion. Motion approved by voice vote.

FFY 2020 Miami Urban Area Budget Request – Pete Gomez, Miami Fire Rescue

Pete Gomez presented the FFY 2020 Miami Urban Area Budget Request that included 27 projects for a total of $8,305,200.

SAC Donna Uzzell asked about the Department of Health Warehouse line item that was also listed on the State Homeland Security Program (SHSP) funding requests. SAC Uzzell clarified that during the Executive Board prioritization meeting, Kevin Guthrie spoke to different funding streams that could be used to cover the cost of this line item. Kevin Guthrie confirmed and stated that he would coordinate with Palm Beach County to include the warehouse in the local mitigation strategy. He stated it could be covered under the Emergency Management Preparedness Grant.

SAC Uzzell asked about the drone line items. The Council agreed that the purchase of drones would be delayed until the Specialty Response Team could develop a statewide strategy for drone regulations and requirements when purchased with SHSP grant funds. Mr. Gomez stated that the UASI does not have to abide by the DSCG rules because the Urban Area Working Group (UAWG) approved it. Lawrence Revell stated that DSOC rules should be unified for both the UASI and DSCG. Mr. Gomez stated the UAWG is the governing body for the UASIs. SAC Uzzell read from Florida Statute 943 and stated that the DSOC approves UASI funds; the group reviewed the minutes from the last meeting for clarification on the drone approval discussion. Commissioner Swearingen stated it was a legal interpretation that needed to be looked at.

John Burke made a motion to accept the budget request pending legal guidance; Lorin Mock seconded the motion. Motion approved by voice vote.

FFY 2020 Orlando Urban Area Budget Request – Mitch Shaban, City of Orlando

Mitch Shaban presented the FFY 2020 Orlando Urban Area Budget Request that included 27 projects for a total of $4,477,467.

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Commissioner Swearingen asked if the drone detection system could be used by the state and local agencies. Scott McAlister stated that federal law only allows the Federal Bureau of Investigations (FBI) and DHS to use the drone detection system for special events; a letter would need to be submitted to the FBI for permission to use. It's a federal violation for local police departments to use detection equipment. Mr. Shaban clarified that the detection system is not counter-measure drone technology.

Shane Pollard made a motion to accept the budget request; Robert Allen seconded the motion. Motion approved by voice vote.

FFY 2020 Tampa Bay Urban Area Budget Request - Garry Lisiewski, Tampa Police Department

Garry Lisiewski presented the FFY 2020 Tampa Urban Area Budget Request that included 24 projects for a total of $4,186,908.

Julius Halas made a motion to accept the budget request; Mark Perez seconded the motion. Motion approved by voice vote.

FFY 2019 SHSP Budget Change Request – Donna Uzzell, FDLE

Donna Uzzell presented one project for the FFY 2019 SHSP Budget Change Request for a total of $20,000 for a campaign project manager.

Shane Pollard made a motion to accept the budget change request; Robert Allen seconded the motion. Motion approved by voice vote.

FFY 2020 SHSP Budget Request – Donna Uzzell, FDLE

Donna Uzzell presented the FFY 2020 SHSP Budget Request that included 28 projects for a total of $11,701,680.

Shane Pollard made a motion to accept the budget request; John Burke seconded the motion. Motion approved by voice vote.

SAC Uzzell spoke to purchasing microphones for domestic security meetings. Kevin Guthrie asked the Council for support to use deobligated funds to purchase the required microphones. He stated that if approved, FDEM would house the equipment and send a point of contact to set up the equipment for meetings.

Julius Halas made a motion to approve the purchase of a microphone system with deobligated funds; Damien Kelly seconded the motion. Motion approved by voice vote.

Julius Halas stated the Council should be made aware of those that are deobligating funds. Kevin Guthrie stated that FDEM would provide a financial update at future DSOC meetings.

There being no further business, the meeting was adjourned.

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Domestic Security Oversight COUNCIL

Via Webinar

March 25, 2020 1:00 – 5:00 PM

AGENDA

Welcome .....Rick Swearingen, FDLE

Roll Call

Approval of November 19, 2019 meeting minutes

UPDATES/PRESENTATIONS:

Homeland Security Advisor Brief .....SAC Mike Phillips, FDLE
DSCG Executive Board/Focus Groups updates

Coronavirus (COVID-19) update.....Christie Luce, FDOH

2020 Grant updates
New DHS priorities.....SAA/FDEM

PLEASE NOTE: The following portion of the meeting is a "CLOSED SESSION".
Only authorized personnel may attend. Thank you.

ACTION ITEMS:

FY 2021 Funding Process.....SAC Mike Phillips, FDLE

New FY 2020 SHSP Funding Projects..... SAC Mike Phillips, FDLE

Miami UASI Budget Change Request.....Robert Hevia, Miami UASI

FY2020 Miami UASI Project Update .....Robert Hevia, Miami UASI

FY2020 Tampa UASI Project Update.....Garry Lisiewski, Tampa UASI

FY2020 Orlando UASI Project Update .....Mitch Shaban, Orlando UASI

Seminole Co Sheriff's Office Budget Change Request .....Sgt Gabe Rhodes, Seminole Co.

Lee County Sheriff's Office Project Request .....Eli Lawson, FDLE

NE Fusion Center Budget Change Request.....Kas Kahn, NEFC

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	A	B	C	D	E	F	G	H	I
1	**Sub-grantee**	**End recipient Agency**	**Item description and purpose of the item (including AEL# or DHS Course Code)**	**Grant (name & FFY)**	**State Strategic Plan Goal/objective item supports**	**Unit Cost**	**Quantity**	**Total Cost**	**Description of item(s) Funds were originally allocated for**
2	FDLE	FDLE	13IT-00-INTL - Microsoft SharePoint Server 2019 License with 25 user CAL	FFY2018 Sustainment of Fusion Centers Budget	2.1: Information and Intelligence Sharing; 2.2 Interdiction of Threats; 2.3 Threats and Violent Extremism	$6,671.21	1	$6,671.21	Crime Mapping Software License
3									
4									
5									
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7									
8			Total					$6,671.21	

AMERICAN OVERSIGHT

	A	B	C	D
1	**Sub-grantee**	**End recipient Agency**	**Item description (including AEL# or DHS Course Code)**	**Grant (name & FFY)**
2	Miami	**City of Sunrise**	Common - Operational Coordination (Smart Boards) AEL 04MD-03-DISP	**2018**
3	Miami	**City of Sunrise**	Response - On Scene Security, Protection and Law Enforcement (Body Armor) AEL 01LE-01-ARMR	**2018**
4	Miami	**City of Sunrise**	Prevention - Screening, Search and Detection (MAGNETOMETER/METAL DETECTORS) AEL 15SC-00-PPSS	**2018**
5	Miami	**City of Fort Lauderdale**	Prevention - Screening, Search and Detection (Camera for Bomb Robot) AEL 02EX-02-RBTL	**2018**
6	Miami	**City of Fort Lauderdale**	Response - On-Scene Security, Protection and Law Enforcement (Training equipment for SWAT to include: Conversion Kits for SWAT, Simunition Magazines, Single Shot Launchers); AEL 03OE-01-NLTA	**2018**
7	Miami	**City of Coral Springs**	Response - On-Scene Security, Protection and Law Enforcement (Video Surveillance Equipment); AEL 13LE-00-SURV	**2018**
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	E	F	G	H
1	**State Strategic Plan Goal/objective item supports**	**Quantity**	**Unit Cost**	**Total Cost**
2	Goal: Prepare for domestic security incidents; Objective: Operational Coordination	4	$7,100.00	**$28,400.00**
3	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	12	$1,003.15	**$12,038.00**
4	Goal: Prevent, preempt and deter acts of terrorism; Objective: Interdiction of threats	4	$4,000.00	**$16,000.00**
5	Goal: Prevent, preempt and deter acts of terrorism; Objective: Interdiction of threats	1	$6,935.00	**$6,935.00**
6	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	1	$2,740.00	**$2,740.00**
7	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	3	$7,829.00	**$23,487.00**
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10		**TOTAL**		**$ 89,600.00**
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12				

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	I	J
1	**Description of item(s) Funds were originally allocated for**	
2	Decreased General Dynamics project, line item 2018-15K, by $93,120 and funds transferred to: Smart Boards project line item 2018-02M $28,400; Magnetometer/Metal Detector project line item 2018-06K $16,000; Portable LPR Trailer line item 2018-06J $48,720.	
3	Decreased Ballistic Helmets project, line item 2018-18A, by $12,037.76 and transferred funds to Body Armor project line item 2018-18C $12,037.76	
4	Decreased General Dynamics project, line item 2018-15K, by $93,120 and funds transferred to: Smart Boards project line item 2018-02M $28,400; Magnetometer/Metal Detector project line item 2018-06K $16,0000; Portable LPR Trailer line item 2018-06J $48,720.	
5	Decreased line item 2018-01D, PT&E Coordinated Attack Exercise, by $13,400 and funds transferred to: Camera for Bomb Project, line item 2018-06L $6935, Training Equipment for SWAT line item 2018-18D $2740, Ballistic Helmets, line item 2018-18A2 $3725.	
6	Decreased line item 2018-01D, PT&E Coordinated Attack Exercise, by $13,400 and funds transferred to: Camera for Bomb Project, line item 2018-06L $6935, Training Equipment for SWAT line item 2018-18D $2740, Ballistic Helmets, line item 2018-18A2 $3725.	
7	Decreased line item 2018-04A, Mobile Trailer with intelligence camera, by $23,487 and transferred funds to Video Surveillance Equipment project, line item 2018-18E.	
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	A	B	C	D
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	A	B	C	D	E	F	G	H	I
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2	SCSO	SCSO	AEL 02EX-02-TLPB	Homeland Security Grant Program FY18	Issue 19-Bomb Building Capabilities	$11,846.00	1	$11,846.00	2 TBT kit without a tactical PAN disruputor. Requesting to purchase 1 TBT kit and a Tactical PAN disruptor. SCSO will pay overage.
3	SCSO	SCSO	AEL 02EX-01-XRAP	Homeland Security Grant Program FY18	Issue 10-Bomb Sustainment	$29,800.00	2	$59,600.00	1 Tactical Portable X-ray. We now have products available to purchase 2 Tactical Portable X-ray systems for the same amount.
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13									
14									
15			Total					$71,446.00	

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From:	Newman, Sunny
To:	Domestic Security Oversight Council; "abecraft@miamigov.com"; "ashaw@hcso.tampa.fl.us"; "Benjamin.Burns@freshfromflorida.com"; Brenda Compton; "brent.wise@dhs.gov"; "CarolBishop@flhsmv.gov"; Christie Luce; Davenport, Jessica; "dbrand@flsheriffs.org"; Desguin, Shane; Diana Gryder; Donna Lusczynski; "douglas.goerke@cityoforlando.net"; Duffey, Mike; Ed Dwyer; "Elizabeth Ryon (Ryon.Elizabeth@flsenate.gov)"; "ElizabethDenmark@flhsmv.gov"; "Garrett.Wienckowski@ocfl. net"; "GeneSpaulding@flhsmv.gov"; Gordon, Kristi; "Jay.Etheridge@myfloridacfo.com"; "John.Kohnke@myfloridacfo.com"; "jrios@hcso.tampa.fl.us"; "Kevin.Johnson@ocfl.net"; "Larry.Zwieg@ocfl.net"; "lawrence.revell@talgov.com"; Lila Mestas; "linda.mcwhorter@em.myflorida.com"; "Lynne.Drawdy@flhealth.gov"; "Margaret.Medina@flhealth.gov"; Mark Pergola; "mdunagan@flsheriffs.org"; "meggsw@leoncountyfl.gov"; Mizell, Lori; Nicole Nelson; Rexroad, Samantha; Samantha Cooksey; "Sarah.Hofmeister@flhealth.gov"; Scott McAllister; "Sherry.hare@ocfl.net"; "Sue.Rantuccio@freshfromflorida.com"; "Tammy.Miller2@ocfl.net"
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Please do not hesitate to contact me if you have any questions or concerns.

Thanks!
Sunny

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AMERICAN OVERSIGHT

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Governor DeSantis charged FDLE to establish a statewide behavioral threat assessment strategy. Commissioner Swearingen discussed the composition of the work group and the four meetings that have taken place to develop the strategy. The strategy will reflect the Regional Domestic Security Task Force structure, to include mental health professionals. It is vital that information is being shared and we are not operating in silos. The draft will be finalized by the end of November. Training curriculum is being developed for basic recruits, a 40-hour course, and executive administrators.

Action Items:

State Cyber Disruption Plan – Molly Akins, FDLE

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AMERICAN OVERSIGHT

Molly Akins, Cyber Terrorism Focus Group Chair, provided an overview of the State Cyber Disruption Plan for the Council. An exercise is planned in 2020 that will test the plan. She discussed the main changes; agency name changes, graphics, and where this plan sits within the Emergency Operation Center. It now sits under ESF-2 and they are deciding where it should be moved. Some other states have it under ESF 2 and some have a separate support function for it. The procurement process for the exercise has begun. After the exercise, an after action report will be provided and allow the group to update the plan based on gaps identified.

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Pete Gomez presented eight Miami Urban Area Budget Change Request for a total of $483,804 that included cyber security equipment, EOC enhancements, access card readers, ballistic shields, portable license plate readers, and night vision goggles.

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There being no further business, the meeting was adjourned.

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AMERICAN OVERSIGHT

Domestic Security Oversight COUNCIL

Via Webinar

March 25, 2020 1:00 – 5:00 PM

AGENDA

Welcome .....Rick Swearingen, FDLE

Roll Call

Approval of November 19, 2019 meeting minutes

UPDATES/PRESENTATIONS:

Homeland Security Advisor Brief .....SAC Mike Phillips, FDLE
DSCG Executive Board/Focus Groups updates

Coronavirus (COVID-19) update.....Christie Luce, FDOH

2020 Grant updates
New DHS priorities.....SAA/FDEM

PLEASE NOTE: The following portion of the meeting is a "CLOSED SESSION".
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DRAFT

AMERICAN OVERSIGHT

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3									
4									
5									
6									
7									
8			Total					$6,671.21	

AMERICAN OVERSIGHT

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5	Miami	**City of Fort Lauderdale**	Prevention - Screening, Search and Detection (Camera for Bomb Robot) AEL 02EX-02-RBTL	**2018**
6	Miami	**City of Fort Lauderdale**	Response - On-Scene Security, Protection and Law Enforcement (Training equipment for SWAT to include: Conversion Kits for SWAT, Simunition Magazines, Single Shot Launchers); AEL 03OE-01-NLTA	**2018**
7	Miami	**City of Coral Springs**	Response - On-Scene Security, Protection and Law Enforcement (Video Surveillance Equipment); AEL 13LE-00-SURV	**2018**
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AMERICAN OVERSIGHT

	E	F	G	H
1	**State Strategic Plan Goal/objective item supports**	**Quantity**	**Unit Cost**	**Total Cost**
2	Goal: Prepare for domestic security incidents; Objective: Operational Coordination	4	$7,100.00	**$28,400.00**
3	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	12	$1,003.15	**$12,038.00**
4	Goal: Prevent, preempt and deter acts of terrorism; Objective: Interdiction of threats	4	$4,000.00	**$16,000.00**
5	Goal: Prevent, preempt and deter acts of terrorism; Objective: Interdiction of threats	1	$6,935.00	**$6,935.00**
6	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	1	$2,740.00	**$2,740.00**
7	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	3	$7,829.00	**$23,487.00**
8				
9				
10		**TOTAL**		**$ 89,600.00**
11				
12				

AMERICAN OVERSIGHT

	I	J
1	**Description of item(s) Funds were originally allocated for**	
2	Decreased General Dynamics project, line item 2018-15K, by $93,120 and funds transferred to: Smart Boards project line item 2018-02M $28,400; Magnetometer/Metal Detector project line item 2018-06K $16,000; Portable LPR Trailer line item 2018-06J $48,720.	
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5	Decreased line item 2018-01D, PT&E Coordinated Attack Exercise, by $13,400 and funds transferred to: Camera for Bomb Project, line item 2018-06L $6935, Training Equipment for SWAT line item 2018-18D $2740, Ballistic Helmets, line item 2018-18A2 $3725.	
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7	Decreased line item 2018-04A, Mobile Trailer with intelligence camera, by $23,487 and transferred funds to Video Surveillance Equipment project, line item 2018-18E.	
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AMERICAN OVERSIGHT

	A	B	C	D
13				
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AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I
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2	SCSO	SCSO	AEL 02EX-02-TLPB	Homeland Security Grant Program FY18	Issue 19-Bomb Building Capabilities	$11,846.00	1	$11,846.00	2 TBT kit without a tactical PAN disruputor. Requesting to purchase 1 TBT kit and a Tactical PAN disruptor. SCSO will pay overage.
3	SCSO	SCSO	AEL 02EX-01-XRAP	Homeland Security Grant Program FY18	Issue 10-Bomb Sustainment	$29,800.00	2	$59,600.00	1 Tactical Portable X-ray. We now have products available to purchase 2 Tactical Portable X-ray systems for the same amount.
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14									
15			Total					$71,446.00	

AMERICAN OVERSIGHT

From:	Newman, Sunny
To:	Domestic Security Oversight Council; "abecraft@miamigov.com"; "ashaw@hcso.tampa.fl.us"; "Benjamin.Burns@freshfromflorida.com"; Brenda Compton; "brent.wise@dhs.gov"; "CarolBishop@flhsmv.gov"; Christie Luce; Davenport, Jessica; "dbrand@flsheriffs.org"; Desguin, Shane; Diana Gryder; Donna Lusczynski; "douglas.goerke@cityoforlando.net"; Duffey, Mike; Ed Dwyer; "Elizabeth Ryon (Ryon.Elizabeth@flsenate.gov)"; "ElizabethDenmark@flhsmv.gov"; "Garrett.Wienckowski@ocfl. net"; "GeneSpaulding@flhsmv.gov"; Gordon, Kristi; "Jay.Etheridge@myfloridacfo.com"; "John.Kohnke@myfloridacfo.com"; "jrios@hcso.tampa.fl.us"; "Kevin.Johnson@ocfl.net"; "Larry.Zwieg@ocfl.net"; "lawrence.revell@talgov.com"; Lila Mestas; "linda.mcwhorter@em.myflorida.com"; "Lynne.Drawdy@flhealth.gov"; "Margaret.Medina@flhealth.gov"; Mark Pergola; "mdunagan@flsheriffs.org"; "meggsw@leoncountyfl.gov"; Mizell, Lori; Nicole Nelson; Rexroad, Samantha; Samantha Cooksey; "Sarah.Hofmeister@flhealth.gov"; Scott McAllister; "Sherry.hare@ocfl.net"; "Sue.Rantuccio@freshfromflorida.com"; "Tammy.Miller2@ocfl.net"
Cc:	Harvey, Robyn; Sasser, Billy E; Kelly, Damien; Wiggins, James; John Wilgis; Swearingen, Rick; Phillips, Mike; Ladd, Michael A COL USARMY NG FLARNG (USA); Burroughs, Joyce; Mark Dubina; Pollard, Vaden; Walker, Troy; Bradshaw, Ric L.; Vaughn, Thomas; Steve Casey; Thomas Storrar Jr - 0145; Halas, Julius; Burke, John; Lemma, Sheriff Dennis; Walt McNeil; Keenan, Gwen; Guthrie, Kevin; Lorin L. Mock; Daniels, Darryl; chiefdowneydc@gmail.com; quin romay; Brutnell, Mark; McPherson, Michael F. (TP) (FBI); Buccione, Charlene K. (TP) (FBI); Brad King; Burns, Ben; Rivkees, Scott A; Hevia, Robert; Luce, Christie; Steven.Thomas@ocfl.net; Moreland, Charles; Perez, Mark; Massie, Lee; Garry Lisiewski; Mandell, Milton; Bradley, Rose; McNeil, Beth; Foy, Tom; Brown, Chasity; Bucci, Joseph; "Yehuda.Green@ocfl.net"; CHRONISTER, CHAD; "Cintron, Morgan"
Subject:	DSOC Meeting Materials and Webinar Information
Attachments:	SCSO Budget change request FY18 Money.xlsx FY2018 Sustainment of Fusion Centers Budget Change Request.xlsx Miami_budget_change_request March 2020.xlsx 19-1119 DSOC draft minutes.docx 20-0325 DSOC Agenda.doc

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Good afternoon,

Attached are meeting materials for the DSOC webinar and the webinar information. If you are logging into the webinar through the guest option, please provide your name. We will not accept individuals logging in as “guest”.

Call in information:
US Dial In #: (888) 585-9008
Conference Room #: 215-384-938 then #
Webinar Link:
https://share.dhs.gov/dsoc_3252020/ <https://share.dhs.gov/dsoc_3252020/>

Please do not hesitate to contact me if you have any questions or concerns.

Thanks!
Sunny

Sunny Newman
Office of Domestic Security
Florida Department of Law Enforcement
Government Analyst II
Work: 850-410-8435
Cell: 850-510-3364
sunnynewman@fdle.state.fl.us <mailto:sunnynewman@fdle.state.fl.us>

AMERICAN OVERSIGHT

DOMESTIC SECURITY OVERSIGHT COUNCIL

November 19, 2019
Ocala, FL
Proceedings

Participants

Commissioner Richard Swearingen, Chairman

Director Jared Moskowitz, Vice Chairman
(represented by Kevin Guthrie)

Oversight Council Members (in attendance):

Director Ashley Moody
(represented by Emery Gainey)
Commissioner Nicole Fried
(represented by James Wiggins)
State Surgeon General Scott Rivkees
Commissioner Richard Corcoran
(represented by Damien Kelly)
Director Julius Halas
Thomas Vaughn
Sheriff Walt McNeil
(represented by Chris Summers)
Sheriff Chad Chronister
(represented by Joel Rios)
Sheriff Dennis Lemma
(represented by Mark Pergola)
Sheriff Kevin Rambosk
(represented by Tom Storrar)
Sheriff Ric Bradshaw
(represented by Robert Allen)
SAC Jack Massey
SAC Mark Perez
SAC John Burke
SAC Mark Brutnell
(represented by John Vecchio)
SAC Lee Massie
SAC Shane Pollard
SAC Troy Walker
Chief Lorin Mock
Chief Mark Oakes
Chief Quin Romay
Mark Dubina
Garry Lisiewski
Pete Gomez
Tammy Miller
(represented by Mitch Shaban)
FBI SAC Michael McPherson
Director Scott McAllister
Steve Casey
(represented by Matt Dunagan)
Executive Director Gene Spaulding

Commissioner Richard Swearingen, Florida Department of Law Enforcement (FDLE), called the meeting to order at 1:02 p.m.

Roll was taken and a quorum was present.

Commissioner Swearingen presented the minutes from the July 31, 2019 meeting for approval.

Julius Halas made a motion to accept the minutes; Emery Gainey seconded the motion. Motion approved by voice vote.

Information Items:

The Foreign Threat in American Business – Joe Morosco, National Counterintelligence and Security Center (NCSC)

Mr. Joe Morosco provided a presentation on the complex counterintelligence landscape. He discussed increasing threats, national counterintelligence priorities, Florida's geopolitical balance, economic espionage and China's strategy on acquiring technology. China's current strategy relies heavily upon technology research and investments within the U.S. Mr. Morosco discussed ways

AMERICAN OVERSIGHT

to mitigate the threat by maintaining connectivity on current threat intelligence, strengthening cyber security and hygiene, and implementing insider threat programs. Donna Uzzell asked if NCSC is speaking with the business community, and if they are available to provide presentations throughout the state. Mr. Morosco stated that there are versions of this message available online to provide to members of industry, and that they would be willing to provide presentations to community leaders and large groups.

Homeland Security Advisor Brief— Special Agent in Charge (SAC) Donna Uzzell

SAC Donna Uzzell provided a homeland security brief to the Council. She stated there would be upcoming meetings to update the Domestic Security Strategic Plan. Focus group members and regional representatives will be asked to volunteer to participate in the update. SAC Uzzell spoke about the "If You See Something, Say Something" promotional campaign and the mobile application. The Council viewed available public service announcement videos associated with the campaign. She stated that collaboration with Department of Homeland Security (DHS) is occurring to ensure that efforts are not duplicative.

SAC Uzzell provided an update on focus group efforts. The Law Enforcement Datasharing focus group is looking at capabilities that would assist in threat assessments through Law Enforcement Exchange (LINX) databases. The Planning, Response, and Recovery focus group is working on reunification plans, and expanding WebEOC boards. The Critical Infrastructure focus group contributed to the annual report due to the legislature. SAC Mike Phillips provided a cyber update to include election security for 2020, table-top exercises through the Florida Supervisors of Elections Association, and a Cyber Security Summit for critical infrastructure partners in Fort Myers.

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AMERICAN OVERSIGHT

Domestic Security Oversight COUNCIL

Via Webinar

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AMERICAN OVERSIGHT

	E	F	G	H
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3	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	12	$1,003.15	**$12,038.00**
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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15			Total					$71,446.00	

AMERICAN OVERSIGHT

From:	Newman, Sunny
To:	Domestic Security Oversight Council; "abecraft@miamigov.com"; "ashaw@hcso.tampa.fl.us"; "Benjamin.Burns@freshfromflorida.com"; Brenda Compton; "brent.wise@dhs.gov"; "CarolBishop@flhsmv.gov"; Christie Luce; Davenport, Jessica; "dbrand@flsheriffs.org"; Desguin, Shane; Diana Gryder; Donna Lusczynski; "douglas.goerke@cityoforlando.net"; Duffey, Mike; Ed Dwyer; "Elizabeth Ryon (Ryon.Elizabeth@flsenate.gov)"; "ElizabethDenmark@flhsmv.gov"; "Garrett.Wienckowski@ocfl. net"; "GeneSpaulding@flhsmv.gov"; Gordon, Kristi; "Jay.Etheridge@myfloridacfo.com"; "John.Kohnke@myfloridacfo.com"; "jrios@hcso.tampa.fl.us"; "Kevin.Johnson@ocfl.net"; "Larry.Zwieg@ocfl.net"; "lawrence.revell@talgov.com"; Lila Mestas; "linda.mcwhorter@em.myflorida.com"; "Lynne.Drawdy@flhealth.gov"; "Margaret.Medina@flhealth.gov"; Mark Pergola; "mdunagan@flsheriffs.org"; "meggsw@leoncountyfl.gov"; Mizell, Lori; Nicole Nelson; Rexroad, Samantha; Samantha Cooksey; "Sarah.Hofmeister@flhealth.gov"; Scott McAllister; "Sherry.hare@ocfl.net"; "Sue.Rantuccio@freshfromflorida.com"; "Tammy.Miller2@ocfl.net"
Cc:	Harvey, Robyn; Sasser, Billy E; Kelly, Damien; Wiggins, James; John Wilgis; Swearingen, Rick; Phillips, Mike; Ladd, Michael A COL USARMY NG FLARNG (USA); Burroughs, Joyce; Mark Dubina; Pollard, Vaden; Walker, Troy; Bradshaw, Ric L.; Vaughn, Thomas; Steve Casey; Thomas Storrar Jr - 0145; Halas, Julius; Burke, John; Lemma, Sheriff Dennis; Walt McNeil; Keenan, Gwen; Guthrie, Kevin; Lorin L. Mock; Daniels, Darryl; chiefdowneydc@gmail.com; quin romay; Brutnell, Mark; McPherson, Michael F. (TP) (FBI); Buccione, Charlene K. (TP) (FBI); Brad King; Burns, Ben; Rivkees, Scott A; Hevia, Robert; Luce, Christie; Steven.Thomas@ocfl.net; Moreland, Charles; Perez, Mark; Massie, Lee; Garry Lisiewski; Mandell, Milton; Bradley, Rose; McNeil, Beth; Foy, Tom; Brown, Chasity; Bucci, Joseph; "Yehuda.Green@ocfl.net"; CHRONISTER, CHAD; "Cintron, Morgan"
Subject:	DSOC Meeting Materials and Webinar Information
Attachments:	SCSO Budget change request FY18 Money.xlsx FY2018 Sustainment of Fusion Centers Budget Change Request.xlsx Miami_budget_change_request March 2020.xlsx 19-1119 DSOC draft minutes.docx 20-0325 DSOC Agenda.doc

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Good afternoon,

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Call in information:
US Dial In #: (888) 585-9008
Conference Room #: 215-384-938 then #
Webinar Link:
https://share.dhs.gov/dsoc_3252020/ <https://share.dhs.gov/dsoc_3252020/>

Please do not hesitate to contact me if you have any questions or concerns.

Thanks!
Sunny

Sunny Newman
Office of Domestic Security
Florida Department of Law Enforcement
Government Analyst II
Work: 850-410-8435
Cell: 850-510-3364
sunnynewman@fdle.state.fl.us <mailto:sunnynewman@fdle.state.fl.us>

AMERICAN OVERSIGHT

DOMESTIC SECURITY OVERSIGHT COUNCIL

November 19, 2019
Ocala, FL
Proceedings

Participants

Commissioner Richard Swearingen, Chairman

Director Jared Moskowitz, Vice Chairman
(represented by Kevin Guthrie)

Oversight Council Members (in attendance):

Director Ashley Moody
(represented by Emery Gainey)
Commissioner Nicole Fried
(represented by James Wiggins)
State Surgeon General Scott Rivkees
Commissioner Richard Corcoran
(represented by Damien Kelly)
Director Julius Halas
Thomas Vaughn
Sheriff Walt McNeil
(represented by Chris Summers)
Sheriff Chad Chronister
(represented by Joel Rios)
Sheriff Dennis Lemma
(represented by Mark Pergola)
Sheriff Kevin Rambosk
(represented by Tom Storrar)
Sheriff Ric Bradshaw
(represented by Robert Allen)
SAC Jack Massey
SAC Mark Perez
SAC John Burke
SAC Mark Brutnell
(represented by John Vecchio)
SAC Lee Massie
SAC Shane Pollard
SAC Troy Walker
Chief Lorin Mock
Chief Mark Oakes
Chief Quin Romay
Mark Dubina
Garry Lisiewski
Pete Gomez
Tammy Miller
(represented by Mitch Shaban)
FBI SAC Michael McPherson
Director Scott McAllister
Steve Casey
(represented by Matt Dunagan)
Executive Director Gene Spaulding

Commissioner Richard Swearingen, Florida Department of Law Enforcement (FDLE), called the meeting to order at 1:02 p.m.

Roll was taken and a quorum was present.

Commissioner Swearingen presented the minutes from the July 31, 2019 meeting for approval.

Julius Halas made a motion to accept the minutes; Emery Gainey seconded the motion. Motion approved by voice vote.

Information Items:

The Foreign Threat in American Business – Joe Morosco, National Counterintelligence and Security Center (NCSC)

Mr. Joe Morosco provided a presentation on the complex counterintelligence landscape. He discussed increasing threats, national counterintelligence priorities, Florida's geopolitical balance, economic espionage and China's strategy on acquiring technology. China's current strategy relies heavily upon technology research and investments within the U.S. Mr. Morosco discussed ways

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to mitigate the threat by maintaining connectivity on current threat intelligence, strengthening cyber security and hygiene, and implementing insider threat programs. Donna Uzzell asked if NCSC is speaking with the business community, and if they are available to provide presentations throughout the state. Mr. Morosco stated that there are versions of this message available online to provide to members of industry, and that they would be willing to provide presentations to community leaders and large groups.

Homeland Security Advisor Brief— Special Agent in Charge (SAC) Donna Uzzell

SAC Donna Uzzell provided a homeland security brief to the Council. She stated there would be upcoming meetings to update the Domestic Security Strategic Plan. Focus group members and regional representatives will be asked to volunteer to participate in the update. SAC Uzzell spoke about the "If You See Something, Say Something" promotional campaign and the mobile application. The Council viewed available public service announcement videos associated with the campaign. She stated that collaboration with Department of Homeland Security (DHS) is occurring to ensure that efforts are not duplicative.

SAC Uzzell provided an update on focus group efforts. The Law Enforcement Datasharing focus group is looking at capabilities that would assist in threat assessments through Law Enforcement Exchange (LINX) databases. The Planning, Response, and Recovery focus group is working on reunification plans, and expanding WebEOC boards. The Critical Infrastructure focus group contributed to the annual report due to the legislature. SAC Mike Phillips provided a cyber update to include election security for 2020, table-top exercises through the Florida Supervisors of Elections Association, and a Cyber Security Summit for critical infrastructure partners in Fort Myers.

Marjory Stoneman Douglas High School Public Safety Commission—SAC Donna Uzzell, FDLE

SAC Donna Uzzell discussed The Marjory Stoneman Douglas High School Public Safety Commission's second report and its' findings and recommendations. She highlighted the need for policies and procedures on reunification and mass-casualty death notifications. She spoke to the chapter on threat assessments and what information is able to be shared. She spoke to the need for training on the Family Educational Rights and Privacy Act (FERPA). Commissioner Swearingen agreed and stated that training on both FERPA and the Health Insurance Portability and Accountability Act (HIPAA) is going to be critical.

Statewide Behavioral Threat Assessment Management Strategy—Commissioner Rick Swearingen, FDLE

Governor DeSantis charged FDLE to establish a statewide behavioral threat assessment strategy. Commissioner Swearingen discussed the composition of the work group and the four meetings that have taken place to develop the strategy. The strategy will reflect the Regional Domestic Security Task Force structure, to include mental health professionals. It is vital that information is being shared and we are not operating in silos. The draft will be finalized by the end of November. Training curriculum is being developed for basic recruits, a 40-hour course, and executive administrators.

Action Items:

State Cyber Disruption Plan – Molly Akins, FDLE

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Molly Akins, Cyber Terrorism Focus Group Chair, provided an overview of the State Cyber Disruption Plan for the Council. An exercise is planned in 2020 that will test the plan. She discussed the main changes; agency name changes, graphics, and where this plan sits within the Emergency Operation Center. It now sits under ESF-2 and they are deciding where it should be moved. Some other states have it under ESF 2 and some have a separate support function for it. The procurement process for the exercise has begun. After the exercise, an after action report will be provided and allow the group to update the plan based on gaps identified.

Tom Storrar made a motion to approve the State Cyber Disruption Plan; John Burke seconded the motion. Motion approved by voice vote.

FFY 2018 Miami UASI Budget Change Request – Pete Gomez, Miami Fire Rescue, FDLE

Pete Gomez presented eight Miami Urban Area Budget Change Request for a total of $483,804 that included cyber security equipment, EOC enhancements, access card readers, ballistic shields, portable license plate readers, and night vision goggles.

Julius Halas made a motion to accept the budget change request; Quin Romay seconded the motion. Motion approved by voice vote.

FFY 2020 Miami Urban Area Budget Request – Pete Gomez, Miami Fire Rescue

Pete Gomez presented the FFY 2020 Miami Urban Area Budget Request that included 27 projects for a total of $8,305,200.

SAC Donna Uzzell asked about the Department of Health Warehouse line item that was also listed on the State Homeland Security Program (SHSP) funding requests. SAC Uzzell clarified that during the Executive Board prioritization meeting, Kevin Guthrie spoke to different funding streams that could be used to cover the cost of this line item. Kevin Guthrie confirmed and stated that he would coordinate with Palm Beach County to include the warehouse in the local mitigation strategy. He stated it could be covered under the Emergency Management Preparedness Grant.

SAC Uzzell asked about the drone line items. The Council agreed that the purchase of drones would be delayed until the Specialty Response Team could develop a statewide strategy for drone regulations and requirements when purchased with SHSP grant funds. Mr. Gomez stated that the UASI does not have to abide by the DSCG rules because the Urban Area Working Group (UAWG) approved it. Lawrence Revell stated that DSOC rules should be unified for both the UASI and DSCG. Mr. Gomez stated the UAWG is the governing body for the UASIs. SAC Uzzell read from Florida Statute 943 and stated that the DSOC approves UASI funds; the group reviewed the minutes from the last meeting for clarification on the drone approval discussion. Commissioner Swearingen stated it was a legal interpretation that needed to be looked at.

John Burke made a motion to accept the budget request pending legal guidance; Lorin Mock seconded the motion. Motion approved by voice vote.

FFY 2020 Orlando Urban Area Budget Request – Mitch Shaban, City of Orlando

Mitch Shaban presented the FFY 2020 Orlando Urban Area Budget Request that included 27 projects for a total of $4,477,467.

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Commissioner Swearingen asked if the drone detection system could be used by the state and local agencies. Scott McAlister stated that federal law only allows the Federal Bureau of Investigations (FBI) and DHS to use the drone detection system for special events; a letter would need to be submitted to the FBI for permission to use. It's a federal violation for local police departments to use detection equipment. Mr. Shaban clarified that the detection system is not counter-measure drone technology.

Shane Pollard made a motion to accept the budget request; Robert Allen seconded the motion. Motion approved by voice vote.

FFY 2020 Tampa Bay Urban Area Budget Request - Garry Lisiewski, Tampa Police Department

Garry Lisiewski presented the FFY 2020 Tampa Urban Area Budget Request that included 24 projects for a total of $4,186,908.

Julius Halas made a motion to accept the budget request; Mark Perez seconded the motion. Motion approved by voice vote.

FFY 2019 SHSP Budget Change Request – Donna Uzzell, FDLE

Donna Uzzell presented one project for the FFY 2019 SHSP Budget Change Request for a total of $20,000 for a campaign project manager.

Shane Pollard made a motion to accept the budget change request; Robert Allen seconded the motion. Motion approved by voice vote.

FFY 2020 SHSP Budget Request – Donna Uzzell, FDLE

Donna Uzzell presented the FFY 2020 SHSP Budget Request that included 28 projects for a total of $11,701,680.

Shane Pollard made a motion to accept the budget request; John Burke seconded the motion. Motion approved by voice vote.

SAC Uzzell spoke to purchasing microphones for domestic security meetings. Kevin Guthrie asked the Council for support to use deobligated funds to purchase the required microphones. He stated that if approved, FDEM would house the equipment and send a point of contact to set up the equipment for meetings.

Julius Halas made a motion to approve the purchase of a microphone system with deobligated funds; Damien Kelly seconded the motion. Motion approved by voice vote.

Julius Halas stated the Council should be made aware of those that are deobligating funds. Kevin Guthrie stated that FDEM would provide a financial update at future DSOC meetings.

There being no further business, the meeting was adjourned.

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Domestic Security Oversight COUNCIL

Via Webinar

March 25, 2020 1:00 – 5:00 PM

AGENDA

Welcome .....Rick Swearingen, FDLE

Roll Call

Approval of November 19, 2019 meeting minutes

UPDATES/PRESENTATIONS:

Homeland Security Advisor Brief .....SAC Mike Phillips, FDLE
DSCG Executive Board/Focus Groups updates

Coronavirus (COVID-19) update.....Christie Luce, FDOH

2020 Grant updates
New DHS priorities.....SAA/FDEM

PLEASE NOTE: The following portion of the meeting is a "CLOSED SESSION".
Only authorized personnel may attend. Thank you.

ACTION ITEMS:

FY 2021 Funding Process.....SAC Mike Phillips, FDLE

New FY 2020 SHSP Funding Projects..... SAC Mike Phillips, FDLE

Miami UASI Budget Change Request.....Robert Hevia, Miami UASI

FY2020 Miami UASI Project Update .....Robert Hevia, Miami UASI

FY2020 Tampa UASI Project Update.....Garry Lisiewski, Tampa UASI

FY2020 Orlando UASI Project Update .....Mitch Shaban, Orlando UASI

Seminole Co Sheriff's Office Budget Change Request .....Sgt Gabe Rhodes, Seminole Co.

Lee County Sheriff's Office Project Request .....Eli Lawson, FDLE

NE Fusion Center Budget Change Request.....Kas Kahn, NEFC

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2	FDLE	FDLE	13IT-00-INTL - Microsoft SharePoint Server 2019 License with 25 user CAL	FFY2018 Sustainment of Fusion Centers Budget	2.1: Information and Intelligence Sharing; 2.2 Interdiction of Threats; 2.3 Threats and Violent Extremism	$6,671.21	1	$6,671.21	Crime Mapping Software License
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8			Total					$6,671.21	

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Cc:	Harvey, Robyn; Sasser, Billy E; Kelly, Damien; Wiggins, James; Wilgis, John; Swearingen, Rick; Phillips, Mike; Ladd, Michael A COL USARMY NG FLARNG (USA); Burroughs, Joyce; Mark Dubina; Pollard, Vaden; Walker, Troy; Bradshaw, Ric L.; Vaughn, Thomas; Steve Casey; Thomas Storrar Jr - 0145; Halas, Julius; Burke, John; Lemma, Sheriff Dennis; Walt McNeil; Keenan, Gwen; Guthrie, Kevin; Lorin L. Mock; Daniels, Darryl; chiefdowneydc@gmail.com; quin romay; Brutnell, Mark; McPherson, Michael F. (TP) (FBI); Buccione, Charlene K. (TP) (FBI); Brad King; Burns, Ben; Rivkees, Scott A; Hevia, Robert; Luce, Christie; Steven.Thomas@ocfl.net; Moreland, Charles; Perez, Mark; Massie, Lee; Garry Lisiewski; Mandell, Milton; Bradley, Rose; McNeil, Beth; Foy, Tom; Brown, Chasity; Bucci, Joseph; "Yehuda.Green@ocfl.net"; CHRONISTER, CHAD; "Cintron, Morgan"
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Please do not hesitate to contact me if you have any questions or concerns.

Thanks!
Sunny

Sunny Newman
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Florida Department of Law Enforcement
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AMERICAN OVERSIGHT

DOMESTIC SECURITY OVERSIGHT COUNCIL

November 19, 2019
Ocala, FL
Proceedings

Participants

Commissioner Richard Swearingen, Chairman

Director Jared Moskowitz, Vice Chairman
(represented by Kevin Guthrie)

Oversight Council Members (in attendance):

Director Ashley Moody
(represented by Emery Gainey)
Commissioner Nicole Fried
(represented by James Wiggins)
State Surgeon General Scott Rivkees
Commissioner Richard Corcoran
(represented by Damien Kelly)
Director Julius Halas
Thomas Vaughn
Sheriff Walt McNeil
(represented by Chris Summers)
Sheriff Chad Chronister
(represented by Joel Rios)
Sheriff Dennis Lemma
(represented by Mark Pergola)
Sheriff Kevin Rambosk
(represented by Tom Storrar)
Sheriff Ric Bradshaw
(represented by Robert Allen)
SAC Jack Massey
SAC Mark Perez
SAC John Burke
SAC Mark Brutnell
(represented by John Vecchio)
SAC Lee Massie
SAC Shane Pollard
SAC Troy Walker
Chief Lorin Mock
Chief Mark Oakes
Chief Quin Romay
Mark Dubina
Garry Lisiewski
Pete Gomez
Tammy Miller
(represented by Mitch Shaban)
FBI SAC Michael McPherson
Director Scott McAllister
Steve Casey
(represented by Matt Dunagan)
Executive Director Gene Spaulding

Commissioner Richard Swearingen, Florida Department of Law Enforcement (FDLE), called the meeting to order at 1:02 p.m.

Roll was taken and a quorum was present.

Commissioner Swearingen presented the minutes from the July 31, 2019 meeting for approval.

Julius Halas made a motion to accept the minutes; Emery Gainey seconded the motion. Motion approved by voice vote.

Information Items:

The Foreign Threat in American Business – Joe Morosco, National Counterintelligence and Security Center (NCSC)

Mr. Joe Morosco provided a presentation on the complex counterintelligence landscape. He discussed increasing threats, national counterintelligence priorities, Florida's geopolitical balance, economic espionage and China's strategy on acquiring technology. China's current strategy relies heavily upon technology research and investments within the U.S. Mr. Morosco discussed ways

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to mitigate the threat by maintaining connectivity on current threat intelligence, strengthening cyber security and hygiene, and implementing insider threat programs. Donna Uzzell asked if NCSC is speaking with the business community, and if they are available to provide presentations throughout the state. Mr. Morosco stated that there are versions of this message available online to provide to members of industry, and that they would be willing to provide presentations to community leaders and large groups.

Homeland Security Advisor Brief— Special Agent in Charge (SAC) Donna Uzzell

SAC Donna Uzzell provided a homeland security brief to the Council. She stated there would be upcoming meetings to update the Domestic Security Strategic Plan. Focus group members and regional representatives will be asked to volunteer to participate in the update. SAC Uzzell spoke about the "If You See Something, Say Something" promotional campaign and the mobile application. The Council viewed available public service announcement videos associated with the campaign. She stated that collaboration with Department of Homeland Security (DHS) is occurring to ensure that efforts are not duplicative.

SAC Uzzell provided an update on focus group efforts. The Law Enforcement Datasharing focus group is looking at capabilities that would assist in threat assessments through Law Enforcement Exchange (LINX) databases. The Planning, Response, and Recovery focus group is working on reunification plans, and expanding WebEOC boards. The Critical Infrastructure focus group contributed to the annual report due to the legislature. SAC Mike Phillips provided a cyber update to include election security for 2020, table-top exercises through the Florida Supervisors of Elections Association, and a Cyber Security Summit for critical infrastructure partners in Fort Myers.

Marjory Stoneman Douglas High School Public Safety Commission—SAC Donna Uzzell, FDLE

SAC Donna Uzzell discussed The Marjory Stoneman Douglas High School Public Safety Commission's second report and its' findings and recommendations. She highlighted the need for policies and procedures on reunification and mass-casualty death notifications. She spoke to the chapter on threat assessments and what information is able to be shared. She spoke to the need for training on the Family Educational Rights and Privacy Act (FERPA). Commissioner Swearingen agreed and stated that training on both FERPA and the Health Insurance Portability and Accountability Act (HIPAA) is going to be critical.

Statewide Behavioral Threat Assessment Management Strategy—Commissioner Rick Swearingen, FDLE

Governor DeSantis charged FDLE to establish a statewide behavioral threat assessment strategy. Commissioner Swearingen discussed the composition of the work group and the four meetings that have taken place to develop the strategy. The strategy will reflect the Regional Domestic Security Task Force structure, to include mental health professionals. It is vital that information is being shared and we are not operating in silos. The draft will be finalized by the end of November. Training curriculum is being developed for basic recruits, a 40-hour course, and executive administrators.

Action Items:

State Cyber Disruption Plan – Molly Akins, FDLE

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Molly Akins, Cyber Terrorism Focus Group Chair, provided an overview of the State Cyber Disruption Plan for the Council. An exercise is planned in 2020 that will test the plan. She discussed the main changes; agency name changes, graphics, and where this plan sits within the Emergency Operation Center. It now sits under ESF-2 and they are deciding where it should be moved. Some other states have it under ESF 2 and some have a separate support function for it. The procurement process for the exercise has begun. After the exercise, an after action report will be provided and allow the group to update the plan based on gaps identified.

Tom Storrar made a motion to approve the State Cyber Disruption Plan; John Burke seconded the motion. Motion approved by voice vote.

FFY 2018 Miami UASI Budget Change Request – Pete Gomez, Miami Fire Rescue, FDLE

Pete Gomez presented eight Miami Urban Area Budget Change Request for a total of $483,804 that included cyber security equipment, EOC enhancements, access card readers, ballistic shields, portable license plate readers, and night vision goggles.

Julius Halas made a motion to accept the budget change request; Quin Romay seconded the motion. Motion approved by voice vote.

FFY 2020 Miami Urban Area Budget Request – Pete Gomez, Miami Fire Rescue

Pete Gomez presented the FFY 2020 Miami Urban Area Budget Request that included 27 projects for a total of $8,305,200.

SAC Donna Uzzell asked about the Department of Health Warehouse line item that was also listed on the State Homeland Security Program (SHSP) funding requests. SAC Uzzell clarified that during the Executive Board prioritization meeting, Kevin Guthrie spoke to different funding streams that could be used to cover the cost of this line item. Kevin Guthrie confirmed and stated that he would coordinate with Palm Beach County to include the warehouse in the local mitigation strategy. He stated it could be covered under the Emergency Management Preparedness Grant.

SAC Uzzell asked about the drone line items. The Council agreed that the purchase of drones would be delayed until the Specialty Response Team could develop a statewide strategy for drone regulations and requirements when purchased with SHSP grant funds. Mr. Gomez stated that the UASI does not have to abide by the DSCG rules because the Urban Area Working Group (UAWG) approved it. Lawrence Revell stated that DSOC rules should be unified for both the UASI and DSCG. Mr. Gomez stated the UAWG is the governing body for the UASIs. SAC Uzzell read from Florida Statute 943 and stated that the DSOC approves UASI funds; the group reviewed the minutes from the last meeting for clarification on the drone approval discussion. Commissioner Swearingen stated it was a legal interpretation that needed to be looked at.

John Burke made a motion to accept the budget request pending legal guidance; Lorin Mock seconded the motion. Motion approved by voice vote.

FFY 2020 Orlando Urban Area Budget Request – Mitch Shaban, City of Orlando

Mitch Shaban presented the FFY 2020 Orlando Urban Area Budget Request that included 27 projects for a total of $4,477,467.

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Commissioner Swearingen asked if the drone detection system could be used by the state and local agencies. Scott McAlister stated that federal law only allows the Federal Bureau of Investigations (FBI) and DHS to use the drone detection system for special events; a letter would need to be submitted to the FBI for permission to use. It's a federal violation for local police departments to use detection equipment. Mr. Shaban clarified that the detection system is not counter-measure drone technology.

Shane Pollard made a motion to accept the budget request; Robert Allen seconded the motion. Motion approved by voice vote.

FFY 2020 Tampa Bay Urban Area Budget Request - Garry Lisiewski, Tampa Police Department

Garry Lisiewski presented the FFY 2020 Tampa Urban Area Budget Request that included 24 projects for a total of $4,186,908.

Julius Halas made a motion to accept the budget request; Mark Perez seconded the motion. Motion approved by voice vote.

FFY 2019 SHSP Budget Change Request – Donna Uzzell, FDLE

Donna Uzzell presented one project for the FFY 2019 SHSP Budget Change Request for a total of $20,000 for a campaign project manager.

Shane Pollard made a motion to accept the budget change request; Robert Allen seconded the motion. Motion approved by voice vote.

FFY 2020 SHSP Budget Request – Donna Uzzell, FDLE

Donna Uzzell presented the FFY 2020 SHSP Budget Request that included 28 projects for a total of $11,701,680.

Shane Pollard made a motion to accept the budget request; John Burke seconded the motion. Motion approved by voice vote.

SAC Uzzell spoke to purchasing microphones for domestic security meetings. Kevin Guthrie asked the Council for support to use deobligated funds to purchase the required microphones. He stated that if approved, FDEM would house the equipment and send a point of contact to set up the equipment for meetings.

Julius Halas made a motion to approve the purchase of a microphone system with deobligated funds; Damien Kelly seconded the motion. Motion approved by voice vote.

Julius Halas stated the Council should be made aware of those that are deobligating funds. Kevin Guthrie stated that FDEM would provide a financial update at future DSOC meetings.

There being no further business, the meeting was adjourned.

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Domestic Security Oversight COUNCIL

Via Webinar

March 25, 2020 1:00 – 5:00 PM

AGENDA

Welcome .....Rick Swearingen, FDLE

Roll Call

Approval of November 19, 2019 meeting minutes

UPDATES/PRESENTATIONS:

Homeland Security Advisor Brief .....SAC Mike Phillips, FDLE
DSCG Executive Board/Focus Groups updates

Coronavirus (COVID-19) update.....Christie Luce, FDOH

2020 Grant updates
New DHS priorities.....SAA/FDEM

PLEASE NOTE: The following portion of the meeting is a "CLOSED SESSION".
Only authorized personnel may attend. Thank you.

ACTION ITEMS:

FY 2021 Funding Process.....SAC Mike Phillips, FDLE

New FY 2020 SHSP Funding Projects..... SAC Mike Phillips, FDLE

Miami UASI Budget Change Request.....Robert Hevia, Miami UASI

FY2020 Miami UASI Project Update .....Robert Hevia, Miami UASI

FY2020 Tampa UASI Project Update.....Garry Lisiewski, Tampa UASI

FY2020 Orlando UASI Project Update .....Mitch Shaban, Orlando UASI

Seminole Co Sheriff's Office Budget Change Request .....Sgt Gabe Rhodes, Seminole Co.

Lee County Sheriff's Office Project Request .....Eli Lawson, FDLE

NE Fusion Center Budget Change Request.....Kas Kahn, NEFC

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	A	B	C	D	E	F	G	H	I
1	**Sub-grantee**	**End recipient Agency**	**Item description and purpose of the item (including AEL# or DHS Course Code)**	**Grant (name & FFY)**	**State Strategic Plan Goal/objective item supports**	**Unit Cost**	**Quantity**	**Total Cost**	**Description of item(s) Funds were originally allocated for**
2	FDLE	FDLE	13IT-00-INTL - Microsoft SharePoint Server 2019 License with 25 user CAL	FFY2018 Sustainment of Fusion Centers Budget	2.1: Information and Intelligence Sharing; 2.2 Interdiction of Threats; 2.3 Threats and Violent Extremism	$6,671.21	1	$6,671.21	Crime Mapping Software License
3									
4									
5									
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7									
8			Total					$6,671.21	

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	A	B	C	D
1	**Sub-grantee**	**End recipient Agency**	**Item description (including AEL# or DHS Course Code)**	**Grant (name & FFY)**
2	Miami	**City of Sunrise**	Common - Operational Coordination (Smart Boards) AEL 04MD-03-DISP	**2018**
3	Miami	**City of Sunrise**	Response - On Scene Security, Protection and Law Enforcement (Body Armor) AEL 01LE-01-ARMR	**2018**
4	Miami	**City of Sunrise**	Prevention - Screening, Search and Detection (MAGNETOMETER/METAL DETECTORS) AEL 15SC-00-PPSS	**2018**
5	Miami	**City of Fort Lauderdale**	Prevention - Screening, Search and Detection (Camera for Bomb Robot) AEL 02EX-02-RBTL	**2018**
6	Miami	**City of Fort Lauderdale**	Response - On-Scene Security, Protection and Law Enforcement (Training equipment for SWAT to include: Conversion Kits for SWAT, Simunition Magazines, Single Shot Launchers); AEL 03OE-01-NLTA	**2018**
7	Miami	**City of Coral Springs**	Response - On-Scene Security, Protection and Law Enforcement (Video Surveillance Equipment); AEL 13LE-00-SURV	**2018**
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12				

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	E	F	G	H
1	**State Strategic Plan Goal/objective item supports**	**Quantity**	**Unit Cost**	**Total Cost**
2	Goal: Prepare for domestic security incidents; Objective: Operational Coordination	4	$7,100.00	**$28,400.00**
3	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	12	$1,003.15	**$12,038.00**
4	Goal: Prevent, preempt and deter acts of terrorism; Objective: Interdiction of threats	4	$4,000.00	**$16,000.00**
5	Goal: Prevent, preempt and deter acts of terrorism; Objective: Interdiction of threats	1	$6,935.00	**$6,935.00**
6	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	1	$2,740.00	**$2,740.00**
7	Goal: Respond utilizing the ICS framework; Objective: On-Scene Security and Protection	3	$7,829.00	**$23,487.00**
8				
9				
10		**TOTAL**		**$ 89,600.00**
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12				

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	I	J
1	**Description of item(s) Funds were originally allocated for**	
2	Decreased General Dynamics project, line item 2018-15K, by $93,120 and funds transferred to: Smart Boards project line item 2018-02M $28,400; Magnetometer/Metal Detector project line item 2018-06K $16,000; Portable LPR Trailer line item 2018-06J $48,720.	
3	Decreased Ballistic Helmets project, line item 2018-18A, by $12,037.76 and transferred funds to Body Armor project line item 2018-18C $12,037.76	
4	Decreased General Dynamics project, line item 2018-15K, by $93,120 and funds transferred to: Smart Boards project line item 2018-02M $28,400; Magnetometer/Metal Detector project line item 2018-06K $16,0000; Portable LPR Trailer line item 2018-06J $48,720.	
5	Decreased line item 2018-01D, PT&E Coordinated Attack Exercise, by $13,400 and funds transferred to: Camera for Bomb Project, line item 2018-06L $6935, Training Equipment for SWAT line item 2018-18D $2740, Ballistic Helmets, line item 2018-18A2 $3725.	
6	Decreased line item 2018-01D, PT&E Coordinated Attack Exercise, by $13,400 and funds transferred to: Camera for Bomb Project, line item 2018-06L $6935, Training Equipment for SWAT line item 2018-18D $2740, Ballistic Helmets, line item 2018-18A2 $3725.	
7	Decreased line item 2018-04A, Mobile Trailer with intelligence camera, by $23,487 and transferred funds to Video Surveillance Equipment project, line item 2018-18E.	
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	A	B	C	D
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	A	B	C	D	E	F	G	H	I
1	**Sub-grantee**	**End recipient Agency**	**Item description and purpose of the item (including AEL# or DHS Course Code)**	**Grant (name & FFY)**	**State Strategic Plan Goal/objective item supports**	**Unit Cost**	**Quantity**	**Total Cost**	**Description of item(s) Funds were originally allocated for**
2	SCSO	SCSO	AEL 02EX-02-TLPB	Homeland Security Grant Program FY18	Issue 19-Bomb Building Capabilities	$11,846.00	1	$11,846.00	2 TBT kit without a tactical PAN disruputor. Requesting to purchase 1 TBT kit and a Tactical PAN disruptor. SCSO will pay overage.
3	SCSO	SCSO	AEL 02EX-01-XRAP	Homeland Security Grant Program FY18	Issue 10-Bomb Sustainment	$29,800.00	2	$59,600.00	1 Tactical Portable X-ray. We now have products available to purchase 2 Tactical Portable X-ray systems for the same amount.
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14									
15			Total					$71,446.00	

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas; Wyatt Barton

Subject: ECHCC General Coalition Meeting

Date: Wednesday, February 12, 2020 8:29:15 AM

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Attachments: AGENDA 2 13 2020.docx

Good morning
this will serve as a reminder that there is NO general coalition meeting today in Washington County
The meeting is scheduled for tomorrow THURSDAY FEBRUARY 13 at the coalition offices located at 755 Lovejoy Road, Ft Walton Beach, FL atm 10:00 am CST

We will have items on display to view, a board to suggest requested trainings, an inventory list that the coalition has on hand for distribution during disasters or affiliated events, speakers on Cyber Security, Lean on Me Project, Training and Exercises, report on Influenza and coronavirus, and more

Please make every attempt to appear in person or send someone from your agency if you are busy. Come see the new training room improvements and learn how to use this facility for your meetings.

Agenda is attached for the meeting - at the top, there is the call-in information
Also, remember that this Friday is the deadline for submitting your project ideas to the coalition

Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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AGENDA

GENERAL COALITION MEETING

February 13, 2020 at 10:00 am CST – ECHCC office, 755 Lovejoy Road, Ft Walton Beach, FL 32548

Teleconference Information: 1-310-372-7549 Participant Code: 875091

Welcome and Introductions	Ann Hill
Ann Hill – updates on Coalition	Several upcoming Trainings Scheduled
James Todd, Sales Engineering Manager Digital Boardwalk	Cyber Security, Spam emails and more updates
Dawn Grace Underwood Anderson & Associates	Cyber Liability Insurance
Phillip Smallcorn Cyalume Technologies (appearing via phone)	Lightsticks for your Security
Dept of Health	Updates on Coronavirus and Flu and others
Katie Scott, Okaloosa DOH	Lean on Me Project
Emerald Coast Emergency Care Symposium	Ann Hill March11, 12 and 13, 2020
Upcoming ECHCC Meetings	May 12th Walton EOC (9 am CST) Escambia EOC (130 pm CST)

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From: Ann Hill

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Subject: ECHCC General Coalition Meeting

Date: Wednesday, February 12, 2020 8:29:15 AM

AMERICAN OVERSIGHT

Attachments: AGENDA 2 13 2020.docx

Good morning
this will serve as a reminder that there is NO general coalition meeting today in Washington County
The meeting is scheduled for tomorrow THURSDAY FEBRUARY 13 at the coalition offices located at 755 Lovejoy Road, Ft Walton Beach, FL atm 10:00 am CST

We will have items on display to view, a board to suggest requested trainings, an inventory list that the coalition has on hand for distribution during disasters or affiliated events, speakers on Cyber Security, Lean on Me Project, Training and Exercises, report on Influenza and coronavirus, and more

Please make every attempt to appear in person or send someone from your agency if you are busy. Come see the new training room improvements and learn how to use this facility for your meetings.

Agenda is attached for the meeting - at the top, there is the call-in information
Also, remember that this Friday is the deadline for submitting your project ideas to the coalition

Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

AGENDA

GENERAL COALITION MEETING

February 13, 2020 at 10:00 am CST – ECHCC office, 755 Lovejoy Road, Ft Walton Beach, FL 32548

Teleconference Information: 1-310-372-7549 Participant Code: 875091

Welcome and Introductions	Ann Hill
Ann Hill – updates on Coalition	Several upcoming Trainings Scheduled
James Todd, Sales Engineering Manager Digital Boardwalk	Cyber Security, Spam emails and more updates
Dawn Grace Underwood Anderson & Associates	Cyber Liability Insurance
Phillip Smallcorn Cyalume Technologies (appearing via phone)	Lightsticks for your Security
Dept of Health	Updates on Coronavirus and Flu and others
Katie Scott, Okaloosa DOH	Lean on Me Project
Emerald Coast Emergency Care Symposium	Ann Hill March11, 12 and 13, 2020
Upcoming ECHCC Meetings	May 12th Walton EOC (9 am CST) Escambia EOC (130 pm CST)

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From: Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD)

To: EIS (CDC); CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC EIS EAC Roster 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Gaertner, Sonnet Jeong Im (CDC/DDPHSS/CSELS/OD); Blackstock, Anna J. (CDC/DDID/NCEZID/DFWED); McColloch, Caitlin (CDC/DDPHSS/CSELS/DSEPD); Wilson, Kendra (CDC/DDPHSS/CSELS/DSEPD); DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Owens, Kevin (CDC/OCOO/OCIO) (CTR); Bauer, Darrell (CDC/DDPHSS/CSELS/DSEPD); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Guerra, Marta (CDC/DDPHSIS/CGH/DGHP); Ali, Hammad (CDC/DDPHSIS/CGH/DGHT); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Cantey, Paul T. (CDC/DDPHSIS/CGH/DPDM); Minta, Anna Akua (CDC/DDPHSIS/CGH/GID); Hsu, Christopher (CDC/DDPHSIS/CGH/GID); Blau, Dianna M. 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Subject:	EIS Supervisor Seminar Virtual Match Slides
Date:	Wednesday, March 18, 2020 3:37:47 PM
Attachments:	EIS Supervisor Seminar_Virtual Match_2020.pdf

EIS Supervisors –

Slides from today's seminar on the virtual match are attached. The presentation recording will be shared with you when available.

Thanks,
Larry

Larry Cohen, MD, MPH
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Center for Surveillance, Epidemiology, and Laboratory Services

EIS Supervisor Seminar: 2020 EIS Virtual Match

Epidemiology Workforce Branch
Division of Scientific Education and Professional Development

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Priorities for EIS conference contingency planning

- **Match incoming EISOs to positions (essential for deployment preparedness)**
- **EISO training on scientific communication**
- **Facilitating job search for graduating EISOs**
- **Bringing EISOs together**

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Recruitment and matching

- **Open recruitment and virtual meetings between incoming EIS officers and positions ASAP**
- **Prepare for 3-week period of video-based interviewing – including the scheduled week of conference**



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Next steps following EIS cancellation

- **Plan for 2-day training in June at Clifton or Sheraton**
  - **Prioritize 2nd year EISOs needing EIS conference for CAL completion**
  - **Considering award sessions, graduation, satirical review**
- **Plan for 5-day scientific program in 2021**

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Post EIS Employment

- **EWB working with CDC leadership to compensate for the loss of interviewing and networking that would normally be at conference**
- **Asking that COVID-19 funds be used for positions for graduating EISOs**

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2020 EIS Virtual Recruitment and Match Timeline

3/20	PDs/CVs Distributed
3/23–4/17	Recruitment Period
4/13–4/17	Interview Scheduling
4/20–5/7	Interviews
5/8, 2pm ET	Submit Ranks/Ratings
5/11	Run Match
5/11–5/14	Scramble
5/15	Release Match Results

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Virtual Recruiting: March 23rd to April 17th



- Develop a system that is as flexible as possible to accommodate the schedules of those of you who are involved in response
- Provide tools for you to facilitate and encourage interaction but not be proscriptive about how you use those tools.
- Slack is a team collaboration tool (not unlike Microsoft Teams) that allows asynchronous or live communication via messaging, voice, or video calls.
- Is available to internal CDC and external users and can be accessed via web browser, desktop, or mobile phone. Note, it doesn't seem to like Internet Explorer, so you may want to go ahead and request Chrome via the SRT.

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Slack is organized into channels.



- Slack is organized into channels (similar to a folder). There will be (1) a general channel that houses information from the EIS Program, (2) An events channel where we will post group events, (3) and a Slack resources channel where we will will post user guides, tips & tricks, and other documentation.
- We will pre-populate Slack with channels for the CIOs, a general field channel, and channels for each individual position.
- Within each channel you can post messages, upcoming recruiting events, videos, etc. Incoming officers will also be able to join your channel and post questions that you can respond to when you have the available time.

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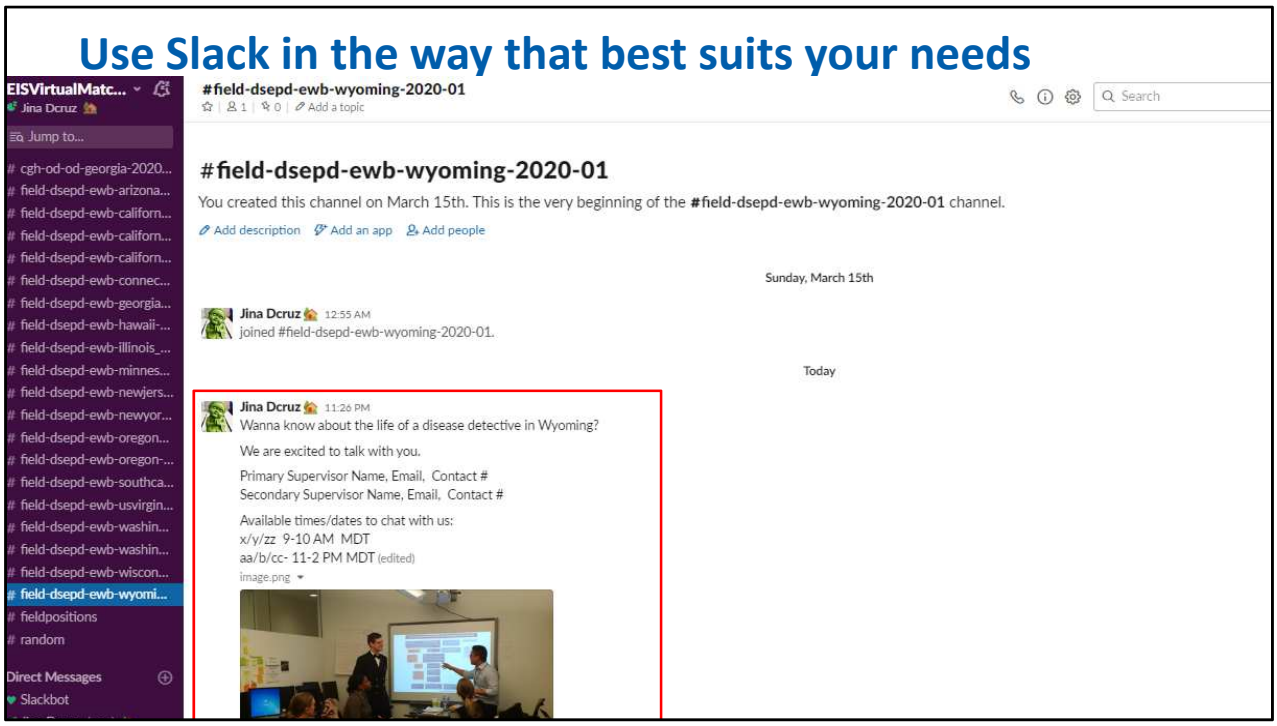
Use Slack in the way that best suits your needs



- Post messages and monitor the slack messages for questions from incoming officers

Use Slack in the way that best suits your needs



- Post videos, PowerPoint slides, and other documentation

Use Slack to post on the main calendar



- We are investigating the best way to set up a shared calendar on slack in the events channel. You will be able to post your recruiting events such as webinars or AMA (Ask Me Anything) sessions.

We prefer you use Slack…



- We prefer you use Slack as we are concerned that incoming officers may be involved in the COVID-19 response or otherwise occupied during this period and Slack will provide them a way to check in on recruiting on their own schedules in one central location. We also understand, however, that you may not have the resources to monitor a slack channel or prefer to use your own method of interaction.

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At a minimum please post a "Preferred Method of Communication" message in Slack.

- **Who can be contacted directly (supervisor, 2ndary supervisor, EISO, etc.)**
  - **How to contact them (via Slack message, email, phone, etc.)**
  - **Best times/ways to contact**
- **Will you monitor your position's Slack channel?**
  - **If so, how often will you expect you will be checking in and responding to messages?**

- At a minimum, please post a pinned message on your preferred method of communication.
- We are going to ask incoming officers **not to initiate one-on-one contact until they have read the "preferred method of communication" post for a given position**

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- We are trying to develop this platform as rapidly as possible, so please bear with us. We will be sending out more detailed guidance.
- Each position will also be assigned an EWB staff POC who can assist you with slack and other issues with virtual recruitment and we will have Slack technical support backing them up.
- We invite your feedback on technical issues and we also ask that you share what seems to be working well for you.

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Questions on Slack or the Virtual Recruitment Period?

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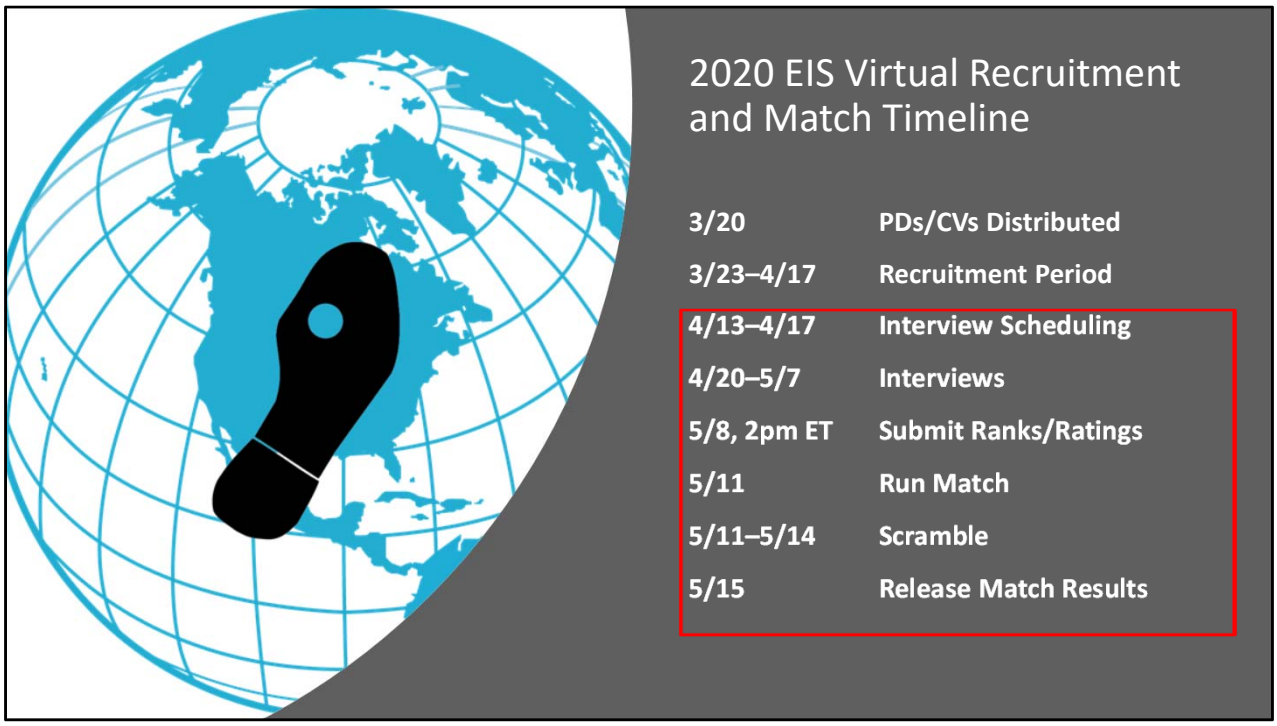

- Now I would like to go into a little more detail with respect to scheduling and conducting virtual interviews, running match, and the scramble process.
- Note that we will schedule another webinar in early to mid-April that will go into more technical detail on the eFMS platform that is used for the interview scheduling, rating submission, and match process.

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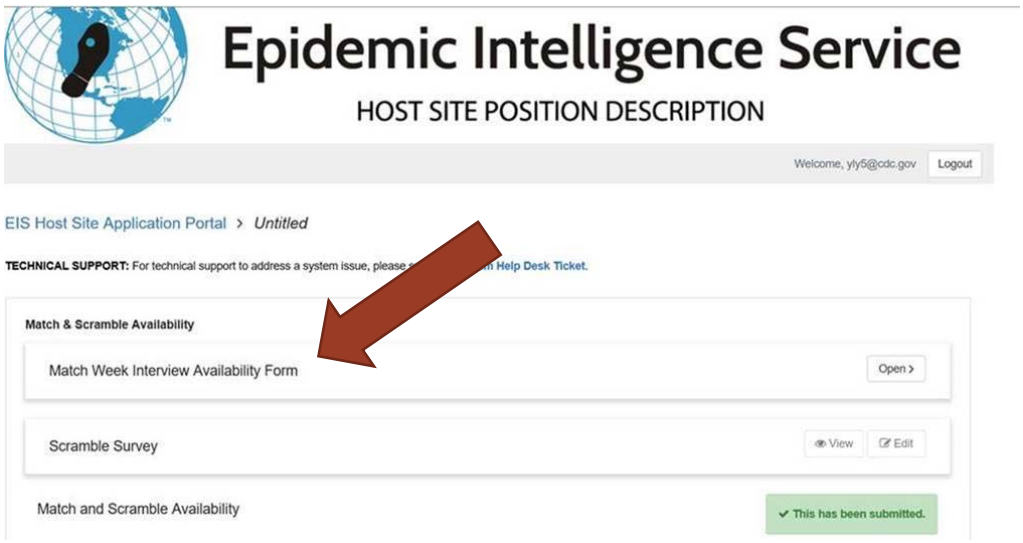
Set your interview availability by COB April 14th



- The first task related to virtual interviews will be for you to set up your availability for the 3 weeks during the interview time period. You can enter your availability in eFMS as was done last year.
- Please submit your schedule by COB on April 14th.
- Incoming officers will select interview slots over the next two days. On Friday April 17th, you will be able to see your schedule in eFMS. You should then send individual invites, including Skype or Zoom information, to the officers.

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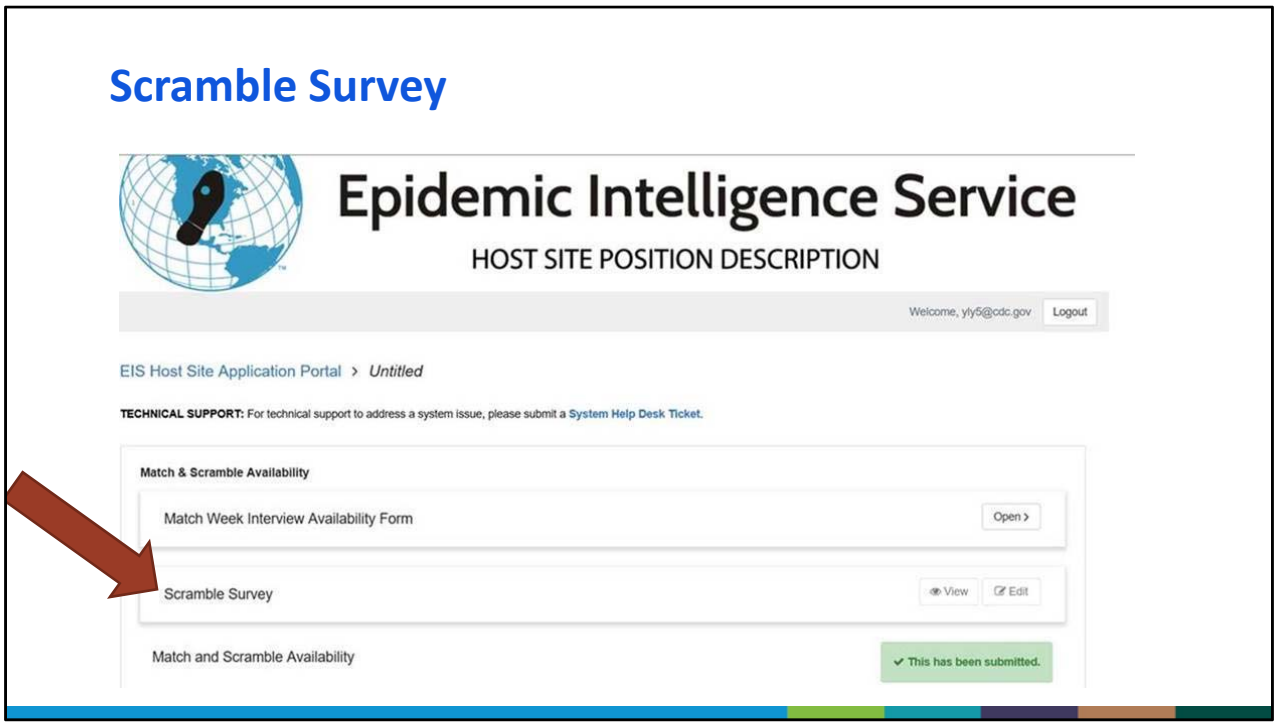
Scramble Survey



- When entering your interview availability, the system will also ask if you want your position to be entered into the scramble. In the event that an officer falls through the match, we will conduct a scramble in which the unmatched officers are given a list of unmatched positions that want to participate in the scramble rather than go unmatched. The officers and positions will then have a last opportunity to interview and match during this process.

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Virtual Interviews
4/20–5/7

Conduct video interviews as scheduled using Skype or your preferred platform (e.g., Zoom).

- From April 20th to May 7th you may conduct your interviews as scheduled using Skype or your preferred platform (e.g., Zoom).
- We want to ensure that interviews are as uniform as possible across positions and officers, so we ask that you conduct only the one 30 minute interview; please do not schedule additional interviews outside of the system with officers or conduct in-person interviews even if the officer is in Atlanta and available. You may, however, have as many people as you wish participate in the one interview.
- We also hope that you will be able to conduct video interviews rather than voice-only calls, but we understand that some who may be in the field may not be able to do this given speed of internet connections and other technical difficulties, so this will not be a requirement.

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- At any time after you complete all of your interviews, you may enter the ratings of the officers you interviewed in eFMS. Please have your ratings submitted by 2pm EST on May 7th. There will be a validation process where you will be asked to confirm your ratings and justify any zero scores. More information on this process will be forthcoming.

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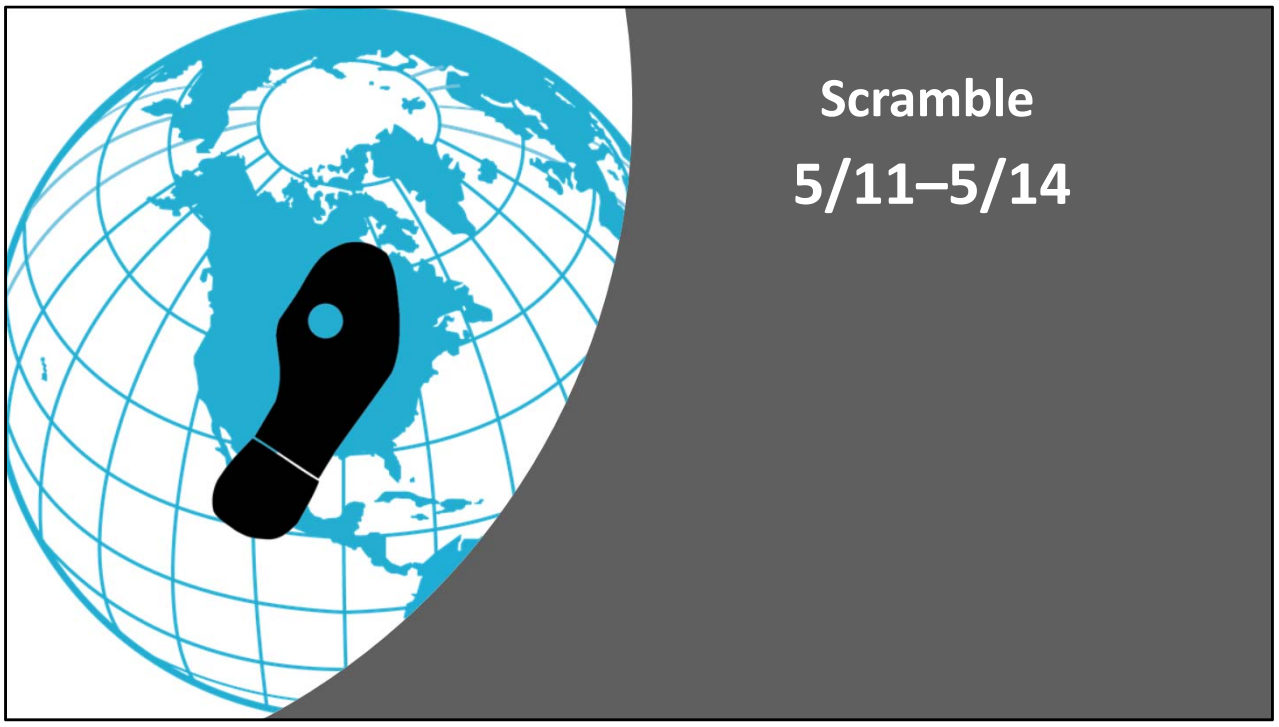

If you elected to have your position participate in the scramble and you do not match, scramble interviews will be conducted between May 11th and the 14th, with final match to be completed by COB on the 14th.

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Match Notification

5/15

- We will notify the EAC, supervisors, and officers of the match results no later than May 15th.

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To Do Checklist

- ❑ Accept the Slack Invitation when it is sent out next week
- ❑ Post a message in your position's channel indicating contact preferences
- ❑ Review incoming officer CVs
- ❑ Plan your recruitment events
- ❑ Contact your EWB POC if you need assistance

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Questions?

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

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



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From: EIS (CDC)

To: Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC EIS EAC Roster 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Abara, Winston E. (CDC/DDID/NCHHSTP/DSTDP); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Annor, Francis (CDC/DDNID/NCIPC/DVP); Appiah, Grace D (CDC/DDID/NCEZID/DFWED); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Arvay, Melissa (CDC/DDID/NCIRD/DBD); awv4@cdc.gov; Bagchi, Suparna (CDC/DDID/NCEZID/DHQP); Balter, Sharon (CDC ph.lacounty.gov); barbara.montana@doh.nj.gov; Barfield, Wanda D. (CDC/DDNID/NCCDPHP/DRH); Basavaraju, Sridhar (CDC/DDID/NCEZID/DHQP); Beer, Karlyn D. (CDC/DDID/NCEZID/DFWED); Bell, Jeneita (CDC/DDID/NCEZID/DHQP); Bell, Linda (CDC dhec.sc.gov); Benowitz, Isaac (CDC/DDID/NCEZID/DHQP); Bish, Connie (CDC/DDNID/NCCDPHP/DRH); Bitsko, Rebecca (CDC/DDNID/NCBDDD/DHDD); Black, Stephanie SB (CDC cityofchicago.org); Blau, Dianna M. (CDC/DDPHSIS/CGH/OD); Bonwitt, Jesse (CDC/DDID/NCEZID/DHCPP); Bozio, Catherine H. (CDC/DDID/NCIRD/ID); Brown, Allison C. (CDC/DDID/NCEZID/DHQP); Bruce, Michael G. (CDC/DDID/NCEZID/DPEI); Busacker, Ashley (CDC wyo.gov); Cantey, Paul T. (CDC/DDPHSIS/CGH/DPDM); Carlson, Susan (CDC/DDNID/NCCDPHP/DNPAO); Carroll, Yulia (CDC/DDNID/NCEH/DEHSP); Cartter, Matthew (CDC ct.gov); Chaleunsy, Charlie (CMS/CMHPO); Chang, Arthur (Art) (CDC/DDNID/NCEH/DEHSP); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Chen, Michael (CDC/DDID/NCIRD/ISD); Cherry, Cara C. (CDC/DDID/NCEZID/DVBD); Chew, Ginger L. (CDC/DDNID/NCEH/DEHSP); Chiu, Sophia (CDC/NIOSH/DFSE/HETAB); Christensen, Bryan E. (CDC/DDID/NCEZID/DHQP); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Cieslak, Paul (CDC dhsoha.state.or.us); Clayton, Heather B. (CDC/DDID/NCHHSTP/DASH); CMMainConfRoom (CDC); Cogdill, Keith (NIH/OD/ORS) [E]; Courtney-Long, Elizabeth A. (CDC/DDNID/NCCDPHP/OSH); Curran, Kathryn (CDC/DDPHSIS/CGH/DGHT); Cwynar, Kevin (NIH/CIT) [C]; Dale, Helen M. (CDC/DDPHSIS/CGH/DGHT); DAngelo, Denise V. (CDC/DDNID/NCCDPHP/DRH); Danielson, Melissa (CDC/DDNID/NCBDDD/DHDD); Dasgupta, Sharoda (CDC/DDID/NCHHSTP/DHPSE); Davies-Cole, John (CDC dc.gov); Dawood, Fatimah S. (CDC/DDID/NCIRD/ID); DBITSD (CDC); Dieffenbach, Carl (NIH/NIAID) [E]; Diekman, Shane T. (CDC/DDPHSIS/CGH/DGHT); Drenzek, Cherie (CDC dph.ga.gov); Eakin, Ann (NIH/NIAID) [E]; Edison, Laura (CDC dph.ga.gov); Elam-Evans, Laurie (CDC/DDID/NCIRD/ISD); Ellis, Esther (CDC doh.vi.gov); Epstein, Lauren H. (CDC/DDID/NCEZID/DHQP); Eyassu, Abinet (CDC/DDID/NCIRD/ISD) (CTR); Fairley, Temeika (CDC/DDNID/NCCDPHP/DCPC); Fechter-Leggett, Ethan (CDC/NIOSH/RHD/FSB); Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD); Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Galang, Romeo Regi (CDC/DDNID/NCCDPHP/DRH); Garcia-Williams, Amanda (CDC/DDID/NCEZID/DFWED); Gargano, Julia Marie W. (CDC/DDID/NCIRD/DVD); Gleason, Brigette (CDC/DDID/NCEZID/DFWED); Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Gould, Carolyn V. (CDC/DDID/NCEZID/DVBD); Gould, Hannah HG (CDC health.nyc.gov); Groenewold, Matthew (CDC/NIOSH/DFSE/HIB); Guerra, Marta (CDC/DDPHSIS/CGH/DGHP); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Gwynn, Charon R (CDC health.nyc.gov); Halik, Lindsay (FDA/CFSAN) (CTR); Hall, Aron (CDC/DDID/NCIRD/DVD); Hall, Noemi (CDC/NIOSH/RHD/SB); Hamner, Heather (CDC/DDNID/NCCDPHP/DNPAO); Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH); Harrist, Alexia (CDC wyo.gov); Heath-Mason, Matthew (NIH/OD) [E]; Henao, Olga (CDC/DDPHSIS/CGH/DGHP); Herzig, Carolyn (CDC/DDID/NCEZID/DHQP); Hill, Holly A. (CDC/DDID/NCIRD/ISD); Hills, Susan (CDC/DDID/NCEZID/DVBD); Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD); Hocevar Adkins, Susan N. (CDC/DDID/NCHHSTP/DASH); Holzbauer, Stacy (CDC state.mn.us); Hsu, Christopher (CDC/DDPHSIS/CGH/GID); Hughes, Christine (CDC/DDID/NCEZID/DHCPP); Hughes, Michelle (CDC/DDNID/NCBDDD/DHDD); Ly, Alpha (FDA/CBER) (CTR); Iyengar, Preetha (CDC dc.gov); Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Jackson, Sandra L. (CDC/DDNID/NCCDPHP/DHDSP); Jain, Seema (CDC cdph.ca.gov); Jannath, Syeda (CDC/OCOO/OFR/OFAS) (CTR); jcorbett@lgc.org (CDC lgc.org); Jennings, Andre"a (CDC/DDPHSS/CSELS/DSEPD) (CTR); Jones, Jefferson (CDC/DDID/NCEZID/DHQP); Jyothi Prakashan, Senthil Kumar (FDA/OC) (CTR); KathleenBuckheit (CDC email.unc.edu); Khetsuriani, Nino (CDC/DDPHSIS/CGH/GID); Kimura, Akiko (CDC cdph.ca.gov); Klabansky, Jennifer (NIH/NCI) [C]; Klos, Rachel (CDC wi.gov); Kmet, Matthew (FDA/CFSAN) (CTR); Kneipp, Teresa (CDC/NIOSH/HELD/CBMB); Ko, Jean Y. (CDC/DDNID/NCCDPHP/DRH); Komatsu, Kenneth (CDC azdhs.gov); Kracalik, Ian (CDC/DDID/NCEZID/DHQP); Lakkamraju, Suneetha (FDA/ORA) (CTR); Laney, Anthony S. (CDC/NIOSH/RHD/SB); Langer, Adam J. (CDC/DDID/NCHHSTP/DTE); Langley, Gayle E. (CDC/DDID/NCIRD/DVD); Laufer Halpin, Alison S. (CDC/DDID/NCEZID/DHQP); Lawson, Christina (Tina) (CDC/NIOSH/DFSE/FRB); Leadbetter, Laurie (NIH/NLM) [C]; Leman, Richard (CDC dhsoha.state.or.us); Lessa, Fernanda (CDC/DDID/NCEZID/DHQP); Li, Ruowei (Rosie) (CDC/DDNID/NCCDPHP/DNPAO); Loustalot, Fleetwood (CDC/DDNID/NCCDPHP/DHDSP); Luckhaupt, Sara E. (CDC/NIOSH/DFSE/HIB); Lundeen, Elizabeth Ann (CDC/DDNID/NCCDPHP/DDT); Lyman, Meghan Marie (CDC/DDID/NCEZID/DFWED); m.weston@ana.org (CDC ana.org); Maenner, Matthew J. (CDC/DDNID/NCBDDD/DHDD); Marano, Nina (CDC/DDID/NCEZID/DGMQ); Marietta, Cheryl (NIH/NIAAA) [E]; Markowitz, Lauri (CDC/DDID/NCIRD/DVD); Martin, Stacey (CDC/DDID/NCEZID/DVBD); Marx, Grace (CDC/DDID/NCEZID/DVBD); Materna, Barbara (CDC cdph.ca.gov); Meites, Elissa M. (CDC/DDID/NCIRD/DVD); Mhali, Tanesha (FDA/ORA); Midgley, Claire (CDC/DDID/NCIRD/DVD); Minta, Anna Akua (CDC/DDPHSIS/CGH/GID); Mirabelli, Maria (CDC/DDNID/NCEH/DEHSP); mstoops@nationalhomeless.org (CDC nationalhomeless.org); Mullins, Jocelyn (CDC ct.gov); Murrill, Christopher S. (CDC/DDPHSIS/CGH/GID); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Nickel, Alexandra K (OIG/OMP) (CTR); Nolen, Leisha (CDC/DDID/NCEZID/DPEI); Omura, John Daniel (CDC/DDNID/NCCDPHP/DNPAO); Parashar, Umesh (CDC/DDID/NCIRD/DVD); Park, Benjamin (CDC/DDID/NCEZID/DHQP); Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD); Pazol, Karen (CDC/DDNID/NCBDDD/DHDD); Perrine, Cria G. (CDC/DDNID/NCCDPHP/DNPAO); Petersen, Brett W. (CDC/DDID/NCEZID/DHCPP); Pierce, Rebecca (CDC dhsoha.state.or.us); Pindyck, Talia (CDC/DDID/NCEZID/DFWED); Plumb, Ian (CDC/DDID/NCEZID/DFWED); Pollack, Loria A. (CDC/DDNID/NCCDPHP/DCPC); Psychas, Paul (CDC usaid.gov); Radcliffe, Rachel (CDC dhec.sc.gov); Rajasingham, Anangu (CDC/DDPHSIS/CGH/DGHP); Rao, Carol (CDC/DDPHSIS/CGH/DGHP); RDB Inquiries (CDC); Reichard, Audrey A. (CDC/NIOSH/DSR/SFIB); Reynolds, Laura (CDC/NIOSH/DFSE/HETAB); Ridpath, Alison D. (CDC/DDID/NCHHSTP/DSTDP); rmartinez@nas.edu (CDC nas.edu); Rolfes, Melissa

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(CDC/DDID/NCIRD/ID); Romero, Lisa (CDC/DDNID/NCCDPHP/DRH); Rose, Erica (CDC/DDID/NCEZID/DFWED); Roth, Joseph (CDC doh.vi.gov); Ryans, Eric (NIH/CIT) [C]; Saydah, Sharon (CDC/DDNID/NCCDPHP/DDT); Serbanescu, Florina (CDC/DDNID/NCCDPHP/DRH); Sferrazza, Giovanni (IHS/HQ) [C]; Shaw, Kelly (CDC/DDNID/NCBDDD/DHDD); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Silk, Benjamin J. (CDC/DDID/NCHHSTP/DTE); Skrobarcek, Kimberly (CDC/DDID/NCEZID/DGMQ); Slayton, Rachel B. (CDC/DDID/NCEZID/DHQP); Smith, Kirk (CDC state.mn.us); Socias-Morales, Christina M. (CDC/NIOSH/DSR/AFEB); Soeters, Heidi (CDC/DDPHSIS/CGH/GID); Sosa, Lynn (CDC ct.gov); Sparkman, Jessica E. (CMS/OFM); Stinn, John (CDC/OCOO/OCIO) (CTR); Straily, Anne (CDC/DDPHSIS/CGH/DPDM); Sweeney, Marie (CDC/NIOSH/DFSE/HIB); Tan, Christina CT (CDC doh.nj.gov); Tate, Jacqueline E. (CDC/DDID/NCIRD/DVD); Terashita, Dawn (CDC ph.lacounty.gov); Terranella, Andrew J (IHS/POR); Thompson-Paul, Angela M. (CDC/DDNID/NCCDPHP/DHDSP); Tomasi, Suzanne (CDC/NIOSH/RHD/FSB); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Trackemas, Jack D. (CDC/NIOSH/PMRD/GCB); Trout, Douglas (CDC/NIOSH/DFSE/HETAB); Twentyman, Evelyn Rebecca Ford (CDC/DDNID/NCCDPHP/OSH); Ussery, Emily Neusel (CDC/DDNID/NCCDPHP/DNPAO); VanFrank, Brenna (CDC/DDNID/NCCDPHP/OSH); Vanhouten, Clay (CDC wyo.gov); Wallace, Ryan (CDC/DDID/NCEZID/DHCPP); Warren-Mears, Victoria (CDC npaihb.org); Waterman, Steve (CDC/DDID/NCEZID/DVBD); Watson, John (CDC/DDID/NCIRD/DVD); Watt, James (CDC cdph.ca.gov); Weiser, Thomas (CDC npaihb.org); Whelan, Elizabeth A. (CDC/NIOSH/DFSE/FRB); Wiggins, Lisa (CDC/DDNID/NCBDDD/DHDD); Wilken, Jason (CDC cdph.ca.gov); Wilkinson, Amanda (CDC/DDPHSIS/CGH/GID); Wise, Matthew E. (CDC/DDID/NCEZID/DFWED); Woodworth, Kate (CDC/DDNID/NCBDDD/DBDID); Wortley, Pascale (CDC dph.ga.gov); Wu, Hsiu (CDC/DDID/NCEZID/DHQP); Zambrano, Laura (CDC/DDNID/NCBDDD/DBDID); Adams, Monica (CDC/DDID/NCHHSTP/DHPSE); Agnew Brune, Christine (CDC/DDID/NCHHSTP/DHPSE)

Subject: EIS Supervisor Seminar: EIS Conference and Match Orientation

Importance: High

This seminar is primarily for supervisors who have been approved to match at the 2020 EIS Conference; however, all supervisors are welcome to participate. As a reminder, final dispositions on approvals to participate in the 2020 EIS match will be sent on March 9.

EIS Supervisors –

Do you have questions about the 2020 EIS Conference and match?

Would you like to become familiar with the recruitment venue?

Would you like to see an overview on how to schedule interviews, and assign and enter your match scores?

Then please join us for the next EIS Supervisor Seminar, where we will be discussing the EIS Conference and match!

During the seminar, we will review 2020 EIS match process, including the recruitment venue, how to enter your interview slots, and how to enter your scores.

If you already have questions about EIS Conference or match that you would like addressed during the seminar, please send them ahead of time to Larry Cohen at cbu1@cdc.gov <mailto:cbu1@cdc.gov> . We will compile the submitted questions and answer them during the seminar.

We look forward to your participation at the next EIS Supervisor Seminar!

Thank you,

EIS Program

Adobe Connect Webinar Information

https://adobeconnect.cdc.gov/ruqnt1n2uhla

If you have never attended an Adobe Connect meeting before:

Test your connection: https://virtualsepd.adobeconnect.com/common/help/en/support/meeting_test.htm

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Get a quick overview: http://www.adobe.com/products/adobeconnect.html

Phone Line Information

(770) 488-3600

Conference ID: 3183827

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Achim, John (CDC/DDID/NCEZID/DPEI); Bellis, Kimberly (CDC/DDID/NCEZID/DPEI); Borrelli, Aaron (CDC/DDID/NCEZID/DPEI); Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Chung, Christina L. (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Hall, Christopher (Jason) (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Light, Megan (CDC/DDID/NCEZID/DPEI); Montgomery, Meagan (CDC/DDID/NCEZID/DPEI) (CTR); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pappas, Danielle (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI)
Subject:	ELC Annual Meeting cancelled
Date:	Monday, March 2, 2020 8:43:38 AM
Importance:	High

Greetings,

With COVID-19 response activities intensifying nationwide, the ELC is electing to cancel the 2020 ELC Annual Meeting (March 11-13, 2020). We sincerely regret any inconvenience this late cancellation causes. In the coming days, the ELC will work to organize webinars aimed at communicating key content that would have been covered during the meeting.

Please stay tuned for additional details. Thank you for your understanding and your continued work to protect the public's health!

Best,

Angelica O'Connor, Jason Snow, and your ELC Team

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	ELC-Internal-Partners (CDC); Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC); Achim, John (CDC/DDID/NCEZID/DPEI); Bellis, Kimberly (CDC/DDID/NCEZID/DPEI); Borrelli, Aaron (CDC/DDID/NCEZID/DPEI); Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Chung, Christina L. (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Hall, Christopher (Jason) (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Light, Megan (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pappas, Danielle (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI); Walke, Henry (CDC/DDID/NCEZID/DPEI); Raziano, Amanda J. (CDC/DDID/NCEZID/DPEI); Browning, Sandra (CDC/DDID/NCEZID/DPEI) (CTR); Zansky, Shelley (CDC/DDID/NCEZID/DPEI) (CTR); O"Connor, Angelica (CDC/DDID/NCEZID/DPEI)
Subject:	ELC CONTINUATION APPLICATION UPDATE
Date:	Friday, March 6, 2020 4:42:30 PM
Importance:	High

Greetings.

Appreciating the challenges the COVID-19 response has placed on ELC-funded recipients, the publication of the BP2 ELC Continuation Guidance this year is likely to only add to current stress-levels. Given the complexity of the ELC portfolio we understand that the standard approach of completing workplans & budget by program/project, while important, is something that is likely to not receive the usual attention because health department resources are stretched thin.

Therefore, please suspend any/all work on completing all program/project application & budget templates for BP2. The ELC is implementing a streamlined application approach for BP2 only to help reduce the burden so that efforts can continue to focus on COVID-19 response activities.

There will be a webinar on Thursday, March 12 from 2:30 – 4:30pm ET that will provide more details and answer any questions you might have around the special application process.

ELC Programmatic Webinar

- **Date:** March 12, 2020
- **Time**: 2:30-4:30 pm, ET
- **Audience:** ELC Recipients
- **Phone:** 1-210-234-8636 or 1-888-946-7208
- **Participant Passcode:** 9749449

For Participants:

- URL: https://www.mymeetings.com/nc/join/
- Conference number: PWXW9986028
- Audience Passcode: 9749449

Participants can join the event directly at:
https://www.mymeetings.com/nc/join.php?i=PWXW9986028&p=9749449&t=c

Sincerely,
Jason Snow, Angelica O'Connor, & the ELC Team

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Lavelle, Judith M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Warner, Cameron (CDC/DDID/NCEZID/DPEI)
Subject:	ELC Reminders
Date:	Tuesday, February 18, 2020 10:09:09 PM

Greetings.
We are looking forward to seeing everyone at the upcoming ELC Annual Meeting on March 11 – 13, 2020. As a reminder, the Annual Meeting will now be held at the Decatur Courtyard Marriott (details can be found on the ELC website here: https://www.cdc.gov/ncezid/dpei/elc/index.html).

In addition to providing important application information and opportunities for technical assistance, we also plan to share the latest guidance related to financial support of your COVID-19 outbreak response efforts. In the interim, please also remember:

1. If/when funding is made available to support COVID-19 response activities via the ELC, the most expeditious method to get these funds to recipients would likely be through funding those 'approved but unfunded' (ABU) activities from the BP1 Emerging Issues (E) budgets. This method does not require a separate application and can be executed very quickly.
2. For current needs that exceed the available ABU budget under your Emerging Issues (E) Project, please remember that the ELC may always receive 'recipient-initiated supplemental requests'. These requests may be submitted at any time and funded as resources are made available. We ask that you let your ELC Project Officer know if you foresee requiring a supplemental request so they may ensure you have all necessary items included in your submission.

Should any relevant information be made available prior to the ELC Annual Meeting we will share it with you immediately. If you have any questions prior to the meeting, please do not hesitate to reach out directly to your Project Officer.

We look forward to seeing you in March and wish you safe travels!

-Your ELC Team

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

Subject: Emerald Coast Healthcare Coalition Information
Date: Monday, March 16, 2020 1:31:41 PM
Attachments: dem-order-no-20-002-in-re-covid-19-public-health-emergency-issued-03-11-2020.pdf
Clinical Guidance Chart_3-15-20_Final-1.pdf

In an abundance of preparedness and caution, your Healthcare Coalition has canceled all upcoming meetings, trainings, and exercises as many of our healthcare partners and members are engaged in or preparing for or responding to the COVID-19 effort.

Please continue to monitor the Florida Department of Health COVID website for the most up to date information on the situation in Florida. http://www.floridahealth.gov/diseases-and-conditions/covid-19/

Please see the attached: Florida Division of Emergency Management Order No. 20-002 prohibiting visitors to certain types of health care facilities within the State. Please read carefully to determine if your facility falls under this order and to understand the actions you may need to take to comply.

The COVID-19 Call Center is available 24/7 (866) 779-6121 or email COVID-19@FLHealth.gov

Please contact me or anyone in our office if we can assist you during this response.

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

Clinical Screening Tool for Identifying Persons Under Investigation for Coronavirus Disease 2019 (COVID-19) per Centers for Disease Control and Prevention (CDC)

Symptomatic individuals should be asked to wear a surgical mask upon arrival. Initiate contact and airborne precautions, using appropriate personal protective equipment (PPE).

Version 4.2 | March 15, 2020

SCREENING CRITERIA

If your patient is exhibiting **symptoms** of acute lower respiratory illness (e.g., fever, cough, and shortness of breath) **and** meets one or more of the following criteria:

1. Persons who have had a close contact with a laboratory-confirmed COVID-19 case
2. Persons hospitalized with acute lower respiratory illness of unknown origin
3. History of travel to or from an affected geographic area with widespread community transmission
4. History of international travel or a cruise
5. ≥65 with chronic health conditions
6. Immunocompromised persons

EXPANDED CRITERIA

If your patient does not meet the above criteria, testing may occur based on clinician's judgement.

1. The health care provider is responsible for specimen collection, handling and shipping. Please follow CDC guidance and use proper PPE.
2. Collected specimens should be processed within your health care facility or a commercial laboratory (e.g., LabCorp and Quest).
3. Follow CDC guidance for specimen collection, handling and shipping.

TESTING

If individual meets criteria for testing, wear appropriate PPE and initiate contact and airborne precautions.

1. The health care provider is responsible for specimen collection, handling and shipping. Please follow CDC guidance.
2. Collected specimens should be processed within your health care facility, if available; a commercial laboratory (e.g., LabCorp and Quest); or a Florida Bureau of Public Health Laboratory (BPHL)
3. Before sending specimens to BPHL, notify your local county health department CHD Epidemiology Contacts.
4. Health care providers may consult local county health departments for additional guidance as needed.

FOR ADDITIONAL GUIDANCE

Providers are encouraged to frequently monitor Florida Department of Health and CDC websites for updated guidance on COVID-19.

- www.flhealth.gov
- https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Please see the CDC's: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

AMERICAN OVERSIGHT

STATE OF FLORIDA
DIVISION OF EMERGENCY MANAGEMENT

IN RE: SUSPENSION OF STATUTES, RULES, AND ORDERS, PURSUANT TO EXECUTIVE ORDER NUMBER 20-52, MADE NECESSARY BY THE COVID-19 PUBLIC HEALTH EMERGENCY

DEM ORDER NO. 20-002

EMERGENCY ORDER

WHEREAS, the Governor of the State of Florida issued Executive Order No. 20-52 in response to the COVID-19 Public Health Emergency which poses a severe threat to the entire State of Florida and requires that timely precautions are taken to protect the communities, critical infrastructure, and general welfare of this State; and,

WHEREAS, the Governor has designated the Director of the Division of Emergency Management as the State Coordinating Officer for the duration of this emergency and has delegated to the State Coordinating Officer the authority to exercise those powers delineated in sections 252.36(5)-(10), Florida Statutes; and,

NOW THEREFORE, I hereby find that the Division of Emergency Management's timely performance of disaster response functions related to COVID-19 Public Health Emergency is hindered by the application of procedures imposed by statute, rule, and/or order.

Therefore, pursuant to Section 2 of Executive Order No. 20-52, I hereby issue the following authorization(s):

I. Suspend sections 393.13(4), 400.022(1)(b), 429.28(1)(d), 429.85(1)(d) Florida Statutes, for the particular purpose of prohibiting certain individuals from visiting facilities. For purposes of this order, a facility includes nursing homes, assisted living

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facilities, adult family-care homes, long-term care facilities, and adult group homes. The order applies as follows:

a. Any person infected with COVID-19 who has not had two consecutive negative test results separated by 24 hours is prohibited from visiting a facility; or

b. Any person showing or presenting signs or symptoms of a respiratory infection, including cough, fever, shortness of breath or sore throat is prohibited from visiting a facility; or

c. Any person who has or may have been in close contact with a person(s) infected with COVID-19 who has not tested negative for COVID-19 is prohibited from visiting a facility until 14 days after their interaction with the person(s) who is infected with COVID-19; or

d. Any person who traveled internationally is prohibited from visiting a facility until 14 days after their return to the United States; or

e. Any person who traveled on a cruise ship is prohibited from visiting a facility until 14 days after their return to the United States; or

f. Any person who has been in a community with confirmed community spread of COVID-19, as identified by the Centers for Disease Control and Prevention or a state public health agency, is prohibited from visiting a facility within 14 days of their presence in the community with community spread; or

g. Any person who resides in a community with confirmed community spread of COVID-19, as identified by the Centers for Disease Control and

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Prevention or a state public health agency, is prohibited from visiting a facility.

Because section 252.36(5)(a), Florida Statutes, allows the Governor to suspend the provisions of "any regulatory statute prescribing the procedures for [the] conduct of state business", and because Executive Order No. 20-52 designates the Director of the Division of Emergency Management as the State Coordinating Officer for this emergency, the requirements of sections 252.46 and 120.54(4), Florida Statutes, do not apply to this Order.

The effective dates of this Order shall correspond with the effective dates of Executive Order No. 20-52.

By Order of the State Coordinating Officer executed this 11th day of March, 2020, in Tallahassee, Leon County, Florida.

Jared Moskowitz
State Coordinating Officer
Florida Division of Emergency Management
2555 Shumard Oak Blvd.
Tallahassee, Florida 32399

Filed on this date, with
the designated Division Clerk,
receipt of which is hereby
acknowledged.

Division Clerk

Date: 3/11/20

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

AMERICAN OVERSIGHT

Subject: Emerald Coast Healthcare Coalition Information
Date: Monday, March 16, 2020 1:31:41 PM
Attachments: dem-order-no-20-002-in-re-covid-19-public-health-emergency-issued-03-11-2020.pdf
Clinical Guidance Chart_3-15-20_Final-1.pdf

In an abundance of preparedness and caution, your Healthcare Coalition has canceled all upcoming meetings, trainings, and exercises as many of our healthcare partners and members are engaged in or preparing for or responding to the COVID-19 effort.

Please continue to monitor the Florida Department of Health COVID website for the most up to date information on the situation in Florida. http://www.floridahealth.gov/diseases-and-conditions/covid-19/

Please see the attached: Florida Division of Emergency Management Order No. 20-002 prohibiting visitors to certain types of health care facilities within the State. Please read carefully to determine if your facility falls under this order and to understand the actions you may need to take to comply.

The COVID-19 Call Center is available 24/7 (866) 779-6121 or email COVID-19@FLHealth.gov

Please contact me or anyone in our office if we can assist you during this response.

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Clinical Screening Tool for Identifying Persons Under Investigation for Coronavirus Disease 2019 (COVID-19) per Centers for Disease Control and Prevention (CDC)

Symptomatic individuals should be asked to wear a surgical mask upon arrival. Initiate contact and airborne precautions, using appropriate personal protective equipment (PPE).

Version 4.2 | March 15, 2020

SCREENING CRITERIA

If your patient is exhibiting **symptoms** of acute lower respiratory illness (e.g., fever, cough, and shortness of breath) **and** meets one or more of the following criteria:

1. Persons who have had a close contact with a laboratory-confirmed COVID-19 case
2. Persons hospitalized with acute lower respiratory illness of unknown origin
3. History of travel to or from an affected geographic area with widespread community transmission
4. History of international travel or a cruise
5. ≥65 with chronic health conditions
6. Immunocompromised persons

EXPANDED CRITERIA

If your patient does not meet the above criteria, testing may occur based on clinician's judgement.

1. The health care provider is responsible for specimen collection, handling and shipping. Please follow CDC guidance and use proper PPE.
2. Collected specimens should be processed within your health care facility or a commercial laboratory (e.g., LabCorp and Quest).
3. Follow CDC guidance for specimen collection, handling and shipping.

TESTING

If individual meets criteria for testing, wear appropriate PPE and initiate contact and airborne precautions.

1. The health care provider is responsible for specimen collection, handling and shipping. Please follow CDC guidance.
2. Collected specimens should be processed within your health care facility, if available; a commercial laboratory (e.g., LabCorp and Quest); or a Florida Bureau of Public Health Laboratory (BPHL)
3. Before sending specimens to BPHL, notify your local county health department CHD Epidemiology Contacts.
4. Health care providers may consult local county health departments for additional guidance as needed.

FOR ADDITIONAL GUIDANCE

Providers are encouraged to frequently monitor Florida Department of Health and CDC websites for updated guidance on COVID-19.

- www.flhealth.gov
- https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Please see the CDC's: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

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STATE OF FLORIDA
DIVISION OF EMERGENCY MANAGEMENT

IN RE: SUSPENSION OF STATUTES, RULES, AND ORDERS, PURSUANT TO EXECUTIVE ORDER NUMBER 20-52, MADE NECESSARY BY THE COVID-19 PUBLIC HEALTH EMERGENCY

DEM ORDER NO. 20-002

EMERGENCY ORDER

WHEREAS, the Governor of the State of Florida issued Executive Order No. 20-52 in response to the COVID-19 Public Health Emergency which poses a severe threat to the entire State of Florida and requires that timely precautions are taken to protect the communities, critical infrastructure, and general welfare of this State; and,

WHEREAS, the Governor has designated the Director of the Division of Emergency Management as the State Coordinating Officer for the duration of this emergency and has delegated to the State Coordinating Officer the authority to exercise those powers delineated in sections 252.36(5)-(10), Florida Statutes; and,

NOW THEREFORE, I hereby find that the Division of Emergency Management's timely performance of disaster response functions related to COVID-19 Public Health Emergency is hindered by the application of procedures imposed by statute, rule, and/or order.

Therefore, pursuant to Section 2 of Executive Order No. 20-52, I hereby issue the following authorization(s):

I. Suspend sections 393.13(4), 400.022(1)(b), 429.28(1)(d), 429.85(1)(d) Florida Statutes, for the particular purpose of prohibiting certain individuals from visiting facilities. For purposes of this order, a facility includes nursing homes, assisted living

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facilities, adult family-care homes, long-term care facilities, and adult group homes. The order applies as follows:

a. Any person infected with COVID-19 who has not had two consecutive negative test results separated by 24 hours is prohibited from visiting a facility; or

b. Any person showing or presenting signs or symptoms of a respiratory infection, including cough, fever, shortness of breath or sore throat is prohibited from visiting a facility; or

c. Any person who has or may have been in close contact with a person(s) infected with COVID-19 who has not tested negative for COVID-19 is prohibited from visiting a facility until 14 days after their interaction with the person(s) who is infected with COVID-19; or

d. Any person who traveled internationally is prohibited from visiting a facility until 14 days after their return to the United States; or

e. Any person who traveled on a cruise ship is prohibited from visiting a facility until 14 days after their return to the United States; or

f. Any person who has been in a community with confirmed community spread of COVID-19, as identified by the Centers for Disease Control and Prevention or a state public health agency, is prohibited from visiting a facility within 14 days of their presence in the community with community spread; or

g. Any person who resides in a community with confirmed community spread of COVID-19, as identified by the Centers for Disease Control and

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Prevention or a state public health agency, is prohibited from visiting a facility.

Because section 252.36(5)(a), Florida Statutes, allows the Governor to suspend the provisions of "any regulatory statute prescribing the procedures for [the] conduct of state business", and because Executive Order No. 20-52 designates the Director of the Division of Emergency Management as the State Coordinating Officer for this emergency, the requirements of sections 252.46 and 120.54(4), Florida Statutes, do not apply to this Order.

The effective dates of this Order shall correspond with the effective dates of Executive Order No. 20-52.

By Order of the State Coordinating Officer executed this 11th day of March, 2020, in Tallahassee, Leon County, Florida.

Jared Moskowitz
State Coordinating Officer
Florida Division of Emergency Management
2555 Shumard Oak Blvd.
Tallahassee, Florida 32399

Filed on this date, with
the designated Division Clerk,
receipt of which is hereby
acknowledged.

Division Clerk

Date: 3/11/20

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Emergency Planning- R4 HHS emPOWER Emergency Planning De-identified Datasets (March 2020)
Date:	Sunday, March 22, 2020 10:07:08 AM
Attachments:	Florida_FL_CMSData_De_Identified_SCZ_2020_03.xlsx
Importance:	High

R4 emPOWER Emergency Planning De-identified Datasets for dissemination to the states to support emergency planning.

I have attached the HHS emPOWER Initiative Emergency Planning de-identified dataset that includes data at the state/territory, county, and zip code levels. The de-identified (HIPAA masked) dataset includes at-risk Medicare beneficiaries from the Medicare Fee-For-Service (FFS/Parts A& B) and Medicare Advantage (CMS' HMO plans/Part C) Programs that rely upon the electricity-dependent durable medical equipment (DME) and cardiac implantable devices and healthcare services that include ESRD (dialysis), oxygen tank services, and home health visits. Detailed information regarding the dataset are included in the Menu tab and the Data Overview tabs of the attached workbook.

State/Territory Zip Aggregation: We weren't able to identify geospatial boundary data for a number of the zip codes in the state/territory. Due to this we have had to aggregate the data for those zip codes (child zip code) with another zip code that it resides in or next to (parent zip code) to ensure we didn't lose population data associated with those zip codes. The third tab in the dataset provides the mapping for zip codes that meet this criteria.

Purpose: ASPR, in partnership with CMS, are providing limited de-identified Medicare data to State and local health departments to enhance situational awareness of and support emergency planning for and public health response activities for at-risk individuals that rely upon select electricity-dependent durable medical equipment (DME), facility-based dialysis and oxygen tank services prior to, during, or after an emergency or disaster. The DME that are included are: ventilators, oxygen concentrators, IV infusion pumps, suction pumps, at-home dialysis, electric wheelchairs and electric beds.

Data Source: The CMS dataset is developed from Medicare Fee For Service (FFS) Part A and B beneficiary administrative claims data (~32M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children) and Medicare Advantage claims data (~17M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children). This data does not include individuals that are only enrolled in a State Medicaid Program. It is important to note that Medicare DME are subject to insurance claim reimbursement caps (e.g. rental caps) that differ by type and therefore may have a different "look-back" periods (e.g. ventilators are 13 months and oxygen concentrators are 36 months) all of which are provided in the Menu and Data Overview tabs of the workbook.

Approved Data Uses: The de-identified dataset is approved for use by the state/territory and local health department, either directly or in collaboration with their ESF-8, 6, recovery or other partners, as appropriate, for public health emergency preparedness, response, recovery, mitigation and resilience activities. This data is not approved for research and all other potential uses of this data require prior approval from ASPR and CMS that must be sent c/o their ASPR REC to Kristen Finne at

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Kristen.finne@hhs.gov.

Privacy Protections: As Medicare beneficiary privacy protection is our priority, all personal identifiable information has been removed from this dataset and numerous de-identified methods have been applied to significantly minimize, if not completely mitigate, any potential for deduction of small cells or re-identification risk. For example, any cell size found between the range of 1 and 10 is masked and shown as 11. Additional information about our privacy protection/de-identification methods can be located on the Menu tab. If a State or local health department were to identify a potential risk for deducing a small cell or re-identification, notification must be immediately sent to Kristen Finne at Kristen.finne@hhs.gov.

Thanks again for all your time and collaboration on this important response effort. As always, please feel free to call or email me with any additional questions.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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HHS emPOWER Program - March 2020 Update
State of Florida
De-Identified Aggregated U.S. State, County, Zip Code

Table of Contents

Data Overview

Reference Dates

Data Description

Notes

U.S. Territory/State Level Data

Geographic Indicators:

State Level Data

Totals*:

Medicare Beneficiaries in Territory/State

Medicare Fee-for-Service Beneficiaries [Part A/Part B] in State

Medicare Advantage Beneficiaries [Part C] in State

Dual-Eligible Medicare Beneficiaries in Territory/State

Residence Indicators*:

Number of Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)

At Risk Populations*:

In-Facility ESRD

Oxygen Services (Tanks)

Home Health Services

At-Home Hospice

Power Dependent [All Devices and DME]***

Power Dependent Cardiac Devices

Ventilators

BiPAPs

Oxygen Concentrators

Enteral Feeding

IV Infusion Pumps

Suction Pumps

At-Home ESRD

County Level Data

Geographic Indicators:

County FIPS Code

County Name

State FIPS Code

State (Two-letter abbreviation)

Number of Zip Codes in County

Totals*:

Medicare Beneficiaries in County

Residence Indicators*:

Number of Beneficiary Addresses (Excludes P.O. Boxes an

At Risk Populations*:

In-Facility ESRD

Oxygen Services (Tanks)

Home Health Services

At-Home Hospice

Power Dependent [All Devices and DME]***

Power Dependent Cardiac Devices

Ventilators

BiPAPs

Oxygen Concentrators

Enteral Feeding

IV Infusion Pumps

Suction Pumps

At-Home ESRD

Lookback Periods
3 months
13 months
3 months
3 months
Varied
5 years
13 months
13 months
36 months
13 months
13 months
13 months
3 months

* Cells with counts between 1-10 are masked to 11.

** Beneficiary addresses do not include beneficiaries in nu

*** The Power Dependent Layer includes beneficiaries wh concentrator in the last 36 months, a ventilator, bi-level p enteral feeding, IV infusion pump, suction pump, motorize the last 13 months, at-home ESRD in the last 3 months, Individuals are counted once regardless of how many type

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	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
1														
2														
3														
4														
5														
6														
7														
8														
9	rsing homes or long term care.													
10														
11	o have a claim for an oxygen													
12	ositive airway pressure device (BiPAP),													
13	d wheelchair, scooter, or electric bed in													
14	or a cardiac device in the last 5 years.													
15	s of DME they utilize.													
16														
17						Zip Code Level Data								
18						**Geographic Indicators:**								
19						Zip Code								
20						County FIPS Code								
21						County Name								
22						State FIPS Code								
23						State (Two-letter abbreviation)								
24														
25						**Totals*:**								
26						# Medicare Beneficiaries in Zip Code								
27														
28														
29														
30														
31						**Residence Indicators*:**								
32						Number of Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)								
33	nd Unknowns)													
34														
35	**Lookback Periods**					**At Risk Populations*:**						**Lookback Periods**		
36	3 months					In-Facility ESRD						3 months		
37	13 months					Oxygen Services (Tanks)						13 months		
38	3 months					Home Health Services						3 months		
39	3 months					At-Home Hospice						3 months		
40	Varied					Power Dependent [All Devices and DME]***						Varied		
41	5 years					Power Dependent Cardiac Devices						5 years		
42	13 months					Ventilators						13 months		
43	13 months					BiPAPs						13 months		
44	36 months					Oxygen Concentrators						36 months		
45	13 months					Enteral Feeding						13 months		
46	13 months					IV Infusion Pumps						13 months		
47	13 months					Suction Pumps						13 months		
48	3 months					At-Home ESRD						3 months		

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
49		Motorized Wheelchairs or Scooters						13 months				Motorized Wheelchairs or Scooters					
50		Electric Beds						13 months				Electric Beds					
51																	
52		**De-Identification Methods/Privacy Protection**										**De-Identification Methods/Privacy Protection**					
53		Removed all personal identifiers and information.										Removed all personal identifiers and information.					
54		Aggregated data to the territory/state level.										Aggregated data to the county level using sums of actual					
55		Masked all data variables with a cell size between 1-10 to 11.										Masked all data variables with a cell size between 1-10 to					
56		Aggregated data to the territory/state level using sums of actual and masked zip code values for										Number of masked counties provided to allow calculating					
57		territories/states with only 1 masked zip code.															

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	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
49	13 months					Motorized Wheelchairs or Scooters						13 months		
50	13 months					Electric Beds						13 months		
51														
52						**De-Identification Methods/Privacy Protection**									
53						Removed all personal identifiers and information.									
54	and masked	zip code values.				Aggregated data to the zip code level.								
55	11.					Masked all data variables with a cell size between 1-10 to 11.								
56	actual range.													
57														

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HHS emPOWER Program - March 2020 Update
Data Overview

REFERENCE DATES

Category	Description	Data as of
Enrollment and Death	We restrict the Medicare population beneficiaries alive as of the most recent Medicare Enrollment Database (EDB) available. We additionally restrict to beneficiaries who are enrolled in either original Medicare (Parts A/B, also known as fee-for-service or FFS), or Medicare Advantage (Part C), as of the most recent month available in the EDB.	1/1/2020
Nursing home	Nursing home residence is determined by using a combination of nursing home-related Medicare FFS/Medicare Advantage claims and the Long-Term Care Minimum Data Set (MDS) assessments as of this date.	12/1/2019
Power Dependent Devices and Durable Medical Equipment Users	Power-dependent device and durable medical equipment use is determined by the presence of Medicare FFS/Medicare Advantage claims during various lookback periods, all ending on this date.	2/28/2020
End-Stage Renal Disease (ESRD)	ESRD patients are identified as receiving In-facility dialysis treatment or at-home dialysis DME by the presence of Medicare FFS claims/Medicare Advantage in the 3 months prior to this date.	2/28/2020

NOTES

* Power-dependent medical equipment users are included in counts only if they are not residing in a nursing home or are not receiving long term care.
* All cells with values from 1-10 have been replaced [masked] with 11.
* County level summary counts reflect sums of masked and unmasked zip codes.
* Territory/state summary counts reflect:
  For territories/states that have contain zero or more than one masked zip code - actual totals.
  For territories/states with exactly one masked zip code - sum of the masked and unmasked zip codes.
  Sums that include exactly one masked zip code are indicated in the State Actual Data tab by an asterisk.

Zip Codes:
Some zip codes do not appear separately in the aggregate-level counts as we were unable to locate specific geospatial boundary data for their given area. Most of the zip codes that fall within this category are P.O. Box zip codes, though in some U.S. Territories these include residential zip codes with a very high prevalence of P.O. Boxes. As many individuals will reside within the geographic area, we have developed a work around to ensure the population data is still captured. This is done by identifying the larger boundary zip code, also named the parent zip code, in which the non-boundary zip code, also named the child zip code, resides. The totals are then added together and displayed under the parent zip code. The list of all child zip codes and their associated parent zip codes is included in the third tab of this workbook.

DATA DESCRIPTI

End-Stage Renal Dise
having received dialy

Oxygen Services [Tar
Term Care/Nursing H
supplemental oxygen

Home Health Service
Term Care/Nursing H
therapy, speech-langu

At-Home Hospice Se
living at home (i.e., n
occupational therapy,
supplies and usage of
ill beneficiaries who

Power-dependent De
not in Long Term C
13 months. The only

* Oxygen concentrat

* At-home dialysis is
use a 3 month lookb
home should their eq

* Cardiac devices su
continued cardiac fu
to identify individual

Additional DME and

Cardiac devices inclu
pumps that are used

A **ventilator** provides
deflating of the ches

A bi-level positive ai
at any moment of th

An **oxygen concentra**
used to provide life-
required for certain

An **enteral feeding** t
safely, or need nutri

An **IV infusion pump**
antibiotics, chemother

A **suction pump** is a
often prescribed for

A **motorized wheelch**
impairments as well

An **electric bed** is a
electronic buttons to

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	A	B	C	D	E	F	G	H
36								For more information

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HHS emPOWER Program - March 2020 Update
Parent-Child Zip Code Mapping

Some zip codes do not appear separately in the aggregate-level counts as we were unable to locate specific geospatial boundary data for their given area. Most of the zip codes that fall within this category are P.O. Box zip codes, though in some U.S. Territories these include residential zip codes with a very high prevalence of P.O. Boxes. As many individuals will reside within the geographic area, we have developed a work around to ensure the population data is still captured. This is done by identifying the larger boundary zip code, also named the parent zip code, in which the non-boundary zip code, also named the child zip code, resides. The totals are then added together and displayed under the parent zip code. The list of all child zip codes and their associated parent zip codes is included below.

Child Zip Code	Parent Zip Code
32004	32082
32006	32073
32007	32177
32026	32083
32030	32068
32035	32034
32041	32097
32042	32044
32050	32068
32056	32055
32067	32073
32072	32087
32079	32043
32085	32084
32099	32220
32105	32180
32111	34472
32115	32114
32116	32118
32120	32114
32121	32119
32122	32114
32123	32114
32125	32117
32126	32118
32133	32179
32135	32136
32138	32666
32142	32136
32147	32177
32149	32148
32157	32181
32158	32159
32160	32656

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	A	B	C	D	E	F	G	H	I	J
49		32170	32169							
50		32173	32174							
51		32175	32174							
52		32178	32177							
53		32183	32179							
54		32185	32666							
55		32192	32113							
56		32198	32114							
57		32201	32202							
58		32203	32204							
59		32214	32212							
60		32215	32221							
61		32229	32218							
62		32231	32207							
63		32232	32209							
64		32235	32206							
65		32236	32205							
66		32237	32257							
67		32238	32244							
68		32239	32277							
69		32240	32250							
70		32241	32223							
71		32245	32216							
72		32247	32207							
73		32255	32207							
74		32260	32259							
75		32302	32301							
76		32313	32304							
77		32314	32301							
78		32315	32303							
79		32316	32304							
80		32318	32305							
81		32323	32322							
82		32326	32327							
83		32329	32320							
84		32330	32351							
85		32335	32321							
86		32337	32344							
87		32341	32340							
88		32345	32344							
89		32353	32351							
90		32356	32359							
91		32357	32347							
92		32360	32334							
93		32361	32344							
94		32362	32305							
95		32395	32301							
96		32399	32311							
97		32402	32401							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
98		32406	32405							
99		32410	32401							
100		32411	32408							
101		32412	32401							
102		32417	32407							
103		32422	32433							
104		32432	32442							
105		32434	32433							
106		32447	32446							
107		32452	32425							
108		32457	32456							
109		32461	32401							
110		32463	32428							
111		32513	32503							
112		32516	32506							
113		32520	32502							
114		32521	32507							
115		32522	32502							
116		32523	32501							
117		32524	32501							
118		32530	32583							
119		32537	32531							
120		32538	32567							
121		32540	32541							
122		32549	32548							
123		32559	32526							
124		32560	32533							
125		32562	32561							
126		32572	32570							
127		32588	32578							
128		32602	32601							
129		32604	32603							
130		32612	32611							
131		32614	32608							
132		32616	32615							
133		32627	32601							
134		32633	32640							
135		32634	32686							
136		32635	32605							
137		32639	34449							
138		32644	32626							
139		32654	32640							
140		32655	32643							
141		32658	32615							
142		32662	32640							
143		32663	32686							
144		32681	32686							
145		32704	32712							
146		32706	32744							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
147		32710	32818							
148		32715	32714							
149		32716	32714							
150		32718	32708							
151		32719	32708							
152		32721	32720							
153		32722	32720							
154		32723	32724							
155		32727	32726							
156		32728	32725							
157		32733	32792							
158		32739	32738							
159		32745	32746							
160		32747	32771							
161		32752	32779							
162		32753	32713							
163		32762	32765							
164		32768	32712							
165		32772	32771							
166		32774	32763							
167		32777	32757							
168		32781	32780							
169		32783	32780							
170		32790	32789							
171		32791	32779							
172		32793	32792							
173		32794	32751							
174		32795	32746							
175		32799	32746							
176		32802	32801							
177		32834	32828							
178		32853	32803							
179		32854	32804							
180		32855	32805							
181		32856	32806							
182		32857	32807							
183		32858	32808							
184		32859	32809							
185		32860	32810							
186		32861	32811							
187		32862	32827							
188		32867	32817							
189		32868	32818							
190		32869	32809							
191		32872	32822							
192		32877	32837							
193		32878	32828							
194		32885	32827							
195		32886	32801							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
196		32887	32821							
197		32891	32803							
198		32897	32801							
199		32902	32901							
200		32906	32905							
201		32910	32907							
202		32911	32905							
203		32912	32904							
204		32919	32901							
205		32923	32922							
206		32924	32922							
207		32932	32931							
208		32936	32935							
209		32941	32901							
210		32954	32953							
211		32956	32955							
212		32957	32958							
213		32959	32927							
214		32961	32960							
215		32964	32960							
216		32965	32962							
217		32969	32966							
218		32970	32967							
219		32971	32967							
220		32978	32958							
221		33002	33012							
222		33008	33009							
223		33011	33010							
224		33017	33015							
225		33022	33020							
226		33041	33040							
227		33045	33040							
228		33052	33050							
229		33061	33060							
230		33072	33069							
231		33074	33064							
232		33075	33067							
233		33077	33071							
234		33081	33021							
235		33082	33027							
236		33083	33023							
237		33084	33024							
238		33090	33030							
239		33092	33032							
240		33093	33063							
241		33097	33073							
242		33101	33136							
243		33102	33122							
244		33106	33193							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
245		33111	33131							
246		33112	33122							
247		33114	33134							
248		33116	33176							
249		33119	33139							
250		33124	33181							
251		33151	33127							
252		33152	33122							
253		33153	33138							
254		33163	33180							
255		33164	33162							
256		33188	33122							
257		33195	33166							
258		33197	33157							
259		33222	33122							
260		33231	33131							
261		33233	33133							
262		33234	33134							
263		33238	33150							
264		33239	33139							
265		33242	33142							
266		33243	33143							
267		33245	33145							
268		33247	33122							
269		33255	33155							
270		33256	33156							
271		33257	33157							
272		33261	33161							
273		33265	33175							
274		33266	33166							
275		33269	33169							
276		33280	33162							
277		33283	33183							
278		33296	33156							
279		33299	33122							
280		33302	33304							
281		33303	33301							
282		33307	33334							
283		33310	33311							
284		33318	33322							
285		33320	33321							
286		33329	33324							
287		33335	33334							
288		33336	33311							
289		33337	33324							
290		33338	33324							
291		33339	33306							
292		33340	33311							
293		33345	33351							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
294		33346	33316							
295		33348	33308							
296		33349	33304							
297		33355	33325							
298		33359	33319							
299		33394	33301							
300		33402	33480							
301		33416	33406							
302		33419	33404							
303		33420	33410							
304		33421	33411							
305		33422	33417							
306		33424	33426							
307		33425	33426							
308		33427	33486							
309		33429	33432							
310		33443	33441							
311		33448	33446							
312		33454	33467							
313		33459	33440							
314		33464	33460							
315		33465	33462							
316		33466	33461							
317		33468	33458							
318		33474	33436							
319		33475	33455							
320		33481	33431							
321		33482	33445							
322		33488	33433							
323		33497	33428							
324		33499	33487							
325		33503	33598							
326		33508	33511							
327		33509	33511							
328		33524	33540							
329		33526	33525							
330		33530	33547							
331		33537	33523							
332		33539	33542							
333		33564	33566							
334		33568	33569							
335		33571	33573							
336		33574	33576							
337		33575	33570							
338		33583	33584							
339		33586	33570							
340		33587	33527							
341		33593	33523							
342		33595	33594							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
343		33601	33602							
344		33608	33621							
345		33622	33607							
346		33623	33607							
347		33630	33607							
348		33631	33607							
349		33633	33607							
350		33646	33602							
351		33650	33607							
352		33655	33602							
353		33660	33619							
354		33661	33619							
355		33662	33619							
356		33663	33607							
357		33664	33607							
358		33672	33602							
359		33673	33603							
360		33674	33604							
361		33675	33605							
362		33679	33629							
363		33680	33610							
364		33681	33611							
365		33682	33612							
366		33684	33634							
367		33685	33615							
368		33686	33616							
369		33687	33617							
370		33688	33618							
371		33689	33619							
372		33694	33624							
373		33729	33716							
374		33730	33713							
375		33731	33701							
376		33732	33702							
377		33733	33713							
378		33734	33704							
379		33736	33706							
380		33737	33707							
381		33738	33708							
382		33740	33706							
383		33741	33706							
384		33742	33702							
385		33743	33710							
386		33747	33711							
387		33757	33755							
388		33758	33765							
389		33766	33763							
390		33769	33765							
391		33775	33772							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
392		33779	33771							
393		33780	33781							
394		33784	33713							
395		33802	33803							
396		33804	33805							
397		33806	33803							
398		33807	33813							
399		33820	33830							
400		33826	33825							
401		33831	33830							
402		33835	33860							
403		33836	33837							
404		33840	33803							
405		33845	33844							
406		33846	33812							
407		33847	33843							
408		33851	33844							
409		33854	33898							
410		33856	33898							
411		33858	33837							
412		33862	33852							
413		33863	33860							
414		33871	33870							
415		33877	33859							
416		33882	33880							
417		33883	33880							
418		33885	33881							
419		33888	33884							
420		33902	33901							
421		33906	33907							
422		33910	33990							
423		33911	33901							
424		33915	33990							
425		33918	33903							
426		33927	33953							
427		33929	33928							
428		33932	33931							
429		33938	33948							
430		33945	33922							
431		33949	33950							
432		33951	33950							
433		33970	33936							
434		33975	33935							
435		33994	33905							
436		34101	34102							
437		34106	34102							
438		34107	34102							
439		34133	34135							
440		34136	34135							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
441		34143	34142							
442		34146	34145							
443		34204	34203							
444		34206	34205							
445		34216	34217							
446		34218	34217							
447		34220	34221							
448		34230	34236							
449		34260	34243							
450		34264	34203							
451		34265	34266							
452		34267	34269							
453		34268	34266							
454		34270	34243							
455		34272	34275							
456		34274	34275							
457		34276	34236							
458		34277	34239							
459		34278	34234							
460		34280	34209							
461		34281	34207							
462		34282	34207							
463		34284	34285							
464		34290	34287							
465		34295	34223							
466		34421	34420							
467		34430	34432							
468		34445	34465							
469		34447	34448							
470		34451	34450							
471		34460	34461							
472		34464	34465							
473		34477	34471							
474		34478	34471							
475		34483	34472							
476		34487	34448							
477		34489	34488							
478		34492	34491							
479		34603	34601							
480		34605	34601							
481		34611	34606							
482		34636	34601							
483		34656	34653							
484		34660	34683							
485		34673	34668							
486		34674	34667							
487		34680	34652							
488		34682	34683							
489		34692	34690							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
490		34697	34698							
491		34712	34711							
492		34713	34714							
493		34729	34715							
494		34740	34787							
495		34742	34741							
496		34745	34741							
497		34749	34748							
498		34755	34715							
499		34770	34769							
500		34777	34787							
501		34778	34787							
502		34789	34788							
503		34948	34950							
504		34954	34983							
505		34958	34957							
506		34973	34972							
507		34979	34950							
508		34985	34952							
509		34988	34986							
510		34991	34990							
511		34992	34997							
512		34995	34994							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1								
2		HHS emPOWER Program - March 2020 Update						
3		De-Identified Aggregated U.S. State						
4								
5				# Medicare Beneficiaries by Plan/Enrollment Type		Demographic Information		Services
6		State	# Medicare Beneficiaries in State	# Medicare Fee-for-Service Beneficiaries [Part A/Part B] in State	# Medicare Advantage Beneficiaries [Part C] in State	# Dual-Eligible Medicare Beneficiaries in State	# Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)	# In-Facility ESRD Dialysis (3 months)
7		FL	4,311,823	2,088,296	2,223,527	841,919	4,077,090	23,635
8								
9		Note: State's dual eligibility data last reported in January 2020.						

AMERICAN OVERSIGHT

	I	J	K	L	M	N	O	P	Q
1									
2									
3									
4									
5	Services	Services	Services	All Power Dependent	Power Depende				
6	# O2 services [tanks] (13 months)	# Home health (3 months)	# At-Home Hospice (3 months)	# Electricity-Dependent Devices and DME	#Cardiac Devices (5 years)	# Ventilators (13 months)	# BiPAPs (13 months)	# O2 Concentrators (36 months)	# Enteral Feeding (13 months)
7	48,545	132,997	14,874	168,269	1,619	4,945	9,516	117,351	6,027
8									
9									

AMERICAN OVERSIGHT

	R	S	T	U	V
1					
2					
3					
4					
5	ent Devices and DME				
6	# IV Infusion Pumps (13 months)	# Suction Pumps (13 months)	# At-Home ESRD Dialysis (3 months)	# Motorized Wheelchairs or Scooters (13 months)	# Electric Beds (13 months)
7	8,648	1,503	2,842	8,801	21,864
8					
9					

AMERICAN OVERSIGHT

HHS emPOWER Program - March 2020 Update
De-Identified Aggregated U.S. County

								Services	
								In-Facility ESRD (3 months)	
	County FIPS Code	County	State FIPS Code	State	# Zip Codes in County	# Medicare Beneficiaries in County	# Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)	# In-Facility ESRD Dialysis	# Masked Zip Codes in County
7	001	Alachua	12	FL	19	42,894	38,109	304	7
8	003	Baker	12	FL	3	4,530	3,648	49	2
9	005	Bay	12	FL	11	35,121	32,027	217	6
10	007	Bradford	12	FL	4	4,873	4,076	59	3
11	009	Brevard	12	FL	30	146,697	140,210	703	9
12	011	Broward	12	FL	54	302,247	292,131	2,368	11
13	013	Calhoun	12	FL	4	2,683	2,193	22	2
14	015	Charlotte	12	FL	13	66,781	64,273	199	6
15	017	Citrus	12	FL	14	56,379	53,236	173	8
16	019	Clay	12	FL	6	39,838	36,537	210	0
17	021	Collier	12	FL	21	96,474	92,717	337	6
18	023	Columbia	12	FL	5	14,814	13,496	90	0
19	027	De Soto	12	FL	2	6,958	5,974	54	1
20	029	Dixie	12	FL	4	3,729	2,748	33	3
21	031	Duval	12	FL	34	153,265	146,765	1,560	2
22	033	Escambia	12	FL	19	65,504	61,164	560	5
23	035	Flagler	12	FL	4	35,344	33,124	110	1
24	037	Franklin	12	FL	3	2,836	1,940	33	3
25	039	Gadsden	12	FL	6	9,534	7,868	103	4
26	041	Gilchrist	12	FL	2	3,687	3,189	23	1
27	043	Glades	12	FL	2	1,414	986	11	1
28	045	Gulf	12	FL	2	3,869	3,212	25	1
29	047	Hamilton	12	FL	3	2,975	2,342	33	3
30	049	Hardee	12	FL	4	4,275	3,221	43	2
31	051	Hendry	12	FL	3	6,070	4,479	61	0
32	053	Hernando	12	FL	10	55,338	53,401	159	5
33	055	Highlands	12	FL	8	32,190	30,290	185	2
34	057	Hillsborough	12	FL	54	224,744	211,895	1,474	10
35	059	Holmes	12	FL	3	4,945	4,469	35	2
36	061	Indian River	12	FL	8	50,959	48,233	232	0
37	063	Jackson	12	FL	11	11,133	9,433	124	9
38	065	Jefferson	12	FL	2	3,356	2,795	33	1
39	067	Lafayette	12	FL	2	1,029	813	11	1
40	069	Lake	12	FL	25	104,996	98,018	498	13
41	071	Lee	12	FL	35	185,549	178,284	682	8
42	073	Leon	12	FL	12	40,833	38,498	217	2
43	075	Levy	12	FL	8	10,412	8,303	69	4
44	077	Liberty	12	FL	2	1,297	960	22	2
45	079	Madison	12	FL	4	4,411	3,627	55	3
46	081	Manatee	12	FL	19	99,892	94,597	406	8

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
1								
2								
3								
4	Services		Services		Services		All Power Dependent	
5	Oxygen Services [Tanks] (13 months)		Home Health (3 months)		At-Home Hospice (3 months)		Cardiac Device, Ventilator, BiPAP, Oxygen Concentrator, Enteral Feeding, IV Infusion Pump, Suction Pump, At-Home ESRD, Motorized Wheelchair, Scooter, or Electric Bed	
6	# O2 Services [Tanks]	# Masked Zip Codes in County	# Home Health	# Masked Zip Codes in County	# At-Home Hospice	# Masked Zip Codes in County	# Electricity-Dependent Devices and DME	# Masked Zip Codes in County
7	450	1	1,470	2	193	14	1,794	2
8	90	0	163	0	33	3	276	0
9	523	1	1,178	0	181	3	2,023	1
10	118	2	175	0	44	4	340	0
11	2,049	3	4,405	2	849	3	6,487	2
12	2,853	3	9,389	0	1,146	13	9,853	0
13	80	2	117	2	44	4	199	1
14	771	1	2,211	0	155	10	2,598	0
15	1,141	1	1,311	1	163	9	2,422	0
16	579	0	1,212	0	108	1	1,887	0
17	638	2	2,931	3	274	6	2,521	5
18	240	0	591	1	45	3	847	1
19	120	0	228	0	22	2	365	0
20	113	2	166	2	22	2	301	2
21	2,201	2	5,550	0	472	14	7,042	1
22	854	1	2,461	1	260	4	2,614	2
23	271	0	1,129	0	180	1	1,240	0
24	42	1	79	0	33	3	190	0
25	205	2	233	2	56	4	477	0
26	68	0	126	0	22	2	207	0
27	28	1	52	1	11	1	83	0
28	65	0	139	0	24	1	226	0
29	49	0	106	0	11	1	151	0
30	95	2	150	1	56	3	296	1
31	91	1	185	1	22	2	264	1
32	1,118	1	1,694	1	160	4	2,785	1
33	676	2	1,325	1	155	2	2,299	0
34	2,416	3	6,758	3	796	22	9,131	3
35	90	0	198	0	47	2	281	0
36	340	1	2,135	0	107	3	1,569	0
37	204	3	485	1	123	8	562	1
38	59	1	76	1	11	1	162	0
39	33	1	39	0	11	1	70	0
40	1,293	6	3,016	3	433	13	4,762	2
41	1,924	3	5,234	1	485	13	6,494	1
42	573	0	910	0	136	7	1,723	1
43	175	2	377	3	55	5	582	2
44	34	0	45	0	11	1	112	0
45	82	1	144	1	33	3	222	0
46	1,046	4	3,044	2	199	11	3,312	2

AMERICAN OVERSIGHT

	S	T	U	V	W	X	Y	Z	AA
1									
2									
3									
4									
5	Cardiac Devices (5 years)		Ventilators (13 months)		BiPAPs (13 months)		O2 Concentrators (36 months)		Enteral (13 m
6	# Cardiac Devices	# Masked Zip Codes in County	# Ventilators	# Masked Zip Codes in County	# BiPAPs	# Masked Zip Codes in County	# O2 Concentrators	# Masked Zip Codes in County	# Enteral Feeding
7	132	12	154	14	154	14	1,224	2	190
8	22	2	33	3	33	3	205	0	33
9	55	5	121	9	129	7	1,524	1	111
10	22	2	44	4	22	2	255	0	44
11	231	21	363	19	345	19	4,977	2	274
12	473	43	572	52	675	38	5,868	1	723
13	11	1	33	3	33	3	174	1	11
14	77	7	143	10	241	3	1,932	0	146
15	99	9	143	13	146	11	1,995	1	132
16	66	6	82	4	140	1	1,364	0	85
17	121	11	179	15	294	9	1,719	4	165
18	33	3	48	3	55	5	641	1	44
19	22	2	22	2	22	2	294	0	22
20	11	1	22	2	22	2	254	2	22
21	330	30	366	24	505	13	4,692	1	375
22	77	7	136	11	163	9	1,715	0	158
23	44	4	50	2	85	2	874	0	60
24	11	1	22	2	33	3	150	0	22
25	22	2	55	5	59	4	336	2	55
26	22	2	22	2	22	2	172	0	11
27	0	0	22	2	11	1	72	0	11
28	22	2	22	2	22	2	178	0	22
29	22	2	33	3	33	3	110	0	22
30	33	3	22	2	22	2	232	1	22
31	11	1	22	2	22	2	209	1	22
32	66	6	96	5	102	8	2,259	1	99
33	77	7	77	7	66	6	1,908	1	88
34	407	37	574	41	644	33	5,957	3	585
35	22	2	33	3	33	3	218	0	11
36	66	6	88	8	81	6	1,124	0	79
37	11	1	77	7	88	8	429	1	88
38	11	1	11	1	23	1	115	0	22
39	11	1	11	1	11	1	49	0	11
40	176	16	254	17	366	14	3,715	2	218
41	253	23	384	25	478	18	4,776	2	381
42	66	6	99	9	157	4	1,132	1	114
43	55	5	66	6	66	6	467	2	56
44	0	0	22	2	22	2	88	0	11
45	33	3	33	3	33	3	155	1	33
46	132	12	165	15	284	7	2,493	2	190

AMERICAN OVERSIGHT

	AB	AC	AD
1			
2			
3			
4	Power Dependent Devices and DME		
5	Feeding onths)	IV Infusion Pumps (13 months)	
6	# Masked Zip Codes in County	# IV Infusion Pumps	# Masked Zip Codes in County
7	13	156	12
8	3	33	3
9	9	179	4
10	4	33	3
11	21	420	12
12	35	620	39
13	1	11	1
14	11	193	9
15	12	168	11
16	2	115	1
17	15	278	8
18	4	44	4
19	2	24	1
20	2	22	2
21	20	448	15
22	11	160	10
23	2	79	2
24	2	33	3
25	5	44	4
26	1	22	2
27	1	11	1
28	2	22	2
29	2	11	1
30	2	33	3
31	2	22	2
32	9	137	5
33	8	93	4
34	44	586	43
35	1	33	3
36	5	102	5
37	8	88	8
38	2	22	2
39	1	11	1
40	17	324	14
41	22	543	16
42	9	126	7
43	4	66	6
44	1	11	1
45	3	33	3
46	15	207	12

AMERICAN OVERSIGHT

	AE	AF	AG	AH	AI	AJ	AK	AL
1								
2								
3								
4								
5	Suction Pumps (13 months)		At-Home ESRD Dialysis (3 months)		# Motorized Wheelchairs or Scooters (13 months)		Electric Beds (13 months)	
6	# Suction Pumps	# Masked Zip Codes in County	# At-Home ESRD Dialysis	# Masked Zip Codes in County	# Motorized Wheelchairs or Scooters	# Masked Zip Codes in County	# Electric Beds	# Masked Zip Codes in County
7	121	11	154	14	227	11	198	7
8	33	3	11	1	39	2	37	2
9	88	8	88	8	129	7	173	4
10	22	2	11	1	59	3	52	3
11	220	20	231	21	357	13	528	8
12	473	43	563	50	648	41	2,488	4
13	0	0	11	1	33	3	33	3
14	99	9	132	12	155	10	180	9
15	33	3	121	11	163	8	154	9
16	55	5	66	6	106	1	145	0
17	143	13	154	14	167	14	187	11
18	33	3	44	4	69	1	106	2
19	11	1	22	2	26	1	26	1
20	11	1	33	3	34	2	33	3
21	275	25	304	25	580	11	898	4
22	110	10	132	12	266	8	413	4
23	33	3	50	3	68	2	116	1
24	11	1	11	1	33	3	38	1
25	33	3	33	3	69	5	93	3
26	11	1	22	2	22	2	22	2
27	0	0	11	1	11	1	11	1
28	11	1	22	2	22	2	22	2
29	0	0	22	2	33	3	33	3
30	0	0	33	3	39	2	37	2
31	11	1	33	3	33	3	22	2
32	88	8	99	9	147	4	248	4
33	44	4	77	7	140	4	213	3
34	440	40	507	45	776	30	1,584	5
35	0	0	22	2	37	2	34	2
36	77	7	77	7	80	6	198	2
37	22	2	66	6	99	9	88	8
38	11	1	11	1	22	2	30	1
39	11	1	11	1	11	1	11	1
40	99	9	209	19	285	15	390	12
41	264	24	298	26	376	28	553	18
42	99	9	99	9	112	9	265	0
43	33	3	44	4	68	5	75	5
44	0	0	11	1	11	1	11	1
45	0	0	22	2	48	3	47	3
46	110	10	165	15	242	10	280	10

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
47		083	Marion	12	FL	24	105,782	98,130	443	6
48		085	Martin	12	FL	7	44,736	42,373	121	1
49		086	Miami-Dade	12	FL	80	445,169	428,501	3,378	15
50		087	Monroe	12	FL	9	16,013	13,440	78	5
51		089	Nassau	12	FL	5	21,091	19,137	75	2
52		091	Okaloosa	12	FL	14	39,812	36,891	268	5
53		093	Okeechobee	12	FL	2	8,961	8,383	55	0
54		095	Orange	12	FL	45	179,279	168,643	1,550	14
55		097	Osceola	12	FL	12	54,666	51,829	429	2
56		099	Palm Beach	12	FL	52	307,951	297,024	1,733	8
57		101	Pasco	12	FL	23	123,094	117,312	476	8
58		103	Pinellas	12	FL	48	229,883	216,954	1,159	11
59		105	Polk	12	FL	33	150,492	139,226	948	7
60		107	Putnam	12	FL	11	17,952	14,275	173	8
61		109	Saint Johns	12	FL	10	54,642	52,182	195	5
62		111	Saint Lucie	12	FL	14	73,235	70,759	458	4
63		113	Santa Rosa	12	FL	7	34,127	32,674	147	2
64		115	Sarasota	12	FL	23	136,872	131,486	439	8
65		117	Seminole	12	FL	13	68,262	64,513	411	3
66		119	Sumter	12	FL	10	72,931	70,224	175	5
67		121	Suwannee	12	FL	6	10,443	8,869	74	4
68		123	Taylor	12	FL	3	4,628	3,782	33	3
69		125	Union	12	FL	3	2,088	1,766	23	1
70		127	Volusia	12	FL	26	141,925	134,268	652	11
71		129	Wakulla	12	FL	4	5,733	4,940	23	1
72		131	Walton	12	FL	5	13,224	12,126	62	3
73		133	Washington	12	FL	4	5,038	4,355	54	3

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
47	1,477	2	2,791	2	351	12	4,772	0
48	497	1	1,855	0	113	2	1,406	0
49	4,654	6	13,128	1	2,572	16	16,535	1
50	113	6	429	2	78	6	378	2
51	339	1	595	0	75	2	891	0
52	525	1	1,479	1	178	5	1,847	2
53	160	0	301	0	22	2	533	0
54	1,765	8	4,724	1	804	16	6,787	1
55	548	3	1,343	3	331	4	2,096	1
56	2,285	5	11,036	2	954	17	8,573	1
57	2,110	1	3,549	1	402	7	5,983	1
58	2,275	3	7,458	2	813	20	8,451	2
59	1,607	3	3,687	4	729	8	6,684	1
60	312	4	646	0	117	9	1,049	0
61	454	0	1,653	0	187	4	1,799	0
62	773	0	2,502	0	185	8	2,615	0
63	482	0	1,109	0	116	2	1,489	0
64	1,126	2	4,500	0	295	15	4,363	0
65	758	0	2,103	0	284	2	2,999	0
66	504	3	1,607	2	132	6	2,091	0
67	181	0	347	0	55	5	588	0
68	99	1	136	0	33	3	315	0
69	63	2	76	2	11	1	152	1
70	1,832	3	4,328	1	709	7	6,211	1
71	129	1	133	2	37	2	324	1
72	160	0	414	0	57	4	559	0
73	113	2	188	1	46	2	296	1

AMERICAN OVERSIGHT

	S	T	U	V	W	X	Y	Z	AA
47	165	15	242	22	287	18	3,718	2	236
48	44	4	88	4	91	5	1,043	0	86
49	594	54	750	63	1,759	27	8,718	1	1,065
50	33	3	55	5	55	5	243	1	88
51	33	3	55	3	64	3	669	0	56
52	88	8	144	9	136	11	1,360	1	143
53	0	0	22	2	22	2	414	0	28
54	319	29	439	33	446	29	4,370	1	453
55	99	9	99	9	128	10	1,383	1	117
56	451	41	541	43	583	44	5,836	1	597
57	176	16	254	17	483	8	4,559	1	231
58	451	41	470	39	595	31	6,248	3	507
59	253	23	342	26	299	26	4,928	2	307
60	55	5	66	6	66	6	802	0	107
61	88	8	100	8	156	3	1,227	0	121
62	110	10	142	9	164	10	1,852	0	153
63	66	6	55	5	108	5	1,032	0	77
64	165	15	243	18	322	14	3,326	0	246
65	99	9	147	11	212	5	2,093	0	142
66	71	5	131	7	189	7	1,548	0	94
67	55	5	60	4	66	6	459	0	55
68	11	1	33	3	22	2	260	0	22
69	0	0	22	2	11	1	125	1	11
70	242	22	282	18	621	12	4,452	1	290
71	0	0	22	2	29	1	271	1	44
72	33	3	46	3	55	5	443	0	55
73	11	1	33	3	44	4	215	1	11

AMERICAN OVERSIGHT

	AB	AC	AD
47	20	301	17
48	5	103	4
49	43	858	70
50	8	45	3
51	4	71	4
52	13	203	8
53	1	25	1
54	29	501	30
55	7	149	4
56	39	742	28
57	21	310	13
58	45	571	30
59	23	440	19
60	8	66	6
61	8	162	4
62	9	235	9
63	7	86	3
64	21	375	11
65	8	205	7
66	6	219	5
67	5	66	6
68	2	33	3
69	1	11	1
70	16	370	13
71	4	11	1
72	5	55	5
73	1	39	2

AMERICAN OVERSIGHT

	AE	AF	AG	AH	AI	AJ	AK	AL
47	154	14	238	19	294	12	362	11
48	66	6	44	4	79	6	119	3
49	809	71	627	57	865	53	5,532	7
50	33	3	44	4	33	3	96	6
51	33	3	33	3	45	3	84	2
52	33	3	99	9	142	7	157	7
53	22	2	22	2	35	0	59	0
54	330	30	405	34	631	20	1,112	11
55	99	9	110	10	188	4	323	3
56	407	37	506	42	589	39	1,056	14
57	154	14	231	21	353	15	495	3
58	407	37	473	43	614	25	760	22
59	198	18	275	25	608	11	777	12
60	44	4	100	8	135	9	152	9
61	77	7	110	10	104	7	172	4
62	121	11	132	12	177	10	311	5
63	44	4	66	6	128	3	195	1
64	187	17	220	20	262	21	293	14
65	121	11	132	12	183	7	408	3
66	55	5	97	7	105	8	127	6
67	33	3	55	5	62	3	70	4
68	0	0	11	1	37	2	33	3
69	0	0	11	1	11	1	26	1
70	176	16	254	22	396	14	615	9
71	0	0	11	1	33	3	43	2
72	11	1	44	4	57	4	57	4
73	22	2	22	2	30	1	47	2

AMERICAN OVERSIGHT

HHS emPOWER Program - March 2020 Update

De-Identified Aggregated U.S. Zip Code - ESRD-Dialysis and Electricity-Dependent DME

Zip Code	County FIPS Code	County	State FIPS Code	State	# Medicare Beneficiaries in Zip Code	# Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)	Services # In-Facility ESRD Dialysis (3 months)	Services # O2 services [tanks] (13 months)
32003	019	Clay	12	FL	5,147	5,055	23	64
32008	121	Suwannee	12	FL	1,423	1,183	11	32
32009	089	Nassau	12	FL	635	561	11	11
32011	089	Nassau	12	FL	3,025	2,630	16	81
32013	067	Lafayette	12	FL	22	11	0	11
32024	023	Columbia	12	FL	4,117	4,056	18	63
32025	023	Columbia	12	FL	4,000	3,850	25	61
32033	109	Saint Johns	12	FL	1,514	1,439	11	12
32034	089	Nassau	12	FL	11,761	10,994	19	125
32038	023	Columbia	12	FL	2,417	2,161	12	55
32040	003	Baker	12	FL	1,403	1,048	11	30
32043	019	Clay	12	FL	8,485	7,109	28	100
32044	007	Bradford	12	FL	479	287	11	11
32046	089	Nassau	12	FL	1,891	1,513	11	37
32052	047	Hamilton	12	FL	1,430	1,104	11	18
32053	047	Hamilton	12	FL	841	710	11	13
32054	125	Union	12	FL	1,779	1,630	12	41
32055	023	Columbia	12	FL	4,216	3,365	35	61
32058	007	Bradford	12	FL	787	620	11	15
32059	079	Madison	12	FL	638	533	11	12
32060	121	Suwannee	12	FL	4,499	4,408	18	66
32061	023	Columbia	12	FL	64	64	0	0
32062	121	Suwannee	12	FL	716	629	11	14
32063	003	Baker	12	FL	2,396	2,038	27	41
32064	121	Suwannee	12	FL	2,063	1,148	12	39
32065	019	Clay	12	FL	5,008	4,820	36	73
32066	067	Lafayette	12	FL	1,007	802	11	22
32068	019	Clay	12	FL	9,288	8,782	46	170
32071	121	Suwannee	12	FL	973	861	11	16
32073	019	Clay	12	FL	8,542	7,917	63	115
32080	109	Saint Johns	12	FL	7,099	6,884	14	45
32081	109	Saint Johns	12	FL	4,424	4,387	11	22
32082	109	Saint Johns	12	FL	7,986	7,513	11	55
32083	125	Union	12	FL	229	136	11	11
32084	109	Saint Johns	12	FL	7,999	7,266	48	102
32086	109	Saint Johns	12	FL	8,497	8,249	31	92
32087	003	Baker	12	FL	731	562	11	19
32091	007	Bradford	12	FL	3,279	2,903	26	81
32092	109	Saint Johns	12	FL	6,579	6,468	24	39
32094	121	Suwannee	12	FL	769	640	11	14

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
1								
2								
3								
4								
5	Services	Services	All Power Dependent					Power Dependent I
6	# Home health (3 months)	# At-Home Hospice (3 months)	# Electricity-Dependent Devices and DME	# Cardiac Devices (5 years)	# Ventilators (13 months)	# BiPAPs (13 months)	# O2 Concentrators (36 months)	# Enteral Feeding (13 months)
7	179	12	199	11	11	13	133	11
8	47	11	79	11	11	11	70	11
9	15	11	35	0	0	11	24	11
10	99	15	198	0	11	15	151	11
11	0	0	0	0	0	0	0	0
12	153	12	230	11	11	11	179	11
13	185	11	229	11	11	11	169	11
14	52	11	76	11	11	11	57	11
15	318	25	346	11	22	16	251	12
16	71	11	130	11	11	11	106	11
17	54	11	81	11	11	11	62	11
18	184	14	300	11	11	21	223	15
19	18	11	38	0	11	0	32	11
20	59	11	111	11	11	11	84	11
21	56	11	64	0	11	11	39	11
22	29	0	49	11	11	11	40	0
23	54	11	123	0	11	11	98	11
24	171	11	247	0	15	11	176	11
25	30	11	49	11	11	11	35	11
26	22	11	38	11	0	11	26	0
27	133	11	227	11	16	11	180	11
28	11	0	11	0	0	11	11	0
29	25	11	37	0	11	11	27	11
30	85	11	150	11	11	11	108	11
31	79	11	145	11	11	11	107	11
32	156	12	256	11	11	21	173	15
33	39	11	70	11	11	11	49	11
34	298	33	537	11	20	42	406	20
35	29	11	50	11	11	11	36	0
36	282	26	403	11	18	32	272	13
37	238	20	214	11	11	22	145	14
38	89	11	111	11	11	12	61	11
39	248	13	219	11	11	18	146	11
40	11	0	18	0	11	0	16	0
41	250	30	304	11	11	16	222	19
42	279	27	333	0	11	31	244	11
43	24	11	45	0	11	11	35	11
44	113	11	230	11	11	11	173	11
45	202	30	206	11	11	24	131	11
46	34	0	50	11	0	11	39	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003506

	S	T	U	V	W
1					
2					
3					
4					
5	Devices and DME				
6	# IV Infusion Pumps (13 months)	# Suction Pumps (13 months)	# At-Home ESRD Dialysis (3 months)	# Motorized Wheelchairs or Scooters (13 months)	# Electric Beds (13 months)
7	23	11	11	11	16
8	11	11	11	11	11
9	11	0	0	0	11
10	11	11	0	11	17
11	0	0	0	0	0
12	11	11	11	17	21
13	11	11	11	20	33
14	11	0	11	11	11
15	27	11	11	11	30
16	11	0	11	11	11
17	11	11	11	11	11
18	16	11	11	12	17
19	11	0	0	11	11
20	11	0	11	11	15
21	11	0	11	11	11
22	0	0	11	11	11
23	11	0	11	11	15
24	11	11	11	21	30
25	0	0	0	11	11
26	11	0	0	11	11
27	11	0	11	13	12
28	0	0	0	0	11
29	11	11	11	11	11
30	11	11	0	17	15
31	11	0	11	16	14
32	13	0	11	15	22
33	11	11	11	11	11
34	27	11	11	23	37
35	11	0	0	11	11
36	25	11	11	33	41
37	14	11	11	11	17
38	16	0	11	11	11
39	18	11	11	11	22
40	0	0	0	0	11
41	11	11	11	14	25
42	26	11	11	11	27
43	11	11	0	11	11
44	11	11	11	26	19
45	19	11	11	11	16
46	11	11	11	0	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
47		32095	109	Saint Johns	12	FL	2,617	2,579	11	19
48		32096	047	Hamilton	12	FL	704	528	11	18
49		32097	089	Nassau	12	FL	3,779	3,439	18	85
50		32102	069	Lake	12	FL	954	720	11	13
51		32110	035	Flagler	12	FL	2,011	1,595	14	27
52		32112	107	Putnam	12	FL	1,715	1,459	13	33
53		32113	083	Marion	12	FL	1,793	1,270	11	29
54		32114	127	Volusia	12	FL	6,507	5,597	97	92
55		32117	127	Volusia	12	FL	5,802	5,493	61	92
56		32118	127	Volusia	12	FL	5,982	5,784	15	64
57		32119	127	Volusia	12	FL	6,017	5,826	26	76
58		32124	127	Volusia	12	FL	1,378	1,367	11	11
59		32127	127	Volusia	12	FL	8,657	8,547	22	97
60		32128	127	Volusia	12	FL	6,041	5,960	16	45
61		32129	127	Volusia	12	FL	6,121	5,730	23	73
62		32130	127	Volusia	12	FL	1,200	883	11	19
63		32131	107	Putnam	12	FL	1,139	886	11	15
64		32132	127	Volusia	12	FL	2,361	2,134	11	27
65		32134	083	Marion	12	FL	2,656	2,146	11	56
66		32136	035	Flagler	12	FL	4,471	3,014	11	27
67		32137	035	Flagler	12	FL	15,880	15,676	40	102
68		32139	107	Putnam	12	FL	471	317	11	11
69		32140	107	Putnam	12	FL	429	335	11	11
70		32141	127	Volusia	12	FL	5,631	5,564	11	75
71		32145	109	Saint Johns	12	FL	1,060	816	11	21
72		32148	107	Putnam	12	FL	2,791	2,342	14	51
73		32159	069	Lake	12	FL	16,249	15,559	32	157
74		32162	119	Sumter	12	FL	41,283	40,921	73	234
75		32163	119	Sumter	12	FL	19,174	19,066	19	59
76		32164	035	Flagler	12	FL	12,982	12,839	45	115
77		32168	127	Volusia	12	FL	8,591	8,436	19	72
78		32169	127	Volusia	12	FL	4,281	3,761	11	24
79		32174	127	Volusia	12	FL	17,391	16,652	47	165
80		32176	127	Volusia	12	FL	4,993	4,931	11	54
81		32177	107	Putnam	12	FL	6,110	5,082	58	95
82		32179	083	Marion	12	FL	2,516	2,135	12	51
83		32180	127	Volusia	12	FL	743	531	11	11
84		32181	107	Putnam	12	FL	811	467	11	19
85		32182	083	Marion	12	FL	160	11	0	11
86		32187	107	Putnam	12	FL	563	322	11	11
87		32189	107	Putnam	12	FL	1,722	1,577	11	32
88		32190	127	Volusia	12	FL	279	163	11	11
89		32193	107	Putnam	12	FL	510	225	11	11
90		32195	083	Marion	12	FL	1,019	769	11	13
91		32202	031	Duval	12	FL	1,149	1,013	16	16
92		32204	031	Duval	12	FL	1,907	1,453	18	29
93		32205	031	Duval	12	FL	4,759	4,421	41	80
94		32206	031	Duval	12	FL	3,239	3,006	65	68
95		32207	031	Duval	12	FL	6,319	5,937	45	93

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
47	73	11	69	0	11	11	50	11
48	21	0	38	11	11	11	31	11
49	104	13	201	11	11	11	159	11
50	15	11	42	11	11	11	34	0
51	66	11	105	11	11	11	76	11
52	52	11	85	11	0	11	67	0
53	34	11	112	0	11	11	83	11
54	167	25	284	11	11	15	186	11
55	241	32	305	11	11	11	222	12
56	177	16	188	11	11	11	129	11
57	174	38	259	11	11	13	210	11
58	28	11	34	11	11	11	23	0
59	285	32	354	11	11	26	262	11
60	160	21	182	11	11	20	123	11
61	197	28	285	11	11	21	223	11
62	30	11	72	0	11	11	54	11
63	40	11	55	11	11	11	42	11
64	74	19	102	11	11	11	74	11
65	55	13	169	11	11	11	144	11
66	128	23	149	11	11	11	98	11
67	485	72	493	11	12	37	346	17
68	16	0	31	0	11	11	25	11
69	17	11	29	0	0	0	22	11
70	181	35	266	11	12	20	209	11
71	28	11	66	11	0	0	52	11
72	86	11	186	11	11	11	148	11
73	569	26	611	11	22	27	484	15
74	940	53	1,067	16	39	80	790	28
75	294	11	339	11	15	32	201	11
76	450	74	493	11	16	26	354	21
77	267	53	297	11	12	28	206	13
78	101	13	90	11	11	11	66	11
79	550	56	588	11	20	26	422	15
80	168	21	167	11	11	11	110	11
81	249	18	355	11	11	11	252	19
82	70	11	157	11	11	11	134	11
83	19	11	34	11	0	11	24	11
84	25	11	43	0	0	0	35	11
85	11	11	12	0	0	0	11	0
86	17	11	30	0	0	0	23	11
87	54	11	131	0	11	11	107	11
88	11	11	11	11	0	11	11	0
89	18	11	28	0	0	0	24	0
90	26	11	41	0	0	11	36	0
91	44	11	62	0	11	11	39	11
92	112	11	87	11	11	11	56	11
93	176	11	257	11	11	13	177	11
94	103	13	218	11	11	14	124	11
95	213	11	304	11	13	23	203	15

AMERICAN OVERSIGHT

	S	T	U	V	W
47	11	11	11	0	11
48	0	0	0	11	11
49	11	11	11	12	11
50	11	0	11	11	0
51	11	11	11	11	11
52	11	11	11	11	11
53	11	11	11	11	11
54	11	0	12	31	33
55	11	11	11	19	36
56	16	11	11	16	21
57	11	11	11	11	13
58	11	0	0	11	11
59	14	11	11	13	27
60	13	11	11	11	14
61	11	0	11	14	18
62	11	0	11	11	11
63	0	0	11	11	11
64	11	11	11	11	14
65	11	0	11	11	11
66	11	0	11	11	19
67	34	11	11	22	45
68	11	0	0	11	11
69	0	0	11	11	11
70	11	0	11	11	11
71	11	0	11	11	11
72	11	0	11	11	11
73	37	11	11	14	27
74	87	11	20	17	30
75	64	11	11	11	19
76	23	11	17	24	41
77	16	11	11	11	30
78	11	0	0	11	11
79	42	11	11	27	71
80	16	11	11	11	18
81	11	0	12	36	41
82	11	0	11	11	11
83	11	0	11	11	11
84	0	11	11	0	11
85	0	0	0	0	11
86	0	0	11	11	11
87	11	11	11	11	11
88	0	0	0	0	11
89	0	0	0	11	11
90	11	0	11	0	11
91	11	11	0	18	11
92	11	11	11	11	13
93	11	11	11	20	37
94	11	11	11	41	29
95	15	11	11	23	39

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
96		32208	031	Duval	12	FL	6,953	6,645	152	128
97		32209	031	Duval	12	FL	7,059	6,726	186	121
98		32210	031	Duval	12	FL	9,923	9,698	126	183
99		32211	031	Duval	12	FL	4,767	4,647	57	85
100		32212	031	Duval	12	FL	11	11	0	0
101		32216	031	Duval	12	FL	6,167	5,719	57	95
102		32217	031	Duval	12	FL	3,887	3,788	24	54
103		32218	031	Duval	12	FL	8,943	8,645	127	147
104		32219	031	Duval	12	FL	2,324	2,275	37	30
105		32220	031	Duval	12	FL	2,415	2,367	19	54
106		32221	031	Duval	12	FL	4,719	4,613	33	72
107		32222	031	Duval	12	FL	1,859	1,706	12	26
108		32223	031	Duval	12	FL	5,787	5,450	18	56
109		32224	031	Duval	12	FL	5,851	5,737	14	46
110		32225	031	Duval	12	FL	8,665	8,527	51	74
111		32226	031	Duval	12	FL	3,106	2,765	13	48
112		32227	031	Duval	12	FL	53	53	0	11
113		32228	031	Duval	12	FL	11	0	0	0
114		32233	031	Duval	12	FL	4,535	4,307	21	41
115		32234	031	Duval	12	FL	1,411	1,310	11	26
116		32244	031	Duval	12	FL	8,893	8,494	118	165
117		32246	031	Duval	12	FL	6,651	6,555	69	87
118		32250	031	Duval	12	FL	5,257	5,022	23	74
119		32254	031	Duval	12	FL	2,252	2,215	47	45
120		32256	031	Duval	12	FL	6,930	6,757	31	59
121		32257	031	Duval	12	FL	6,836	6,644	38	83
122		32258	031	Duval	12	FL	4,522	4,429	26	41
123		32259	109	Saint Johns	12	FL	6,867	6,581	23	47
124		32266	031	Duval	12	FL	1,264	1,246	11	11
125		32277	031	Duval	12	FL	4,841	4,584	54	53
126		32301	073	Leon	12	FL	3,469	2,890	26	41
127		32303	073	Leon	12	FL	6,070	5,832	26	87
128		32304	073	Leon	12	FL	2,342	2,132	25	51
129		32305	073	Leon	12	FL	3,674	3,246	40	73
130		32306	073	Leon	12	FL	0	0	0	0
131		32307	073	Leon	12	FL	11	11	0	0
132		32308	073	Leon	12	FL	4,931	4,751	17	63
133		32309	073	Leon	12	FL	6,221	6,144	19	65
134		32310	073	Leon	12	FL	2,250	2,210	24	49
135		32311	073	Leon	12	FL	2,934	2,896	18	35
136		32312	073	Leon	12	FL	6,041	5,973	11	74
137		32317	073	Leon	12	FL	2,890	2,413	11	35
138		32320	037	Franklin	12	FL	975	743	11	15
139		32321	077	Liberty	12	FL	938	715	11	19
140		32322	037	Franklin	12	FL	954	541	11	16
141		32324	039	Gadsden	12	FL	1,101	877	11	28
142		32327	129	Wakulla	12	FL	4,542	4,124	12	106
143		32328	037	Franklin	12	FL	907	656	11	11
144		32331	079	Madison	12	FL	1,027	826	11	17

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
96	266	14	359	11	11	31	221	13
97	291	21	395	11	13	23	232	14
98	406	38	500	11	20	25	363	25
99	153	16	247	11	12	12	165	11
100	0	0	0	0	0	0	0	0
101	206	14	282	11	13	13	208	14
102	169	14	162	11	11	19	102	11
103	253	28	421	11	12	25	295	13
104	78	11	111	11	11	11	70	11
105	70	11	141	11	11	11	101	11
106	144	11	234	11	11	17	165	11
107	63	11	105	11	11	11	70	11
108	195	20	225	11	11	18	137	12
109	280	12	191	11	11	17	120	13
110	303	21	314	11	11	22	191	15
111	78	11	137	11	11	11	103	11
112	0	0	11	0	0	0	11	0
113	0	0	0	0	0	0	0	0
114	180	11	158	11	11	11	122	11
115	53	11	85	11	11	11	69	11
116	291	28	450	11	19	34	300	21
117	211	16	302	11	11	19	207	11
118	221	13	206	11	11	11	145	11
119	77	11	153	11	11	11	99	11
120	337	17	254	11	11	16	164	11
121	280	19	286	11	11	21	191	11
122	105	14	157	11	11	11	92	11
123	194	23	201	11	12	11	119	11
124	37	11	41	11	11	11	27	0
125	155	11	187	11	11	11	123	11
126	77	11	136	0	11	17	83	11
127	127	20	279	11	11	22	180	15
128	49	11	117	11	11	11	79	11
129	83	11	210	11	11	13	144	11
130	0	0	0	0	0	0	0	0
131	0	0	11	0	0	0	11	0
132	129	11	195	0	0	19	129	11
133	133	18	215	11	11	23	133	11
134	58	11	131	11	11	11	84	11
135	78	11	114	11	11	11	81	11
136	125	21	220	0	11	19	143	11
137	51	11	95	0	11	11	65	11
138	31	11	71	0	11	11	57	11
139	30	11	83	0	11	11	62	11
140	24	11	60	0	0	11	49	0
141	30	11	68	11	11	11	52	11
142	89	15	255	0	11	18	213	11
143	24	11	59	11	11	11	44	11
144	29	11	54	11	11	11	41	11

AMERICAN OVERSIGHT

	S	T	U	V	W
96	14	11	11	43	61
97	12	11	15	54	72
98	14	11	11	33	61
99	12	11	11	15	37
100	0	0	0	0	0
101	13	11	11	21	29
102	11	11	11	11	25
103	19	11	14	20	42
104	11	11	0	11	21
105	11	0	11	13	11
106	15	11	11	11	23
107	11	0	11	11	16
108	22	11	11	11	30
109	15	11	11	11	21
110	18	11	11	27	28
111	11	0	11	11	12
112	0	0	0	0	0
113	0	0	0	0	0
114	11	0	11	11	15
115	11	0	0	11	11
116	31	11	11	35	59
117	18	11	11	16	37
118	11	11	11	14	32
119	11	11	11	19	16
120	20	11	11	16	28
121	28	11	11	18	32
122	17	11	11	11	20
123	25	11	11	13	21
124	11	0	0	0	11
125	11	11	11	13	19
126	11	0	11	11	21
127	14	11	11	13	43
128	11	11	11	11	23
129	11	11	11	11	33
130	0	0	0	0	0
131	0	0	0	0	0
132	11	11	11	11	34
133	17	11	11	11	32
134	11	11	11	11	20
135	11	11	11	11	13
136	18	11	11	11	30
137	11	11	0	11	16
138	11	11	0	11	14
139	11	0	11	11	11
140	11	0	11	11	11
141	11	11	0	11	11
142	11	0	11	11	21
143	11	0	0	11	13
144	11	0	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
145		32332	039	Gadsden	12	FL	397	153	11	11
146		32333	039	Gadsden	12	FL	2,854	2,550	17	39
147		32334	077	Liberty	12	FL	359	245	11	15
148		32336	065	Jefferson	12	FL	408	351	11	11
149		32340	079	Madison	12	FL	2,353	1,967	22	42
150		32343	039	Gadsden	12	FL	423	266	11	11
151		32344	065	Jefferson	12	FL	2,948	2,444	22	48
152		32346	129	Wakulla	12	FL	576	400	11	12
153		32347	123	Taylor	12	FL	1,696	1,594	11	45
154		32348	123	Taylor	12	FL	2,234	1,929	11	43
155		32350	079	Madison	12	FL	393	301	11	11
156		32351	039	Gadsden	12	FL	3,545	2,818	42	82
157		32352	039	Gadsden	12	FL	1,214	1,204	11	34
158		32355	129	Wakulla	12	FL	102	11	0	0
159		32358	129	Wakulla	12	FL	513	405	0	11
160		32359	123	Taylor	12	FL	698	259	11	11
161		32401	005	Bay	12	FL	5,470	4,725	54	66
162		32403	005	Bay	12	FL	11	11	0	11
163		32404	005	Bay	12	FL	6,758	6,590	49	117
164		32405	005	Bay	12	FL	5,250	4,965	32	100
165		32407	005	Bay	12	FL	2,563	2,165	11	24
166		32408	005	Bay	12	FL	3,560	2,888	11	41
167		32409	005	Bay	12	FL	1,819	1,772	11	35
168		32413	005	Bay	12	FL	3,557	3,363	11	37
169		32420	063	Jackson	12	FL	645	560	11	13
170		32421	013	Calhoun	12	FL	922	792	11	25
171		32423	063	Jackson	12	FL	326	311	11	11
172		32424	013	Calhoun	12	FL	1,337	1,040	11	33
173		32425	059	Holmes	12	FL	2,987	2,662	13	64
174		32426	063	Jackson	12	FL	272	198	11	11
175		32427	133	Washington	12	FL	309	300	11	11
176		32428	133	Washington	12	FL	3,701	3,257	21	73
177		32430	013	Calhoun	12	FL	304	242	0	11
178		32431	063	Jackson	12	FL	1,153	1,016	12	25
179		32433	131	Walton	12	FL	3,323	3,239	16	50
180		32435	131	Walton	12	FL	1,725	1,387	11	22
181		32437	133	Washington	12	FL	134	96	11	11
182		32438	005	Bay	12	FL	865	746	11	23
183		32439	131	Walton	12	FL	2,293	2,112	13	41
184		32440	063	Jackson	12	FL	1,300	1,113	11	19
185		32442	063	Jackson	12	FL	914	753	11	17
186		32443	063	Jackson	12	FL	754	597	11	13
187		32444	005	Bay	12	FL	3,972	3,598	16	42
188		32445	063	Jackson	12	FL	323	192	11	11
189		32446	063	Jackson	12	FL	2,635	2,161	11	36
190		32448	063	Jackson	12	FL	1,917	1,869	13	31
191		32449	013	Calhoun	12	FL	120	119	0	11
192		32455	059	Holmes	12	FL	1,030	931	11	14
193		32456	045	Gulf	12	FL	2,375	2,039	14	26

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
145	11	0	18	0	11	0	11	11
146	46	12	119	0	11	11	84	11
147	15	0	29	0	11	11	26	0
148	11	0	23	0	0	11	16	11
149	82	11	114	0	11	11	77	11
150	11	11	16	0	0	11	11	0
151	65	11	139	11	11	12	99	11
152	22	11	33	0	0	11	27	11
153	49	11	125	0	11	11	104	11
154	65	11	159	11	11	11	126	11
155	11	0	16	11	11	0	11	11
156	94	11	182	11	11	15	127	11
157	41	11	74	0	11	11	51	11
158	11	0	11	0	0	0	11	11
159	11	11	25	0	11	0	20	11
160	22	11	31	0	11	0	30	0
161	177	24	309	0	11	17	216	12
162	0	0	11	0	0	0	11	0
163	249	30	450	11	22	21	350	11
164	203	35	337	11	11	14	256	11
165	90	12	102	0	11	11	71	11
166	114	16	175	11	11	11	132	11
167	53	11	124	0	11	11	101	11
168	97	13	147	0	11	11	113	11
169	26	11	37	0	0	11	30	0
170	35	11	76	11	11	11	65	0
171	23	11	11	0	11	0	11	11
172	60	11	95	0	11	11	82	11
173	114	25	189	11	11	11	146	0
174	11	0	15	0	0	11	13	11
175	16	11	19	0	11	11	14	0
176	131	24	221	11	11	11	158	11
177	11	11	17	0	11	0	16	0
178	47	11	71	11	11	11	56	11
179	105	13	182	11	13	11	145	11
180	57	11	75	11	11	11	64	11
181	11	0	11	0	0	11	11	0
182	15	11	80	0	11	11	65	11
183	100	11	140	0	11	11	112	11
184	43	12	71	0	11	11	49	11
185	38	11	43	0	11	11	32	0
186	51	11	39	0	0	0	27	11
187	144	18	204	11	11	11	143	11
188	15	11	15	0	0	0	14	11
189	113	23	113	0	11	11	87	11
190	78	11	102	0	11	11	70	11
191	11	11	11	0	0	11	11	0
192	44	11	51	11	11	11	40	0
193	78	13	117	11	11	11	90	11

AMERICAN OVERSIGHT

	S	T	U	V	W
145	0	11	0	11	11
146	11	0	11	11	17
147	0	0	0	0	0
148	11	11	0	11	11
149	11	0	11	15	14
150	0	0	11	11	11
151	11	0	11	11	19
152	0	0	0	11	11
153	11	0	0	11	11
154	11	0	11	15	11
155	0	0	0	11	11
156	11	11	11	14	25
157	11	0	0	11	18
158	0	0	0	0	0
159	0	0	0	11	11
160	11	0	0	11	11
161	24	11	11	23	23
162	0	0	0	0	0
163	37	11	11	16	34
164	29	11	11	13	28
165	11	0	11	11	11
166	12	11	11	11	13
167	11	11	0	11	11
168	13	11	11	11	11
169	11	0	0	11	0
170	0	0	0	11	11
171	0	11	11	11	11
172	11	0	11	11	11
173	11	0	11	15	12
174	11	0	0	0	0
175	11	0	0	0	11
176	17	11	11	19	25
177	0	0	0	11	11
178	11	0	11	11	11
179	11	0	11	13	13
180	11	0	0	11	11
181	0	0	0	0	0
182	11	11	0	11	11
183	11	0	11	11	11
184	11	0	0	11	11
185	11	0	11	11	11
186	11	0	11	11	11
187	20	11	11	11	19
188	0	0	0	11	0
189	11	0	0	11	11
190	11	11	11	11	11
191	0	0	0	0	0
192	11	0	11	11	11
193	11	11	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
194		32459	131	Walton	12	FL	3,338	3,062	11	25
195		32460	063	Jackson	12	FL	894	663	11	17
196		32462	133	Washington	12	FL	894	702	11	18
197		32464	059	Holmes	12	FL	928	876	11	12
198		32465	045	Gulf	12	FL	1,494	1,173	11	39
199		32466	005	Bay	12	FL	1,296	1,204	11	27
200		32501	033	Escambia	12	FL	2,812	2,334	51	33
201		32502	033	Escambia	12	FL	912	770	11	11
202		32503	033	Escambia	12	FL	7,477	6,341	53	68
203		32504	033	Escambia	12	FL	4,857	4,739	19	64
204		32505	033	Escambia	12	FL	5,561	5,439	102	103
205		32506	033	Escambia	12	FL	7,233	6,807	60	109
206		32507	033	Escambia	12	FL	6,827	6,528	41	85
207		32508	033	Escambia	12	FL	25	19	0	0
208		32509	033	Escambia	12	FL	0	0	0	0
209		32511	033	Escambia	12	FL	11	11	0	0
210		32512	033	Escambia	12	FL	0	0	0	0
211		32514	033	Escambia	12	FL	8,040	7,728	58	88
212		32526	033	Escambia	12	FL	8,573	8,382	56	110
213		32531	091	Okaloosa	12	FL	1,341	1,223	11	15
214		32533	033	Escambia	12	FL	6,366	5,975	35	86
215		32534	033	Escambia	12	FL	3,520	3,294	30	42
216		32535	033	Escambia	12	FL	1,125	910	11	22
217		32536	091	Okaloosa	12	FL	5,672	4,716	43	70
218		32539	091	Okaloosa	12	FL	4,626	4,488	30	72
219		32541	091	Okaloosa	12	FL	3,727	3,412	13	30
220		32542	091	Okaloosa	12	FL	26	13	0	0
221		32544	091	Okaloosa	12	FL	11	11	0	0
222		32547	091	Okaloosa	12	FL	5,532	5,426	52	84
223		32548	091	Okaloosa	12	FL	4,560	4,198	50	73
224		32550	131	Walton	12	FL	2,545	2,326	11	22
225		32561	113	Santa Rosa	12	FL	2,242	2,043	11	15
226		32563	113	Santa Rosa	12	FL	5,234	5,138	15	54
227		32564	091	Okaloosa	12	FL	696	606	0	12
228		32565	113	Santa Rosa	12	FL	1,375	1,237	11	30
229		32566	113	Santa Rosa	12	FL	6,410	6,180	19	75
230		32567	091	Okaloosa	12	FL	1,070	927	11	11
231		32568	033	Escambia	12	FL	818	774	11	13
232		32569	091	Okaloosa	12	FL	2,028	1,917	11	23
233		32570	113	Santa Rosa	12	FL	7,016	6,556	33	119
234		32571	113	Santa Rosa	12	FL	6,555	6,464	33	88
235		32577	033	Escambia	12	FL	1,210	1,102	11	20
236		32578	091	Okaloosa	12	FL	6,915	6,600	25	91
237		32579	091	Okaloosa	12	FL	2,800	2,601	11	28
238		32580	091	Okaloosa	12	FL	808	753	11	16
239		32583	113	Santa Rosa	12	FL	5,295	5,056	25	101
240		32591	033	Escambia	12	FL	137	11	11	0
241		32601	001	Alachua	12	FL	1,676	1,439	23	24
242		32603	001	Alachua	12	FL	276	120	11	11

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
194	82	11	95	0	0	11	69	11
195	40	11	45	0	11	11	40	0
196	30	11	45	0	11	11	32	0
197	40	11	41	0	11	11	32	11
198	61	11	109	11	11	11	88	11
199	36	11	84	11	11	11	66	11
200	113	11	125	11	0	11	71	11
201	27	0	26	0	0	11	16	11
202	297	28	252	11	11	11	161	11
203	184	25	183	0	11	11	121	12
204	200	18	273	11	11	11	187	11
205	295	24	317	11	11	13	205	12
206	241	19	247	11	11	11	175	11
207	0	0	11	0	11	0	0	0
208	0	0	0	0	0	0	0	0
209	0	0	0	0	0	0	0	0
210	0	0	0	0	0	0	0	0
211	327	21	311	0	11	21	185	13
212	314	24	338	11	15	17	241	11
213	43	11	72	0	11	11	54	11
214	222	30	251	11	11	13	160	11
215	119	27	142	0	11	11	101	11
216	49	0	50	0	11	11	40	11
217	162	13	238	11	17	11	179	11
218	196	20	279	11	13	11	209	11
219	119	12	115	11	11	11	91	11
220	11	0	11	0	0	0	11	0
221	0	0	11	0	0	0	0	11
222	218	18	274	11	11	11	203	11
223	186	20	234	11	15	11	167	11
224	70	11	67	11	11	11	53	11
225	104	11	63	0	0	11	37	11
226	155	21	180	11	11	11	121	11
227	24	11	37	0	11	11	29	11
228	58	11	68	11	0	11	47	11
229	180	15	258	11	11	11	181	11
230	44	11	46	11	11	11	34	11
231	30	11	26	0	0	0	19	11
232	54	14	76	11	11	11	59	11
233	250	27	383	11	11	26	262	11
234	213	17	293	11	11	27	197	11
235	32	11	51	0	11	11	33	11
236	254	26	287	11	11	15	204	11
237	130	11	111	0	11	11	80	11
238	38	11	56	0	11	11	40	11
239	149	14	244	11	11	11	187	11
240	11	11	11	0	0	0	0	0
241	48	11	81	11	11	11	51	11
242	11	11	11	0	11	0	11	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
194	11	11	11	11	11
195	0	0	11	0	11
196	11	11	11	11	11
197	11	0	0	11	11
198	11	0	11	11	11
199	11	0	11	11	12
200	11	11	11	15	28
201	11	0	11	11	11
202	11	11	11	24	45
203	11	11	11	11	30
204	11	11	11	21	44
205	11	11	11	37	46
206	11	11	11	11	34
207	0	0	0	0	0
208	0	0	0	0	0
209	0	0	0	0	0
210	0	0	0	0	0
211	16	11	11	28	57
212	14	11	11	30	35
213	11	0	11	11	11
214	20	11	11	23	26
215	11	0	11	11	24
216	0	0	0	11	11
217	21	0	11	14	14
218	21	0	11	21	22
219	11	11	0	11	11
220	0	0	0	0	0
221	11	0	0	0	0
222	16	11	11	11	18
223	28	0	11	17	12
224	11	0	11	11	11
225	11	0	11	11	18
226	11	11	11	11	31
227	11	0	0	0	11
228	0	0	0	11	11
229	20	0	11	14	30
230	11	0	0	11	11
231	11	0	11	11	11
232	11	0	11	11	11
233	14	11	11	36	51
234	19	11	11	25	32
235	11	11	0	11	11
236	29	11	11	13	14
237	11	0	11	11	11
238	11	0	11	11	11
239	11	11	11	20	22
240	0	0	0	11	0
241	11	11	11	17	14
242	0	0	0	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
243		32605	001	Alachua	12	FL	4,756	4,413	23	38
244		32606	001	Alachua	12	FL	4,403	4,265	18	39
245		32607	001	Alachua	12	FL	2,899	2,800	25	24
246		32608	001	Alachua	12	FL	5,545	5,109	33	36
247		32609	001	Alachua	12	FL	3,123	3,023	27	29
248		32610	001	Alachua	12	FL	0	0	0	0
249		32611	001	Alachua	12	FL	11	11	0	0
250		32615	001	Alachua	12	FL	3,510	2,713	21	43
251		32617	083	Marion	12	FL	1,033	759	11	19
252		32618	001	Alachua	12	FL	1,490	1,237	11	16
253		32619	041	Gilchrist	12	FL	1,195	972	11	30
254		32621	075	Levy	12	FL	1,265	827	11	20
255		32622	007	Bradford	12	FL	328	266	11	11
256		32625	075	Levy	12	FL	537	243	0	11
257		32626	075	Levy	12	FL	2,487	1,990	11	41
258		32628	029	Dixie	12	FL	861	422	11	23
259		32631	001	Alachua	12	FL	154	44	0	0
260		32640	001	Alachua	12	FL	2,787	2,161	11	30
261		32641	001	Alachua	12	FL	2,402	2,345	44	37
262		32643	001	Alachua	12	FL	2,697	2,123	11	38
263		32648	029	Dixie	12	FL	101	45	0	11
264		32653	001	Alachua	12	FL	2,931	2,892	13	31
265		32656	019	Clay	12	FL	3,368	2,854	14	57
266		32664	083	Marion	12	FL	231	11	0	11
267		32666	107	Putnam	12	FL	1,691	1,263	11	23
268		32667	001	Alachua	12	FL	998	789	11	14
269		32668	075	Levy	12	FL	1,509	1,404	11	25
270		32669	001	Alachua	12	FL	2,780	2,385	11	28
271		32680	029	Dixie	12	FL	2,635	2,270	11	68
272		32683	075	Levy	12	FL	46	11	11	0
273		32686	083	Marion	12	FL	1,440	803	16	18
274		32692	029	Dixie	12	FL	132	11	11	11
275		32693	041	Gilchrist	12	FL	2,492	2,217	12	38
276		32694	001	Alachua	12	FL	456	240	11	12
277		32696	075	Levy	12	FL	3,034	2,717	25	33
278		32697	125	Union	12	FL	80	0	0	11
279		32701	117	Seminole	12	FL	4,257	4,146	34	37
280		32702	069	Lake	12	FL	1,128	815	11	21
281		32703	095	Orange	12	FL	7,168	6,977	70	116
282		32707	117	Seminole	12	FL	6,533	6,423	23	80
283		32708	117	Seminole	12	FL	8,426	8,041	40	83
284		32709	095	Orange	12	FL	511	364	11	11
285		32712	095	Orange	12	FL	8,119	7,389	55	85
286		32713	127	Volusia	12	FL	5,736	5,459	21	79
287		32714	117	Seminole	12	FL	5,643	5,200	43	53
288		32720	127	Volusia	12	FL	7,846	6,958	30	132
289		32724	127	Volusia	12	FL	9,820	9,604	37	144
290		32725	127	Volusia	12	FL	10,092	9,550	47	162
291		32726	069	Lake	12	FL	5,138	4,683	29	82

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
243	147	11	150	11	11	11	99	11
244	252	13	170	11	11	11	113	11
245	106	11	118	11	11	11	77	11
246	158	14	181	11	11	11	107	18
247	91	11	150	0	11	11	84	29
248	0	0	0	0	0	0	0	0
249	0	0	0	0	0	0	0	0
250	96	11	151	11	11	11	113	11
251	29	11	47	0	11	11	36	11
252	39	11	63	0	11	11	46	11
253	44	11	75	11	11	11	63	11
254	50	11	70	11	11	11	57	11
255	14	11	23	0	11	0	15	11
256	11	0	25	0	11	11	19	0
257	106	11	144	11	11	11	114	11
258	48	11	72	0	11	11	56	11
259	11	11	11	0	0	0	11	0
260	75	11	141	11	11	11	104	11
261	89	11	133	11	11	11	91	11
262	99	11	126	11	11	11	97	11
263	11	0	11	0	0	0	11	0
264	98	11	117	11	11	11	83	11
265	113	11	192	11	11	11	157	11
266	11	11	13	0	11	0	11	11
267	72	11	76	11	11	0	57	11
268	24	11	41	0	0	11	29	11
269	44	11	78	11	11	11	68	11
270	107	12	124	11	11	11	84	11
271	96	11	207	11	11	11	176	11
272	11	0	11	0	0	0	11	0
273	36	11	74	0	11	11	58	11
274	11	0	11	0	0	0	11	0
275	82	11	132	11	11	11	109	0
276	19	11	26	11	0	0	24	0
277	123	11	170	11	11	11	125	12
278	11	0	11	0	0	0	11	0
279	154	20	170	11	11	11	114	11
280	38	11	81	0	11	11	68	11
281	221	35	351	11	11	16	252	11
282	186	24	314	11	11	15	229	14
283	266	30	360	11	11	20	253	11
284	14	11	33	0	11	0	26	11
285	203	42	354	11	11	23	234	16
286	177	34	283	11	11	38	207	11
287	162	12	259	0	11	19	179	11
288	225	29	400	11	13	56	274	20
289	319	37	489	11	11	65	340	15
290	289	73	549	11	12	75	380	19
291	163	21	319	11	11	22	250	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
243	12	11	11	11	17
244	11	11	11	18	18
245	11	0	11	11	15
246	12	11	11	23	16
247	11	11	11	18	15
248	0	0	0	0	0
249	0	0	0	0	0
250	11	11	11	11	11
251	11	0	11	11	11
252	11	11	11	11	11
253	11	0	11	11	11
254	11	11	11	11	11
255	11	11	0	11	11
256	11	0	0	11	11
257	11	0	11	11	11
258	11	0	11	11	11
259	0	0	0	11	0
260	11	11	11	11	12
261	11	0	11	15	14
262	11	11	11	11	11
263	0	0	0	0	11
264	11	11	11	11	11
265	11	11	11	12	12
266	0	11	0	11	11
267	11	11	11	11	12
268	11	11	11	11	11
269	11	11	0	11	11
270	11	0	11	15	11
271	11	11	11	12	11
272	0	0	0	0	0
273	0	0	11	11	11
274	0	0	11	11	0
275	11	11	11	11	11
276	0	0	0	11	0
277	11	11	11	13	20
278	0	0	0	0	0
279	11	11	11	11	32
280	0	0	0	11	11
281	15	11	11	17	49
282	11	11	11	20	34
283	26	11	11	16	48
284	0	0	11	11	11
285	20	11	11	24	51
286	15	11	11	11	23
287	19	11	11	14	27
288	14	11	11	24	31
289	17	11	11	25	36
290	19	11	11	18	59
291	11	11	11	22	17

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
292		32730	117	Seminole	12	FL	1,211	1,100	11	18
293		32732	117	Seminole	12	FL	1,099	811	11	23
294		32735	069	Lake	12	FL	1,530	1,399	11	15
295		32736	069	Lake	12	FL	2,232	2,188	11	32
296		32738	127	Volusia	12	FL	8,106	7,800	52	144
297		32744	127	Volusia	12	FL	1,047	867	11	19
298		32746	117	Seminole	12	FL	7,274	6,852	32	60
299		32750	117	Seminole	12	FL	4,722	4,603	14	64
300		32751	095	Orange	12	FL	3,918	3,606	24	27
301		32754	009	Brevard	12	FL	3,011	2,743	11	45
302		32756	069	Lake	12	FL	366	11	11	11
303		32757	069	Lake	12	FL	7,481	7,213	29	85
304		32759	127	Volusia	12	FL	977	816	11	12
305		32763	127	Volusia	12	FL	5,487	5,170	18	117
306		32764	127	Volusia	12	FL	839	685	11	15
307		32765	117	Seminole	12	FL	8,384	7,866	30	80
308		32766	117	Seminole	12	FL	1,766	1,744	11	14
309		32767	069	Lake	12	FL	667	479	11	13
310		32771	117	Seminole	12	FL	8,562	7,812	100	125
311		32773	117	Seminole	12	FL	4,205	4,125	48	74
312		32775	009	Brevard	12	FL	113	0	11	11
313		32776	069	Lake	12	FL	2,275	2,005	11	32
314		32778	069	Lake	12	FL	7,227	6,827	33	104
315		32779	117	Seminole	12	FL	6,180	5,790	14	47
316		32780	009	Brevard	12	FL	10,359	9,886	42	145
317		32784	069	Lake	12	FL	2,523	2,017	14	54
318		32789	095	Orange	12	FL	5,149	4,684	13	40
319		32792	095	Orange	12	FL	7,691	7,137	40	75
320		32796	009	Brevard	12	FL	5,257	5,150	35	67
321		32798	095	Orange	12	FL	1,538	1,212	11	25
322		32801	095	Orange	12	FL	2,813	2,416	20	36
323		32803	095	Orange	12	FL	2,711	2,570	11	22
324		32804	095	Orange	12	FL	3,015	2,809	11	28
325		32805	095	Orange	12	FL	4,534	4,019	116	60
326		32806	095	Orange	12	FL	4,193	3,834	22	48
327		32807	095	Orange	12	FL	5,160	4,904	50	54
328		32808	095	Orange	12	FL	6,846	6,500	136	84
329		32809	095	Orange	12	FL	3,871	3,383	44	42
330		32810	095	Orange	12	FL	5,105	4,817	64	55
331		32811	095	Orange	12	FL	4,466	4,078	74	46
332		32812	095	Orange	12	FL	5,190	5,090	28	72
333		32814	095	Orange	12	FL	848	776	0	11
334		32815	009	Brevard	12	FL	0	0	0	0
335		32816	095	Orange	12	FL	11	11	0	0
336		32817	095	Orange	12	FL	4,560	4,291	25	32
337		32818	095	Orange	12	FL	6,757	6,207	105	58
338		32819	095	Orange	12	FL	4,379	4,305	17	26
339		32820	095	Orange	12	FL	1,287	1,257	11	11
340		32821	095	Orange	12	FL	1,927	1,889	11	15

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
292	33	11	61	0	11	11	45	11
293	24	11	55	0	11	11	41	0
294	56	11	73	0	11	11	57	11
295	54	11	106	11	0	11	83	11
296	219	44	486	11	15	53	336	20
297	38	11	59	0	11	11	44	11
298	274	30	280	11	11	25	188	12
299	155	24	215	11	11	11	146	11
300	126	11	135	11	11	11	77	11
301	63	24	142	0	11	11	114	11
302	12	11	11	0	0	11	11	0
303	196	38	337	11	11	19	257	11
304	25	11	45	0	11	11	37	0
305	186	26	336	11	11	33	248	11
306	20	11	46	0	11	11	32	11
307	219	24	327	11	14	12	227	11
308	50	13	77	0	11	11	53	11
309	19	11	44	0	11	0	35	0
310	262	47	399	11	12	30	277	16
311	115	14	255	11	11	23	193	11
312	11	0	11	11	11	0	11	0
313	48	11	113	0	11	11	85	11
314	241	34	412	0	11	35	333	11
315	203	24	227	11	11	13	148	12
316	339	73	548	11	23	20	426	19
317	86	11	155	11	11	11	133	11
318	141	19	163	0	11	11	97	11
319	277	31	303	11	13	12	198	14
320	177	48	291	11	11	11	218	11
321	47	11	80	0	11	11	64	11
322	101	11	139	11	11	11	100	0
323	72	11	94	11	11	11	55	11
324	84	16	99	0	11	11	58	12
325	96	19	195	11	11	11	125	11
326	129	13	156	11	11	11	111	11
327	159	32	218	11	13	11	158	11
328	166	34	295	11	11	17	162	13
329	88	16	140	11	11	11	105	0
330	173	25	234	11	11	11	140	21
331	107	15	176	11	11	11	99	11
332	138	26	199	0	11	11	145	11
333	23	11	17	11	11	0	13	0
334	0	0	0	0	0	0	0	0
335	0	0	0	0	0	0	0	0
336	125	28	173	11	11	11	100	11
337	148	20	252	11	11	16	144	14
338	101	11	129	11	11	11	73	11
339	20	11	57	0	11	11	34	11
340	49	11	69	0	11	11	48	11

AMERICAN OVERSIGHT

	S	T	U	V	W
292	11	0	11	11	11
293	11	0	0	11	11
294	11	11	11	11	11
295	11	0	11	11	11
296	24	11	11	30	50
297	11	11	11	11	11
298	17	11	11	11	32
299	18	11	11	19	28
300	11	11	11	11	27
301	11	11	0	11	11
302	0	0	0	11	0
303	19	11	11	15	26
304	11	0	11	11	11
305	21	11	11	25	22
306	11	0	11	11	11
307	29	11	11	16	49
308	11	11	11	11	11
309	11	0	11	11	11
310	19	11	11	21	64
311	11	11	11	11	25
312	0	0	0	0	0
313	11	0	11	11	11
314	17	11	11	12	18
315	11	11	11	11	36
316	23	11	11	20	51
317	11	0	11	11	11
318	11	11	11	15	28
319	22	0	11	17	49
320	11	11	11	21	26
321	11	0	0	11	11
322	11	0	0	13	21
323	11	11	11	11	18
324	11	0	11	11	14
325	11	11	11	24	25
326	11	11	11	11	22
327	11	11	11	15	30
328	11	11	19	40	49
329	11	0	0	11	15
330	12	11	11	15	46
331	11	11	11	25	34
332	11	11	11	11	22
333	11	0	0	0	11
334	0	0	0	0	0
335	0	0	0	0	0
336	15	11	11	11	32
337	19	11	11	24	32
338	11	11	11	16	23
339	11	0	11	11	11
340	11	0	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
341		32822	095	Orange	12	FL	9,394	8,971	80	100
342		32824	095	Orange	12	FL	5,686	5,607	46	39
343		32825	095	Orange	12	FL	8,012	7,860	62	72
344		32826	095	Orange	12	FL	2,877	2,821	18	40
345		32827	095	Orange	12	FL	1,798	1,667	11	11
346		32828	095	Orange	12	FL	6,718	6,425	45	40
347		32829	095	Orange	12	FL	2,252	2,218	19	16
348		32830	095	Orange	12	FL	11	0	11	0
349		32831	095	Orange	12	FL	11	11	0	0
350		32832	095	Orange	12	FL	2,074	2,039	11	11
351		32833	095	Orange	12	FL	1,562	1,538	11	11
352		32835	095	Orange	12	FL	3,966	3,885	34	35
353		32836	095	Orange	12	FL	2,676	2,641	11	15
354		32837	095	Orange	12	FL	6,425	6,029	39	38
355		32839	095	Orange	12	FL	4,859	4,760	68	59
356		32899	009	Brevard	12	FL	11	11	0	0
357		32901	009	Brevard	12	FL	7,091	6,407	50	108
358		32903	009	Brevard	12	FL	3,425	3,291	11	36
359		32904	009	Brevard	12	FL	7,747	7,416	23	115
360		32905	009	Brevard	12	FL	6,449	5,887	43	113
361		32907	009	Brevard	12	FL	9,638	9,260	64	152
362		32908	009	Brevard	12	FL	2,247	2,207	16	35
363		32909	009	Brevard	12	FL	7,024	6,908	44	94
364		32920	009	Brevard	12	FL	3,140	2,942	11	42
365		32922	009	Brevard	12	FL	3,417	3,021	41	40
366		32925	009	Brevard	12	FL	155	123	0	11
367		32926	009	Brevard	12	FL	5,448	5,365	25	83
368		32927	009	Brevard	12	FL	5,009	4,785	33	67
369		32931	009	Brevard	12	FL	4,412	4,209	11	45
370		32934	009	Brevard	12	FL	4,484	4,403	16	64
371		32935	009	Brevard	12	FL	8,908	8,524	44	171
372		32937	009	Brevard	12	FL	6,495	6,300	20	78
373		32940	009	Brevard	12	FL	12,070	11,918	24	111
374		32948	061	Indian River	12	FL	784	596	13	11
375		32949	009	Brevard	12	FL	772	633	11	11
376		32950	009	Brevard	12	FL	1,248	1,113	11	14
377		32951	009	Brevard	12	FL	3,716	3,581	11	30
378		32952	009	Brevard	12	FL	5,178	5,043	11	62
379		32953	009	Brevard	12	FL	6,033	5,686	22	100
380		32955	009	Brevard	12	FL	8,988	8,645	48	115
381		32958	061	Indian River	12	FL	10,331	9,715	37	86
382		32960	061	Indian River	12	FL	6,067	5,223	40	45
383		32962	061	Indian River	12	FL	6,942	6,637	30	38
384		32963	061	Indian River	12	FL	7,327	7,227	13	28
385		32966	061	Indian River	12	FL	8,399	8,065	33	66
386		32967	061	Indian River	12	FL	7,159	6,872	53	37
387		32968	061	Indian River	12	FL	3,950	3,898	13	29
388		32976	009	Brevard	12	FL	4,852	4,753	14	84
389		33001	087	Monroe	12	FL	119	11	0	0

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
341	242	50	342	11	11	16	220	16
342	125	32	187	11	11	11	107	11
343	219	36	317	11	13	14	199	16
344	87	15	141	0	11	11	100	11
345	52	11	44	0	11	11	26	11
346	196	23	237	11	12	11	141	12
347	56	11	80	0	0	11	45	11
348	0	0	0	0	0	0	0	0
349	0	0	0	0	0	0	0	0
350	57	13	54	0	11	11	27	11
351	34	11	50	0	11	0	35	11
352	86	11	120	11	11	11	77	11
353	59	11	67	11	11	11	41	11
354	154	27	198	11	11	11	119	11
355	103	19	179	11	11	11	118	11
356	0	0	0	0	0	0	0	0
357	293	36	347	11	11	11	259	11
358	90	16	110	0	11	11	81	11
359	225	45	355	11	14	16	275	11
360	205	38	295	0	16	13	216	11
361	235	62	453	11	32	21	333	11
362	52	11	96	11	11	11	67	0
363	173	38	268	0	13	11	211	11
364	76	12	114	11	11	11	86	11
365	84	19	181	11	11	13	123	11
366	11	0	11	0	0	11	11	0
367	136	28	266	11	11	11	213	11
368	156	34	268	11	11	11	209	11
369	135	33	147	11	11	11	121	11
370	108	27	206	11	11	11	161	11
371	315	52	446	11	16	16	367	11
372	178	24	257	11	20	11	187	11
373	370	57	397	11	20	20	295	12
374	18	11	34	0	11	0	27	0
375	17	11	24	0	11	11	18	0
376	32	11	47	11	11	11	28	11
377	97	19	92	0	11	11	68	11
378	181	27	199	11	11	11	159	11
379	211	31	298	11	11	11	234	11
380	267	44	407	11	11	17	307	12
381	366	18	342	11	11	11	262	11
382	296	11	210	0	11	11	142	11
383	268	13	209	11	11	11	146	11
384	290	13	136	11	11	11	94	11
385	445	12	300	11	11	15	224	12
386	322	18	211	11	11	11	137	12
387	130	11	127	11	11	11	92	11
388	168	29	211	11	11	11	179	11
389	11	0	11	0	0	0	0	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
341	11	11	12	26	65
342	11	11	11	13	48
343	16	11	11	25	52
344	11	11	11	14	11
345	11	11	11	11	11
346	21	11	11	17	40
347	11	11	11	11	18
348	0	0	0	0	0
349	0	0	0	0	0
350	11	11	11	11	15
351	11	11	11	11	11
352	11	11	11	12	21
353	11	0	11	11	11
354	11	11	11	11	37
355	11	11	11	23	33
356	0	0	0	0	0
357	24	11	11	25	30
358	11	11	0	11	11
359	21	11	11	18	17
360	20	11	11	18	28
361	34	11	11	17	34
362	11	11	11	11	11
363	20	11	11	11	19
364	11	0	11	11	13
365	15	11	11	11	16
366	0	0	0	0	0
367	13	11	11	12	21
368	11	11	11	19	24
369	11	11	0	11	11
370	13	0	11	11	17
371	23	11	11	16	22
372	17	11	11	12	18
373	33	11	11	16	25
374	11	0	0	11	11
375	11	0	0	11	11
376	11	0	0	11	11
377	11	11	11	0	11
378	11	0	11	11	16
379	13	0	11	11	31
380	19	11	11	20	32
381	17	11	11	11	34
382	11	11	11	11	42
383	15	11	11	11	27
384	11	11	11	0	21
385	15	11	11	14	18
386	11	11	11	11	34
387	11	11	11	11	11
388	11	11	11	11	11
389	0	0	11	0	0

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
390		33004	011	Broward	12	FL	3,051	2,791	32	35
391		33009	011	Broward	12	FL	8,678	8,271	50	77
392		33010	086	Miami-Dade	12	FL	10,181	9,761	59	137
393		33012	086	Miami-Dade	12	FL	17,237	16,663	76	229
394		33013	086	Miami-Dade	12	FL	7,828	7,602	26	105
395		33014	086	Miami-Dade	12	FL	7,453	7,276	36	90
396		33015	086	Miami-Dade	12	FL	8,415	8,050	50	93
397		33016	086	Miami-Dade	12	FL	8,305	8,112	42	117
398		33018	086	Miami-Dade	12	FL	8,283	8,190	47	85
399		33019	011	Broward	12	FL	3,686	3,651	11	33
400		33020	011	Broward	12	FL	6,469	6,057	58	68
401		33021	011	Broward	12	FL	9,136	8,845	59	120
402		33023	011	Broward	12	FL	8,855	8,628	141	77
403		33024	011	Broward	12	FL	10,223	9,874	86	123
404		33025	011	Broward	12	FL	7,573	7,366	91	69
405		33026	011	Broward	12	FL	5,588	5,446	23	69
406		33027	011	Broward	12	FL	12,194	11,788	89	137
407		33028	011	Broward	12	FL	3,015	2,983	23	44
408		33029	011	Broward	12	FL	5,074	4,993	16	47
409		33030	086	Miami-Dade	12	FL	4,132	3,759	54	35
410		33031	086	Miami-Dade	12	FL	1,224	1,211	0	14
411		33032	086	Miami-Dade	12	FL	5,533	5,305	76	44
412		33033	086	Miami-Dade	12	FL	7,065	6,995	70	82
413		33034	086	Miami-Dade	12	FL	2,690	2,423	46	25
414		33035	086	Miami-Dade	12	FL	1,544	1,519	23	12
415		33036	087	Monroe	12	FL	928	696	11	11
416		33037	087	Monroe	12	FL	3,135	2,704	11	13
417		33039	086	Miami-Dade	12	FL	11	11	0	0
418		33040	087	Monroe	12	FL	5,774	5,082	23	34
419		33042	087	Monroe	12	FL	1,516	1,379	0	11
420		33043	087	Monroe	12	FL	1,022	827	11	11
421		33050	087	Monroe	12	FL	2,015	1,750	11	11
422		33051	087	Monroe	12	FL	313	11	0	11
423		33054	086	Miami-Dade	12	FL	4,939	4,717	92	48
424		33055	086	Miami-Dade	12	FL	8,450	8,184	99	115
425		33056	086	Miami-Dade	12	FL	5,993	5,937	139	52
426		33060	011	Broward	12	FL	5,717	5,330	65	56
427		33062	011	Broward	12	FL	7,485	7,384	22	50
428		33063	011	Broward	12	FL	11,143	10,817	77	115
429		33064	011	Broward	12	FL	8,293	7,979	68	78
430		33065	011	Broward	12	FL	6,348	6,265	33	62
431		33066	011	Broward	12	FL	5,652	5,469	26	56
432		33067	011	Broward	12	FL	3,401	3,212	11	27
433		33068	011	Broward	12	FL	5,236	5,164	63	46
434		33069	011	Broward	12	FL	5,416	5,298	45	45
435		33070	087	Monroe	12	FL	1,191	980	11	11
436		33071	011	Broward	12	FL	5,242	5,011	35	41
437		33073	011	Broward	12	FL	3,138	3,045	11	26
438		33076	011	Broward	12	FL	4,229	4,177	18	36

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
390	82	17	133	0	11	11	83	11
391	248	29	268	11	11	14	156	22
392	424	67	440	11	11	26	234	23
393	634	120	707	11	13	76	380	46
394	250	59	336	11	11	29	178	19
395	235	53	295	11	11	32	163	11
396	196	47	319	11	11	31	174	17
397	247	47	355	11	11	36	202	21
398	205	45	326	11	11	33	181	18
399	119	14	107	0	11	11	63	11
400	283	13	237	11	11	14	139	16
401	267	43	361	11	11	12	218	17
402	233	31	318	0	11	14	179	24
403	317	27	414	11	11	20	244	14
404	183	29	222	11	11	13	121	11
405	141	20	202	11	11	11	124	17
406	403	63	453	11	11	33	258	21
407	87	15	108	0	11	11	73	11
408	130	26	178	11	11	11	93	11
409	140	27	155	0	11	19	87	11
410	37	11	43	0	11	11	25	11
411	162	23	210	11	11	23	100	12
412	225	37	278	0	11	25	165	12
413	81	11	94	0	0	11	55	11
414	41	11	43	11	0	11	22	11
415	34	11	25	0	0	0	21	0
416	75	12	69	11	11	11	44	11
417	0	0	0	0	0	0	0	0
418	170	11	138	11	11	11	87	11
419	34	0	33	0	11	11	23	11
420	23	11	25	11	0	0	15	11
421	36	11	42	0	11	11	30	11
422	11	11	11	0	0	0	11	11
423	126	21	201	11	11	15	126	11
424	211	50	388	11	11	39	216	18
425	134	44	230	11	11	26	117	16
426	222	30	200	11	11	11	125	11
427	279	26	207	11	11	11	143	11
428	310	50	393	11	11	12	246	15
429	230	18	276	11	11	11	177	19
430	195	18	197	11	11	11	130	11
431	244	30	200	11	11	11	132	11
432	84	11	94	11	11	11	47	11
433	128	11	152	11	11	11	86	11
434	183	20	185	11	11	11	112	11
435	35	11	24	0	11	11	12	11
436	140	17	146	11	11	11	85	11
437	90	12	113	11	11	11	65	11
438	159	13	107	11	11	11	71	11

AMERICAN OVERSIGHT

	S	T	U	V	W
390	11	11	11	11	43
391	11	11	11	11	60
392	11	11	11	15	166
393	12	16	11	22	237
394	11	11	11	11	117
395	11	11	11	11	97
396	11	11	11	11	103
397	11	11	0	14	110
398	11	11	0	11	100
399	11	0	11	11	21
400	11	11	11	11	67
401	15	11	11	12	107
402	11	11	11	20	102
403	12	11	11	20	125
404	11	11	11	11	78
405	11	11	11	11	54
406	12	11	11	23	145
407	11	11	11	11	31
408	11	11	11	11	54
409	11	0	0	16	40
410	11	11	0	0	12
411	11	11	11	11	69
412	11	11	11	19	64
413	11	11	0	11	22
414	11	11	0	11	15
415	0	0	0	0	11
416	11	11	11	0	11
417	0	0	0	0	0
418	12	11	11	11	30
419	11	11	11	11	11
420	11	0	0	11	11
421	0	0	0	0	11
422	0	0	0	0	0
423	11	11	11	14	46
424	11	11	11	17	115
425	11	11	0	11	75
426	11	11	11	11	38
427	18	11	11	11	32
428	12	11	11	12	99
429	12	11	11	12	50
430	13	11	11	11	43
431	11	11	11	11	34
432	11	11	11	11	22
433	11	11	11	11	51
434	12	11	11	11	36
435	0	0	0	0	11
436	12	0	11	11	34
437	11	11	11	11	21
438	11	11	11	11	21

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
439		33109	086	Miami-Dade	12	FL	189	189	11	0
440		33122	086	Miami-Dade	12	FL	1,206	82	11	11
441		33125	086	Miami-Dade	12	FL	10,294	10,162	52	130
442		33126	086	Miami-Dade	12	FL	9,098	8,874	43	120
443		33127	086	Miami-Dade	12	FL	4,524	4,450	86	48
444		33128	086	Miami-Dade	12	FL	1,505	1,402	12	14
445		33129	086	Miami-Dade	12	FL	2,403	2,378	11	20
446		33130	086	Miami-Dade	12	FL	4,070	3,980	33	42
447		33131	086	Miami-Dade	12	FL	1,483	1,426	11	11
448		33132	086	Miami-Dade	12	FL	780	772	11	11
449		33133	086	Miami-Dade	12	FL	6,097	5,871	31	54
450		33134	086	Miami-Dade	12	FL	8,173	7,611	29	84
451		33135	086	Miami-Dade	12	FL	7,271	6,922	41	94
452		33136	086	Miami-Dade	12	FL	2,411	1,989	51	21
453		33137	086	Miami-Dade	12	FL	2,204	1,957	24	13
454		33138	086	Miami-Dade	12	FL	4,668	4,478	45	32
455		33139	086	Miami-Dade	12	FL	5,362	5,036	11	32
456		33140	086	Miami-Dade	12	FL	3,644	3,515	11	26
457		33141	086	Miami-Dade	12	FL	5,166	4,896	16	48
458		33142	086	Miami-Dade	12	FL	9,805	9,335	133	99
459		33143	086	Miami-Dade	12	FL	5,393	5,196	23	48
460		33144	086	Miami-Dade	12	FL	6,257	5,875	35	89
461		33145	086	Miami-Dade	12	FL	5,964	5,682	34	73
462		33146	086	Miami-Dade	12	FL	1,881	1,846	11	17
463		33147	086	Miami-Dade	12	FL	8,110	7,966	131	96
464		33149	086	Miami-Dade	12	FL	1,957	1,904	11	11
465		33150	086	Miami-Dade	12	FL	5,015	4,643	102	38
466		33154	086	Miami-Dade	12	FL	2,636	2,531	11	25
467		33155	086	Miami-Dade	12	FL	9,839	9,555	41	130
468		33156	086	Miami-Dade	12	FL	5,455	5,008	15	46
469		33157	086	Miami-Dade	12	FL	11,721	11,162	108	91
470		33158	086	Miami-Dade	12	FL	1,154	1,145	11	11
471		33160	086	Miami-Dade	12	FL	8,657	8,416	30	67
472		33161	086	Miami-Dade	12	FL	7,585	6,909	94	36
473		33162	086	Miami-Dade	12	FL	6,696	6,477	102	43
474		33165	086	Miami-Dade	12	FL	13,195	13,059	63	193
475		33166	086	Miami-Dade	12	FL	4,420	3,837	19	34
476		33167	086	Miami-Dade	12	FL	3,717	3,668	54	35
477		33168	086	Miami-Dade	12	FL	4,767	4,434	65	23
478		33169	086	Miami-Dade	12	FL	6,379	6,058	122	51
479		33170	086	Miami-Dade	12	FL	2,084	1,986	34	14
480		33172	086	Miami-Dade	12	FL	6,746	6,662	39	68
481		33173	086	Miami-Dade	12	FL	6,991	6,895	28	86
482		33174	086	Miami-Dade	12	FL	6,983	6,905	33	105
483		33175	086	Miami-Dade	12	FL	12,210	11,833	47	130
484		33176	086	Miami-Dade	12	FL	9,984	9,616	61	86
485		33177	086	Miami-Dade	12	FL	8,622	8,405	67	88
486		33178	086	Miami-Dade	12	FL	3,447	3,427	11	22
487		33179	086	Miami-Dade	12	FL	7,089	6,876	61	55

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
439	11	0	11	0	0	0	0	0
440	12	11	27	0	0	11	17	11
441	411	51	449	11	11	38	235	21
442	307	57	403	0	11	40	210	14
443	143	17	146	11	11	11	84	11
444	69	11	65	0	11	11	37	11
445	52	19	71	0	0	11	37	11
446	129	17	134	11	11	12	76	11
447	29	11	32	0	0	11	19	11
448	13	11	24	0	11	11	11	11
449	180	26	182	11	11	11	107	11
450	297	72	311	11	11	22	156	12
451	268	23	277	11	11	20	157	14
452	57	11	89	11	0	11	50	11
453	55	11	57	11	11	11	27	11
454	116	15	131	0	11	11	75	11
455	177	13	146	11	11	11	60	11
456	128	11	102	11	11	11	54	11
457	157	22	161	0	11	11	84	11
458	304	35	389	11	11	31	212	27
459	163	44	213	11	18	22	106	12
460	184	68	281	11	11	29	145	11
461	182	51	239	11	11	14	120	11
462	60	11	54	0	11	11	30	11
463	236	29	337	11	11	25	181	18
464	52	11	46	0	11	11	24	11
465	131	14	160	11	0	11	79	14
466	102	16	97	0	11	11	52	11
467	291	82	442	11	11	32	234	23
468	153	39	181	0	11	16	98	11
469	335	65	414	11	11	43	185	21
470	34	11	29	0	11	0	18	11
471	297	27	269	11	11	20	173	11
472	171	22	171	11	11	15	87	12
473	164	25	183	11	11	15	93	16
474	389	119	630	11	13	74	329	25
475	134	20	138	0	11	11	52	18
476	121	13	126	11	11	14	70	11
477	100	20	123	11	11	12	53	11
478	166	31	224	11	11	26	112	18
479	48	14	67	0	11	11	32	11
480	172	31	232	11	11	33	122	11
481	225	55	288	0	11	38	140	14
482	235	44	294	11	11	40	163	11
483	335	95	482	11	11	61	249	14
484	257	57	350	11	11	47	167	14
485	231	36	312	11	11	33	166	13
486	54	14	95	11	11	11	44	11
487	183	26	224	11	11	25	118	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003533

	S	T	U	V	W
439	0	0	0	0	11
440	0	11	0	11	11
441	11	11	11	24	160
442	11	11	11	11	158
443	11	11	11	11	46
444	11	11	11	11	19
445	11	11	0	0	27
446	11	11	0	11	42
447	11	11	11	0	11
448	11	11	11	11	11
449	11	11	0	11	54
450	11	11	0	11	141
451	11	11	11	17	96
452	11	11	0	11	20
453	11	11	0	11	17
454	11	11	11	11	39
455	11	11	11	15	46
456	11	11	11	11	39
457	11	11	11	11	52
458	11	11	11	27	120
459	11	11	11	11	66
460	11	11	11	11	106
461	11	11	11	11	110
462	11	11	11	0	16
463	11	11	11	16	116
464	11	11	0	0	11
465	11	11	0	12	51
466	11	11	0	11	30
467	11	11	11	11	175
468	11	11	11	11	60
469	18	11	11	28	136
470	11	0	11	0	11
471	12	11	11	11	59
472	11	11	11	11	51
473	11	11	11	11	47
474	11	12	11	11	240
475	11	0	11	11	64
476	11	11	0	11	44
477	11	11	11	11	53
478	11	11	11	12	62
479	11	11	11	0	24
480	11	11	11	11	84
481	11	11	11	11	107
482	11	11	0	11	105
483	15	11	11	11	170
484	17	11	11	11	119
485	11	11	11	14	103
486	11	11	11	11	30
487	11	11	11	11	73

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
488		33180	086	Miami-Dade	12	FL	6,327	6,148	26	70
489		33181	086	Miami-Dade	12	FL	2,350	2,310	15	13
490		33182	086	Miami-Dade	12	FL	2,460	2,438	11	26
491		33183	086	Miami-Dade	12	FL	7,057	6,759	29	73
492		33184	086	Miami-Dade	12	FL	4,834	4,792	26	68
493		33185	086	Miami-Dade	12	FL	3,993	3,960	16	45
494		33186	086	Miami-Dade	12	FL	11,132	11,018	45	108
495		33187	086	Miami-Dade	12	FL	2,877	2,831	15	37
496		33189	086	Miami-Dade	12	FL	3,979	3,940	37	49
497		33190	086	Miami-Dade	12	FL	1,312	1,300	11	16
498		33193	086	Miami-Dade	12	FL	7,119	7,051	35	84
499		33194	086	Miami-Dade	12	FL	647	498	11	11
500		33196	086	Miami-Dade	12	FL	6,481	6,429	30	50
501		33199	086	Miami-Dade	12	FL	11	11	0	0
502		33301	011	Broward	12	FL	2,586	2,493	11	12
503		33304	011	Broward	12	FL	3,462	3,163	17	26
504		33305	011	Broward	12	FL	2,354	2,294	11	12
505		33306	011	Broward	12	FL	969	833	11	11
506		33308	011	Broward	12	FL	8,497	8,300	17	62
507		33309	011	Broward	12	FL	4,810	4,731	54	49
508		33311	011	Broward	12	FL	11,585	10,869	252	88
509		33312	011	Broward	12	FL	7,240	7,051	82	74
510		33313	011	Broward	12	FL	8,309	8,104	152	69
511		33314	011	Broward	12	FL	2,939	2,892	28	36
512		33315	011	Broward	12	FL	2,091	2,059	17	17
513		33316	011	Broward	12	FL	2,500	2,302	11	14
514		33317	011	Broward	12	FL	5,663	5,571	34	59
515		33319	011	Broward	12	FL	9,492	9,206	93	87
516		33321	011	Broward	12	FL	12,560	12,187	75	126
517		33322	011	Broward	12	FL	11,538	11,176	69	114
518		33323	011	Broward	12	FL	2,600	2,576	17	11
519		33324	011	Broward	12	FL	7,285	6,952	33	69
520		33325	011	Broward	12	FL	3,604	3,483	13	35
521		33326	011	Broward	12	FL	4,023	3,904	14	33
522		33327	011	Broward	12	FL	1,518	1,511	11	14
523		33328	011	Broward	12	FL	3,919	3,888	17	39
524		33330	011	Broward	12	FL	2,153	2,105	11	17
525		33331	011	Broward	12	FL	2,978	2,949	11	20
526		33332	011	Broward	12	FL	1,137	1,112	11	11
527		33334	011	Broward	12	FL	4,740	4,397	27	62
528		33351	011	Broward	12	FL	4,187	3,943	43	28
529		33388	011	Broward	12	FL	0	0	0	0
530		33401	099	Palm Beach	12	FL	5,312	5,100	52	49
531		33403	099	Palm Beach	12	FL	1,818	1,696	24	14
532		33404	099	Palm Beach	12	FL	6,035	5,727	106	71
533		33405	099	Palm Beach	12	FL	2,990	2,896	22	29
534		33406	099	Palm Beach	12	FL	3,795	3,389	22	36
535		33407	099	Palm Beach	12	FL	4,294	4,075	78	44
536		33408	099	Palm Beach	12	FL	5,625	5,452	11	47

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
488	261	21	210	0	11	15	132	15
489	64	11	62	11	0	11	34	11
490	64	21	86	11	0	11	47	11
491	186	33	265	11	11	48	136	12
492	132	42	203	11	11	27	112	11
493	131	33	153	11	11	22	74	14
494	262	57	382	11	13	50	188	16
495	70	19	125	11	11	13	73	11
496	127	17	149	11	11	16	85	11
497	30	11	60	0	11	11	25	11
498	171	52	279	11	11	42	135	13
499	16	11	28	0	0	11	15	11
500	146	37	205	11	11	22	87	11
501	0	0	0	0	0	0	0	0
502	67	11	49	0	11	11	26	11
503	121	11	85	0	11	11	54	11
504	92	11	52	11	11	11	31	11
505	37	11	24	0	11	11	14	11
506	265	23	206	11	11	11	134	17
507	159	16	162	11	11	11	102	11
508	351	41	427	11	11	26	229	28
509	190	16	241	11	11	12	140	15
510	245	35	258	11	11	16	139	25
511	79	13	134	11	11	11	83	11
512	58	11	51	0	11	11	36	11
513	79	11	55	11	11	11	32	11
514	168	27	191	11	11	16	106	11
515	330	37	296	11	11	11	159	19
516	404	61	436	11	11	28	266	27
517	336	35	345	11	11	15	218	12
518	65	16	64	0	11	11	31	11
519	236	23	242	11	11	11	147	18
520	96	15	118	11	11	11	70	11
521	112	12	102	11	11	11	59	11
522	39	11	40	11	11	11	23	11
523	135	14	128	11	11	11	73	11
524	82	11	82	11	11	11	36	11
525	86	11	82	0	11	11	40	11
526	25	11	27	11	0	11	11	11
527	124	16	151	11	11	11	111	11
528	156	11	125	11	11	11	55	12
529	0	0	0	0	0	0	0	0
530	216	14	172	11	11	11	101	11
531	56	11	56	11	11	11	39	11
532	149	19	194	0	11	11	126	11
533	128	13	86	0	11	11	62	11
534	106	14	112	0	11	11	77	11
535	145	11	148	11	11	11	94	13
536	196	11	156	11	11	11	124	11

AMERICAN OVERSIGHT

	S	T	U	V	W
488	11	11	11	11	43
489	11	11	11	11	17
490	11	11	11	11	33
491	11	11	11	11	78
492	11	11	11	11	68
493	11	11	11	11	54
494	14	11	11	11	139
495	11	11	11	11	36
496	11	11	11	11	38
497	11	11	11	11	21
498	11	11	11	11	87
499	11	0	0	0	11
500	11	11	11	11	76
501	0	0	0	0	0
502	11	0	11	11	12
503	11	11	11	11	14
504	11	0	11	11	11
505	11	0	11	0	11
506	14	11	11	11	32
507	11	11	11	11	35
508	18	11	13	27	130
509	11	11	11	24	52
510	11	11	11	11	79
511	11	11	11	11	35
512	11	11	0	11	11
513	11	11	11	11	15
514	11	11	11	11	55
515	11	11	11	13	100
516	25	11	11	20	94
517	16	11	11	11	85
518	11	11	11	11	19
519	11	11	11	11	53
520	11	0	11	11	23
521	11	0	11	11	21
522	11	11	11	11	11
523	11	11	11	11	33
524	11	11	11	11	17
525	11	0	11	11	19
526	0	11	0	11	12
527	11	11	11	11	23
528	11	0	11	11	43
529	0	0	0	0	0
530	11	11	11	18	26
531	11	11	11	11	11
532	12	11	11	17	31
533	11	11	11	11	11
534	11	0	11	11	17
535	11	11	11	11	22
536	12	0	0	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
537		33409	099	Palm Beach	12	FL	3,350	3,210	32	27
538		33410	099	Palm Beach	12	FL	7,553	7,176	22	65
539		33411	099	Palm Beach	12	FL	12,953	12,595	56	92
540		33412	099	Palm Beach	12	FL	3,704	3,664	13	26
541		33413	099	Palm Beach	12	FL	1,808	1,788	11	13
542		33414	099	Palm Beach	12	FL	7,948	7,847	24	60
543		33415	099	Palm Beach	12	FL	6,741	6,566	47	71
544		33417	099	Palm Beach	12	FL	8,104	7,645	51	75
545		33418	099	Palm Beach	12	FL	11,353	11,164	23	66
546		33426	099	Palm Beach	12	FL	4,868	4,545	25	48
547		33428	099	Palm Beach	12	FL	6,318	6,149	25	55
548		33430	099	Palm Beach	12	FL	2,884	2,274	73	26
549		33431	099	Palm Beach	12	FL	3,433	3,246	12	16
550		33432	099	Palm Beach	12	FL	4,946	4,724	16	31
551		33433	099	Palm Beach	12	FL	11,280	10,890	41	85
552		33434	099	Palm Beach	12	FL	7,918	7,793	34	51
553		33435	099	Palm Beach	12	FL	6,747	6,612	54	42
554		33436	099	Palm Beach	12	FL	10,498	10,000	47	78
555		33437	099	Palm Beach	12	FL	18,007	17,813	55	97
556		33438	099	Palm Beach	12	FL	151	23	11	11
557		33440	051	Hendry	12	FL	2,808	2,005	38	28
558		33441	011	Broward	12	FL	4,993	4,749	54	52
559		33442	011	Broward	12	FL	7,673	7,487	19	69
560		33444	099	Palm Beach	12	FL	3,696	3,619	58	29
561		33445	099	Palm Beach	12	FL	8,008	7,604	41	54
562		33446	099	Palm Beach	12	FL	13,277	13,052	53	58
563		33449	099	Palm Beach	12	FL	2,144	2,115	11	11
564		33455	085	Martin	12	FL	7,114	6,679	15	90
565		33458	099	Palm Beach	12	FL	8,115	7,624	26	83
566		33460	099	Palm Beach	12	FL	3,858	3,550	47	26
567		33461	099	Palm Beach	12	FL	5,300	5,079	41	44
568		33462	099	Palm Beach	12	FL	5,836	5,617	42	64
569		33463	099	Palm Beach	12	FL	7,156	7,057	56	63
570		33467	099	Palm Beach	12	FL	14,225	13,884	58	93
571		33469	099	Palm Beach	12	FL	4,368	4,209	13	42
572		33470	099	Palm Beach	12	FL	3,832	3,635	22	31
573		33471	043	Glades	12	FL	1,317	986	11	17
574		33472	099	Palm Beach	12	FL	6,444	6,356	23	38
575		33473	099	Palm Beach	12	FL	3,444	3,428	11	11
576		33476	099	Palm Beach	12	FL	1,088	888	34	11
577		33477	099	Palm Beach	12	FL	5,306	5,258	12	26
578		33478	099	Palm Beach	12	FL	2,559	2,534	11	19
579		33480	099	Palm Beach	12	FL	4,396	3,836	11	18
580		33483	099	Palm Beach	12	FL	3,697	3,638	11	21
581		33484	099	Palm Beach	12	FL	11,431	11,212	72	95
582		33486	099	Palm Beach	12	FL	3,456	3,273	15	22
583		33487	099	Palm Beach	12	FL	5,003	4,943	18	36
584		33493	099	Palm Beach	12	FL	454	243	14	11
585		33496	099	Palm Beach	12	FL	7,383	7,305	30	42

AMERICAN OVERSIGHT

Zip Code De-Identified Data

	K	L	M	N	O	P	Q	R
537	80	11	103	11	11	11	60	11
538	262	16	254	11	11	13	188	11
539	341	47	372	11	11	18	248	12
540	80	14	102	11	11	11	62	11
541	52	0	63	0	0	11	37	11
542	199	24	211	11	11	11	151	11
543	213	20	252	11	15	11	163	11
544	287	26	286	11	11	11	201	12
545	402	24	309	11	13	12	214	18
546	203	18	161	11	11	11	114	11
547	282	18	182	11	11	11	111	11
548	71	11	91	0	11	11	55	11
549	123	13	77	11	11	11	53	11
550	181	14	128	11	11	11	88	11
551	526	35	299	11	12	11	216	16
552	343	26	208	11	11	11	149	11
553	233	11	182	11	11	11	107	11
554	371	29	293	11	13	12	205	13
555	889	56	451	11	15	12	317	20
556	11	0	11	0	0	11	11	0
557	73	11	121	0	11	11	94	11
558	140	19	157	11	11	11	104	11
559	355	23	252	11	11	12	169	11
560	107	11	93	11	11	11	61	11
561	318	34	225	11	11	11	157	11
562	580	30	301	11	11	17	182	21
563	61	11	47	11	11	11	33	11
564	246	21	248	11	15	11	179	15
565	263	22	277	11	11	11	221	11
566	126	11	104	11	11	11	66	11
567	152	13	159	11	11	11	107	11
568	308	20	196	11	11	11	139	11
569	183	16	211	11	11	11	131	16
570	439	52	370	11	11	11	241	13
571	152	14	104	11	11	11	80	11
572	85	11	100	0	11	11	70	11
573	41	11	70	0	11	11	60	11
574	275	21	179	11	11	11	123	11
575	90	11	42	0	11	11	28	11
576	34	11	50	0	11	11	24	11
577	165	20	120	11	11	11	89	11
578	50	11	78	11	11	11	56	11
579	142	11	79	0	0	11	62	11
580	107	11	76	11	11	11	51	11
581	595	36	324	11	11	15	221	14
582	106	15	96	11	11	11	67	11
583	145	11	111	11	11	11	78	0
584	11	0	19	0	0	0	12	11
585	287	34	183	11	11	11	123	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
537	11	11	11	11	14
538	14	11	11	11	22
539	24	0	15	19	56
540	13	11	11	11	14
541	11	0	11	11	11
542	14	11	11	11	25
543	16	11	11	18	43
544	11	11	11	14	37
545	30	11	11	11	28
546	11	11	11	11	25
547	16	11	11	14	35
548	11	11	11	11	17
549	11	0	11	11	11
550	11	11	11	11	15
551	15	11	11	11	29
552	12	0	11	11	28
553	13	11	11	14	28
554	17	11	11	14	32
555	41	11	17	11	36
556	0	0	0	0	0
557	11	11	11	11	11
558	11	11	11	14	28
559	11	0	11	11	47
560	11	0	11	11	12
561	13	11	11	11	20
562	34	11	11	11	34
563	11	11	0	0	11
564	11	11	11	11	18
565	17	11	11	11	15
566	11	0	11	11	15
567	11	0	11	11	20
568	11	11	11	12	19
569	19	11	11	11	25
570	36	11	12	20	40
571	11	11	0	0	11
572	11	11	11	11	14
573	11	0	11	11	11
574	20	11	11	11	12
575	11	0	11	11	11
576	11	0	11	11	11
577	11	11	11	11	11
578	11	11	11	11	11
579	11	0	0	11	11
580	11	11	0	11	11
581	26	11	11	11	35
582	11	0	11	11	16
583	11	11	11	11	17
584	0	0	11	11	11
585	20	11	11	11	16

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
586		33498	099	Palm Beach	12	FL	3,042	3,006	16	12
587		33510	057	Hillsborough	12	FL	4,439	4,350	31	65
588		33511	057	Hillsborough	12	FL	8,310	7,613	47	100
589		33513	119	Sumter	12	FL	3,094	2,463	11	46
590		33514	119	Sumter	12	FL	352	199	0	11
591		33521	119	Sumter	12	FL	195	0	0	11
592		33523	101	Pasco	12	FL	3,856	3,492	24	89
593		33525	101	Pasco	12	FL	5,196	4,569	24	97
594		33527	057	Hillsborough	12	FL	2,373	2,019	11	37
595		33534	057	Hillsborough	12	FL	1,637	1,403	14	38
596		33538	119	Sumter	12	FL	1,464	1,111	11	23
597		33540	101	Pasco	12	FL	2,750	2,547	11	71
598		33541	101	Pasco	12	FL	7,106	6,985	17	138
599		33542	101	Pasco	12	FL	7,209	6,543	32	168
600		33543	101	Pasco	12	FL	4,640	4,576	27	56
601		33544	101	Pasco	12	FL	3,679	3,632	19	33
602		33545	101	Pasco	12	FL	2,291	2,127	11	24
603		33547	057	Hillsborough	12	FL	3,280	2,925	13	41
604		33548	057	Hillsborough	12	FL	1,713	1,468	11	13
605		33549	057	Hillsborough	12	FL	3,243	3,175	14	42
606		33550	057	Hillsborough	12	FL	196	11	11	11
607		33556	057	Hillsborough	12	FL	4,425	4,258	11	28
608		33558	057	Hillsborough	12	FL	3,768	3,712	20	22
609		33559	057	Hillsborough	12	FL	2,112	2,081	12	35
610		33563	057	Hillsborough	12	FL	4,203	3,792	49	84
611		33565	057	Hillsborough	12	FL	3,678	3,628	14	83
612		33566	057	Hillsborough	12	FL	3,515	3,250	16	74
613		33567	057	Hillsborough	12	FL	1,608	1,579	11	25
614		33569	057	Hillsborough	12	FL	4,695	4,135	20	61
615		33570	057	Hillsborough	12	FL	4,874	4,487	36	64
616		33572	057	Hillsborough	12	FL	4,530	4,423	13	36
617		33573	057	Hillsborough	12	FL	15,667	15,202	33	143
618		33576	101	Pasco	12	FL	2,478	2,104	11	25
619		33578	057	Hillsborough	12	FL	5,461	5,372	29	64
620		33579	057	Hillsborough	12	FL	3,872	3,826	18	35
621		33584	057	Hillsborough	12	FL	4,544	4,189	20	62
622		33585	119	Sumter	12	FL	295	216	11	11
623		33592	057	Hillsborough	12	FL	2,259	1,978	16	52
624		33594	057	Hillsborough	12	FL	6,445	6,039	32	85
625		33596	057	Hillsborough	12	FL	5,094	5,032	17	37
626		33597	119	Sumter	12	FL	1,883	1,624	11	40
627		33598	057	Hillsborough	12	FL	4,272	3,890	13	24
628		33602	057	Hillsborough	12	FL	2,542	2,201	24	25
629		33603	057	Hillsborough	12	FL	3,015	2,862	24	32
630		33604	057	Hillsborough	12	FL	6,188	5,828	61	61
631		33605	057	Hillsborough	12	FL	3,357	2,965	72	33
632		33606	057	Hillsborough	12	FL	2,129	2,078	11	11
633		33607	057	Hillsborough	12	FL	4,085	3,833	39	38
634		33609	057	Hillsborough	12	FL	2,513	2,469	11	19

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
586	110	11	70	11	11	11	41	11
587	105	14	214	11	11	12	148	11
588	281	26	371	11	13	20	236	11
589	70	13	168	11	11	11	133	11
590	16	11	22	0	11	11	18	0
591	11	0	14	0	0	11	12	0
592	100	15	229	11	11	28	174	11
593	119	11	260	11	11	40	179	11
594	56	11	113	11	11	11	85	11
595	30	11	97	0	11	11	73	11
596	34	11	77	0	11	11	65	11
597	79	11	204	0	11	27	152	11
598	168	25	431	11	12	69	324	11
599	191	30	490	0	11	69	350	11
600	118	14	186	11	11	18	124	11
601	75	11	147	11	11	26	81	11
602	34	11	92	11	11	11	53	11
603	101	16	167	0	11	12	113	11
604	68	11	61	11	11	11	31	11
605	91	11	143	11	13	11	90	11
606	11	0	11	0	0	11	11	0
607	116	16	118	11	11	11	71	11
608	112	13	118	11	11	11	72	11
609	57	11	100	11	11	11	73	11
610	108	21	270	0	11	17	214	11
611	99	16	231	0	11	11	187	11
612	90	11	185	0	11	11	143	11
613	52	11	92	11	11	11	63	11
614	110	15	213	0	11	11	153	11
615	117	20	207	11	11	11	158	11
616	93	12	151	11	11	11	98	11
617	500	46	576	11	11	49	400	15
618	36	11	85	0	11	16	58	11
619	155	11	231	11	14	12	160	11
620	93	13	165	0	11	11	101	11
621	118	18	229	11	11	14	164	11
622	11	0	18	0	11	0	15	0
623	57	11	141	0	11	11	106	11
624	179	27	280	11	13	12	195	11
625	119	15	176	11	11	11	115	11
626	44	11	120	11	11	11	93	11
627	84	11	128	11	11	16	78	11
628	93	11	107	0	11	11	48	11
629	88	11	120	11	11	11	65	11
630	179	23	237	11	12	11	151	11
631	108	11	150	11	11	11	70	11
632	106	11	66	11	11	11	28	11
633	141	25	159	11	11	11	100	11
634	97	11	76	0	11	11	51	11

AMERICAN OVERSIGHT

	S	T	U	V	W
586	11	11	0	11	12
587	11	11	11	13	27
588	17	11	11	11	80
589	11	11	11	11	12
590	0	0	11	11	11
591	0	0	0	0	11
592	11	0	11	11	18
593	15	11	11	11	20
594	11	11	11	11	12
595	11	11	11	11	12
596	11	0	11	11	11
597	11	0	11	19	14
598	14	11	11	11	20
599	12	11	11	36	45
600	11	11	11	11	21
601	11	0	11	11	23
602	11	11	11	11	13
603	11	11	11	11	21
604	11	0	11	11	12
605	11	11	11	18	14
606	0	0	0	11	11
607	12	0	11	11	22
608	11	11	11	11	18
609	11	11	11	11	11
610	11	0	11	15	27
611	11	11	11	11	20
612	11	0	11	13	19
613	0	11	0	11	16
614	11	11	11	15	26
615	11	0	11	11	22
616	11	11	11	11	16
617	36	11	11	26	69
618	11	0	11	11	11
619	11	11	12	16	29
620	11	11	11	11	33
621	11	11	11	15	31
622	11	0	0	11	0
623	11	0	11	11	19
624	11	11	11	17	36
625	11	11	11	14	30
626	11	0	11	11	11
627	11	0	11	11	23
628	11	11	0	21	22
629	11	11	11	11	32
630	11	11	11	30	45
631	11	11	11	29	38
632	11	0	0	11	20
633	11	11	11	11	43
634	11	11	11	11	16

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
635		33610	057	Hillsborough	12	FL	6,925	6,303	145	77
636		33611	057	Hillsborough	12	FL	5,438	5,131	18	41
637		33612	057	Hillsborough	12	FL	7,384	6,778	72	104
638		33613	057	Hillsborough	12	FL	4,432	4,269	46	61
639		33614	057	Hillsborough	12	FL	7,063	6,878	43	61
640		33615	057	Hillsborough	12	FL	7,245	6,825	49	60
641		33616	057	Hillsborough	12	FL	1,865	1,829	11	19
642		33617	057	Hillsborough	12	FL	6,621	6,160	68	56
643		33618	057	Hillsborough	12	FL	5,653	5,220	23	30
644		33619	057	Hillsborough	12	FL	5,134	4,952	57	82
645		33620	057	Hillsborough	12	FL	12	12	0	0
646		33621	057	Hillsborough	12	FL	74	21	0	0
647		33624	057	Hillsborough	12	FL	6,653	6,265	30	51
648		33625	057	Hillsborough	12	FL	4,022	3,943	30	23
649		33626	057	Hillsborough	12	FL	3,441	3,382	11	18
650		33629	057	Hillsborough	12	FL	4,063	3,792	11	17
651		33634	057	Hillsborough	12	FL	3,232	2,940	21	23
652		33635	057	Hillsborough	12	FL	2,385	2,345	13	29
653		33637	057	Hillsborough	12	FL	1,976	1,943	16	35
654		33647	057	Hillsborough	12	FL	6,935	6,823	36	38
655		33677	057	Hillsborough	12	FL	149	11	0	11
656		33701	103	Pinellas	12	FL	5,086	4,271	22	33
657		33702	103	Pinellas	12	FL	6,360	5,952	31	77
658		33703	103	Pinellas	12	FL	4,520	4,412	21	48
659		33704	103	Pinellas	12	FL	3,877	2,801	11	21
660		33705	103	Pinellas	12	FL	5,569	5,242	100	53
661		33706	103	Pinellas	12	FL	4,846	4,571	11	30
662		33707	103	Pinellas	12	FL	8,056	7,788	38	69
663		33708	103	Pinellas	12	FL	5,307	5,092	11	45
664		33709	103	Pinellas	12	FL	6,981	6,661	29	111
665		33710	103	Pinellas	12	FL	7,136	6,661	22	80
666		33711	103	Pinellas	12	FL	4,290	3,985	47	36
667		33712	103	Pinellas	12	FL	4,778	4,548	93	74
668		33713	103	Pinellas	12	FL	5,963	4,997	32	78
669		33714	103	Pinellas	12	FL	3,788	3,688	23	75
670		33715	103	Pinellas	12	FL	3,186	3,145	11	11
671		33716	103	Pinellas	12	FL	1,439	1,341	11	15
672		33744	103	Pinellas	12	FL	60	11	0	0
673		33755	103	Pinellas	12	FL	4,689	4,431	35	44
674		33756	103	Pinellas	12	FL	7,350	7,033	44	73
675		33759	103	Pinellas	12	FL	3,798	3,676	15	37
676		33760	103	Pinellas	12	FL	2,397	2,352	16	27
677		33761	103	Pinellas	12	FL	5,395	5,302	13	39
678		33762	103	Pinellas	12	FL	1,448	1,372	11	11
679		33763	103	Pinellas	12	FL	6,720	6,516	31	55
680		33764	103	Pinellas	12	FL	6,161	6,030	28	69
681		33765	103	Pinellas	12	FL	2,897	2,462	24	29
682		33767	103	Pinellas	12	FL	3,218	3,134	11	12
683		33770	103	Pinellas	12	FL	6,009	5,833	28	82

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
635	255	29	288	11	14	16	167	22
636	212	17	209	11	11	12	124	11
637	209	28	348	11	18	17	230	13
638	154	16	192	11	11	11	132	11
639	214	16	263	11	11	15	152	13
640	252	16	283	0	12	11	168	19
641	57	11	72	0	11	11	49	11
642	181	25	228	11	14	15	134	11
643	207	13	170	11	11	11	96	11
644	122	20	234	11	11	12	167	11
645	0	0	0	0	0	0	0	0
646	11	0	11	0	0	0	11	0
647	209	23	218	11	11	12	127	19
648	116	11	131	11	11	11	84	11
649	147	11	125	11	11	11	70	11
650	160	11	116	11	11	11	63	11
651	101	15	121	11	11	11	69	11
652	60	11	106	11	11	0	73	11
653	78	11	107	0	11	11	66	11
654	188	11	195	11	11	18	113	11
655	11	0	11	0	0	0	11	0
656	177	11	137	11	11	11	91	11
657	175	23	250	11	11	11	199	11
658	114	14	161	11	11	11	129	11
659	140	11	104	11	11	11	70	11
660	197	12	183	11	11	11	128	11
661	118	11	109	11	11	11	81	11
662	253	25	263	11	12	11	204	11
663	139	11	155	11	11	11	119	11
664	196	18	329	11	11	12	257	11
665	247	22	254	11	11	12	194	11
666	130	11	120	11	0	11	85	11
667	173	11	186	11	11	11	123	11
668	140	11	224	11	11	11	173	11
669	112	15	199	11	11	12	150	11
670	75	11	58	11	11	11	38	11
671	37	11	49	11	0	11	38	11
672	11	11	11	11	0	0	11	0
673	138	19	181	11	11	11	129	11
674	283	24	309	11	11	23	228	11
675	208	19	141	11	11	11	104	11
676	76	11	78	0	11	11	51	11
677	173	18	190	11	11	11	148	11
678	40	11	31	0	0	11	20	11
679	236	32	241	11	11	18	170	11
680	173	22	258	11	11	23	193	11
681	72	14	115	11	11	11	79	11
682	103	11	81	0	11	11	55	11
683	275	30	263	11	11	12	198	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
635	11	11	11	33	56
636	11	11	11	15	43
637	11	11	11	36	57
638	11	0	11	19	35
639	11	11	11	11	78
640	11	11	11	30	64
641	11	11	0	11	11
642	11	11	11	20	45
643	19	11	11	11	36
644	11	11	11	20	29
645	0	0	0	0	0
646	0	0	0	0	11
647	11	11	11	15	44
648	11	11	11	11	23
649	11	11	11	11	27
650	15	11	11	11	23
651	11	11	11	11	38
652	11	0	11	11	19
653	11	11	11	16	26
654	14	11	11	11	36
655	0	0	0	11	11
656	11	11	0	17	16
657	12	11	11	14	12
658	11	11	11	11	11
659	11	11	11	11	17
660	11	11	11	17	21
661	11	11	0	11	11
662	11	11	11	14	15
663	11	11	11	11	11
664	15	11	11	20	23
665	16	11	11	12	24
666	11	11	11	11	11
667	14	11	11	18	24
668	17	11	11	11	15
669	11	11	11	12	14
670	11	11	11	11	11
671	0	0	11	11	11
672	0	0	0	0	0
673	11	11	11	11	23
674	14	11	11	24	29
675	11	11	11	11	11
676	11	11	11	11	11
677	11	11	11	11	11
678	11	0	0	11	11
679	15	11	11	16	22
680	14	11	11	11	15
681	11	11	11	11	11
682	11	11	11	11	11
683	17	11	11	16	19

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
684		33771	103	Pinellas	12	FL	8,978	8,429	42	115
685		33772	103	Pinellas	12	FL	6,595	6,191	27	79
686		33773	103	Pinellas	12	FL	3,748	3,666	18	41
687		33774	103	Pinellas	12	FL	4,690	4,551	17	41
688		33776	103	Pinellas	12	FL	3,187	3,129	11	26
689		33777	103	Pinellas	12	FL	4,147	4,015	15	48
690		33778	103	Pinellas	12	FL	3,871	3,776	17	43
691		33781	103	Pinellas	12	FL	5,264	4,911	47	83
692		33782	103	Pinellas	12	FL	5,889	5,673	29	83
693		33785	103	Pinellas	12	FL	1,648	1,466	0	12
694		33786	103	Pinellas	12	FL	489	483	0	11
695		33801	105	Polk	12	FL	6,014	5,885	38	65
696		33803	105	Polk	12	FL	7,011	6,034	35	70
697		33805	105	Polk	12	FL	5,169	4,531	52	70
698		33809	105	Polk	12	FL	6,766	6,563	25	71
699		33810	105	Polk	12	FL	10,835	10,630	45	112
700		33811	105	Polk	12	FL	4,291	4,217	18	57
701		33812	105	Polk	12	FL	2,141	1,833	14	19
702		33813	105	Polk	12	FL	7,225	6,782	22	62
703		33815	105	Polk	12	FL	3,213	3,156	22	75
704		33823	105	Polk	12	FL	6,877	6,350	49	77
705		33825	055	Highlands	12	FL	6,813	6,334	62	134
706		33827	105	Polk	12	FL	582	427	11	11
707		33830	105	Polk	12	FL	5,364	4,854	40	57
708		33834	049	Hardee	12	FL	831	627	11	11
709		33837	105	Polk	12	FL	6,488	5,829	27	64
710		33838	105	Polk	12	FL	1,087	763	11	14
711		33839	105	Polk	12	FL	858	444	11	12
712		33841	105	Polk	12	FL	1,640	1,468	11	29
713		33843	105	Polk	12	FL	2,733	2,449	18	46
714		33844	105	Polk	12	FL	8,678	7,871	67	77
715		33848	097	Osceola	12	FL	229	11	11	11
716		33849	105	Polk	12	FL	360	112	11	11
717		33850	105	Polk	12	FL	2,250	2,063	20	23
718		33852	055	Highlands	12	FL	7,156	6,602	25	146
719		33853	105	Polk	12	FL	2,364	2,251	33	22
720		33855	105	Polk	12	FL	449	16	11	11
721		33857	055	Highlands	12	FL	517	362	11	11
722		33859	105	Polk	12	FL	4,078	3,450	16	44
723		33860	105	Polk	12	FL	4,088	3,683	24	42
724		33865	049	Hardee	12	FL	180	147	0	11
725		33867	105	Polk	12	FL	65	63	0	0
726		33868	105	Polk	12	FL	2,643	2,406	11	31
727		33870	055	Highlands	12	FL	6,924	6,544	47	162
728		33872	055	Highlands	12	FL	5,340	5,088	15	118
729		33873	049	Hardee	12	FL	2,288	1,763	21	54
730		33875	055	Highlands	12	FL	3,284	3,248	14	62
731		33876	055	Highlands	12	FL	1,947	1,925	11	32
732		33880	105	Polk	12	FL	7,632	6,995	62	82

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
684	324	40	438	11	14	26	337	11
685	307	14	280	11	11	19	213	11
686	99	11	148	11	11	11	119	11
687	161	16	158	11	11	11	116	11
688	108	11	118	11	11	11	93	11
689	161	14	165	11	11	11	122	11
690	107	11	171	11	11	11	120	11
691	215	14	248	0	11	11	184	11
692	189	16	266	11	11	12	205	11
693	37	11	47	0	11	0	34	11
694	17	11	19	0	0	11	11	11
695	184	37	327	11	13	13	243	11
696	197	38	320	11	11	11	219	12
697	156	27	268	11	12	11	194	11
698	188	26	322	0	11	11	242	11
699	247	59	492	11	14	11	380	15
700	105	16	193	11	11	11	143	11
701	53	11	90	0	11	11	63	11
702	180	36	282	11	11	11	208	11
703	79	24	219	0	11	11	173	11
704	166	31	319	0	11	11	241	11
705	247	30	446	11	11	11	357	11
706	11	11	13	0	0	0	11	0
707	122	39	271	11	17	11	190	11
708	19	11	44	11	11	0	35	11
709	117	25	232	11	11	11	168	11
710	21	11	41	11	11	0	33	11
711	20	11	32	0	11	0	28	0
712	36	11	100	0	11	11	76	11
713	61	12	147	11	11	0	127	11
714	199	39	333	11	11	11	230	12
715	11	11	11	0	0	11	11	0
716	11	0	21	0	11	0	18	0
717	67	11	122	11	11	11	91	0
718	273	31	517	11	11	11	427	11
719	68	11	107	11	11	11	75	11
720	11	0	19	0	0	11	14	0
721	23	11	42	11	11	11	34	11
722	91	15	159	11	11	11	118	11
723	93	22	206	11	11	11	155	11
724	11	11	11	11	0	0	11	0
725	11	0	11	0	0	0	11	0
726	68	13	122	11	11	11	93	11
727	365	34	543	11	11	11	455	11
728	209	24	378	11	11	11	319	11
729	88	23	169	11	11	11	132	11
730	126	14	226	11	11	11	190	11
731	71	11	134	11	11	0	115	11
732	204	45	372	11	11	11	269	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
684	19	11	11	25	34
685	12	11	11	18	15
686	11	0	11	11	11
687	11	11	11	11	11
688	11	0	11	11	11
689	11	11	11	16	11
690	11	0	11	15	20
691	11	11	11	18	26
692	21	11	11	20	18
693	11	0	11	11	11
694	0	0	0	0	11
695	11	0	11	30	41
696	21	11	11	25	46
697	11	0	11	25	48
698	11	11	11	28	34
699	25	11	11	36	45
700	11	0	11	17	16
701	11	0	11	11	11
702	16	11	11	17	37
703	11	11	11	25	17
704	20	11	11	23	30
705	13	0	11	40	42
706	11	0	0	11	11
707	17	0	11	18	39
708	0	0	0	11	11
709	19	11	11	17	16
710	11	0	0	11	11
711	11	0	0	11	11
712	11	11	0	11	11
713	11	11	11	11	14
714	17	11	11	28	41
715	0	0	11	0	11
716	0	0	0	11	0
717	11	0	0	17	13
718	22	11	11	23	38
719	11	0	11	15	11
720	11	0	0	0	11
721	11	0	11	11	11
722	11	0	11	11	11
723	11	11	11	15	16
724	11	0	11	0	0
725	0	0	0	11	0
726	11	11	11	12	11
727	14	11	11	33	55
728	11	11	11	11	31
729	11	0	11	17	15
730	11	0	11	11	14
731	11	11	11	11	11
732	20	11	11	33	46

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
733		33881	105	Polk	12	FL	9,659	9,177	81	91
734		33884	105	Polk	12	FL	8,470	8,278	27	82
735		33890	049	Hardee	12	FL	976	684	11	19
736		33896	105	Polk	12	FL	2,075	2,045	15	16
737		33897	105	Polk	12	FL	3,729	3,685	19	44
738		33898	105	Polk	12	FL	5,093	4,442	33	59
739		33901	071	Lee	12	FL	4,651	4,148	42	62
740		33903	071	Lee	12	FL	9,108	8,590	23	133
741		33904	071	Lee	12	FL	9,604	9,449	30	121
742		33905	071	Lee	12	FL	6,862	6,562	46	101
743		33907	071	Lee	12	FL	5,029	4,624	13	59
744		33908	071	Lee	12	FL	15,072	14,726	39	107
745		33909	071	Lee	12	FL	5,039	4,985	18	60
746		33912	071	Lee	12	FL	6,389	6,303	14	58
747		33913	071	Lee	12	FL	7,676	7,623	13	40
748		33914	071	Lee	12	FL	10,652	10,543	36	97
749		33916	071	Lee	12	FL	3,269	3,214	56	48
750		33917	071	Lee	12	FL	11,019	10,865	34	163
751		33919	071	Lee	12	FL	9,636	9,451	24	97
752		33920	071	Lee	12	FL	1,811	1,619	11	20
753		33921	071	Lee	12	FL	753	12	0	11
754		33922	071	Lee	12	FL	1,508	1,201	11	13
755		33924	071	Lee	12	FL	140	11	0	11
756		33928	071	Lee	12	FL	9,677	9,445	12	61
757		33930	051	Hendry	12	FL	114	11	0	11
758		33931	071	Lee	12	FL	3,804	3,634	11	29
759		33935	051	Hendry	12	FL	3,148	2,463	23	52
760		33936	071	Lee	12	FL	5,846	5,410	28	97
761		33944	043	Glades	12	FL	97	0	0	11
762		33946	015	Charlotte	12	FL	1,252	883	0	11
763		33947	015	Charlotte	12	FL	4,701	4,657	11	50
764		33948	015	Charlotte	12	FL	5,898	5,600	17	63
765		33950	015	Charlotte	12	FL	11,937	10,959	16	104
766		33952	015	Charlotte	12	FL	9,228	9,027	49	137
767		33953	015	Charlotte	12	FL	2,746	2,685	11	23
768		33954	015	Charlotte	12	FL	3,015	2,928	13	36
769		33955	015	Charlotte	12	FL	4,041	4,009	11	51
770		33956	071	Lee	12	FL	1,750	1,636	11	19
771		33957	071	Lee	12	FL	2,866	2,627	11	11
772		33960	055	Highlands	12	FL	209	187	0	11
773		33965	071	Lee	12	FL	0	0	0	0
774		33966	071	Lee	12	FL	2,579	2,557	11	21
775		33967	071	Lee	12	FL	3,421	3,372	13	37
776		33971	071	Lee	12	FL	2,430	2,395	17	38
777		33972	071	Lee	12	FL	2,080	2,056	12	30
778		33973	071	Lee	12	FL	944	937	11	13
779		33974	071	Lee	12	FL	1,646	1,625	12	23
780		33976	071	Lee	12	FL	1,205	1,187	12	20
781		33980	015	Charlotte	12	FL	4,642	4,498	11	70

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
733	272	40	443	11	11	11	315	15
734	208	38	340	11	11	11	245	11
735	32	11	72	0	0	11	54	0
736	72	11	91	11	11	11	62	11
737	67	14	151	11	11	11	115	11
738	122	14	206	11	11	11	172	11
739	209	11	192	11	11	11	143	11
740	276	21	429	11	13	18	344	14
741	307	22	351	11	19	13	268	20
742	223	13	315	11	11	16	224	17
743	184	14	201	11	11	11	156	11
744	409	28	423	11	13	26	314	17
745	128	11	224	0	12	15	151	11
746	172	14	189	11	11	11	137	11
747	192	16	192	11	11	23	122	13
748	283	17	345	11	11	22	260	14
749	101	11	127	11	11	11	97	11
750	337	26	506	11	21	25	394	11
751	275	30	333	11	15	18	257	11
752	54	11	75	0	11	11	49	11
753	21	0	17	0	11	11	11	0
754	35	11	39	0	11	0	32	11
755	11	0	11	0	11	0	11	0
756	202	19	243	11	11	13	159	13
757	11	0	11	0	0	0	11	0
758	104	11	79	11	11	11	60	0
759	101	11	132	11	11	11	104	11
760	176	13	310	11	11	11	238	11
761	11	0	13	0	11	0	12	0
762	31	11	30	0	0	0	24	11
763	130	11	164	11	11	11	127	11
764	205	14	249	11	11	28	169	11
765	391	15	383	11	17	33	262	12
766	361	11	459	11	16	40	345	13
767	59	11	84	0	11	11	64	11
768	100	11	113	11	11	13	74	11
769	104	11	153	0	11	17	115	11
770	48	11	62	0	11	11	52	11
771	55	11	59	0	0	11	37	11
772	11	0	13	0	0	0	11	11
773	0	0	0	0	0	0	0	0
774	52	11	70	11	11	11	47	11
775	76	13	122	11	11	11	89	11
776	66	11	117	0	11	11	88	11
777	63	11	104	11	11	11	66	11
778	15	11	41	0	11	11	31	11
779	38	0	73	11	0	11	53	11
780	34	11	52	11	11	11	37	11
781	203	11	195	0	11	21	149	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
733	18	11	11	46	59
734	24	11	11	19	38
735	11	0	11	11	11
736	11	0	11	11	11
737	11	11	11	15	11
738	12	11	11	11	11
739	11	11	11	15	13
740	17	11	11	17	34
741	22	11	11	11	28
742	23	0	11	11	33
743	11	11	11	11	11
744	31	11	11	11	25
745	23	11	11	11	23
746	18	11	0	11	17
747	22	11	11	11	11
748	18	11	11	11	28
749	11	11	11	11	19
750	29	11	12	12	23
751	21	11	11	11	22
752	11	11	0	11	11
753	11	0	0	11	11
754	11	0	11	0	11
755	0	0	0	0	0
756	30	11	11	11	11
757	0	0	11	11	0
758	11	11	0	11	11
759	11	0	11	11	11
760	11	11	11	24	31
761	0	0	0	0	0
762	11	0	0	0	11
763	11	11	11	11	11
764	16	11	11	11	21
765	37	11	11	19	22
766	22	11	11	26	24
767	11	0	11	11	11
768	11	0	11	11	11
769	11	11	11	11	11
770	11	11	11	11	11
771	11	0	0	11	11
772	0	0	0	0	11
773	0	0	0	0	0
774	11	0	0	11	11
775	12	11	11	11	11
776	11	0	11	11	13
777	11	11	11	11	11
778	11	0	11	11	11
779	11	0	11	11	11
780	11	0	11	11	11
781	11	11	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
782		33981	015	Charlotte	12	FL	4,549	4,504	11	50
783		33982	015	Charlotte	12	FL	3,060	2,987	11	43
784		33983	015	Charlotte	12	FL	5,477	5,385	23	57
785		33990	071	Lee	12	FL	7,690	6,953	32	84
786		33991	071	Lee	12	FL	5,337	5,220	15	53
787		33993	071	Lee	12	FL	4,652	4,555	16	58
788		34102	021	Collier	12	FL	4,269	3,400	13	17
789		34103	021	Collier	12	FL	4,319	4,252	11	24
790		34104	021	Collier	12	FL	6,479	6,411	18	45
791		34105	021	Collier	12	FL	5,227	5,148	11	32
792		34108	021	Collier	12	FL	6,750	6,330	11	41
793		34109	021	Collier	12	FL	7,052	6,957	19	56
794		34110	021	Collier	12	FL	8,884	8,763	20	58
795		34112	021	Collier	12	FL	8,527	8,393	25	63
796		34113	021	Collier	12	FL	6,623	6,535	20	43
797		34114	021	Collier	12	FL	7,019	6,972	18	49
798		34116	021	Collier	12	FL	3,227	3,028	29	36
799		34117	021	Collier	12	FL	2,160	2,136	12	27
800		34119	021	Collier	12	FL	9,460	9,383	20	35
801		34120	021	Collier	12	FL	6,399	6,347	21	41
802		34134	071	Lee	12	FL	7,129	7,046	11	38
803		34135	071	Lee	12	FL	14,275	13,703	37	91
804		34137	021	Collier	12	FL	27	0	11	11
805		34138	021	Collier	12	FL	132	11	0	0
806		34139	021	Collier	12	FL	149	11	0	0
807		34140	021	Collier	12	FL	129	11	0	11
808		34141	021	Collier	12	FL	52	24	11	0
809		34142	021	Collier	12	FL	3,178	2,511	56	19
810		34145	021	Collier	12	FL	6,412	6,094	11	30
811		34201	081	Manatee	12	FL	1,999	1,987	11	11
812		34202	081	Manatee	12	FL	7,468	7,384	14	29
813		34203	081	Manatee	12	FL	9,416	8,838	46	138
814		34205	081	Manatee	12	FL	7,080	6,640	32	101
815		34207	081	Manatee	12	FL	7,513	6,648	35	140
816		34208	081	Manatee	12	FL	6,002	5,812	47	71
817		34209	081	Manatee	12	FL	10,649	10,214	26	102
818		34210	081	Manatee	12	FL	4,535	4,444	11	33
819		34211	081	Manatee	12	FL	3,920	3,764	11	21
820		34212	081	Manatee	12	FL	4,953	4,898	11	28
821		34215	081	Manatee	12	FL	392	201	11	11
822		34217	081	Manatee	12	FL	1,956	1,384	11	16
823		34219	081	Manatee	12	FL	6,069	5,843	12	62
824		34221	081	Manatee	12	FL	9,817	9,292	62	139
825		34222	081	Manatee	12	FL	4,697	4,481	18	72
826		34223	115	Sarasota	12	FL	8,367	7,985	14	88
827		34224	015	Charlotte	12	FL	6,235	6,151	15	76
828		34228	081	Manatee	12	FL	3,577	3,463	11	11
829		34229	115	Sarasota	12	FL	3,207	2,999	11	11
830		34231	115	Sarasota	12	FL	8,824	8,606	20	67

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
782	131	11	153	11	11	11	119	11
783	100	11	132	0	11	18	97	11
784	178	11	212	11	11	22	158	11
785	220	26	322	0	11	19	237	15
786	170	18	170	11	11	11	130	11
787	102	12	168	11	11	13	125	11
788	105	11	86	0	11	11	62	11
789	132	18	99	0	11	11	65	11
790	211	20	156	11	11	20	109	11
791	152	12	135	11	11	13	97	11
792	189	20	165	11	11	22	109	11
793	312	24	221	11	11	18	149	11
794	332	20	240	11	11	29	170	11
795	238	25	235	11	11	21	183	11
796	232	20	176	11	11	14	123	11
797	175	16	187	11	11	26	119	11
798	94	11	106	11	11	11	76	11
799	74	11	74	0	11	11	51	11
800	262	19	207	11	14	18	120	11
801	153	14	180	0	11	11	115	11
802	214	15	157	0	11	18	104	11
803	382	25	376	11	16	41	253	16
804	0	0	11	0	0	0	11	0
805	11	11	11	0	0	11	11	0
806	11	0	11	0	0	11	11	0
807	11	0	11	0	0	11	11	0
808	0	0	11	0	0	0	0	0
809	61	11	70	0	11	11	43	0
810	176	11	129	11	11	14	84	11
811	43	11	37	0	11	11	19	11
812	215	12	152	11	11	15	98	11
813	269	12	351	11	11	14	284	12
814	347	11	290	11	0	22	214	11
815	241	12	374	11	11	19	304	11
816	190	11	224	11	11	15	172	11
817	368	15	360	11	11	23	278	13
818	127	11	143	11	11	13	106	11
819	103	11	77	0	11	11	47	11
820	104	11	109	11	11	16	72	11
821	11	11	11	0	11	11	11	0
822	54	11	51	0	0	11	43	11
823	141	11	191	11	11	16	140	11
824	282	13	402	11	11	24	307	11
825	142	11	198	11	11	15	161	11
826	279	13	308	0	11	16	234	11
827	218	16	271	0	11	16	229	11
828	108	11	75	0	11	11	50	11
829	94	11	74	0	0	11	53	11
830	323	12	273	0	11	13	207	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
782	11	11	11	11	11
783	11	0	11	11	11
784	11	11	11	11	14
785	17	11	11	11	33
786	14	11	11	11	11
787	12	11	11	11	11
788	11	11	0	11	11
789	11	0	0	11	11
790	15	11	11	11	11
791	11	0	11	11	11
792	16	11	11	0	11
793	23	11	11	11	12
794	22	11	11	11	11
795	18	11	11	11	11
796	12	11	11	11	13
797	27	11	11	11	11
798	11	11	11	11	11
799	11	0	11	11	13
800	32	11	11	11	16
801	25	11	11	11	12
802	21	11	11	11	11
803	37	11	11	11	13
804	0	0	0	0	0
805	0	0	0	0	0
806	11	0	0	0	0
807	0	0	0	0	0
808	0	0	11	0	0
809	11	11	0	13	11
810	11	11	11	11	11
811	11	0	0	11	11
812	11	11	11	11	14
813	12	0	11	18	20
814	11	0	11	22	26
815	11	11	11	21	20
816	11	11	11	14	18
817	15	0	11	14	24
818	11	11	11	11	11
819	11	11	11	11	11
820	11	0	11	11	11
821	0	0	0	0	11
822	11	0	0	11	11
823	15	11	11	11	11
824	16	11	11	31	26
825	11	11	11	11	11
826	22	11	11	11	18
827	19	11	11	11	11
828	11	11	11	11	11
829	11	0	11	11	11
830	21	11	11	11	15

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
831		34232	115	Sarasota	12	FL	7,772	7,345	37	69
832		34233	115	Sarasota	12	FL	5,302	5,173	13	48
833		34234	115	Sarasota	12	FL	4,543	4,356	66	55
834		34235	115	Sarasota	12	FL	4,719	4,562	15	39
835		34236	115	Sarasota	12	FL	6,595	5,412	17	28
836		34237	115	Sarasota	12	FL	2,638	2,543	20	22
837		34238	115	Sarasota	12	FL	9,054	8,895	20	57
838		34239	115	Sarasota	12	FL	3,959	3,572	12	35
839		34240	115	Sarasota	12	FL	3,140	3,065	11	19
840		34241	115	Sarasota	12	FL	3,790	3,734	11	22
841		34242	115	Sarasota	12	FL	2,817	2,751	11	13
842		34243	081	Manatee	12	FL	8,685	8,407	26	50
843		34250	081	Manatee	12	FL	163	11	0	0
844		34251	081	Manatee	12	FL	1,001	886	11	11
845		34266	027	De Soto	12	FL	5,272	4,475	43	93
846		34269	027	De Soto	12	FL	1,686	1,499	11	27
847		34275	115	Sarasota	12	FL	8,072	7,729	13	50
848		34285	115	Sarasota	12	FL	9,169	8,624	20	94
849		34286	115	Sarasota	12	FL	4,067	4,018	19	36
850		34287	115	Sarasota	12	FL	9,224	8,912	32	107
851		34288	115	Sarasota	12	FL	2,977	2,937	11	30
852		34289	115	Sarasota	12	FL	1,051	1,013	11	11
853		34291	115	Sarasota	12	FL	1,559	1,536	11	15
854		34292	115	Sarasota	12	FL	8,101	7,990	11	57
855		34293	115	Sarasota	12	FL	17,925	17,729	33	153
856		34420	083	Marion	12	FL	4,182	3,613	15	84
857		34423	017	Citrus	12	FL	393	11	0	11
858		34428	017	Citrus	12	FL	2,825	2,781	15	66
859		34429	017	Citrus	12	FL	3,100	2,996	11	49
860		34431	083	Marion	12	FL	2,730	2,699	11	46
861		34432	083	Marion	12	FL	5,379	4,824	21	58
862		34433	017	Citrus	12	FL	2,203	2,173	11	51
863		34434	017	Citrus	12	FL	2,541	2,504	11	55
864		34436	017	Citrus	12	FL	2,866	2,616	11	71
865		34442	017	Citrus	12	FL	7,388	7,276	16	121
866		34446	017	Citrus	12	FL	7,972	7,825	17	142
867		34448	017	Citrus	12	FL	4,144	3,502	11	99
868		34449	075	Levy	12	FL	1,312	946	0	34
869		34450	017	Citrus	12	FL	4,462	4,007	11	107
870		34452	017	Citrus	12	FL	3,568	3,476	22	82
871		34453	017	Citrus	12	FL	3,489	3,400	11	69
872		34461	017	Citrus	12	FL	4,159	3,772	11	84
873		34465	017	Citrus	12	FL	7,269	6,897	15	134
874		34470	083	Marion	12	FL	4,813	4,702	22	80
875		34471	083	Marion	12	FL	6,838	5,384	30	91
876		34472	083	Marion	12	FL	6,782	6,312	38	92
877		34473	083	Marion	12	FL	5,264	5,202	34	51
878		34474	083	Marion	12	FL	3,311	3,189	18	61
879		34475	083	Marion	12	FL	2,144	2,090	31	36

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
831	267	12	257	11	11	11	205	11
832	204	11	189	0	11	11	153	11
833	165	11	177	11	11	11	138	11
834	160	11	151	11	0	11	110	11
835	263	11	153	0	11	11	121	11
836	95	11	94	0	11	11	69	11
837	285	11	226	11	11	11	160	11
838	106	11	121	0	11	11	94	11
839	96	11	85	11	11	11	63	11
840	105	11	92	0	11	11	68	11
841	88	11	66	11	11	11	51	11
842	265	14	233	11	11	15	158	11
843	11	0	11	0	0	11	11	0
844	23	0	23	0	0	11	18	11
845	181	11	286	11	11	11	231	11
846	47	11	79	11	11	11	63	11
847	220	14	223	11	11	15	172	11
848	338	14	340	11	13	22	263	11
849	96	11	156	11	11	14	110	11
850	329	25	376	11	12	32	289	11
851	86	11	120	11	11	12	76	11
852	20	11	29	11	11	11	22	0
853	41	11	54	11	11	11	42	11
854	319	12	239	11	11	21	190	11
855	521	28	560	11	20	23	436	15
856	113	13	228	11	11	11	186	0
857	11	0	12	0	0	0	11	0
858	61	11	154	11	11	11	134	0
859	63	11	115	11	11	11	101	11
860	65	11	125	11	11	11	101	11
861	117	11	231	11	11	11	181	11
862	29	11	114	11	11	11	94	11
863	68	11	119	11	11	11	99	11
864	71	12	138	11	11	11	119	11
865	147	15	268	0	11	11	215	11
866	165	18	307	11	11	13	249	11
867	77	11	226	11	11	11	193	11
868	21	11	73	11	11	0	62	11
869	137	11	204	11	11	11	165	11
870	112	11	169	11	11	11	136	11
871	80	11	136	0	11	11	110	11
872	108	11	171	0	11	11	137	11
873	182	19	289	0	11	12	232	11
874	139	16	261	0	11	11	206	11
875	281	18	311	11	11	12	233	16
876	173	24	310	11	11	11	237	11
877	93	16	197	11	11	11	137	11
878	105	11	179	11	11	11	137	11
879	50	11	105	11	11	11	77	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
831	16	0	11	11	21
832	14	0	11	11	11
833	11	11	11	11	14
834	15	0	11	11	11
835	11	11	0	11	11
836	11	0	11	11	11
837	18	11	11	11	15
838	11	11	11	11	11
839	11	11	11	11	11
840	11	11	11	11	11
841	11	11	11	11	11
842	17	11	11	12	22
843	11	0	0	0	0
844	0	0	11	11	11
845	13	11	11	15	15
846	11	0	11	11	11
847	21	11	11	11	11
848	27	11	11	11	12
849	17	11	11	11	11
850	17	11	11	12	23
851	11	11	0	11	11
852	11	0	0	11	0
853	11	11	11	11	11
854	20	11	11	11	11
855	46	11	11	19	21
856	11	0	11	12	11
857	11	0	0	0	0
858	11	0	0	11	11
859	11	0	11	11	11
860	11	11	0	11	11
861	11	11	11	11	13
862	11	11	0	11	11
863	11	0	11	11	11
864	11	0	11	11	11
865	19	11	11	13	14
866	16	0	11	14	13
867	11	0	11	11	11
868	11	0	11	11	11
869	11	11	11	13	11
870	11	0	11	16	11
871	11	0	11	11	11
872	11	0	11	11	12
873	12	0	11	19	16
874	11	11	11	15	16
875	11	0	11	21	36
876	11	11	11	15	29
877	11	11	16	13	13
878	11	11	11	11	19
879	11	11	11	14	0

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
880		34476	083	Marion	12	FL	10,065	9,934	30	114
881		34479	083	Marion	12	FL	2,955	2,908	11	47
882		34480	083	Marion	12	FL	3,659	3,603	14	52
883		34481	083	Marion	12	FL	13,838	13,694	28	130
884		34482	083	Marion	12	FL	5,858	5,789	29	103
885		34484	119	Sumter	12	FL	1,556	1,367	11	17
886		34488	083	Marion	12	FL	3,657	3,268	13	73
887		34491	083	Marion	12	FL	13,459	13,015	26	151
888		34498	075	Levy	12	FL	222	165	0	11
889		34601	053	Hernando	12	FL	6,896	6,225	23	148
890		34602	053	Hernando	12	FL	1,948	1,916	11	32
891		34604	053	Hernando	12	FL	2,668	2,532	11	54
892		34606	053	Hernando	12	FL	10,267	9,706	36	215
893		34607	053	Hernando	12	FL	2,991	2,952	11	51
894		34608	053	Hernando	12	FL	8,773	8,657	22	179
895		34609	053	Hernando	12	FL	11,700	11,557	23	212
896		34610	101	Pasco	12	FL	3,237	3,089	11	84
897		34613	053	Hernando	12	FL	8,051	7,970	11	177
898		34614	053	Hernando	12	FL	1,893	1,875	11	39
899		34637	101	Pasco	12	FL	1,800	1,781	11	13
900		34638	101	Pasco	12	FL	3,592	3,540	11	35
901		34639	101	Pasco	12	FL	4,482	4,125	11	58
902		34652	101	Pasco	12	FL	7,130	6,826	18	119
903		34653	101	Pasco	12	FL	9,017	8,513	44	170
904		34654	101	Pasco	12	FL	6,049	5,915	19	97
905		34655	101	Pasco	12	FL	11,704	11,498	29	120
906		34661	053	Hernando	12	FL	151	11	0	11
907		34667	101	Pasco	12	FL	12,757	12,243	43	239
908		34668	101	Pasco	12	FL	12,080	11,624	55	227
909		34669	101	Pasco	12	FL	3,691	3,623	11	83
910		34677	103	Pinellas	12	FL	4,759	4,498	11	37
911		34679	101	Pasco	12	FL	118	11	0	11
912		34681	103	Pinellas	12	FL	427	11	0	0
913		34683	103	Pinellas	12	FL	6,954	6,529	25	43
914		34684	103	Pinellas	12	FL	8,458	8,204	26	61
915		34685	103	Pinellas	12	FL	4,024	3,943	11	15
916		34688	103	Pinellas	12	FL	2,250	1,935	11	21
917		34689	103	Pinellas	12	FL	7,345	7,162	33	61
918		34690	101	Pasco	12	FL	3,176	2,981	14	70
919		34691	101	Pasco	12	FL	5,056	4,968	23	83
920		34695	103	Pinellas	12	FL	4,479	4,235	14	35
921		34698	103	Pinellas	12	FL	11,357	10,840	36	86
922		34705	069	Lake	12	FL	559	437	11	11
923		34711	069	Lake	12	FL	14,263	13,762	70	154
924		34714	069	Lake	12	FL	3,276	2,997	20	29
925		34715	069	Lake	12	FL	3,272	2,876	13	37
926		34731	069	Lake	12	FL	3,220	3,008	11	46
927		34734	095	Orange	12	FL	658	538	11	11
928		34736	069	Lake	12	FL	4,414	4,200	26	47

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
880	265	24	416	11	11	21	316	11
881	78	12	152	0	11	11	132	11
882	82	13	177	0	11	11	139	11
883	372	17	421	11	11	23	317	11
884	161	19	291	11	11	11	234	11
885	80	11	76	11	11	11	59	11
886	86	11	205	11	11	11	162	11
887	339	34	538	11	11	33	410	11
888	11	0	11	0	0	11	11	0
889	246	27	367	0	11	11	293	11
890	41	11	103	0	11	11	78	11
891	77	11	125	11	11	11	100	11
892	358	27	537	11	14	11	452	11
893	64	11	123	11	11	11	99	11
894	298	21	467	11	12	11	379	11
895	340	23	537	11	15	14	417	11
896	84	11	195	11	11	11	156	11
897	217	18	430	11	11	11	361	11
898	42	11	85	0	0	11	69	11
899	40	11	47	0	11	11	37	0
900	80	17	119	0	11	11	90	11
901	120	21	186	11	11	19	123	11
902	227	20	355	0	11	13	277	11
903	363	22	483	11	12	14	381	11
904	181	29	268	11	11	11	213	11
905	360	25	392	11	12	18	308	11
906	11	0	11	0	0	0	11	0
907	422	39	605	11	17	11	506	11
908	384	31	598	11	14	23	486	11
909	114	13	198	11	11	11	161	11
910	116	18	142	11	11	11	105	11
911	11	0	11	0	0	0	11	0
912	11	11	11	0	0	0	11	0
913	210	21	242	11	11	26	162	12
914	320	32	320	11	11	17	237	11
915	119	14	134	11	11	11	93	11
916	80	11	87	11	11	11	58	11
917	202	29	246	11	11	15	177	11
918	103	12	173	11	11	11	131	11
919	140	12	229	11	11	15	184	11
920	106	16	145	11	11	11	103	11
921	358	42	386	11	15	27	283	11
922	14	11	29	0	0	11	26	11
923	372	48	542	11	17	34	404	11
924	68	17	121	11	11	11	83	11
925	91	18	144	11	11	11	104	11
926	103	12	141	11	11	11	113	11
927	18	11	29	11	0	0	21	11
928	98	17	175	11	11	11	121	11

AMERICAN OVERSIGHT

	S	T	U	V	W
880	23	11	13	19	26
881	11	0	11	11	11
882	11	11	11	11	17
883	35	11	11	11	23
884	13	11	11	15	12
885	11	11	11	11	11
886	11	0	11	17	13
887	43	11	11	21	24
888	0	0	0	0	0
889	11	11	11	24	35
890	11	11	11	11	11
891	11	11	11	11	11
892	22	11	11	20	42
893	11	0	11	11	11
894	15	11	11	22	50
895	32	11	11	25	47
896	11	11	0	11	14
897	13	11	11	12	30
898	11	11	11	11	11
899	11	0	11	0	11
900	11	0	11	11	11
901	11	11	11	11	28
902	20	11	11	11	32
903	19	11	11	34	48
904	13	0	11	15	20
905	20	0	11	20	25
906	0	0	0	0	0
907	29	11	11	29	39
908	25	11	11	35	36
909	11	11	11	11	12
910	11	11	11	11	11
911	0	0	0	11	0
912	11	0	11	0	11
913	13	11	11	12	18
914	21	0	11	11	20
915	11	11	11	11	11
916	11	0	11	11	11
917	11	11	11	18	25
918	11	11	11	11	20
919	11	11	11	11	14
920	11	11	11	11	12
921	21	11	11	17	41
922	0	0	0	0	11
923	29	11	11	32	42
924	11	0	11	11	18
925	11	0	11	11	20
926	11	0	11	11	11
927	11	0	11	11	11
928	14	11	11	11	21

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
929		34737	069	Lake	12	FL	833	786	11	11
930		34739	097	Osceola	12	FL	230	184	0	11
931		34741	097	Osceola	12	FL	7,100	6,108	76	66
932		34743	097	Osceola	12	FL	6,422	6,297	61	44
933		34744	097	Osceola	12	FL	8,565	8,418	65	63
934		34746	097	Osceola	12	FL	8,103	7,941	62	59
935		34747	097	Osceola	12	FL	2,952	2,781	13	16
936		34748	069	Lake	12	FL	18,515	17,866	71	188
937		34753	069	Lake	12	FL	775	623	11	11
938		34756	069	Lake	12	FL	637	523	11	12
939		34758	097	Osceola	12	FL	6,722	6,471	57	49
940		34759	105	Polk	12	FL	10,565	10,474	69	61
941		34760	095	Orange	12	FL	239	11	11	11
942		34761	095	Orange	12	FL	5,382	5,119	31	68
943		34762	069	Lake	12	FL	265	87	0	11
944		34769	097	Osceola	12	FL	5,279	4,714	29	104
945		34771	097	Osceola	12	FL	3,516	3,460	13	47
946		34772	097	Osceola	12	FL	4,851	4,753	31	67
947		34773	097	Osceola	12	FL	697	691	11	11
948		34785	119	Sumter	12	FL	3,635	3,257	28	52
949		34786	095	Orange	12	FL	4,206	3,820	11	26
950		34787	095	Orange	12	FL	8,706	8,158	51	83
951		34788	069	Lake	12	FL	6,754	6,536	18	106
952		34797	069	Lake	12	FL	443	401	11	11
953		34945	111	Saint Lucie	12	FL	992	976	11	12
954		34946	111	Saint Lucie	12	FL	1,570	1,544	21	18
955		34947	111	Saint Lucie	12	FL	1,802	1,741	32	25
956		34949	111	Saint Lucie	12	FL	3,260	3,231	11	16
957		34950	111	Saint Lucie	12	FL	3,046	2,606	49	32
958		34951	111	Saint Lucie	12	FL	5,023	4,945	16	51
959		34952	111	Saint Lucie	12	FL	12,957	12,396	64	148
960		34953	111	Saint Lucie	12	FL	10,895	10,750	85	131
961		34956	085	Martin	12	FL	1,108	810	15	11
962		34957	085	Martin	12	FL	7,388	7,058	15	83
963		34972	093	Okeechobee	12	FL	3,024	2,546	30	65
964		34974	093	Okeechobee	12	FL	5,937	5,837	25	95
965		34981	111	Saint Lucie	12	FL	806	777	11	12
966		34982	111	Saint Lucie	12	FL	5,780	5,689	39	76
967		34983	111	Saint Lucie	12	FL	8,867	8,324	54	103
968		34984	111	Saint Lucie	12	FL	3,253	3,219	20	30
969		34986	111	Saint Lucie	12	FL	10,616	10,222	34	98
970		34987	111	Saint Lucie	12	FL	4,368	4,339	11	21
971		34990	085	Martin	12	FL	8,374	7,969	16	74
972		34994	085	Martin	12	FL	4,597	4,143	22	61
973		34996	085	Martin	12	FL	4,172	4,108	11	42
974		34997	085	Martin	12	FL	11,983	11,606	27	136

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
929	18	11	31	11	11	11	21	0
930	11	11	13	0	0	0	12	0
931	174	31	265	11	11	11	176	13
932	138	61	223	11	11	11	129	11
933	204	48	313	11	11	11	190	12
934	192	34	298	11	11	18	185	15
935	92	11	74	11	11	11	42	11
936	522	38	786	11	28	51	611	16
937	16	11	39	11	11	0	28	11
938	11	11	26	0	0	0	23	11
939	158	46	237	11	11	11	148	11
940	180	31	313	11	11	11	206	11
941	11	0	11	0	0	0	11	0
942	138	18	232	11	12	11	169	11
943	11	0	11	0	0	0	11	0
944	161	23	265	11	11	11	209	11
945	84	22	167	11	11	11	118	11
946	107	22	197	11	11	11	143	11
947	11	11	33	0	0	11	20	11
948	107	11	190	11	11	11	162	11
949	114	11	108	11	11	11	65	11
950	165	24	330	11	13	13	231	11
951	184	21	380	11	11	24	310	11
952	11	11	33	11	11	11	30	0
953	30	11	37	11	0	0	29	0
954	58	11	71	0	11	11	48	11
955	54	11	73	11	11	11	38	11
956	106	11	82	11	11	11	51	11
957	103	11	128	11	11	11	81	11
958	195	11	178	0	11	11	139	11
959	471	28	478	11	18	20	364	12
960	347	22	423	11	13	15	295	15
961	42	11	50	0	11	11	35	11
962	330	17	257	11	12	19	189	11
963	90	11	183	0	11	11	139	11
964	211	11	350	0	11	11	275	17
965	34	0	39	0	0	11	27	11
966	224	13	237	11	11	11	172	14
967	288	21	333	11	11	11	242	13
968	102	11	100	11	11	11	63	11
969	344	13	333	11	12	19	227	11
970	146	11	103	0	11	11	76	11
971	361	21	221	11	11	11	153	11
972	216	11	151	0	11	11	128	11
973	175	14	122	0	11	11	93	11
974	485	18	357	11	17	17	266	16

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	S	T	U	V	W
929	11	0	11	11	11
930	0	0	0	11	11
931	11	11	11	18	42
932	12	11	11	17	52
933	22	11	11	21	58
934	11	11	11	33	40
935	11	11	11	11	12
936	37	11	11	25	46
937	11	0	11	11	11
938	11	0	0	0	11
939	18	11	11	28	34
940	22	11	11	26	49
941	0	0	0	11	11
942	14	11	11	14	23
943	0	0	0	0	0
944	17	11	11	14	21
945	15	11	11	13	17
946	21	11	11	11	14
947	11	0	0	11	11
948	13	11	11	11	11
949	11	11	0	11	16
950	17	11	11	22	36
951	17	0	11	11	23
952	11	11	0	0	11
953	11	0	0	11	11
954	11	0	11	11	15
955	11	0	11	11	18
956	11	11	11	11	11
957	11	11	11	17	21
958	11	11	11	11	11
959	28	11	11	21	44
960	34	11	11	16	57
961	11	0	0	11	11
962	17	11	11	13	14
963	11	11	11	18	20
964	14	11	11	17	39
965	11	11	11	11	11
966	15	11	11	11	21
967	24	11	11	13	35
968	11	11	0	11	14
969	35	11	11	11	31
970	11	11	11	11	11
971	22	11	0	11	23
972	11	11	0	11	11
973	11	11	11	11	11
974	20	11	11	11	31

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Emergency Planning- R4 HHS emPOWER Emergency Planning De-identified Datasets (March 2020)
Date:	Sunday, March 22, 2020 10:05:24 AM
Attachments:	Florida_FL_CMSData_De_Identified_SCZ_2020_03.xlsx
Importance:	High

R4 emPOWER Emergency Planning De-identified Datasets for dissemination to the states to support emergency planning.

I have attached the HHS emPOWER Initiative Emergency Planning de-identified dataset that includes data at the state/territory, county, and zip code levels. The de-identified (HIPAA masked) dataset includes at-risk Medicare beneficiaries from the Medicare Fee-For-Service (FFS/Parts A& B) and Medicare Advantage (CMS' HMO plans/Part C) Programs that rely upon the electricity-dependent durable medical equipment (DME) and cardiac implantable devices and healthcare services that include ESRD (dialysis), oxygen tank services, and home health visits. Detailed information regarding the dataset are included in the Menu tab and the Data Overview tabs of the attached workbook.

State/Territory Zip Aggregation: We weren't able to identify geospatial boundary data for a number of the zip codes in the state/territory. Due to this we have had to aggregate the data for those zip codes (child zip code) with another zip code that it resides in or next to (parent zip code) to ensure we didn't lose population data associated with those zip codes. The third tab in the dataset provides the mapping for zip codes that meet this criteria.

Purpose: ASPR, in partnership with CMS, are providing limited de-identified Medicare data to State and local health departments to enhance situational awareness of and support emergency planning for and public health response activities for at-risk individuals that rely upon select electricity-dependent durable medical equipment (DME), facility-based dialysis and oxygen tank services prior to, during, or after an emergency or disaster. The DME that are included are: ventilators, oxygen concentrators, IV infusion pumps, suction pumps, at-home dialysis, electric wheelchairs and electric beds.

Data Source: The CMS dataset is developed from Medicare Fee For Service (FFS) Part A and B beneficiary administrative claims data (~32M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children) and Medicare Advantage claims data (~17M 65+, blind, ESRD (dialysis), dual-eligible, disabled-can include adults and children). This data does not include individuals that are only enrolled in a State Medicaid Program. It is important to note that Medicare DME are subject to insurance claim reimbursement caps (e.g. rental caps) that differ by type and therefore may have a different "look-back" periods (e.g. ventilators are 13 months and oxygen concentrators are 36 months) all of which are provided in the Menu and Data Overview tabs of the workbook.

Approved Data Uses: The de-identified dataset is approved for use by the state/territory and local health department, either directly or in collaboration with their ESF-8, 6, recovery or other partners, as appropriate, for public health emergency preparedness, response, recovery, mitigation and resilience activities. This data is not approved for research and all other potential uses of this data require prior approval from ASPR and CMS that must be sent c/o their ASPR REC to Kristen Finne at

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Kristen.finne@hhs.gov.

Privacy Protections: As Medicare beneficiary privacy protection is our priority, all personal identifiable information has been removed from this dataset and numerous de-identified methods have been applied to significantly minimize, if not completely mitigate, any potential for deduction of small cells or re-identification risk. For example, any cell size found between the range of 1 and 10 is masked and shown as 11. Additional information about our privacy protection/de-identification methods can be located on the Menu tab. If a State or local health department were to identify a potential risk for deducing a small cell or re-identification, notification must be immediately sent to Kristen Finne at Kristen.finne@hhs.gov.

Thanks again for all your time and collaboration on this important response effort. As always, please feel free to call or email me with any additional questions.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
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cell: 202.322.1930 AT&T (primary)
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HHS emPOWER Program - March 2020 Update
State of Florida
De-Identified Aggregated U.S. State, County, Zip Code

Table of Contents

Data Overview

Reference Dates

Data Description

Notes

U.S. Territory/State Level Data

County Level Data

* Cells with counts between 1-10 are masked to 11.

** Beneficiary addresses do not include beneficiaries in nu

*** The Power Dependent Layer includes beneficiaries wh concentrator in the last 36 months, a ventilator, bi-level p enteral feeding, IV infusion pump, suction pump, motorize the last 13 months, at-home ESRD in the last 3 months, Individuals are counted once regardless of how many type

Geographic Indicators:
State Level Data

Totals*:
Medicare Beneficiaries in Territory/State
Medicare Fee-for-Service Beneficiaries [Part A/Part B] in State
Medicare Advantage Beneficiaries [Part C] in State
Dual-Eligible Medicare Beneficiaries in Territory/State

Residence Indicators*:
Number of Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)

At Risk Populations*:	Lookback Periods
In-Facility ESRD	3 months
Oxygen Services (Tanks)	13 months
Home Health Services	3 months
At-Home Hospice	3 months
Power Dependent [All Devices and DME]***	Varied
Power Dependent Cardiac Devices	5 years
Ventilators	13 months
BiPAPs	13 months
Oxygen Concentrators	36 months
Enteral Feeding	13 months
IV Infusion Pumps	13 months
Suction Pumps	13 months
At-Home ESRD	3 months

Geographic Indicators:
County FIPS Code
County Name
State FIPS Code
State (Two-letter abbreviation)
Number of Zip Codes in County

Totals*:
Medicare Beneficiaries in County

Residence Indicators*:
Number of Beneficiary Addresses (Excludes P.O. Boxes an

At Risk Populations*:
In-Facility ESRD
Oxygen Services (Tanks)
Home Health Services
At-Home Hospice
Power Dependent [All Devices and DME]***
Power Dependent Cardiac Devices
Ventilators
BiPAPs
Oxygen Concentrators
Enteral Feeding
IV Infusion Pumps
Suction Pumps
At-Home ESRD

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	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
1														
2														
3														
4														
5														
6														
7														
8														
9	rsing homes or long term care.													
10														
11	o have a claim for an oxygen													
12	ositive airway pressure device (BiPAP),													
13	d wheelchair, scooter, or electric bed in													
14	or a cardiac device in the last 5 years.													
15	s of DME they utilize.													
16														
17						Zip Code Level Data								
18						**Geographic Indicators:**								
19						Zip Code								
20						County FIPS Code								
21						County Name								
22						State FIPS Code								
23						State (Two-letter abbreviation)								
24														
25						**Totals*:**								
26						# Medicare Beneficiaries in Zip Code								
27														
28														
29														
30														
31						**Residence Indicators*:**								
32						Number of Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)								
33	nd Unknowns)													
34														
35	**Lookback Periods**					**At Risk Populations*:**						**Lookback Periods**		
36	3 months					In-Facility ESRD						3 months		
37	13 months					Oxygen Services (Tanks)						13 months		
38	3 months					Home Health Services						3 months		
39	3 months					At-Home Hospice						3 months		
40	Varied					Power Dependent [All Devices and DME]***						Varied		
41	5 years					Power Dependent Cardiac Devices						5 years		
42	13 months					Ventilators						13 months		
43	13 months					BiPAPs						13 months		
44	36 months					Oxygen Concentrators						36 months		
45	13 months					Enteral Feeding						13 months		
46	13 months					IV Infusion Pumps						13 months		
47	13 months					Suction Pumps						13 months		
48	3 months					At-Home ESRD						3 months		

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
49		Motorized Wheelchairs or Scooters						13 months				Motorized Wheelchairs or Scooters					
50		Electric Beds						13 months				Electric Beds					
51																	
52		**De-Identification Methods/Privacy Protection**										**De-Identification Methods/Privacy Protection**					
53		Removed all personal identifiers and information.										Removed all personal identifiers and information.					
54		Aggregated data to the territory/state level.										Aggregated data to the county level using sums of actual					
55		Masked all data variables with a cell size between 1-10 to 11.										Masked all data variables with a cell size between 1-10 to					
56		Aggregated data to the territory/state level using sums of actual and masked zip code values for										Number of masked counties provided to allow calculating					
57		territories/states with only 1 masked zip code.															

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	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE
49	13 months					Motorized Wheelchairs or Scooters						13 months		
50	13 months					Electric Beds						13 months		
51														
52						**De-Identification Methods/Privacy Protection**									
53						Removed all personal identifiers and information.									
54	and masked	zip code values.				Aggregated data to the zip code level.								
55	11.					Masked all data variables with a cell size between 1-10 to 11.								
56	actual range.													
57														

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HHS emPOWER Program - March 2020 Update
Data Overview

REFERENCE DATES

Category	Description	Data as of
Enrollment and Death	We restrict the Medicare population beneficiaries alive as of the most recent Medicare Enrollment Database (EDB) available. We additionally restrict to beneficiaries who are enrolled in either original Medicare (Parts A/B, also known as fee-for-service or FFS), or Medicare Advantage (Part C), as of the most recent month available in the EDB.	1/1/2020
Nursing home	Nursing home residence is determined by using a combination of nursing home-related Medicare FFS/Medicare Advantage claims and the Long-Term Care Minimum Data Set (MDS) assessments as of this date.	12/1/2019
Power Dependent Devices and Durable Medical Equipment Users	Power-dependent device and durable medical equipment use is determined by the presence of Medicare FFS/Medicare Advantage claims during various lookback periods, all ending on this date.	2/28/2020
End-Stage Renal Disease (ESRD)	ESRD patients are identified as receiving In-facility dialysis treatment or at-home dialysis DME by the presence of Medicare FFS claims/Medicare Advantage in the 3 months prior to this date.	2/28/2020

NOTES

* Power-dependent medical equipment users are included in counts only if they are not residing in a nursing home or are not receiving long term care.

* All cells with values from 1-10 have been replaced [masked] with 11.

* County level summary counts reflect sums of masked and unmasked zip codes.

* Territory/state summary counts reflect:
  For territories/states that have contain zero or more than one masked zip code - actual totals.
  For territories/states with exactly one masked zip code - sum of the masked and unmasked zip codes.
  Sums that include exactly one masked zip code are indicated in the State Actual Data tab by an asterisk.

Zip Codes:
Some zip codes do not appear separately in the aggregate-level counts as we were unable to locate specific geospatial boundary data for their given area. Most of the zip codes that fall within this category are P.O. Box zip codes, though in some U.S. Territories these include residential zip codes with a very high prevalence of P.O. Boxes. As many individuals will reside within the geographic area, we have developed a work around to ensure the population data is still captured. This is done by identifying the larger boundary zip code, also named the parent zip code, in which the non-boundary zip code, also named the child zip code, resides. The totals are then added together and displayed under the parent zip code. The list of all child zip codes and their associated parent zip codes is included in the third tab of this workbook.

DATA DESCRIPTI

End-Stage Renal Dise
having received dialy

Oxygen Services [Tar
Term Care/Nursing H
supplemental oxygen

Home Health Service
Term Care/Nursing H
therapy, speech-langu

At-Home Hospice Se
living at home (i.e., n
occupational therapy,
supplies and usage of
ill beneficiaries who

Power-dependent De
not in Long Term C
13 months. The only

* Oxygen concentrat

* At-home dialysis is
use a 3 month lookb
home should their eq

* Cardiac devices su
continued cardiac fu
to identify individual

Additional DME and

Cardiac devices inclu
pumps that are used

A **ventilator** provides
deflating of the ches

A bi-level positive ai
at any moment of th

An **oxygen concentra**
used to provide life-
required for certain

An **enteral feeding** t
safely, or need nutri

An **IV infusion pump**
antibiotics, chemother

A **suction pump** is a
often prescribed for

A **motorized wheelch**
impairments as well

An **electric bed** is a
electronic buttons to

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	A	B	C	D	E	F	G	H
36								For more information

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HHS emPOWER Program - March 2020 Update
Parent-Child Zip Code Mapping

Some zip codes do not appear separately in the aggregate-level counts as we were unable to locate specific geospatial boundary data for their given area. Most of the zip codes that fall within this category are P.O. Box zip codes, though in some U.S. Territories these include residential zip codes with a very high prevalence of P.O. Boxes. As many individuals will reside within the geographic area, we have developed a work around to ensure the population data is still captured. This is done by identifying the larger boundary zip code, also named the parent zip code, in which the non-boundary zip code, also named the child zip code, resides. The totals are then added together and displayed under the parent zip code. The list of all child zip codes and their associated parent zip codes is included below.

Child Zip Code	Parent Zip Code
32004	32082
32006	32073
32007	32177
32026	32083
32030	32068
32035	32034
32041	32097
32042	32044
32050	32068
32056	32055
32067	32073
32072	32087
32079	32043
32085	32084
32099	32220
32105	32180
32111	34472
32115	32114
32116	32118
32120	32114
32121	32119
32122	32114
32123	32114
32125	32117
32126	32118
32133	32179
32135	32136
32138	32666
32142	32136
32147	32177
32149	32148
32157	32181
32158	32159
32160	32656

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	A	B	C	D	E	F	G	H	I	J
49		32170	32169							
50		32173	32174							
51		32175	32174							
52		32178	32177							
53		32183	32179							
54		32185	32666							
55		32192	32113							
56		32198	32114							
57		32201	32202							
58		32203	32204							
59		32214	32212							
60		32215	32221							
61		32229	32218							
62		32231	32207							
63		32232	32209							
64		32235	32206							
65		32236	32205							
66		32237	32257							
67		32238	32244							
68		32239	32277							
69		32240	32250							
70		32241	32223							
71		32245	32216							
72		32247	32207							
73		32255	32207							
74		32260	32259							
75		32302	32301							
76		32313	32304							
77		32314	32301							
78		32315	32303							
79		32316	32304							
80		32318	32305							
81		32323	32322							
82		32326	32327							
83		32329	32320							
84		32330	32351							
85		32335	32321							
86		32337	32344							
87		32341	32340							
88		32345	32344							
89		32353	32351							
90		32356	32359							
91		32357	32347							
92		32360	32334							
93		32361	32344							
94		32362	32305							
95		32395	32301							
96		32399	32311							
97		32402	32401							

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	A	B	C	D	E	F	G	H	I	J
98		32406	32405							
99		32410	32401							
100		32411	32408							
101		32412	32401							
102		32417	32407							
103		32422	32433							
104		32432	32442							
105		32434	32433							
106		32447	32446							
107		32452	32425							
108		32457	32456							
109		32461	32401							
110		32463	32428							
111		32513	32503							
112		32516	32506							
113		32520	32502							
114		32521	32507							
115		32522	32502							
116		32523	32501							
117		32524	32501							
118		32530	32583							
119		32537	32531							
120		32538	32567							
121		32540	32541							
122		32549	32548							
123		32559	32526							
124		32560	32533							
125		32562	32561							
126		32572	32570							
127		32588	32578							
128		32602	32601							
129		32604	32603							
130		32612	32611							
131		32614	32608							
132		32616	32615							
133		32627	32601							
134		32633	32640							
135		32634	32686							
136		32635	32605							
137		32639	34449							
138		32644	32626							
139		32654	32640							
140		32655	32643							
141		32658	32615							
142		32662	32640							
143		32663	32686							
144		32681	32686							
145		32704	32712							
146		32706	32744							

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	A	B	C	D	E	F	G	H	I	J
147		32710	32818							
148		32715	32714							
149		32716	32714							
150		32718	32708							
151		32719	32708							
152		32721	32720							
153		32722	32720							
154		32723	32724							
155		32727	32726							
156		32728	32725							
157		32733	32792							
158		32739	32738							
159		32745	32746							
160		32747	32771							
161		32752	32779							
162		32753	32713							
163		32762	32765							
164		32768	32712							
165		32772	32771							
166		32774	32763							
167		32777	32757							
168		32781	32780							
169		32783	32780							
170		32790	32789							
171		32791	32779							
172		32793	32792							
173		32794	32751							
174		32795	32746							
175		32799	32746							
176		32802	32801							
177		32834	32828							
178		32853	32803							
179		32854	32804							
180		32855	32805							
181		32856	32806							
182		32857	32807							
183		32858	32808							
184		32859	32809							
185		32860	32810							
186		32861	32811							
187		32862	32827							
188		32867	32817							
189		32868	32818							
190		32869	32809							
191		32872	32822							
192		32877	32837							
193		32878	32828							
194		32885	32827							
195		32886	32801							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
196		32887	32821							
197		32891	32803							
198		32897	32801							
199		32902	32901							
200		32906	32905							
201		32910	32907							
202		32911	32905							
203		32912	32904							
204		32919	32901							
205		32923	32922							
206		32924	32922							
207		32932	32931							
208		32936	32935							
209		32941	32901							
210		32954	32953							
211		32956	32955							
212		32957	32958							
213		32959	32927							
214		32961	32960							
215		32964	32960							
216		32965	32962							
217		32969	32966							
218		32970	32967							
219		32971	32967							
220		32978	32958							
221		33002	33012							
222		33008	33009							
223		33011	33010							
224		33017	33015							
225		33022	33020							
226		33041	33040							
227		33045	33040							
228		33052	33050							
229		33061	33060							
230		33072	33069							
231		33074	33064							
232		33075	33067							
233		33077	33071							
234		33081	33021							
235		33082	33027							
236		33083	33023							
237		33084	33024							
238		33090	33030							
239		33092	33032							
240		33093	33063							
241		33097	33073							
242		33101	33136							
243		33102	33122							
244		33106	33193							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
245		33111	33131							
246		33112	33122							
247		33114	33134							
248		33116	33176							
249		33119	33139							
250		33124	33181							
251		33151	33127							
252		33152	33122							
253		33153	33138							
254		33163	33180							
255		33164	33162							
256		33188	33122							
257		33195	33166							
258		33197	33157							
259		33222	33122							
260		33231	33131							
261		33233	33133							
262		33234	33134							
263		33238	33150							
264		33239	33139							
265		33242	33142							
266		33243	33143							
267		33245	33145							
268		33247	33122							
269		33255	33155							
270		33256	33156							
271		33257	33157							
272		33261	33161							
273		33265	33175							
274		33266	33166							
275		33269	33169							
276		33280	33162							
277		33283	33183							
278		33296	33156							
279		33299	33122							
280		33302	33304							
281		33303	33301							
282		33307	33334							
283		33310	33311							
284		33318	33322							
285		33320	33321							
286		33329	33324							
287		33335	33334							
288		33336	33311							
289		33337	33324							
290		33338	33324							
291		33339	33306							
292		33340	33311							
293		33345	33351							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
294		33346	33316							
295		33348	33308							
296		33349	33304							
297		33355	33325							
298		33359	33319							
299		33394	33301							
300		33402	33480							
301		33416	33406							
302		33419	33404							
303		33420	33410							
304		33421	33411							
305		33422	33417							
306		33424	33426							
307		33425	33426							
308		33427	33486							
309		33429	33432							
310		33443	33441							
311		33448	33446							
312		33454	33467							
313		33459	33440							
314		33464	33460							
315		33465	33462							
316		33466	33461							
317		33468	33458							
318		33474	33436							
319		33475	33455							
320		33481	33431							
321		33482	33445							
322		33488	33433							
323		33497	33428							
324		33499	33487							
325		33503	33598							
326		33508	33511							
327		33509	33511							
328		33524	33540							
329		33526	33525							
330		33530	33547							
331		33537	33523							
332		33539	33542							
333		33564	33566							
334		33568	33569							
335		33571	33573							
336		33574	33576							
337		33575	33570							
338		33583	33584							
339		33586	33570							
340		33587	33527							
341		33593	33523							
342		33595	33594							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
343		33601	33602							
344		33608	33621							
345		33622	33607							
346		33623	33607							
347		33630	33607							
348		33631	33607							
349		33633	33607							
350		33646	33602							
351		33650	33607							
352		33655	33602							
353		33660	33619							
354		33661	33619							
355		33662	33619							
356		33663	33607							
357		33664	33607							
358		33672	33602							
359		33673	33603							
360		33674	33604							
361		33675	33605							
362		33679	33629							
363		33680	33610							
364		33681	33611							
365		33682	33612							
366		33684	33634							
367		33685	33615							
368		33686	33616							
369		33687	33617							
370		33688	33618							
371		33689	33619							
372		33694	33624							
373		33729	33716							
374		33730	33713							
375		33731	33701							
376		33732	33702							
377		33733	33713							
378		33734	33704							
379		33736	33706							
380		33737	33707							
381		33738	33708							
382		33740	33706							
383		33741	33706							
384		33742	33702							
385		33743	33710							
386		33747	33711							
387		33757	33755							
388		33758	33765							
389		33766	33763							
390		33769	33765							
391		33775	33772							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
392		33779	33771							
393		33780	33781							
394		33784	33713							
395		33802	33803							
396		33804	33805							
397		33806	33803							
398		33807	33813							
399		33820	33830							
400		33826	33825							
401		33831	33830							
402		33835	33860							
403		33836	33837							
404		33840	33803							
405		33845	33844							
406		33846	33812							
407		33847	33843							
408		33851	33844							
409		33854	33898							
410		33856	33898							
411		33858	33837							
412		33862	33852							
413		33863	33860							
414		33871	33870							
415		33877	33859							
416		33882	33880							
417		33883	33880							
418		33885	33881							
419		33888	33884							
420		33902	33901							
421		33906	33907							
422		33910	33990							
423		33911	33901							
424		33915	33990							
425		33918	33903							
426		33927	33953							
427		33929	33928							
428		33932	33931							
429		33938	33948							
430		33945	33922							
431		33949	33950							
432		33951	33950							
433		33970	33936							
434		33975	33935							
435		33994	33905							
436		34101	34102							
437		34106	34102							
438		34107	34102							
439		34133	34135							
440		34136	34135							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
441		34143	34142							
442		34146	34145							
443		34204	34203							
444		34206	34205							
445		34216	34217							
446		34218	34217							
447		34220	34221							
448		34230	34236							
449		34260	34243							
450		34264	34203							
451		34265	34266							
452		34267	34269							
453		34268	34266							
454		34270	34243							
455		34272	34275							
456		34274	34275							
457		34276	34236							
458		34277	34239							
459		34278	34234							
460		34280	34209							
461		34281	34207							
462		34282	34207							
463		34284	34285							
464		34290	34287							
465		34295	34223							
466		34421	34420							
467		34430	34432							
468		34445	34465							
469		34447	34448							
470		34451	34450							
471		34460	34461							
472		34464	34465							
473		34477	34471							
474		34478	34471							
475		34483	34472							
476		34487	34448							
477		34489	34488							
478		34492	34491							
479		34603	34601							
480		34605	34601							
481		34611	34606							
482		34636	34601							
483		34656	34653							
484		34660	34683							
485		34673	34668							
486		34674	34667							
487		34680	34652							
488		34682	34683							
489		34692	34690							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
490		34697	34698							
491		34712	34711							
492		34713	34714							
493		34729	34715							
494		34740	34787							
495		34742	34741							
496		34745	34741							
497		34749	34748							
498		34755	34715							
499		34770	34769							
500		34777	34787							
501		34778	34787							
502		34789	34788							
503		34948	34950							
504		34954	34983							
505		34958	34957							
506		34973	34972							
507		34979	34950							
508		34985	34952							
509		34988	34986							
510		34991	34990							
511		34992	34997							
512		34995	34994							

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H
1								
2		HHS emPOWER Program - March 2020 Update						
3		De-Identified Aggregated U.S. State						
4								
5				# Medicare Beneficiaries by Plan/Enrollment Type		Demographic Information		Services
6		State	# Medicare Beneficiaries in State	# Medicare Fee-for-Service Beneficiaries [Part A/Part B] in State	# Medicare Advantage Beneficiaries [Part C] in State	# Dual-Eligible Medicare Beneficiaries in State	# Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)	# In-Facility ESRD Dialysis (3 months)
7		FL	4,311,823	2,088,296	2,223,527	841,919	4,077,090	23,635
8								
9		Note: State's dual eligibility data last reported in January 2020.						

AMERICAN OVERSIGHT

	I	J	K	L	M	N	O	P	Q
1									
2									
3									
4									
5	Services	Services	Services	All Power Dependent					Power Depende
6	# O2 services [tanks] (13 months)	# Home health (3 months)	# At-Home Hospice (3 months)	# Electricity-Dependent Devices and DME	#Cardiac Devices (5 years)	# Ventilators (13 months)	# BiPAPs (13 months)	# O2 Concentrators (36 months)	# Enteral Feeding (13 months)
7	48,545	132,997	14,874	168,269	1,619	4,945	9,516	117,351	6,027
8									
9									

AMERICAN OVERSIGHT

	R	S	T	U	V
1					
2					
3					
4					
5	ent Devices and DME				
6	# IV Infusion Pumps (13 months)	# Suction Pumps (13 months)	# At-Home ESRD Dialysis (3 months)	# Motorized Wheelchairs or Scooters (13 months)	# Electric Beds (13 months)
7	8,648	1,503	2,842	8,801	21,864
8					
9					

AMERICAN OVERSIGHT

HHS emPOWER Program - March 2020 Update
De-Identified Aggregated U.S. County

								Services	
								In-Facility ESRD (3 months)	
	County FIPS Code	County	State FIPS Code	State	# Zip Codes in County	# Medicare Beneficiaries in County	# Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)	# In-Facility ESRD Dialysis	# Masked Zip Codes in County
	001	Alachua	12	FL	19	42,894	38,109	304	7
	003	Baker	12	FL	3	4,530	3,648	49	2
	005	Bay	12	FL	11	35,121	32,027	217	6
	007	Bradford	12	FL	4	4,873	4,076	59	3
	009	Brevard	12	FL	30	146,697	140,210	703	9
	011	Broward	12	FL	54	302,247	292,131	2,368	11
	013	Calhoun	12	FL	4	2,683	2,193	22	2
	015	Charlotte	12	FL	13	66,781	64,273	199	6
	017	Citrus	12	FL	14	56,379	53,236	173	8
	019	Clay	12	FL	6	39,838	36,537	210	0
	021	Collier	12	FL	21	96,474	92,717	337	6
	023	Columbia	12	FL	5	14,814	13,496	90	0
	027	De Soto	12	FL	2	6,958	5,974	54	1
	029	Dixie	12	FL	4	3,729	2,748	33	3
	031	Duval	12	FL	34	153,265	146,765	1,560	2
	033	Escambia	12	FL	19	65,504	61,164	560	5
	035	Flagler	12	FL	4	35,344	33,124	110	1
	037	Franklin	12	FL	3	2,836	1,940	33	3
	039	Gadsden	12	FL	6	9,534	7,868	103	4
	041	Gilchrist	12	FL	2	3,687	3,189	23	1
	043	Glades	12	FL	2	1,414	986	11	1
	045	Gulf	12	FL	2	3,869	3,212	25	1
	047	Hamilton	12	FL	3	2,975	2,342	33	3
	049	Hardee	12	FL	4	4,275	3,221	43	2
	051	Hendry	12	FL	3	6,070	4,479	61	0
	053	Hernando	12	FL	10	55,338	53,401	159	5
	055	Highlands	12	FL	8	32,190	30,290	185	2
	057	Hillsborough	12	FL	54	224,744	211,895	1,474	10
	059	Holmes	12	FL	3	4,945	4,469	35	2
	061	Indian River	12	FL	8	50,959	48,233	232	0
	063	Jackson	12	FL	11	11,133	9,433	124	9
	065	Jefferson	12	FL	2	3,356	2,795	33	1
	067	Lafayette	12	FL	2	1,029	813	11	1
	069	Lake	12	FL	25	104,996	98,018	498	13
	071	Lee	12	FL	35	185,549	178,284	682	8
	073	Leon	12	FL	12	40,833	38,498	217	2
	075	Levy	12	FL	8	10,412	8,303	69	4
	077	Liberty	12	FL	2	1,297	960	22	2
	079	Madison	12	FL	4	4,411	3,627	55	3
	081	Manatee	12	FL	19	99,892	94,597	406	8

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
1								
2								
3								
4	Services		Services		Services		All Power Dependent	
5	Oxygen Services [Tanks] (13 months)		Home Health (3 months)		At-Home Hospice (3 months)		Cardiac Device, Ventilator, BiPAP, Oxygen Concentrator, Enteral Feeding, IV Infusion Pump, Suction Pump, At-Home ESRD, Motorized Wheelchair, Scooter, or Electric Bed	
6	# O2 Services [Tanks]	# Masked Zip Codes in County	# Home Health	# Masked Zip Codes in County	# At-Home Hospice	# Masked Zip Codes in County	# Electricity-Dependent Devices and DME	# Masked Zip Codes in County
7	450	1	1,470	2	193	14	1,794	2
8	90	0	163	0	33	3	276	0
9	523	1	1,178	0	181	3	2,023	1
10	118	2	175	0	44	4	340	0
11	2,049	3	4,405	2	849	3	6,487	2
12	2,853	3	9,389	0	1,146	13	9,853	0
13	80	2	117	2	44	4	199	1
14	771	1	2,211	0	155	10	2,598	0
15	1,141	1	1,311	1	163	9	2,422	0
16	579	0	1,212	0	108	1	1,887	0
17	638	2	2,931	3	274	6	2,521	5
18	240	0	591	1	45	3	847	1
19	120	0	228	0	22	2	365	0
20	113	2	166	2	22	2	301	2
21	2,201	2	5,550	0	472	14	7,042	1
22	854	1	2,461	1	260	4	2,614	2
23	271	0	1,129	0	180	1	1,240	0
24	42	1	79	0	33	3	190	0
25	205	2	233	2	56	4	477	0
26	68	0	126	0	22	2	207	0
27	28	1	52	1	11	1	83	0
28	65	0	139	0	24	1	226	0
29	49	0	106	0	11	1	151	0
30	95	2	150	1	56	3	296	1
31	91	1	185	1	22	2	264	1
32	1,118	1	1,694	1	160	4	2,785	1
33	676	2	1,325	1	155	2	2,299	0
34	2,416	3	6,758	3	796	22	9,131	3
35	90	0	198	0	47	2	281	0
36	340	1	2,135	0	107	3	1,569	0
37	204	3	485	1	123	8	562	1
38	59	1	76	1	11	1	162	0
39	33	1	39	0	11	1	70	0
40	1,293	6	3,016	3	433	13	4,762	2
41	1,924	3	5,234	1	485	13	6,494	1
42	573	0	910	0	136	7	1,723	1
43	175	2	377	3	55	5	582	2
44	34	0	45	0	11	1	112	0
45	82	1	144	1	33	3	222	0
46	1,046	4	3,044	2	199	11	3,312	2

AMERICAN OVERSIGHT

	S	T	U	V	W	X	Y	Z	AA
1									
2									
3									
4									
5	Cardiac Devices (5 years)		Ventilators (13 months)		BiPAPs (13 months)		O2 Concentrators (36 months)		Enteral (13 m
6	# Cardiac Devices	# Masked Zip Codes in County	# Ventilators	# Masked Zip Codes in County	# BiPAPs	# Masked Zip Codes in County	# O2 Concentrators	# Masked Zip Codes in County	# Enteral Feeding
7	132	12	154	14	154	14	1,224	2	190
8	22	2	33	3	33	3	205	0	33
9	55	5	121	9	129	7	1,524	1	111
10	22	2	44	4	22	2	255	0	44
11	231	21	363	19	345	19	4,977	2	274
12	473	43	572	52	675	38	5,868	1	723
13	11	1	33	3	33	3	174	1	11
14	77	7	143	10	241	3	1,932	0	146
15	99	9	143	13	146	11	1,995	1	132
16	66	6	82	4	140	1	1,364	0	85
17	121	11	179	15	294	9	1,719	4	165
18	33	3	48	3	55	5	641	1	44
19	22	2	22	2	22	2	294	0	22
20	11	1	22	2	22	2	254	2	22
21	330	30	366	24	505	13	4,692	1	375
22	77	7	136	11	163	9	1,715	0	158
23	44	4	50	2	85	2	874	0	60
24	11	1	22	2	33	3	150	0	22
25	22	2	55	5	59	4	336	2	55
26	22	2	22	2	22	2	172	0	11
27	0	0	22	2	11	1	72	0	11
28	22	2	22	2	22	2	178	0	22
29	22	2	33	3	33	3	110	0	22
30	33	3	22	2	22	2	232	1	22
31	11	1	22	2	22	2	209	1	22
32	66	6	96	5	102	8	2,259	1	99
33	77	7	77	7	66	6	1,908	1	88
34	407	37	574	41	644	33	5,957	3	585
35	22	2	33	3	33	3	218	0	11
36	66	6	88	8	81	6	1,124	0	79
37	11	1	77	7	88	8	429	1	88
38	11	1	11	1	23	1	115	0	22
39	11	1	11	1	11	1	49	0	11
40	176	16	254	17	366	14	3,715	2	218
41	253	23	384	25	478	18	4,776	2	381
42	66	6	99	9	157	4	1,132	1	114
43	55	5	66	6	66	6	467	2	56
44	0	0	22	2	22	2	88	0	11
45	33	3	33	3	33	3	155	1	33
46	132	12	165	15	284	7	2,493	2	190

AMERICAN OVERSIGHT

	AB	AC	AD
1			
2			
3			
4	Power Dependent Devices and DME		
5	Feeding onths)	IV Infusion Pumps (13 months)	
6	# Masked Zip Codes in County	# IV Infusion Pumps	# Masked Zip Codes in County
7	13	156	12
8	3	33	3
9	9	179	4
10	4	33	3
11	21	420	12
12	35	620	39
13	1	11	1
14	11	193	9
15	12	168	11
16	2	115	1
17	15	278	8
18	4	44	4
19	2	24	1
20	2	22	2
21	20	448	15
22	11	160	10
23	2	79	2
24	2	33	3
25	5	44	4
26	1	22	2
27	1	11	1
28	2	22	2
29	2	11	1
30	2	33	3
31	2	22	2
32	9	137	5
33	8	93	4
34	44	586	43
35	1	33	3
36	5	102	5
37	8	88	8
38	2	22	2
39	1	11	1
40	17	324	14
41	22	543	16
42	9	126	7
43	4	66	6
44	1	11	1
45	3	33	3
46	15	207	12

AMERICAN OVERSIGHT

	AE	AF	AG	AH	AI	AJ	AK	AL
1								
2								
3								
4								
5	Suction Pumps (13 months)		At-Home ESRD Dialysis (3 months)		# Motorized Wheelchairs or Scooters (13 months)		Electric Beds (13 months)	
6	# Suction Pumps	# Masked Zip Codes in County	# At-Home ESRD Dialysis	# Masked Zip Codes in County	# Motorized Wheelchairs or Scooters	# Masked Zip Codes in County	# Electric Beds	# Masked Zip Codes in County
7	121	11	154	14	227	11	198	7
8	33	3	11	1	39	2	37	2
9	88	8	88	8	129	7	173	4
10	22	2	11	1	59	3	52	3
11	220	20	231	21	357	13	528	8
12	473	43	563	50	648	41	2,488	4
13	0	0	11	1	33	3	33	3
14	99	9	132	12	155	10	180	9
15	33	3	121	11	163	8	154	9
16	55	5	66	6	106	1	145	0
17	143	13	154	14	167	14	187	11
18	33	3	44	4	69	1	106	2
19	11	1	22	2	26	1	26	1
20	11	1	33	3	34	2	33	3
21	275	25	304	25	580	11	898	4
22	110	10	132	12	266	8	413	4
23	33	3	50	3	68	2	116	1
24	11	1	11	1	33	3	38	1
25	33	3	33	3	69	5	93	3
26	11	1	22	2	22	2	22	2
27	0	0	11	1	11	1	11	1
28	11	1	22	2	22	2	22	2
29	0	0	22	2	33	3	33	3
30	0	0	33	3	39	2	37	2
31	11	1	33	3	33	3	22	2
32	88	8	99	9	147	4	248	4
33	44	4	77	7	140	4	213	3
34	440	40	507	45	776	30	1,584	5
35	0	0	22	2	37	2	34	2
36	77	7	77	7	80	6	198	2
37	22	2	66	6	99	9	88	8
38	11	1	11	1	22	2	30	1
39	11	1	11	1	11	1	11	1
40	99	9	209	19	285	15	390	12
41	264	24	298	26	376	28	553	18
42	99	9	99	9	112	9	265	0
43	33	3	44	4	68	5	75	5
44	0	0	11	1	11	1	11	1
45	0	0	22	2	48	3	47	3
46	110	10	165	15	242	10	280	10

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
47		083	Marion	12	FL	24	105,782	98,130	443	6
48		085	Martin	12	FL	7	44,736	42,373	121	1
49		086	Miami-Dade	12	FL	80	445,169	428,501	3,378	15
50		087	Monroe	12	FL	9	16,013	13,440	78	5
51		089	Nassau	12	FL	5	21,091	19,137	75	2
52		091	Okaloosa	12	FL	14	39,812	36,891	268	5
53		093	Okeechobee	12	FL	2	8,961	8,383	55	0
54		095	Orange	12	FL	45	179,279	168,643	1,550	14
55		097	Osceola	12	FL	12	54,666	51,829	429	2
56		099	Palm Beach	12	FL	52	307,951	297,024	1,733	8
57		101	Pasco	12	FL	23	123,094	117,312	476	8
58		103	Pinellas	12	FL	48	229,883	216,954	1,159	11
59		105	Polk	12	FL	33	150,492	139,226	948	7
60		107	Putnam	12	FL	11	17,952	14,275	173	8
61		109	Saint Johns	12	FL	10	54,642	52,182	195	5
62		111	Saint Lucie	12	FL	14	73,235	70,759	458	4
63		113	Santa Rosa	12	FL	7	34,127	32,674	147	2
64		115	Sarasota	12	FL	23	136,872	131,486	439	8
65		117	Seminole	12	FL	13	68,262	64,513	411	3
66		119	Sumter	12	FL	10	72,931	70,224	175	5
67		121	Suwannee	12	FL	6	10,443	8,869	74	4
68		123	Taylor	12	FL	3	4,628	3,782	33	3
69		125	Union	12	FL	3	2,088	1,766	23	1
70		127	Volusia	12	FL	26	141,925	134,268	652	11
71		129	Wakulla	12	FL	4	5,733	4,940	23	1
72		131	Walton	12	FL	5	13,224	12,126	62	3
73		133	Washington	12	FL	4	5,038	4,355	54	3

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
47	1,477	2	2,791	2	351	12	4,772	0
48	497	1	1,855	0	113	2	1,406	0
49	4,654	6	13,128	1	2,572	16	16,535	1
50	113	6	429	2	78	6	378	2
51	339	1	595	0	75	2	891	0
52	525	1	1,479	1	178	5	1,847	2
53	160	0	301	0	22	2	533	0
54	1,765	8	4,724	1	804	16	6,787	1
55	548	3	1,343	3	331	4	2,096	1
56	2,285	5	11,036	2	954	17	8,573	1
57	2,110	1	3,549	1	402	7	5,983	1
58	2,275	3	7,458	2	813	20	8,451	2
59	1,607	3	3,687	4	729	8	6,684	1
60	312	4	646	0	117	9	1,049	0
61	454	0	1,653	0	187	4	1,799	0
62	773	0	2,502	0	185	8	2,615	0
63	482	0	1,109	0	116	2	1,489	0
64	1,126	2	4,500	0	295	15	4,363	0
65	758	0	2,103	0	284	2	2,999	0
66	504	3	1,607	2	132	6	2,091	0
67	181	0	347	0	55	5	588	0
68	99	1	136	0	33	3	315	0
69	63	2	76	2	11	1	152	1
70	1,832	3	4,328	1	709	7	6,211	1
71	129	1	133	2	37	2	324	1
72	160	0	414	0	57	4	559	0
73	113	2	188	1	46	2	296	1

AMERICAN OVERSIGHT

	S	T	U	V	W	X	Y	Z	AA
47	165	15	242	22	287	18	3,718	2	236
48	44	4	88	4	91	5	1,043	0	86
49	594	54	750	63	1,759	27	8,718	1	1,065
50	33	3	55	5	55	5	243	1	88
51	33	3	55	3	64	3	669	0	56
52	88	8	144	9	136	11	1,360	1	143
53	0	0	22	2	22	2	414	0	28
54	319	29	439	33	446	29	4,370	1	453
55	99	9	99	9	128	10	1,383	1	117
56	451	41	541	43	583	44	5,836	1	597
57	176	16	254	17	483	8	4,559	1	231
58	451	41	470	39	595	31	6,248	3	507
59	253	23	342	26	299	26	4,928	2	307
60	55	5	66	6	66	6	802	0	107
61	88	8	100	8	156	3	1,227	0	121
62	110	10	142	9	164	10	1,852	0	153
63	66	6	55	5	108	5	1,032	0	77
64	165	15	243	18	322	14	3,326	0	246
65	99	9	147	11	212	5	2,093	0	142
66	71	5	131	7	189	7	1,548	0	94
67	55	5	60	4	66	6	459	0	55
68	11	1	33	3	22	2	260	0	22
69	0	0	22	2	11	1	125	1	11
70	242	22	282	18	621	12	4,452	1	290
71	0	0	22	2	29	1	271	1	44
72	33	3	46	3	55	5	443	0	55
73	11	1	33	3	44	4	215	1	11

AMERICAN OVERSIGHT

	AB	AC	AD
47	20	301	17
48	5	103	4
49	43	858	70
50	8	45	3
51	4	71	4
52	13	203	8
53	1	25	1
54	29	501	30
55	7	149	4
56	39	742	28
57	21	310	13
58	45	571	30
59	23	440	19
60	8	66	6
61	8	162	4
62	9	235	9
63	7	86	3
64	21	375	11
65	8	205	7
66	6	219	5
67	5	66	6
68	2	33	3
69	1	11	1
70	16	370	13
71	4	11	1
72	5	55	5
73	1	39	2

AMERICAN OVERSIGHT

	AE	AF	AG	AH	AI	AJ	AK	AL
47	154	14	238	19	294	12	362	11
48	66	6	44	4	79	6	119	3
49	809	71	627	57	865	53	5,532	7
50	33	3	44	4	33	3	96	6
51	33	3	33	3	45	3	84	2
52	33	3	99	9	142	7	157	7
53	22	2	22	2	35	0	59	0
54	330	30	405	34	631	20	1,112	11
55	99	9	110	10	188	4	323	3
56	407	37	506	42	589	39	1,056	14
57	154	14	231	21	353	15	495	3
58	407	37	473	43	614	25	760	22
59	198	18	275	25	608	11	777	12
60	44	4	100	8	135	9	152	9
61	77	7	110	10	104	7	172	4
62	121	11	132	12	177	10	311	5
63	44	4	66	6	128	3	195	1
64	187	17	220	20	262	21	293	14
65	121	11	132	12	183	7	408	3
66	55	5	97	7	105	8	127	6
67	33	3	55	5	62	3	70	4
68	0	0	11	1	37	2	33	3
69	0	0	11	1	11	1	26	1
70	176	16	254	22	396	14	615	9
71	0	0	11	1	33	3	43	2
72	11	1	44	4	57	4	57	4
73	22	2	22	2	30	1	47	2

AMERICAN OVERSIGHT

HHS emPOWER Program - March 2020 Update
De-Identified Aggregated U.S. Zip Code - ESRD-Dialysis and Electricity-Dependent DME

Zip Code	County FIPS Code	County	State FIPS Code	State	# Medicare Beneficiaries in Zip Code	# Beneficiary Addresses (Excludes P.O. Boxes and Unknowns)	Services # In-Facility ESRD Dialysis (3 months)	Services # O2 services [tanks] (13 months)
32003	019	Clay	12	FL	5,147	5,055	23	64
32008	121	Suwannee	12	FL	1,423	1,183	11	32
32009	089	Nassau	12	FL	635	561	11	11
32011	089	Nassau	12	FL	3,025	2,630	16	81
32013	067	Lafayette	12	FL	22	11	0	11
32024	023	Columbia	12	FL	4,117	4,056	18	63
32025	023	Columbia	12	FL	4,000	3,850	25	61
32033	109	Saint Johns	12	FL	1,514	1,439	11	12
32034	089	Nassau	12	FL	11,761	10,994	19	125
32038	023	Columbia	12	FL	2,417	2,161	12	55
32040	003	Baker	12	FL	1,403	1,048	11	30
32043	019	Clay	12	FL	8,485	7,109	28	100
32044	007	Bradford	12	FL	479	287	11	11
32046	089	Nassau	12	FL	1,891	1,513	11	37
32052	047	Hamilton	12	FL	1,430	1,104	11	18
32053	047	Hamilton	12	FL	841	710	11	13
32054	125	Union	12	FL	1,779	1,630	12	41
32055	023	Columbia	12	FL	4,216	3,365	35	61
32058	007	Bradford	12	FL	787	620	11	15
32059	079	Madison	12	FL	638	533	11	12
32060	121	Suwannee	12	FL	4,499	4,408	18	66
32061	023	Columbia	12	FL	64	64	0	0
32062	121	Suwannee	12	FL	716	629	11	14
32063	003	Baker	12	FL	2,396	2,038	27	41
32064	121	Suwannee	12	FL	2,063	1,148	12	39
32065	019	Clay	12	FL	5,008	4,820	36	73
32066	067	Lafayette	12	FL	1,007	802	11	22
32068	019	Clay	12	FL	9,288	8,782	46	170
32071	121	Suwannee	12	FL	973	861	11	16
32073	019	Clay	12	FL	8,542	7,917	63	115
32080	109	Saint Johns	12	FL	7,099	6,884	14	45
32081	109	Saint Johns	12	FL	4,424	4,387	11	22
32082	109	Saint Johns	12	FL	7,986	7,513	11	55
32083	125	Union	12	FL	229	136	11	11
32084	109	Saint Johns	12	FL	7,999	7,266	48	102
32086	109	Saint Johns	12	FL	8,497	8,249	31	92
32087	003	Baker	12	FL	731	562	11	19
32091	007	Bradford	12	FL	3,279	2,903	26	81
32092	109	Saint Johns	12	FL	6,579	6,468	24	39
32094	121	Suwannee	12	FL	769	640	11	14

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003597

	K	L	M	N	O	P	Q	R
1								
2								
3								
4								
5	Services	Services	All Power Dependent					Power Dependent I
6	# Home health (3 months)	# At-Home Hospice (3 months)	# Electricity-Dependent Devices and DME	# Cardiac Devices (5 years)	# Ventilators (13 months)	# BiPAPs (13 months)	# O2 Concentrators (36 months)	# Enteral Feeding (13 months)
7	179	12	199	11	11	13	133	11
8	47	11	79	11	11	11	70	11
9	15	11	35	0	0	11	24	11
10	99	15	198	0	11	15	151	11
11	0	0	0	0	0	0	0	0
12	153	12	230	11	11	11	179	11
13	185	11	229	11	11	11	169	11
14	52	11	76	11	11	11	57	11
15	318	25	346	11	22	16	251	12
16	71	11	130	11	11	11	106	11
17	54	11	81	11	11	11	62	11
18	184	14	300	11	11	21	223	15
19	18	11	38	0	11	0	32	11
20	59	11	111	11	11	11	84	11
21	56	11	64	0	11	11	39	11
22	29	0	49	11	11	11	40	0
23	54	11	123	0	11	11	98	11
24	171	11	247	0	15	11	176	11
25	30	11	49	11	11	11	35	11
26	22	11	38	11	0	11	26	0
27	133	11	227	11	16	11	180	11
28	11	0	11	0	0	11	11	0
29	25	11	37	0	11	11	27	11
30	85	11	150	11	11	11	108	11
31	79	11	145	11	11	11	107	11
32	156	12	256	11	11	21	173	15
33	39	11	70	11	11	11	49	11
34	298	33	537	11	20	42	406	20
35	29	11	50	11	11	11	36	0
36	282	26	403	11	18	32	272	13
37	238	20	214	11	11	22	145	14
38	89	11	111	11	11	12	61	11
39	248	13	219	11	11	18	146	11
40	11	0	18	0	11	0	16	0
41	250	30	304	11	11	16	222	19
42	279	27	333	0	11	31	244	11
43	24	11	45	0	11	11	35	11
44	113	11	230	11	11	11	173	11
45	202	30	206	11	11	24	131	11
46	34	0	50	11	0	11	39	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003598

	S	T	U	V	W
1					
2					
3					
4					
5	Devices and DME				
6	# IV Infusion Pumps (13 months)	# Suction Pumps (13 months)	# At-Home ESRD Dialysis (3 months)	# Motorized Wheelchairs or Scooters (13 months)	# Electric Beds (13 months)
7	23	11	11	11	16
8	11	11	11	11	11
9	11	0	0	0	11
10	11	11	0	11	17
11	0	0	0	0	0
12	11	11	11	17	21
13	11	11	11	20	33
14	11	0	11	11	11
15	27	11	11	11	30
16	11	0	11	11	11
17	11	11	11	11	11
18	16	11	11	12	17
19	11	0	0	11	11
20	11	0	11	11	15
21	11	0	11	11	11
22	0	0	11	11	11
23	11	0	11	11	15
24	11	11	11	21	30
25	0	0	0	11	11
26	11	0	0	11	11
27	11	0	11	13	12
28	0	0	0	0	11
29	11	11	11	11	11
30	11	11	0	17	15
31	11	0	11	16	14
32	13	0	11	15	22
33	11	11	11	11	11
34	27	11	11	23	37
35	11	0	0	11	11
36	25	11	11	33	41
37	14	11	11	11	17
38	16	0	11	11	11
39	18	11	11	11	22
40	0	0	0	0	11
41	11	11	11	14	25
42	26	11	11	11	27
43	11	11	0	11	11
44	11	11	11	26	19
45	19	11	11	11	16
46	11	11	11	0	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
47		32095	109	Saint Johns	12	FL	2,617	2,579	11	19
48		32096	047	Hamilton	12	FL	704	528	11	18
49		32097	089	Nassau	12	FL	3,779	3,439	18	85
50		32102	069	Lake	12	FL	954	720	11	13
51		32110	035	Flagler	12	FL	2,011	1,595	14	27
52		32112	107	Putnam	12	FL	1,715	1,459	13	33
53		32113	083	Marion	12	FL	1,793	1,270	11	29
54		32114	127	Volusia	12	FL	6,507	5,597	97	92
55		32117	127	Volusia	12	FL	5,802	5,493	61	92
56		32118	127	Volusia	12	FL	5,982	5,784	15	64
57		32119	127	Volusia	12	FL	6,017	5,826	26	76
58		32124	127	Volusia	12	FL	1,378	1,367	11	11
59		32127	127	Volusia	12	FL	8,657	8,547	22	97
60		32128	127	Volusia	12	FL	6,041	5,960	16	45
61		32129	127	Volusia	12	FL	6,121	5,730	23	73
62		32130	127	Volusia	12	FL	1,200	883	11	19
63		32131	107	Putnam	12	FL	1,139	886	11	15
64		32132	127	Volusia	12	FL	2,361	2,134	11	27
65		32134	083	Marion	12	FL	2,656	2,146	11	56
66		32136	035	Flagler	12	FL	4,471	3,014	11	27
67		32137	035	Flagler	12	FL	15,880	15,676	40	102
68		32139	107	Putnam	12	FL	471	317	11	11
69		32140	107	Putnam	12	FL	429	335	11	11
70		32141	127	Volusia	12	FL	5,631	5,564	11	75
71		32145	109	Saint Johns	12	FL	1,060	816	11	21
72		32148	107	Putnam	12	FL	2,791	2,342	14	51
73		32159	069	Lake	12	FL	16,249	15,559	32	157
74		32162	119	Sumter	12	FL	41,283	40,921	73	234
75		32163	119	Sumter	12	FL	19,174	19,066	19	59
76		32164	035	Flagler	12	FL	12,982	12,839	45	115
77		32168	127	Volusia	12	FL	8,591	8,436	19	72
78		32169	127	Volusia	12	FL	4,281	3,761	11	24
79		32174	127	Volusia	12	FL	17,391	16,652	47	165
80		32176	127	Volusia	12	FL	4,993	4,931	11	54
81		32177	107	Putnam	12	FL	6,110	5,082	58	95
82		32179	083	Marion	12	FL	2,516	2,135	12	51
83		32180	127	Volusia	12	FL	743	531	11	11
84		32181	107	Putnam	12	FL	811	467	11	19
85		32182	083	Marion	12	FL	160	11	0	11
86		32187	107	Putnam	12	FL	563	322	11	11
87		32189	107	Putnam	12	FL	1,722	1,577	11	32
88		32190	127	Volusia	12	FL	279	163	11	11
89		32193	107	Putnam	12	FL	510	225	11	11
90		32195	083	Marion	12	FL	1,019	769	11	13
91		32202	031	Duval	12	FL	1,149	1,013	16	16
92		32204	031	Duval	12	FL	1,907	1,453	18	29
93		32205	031	Duval	12	FL	4,759	4,421	41	80
94		32206	031	Duval	12	FL	3,239	3,006	65	68
95		32207	031	Duval	12	FL	6,319	5,937	45	93

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
47	73	11	69	0	11	11	50	11
48	21	0	38	11	11	11	31	11
49	104	13	201	11	11	11	159	11
50	15	11	42	11	11	11	34	0
51	66	11	105	11	11	11	76	11
52	52	11	85	11	0	11	67	0
53	34	11	112	0	11	11	83	11
54	167	25	284	11	11	15	186	11
55	241	32	305	11	11	11	222	12
56	177	16	188	11	11	11	129	11
57	174	38	259	11	11	13	210	11
58	28	11	34	11	11	11	23	0
59	285	32	354	11	11	26	262	11
60	160	21	182	11	11	20	123	11
61	197	28	285	11	11	21	223	11
62	30	11	72	0	11	11	54	11
63	40	11	55	11	11	11	42	11
64	74	19	102	11	11	11	74	11
65	55	13	169	11	11	11	144	11
66	128	23	149	11	11	11	98	11
67	485	72	493	11	12	37	346	17
68	16	0	31	0	11	11	25	11
69	17	11	29	0	0	0	22	11
70	181	35	266	11	12	20	209	11
71	28	11	66	11	0	0	52	11
72	86	11	186	11	11	11	148	11
73	569	26	611	11	22	27	484	15
74	940	53	1,067	16	39	80	790	28
75	294	11	339	11	15	32	201	11
76	450	74	493	11	16	26	354	21
77	267	53	297	11	12	28	206	13
78	101	13	90	11	11	11	66	11
79	550	56	588	11	20	26	422	15
80	168	21	167	11	11	11	110	11
81	249	18	355	11	11	11	252	19
82	70	11	157	11	11	11	134	11
83	19	11	34	11	0	11	24	11
84	25	11	43	0	0	0	35	11
85	11	11	12	0	0	0	11	0
86	17	11	30	0	0	0	23	11
87	54	11	131	0	11	11	107	11
88	11	11	11	11	0	11	11	0
89	18	11	28	0	0	0	24	0
90	26	11	41	0	0	11	36	0
91	44	11	62	0	11	11	39	11
92	112	11	87	11	11	11	56	11
93	176	11	257	11	11	13	177	11
94	103	13	218	11	11	14	124	11
95	213	11	304	11	13	23	203	15

AMERICAN OVERSIGHT

	S	T	U	V	W
47	11	11	11	0	11
48	0	0	0	11	11
49	11	11	11	12	11
50	11	0	11	11	0
51	11	11	11	11	11
52	11	11	11	11	11
53	11	11	11	11	11
54	11	0	12	31	33
55	11	11	11	19	36
56	16	11	11	16	21
57	11	11	11	11	13
58	11	0	0	11	11
59	14	11	11	13	27
60	13	11	11	11	14
61	11	0	11	14	18
62	11	0	11	11	11
63	0	0	11	11	11
64	11	11	11	11	14
65	11	0	11	11	11
66	11	0	11	11	19
67	34	11	11	22	45
68	11	0	0	11	11
69	0	0	11	11	11
70	11	0	11	11	11
71	11	0	11	11	11
72	11	0	11	11	11
73	37	11	11	14	27
74	87	11	20	17	30
75	64	11	11	11	19
76	23	11	17	24	41
77	16	11	11	11	30
78	11	0	0	11	11
79	42	11	11	27	71
80	16	11	11	11	18
81	11	0	12	36	41
82	11	0	11	11	11
83	11	0	11	11	11
84	0	11	11	0	11
85	0	0	0	0	11
86	0	0	11	11	11
87	11	11	11	11	11
88	0	0	0	0	11
89	0	0	0	11	11
90	11	0	11	0	11
91	11	11	0	18	11
92	11	11	11	11	13
93	11	11	11	20	37
94	11	11	11	41	29
95	15	11	11	23	39

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
96		32208	031	Duval	12	FL	6,953	6,645	152	128
97		32209	031	Duval	12	FL	7,059	6,726	186	121
98		32210	031	Duval	12	FL	9,923	9,698	126	183
99		32211	031	Duval	12	FL	4,767	4,647	57	85
100		32212	031	Duval	12	FL	11	11	0	0
101		32216	031	Duval	12	FL	6,167	5,719	57	95
102		32217	031	Duval	12	FL	3,887	3,788	24	54
103		32218	031	Duval	12	FL	8,943	8,645	127	147
104		32219	031	Duval	12	FL	2,324	2,275	37	30
105		32220	031	Duval	12	FL	2,415	2,367	19	54
106		32221	031	Duval	12	FL	4,719	4,613	33	72
107		32222	031	Duval	12	FL	1,859	1,706	12	26
108		32223	031	Duval	12	FL	5,787	5,450	18	56
109		32224	031	Duval	12	FL	5,851	5,737	14	46
110		32225	031	Duval	12	FL	8,665	8,527	51	74
111		32226	031	Duval	12	FL	3,106	2,765	13	48
112		32227	031	Duval	12	FL	53	53	0	11
113		32228	031	Duval	12	FL	11	0	0	0
114		32233	031	Duval	12	FL	4,535	4,307	21	41
115		32234	031	Duval	12	FL	1,411	1,310	11	26
116		32244	031	Duval	12	FL	8,893	8,494	118	165
117		32246	031	Duval	12	FL	6,651	6,555	69	87
118		32250	031	Duval	12	FL	5,257	5,022	23	74
119		32254	031	Duval	12	FL	2,252	2,215	47	45
120		32256	031	Duval	12	FL	6,930	6,757	31	59
121		32257	031	Duval	12	FL	6,836	6,644	38	83
122		32258	031	Duval	12	FL	4,522	4,429	26	41
123		32259	109	Saint Johns	12	FL	6,867	6,581	23	47
124		32266	031	Duval	12	FL	1,264	1,246	11	11
125		32277	031	Duval	12	FL	4,841	4,584	54	53
126		32301	073	Leon	12	FL	3,469	2,890	26	41
127		32303	073	Leon	12	FL	6,070	5,832	26	87
128		32304	073	Leon	12	FL	2,342	2,132	25	51
129		32305	073	Leon	12	FL	3,674	3,246	40	73
130		32306	073	Leon	12	FL	0	0	0	0
131		32307	073	Leon	12	FL	11	11	0	0
132		32308	073	Leon	12	FL	4,931	4,751	17	63
133		32309	073	Leon	12	FL	6,221	6,144	19	65
134		32310	073	Leon	12	FL	2,250	2,210	24	49
135		32311	073	Leon	12	FL	2,934	2,896	18	35
136		32312	073	Leon	12	FL	6,041	5,973	11	74
137		32317	073	Leon	12	FL	2,890	2,413	11	35
138		32320	037	Franklin	12	FL	975	743	11	15
139		32321	077	Liberty	12	FL	938	715	11	19
140		32322	037	Franklin	12	FL	954	541	11	16
141		32324	039	Gadsden	12	FL	1,101	877	11	28
142		32327	129	Wakulla	12	FL	4,542	4,124	12	106
143		32328	037	Franklin	12	FL	907	656	11	11
144		32331	079	Madison	12	FL	1,027	826	11	17

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
96	266	14	359	11	11	31	221	13
97	291	21	395	11	13	23	232	14
98	406	38	500	11	20	25	363	25
99	153	16	247	11	12	12	165	11
100	0	0	0	0	0	0	0	0
101	206	14	282	11	13	13	208	14
102	169	14	162	11	11	19	102	11
103	253	28	421	11	12	25	295	13
104	78	11	111	11	11	11	70	11
105	70	11	141	11	11	11	101	11
106	144	11	234	11	11	17	165	11
107	63	11	105	11	11	11	70	11
108	195	20	225	11	11	18	137	12
109	280	12	191	11	11	17	120	13
110	303	21	314	11	11	22	191	15
111	78	11	137	11	11	11	103	11
112	0	0	11	0	0	0	11	0
113	0	0	0	0	0	0	0	0
114	180	11	158	11	11	11	122	11
115	53	11	85	11	11	11	69	11
116	291	28	450	11	19	34	300	21
117	211	16	302	11	11	19	207	11
118	221	13	206	11	11	11	145	11
119	77	11	153	11	11	11	99	11
120	337	17	254	11	11	16	164	11
121	280	19	286	11	11	21	191	11
122	105	14	157	11	11	11	92	11
123	194	23	201	11	12	11	119	11
124	37	11	41	11	11	11	27	0
125	155	11	187	11	11	11	123	11
126	77	11	136	0	11	17	83	11
127	127	20	279	11	11	22	180	15
128	49	11	117	11	11	11	79	11
129	83	11	210	11	11	13	144	11
130	0	0	0	0	0	0	0	0
131	0	0	11	0	0	0	11	0
132	129	11	195	0	0	19	129	11
133	133	18	215	11	11	23	133	11
134	58	11	131	11	11	11	84	11
135	78	11	114	11	11	11	81	11
136	125	21	220	0	11	19	143	11
137	51	11	95	0	11	11	65	11
138	31	11	71	0	11	11	57	11
139	30	11	83	0	11	11	62	11
140	24	11	60	0	0	11	49	0
141	30	11	68	11	11	11	52	11
142	89	15	255	0	11	18	213	11
143	24	11	59	11	11	11	44	11
144	29	11	54	11	11	11	41	11

AMERICAN OVERSIGHT

	S	T	U	V	W
96	14	11	11	43	61
97	12	11	15	54	72
98	14	11	11	33	61
99	12	11	11	15	37
100	0	0	0	0	0
101	13	11	11	21	29
102	11	11	11	11	25
103	19	11	14	20	42
104	11	11	0	11	21
105	11	0	11	13	11
106	15	11	11	11	23
107	11	0	11	11	16
108	22	11	11	11	30
109	15	11	11	11	21
110	18	11	11	27	28
111	11	0	11	11	12
112	0	0	0	0	0
113	0	0	0	0	0
114	11	0	11	11	15
115	11	0	0	11	11
116	31	11	11	35	59
117	18	11	11	16	37
118	11	11	11	14	32
119	11	11	11	19	16
120	20	11	11	16	28
121	28	11	11	18	32
122	17	11	11	11	20
123	25	11	11	13	21
124	11	0	0	0	11
125	11	11	11	13	19
126	11	0	11	11	21
127	14	11	11	13	43
128	11	11	11	11	23
129	11	11	11	11	33
130	0	0	0	0	0
131	0	0	0	0	0
132	11	11	11	11	34
133	17	11	11	11	32
134	11	11	11	11	20
135	11	11	11	11	13
136	18	11	11	11	30
137	11	11	0	11	16
138	11	11	0	11	14
139	11	0	11	11	11
140	11	0	11	11	11
141	11	11	0	11	11
142	11	0	11	11	21
143	11	0	0	11	13
144	11	0	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
145		32332	039	Gadsden	12	FL	397	153	11	11
146		32333	039	Gadsden	12	FL	2,854	2,550	17	39
147		32334	077	Liberty	12	FL	359	245	11	15
148		32336	065	Jefferson	12	FL	408	351	11	11
149		32340	079	Madison	12	FL	2,353	1,967	22	42
150		32343	039	Gadsden	12	FL	423	266	11	11
151		32344	065	Jefferson	12	FL	2,948	2,444	22	48
152		32346	129	Wakulla	12	FL	576	400	11	12
153		32347	123	Taylor	12	FL	1,696	1,594	11	45
154		32348	123	Taylor	12	FL	2,234	1,929	11	43
155		32350	079	Madison	12	FL	393	301	11	11
156		32351	039	Gadsden	12	FL	3,545	2,818	42	82
157		32352	039	Gadsden	12	FL	1,214	1,204	11	34
158		32355	129	Wakulla	12	FL	102	11	0	0
159		32358	129	Wakulla	12	FL	513	405	0	11
160		32359	123	Taylor	12	FL	698	259	11	11
161		32401	005	Bay	12	FL	5,470	4,725	54	66
162		32403	005	Bay	12	FL	11	11	0	11
163		32404	005	Bay	12	FL	6,758	6,590	49	117
164		32405	005	Bay	12	FL	5,250	4,965	32	100
165		32407	005	Bay	12	FL	2,563	2,165	11	24
166		32408	005	Bay	12	FL	3,560	2,888	11	41
167		32409	005	Bay	12	FL	1,819	1,772	11	35
168		32413	005	Bay	12	FL	3,557	3,363	11	37
169		32420	063	Jackson	12	FL	645	560	11	13
170		32421	013	Calhoun	12	FL	922	792	11	25
171		32423	063	Jackson	12	FL	326	311	11	11
172		32424	013	Calhoun	12	FL	1,337	1,040	11	33
173		32425	059	Holmes	12	FL	2,987	2,662	13	64
174		32426	063	Jackson	12	FL	272	198	11	11
175		32427	133	Washington	12	FL	309	300	11	11
176		32428	133	Washington	12	FL	3,701	3,257	21	73
177		32430	013	Calhoun	12	FL	304	242	0	11
178		32431	063	Jackson	12	FL	1,153	1,016	12	25
179		32433	131	Walton	12	FL	3,323	3,239	16	50
180		32435	131	Walton	12	FL	1,725	1,387	11	22
181		32437	133	Washington	12	FL	134	96	11	11
182		32438	005	Bay	12	FL	865	746	11	23
183		32439	131	Walton	12	FL	2,293	2,112	13	41
184		32440	063	Jackson	12	FL	1,300	1,113	11	19
185		32442	063	Jackson	12	FL	914	753	11	17
186		32443	063	Jackson	12	FL	754	597	11	13
187		32444	005	Bay	12	FL	3,972	3,598	16	42
188		32445	063	Jackson	12	FL	323	192	11	11
189		32446	063	Jackson	12	FL	2,635	2,161	11	36
190		32448	063	Jackson	12	FL	1,917	1,869	13	31
191		32449	013	Calhoun	12	FL	120	119	0	11
192		32455	059	Holmes	12	FL	1,030	931	11	14
193		32456	045	Gulf	12	FL	2,375	2,039	14	26

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
145	11	0	18	0	11	0	11	11
146	46	12	119	0	11	11	84	11
147	15	0	29	0	11	11	26	0
148	11	0	23	0	0	11	16	11
149	82	11	114	0	11	11	77	11
150	11	11	16	0	0	11	11	0
151	65	11	139	11	11	12	99	11
152	22	11	33	0	0	11	27	11
153	49	11	125	0	11	11	104	11
154	65	11	159	11	11	11	126	11
155	11	0	16	11	11	0	11	11
156	94	11	182	11	11	15	127	11
157	41	11	74	0	11	11	51	11
158	11	0	11	0	0	0	11	11
159	11	11	25	0	11	0	20	11
160	22	11	31	0	11	0	30	0
161	177	24	309	0	11	17	216	12
162	0	0	11	0	0	0	11	0
163	249	30	450	11	22	21	350	11
164	203	35	337	11	11	14	256	11
165	90	12	102	0	11	11	71	11
166	114	16	175	11	11	11	132	11
167	53	11	124	0	11	11	101	11
168	97	13	147	0	11	11	113	11
169	26	11	37	0	0	11	30	0
170	35	11	76	11	11	11	65	0
171	23	11	11	0	11	0	11	11
172	60	11	95	0	11	11	82	11
173	114	25	189	11	11	11	146	0
174	11	0	15	0	0	11	13	11
175	16	11	19	0	11	11	14	0
176	131	24	221	11	11	11	158	11
177	11	11	17	0	11	0	16	0
178	47	11	71	11	11	11	56	11
179	105	13	182	11	13	11	145	11
180	57	11	75	11	11	11	64	11
181	11	0	11	0	0	11	11	0
182	15	11	80	0	11	11	65	11
183	100	11	140	0	11	11	112	11
184	43	12	71	0	11	11	49	11
185	38	11	43	0	11	11	32	0
186	51	11	39	0	0	0	27	11
187	144	18	204	11	11	11	143	11
188	15	11	15	0	0	0	14	11
189	113	23	113	0	11	11	87	11
190	78	11	102	0	11	11	70	11
191	11	11	11	0	0	11	11	0
192	44	11	51	11	11	11	40	0
193	78	13	117	11	11	11	90	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
145	0	11	0	11	11
146	11	0	11	11	17
147	0	0	0	0	0
148	11	11	0	11	11
149	11	0	11	15	14
150	0	0	11	11	11
151	11	0	11	11	19
152	0	0	0	11	11
153	11	0	0	11	11
154	11	0	11	15	11
155	0	0	0	11	11
156	11	11	11	14	25
157	11	0	0	11	18
158	0	0	0	0	0
159	0	0	0	11	11
160	11	0	0	11	11
161	24	11	11	23	23
162	0	0	0	0	0
163	37	11	11	16	34
164	29	11	11	13	28
165	11	0	11	11	11
166	12	11	11	11	13
167	11	11	0	11	11
168	13	11	11	11	11
169	11	0	0	11	0
170	0	0	0	11	11
171	0	11	11	11	11
172	11	0	11	11	11
173	11	0	11	15	12
174	11	0	0	0	0
175	11	0	0	0	11
176	17	11	11	19	25
177	0	0	0	11	11
178	11	0	11	11	11
179	11	0	11	13	13
180	11	0	0	11	11
181	0	0	0	0	0
182	11	11	0	11	11
183	11	0	11	11	11
184	11	0	0	11	11
185	11	0	11	11	11
186	11	0	11	11	11
187	20	11	11	11	19
188	0	0	0	11	0
189	11	0	0	11	11
190	11	11	11	11	11
191	0	0	0	0	0
192	11	0	11	11	11
193	11	11	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
194		32459	131	Walton	12	FL	3,338	3,062	11	25
195		32460	063	Jackson	12	FL	894	663	11	17
196		32462	133	Washington	12	FL	894	702	11	18
197		32464	059	Holmes	12	FL	928	876	11	12
198		32465	045	Gulf	12	FL	1,494	1,173	11	39
199		32466	005	Bay	12	FL	1,296	1,204	11	27
200		32501	033	Escambia	12	FL	2,812	2,334	51	33
201		32502	033	Escambia	12	FL	912	770	11	11
202		32503	033	Escambia	12	FL	7,477	6,341	53	68
203		32504	033	Escambia	12	FL	4,857	4,739	19	64
204		32505	033	Escambia	12	FL	5,561	5,439	102	103
205		32506	033	Escambia	12	FL	7,233	6,807	60	109
206		32507	033	Escambia	12	FL	6,827	6,528	41	85
207		32508	033	Escambia	12	FL	25	19	0	0
208		32509	033	Escambia	12	FL	0	0	0	0
209		32511	033	Escambia	12	FL	11	11	0	0
210		32512	033	Escambia	12	FL	0	0	0	0
211		32514	033	Escambia	12	FL	8,040	7,728	58	88
212		32526	033	Escambia	12	FL	8,573	8,382	56	110
213		32531	091	Okaloosa	12	FL	1,341	1,223	11	15
214		32533	033	Escambia	12	FL	6,366	5,975	35	86
215		32534	033	Escambia	12	FL	3,520	3,294	30	42
216		32535	033	Escambia	12	FL	1,125	910	11	22
217		32536	091	Okaloosa	12	FL	5,672	4,716	43	70
218		32539	091	Okaloosa	12	FL	4,626	4,488	30	72
219		32541	091	Okaloosa	12	FL	3,727	3,412	13	30
220		32542	091	Okaloosa	12	FL	26	13	0	0
221		32544	091	Okaloosa	12	FL	11	11	0	0
222		32547	091	Okaloosa	12	FL	5,532	5,426	52	84
223		32548	091	Okaloosa	12	FL	4,560	4,198	50	73
224		32550	131	Walton	12	FL	2,545	2,326	11	22
225		32561	113	Santa Rosa	12	FL	2,242	2,043	11	15
226		32563	113	Santa Rosa	12	FL	5,234	5,138	15	54
227		32564	091	Okaloosa	12	FL	696	606	0	12
228		32565	113	Santa Rosa	12	FL	1,375	1,237	11	30
229		32566	113	Santa Rosa	12	FL	6,410	6,180	19	75
230		32567	091	Okaloosa	12	FL	1,070	927	11	11
231		32568	033	Escambia	12	FL	818	774	11	13
232		32569	091	Okaloosa	12	FL	2,028	1,917	11	23
233		32570	113	Santa Rosa	12	FL	7,016	6,556	33	119
234		32571	113	Santa Rosa	12	FL	6,555	6,464	33	88
235		32577	033	Escambia	12	FL	1,210	1,102	11	20
236		32578	091	Okaloosa	12	FL	6,915	6,600	25	91
237		32579	091	Okaloosa	12	FL	2,800	2,601	11	28
238		32580	091	Okaloosa	12	FL	808	753	11	16
239		32583	113	Santa Rosa	12	FL	5,295	5,056	25	101
240		32591	033	Escambia	12	FL	137	11	11	0
241		32601	001	Alachua	12	FL	1,676	1,439	23	24
242		32603	001	Alachua	12	FL	276	120	11	11

AMERICAN OVERSIGHT

Zip Code De-Identified Data

	K	L	M	N	O	P	Q	R
194	82	11	95	0	0	11	69	11
195	40	11	45	0	11	11	40	0
196	30	11	45	0	11	11	32	0
197	40	11	41	0	11	11	32	11
198	61	11	109	11	11	11	88	11
199	36	11	84	11	11	11	66	11
200	113	11	125	11	0	11	71	11
201	27	0	26	0	0	11	16	11
202	297	28	252	11	11	11	161	11
203	184	25	183	0	11	11	121	12
204	200	18	273	11	11	11	187	11
205	295	24	317	11	11	13	205	12
206	241	19	247	11	11	11	175	11
207	0	0	11	0	11	0	0	0
208	0	0	0	0	0	0	0	0
209	0	0	0	0	0	0	0	0
210	0	0	0	0	0	0	0	0
211	327	21	311	0	11	21	185	13
212	314	24	338	11	15	17	241	11
213	43	11	72	0	11	11	54	11
214	222	30	251	11	11	13	160	11
215	119	27	142	0	11	11	101	11
216	49	0	50	0	11	11	40	11
217	162	13	238	11	17	11	179	11
218	196	20	279	11	13	11	209	11
219	119	12	115	11	11	11	91	11
220	11	0	11	0	0	0	11	0
221	0	0	11	0	0	0	0	11
222	218	18	274	11	11	11	203	11
223	186	20	234	11	15	11	167	11
224	70	11	67	11	11	11	53	11
225	104	11	63	0	0	11	37	11
226	155	21	180	11	11	11	121	11
227	24	11	37	0	11	11	29	11
228	58	11	68	11	0	11	47	11
229	180	15	258	11	11	11	181	11
230	44	11	46	11	11	11	34	11
231	30	11	26	0	0	0	19	11
232	54	14	76	11	11	11	59	11
233	250	27	383	11	11	26	262	11
234	213	17	293	11	11	27	197	11
235	32	11	51	0	11	11	33	11
236	254	26	287	11	11	15	204	11
237	130	11	111	0	11	11	80	11
238	38	11	56	0	11	11	40	11
239	149	14	244	11	11	11	187	11
240	11	11	11	0	0	0	0	0
241	48	11	81	11	11	11	51	11
242	11	11	11	0	11	0	11	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
194	11	11	11	11	11
195	0	0	11	0	11
196	11	11	11	11	11
197	11	0	0	11	11
198	11	0	11	11	11
199	11	0	11	11	12
200	11	11	11	15	28
201	11	0	11	11	11
202	11	11	11	24	45
203	11	11	11	11	30
204	11	11	11	21	44
205	11	11	11	37	46
206	11	11	11	11	34
207	0	0	0	0	0
208	0	0	0	0	0
209	0	0	0	0	0
210	0	0	0	0	0
211	16	11	11	28	57
212	14	11	11	30	35
213	11	0	11	11	11
214	20	11	11	23	26
215	11	0	11	11	24
216	0	0	0	11	11
217	21	0	11	14	14
218	21	0	11	21	22
219	11	11	0	11	11
220	0	0	0	0	0
221	11	0	0	0	0
222	16	11	11	11	18
223	28	0	11	17	12
224	11	0	11	11	11
225	11	0	11	11	18
226	11	11	11	11	31
227	11	0	0	0	11
228	0	0	0	11	11
229	20	0	11	14	30
230	11	0	0	11	11
231	11	0	11	11	11
232	11	0	11	11	11
233	14	11	11	36	51
234	19	11	11	25	32
235	11	11	0	11	11
236	29	11	11	13	14
237	11	0	11	11	11
238	11	0	11	11	11
239	11	11	11	20	22
240	0	0	0	11	0
241	11	11	11	17	14
242	0	0	0	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
243		32605	001	Alachua	12	FL	4,756	4,413	23	38
244		32606	001	Alachua	12	FL	4,403	4,265	18	39
245		32607	001	Alachua	12	FL	2,899	2,800	25	24
246		32608	001	Alachua	12	FL	5,545	5,109	33	36
247		32609	001	Alachua	12	FL	3,123	3,023	27	29
248		32610	001	Alachua	12	FL	0	0	0	0
249		32611	001	Alachua	12	FL	11	11	0	0
250		32615	001	Alachua	12	FL	3,510	2,713	21	43
251		32617	083	Marion	12	FL	1,033	759	11	19
252		32618	001	Alachua	12	FL	1,490	1,237	11	16
253		32619	041	Gilchrist	12	FL	1,195	972	11	30
254		32621	075	Levy	12	FL	1,265	827	11	20
255		32622	007	Bradford	12	FL	328	266	11	11
256		32625	075	Levy	12	FL	537	243	0	11
257		32626	075	Levy	12	FL	2,487	1,990	11	41
258		32628	029	Dixie	12	FL	861	422	11	23
259		32631	001	Alachua	12	FL	154	44	0	0
260		32640	001	Alachua	12	FL	2,787	2,161	11	30
261		32641	001	Alachua	12	FL	2,402	2,345	44	37
262		32643	001	Alachua	12	FL	2,697	2,123	11	38
263		32648	029	Dixie	12	FL	101	45	0	11
264		32653	001	Alachua	12	FL	2,931	2,892	13	31
265		32656	019	Clay	12	FL	3,368	2,854	14	57
266		32664	083	Marion	12	FL	231	11	0	11
267		32666	107	Putnam	12	FL	1,691	1,263	11	23
268		32667	001	Alachua	12	FL	998	789	11	14
269		32668	075	Levy	12	FL	1,509	1,404	11	25
270		32669	001	Alachua	12	FL	2,780	2,385	11	28
271		32680	029	Dixie	12	FL	2,635	2,270	11	68
272		32683	075	Levy	12	FL	46	11	11	0
273		32686	083	Marion	12	FL	1,440	803	16	18
274		32692	029	Dixie	12	FL	132	11	11	11
275		32693	041	Gilchrist	12	FL	2,492	2,217	12	38
276		32694	001	Alachua	12	FL	456	240	11	12
277		32696	075	Levy	12	FL	3,034	2,717	25	33
278		32697	125	Union	12	FL	80	0	0	11
279		32701	117	Seminole	12	FL	4,257	4,146	34	37
280		32702	069	Lake	12	FL	1,128	815	11	21
281		32703	095	Orange	12	FL	7,168	6,977	70	116
282		32707	117	Seminole	12	FL	6,533	6,423	23	80
283		32708	117	Seminole	12	FL	8,426	8,041	40	83
284		32709	095	Orange	12	FL	511	364	11	11
285		32712	095	Orange	12	FL	8,119	7,389	55	85
286		32713	127	Volusia	12	FL	5,736	5,459	21	79
287		32714	117	Seminole	12	FL	5,643	5,200	43	53
288		32720	127	Volusia	12	FL	7,846	6,958	30	132
289		32724	127	Volusia	12	FL	9,820	9,604	37	144
290		32725	127	Volusia	12	FL	10,092	9,550	47	162
291		32726	069	Lake	12	FL	5,138	4,683	29	82

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
243	147	11	150	11	11	11	99	11
244	252	13	170	11	11	11	113	11
245	106	11	118	11	11	11	77	11
246	158	14	181	11	11	11	107	18
247	91	11	150	0	11	11	84	29
248	0	0	0	0	0	0	0	0
249	0	0	0	0	0	0	0	0
250	96	11	151	11	11	11	113	11
251	29	11	47	0	11	11	36	11
252	39	11	63	0	11	11	46	11
253	44	11	75	11	11	11	63	11
254	50	11	70	11	11	11	57	11
255	14	11	23	0	11	0	15	11
256	11	0	25	0	11	11	19	0
257	106	11	144	11	11	11	114	11
258	48	11	72	0	11	11	56	11
259	11	11	11	0	0	0	11	0
260	75	11	141	11	11	11	104	11
261	89	11	133	11	11	11	91	11
262	99	11	126	11	11	11	97	11
263	11	0	11	0	0	0	11	0
264	98	11	117	11	11	11	83	11
265	113	11	192	11	11	11	157	11
266	11	11	13	0	11	0	11	11
267	72	11	76	11	11	0	57	11
268	24	11	41	0	0	11	29	11
269	44	11	78	11	11	11	68	11
270	107	12	124	11	11	11	84	11
271	96	11	207	11	11	11	176	11
272	11	0	11	0	0	0	11	0
273	36	11	74	0	11	11	58	11
274	11	0	11	0	0	0	11	0
275	82	11	132	11	11	11	109	0
276	19	11	26	11	0	0	24	0
277	123	11	170	11	11	11	125	12
278	11	0	11	0	0	0	11	0
279	154	20	170	11	11	11	114	11
280	38	11	81	0	11	11	68	11
281	221	35	351	11	11	16	252	11
282	186	24	314	11	11	15	229	14
283	266	30	360	11	11	20	253	11
284	14	11	33	0	11	0	26	11
285	203	42	354	11	11	23	234	16
286	177	34	283	11	11	38	207	11
287	162	12	259	0	11	19	179	11
288	225	29	400	11	13	56	274	20
289	319	37	489	11	11	65	340	15
290	289	73	549	11	12	75	380	19
291	163	21	319	11	11	22	250	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
243	12	11	11	11	17
244	11	11	11	18	18
245	11	0	11	11	15
246	12	11	11	23	16
247	11	11	11	18	15
248	0	0	0	0	0
249	0	0	0	0	0
250	11	11	11	11	11
251	11	0	11	11	11
252	11	11	11	11	11
253	11	0	11	11	11
254	11	11	11	11	11
255	11	11	0	11	11
256	11	0	0	11	11
257	11	0	11	11	11
258	11	0	11	11	11
259	0	0	0	11	0
260	11	11	11	11	12
261	11	0	11	15	14
262	11	11	11	11	11
263	0	0	0	0	11
264	11	11	11	11	11
265	11	11	11	12	12
266	0	11	0	11	11
267	11	11	11	11	12
268	11	11	11	11	11
269	11	11	0	11	11
270	11	0	11	15	11
271	11	11	11	12	11
272	0	0	0	0	0
273	0	0	11	11	11
274	0	0	11	11	0
275	11	11	11	11	11
276	0	0	0	11	0
277	11	11	11	13	20
278	0	0	0	0	0
279	11	11	11	11	32
280	0	0	0	11	11
281	15	11	11	17	49
282	11	11	11	20	34
283	26	11	11	16	48
284	0	0	11	11	11
285	20	11	11	24	51
286	15	11	11	11	23
287	19	11	11	14	27
288	14	11	11	24	31
289	17	11	11	25	36
290	19	11	11	18	59
291	11	11	11	22	17

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
292		32730	117	Seminole	12	FL	1,211	1,100	11	18
293		32732	117	Seminole	12	FL	1,099	811	11	23
294		32735	069	Lake	12	FL	1,530	1,399	11	15
295		32736	069	Lake	12	FL	2,232	2,188	11	32
296		32738	127	Volusia	12	FL	8,106	7,800	52	144
297		32744	127	Volusia	12	FL	1,047	867	11	19
298		32746	117	Seminole	12	FL	7,274	6,852	32	60
299		32750	117	Seminole	12	FL	4,722	4,603	14	64
300		32751	095	Orange	12	FL	3,918	3,606	24	27
301		32754	009	Brevard	12	FL	3,011	2,743	11	45
302		32756	069	Lake	12	FL	366	11	11	11
303		32757	069	Lake	12	FL	7,481	7,213	29	85
304		32759	127	Volusia	12	FL	977	816	11	12
305		32763	127	Volusia	12	FL	5,487	5,170	18	117
306		32764	127	Volusia	12	FL	839	685	11	15
307		32765	117	Seminole	12	FL	8,384	7,866	30	80
308		32766	117	Seminole	12	FL	1,766	1,744	11	14
309		32767	069	Lake	12	FL	667	479	11	13
310		32771	117	Seminole	12	FL	8,562	7,812	100	125
311		32773	117	Seminole	12	FL	4,205	4,125	48	74
312		32775	009	Brevard	12	FL	113	0	11	11
313		32776	069	Lake	12	FL	2,275	2,005	11	32
314		32778	069	Lake	12	FL	7,227	6,827	33	104
315		32779	117	Seminole	12	FL	6,180	5,790	14	47
316		32780	009	Brevard	12	FL	10,359	9,886	42	145
317		32784	069	Lake	12	FL	2,523	2,017	14	54
318		32789	095	Orange	12	FL	5,149	4,684	13	40
319		32792	095	Orange	12	FL	7,691	7,137	40	75
320		32796	009	Brevard	12	FL	5,257	5,150	35	67
321		32798	095	Orange	12	FL	1,538	1,212	11	25
322		32801	095	Orange	12	FL	2,813	2,416	20	36
323		32803	095	Orange	12	FL	2,711	2,570	11	22
324		32804	095	Orange	12	FL	3,015	2,809	11	28
325		32805	095	Orange	12	FL	4,534	4,019	116	60
326		32806	095	Orange	12	FL	4,193	3,834	22	48
327		32807	095	Orange	12	FL	5,160	4,904	50	54
328		32808	095	Orange	12	FL	6,846	6,500	136	84
329		32809	095	Orange	12	FL	3,871	3,383	44	42
330		32810	095	Orange	12	FL	5,105	4,817	64	55
331		32811	095	Orange	12	FL	4,466	4,078	74	46
332		32812	095	Orange	12	FL	5,190	5,090	28	72
333		32814	095	Orange	12	FL	848	776	0	11
334		32815	009	Brevard	12	FL	0	0	0	0
335		32816	095	Orange	12	FL	11	11	0	0
336		32817	095	Orange	12	FL	4,560	4,291	25	32
337		32818	095	Orange	12	FL	6,757	6,207	105	58
338		32819	095	Orange	12	FL	4,379	4,305	17	26
339		32820	095	Orange	12	FL	1,287	1,257	11	11
340		32821	095	Orange	12	FL	1,927	1,889	11	15

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
292	33	11	61	0	11	11	45	11
293	24	11	55	0	11	11	41	0
294	56	11	73	0	11	11	57	11
295	54	11	106	11	0	11	83	11
296	219	44	486	11	15	53	336	20
297	38	11	59	0	11	11	44	11
298	274	30	280	11	11	25	188	12
299	155	24	215	11	11	11	146	11
300	126	11	135	11	11	11	77	11
301	63	24	142	0	11	11	114	11
302	12	11	11	0	0	11	11	0
303	196	38	337	11	11	19	257	11
304	25	11	45	0	11	11	37	0
305	186	26	336	11	11	33	248	11
306	20	11	46	0	11	11	32	11
307	219	24	327	11	14	12	227	11
308	50	13	77	0	11	11	53	11
309	19	11	44	0	11	0	35	0
310	262	47	399	11	12	30	277	16
311	115	14	255	11	11	23	193	11
312	11	0	11	11	11	0	11	0
313	48	11	113	0	11	11	85	11
314	241	34	412	0	11	35	333	11
315	203	24	227	11	11	13	148	12
316	339	73	548	11	23	20	426	19
317	86	11	155	11	11	11	133	11
318	141	19	163	0	11	11	97	11
319	277	31	303	11	13	12	198	14
320	177	48	291	11	11	11	218	11
321	47	11	80	0	11	11	64	11
322	101	11	139	11	11	11	100	0
323	72	11	94	11	11	11	55	11
324	84	16	99	0	11	11	58	12
325	96	19	195	11	11	11	125	11
326	129	13	156	11	11	11	111	11
327	159	32	218	11	13	11	158	11
328	166	34	295	11	11	17	162	13
329	88	16	140	11	11	11	105	0
330	173	25	234	11	11	11	140	21
331	107	15	176	11	11	11	99	11
332	138	26	199	0	11	11	145	11
333	23	11	17	11	11	0	13	0
334	0	0	0	0	0	0	0	0
335	0	0	0	0	0	0	0	0
336	125	28	173	11	11	11	100	11
337	148	20	252	11	11	16	144	14
338	101	11	129	11	11	11	73	11
339	20	11	57	0	11	11	34	11
340	49	11	69	0	11	11	48	11

AMERICAN OVERSIGHT

	S	T	U	V	W
292	11	0	11	11	11
293	11	0	0	11	11
294	11	11	11	11	11
295	11	0	11	11	11
296	24	11	11	30	50
297	11	11	11	11	11
298	17	11	11	11	32
299	18	11	11	19	28
300	11	11	11	11	27
301	11	11	0	11	11
302	0	0	0	11	0
303	19	11	11	15	26
304	11	0	11	11	11
305	21	11	11	25	22
306	11	0	11	11	11
307	29	11	11	16	49
308	11	11	11	11	11
309	11	0	11	11	11
310	19	11	11	21	64
311	11	11	11	11	25
312	0	0	0	0	0
313	11	0	11	11	11
314	17	11	11	12	18
315	11	11	11	11	36
316	23	11	11	20	51
317	11	0	11	11	11
318	11	11	11	15	28
319	22	0	11	17	49
320	11	11	11	21	26
321	11	0	0	11	11
322	11	0	0	13	21
323	11	11	11	11	18
324	11	0	11	11	14
325	11	11	11	24	25
326	11	11	11	11	22
327	11	11	11	15	30
328	11	11	19	40	49
329	11	0	0	11	15
330	12	11	11	15	46
331	11	11	11	25	34
332	11	11	11	11	22
333	11	0	0	0	11
334	0	0	0	0	0
335	0	0	0	0	0
336	15	11	11	11	32
337	19	11	11	24	32
338	11	11	11	16	23
339	11	0	11	11	11
340	11	0	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
341		32822	095	Orange	12	FL	9,394	8,971	80	100
342		32824	095	Orange	12	FL	5,686	5,607	46	39
343		32825	095	Orange	12	FL	8,012	7,860	62	72
344		32826	095	Orange	12	FL	2,877	2,821	18	40
345		32827	095	Orange	12	FL	1,798	1,667	11	11
346		32828	095	Orange	12	FL	6,718	6,425	45	40
347		32829	095	Orange	12	FL	2,252	2,218	19	16
348		32830	095	Orange	12	FL	11	0	11	0
349		32831	095	Orange	12	FL	11	11	0	0
350		32832	095	Orange	12	FL	2,074	2,039	11	11
351		32833	095	Orange	12	FL	1,562	1,538	11	11
352		32835	095	Orange	12	FL	3,966	3,885	34	35
353		32836	095	Orange	12	FL	2,676	2,641	11	15
354		32837	095	Orange	12	FL	6,425	6,029	39	38
355		32839	095	Orange	12	FL	4,859	4,760	68	59
356		32899	009	Brevard	12	FL	11	11	0	0
357		32901	009	Brevard	12	FL	7,091	6,407	50	108
358		32903	009	Brevard	12	FL	3,425	3,291	11	36
359		32904	009	Brevard	12	FL	7,747	7,416	23	115
360		32905	009	Brevard	12	FL	6,449	5,887	43	113
361		32907	009	Brevard	12	FL	9,638	9,260	64	152
362		32908	009	Brevard	12	FL	2,247	2,207	16	35
363		32909	009	Brevard	12	FL	7,024	6,908	44	94
364		32920	009	Brevard	12	FL	3,140	2,942	11	42
365		32922	009	Brevard	12	FL	3,417	3,021	41	40
366		32925	009	Brevard	12	FL	155	123	0	11
367		32926	009	Brevard	12	FL	5,448	5,365	25	83
368		32927	009	Brevard	12	FL	5,009	4,785	33	67
369		32931	009	Brevard	12	FL	4,412	4,209	11	45
370		32934	009	Brevard	12	FL	4,484	4,403	16	64
371		32935	009	Brevard	12	FL	8,908	8,524	44	171
372		32937	009	Brevard	12	FL	6,495	6,300	20	78
373		32940	009	Brevard	12	FL	12,070	11,918	24	111
374		32948	061	Indian River	12	FL	784	596	13	11
375		32949	009	Brevard	12	FL	772	633	11	11
376		32950	009	Brevard	12	FL	1,248	1,113	11	14
377		32951	009	Brevard	12	FL	3,716	3,581	11	30
378		32952	009	Brevard	12	FL	5,178	5,043	11	62
379		32953	009	Brevard	12	FL	6,033	5,686	22	100
380		32955	009	Brevard	12	FL	8,988	8,645	48	115
381		32958	061	Indian River	12	FL	10,331	9,715	37	86
382		32960	061	Indian River	12	FL	6,067	5,223	40	45
383		32962	061	Indian River	12	FL	6,942	6,637	30	38
384		32963	061	Indian River	12	FL	7,327	7,227	13	28
385		32966	061	Indian River	12	FL	8,399	8,065	33	66
386		32967	061	Indian River	12	FL	7,159	6,872	53	37
387		32968	061	Indian River	12	FL	3,950	3,898	13	29
388		32976	009	Brevard	12	FL	4,852	4,753	14	84
389		33001	087	Monroe	12	FL	119	11	0	0

AMERICAN OVERSIGHT

Zip Code De-Identified Data

	K	L	M	N	O	P	Q	R
341	242	50	342	11	11	16	220	16
342	125	32	187	11	11	11	107	11
343	219	36	317	11	13	14	199	16
344	87	15	141	0	11	11	100	11
345	52	11	44	0	11	11	26	11
346	196	23	237	11	12	11	141	12
347	56	11	80	0	0	11	45	11
348	0	0	0	0	0	0	0	0
349	0	0	0	0	0	0	0	0
350	57	13	54	0	11	11	27	11
351	34	11	50	0	11	0	35	11
352	86	11	120	11	11	11	77	11
353	59	11	67	11	11	11	41	11
354	154	27	198	11	11	11	119	11
355	103	19	179	11	11	11	118	11
356	0	0	0	0	0	0	0	0
357	293	36	347	11	11	11	259	11
358	90	16	110	0	11	11	81	11
359	225	45	355	11	14	16	275	11
360	205	38	295	0	16	13	216	11
361	235	62	453	11	32	21	333	11
362	52	11	96	11	11	11	67	0
363	173	38	268	0	13	11	211	11
364	76	12	114	11	11	11	86	11
365	84	19	181	11	11	13	123	11
366	11	0	11	0	0	11	11	0
367	136	28	266	11	11	11	213	11
368	156	34	268	11	11	11	209	11
369	135	33	147	11	11	11	121	11
370	108	27	206	11	11	11	161	11
371	315	52	446	11	16	16	367	11
372	178	24	257	11	20	11	187	11
373	370	57	397	11	20	20	295	12
374	18	11	34	0	11	0	27	0
375	17	11	24	0	11	11	18	0
376	32	11	47	11	11	11	28	11
377	97	19	92	0	11	11	68	11
378	181	27	199	11	11	11	159	11
379	211	31	298	11	11	11	234	11
380	267	44	407	11	11	17	307	12
381	366	18	342	11	11	11	262	11
382	296	11	210	0	11	11	142	11
383	268	13	209	11	11	11	146	11
384	290	13	136	11	11	11	94	11
385	445	12	300	11	11	15	224	12
386	322	18	211	11	11	11	137	12
387	130	11	127	11	11	11	92	11
388	168	29	211	11	11	11	179	11
389	11	0	11	0	0	0	0	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003619

	S	T	U	V	W
341	11	11	12	26	65
342	11	11	11	13	48
343	16	11	11	25	52
344	11	11	11	14	11
345	11	11	11	11	11
346	21	11	11	17	40
347	11	11	11	11	18
348	0	0	0	0	0
349	0	0	0	0	0
350	11	11	11	11	15
351	11	11	11	11	11
352	11	11	11	12	21
353	11	0	11	11	11
354	11	11	11	11	37
355	11	11	11	23	33
356	0	0	0	0	0
357	24	11	11	25	30
358	11	11	0	11	11
359	21	11	11	18	17
360	20	11	11	18	28
361	34	11	11	17	34
362	11	11	11	11	11
363	20	11	11	11	19
364	11	0	11	11	13
365	15	11	11	11	16
366	0	0	0	0	0
367	13	11	11	12	21
368	11	11	11	19	24
369	11	11	0	11	11
370	13	0	11	11	17
371	23	11	11	16	22
372	17	11	11	12	18
373	33	11	11	16	25
374	11	0	0	11	11
375	11	0	0	11	11
376	11	0	0	11	11
377	11	11	11	0	11
378	11	0	11	11	16
379	13	0	11	11	31
380	19	11	11	20	32
381	17	11	11	11	34
382	11	11	11	11	42
383	15	11	11	11	27
384	11	11	11	0	21
385	15	11	11	14	18
386	11	11	11	11	34
387	11	11	11	11	11
388	11	11	11	11	11
389	0	0	11	0	0

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
390		33004	011	Broward	12	FL	3,051	2,791	32	35
391		33009	011	Broward	12	FL	8,678	8,271	50	77
392		33010	086	Miami-Dade	12	FL	10,181	9,761	59	137
393		33012	086	Miami-Dade	12	FL	17,237	16,663	76	229
394		33013	086	Miami-Dade	12	FL	7,828	7,602	26	105
395		33014	086	Miami-Dade	12	FL	7,453	7,276	36	90
396		33015	086	Miami-Dade	12	FL	8,415	8,050	50	93
397		33016	086	Miami-Dade	12	FL	8,305	8,112	42	117
398		33018	086	Miami-Dade	12	FL	8,283	8,190	47	85
399		33019	011	Broward	12	FL	3,686	3,651	11	33
400		33020	011	Broward	12	FL	6,469	6,057	58	68
401		33021	011	Broward	12	FL	9,136	8,845	59	120
402		33023	011	Broward	12	FL	8,855	8,628	141	77
403		33024	011	Broward	12	FL	10,223	9,874	86	123
404		33025	011	Broward	12	FL	7,573	7,366	91	69
405		33026	011	Broward	12	FL	5,588	5,446	23	69
406		33027	011	Broward	12	FL	12,194	11,788	89	137
407		33028	011	Broward	12	FL	3,015	2,983	23	44
408		33029	011	Broward	12	FL	5,074	4,993	16	47
409		33030	086	Miami-Dade	12	FL	4,132	3,759	54	35
410		33031	086	Miami-Dade	12	FL	1,224	1,211	0	14
411		33032	086	Miami-Dade	12	FL	5,533	5,305	76	44
412		33033	086	Miami-Dade	12	FL	7,065	6,995	70	82
413		33034	086	Miami-Dade	12	FL	2,690	2,423	46	25
414		33035	086	Miami-Dade	12	FL	1,544	1,519	23	12
415		33036	087	Monroe	12	FL	928	696	11	11
416		33037	087	Monroe	12	FL	3,135	2,704	11	13
417		33039	086	Miami-Dade	12	FL	11	11	0	0
418		33040	087	Monroe	12	FL	5,774	5,082	23	34
419		33042	087	Monroe	12	FL	1,516	1,379	0	11
420		33043	087	Monroe	12	FL	1,022	827	11	11
421		33050	087	Monroe	12	FL	2,015	1,750	11	11
422		33051	087	Monroe	12	FL	313	11	0	11
423		33054	086	Miami-Dade	12	FL	4,939	4,717	92	48
424		33055	086	Miami-Dade	12	FL	8,450	8,184	99	115
425		33056	086	Miami-Dade	12	FL	5,993	5,937	139	52
426		33060	011	Broward	12	FL	5,717	5,330	65	56
427		33062	011	Broward	12	FL	7,485	7,384	22	50
428		33063	011	Broward	12	FL	11,143	10,817	77	115
429		33064	011	Broward	12	FL	8,293	7,979	68	78
430		33065	011	Broward	12	FL	6,348	6,265	33	62
431		33066	011	Broward	12	FL	5,652	5,469	26	56
432		33067	011	Broward	12	FL	3,401	3,212	11	27
433		33068	011	Broward	12	FL	5,236	5,164	63	46
434		33069	011	Broward	12	FL	5,416	5,298	45	45
435		33070	087	Monroe	12	FL	1,191	980	11	11
436		33071	011	Broward	12	FL	5,242	5,011	35	41
437		33073	011	Broward	12	FL	3,138	3,045	11	26
438		33076	011	Broward	12	FL	4,229	4,177	18	36

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
390	82	17	133	0	11	11	83	11
391	248	29	268	11	11	14	156	22
392	424	67	440	11	11	26	234	23
393	634	120	707	11	13	76	380	46
394	250	59	336	11	11	29	178	19
395	235	53	295	11	11	32	163	11
396	196	47	319	11	11	31	174	17
397	247	47	355	11	11	36	202	21
398	205	45	326	11	11	33	181	18
399	119	14	107	0	11	11	63	11
400	283	13	237	11	11	14	139	16
401	267	43	361	11	11	12	218	17
402	233	31	318	0	11	14	179	24
403	317	27	414	11	11	20	244	14
404	183	29	222	11	11	13	121	11
405	141	20	202	11	11	11	124	17
406	403	63	453	11	11	33	258	21
407	87	15	108	0	11	11	73	11
408	130	26	178	11	11	11	93	11
409	140	27	155	0	11	19	87	11
410	37	11	43	0	11	11	25	11
411	162	23	210	11	11	23	100	12
412	225	37	278	0	11	25	165	12
413	81	11	94	0	0	11	55	11
414	41	11	43	11	0	11	22	11
415	34	11	25	0	0	0	21	0
416	75	12	69	11	11	11	44	11
417	0	0	0	0	0	0	0	0
418	170	11	138	11	11	11	87	11
419	34	0	33	0	11	11	23	11
420	23	11	25	11	0	0	15	11
421	36	11	42	0	11	11	30	11
422	11	11	11	0	0	0	11	11
423	126	21	201	11	11	15	126	11
424	211	50	388	11	11	39	216	18
425	134	44	230	11	11	26	117	16
426	222	30	200	11	11	11	125	11
427	279	26	207	11	11	11	143	11
428	310	50	393	11	11	12	246	15
429	230	18	276	11	11	11	177	19
430	195	18	197	11	11	11	130	11
431	244	30	200	11	11	11	132	11
432	84	11	94	11	11	11	47	11
433	128	11	152	11	11	11	86	11
434	183	20	185	11	11	11	112	11
435	35	11	24	0	11	11	12	11
436	140	17	146	11	11	11	85	11
437	90	12	113	11	11	11	65	11
438	159	13	107	11	11	11	71	11

AMERICAN OVERSIGHT

	S	T	U	V	W
390	11	11	11	11	43
391	11	11	11	11	60
392	11	11	11	15	166
393	12	16	11	22	237
394	11	11	11	11	117
395	11	11	11	11	97
396	11	11	11	11	103
397	11	11	0	14	110
398	11	11	0	11	100
399	11	0	11	11	21
400	11	11	11	11	67
401	15	11	11	12	107
402	11	11	11	20	102
403	12	11	11	20	125
404	11	11	11	11	78
405	11	11	11	11	54
406	12	11	11	23	145
407	11	11	11	11	31
408	11	11	11	11	54
409	11	0	0	16	40
410	11	11	0	0	12
411	11	11	11	11	69
412	11	11	11	19	64
413	11	11	0	11	22
414	11	11	0	11	15
415	0	0	0	0	11
416	11	11	11	0	11
417	0	0	0	0	0
418	12	11	11	11	30
419	11	11	11	11	11
420	11	0	0	11	11
421	0	0	0	0	11
422	0	0	0	0	0
423	11	11	11	14	46
424	11	11	11	17	115
425	11	11	0	11	75
426	11	11	11	11	38
427	18	11	11	11	32
428	12	11	11	12	99
429	12	11	11	12	50
430	13	11	11	11	43
431	11	11	11	11	34
432	11	11	11	11	22
433	11	11	11	11	51
434	12	11	11	11	36
435	0	0	0	0	11
436	12	0	11	11	34
437	11	11	11	11	21
438	11	11	11	11	21

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
439		33109	086	Miami-Dade	12	FL	189	189	11	0
440		33122	086	Miami-Dade	12	FL	1,206	82	11	11
441		33125	086	Miami-Dade	12	FL	10,294	10,162	52	130
442		33126	086	Miami-Dade	12	FL	9,098	8,874	43	120
443		33127	086	Miami-Dade	12	FL	4,524	4,450	86	48
444		33128	086	Miami-Dade	12	FL	1,505	1,402	12	14
445		33129	086	Miami-Dade	12	FL	2,403	2,378	11	20
446		33130	086	Miami-Dade	12	FL	4,070	3,980	33	42
447		33131	086	Miami-Dade	12	FL	1,483	1,426	11	11
448		33132	086	Miami-Dade	12	FL	780	772	11	11
449		33133	086	Miami-Dade	12	FL	6,097	5,871	31	54
450		33134	086	Miami-Dade	12	FL	8,173	7,611	29	84
451		33135	086	Miami-Dade	12	FL	7,271	6,922	41	94
452		33136	086	Miami-Dade	12	FL	2,411	1,989	51	21
453		33137	086	Miami-Dade	12	FL	2,204	1,957	24	13
454		33138	086	Miami-Dade	12	FL	4,668	4,478	45	32
455		33139	086	Miami-Dade	12	FL	5,362	5,036	11	32
456		33140	086	Miami-Dade	12	FL	3,644	3,515	11	26
457		33141	086	Miami-Dade	12	FL	5,166	4,896	16	48
458		33142	086	Miami-Dade	12	FL	9,805	9,335	133	99
459		33143	086	Miami-Dade	12	FL	5,393	5,196	23	48
460		33144	086	Miami-Dade	12	FL	6,257	5,875	35	89
461		33145	086	Miami-Dade	12	FL	5,964	5,682	34	73
462		33146	086	Miami-Dade	12	FL	1,881	1,846	11	17
463		33147	086	Miami-Dade	12	FL	8,110	7,966	131	96
464		33149	086	Miami-Dade	12	FL	1,957	1,904	11	11
465		33150	086	Miami-Dade	12	FL	5,015	4,643	102	38
466		33154	086	Miami-Dade	12	FL	2,636	2,531	11	25
467		33155	086	Miami-Dade	12	FL	9,839	9,555	41	130
468		33156	086	Miami-Dade	12	FL	5,455	5,008	15	46
469		33157	086	Miami-Dade	12	FL	11,721	11,162	108	91
470		33158	086	Miami-Dade	12	FL	1,154	1,145	11	11
471		33160	086	Miami-Dade	12	FL	8,657	8,416	30	67
472		33161	086	Miami-Dade	12	FL	7,585	6,909	94	36
473		33162	086	Miami-Dade	12	FL	6,696	6,477	102	43
474		33165	086	Miami-Dade	12	FL	13,195	13,059	63	193
475		33166	086	Miami-Dade	12	FL	4,420	3,837	19	34
476		33167	086	Miami-Dade	12	FL	3,717	3,668	54	35
477		33168	086	Miami-Dade	12	FL	4,767	4,434	65	23
478		33169	086	Miami-Dade	12	FL	6,379	6,058	122	51
479		33170	086	Miami-Dade	12	FL	2,084	1,986	34	14
480		33172	086	Miami-Dade	12	FL	6,746	6,662	39	68
481		33173	086	Miami-Dade	12	FL	6,991	6,895	28	86
482		33174	086	Miami-Dade	12	FL	6,983	6,905	33	105
483		33175	086	Miami-Dade	12	FL	12,210	11,833	47	130
484		33176	086	Miami-Dade	12	FL	9,984	9,616	61	86
485		33177	086	Miami-Dade	12	FL	8,622	8,405	67	88
486		33178	086	Miami-Dade	12	FL	3,447	3,427	11	22
487		33179	086	Miami-Dade	12	FL	7,089	6,876	61	55

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
439	11	0	11	0	0	0	0	0
440	12	11	27	0	0	11	17	11
441	411	51	449	11	11	38	235	21
442	307	57	403	0	11	40	210	14
443	143	17	146	11	11	11	84	11
444	69	11	65	0	11	11	37	11
445	52	19	71	0	0	11	37	11
446	129	17	134	11	11	12	76	11
447	29	11	32	0	0	11	19	11
448	13	11	24	0	11	11	11	11
449	180	26	182	11	11	11	107	11
450	297	72	311	11	11	22	156	12
451	268	23	277	11	11	20	157	14
452	57	11	89	11	0	11	50	11
453	55	11	57	11	11	11	27	11
454	116	15	131	0	11	11	75	11
455	177	13	146	11	11	11	60	11
456	128	11	102	11	11	11	54	11
457	157	22	161	0	11	11	84	11
458	304	35	389	11	11	31	212	27
459	163	44	213	11	18	22	106	12
460	184	68	281	11	11	29	145	11
461	182	51	239	11	11	14	120	11
462	60	11	54	0	11	11	30	11
463	236	29	337	11	11	25	181	18
464	52	11	46	0	11	11	24	11
465	131	14	160	11	0	11	79	14
466	102	16	97	0	11	11	52	11
467	291	82	442	11	11	32	234	23
468	153	39	181	0	11	16	98	11
469	335	65	414	11	11	43	185	21
470	34	11	29	0	11	0	18	11
471	297	27	269	11	11	20	173	11
472	171	22	171	11	11	15	87	12
473	164	25	183	11	11	15	93	16
474	389	119	630	11	13	74	329	25
475	134	20	138	0	11	11	52	18
476	121	13	126	11	11	14	70	11
477	100	20	123	11	11	12	53	11
478	166	31	224	11	11	26	112	18
479	48	14	67	0	11	11	32	11
480	172	31	232	11	11	33	122	11
481	225	55	288	0	11	38	140	14
482	235	44	294	11	11	40	163	11
483	335	95	482	11	11	61	249	14
484	257	57	350	11	11	47	167	14
485	231	36	312	11	11	33	166	13
486	54	14	95	11	11	11	44	11
487	183	26	224	11	11	25	118	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003625

	S	T	U	V	W
439	0	0	0	0	11
440	0	11	0	11	11
441	11	11	11	24	160
442	11	11	11	11	158
443	11	11	11	11	46
444	11	11	11	11	19
445	11	11	0	0	27
446	11	11	0	11	42
447	11	11	11	0	11
448	11	11	11	11	11
449	11	11	0	11	54
450	11	11	0	11	141
451	11	11	11	17	96
452	11	11	0	11	20
453	11	11	0	11	17
454	11	11	11	11	39
455	11	11	11	15	46
456	11	11	11	11	39
457	11	11	11	11	52
458	11	11	11	27	120
459	11	11	11	11	66
460	11	11	11	11	106
461	11	11	11	11	110
462	11	11	11	0	16
463	11	11	11	16	116
464	11	11	0	0	11
465	11	11	0	12	51
466	11	11	0	11	30
467	11	11	11	11	175
468	11	11	11	11	60
469	18	11	11	28	136
470	11	0	11	0	11
471	12	11	11	11	59
472	11	11	11	11	51
473	11	11	11	11	47
474	11	12	11	11	240
475	11	0	11	11	64
476	11	11	0	11	44
477	11	11	11	11	53
478	11	11	11	12	62
479	11	11	11	0	24
480	11	11	11	11	84
481	11	11	11	11	107
482	11	11	0	11	105
483	15	11	11	11	170
484	17	11	11	11	119
485	11	11	11	14	103
486	11	11	11	11	30
487	11	11	11	11	73

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
488		33180	086	Miami-Dade	12	FL	6,327	6,148	26	70
489		33181	086	Miami-Dade	12	FL	2,350	2,310	15	13
490		33182	086	Miami-Dade	12	FL	2,460	2,438	11	26
491		33183	086	Miami-Dade	12	FL	7,057	6,759	29	73
492		33184	086	Miami-Dade	12	FL	4,834	4,792	26	68
493		33185	086	Miami-Dade	12	FL	3,993	3,960	16	45
494		33186	086	Miami-Dade	12	FL	11,132	11,018	45	108
495		33187	086	Miami-Dade	12	FL	2,877	2,831	15	37
496		33189	086	Miami-Dade	12	FL	3,979	3,940	37	49
497		33190	086	Miami-Dade	12	FL	1,312	1,300	11	16
498		33193	086	Miami-Dade	12	FL	7,119	7,051	35	84
499		33194	086	Miami-Dade	12	FL	647	498	11	11
500		33196	086	Miami-Dade	12	FL	6,481	6,429	30	50
501		33199	086	Miami-Dade	12	FL	11	11	0	0
502		33301	011	Broward	12	FL	2,586	2,493	11	12
503		33304	011	Broward	12	FL	3,462	3,163	17	26
504		33305	011	Broward	12	FL	2,354	2,294	11	12
505		33306	011	Broward	12	FL	969	833	11	11
506		33308	011	Broward	12	FL	8,497	8,300	17	62
507		33309	011	Broward	12	FL	4,810	4,731	54	49
508		33311	011	Broward	12	FL	11,585	10,869	252	88
509		33312	011	Broward	12	FL	7,240	7,051	82	74
510		33313	011	Broward	12	FL	8,309	8,104	152	69
511		33314	011	Broward	12	FL	2,939	2,892	28	36
512		33315	011	Broward	12	FL	2,091	2,059	17	17
513		33316	011	Broward	12	FL	2,500	2,302	11	14
514		33317	011	Broward	12	FL	5,663	5,571	34	59
515		33319	011	Broward	12	FL	9,492	9,206	93	87
516		33321	011	Broward	12	FL	12,560	12,187	75	126
517		33322	011	Broward	12	FL	11,538	11,176	69	114
518		33323	011	Broward	12	FL	2,600	2,576	17	11
519		33324	011	Broward	12	FL	7,285	6,952	33	69
520		33325	011	Broward	12	FL	3,604	3,483	13	35
521		33326	011	Broward	12	FL	4,023	3,904	14	33
522		33327	011	Broward	12	FL	1,518	1,511	11	14
523		33328	011	Broward	12	FL	3,919	3,888	17	39
524		33330	011	Broward	12	FL	2,153	2,105	11	17
525		33331	011	Broward	12	FL	2,978	2,949	11	20
526		33332	011	Broward	12	FL	1,137	1,112	11	11
527		33334	011	Broward	12	FL	4,740	4,397	27	62
528		33351	011	Broward	12	FL	4,187	3,943	43	28
529		33388	011	Broward	12	FL	0	0	0	0
530		33401	099	Palm Beach	12	FL	5,312	5,100	52	49
531		33403	099	Palm Beach	12	FL	1,818	1,696	24	14
532		33404	099	Palm Beach	12	FL	6,035	5,727	106	71
533		33405	099	Palm Beach	12	FL	2,990	2,896	22	29
534		33406	099	Palm Beach	12	FL	3,795	3,389	22	36
535		33407	099	Palm Beach	12	FL	4,294	4,075	78	44
536		33408	099	Palm Beach	12	FL	5,625	5,452	11	47

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
488	261	21	210	0	11	15	132	15
489	64	11	62	11	0	11	34	11
490	64	21	86	11	0	11	47	11
491	186	33	265	11	11	48	136	12
492	132	42	203	11	11	27	112	11
493	131	33	153	11	11	22	74	14
494	262	57	382	11	13	50	188	16
495	70	19	125	11	11	13	73	11
496	127	17	149	11	11	16	85	11
497	30	11	60	0	11	11	25	11
498	171	52	279	11	11	42	135	13
499	16	11	28	0	0	11	15	11
500	146	37	205	11	11	22	87	11
501	0	0	0	0	0	0	0	0
502	67	11	49	0	11	11	26	11
503	121	11	85	0	11	11	54	11
504	92	11	52	11	11	11	31	11
505	37	11	24	0	11	11	14	11
506	265	23	206	11	11	11	134	17
507	159	16	162	11	11	11	102	11
508	351	41	427	11	11	26	229	28
509	190	16	241	11	11	12	140	15
510	245	35	258	11	11	16	139	25
511	79	13	134	11	11	11	83	11
512	58	11	51	0	11	11	36	11
513	79	11	55	11	11	11	32	11
514	168	27	191	11	11	16	106	11
515	330	37	296	11	11	11	159	19
516	404	61	436	11	11	28	266	27
517	336	35	345	11	11	15	218	12
518	65	16	64	0	11	11	31	11
519	236	23	242	11	11	11	147	18
520	96	15	118	11	11	11	70	11
521	112	12	102	11	11	11	59	11
522	39	11	40	11	11	11	23	11
523	135	14	128	11	11	11	73	11
524	82	11	82	11	11	11	36	11
525	86	11	82	0	11	11	40	11
526	25	11	27	11	0	11	11	11
527	124	16	151	11	11	11	111	11
528	156	11	125	11	11	11	55	12
529	0	0	0	0	0	0	0	0
530	216	14	172	11	11	11	101	11
531	56	11	56	11	11	11	39	11
532	149	19	194	0	11	11	126	11
533	128	13	86	0	11	11	62	11
534	106	14	112	0	11	11	77	11
535	145	11	148	11	11	11	94	13
536	196	11	156	11	11	11	124	11

AMERICAN OVERSIGHT

	S	T	U	V	W
488	11	11	11	11	43
489	11	11	11	11	17
490	11	11	11	11	33
491	11	11	11	11	78
492	11	11	11	11	68
493	11	11	11	11	54
494	14	11	11	11	139
495	11	11	11	11	36
496	11	11	11	11	38
497	11	11	11	11	21
498	11	11	11	11	87
499	11	0	0	0	11
500	11	11	11	11	76
501	0	0	0	0	0
502	11	0	11	11	12
503	11	11	11	11	14
504	11	0	11	11	11
505	11	0	11	0	11
506	14	11	11	11	32
507	11	11	11	11	35
508	18	11	13	27	130
509	11	11	11	24	52
510	11	11	11	11	79
511	11	11	11	11	35
512	11	11	0	11	11
513	11	11	11	11	15
514	11	11	11	11	55
515	11	11	11	13	100
516	25	11	11	20	94
517	16	11	11	11	85
518	11	11	11	11	19
519	11	11	11	11	53
520	11	0	11	11	23
521	11	0	11	11	21
522	11	11	11	11	11
523	11	11	11	11	33
524	11	11	11	11	17
525	11	0	11	11	19
526	0	11	0	11	12
527	11	11	11	11	23
528	11	0	11	11	43
529	0	0	0	0	0
530	11	11	11	18	26
531	11	11	11	11	11
532	12	11	11	17	31
533	11	11	11	11	11
534	11	0	11	11	17
535	11	11	11	11	22
536	12	0	0	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
537		33409	099	Palm Beach	12	FL	3,350	3,210	32	27
538		33410	099	Palm Beach	12	FL	7,553	7,176	22	65
539		33411	099	Palm Beach	12	FL	12,953	12,595	56	92
540		33412	099	Palm Beach	12	FL	3,704	3,664	13	26
541		33413	099	Palm Beach	12	FL	1,808	1,788	11	13
542		33414	099	Palm Beach	12	FL	7,948	7,847	24	60
543		33415	099	Palm Beach	12	FL	6,741	6,566	47	71
544		33417	099	Palm Beach	12	FL	8,104	7,645	51	75
545		33418	099	Palm Beach	12	FL	11,353	11,164	23	66
546		33426	099	Palm Beach	12	FL	4,868	4,545	25	48
547		33428	099	Palm Beach	12	FL	6,318	6,149	25	55
548		33430	099	Palm Beach	12	FL	2,884	2,274	73	26
549		33431	099	Palm Beach	12	FL	3,433	3,246	12	16
550		33432	099	Palm Beach	12	FL	4,946	4,724	16	31
551		33433	099	Palm Beach	12	FL	11,280	10,890	41	85
552		33434	099	Palm Beach	12	FL	7,918	7,793	34	51
553		33435	099	Palm Beach	12	FL	6,747	6,612	54	42
554		33436	099	Palm Beach	12	FL	10,498	10,000	47	78
555		33437	099	Palm Beach	12	FL	18,007	17,813	55	97
556		33438	099	Palm Beach	12	FL	151	23	11	11
557		33440	051	Hendry	12	FL	2,808	2,005	38	28
558		33441	011	Broward	12	FL	4,993	4,749	54	52
559		33442	011	Broward	12	FL	7,673	7,487	19	69
560		33444	099	Palm Beach	12	FL	3,696	3,619	58	29
561		33445	099	Palm Beach	12	FL	8,008	7,604	41	54
562		33446	099	Palm Beach	12	FL	13,277	13,052	53	58
563		33449	099	Palm Beach	12	FL	2,144	2,115	11	11
564		33455	085	Martin	12	FL	7,114	6,679	15	90
565		33458	099	Palm Beach	12	FL	8,115	7,624	26	83
566		33460	099	Palm Beach	12	FL	3,858	3,550	47	26
567		33461	099	Palm Beach	12	FL	5,300	5,079	41	44
568		33462	099	Palm Beach	12	FL	5,836	5,617	42	64
569		33463	099	Palm Beach	12	FL	7,156	7,057	56	63
570		33467	099	Palm Beach	12	FL	14,225	13,884	58	93
571		33469	099	Palm Beach	12	FL	4,368	4,209	13	42
572		33470	099	Palm Beach	12	FL	3,832	3,635	22	31
573		33471	043	Glades	12	FL	1,317	986	11	17
574		33472	099	Palm Beach	12	FL	6,444	6,356	23	38
575		33473	099	Palm Beach	12	FL	3,444	3,428	11	11
576		33476	099	Palm Beach	12	FL	1,088	888	34	11
577		33477	099	Palm Beach	12	FL	5,306	5,258	12	26
578		33478	099	Palm Beach	12	FL	2,559	2,534	11	19
579		33480	099	Palm Beach	12	FL	4,396	3,836	11	18
580		33483	099	Palm Beach	12	FL	3,697	3,638	11	21
581		33484	099	Palm Beach	12	FL	11,431	11,212	72	95
582		33486	099	Palm Beach	12	FL	3,456	3,273	15	22
583		33487	099	Palm Beach	12	FL	5,003	4,943	18	36
584		33493	099	Palm Beach	12	FL	454	243	14	11
585		33496	099	Palm Beach	12	FL	7,383	7,305	30	42

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
537	80	11	103	11	11	11	60	11
538	262	16	254	11	11	13	188	11
539	341	47	372	11	11	18	248	12
540	80	14	102	11	11	11	62	11
541	52	0	63	0	0	11	37	11
542	199	24	211	11	11	11	151	11
543	213	20	252	11	15	11	163	11
544	287	26	286	11	11	11	201	12
545	402	24	309	11	13	12	214	18
546	203	18	161	11	11	11	114	11
547	282	18	182	11	11	11	111	11
548	71	11	91	0	11	11	55	11
549	123	13	77	11	11	11	53	11
550	181	14	128	11	11	11	88	11
551	526	35	299	11	12	11	216	16
552	343	26	208	11	11	11	149	11
553	233	11	182	11	11	11	107	11
554	371	29	293	11	13	12	205	13
555	889	56	451	11	15	12	317	20
556	11	0	11	0	0	11	11	0
557	73	11	121	0	11	11	94	11
558	140	19	157	11	11	11	104	11
559	355	23	252	11	11	12	169	11
560	107	11	93	11	11	11	61	11
561	318	34	225	11	11	11	157	11
562	580	30	301	11	11	17	182	21
563	61	11	47	11	11	11	33	11
564	246	21	248	11	15	11	179	15
565	263	22	277	11	11	11	221	11
566	126	11	104	11	11	11	66	11
567	152	13	159	11	11	11	107	11
568	308	20	196	11	11	11	139	11
569	183	16	211	11	11	11	131	16
570	439	52	370	11	11	11	241	13
571	152	14	104	11	11	11	80	11
572	85	11	100	0	11	11	70	11
573	41	11	70	0	11	11	60	11
574	275	21	179	11	11	11	123	11
575	90	11	42	0	11	11	28	11
576	34	11	50	0	11	11	24	11
577	165	20	120	11	11	11	89	11
578	50	11	78	11	11	11	56	11
579	142	11	79	0	0	11	62	11
580	107	11	76	11	11	11	51	11
581	595	36	324	11	11	15	221	14
582	106	15	96	11	11	11	67	11
583	145	11	111	11	11	11	78	0
584	11	0	19	0	0	0	12	11
585	287	34	183	11	11	11	123	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003631

	S	T	U	V	W
537	11	11	11	11	14
538	14	11	11	11	22
539	24	0	15	19	56
540	13	11	11	11	14
541	11	0	11	11	11
542	14	11	11	11	25
543	16	11	11	18	43
544	11	11	11	14	37
545	30	11	11	11	28
546	11	11	11	11	25
547	16	11	11	14	35
548	11	11	11	11	17
549	11	0	11	11	11
550	11	11	11	11	15
551	15	11	11	11	29
552	12	0	11	11	28
553	13	11	11	14	28
554	17	11	11	14	32
555	41	11	17	11	36
556	0	0	0	0	0
557	11	11	11	11	11
558	11	11	11	14	28
559	11	0	11	11	47
560	11	0	11	11	12
561	13	11	11	11	20
562	34	11	11	11	34
563	11	11	0	0	11
564	11	11	11	11	18
565	17	11	11	11	15
566	11	0	11	11	15
567	11	0	11	11	20
568	11	11	11	12	19
569	19	11	11	11	25
570	36	11	12	20	40
571	11	11	0	0	11
572	11	11	11	11	14
573	11	0	11	11	11
574	20	11	11	11	12
575	11	0	11	11	11
576	11	0	11	11	11
577	11	11	11	11	11
578	11	11	11	11	11
579	11	0	0	11	11
580	11	11	0	11	11
581	26	11	11	11	35
582	11	0	11	11	16
583	11	11	11	11	17
584	0	0	11	11	11
585	20	11	11	11	16

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
586		33498	099	Palm Beach	12	FL	3,042	3,006	16	12
587		33510	057	Hillsborough	12	FL	4,439	4,350	31	65
588		33511	057	Hillsborough	12	FL	8,310	7,613	47	100
589		33513	119	Sumter	12	FL	3,094	2,463	11	46
590		33514	119	Sumter	12	FL	352	199	0	11
591		33521	119	Sumter	12	FL	195	0	0	11
592		33523	101	Pasco	12	FL	3,856	3,492	24	89
593		33525	101	Pasco	12	FL	5,196	4,569	24	97
594		33527	057	Hillsborough	12	FL	2,373	2,019	11	37
595		33534	057	Hillsborough	12	FL	1,637	1,403	14	38
596		33538	119	Sumter	12	FL	1,464	1,111	11	23
597		33540	101	Pasco	12	FL	2,750	2,547	11	71
598		33541	101	Pasco	12	FL	7,106	6,985	17	138
599		33542	101	Pasco	12	FL	7,209	6,543	32	168
600		33543	101	Pasco	12	FL	4,640	4,576	27	56
601		33544	101	Pasco	12	FL	3,679	3,632	19	33
602		33545	101	Pasco	12	FL	2,291	2,127	11	24
603		33547	057	Hillsborough	12	FL	3,280	2,925	13	41
604		33548	057	Hillsborough	12	FL	1,713	1,468	11	13
605		33549	057	Hillsborough	12	FL	3,243	3,175	14	42
606		33550	057	Hillsborough	12	FL	196	11	11	11
607		33556	057	Hillsborough	12	FL	4,425	4,258	11	28
608		33558	057	Hillsborough	12	FL	3,768	3,712	20	22
609		33559	057	Hillsborough	12	FL	2,112	2,081	12	35
610		33563	057	Hillsborough	12	FL	4,203	3,792	49	84
611		33565	057	Hillsborough	12	FL	3,678	3,628	14	83
612		33566	057	Hillsborough	12	FL	3,515	3,250	16	74
613		33567	057	Hillsborough	12	FL	1,608	1,579	11	25
614		33569	057	Hillsborough	12	FL	4,695	4,135	20	61
615		33570	057	Hillsborough	12	FL	4,874	4,487	36	64
616		33572	057	Hillsborough	12	FL	4,530	4,423	13	36
617		33573	057	Hillsborough	12	FL	15,667	15,202	33	143
618		33576	101	Pasco	12	FL	2,478	2,104	11	25
619		33578	057	Hillsborough	12	FL	5,461	5,372	29	64
620		33579	057	Hillsborough	12	FL	3,872	3,826	18	35
621		33584	057	Hillsborough	12	FL	4,544	4,189	20	62
622		33585	119	Sumter	12	FL	295	216	11	11
623		33592	057	Hillsborough	12	FL	2,259	1,978	16	52
624		33594	057	Hillsborough	12	FL	6,445	6,039	32	85
625		33596	057	Hillsborough	12	FL	5,094	5,032	17	37
626		33597	119	Sumter	12	FL	1,883	1,624	11	40
627		33598	057	Hillsborough	12	FL	4,272	3,890	13	24
628		33602	057	Hillsborough	12	FL	2,542	2,201	24	25
629		33603	057	Hillsborough	12	FL	3,015	2,862	24	32
630		33604	057	Hillsborough	12	FL	6,188	5,828	61	61
631		33605	057	Hillsborough	12	FL	3,357	2,965	72	33
632		33606	057	Hillsborough	12	FL	2,129	2,078	11	11
633		33607	057	Hillsborough	12	FL	4,085	3,833	39	38
634		33609	057	Hillsborough	12	FL	2,513	2,469	11	19

AMERICAN OVERSIGHT

Zip Code De-Identified Data

	K	L	M	N	O	P	Q	R
586	110	11	70	11	11	11	41	11
587	105	14	214	11	11	12	148	11
588	281	26	371	11	13	20	236	11
589	70	13	168	11	11	11	133	11
590	16	11	22	0	11	11	18	0
591	11	0	14	0	0	11	12	0
592	100	15	229	11	11	28	174	11
593	119	11	260	11	11	40	179	11
594	56	11	113	11	11	11	85	11
595	30	11	97	0	11	11	73	11
596	34	11	77	0	11	11	65	11
597	79	11	204	0	11	27	152	11
598	168	25	431	11	12	69	324	11
599	191	30	490	0	11	69	350	11
600	118	14	186	11	11	18	124	11
601	75	11	147	11	11	26	81	11
602	34	11	92	11	11	11	53	11
603	101	16	167	0	11	12	113	11
604	68	11	61	11	11	11	31	11
605	91	11	143	11	13	11	90	11
606	11	0	11	0	0	11	11	0
607	116	16	118	11	11	11	71	11
608	112	13	118	11	11	11	72	11
609	57	11	100	11	11	11	73	11
610	108	21	270	0	11	17	214	11
611	99	16	231	0	11	11	187	11
612	90	11	185	0	11	11	143	11
613	52	11	92	11	11	11	63	11
614	110	15	213	0	11	11	153	11
615	117	20	207	11	11	11	158	11
616	93	12	151	11	11	11	98	11
617	500	46	576	11	11	49	400	15
618	36	11	85	0	11	16	58	11
619	155	11	231	11	14	12	160	11
620	93	13	165	0	11	11	101	11
621	118	18	229	11	11	14	164	11
622	11	0	18	0	11	0	15	0
623	57	11	141	0	11	11	106	11
624	179	27	280	11	13	12	195	11
625	119	15	176	11	11	11	115	11
626	44	11	120	11	11	11	93	11
627	84	11	128	11	11	16	78	11
628	93	11	107	0	11	11	48	11
629	88	11	120	11	11	11	65	11
630	179	23	237	11	12	11	151	11
631	108	11	150	11	11	11	70	11
632	106	11	66	11	11	11	28	11
633	141	25	159	11	11	11	100	11
634	97	11	76	0	11	11	51	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
586	11	11	0	11	12
587	11	11	11	13	27
588	17	11	11	11	80
589	11	11	11	11	12
590	0	0	11	11	11
591	0	0	0	0	11
592	11	0	11	11	18
593	15	11	11	11	20
594	11	11	11	11	12
595	11	11	11	11	12
596	11	0	11	11	11
597	11	0	11	19	14
598	14	11	11	11	20
599	12	11	11	36	45
600	11	11	11	11	21
601	11	0	11	11	23
602	11	11	11	11	13
603	11	11	11	11	21
604	11	0	11	11	12
605	11	11	11	18	14
606	0	0	0	11	11
607	12	0	11	11	22
608	11	11	11	11	18
609	11	11	11	11	11
610	11	0	11	15	27
611	11	11	11	11	20
612	11	0	11	13	19
613	0	11	0	11	16
614	11	11	11	15	26
615	11	0	11	11	22
616	11	11	11	11	16
617	36	11	11	26	69
618	11	0	11	11	11
619	11	11	12	16	29
620	11	11	11	11	33
621	11	11	11	15	31
622	11	0	0	11	0
623	11	0	11	11	19
624	11	11	11	17	36
625	11	11	11	14	30
626	11	0	11	11	11
627	11	0	11	11	23
628	11	11	0	21	22
629	11	11	11	11	32
630	11	11	11	30	45
631	11	11	11	29	38
632	11	0	0	11	20
633	11	11	11	11	43
634	11	11	11	11	16

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
635		33610	057	Hillsborough	12	FL	6,925	6,303	145	77
636		33611	057	Hillsborough	12	FL	5,438	5,131	18	41
637		33612	057	Hillsborough	12	FL	7,384	6,778	72	104
638		33613	057	Hillsborough	12	FL	4,432	4,269	46	61
639		33614	057	Hillsborough	12	FL	7,063	6,878	43	61
640		33615	057	Hillsborough	12	FL	7,245	6,825	49	60
641		33616	057	Hillsborough	12	FL	1,865	1,829	11	19
642		33617	057	Hillsborough	12	FL	6,621	6,160	68	56
643		33618	057	Hillsborough	12	FL	5,653	5,220	23	30
644		33619	057	Hillsborough	12	FL	5,134	4,952	57	82
645		33620	057	Hillsborough	12	FL	12	12	0	0
646		33621	057	Hillsborough	12	FL	74	21	0	0
647		33624	057	Hillsborough	12	FL	6,653	6,265	30	51
648		33625	057	Hillsborough	12	FL	4,022	3,943	30	23
649		33626	057	Hillsborough	12	FL	3,441	3,382	11	18
650		33629	057	Hillsborough	12	FL	4,063	3,792	11	17
651		33634	057	Hillsborough	12	FL	3,232	2,940	21	23
652		33635	057	Hillsborough	12	FL	2,385	2,345	13	29
653		33637	057	Hillsborough	12	FL	1,976	1,943	16	35
654		33647	057	Hillsborough	12	FL	6,935	6,823	36	38
655		33677	057	Hillsborough	12	FL	149	11	0	11
656		33701	103	Pinellas	12	FL	5,086	4,271	22	33
657		33702	103	Pinellas	12	FL	6,360	5,952	31	77
658		33703	103	Pinellas	12	FL	4,520	4,412	21	48
659		33704	103	Pinellas	12	FL	3,877	2,801	11	21
660		33705	103	Pinellas	12	FL	5,569	5,242	100	53
661		33706	103	Pinellas	12	FL	4,846	4,571	11	30
662		33707	103	Pinellas	12	FL	8,056	7,788	38	69
663		33708	103	Pinellas	12	FL	5,307	5,092	11	45
664		33709	103	Pinellas	12	FL	6,981	6,661	29	111
665		33710	103	Pinellas	12	FL	7,136	6,661	22	80
666		33711	103	Pinellas	12	FL	4,290	3,985	47	36
667		33712	103	Pinellas	12	FL	4,778	4,548	93	74
668		33713	103	Pinellas	12	FL	5,963	4,997	32	78
669		33714	103	Pinellas	12	FL	3,788	3,688	23	75
670		33715	103	Pinellas	12	FL	3,186	3,145	11	11
671		33716	103	Pinellas	12	FL	1,439	1,341	11	15
672		33744	103	Pinellas	12	FL	60	11	0	0
673		33755	103	Pinellas	12	FL	4,689	4,431	35	44
674		33756	103	Pinellas	12	FL	7,350	7,033	44	73
675		33759	103	Pinellas	12	FL	3,798	3,676	15	37
676		33760	103	Pinellas	12	FL	2,397	2,352	16	27
677		33761	103	Pinellas	12	FL	5,395	5,302	13	39
678		33762	103	Pinellas	12	FL	1,448	1,372	11	11
679		33763	103	Pinellas	12	FL	6,720	6,516	31	55
680		33764	103	Pinellas	12	FL	6,161	6,030	28	69
681		33765	103	Pinellas	12	FL	2,897	2,462	24	29
682		33767	103	Pinellas	12	FL	3,218	3,134	11	12
683		33770	103	Pinellas	12	FL	6,009	5,833	28	82

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
635	255	29	288	11	14	16	167	22
636	212	17	209	11	11	12	124	11
637	209	28	348	11	18	17	230	13
638	154	16	192	11	11	11	132	11
639	214	16	263	11	11	15	152	13
640	252	16	283	0	12	11	168	19
641	57	11	72	0	11	11	49	11
642	181	25	228	11	14	15	134	11
643	207	13	170	11	11	11	96	11
644	122	20	234	11	11	12	167	11
645	0	0	0	0	0	0	0	0
646	11	0	11	0	0	0	11	0
647	209	23	218	11	11	12	127	19
648	116	11	131	11	11	11	84	11
649	147	11	125	11	11	11	70	11
650	160	11	116	11	11	11	63	11
651	101	15	121	11	11	11	69	11
652	60	11	106	11	11	0	73	11
653	78	11	107	0	11	11	66	11
654	188	11	195	11	11	18	113	11
655	11	0	11	0	0	0	11	0
656	177	11	137	11	11	11	91	11
657	175	23	250	11	11	11	199	11
658	114	14	161	11	11	11	129	11
659	140	11	104	11	11	11	70	11
660	197	12	183	11	11	11	128	11
661	118	11	109	11	11	11	81	11
662	253	25	263	11	12	11	204	11
663	139	11	155	11	11	11	119	11
664	196	18	329	11	11	12	257	11
665	247	22	254	11	11	12	194	11
666	130	11	120	11	0	11	85	11
667	173	11	186	11	11	11	123	11
668	140	11	224	11	11	11	173	11
669	112	15	199	11	11	12	150	11
670	75	11	58	11	11	11	38	11
671	37	11	49	11	0	11	38	11
672	11	11	11	11	0	0	11	0
673	138	19	181	11	11	11	129	11
674	283	24	309	11	11	23	228	11
675	208	19	141	11	11	11	104	11
676	76	11	78	0	11	11	51	11
677	173	18	190	11	11	11	148	11
678	40	11	31	0	0	11	20	11
679	236	32	241	11	11	18	170	11
680	173	22	258	11	11	23	193	11
681	72	14	115	11	11	11	79	11
682	103	11	81	0	11	11	55	11
683	275	30	263	11	11	12	198	11

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003637

	S	T	U	V	W
635	11	11	11	33	56
636	11	11	11	15	43
637	11	11	11	36	57
638	11	0	11	19	35
639	11	11	11	11	78
640	11	11	11	30	64
641	11	11	0	11	11
642	11	11	11	20	45
643	19	11	11	11	36
644	11	11	11	20	29
645	0	0	0	0	0
646	0	0	0	0	11
647	11	11	11	15	44
648	11	11	11	11	23
649	11	11	11	11	27
650	15	11	11	11	23
651	11	11	11	11	38
652	11	0	11	11	19
653	11	11	11	16	26
654	14	11	11	11	36
655	0	0	0	11	11
656	11	11	0	17	16
657	12	11	11	14	12
658	11	11	11	11	11
659	11	11	11	11	17
660	11	11	11	17	21
661	11	11	0	11	11
662	11	11	11	14	15
663	11	11	11	11	11
664	15	11	11	20	23
665	16	11	11	12	24
666	11	11	11	11	11
667	14	11	11	18	24
668	17	11	11	11	15
669	11	11	11	12	14
670	11	11	11	11	11
671	0	0	11	11	11
672	0	0	0	0	0
673	11	11	11	11	23
674	14	11	11	24	29
675	11	11	11	11	11
676	11	11	11	11	11
677	11	11	11	11	11
678	11	0	0	11	11
679	15	11	11	16	22
680	14	11	11	11	15
681	11	11	11	11	11
682	11	11	11	11	11
683	17	11	11	16	19

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
684		33771	103	Pinellas	12	FL	8,978	8,429	42	115
685		33772	103	Pinellas	12	FL	6,595	6,191	27	79
686		33773	103	Pinellas	12	FL	3,748	3,666	18	41
687		33774	103	Pinellas	12	FL	4,690	4,551	17	41
688		33776	103	Pinellas	12	FL	3,187	3,129	11	26
689		33777	103	Pinellas	12	FL	4,147	4,015	15	48
690		33778	103	Pinellas	12	FL	3,871	3,776	17	43
691		33781	103	Pinellas	12	FL	5,264	4,911	47	83
692		33782	103	Pinellas	12	FL	5,889	5,673	29	83
693		33785	103	Pinellas	12	FL	1,648	1,466	0	12
694		33786	103	Pinellas	12	FL	489	483	0	11
695		33801	105	Polk	12	FL	6,014	5,885	38	65
696		33803	105	Polk	12	FL	7,011	6,034	35	70
697		33805	105	Polk	12	FL	5,169	4,531	52	70
698		33809	105	Polk	12	FL	6,766	6,563	25	71
699		33810	105	Polk	12	FL	10,835	10,630	45	112
700		33811	105	Polk	12	FL	4,291	4,217	18	57
701		33812	105	Polk	12	FL	2,141	1,833	14	19
702		33813	105	Polk	12	FL	7,225	6,782	22	62
703		33815	105	Polk	12	FL	3,213	3,156	22	75
704		33823	105	Polk	12	FL	6,877	6,350	49	77
705		33825	055	Highlands	12	FL	6,813	6,334	62	134
706		33827	105	Polk	12	FL	582	427	11	11
707		33830	105	Polk	12	FL	5,364	4,854	40	57
708		33834	049	Hardee	12	FL	831	627	11	11
709		33837	105	Polk	12	FL	6,488	5,829	27	64
710		33838	105	Polk	12	FL	1,087	763	11	14
711		33839	105	Polk	12	FL	858	444	11	12
712		33841	105	Polk	12	FL	1,640	1,468	11	29
713		33843	105	Polk	12	FL	2,733	2,449	18	46
714		33844	105	Polk	12	FL	8,678	7,871	67	77
715		33848	097	Osceola	12	FL	229	11	11	11
716		33849	105	Polk	12	FL	360	112	11	11
717		33850	105	Polk	12	FL	2,250	2,063	20	23
718		33852	055	Highlands	12	FL	7,156	6,602	25	146
719		33853	105	Polk	12	FL	2,364	2,251	33	22
720		33855	105	Polk	12	FL	449	16	11	11
721		33857	055	Highlands	12	FL	517	362	11	11
722		33859	105	Polk	12	FL	4,078	3,450	16	44
723		33860	105	Polk	12	FL	4,088	3,683	24	42
724		33865	049	Hardee	12	FL	180	147	0	11
725		33867	105	Polk	12	FL	65	63	0	0
726		33868	105	Polk	12	FL	2,643	2,406	11	31
727		33870	055	Highlands	12	FL	6,924	6,544	47	162
728		33872	055	Highlands	12	FL	5,340	5,088	15	118
729		33873	049	Hardee	12	FL	2,288	1,763	21	54
730		33875	055	Highlands	12	FL	3,284	3,248	14	62
731		33876	055	Highlands	12	FL	1,947	1,925	11	32
732		33880	105	Polk	12	FL	7,632	6,995	62	82

AMERICAN OVERSIGHT

Zip Code De-Identified Data

	K	L	M	N	O	P	Q	R
684	324	40	438	11	14	26	337	11
685	307	14	280	11	11	19	213	11
686	99	11	148	11	11	11	119	11
687	161	16	158	11	11	11	116	11
688	108	11	118	11	11	11	93	11
689	161	14	165	11	11	11	122	11
690	107	11	171	11	11	11	120	11
691	215	14	248	0	11	11	184	11
692	189	16	266	11	11	12	205	11
693	37	11	47	0	11	0	34	11
694	17	11	19	0	0	11	11	11
695	184	37	327	11	13	13	243	11
696	197	38	320	11	11	11	219	12
697	156	27	268	11	12	11	194	11
698	188	26	322	0	11	11	242	11
699	247	59	492	11	14	11	380	15
700	105	16	193	11	11	11	143	11
701	53	11	90	0	11	11	63	11
702	180	36	282	11	11	11	208	11
703	79	24	219	0	11	11	173	11
704	166	31	319	0	11	11	241	11
705	247	30	446	11	11	11	357	11
706	11	11	13	0	0	0	11	0
707	122	39	271	11	17	11	190	11
708	19	11	44	11	11	0	35	11
709	117	25	232	11	11	11	168	11
710	21	11	41	11	11	0	33	11
711	20	11	32	0	11	0	28	0
712	36	11	100	0	11	11	76	11
713	61	12	147	11	11	0	127	11
714	199	39	333	11	11	11	230	12
715	11	11	11	0	0	11	11	0
716	11	0	21	0	11	0	18	0
717	67	11	122	11	11	11	91	0
718	273	31	517	11	11	11	427	11
719	68	11	107	11	11	11	75	11
720	11	0	19	0	0	11	14	0
721	23	11	42	11	11	11	34	11
722	91	15	159	11	11	11	118	11
723	93	22	206	11	11	11	155	11
724	11	11	11	11	0	0	11	0
725	11	0	11	0	0	0	11	0
726	68	13	122	11	11	11	93	11
727	365	34	543	11	11	11	455	11
728	209	24	378	11	11	11	319	11
729	88	23	169	11	11	11	132	11
730	126	14	226	11	11	11	190	11
731	71	11	134	11	11	0	115	11
732	204	45	372	11	11	11	269	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
684	19	11	11	25	34
685	12	11	11	18	15
686	11	0	11	11	11
687	11	11	11	11	11
688	11	0	11	11	11
689	11	11	11	16	11
690	11	0	11	15	20
691	11	11	11	18	26
692	21	11	11	20	18
693	11	0	11	11	11
694	0	0	0	0	11
695	11	0	11	30	41
696	21	11	11	25	46
697	11	0	11	25	48
698	11	11	11	28	34
699	25	11	11	36	45
700	11	0	11	17	16
701	11	0	11	11	11
702	16	11	11	17	37
703	11	11	11	25	17
704	20	11	11	23	30
705	13	0	11	40	42
706	11	0	0	11	11
707	17	0	11	18	39
708	0	0	0	11	11
709	19	11	11	17	16
710	11	0	0	11	11
711	11	0	0	11	11
712	11	11	0	11	11
713	11	11	11	11	14
714	17	11	11	28	41
715	0	0	11	0	11
716	0	0	0	11	0
717	11	0	0	17	13
718	22	11	11	23	38
719	11	0	11	15	11
720	11	0	0	0	11
721	11	0	11	11	11
722	11	0	11	11	11
723	11	11	11	15	16
724	11	0	11	0	0
725	0	0	0	11	0
726	11	11	11	12	11
727	14	11	11	33	55
728	11	11	11	11	31
729	11	0	11	17	15
730	11	0	11	11	14
731	11	11	11	11	11
732	20	11	11	33	46

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
733		33881	105	Polk	12	FL	9,659	9,177	81	91
734		33884	105	Polk	12	FL	8,470	8,278	27	82
735		33890	049	Hardee	12	FL	976	684	11	19
736		33896	105	Polk	12	FL	2,075	2,045	15	16
737		33897	105	Polk	12	FL	3,729	3,685	19	44
738		33898	105	Polk	12	FL	5,093	4,442	33	59
739		33901	071	Lee	12	FL	4,651	4,148	42	62
740		33903	071	Lee	12	FL	9,108	8,590	23	133
741		33904	071	Lee	12	FL	9,604	9,449	30	121
742		33905	071	Lee	12	FL	6,862	6,562	46	101
743		33907	071	Lee	12	FL	5,029	4,624	13	59
744		33908	071	Lee	12	FL	15,072	14,726	39	107
745		33909	071	Lee	12	FL	5,039	4,985	18	60
746		33912	071	Lee	12	FL	6,389	6,303	14	58
747		33913	071	Lee	12	FL	7,676	7,623	13	40
748		33914	071	Lee	12	FL	10,652	10,543	36	97
749		33916	071	Lee	12	FL	3,269	3,214	56	48
750		33917	071	Lee	12	FL	11,019	10,865	34	163
751		33919	071	Lee	12	FL	9,636	9,451	24	97
752		33920	071	Lee	12	FL	1,811	1,619	11	20
753		33921	071	Lee	12	FL	753	12	0	11
754		33922	071	Lee	12	FL	1,508	1,201	11	13
755		33924	071	Lee	12	FL	140	11	0	11
756		33928	071	Lee	12	FL	9,677	9,445	12	61
757		33930	051	Hendry	12	FL	114	11	0	11
758		33931	071	Lee	12	FL	3,804	3,634	11	29
759		33935	051	Hendry	12	FL	3,148	2,463	23	52
760		33936	071	Lee	12	FL	5,846	5,410	28	97
761		33944	043	Glades	12	FL	97	0	0	11
762		33946	015	Charlotte	12	FL	1,252	883	0	11
763		33947	015	Charlotte	12	FL	4,701	4,657	11	50
764		33948	015	Charlotte	12	FL	5,898	5,600	17	63
765		33950	015	Charlotte	12	FL	11,937	10,959	16	104
766		33952	015	Charlotte	12	FL	9,228	9,027	49	137
767		33953	015	Charlotte	12	FL	2,746	2,685	11	23
768		33954	015	Charlotte	12	FL	3,015	2,928	13	36
769		33955	015	Charlotte	12	FL	4,041	4,009	11	51
770		33956	071	Lee	12	FL	1,750	1,636	11	19
771		33957	071	Lee	12	FL	2,866	2,627	11	11
772		33960	055	Highlands	12	FL	209	187	0	11
773		33965	071	Lee	12	FL	0	0	0	0
774		33966	071	Lee	12	FL	2,579	2,557	11	21
775		33967	071	Lee	12	FL	3,421	3,372	13	37
776		33971	071	Lee	12	FL	2,430	2,395	17	38
777		33972	071	Lee	12	FL	2,080	2,056	12	30
778		33973	071	Lee	12	FL	944	937	11	13
779		33974	071	Lee	12	FL	1,646	1,625	12	23
780		33976	071	Lee	12	FL	1,205	1,187	12	20
781		33980	015	Charlotte	12	FL	4,642	4,498	11	70

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
733	272	40	443	11	11	11	315	15
734	208	38	340	11	11	11	245	11
735	32	11	72	0	0	11	54	0
736	72	11	91	11	11	11	62	11
737	67	14	151	11	11	11	115	11
738	122	14	206	11	11	11	172	11
739	209	11	192	11	11	11	143	11
740	276	21	429	11	13	18	344	14
741	307	22	351	11	19	13	268	20
742	223	13	315	11	11	16	224	17
743	184	14	201	11	11	11	156	11
744	409	28	423	11	13	26	314	17
745	128	11	224	0	12	15	151	11
746	172	14	189	11	11	11	137	11
747	192	16	192	11	11	23	122	13
748	283	17	345	11	11	22	260	14
749	101	11	127	11	11	11	97	11
750	337	26	506	11	21	25	394	11
751	275	30	333	11	15	18	257	11
752	54	11	75	0	11	11	49	11
753	21	0	17	0	11	11	11	0
754	35	11	39	0	11	0	32	11
755	11	0	11	0	11	0	11	0
756	202	19	243	11	11	13	159	13
757	11	0	11	0	0	0	11	0
758	104	11	79	11	11	11	60	0
759	101	11	132	11	11	11	104	11
760	176	13	310	11	11	11	238	11
761	11	0	13	0	11	0	12	0
762	31	11	30	0	0	0	24	11
763	130	11	164	11	11	11	127	11
764	205	14	249	11	11	28	169	11
765	391	15	383	11	17	33	262	12
766	361	11	459	11	16	40	345	13
767	59	11	84	0	11	11	64	11
768	100	11	113	11	11	13	74	11
769	104	11	153	0	11	17	115	11
770	48	11	62	0	11	11	52	11
771	55	11	59	0	0	11	37	11
772	11	0	13	0	0	0	11	11
773	0	0	0	0	0	0	0	0
774	52	11	70	11	11	11	47	11
775	76	13	122	11	11	11	89	11
776	66	11	117	0	11	11	88	11
777	63	11	104	11	11	11	66	11
778	15	11	41	0	11	11	31	11
779	38	0	73	11	0	11	53	11
780	34	11	52	11	11	11	37	11
781	203	11	195	0	11	21	149	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
733	18	11	11	46	59
734	24	11	11	19	38
735	11	0	11	11	11
736	11	0	11	11	11
737	11	11	11	15	11
738	12	11	11	11	11
739	11	11	11	15	13
740	17	11	11	17	34
741	22	11	11	11	28
742	23	0	11	11	33
743	11	11	11	11	11
744	31	11	11	11	25
745	23	11	11	11	23
746	18	11	0	11	17
747	22	11	11	11	11
748	18	11	11	11	28
749	11	11	11	11	19
750	29	11	12	12	23
751	21	11	11	11	22
752	11	11	0	11	11
753	11	0	0	11	11
754	11	0	11	0	11
755	0	0	0	0	0
756	30	11	11	11	11
757	0	0	11	11	0
758	11	11	0	11	11
759	11	0	11	11	11
760	11	11	11	24	31
761	0	0	0	0	0
762	11	0	0	0	11
763	11	11	11	11	11
764	16	11	11	11	21
765	37	11	11	19	22
766	22	11	11	26	24
767	11	0	11	11	11
768	11	0	11	11	11
769	11	11	11	11	11
770	11	11	11	11	11
771	11	0	0	11	11
772	0	0	0	0	11
773	0	0	0	0	0
774	11	0	0	11	11
775	12	11	11	11	11
776	11	0	11	11	13
777	11	11	11	11	11
778	11	0	11	11	11
779	11	0	11	11	11
780	11	0	11	11	11
781	11	11	11	11	11

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
782		33981	015	Charlotte	12	FL	4,549	4,504	11	50
783		33982	015	Charlotte	12	FL	3,060	2,987	11	43
784		33983	015	Charlotte	12	FL	5,477	5,385	23	57
785		33990	071	Lee	12	FL	7,690	6,953	32	84
786		33991	071	Lee	12	FL	5,337	5,220	15	53
787		33993	071	Lee	12	FL	4,652	4,555	16	58
788		34102	021	Collier	12	FL	4,269	3,400	13	17
789		34103	021	Collier	12	FL	4,319	4,252	11	24
790		34104	021	Collier	12	FL	6,479	6,411	18	45
791		34105	021	Collier	12	FL	5,227	5,148	11	32
792		34108	021	Collier	12	FL	6,750	6,330	11	41
793		34109	021	Collier	12	FL	7,052	6,957	19	56
794		34110	021	Collier	12	FL	8,884	8,763	20	58
795		34112	021	Collier	12	FL	8,527	8,393	25	63
796		34113	021	Collier	12	FL	6,623	6,535	20	43
797		34114	021	Collier	12	FL	7,019	6,972	18	49
798		34116	021	Collier	12	FL	3,227	3,028	29	36
799		34117	021	Collier	12	FL	2,160	2,136	12	27
800		34119	021	Collier	12	FL	9,460	9,383	20	35
801		34120	021	Collier	12	FL	6,399	6,347	21	41
802		34134	071	Lee	12	FL	7,129	7,046	11	38
803		34135	071	Lee	12	FL	14,275	13,703	37	91
804		34137	021	Collier	12	FL	27	0	11	11
805		34138	021	Collier	12	FL	132	11	0	0
806		34139	021	Collier	12	FL	149	11	0	0
807		34140	021	Collier	12	FL	129	11	0	11
808		34141	021	Collier	12	FL	52	24	11	0
809		34142	021	Collier	12	FL	3,178	2,511	56	19
810		34145	021	Collier	12	FL	6,412	6,094	11	30
811		34201	081	Manatee	12	FL	1,999	1,987	11	11
812		34202	081	Manatee	12	FL	7,468	7,384	14	29
813		34203	081	Manatee	12	FL	9,416	8,838	46	138
814		34205	081	Manatee	12	FL	7,080	6,640	32	101
815		34207	081	Manatee	12	FL	7,513	6,648	35	140
816		34208	081	Manatee	12	FL	6,002	5,812	47	71
817		34209	081	Manatee	12	FL	10,649	10,214	26	102
818		34210	081	Manatee	12	FL	4,535	4,444	11	33
819		34211	081	Manatee	12	FL	3,920	3,764	11	21
820		34212	081	Manatee	12	FL	4,953	4,898	11	28
821		34215	081	Manatee	12	FL	392	201	11	11
822		34217	081	Manatee	12	FL	1,956	1,384	11	16
823		34219	081	Manatee	12	FL	6,069	5,843	12	62
824		34221	081	Manatee	12	FL	9,817	9,292	62	139
825		34222	081	Manatee	12	FL	4,697	4,481	18	72
826		34223	115	Sarasota	12	FL	8,367	7,985	14	88
827		34224	015	Charlotte	12	FL	6,235	6,151	15	76
828		34228	081	Manatee	12	FL	3,577	3,463	11	11
829		34229	115	Sarasota	12	FL	3,207	2,999	11	11
830		34231	115	Sarasota	12	FL	8,824	8,606	20	67

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
782	131	11	153	11	11	11	119	11
783	100	11	132	0	11	18	97	11
784	178	11	212	11	11	22	158	11
785	220	26	322	0	11	19	237	15
786	170	18	170	11	11	11	130	11
787	102	12	168	11	11	13	125	11
788	105	11	86	0	11	11	62	11
789	132	18	99	0	11	11	65	11
790	211	20	156	11	11	20	109	11
791	152	12	135	11	11	13	97	11
792	189	20	165	11	11	22	109	11
793	312	24	221	11	11	18	149	11
794	332	20	240	11	11	29	170	11
795	238	25	235	11	11	21	183	11
796	232	20	176	11	11	14	123	11
797	175	16	187	11	11	26	119	11
798	94	11	106	11	11	11	76	11
799	74	11	74	0	11	11	51	11
800	262	19	207	11	14	18	120	11
801	153	14	180	0	11	11	115	11
802	214	15	157	0	11	18	104	11
803	382	25	376	11	16	41	253	16
804	0	0	11	0	0	0	11	0
805	11	11	11	0	0	11	11	0
806	11	0	11	0	0	11	11	0
807	11	0	11	0	0	11	11	0
808	0	0	11	0	0	0	0	0
809	61	11	70	0	11	11	43	0
810	176	11	129	11	11	14	84	11
811	43	11	37	0	11	11	19	11
812	215	12	152	11	11	15	98	11
813	269	12	351	11	11	14	284	12
814	347	11	290	11	0	22	214	11
815	241	12	374	11	11	19	304	11
816	190	11	224	11	11	15	172	11
817	368	15	360	11	11	23	278	13
818	127	11	143	11	11	13	106	11
819	103	11	77	0	11	11	47	11
820	104	11	109	11	11	16	72	11
821	11	11	11	0	11	11	11	0
822	54	11	51	0	0	11	43	11
823	141	11	191	11	11	16	140	11
824	282	13	402	11	11	24	307	11
825	142	11	198	11	11	15	161	11
826	279	13	308	0	11	16	234	11
827	218	16	271	0	11	16	229	11
828	108	11	75	0	11	11	50	11
829	94	11	74	0	0	11	53	11
830	323	12	273	0	11	13	207	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
782	11	11	11	11	11
783	11	0	11	11	11
784	11	11	11	11	14
785	17	11	11	11	33
786	14	11	11	11	11
787	12	11	11	11	11
788	11	11	0	11	11
789	11	0	0	11	11
790	15	11	11	11	11
791	11	0	11	11	11
792	16	11	11	0	11
793	23	11	11	11	12
794	22	11	11	11	11
795	18	11	11	11	11
796	12	11	11	11	13
797	27	11	11	11	11
798	11	11	11	11	11
799	11	0	11	11	13
800	32	11	11	11	16
801	25	11	11	11	12
802	21	11	11	11	11
803	37	11	11	11	13
804	0	0	0	0	0
805	0	0	0	0	0
806	11	0	0	0	0
807	0	0	0	0	0
808	0	0	11	0	0
809	11	11	0	13	11
810	11	11	11	11	11
811	11	0	0	11	11
812	11	11	11	11	14
813	12	0	11	18	20
814	11	0	11	22	26
815	11	11	11	21	20
816	11	11	11	14	18
817	15	0	11	14	24
818	11	11	11	11	11
819	11	11	11	11	11
820	11	0	11	11	11
821	0	0	0	0	11
822	11	0	0	11	11
823	15	11	11	11	11
824	16	11	11	31	26
825	11	11	11	11	11
826	22	11	11	11	18
827	19	11	11	11	11
828	11	11	11	11	11
829	11	0	11	11	11
830	21	11	11	11	15

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
831		34232	115	Sarasota	12	FL	7,772	7,345	37	69
832		34233	115	Sarasota	12	FL	5,302	5,173	13	48
833		34234	115	Sarasota	12	FL	4,543	4,356	66	55
834		34235	115	Sarasota	12	FL	4,719	4,562	15	39
835		34236	115	Sarasota	12	FL	6,595	5,412	17	28
836		34237	115	Sarasota	12	FL	2,638	2,543	20	22
837		34238	115	Sarasota	12	FL	9,054	8,895	20	57
838		34239	115	Sarasota	12	FL	3,959	3,572	12	35
839		34240	115	Sarasota	12	FL	3,140	3,065	11	19
840		34241	115	Sarasota	12	FL	3,790	3,734	11	22
841		34242	115	Sarasota	12	FL	2,817	2,751	11	13
842		34243	081	Manatee	12	FL	8,685	8,407	26	50
843		34250	081	Manatee	12	FL	163	11	0	0
844		34251	081	Manatee	12	FL	1,001	886	11	11
845		34266	027	De Soto	12	FL	5,272	4,475	43	93
846		34269	027	De Soto	12	FL	1,686	1,499	11	27
847		34275	115	Sarasota	12	FL	8,072	7,729	13	50
848		34285	115	Sarasota	12	FL	9,169	8,624	20	94
849		34286	115	Sarasota	12	FL	4,067	4,018	19	36
850		34287	115	Sarasota	12	FL	9,224	8,912	32	107
851		34288	115	Sarasota	12	FL	2,977	2,937	11	30
852		34289	115	Sarasota	12	FL	1,051	1,013	11	11
853		34291	115	Sarasota	12	FL	1,559	1,536	11	15
854		34292	115	Sarasota	12	FL	8,101	7,990	11	57
855		34293	115	Sarasota	12	FL	17,925	17,729	33	153
856		34420	083	Marion	12	FL	4,182	3,613	15	84
857		34423	017	Citrus	12	FL	393	11	0	11
858		34428	017	Citrus	12	FL	2,825	2,781	15	66
859		34429	017	Citrus	12	FL	3,100	2,996	11	49
860		34431	083	Marion	12	FL	2,730	2,699	11	46
861		34432	083	Marion	12	FL	5,379	4,824	21	58
862		34433	017	Citrus	12	FL	2,203	2,173	11	51
863		34434	017	Citrus	12	FL	2,541	2,504	11	55
864		34436	017	Citrus	12	FL	2,866	2,616	11	71
865		34442	017	Citrus	12	FL	7,388	7,276	16	121
866		34446	017	Citrus	12	FL	7,972	7,825	17	142
867		34448	017	Citrus	12	FL	4,144	3,502	11	99
868		34449	075	Levy	12	FL	1,312	946	0	34
869		34450	017	Citrus	12	FL	4,462	4,007	11	107
870		34452	017	Citrus	12	FL	3,568	3,476	22	82
871		34453	017	Citrus	12	FL	3,489	3,400	11	69
872		34461	017	Citrus	12	FL	4,159	3,772	11	84
873		34465	017	Citrus	12	FL	7,269	6,897	15	134
874		34470	083	Marion	12	FL	4,813	4,702	22	80
875		34471	083	Marion	12	FL	6,838	5,384	30	91
876		34472	083	Marion	12	FL	6,782	6,312	38	92
877		34473	083	Marion	12	FL	5,264	5,202	34	51
878		34474	083	Marion	12	FL	3,311	3,189	18	61
879		34475	083	Marion	12	FL	2,144	2,090	31	36

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
831	267	12	257	11	11	11	205	11
832	204	11	189	0	11	11	153	11
833	165	11	177	11	11	11	138	11
834	160	11	151	11	0	11	110	11
835	263	11	153	0	11	11	121	11
836	95	11	94	0	11	11	69	11
837	285	11	226	11	11	11	160	11
838	106	11	121	0	11	11	94	11
839	96	11	85	11	11	11	63	11
840	105	11	92	0	11	11	68	11
841	88	11	66	11	11	11	51	11
842	265	14	233	11	11	15	158	11
843	11	0	11	0	0	11	11	0
844	23	0	23	0	0	11	18	11
845	181	11	286	11	11	11	231	11
846	47	11	79	11	11	11	63	11
847	220	14	223	11	11	15	172	11
848	338	14	340	11	13	22	263	11
849	96	11	156	11	11	14	110	11
850	329	25	376	11	12	32	289	11
851	86	11	120	11	11	12	76	11
852	20	11	29	11	11	11	22	0
853	41	11	54	11	11	11	42	11
854	319	12	239	11	11	21	190	11
855	521	28	560	11	20	23	436	15
856	113	13	228	11	11	11	186	0
857	11	0	12	0	0	0	11	0
858	61	11	154	11	11	11	134	0
859	63	11	115	11	11	11	101	11
860	65	11	125	11	11	11	101	11
861	117	11	231	11	11	11	181	11
862	29	11	114	11	11	11	94	11
863	68	11	119	11	11	11	99	11
864	71	12	138	11	11	11	119	11
865	147	15	268	0	11	11	215	11
866	165	18	307	11	11	13	249	11
867	77	11	226	11	11	11	193	11
868	21	11	73	11	11	0	62	11
869	137	11	204	11	11	11	165	11
870	112	11	169	11	11	11	136	11
871	80	11	136	0	11	11	110	11
872	108	11	171	0	11	11	137	11
873	182	19	289	0	11	12	232	11
874	139	16	261	0	11	11	206	11
875	281	18	311	11	11	12	233	16
876	173	24	310	11	11	11	237	11
877	93	16	197	11	11	11	137	11
878	105	11	179	11	11	11	137	11
879	50	11	105	11	11	11	77	11

AMERICAN OVERSIGHT

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	S	T	U	V	W
831	16	0	11	11	21
832	14	0	11	11	11
833	11	11	11	11	14
834	15	0	11	11	11
835	11	11	0	11	11
836	11	0	11	11	11
837	18	11	11	11	15
838	11	11	11	11	11
839	11	11	11	11	11
840	11	11	11	11	11
841	11	11	11	11	11
842	17	11	11	12	22
843	11	0	0	0	0
844	0	0	11	11	11
845	13	11	11	15	15
846	11	0	11	11	11
847	21	11	11	11	11
848	27	11	11	11	12
849	17	11	11	11	11
850	17	11	11	12	23
851	11	11	0	11	11
852	11	0	0	11	0
853	11	11	11	11	11
854	20	11	11	11	11
855	46	11	11	19	21
856	11	0	11	12	11
857	11	0	0	0	0
858	11	0	0	11	11
859	11	0	11	11	11
860	11	11	0	11	11
861	11	11	11	11	13
862	11	11	0	11	11
863	11	0	11	11	11
864	11	0	11	11	11
865	19	11	11	13	14
866	16	0	11	14	13
867	11	0	11	11	11
868	11	0	11	11	11
869	11	11	11	13	11
870	11	0	11	16	11
871	11	0	11	11	11
872	11	0	11	11	12
873	12	0	11	19	16
874	11	11	11	15	16
875	11	0	11	21	36
876	11	11	11	15	29
877	11	11	16	13	13
878	11	11	11	11	19
879	11	11	11	14	0

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
880		34476	083	Marion	12	FL	10,065	9,934	30	114
881		34479	083	Marion	12	FL	2,955	2,908	11	47
882		34480	083	Marion	12	FL	3,659	3,603	14	52
883		34481	083	Marion	12	FL	13,838	13,694	28	130
884		34482	083	Marion	12	FL	5,858	5,789	29	103
885		34484	119	Sumter	12	FL	1,556	1,367	11	17
886		34488	083	Marion	12	FL	3,657	3,268	13	73
887		34491	083	Marion	12	FL	13,459	13,015	26	151
888		34498	075	Levy	12	FL	222	165	0	11
889		34601	053	Hernando	12	FL	6,896	6,225	23	148
890		34602	053	Hernando	12	FL	1,948	1,916	11	32
891		34604	053	Hernando	12	FL	2,668	2,532	11	54
892		34606	053	Hernando	12	FL	10,267	9,706	36	215
893		34607	053	Hernando	12	FL	2,991	2,952	11	51
894		34608	053	Hernando	12	FL	8,773	8,657	22	179
895		34609	053	Hernando	12	FL	11,700	11,557	23	212
896		34610	101	Pasco	12	FL	3,237	3,089	11	84
897		34613	053	Hernando	12	FL	8,051	7,970	11	177
898		34614	053	Hernando	12	FL	1,893	1,875	11	39
899		34637	101	Pasco	12	FL	1,800	1,781	11	13
900		34638	101	Pasco	12	FL	3,592	3,540	11	35
901		34639	101	Pasco	12	FL	4,482	4,125	11	58
902		34652	101	Pasco	12	FL	7,130	6,826	18	119
903		34653	101	Pasco	12	FL	9,017	8,513	44	170
904		34654	101	Pasco	12	FL	6,049	5,915	19	97
905		34655	101	Pasco	12	FL	11,704	11,498	29	120
906		34661	053	Hernando	12	FL	151	11	0	11
907		34667	101	Pasco	12	FL	12,757	12,243	43	239
908		34668	101	Pasco	12	FL	12,080	11,624	55	227
909		34669	101	Pasco	12	FL	3,691	3,623	11	83
910		34677	103	Pinellas	12	FL	4,759	4,498	11	37
911		34679	101	Pasco	12	FL	118	11	0	11
912		34681	103	Pinellas	12	FL	427	11	0	0
913		34683	103	Pinellas	12	FL	6,954	6,529	25	43
914		34684	103	Pinellas	12	FL	8,458	8,204	26	61
915		34685	103	Pinellas	12	FL	4,024	3,943	11	15
916		34688	103	Pinellas	12	FL	2,250	1,935	11	21
917		34689	103	Pinellas	12	FL	7,345	7,162	33	61
918		34690	101	Pasco	12	FL	3,176	2,981	14	70
919		34691	101	Pasco	12	FL	5,056	4,968	23	83
920		34695	103	Pinellas	12	FL	4,479	4,235	14	35
921		34698	103	Pinellas	12	FL	11,357	10,840	36	86
922		34705	069	Lake	12	FL	559	437	11	11
923		34711	069	Lake	12	FL	14,263	13,762	70	154
924		34714	069	Lake	12	FL	3,276	2,997	20	29
925		34715	069	Lake	12	FL	3,272	2,876	13	37
926		34731	069	Lake	12	FL	3,220	3,008	11	46
927		34734	095	Orange	12	FL	658	538	11	11
928		34736	069	Lake	12	FL	4,414	4,200	26	47

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
880	265	24	416	11	11	21	316	11
881	78	12	152	0	11	11	132	11
882	82	13	177	0	11	11	139	11
883	372	17	421	11	11	23	317	11
884	161	19	291	11	11	11	234	11
885	80	11	76	11	11	11	59	11
886	86	11	205	11	11	11	162	11
887	339	34	538	11	11	33	410	11
888	11	0	11	0	0	11	11	0
889	246	27	367	0	11	11	293	11
890	41	11	103	0	11	11	78	11
891	77	11	125	11	11	11	100	11
892	358	27	537	11	14	11	452	11
893	64	11	123	11	11	11	99	11
894	298	21	467	11	12	11	379	11
895	340	23	537	11	15	14	417	11
896	84	11	195	11	11	11	156	11
897	217	18	430	11	11	11	361	11
898	42	11	85	0	0	11	69	11
899	40	11	47	0	11	11	37	0
900	80	17	119	0	11	11	90	11
901	120	21	186	11	11	19	123	11
902	227	20	355	0	11	13	277	11
903	363	22	483	11	12	14	381	11
904	181	29	268	11	11	11	213	11
905	360	25	392	11	12	18	308	11
906	11	0	11	0	0	0	11	0
907	422	39	605	11	17	11	506	11
908	384	31	598	11	14	23	486	11
909	114	13	198	11	11	11	161	11
910	116	18	142	11	11	11	105	11
911	11	0	11	0	0	0	11	0
912	11	11	11	0	0	0	11	0
913	210	21	242	11	11	26	162	12
914	320	32	320	11	11	17	237	11
915	119	14	134	11	11	11	93	11
916	80	11	87	11	11	11	58	11
917	202	29	246	11	11	15	177	11
918	103	12	173	11	11	11	131	11
919	140	12	229	11	11	15	184	11
920	106	16	145	11	11	11	103	11
921	358	42	386	11	15	27	283	11
922	14	11	29	0	0	11	26	11
923	372	48	542	11	17	34	404	11
924	68	17	121	11	11	11	83	11
925	91	18	144	11	11	11	104	11
926	103	12	141	11	11	11	113	11
927	18	11	29	11	0	0	21	11
928	98	17	175	11	11	11	121	11

AMERICAN OVERSIGHT

	S	T	U	V	W
880	23	11	13	19	26
881	11	0	11	11	11
882	11	11	11	11	17
883	35	11	11	11	23
884	13	11	11	15	12
885	11	11	11	11	11
886	11	0	11	17	13
887	43	11	11	21	24
888	0	0	0	0	0
889	11	11	11	24	35
890	11	11	11	11	11
891	11	11	11	11	11
892	22	11	11	20	42
893	11	0	11	11	11
894	15	11	11	22	50
895	32	11	11	25	47
896	11	11	0	11	14
897	13	11	11	12	30
898	11	11	11	11	11
899	11	0	11	0	11
900	11	0	11	11	11
901	11	11	11	11	28
902	20	11	11	11	32
903	19	11	11	34	48
904	13	0	11	15	20
905	20	0	11	20	25
906	0	0	0	0	0
907	29	11	11	29	39
908	25	11	11	35	36
909	11	11	11	11	12
910	11	11	11	11	11
911	0	0	0	11	0
912	11	0	11	0	11
913	13	11	11	12	18
914	21	0	11	11	20
915	11	11	11	11	11
916	11	0	11	11	11
917	11	11	11	18	25
918	11	11	11	11	20
919	11	11	11	11	14
920	11	11	11	11	12
921	21	11	11	17	41
922	0	0	0	0	11
923	29	11	11	32	42
924	11	0	11	11	18
925	11	0	11	11	20
926	11	0	11	11	11
927	11	0	11	11	11
928	14	11	11	11	21

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
929		34737	069	Lake	12	FL	833	786	11	11
930		34739	097	Osceola	12	FL	230	184	0	11
931		34741	097	Osceola	12	FL	7,100	6,108	76	66
932		34743	097	Osceola	12	FL	6,422	6,297	61	44
933		34744	097	Osceola	12	FL	8,565	8,418	65	63
934		34746	097	Osceola	12	FL	8,103	7,941	62	59
935		34747	097	Osceola	12	FL	2,952	2,781	13	16
936		34748	069	Lake	12	FL	18,515	17,866	71	188
937		34753	069	Lake	12	FL	775	623	11	11
938		34756	069	Lake	12	FL	637	523	11	12
939		34758	097	Osceola	12	FL	6,722	6,471	57	49
940		34759	105	Polk	12	FL	10,565	10,474	69	61
941		34760	095	Orange	12	FL	239	11	11	11
942		34761	095	Orange	12	FL	5,382	5,119	31	68
943		34762	069	Lake	12	FL	265	87	0	11
944		34769	097	Osceola	12	FL	5,279	4,714	29	104
945		34771	097	Osceola	12	FL	3,516	3,460	13	47
946		34772	097	Osceola	12	FL	4,851	4,753	31	67
947		34773	097	Osceola	12	FL	697	691	11	11
948		34785	119	Sumter	12	FL	3,635	3,257	28	52
949		34786	095	Orange	12	FL	4,206	3,820	11	26
950		34787	095	Orange	12	FL	8,706	8,158	51	83
951		34788	069	Lake	12	FL	6,754	6,536	18	106
952		34797	069	Lake	12	FL	443	401	11	11
953		34945	111	Saint Lucie	12	FL	992	976	11	12
954		34946	111	Saint Lucie	12	FL	1,570	1,544	21	18
955		34947	111	Saint Lucie	12	FL	1,802	1,741	32	25
956		34949	111	Saint Lucie	12	FL	3,260	3,231	11	16
957		34950	111	Saint Lucie	12	FL	3,046	2,606	49	32
958		34951	111	Saint Lucie	12	FL	5,023	4,945	16	51
959		34952	111	Saint Lucie	12	FL	12,957	12,396	64	148
960		34953	111	Saint Lucie	12	FL	10,895	10,750	85	131
961		34956	085	Martin	12	FL	1,108	810	15	11
962		34957	085	Martin	12	FL	7,388	7,058	15	83
963		34972	093	Okeechobee	12	FL	3,024	2,546	30	65
964		34974	093	Okeechobee	12	FL	5,937	5,837	25	95
965		34981	111	Saint Lucie	12	FL	806	777	11	12
966		34982	111	Saint Lucie	12	FL	5,780	5,689	39	76
967		34983	111	Saint Lucie	12	FL	8,867	8,324	54	103
968		34984	111	Saint Lucie	12	FL	3,253	3,219	20	30
969		34986	111	Saint Lucie	12	FL	10,616	10,222	34	98
970		34987	111	Saint Lucie	12	FL	4,368	4,339	11	21
971		34990	085	Martin	12	FL	8,374	7,969	16	74
972		34994	085	Martin	12	FL	4,597	4,143	22	61
973		34996	085	Martin	12	FL	4,172	4,108	11	42
974		34997	085	Martin	12	FL	11,983	11,606	27	136

AMERICAN OVERSIGHT

	K	L	M	N	O	P	Q	R
929	18	11	31	11	11	11	21	0
930	11	11	13	0	0	0	12	0
931	174	31	265	11	11	11	176	13
932	138	61	223	11	11	11	129	11
933	204	48	313	11	11	11	190	12
934	192	34	298	11	11	18	185	15
935	92	11	74	11	11	11	42	11
936	522	38	786	11	28	51	611	16
937	16	11	39	11	11	0	28	11
938	11	11	26	0	0	0	23	11
939	158	46	237	11	11	11	148	11
940	180	31	313	11	11	11	206	11
941	11	0	11	0	0	0	11	0
942	138	18	232	11	12	11	169	11
943	11	0	11	0	0	0	11	0
944	161	23	265	11	11	11	209	11
945	84	22	167	11	11	11	118	11
946	107	22	197	11	11	11	143	11
947	11	11	33	0	0	11	20	11
948	107	11	190	11	11	11	162	11
949	114	11	108	11	11	11	65	11
950	165	24	330	11	13	13	231	11
951	184	21	380	11	11	24	310	11
952	11	11	33	11	11	11	30	0
953	30	11	37	11	0	0	29	0
954	58	11	71	0	11	11	48	11
955	54	11	73	11	11	11	38	11
956	106	11	82	11	11	11	51	11
957	103	11	128	11	11	11	81	11
958	195	11	178	0	11	11	139	11
959	471	28	478	11	18	20	364	12
960	347	22	423	11	13	15	295	15
961	42	11	50	0	11	11	35	11
962	330	17	257	11	12	19	189	11
963	90	11	183	0	11	11	139	11
964	211	11	350	0	11	11	275	17
965	34	0	39	0	0	11	27	11
966	224	13	237	11	11	11	172	14
967	288	21	333	11	11	11	242	13
968	102	11	100	11	11	11	63	11
969	344	13	333	11	12	19	227	11
970	146	11	103	0	11	11	76	11
971	361	21	221	11	11	11	153	11
972	216	11	151	0	11	11	128	11
973	175	14	122	0	11	11	93	11
974	485	18	357	11	17	17	266	16

AMERICAN OVERSIGHT

	S	T	U	V	W
929	11	0	11	11	11
930	0	0	0	11	11
931	11	11	11	18	42
932	12	11	11	17	52
933	22	11	11	21	58
934	11	11	11	33	40
935	11	11	11	11	12
936	37	11	11	25	46
937	11	0	11	11	11
938	11	0	0	0	11
939	18	11	11	28	34
940	22	11	11	26	49
941	0	0	0	11	11
942	14	11	11	14	23
943	0	0	0	0	0
944	17	11	11	14	21
945	15	11	11	13	17
946	21	11	11	11	14
947	11	0	0	11	11
948	13	11	11	11	11
949	11	11	0	11	16
950	17	11	11	22	36
951	17	0	11	11	23
952	11	11	0	0	11
953	11	0	0	11	11
954	11	0	11	11	15
955	11	0	11	11	18
956	11	11	11	11	11
957	11	11	11	17	21
958	11	11	11	11	11
959	28	11	11	21	44
960	34	11	11	16	57
961	11	0	0	11	11
962	17	11	11	13	14
963	11	11	11	18	20
964	14	11	11	17	39
965	11	11	11	11	11
966	15	11	11	11	21
967	24	11	11	13	35
968	11	11	0	11	14
969	35	11	11	11	31
970	11	11	11	11	11
971	22	11	0	11	23
972	11	11	0	11	11
973	11	11	11	11	11
974	20	11	11	11	31

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: "Vuong, Nga (CDC/OID/NCEZID) <ypg2@cdc.gov>"
Subject: emergency presentation
Date: Tuesday, February 18, 2020 6:34:25 PM
Attachments: MCIRT SART vectorweek.pdf

For vector week for your review.

Thanks
CB

AMERICAN OVERSIGHT

Emergency Mosquito Control in Florida

Carina Blackmore, DVM, PhD

Florida Department of Health

On behalf of

Marah Clark

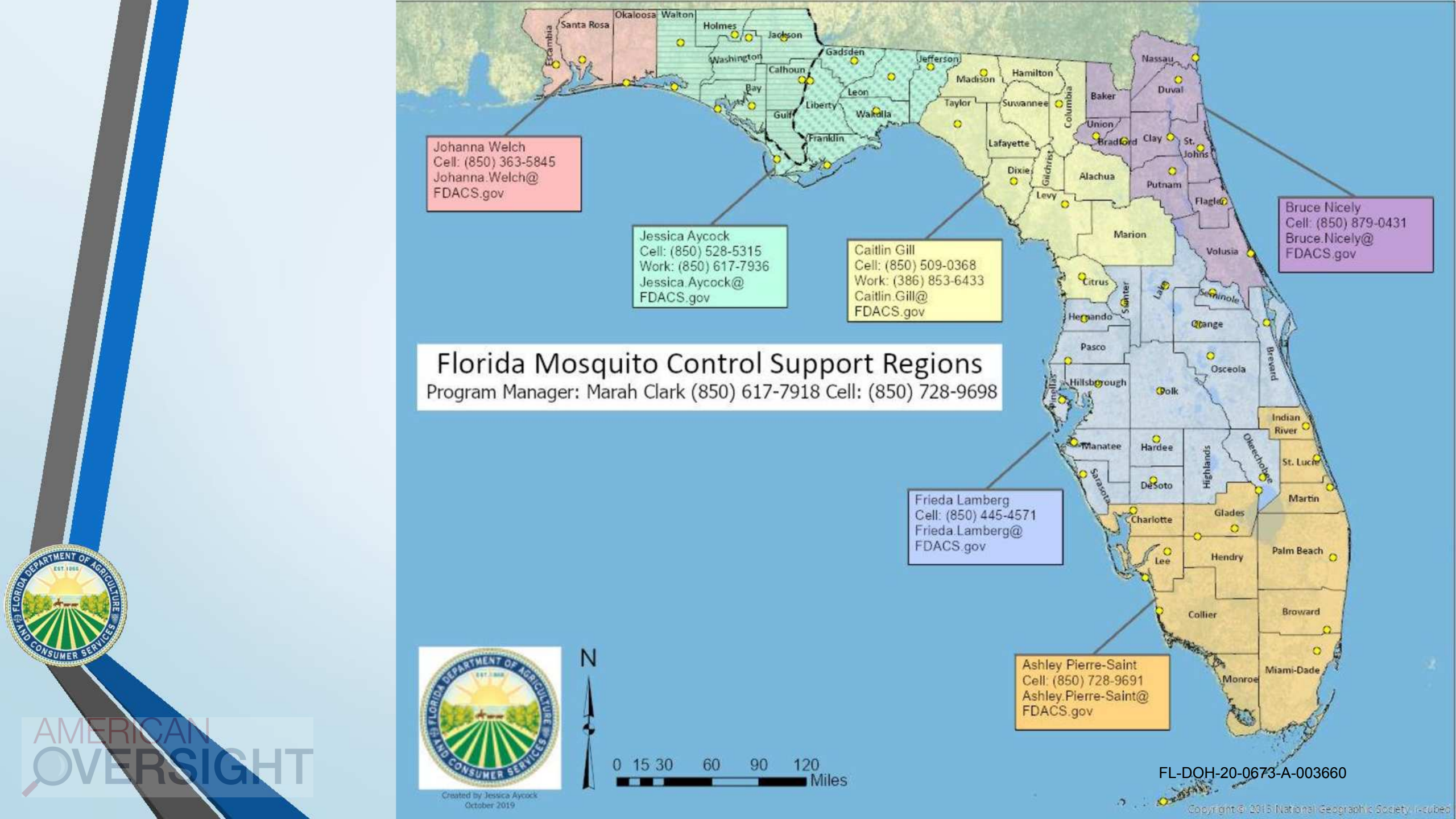
Florida Department of Agriculture and Consumer Services

AMERICAN OVERSIGHT

Mosquito control in Florida

- Independent taxing districts
- County government
- County health departments
- Nothing

AMERICAN OVERSIGHT



FL-DOH-20-0673-A-003660

AMERICAN OVERSIGHT

Emergency Response

All disasters are local

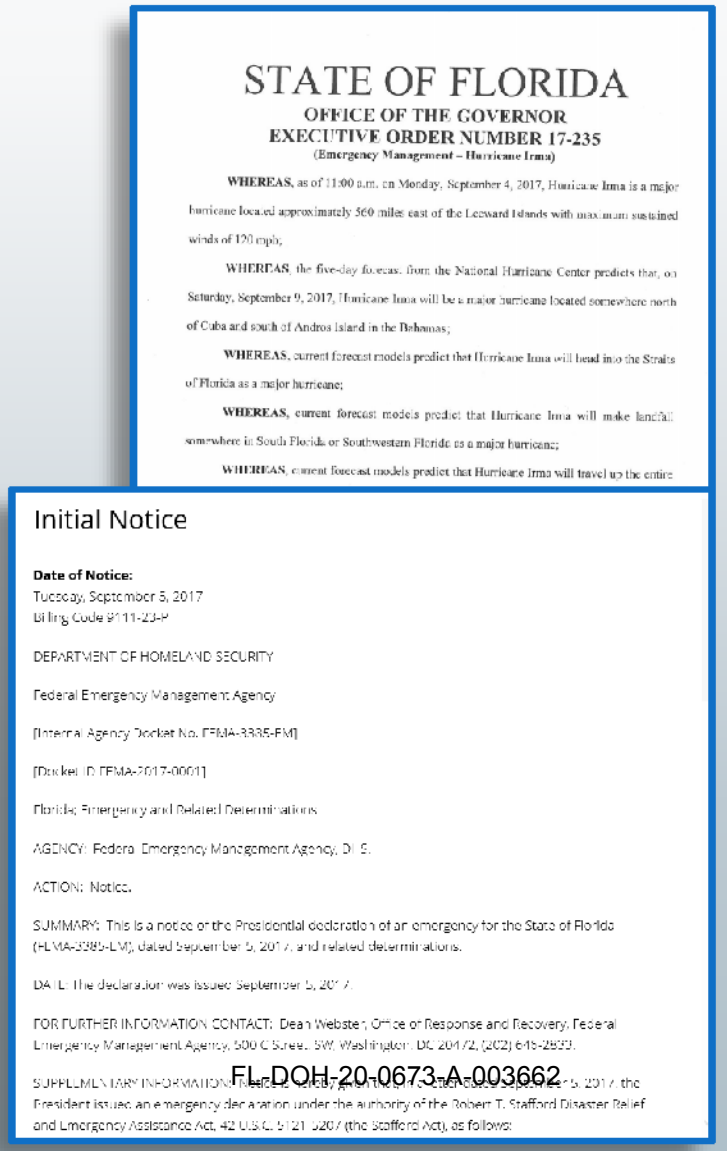
State Department of Emergency Management

- Emergency Support Function (ESF) 8- Health
- ESF-17- Animal Protection
  - Funding
  - Technical support

AMERICAN OVERSIGHT

Declarations and Public Assistance

- **State of FL-Governor's executive order**
  - Declaration of a State of Emergency
    - Provides availability of funding for relief & recovery efforts
- **Presidential Declaration**
  - Initiates availability of Federal Emergency Management Agency (FEMA) Public Assistance Program providing for reimbursement for recovery and response expenses



STATE OF FLORIDA

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER NUMBER 17-235

(Emergency Management – Hurricane Irma)

WHEREAS, as of 11:00 a.m. on Monday, September 4, 2017, Hurricane Irma is a major hurricane located approximately 560 miles east of the Leeward Islands with maximum sustained winds of 120 mph;

WHEREAS, the five-day forecast from the National Hurricane Center predicts that, on Saturday, September 9, 2017, Hurricane Irma will be a major hurricane located somewhere north of Cuba and south of Andros Island in the Bahamas;

WHEREAS, current forecast models predict that Hurricane Irma will head into the Straits of Florida as a major hurricane;

WHEREAS, current forecast models predict that Hurricane Irma will make landfall somewhere in South Florida or Southwestern Florida as a major hurricane;

WHEREAS, current forecast models predict that Hurricane Irma will travel up the entire

Initial Notice

Date of Notice:
Tuesday, September 5, 2017
Billing Code 9111-23-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA-3385-EM]

[Docket ID FEMA-2017-0001]

Florida; Emergency and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of an emergency for the State of Florida (FEMA-3385-EM), dated September 5, 2017, and related determinations.

DATE: The declaration was issued September 5, 2017.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472, (202) 646-2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, on September 5, 2017, the President issued an emergency declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the Stafford Act), as follows:

AMERICAN OVERSIGHT

State Role

- Department of Emergency Management
  - Coordinates local assistance requests through WebEOC
  - Coordinates with federal partners
  - Activates Memoranda of Understanding
- Florida Department of Agriculture and Consumer Services (FDACS)
  - Contacts local mosquito control or county officials
  - Collects surveillance data and provides technical assistance
  - Coordinates with Florida Department of Environmental Protection if spraying on state lands
  - Works with pesticide application contractors
- Florida Department of Health (FDOH)
  - Local health department letter, technical assistance if needed

AMERICAN OVERSIGHT

Local Role

- Documentation required for Public Assistance Request
  - A letter from the County Health Department indicating a serious health threat or mosquito nuisance exists that hampers recovery efforts
  - Trap data that verifies the increase in mosquito populations
  - Three years of baseline data from non-event years
  - Maps showing the areas affected and in need of treatment

AMERICAN OVERSIGHT

Surveillance and Treatment

Florida Administrative Code 5E-13.036: surveillance activities must detect an increase in the mosquito population above a predetermined baseline prior to conducting adulticide activities

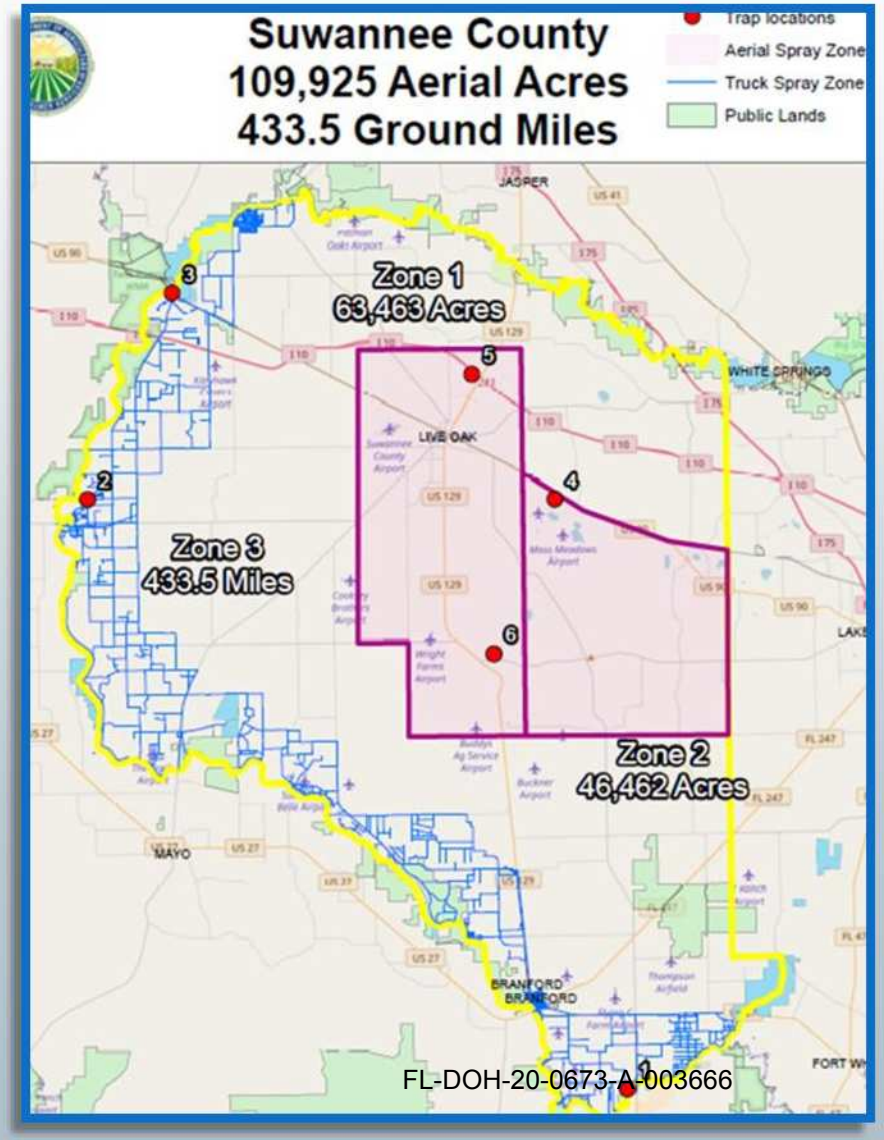
- > 50% above baseline is an indication of the potential for transmission of mosquito-borne disease
- A quantifiable and sustained increase can hamper recover efforts in post-storm cleanup efforts
  - Increase in species distribution and relative abundance to justify treatment
    - > 25 adult mosquitoes/trap/trap night
  - Increase in constituent complaints and service requests



AMERICAN OVERSIGHT

Identifying Trap Locations

- All traps are deployed within treatment zones
- FEMA requires minimum of 5 traps per county
- Each aerial spray zone should have at least 1 CDC Light Trap
  - If less than 3 zones, traps should be distributed as evenly as possible within zones; not on the edge of zones



FL-DOH-20-0673-A-003666

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CDC Light Trap





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Post-treatment Surveillance

- **Conducted again to assess effectiveness of the treatment**
  - Traps are deployed again the day after treatment is completed
  - Traps are placed in exact geographical location as pre-treatment surveillance
  - Methods are the same as pre-treatment surveillance
    - Trap deployment form
    - Trap set-up
    - Timing of deployment and retrieval



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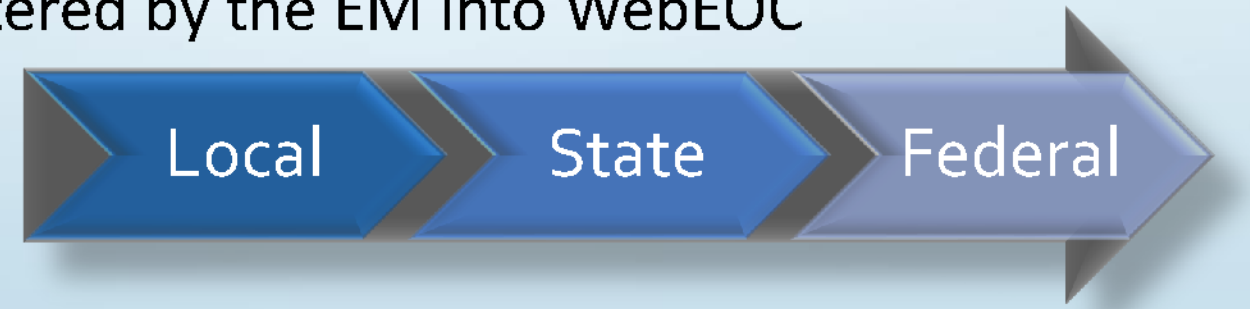
Ground Zero for Mosquito Abatement

- Everything begins at the local level!
  - Emergency Management (EM) communicates with local mosquito control to determine capabilities for post-storm abatement.
    - If a county does not require assistance, then expenses associated with post-storm treatment can be submitted through FEMA directly
    - If a county requires assistance, then requests must be entered by the EM into WebEOC



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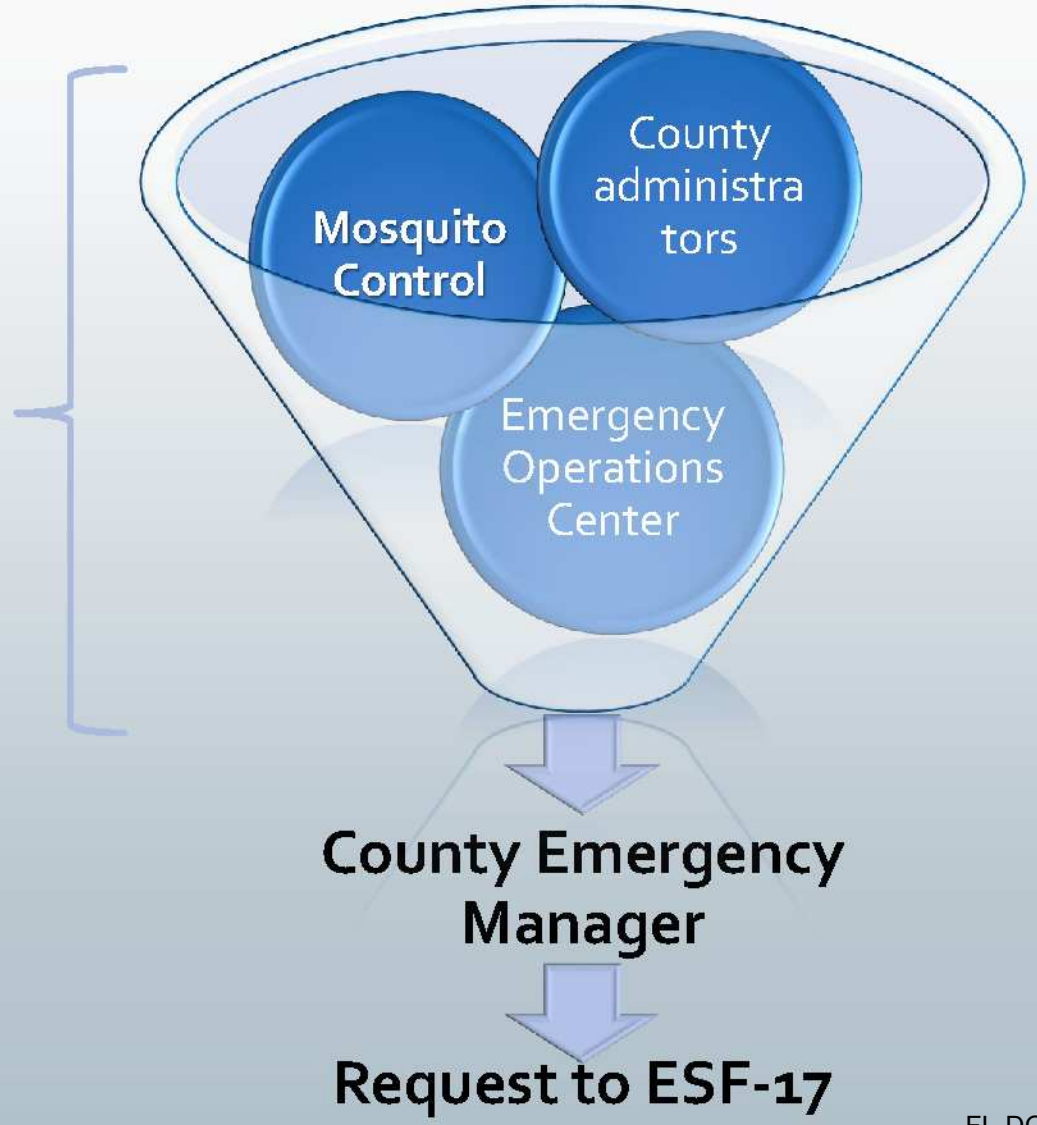
Hierarchy

Open communication between local agencies to ensure a unified message is sent to the County Emergency Manager



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County Notifications

- FDACS requires written verification that the county has made adequate efforts in notifying its constituents prior to initiation of treatment:
  - Local law enforcement, emergency operations, fire departments, department of health, agriculture extension agents, newspaper, radio, television, and social media
  - Local apiaries, aquaculture, and those who may be chemically sensitive
  - Notifications are "weather pending" and may need to be updated based on schedule of treatment

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Notifications

Subject: Florida State Beekeepers note of thanks

On behalf of the Florida beekeepers, I wish to express our a
about mosquito spraying after hurricane Irma. Your timely
to beekeepers in the counties designated for aerial sprayin
beekeepers can use to take precautionary action when and
10 FSBA sent 4370 mosquito spray information emails to Fl
makes Fl agriculture work.

Thanks for your support

Tony Hobb

Florida State Beekeepers Assn



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FDACS Mosquito Control Incident Response Teams

- **Roles During Incident Response:**
  - Assembly and analyses of baseline data
  - Conduct pre-treatment surveillance
  - Perform trap evaluation
  - Mapping of treatment zones
  - Public notifications
  - Contract applications
  - Conduct post-treatment surveillance
  - Data analysis



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Mosquito Control Incidence Response Team

- Activated 10 times since 2001
  - Organized treatment of over 11 million acres
  - Aerial and truck
- West Nile virus, Zika and Dengue virus response
- Flooding from hurricanes
  - Wide area spraying to combat pestiferous species







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FL-DOH-20-0673-A-003074

Response– Hurricane Michael

- 7 counties requested assistance
- 25 Division personnel participated
- 781,210 acres treated aerially with Dibrom
- $1,566,860.81 expended





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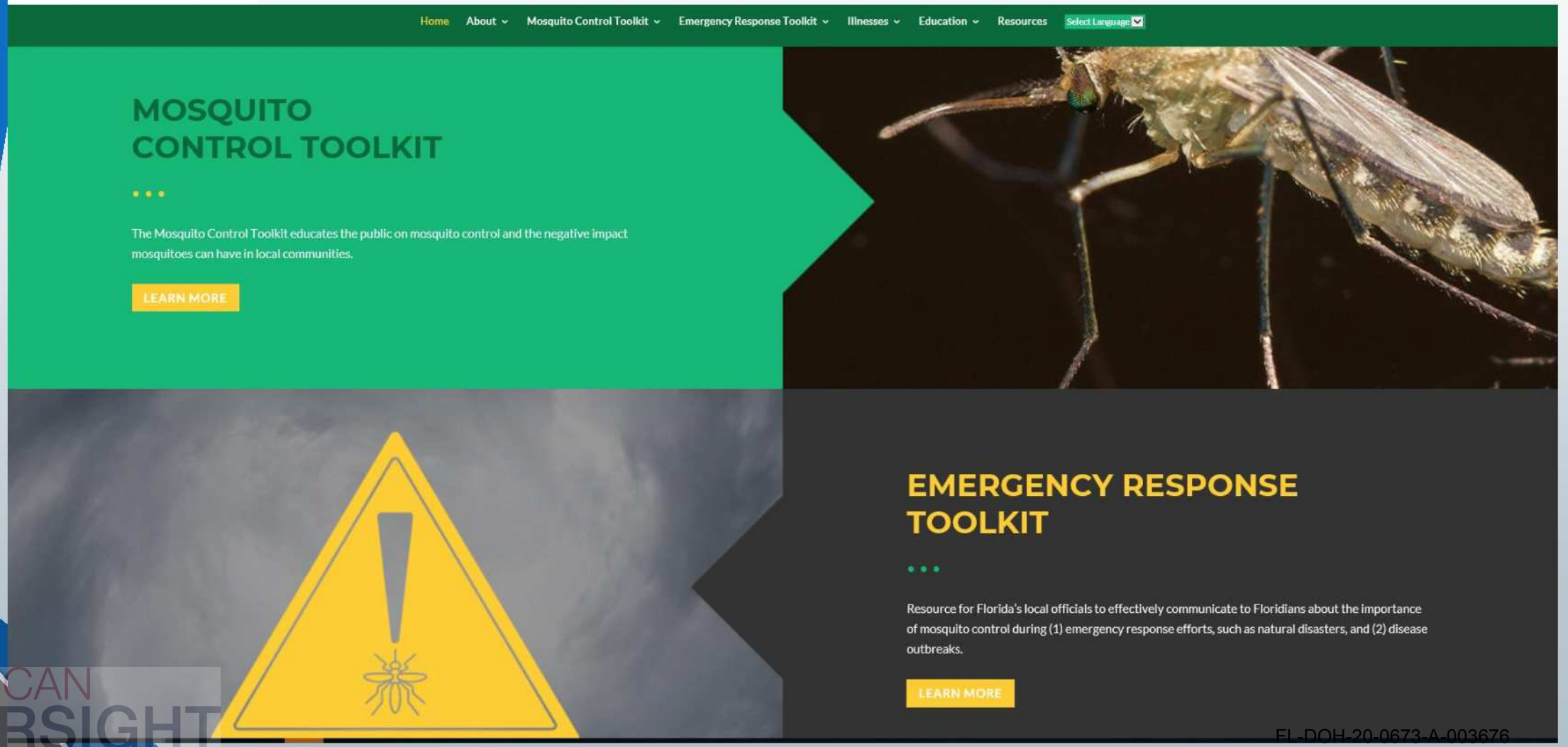
Center for Public Issues Education

University of Florida PIE Center



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Questions?

Carina.Blackmore@FLHealth.gov

Director, Division of Disease Control and Health Protection
State Epidemiologist
Florida Department of Health

Marah.Clark@FDACS.gov

Entomology and Pest Control Section
Bureau of Scientific Evaluation and Technical Assistance
Division of Agricultural Environmental Services

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	yet7@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C
Subject:	EOC PUI team Questions
Date:	Saturday, February 1, 2020 8:28:45 AM

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

AMERICAN OVERSIGHT

From:	Mejia-Echeverry, Alvaro
To:	Aguilar, Alexandra; Alexandre, Antonine; Amores, Norma A.; Anderson, Erica C; Arseda, Nurya; Arshad, Amena; Barrera, Anne; Becerra, Ana; Bula, Evelyn A; Calle, Stephanie; Camacho, Walter; Cartaya, Gabriella W; Castillo, Klelia S; Celorio, Oscar; Charlot-Aladin, Mary; Coello, Erika X; Concepcion, Chaveli; Corzo-Sanchez, Elisa M; Cuevas, Carlos; Curbelo, Oswaldo; Cyril, Lorrie; Davidson, Khaleeq J; Dobson, Jolie T; Ejiofor, Ngozichukwuka; Eldanaf, Amal H; Estrada, Juan Jose; FernandezdeCastro, Ana; Goldberg, Cynthia; Gonzalez, Irima V; Grajales, Janet; Jit, Mohnisha; Johnson, Venus; Laine, Claudia B; Llau, Anthoni; Lopez, Victor J; Lyonel, Elsie; Martinez, Anita; Martinez, Yuray; Mauck, Daniel E; Melus, Vickie; Menoscal, Paola C; Morales, Fernando X; Muse, Nicole J; Nowotny, Kyle; Noya-Chaveco, Pedro A; Oliver, Christine M; Paul, Paulette J; Paulynice, Berthamise; Ramos, Vivian L; Rodriguez, Daniel; Rojas, Mercedes C; Salvador, Cristina G; Schroeder, Wayne A; Stallworth, Barbara; Suarez, Juan; Suazo, Ingrid E; Summers, Debbie; Tassy-Toussaint, Gastrude; Torrecilla, Ana; Urbina, Angelica; Uribarri, Enrique S; Vera, Raul A; Veras, Braulio; Villamil, Vanessa; Webb, Jenna; Schmitz, Ann; White, Stephen L; Connor, Olga; Jean, Reynald; Villalta, Yesenia D; egarc264@fiu.edu; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Alghawi, Wissam; Etienne, Marie Ketty (Epi); Joseph, Keren; Lopez, Jose M; Paramo, Christian; Rico, Edhelene; Sandoval, Lydia; Zhang, Guoyan
Cc:	Caballero, Reinaldo; Casimir, Yanick; Lowe, Camille N; Munoz, Virginia E; Olguin, Lourdes; Ortega, Marisabel; Toledo, Marilyn X
Subject:	EpiRT Training/Tabletop exercise
Attachments:	COVID19 training agenda_02142020.pdf

Good afternoon, team members!

Attached, please find the agenda for our training/tabletop exercise this Friday, February 14. The address is included in the calendar invite. I have copied your supervisors for awareness. Please note that parking is in the back of the building, and it is important to arrive early, as the parking lot fills up soon. Please, make an effort to attend as this is a great opportunity to prepare to respond to large infectious disease outbreaks in case you are deployed. Please, remember to contact Amena Arshad at 305-470-5657 or amena.arshad@flhealth.gov <mailto:amena.arshad@flhealth.gov> if you have any questions. Thank you for your attention and I hope to see you all at the training/exercise on Friday!

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EpiRT COVID-19 Training/Exercise - Agenda
February 14, 2020
MDFR Training Center - Auditorium 2-001
9300 NW 41st Street
Miami, FL 33178

8:00 a.m.	**REGISTRATION & NETWORKING**	
8:30 a.m.	Introduction & Disclaimer	Alvaro Mejía-Echeverry
8:35 a.m.	EpiRT Call-Down List/Epi Response Team: Concept and Membership	Álvaro Mejía-Echeverry
8:50 a.m.	**Exercise begins with scenario presentation**	
9:05 a.m.	Background information on COVID-19	Jolie Dobson
9:15 a.m.	**Scenario continues**	
9:30 a.m.	Infection Control	Marie K. Etienne
9:40 a.m.	**Scenario continues**	
9:55 a.m.	Personal Protective Equipment (PPE)	Cynthia Goldberg
10:10 a.m.	**Scenario continues**	
10:25 a.m.	Laboratory testing/Specimen packaging and shipping	Stephen White
10:40 a.m.	**BREAK**	
10:55 a.m.	**Scenario continues**	
11:10 a.m.	Risk Communication	Olga Connor
11:20 a.m.	**Scenario continues**	
11:35 a.m.	Interview techniques	Juan Suarez
11:50 a.m.	DOH Bureau of Epidemiology Guidance for Epidemiological Investigations	Dr. Ann Schmitz
12:05 p.m.	COVID-19 data collection form and local investigation process	Edhelene “Gigi” Rico
12:15 p.m.	**Scenario continues**	
12:30 p.m.	Isolation/Quarantine/Social Distancing: Legal authority	Heather Beaton
12:40 p.m.	Current air traveler enhanced monitoring	Michelle Decenteceo, CDC MIA QS
12:50 p.m.	**Scenario continues**	
12:55 p.m.	Exercise conclusion and evaluation	
1:00 p.m.	**ADJOURN**	

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: Epi-X notifications for COVID-19 entry screenings
Date: Tuesday, February 18, 2020 12:39:48 PM

Dear State Partners,

This is an update regarding Epi-X notifications for COVID-19 entry screenings. Please circulate it to state epidemiology staffers.

Epi-X notifications with entry screening data were not sent out on Monday (2/17/2020) while we made changes to improve data quality. Today, you will see several changes to the Excel file attached to Epi-X notifications. We understand there may be challenges for you when the Epi-X format changes. Thank you for your patience. We hope that the new data format will provide you with better, more complete data for monitoring.

During this transition, you may find duplicate records for the same traveler. For instance, you may receive a notification for a passenger you already received on 2/16/2020 with a different DGMQ ID. We recommend using today's notification for duplicates. Passengers' contact information is updated in the notifications you receive today.

In addition, notifications from today (2/18/2020) may be sent throughout the day (not at 9AM and 4PM, as usual). We plan to resume 9AM and 4PM distribution as soon as possible.

Thank you,

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

Sent by BCC to first and second COVID-19 POCs and State Epidemiologists

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From:	DNPAO Program (CDC)
To:	DNPAO Program (CDC)
Cc:	CDC ONDIEH NCCDPHP NCCD DNPAO PDEB; Annie Hardison-Moody
Subject:	Faith-Based Networking Call Postponed
Date:	Thursday, March 19, 2020 11:50:58 AM

Hello!

Due to the COVID-19 response efforts, today's CDC-DNPAO Networking Call entitled "Faith-Based Settings: Peer Sharing" is postponed due to less than half of our recipients working in faith-based settings being available.

Thank you to those who responded regarding their availability. We will send an announcement with a new date once this Networking Call has been rescheduled.

If you would like information on CDC's COVID-19 response, please visit coronavirus.gov.

Kindest regards,

DNPAO Program

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From:	Stevens, Lee (OS/IEA)
To:	Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA); Baker, Michael (OS/IEA)
Subject:	FDA: States Are Now In Charge of Testing
Date:	Thursday, March 19, 2020 11:15:37 AM
Attachments:	States are Now In Charge of Testing 03192020.pdf

Dear State Health Officials,

Please find an important info-graphic attached outlining new testing guidance from FDA. We are standing by to answer questions. 1-888-INFO-FDA.

Best,

Darcie

Darcie Johnston, Director
Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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STATES ARE NOW IN CHARGE OF TESTING

YOU CAN APPROVE TESTS

You may design a test using whatever supplies, reagents, and swabbing (including self-swab) that you choose and begin testing patients as long as you can validate your test. This applies to lab-developed tests at labs and hospitals as well as to clinical lab companies.

YOU CAN USE THE COMMERCIAL MARKET

Swabs, reagents, and other supplies are generally available on the commercial market. Please access your normal distribution channels.

YOU HAVE MULTIPLE SWAB OPTIONS

Even for existing FDA-authorized tests, you are not locked into one brand of swab. (FDA has a list of options on its website.)

YOU HAVE MULTIPLE TRANSPORT OPTIONS

You may use saline as a transport medium.

YOU HAVE MULTIPLE REAGENT OPTIONS

Even for existing tests, you are not locked into the one brand of extracting reagent. FDA has approved use of research-grade reagents and has made clear there are other extracting reagents that can be used.

FDA stands ready to help labs 24/7 with any questions they may have about the EUA process, FDA's policies or getting supplies.
*Call 1-888-INFO-FDA, choose option **

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Moskowitz, Jared; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc: Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Toro, Manny J; ASPR Region 4 (HHS/ASPR/OEM)
Subject: FDOH/FDEM request for synchronization
Date: Thursday, March 19, 2020 8:14:22 PM
Attachments: HHS_ASPR_Request for Resources Form_blank_05Mar2020.pdf

Good evening Florida

This email is meant to seek clarity on your requests and to determine a path forward for improved synchronization between FDOH and FDEM.

I am in receipt of the following requests and need some clarification to process in a timely manner. It is imperative that we understand Florida's need so we can source these requests appropriately. The DEM RRFs have been forwarded through the WebEOC system but the justification and need has not been received for all of them. Just like the document provided (attached below) this gives you an opportunity to provide the rationale for the need. Please coordinate the requests (FDOH/FDEM) so we do not have to slow the process with the need to seek further clarification. Also, we need to understand the priority and actual need. Just putting requests "in the queue" is not helpful and slows the prioritization process.

Please help me understand what you really need. I know you answered a White House RFI today but questions still remain. Incorporating your response to the RFI I tried to only include the outstanding items in the table below. I believe we could have worked these issues into your initial RRFs and we all could be working on the next issue at this time.

Date	Tracking Number	Resource Request	HHS Need/Request
3/14/2020	FL-0477	500,000 COVID-19 Test Kits and 100,000 16 oz bottles and 50,000 2 oz bottles of hand sanitizer	Florida has zero remaining in state caches, despite placing orders for over 1,000,000 specimen collection supplies. Test kits for the CBIS have all arrived • (arrived 3/18 1606 at JAX, 3/19 0854 at Orlando, 3/19 1005 at Miami) Based on conversations with FDEM and FDOH it appears that FDEM was managing the CBIS independent of FDOH. Please coordinate the activity and ensure all are working together. If swabs remain an issue please notify immediately.
3/14/2020	FL-0524	150,000 Goggles, Tyvek Suits, Gowns, and Booties	Sanitizer requests pushed to the Task Force SNS has begun its delivery allocation to states. I am told FL has received their initial push. We recognize the burn rate has been high in FL and have pushed the request up to the Task Force
3/15/2020	FL-0605	5,000 Ventilators for hospital and patient care	With current requests increasing and the directive to expand isolation capacities to stand alone clinics, ambulatory services, and alternate care sites we are requesting 5,000 additional ventilators What type of ventilator is to be requested. SNS has three types • Covidien (Puritan Bennett) LP10 • Vyaire (CareFusion) LTV1200 • and the Zoll (Impact Implementation) Does FL have the respiratory therapists needed to manage these ventilators? Are there enough ICU beds or hospital locations to manage these vents?
3/16/2020	FL-0667	1,000,000 N95 Respirator Masks	This order is in conflict with the request for 1.5M masks Sourced through the SNS initial distribution and have been told this has been received.
3/16/2020	FL-0672	5,000 Portable Medical Field Cots with IV Pole	Define the type of cots are requested; shelter, bariatric or both? Where and how are these to be used? Have you exhausted the state cache of cots? Are there regional caches managed by the coalitions and have they been exhausted? Who will staff the locations identified where these cots are to be placed? Are there wrap around services identified for the location of where the cots are to be used?
3/17/2020	FL-0896	USS Mercy & USS Hope	There is no USS Hope ship. The ships are the Mercy and the Comfort. Please describe what function these ships will be expected to perform. Is the FL healthcare system without any beds at this time? What type of patient does FL intend to put on these ships? How does FL plan to supplement the staffing of the ships?
3/17/2020	FL-0944	1 DMAT Team for Broward ALF	What is the mission you are trying to accomplish with a DMAT team? What number of residents and type are in this ALF? Identify and describe the capability that needs to be sourced. Is there a need for EPI education? How long is the team expected to be on site?
3/17/2020	FL-1249	5 Mobile ICUs	This is not a "typed" resources. What are you requesting? How many ICU beds are needed? Are all the ICU beds in the state occupied? How do you intend to staff these resources? Do you have critical care nurses, respiratory therapist and support staff to manage this population?
3/17/2020	FL-1261	1,000,000 N95 Respirator Masks, 500,000 gloves, 250,000 Tyvek Coveralls, 500,0000 gowns	SNS has begun its delivery allocation to states. I am told FL has received their initial push. We recognize the burn rate has been high in FL and have pushed the N-95 mask request up to the Task Force.

From the State of Florida ESF 8 today (3/19 1100)

- **Ventilators for 5000 intensive care patients**. - Florida has an existing cache of 380 ventilators and has ordered an additional 500 with an approximate delivery date of 3/31/20. These ventilators have been allocated based on a ratio for licensed beds. However, this allocation is not sufficient to support the projected needs of Florida's healthcare system. With current requests increasing and the directive to expand isolation capacities to stand alone clinics, ambulatory services, and alternate care sites we are requesting 5,000 additional ventilators. These units will be distributed using similar allocation strategies.
- **Field intensive care units with medical staffing in order to provide expanded ICU capabilities in the field for each of Florida's five most populated counties**. Florida has

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two state medical assistance teams and existing MOUs with volunteer medical organizations but due to widespread impact of this response, very limited personnel are available to support missions based on commitments to primary employers in the healthcare sector. Florida has contracted with nurse augmentation staff but their ability to operate an intensive care unit is limited.

- **Medical-grade cots of field care for 5000 patients** – Florida plans to fully deploy all special needs cots and capabilities with a significant gap.
- **Alternate care facilities to include medical ships with patient care capabilities.** – Florida's most populated areas are on major seaports. Using ship based hospital systems provides expanded patient care capabilities. The State of Florida is observing increasing numbers of COVID-19 cases with an expectation to see continued cases. The hospitals are currently at surge capacity and with continued support we are anticipating the need to establish community based alternate care sites. However, with limited facilities and staff to establish hard-sided services the State of Florida has a need for facilities and staff that would support the establishment of the community based alternate care sites. The State of Florida is requesting the Comfort and Mercy to include the staff to support the care of Floridians. These ships would be moored at Port Everglades.
- The State of Florida requests supplies to include **nasal pharyngeal and oral pharyngeal swabs and viral transfer media to collect specimens from 500,000 people**. Florida has provided diagnostic testing capability to all major hospitals and laboratories across the state but is unable to obtain additional specimen collection supplies. County Health Departments, Community Health Centers, and hospitals are unable to obtain the necessary supplies. Florida has zero remaining in state caches, despite placing orders for over 1,000,000 specimen collection supplies.
- The State of Florida requests **medical personnel experienced in acute care and infection control to provide patient care in long term care facilities experiencing outbreaks** of COVID-19. Florida currently has two assisted living with active cases and over 3,000 assisted living facilities and 696 nursing homes. These facilities are not operated with skilled nursing care and do not have experience to control an outbreak of this scale. These staff would be used to rapidly deploy into long term care facilities, stabilize the situation, provide on the job training for infection control to on-site clinicians.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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COVID-19 –STATE / LOCAL RESOURCE REQUEST FORM

A. REQUEST FOR ASSISTANCE (To be completed by requesting State DOH) **ALL FIELDS REQUIRED**			
1. Requestor's Name (Please print)	**2.** Title		**3.** Phone No.
4. Requestor's Organization	**5.** Cell Phone No.	**6.** Email Address	
7. Description of Requested Assistance (describe resource type and need in plain language – no acronyms)			
8. Requested Item	☐ N-95 Masks ☐ Goggles ☐ Gowns ☐ Gloves: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ Medical Providers ☐ Technical SME		
10. Date and Time Needed By		**11.** Estimated Duration of Need (days)	
12. Delivery Site Location (Address, City, Zip)		**13.** Site Point of Contact (POC) Name and Title	
14. Delivery Site Location (☐USNG or ☐Decimal Degrees)		**15.** Site 24 Hour Phone No.	**16.** Site email Address

B. HHS REGIONAL REVIEW (To be completed by HHS Region where request was initiated)			
Reviewed By (Name & Title)		Date and Time	
Disposition	☐ Sent to IMTNAT ☐ Sent to SOC/IST ☐ ASPR/FEMA RSP POCs notified		
Priority	☐ High ☐ Medium ☐ Low		
Regional Approving Official (Name, Title, Date, Time)			
ASPR Region Request Number			

HHS RFR ID Number	

C. HHS RCB/SNS REVIEW (To be completed by RCB/SNS Section only)			
Received By (Name & Title)		Date and Time	
1. Resource Typing/Adjustment			
2. Special Instructions			
Entered in EMPortal by (Name & Title)		Date and Time	
Disposition	☐ New Request ☐ Assigned ☐ Tasked to: _____ ☐ In Process ☐ Need More Information ☐ Out for Delivery ☐ En-route ☐ On Hold ☐ Complete ☐ Cancelled ☐ Request Withdrawn ☐ Demobilized		
Assigned To (Name and Title)			
Point of Contact (Name and Title)		24-Hr. POC Phone	
Approved By (Name & Title)		Date and Time	
3. Cost Estimate			
4. Priority	☐ High ☐ Medium ☐ Low		

State Government Tracking Number	

D. STATE GOVERNMENT REVIEW (To be completed by requesting State - Department of Health Agency)			
Received By (Name & Title)		Date and Time	
Disposition	☐ Requested Federal Resources ☐ Filled with Local Resource(s) ☐ Filled with State Resources ☐ Denied		
Assigned To (Department Name)			
Point of Contact (Name and Title)		24-Hr. POC Phone	
Approved By (Name & Title)		Date and Time	

F. REQUESTOR NOTIFIED (To be handled by HHS RCB/SNS Logistics)			
Region Notified By (Name & Title)		Date and Time	
State Notified By (Name & Title)		Date and Time	
Other Notes:			

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Moskowitz, Jared; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc: Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Toro, Manny J; ASPR Region 4 (HHS/ASPR/OEM)
Subject: FDOH/FDEM request for synchronization
Date: Thursday, March 19, 2020 8:14:08 PM
Attachments: HHS_ASPR_Request for Resources Form_blank_05Mar2020.pdf

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3/14/2020	FL-0524	150,000 Goggles, Tyvek Suits, Gowns, and Booties	Sanitizer requests pushed to the Task Force SNS has begun its delivery allocation to states. I am told FL has received their initial push. We recognize the burn rate has been high in FL and have pushed the request up to the Task Force
3/15/2020	FL-0605	5,000 Ventilators for hospital and patient care	With current requests increasing and the directive to expand isolation capacities to stand alone clinics, ambulatory services, and alternate care sites we are requesting 5,000 additional ventilators What type of ventilator is to be requested. SNS has three types • Covidien (Puritan Bennett) LP10 • Vyaire (CareFusion) LTV1200 • and the Zoll (Impact Implementation) Does FL have the respiratory therapists needed to manage these ventilators? Are there enough ICU beds or hospital locations to manage these vents?
3/16/2020	FL-0667	1,000,000 N95 Respirator Masks	This order is in conflict with the request for 1.5M masks Sourced through the SNS initial distribution and have been told this has been received.
3/16/2020	FL-0672	5,000 Portable Medical Field Cots with IV Pole	Define the type of cots are requested; shelter, bariatric or both? Where and how are these to be used? Have you exhausted the state cache of cots? Are there regional caches managed by the coalitions and have they been exhausted? Who will staff the locations identified where these cots are to be placed? Are there wrap around services identified for the location of where the cots are to be used?
3/17/2020	FL-0896	USS Mercy & USS Hope	There is no USS Hope ship. The ships are the Mercy and the Comfort. Please describe what function these ships will be expected to perform. Is the FL healthcare system without any beds at this time? What type of patient does FL intend to put on these ships? How does FL plan to supplement the staffing of the ships?
3/17/2020	FL-0944	1 DMAT Team for Broward ALF	What is the mission you are trying to accomplish with a DMAT team? What number of residents and type are in this ALF? Identify and describe the capability that needs to be sourced. Is there a need for EPI education? How long is the team expected to be on site?
3/17/2020	FL-1249	5 Mobile ICUs	This is not a "typed" resources. What are you requesting? How many ICU beds are needed? Are all the ICU beds in the state occupied? How do you intend to staff these resources? Do you have critical care nurses, respiratory therapist and support staff to manage this population?
3/17/2020	FL-1261	1,000,000 N95 Respirator Masks, 500,000 gloves, 250,000 Tyvek Coveralls, 500,0000 gowns	SNS has begun its delivery allocation to states. I am told FL has received their initial push. We recognize the burn rate has been high in FL and have pushed the N-95 mask request up to the Task Force.

From the State of Florida ESF 8 today (3/19 1100)

- **Ventilators for 5000 intensive care patients**. - Florida has an existing cache of 380 ventilators and has ordered an additional 500 with an approximate delivery date of 3/31/20. These ventilators have been allocated based on a ratio for licensed beds. However, this allocation is not sufficient to support the projected needs of Florida's healthcare system. With current requests increasing and the directive to expand isolation capacities to stand alone clinics, ambulatory services, and alternate care sites we are requesting 5,000 additional ventilators. These units will be distributed using similar allocation strategies.
- **Field intensive care units with medical staffing in order to provide expanded ICU capabilities in the field for each of Florida's five most populated counties**. Florida has

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two state medical assistance teams and existing MOUs with volunteer medical organizations but due to widespread impact of this response, very limited personnel are available to support missions based on commitments to primary employers in the healthcare sector. Florida has contracted with nurse augmentation staff but their ability to operate an intensive care unit is limited.

- **Medical-grade cots of field care for 5000 patients** – Florida plans to fully deploy all special needs cots and capabilities with a significant gap.
- **Alternate care facilities to include medical ships with patient care capabilities.** – Florida's most populated areas are on major seaports. Using ship based hospital systems provides expanded patient care capabilities. The State of Florida is observing increasing numbers of COVID-19 cases with an expectation to see continued cases. The hospitals are currently at surge capacity and with continued support we are anticipating the need to establish community based alternate care sites. However, with limited facilities and staff to establish hard-sided services the State of Florida has a need for facilities and staff that would support the establishment of the community based alternate care sites. The State of Florida is requesting the Comfort and Mercy to include the staff to support the care of Floridians. These ships would be moored at Port Everglades.
- The State of Florida requests supplies to include **nasal pharyngeal and oral pharyngeal swabs and viral transfer media to collect specimens from 500,000 people**. Florida has provided diagnostic testing capability to all major hospitals and laboratories across the state but is unable to obtain additional specimen collection supplies. County Health Departments, Community Health Centers, and hospitals are unable to obtain the necessary supplies. Florida has zero remaining in state caches, despite placing orders for over 1,000,000 specimen collection supplies.
- The State of Florida requests **medical personnel experienced in acute care and infection control to provide patient care in long term care facilities experiencing outbreaks** of COVID-19. Florida currently has two assisted living with active cases and over 3,000 assisted living facilities and 696 nursing homes. These facilities are not operated with skilled nursing care and do not have experience to control an outbreak of this scale. These staff would be used to rapidly deploy into long term care facilities, stabilize the situation, provide on the job training for infection control to on-site clinicians.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
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COVID-19 –STATE / LOCAL RESOURCE REQUEST FORM

A. REQUEST FOR ASSISTANCE (To be completed by requesting State DOH) **ALL FIELDS REQUIRED**			
1. Requestor's Name (Please print)	**2.** Title		**3.** Phone No.
4. Requestor's Organization	**5.** Cell Phone No.	**6.** Email Address	
7. Description of Requested Assistance (describe resource type and need in plain language – no acronyms)			
8. Requested Item	☐ N-95 Masks ☐ Goggles ☐ Gowns ☐ Gloves: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ Medical Providers ☐ Technical SME		
10. Date and Time Needed By		**11.** Estimated Duration of Need (days)	
12. Delivery Site Location (Address, City, Zip)		**13.** Site Point of Contact (POC) Name and Title	
14. Delivery Site Location (☐USNG or ☐Decimal Degrees)		**15.** Site 24 Hour Phone No.	**16.** Site email Address

B. HHS REGIONAL REVIEW (To be completed by HHS Region where request was initiated)			
Reviewed By (Name & Title)		Date and Time	
Disposition	☐ Sent to IMTNAT ☐ Sent to SOC/IST ☐ ASPR/FEMA RSP POCs notified		
Priority	☐ High ☐ Medium ☐ Low		
Regional Approving Official (Name, Title, Date, Time)			
ASPR Region Request Number			

HHS RFR ID Number	

C. HHS RCB/SNS REVIEW (To be completed by RCB/SNS Section only)			
Received By (Name & Title)		Date and Time	
1. Resource Typing/Adjustment			
2. Special Instructions			
Entered in EMPortal by (Name & Title)		Date and Time	
Disposition	☐ New Request ☐ Assigned ☐ Tasked to: _____ ☐ In Process ☐ Need More Information ☐ Out for Delivery ☐ En-route ☐ On Hold ☐ Complete ☐ Cancelled ☐ Request Withdrawn ☐ Demobilized		
Assigned To (Name and Title)			
Point of Contact (Name and Title)		24-Hr. POC Phone	
Approved By (Name & Title)		Date and Time	
3. Cost Estimate			
4. Priority	☐ High ☐ Medium ☐ Low		

State Government Tracking Number	

D. STATE GOVERNMENT REVIEW (To be completed by requesting State - Department of Health Agency)			
Received By (Name & Title)		Date and Time	
Disposition	☐ Requested Federal Resources ☐ Filled with Local Resource(s) ☐ Filled with State Resources ☐ Denied		
Assigned To (Department Name)			
Point of Contact (Name and Title)		24-Hr. POC Phone	
Approved By (Name & Title)		Date and Time	

F. REQUESTOR NOTIFIED (To be handled by HHS RCB/SNS Logistics)			
Region Notified By (Name & Title)		Date and Time	
State Notified By (Name & Title)		Date and Time	
Other Notes:			

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From:	Beynon, Valerie
To:	DL DEPCS00 BPR HCCTF
Cc:	Paul Link; Wilgis, John; Yow, Annmarie; Peggy Brown; John James; Hill, Ann; Schenk, Terry; Kelley, Debbie A; Mooney, Dayle; Wilsey, Leigh; Eric Anderson; Carhart, Ty; Kevin Gingras; Matt Meyers; Jeanne Eckes-Roper; Denise Imbler; Webb, Dawn; Riddle, Franklin; Knox, Thomas; Central Florida Disaster Medical Coalition; Zyna Wright
Subject:	February HCC Task Force Meeting
Attachments:	012320 HCCTF Minutes DRAFT.docx February 2020 HCCTF Consent Agenda Draft.docx

This is a reminder of the monthly conference call for the HCC Task Force. Please submit consent agenda reports and proposed agenda items by Monday, February 17.

Thanks,

Valerie

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HEALTH CARE COALITION TASK FORCE (HCCTF) MEETING

Minutes

Thursday, January 23, 2019

Call To Order: 2:00 p.m.

Roll Call:

Region 1 – Ann Hill, Retha Jensen

Region 2 – Denise Imbler, Zach Arnett

Region 3 – Leigh Wilsey

Region 4 – Dan Johnson, Franklin Riddle, Hunter Zager

Region 5 – Lynne Drawdy

Region 6 – Kevin Gingras, Caitlyn Eck,

Region 7 Broward – Reshena Clark

Region 7 Keys – Cyna Wright

Region 7 Miami Dade – Marilia Van Keeken

Region 7 Palm Beach – John James

FHA: John Wilgis

DOH: Dayle Mooney, Valerie Beynon, Samantha Cooksey, Ty Carhart, Debbie Kelley, Sue James, Terry Schenk, Dawn Webb

HHS: Jeanne Eckes-Roper, Paul Link

FACHC: Tom Knox

Lynne will send FCRT contact to Dayle to add to the meeting DL.

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Motion to accept agenda:

1st Ann Hill

2nd Lynne Drawdy

No objections

Motion to Accept Amended Minutes:

1st Leigh Wilsey

2nd Tom Knox

No objections

Motion to Accept Consent Agenda:

1st Ann Hill

2nd Franklin Riddle

No objections

Old Business

Governor's Hurricane Conference Planning **John Wilgis**

John will send an overview of planning of the GHC health concentration to task force members after the call.

For the first time, GHC does not begin on Mother's Day but on May 17 instead at the Palm Beach Convention Center. John James is assisting us with planning the health care track including several training sessions. The trainings include:

- Health Care in Emergency Management
- Psychological First Aid for Shelter Workers
- A training being developed in coordination with FHCA
- Computer lab overview of ESS (AHCA will conduct a six hour training)

Workshops

- Communication Flow of EEI in Health Care
- CMS Regulations for Health Care and Long Term Care
- HCC Integration Strategies for Non-Acute Providers

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- Recovery and Continuity of Operations (panel discussion about real world)
- Patient Movement and Tracking (panel discussion)

John would like HCCs to notice where we have panels, we need SMEs to provide input. Please reach out to participate. Dayle is also asking DOH for SMEs to participate. It makes for a more interesting presentation if we are engaged in dialogue than death by Powerpoint.

Questions

Leigh – The train the trainer for Health Care in Emergency Management at FEPA was cancelled. John will reschedule this training.

New Business

Repatriation Program Update **Samantha Cooksey**

This is a brief update on a conversation with our federal partners about contingency planning and bringing people to the US from foreign countries. This is coordinated within HHS and would work with DCF in Florida. In the event the system is overwhelmed, the process internally transitions to ASPR. The conversations on health medical aspect of this subject have been going on long before recent events in China and Iran. Jeanne reached out to us so we can determine how we want that to look in Florida.

Past examples have included Lebanon, Haiti, and Japan.

When a repatriation takes place bringing medical patients back, they are first moved a short distance to a safe haven. They are then stabilized and sent to a medical waypoint where they are ready to be treated. They are then moved to the US where they go into the FCC system. There are 11 places that receive general population patients who are healthy (3-5% low acuity medical need). For our region, non-injured people would go to Hartsfield airport in Atlanta and injured military would go to NAS JAX. For the military, the backup is the VA hospital. The Miami FCC is not on an official list but, if we have a high volume, they will identify additional hubs. Miami is a potential secondary site.

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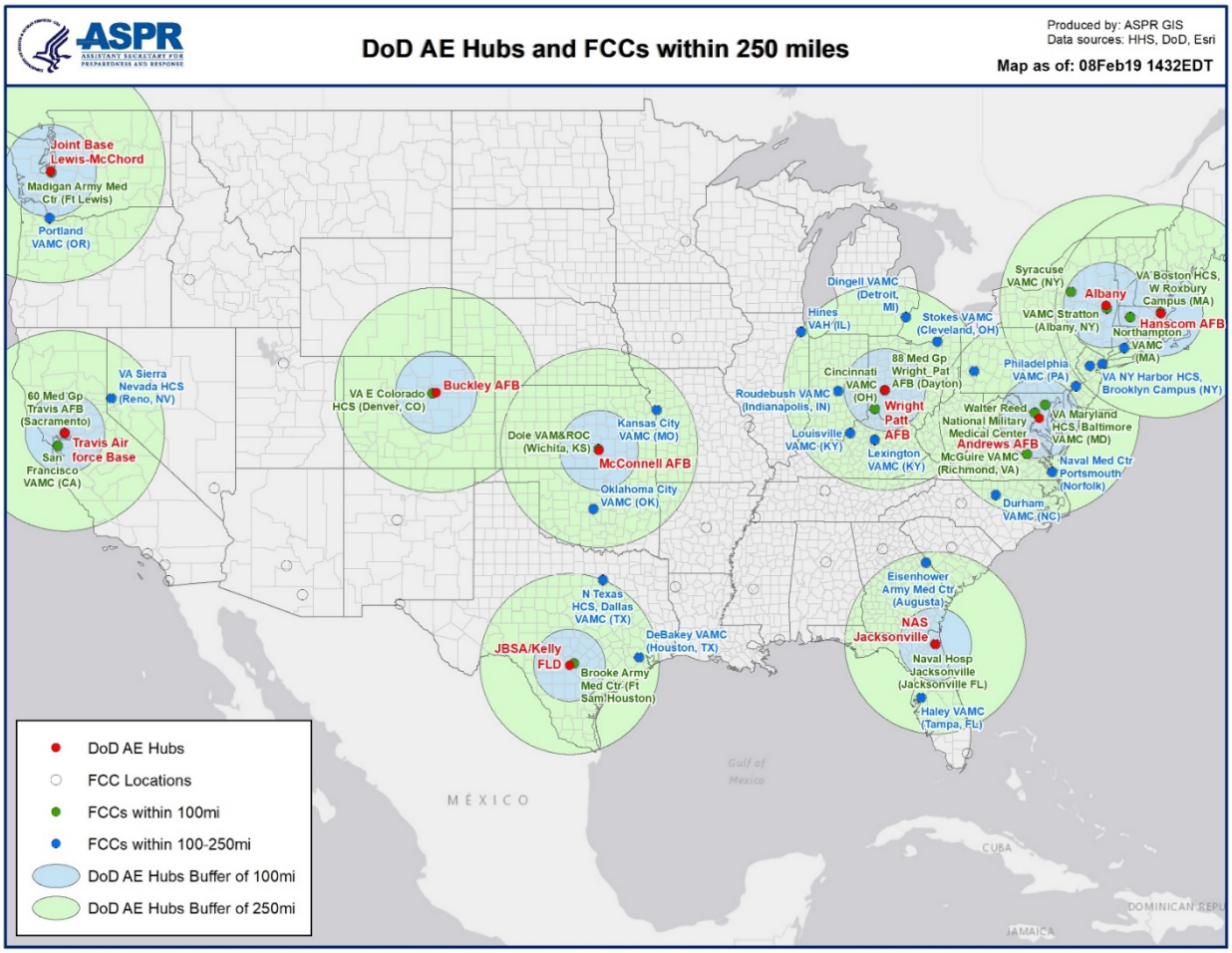

We want to ensure through this call that Regions 3 and 7 have a heightened awareness. We are planning a field trip to NAS JAX to learn more about their process. If this was used, we would receive notifications through the usual channels.

HHS is trying to get facilities in their NDMS file so they could potentially receive patients and be reimbursed for their use. We need to make sure the MOU's are signed before that happens.

Questions

Leigh – We just discussed this at our hospital meeting. Is NAS JAX only used for active duty military and some dependents?

Jeanne – Yes, we will be glad to reach out and help in your area. This is only for repatriation.

Lynne – Can we get a list of hospitals with MOUs?

Dayle - Yes, email was sent today with attachments. Please forward this out to members. Contact information is located in the documents.

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Jeanne – Hospitals are more than welcome to fill out a new MOA or MOU to update their information.

Novel Coronavirus Situational Brief **Samantha Cooksey**

The Florida Department of Health is monitoring the situation and is participating on calls. The CDC is developing guidance quickly as the situation is rapidly unfolding. The goal is to identify, isolate, and inform. We have done a lot of work on Ebola isolation in the past. The point is to maintain and control the disease. Leadership is making decisions and we are working with our Division of Disease Control.

The federal situation involves airport monitoring in Los Angeles, San Francisco, New York City with additional checkpoints in Atlanta and Chicago. This involves temperature monitoring.

Florida Infectious Disease Transportation Network (FIDTN) **Terry Schenk**

- All 8 teams are fully operational for 24/7/365 response.
- Monitoring the 2019nCoV situation for response as needed.
- Recently received additional supplies and equipment to beef up our teams ahead of the Ebola grant sunsetting in May. Some additional supplies are cached at our warehouse. We held a face to face leaders meeting in November which allowed us the opportunity to plan future Network operations.
- We have an epi provided list of 20 highly infectious diseases we may be called upon to respond to. Corona viruses are included.
- We are working with Dayle and also John Wilgis to better identify specific hospital capabilities around the state for handling the various HIDS, as the RESPTC in Atlanta, of course, has a limited number of beds and serves the entire southeast. Trying to achieve a better awareness of which hospitals have particular expertise with certain HIDS. We would welcome input from the HCCs on this endeavor.
- As you know, we utilize the AeroClave decontamination units for our equipment and transport unit decontamination. I know several HCCs have purchased this same equipment. They use VitalOxide. Our vendor sent us information on the applicability for various kinds and the agent has been tested against and kills corona viruses.
- Continue exercising at the local level, most recent being in Jacksonville, which was actually part of a Region 4 region wide Ebola exercise titled Operation Wesley exercise which was held in November. Paul Link is on the line and led that effort. Lessons learned are being applied to an update of the Regional plan, regional checklists, and will benefit the update of our Florida FIDTN Plan.

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Our statewide exercise, still under development, will be held in March and we hope to do more localized exercises in the coming year. Training of personnel by Emory University continues statewide with the most recent being in Orange County and Lee County.

- Bottom line is that the Network is ready to respond as needed!

Comments

Leigh Wilsey - When is the agenda for the March meeting coming out?

Dayle – We're putting that together and would appreciate agenda suggestions. We currently have a request to do a sustainment strategy presentation by Paul Link, a legislative session wrap up, and a pediatric surge annex. We will get a rough draft out shortly.

Leigh Wilsey – What is the timeline for the procurement process?

Dayle - We will be wrapping up and starting the routing before the end of this month.

Reshena Clark – Is there an update on my email?

Dayle – IT is aware of and currently working on it.

Next Meeting: February 27, 2020 at 2 p.m. EDT. Please send agenda items.

Adjourned: 2:49 p.m.

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HCCTF CONSENT AGENDA

FEBRUARY 2020

Region 1

Coalition Name: Emerald Coast Health Care Coalition

- Hosted our next coalition general meetings in February with speakers on Cyber issues for healthcare partners and updates on project funding and symposium conference. Also had speaker from Okaloosa County MRC on the Lean on Me Project that they developed.
- The Ambubus will be on display at the symposium in March and it is ready for emergency response and evacuations along with the Mobile Oxygen Trailer from Okaloosa County and possibly a new ambulance from Ten-8. There are over 25 vendors at the conference this year scheduled for March 11, 12, 13, 2020 in Destin FL We are hosting the conference with hands on exercises in afternoons and guest speakers in mornings – confirmed speakers – Teleflex bringing training with cadaveric tissue on Friday March 13th
- Met with EMS< Fire, EM and hospital to develop our next coalition exercise which is scheduled for April 16, 2020 in Crestview, FL – Scenario is a small plane crash at the small airport north Okaloosa County.
- Hosted requested training for incident command at Sacred Heart Hospital in Destin.
- Attending regional Emergency Manager meetings and County specific ESF8 meetings – attended County Planner meeting for Region 1 with RERA.
- Worked on deliverables starting the third quarter.
- Setting up meeting for Trauma Agency information gathering for the Region. Planning exercise for March with Nursing schools, and a COOP exercise in Jackson County for June.
- Worked on pediatric facilities conference calls and participated in group discussion.

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- Planning COOP exercise for Jackson County DOH and EM in May 2020.
- Integrating information with partners on Chemical Threat Exposure Exercise scheduled for February

Region 2

Coalition Name: Big Bend Health Care Coalition

Highlights

- Held Board of Directors and General Membership Meeting

Activities

- Submitted regional information on acute care and pediatric capabilities to DOH.
- Set the date for the next Board of Directors and General Membership Meeting for March 10th.
- Continued working with multiple BBHCC member organizations to plan the Surge Tool Exercise scheduled for April 7, 2020.
- Hosting an Active Shooter Workshop for members in March and April.
- Working with DOH to host a meeting on lessons learned from Hurricane Michael to further enhance HVA plans and operational plans.
- Attended the Region 2 Health Departments Training and Exercise Plan development meeting.
- Finalized member project agreements.

Region 3

Coalition Name: Northeast Florida Health Care Coalition

Region 3 Alliance:

- Conducted Infectious Disease Survey in preparation for the March Infectious Disease Workshops.
- Updating the Alliance HVA
- Completing the MYTEP process
- Participating on the Pediatric and Neonatal Surge Project Working Group

CHAMP:

- Conducted PPE training for Highly infectious diseases to local hospitals
- Conducted Initial Planning Meeting for Hospital Mass Casualty Exercise

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North Central HCC

- Completed the COOP Planning Workshops for facilities
- Disaster Response & Recovery: Mental Health First Aid course through IFAS

Northeast HCC

- Shelter-in-Place training for 120 facilities in partnership with the NE FL LEPC
- COOP Planning Workshops for members
- Disaster Response & Recovery: Mental Health First Aid course through IFAS

Region 4

Coalition Name: Tampa Bay Health & Medical Preparedness Coalition

- Quarter 3 deliverables in process
- TBHMPC continues to add new members
- 2nd round of project funding in process
- TBHMPC Board of Directors underwent formal Parliamentary Roberts Rules of Order training on January 21st. This include each county Chair, Co-chair, core member representatives, and coalition staff.
- ReadyOp has been adopted and will be the primary communication platform throughout our Coalition region. We are currently building out our dashboard and familiarizing ourselves with its vast capabilities.
- Partnering with regional DOH nCoV preparedness initiatives supporting communications, fit test training, and supply chain management.
- Partnering with International Medical Corp (IMC) and DOH to offer an HVA workshop
- Partnering with our regional FDLE, FBI, and DOH partners in hosting a Healthcare Security Summit on June 10th (tentative date)
- TBHMPC training and exercise calendar continues to expand with currently 43 various Coalition sponsored events taking place from now until the end of our fiscal year. With the expectation of additional offerings to be added as we are in the process of a coalition-wide Training and Needs Assessment.

Region 5

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Coalition Name: Central Florida Disaster Medical Coalition

- The coalition hosted a call on the corona virus with hospitals and emergency managers on February 13. The state shared a website with guidance that is continuously updated and the weekly calls with the State Surgeon General. The hospitals agreed they need a communication process for the first case in Central Florida and this has been drafted and is being vetted by the hospitals.

- Emerging Infectious Diseases: On January 16 the Coalition hosted Ebola frontline training for hospitals. Hospitals agreed that capabilities have decreased since 2016 and we are working to ensure all hospitals are frontline ready. The hospitals have converged on PPE and the Coalition is working on purchasing and distributing this to all hospitals. The hospitals also came to consensus on donning and doffing protocols and we are developing an on-line training on donning and doffing. The hospitals are working to converge on screening protocols, and the next steps will be identifying best practices in employee management, and identifying ongoing training and exercise needs.

- Joint Exercise: The regional mass casualty exercise will be held on April 9. This is the joint state-coalition exercise. Almost all of the hospitals in the region are participating. The scenario is a complex, coordinated attack involving train derailments and chemical spills. We are recruiting victim volunteers, evaluators and volunteer management staff; please distribute the recruitment flyers within your networks.

- Communications: Communication failures remain the number one issue in events and exercises. A communications forum has been scheduled for February 21, including hospitals, EMS, emergency management, and ESF8. We will confirm EEIs (essential elements of information) for all stakeholders, review all existing communication platforms, and identify and prioritize gaps.

- Evacuation: Following the communications forum, the same group with nursing homes invited are going to meet to review the results of the evacuation equipment assessment and identify and prioritize evacuation equipment issues and gaps.

- The Coalition will partner with UCF in a full-scale FRC/FAC exercise in spring 2021. To prepare, the Coalition will be hosting a tabletop in the near future with the FAC team members to vet the plan and do role training.

- The Coalition is sponsoring Mental Health First Aid training in May – a flyer is coming soon.

- Matt Meyers joined the Coalition staff on February 7.

Region 6

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Coalition Name: Health Planning Council of Southwest Florida

- Members of the Region 6 SWFL Healthcare Coalition participated in the Statewide Tornado drill held January 29th. This drill emphasized what our agencies would do in the case of a Tornado touching down that affected our facilities. This drill tested response capability and helped reveal gaps in our agency plans.
- Surge exercise planning is underway with gathering registrations
- Registrations and class signups for the National Hurricane Conference and Governors Hurricane Conference has been ongoing.
- The HVA/GAP Analysis results were packaged and sent to all members. These results are assisting in the selection for the rest of this year's trainings through the TEPW Program.
- Briefings were held with regards to Hepatitis A to discuss the overview, transmissions, symptoms, diagnosis and prevention of Hepatitis A.
- The coalition has voted to hire a temporary assistant to work on streamlining the contact list to help keep the members of the coalition better informed.
- Behavioral mental health trainers are determining scheduling availability to hold trainings with coalition members.
- Todd Stalbaum EMT-P, HRM, CQM, Disaster Health & Medical Manager, Orange County, Florida gave a powerful discussion on his direct experience with the Pulse nightclub shooting and how he worked with local coalitions before, during and after the event.

Region 7

Coalition Name: Broward County Health Care Coalition

Projects:

- Elections: BCHC is currently requesting nominations for the Vice Chair, Treasurer, and Communication positions available on the board.

Training:

- PHTLS training TBD.
- ALMS training 1/23/ 2020& 1/24/2020 was postponed. Reschedule date TBD.
- Regional trainings can be found on SERT trac: www.trac.floridadisaster.org

Exercises:

- Med Surge Drill 4/2020. Looking for hospitals involvement.
- Broward College MCI 4/2020.

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- FAA MCI Drill- 4/2020.
- Statewide Hurrex Exercise 5/2020.
- Broward County Hurrex Exercise 5/2020/
- CRI-Regional POD Exercise 11/2020.

Communications:

- Currently working on the progress, the ReadyOp project which utilizes patient tracking and radio interoperability between hospitals and fire rescues. Agencies must complete the ReadyOp Authorization form to give users access to the system. The Broward County Healthcare Coalition will begin using Ready Op for notifications and reminders.
- Cut off has begun and will continue until March 2020. Facilities should be upgraded to the P25 System for communication purposes.

Coalition Name: Keys Health Ready Coalition

Current projects and trainings:

- Airport exercise for mass casualty on Feb 20.
- Final HVA member input and approval -completed
- Moulage and manikin project approved
- Training program approved for CPR, stop bleed and psychological first aid.
- Clearspace Respirator project expanded from pilot to regular use in Baptist system
- Next Full Scale Exercise deliverable 3rd planning meeting- March 26

Other updates:

- Next general meeting on March 26

Coalition Name: Miami-Dade County Health Preparedness Coalition

- The Coalition's 10th Annual Miami Dade County Healthcare Preparedness Symposium is open for registration. Registration can be completed at http://www.cvent.com/d/cyq47b.
- Super Bowl LIV went off without any major issues. Having the report of some minor shaking felt during the earthquake that same week sparked some interesting conversation at our last Exercise and Training committee meeting on no-notice events. We will be dedicating time in the future to focus on no-notice drills.

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- The coalition has started to complete some of its proposed projects. The Coalition will be hosting a CHEP course, two CPR TTT, and is working with Mount Sinai Medical Center to purchase fire extinguisher trainings. We also hope to host the International Medical Corps for an HVA training in April. Our CST is scheduled for April 8th.
- The executive committee is in the process of updating our bylaws. The board is also preparing to hire a new coordinator.

Coalition Name: Palm Beach County HERC

The Coalition continues to work on the following projects:

- **Stop the Bleed** – approximately 400 ppl trained /quarter and over 4k first responders, healthcare and community members trained since the program's inception.

- **Patient Tracking System** – Coalition has been working with the Division of EM since 2018 to develop a countywide system to track patients from the incident scene to final destination (hospital, morgue, etc…). Currently working to address HIPAA and other concerns, with hopes to run a pilot by fall 2020, more to come.

- **Opioid Healthcare Response** – created a response plan and held four educational summits including two that offered CMEs; also developed an Addiction Treatment Checklist and an Opioid Treatment Guide see below…
    - Opioid Resources: https://www.pbcms.org/opioid-addiction-treatment-resources
    - HERC Resources page: https://pbcherc.org/resources/

The Coalition will hold its next monthly meeting on February 28th.

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From: DNPAO Comm TA (CDC)
To: DNPAO Comm TA (CDC)
Subject: Feedback requested by Mar 26 @ 9pm ET – DNPAO Comm TA mailbox
Date: Tuesday, March 24, 2020 4:21:01 PM

Dear DNAPO Ambassador Media/Communication Contacts,

During the COVID-19 response, we would like your feedback on content and frequency of emails from the DNPAOCommTA@cdc.gov mailbox.

Please click the link below and complete the assessment by March 26 at 9:00pm Eastern. We estimate this will take about 1-2 minutes. Your responses are anonymous and will inform email content and frequency during the COVID-19 response.
https://www.surveymonkey.com/r/95MLK75

You can find COVID-19 content including information on Protecting Your Family, Pregnancy & Breastfeeding, Schools and Childcare, High Risk groups including those with severe obesity, and Managing Stress & Anxiety which includes mention of physical activity and healthy diet. Syndicated content for these pages and many more that you can use on your own webpages are found at here.

Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	Final Interim Cleaning Guidance for Persons Under Quarantine Attached
Date:	Sunday, March 1, 2020 1:29:03 PM
Attachments:	FinalInterimCleaningGuidanceforPersonsUnderQuarantineforCOVID19_030120.docx
Importance:	High

For distribution - FYSA

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
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Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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Interim Cleaning Recommendations for Facilities Housing Persons Under Quarantine for Coronavirus Disease 2019 (COVID-19), Updated February 29, 2020

Background

There is much to learn about the newly emerged coronavirus disease 2019 (COVID-19). Based on what is known about early cases of COVID-19, spread from person-to-person via the respiratory route and usually happens among close contacts (within about 6 feet).

People with certain types of exposure to cases of COVID-19 may be housed and quarantined for observation until 14 days after their exposure. The purpose of the observation period is to ensure they don't develop symptoms and infect others during this time. Some people stay at home for the observation period, but others may be housed either separately or in groups in other types of facilities.

In these facilities, individuals and families are provided separate quarters with separate bathroom facilities. They are instructed that congregation and shared public spaces are to be avoided. Because the people under quarantine are not ill, the risk to cleaning staff is inherently low.

Purpose

This guidance provides recommendation on the cleaning and disinfection of rooms of persons under quarantine, as well as associated worker protection practices according to expected job tasks. The goal is to minimize interactions between persons under quarantine and cleaning staff. These recommendations will be updated if additional information becomes available.

General Recommendations for Housing Facilities for Persons Under Quarantine

- Employers should develop policies for worker protection and provide training to all cleaning staff on-site prior to beginning work. Training should include:
  - An understanding of when to use personal protective equipment (PPE)
  - What PPE is necessary and why (see below for PPE recommendations)
  - How to properly don (put on), use, and doff (take off) PPE
  - How to properly dispose of PPE
- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard, 29 CFR 1910.1200.
- Employers must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste, and PPE (29 CFR 1910.132).
- Cleaning staff should perform hand hygiene often including immediately after removing PPE by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

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- Cleaning staff should immediately report breaches in PPE (e.g., tear in gloves) or any potential exposures (e.g., contact with a quarantined individual without wearing appropriate PPE) to their supervisor.
- Employers should educate workers to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms until 14 days after the last day they had possible exposure to the virus.
    - Cleaning staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Cleaning staff should follow normal preventive actions while at work and home including covering their mouth and nose with a tissue when coughing or sneezing and avoiding touching eyes, nose, or mouth with unwashed hands.
- If surfaces are dirty, they should be cleaned using a detergent and water prior to disinfection.
    - A list of products with EPA-approved emerging viral pathogens claims, maintained by the American Chemistry Council Center for Biocide Chemistries (CBC), is available at: https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf.
    - Products with EPA-approved emerging viral pathogens claims are expected to be effective against COVID-19 based on data for harder to kill viruses.
    - Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE) for use.

Cleaning Activities During the Quarantine Period

Because cleaning needs are limited during the quarantine period, CDC is recommending that cleaning staff do not clean occupied rooms in quarantine facilities. Instead, all rooms should be provisioned with personal cleaning supplies, e.g., tissues, paper towels, cleaners and disinfectants that are EPA-approved against emerging viral pathogens (see list above) for use by persons under quarantine as needed. Rooms and common areas occupied by persons under quarantine should not be cleaned by cleaning staff until all persons under quarantine have been released from quarantine and have vacated the area and no sooner than 24 hours after rooms and common areas have been vacated.

During the quarantine:

- Persons under quarantine should bag trash and place the closed bag outside their door for daily pick up.
- Similarly, persons under quarantine should bag soiled linens and place the closed bag outside their door for pick up.
- Cleaning, laundry, and trash removal staff should wear disposable gloves and gowns for all tasks in the cleaning process, including collection of closed bags.
    - Staff should remove gloves after cleaning a room or area occupied by persons under quarantine before moving to the next room.
    - After delivering bags to their final destination, staff should clean and disinfect any hard, cleanable surfaces where bags have been stored (such as on carts or on the floor).

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- Laundry and trash removal staff collecting the closed bags should remove their gloves promptly after bags are delivered to their destination and cleaning and disinfection has been performed.
- Any time staff remove gloves, they should perform hand hygiene immediately by washing their hands with soap and water for 20 seconds. If hands are not visibly dirty and soap and water are not available, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.

- If possible, for fabrics or other materials that can be laundered, use the warm water setting and dry items completely on high heat.
- If a person under quarantine has a special need for assisted cleaning (e.g., an elderly person who is unable to clean a spill such as vomiting in their quarters), public health staff will oversee the cleaning process as part of their evaluation of the individual.

Cleaning a Room Vacated by a Person under Quarantine with COVID-19 (Enhanced Cleaning)

Rooms that housed a person under quarantine with COVID-19 should remain closed to further use until cleaned and disinfected by appropriately trained cleaning staff. The room should not be entered by cleaning staff for at least for 24 hours.

- Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process.
  - These gloves and gowns should be compatible with the disinfectant products being used
  - Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk for splash.
  - Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area.
- Cleaning should be undertaken using products with EPA-approved emerging viral pathogens claims (https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf). All products should be used according to label instructions.
  - Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
  - Adhere to any safety precautions or other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE).
  - Avoid using product application methods that cause splashing or generate aerosols.
  - Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
  - After cleaning and removal and disposal of gloves, staff should perform hand hygiene by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.

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- Clean and disinfect all frequently touched surfaces in quarantine locations (e.g., counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, remotes and bedside tables) according to instructions described for products with EPA-approved emerging viral pathogens claims.
- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present. Launder items as appropriate in accordance with the manufacturer's instructions. Porous materials that will be laundered can be transported to the laundry facility in the usual manner. If possible, launder items using the warm water setting and dry items completely on high heat.
- When cleaning is completed, collect soiled material and PPE in a sturdy, leak-proof (e.g., plastic) bag that is tied shut and not reopened. This waste can go to the regular solid waste stream (e.g., municipal trash) as it is not biohazardous or regulated medical waste.
- If bulk material and spills containing blood or body substances are present, cleaning staff should use absorbent materials, such as towels, to remove the material. The area should then be cleaned and then disinfected with products with EPA-approved emerging viral pathogens claims used according to product label instructions.
- No additional cleaning is needed for supply and return ventilation registers or filtration systems for the building.
- No additional treatment of wastewater is needed before discharging to sanitary sewer.

Cleaning Recommendations for Quarantined Persons from Uncontrolled Sources (e.g. increased likelihood of many cases such as on cruise ships, etc.)

Cleaning for facilities housing persons under quarantine because of exposure from an uncontrolled source should be conducted following the Enhanced Cleaning procedures and include cleaning of common areas outlined above.

Cleaning a Room Vacated by persons under quarantine without COVID-19

After all persons under quarantine are released and assuming the quarantined persons are not from an uncontrolled source (see above):

- If all persons under quarantine have been released and vacated the housing area and no persons tested positive for COVID-19, the facility (e.g., rooms, common areas) should be cleaned according to standard procedures.
- No additional PPE is required beyond what is normally worn for regular housekeeping activities.

Cleaning of Common Areas of a Housing Facility (if used)

If common areas are used by persons under quarantine, those areas will require cleaning and disinfection during the quarantine period.

- Common areas of a facility should be cleaned on a daily basis, and as needed.
- Regardless of known COVID-19 status of persons under quarantine, common areas should be cleaned according to ***Cleaning a Room Vacated by a person under quarantine with COVID-19(Enhanced Cleaning)*** recommendations, since

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communication to cleaning staff about persons under quarantine who develop symptoms or test positive for COVID-19 may not be able to occur as quickly as cleaning services are required.

- No quarantined individuals should be present in a common area during cleaning. Common areas of a facility should be closed off to all persons except for cleaning staff before cleaning and disinfection activities take place.

Additional Resource:

OSHA COVID-19 Website:
https://www.osha.gov/SLTC/covid-19/

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From: Ann Hill

To: 21st Century Oncology Inc.; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fit testing

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Date: Wednesday, March 11, 2020 4:38:53 PM

Emerald Coast Healthcare Coalition has instructors and kits to do Fit Testing
We can come to your facility for multiple personnel needing to be fit tested or you can come to our facility
We have several instructors and kits for testing abilities
Please contact me for information on availability and pricing for the fit testing

Thank you

--



Ann Hill, Executive Director
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850-585-1679

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Thank you

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; Jacobs Slifka, Kara (CDC/DDID/NCEZID/DHQP); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Subject:	FL Call Follow-up
Date:	Tuesday, March 17, 2020 11:35:28 AM
Attachments:	HCP symptom monitoring from.docx PPE Strategies for LTCFs_ES.docx 20200315 Strategies for Optimizing the Supply of Eye protection_clean.docx 20200315 Strategies for optimizing the supply of facemasks_clean.docx 20200315 Strategies for Optimizing the Supply of Isolation Gowns_clean.docx LTC_nursing home letter to families_share.docx Plain language_Cleaning and disinfection tips for SARS_CoV_2_Upd 3.10.docx LTCLine List_3.7.20.docx rapid facility phone assessment.docx

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Hello Everyone,

Thank you for chatting with us today.

As I mentioned the CDC Healthcare Infection Control can be reached for further TA via eocevent141@cdc.gov or via phone at 404-414-8385

I think your biggest challenge is going to be figuring out the contracted staff and how they have interacted with other facilities. It would be reasonable to apply many of the below listed concepts to other at risk facilities based upon how these staff moved to detect cases earlier among residents and staff. If helpful someone from our team developed a rapid facility phone assessment which could be deployed (attached).

Here are some good links:
LTC guidance which can apply to AL: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
General IPC guidance: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
Criteria for return to work for HCP (healthcare personnel): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Please remember many of the docs I have attached are not CDC cleared. Some were created as tools by our field team or by other jurisdictions so feel free to modify to your own needs.

A couple important points and lessons learned from other states:

1. Ensure a good active monitoring system for residents (at least once a day although more often if possible). They should be mindful (as you know) the elderly may present in other and potentially less dramatic fashion especially if they have baseline lung disease. I have attached a symptom/temp checking that we created for HCP but could be modified for use with residents.
2. Likewise a good monitoring system for all HCP is key. They should be self-monitoring with delegation (i.e., they know who to call with symptoms) when at home and then have a symptom/temp check before starting their shift. This pre-shift check could happen upon

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facility arrival or via something like facetime before leaving for work. Just make sure they take their temp and show while on facetime.

3. Implement universal masking for HCP while in the facility. Attached is a PPE strategy for LTC which accounts for shortages in gowns and extend use of masks and eye protection. In addition, I have attached some docs about general PPE for all HCF which we do expect to be posted to the web soon.
4. Ideally gowns, gloves, mask/respirator, eye should be used for all cases, PUIs, and anyone with unknown respiratory illness. Again may need to refer to the PPE strategy doc if not doable. NTEC has a good video that helps with donning and doffing: https://repository.netecweb.org/items/show/688
5. Restrict visitors. Any visitor that must enter should have symptom/temp check, masked, and controlled movement in and out of resident rooms. I have attached an example letter to families that can be modified.
6. Restrict resident movements, no congregate settings.
7. I have attached some cleaning consideration as well to include the use of nursing/CNAs to wipe high touch surfaces for cases or PUIs instead of EVS.
8. I have also attached a line list if you want it.
9. Contact tracing and risk assessment is not practical in this setting and ideally time should be spent in the above activities plus IPC. We understand that work restricting staff may shutter the entire facility and thus the emphasis of the good monitoring of HCP. We discuss this in the new risk assessment at the very bottom of the page: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
10. You and other PH staff should be wearing a facemask when you enter the facility and institute self-monitoring as well.

Please feel free to reach out with questions.

Best,
Elizabeth and Nicola

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Strategies for Optimizing the Supply of Isolation Gowns

Audience: These considerations are intended for use by federal, state, and local public health officials, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of isolation gowns in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare settings can refer to COVID-19 preparedness plans to address other aspects of preparing to respond to novel coronavirus disease 2019 (COVID-19).

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no widely accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of isolation gowns during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve isolation gown supplies along the continuum of care.1

- **Conventional capacity**: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency capacity**: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily when isolation gown demands exceed resources.
- **Crisis capacity**: strategies that are not commensurate with standard U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of expected or known isolation gown shortages.

The following contingency and crisis strategies are based upon these assumptions:
1) facilities understand their current isolation gown inventory and supply chain
2) facilities understand their isolation gown utilization rate
3) facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
4) facilities have already implemented other engineering and administrative control measures within conventional capacity strategies including:

- Reducing the number of patients going to the hospital or outpatient settings
- Excluding healthcare personnel (HCP) not directly involved in patient care
- Reducing face-to-face HCP encounters with patients
- Excluding visitors to patients with confirmed or suspected COVID-19
- Cohorting patients and HCP
- Maximizing use of telemedicine

5) facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

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Conventional Capacity Strategies

Use of isolation gown alternatives that offer equivalent or higher protection
Several fluid-resistant and impermeable protective clothing options are available in the marketplace for HCP. These include isolation gowns and surgical gowns. When selecting the most appropriate protective clothing, employers should consider all of the available information on recommended protective clothing, including the potential limitations. Nonsterile, disposable patient isolation gowns, which are used for routine patient care in healthcare settings, are appropriate for use by HCP when caring for patients with suspected or confirmed COVID-19. In times of gown shortages, surgical gowns should be prioritized for surgical and other sterile procedures. Current U.S. guidelines do not require use of gowns that conform to any standards.

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which a gown is typically used by HCP

Shift gown use towards cloth isolation gowns
Reusable (i.e., washable) gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered according to routine procedures and reused. Care should be taken to ensure that HCP do not touch outer surfaces of the gown during care.

- Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles
- Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties), and replace reusable gowns when needed (e.g., when they are thin or ripped)

Consider the use of coveralls
Coveralls typically provide 360-degree protection because they are designed to cover the whole body, including the back and lower legs, and sometimes the head and feet as well. While the material and seam barrier properties are essential for defining the protective level, the coverage provided by the material used in the garment design, as well as certain features including closures, will greatly affect the protective level. HCP unfamiliar with the use of coveralls must be trained and practiced in their use, prior to using during patient care.
In the United States, the NFPA 1999 standard specifies the minimum design, performance, testing, documentation, and certification requirements for new single-use and new multiple-use emergency medical operations protective clothing, including coveralls for HCP."

Use of expired gowns beyond the manufacturer-designated shelf life for training
The majority of isolation gowns do not have a manufacturer-designated shelf life. However, consideration can be made to using gowns that do and are past their manufacturer-designated shelf life. If there is no date available on the gown label or packaging, facilities should contact the manufacturer.

Use of gowns or coveralls conforming to international standards

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Current guidelines do not require use of gowns that conform to any standards. In times of shortages, healthcare facilities can consider using international gowns and coveralls. Gowns and coveralls that conform to international standards, including with EN 13795 and EN14126, could be reserved for activities that may involve moderate to high amounts of body fluids.

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Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which a gown is typically used by HCP

Extended use of isolation gowns

Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridium difficile*) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.

Re-use of cloth isolation gowns among multiple patients in a patient cohort area

Disposable gowns are not typically amenable to being doffed and re-used because the ties and fasteners typically break during doffing. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between.

In a situation where the gown is being used as part of standard precautions to protect HCP from a splash, the risk of re-using a non-visibly soiled cloth isolation gown may be lower. However, for care of patients with suspected or confirmed COVID-19, the risk of re-use of cloth isolation gowns without laundering among single HCP caring for multiple patients or among multiple HCP is unclear. Any gown that becomes visibly soiled during patient care should be disposed of and cleaned.

Prioritization of gowns

Gowns should be prioritized for the following activities:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:
    - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

Surgical gowns should be prioritized for surgical and other sterile procedures. Facilities may consider suspending use of gowns for endemic multidrug resistant organisms (MDROs), (e.g., MRSA, VRE, ESBL-producing organisms).

When No Gowns Are Available

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Use of gown alternatives that have not been evaluated as effective

In situation of severely limited or no available isolation gowns, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients as single use. However, none of these options can be considered PPE, since their capability to protect HCP is unknown. Preferable features include long sleeves and closures (snaps, buttons) that can be fastened and secured..

Disposable laboratory coats

- Reusable (washable) patient gownsReusable (washable) laboratory coats
  Disposable aprons
- Combinations of clothing: Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available:
  - Long sleeve aprons in combination with long sleeve patient gowns or laboratory coats
  - Open back gowns with long sleeve patient gowns or laboratory coats
  - Sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats

Reusable patient gowns and lab coats can be safely laundered according to routine procedures.

- Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles
- Systems are established to routinely inspect, maintain (e.g., mend a small hole in a gown, replace missing fastening ties) and replace reusable gowns when needed (e.g., when they are thin or ripped)

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Strategies for Optimizing the Supply of Facemasks

Audience: These considerations are intended for use by federal, state, and local public health officials, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of facemasks in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare settings can refer to COVID-19 preparedness plans to address other aspects of preparing to respond to novel coronavirus disease 2019 (COVID-19).

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of facemasks during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve facemask supplies along the continuum of care.

- **Conventional capacity**: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency capacity**: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of healthcare personnel (HCP). These practices may be used temporarily when facemask demands exceed resources.
- **Crisis capacity**: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of expected or known facemask shortages.

The following contingency and crisis strategies are based upon these assumptions:
1) facilities understand their facemask inventory and supply chain
2) facilities understand their facemask utilization rate
3) facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies.
4) facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not essential for patient care from entering their care area
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5) facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use facemasks according to product labeling and local, state, and federal requirements

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- FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures
- Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays

Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which a facemask is typically used by HCP

Remove facemasks for visitors in public areas

Healthcare facilities can consider removing all facemasks from public areas. Facemasks can be available to provide to symptomatic patients upon check in at entry points. All facemasks should be placed in a secure and monitored site. This is especially important in high-traffic areas like emergency departments.

Implement extended use of facemasks

Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- HCP must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene.
- HCP should leave the patient care area if they need to remove the facemask.

Restrict facemasks to use by HCP, rather than patients for source control.

Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which a facemask is typically used by HCP.

Use facemasks beyond the manufacturer-designated shelf life during patient care activities.

If there is no date available on the facemask label or packaging, facilities should contact the manufacturer. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials or visible tears), discard the product.

Implement limited re-use of facemasks.

Limited re-use of facemasks is the practice of using the same facemask by one HCP for multiple encounters with different patients but removing it after each encounter. As it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, care should be taken to ensure that HCP do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.

- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- Not all facemasks can be re-used.
    - Facemasks that fasten to the provider via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.

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    - Facemasks with elastic ear hooks may be more suitable for re-use.
- HCP should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

Prioritize facemasks for selected activities such as:

- For provision of essential surgeries and procedures
- During care activities where splashes and sprays are anticipated
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable
- For performing aerosol generating procedures, if respirators are no longer available

When No Facemasks Are Available, Options Include

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients

During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients

It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Consider use of expedient patient isolation rooms for risk reduction

Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a “clean” larger ventilated zone.

Consider use of ventilated headboards

NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters.

HCP use of homemade masks

In settings where facemasks are not available, HCP might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered

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PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

Use a faceshield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask

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Strategies for Optimizing the Supply of Eye Protection

Audience: These considerations are intended for use by federal, state, and local public health officials, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.

Purpose: This document offers a series of strategies or options to optimize supplies of eye protection in healthcare settings when there is limited supply. It does not address other aspects of pandemic planning; for those, healthcare settings can refer to COVID-19 preparedness plans to address other aspects of preparing to respond to novel coronavirus disease 2019 (COVID-19).

Surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of eye protection during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve eye protection supplies along the continuum of care.

- **Conventional capacity**: measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency capacity**: measures may change daily standard practices but may not have any significant impact on the care delivered to the patient or the safety of HCP. These practices may be used temporarily when eye protection demands exceed resources.
- **Crisis capacity**: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of expected or known eye protection shortages.

The following contingency and crisis strategies are based upon these assumptions:
1) facilities understand their eye protection inventory and supply chain
2) facilities understand their eye protection utilization rate
3) facilities are in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) regarding identification of additional supplies
4) facilities have already implemented other engineering and administrative control measures including:
    - Reducing the number of patients going to the hospital or outpatient settings
    - Excluding HCP not essential for patient care from entering their care area
    - Reducing face-to-face HCP encounters with patients
    - Excluding visitors to patients with confirmed or suspected COVID-19
    - Cohorting patients and HCP
    - Maximizing use of telemedicine
5) facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

Conventional Capacity Strategies

Use eye protection according to product labeling and local, state, and federal requirements

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Contingency Capacity Strategies

Selectively cancel elective and non-urgent procedures and appointments for which eye protection is typically used by HCP

Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields)

- Consider preferential use of powered air purifying respirators (PAPRs) or full-face elastomeric respirators which have built-in eye protection.
- Ensure appropriate cleaning and disinfection between users if goggles or reusable face shields are used.

Implement extended use of eye protection

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
    - If a disposable face shield is reprocessed, it should be **dedicated to one HCP** and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- HCP should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.
- HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing eye protection below.

Crisis Capacity Strategies

Cancel all elective and non-urgent procedures and appointments for which eye protection is typically used by HCP

Use eye protection devices beyond the manufacturer-designated shelf life during patient care activities

If there is no date available on the eye protection device label or packaging, facilities should contact the manufacturer. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials), discard the product.

Prioritize eye protection for selected activities such as:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures
- During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable

Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of the eyes

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Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients

- During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients

- It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Selected options for Reprocessing Eye Protection

Adhere to recommended manufacturer instructions for cleaning and disinfection

When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable faceshields, consider

1. While wearing gloves, carefully wipe the *inside, followed by the outside* of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
2. Carefully wipe the *outside* of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
3. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
4. Fully dry (air dry or use clean absorbent towels).
5. Remove gloves and perform hand hygiene.

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Self-Monitoring of Asymptomatic Healthcare Personnel (HCP)

Instructions: HCP should check their temperature and complete this form twice daily for 14 days after the date of the last exposure. If temperature is above or equal to 38.0°C/100.0°F, HCP report subjective fevers or any of the following symptoms, they should separate yourself from others and call their local or state public health authority or healthcare facility. They should ensure their temperature is below 38.0°C/100.0°F and that they don't have any of the following symptoms before they leave home and report to work.

Name			Employee ID #	Phone			Email		Job Title			Supervisor		Date of last exposure		
Day # After Exposure	Date	Time	Temp	Symptoms (check if you have any of the following)												
				Subjective Fever	Cough	Sore throat	Shortness of breath	Runny Nose	Chills	Muscle aches	Headache	Fatigue	Abdominal Pain	Nausea or Vomiting	Diarrhea	None	Other
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Evaluation of Asymptomatic Healthcare Personnel (HCP)

Instructions: HCP can start work if temperature is below 38.0°C/100.0°F, and no subjective fever or any of the following symptoms are reported.

Name	Employee ID #	Phone	Email	Job Title	Supervisor	Date of last exposure	Screening Personnel Name

Day # After Exposure	Date	Time	Temperature	Symptoms (check if you have any of the following)														Screening Personnel Name and Signature
				Subjective Fever	Cough	Sore throat	Shortness of breath	Runny Nose	Chills	Muscle aches	Headache	Fatigue	Abdominal Pain	Nausea or Vomiting	Diarrhea	None	Other	
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AMERICAN OVERSIGHT

Help Keep our Residents Safe from COVID-19

Dear Residents, Families, Friends, Volunteers,

[Nursing home A] is committed to keeping our residents safe and need your help. The virus causing Coronavirus Disease 2019 (abbreviated COVID-19) can cause outbreaks in nursing homes. Many nursing home residents are elderly or have medical conditions putting them at a very high risk of becoming sick, or even severely ill with COVID-19. Visitors and healthcare personnel (HCP) are the most likely sources of introduction of the virus that causes COVID-19 into a facility.

To protect our vulnerable residents, even before COVID-19 is seen in our community, we are immediately taking the following aggressive actions to reduce the risk of COVID-19 in our residents and staff:

1. **We are limiting visitation.**

We strongly encourage you to postpone your visit. We know that your presence is important for your loved one but, per guidance from the Centers for Disease Control and Prevention (CDC), this is a necessary action to protect their health. We are introducing alternative methods of visitation (such as skype, FaceTime, etc.) so that you can continue to communicate with your loved ones. As the situation with COVID-19 is rapidly changing, we might need to further limit visitation to those who are essential for the resident's emotional well-being and care or end of life situations. Anyone who does enter the building will be expected to frequently clean their hands and limit their visit to a designated area within the building. You may be asked to wear a mask while you are in the building.

Ill people should not visit. We will be performing screenings; visitors with any of the following will not be allowed into the building:

- Fever or symptoms of respiratory infection (e.g., cough, sore throat, or shortness of breath)
- International travel within the last 14 days to affected countries. For updated information on high-risk countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
- Contact with an individual with COVID-19.

2. **We are monitoring healthcare personnel and residents for symptoms of respiratory illness:**

We are asking non-essential personnel including volunteers and consultant personnel not to enter the building. Healthcare personnel will be monitored for fever and symptoms of respiratory infection. Ill healthcare personnel will be asked to stay home. You may see healthcare personnel wearing facemasks, eye protection, gown, and gloves in order to prevent germs from spreading and help keep residents safe. Healthcare personnel will clean their hands frequently.

We are assessing residents daily for fevers and symptoms of respiratory infection in order to quickly identify ill residents and implement additional infection prevention activities. When ill residents are identified, they will be monitored closely, asked to stay in their rooms or wear a mask.

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3. We are limiting activities within the facility:

We will be limiting group activities and community outings for residents in order to keep our residents and healthcare personnel safe. If there is COVID-19 in the community or in the facility, we will need to completely cancel activities, further restrict visitation, and deliver meals resident rooms.

We encourage you to review the CDC website for information about COVID-19, including its symptoms, how it spreads, and actions you can take to protect your health: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Thank you very much for everything you are doing to keep our residents and facility staff safe and healthy. We continue to monitor the situation in our community; we will keep you informed about any new precautions we think are necessary to keep your loved one safe. Please contact us with additional questions at **[facility contact info]**.

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Sincerely,

[NURSING HOME A]

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Line List for COVID-19 Outbreaks in Long Term Care Facilities

Please list all residents ill with COVID respiratory symptoms.

Name	DOB	Unit Or Room	Onset Date	Cough (Y/N)	Fever Y/N)	Measured (degrees F)	Shortness of Breath (Y/N)	SARS CoV-2 test result (+/-)	Respiratory Panel Test Result (+/-)	Hospitalized (Y/N)	Died (Y/N)	Notes

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Guidelines for cleaning and disinfection for SARS_CoV_2

- Dedicated medical equipment should be used for patient care.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Use EPA-approved disinfection products listed on this website: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE) for use.
- Clean the surface first, and then apply the disinfectant as instructed on the disinfectant manufacturer's label. Ensure adequate contact time for effective disinfection.
- Adhere to any safety precautions or other label recommendations as directed (e.g., allowing adequate ventilation in confined areas, proper disposal of unused product or used containers and donning appropriate PPE).
- After cleaning and removal and disposal of gloves, staff should perform hand hygiene by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol. Soap and water should be used if the hands are visibly soiled.

Best practices for long-term care facilities:

- Avoid using product application methods that cause splashing or generate aerosols.
- Cleaning activities should be supervised and inspected periodically to ensure correct procedures are followed.
- Review cleaning and disinfection products and protocols with floor staff and housekeeping
    - Ensure they understand the necessary contact time
    - Differences between porous and non-porous surfaces
- Room cleaning
    - Daily cleaning
    - High touch surfaces every shift (door handles, bedside tables, bed rails, TV remote, call button, light switches
- Facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient.
- Shared equipment: clean and disinfect after every resident use
- Dedicated equipment: clean and disinfect prior to storage

Resources:

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- This document contains those disinfectants already registered with EPA for coronavirus effectiveness, at the link here https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 .
- Overall IPC guidance for COVID-19 can be found on CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment].

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PPE Strategies for LTCFs during Cluster of COVID-19 Infections:

When there are cases if the facility:

- Universal masking of HCP while in the facility
  - Consider changing every 2 hours or if it become visibly soiled or wet (see further guidance below for extended use).
- Consider using all recommend PPE (mask/respirator, eye protection, gowns, gloves) for the care of any resident if available.

For any contact with residents with respiratory infections, healthcare personnel (HCP) MUST wear all of the following if gowns are not readily available:

- Respirator (or Facemask if Respirator is not available or HCP are not fit-tested)
  - A respirator must be used if performing an aerosol-generating procedure (e.g., nebulizer therapy)
- Eye protection (Goggles or Face shield); Any eye protection that is not immediately discarded after use must be dedicated to each provider
- Gloves

Gowns MUST be added in the following situations:

- Performing an aerosol-generating procedure (e.g., nebulizer therapy);
- During care activities where splashes and sprays are anticipated;
- During the following high-contact resident care activities:
  - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

The following PPE must NEVER be used for more than one resident:

- Gloves
- Gown

Using the same respirator (or facemask if used) and eye protection is permitted for repeated close contact encounters with several residents, without removing between resident encounters (Extended Use).

- This should only be done between roommate pairs or residents in different rooms who are symptomatic
  - In units where illness is wide-spread, HCP could continue use of same respirator (or facemask if used) and eye protection for 2 hours before changing
- **HCP should avoid touching their face protection**.
- Hand hygiene must be performed after the HCP touches their face protection at any point.

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- The respirator (or facemask if used) MUST be discarded and the eye protection must be replaced (can be reused after cleaning and disinfection) in the following scenarios:
    - If damp, damaged, or hard to breathe through.
    - If used during aerosol generating procedures.
    - If contaminated with blood, respiratory or nasal secretions, or other bodily fluids from residents.
- The face shield MUST be discarded if it becomes damaged such that it can no longer fasten securely to the provider or become even slightly difficult to see through.

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Rapid Telephone Assessment and Recommendations for Facilities during COVID-19 Outbreak

The purpose of this document is to provide guidance on infection prevention and control information to obtain from facilities and recommendations in the setting of a COVID-19 outbreak.

Facility name: _____

Facility type: _____

Date of contact: _____

Facility demographics –

1. Who oversees infection prevention at your facility?

2. How would you describe your facility? What kind of care is provided at your facility?

3. What is your current census and breakdown by different units?

4. Have you made any changes at your facility in response to the coronavirus outbreak? If so, what are those

5. Are you restricting visitors at your facility? If so, are there any exceptions? How are your preventing visitors from entering the facility?

   (If they are not doing this, would recommend that they restrict all visitors except for end of life visitation; this has been mandated by the governor)

6. Are you performing screening of all employees before they report to work?

   (Ideally, this would occur at the entrance to the facility, before they begin their shift. Includes temperature check and check for symptoms like subjective fever, cough, difficulty breathing. If

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they have a fever of 100.0F or higher or symptoms, they should be asked to leave work and consider seeing a healthcare provider.)

7. Are group activities still occurring at your facility (e.g., communal meals, mass/church, art or gym classes, etc.)?

   (ideally, this should be discontinued if there are cases in the community or any cases within the facility)

8. Are the residents/patients at your facility screened regularly? What type of screening are you doing?

   (Ideally, the facility should be screening their patients/residents at least once a day, but preferably 2+ times daily. This should include either measuring temperatures or report of subjective fever and any symptoms like difficulty breathing, shortness of breath, and cough. If they have a fever (temperature of 100.0F or higher) or symptoms, they should be evaluated by a medical professional and can consider testing for coronavirus.)

There are three main components to infection prevention and control that I would like to talk about today. The three big things that we know prevents the spread of infections in facilities is good hand hygiene, appropriate use of personal protective equipment, and good environmental cleaning. The first one we will talk about is hand hygiene.

Hand Hygiene

1. Can you tell me about your hand hygiene (HH) policy at your facility?

2. Is there a preference for soap and water or alcohol-based hand rub (ABHR)?

3. Do you have a program in place where you audit HH? If so, what are your rates for HH?

4. How is your supply of soap/alcohol-based hand rub?

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(Consider discussing that ABHR is generally better at cleaning healthcare workers' hands and that staff generally do not wash their hands appropriately. ABHR should be prioritized for coronavirus these reasons and would be the preferred way to clean hands for this outbreak. There are concerns that surveyors may be requiring some facilities to use soap and water with every third application of ABHR, but you could consider telling them that this should not prevent them from using ABHR in this setting.)

Next we can move into personal protection equipment or PPE use.

1. What type of training do your employees get for PPE use and how frequently?

   (If it is only at the time or hire or annually, consider recommending an in-service with staff to ensure they are competent is appropriate PPE use)

2. Is PPE use audited? For example, does anyone watch how PPE is used as people enter and leave a room? If so, do you have any issues with PPE use?

3. How is your supply of PPE?
   a. Surgical masks
   b. Respirators
   c. Gowns
   d. Gloves
   e. Eye protection

4. Where do your employees take off PPE?

   (ideally as they exit the room, by the door)
5. Do you have signs (or signage) to indicate what type of precautions a patient is on or what PPE is needed to enter a room?

   (Many LTC facilities will have a sign that says see nurse. This is done to try and protect personal healthcare information, but it doesn't tell staff what they need to wear. You can recommend using a transmission based precaution sign such as https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html#anchor_1564058318)

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6. What precautions are being used for your patients that may be suspect or confirmed cases?

   (Should be gowns, gloves, N95/respirator or surgical mask if running low, and eye protection)
7. How do you communicate isolation status or needs at the time of patient transfer to another facility?

   (Often this is a verbal report to the receiving nurse or facility)

If you are having issues with your supply of PPE or ABHR, consider reaching out to the DRC's for supplies and coordination – they can be reached ***how***

Finally, we will talk about environmental cleaning. Making sure the environment is cleaned well is one of the best ways to prevent spread of infections to other patients.

8. What type of cleaning product is used at your facility?

   (If you are talking to the IP head [like the DON/ADON] they probably won't be able to answer this. If they cannot, that's not unusual. You can share List N from the FDA which includes all products that are authorized for use for coronavirus in healthcare settings: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2)

9. Do you know the contact time for that product?

   (Contact time is how long the product needs to sit on a surface for it to kill/inactivate bacteria and viruses. This ranges from 1 minute to 10 minutes depending on the product. It's imperative that the facility know what the contact time is for their products and ensuring that environmental services knows exactly how long to keep surfaces wet. Many times that means reapplying a product before it dries until it reaches that contact time – reinforce this).
10. Who cleans common or shared equipment like nurse-on-a-stick/blood pressure machine or thermometers?

11. What product is used for that? (Again, reinforcing contact time)

    (These should be cleaned after every patient use. The facility should also dedicate whatever equipment is possible to a suspect or case-patient like thermometers or stethoscopes)

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That is all of my questions. Any questions that you have for me?

Next we can recap the recommendations for your facility:

1.
2.
3.
4.
5.

Any last questions or thoughts?

You can reach us at *** if you have further questions or to follow-up on some of this information. We will also be sending you an e-mail; could you provide me with a good e-mail address to send this to?

_____

-Wrap up and thanks!

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From:	Pritchard, Scott
To:	ftu2@cdc.gov; Drennon, Michael T; Henry, Charles H; Blackmore, Carina; CDC IMS 2019 NCOV Response Epi TF Case Tracking Team; Bowen, Virginia B. (CDC/DDID/NCHHSTP/DSTDP); Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Wen, John (CDC/DDPHSIS/CGH/DGHT)
Subject:	FL Health Care Contact Investigation Call

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From:	Pritchard, Scott
To:	ftu2@cdc.gov; Drennon, Michael T; Henry, Charles H; Blackmore, Carina; CDC IMS 2019 NCOV Response Epi TF Case Tracking Team
Subject:	FL Health Care Contact Investigation Call

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alachua County Emergency Management; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Halbritter, Julia; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McInnis, Sarah; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Morrison, Andrea; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stanek, Danielle R; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sumner, Samuel M; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Subject: Florida Arbovirus Surveillance Week 10: March 1-7, 2020

Date: Monday, March 9, 2020 5:36:54 PM

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Florida Arbovirus Surveillance
Week 10: March 1-7, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 1-7, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. No sentinel chickens tested positive for antibodies to WNV this week. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Three sentinel chickens tested positive for antibodies to EEEV this week in Orange and Volusia counties. In 2020, 10 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: No cases of dengue fever were reported this week in persons that had international travel. In 2020, seventeen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: One case of locally acquired dengue fever was reported this week in Monroe County. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

Vector-Borne Disease Surveillance Coordinator
Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Epidemiology
4052 Bald Cypress Way, Bin # A12
Tallahassee, Florida 32399-1710
(phone): 850-901-6887
(cell): 850-509-3630
(confidential fax): 850-414-6894
(email): Andrea.Morrison@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 10: March 1-7, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 1-7, 2020, the following arboviral activity was recorded in Florida.

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EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Three sentinel chickens tested positive for antibodies to EEEV this week in Orange and Volusia counties. In 2020, 10 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

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International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Seventeen cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Brevard, Broward (5), Franklin, Hillsborough (3), Miami-Dade (5), Seminole, and St. Lucie. Two cases were reported in non-Florida residents. In 2020, sixteen cases of dengue reported in Florida have been serotyped by PCR. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-2	DENV-3	DENV-4	DENV-1/ DENV-3	Unknown	Total
Jamaica			3		1		4
Colombia	2						2
Cuba	1	1					2
Dominican Republic	2						2
Bahamas	1						1
Bolivia	1						1
Brazil		1					1
Nicaragua		1					1
Paraguay				1			1
Puerto Rico/US Virgin Islands	1						1
US Virgin Islands						1	1
Total	**8**	**3**	**3**	**1**	**1**	**1**	**17**

Dengue Fever Cases Acquired in Florida: In 2020, one case of locally acquired dengue fever has been reported in Monroe County, with onset in February. The case was reported in a non-Florida resident.

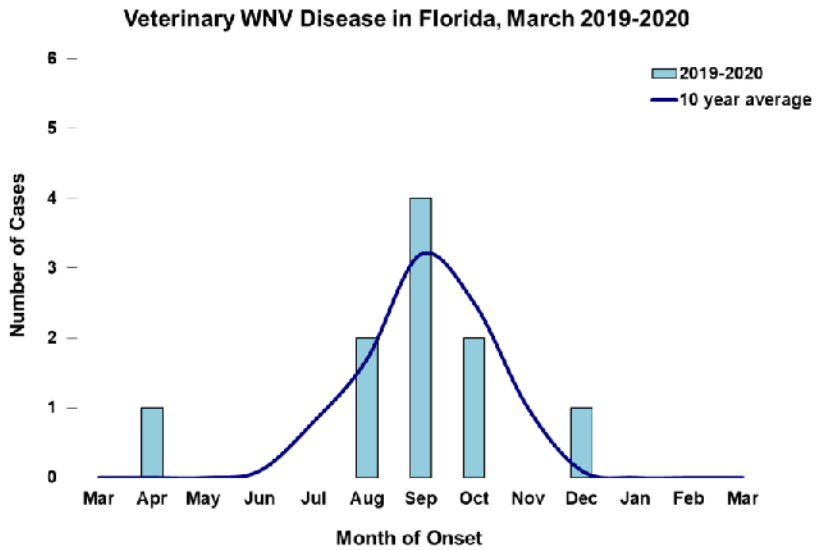
International Travel-Associated Malaria Cases: Four cases of malaria with onset in 2020 have been reported. Countries of origin were: Cameroon, Dominican Republic, Nicaragua, and Nigeria. Counties reporting cases were: Miami-Dade (2), Orange, and Polk. One case was reported in a non-Florida resident.

Three cases (75%) were diagnosed with *Plasmodium falciparum*. One case (25%) was diagnosed with *Plasmodium vivax*.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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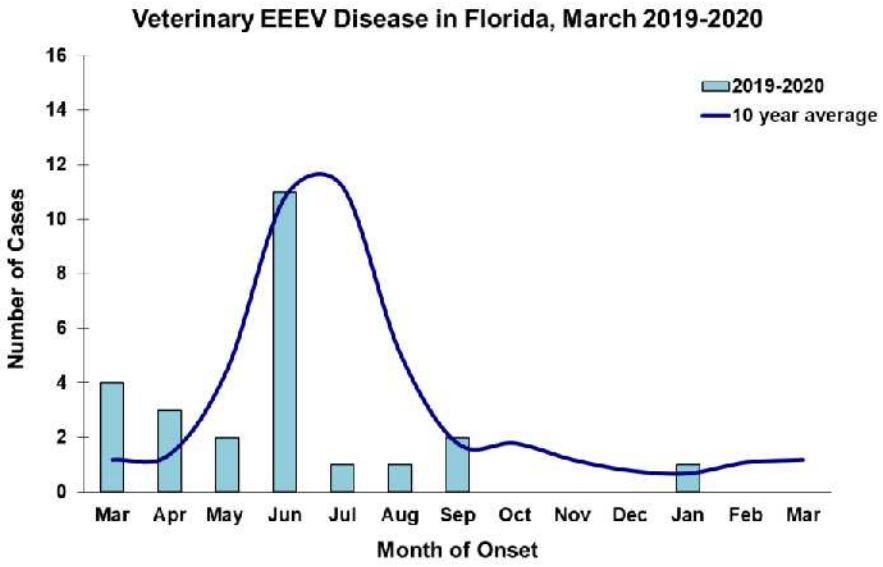
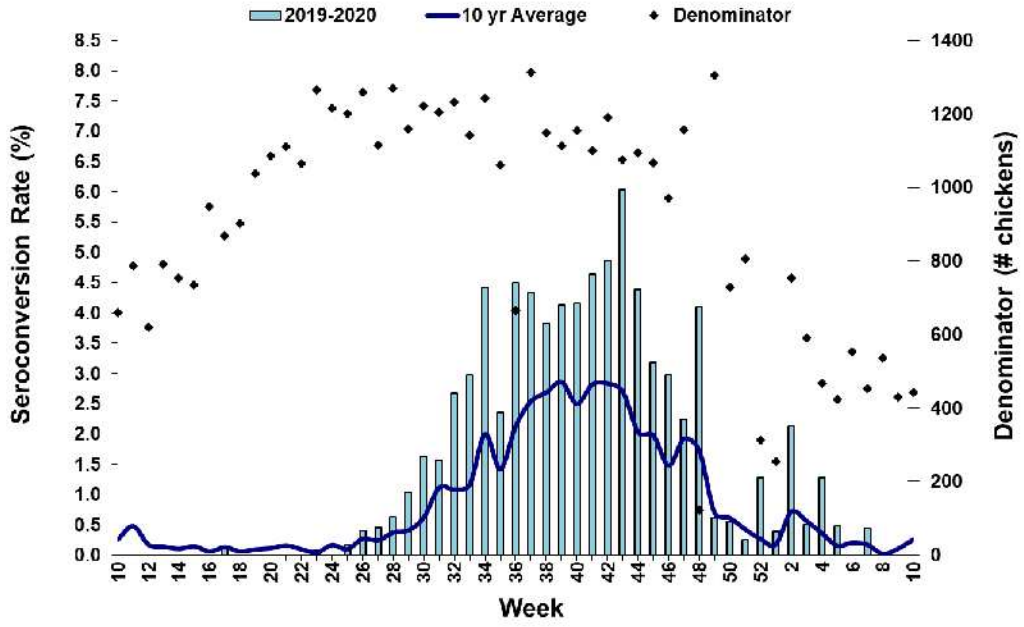


Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Three sentinel chickens tested positive for antibodies to EEEV this week in Orange and Volusia counties

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Orange	2/24/20				3.13	3.13		2 EEEV	3 WNV, 7 EEEV
Volusia	2/24/20				2.08	2.08		1 EEEV	1 EEEV



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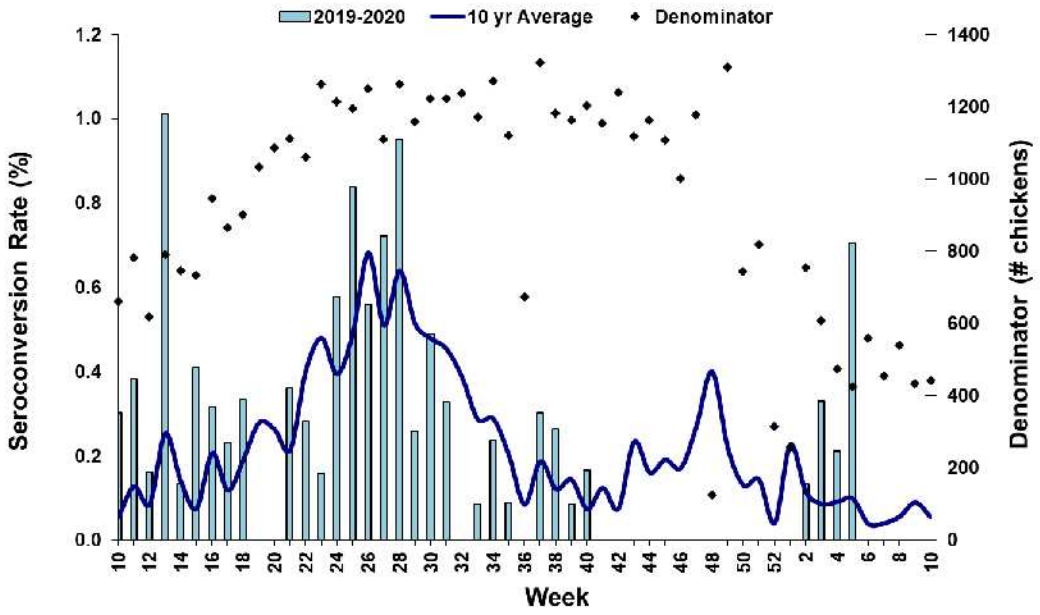
Sentinel Seroconversions to EEEV in Florida, 2019-2020



Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, six reports representing a total of 36 dead birds, including one crow, one raptor, and six doves, were received from six counties.

In 2020, 78 reports representing a total of 218 dead birds (17 crows, 1 jay, 18 raptors, 6 doves) were received from 27 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Duval	15	1	0	0	0
Lake	1	0	0	1	0
Lee	6	0	0	0	0
Miami-Dade	15	0	0	0	6
Palm Beach	2	0	0	0	0
Sarasota	1	0	0	0	0

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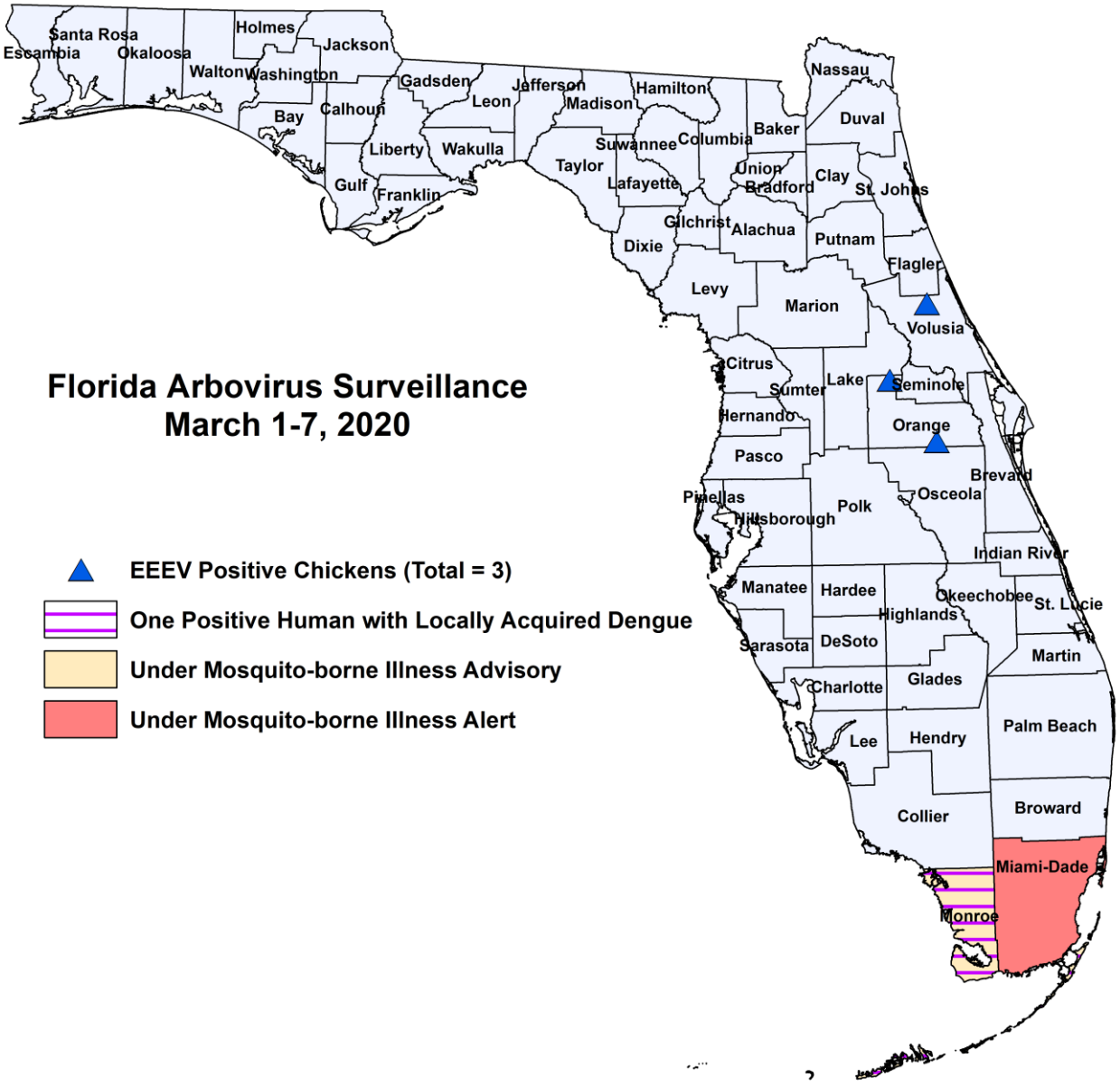
Maps



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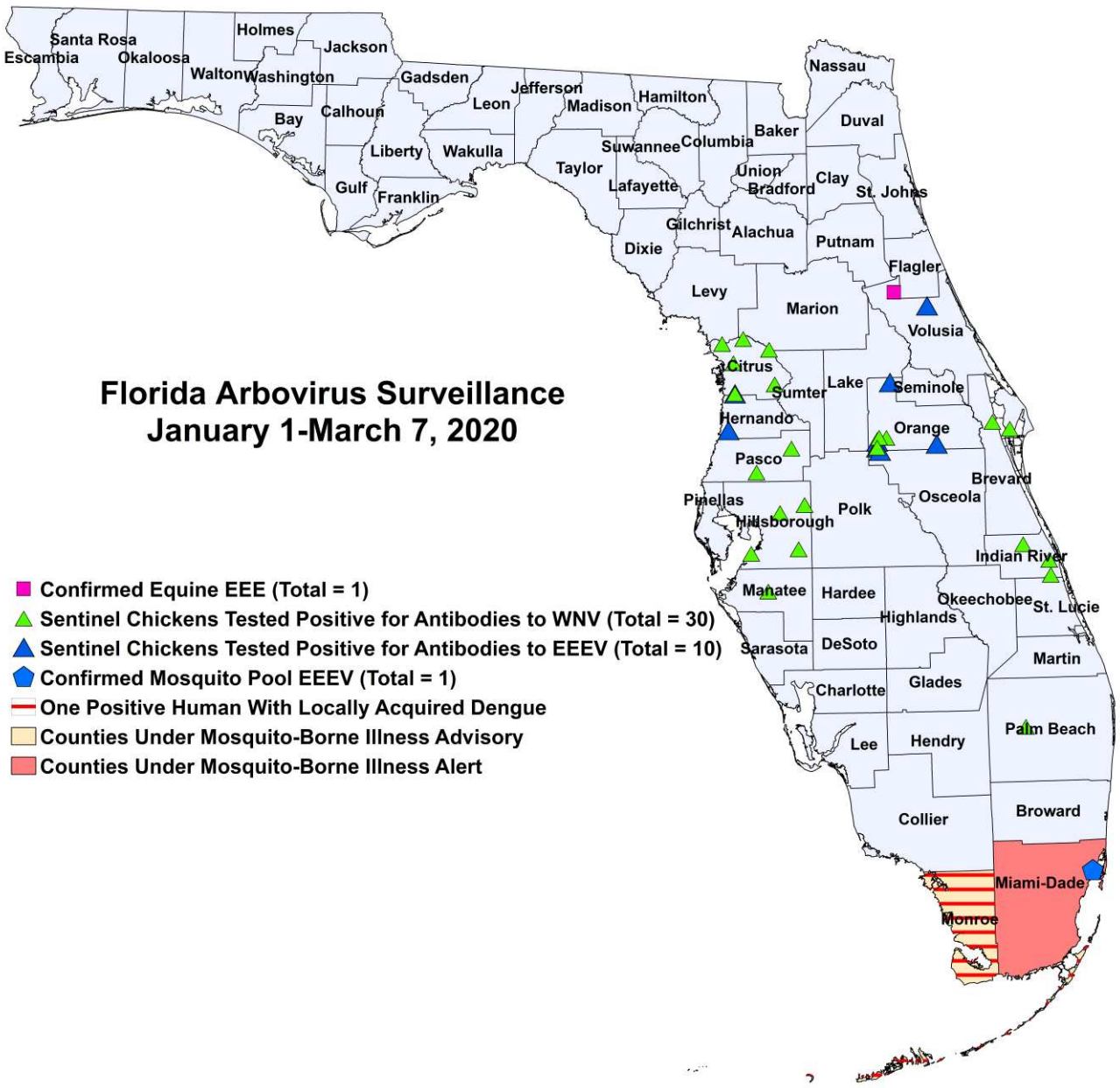

2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Brevard	WNV: 2 sentinels (1/23, 1/24)
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 1 sentinel (1/8)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 8 sentinels (1/6, 1/21, 1/29, 2/11)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Monroe	Dengue: 1 human (February)
Orange	WNV: 3 sentinels (1/6) EEEV: 7 sentinels (1/13, 1/27, 1/28, 2/24)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24), 1 sentinel (2/24)

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Acknowledgements and Data Sources

Contributors: Andrea Morrison, PhD, MSPH, Devin Rowe, MS, Catherine McDermott, MPH, MHS, and Danielle Stanek, DVM, DOH Bureau of Epidemiology; Lea Heberlein-Larson, DrPH; Alexis LaCrue, PhD, MS; Maribel Castaneda, and Valerie Mock, BS; DOH Bureau of Public Health Laboratories; Carina Blackmore, DVM, PhD, DOH Division of Disease Control and Health Protection.

For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

Case tallies included in the weekly Florida arbovirus surveillance report include confirmed and probable cases for EEE, WNV infection, SLE, dengue, chikungunya, and malaria by date of onset. Suspect cases are not included. Activity is mapped by county of exposure rather than county of residence. Case definitions being used in Florida are consistent with national criteria provided by the Council of State and Territorial Epidemiologists (CSTE) and may be viewed at: www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html. Case tallies reported by CDC do not include suspect cases and cases are reported by patient state of residence rather than where the exposure occurred. Data is provided by county health departments, Department of Health Bureau of Public Health Laboratories, Department of Agriculture and Consumer Services, mosquito control agencies, Florida Fish and Wildlife Conservation Commission, medical providers and veterinarians. Equine cases are provided by the Department of Agriculture and Consumer Services.

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alachua County Emergency Management; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Ford, Jace; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Halbritter, Julia; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Morrison, Andrea; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stanek, Danielle R; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Subject: Florida Arbovirus Surveillance Week 11: March 8-14, 2020

Date: Monday, March 16, 2020 5:47:59 PM

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Florida Arbovirus Surveillance
Week 11: March 8-14, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 8-14, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. No sentinel chickens tested positive for antibodies to WNV this week. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Two sentinel chickens tested positive for antibodies to EEEV this week in Citrus and Orange counties. In 2020, 12 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, 18 travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 11: March 8-14, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 8-14, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. No sentinel chickens tested positive for antibodies to WNV this week. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Two sentinel chickens tested positive for antibodies to EEEV this week in Citrus and Orange counties. In 2020, 12 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, 18 travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Eighteen cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Brevard, Broward (5), Duval, Franklin, Hillsborough (3), Miami-Dade (5), Seminole, and St. Lucie. Two cases were reported in non-Florida residents. In 2020, sixteen cases of dengue reported in Florida have been serotyped by PCR. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-2	DENV-3	DENV-4	DENV-1/ DENV-3	Unknown	Total
Jamaica			3		1		4
Colombia	2						2
Cuba	1	1					2
Dominican Republic	2						2
Bahamas	1						1
Bolivia	1						1
Brazil		1					1
Mexico						1	1
Nicaragua		1					1
Paraguay				1			1
Puerto Rico/US Virgin Islands	1						1
US Virgin Islands						1	1
Total	**8**	**3**	**3**	**1**	**1**	**2**	**18**

Dengue Fever Cases Acquired in Florida: In 2020, one case of locally acquired dengue fever has been reported in Monroe County, with onset in February. The case was reported in a non-Florida resident.

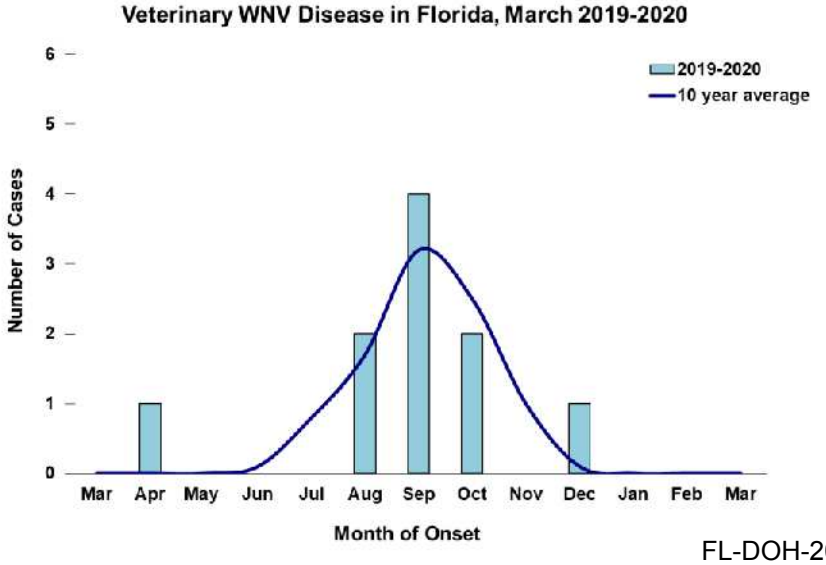
International Travel-Associated Malaria Cases: Five cases of malaria with onset in 2020 have been reported. Countries of origin were: Cameroon, Dominican Republic, Nicaragua, Nigeria, and Uganda. Counties reporting cases were: Miami-Dade (2), Orange, Palm Beach, and Polk. One case was reported in a non-Florida resident.

Four cases (80%) were diagnosed with *Plasmodium falciparum*. One case (20%) was diagnosed with *Plasmodium vivax*.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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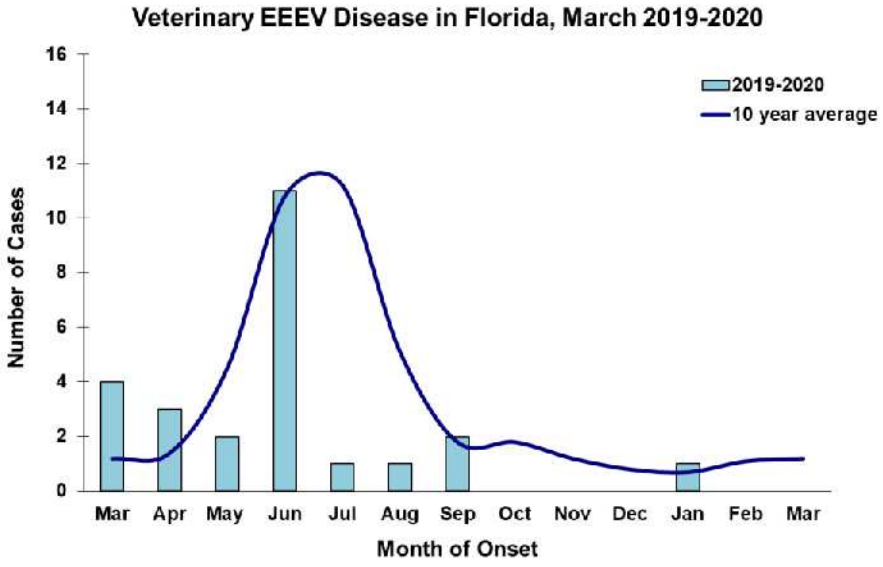
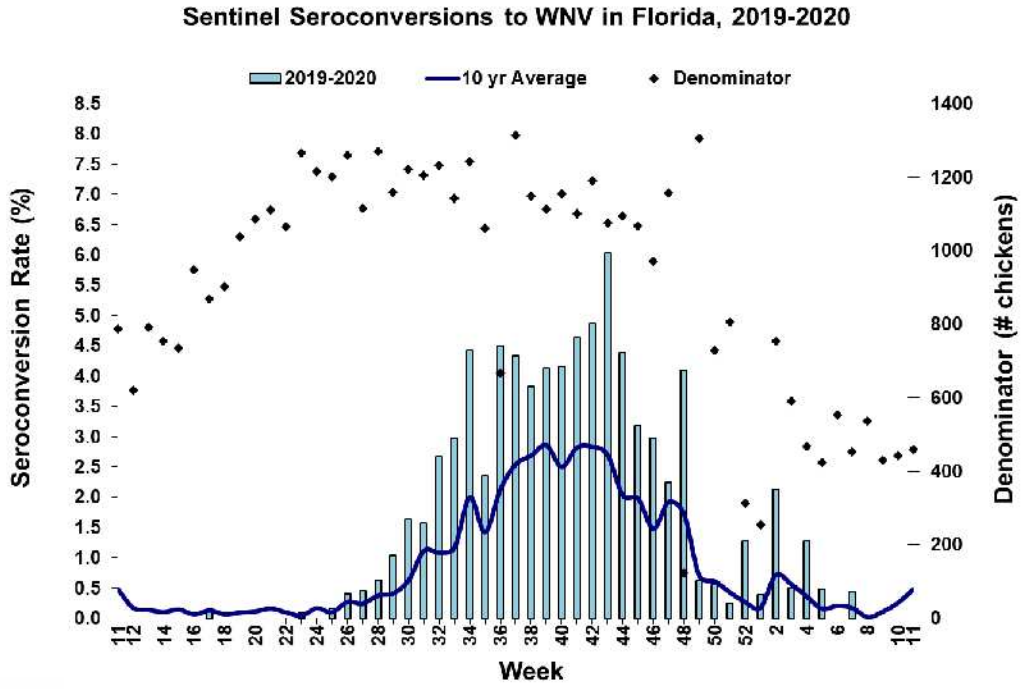


Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Two sentinel chickens tested positive for antibodies to EEEV this week in Citrus and Orange counties.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Citrus	3/2/2020				1.28	1.28		1 EEEV	8 WNV, 2 EEEV
Orange	3/2/2020				1.59	1.59		1 EEEV	3 WNV, 8 EEEV



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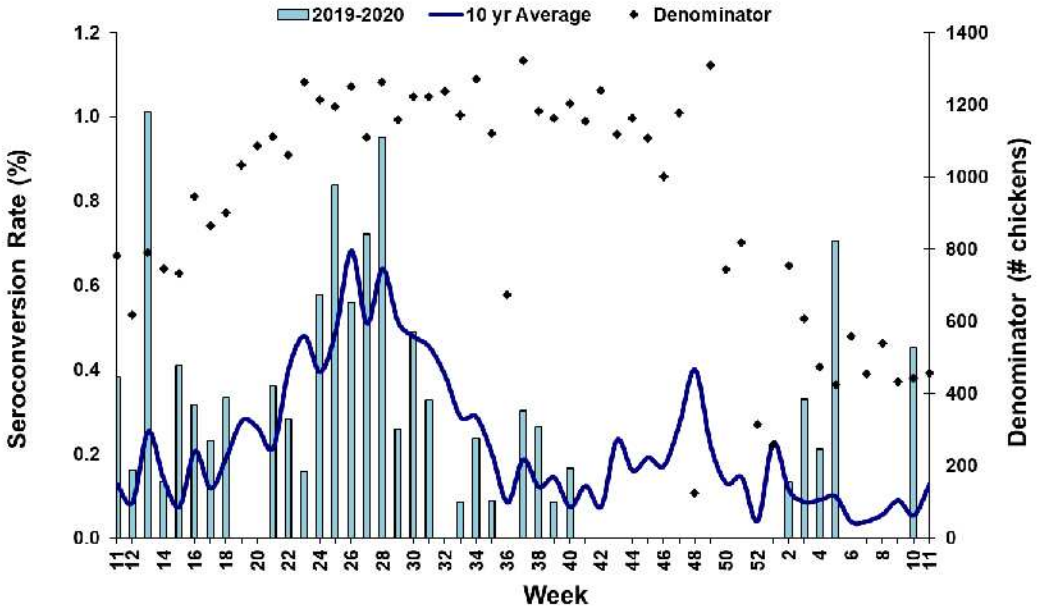
Sentinel Seroconversions to EEEV in Florida, 2019-2020



Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, 13 reports representing a total of 37 dead birds, including one crow, one raptor, and one dove, were received from nine counties.

In 2020, 91 reports representing a total of 255 dead birds (18 crows, 1 jay, 19 raptors, 7 doves) were received from 27 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Brevard	1	0	0	0	0
Collier	1	0	0	0	0
Duval	15	0	0	0	0
Lee	4	0	0	1	0
Okaloosa	1	0	0	0	0
Pinellas	2	0	0	0	0
Polk	7	1	0	0	1
Sarasota	1	0	0	0	0
Volusia	5	0	0	0	0

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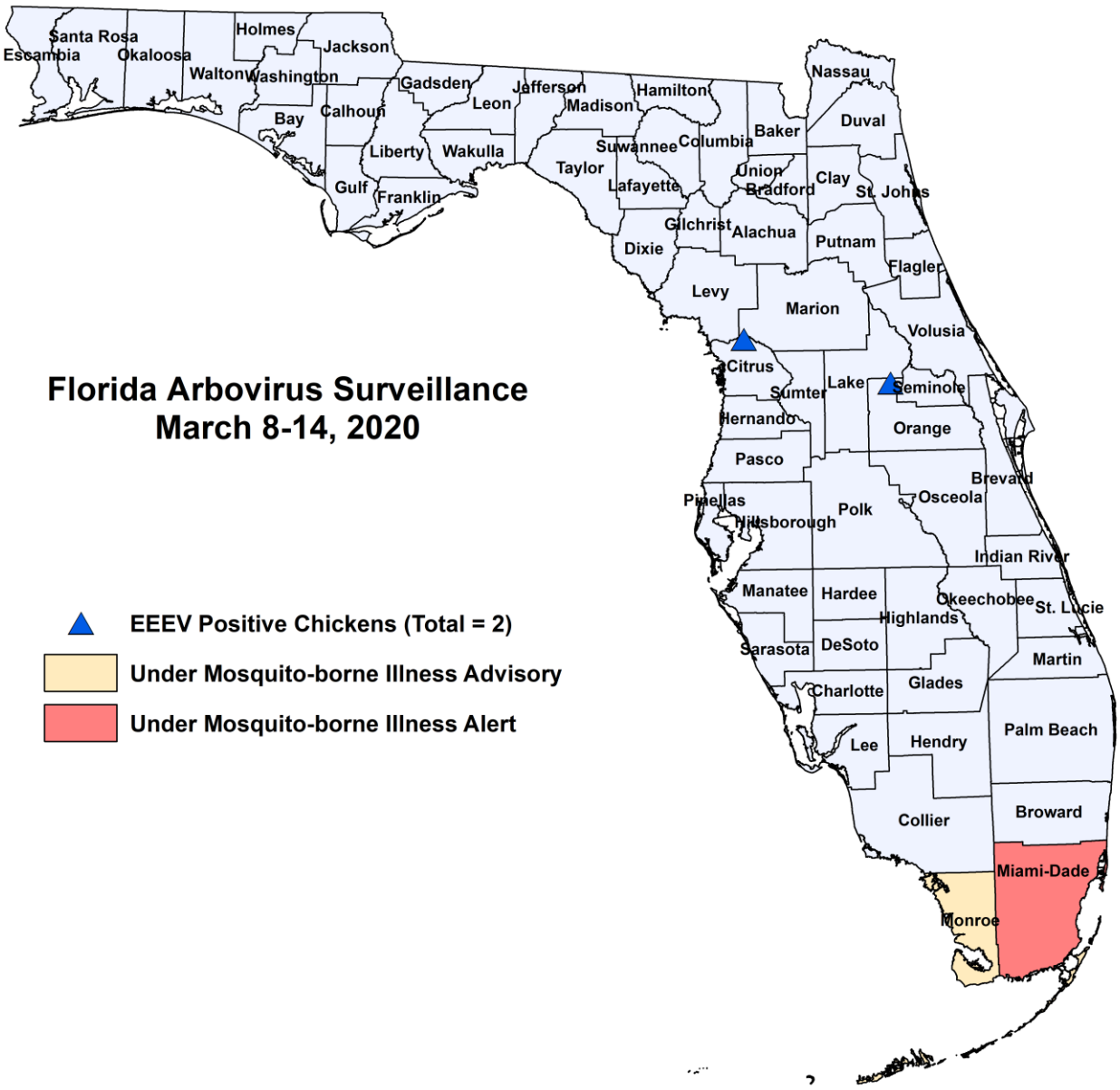
Maps



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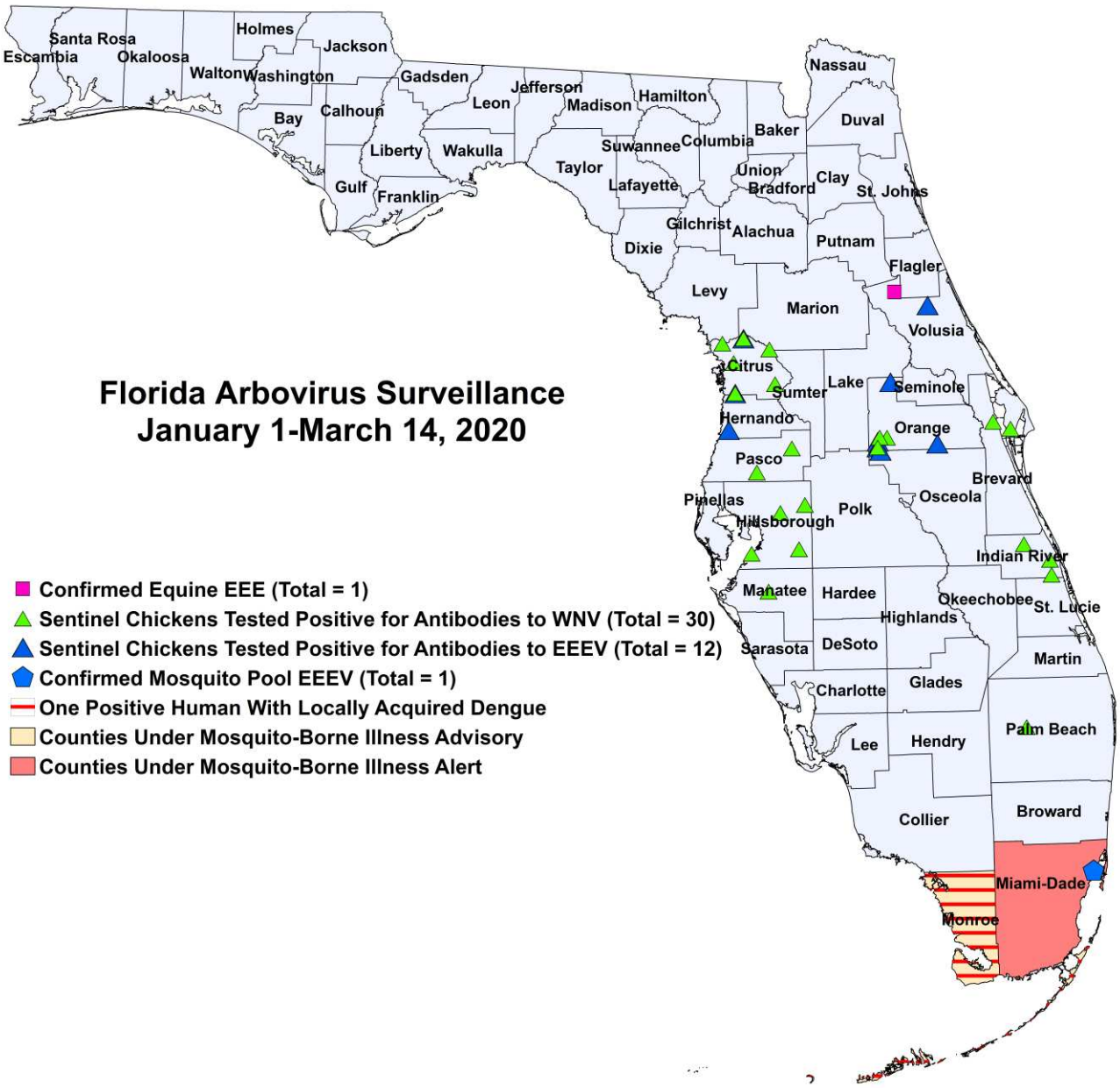

2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Brevard	WNV: 2 sentinels (1/23, 1/24)
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 2 sentinels (1/8, 3/2)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 8 sentinels (1/6, 1/21, 1/29, 2/11)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Monroe	Dengue: 1 human (February)
Orange	WNV: 3 sentinels (1/6) EEEV: 8 sentinels (1/13, 1/27, 1/28, 2/24, 3/2)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24), 1 sentinel (2/24)

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Acknowledgements and Data Sources

Contributors: Andrea Morrison, PhD, MSPH, Devin Rowe, MS, Catherine McDermott, MPH, MHS, and Danielle Stanek, DVM, DOH Bureau of Epidemiology; Lea Heberlein-Larson, DrPH; Alexis LaCrue, PhD, MS; Maribel Castaneda, and Valerie Mock, BS; DOH Bureau of Public Health Laboratories; Carina Blackmore, DVM, PhD, DOH Division of Disease Control and Health Protection.

For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

Case tallies included in the weekly Florida arbovirus surveillance report include confirmed and probable cases for EEE, WNV infection, SLE, dengue, chikungunya, and malaria by date of onset. Suspect cases are not included. Activity is mapped by county of exposure rather than county of residence. Case definitions being used in Florida are consistent with national criteria provided by the Council of State and Territorial Epidemiologists (CSTE) and may be viewed at: www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html. Case tallies reported by CDC do not include suspect cases and cases are reported by patient state of residence rather than where the exposure occurred. Data is provided by county health departments, Department of Health Bureau of Public Health Laboratories, Department of Agriculture and Consumer Services, mosquito control agencies, Florida Fish and Wildlife Conservation Commission, medical providers and veterinarians. Equine cases are provided by the Department of Agriculture and Consumer Services.

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From: Stanek, Danielle R

To: Morrison, Andrea; Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alachua County Emergency Management; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Ford, Jace; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Halbritter, Julia; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Cc: Morrison, Andrea; Rowe, Devin R

Subject: Florida Arbovirus Surveillance Week 12: March 15-21, 2020

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Florida Arbovirus Surveillance

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Week 12: March 15-21, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of March 15-21, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week Four sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 34 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, 12 sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, 19 travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

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There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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(email): Andrea.Morrison@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 12: March 15-21, 2020

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International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, 19 travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, one case of locally acquired dengue fever has been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Monroe County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Nineteen cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Brevard, Broward (5), Collier, Duval, Franklin, Hillsborough (3), Miami-Dade (5), Seminole, and St. Lucie. Three cases were reported in non-Florida residents. In 2020, sixteen cases of dengue reported in Florida have been serotyped by PCR. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-2	DENV-3	DENV-4	DENV-1/ DENV-3	Unknown	Total
Jamaica			3		1		4
Colombia	2						2
Cuba	1	1					2
Dominican Republic	2						2
Bahamas	1						1
Bolivia	1						1
Brazil		1					1
Mexico						1	1
Nicaragua		1					1
Paraguay				1			1
Puerto Rico						1	1
Puerto Rico/US Virgin Islands	1						1
US Virgin Islands						1	1
Total	**8**	**3**	**3**	**1**	**1**	**3**	**19**

Dengue Fever Cases Acquired in Florida: In 2020, one case of locally acquired dengue fever has been reported in Monroe County, with onset in February. The case was reported in a non-Florida resident.

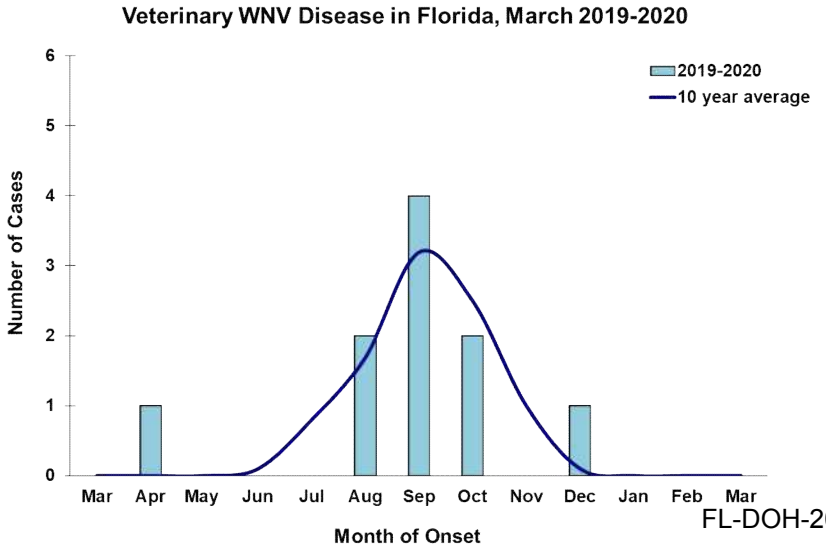
International Travel-Associated Malaria Cases: Five cases of malaria with onset in 2020 have been reported. Countries of origin were: Cameroon, Dominican Republic, Nicaragua, Nigeria, and Uganda. Counties reporting cases were: Miami-Dade (2), Orange, Palm Beach, and Polk. One case was reported in a non-Florida resident.

Four cases (80%) were diagnosed with *Plasmodium falciparum.* One case (20%) was diagnosed with *Plasmodium vivax*.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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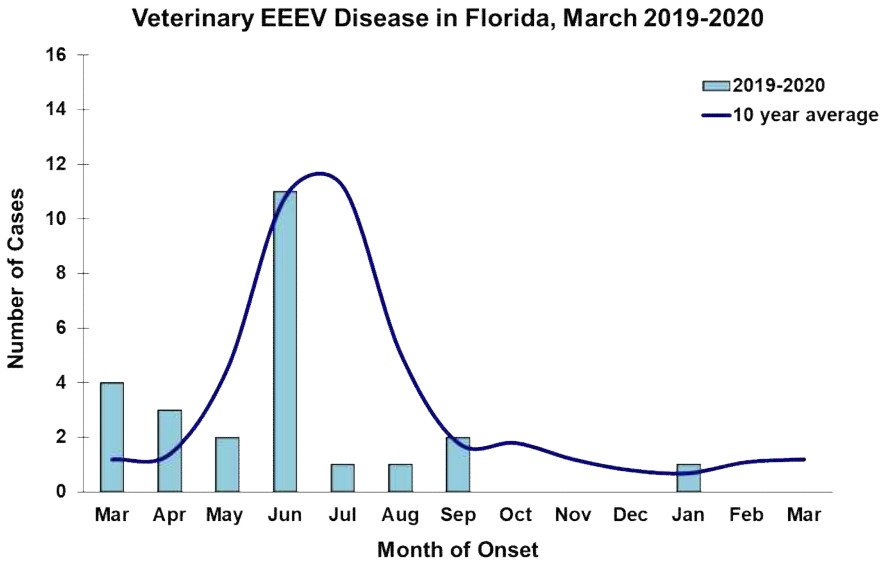


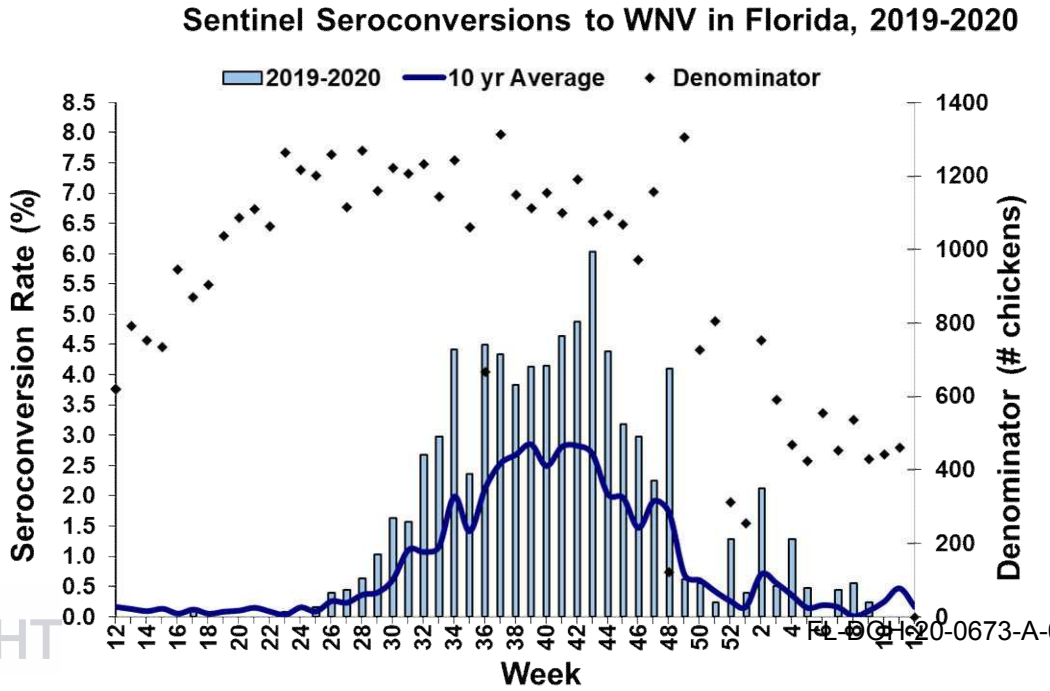
Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Four sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County.

Due to increased testing needs in response to COVID-19, the Florida Department of Health is temporarily suspending testing of sentinel chickens. After this week, there will be no sentinel chicken test results posted until testing is reinstituted.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Hillsborough	2/18/2020	6.25		6.25				3 WNV	12 WNV
	2/25/2020	2.33		2.33				1 WNV	



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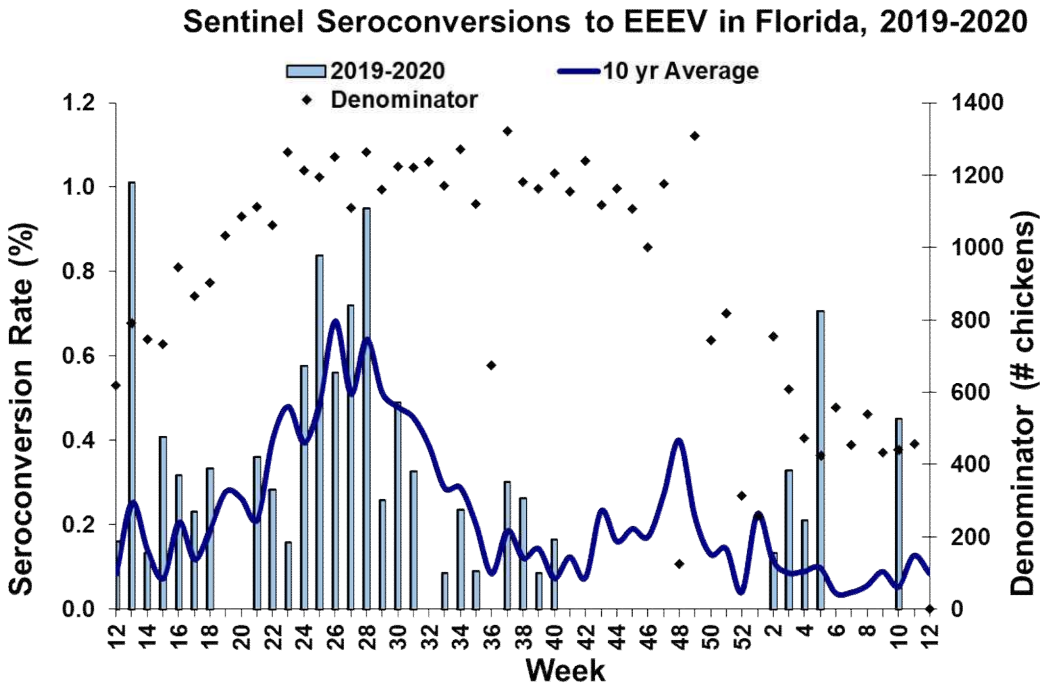

Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, seven reports representing a total of 17 dead birds, including three raptors, were received from seven counties.

In 2020, 98 reports representing a total of 272 dead birds (18 crows, 1 jay, 22 raptors, 7 doves) were received from 31 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Alachua	2	0	0	0	0
Bay	1	0	0	0	0
Dade	1	0	0	1	0
Levy	10	0	0	0	0
Manatee	1	0	0	1	0
Pinellas	1	0	0	0	0
Walton	1	0	0	1	0

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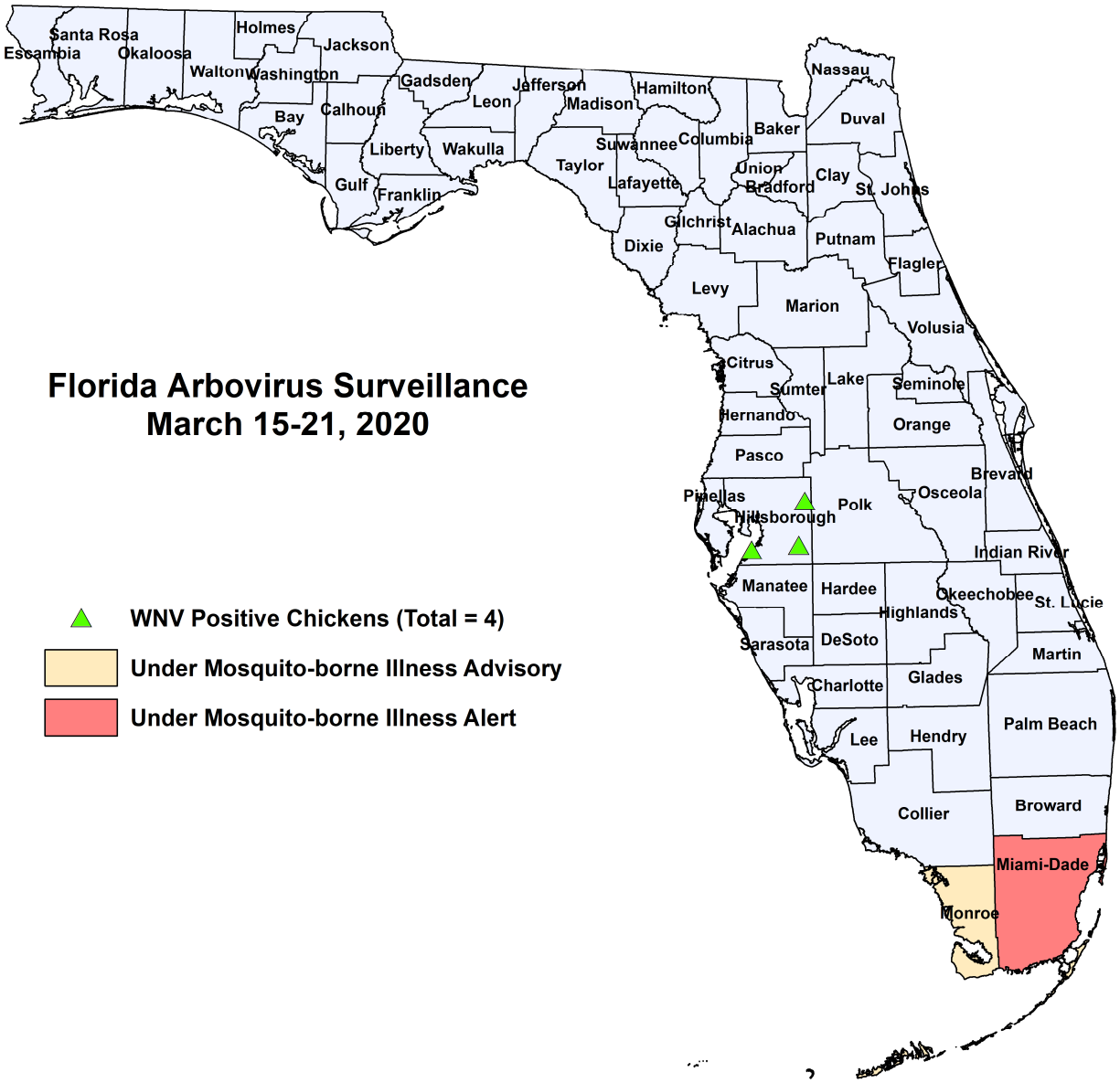
Maps



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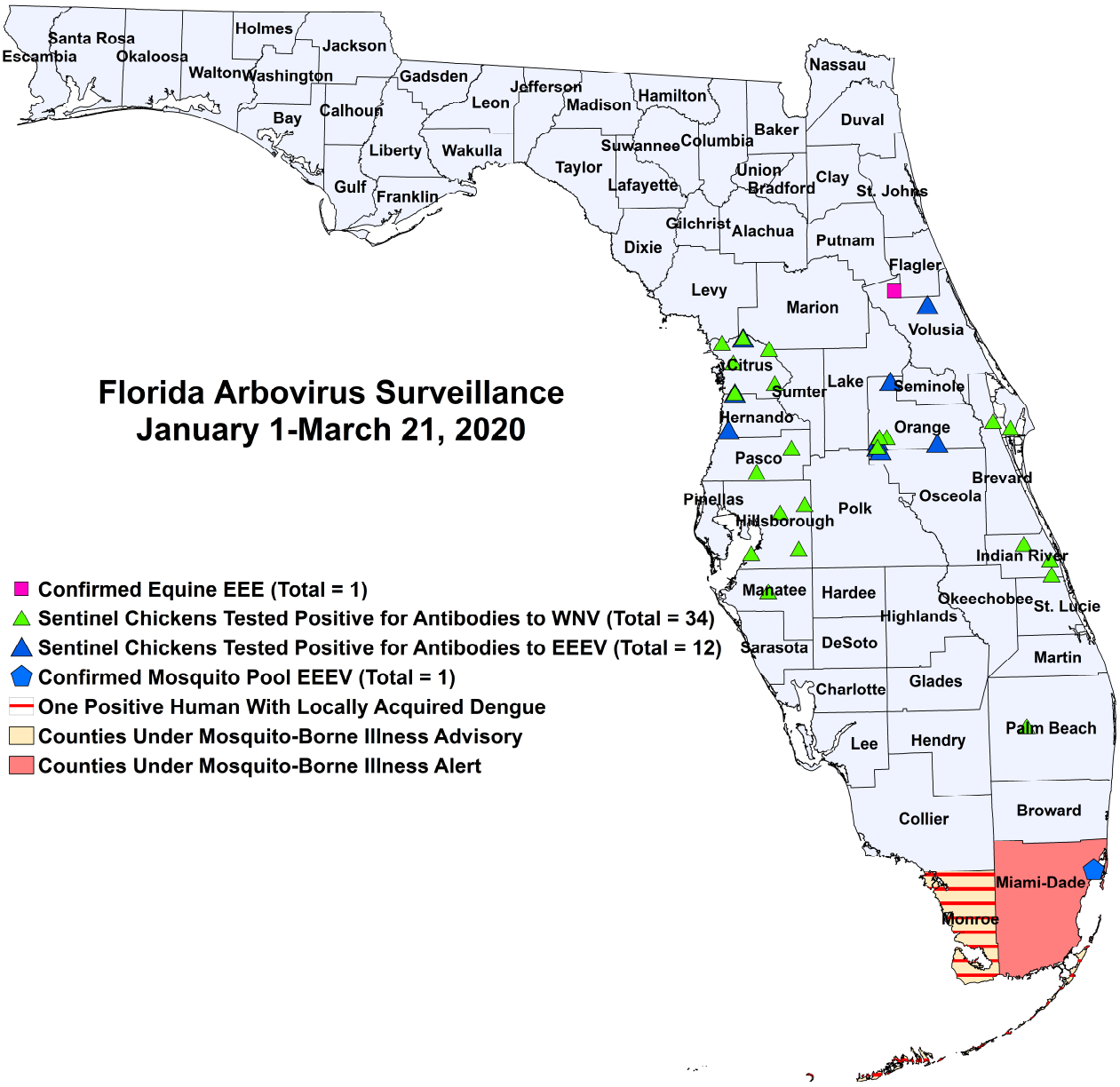

2020 Arbovirus Activity by County

County	Arbovirus Activity
Brevard	WNV: 2 sentinels (1/23, 1/24)
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 2 sentinels (1/8, 3/2)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 12 sentinels (1/6, 1/21, 1/29, 2/11, 2/18, 2/25)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Monroe	Dengue: 1 human (February)
Orange	WNV: 3 sentinels (1/6) EEEV: 8 sentinels (1/13, 1/27, 1/28, 2/24, 3/2)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24), 1 sentinel (2/24)

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Acknowledgements and Data Sources

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For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Cosgrove, Robert G; Crawford, Brian; Cunningham, Mark; Daiker, Dave; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; Hunter, Johnny; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McInnis, Sarah; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Morrison, Andrea; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Phillips, Sheila; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stanek, Danielle R; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sumner, Samuel M; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Subject: Florida Arbovirus Surveillance Week 5: January 26-February 1, 2020

Date: Monday, February 3, 2020 4:34:30 PM

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2020Week5ArbovirusReport_2-01-20.pdf

Florida Arbovirus Surveillance
Week 5: January 26-February 1, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of January 26-February 1, 2020, the following arboviral activity was recorded in Florida.

This report contains information for 2019 and 2020. This week's report will be the last update for 2019.
Please visit the following website for up to date 2019 human case numbers as final data cleaning occurs: FloridaHealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Four sentinel chickens tested positive for antibodies to WNV this week in Citrus, Hillsborough, and Palm Beach counties. In 2020, 19 sentinel chickens have been reported from seven counties. In 2019, positive samples from two humans, one blood donor, ten horses, one eagle, and 808 sentinel chickens have been reported from 31 counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported. In 2019, positive samples from eight sentinel chickens have been reported from eight counties.

EEEV activity: No human cases of EEEV infection were reported this week. One horse with EEEV infection was reported this week in Volusia County. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, three sentinel chickens, one horse, and one mosquito pool have been reported from four counties. In 2019, positive samples from 28 horses, one emu, one eagle, and 115 sentinel chickens have been reported from 31 counties.

International Travel-Associated Dengue Fever Cases: One 2019 case of dengue fever was reported this week in a person that had international travel. In 2019, 406 travel-associated cases have been reported. Seven 2020 cases of dengue fever were reported this week in persons that had international travel. In 2020, seven travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2019, 16 cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2019, eight travel-associated cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2019, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2019, 36 travel-associated cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were

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reported this week. In 2019, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Broward County is currently under a mosquito-borne illness advisory. Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 5: January 26-February 1, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of January 26-February 1, 2020, the following arboviral activity was recorded in Florida.

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2019 Human Case Summary*

West Nile Virus Illnesses Acquired in Florida: Two human cases of WNV illness acquired in Florida has been reported in 2019 in Duval (July) and Sumter (October) counties. One asymptomatic positive blood donor has been reported in 2019 from Bay County (August).

International Travel-Associated Chikungunya Fever Cases: Eight cases of chikungunya fever with onset in 2019 have been reported in individuals with travel history to a chikungunya endemic country in the two weeks prior to onset. Countries of origin were: Brazil, Haiti, India (3), and Thailand (3). Counties reporting cases were: Alachua, Lee, Manatee, Marion, Miami-Dade (2), Orange, and Palm Beach. Two cases were reported in non-Florida residents.

International Travel-Associated Dengue Fever Cases: Four hundred six cases of dengue fever with onset in 2019 have been reported in individuals with travel history to a dengue endemic country in the two weeks prior to onset. Counties reporting cases were: Alachua (4), Brevard (2), Broward (47), Charlotte, Citrus, Collier (4), Desoto, Duval (6), Hillsborough (22), Lake (2), Lee (13), Manatee (2), Marion, Miami-Dade (232), Orange (18), Osceola (3), Palm Beach (26), Pasco (4), Pinellas (3), Polk, Putnam, Sarasota (2), Seminole (4), St. Lucie (5), and Volusia. Twenty-six cases were reported in non-Florida residents. Thirteen cases met the criteria for severe dengue (dengue shock syndrome [DSS] or dengue hemorrhagic fever [DHF]). Those at greater risk for DSS and DHF include persons with previous dengue infection, pregnant women, infants, the elderly, and those with co-morbidities. However, severe illness can also occur in those without any of these risk factors. In 2019, 335 cases of dengue reported in Florida have been serotyped by PCR.* Please see the below table for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-2	DENV-3	DENV-4	DENV-1/ DENV-2	DENV-1/ DENV-3	DENV-2/ DENV-3	Unknown*	Total
Cuba	18	189			3			34	244
Dominican Republic	24	1						4	29
Jamaica		2	20			1		6	29
Honduras	2	10	1					5	18
Nicaragua		11					1	5	17
Haiti	7	1						4	12
India		3	3	1				3	10
Mexico	2	3							5
Venezuela	5								5
Brazil		2						1	3
Dominica			2					1	3
El Salvador		2						1	3
Guatemala		1	2						3
Philippines		2						1	3
Belize		2							2
Colombia			1					1	2
Costa Rica		2							2
Thailand		2							2
Vietnam	2								2
Antigua and Barbuda			1						1
Asia	1								1
Bangladesh			1						1
Belize/Cuba/Honduras/Mexico		1							1
Cambodia/Thailand/Vietnam	1								1
Cayman Islands/Mexico		1							1
Central America/Mexico								1	1
Colombia/Venezuela								1	1
Cuba/Jamaica								1	1
India/Malaysia								1	1
Malaysia/Singapore		1							1
Panama	1								1
Total	**63**	**236**	**31**	**1**	**3**	**1**	**1**	**70**	**406**

* Serotyping for 5 cases are pending and will be added in future weeks.

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Seven cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Broward (2), Franklin, Hillsborough, Miami-Dade (2), and St. Lucie. One case was reported in a non-Florida resident. In 2020, two cases of dengue reported in Florida have been serotyped by PCR**. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-1/ DENV-3	Unknown**	Total
Cuba			2	2
Jamaica		1	1	2
Bahamas	1			1
Dominican Republic			1	1
Puerto Rico/U.S. Virgin Islands			1	1
Total	**1**	**1**	**5**	**7**

**Serotyping for 5 cases are pending and will be added in future weeks.

Dengue Fever Cases Acquired in Florida: In 2019, 16 cases of locally acquired dengue fever have been reported in Broward, Hillsborough, and Miami-Dade (14) counties, with onsets in March, July (2), August (3), September (6), October (2), and December (2).

International Travel-Associated Zika Fever Cases: In 2019, 36 cases of Zika fever have been reported in individuals with travel history to a country or area experiencing Zika virus activity. Countries of origin were: Brazil, Colombia (1), Cuba (6), Guatemala (5), Haiti (11), Honduras (4), Jamaica, Nicaragua, Philippines, Puerto Rico, and Venezuela (3). Counties reporting cases were: Broward (5), Collier (3), Duval, Hillsborough (2), Indian River, Lee, Miami-Dade (17), Orange (4), Palm Beach, and Sarasota. Three cases were reported in non-Florida residents. Florida is monitoring a total of 23 pregnant women in 2019.

International Travel-Associated Malaria Cases: Seventy-three cases of malaria with onset in 2019 have been reported. Countries of origin were: Afghanistan, Angola (3), Central African Republic (3), Chad, Congo, Democratic Republic of the Congo (4), Gabon (2), Ghana (10), Guinea, Guyana, India (4), Ivory Coast (6), Kenya (3), Liberia (3), Nicaragua, Nigeria (16), Papua New Guinea, Sierra Leone (2), Sudan, Togo, Uganda (4), Venezuela, and Zambia (3). Counties reporting cases were: Bay, Brevard (3), Broward (6), Duval (10), Hillsborough (5), Lake (2), Lee, Manatee, Miami-Dade (13), Okaloosa, Orange (9), Pasco (6), Pinellas (6), Polk (3), Seminole (4), Volusia and Washington. Twenty cases were reported in non-Florida residents.

Fifty-nine cases (81%) were diagnosed with *Plasmodium falciparum*. Nine cases (12%) were diagnosed with *Plasmodium vivax*. Three cases (4%) were diagnosed with *Plasmodium ovale*. Two cases (3%) were diagnosed with *Plasmodium malariae*.

Two cases of malaria with onset in 2020 has been reported. Countries of origin were: Dominican Republic and Nigeria. Counties reporting cases were: Miami-Dade and Polk. Both cases were diagnosed with *Plasmodium falciparum*. One case was reported in a non-Florida resident.

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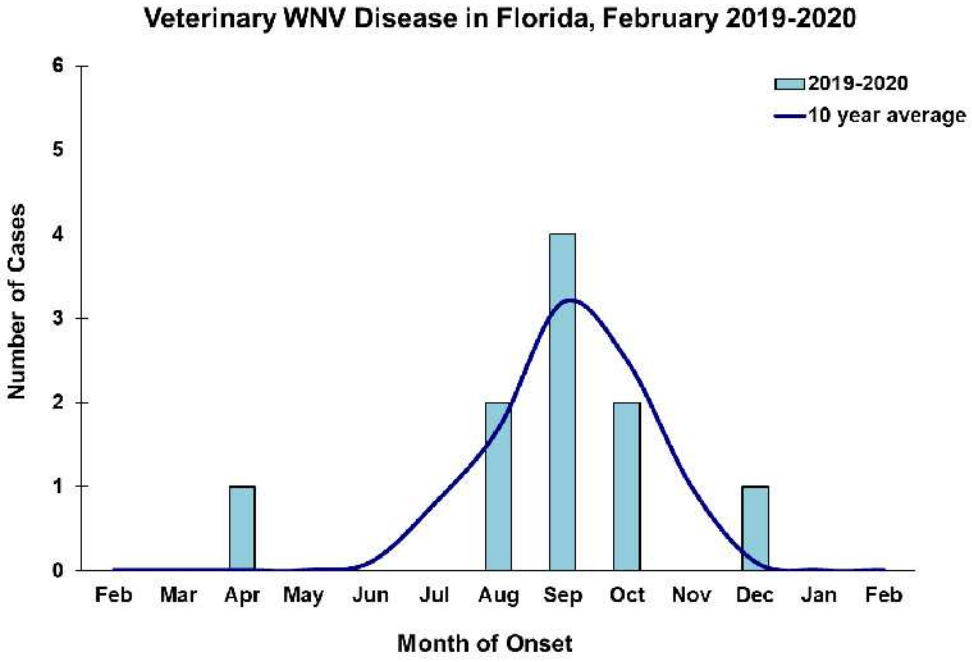
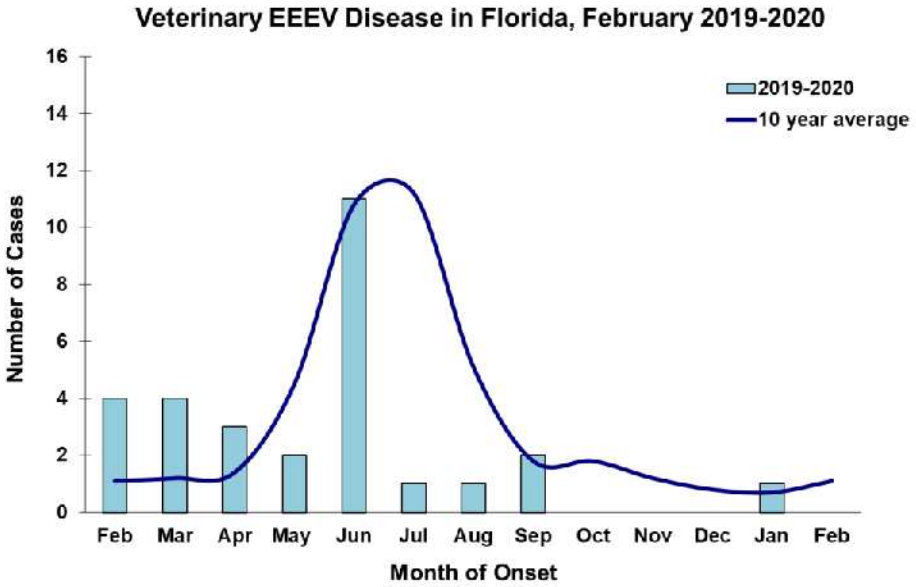
Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

One horse with EEEV infection was reported this week in Volusia County.





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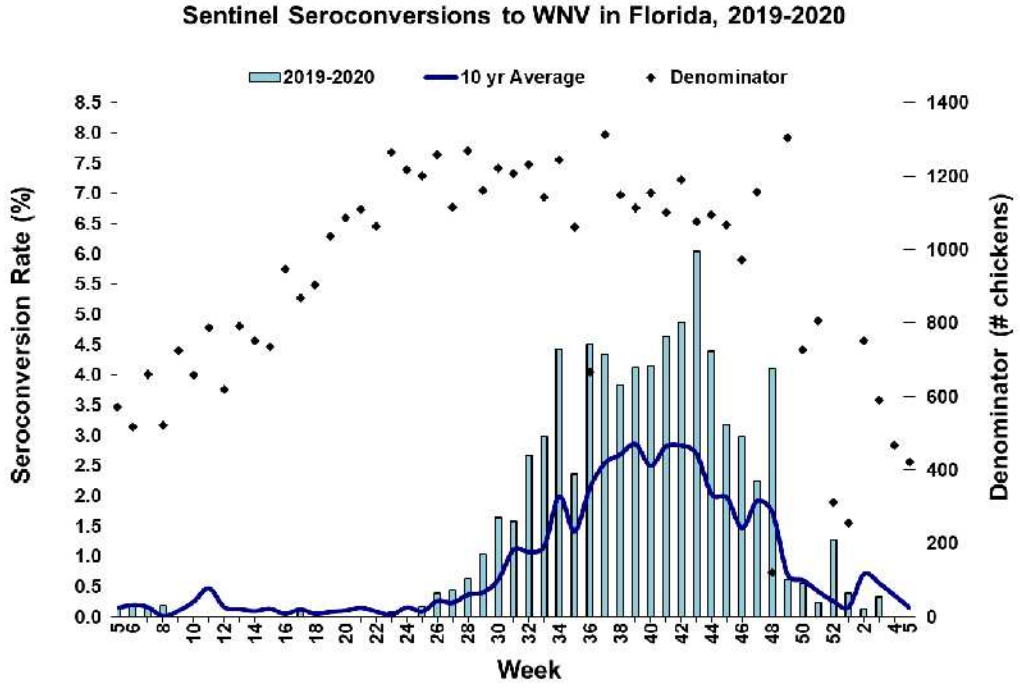
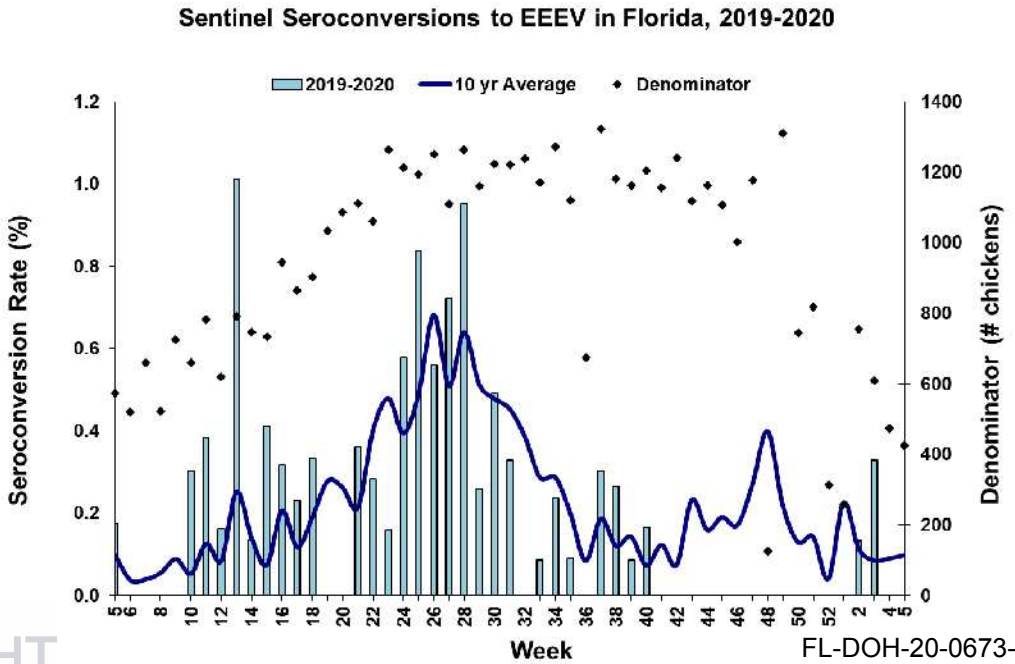
Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Four sentinel chickens tested positive for antibodies to WNV this week in Citrus, Hillsborough, and Palm Beach counties.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Citrus	1/21/2020	1.41		1.41				1 WNV	7 WNV, 1 EEEV
Hillsborough	1/6/2020	4.44		4.44				2 WNV	2 WNV
Palm Beach	1/20/2020	4.17		4.17				1 WNV	1 WNV





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Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

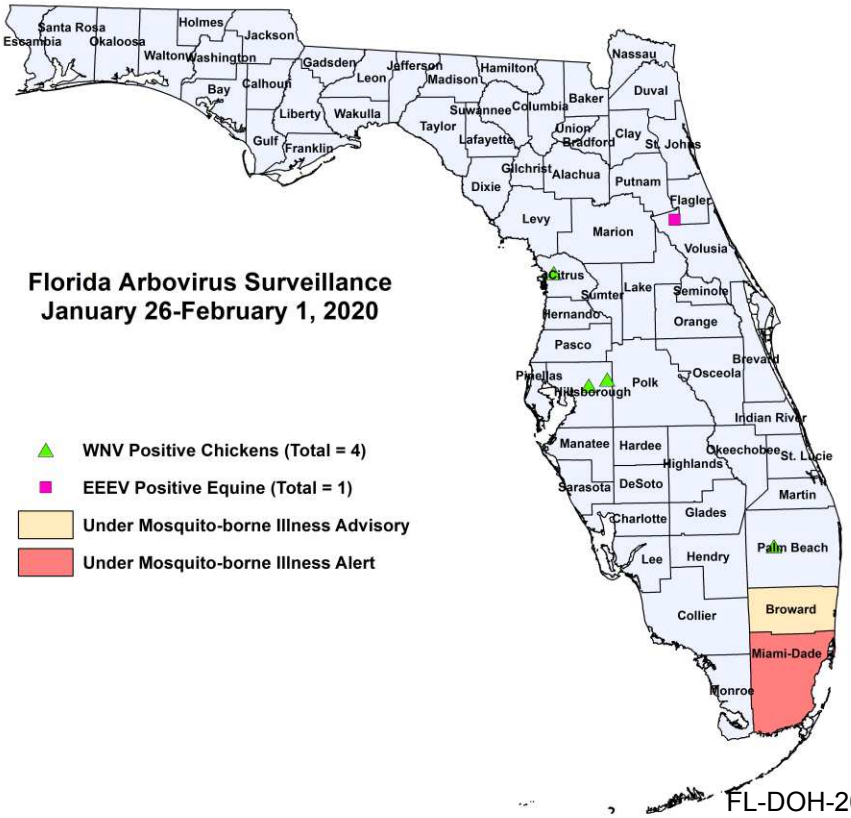
The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, 12 reports representing a total of 61 dead birds, including 16 crows and one raptor, were received from eight counties.

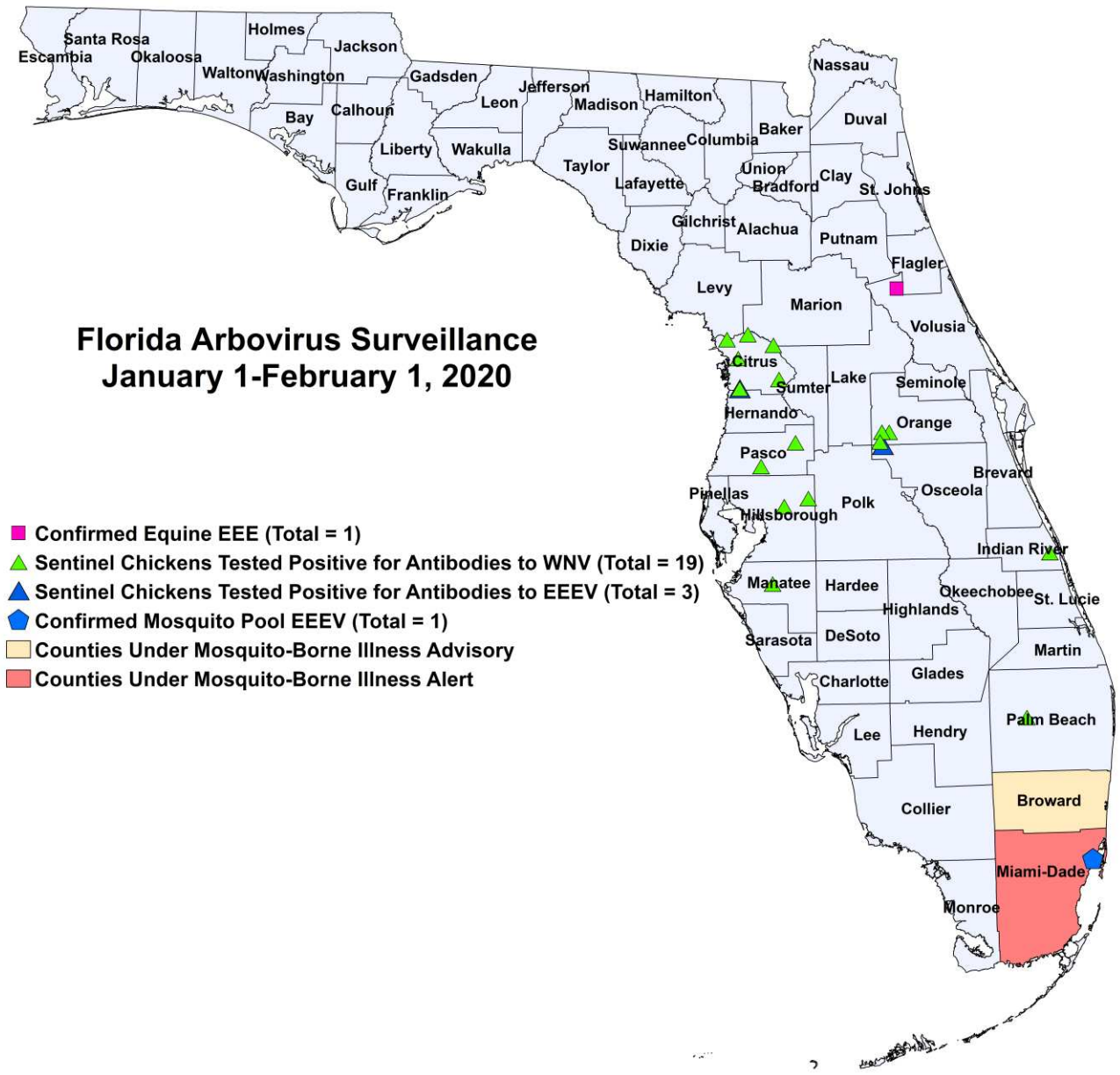
In 2020, 36 reports representing a total of 111 dead birds (16 crows, 9 raptors) were received from 20 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Baker	15	15	0	0	0
Charlotte	1	0	0	0	0
Escambia	5	0	0	0	0
Hillsborough	1	0	0	1	0
Pinellas	28	0	0	0	0
Sarasota	3	1	0	0	0
Seminole	1	0	0	0	0
St. Lucie	7	0	0	0	0

Maps





2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Citrus	WNV: 7 sentinels (1/8, 1/14, 1/21) EEEV: 1 sentinel (1/8)
Hillsborough	WNV: 2 sentinels (1/6)
Indian River	WNV: 1 sentinel (1/2)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Orange	WNV: 3 sentinels (1/6) EEEV: 2 sentinels (1/13)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24)

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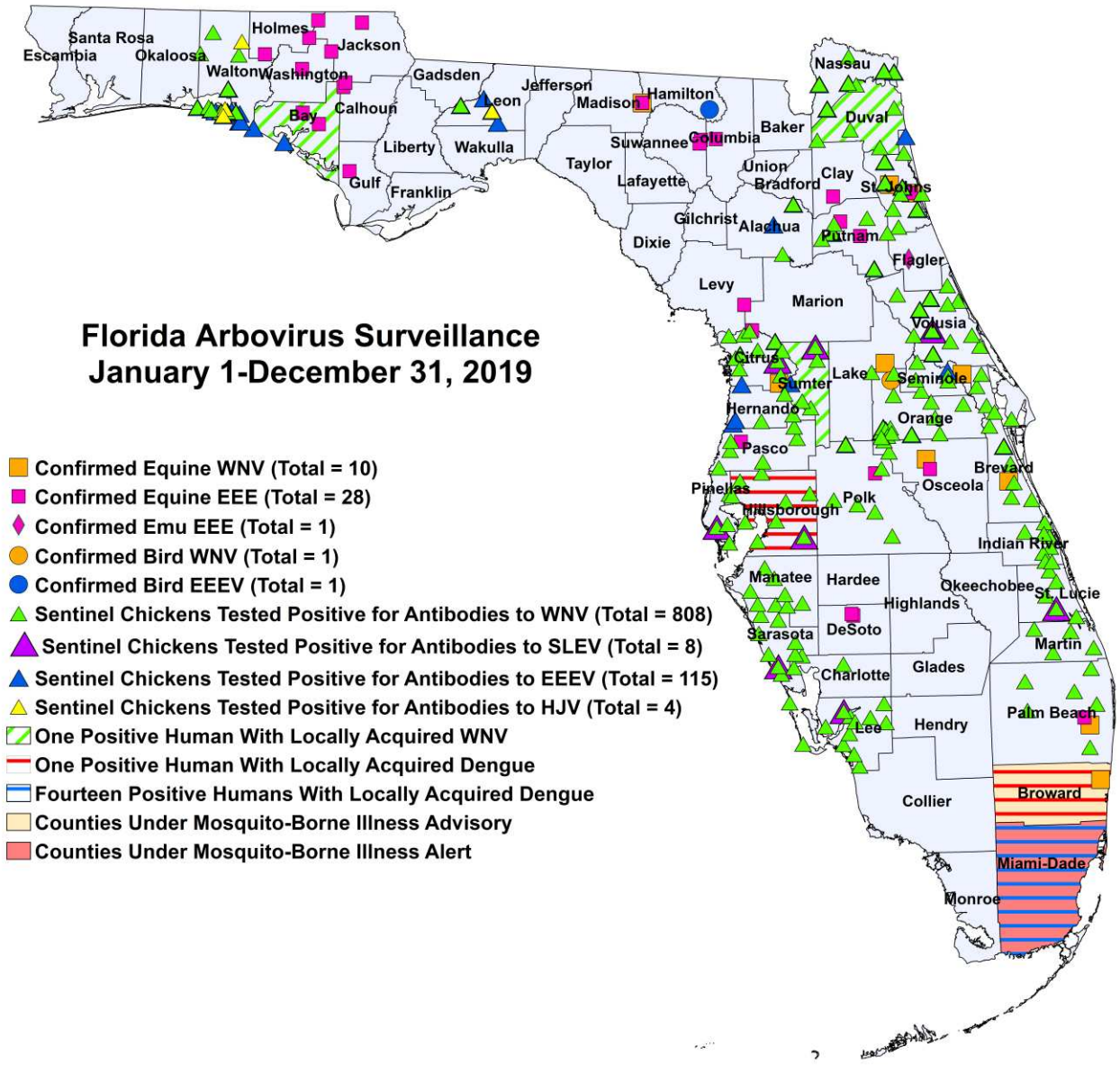

2019 Arbovirus Activity by County	
County	**Arbovirus Activity**
Alachua	WNV: 5 sentinels (9/9, 9/13, 9/30, 11/18) EEEV: 2 sentinels (7/8, 8/19)
Bay	WNV: 1 asymptomatic blood donor (August) EEEV: 2 horses (2/24, 2/26), 9 sentinels (4/29, 7/1)
Brevard	WNV: 1 horse (8/27), 60 sentinels (1/3, 7/18, 7/19, 7/25, 7/26, 7/31, 8/1, 8/8, 8/14, 8/15, 8/16, 8/21, 8/22, 8/23, 9/12, 9/13, 9/18, 9/19, 9/20, 9/25, 10/9, 10/10, 10/11, 10/17, 10/18, 10/23, 10/24, 11/1, 11/8, 11/13, 11/19, 11/20) EEEV: 1 sentinel (7/18)
Broward	Dengue: 1 human (August) WNV: 1 horse (10/5)
Calhoun	EEEV: 3 horses (3/3, 3/22)
Charlotte	WNV: 11sentinels (7/23, 8/5, 10/18, 10/25, 11/1, 11/7)
Citrus	WNV: 1 horse (9/24), 76 sentinels (1/8, 1/29, 7/23, 8/6, 8/20, 8/27, 9/3, 9/10, 9/17, 9/24, 10/1, 10/8, 10/15, 10/22,10/29, 11/5, 11/12, 11/18, 12/3, 12/10) SLEV: 1 sentinel (10/22) EEEV: 1 horse (5/11), 6 sentinels (4/26, 6/18, 7/30, 9/10, 10/1)
Clay	EEEV: 1 horse (9/20)

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Columbia	EEEV: 1 horse (3/30)
DeSoto	EEEV: 2 horses (6/23, 7/2)
Duval	WNV: 1 human (July), 20 sentinels (9/9, 9/23, 10/7, 10/14, 10/21, 10/28, 11/12)
Flagler	EEEV: 1 emu (3/17)
Gulf	EEEV: 1 horse (2/27)
Hamilton	EEEV: 1 eagle (3/21)
Hernando	WNV: 8 sentinels (8/19, 9/9, 9/16, 9/23, 10/7, 10/21, 11/4) EEEV: 2 sentinels (3/4, 9/16)
Hillsborough	Dengue: 1 human (September) WNV: 38 sentinels (8/20, 8/27, 9/3, 9/10, 9/17, 9/24, 10/1, 10/8, 10/15, 10/21, 10/22, 10/29, 11/5, 11/12, 12/3, 12/10, 12/16, 12/23) SLEV: 1 sentinel (10/15)
Holmes	EEEV: 3 horses (6/1, 6/5, 6/20)
Indian River	WNV: 72 sentinels (1/10, 7/3, 7/5, 7/12, 719, 7/26, 8/2, 8/8, 8/9, 8/15, 8/16, 8/22, 8/23, 8/29, 9/5, 9/13, 9/19, 9/20, 10/3, 10/4, 10/10, 10/17, 10/18, 10/25, 10/30, 10/31, 11/7, 11/8, 11/15, 11/22, 11/26, 12/6, 12/27)
Jackson	EEEV: 1 horse (6/19)
Lake	WNV: 1 horse (10/6)
Lee	WNV: 40 sentinels (7/9, 8/5, 8/6, 8/12, 8/19, 8/20, 8/27, 9/4, 9/9, 9/12, 9/16, 9/17, 9/26, 9/27, 9/30, 10/1, 10/7, 10/15, 10/28, 10/29, 11/5) SLEV: 1 sentinel (9/4)
Leon	WNV: 2 sentinels (9/3, 10/14) EEEV: 7 sentinels (5/28, 6/10, 8/26, 9/10, 9/30) HJV: 1 sentinel (8/19)
Levy	EEEV: 1 horse (6/19)
Madison	WNV: 1 horse (4/1) EEEV: 1 horse (4/1)
Manatee	WNV: 9 sentinels (2/5, 10/7, 10/15, 10/22, 11/5, 11/20)
Martin	WNV: 23 sentinels (8/16, 8/29, 9/13, 9/20, 10/11, 10/25, 11/1, 11/15, 11/22, 11/25, 12/20)
Miami-Dade	Dengue: 14 humans (March, July (2), August (2), September (5), October (2) December (2))
Nassau	WNV: 24 sentinels (8/3, 8/17, 8/24, 9/7, 9/14, 9/21, 9/28, 10/12, 10/19, 10/26, 11/2, 11/9, 11/16) EEEV: 9 sentinels (6/21, 7/13, 7/27, 8/3, 9/21, 11/23)
Orange	WNV: 1 eagle (6/22), 82 sentinels (1/7, 1/10, 1/14, 6/27, 6/20, 6/24, 7/1, 7/11, 7/22, 8/1, 8/8, 8/19, 8/22, 8/26, 9/9, 9/16, 9/23, 9/30, 10/7, 10/14, 10/21, 10/28, 11/4, 11/11, 11/18, 11/19, 12/2, 12/16) EEEV: 7 sentinels (6/17, 7/11, 7/18, 7/25, 11/25)
Osceola	WNV: 1 horse (8/30) EEEV: 1 horse (6/10)
Palm Beach	WNV: 30 sentinels (7/8, 7/22, 8/5, 8/19, 9/9, 9/16, 9/23, 10/7, 10/21, 10/28, 11/25) EEEV: 2 horses (2/25, 12/3)
Pasco	WNV: 29 sentinels (8/28, 9/4, 9/24, 10/1, 10/9, 10/23, 10/30, 11/6, 11/13, 11/20, 11/25, 12/4, 12/11, 12/18, 12/23) EEEV: 1 horse (6/20)
Pinellas	WNV: 12 sentinels (8/26, 9/9, 10/14, 10/21, 11/4, 11/12, 11/18) SLEV: 1 sentinel (9/30)
Polk	WNV: 36 sentinels (7/8, 7/15, 7/22, 7/29, 8/5, 8/12, 8/16, 8/19, 8/29, 8/30, 9/6, 9/13, 9/24, 9/30, 10/14, 10/22, 10/25, 10/28, 11/1, 11/4, 11/12, 11/15) EEEV: 1 horse (4/24), 5 sentinels (5/21, 5/24, 5/31, 6/21, 6/28)
Putnam	WNV: 19 sentinels (6/24, 7/17, 7/24, 8/2, 8/7, 8/8, 8/16, 8/23, 9/13, 10/10) EEEV: 2 horses (4/28, 8/17), 4 sentinels (5/29, 6/12, 7/24, 9/13)
Sarasota	WNV: 30 sentinels (2/15, 2/22, 7/29, 8/9, 8/19, 8/23, 9/3, 9/6, 9/10, 9/13, 9/16, 9/20, 10/7, 10/11, 10/14, 10/21, 11/1, 11/8. 11/12, 11/15, 11/22, 12/13, 12/26) SLEV: 1 sentinel (10/18)
Seminole	WNV: 18 sentinels (6/3, 7/15, 7/29, 8/20, 8/26, 9/9, 9/16, 9/23, 10/14, 11/18) EEEV: 1 sentinel (4/8)
St. Johns	WNV: 2 horses (9/7, 9/20), 55 sentinels (7/1, 7/19, 7/29, 8/5, 8/12, 8/19, 8/26, 9/23, 9/30, 10/7, 10/14, 10/21, 10/28, 11/4, 11/18, 11/25) EEEV: 1 horse (9/7), 8 sentinels (4/8, 4/15, 6/3, 6/24, 7/8, 7/29, 8/12, 8/19)

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St. Lucie	WNV: 12 sentinels (8/1, 8/8, 8/15, 8/26, 9/6, 9/12, 9/25, 9/26, 10/3) SLEV: 1 sentinel (11/13)
Sumter	WNV: 1 human (October), 12 sentinels (1/8, 9/18, 9/25, 10/4, 10/11, 10/28, 10/29, 11/13, 11/19) SLEV: 1 sentinel (9/25) EEEV: 1 sentinel (8/22)
Suwannee	EEEV: 2 horses (6/4, 6/7)
Volusia	WNV: 1 horse (9/10), 64 sentinels (6/17, 6/24, 7/1, 7/15, 7/22, 7/29, 8/5, 8/12, 8/12, 8/19, 8/26, 9/2, 9/9, 9/17, 9/23, 9/30, 10/7, 10/15, 10/18, 10/21, 11/11, 11/25) SLEV: 1 sentinel (10/21) EEEV: 7 sentinels (1/14, 1/22, 1/28, 7/1, 7/15, 12/9, 12/30)
Walton	WNV: 21 sentinels (4/23, 8/5, 8/26, 9/3, 9/17, 9/23, 9/30, 10/1, 10/14, 10/21, 10/29, 11/12, 11/18, 11/19, 12/2) EEEV: 45 sentinels (3/5, 3/11, 3/12, 3/18, 3/25, 3/26, 4/1, 4/9, 4/15, 4/23, 5/20, 6/3, 6/10, 6/17, 6/24, 7/1, 7/8, 7/22, 7/23, 9/9, 9/16, 9/23) HJV: 3 sentinels (6/3, 7/9, 7/29)
Washington	EEEV: 2 horses (5/28, 6/19)

Acknowledgements and Data Sources

Contributors: Andrea Morrison, PhD, MSPH, Devin Rowe, MS, Catherine McDermott, MPH, MHS, and Danielle Stanek, DVM, DOH Bureau of Epidemiology; Lea Heberlein-Larson, DrPH; Alexis LaCrue, PhD, MS; Maribel Castaneda, and Valerie Mock, BS; DOH Bureau of Public Health Laboratories; Carina Blackmore, DVM, PhD, DOH Division of Disease Control and Health Protection.

For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

Case tallies included in the weekly Florida arbovirus surveillance report include confirmed and probable cases for EEE, WNV infection, SLE, dengue, chikungunya, and malaria by date of onset. Suspect cases are not included. Activity is mapped by county of exposure rather than county of residence. Case definitions being used in Florida are consistent with national criteria provided by the Council of State and Territorial Epidemiologists (CSTE) and may be viewed at: www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html. Case tallies reported by CDC do not include suspect cases and cases are reported by patient state of residence rather than where the exposure occurred. Data is provided by county health departments, Department of Health Bureau of Public Health Laboratories, Department of Agriculture and Consumer Services, mosquito control agencies, Florida Fish and Wildlife Conservation Commission, medical providers and veterinarians. Equine cases are provided by the Department of Agriculture and Consumer Services.

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Cosgrove, Robert G; Crawford, Brian; Cunningham, Mark; Daiker, Dave; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; Hunter, Johnny; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McInnis, Sarah; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Morrison, Andrea; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Phillips, Sheila; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stanek, Danielle R; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sumner, Samuel M; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Subject: Florida Arbovirus Surveillance Week 6: February 2-8, 2020

Date: Monday, February 10, 2020 5:19:37 PM

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Florida Arbovirus Surveillance
Week 6: February 2-8, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 2-8, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Three sentinel chickens tested positive for antibodies to WNV this week in Citrus and Indian River counties. In 2020, 22 sentinel chickens have been reported from eight counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Three sentinel chickens tested positive for antibodies to EEEV this week in Hernando and Orange counties. In 2020, six sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, eight travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 6: February 2-8, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 2-8, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Three sentinel chickens tested positive for antibodies to WNV this week in Citrus and Indian River counties. In 2020, 22 sentinel chickens have been reported from eight counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. Three sentinel chickens tested positive for antibodies to EEEV this week in Hernando and Orange counties. In 2020, six sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, eight travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Eight cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Broward (2), Franklin, Hillsborough, Miami-Dade (3), and St. Lucie. One case was reported in a non-Florida resident. In 2020, two cases of dengue reported in Florida have been serotyped by PCR*. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-1/ DENV-3	Unknown**	Total
Bolivia			1	1
Cuba			2	2
Jamaica		1	1	2
Bahamas	1			1
Dominican Republic			1	1
Puerto Rico/U.S. Virgin Islands			1	1
Total	**1**	**1**	**6**	**8**

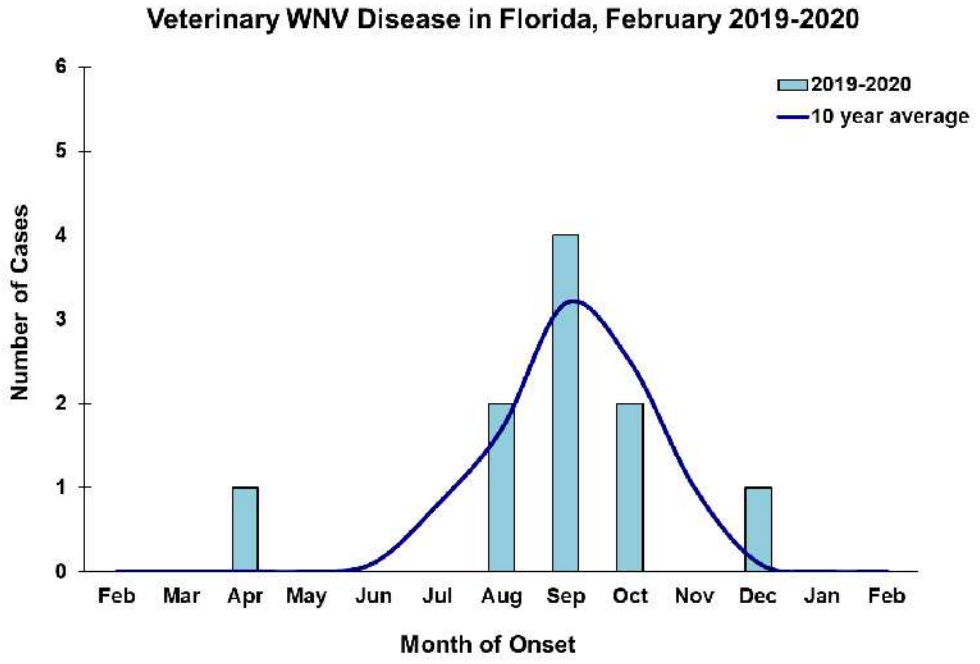
*Serotyping for 6 cases are pending and will be added in future weeks.

International Travel-Associated Malaria Cases: Two cases of malaria with onset in 2020 has been reported. Countries of origin were: Dominican Republic and Nigeria. Counties reporting cases were: Miami-Dade and Polk. Both cases were diagnosed with *Plasmodium falciparum*. One case was reported in a non-Florida resident.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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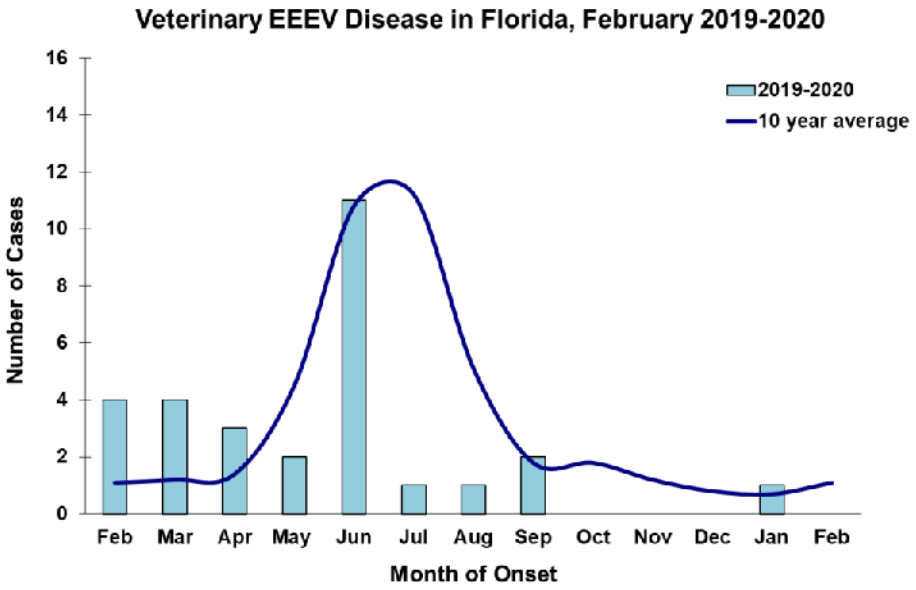
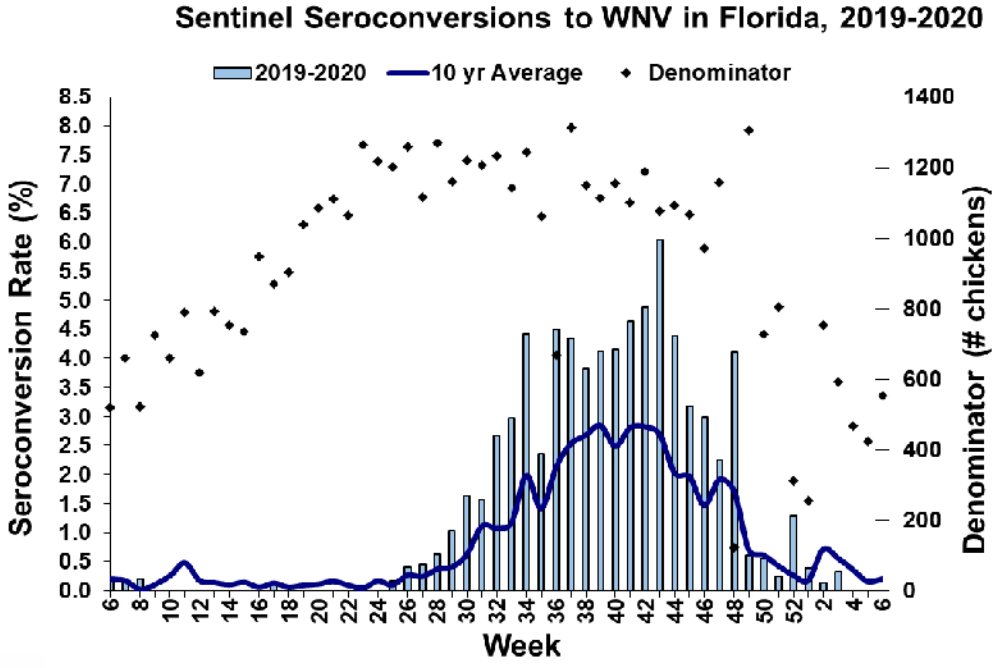


Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Three sentinel chickens tested positive for antibodies to WNV this week in Citrus and Indian River counties. Three sentinel chickens tested positive for antibodies to EEEV this week in Hernando and Orange counties.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Citrus	1/14/20	4.05		4.05				1 WNV	8 WNV, 1 EEEV
Hernando	1/21/20				5.56	5.56		1 EEEV	1 EEEV
Indian River	1/9/20-1/10/20	2.63		2.63				2 WNV	2 WNV
Orange	1/27/20-1/28/20				2.47	2.47		2 EEEV	3 WNV, 4 EEEV



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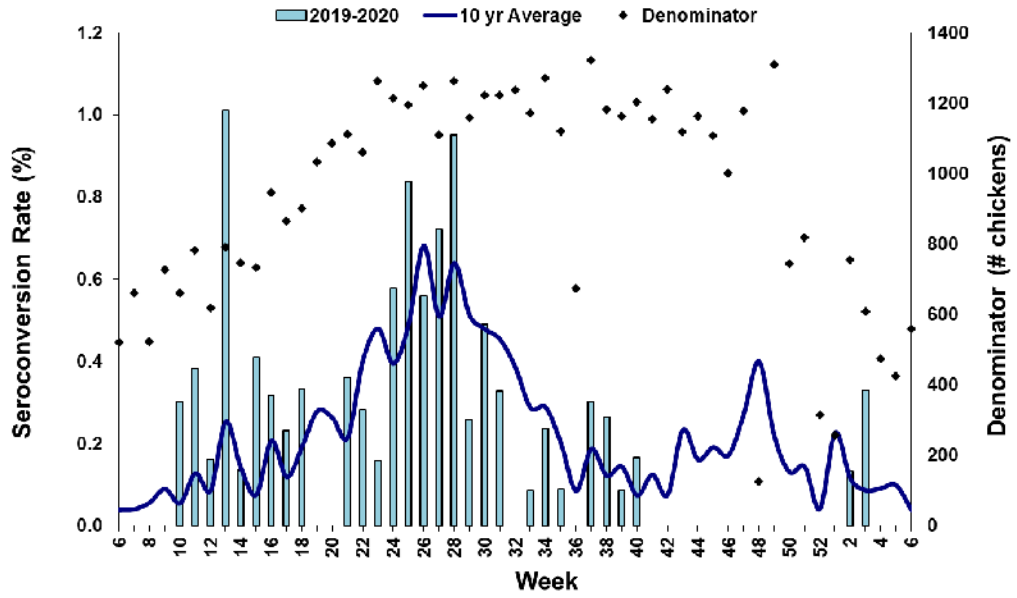
Sentinel Seroconversions to EEEV in Florida, 2019-2020



Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, 12 reports representing a total of 28 dead birds, including one jay and two raptors, were received from nine counties.

In 2020, 48 reports representing a total of 139 dead birds (16 crows, 1 jay, 11 raptors) were received from 22 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Escambia	15	0	0	0	0
Hillsborough	1	0	0	0	0
Lee	1	0	0	1	0
Manatee	1	0	0	0	0
Nassau	1	0	0	0	0
Okaloosa	1	0	0	1	0
Pinellas	4	0	0	0	0
Sarasota	2	0	1	0	0
Seminole	2	0	0	0	0

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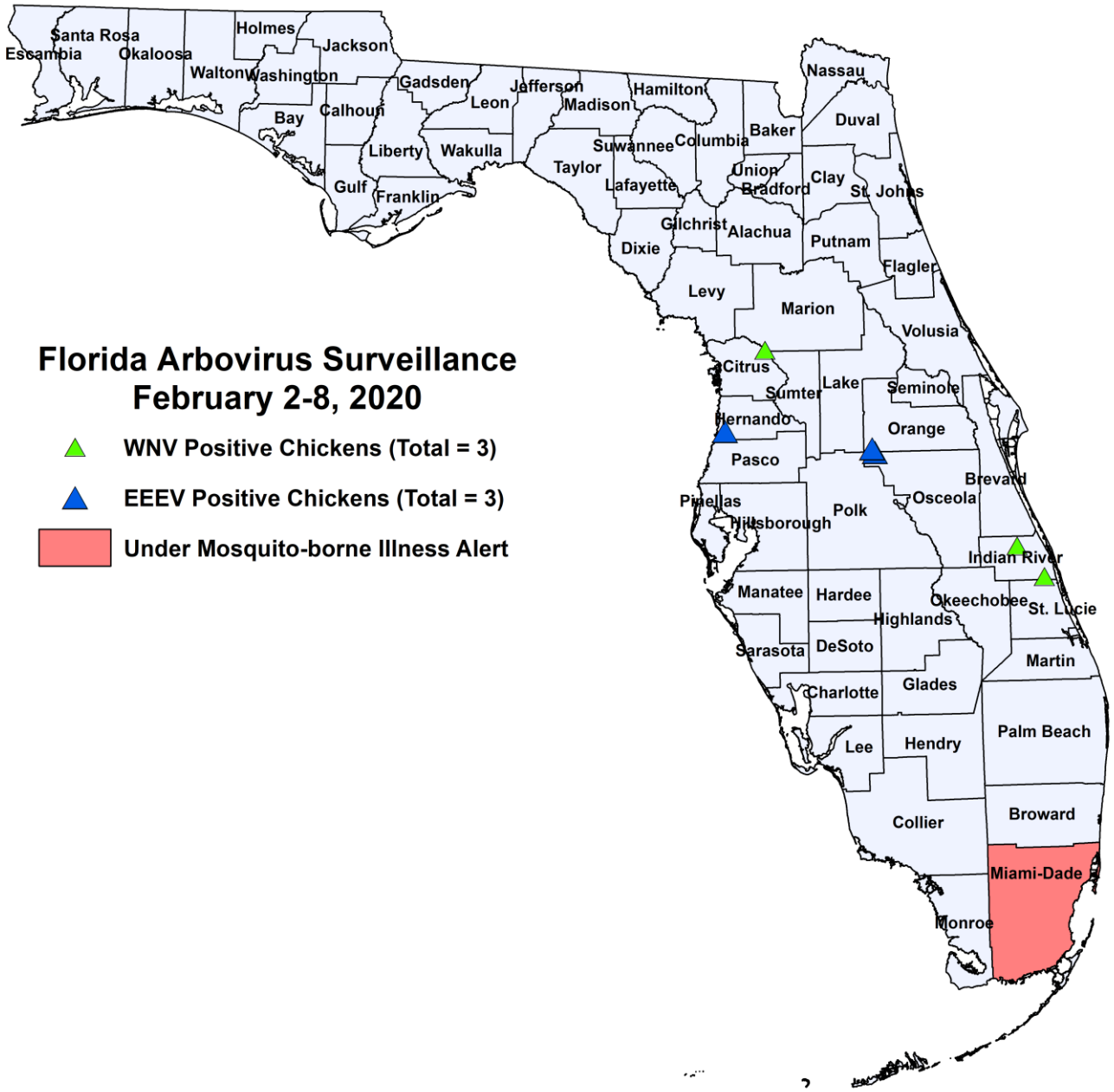
Maps



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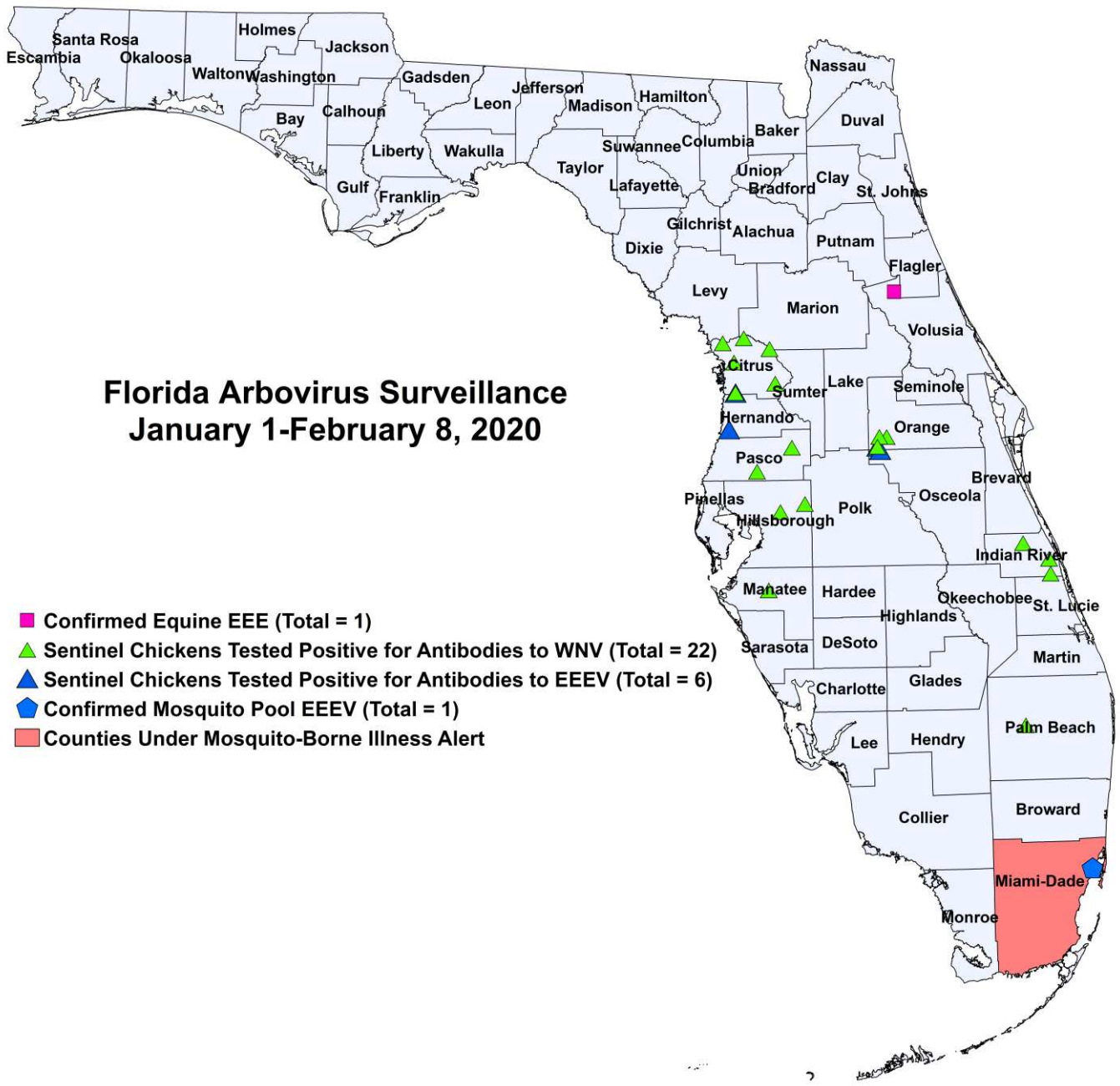

2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 1 sentinel (1/8)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 2 sentinels (1/6)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Orange	WNV: 3 sentinels (1/6) EEEV: 4 sentinels (1/13, 1/27, 1/28)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24)

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Acknowledgements and Data Sources

Contributors: Andrea Morrison, PhD, MSPH, Devin Rowe, MS, Catherine McDermott, MPH, MHS, and Danielle Stanek, DVM, DOH Bureau of Epidemiology; Lea Heberlein-Larson, DrPH; Alexis LaCrue, PhD, MS; Maribel Castaneda, and Valerie Mock, BS; DOH Bureau of Public Health Laboratories; Carina Blackmore, DVM, PhD, DOH Division of Disease Control and Health Protection.

For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

Case tallies included in the weekly Florida arbovirus surveillance report include confirmed and probable cases for EEE, WNV infection, SLE, dengue, chikungunya, and malaria by date of onset. Suspect cases are not included. Activity is mapped by county of exposure rather than county of residence. Case definitions being used in Florida are consistent with national criteria provided by the Council of State and Territorial Epidemiologists (CSTE) and may be viewed at: www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html. Case tallies reported by CDC do not include suspect cases and cases are reported by patient state of residence rather than where the exposure occurred. Data is provided by county health departments, Department of Health Bureau of Public Health Laboratories, Department of Agriculture and Consumer Services, mosquito control agencies, Florida Fish and Wildlife Conservation Commission, medical providers and veterinarians. Equine cases are provided by the Department of Agriculture and Consumer Services.

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Cosgrove, Robert G; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; Hunter, Johnny; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McInnis, Sarah; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Morrison, Andrea; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Phillips, Sheila; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stanek, Danielle R; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sumner, Samuel M; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Subject: Florida Arbovirus Surveillance Week 7: February 9-15, 2020

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Florida Arbovirus Surveillance
Week 7: February 9-15, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 9-15, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 24 sentinel chickens have been reported from eight counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, six sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: Five cases of dengue fever were reported this week in persons that had international travel. In 2020, thirteen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia

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related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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(email): Andrea.Morrison@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 7: February 9-15, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 9-15, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 24 sentinel chickens have been reported from eight counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, six sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: Five cases of dengue fever were reported this week in persons that had international travel. In 2020, thirteen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Thirteen cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Broward (5), Franklin, Hillsborough (3), Miami-Dade (3), and St. Lucie. One case was reported in a non-Florida resident. In 2020, two cases of dengue reported in Florida have been serotyped by PCR*. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-1/ DENV-3	Unknown*	Total
Jamaica		1	2	3
Cuba			2	2
Bahamas	1			1
Bolivia			1	1
Brazil			1	1
Colombia			1	1
Dominican Republic			1	1
Nicaragua			1	1
Puerto Rico/U.S. Virgin Islands			1	1
U.S. Virgin Islands			1	1
Total	**1**	**1**	**10**	**13**

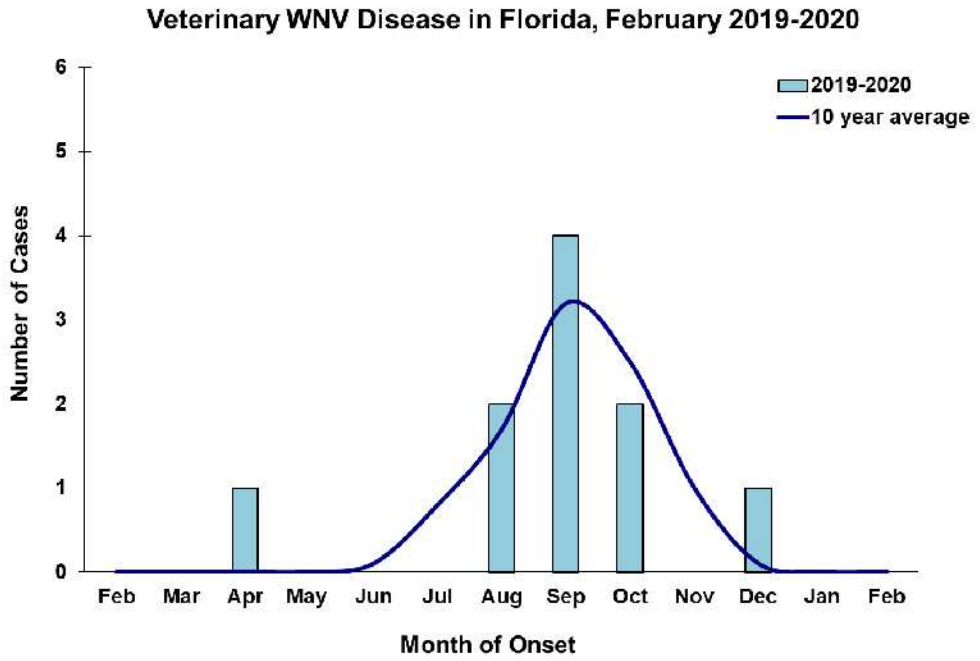
*Serotyping for 10 cases are pending and will be added in future weeks.

International Travel-Associated Malaria Cases: Two cases of malaria with onset in 2020 have been reported. Countries of origin were: Dominican Republic and Nigeria. Counties reporting cases were: Miami-Dade and Polk. Both cases were diagnosed with *Plasmodium falciparum*. One case was reported in a non-Florida resident.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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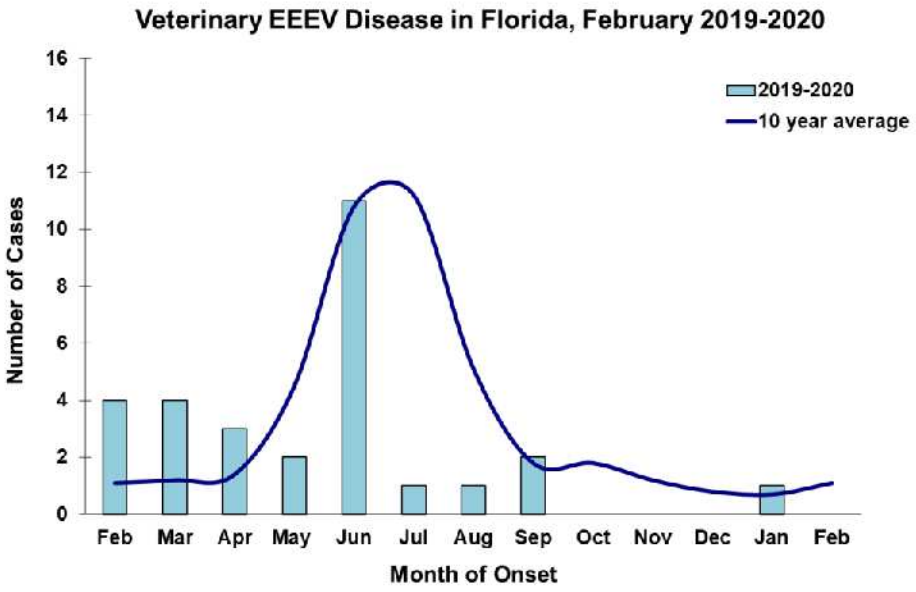
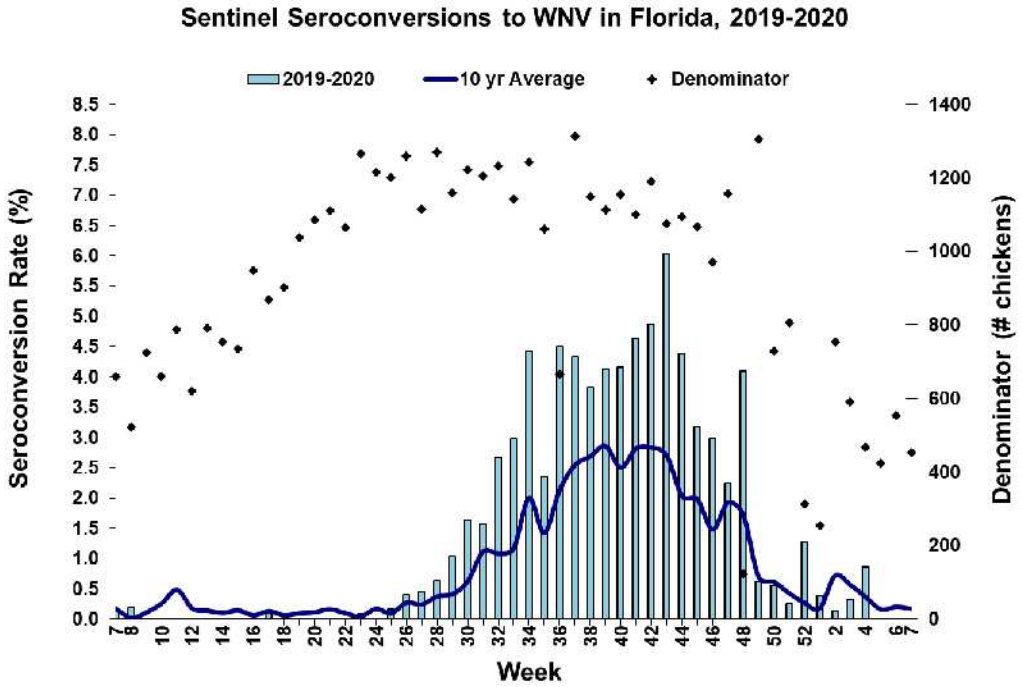


Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Hillsborough	1/21/2020	4.00		4.00				2 WNV	4 WNV



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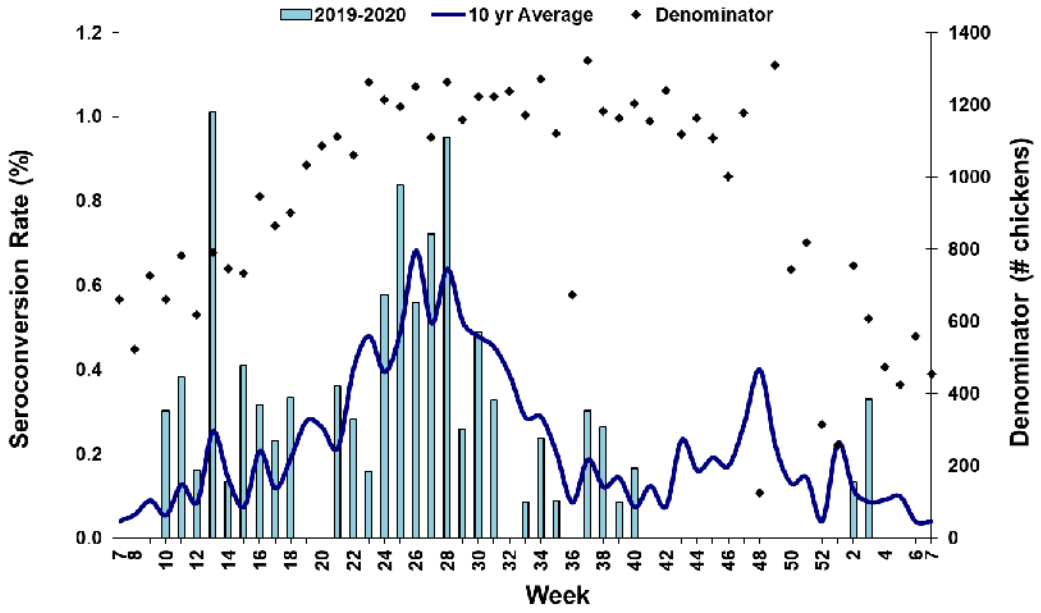
Sentinel Seroconversions to EEEV in Florida, 2019-2020



Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, eight reports representing a total of 13 dead birds, including three raptors, were received from seven counties.

In 2020, 56 reports representing a total of 152 dead birds (16 crows, 1 jay, 14 raptors) were received from 24 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Charlotte	1	0	0	0	0
Escambia	2	0	0	0	0
Indian River	1	0	0	1	0
Lee	6	0	0	0	0
Martin	1	0	0	1	0
Palm Beach	1	0	0	1	0
Santa Rosa	1	0	0	0	0

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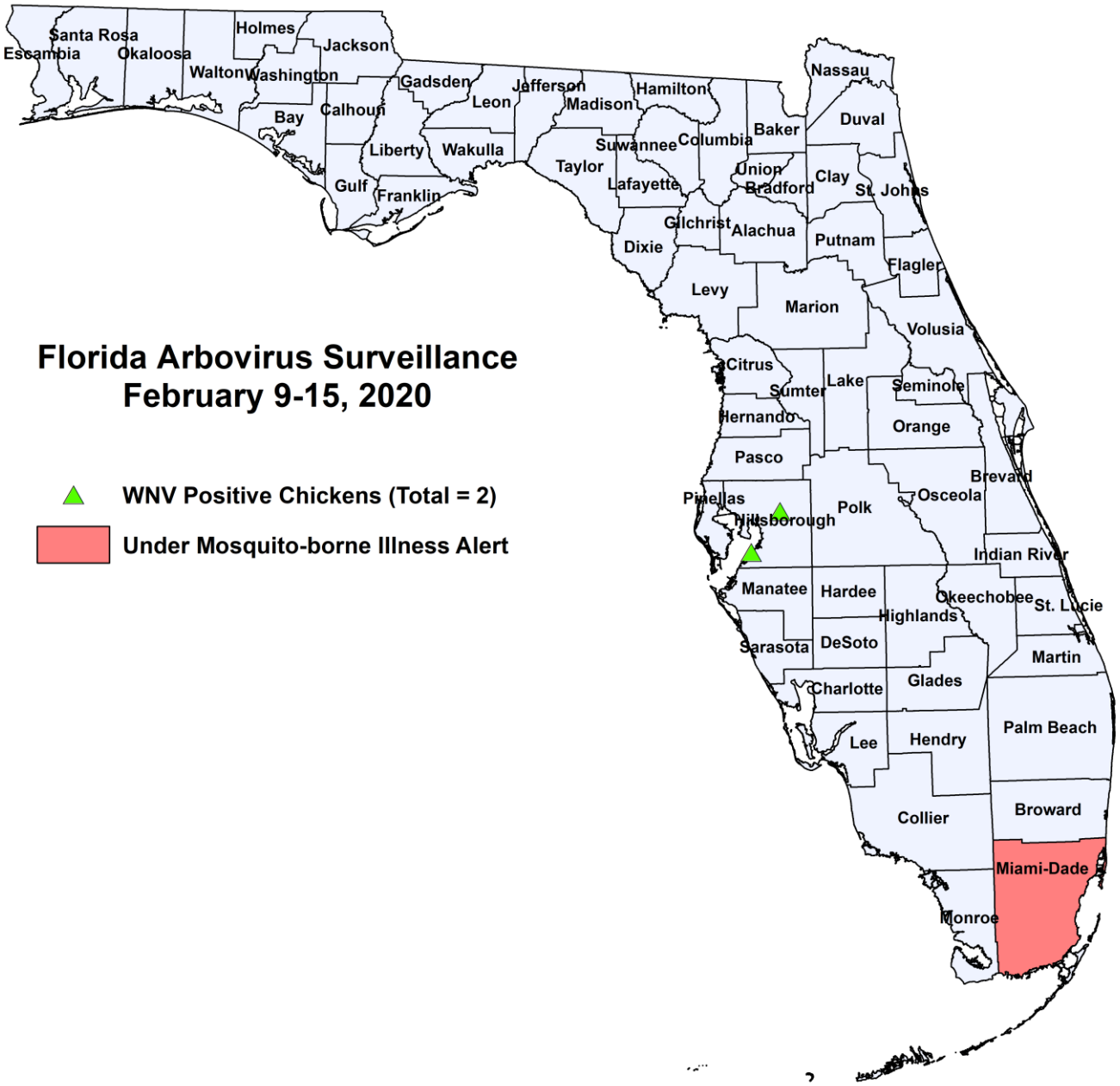
Maps



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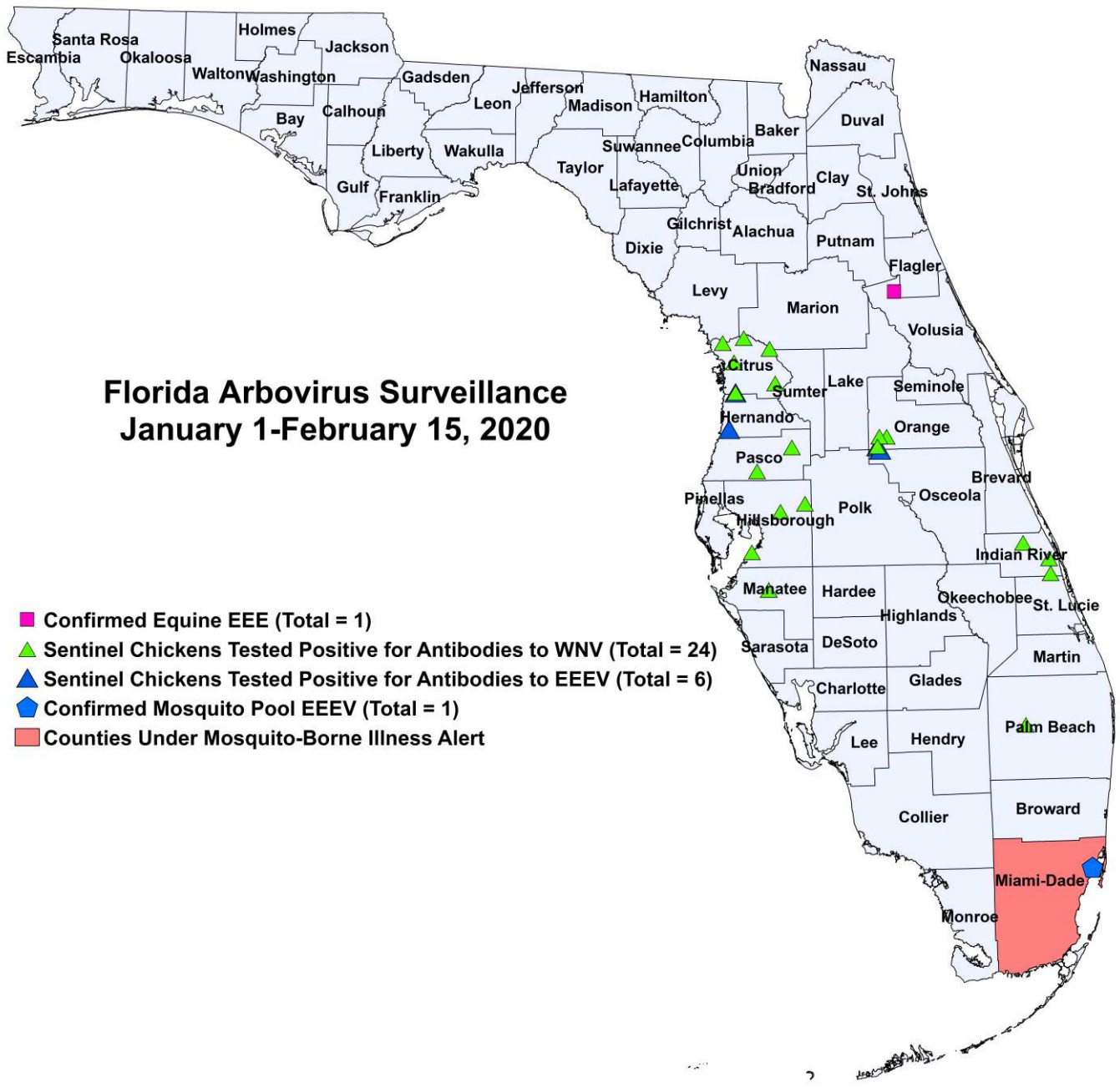

2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 1 sentinel (1/8)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 4 sentinels (1/6, 1/21)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Orange	WNV: 3 sentinels (1/6) EEEV: 4 sentinels (1/13, 1/27, 1/28)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24)

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Acknowledgements and Data Sources

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For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

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From: Stanek, Danielle R

To: Morrison, Andrea; Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alderman, Margie L; Allan, Sandy; Allicock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Cosgrove, Robert G; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; Hunter, Johnny; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McInnis, Sarah; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Phillips, Sheila; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sumner, Samuel M; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel; "julia.halbritter@rentokil.com"

Cc: Morrison, Andrea; Rowe, Devin R; McDermott, Catherine

Subject: Florida Arbovirus Surveillance Week 8: February 16-22, 2020

Date: Monday, February 24, 2020 5:03:12 PM

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Florida Arbovirus Surveillance

Week 8: February 16-22, 2020

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Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 16-22, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Four sentinel chickens tested positive for antibodies to WNV this week in Hillsborough and Brevard counties. In 2020, 28 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. One sentinel chicken tested positive for antibodies to EEEV this week in Orange County. In 2020, seven sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: One case of dengue fever was reported this week in a person that had international travel. In 2020, fourteen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America,

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Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

-

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

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Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 8: February 16-22, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 16-22, 2020, the following arboviral activity was recorded in Florida.

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International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Fourteen cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Broward (5), Franklin, Hillsborough (3), Miami-Dade (3), Seminole, and St. Lucie. Two cases were reported in non-Florida residents. In 2020, three cases of dengue reported in Florida have been serotyped by PCR*. Please see the table below for a breakdown of cases by country of origin and serotype.

Country of Exposure	DENV-1	DENV-3	DENV-1/ DENV-3	Unknown*	Total
Jamaica		1	1	2	4
Cuba				2	2
Bahamas	1				1
Bolivia				1	1
Brazil				1	1
Colombia				1	1
Dominican Republic				1	1
Nicaragua				1	1
Puerto Rico/U.S. Virgin Islands				1	1
U.S. Virgin Islands				1	1
Total	**1**	**1**	**1**	**11**	**14**

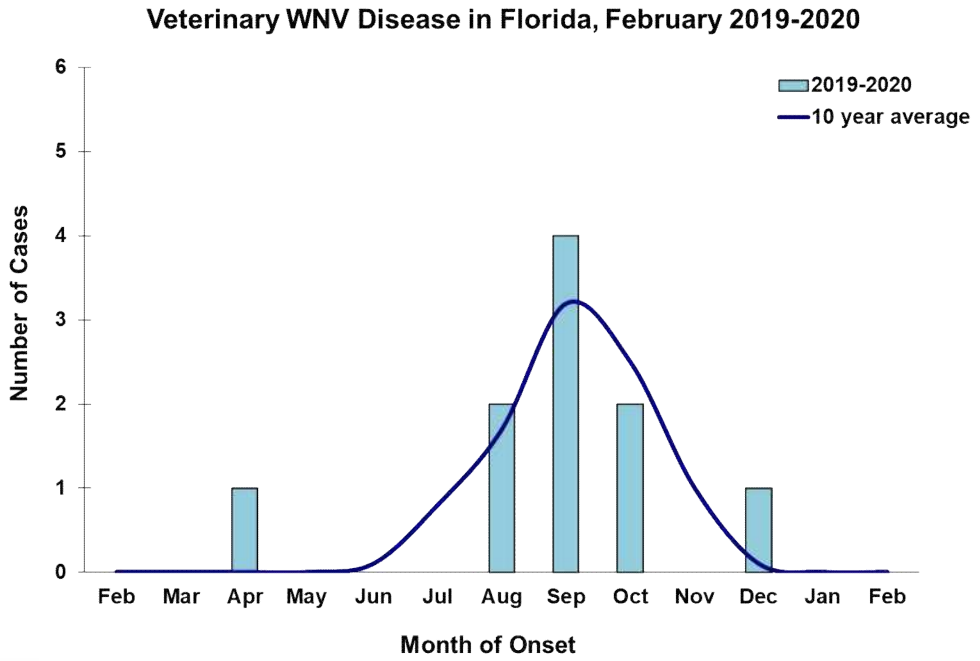
*Serotyping for 10 cases are pending and will be added in future weeks.

International Travel-Associated Malaria Cases: Two cases of malaria with onset in 2020 have been reported. Countries of origin were: Dominican Republic and Nigeria. Counties reporting cases were: Miami-Dade and Polk. Both cases were diagnosed with *Plasmodium falciparum*. One case was reported in a non-Florida resident.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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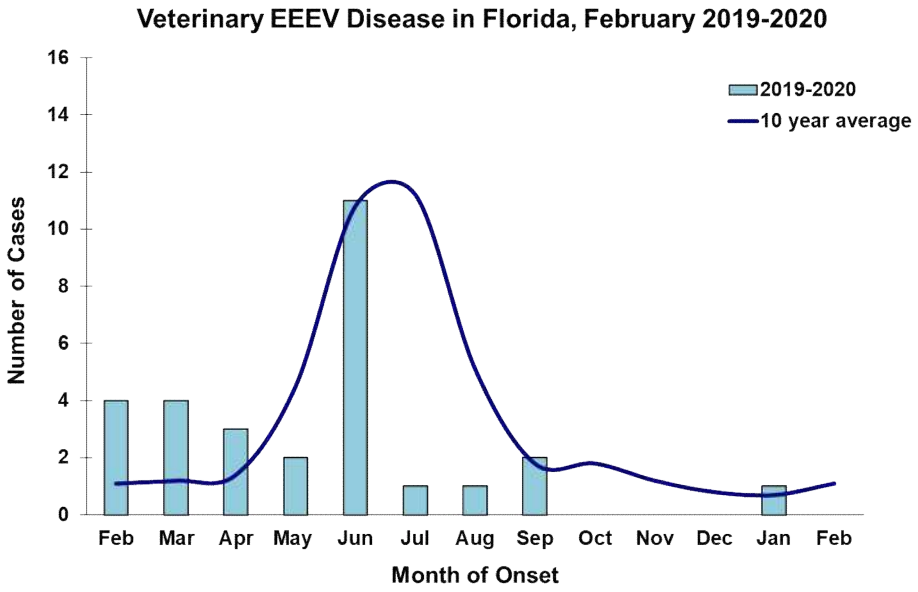
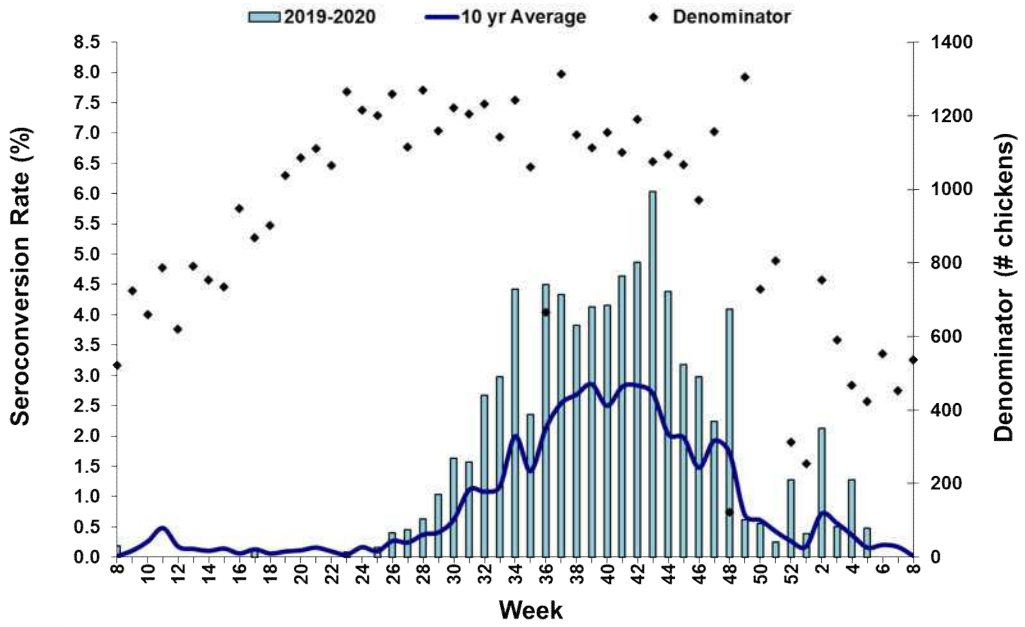


Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Four sentinel chickens tested positive for antibodies to WNV this week in Hillsborough and Brevard counties. One sentinel chicken tested positive for antibodies to EEEV this week in Orange County.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Brevard	1/23/20-1/24/20	3.77		3.77				2 WNV	2 WNV
Hillsborough	1/29/20	4.44		4.44				2 WNV	6 WNV
Orange	1/27/20				3.70	3.70		3 EEEV	3 WNV, 5 EEEV



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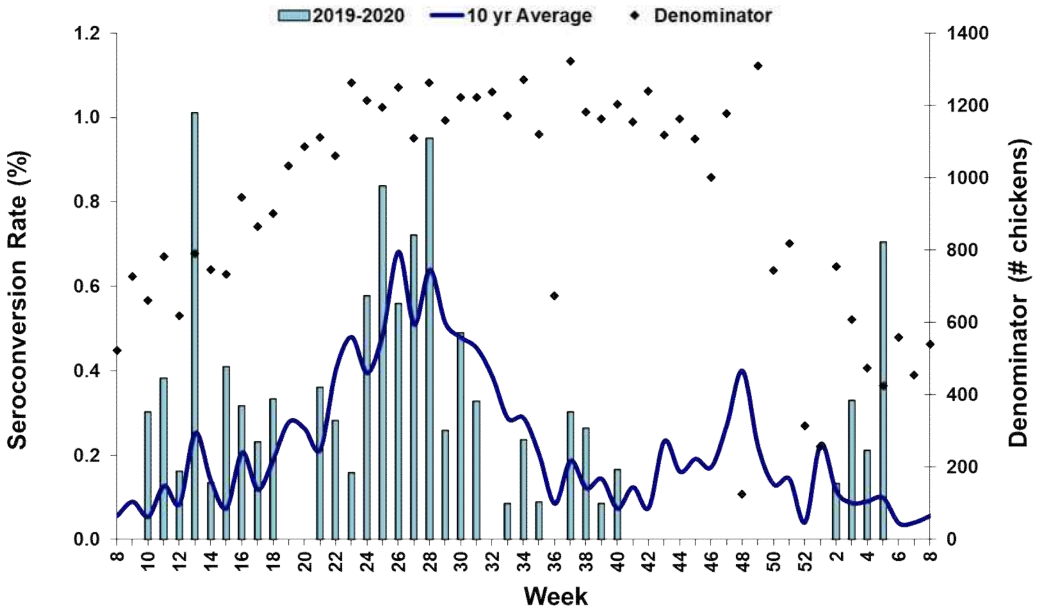
Sentinel Seroconversions to EEEV in Florida, 2019-2020



Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, six reports representing a total of 19 dead birds, including two raptors, were received from six counties.

In 2020, 62 reports representing a total of 171 dead birds (16 crows, 1 jay, 16 raptors) were received from 25 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Broward	1	0	0	1	0
Charlotte	1	0	0	0	0
Collier	1	0	0	0	0
Okaloosa	5	0	0	0	0
Palm Beach	1	0	0	1	0
Volusia	10	0	0	0	0

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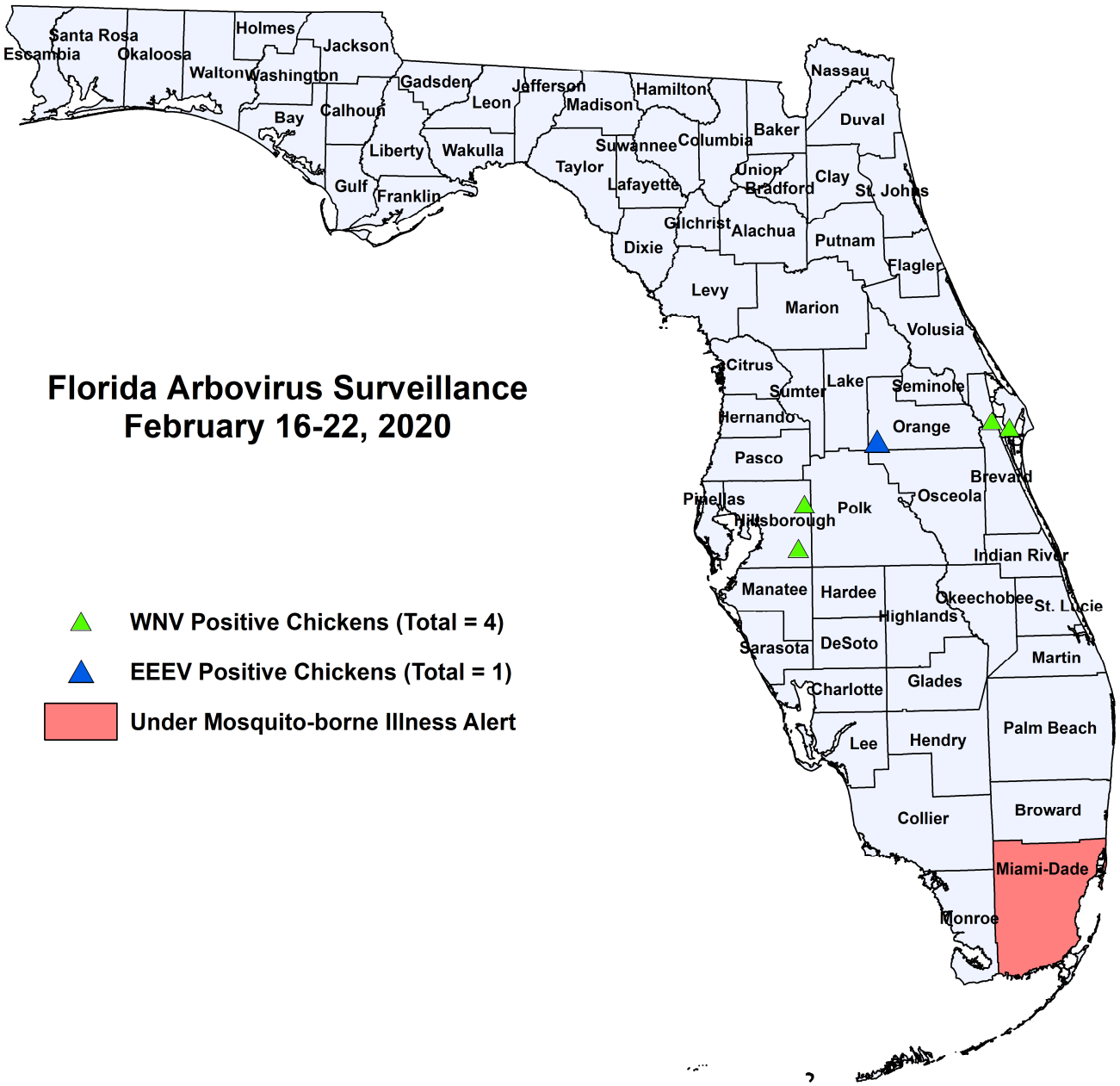
Maps



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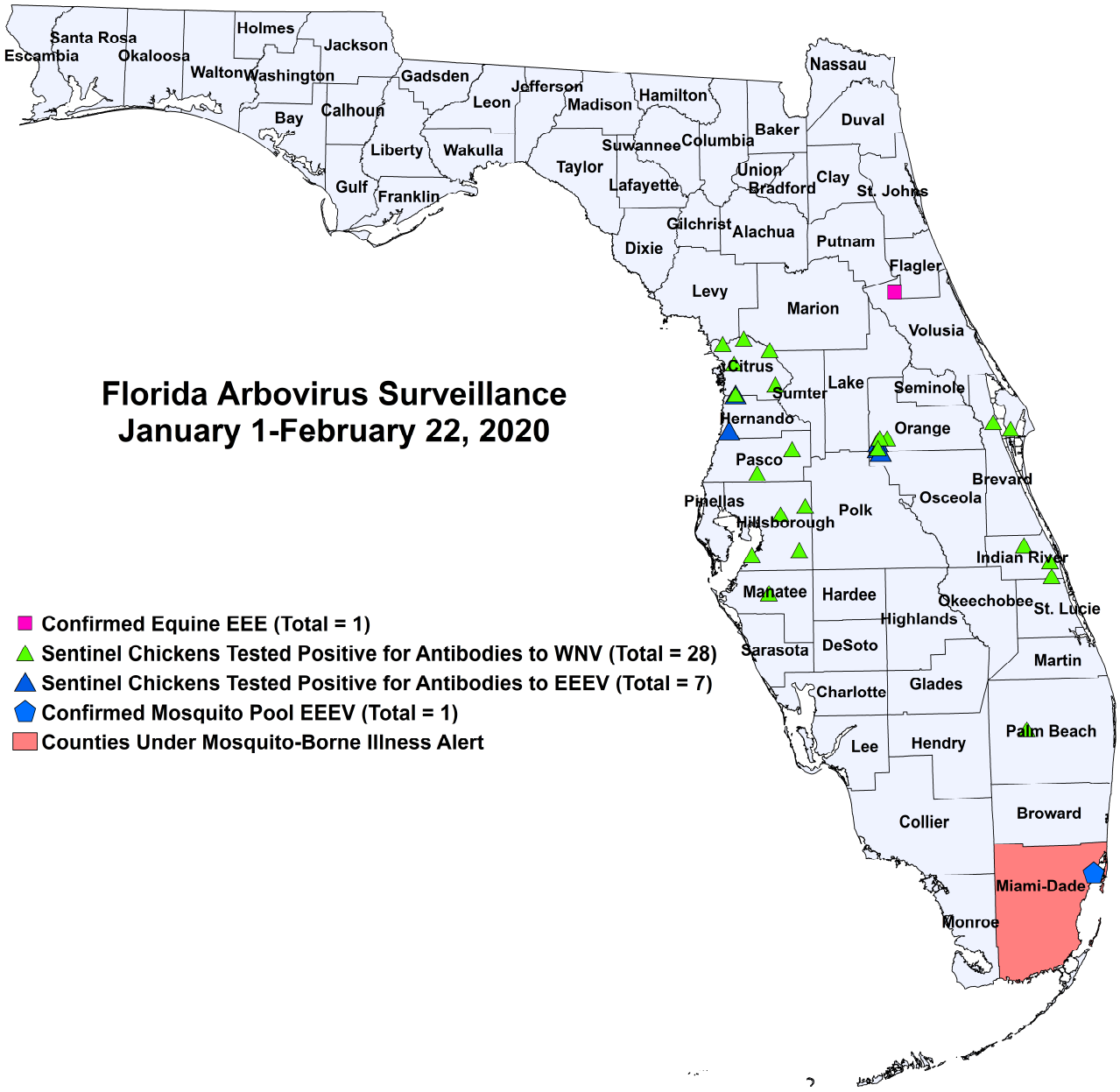

2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Brevard	WNV: 2 sentinels (1/23, 1/24)
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 1 sentinel (1/8)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 6 sentinels (1/6, 1/21, 1/29)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Orange	WNV: 3 sentinels (1/6) EEEV: 5 sentinels (1/13, 1/27, 1/28)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24)

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Acknowledgements and Data Sources

Contributors: Andrea Morrison, PhD, MSPH, Devin Rowe, MS, Catherine McDermott, MPH, MHS, and Danielle Stanek, DVM, DOH Bureau of Epidemiology; Lea Heberlein-Larson, DrPH; Alexis LaCrue, PhD, MS; Maribel Castaneda, and Valerie Mock, BS; DOH Bureau of Public Health Laboratories; Carina Blackmore, DVM, PhD, DOH Division of Disease Control and Health Protection.

For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

Case tallies included in the weekly Florida arbovirus surveillance report include confirmed and probable cases for EEE, WNV infection, SLE, dengue, chikungunya, and malaria by date of onset. Suspect cases are not included. Activity is mapped by county of exposure rather than county of residence. Case definitions being used in Florida are consistent with national criteria provided by the Council of State and Territorial Epidemiologists (CSTE) and may be viewed at: www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html. Case tallies reported by CDC do not include suspect cases and cases are reported by patient state of residence rather than where the exposure occurred. Data is provided by county health departments, Department of Health Bureau of Public Health Laboratories, Department of Agriculture and Consumer Services, mosquito control agencies, Florida Fish and Wildlife Conservation Commission, medical providers and veterinarians. Equine cases are provided by the Department of Agriculture and Consumer Services.

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From: Morrison, Andrea

To: Abbasi, Muhammad J; Abbott, Jeffrey; Abella, Eleanor C; acurtis1@hotmail.com; Adams, Cami; Adams, Laura; Alachua Emergency Management; Alderman, Margie L; Allan, Sandy; Allcock, Dawn; Allred, David; Alonso, Alina M; Alyssa; Artman, Scott; Austin, Richard; Aycock, Jessica; Baker, Kevin M; Barbert, Anthoiny; Barnard, Don; Barrera, Roberto; Bartlett, Sue; Bayer, Barbara; Beard, Charles; Beckham, Fred; Beeman, Sean; Bencie, Jennifer L; BermudezPerez, Maria D; Bertholf, Marsha; Bey, John M; Black, Grant; Blackmore, Carina; Blackmore, Mark; Blosser, Erik; Boobyer, Pamela D; Boohene, Carl; Booker, Stacey; Borgert, Brooke; Bossart, Gregory; Bowers, Doria; Bowman, Anne C; Britch, Seth; Brown, Amy; Brown, Keith; Bryant, Glenn W; Buckner, Eva; Burbaugh, Bradley; Burger, Ron; Burkett-Cadena, Nathan; Burns, Leonard; Burroughs, Sherry; Bustillo, Eduardo; Butler, Paul D; Cannons, Andrew C; Carbon, Peter; Carbonneau, Dwayne; Carey, Beth; Carlson, Doug; Cason, Emily; Chang, Aileen; Chapman, Karen A; Cheatham, Russell ; Chen, William; Choe, Ulyee; Greg Christy; Cilek, James; Clark, Marah; Clauson, James; Coatsworth, Heather; Connor, Olga; Conti, Lisa; Cook, David; Cope, Eric; Cori; Crawford, Brian; Cunningham, Mark; Dame, David; Dame, John; Daniels, Miranda; Danyluk, Gregory M; Dark, Michael; Daugherty, Stephanie L; Davidson, Sherri; Davis, Cynthia; Davis, Pam; Day, Jonathan; Debaldo, Ann; Decenteceo, Michelle; Deidre.K.Fontenot@disney.com; Dennis, Anthony D; Dillon, Joanna; Dinglasan, Rhoel; Dixon, Daniel; Doblecki-Lewis, Susanne; Dominy, Randy; Dooley, Daniel O; Doonan, Terry; Drennon, Michael T; Duesterbeck, Geoffrey; Eckert, Nancy; Efstathion, Caroline ; Elbadry, Maha; Elliott, Karen E; Ellis, Esther; English, Trey; Ernst, Kacey; Evans, Jill; Falcon, Drake; Fasulo, Thomas; Fazekas, Steven; Feinman, Shawna; Fernandez, Michael; Ferrer, Esther; Fisch, William; Florida Animal Control Association; Fontaine, Arden; Fricano, Pat; Friend, Kelly; Fulcher, Ali; Furlong, Heather; Gale, Wayne; Garcia, Mary L; Giandomenico, Dana A.; Gibs, Paul; Gill, Caitlin; Glicksberg, David; Godwin, Michael D; Goode, Gary; Gosselin, Susan; Gray, Greg; Grimes, Bryan; Guidash, Gayle; Halbritter, Julia; Hall, Margarita; Hamilton, Mary; Harris, Cynthia; Harris, Ed; Hawker, Miranda C; Hayes, Donald; Healy, Brandon; Heberlein-Larson, Lea A.; Heinig, Rebecca; Higginbotham, William T; Hogan, Lisa C; Holloway, Brandon; Holt, Douglas A. (Doug); Holt, Holly; Howard, Jessi; Howell, Wes; Hoyer, Isaiah; Hribar, Larry; Huff, Chad; Mosquito Control-North; Hunter, Johnny; BRUCE Hyers; Inman, Barry; Iovine, Nicole; Isaacs, Paul; Isern, Sharon; Jackson, Eric; Jackson, Sharon D; Jenkins, Alex; Jeter, Bill; Jiang, Peter; John, Ava; Johnson, Suzanne J; Juengst, Benjamin D; Kartzinel, Mark; Kaur, Ramandeep; Kelly, Rosmarie; Kernbach, Meredith; Kline, Dan; Koller, Kyle; Krause, Keary; Kublalsingh, Liza; Lacey, Rachel; Lamb, JoAnne; Lamberg, Frieda; Lang, Jerry; Larkin, Tom B; andrea leal; Leckey, Cynthia M; Lee, Chris; Lee, Rafael; Lehman, Jennifer; Lenes, Bruce; Li-Espino, Edgardo; Linser, Paul; Linthicum, Kenneth; Lloyd, Aaron; Locke, Barbara L; Long, Maureen; Lontz, Ed; Lord, Cynthia; Lucas, Keira; Lynn, Angelica; MacHardy, Tim; Magturo, Narrie; Maguire, Ken G; Mallicote, Martha; Martin, Marty; Matthias, James M; McCoy, Kaci; McDermott, Catherine; McDonough, Marcus; McGowan, Austin; McGowen, Pamela S; McGregor, Bethany; McInnis, Sarah; McKay, Leslie W; McLane, Dawn; Medina, Johana; Mello, Matthew; Mena, Lourdes; Mendoza, Rafael M; Michael, Scott; Miley, Kristy; Miller, Peter; Mock, Valerie; Moffis, Brooke; Moley, Ray; Montgomery, R; Moody-Geissler, Stephanie; Dennis Moore; Morales, Edgar E; Morris, Glenn; Morrison, Andrea; Mosley, Jackson; Motiska, Melanie S; Mukhtar, Saqib; Mulla, Cindy; Munroe, Julia; Napier, Mike J.; Newton, Michele; Ngo-Seidel, Eugenia J; Nicely, Bruce; Nimmo, Derric; Noya-Chaveco, Pedro A; nwbell@yahoo.com; Obenauer, Peter; Ortiz, Maritza; Ortiz-Saavedra, Hugo; Otis, Aaron; Paranjape, Geeta; Parker, Casey; Parker, Joseph; Payne, Wes; Pelley, David; Persaud, Michelle; Peterson, Jack; Petrie, William; Phillips, Sheila; Progulske, Barbara A; Progulske, Barbara A; Puckett, Jeremy; Ramos, Victoria L; Ranson, Beth; reception@swcmcd.org; Reddy Bommineni (Reddy.Bommineni@freshfromflorida.com); Reeves, Lary; Rehme, Paul A; Reik, Rita; Reinhold, Todd A; Reisinger, Chris; Reliford, Michele; Rey, Jorge; Rodriguez, Carlos; Rogers, Adriane; Root, Bruce; Rowe, Devin R; paul.rygiel@freshfromflorida.com; Sanchez, Shannon; Sayler, Katherine; Schaefer, Donald; Schermerhorn, Scott; Scholl, Bud; Scott, Blake; Scuteri, Ana C; Seaton, Lylah J; Sentman, Michael L; Shafter, Sarah; Sharp, Tyler; Shaw, Alexander I; Sheridan, Candy (Candy.Sheridan@freshfromflorida.com); Shirley, Michael; Short, Mike; Shroyer, Don; Sloyer, Kristin; Small, Parks; Smith, Angela M; Smith, Bret A; Smith, John; Smith, Tyson; Snyder, Robert E; Solis, Amy; Spencer, Jamison; Stanek, Danielle R; Stasko, Audrey R; Stauffer, Kendra; Stephenson, Caroline J; Sterling, Milton; Stiles, Arthur; Stockdale, Healther; Stokes, Jared; Stramer, Susan; Sudano, Hyatt; Sumner, Samuel M; Sylvester, Therese ; Tabachnick, Walter; Tannenbaum, Deborah; Terrell, Scott; Terry Sweat; Thaqi, Paula M; Thomas, Karen A; Thrall, Taylor; Tiffany; Torres, Midna; Torres, Yari; Trent, Stuart; Tressler, Miranda; Turner, Edna L; Ulery, Sheryl P; Unnasch, Thomas; VanDine, Jennifer; Vasconcellos-Byrd, Tia; Vazquez, Griselda; Vazquez, Jonathan; Volz, Chris; Voss, Ruth; Wakefield, Fred; Walker, Gregg; Walsh, Donna; Wamolt, Gary; Waterman, Steve; Weeks-Samanie, Angela; Weiss, Ursula; Welch, Johanna; Wells, Steve; Whidden, Connie; White, Cheryl; Whitehurst, Jared; Whiteside, Mark X; Wickens, Chrissa; Williams, Katie; Wilson, Tiffany; Winters, Kirt; Zimler, Rebecca; Zimmel, Dana; Kylie Zirbel

Subject: Florida Arbovirus Surveillance Week 9: February 23-29, 2020

Date: Monday, March 2, 2020 5:44:47 PM

Attachments: image003.png
2020Week9ArbovirusReport_2-29-20.pdf

Florida Arbovirus Surveillance
Week 9: February 23-29, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West

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Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 23-29, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, seven sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: Three cases of dengue fever were reported this week in persons that had international travel. In 2020, seventeen travel-associated cases have been reported.
Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be

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found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

Andrea Morrison*, PhD

*please note my last name has changed from Bingham

Vector-Borne Disease Surveillance Coordinator
Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Epidemiology
4052 Bald Cypress Way, Bin # A12
Tallahassee, Florida 32399-1710
(phone): 850-901-6887
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(confidential fax): 850-414-6894
(email): Andrea.Morrison@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure

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Florida Arbovirus Surveillance
Week 9: February 23-29, 2020

Arbovirus surveillance in Florida includes endemic mosquito-borne viruses such as West Nile virus (WNV), Eastern equine encephalitis virus (EEEV), and St. Louis encephalitis virus (SLEV), as well as exotic viruses such as dengue virus (DENV), chikungunya virus (CHIKV), Zika virus (ZIKV), and California encephalitis group viruses (CEV). Malaria, a parasitic mosquito-borne disease is also included. During the period of February 23-29, 2020, the following arboviral activity was recorded in Florida.

WNV activity: No human cases of WNV infection were reported this week. No horses with WNV infection were reported this week. Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County. In 2020, 30 sentinel chickens have been reported from nine counties.

SLEV activity: No human cases of SLEV infection were reported this week. No sentinel chickens tested positive for antibodies to SLEV this week. In 2020, no positive samples have been reported.

EEEV activity: No human cases of EEEV infection were reported this week. No horses with EEEV infection were reported this week. No sentinel chickens tested positive for antibodies to EEEV this week. In 2020, seven sentinel chickens, one horse, and one mosquito pool have been reported from five counties.

International Travel-Associated Dengue Fever Cases: Three cases of dengue fever were reported this week in persons that had international travel. In 2020, seventeen travel-associated cases have been reported.

Dengue Fever Cases Acquired in Florida: No cases of locally acquired dengue fever were reported this week. In 2020, no cases of locally acquired dengue fever have been reported.

International Travel-Associated Chikungunya Fever Cases: No cases of chikungunya fever were reported this week in persons that had international travel. In 2020, no travel-associated chikungunya fever cases have been reported.

Chikungunya Fever Cases Acquired in Florida: No cases of locally acquired chikungunya fever were reported this week. In 2020, no cases of locally acquired chikungunya fever have been reported.

International Travel-Associated Zika Fever Cases: No cases of Zika fever were reported this week in persons that had international travel. In 2020, no travel-associated Zika fever cases have been reported.

Zika Fever Cases Acquired in Florida: No cases of locally acquired Zika fever were reported this week. In 2020, no cases of locally acquired Zika fever have been reported.

Advisories/Alerts: Miami-Dade County is currently under a mosquito-borne illness alert. No other counties are currently under mosquito-borne illness advisory or alert.

There is a Level 2 Travel Health Notice for Nigeria related to the transmission of yellow fever virus. There are also Level 1 Travel Health Notices for Central and South America, Mexico, the Caribbean, Asia, the Pacific Islands, Africa, and the Middle East related to the transmission of dengue virus, for Burundi related to Malaria transmission, and for Ethiopia related to chikungunya transmission. Additional information on travel health notices can be found at the following link: wwwnc.cdc.gov/travel/notices. For a map of arboviral disease activity in the United States visit: wwwn.cdc.gov/arbonet/maps/ADB_Diseases_Map/index.html.

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2020 Human Case Summary*

International Travel-Associated Dengue Fever Cases
Seventeen cases of dengue fever with onset in 2020 have been reported in individuals with travel history to a dengue endemic area in the two weeks prior to onset. Counties reporting cases were: Brevard, Broward (5), Franklin, Hillsborough (3), Miami-Dade (5), Seminole, and St. Lucie. Two cases were reported in non-Florida residents. In 2020, sixteen cases of dengue reported in Florida have been serotyped by PCR. Please see the table below for a breakdown of cases by country of origin and serotype.

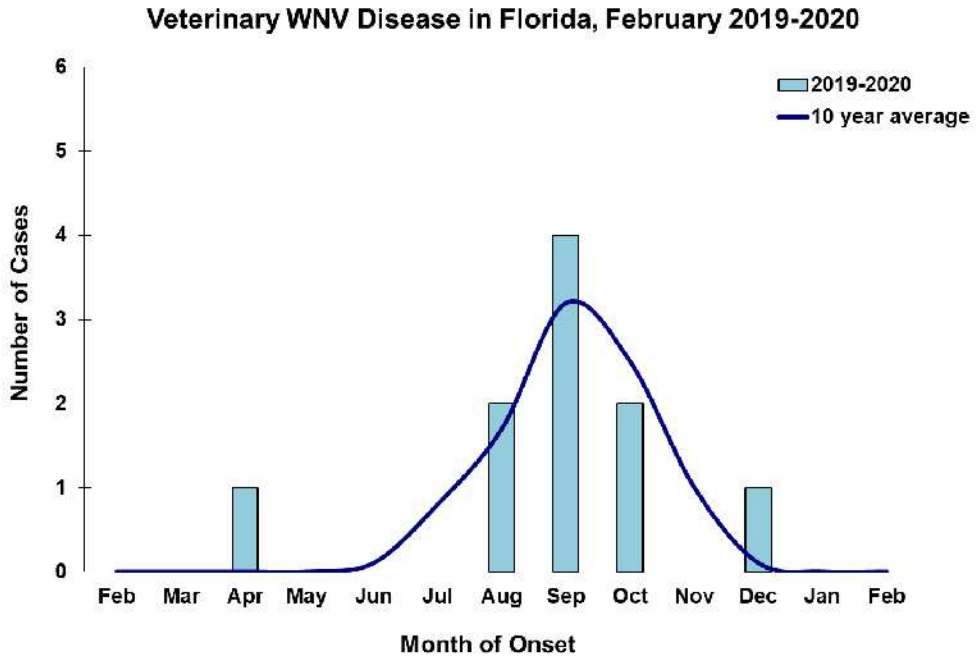
Country of Exposure	DENV-1	DENV-2	DENV-3	DENV-4	DENV-1/ DENV-3	Unknown	Total
Jamaica			3		1		4
Cuba	1	1					2
Colombia	2						2
Dominican Republic	2						2
Bolivia	1						1
Puerto Rico/US Virgin Islands	1						1
Bahamas	1						1
US Virgin Islands						1	1
Paraguay				1			1
Brazil		1					1
Nicaragua		1					1
Total	**8**	**3**	**3**	**1**	**1**	**1**	**17**

International Travel-Associated Malaria Cases: Two cases of malaria with onset in 2020 have been reported. Countries of origin were: Dominican Republic and Nigeria. Counties reporting cases were: Miami-Dade and Polk. Both cases were diagnosed with *Plasmodium falciparum*. One case was reported in a non-Florida resident.

Veterinary Cases*

*Veterinary cases are reported by date of onset. Only mammalian veterinary cases are included in the graphs.

No veterinary cases were reported this week.



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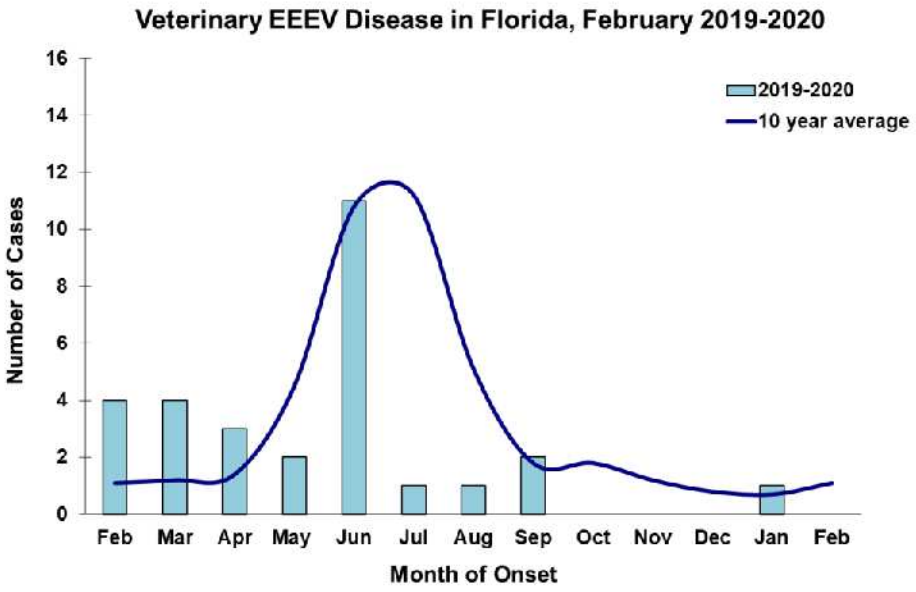
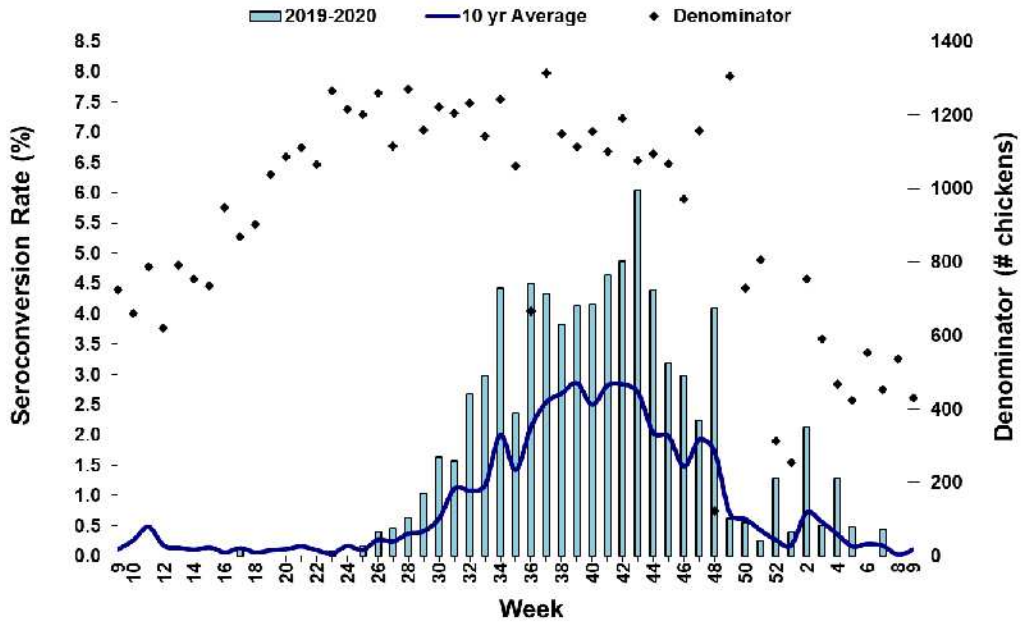


Sentinel Chickens*

The table below is for the reporting of confirmatory laboratory results from this week. Some of the samples were collected at earlier dates. The date of collection is recorded for samples collected on that day along with the total number of positives and the corresponding seroconversion rate for the week the sample was collected.

Two sentinel chickens tested positive for antibodies to WNV this week in Hillsborough County.

County	Collection Date	Seroconversion Rates (%)						County Totals	
		Flavi	SLEV	WNV	Alpha	EEEV	HJV	Collection Week	YTD
Hillsborough	1/29/20	4.17		4.17				2 WNV	8 WNV



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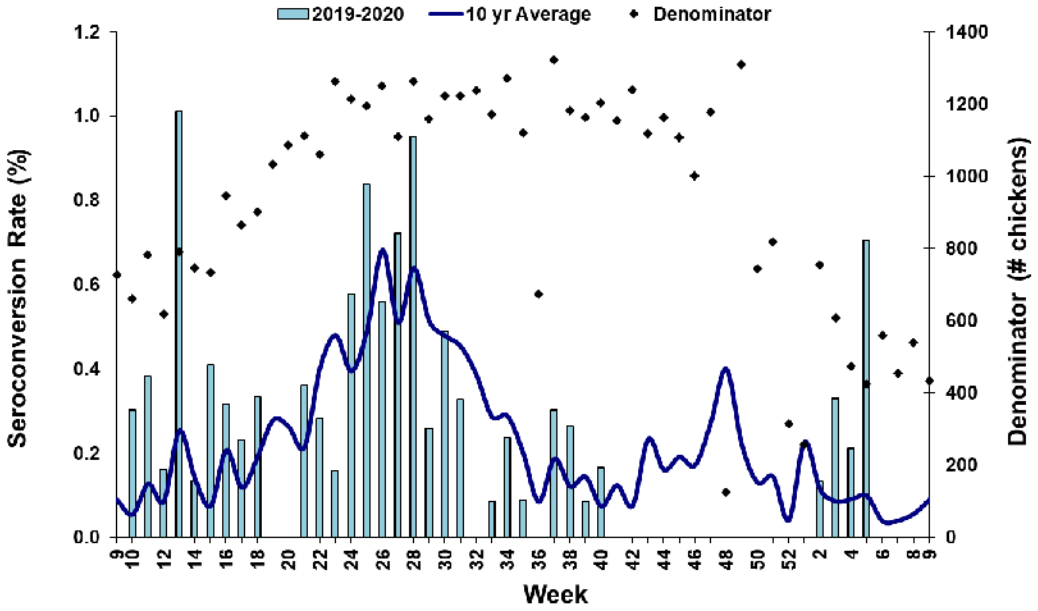
Sentinel Seroconversions to EEEV in Florida, 2019-2020



Mosquito Pools

No mosquito pools tested positive for EEEV or WNV this week.

County	Collection Date	Result	Species	County YTD

Dead Birds

The Fish and Wildlife Conservation Commission (FWC) collects reports of dead birds, which can be an indication of arbovirus circulation in an area. This week, 10 reports representing a total of 11 dead birds, including one raptor, were received from nine counties.

In 2020, 72 reports representing a total of 182 dead birds (16 crows, 1 jay, 17 raptors) were received from 25 of Florida's 67 counties.

2020

County	Total Dead Birds	Crows	Jays	Raptors	Doves
Collier	1	0	0	0	0
Escambia	2	0	0	0	0
Hillsborough	2	0	0	0	0
Manatee	1	0	0	0	0
Okaloosa	1	0	0	0	0
Palm Beach	1	0	0	1	0
Pinellas	1	0	0	0	0
Sarasota	1	0	0	0	0
St. Lucie	1	0	0	0	0

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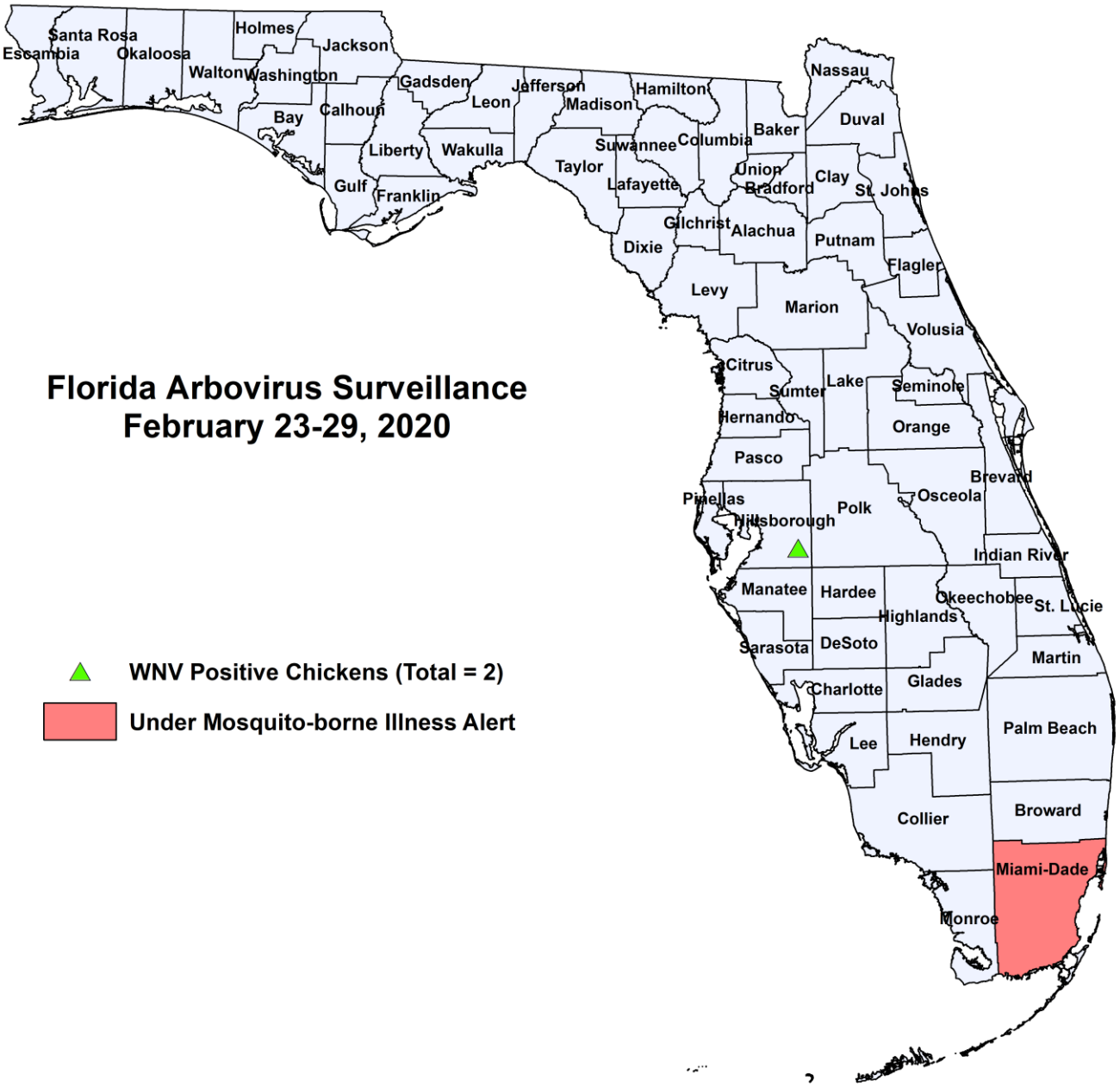
Maps



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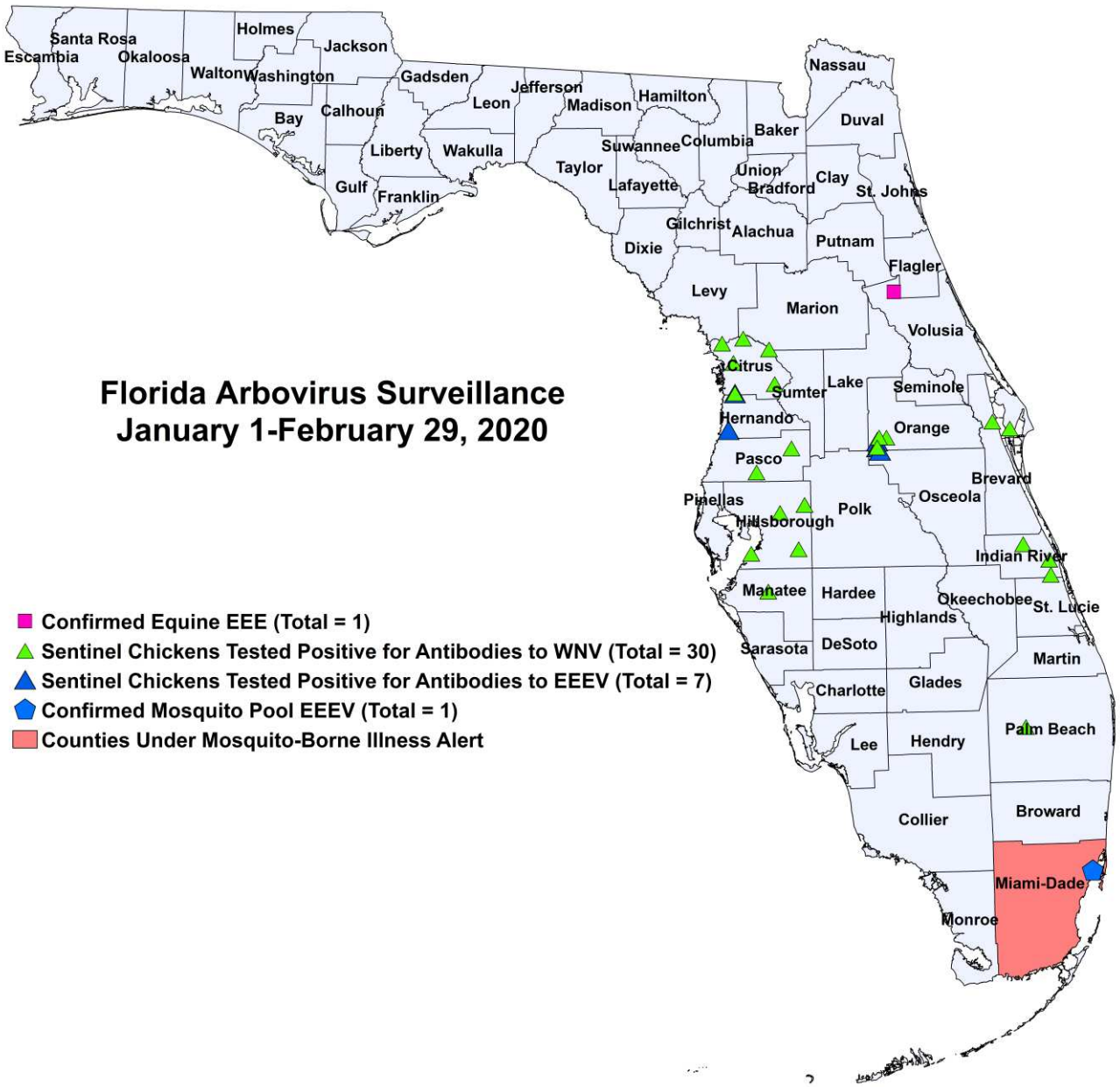

2020 Arbovirus Activity by County	
County	**Arbovirus Activity**
Brevard	WNV: 2 sentinels (1/23, 1/24)
Citrus	WNV: 8 sentinels (1/8, 1/14, 1/21) EEEV: 1 sentinel (1/8)
Hernando	EEEV: 1 sentinel (1/21)
Hillsborough	WNV: 8 sentinels (1/6, 1/21, 1/29, 2/11)
Indian River	WNV: 3 sentinels (1/2, 1/9, 1/10)
Manatee	WNV: 3 sentinels (1/8)
Miami-Dade	EEEV: 1 mosquito pool (1/7)
Orange	WNV: 3 sentinels (1/6) EEEV: 5 sentinels (1/13, 1/27, 1/28)
Palm Beach	WNV: 1 sentinel (1/20)
Pasco	WNV: 2 sentinels (1/7)
Volusia	EEEV: 1 horse (1/24)

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Acknowledgements and Data Sources

Contributors: Andrea Morrison, PhD, MSPH, Devin Rowe, MS, Catherine McDermott, MPH, MHS, and Danielle Stanek, DVM, DOH Bureau of Epidemiology; Lea Heberlein-Larson, DrPH; Alexis LaCrue, PhD, MS; Maribel Castaneda, and Valerie Mock, BS; DOH Bureau of Public Health Laboratories; Carina Blackmore, DVM, PhD, DOH Division of Disease Control and Health Protection.

For more surveillance information, please see the DOH website at: www.floridahealth.gov/diseases-and-conditions/mosquito-borne-diseases/surveillance.html

For arbovirus surveillance information for the United States, please see the Centers for Disease Control and Prevention website at: www.cdc.gov/ncidod/dvbid/westnile/surv&control.htm

Case tallies included in the weekly Florida arbovirus surveillance report include confirmed and probable cases for EEE, WNV infection, SLE, dengue, chikungunya, and malaria by date of onset. Suspect cases are not included. Activity is mapped by county of exposure rather than county of residence. Case definitions being used in Florida are consistent with national criteria provided by the Council of State and Territorial Epidemiologists (CSTE) and may be viewed at: www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/index.html. Case tallies reported by CDC do not include suspect cases and cases are reported by patient state of residence rather than where the exposure occurred. Data is provided by county health departments, Department of Health Bureau of Public Health Laboratories, Department of Agriculture and Consumer Services, mosquito control agencies, Florida Fish and Wildlife Conservation Commission, medical providers and veterinarians. Equine cases are provided by the Department of Agriculture and Consumer Services.

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From:	Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI)
To:	State and Local Readiness (CDC)
Cc:	Simmons, Jerome (CDC/DDPHSIS/CPR/DSLR); O"Connor, Angelica (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); Blackmore, Carina (CDC flhealth.gov); Marla.Wallace@flhealth.gov
Subject:	Florida Department of Health COVID-19 Request
Date:	Tuesday, March 10, 2020 4:14:56 PM
Attachments:	Florida Department of Health Funding Request (2.48 MB).msg
Importance:	High

Good afternoon,

The ELC has been informed all funding for COVID-19 response is being funded thru the Crisis NOFO. Therefore, I am forwarding this request I received for financial assistance from Florida Department of Health in the amount of $874,632.

Thanking you in advance for your consideration of this request. Please let me know if you need further assistance from the ELC.

De'Lisa

De'Lisa D. Simpson, MBA
Program Advisor/Project Officer
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)
Division of Preparedness and Emerging Infections
National Center for Emerging & Zoonotic Infectious Diseases (NCEZID)
Centers for Disease Control and Prevention
1600 Clifton Rd, Mailstop C-12
Atlanta, GA 30333
Office: 404-639-3629
Blackberry: 404-372-5928
Fax: 404-718-1874
ion9@cdc.gov

AMERICAN OVERSIGHT

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Wednesday, March 04, 2020 12:39 PM EST
To: Simpson, De'Lisa D. (CDC/DDID/NCEZID/DPEI) <ion9@cdc.gov>
CC: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Department of Health Funding Request
Attachment(s): "COVER LETTER COVID-19.pdf","ELC Budget Emerging Cross-Cutting COVID-19 3-4-20.pdf","Florida Indirect Rate Agreement.pdf","Florida ELC 424A COVID-19.xls"

De'Lisa

Please find the attached request from the Florida Department of Health for supplemental ELC funding from the Cross Cutting Emerging Issues Project. This request will be used to support Florida's Epidemiology and Laboratory Response to the current COVID-19 Outbreak. This funding was previously applied for in funding opportunity number: CDC RFA-CK19-1904 and was approved but was not funded. Please feel free to reach out to Dr. Blackmore or myself if you have any questions or concerns regarding this matter.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

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Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

March 4, 2020

Ms. De'Lisa Simpson
Project officer
Epidemiology and Laboratory for Infectious Diseases Program
Centers for Disease Control and Prevention
2920 Brandywine Road
Atlanta, Georgia 30341

Dear Ms. Simpson,

Please find this request submitted by the Florida Department of Health for funding to support Coronavirus Response (COVID-19) from the Cross Cutting Emerging Issues Project, Epidemiology and Laboratory Capacity Grant (ELC). This funding was previously applied for in funding opportunity number: CDC-RFA-CK19-1904, in the ELC Grant and was approved but was not funded. The grant project period is from August 1, 2019 to July 31, 2024. This request includes a detailed budget with justification and indirect cost rate agreement.

Thank you for your continued support of this important public health program. If further information is needed, please contact Dr. Carina Blackmore, Principal Investigator, at 850 245-4732 or at Carina.Blackmore@flhealth.gov

Sincerely,

Carina Blackmore

Carina Blackmore, DVM, PhD. Dipl. ACVPM
State Epidemiologist
Director Division of Disease Control and Health Protection
Principal Investigator, ELC Grant

CB/mdw
Enclosures

Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Epidemiology
4052 Bald Cypress Way, Bin A-9 • Tallahassee, FL 32399
PHONE: 850/245-4300 • FAX: 850/413-9113
FloridaHealth.gov

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PHAB Accredited Health Department
Public Health Accreditation Board

FL-DOH-20-0673-A-003838

Epidemiology and Laboratory Capacity
for Prevention and Control of Emerging Inectious Diseases (ELC)
Cross-Cutting Emerging Issues Coronavirus (COVID-19)
Florida Department of Health

Budgetary Summary of Expenditures by Category

Personnel	**$240,000**
Fringe	**$48,000**
Equipment	**$35,000**
Supplies	**$145,094**
Travel	**$22,200**
Other	**$960**
Contractual	**$307,000**
Total Direct Costs	**$798,254**
Indirect Costs	**$76,378**
Total	**$874,632**

A.

Personnel Category	**FTEs**	**(All are Other Personnel Services)**	
Epidemiology	**6.00**		**$120,000**
Laboratory	**9.00**		**$120,000**
Salary Total	**6.00**		**$240,000**

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	South Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in Miami-Dade, Broward, Palm Beach Counties in South Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	South Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in Miami-Dade, Broward, Palm Beach Counties in West Central Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	Central Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in Central Florida (Orlando Area) Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	West Central Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in West Central Florida (Tampa, St. Peterburg Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	Hillsborough CHD	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work at the Hillsborough. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	Orange CHD	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work at the Orange CHD.. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Medical Laboratory Scientist II	Tampa Laboratory	4	3.00	$40,000

These positions will support Coronavirus (COVID-19) laboratory analysis and detection work.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Medical Laboratory Scientist II	Jacksonville Laboratory	4	3.00	$40,000

These positions will support Coronavirus (COVID-19) laboratory analysis and detection work.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Medical Laboratory Scientist II	Miami Laboratory	4	3.00	$40,000

These positions will support Coronavirus (COVID-19) laboratory analysis and detection work.

AMERICAN OVERSIGHT

B.

Fringe Benefits Category	Salary		Fringe	
FICA, Health Insurance and Retirement	**$240,000**	**x**	**20%**	**$48,000**
Fringe Benefits Total				**$48,000**

C.

Equipment	
EZ1	**$35,000**
Equipment Total	**$35,000**

The EZ1 automated extraction instrument will be used for testing COVID-19.

D.

Supplies Category	Quantity	Cost/Item	Total
Computers	6	$999.00	$5,994
Mobile Devices	6	$500.00	$3,000
Portable Monitor	6	$350.00	$2,100
Laboratory Testing Supplies			$134,000
Supplies Total			**$145,094**

E.

Travel Category	Staff	Cost	Trips	Total
In-state	6	$370	10	$22,200
Travel Total				**$22,200**

In-State Justification

In-State: Travel for epidemiologists to travel to affected counties to support the Coronavirus response.

(cost per 2-day trip):

Meals/Per Diem	$116
Hotels ($150 per night)	$150
Rental Car ($26 per day)	$52
Gas for Rental Vehicle	$30
Incidentals Tolls/Parking	$22
	$370

F.

Other Category	Cost	Quantity	Months	Total
Mobile Device Service	$40	6	4	$960
Other Total				**$960**

G.

Contractual Category	
LabWare Consultants	$50,000
Biostatistician	$42,000
Merlin System Development	$135,000
Merlin System Tester	$80,000
Contractual Total	**$307,000**

Contractor: LabWare, Inc.

Period of Performance: TBD

Method of Selection: Single Source

Scope of Work: LabWare consultants will assist the Bureau of Public Health Laboratory's in-house LabWare system administrators to implement system enhancements to more rapidly track, prioritize and process Coronavirus specimens. LabWare modifications will process information associated with specimens ordered through the in-house electronic laboratory order system for county health departments. Through the interface, local county health departments provide information about pregnancy status, symptoms, and travel history, but the order information is not viewable from within the LabWare system to the laboratorians performing the testing or the staff responsible for the receipt and triaging specimens for testing. LabWare modifications will be made to communicate critical information collected via the order process to the surveillance application (Merlin). Enhancements to LabWare will also be made to improve the order experience by clinical providers external to the health department. This will enable providers to order Coronavirus testing via a web interface. The order interface will accommodate collection of Coronavirus specific questions (symptoms and onset date, travel history, and pregnancy status). Providers will also be able to see, print and access the results from the order interface which will reduce or alleviate the need for laboratory staff time to print and fax results. LabWare modifications will be made to store CDC test result information and send that result (after entered) to Merlin. LabWare modifications will be made to further interoperability with the surveillance application (Merlin) to enable laboratory staff to view Person Under Investigation Information. Consultants will complete system modifications, test scripts and regression testing and attend weekly project meetings.

Cost: 1 Consultant at $1,000 per day x 50 days = $50,000

AMERICAN OVERSIGHT

Contractor: TBD
Period of Performance: TBD
Method of Selection: State Term Contract
Scope of Work: The Biostatistician will perform activities associated with Coronavirus surveillance, including monitoring data quality, creating guidance materials as needed, providing training, and assisting with system development to collect and manage data; Review data both at the case, community and state level, as well as looking at trends over time and in special populations; Provide support to the state and county health departments as needed with data entry, data cleaning, and data management of Coronavirus cases; Review data in-depth to identify and address data quality issues, including proposing system solutions and following-up regularly with the state and county health department users to ensure high data quality; Produce daily and weekly Coronavirus surveillance reports to be shared internally and externally; Develop and distribute reports to manage case and laboratory data and those that can be used by the state and county health department staff to quickly assess Coronavirus trends to support decision making and guide policy development; Serve as a liaison with other key stakeholders involved in Coronavirus response.

Cost: $70 per hour x 600 hours = $42,000

Contractor: TBD (Merlin System Developer
Period of Performance: TBD
Method of Selection: State Term Contract
Scope of Work: Developer will perform system modifications to the Central Outbreak Documentation system and Merlin Outbreak Module to ensure specific outbreak response activities are met. Additional modifications will be performed following the response hot wash and gap analyses. Development will be performed in SQL and may include linkages to EpiInfo and web-based data collection and LabWare (the state laboratory information management system). Selection Type - State Term; Contract Type – Commercial; Company Name - TBD; Program Area Support - Outbreak Response; Contract Period - TBD; Accountability - Monthly Report; Description - Position contract for systems development.

Cost: $90 per hour x 1,500 hours = $135,000

Contractor: TBD (Merlin System Tester)
Period of Performance: TBD
Method of Selection: State Term Contract
Scope of Work: Ensure all the changes have been properly implemented and the core functionality in Merlin remains intact following implementation of development changes necessary to support the response. Conducts testing on coding changes completed by the developer prior to changes released to the production environment (see changes described above under developer and project manager). The tester will complete regression testing and produce automated test scripts to ensure that all following changes in Merlin do not create any disruptions on the existing code. All code released to production systems are required to go through a skilled systems tester prior to production release. Selection Type - State Term; Contract Type – Commercial; Company Name –TBD; Program Area Support – Health Information Systems; Contract Period - TBD; Accountability - Monthly Report; Description - Position contract for systems testing.

Cost: $80 per hour x 1,000 hours = $80,000

H.	**Total Direct Costs**	**$798,254**
I.	**Indirect Costs**	**$76,378**

Indirect Cost rates are negotiated between the Florida Department of Health and the U.S. Department of Health and Human Services – Cost Allocation Unit. These costs cover administrative expenses that support multiple programs and cannot be identified as program or grant specific costs.

Costs associated with fixed costs such as lease space, utilities, phone, etc., are not considered part of the indirect cost pool and are charged directly to the grants where the staff are housed and paid directly from a grant. These fixed costs are standard costs associated with a full time equivalent (FTE) and are developed by the Executive Office of the Governor as part of the Legislative Budget Standards each year. These costs are listed under the "Other" category of the grant.

Sala	+ Fringe	= Subtotal	Indirect Rate	= Total
$240,000	$48,000	$288,000	26.52%	**$76,378**

J.	**Total ELC 2020 Coronavirus Supplemental Request**	**$874,632**

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1				BUDGET INFORMATION - Non-Construction Programs						
2										
3	SECTION A - BUDGET SUMMARY									
4	Grant Program		Catalog of Federal							
5	Function		Domestic Assistance			Estimated Unobligated Funds				New or Revised Budget
6	or Activity		Number		Federal		Non-Federal		Federal	Non-Federal
7	(a)		(b)		(c)		(d)		(e)	(f)
8	1 Epidemiology and Laboratory Capacity for Infectious Diseases , COVID-19		93.323							
9					$0		$0		$874,632	$0
10	2.									
11										
12	3									
13										
14	4.									
15										
16	5.									
17	Totals				$0		$0		$874,632	$0
18	SECTION B - BUDGET CATEGORIES									
19						Grant Program, Function, or Activity				
20	6. Object Class Categories				(1) CDC Grant	Budget	(2)	Match	(3)	(4) Unobligated
21										
22	a. Personnel					240,000				
23										
24	b. Fringe Benefits					48,000				
25										
26	c. Travel					22,200				
27										
28	d. Equipment					35,000				
29										
30	e. Supplies					145,094				
31										
32	f. Contractual					307,000				
33										
34	g. Construction					0				
35										
36	h. Other					960				
37										
38	i. Total Direct Charges (sum 6a-6h)					798,254				
39										
40	j. Indirect Charges					76,378				
41										

AMERICAN OVERSIGHT

	K	L	M
1	**OMB Approval No. 0348-0044**		
2			
3	[redacted]		
4			
5			
6	**Total**		
7	**(g)**		
8			
9	$874,632		
10			
11	$0		
12			
13	$0		
14			
15	$0		
16			
17	$874,632		
18	[redacted]		
19	**Total**		
20	**(5)**		
21			
22	240,000		
23			
24	48,000		
25			
26	22,200		
27			
28	35,000		
29			
30	145,094		
31			
32	307,000		
33			
34	0		
35			
36	960		
37			
38	798,254		
39			
40	76,378		
41			

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
42	**k. Totals (sum of 6i/ 6j)**			#		874,632		0	0	0
43										
44										
45	**7. Program Income**			#	0		0		0	0
46										
47										

AMERICAN OVERSIGHT

	K	L	M
42	874,632		
43			
44			
45	0		
46	SF 424-A (7-97)		
47	Prescribed by OMB Circular A-102		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
48										
49	**SECTION C - NON-FEDERAL RESOURCES**									
50			**(a) Grant Program**			**(b)Applicant**	**(c) State - Maintenance Effort**		**(c) Other Sources**	
51										
52	**8.**									
53										
54	**9.**									
55										
56	**10.**									
57										
58	**11.**									
59										
60	**12. TOTALS (sum of lines 8 and 11)**									
61										
62	**SECTION D - FORECASTED CASH NEEDS**									
63					**Total for 1st Yr**	**1st Quarter**	**2nd Quarter**		**3rd Quarter**	
64										
65	**13. Federal**									
66										
67	**14. NonFederal**									
68										
69	**15. TOTAL (sum of lines 13 and 14)**				$0	$0	$0		$0	
70	**SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED**									
71	**FOR BALANCE OF PROJECT**									
72										
73			**(a) Grant Program**			**(b) First Year**	**(c) Second Year**		**(d) Third Year**	
74										
75	**16.**						$0		$0	
76										
77	**17.**									
78										
79	**18.**									
80										
81	**19.**									
82										
83	**20. TOTALS (sum of lines 16-19)**					$0	$0		$0	
84	**SECTION F - OTHER BUDGET INFORMATION**									
85	**(Attach Additional Sheets if Necessary)**									
86										
87	**21. Direct Charges:**				$798,254		**22. Indirect Charges:**		$76,378	
88										
89	**23. REMARKS**									
90										
91	S:\SHARED\SURVGRAN\96\NEW4242A.XLS									

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003846

	K	L	M
48	[redacted]		
49			
50	(c) TOTALS		
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61	[redacted]		
62			
63	4th Quarter		
64			
65			
66	$0		
67			
68			
69	$0		
70	[redacted]		
71			
72			
73	(e) Fourth Year		
74			
75			
76			
77			
78			
79			
80			
81			
82			
83	$0		
84	[redacted]		
85			
86			
87			
88			
89			
90	SF 424-A (7-97) Page 2		
91	Prescribed by OMB Circular A-102		

AMERICAN OVERSIGHT

STATE AND LOCAL GOVERNMENTS RATE AGREEMENT

EIN: 59-3502843

ORGANIZATION:
Florida Department of Health
4052 Bald Cypress Way
Bin #B-20
Tallahassee, FL 32399-1729

DATE:01/18/2019

FILING REF.: The preceding agreement was dated 03/23/2018

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES: FIXED FINAL PROV. (PROVISIONAL) PRED. (PREDETERMINED)

	EFFECTIVE PERIOD				
TYPE	**FROM**	**TO**	**RATE(%)**	**LOCATION**	**APPLICABLE TO**
FIXED	07/01/2019	06/30/2020	26.52	On Site	State Health
FIXED	07/01/2019	06/30/2020	9.10	On Site	Children Medical Services (1)
FIXED	07/01/2019	06/30/2020	12.21	On Site	Medical Quality Assurance
FIXED	07/01/2019	06/30/2020	9.64	On Site	Disability Determination
PROV.	07/01/2020	06/30/2023			Use same rates and conditions as those cited for fiscal year ending June 30, 2020.
PRED.	07/01/2016	06/30/2020	6.80	All	Children's Medical Services (2)

*BASE

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Direct salaries and wages including all fringe benefits.

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SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

The fringe benefits are specifically identified to each employee and are charged individually as direct costs. The directly claimed fringe benefits are listed below.

TREATMENT OF PAID ABSENCES

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims are not made for the cost of these paid absences.

(1) Unrestricted Rate
(2) Restricted Rate

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Equipment means an article of nonexpendable, tangible personal property having a useful life of more than 1 year(s) and an acquisition cost of $5,000 or more per unit.

Fringe Benefits:
FICA
Retirement
Disability Insurance
Health Insurance
Life Insurance

STATE HEALTH SERVICES:

The fixed rate for the fiscal year ending 06/30/20 includes an over recovery of $554,671 from final settlement of the actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

CHILDREN'S MEDICAL SERVICES:

The fixed rate for the fiscal year ending 06/30/20 includes an under recovery of $22,566 from final settlement of the actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

MEDICAL QUALITY ASSURANCE:

The fixed rate for the fiscal year ending 06/30/20 includes an over recovery of $706,431 from final settlement of actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

DISABILITY DETERMINATION:

The fixed rate for the fiscal year ending 06/30/20 includes an under recovery of $43,666 from final settlement of the actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

Your next proposal based on actual costs for the fiscal year ending 06/30/19 is due in our office by 12/31/19.

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SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted: such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the authority in Title 2 of the Code of Federal Regulations, Part 200 (2 CFR 200), and should be applied to grants, contracts and other agreements covered by 2 CFR 200, subject to any limitations in A above. The organization may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:	ON BEHALF OF THE FEDERAL GOVERNMENT:
Florida Department of Health	DEPARTMENT OF HEALTH AND HUMAN SERVICES
(INSTITUTION)	(AGENCY)
(SIGNATURE)	Darryl W. Mayes -S Digitally signed by Darryl W. Mayes -S DN: c=US, o=U.S. Government, ou=HHS, ou=PSC, ou=People, 0.9.2342.19200300.100.1.1=2000131669, cn=Darryl W. Mayes -S Date: 2019.01.23 11:24:23 -05'00' (SIGNATURE)
Ed McEachron	for Arif Karim
(NAME)	(NAME)
Director, Division of Administration	Director, Cost Allocation Services
(TITLE)	(TITLE)
1/28/2019	1/18/2019
(DATE)	(DATE) 3025

FDOH REPRESENTATIVE: Kenol Saint-Fort

Telephone: (850) 245-4534

HHS REPRESENTATIVE: Michael Phillips

Telephone: (214) 767-3261

AMERICAN OVERSIGHT

From:	Wallace, Marla D.
To:	Simpson, De"Lisa D. (CDC/OID/NCEZID)
Cc:	Blackmore, Carina
Subject:	Florida Department of Health Funding Request
Date:	Wednesday, March 4, 2020 12:39:20 PM
Attachments:	COVER LETTER COVID-19.pdf ELC Budget Emerging Cross-Cutting COVID-19 3-4-20.pdf Florida Indirect Rate Agreement.pdf Florida ELC 424A COVID-19.xls

---

De'Lisa

Please find the attached request from the Florida Department of Health for supplemental ELC funding from the Cross Cutting Emerging Issues Project. This request will be used to support Florida's Epidemiology and Laboratory Response to the current COVID-19 Outbreak. This funding was previously applied for in funding opportunity number: CDC RFA-CK19-1904 and was approved but was not funded. Please feel free to reach out to Dr. Blackmore or myself if you have any questions or concerns regarding this matter.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

March 4, 2020

Ms. De'Lisa Simpson
Project officer
Epidemiology and Laboratory for Infectious Diseases Program
Centers for Disease Control and Prevention
2920 Brandywine Road
Atlanta, Georgia 30341

Dear Ms. Simpson,

Please find this request submitted by the Florida Department of Health for funding to support Coronavirus Response (COVID-19) from the Cross Cutting Emerging Issues Project, Epidemiology and Laboratory Capacity Grant (ELC). This funding was previously applied for in funding opportunity number: CDC-RFA-CK19-1904, in the ELC Grant and was approved but was not funded. The grant project period is from August 1, 2019 to July 31, 2024. This request includes a detailed budget with justification and indirect cost rate agreement.

Thank you for your continued support of this important public health program. If further information is needed, please contact Dr. Carina Blackmore, Principal Investigator, at 850 245-4732 or at Carina.Blackmore@flhealth.gov

Sincerely,

Carina Blackmore, DVM, PhD. Dipl. ACVPM
State Epidemiologist
Director Division of Disease Control and Health Protection
Principal Investigator, ELC Grant

CB/mdw
Enclosures

AMERICAN OVERSIGHT

Epidemiology and Laboratory Capacity
for Prevention and Control of Emerging Inectious Diseases (ELC)
Cross-Cutting Emerging Issues Coronavirus (COVID-19)
Florida Department of Health

Budgetary Summary of Expenditures by Category

Personnel	**$240,000**
Fringe	**$48,000**
Equipment	**$35,000**
Supplies	**$145,094**
Travel	**$22,200**
Other	**$960**
Contractual	**$307,000**
Total Direct Costs	**$798,254**
Indirect Costs	**$76,378**
Total	**$874,632**

A.

Personnel Category	**FTEs**	**(All are Other Personnel Services)**	
Epidemiology	**6.00**		**$120,000**
Laboratory	**9.00**		**$120,000**
Salary Total	**6.00**		**$240,000**

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	South Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in Miami-Dade, Broward, Palm Beach Counties in South Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	South Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in Miami-Dade, Broward, Palm Beach Counties in West Central Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	Central Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in Central Florida (Orlando Area) Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	West Central Florida	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work in West Central Florida (Tampa, St. Peterburg Florida. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	Hillsborough CHD	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work at the Hillsborough. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Biological Scientist IV	Orange CHD	4	1.00	$20,000

This position will support Coronavirus (COVID-19) field investigation and surveillance work at the Orange CHD.. The current model of deploying existing state and county health department personnel to assist with the surge of cases is unsustainable.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Medical Laboratory Scientist II	Tampa Laboratory	4	3.00	$40,000

These positions will support Coronavirus (COVID-19) laboratory analysis and detection work.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Medical Laboratory Scientist II	Jacksonville Laboratory	4	3.00	$40,000

These positions will support Coronavirus (COVID-19) laboratory analysis and detection work.

Employee	Position Title	Location	Months	FTEs	Amount
TBD	Medical Laboratory Scientist II	Miami Laboratory	4	3.00	$40,000

These positions will support Coronavirus (COVID-19) laboratory analysis and detection work.

AMERICAN OVERSIGHT

B.

Fringe Benefits Category	Salary		Fringe	
FICA, Health Insurance and Retirement	**$240,000**	**x**	**20%**	**$48,000**
Fringe Benefits Total				**$48,000**

C.

Equipment	
EZ1	**$35,000**
Equipment Total	**$35,000**

The EZ1 automated extraction instrument will be used for testing COVID-19.

D.

Supplies Category	Quantity	Cost/Item	Total
Computers	6	$999.00	$5,994
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Laboratory Testing Supplies			$134,000
Supplies Total			**$145,094**

E.

Travel Category	Staff	Cost	Trips	Total
In-state	6	$370	10	$22,200
Travel Total				**$22,200**

In-State Justification

In-State: Travel for epidemiologists to travel to affected counties to support the Coronavirus response.

(cost per 2-day trip):

Meals/Per Diem	$116
Hotels ($150 per night)	$150
Rental Car ($26 per day)	$52
Gas for Rental Vehicle	$30
Incidentals Tolls/Parking	$22
	$370

F.

Other Category	Cost	Quantity	Months	Total
Mobile Device Service	$40	6	4	$960
Other Total				**$960**

G.

Contractual Category	
LabWare Consultants	$50,000
Biostatistician	$42,000
Merlin System Development	$135,000
Merlin System Tester	$80,000
Contractual Total	**$307,000**

Contractor: LabWare, Inc.

Period of Performance: TBD

Method of Selection: Single Source

Scope of Work: LabWare consultants will assist the Bureau of Public Health Laboratory's in-house LabWare system administrators to implement system enhancements to more rapidly track, prioritize and process Coronavirus specimens. LabWare modifications will process information associated with specimens ordered through the in-house electronic laboratory order system for county health departments. Through the interface, local county health departments provide information about pregnancy status, symptoms, and travel history, but the order information is not viewable from within the LabWare system to the laboratorians performing the testing or the staff responsible for the receipt and triaging specimens for testing. LabWare modifications will be made to communicate critical information collected via the order process to the surveillance application (Merlin). Enhancements to LabWare will also be made to improve the order experience by clinical providers external to the health department. This will enable providers to order Coronavirus testing via a web interface. The order interface will accommodate collection of Coronavirus specific questions (symptoms and onset date, travel history, and pregnancy status). Providers will also be able to see, print and access the results from the order interface which will reduce or alleviate the need for laboratory staff time to print and fax results. LabWare modifications will be made to store CDC test result information and send that result (after entered) to Merlin. LabWare modifications will be made to further interoperability with the surveillance application (Merlin) to enable laboratory staff to view Person Under Investigation Information. Consultants will complete system modifications, test scripts and regression testing and attend weekly project meetings.

Cost: 1 Consultant at $1,000 per day x 50 days = $50,000

AMERICAN OVERSIGHT

Contractor: TBD
Period of Performance: TBD
Method of Selection: State Term Contract
Scope of Work: The Biostatistician will perform activities associated with Coronavirus surveillance, including monitoring data quality, creating guidance materials as needed, providing training, and assisting with system development to collect and manage data; Review data both at the case, community and state level, as well as looking at trends over time and in special populations; Provide support to the state and county health departments as needed with data entry, data cleaning, and data management of Coronavirus cases; Review data in-depth to identify and address data quality issues, including proposing system solutions and following-up regularly with the state and county health department users to ensure high data quality; Produce daily and weekly Coronavirus surveillance reports to be shared internally and externally; Develop and distribute reports to manage case and laboratory data and those that can be used by the state and county health department staff to quickly assess Coronavirus trends to support decision making and guide policy development; Serve as a liaison with other key stakeholders involved in Coronavirus response.

Cost: $70 per hour x 600 hours = $42,000

Contractor: TBD (Merlin System Developer
Period of Performance: TBD
Method of Selection: State Term Contract
Scope of Work: Developer will perform system modifications to the Central Outbreak Documentation system and Merlin Outbreak Module to ensure specific outbreak response activities are met. Additional modifications will be performed following the response hot wash and gap analyses. Development will be performed in SQL and may include linkages to EpiInfo and web-based data collection and LabWare (the state laboratory information management system). Selection Type - State Term; Contract Type – Commercial; Company Name - TBD; Program Area Support - Outbreak Response; Contract Period - TBD; Accountability - Monthly Report; Description - Position contract for systems development.

Cost: $90 per hour x 1,500 hours = $135,000

Contractor: TBD (Merlin System Tester)
Period of Performance: TBD
Method of Selection: State Term Contract
Scope of Work: Ensure all the changes have been properly implemented and the core functionality in Merlin remains intact following implementation of development changes necessary to support the response. Conducts testing on coding changes completed by the developer prior to changes released to the production environment (see changes described above under developer and project manager). The tester will complete regression testing and produce automated test scripts to ensure that all following changes in Merlin do not create any disruptions on the existing code. All code released to production systems are required to go through a skilled systems tester prior to production release. Selection Type - State Term; Contract Type – Commercial; Company Name –TBD; Program Area Support – Health Information Systems; Contract Period - TBD; Accountability - Monthly Report; Description - Position contract for systems testing.

Cost: $80 per hour x 1,000 hours = $80,000

H.	**Total Direct Costs**	**$798,254**
I.	**Indirect Costs**	**$76,378**

Indirect Cost rates are negotiated between the Florida Department of Health and the U.S. Department of Health and Human Services – Cost Allocation Unit. These costs cover administrative expenses that support multiple programs and cannot be identified as program or grant specific costs.

Costs associated with fixed costs such as lease space, utilities, phone, etc., are not considered part of the indirect cost pool and are charged directly to the grants where the staff are housed and paid directly from a grant. These fixed costs are standard costs associated with a full time equivalent (FTE) and are developed by the Executive Office of the Governor as part of the Legislative Budget Standards each year. These costs are listed under the "Other" category of the grant.

Sala	+ Fringe	= Subtotal	Indirect Rate	= Total
$240,000	$48,000	$288,000	26.52%	**$76,378**

J.	**Total ELC 2020 Coronavirus Supplemental Request**	**$874,632**

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
1				BUDGET INFORMATION - Non-Construction Programs						
2										
3	SECTION A - BUDGET SUMMARY									
4	Grant Program		Catalog of Federal							
5	Function		Domestic Assistance			Estimated Unobligated Funds				New or Revised Budget
6	or Activity		Number		Federal		Non-Federal		Federal	Non-Federal
7	(a)		(b)		(c)		(d)		(e)	(f)
8	1 Epidemiology and Laboratory Capacity for Infectious Diseases , COVID-19		93.323							
9					$0		$0		$874,632	$0
10	2.									
11										
12	3									
13										
14	4.									
15										
16	5.									
17	Totals				$0		$0		$874,632	$0
18	SECTION B - BUDGET CATEGORIES									
19						Grant Program, Function, or Activity				
20	6. Object Class Categories				(1) CDC Grant	Budget	(2)	Match	(3)	(4) Unobligated
21										
22	a. Personnel					240,000				
23										
24	b. Fringe Benefits					48,000				
25										
26	c. Travel					22,200				
27										
28	d. Equipment					35,000				
29										
30	e. Supplies					145,094				
31										
32	f. Contractual					307,000				
33										
34	g. Construction					0				
35										
36	h. Other					960				
37										
38	i. Total Direct Charges (sum 6a-6h)					798,254				
39										
40	j. Indirect Charges					76,378				
41										

AMERICAN OVERSIGHT

	K	L	M
1	**OMB Approval No. 0348-0044**		
2			
3	[redacted]		
4			
5			
6	**Total**		
7	**(g)**		
8			
9	$874,632		
10			
11	$0		
12			
13	$0		
14			
15	$0		
16			
17	$874,632		
18	[redacted]		
19	**Total**		
20	**(5)**		
21			
22	240,000		
23			
24	48,000		
25			
26	22,200		
27			
28	35,000		
29			
30	145,094		
31			
32	307,000		
33			
34	0		
35			
36	960		
37			
38	798,254		
39			
40	76,378		
41			

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003859

	A	B	C	D	E	F	G	H	I	J
42	**k. Totals (sum of 6i/ 6j)**			#		874,632		0	0	0
43										
44										
45	**7. Program Income**			#	0		0		0	0
46										
47										

AMERICAN OVERSIGHT

	K	L	M
42	874,632		
43			
44			
45	0		
46	SF 424-A (7-97)		
47	Prescribed by OMB Circular A-102		

AMERICAN OVERSIGHT

	A	B	C	D	E	F	G	H	I	J
48										
49	**SECTION C - NON-FEDERAL RESOURCES**									
50			**(a) Grant Program**			**(b)Applicant**	**(c) State - Maintenance Effort**		**(c) Other Sources**	
51										
52	**8.**									
53										
54	**9.**									
55										
56	**10.**									
57										
58	**11.**									
59										
60	**12. TOTALS (sum of lines 8 and 11)**									
61										
62	**SECTION D - FORECASTED CASH NEEDS**									
63					**Total for 1st Yr**	**1st Quarter**	**2nd Quarter**		**3rd Quarter**	
64										
65	**13. Federal**									
66										
67	**14. NonFederal**									
68										
69	**15. TOTAL (sum of lines 13 and 14)**				$0	$0	$0		$0	
70	**SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED**									
71	**FOR BALANCE OF PROJECT**									
72										
73			**(a) Grant Program**			**(b) First Year**	**(c) Second Year**		**(d) Third Year**	
74										
75	**16.**						$0		$0	
76										
77	**17.**									
78										
79	**18.**									
80										
81	**19.**									
82										
83	**20. TOTALS (sum of lines 16-19)**					$0	$0		$0	
84	**SECTION F - OTHER BUDGET INFORMATION**									
85	**(Attach Additional Sheets if Necessary)**									
86										
87	**21. Direct Charges:**				$798,254		**22. Indirect Charges:**		$76,378	
88										
89	**23. REMARKS**									
90										
91	S:\SHARED\SURVGRAN\96\NEW4242A.XLS									

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-003862

	K	L	M
48	[redacted]		
49			
50	(c) TOTALS		
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61	[redacted]		
62			
63	4th Quarter		
64			
65			
66	$0		
67			
68			
69	$0		
70	[redacted]		
71			
72			
73	(e) Fourth Year		
74			
75			
76			
77			
78			
79			
80			
81			
82			
83	$0		
84	[redacted]		
85			
86			
87			
88			
89			
90	SF 424-A (7-97) Page 2		
91	Prescribed by OMB Circular A-102		

AMERICAN OVERSIGHT

STATE AND LOCAL GOVERNMENTS RATE AGREEMENT

EIN: 59-3502843

ORGANIZATION:
Florida Department of Health
4052 Bald Cypress Way
Bin #B-20
Tallahassee, FL 32399-1729

DATE:01/18/2019

FILING REF.: The preceding agreement was dated 03/23/2018

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES: FIXED FINAL PROV. (PROVISIONAL) PRED. (PREDETERMINED)

	EFFECTIVE PERIOD				
TYPE	**FROM**	**TO**	**RATE(%)**	**LOCATION**	**APPLICABLE TO**
FIXED	07/01/2019	06/30/2020	26.52	On Site	State Health
FIXED	07/01/2019	06/30/2020	9.10	On Site	Children Medical Services (1)
FIXED	07/01/2019	06/30/2020	12.21	On Site	Medical Quality Assurance
FIXED	07/01/2019	06/30/2020	9.64	On Site	Disability Determination
PROV.	07/01/2020	06/30/2023			Use same rates and conditions as those cited for fiscal year ending June 30, 2020.
PRED.	07/01/2016	06/30/2020	6.80	All	Children's Medical Services (2)

*BASE

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Direct salaries and wages including all fringe benefits.

AMERICAN OVERSIGHT

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

The fringe benefits are specifically identified to each employee and are charged individually as direct costs. The directly claimed fringe benefits are listed below.

TREATMENT OF PAID ABSENCES

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims are not made for the cost of these paid absences.

(1) Unrestricted Rate
(2) Restricted Rate

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Equipment means an article of nonexpendable, tangible personal property having a useful life of more than 1 year(s) and an acquisition cost of $5,000 or more per unit.

Fringe Benefits:
FICA
Retirement
Disability Insurance
Health Insurance
Life Insurance

STATE HEALTH SERVICES:

The fixed rate for the fiscal year ending 06/30/20 includes an over recovery of $554,671 from final settlement of the actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

CHILDREN'S MEDICAL SERVICES:

The fixed rate for the fiscal year ending 06/30/20 includes an under recovery of $22,566 from final settlement of the actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

MEDICAL QUALITY ASSURANCE:

The fixed rate for the fiscal year ending 06/30/20 includes an over recovery of $706,431 from final settlement of actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

DISABILITY DETERMINATION:

The fixed rate for the fiscal year ending 06/30/20 includes an under recovery of $43,666 from final settlement of the actual costs for the fiscal year ended 06/30/18. The fixed rate for the fiscal year ended 06/30/18 is considered final.

Your next proposal based on actual costs for the fiscal year ending 06/30/19 is due in our office by 12/31/19.

AMERICAN OVERSIGHT

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted: such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the authority in Title 2 of the Code of Federal Regulations, Part 200 (2 CFR 200), and should be applied to grants, contracts and other agreements covered by 2 CFR 200, subject to any limitations in A above. The organization may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:	ON BEHALF OF THE FEDERAL GOVERNMENT:
Florida Department of Health	DEPARTMENT OF HEALTH AND HUMAN SERVICES
(INSTITUTION)	(AGENCY)
(SIGNATURE)	Darryl W. Mayes -S Digitally signed by Darryl W. Mayes -S DN: c=US, o=U.S. Government, ou=HHS, ou=PSC, ou=People, 0.9.2342.19200300.100.1.1=2000131669, cn=Darryl W. Mayes -S Date: 2019.01.23 11:24:23 -05'00' (SIGNATURE)
Ed McEachron	for Arif Karim
(NAME)	(NAME)
Director, Division of Administration	Director, Cost Allocation Services
(TITLE)	(TITLE)
1/28/2019	1/18/2019
(DATE)	(DATE) 3025
FDOH REPRESENTATIVE: Kenol Saint-Fort	HHS REPRESENTATIVE: Michael Phillips
Telephone: (850) 245-4534	Telephone: (214) 767-3261

AMERICAN OVERSIGHT

From:	Wallace, Marla D.
To:	Simpson, De"Lisa D. (CDC/OID/NCEZID)
Cc:	Blackmore, Carina
Subject:	Florida ELC Redirection Request
Date:	Wednesday, March 11, 2020 5:47:27 PM
Attachments:	COVER LETTER COVID-19.pdf ELC Redirection Non-Influenza.pdf ELC Redirection A2 Laboratory Cross Cutting.pdf REDIRECTION ELC.pdf

---

De'Lisa

I submitted 2 project redirections for COVID-19 in REDCap and Grant Solutions. Please email or call me if you have any questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

March 4, 2020

Ms. De'Lisa Simpson
Project officer
Epidemiology and Laboratory for Infectious Diseases Program
Centers for Disease Control and Prevention
2920 Brandywine Road
Atlanta, Georgia 30341

Dear Ms. Simpson,

Please find this request submitted by the Florida Department of Health for funding to support Coronavirus Response (COVID-19) from the Cross Cutting Emerging Issues Project, Epidemiology and Laboratory Capacity Grant (ELC). This funding was previously applied for in funding opportunity number: CDC-RFA-CK19-1904, in the ELC Grant and was approved but was not funded. The grant project period is from August 1, 2019 to July 31, 2024. This request includes a detailed budget with justification and indirect cost rate agreement.

Thank you for your continued support of this important public health program. If further information is needed, please contact Dr. Carina Blackmore, Principal Investigator, at 850 245-4732 or at Carina.Blackmore@flhealth.gov

Sincerely,

Carina Blackmore

Carina Blackmore, DVM, PhD. Dipl. ACVPM
State Epidemiologist
Director Division of Disease Control and Health Protection
Principal Investigator, ELC Grant

CB/mdw
Enclosures

AMERICAN OVERSIGHT

Florida Department of Health
Epidemiology and Laboratory for Infectious Diseases
1 NU50CK000554-01
Budget Period: August 1, 2019 through July 31,2020
A2. Cross-Cutting Laboratory Capacity

	Original	Revised	
Personnel	$106,080	$81,560	($24,520)
Fringe	$21,216	$16,312	($4,904)
Equipment	$4,500	$39,373	$34,873
Supplies	$33,000	$100,395	$67,395
Travel	$16,000	$3,000	($13,000)
Other	$29,000	$26,959	($2,041)
Contractual	$104,000	$54,000	($50,000)
Total Direct Costs	$313,796	$321,599	$7,803
Indirect Costs	$33,759	$25,956	($7,803)
Total	**$347,555**	**$347,555**	$0

A.

Personnel Category	**FTE's**	
Medical Laboratory Scientist II Previously Approved	**1.00**	$35,360
Medical Laboratory Scientist II Previously Approved	**1.00**	$17,000
Medical Laboratory Scientist II Previously Approved	**1.00**	$7,300
Medical Laboratory Scientist II New	**1.00**	$7,300
Medical Laboratory Scientist II New	**1.00**	$7,300
Medical Laboratory Scientist II New	**1.00**	$7,300
Previously Approved ($106,080)		
Category Summary	**6.00**	$81,560

Employee	Position Title	Location	Months	FTE's	Amount
Samatha Vacarro	Medical Laboratory Scientist II	Tampa	12	1.00	$35,360
Employee	Position Title	Location	Months	FTE's	Amount
Andrew Hagy	Medical Laboratory Scientist II	Tampa	5.25 Months	1.00	$17,000
Employee	Position Title	Location	Months	FTE's	Amount
Vacant	Medical Laboratory Scientist II	Tampa	3	1.00	$7,500
Employee	Position Title	Location	Months	FTE's	Amount
Vacant	Medical Laboratory Scientist II	Jacksonville	3	1.00	$7,500
Employee	Position Title	Location	Months	FTE's	Amount
Vacant	Medical Laboratory Scientist II	Jacksonville	3	1.00	$7,500
Employee	Position Title	Location	Months	FTE's	Amount
Vacant	Medical Laboratory Scientist II	Jacksonville	3	1.00	$7,500

B.

Fringe Benefits	Salary	X	Fringe	
Retirement	$81,560		20%	**$16,312**
Previously Approved **($21,616)**				
Category Summary				**$16,312**

C.

Equipment	
QIAGEN - EZ1 instrument	**$5,644**
FISHER CLEAN SPOT PCR WORKSTATION FOR nCOV RESPONSE	**$29,229**
Previously Approved	**$4,500**
Category Summary	**$39,373**

D.

Supplies	
COVID-19 Testing Supplies	**$79,766**
Previously Approved	$33,000
Category Summary	**$112,766**

E.

Travel	
Reduction AMD Bioinformatics Resource Lead (Not Yet Hired)	**$3,000**
Previously Approved **(Reduced by $13,000)**	$16,000
Category Summary	**$3,000**

F.

Other	
Cost Savings	**$26,959**
Previously Approved **(Reduced by $2,041)**	$29,000
Category Summary	**$26,959**

G.

Contractual	
Bioinformatics Resource Support/Academic Partnership	**$24,000**
Bioinformatics Resource Lead Prevously Approved Reduce by $50,000 Vacant	**$30,000**
Category Summary	**$54,000**

H.

Total Direct Costs	**$321,599**

I.

Total Indirect Direct Costs	**$25,956**

J.

Total Costs	**$347,555**

AMERICAN OVERSIGHT

Florida Department of Health
Epidemiology and Laboratory for Infectious Diseases
1 NU50CK000554-01
Budget Period: August 1, 2019 through July 31,2020
R. Non-Inluenza Respiratory Diseases Diagnotic Reporting and Surveillance

	Original	Revised	
Personnel	$3,328	$0	($3,328)
Fringe	$48	$0	($48)
Equipment	$0	$0	$0
Supplies	$15,000	$34,671	$19,671
Travel		$0	$0
Other	$0	$0	$0
Contractual	$15,400	$0	($15,400)
Total Direct Costs	$33,776	$34,671	$895
Indirect Costs	$895	$0	($895)
Total	**$34,671**	**$34,671**	$0

A.

Personnel Category	**FTE's**	
Medical Laboratory Scientist II Previously Approved	**0.10**	$0
Previously Approved ($3,328)		
Category Summary	**0.10**	$0

Employee	Position Title	Location	Months	FTE's	Amount
Vacant	Biological Scientist I	Tampa	12	0.10	$0

B.

Fringe Benefits	Salary	X	Fringe	
Retirement	$0		20%	**$0**
Previously Approved **($48)**				
Category Summary				**$0**

C.

Equipment	
Category Summary	**$0**

D.

Supplies	
COVID-19 Testing Supplies	**$19,671**
Previously Approved	$15,000
Category Summary	**$34,671**

E.

Travel	
Category Summary	**$0**

F.

Other	
Category Summary	**$0**

G.

Contractual	
Biological Scientist III (Epidemiologist Vacant ($15,000)	
Category Summary	**$0**

H.

Total Direct Costs	**$34,671**

I.

Total Indirect Direct Costs	**$0**

J.

Total Costs	**$34,671**

AMERICAN OVERSIGHT

REDIRECTON

REQUEST FOR BUDGET YEAR 01

Florida Department of Health			
Epidemiology and Laboratory Capacity for Infectious Diseases			
Grant #1 NU50CK000554-01			
Carina Blackmore, Principal Investigator			
Cost Categories		**Change**	
	Current	**(Redirecton)**	**Revised**
	Award		**Award**
Salary	$1,601,404	($27,848)	$1,573,556
Fringe Benefits	$428,125	($4,952)	$423,173
Equipment	$4,500	$34,873	$39,373
Supplies	$667,394	$87,066	$754,460
Travel	$123,698	($13,000)	$110,698
Other	$159,796	($2,041)	$157,755
Contractual	$1,733,115	($65,400)	$1,667,715
Total Direct Costs	$4,718,032		$4,726,730
Indirect Costs	$533,630	($8,698)	$524,932
Total Approved Budget			
Total Award Amount	**$5,251,662**	**($8,698)**	**$5,251,662**

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Johansson, Michael (CDC/OID/NCEZID); Biggerstaff, Matthew (CDC/DDID/NCIRD/ID)
Subject:	Florida model
Date:	Tuesday, March 24, 2020 12:45:45 PM

Hi Matt and Mike. I am sure you are both busy with the COVID response. As many states are, we are dabbling with modeling. Came across this the model below. Do you know anything about it? Also in the modeling you are doing, anything that would be of value to learn from your work from a state (Florida specifically). Any guidance on priorities we should try to model (where we may have solid enough data to inform policy). We have some thoughts of course but if we can make short cuts we are all for it. If more easily discussed over the phone and you have the time my cell is +18505281595 Take care Carina

https://covidactnow.org/state/FL

Please note that under Florida law correspondence, which is not confidential or exempt pursuant to the Florida Statutes, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Cohn, Amanda (CDC/DDID/NCIRD/OD)
To:	Meaney Delman, Dana M. (CDC/DDNID/NCBDDD/DBDID); Blackmore, Carina (CDC flhealth.gov)
Subject:	Florida plan
Date:	Thursday, March 12, 2020 6:03:34 PM
Attachments:	Florida_Community_Mitigtion_12MAR2020.docx

Amanda Cohn, MD
CAPT, USPHS
Chief Medical Officer
National Center for Immunization
And Respiratory Diseases
Centers for Disease Control and Prevention
Phone: 404-639-6039
Email: acohn@cdc.gov

AMERICAN OVERSIGHT

CDC's recommendations for implementation of mitigation strategies for Florida, based on current situation with COVID-19 transmission and consideration of the state's large older adult population

Note: Florida has recently implemented many interventions included in the CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/community/index.html).

The most recent recommendations from Florida can be found at: http://www.floridahealth.gov/diseases-and-conditions/COVID-19/index.html

The following describes CDC recommendations for community interventions in Florida**.**

Bottom Line Up Front:

Florida has had several COVID-19 confirmed cases and exposures related to ports of entry, including shipping ports and airports. Additionally, Florida is a large tourism hub and has an older age population. However, at this time there is not widespread transmission. Due to the current level of COVID-19 transmission in the United States, and Florida's large older adult population, CDC recommends certain community mitigation activities to help slow the spread of COVID-19 into the community and to protect vulnerable members of the community. CDC recommends the following interventions be implemented at this time (Table). These recommendations may be updated, if necessary, based on any changes in the current local situation.

Goals

The goals for using mitigation strategies for Florida are to protect:

- Individuals at increased risk for severe illness, including older adults and persons of any age with underlying health conditions (See Appendix A).
- The healthcare workforce and critical infrastructure workforces

These approaches are used to minimize morbidity and mortality caused by COVID-19 and minimize social and economic impacts of COVID-19. Individuals, communities, businesses, and healthcare organizations are all part of a community mitigation strategy.

Implementation emphasizes:

- Emphasizing individual responsibility for implementation of recommended personal-level actions,
- Empowering businesses, schools, and community organizations to implement recommended actions, particularly in ways that protect persons at risk of severe illness such as older adults and persons with serious underlying health conditions (e.g., Dialysis patients, congestive heart failure, emphysema)
- Focusing on settings that provide critical services to implement recommended actions to protect critical infrastructure and individuals at risk of severe disease

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- Minimizing disruptions to daily life to the extent possible

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Table. Community mitigation strategies for Florida

For Every Individual and Families at Home	• Monitor local information about COVID-19 in your community.
	• Know the signs and symptoms of COVID-19 and what to do if you become symptomatic.
	• Practice personal protective measures (e.g., hand washing).
	• Create a household plan of action (https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf)
	• Ensure 30-day supply of all medicines.
	• Know about emergency operations plans for schools/workplaces of household members.
	• **Individuals at risk of severe illness (including older adults and persons of any age with underlying health conditions) should stay at home as much as possible.**
	  ○ **Avoid cruise travel and non-essential air travel**
	  ○ **Avoid gatherings or other situations of potential exposures, including church attendance and social events with 10 or more people as much as possible.**

For Every School/Childcare Facility	• Monitor local information about COVID-19 in your community. • Know the signs and symptoms of COVID-19 and what to do if students or staff become symptomatic at school/childcare site. • Review and update emergency operations plan (including implementation of social distancing measures) or develop plan if one is not available. • Students at increased risk of severe illness should consider implementing individual plans for distance learning (e-learning). • Short-term dismissals for school and extracurricular activities as needed (e.g., if cases in staff/students) for cleaning and contact tracing.
For Every Assisted Living Facility, Senior Living Facility, and Adult Day Programs	• **Conduct daily temperature and symptom screening of attendees, staff, and visitors.** • **Support training of staff about strong infection control practices.** • **Restrict visitors to long-term care facilities.**

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	• Monitor local information about COVID-19 in your community. • Know the signs and symptoms of COVID-19 and what to do if clients/residents or staff become symptomatic. • Review and update emergency operations plan (including implementation of social distancing measures) or develop a plan if one is not available. • Encourage personal protective measures among staff, residents and clients who live elsewhere (e.g., stay home or in residences when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in all buildings.

Every Workplace	• Monitor local information about COVID-19 in your community.
	• Know the signs and symptoms of COVID-19 and what to do if staff become symptomatic at the worksite.
	• Review, update, or develop workplace plans to include liberal leave and telework policies.
	  ○ Consider 7-day leave policies for people with COVID-19 symptoms
	  ○ Consider alternate team approaches for work schedules.
	  ○ Encourage staff to telework (when feasible), particularly individuals at increased risk of severe disease.
	• Work with all local employers to ensure all workers have the financial support to stay home with any respiratory symptoms
	• Encourage personal protective measures among staff (e.g., stay home when sick, handwashing, respiratory etiquette).
	• Clean and disinfect frequently touched surfaces daily.
	• Ensure hand hygiene supplies are readily available in building.
	• Limit large work-related gatherings (e.g., staff meetings, after-work functions).
	• Cancel non-essential work travel.
	• Cancel work-sponsored conferences, tradeshows, etc.

Every Community and Faith-Based Organization	• **Cancel large gatherings (e.g., >250 people), and smaller gatherings that may bring persons together from multiple parts of the country.**

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	• **Conduct fever and respiratory screening of staff working at theme parks** • **Reduce number of visitors to theme parks** • Monitor local information about COVID-19 in your community. • Know the signs and symptoms of COVID-19 and what to do if organization members/staff become symptomatic. • Determine ways to continue providing support services to individuals at increased risk of severe disease (services, meals, checking in) while limiting group settings and exposures. • For organizations that serve high-risk populations, consider cancelling gatherings of more than 10 people. • Encourage staff and members to stay home and notify organization administrators of illness when sick. • Encourage personal protective measures among organization/members and staff (e.g., stay home when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces at organization gathering points daily. • Ensure hand hygiene supplies are readily available in building. • Close areas with known exposures in highly trafficked tourist areas, such as cruise ship wharfs.
Healthcare Settings and Healthcare Providers (Including Outpatient, Nursing Homes/Long-Term Care Facilities, Inpatient, Telehealth)	• **Implement telehealth for rural communities** • **Consider reducing elective procedures** • Implement triage before entering facilities (e.g. parking lot triage, front door); phone triage and telemedicine; limit unnecessary healthcare visits • Encourage HCP to stay home and notify healthcare facility administrators when sick. • Actively monitor HCP absenteeism and respiratory illness among HCP and patients. • Consider implementing temperature/symptom checks for staff, visitors, limit visitor movement in the facility. • Actively monitor PPE supplies • Establish processes to evaluate and test large numbers of patients and HCP with respiratory symptoms (e.g. designated clinics for people with fever, surge tent for overflow triage, offsite testing locations) • Cross train HCP for working in other units to support staffing shortages

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Appendix A: Underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age.

- **Blood disorders** (e.g., sickle cell disease or on blood thinners)
- **Chronic kidney disease as defined by your doctor**. Patient has been told to avoid or reduce the dose of medications because kidney disease, or is under treatment for kidney disease, including receiving dialysis
- **Chronic liver disease as defined by your doctor**. (e.g., cirrhosis, chronic hepatitis) Patient has been told to avoid or reduce the dose of medications because liver disease or is under treatment for liver disease.
- **Compromised immune system (immunosuppression)** (e.g., seeing a doctor for cancer and treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS)
- **Current or recent pregnancy** in the last two weeks
- **Endocrine disorders** (e.g., diabetes mellitus)
- **Metabolic disorders** (such as inherited metabolic disorders and mitochondrial disorders)
- **Heart disease** (such as congenital heart disease, congestive heart failure and coronary artery disease)
- **Lung disease including asthma or chronic obstructive pulmonary disease** (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
- **Neurological and neurologic and neurodevelopment conditions** [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury].

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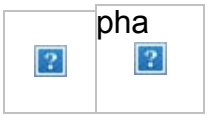
From: Roberson, Shamarial
To: MMeltzer@cdc.gov
Cc: Grant, Courtni J; Blackmore, Carina
Subject: Florida
Date: Wednesday, March 25, 2020 12:35:00 PM

Good Afternoon Dr. Meltzer,

Thanks for your support, as we continue to enhance public health efforts. Please share any materials and tools as it relates to modeling that may be helpful in this response. We are interested in learning more about the FluSurge tool and participating in any beta testing of this tool and other tools as they become available. Additionally, please share literature as it relates to these topics that we can review to enhance our understanding of these topics. We sincerely appreciate the continuous support of the Centers for Disease Control and Prevention.

Best Regards,

Shamarial Roberson, DrPH, MPH
Deputy Secretary for Health
Florida Department of Health
4052 Bald Cypress Way, Bin A-13
Tallahassee, FL 32399-1721
Phone: 850-245-4391
Email: shamarial.roberson@flhealth.gov
****



Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts. Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media on request. Your e-mail communications may therefore be subject to public disclosure.

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From:	Schauer, Gillian (CDC/DDNID/NCCDPHP/OSH) (CTR)
To:	Ali Hamade; Amanda Borup; Michele.nakata@doh.hawaii.gov; Amanda Cue; Amanda Faulkner; Andre Ourso; Andrea Wojcik; Andrew Brisbo; Arian Gibson; Bagley, Bridget; Beth McLaughlin; Brian Lopez; Caitlin Barry-King; Cheryl Petersen-Kroeber; Chris Tholkes; Christina Dempsey; Christine Theriault; Cichowski, Cheryl; Courtney Coppola; Cristal Connelly; Tomiyasu, Danette W. (CDC doh.hawaii.gov); David Olsen; Doug Schultz; Eden Wells; Eliza Muse; Elyse Contreras; Erik Gundersen; Erin Reed; Errica Ferrelli; Ilana Kurtzig; Markiewicz, James (CDC maine.gov); Jamie Margetta; Jared Welehodsky; Jason Frame; Jason Wahl; Jennifer Epstein; Layden, Jennifer (CDC illinois.gov); Jessica Filley; Jessica Neuwirth; Jim Burak; McLaughlin, Joseph (CDC alaska.gov); Judy Barrett; Julia Dilley; Julia Hitchingham; Peek, Julia (CDC health.nv.gov); Julie Johnson; Karen Girard; Karyl Rattay; Katelyn Hall; Lofy, Kathy KL (CDC doh.wa.gov); Kay Doyle; Kristen Haley; Kyle Devine; Kyle Lambert; Kyril Plaskon; Linda Scarpetta; Lori Dodson; Lori Uerz; Lyla Hunt; Lyndall Fraker; Nascarella, Marc (CDC state.ma.us); Margaret Flerchinger; Margaret Machaiek; Marie Dotseth; Mark Hurst; Mark Krueger; Mark Pettinger; Mark Starr; Martha Stanbury; Megan Lockwood; Melissa Finnegan; Beardsley, Nancy (CDC maine.gov); Nancy McBrady; Ngozi Ezike; Nirav Shah; Paul Hyland; Rebecca Rodman; Rebecca Walsh; Rick Garza; Samantha Doonan; Sara Broschart; Shannon OFallon; Sharlet Kroll; Shelly Rowden; Stephanie Klapstein; Stephanie Woodard; Steve Marks; Steve Smothers; Steven Rekand; Susan Fanelli; Sydney King; Thomas Jeanne; TJ Sheehy; Todd Orlando; Travis Kirkpatrick; Trecia Ehrlich; Trevor Christensen; Tricia Blocher; gregory.mcilvaine@state.oh.us; Haegerich, Tamara M. (CDC/DDNID/NCIPC/DOP); Grant, Althea M. (CDC/DDNID/OD); norman.birenbaum@exec.ny.gov
Cc:	Klein, Miren@CDPH; SIDELINGER DEAN E; Tapscott, Ryan (CDC/DDNID/NCIPC/DOP); heather.krug@state.co.us; Putnam, Michelle (CDC/DDNID/NCIPC/DOP); Thimjon, Lisa (MDH); Ferguson, Christopher K; farahaths.dave@maryland.gov; Scott, Megan; Pierre, Ermion; brandon.jeffery@state.co.us
Subject:	Follow up from: Monthly Multi-State Collaborative and Cannabis Regulators discussion call on vaping
Date:	Monday, February 3, 2020 3:23:51 PM
Attachments:	Notes from lung injury and cannabis call 011720_For States.pdf

Dear State Colleagues,

It's hard to believe February is already upon us. **I wanted to send out the notes from our cannabis vaping call earlier in January** (see attached). Per our discussions on that call, we'll be **moving to hold these multi-state, all state calls on a quarterly basis**, and will continue to facilitate discussion on cannabis vaping issues, but will incorporate other cannabis and public health topics that are of interest to both medical and adult use states. If you are interested in continuing to participate in all-state cannabis and public health calls, please complete this When2Meet poll so we can try to schedule a March call. We'll talk on that call about getting a standing quarterly call on the calendar (e.g., X day of the last week of the second month of the quarter, or something like that). As a reminder, When2Meet automatically saves your entries. Please remember to select your timezone before completing the poll.

We will also pick back up with quarterly topic-based calls for adult use states only (the multi-state collaborative group), since some additional public health and policy issues exist in the adult use landscape. Adult use states - I will be sending a separate poll to try to schedule one of those calls in February, as I know some of you already have issues you'd like to discuss with each other, with legislative sessions underway.

For both the all-state and adult use state calls, I will continue to develop the agenda in the same manner - reaching out to a variety of states to solicit topics. Please feel free to reach out to me any time with policy questions, TA requests, or topics for these multi-state calls.

Thanks again for all you do in the field!

Respectfully,

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Gillian

Gillian L. Schauer, PhD, MPH
Senior Consultant to:
Division of Overdose Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
gschauer@cdc.gov

From: Schauer, Gillian (CDC/DDNID/NCCDPHP/OSH) (CTR)
Sent: Thursday, January 2, 2020 10:09 PM
To: <Multi-State Cannabis and Public Health Listserv>
Subject: Monthly Multi-State Collaborative and Cannabis Regulators discussion call on vaping
When: Friday, January 17, 2020 10:30 AM-11:30 AM.
Where: Call in line: 1-877-680-2010 Participant code: 23065250

Updated with call in and agenda
Call in line: 1-877-680-2010 Participant code: 23065250

Proposed Agenda for multi-state vaping discussion call:

- Brief roll call by state
- Call purpose/announcements
  - Brief CDC announcement about standing down EVALI Emergency Operations Center
  - Future of these discussion calls
  - Vaping policy tracking
- Updates from states re: marijuana related vaping responses/policy changes
  - General vaping policy & implementation updates, Executive order updates, Legislative session vaping updates, State Cannabis Vaping Response updates
- Specific discussion about:
  - Excipient bans and FDAs inactive ingredient database
  - Regulations to improve the safety of vaping devices
  - Comparing the epidemiology of cases from state to state
  - Flavor bans
- Non-vaping packaging & labeling question from CO (time permitting)
- Next steps and Adjourn

Original message

This time looked the best for those of you who responded to the When2Meet call. As with our prior monthly multi-state collaborative/cannabis regulator EVALI calls, the purpose of this call is to provide a forum for individuals from state public health and regulatory agencies to discuss issues pertinent to state-related work on EVALI. CDC will not provide extensive EVALI updates on this call. CDC holds regular Thursday calls to provide those updates. This call will be discussion based. An agenda will be

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developed in collaboration with attendees and will be sent in advance of the call.

Please let me know if you have any specific EVALI topics you would like to discuss as part of the agenda.

Respectfully,
Gillian

Gillian L. Schauer, PhD, MPH
Senior Consultant to:
Division of Overdose Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
gschauer@cdc.gov

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NOTES FROM MULTI-STATE COLLABORATIVE ON CANNABIS AND PUBLIC HEALTH CALL ON VAPING LUNG INJURY, 01/17/2020

- **State attendees**: CO, WA, AK, OR, MA, NV, ME, CA, MI, IL, DC, MD, RI, OK, NY, OH, HI, DE
- **Purpose of call:**
  - These calls have been convening state public health professionals and cannabis regulators to provide time/space for discussion about vaping lung injury and cannabis. The standing Thursday weekly calls conducted by CDC have provided a full briefing to partners on EVALI.
- **Housekeeping**
  - Due to a continued decline in new EVALI cases being reported, **CDC is standing down the EVALI Emergency Operations Center** that has been centralizing and coordinating the response at CDC. Work on EVALI will transition back to specific CDC Centers and Divisions. This is a process that routinely occurs for emergency response efforts at CDC. CDC's work will continue to focus round the clock on protecting the nation from this health threat, including by conducting surveillance, examining product and biological samples, providing guidance and TA to state and local health departments, healthcare providers, and the public, and ensuring prompt communication of any new information.
  - **States on this call reported an interest in continuing to convene periodically to discuss Cannabis vaping related public health and policy issues.** Gillian proposed quarterly call with this larger group of medical and non-medical states to discuss a variety of cross cutting policy issues, and quarterly calls with just adult use states (given some unique policy issues in those states). A call will be scheduled for February with adult use states, and for March/early April with the larger group of medical and adult use states.

- **Discussion:**
  - *Update from states on implementation of executive orders*
    - **Washington** – VEA ban will stay in place through March 19th. Two bills introduced in legislature around vaping – one focuses on THC. Challenges with language around flavor ban (which, through executive order in WA, banned any non-cannabis derived flavor additives). Push to allow plant-based, botanically derived terpenes in legislation under consideration now. Industry challenged enforcement of flavor bans (can you tell if botanically derived or derived from cannabis?).
    - **Michigan** – Rules requiring that all products be tested for VEA but did not require for newly manufactured vape products. Requires records of formulation. Have had had a number of testing failures for VEA in products, but non from the regulated market. Bill being considered that would add criminal penalty for anyone who manufactures marijuana products and adds VEA. Draft rules would prohibit any inactive ingredients not approved by FDA for that purpose. Also experiencing a push to allow for plant-based, botanically derived terpenes.
    - **Oregon** – OLCC flavor ban on hold, court case no longer being pursued due to timeline for executive order. Licensed lab in Oregon has purchased botanically derived terpenes to test for a variety of ingredients. No timeline on test results, but will likely be useful knowledge for regulators, public health. EVALI cases in Oregon skew older and more female; 1/3 report nicotine only. Trying to understand if other states seeing different patterns demographically.
    - **Maryland** – Quarantined all vape products until tested for VEA – have not detected any. Working with lab on other potential additives should consider testing for.

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- **Massachusetts** – MA CCC has had a quarantine on all vaped products, but now allowing companies to produce new products, but maintaining the right to sequester/quarantine product if any additional concerns arise. CCC has tested products that were quarantined. Has not found VEA, but has found very high levels of lead, suggesting that something is going on with device/cartridge leaching into liquid.
- **California** – Still evaluating options for VEA – but has mostly been confined to unregulated sources in CA. No flavor bans have been proposed for cannabis, but added flavors not widely used in regulated CA market. CA Gov budget proposal seeks to create a new department of marijuana regulation that would consolidate three current agencies involved in regulation.

- *Specific discussion about use of FDA inactive ingredients database*
  - **Colorado:** White paper from CDPHE to make recommendations to MED – suggested FDAs GRAS list and inactive ingredients list. Pros of using it – easily accessible and online database, updated 4x per year. Lists additives that have been declared safe for that intended use. The database includes important identifying numbers (the chemical abstract service number) that can be used to look up the inactive ingredient and quickly get more information on the chemistry and how it interacts with other ingredients. Some cons of the FDA GRAS list: they don't tell you what was reviewed but deemed unsafe and why.
  - **Oregon:** In Oregon, seeing a big influx of PG and other chemicals in infused prerolls (big influx of applications). Unsure how to use the FDA inactive ingredient list for that, since PG appears OK for oral nebulizers and inhalers, but not for vaporization or combustion. The act of heating could cause problems.
  - **Colorado:** Has considered that as well. Consulted with toxicologists. At the end of the day, reverted back to the list. If FDA has deemed it safe, they CO allows, but it's a tricky question, particularly with mode of use.

- *Regulations to improve public health and safety of vaping devices*
  - **Massachusetts:** Interested in this area – and looking at European standards. Looks like there may be an ISO standard for testing vaping devices. Has anyone seen that?
  - **Ohio:** Vapor device rules came about a few years ago. Because you aren't allowed to smoke MJ in Ohio, rules require that the vaping device chamber prevents marijuana from coming into direct contact with the heating elements. This has resulted in people having to buy more expensive devices and may help avoid some of the leaching that other states have described.
  - **Hawaii:** Devices for vaping are the only paraphernalia that retail locations are allowed to sell. Rules required that heating element of device has to be made of an inert material. Cartridges must be single use, pre-sealed, temperature controlled. Hawaii has struggled a bit with what these definitions mean. Two cartridge makers were using clue to make tamper resistant that was then thought to be leaching into product, so now using screw top containers.

- **Next steps and adjourn**

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From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Follow-up Call
Date:	Friday, March 20, 2020 7:20:02 AM

Hello Dr. Blackmore,

We were alerted that you would like to schedule a follow-up call regarding the LTC facility. The healthcare infection control team is happy to chat. Let us know what time works best.

Thanks,
Elizabeth Soda

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From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: Follow-up items from today"s call on COVID-19
Date: Thursday, February 20, 2020 6:18:30 PM

Dear Partner –

Thank you to all that joined us on today's call on COVID-19 with Secretary Azar, HHS, and DHS officials. While the immediate risk to the American public is still currently low, that has the potential to change rapidly. We strive to continue to provide updates to you, our valuable state partners, so that you have the best information available when developing and executing your preparedness plans.

As mentioned on the call, we wanted to provide you with some further information about available resources and to share again some prompts for consideration when planning state actions.

First, please find below links to CDC and select partner organization sites that focus on state and local readiness. Some of these link to the latest COVID-19 information, while others link to sites focused on resources for any response. As has been noted, pandemic influenza plans often provide some overlap for other infectious disease outbreak plans, so some link to CDC or external partner influenza preparedness guides.

CDC Resources

- Coronavirus Disease 2019 homepage
- State and Local Readiness homepage
- State and Local Government Planning for Influenza
- Public Health Emergency Preparedness (PHEP) Cooperative Agreement
- Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC)

Related Links

- Association of State and Territorial Health Officials (ASTHO): Pandemic Influenza
- National Association of County and City Health Officials Local Health Department Pandemic Influenza Guide

In addition to the above links, we wanted to share with you some questions that can inform preparedness plans. These will be particularly important if the U.S. response has to move from aggressive containment to a mitigation response. We encourage you to use these to reflect on these as you explore possible necessary response actions. In a response focused on mitigation rather than containment, state and local officials will be responsible for three key pieces of a state's response:

- Transportation;
- Housing for individuals under observation or quarantine; and
- Communication and Coordination with local and private sector partners.

We encourage you to confer and collaborate with your Attorneys General and legislature leaders to confirm and identify what authorities that you have and any that you may need to be granted.

Authorities & Responsibilities for Prudent State and Local Planning:

- Have you reviewed the scope of your emergency authorities as Governor to respond to a public health crisis in your state?
    - When have you last exercised these authorities?
    - Do you have plans to in the future?

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What are your quarantine and isolation authorities, roles, and responsibilities?

- Do you have plans for canceling large events and community gatherings?
- Do you have a mechanism to encourage or compel school closures, if necessary? If so, what is its scope? (public v. private, secondary v. university, time limited, etc.)?
- What are your policies for limiting or discouraging mass transit?
- Coordination and Communication with Local Governments – what authorities do local governments have in your state? What is your coordination plan between state, local, and tribal governments?
- What public health and human resource resources do you have for local governments, the private sector, and non-profits on hygiene or social distancing?
- What are your critical infrastructure, key resources, and essential services that might face personnel shortages?
- Do you have policies and plans in place for state and local government workers?

Finally, the U.S. State Department has posted guidance for cruise ship passengers in the event of planned travel to or within East Asia and the Asia-Pacific Region . That guidance can be found here.

Please don't hesitate to follow up with the Office of Intergovernmental and External Affairs if there are any questions!

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

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From:	Walke, Henry (CDC/DDID/NCEZID/DPEI)
To:	scott.rivkees@flhealth.gov
Cc:	Bresee, Joseph (CDC/DDID/NCIRD/ID); Butler, Jay C. (CDC/DDID/OD)
Subject:	Follow-up on modeling and social distancing
Date:	Tuesday, March 24, 2020 9:52:52 AM

Scott,

Jay said you have a couple of questions.

- I am connecting you to Joe Bresee, 404 421 5648, who has wide visibility on the modeling activities at CDC and can help answer your questions.

- The evidence base for social distancing is best found in the 2017 Community Mitigation Guidelines to Prevent Pandemic Influenza.
  https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

Best, Henry

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
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Cc:	R4 PHUL (FEMA.DHS.GOV); ASPR Region 4 (HHS/ASPR/OEM)
Subject:	FOUO FW: COVID 19 Update dated 22 Mar at (FMS Fact Sheet, A1 Medcom Guidance, Alt Healthcare Facilities)
Date:	Monday, March 23, 2020 7:17:24 PM
Attachments:	FMS Fact Sheet.pdf H2HC and A2HC - HOTEL+ ARENA COAs 191930Mar20 (002).pdf Corporate Partners Items-Equipment.xlsx Medical Support Task Force Initial Questions.docx

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UPC team

This is some of what I was speaking to on the phone today about alternate care sites and isolation facilities. More to coma as the days continue.
Thank you Rick for sending.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
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(please cc all correspondence to this ESF 8 desk address)

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cell: 202.909.6950 Verizon (secondary)

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	A	B	C	D	E
1	CORPORATE PARTNERS ITEMS/EQUIPMENT				
2	COMPANY	ITEMS/EQUIPMENT	POC	CELL PHONE	E-MAIL ADDRESS
3					
4	ADS, Inc	PPE, Disinfectant Wipes, Isolation & Hospital Shelters, Field Hospital Beds, Full Spectrum Germicidal Wipes, One Step Cleaner & Disinfector, Micro ULV Cold Sprayer/Fogger, Combat One Sin Wipes, Bathing Wipes, Disinfectant Robot, Individual Decontamination Kits, Tyvec Suits, SCBA's Electrolyte Hydration Packs, Portable Ultrasound, Portable Ventilator, Portable X-Ray, Therm-App Thermal Imaging Cameras to Measure Skin Temperature, Blue Med Field Hospital, Portable Hand-Washing Stations, KAMS Medical Module, Beds, Cots, Litters	Brad Smith Benny Brown Mike Matthews	(757) 319-0600 (757) 274-7319 (757) 793-5733	bradsmith@adsinc.com bbrown@adsinc.com mmatthews@adsinc.com
5					
6	Air Shelter USA, LLC (ZUMRO)	Rapidly Deployable Shelters - Infection Control/Isolation/Quarantine; Medical Surge/Triage; Drive-Thru Screening; Field Hospital	Trent Baer	(254) 247-8236	tbaer@bfxfire.com
7		Air Handling - Scrubbers/Filtration; Climate Control			
8		Power Generation			
9					
10	Arbill	Through our comprehensive safety offerings - comprising nearly 60 safety services and technology tools to reduce incidents and more than 200,000 stocked safety products (800 items manufactured under our Turline brand). Arbill makes it easy for safety conscious agencies to provide their team members with the tools they need to create a culture of safety throughout their organization and reduce injuries. NOTE: the COVID-19 requirements and our existing relationships with DHS, CDC, USDA, States and City agencies have put some product lines on back order with long lead times. Recommend visiting our website at Arbill.com to determine your safety needs.	Mike Bobeck	(703) 314-0858	mbobeck@arbill.com
11					
12	BOH FPU Systems, a division of BOH Environmental, LLC	BOH Mobile Patient Isolation Unit. Government Pricing Qty 1-24 - $146,153.84 Qty 25+ - $141,538.42	Ronald Riling	(256) 425-4235	rriling@bohfpusystems.com
13					
14	Brief Relief a Division of American Innotek, Inc	Portable disposable sanitation facilities when normal facilities are not available (WAG BAGS). All products are in stock. Can ship in 48 hours.	Lou Ortego	(858) 354-5034	lortego@briefrelief.com
15					
16	Caliburn Intl (acquired Comprehensive Health Services)	Rapid Response Medical Capabilities - Rapid transition including all medical facilitites up to Level III, logistics, supply chain, and equipment; 210+ medical Professionals, 24/7 Medical Support, 10,000+ Population at Risk (PAR), 730+ Patients Monthly;	Kathleen Cyphert	(571) 318-4227	Kathleen.Cyphert@caliburnintl.com
17		Modular Medical Facilities - Fully equipped to isolate and treat COVID-19 patients, Negative pressure units meets CDC's airborne infection isolation (AII) requirements, with HEPA and UV filtration, based on standard modular containers, U.S. MADE.			
18		Medical Staffing - Qualified medical professionals, registered nurses, nursse practitioners, physicians, we analyze the population at risk, the expected pathology, patient load and acuity, then tailor a staffing plan.			
19					
20	Cambium Networks	Cambium Connectivity Kits securely extend communications from a Command Post to other locations using point to point and point to multi point technologies in NATO Band IV, Unlicensed, and NTIA7 & 8GHz, for Voice/Data Command & Control, Surveillance, & C4ISR backhaul. The kits provide rapidly deployagble capabilities configured in a self-contained 450 Mbps ultra-wide band radio & 18M antenna mask. They are also available in Vehicle Platform configurations. The kits have been deployed in disaster responses such as the Puerto Rico Hurricance Response, CBP Mobile Border Ops, US Marshall Prison Breakout in NY, FEMA Mobile response, & Teams with US DoD Force Protection missions. Multiple States with the National guard have purchased these units. Unit price is $110,000. Available today.	Mike Bristol	(703) 472-1940	Michael.Bristol@fairwinds-tech.com
21					
22	Canadus Power Systems	Canadus HD-1224 Battery Desulfator - this inexpensive item will help your trucks and equipment start when you need them to. Easily bolts onto the battery terminals in 10-15 minutes & will help keep your Lead-Acid and AGM batteries in top performing condition. Can be purchased with Government credit card direct from manufacturer or for orders above $10,000 through GSA.	Andy VanElzen	(330) 858-8850	avanelzen@canadus.com
23		https://www.gsaadvantage.gov/advantage/s/search.do?q=0:2canadus&db=0&searchType=0			
24					
25	Carcoon America, LLC	The CARCOON product line helps with shelters, medical & organizational facilities, decontamination chambers, Rapidly Deployable Mobile Isolation Chambers, and Personal Units. These shelters range in size from one person unit to one big enough to hold a freight train or 747 aircraft. (Economically Disadvantaged Woman Owned Small Business) CAGE Code 8G7Z7	Janet Bernard David Bernard	(904) 567-3825 (904) 910-0336	info@carcoonamerica.com
26		www.carcoonmedical.com			
27					
28	Cascade Designs	Emergency Shelter and Pop-Up Clinic Pads; Emergency Shelter & Po-Up Clinic Water Treatment and Decontamination; Field Sanitation	Tim Davis	(206) 963-4343	Tim.Davis@CascadeDesigns.com
29					

AMERICAN OVERSIGHT

	A	B	C	D	E
30	Cerego	Rapid development of world-class remote training for immediate applications. State-of-the-art adaptive learning, with one-of-a-kind feedback and monitoring capabilities.	Ron Houle	(914) 806-3775	ron.houle76@gmail.com
31					
32	Climb2Glory LLC (SDVOSB certified)	Protective Masks: N95 (30 types), N99 (4 types) NIOSH certified; Anti-Microbial Liquid Super Durable Cleaner; Emergency power Supplies w/wind or solar backup charging capabilities - from 3,000 to 10,000W/hour range.	Ted Reich	(719)447-7749	treich@climb2glory.com
33					
34	Cobham	Cobham RT-7000 radio - 3 transceivers in an 8.9 lb box; ability to step down to first responder frequencies (and civilian hospitals); has input jacks for hand-held radios allowing first responders to hop in the aircraft and plug-in and simulcast across whatever frequencies desired.	Garrett Jensen	(571) 970-8669	garrett.jensen@peduzziassociates.com
35					
36	DripDrop Hydration Inc	DripDrop ORS is DoD and AMEDD approved Oral Rehydration Solution with NSNs. The class VII part #s are 61406 Lemon; 61407 Berry; 61408 Watermelon; and 61410 Orange. DripDrop ORS has a great taste while having half the sugar and three times the electrolytes than a sports drink. it works as well as an IV and is infinitely more useful because it is easily transported and can be administered by anyone (pour powder into 16 oz water and drink). DripDrop ORS consequently reduces IV need. Has been used in the US by prominent institutions including UCSF, Mayo Clinic, Stanford, Boston Childrfen's and all branches of the US Military 9as well as both professional and collegiate sports teeams). It has been used in the US and around the globe in disaster situations as well. The CDC used DripDrop in Sierra leone and Liberia in the treatment of Ebola and it is currently being used in the Congo for the same. DripDrop has been used for Cholera in Haiti. In the US, medical professionals and consumers use DripDrop ORS to treat dehydration from the cold and flu and it can be used the same in connection with COVID-19.	Steve Duran	(724) 513-4692	steve.duran@dripdropors.com
37					
38	Eureka! (A Division of Johnson Outdoor Gear)	Tents & sidewalls available for immediate shipment	Tim Cronk	(607) 972-1814	tim.cronk@johnsonoutdoors.com
39					
40	ForceProtector Gear	Deployments Bags (including medical kit bags); ThermalShield (clean environment for medics to work on/thermal barrier). We are 100% Berry and 100% material sourced in the United States. We have not only a warehouse of raw goods, but also have finished products available for immediate shipment.	John Carswell	(818) 439-6261	john@forceprotector.com
41					
42	Galls	PPE/Infection Control: Sanitizer, Antiseptic wipes, N95 Surgucal Masks, Nitrile Gloves, TyChem/Healthcare Coveralls, Goggles/Eyewear, Protective/Chemical Resistant Footwear, Protective Headwear, Shoe Covers.	Earl Wilder	(859) 800-1038	wilder-earl@galls.com
43		Medical/Emergency Gear: IFAK, Medical bags/Kits, Emergency blankets, Spine Board, Diagnostic equipment, CPR, Oxygen equipment, First Aid supplies, Medical gloves, Shears, AEDS, sleeping cots.			
44		Rescue Mission Gear: Tents, Sleeping bags, Tactical bags/Backpacks, Flashlights, Flares, MRE's, Camelbaks/Canteens, Knives, Multitools, Nightvision, Optics/scopes.			
45		Civil Disturbance Operations Gear: Emergency power sources, Area lighting, Riot gear/suits/shields, Face shields, Traffic signs, Portable Traffic barriers, OC spray, Megaphone, Batons, Body armor, Molle pouches, Plate carriers & Plat3es, Ballistic helmets, Assault packs, Weapon slings, Active shooter kits, metal detectors, traffic spikes, Inspection mirror, Hi Vis traffic vests, Restraints/handcuffs/flex cuffs, Pelican cases.			
46		Operational Clothing: OCP uniforms, BDUs, SFS/police Class A uniforms, Fire/EMS uniforms & Stationwear, Jackets/outerwear, ECWCS system clothing, Tactical pants, Polos, base layers, Custom patches/embroidery/Screen print/heat press.			
47		Footwear: Military boots, Fire & EMS boots, Tactical/Duty boots, Athletic & Training boots, Socks.			
48		http://www.galls.com/govops/index.html			
49					
50	Genasys Inc (also known as LRAD)	LRAD 100X Portable Long Range Communication System. We currently have 196 100X units in stock ready to be shipped. We also have six 450XLs, Tripod Kits and 24V Power Packs readily available. We have already helped National Guard units with communicating to the public from long and safe distances. These systems are already MILSPEC'd items being purchased by all our Military Services and First Responders.	Jeff Palmer	(858) 204-8514	jpalmer@genasys.com
51					
52	Gordian	We provide a service that would be a great assset to the States as they start to receive and execute large amounts of SRM dollars in response to the stimulus packages. We are industry leader in construction cost data and job order contracting. We hhave established job order contracts in several States that the Guard would be able to quickly find contractors.	Lisa Cooley	(505) 239-3446	L.cooley@gordian.com
53					
54	Hughes Network Systems	Hughes Cellular On-Demand ManPack creates an independent LTE wireless network with a wide radius to keep teams connected to each other via smartphones and other devices. Offers an ultra-small, completely virtualized 3GPP LTE core network to deliver fully functional cellular communications which can be deployed for operations around the world. Light and energy-efficient LTE network core creat3es a cellular and Wi-Fi bubble in just minues to meet mission-critical wireless connectivity requirements. With the option to add satellite for backhaul, Hughes can provide an agile, turnkey communications solution for resilient, time-sensitive military and disaster response. Unit price $180,000.	Janie Robinson	(703) 785-7618	Janie.Robinson@hughes.com
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AMERICAN OVERSIGHT

	A	B	C	D	E
56	ibvi Industries - for the Blind & Visually Impaired	We can kit nearly anything needed. Eamples - Direct Responde Aid Kits (DRAK), Vertical Skills Engineering and Construction Kits (VSECK) and more. Cotton masks available.	Martin Brill	(414) 405-0341	Martin.Brill@ibvi.org
57		https://ibvi.org			
58					
59	isf	Enterprise wide Personnel and Logistical Tracking Software that allows States to manage, track and report on SAD and long-term standing missions. Gives States a centgralized system that allows them to work more efficiently when preparing for an activation or emergency. It enables States to manage the events & expedite the recovery and reimbursement process in a fashion not available with any other software.	Lawrence Salerno	(850) 212-7130	lsalerno@isf.com
60					
61	Kimball Midwest	Cleaners, Hand-Sanitation, MRO, etc	Shane Steele	(254) 577-0337	shane.steele@kimballmidwest.com
62					
63	Laerdal Medical	Laerdal Medical Simulator Scenariofor COVID-19 Training of Medical Personnel; Human patient Simulators (adult, toddler & infant); Laerdal Silicone Resuscitator; The Bag Disposable Resuscitator; Laerdal Compact Suction Unit 4	Steve Parrish	(845) 514-8737	Steve.Parrish@laerdal.com
64					
65	Leonardo DRS	We have an M1152 HMMWV outfitted with the On Board Vehcile Power (OBVP) system (30kW, 120/208 VAC) that is ready to roll as an Emergency Power Source. It is currently located in our DRS facility in Huntsville, AL.	Carlos Aguirre	(256) 653-6604	carlos.aguirre@drs.com
66					
67	LiteFighter Systems, LLC	Litefighter 1 (NSN 8340-01-628-8855) Individual Shelter Systems for Tactical "Social Distancing"	Rich Coachys	(404) 718-9818	rcoachys@litefighter.com
68		Olympus Emergency Response Mobility Bags (NSN 8465-01-679-7717) in OCP Camouflage			
69		Olympus Emergency Response Mobility Bags (NSN 8465-01-679-7709) in Coyote Tan			
70		Olympus Emergency Response Mobility Bags (NSN 8465-01-679-7698) in Black			
71					
72	Mack Defense	All GSA Class 8 truck options are available & simple parts.	Rob Gordon	(484) 695-2086	robert.gordon@mackdefense.com
73					
74	Mahaffey Fabric Structures	Complete shelter and life support solutions that can be rented! Leasing arrangements are flexible & customer-driven.	Ron Houle	(914) 806-3775	ron.houle76@gmail.com
75					
76	MASSIF	Massif fire resistant base layers - lightweight, midweight, and heavyweight tops and bottoms. Also beanies and balaclavas.	Sarah Rehfeldt	(541) 531-0558	sarah@massif.com
77		https://www.massif.com/shop/light-mid-heavy-layers.html			
78					
79	McFall Consulting	ZONO Sanitizing Cabinet - Ready to Ship! The ZONO cabinet is recognized by CDC and WHO as an efficient sanitizing agent and eco-friendly solution to wiping out 99.9% of common bacteria and 99.99% of common viruses (under EPA regs, ZONO cannot say it kills COVID 19 until it is able to test with the virus. However, ZONO has tested with Norovirus, widely known as one of the hardest type of virus to kill, and the ZONO kills 99.99% (disinfecting level) of Norovirus. ZONO plans to test with COVID-19 ASAP.) ZONO sanitizes items safely and as effectively as bleach or other chemicals without compromising their integrity:	Davis Murphy	(504) 813-9574	davis@mcfallconsulting.com
80		Tactical Communities (military, LE/Fire, First Responders): body armor, vests, helmets, boots, shoes, physical training gear, radios, anything that is checked out daily, etc.			
81		Fitness/Strength & Conditioning/Physical Therapy: group X equipment, yoga mats/blocks/bands/med ball, Ab mats, cable crossover attachments, bands, collars, etc.			
82		Parks & Rec/Campus Rec: In addition to above, anthyhhing that is checked out on a daily basis or use in general play.			
83		Office/Front Desk/Corporate Wellness Lounges: computers, keyboards, mouse, mousepads, power-nap mats, etc.			
84		ISDs/Daycare/Kids Zones in Fitness Ccenters: PE equipment, sports equipment, toys, arts & craft supplies, crayons, sleep mats, etc.			
85					
86	Military Battery Systems, Inc	Rugged COTS portable (emergency) power sources. Quiet power for charging/powering laptops, tablets, comms gear, lighting, etc. Portable,powered cellular/WiFi hotspots. Dual sim portable routers that work on AT&T, Verizon, FirstNet, etc. For up to 128 uswers.	Jim Wagner	(303) 641-1845	jim@milbatteries.com
87					
88	Motel 6 & Studio 6	Discount on Lodging	Kirsten Jenkins	(214) 641-8969	k jenkins@g6hospitality.com
89					
90	Motorola Solutions, Inc	Portable radios & accessories, mobile radios, transportable repeater systems, transportable LTE (broadband) solutions, hardened and secure Android smartphones, video solutions, video analytics, body worn cameras, professional communication services.	Bob Nosenchuk Chris Sarantos	(201) 874-9104 (434) 258-1676	bob.nosenchuk@motorolasolutions.com chris.sarantos@motorolasolutions.com
91					

AMERICAN OVERSIGHT

	A	B	C	D	E
92	MulePAC	Portable All-mode Container is a system of lightweight, plastic, collapsible, modular, intermodal, nearly indestructible secondary containers designed specifically for the U.S. Military for transporting and storing all classes of military supplies to, from and within theater all the way to the last tactical mile. Built to withstand the toughest environments, MulePAC saves time, money and lives! They are on Army Standing Resolution ARNG-5, Item "V" and all sizes/configurations have noth NSNs and MulePAC Part Numbers. These contgainers wll be of great value to store and transport both Emergency Supplies as well as Mobilized Unit Equipment.	Rick Segeleon	(502) 608-8400	rick@getmulepac.com
93					
94	North American Rescue	All medical items from point of injusry through hospital, dental & veterinary.	Matt Westra	(864) 293-2468	mwestra@narescue.com
95					
96	Pelican Products	Protective Cases along with Lighting Solutions	Jason Russell Mike Thompson	(757) 285-6883 (757) 372-3065	jason.russell@pelican.com mike.thompson@pelican.com
97	Phantom Products, Inc	Flashlights (safety, MP/SF, and covert); tent lights, traffic control lighting (wands and road flares), vehicle marking lights (rotary/steady and flashing-all sizes); crowd control lighting; emergency lighting.	Victoria McDermott	(703) 906-2066	vmcdermott@phantomlights.com
98					
99	PowerFlare	Safety Lighting	Tricia Callahan	(703) 599-9514	tricia@pfdci.com
100					
101	Progressive Expert Consulting, Inc	Online Virtual Platform for Training, Instruction & Meetings - on GSA schedule.	Michael Feng	(315) 5603364	michael.feng@peinc.com
102					
103	Proksi Systems	Pharmacy Consultation in VIRGINIA ONLY	Pragnay Choski	(215) 588-8374	pragnay@proksisystems.com
104					
105	PTS-Inc	Emergency Operations Center Communications Systems - Expeditionary Communications that require NO generator or vehicle power to operate SINCGARS, all Harris radios to include the ANPRC 150, ANPRC 117G, ANPRC 117F, PSC 5, and the ANPRC 160.	Keith Hudson	(757) 641-7435	khudson@pts-inc.com
106					
107	Rite in the Rain	Weatherproof Paper/Card Stock, to be used for outdoor emergency signage; Weatherproof Medic Cards; Emergency Medical Response Notebooks; CERT Field Operating Guide Notebooks; All Weather Pens.	Debra Johnson Pierson	(360) 550-5519	debra@riteintherain.com
108					
109	Robertson Fuel Systems	Army Aviation: Internal Auxiliary Fuel Tank Systems (IAFTS) for the Guard's UH-60M Black Hawks. Currently,this is the only airframe that does not have IAFTS. Both the Guards UH-60As & UH-60Ls have IAFTS capability to extend range. At this time, the Guard would likely use their UH-60A/Ls in lieu of the newer UH-60M, as these aircraft are operationally better equipped to extend time and range. NGB has listed IAFTS for UH-60M on their 2020 Buy List, but the funding has been reprogrammed by the Big Army.	Chip Lunn	(480) 298-5684	chip.lunn@robbietank.com
110					
111	Sikorsky/A Lockheed Company	The company is available to assist, but need to know what is needed. Please call.	Tom Nicolett	(703) 851-9280	tom.v.nicolett@lmco.com
112					
113	Stanley Black and Decker Storage Solutions (Vidmar Lista)	In the increased cimate of medical testing and laboratory facility volumes, Stanley Black and Decker provides a product that will allow for efficiency of work and work place solutions. Our work benching and storage cabinets can be a viable source to help with any medical process in support of the COVID-19 virus.	Darin Gilderoy	(678) 316-0972	darin.gilderoy@sbdinc.com
114		https://www.listaintl.com/industry-solutions/healthcare			
115		https://www.listaintl.com/industry-solutions/dental-labs			
116					
117	Freedom Surveillance, dba Strongwatch	In support of DOMOPS, Homeland Security, Installation Security, and FEMA ESFs' 3, 4, 5, 9 and 10 missions. This ground system is a fully mobile and on the move, stabilized zoom cameria system with Thermal infrared, High Definition Color, Laser Range Finder, and Laser Illuminator that can record video, snapshot pictures, designate grid coordinates (LAT/LOG & MGRS) & human detection up to 12,000 meters (7 miles) that includes interoperability capability to simultaneously live stream into multiple agencies Command Posts, computers, smart phone, and tablets significantly increasing info sharing & accuracy of the common operating picture. The J3's, NGAUS and ANG 5/7 Domestic Capabilities Priorities are in support of this system in multiple areas of priorities.	Robert Mouw	(360) 524-5542	robert.mouw@strongwatch.com
118		https://strongwatch.com			
119					
120	SyTech Corp	SyTech Corps's communication product, RIOS, in an interoperative gateway that connects all types of communication devices, including radio, smartphone and computers. RIOS is immediately deployable to the most challenging environments. RIOS connects networks anywhere in the world with ethernet, satellie or wireless IP. This product has been completely vetted by NGB HQ staff and State representatives. It is currently the number-one priorityfor communication equipment for the ANG for somestic operations. Unit price is $58,000.	Aaron Armendariz	(703) 268-1561	aarmendariz@sytechcorp.com
121					

AMERICAN OVERSIGHT

	A	B	C	D	E
122	TeleSwivel LLC	Emergency Lighting Equipment; portable LED light sets - same orbetter performance as big diessel generator sets at 1/3 to 1/2 the cost. Probiotic Disinfectant for vehicles & equipment. Non-chemical disinfectant, highly effective on a range of bacteria and allergans. We are working on trials to show efficacy onr espiratory (Corona) viruses).	Dave Woolf	(919) 623-2031	dwoolf@teleswivel.com
123					
124	The Last US Bag Company	Medical Bags, Nylon or Polyester for kitting and transport; reusable protective shoe covers; reusable protective masks.	Will Macia	(503) 816-4001	will@lastusbag.com
125					
126	Unifire, Inc	Medical, Clothing, Tents/Shelters, Cleaning Supplies, PPE, Rescue Equipment, Decon Stations, Crown Control, Helmets, Footwear, etc. We hold multiple GSA schedules, are a TLS Prime Contractor and sub-contractor under the FES contract.	Bryan Mills	(336) 417-1699	govsales@unifireusa.com
127					
128	Vizsafe	Geoaware COVID-19 Information Sharing & Monitoring Solution. Solutions available immediately that can help improve information sharing, communications, incident reporting, monitoring and response to the COVID-19 crisis for healthcare and public safety organizations. Theis application would enable the National Guard to securely communicate and track their teams in the field, as well as share actionable intelligence with local, state and Federal partners/resources.	Peter Mottur	(401) 862-2029	pmottur@vizsafe.com
129					
130	Weatherhaven	Mobile negative pressure isolation units; turnkey base camps; mobile power; environmental control units (ECUs); mobile billeting; mobile field hospitals.	Ron Houle	(914) 806-3775	ron.houle76@gmail.com
131					
132	XGO	Ag47 Silver Anti-Microbial/Anti-Fungal clothing & accessories.	Mackenzie Huston	(859) 492-2675	Mackenzie.huston@proxgo.com
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AMERICAN OVERSIGHT

Federal Medical Stations

From 2005-2012, DSNS deployed FMS aid to victims of Hurricanes Katrina, Rita, Dean, Gustav, Ike, and Sandy.



Managed by the Division of Strategic National Stockpile (DSNS), federal medical stations (FMS) are rapidly deployable caches containing beds, supplies, and medicines which can quickly turn a pre-identified building into a temporary medical shelter during a national emergency. Care can be provided for 50-250 displaced people for three days before resupply is necessary. The FMS offers health and medical surge capability and capacity for short-term inpatient persons who have sub-acute medical, mental health, or other healthcare needs that cannot be accommodated or provided for in a general shelter.

Each FMS has the ability to increase local healthcare capabilities in mass casualty incidents or potential public health threats. They are flexible, modular, scalable, and tailored to meet the requirements of each incident. The FMS operates in cooperation with federal, state and local authorities.

Use of an FMS requires pre-planning, and prior to an event, state, local, tribal, and territorial (SLTT) jurisdictions collaborate with Health and Human Services' (HHS) Regional Emergency Coordinators (REC) to identify anticipated requirements for FMS support (e.g., conduct FMS site surveys to ensure logistical wraparound services are appropriate and to identify any gaps requiring resolution during a response.) FMS site selection criteria should be met for all potential FMS facilities. Pre-identification of possible FMS sites should be included in SLTT or regional jurisdiction emergency plans.

To assist stakeholders, DSNS deploys an FMS Strike Team (FMSST) to facilitate FMS cache set-up, conduct training for volunteers, and provide subject matter expertise, which can include among others, assessing the facility's limiting factors, providing advice and assistance in support of the FFMS internal set-up, and conducting recovery procedures. FMSST members do not operate the FMS; this is done by teams from the United States Public Health Service Rapid Deployment Force, or the Department of Veterans Affairs, or a combination of other designated groups. FMS deployment for specific locations is organized through the REC.

Federal Medical Stations Minimum Requirements

One FMS requires approximately 40,000 square feet of enclosed, climate-controlled space with the following features:

- Loading dock/ramps, forklifts, pallet jacks, and parking
- Sufficient existing communications/IT support and power supply with back-up
- Availability of support services including, food and water, waste disposal, medical oxygen, laundry, and mortuary services
- Refrigeration and locked storage
- Bathroom and shower capability

Quick Facts
Federal Medical Stations

- Each FMS has a base, treatment, and pharmacy module.
- Each FMS can quickly turn a building into a temporary medical shelter.
- Each FMS is modeled for all age populations.
- Each FMS can be transported by air, water, or ground for maximum geographic distribution.

For additional information, email sns_opcext@cdc.gov.

AMERICAN OVERSIGHT

HOTEL TO HEALTHCARE CONCEPT (H2HC)

ALTERNATE HEALTHCARE FACILITY

19 March 2020







US Army Corps of Engineers®

AMERICAN MEDBRIGHT

FL-DOH-20-0673-A-003899

H2HC – CONCEPT OF THE OPERATION

PHASES

1. SITE – STATE Responsibility

- Identify existing, available facility
- Assess for suitability
- Technical advice/assistance from USACE under FEMA MA – Critical Public Facilities PRT
- Existing utilities and infrastructure (electric, power, water, HVAC, IT,…)
- Lease facility
- Transfer authority to USACE to convert and retrofit facility

2. BUILD – USACE Mission (MA from FEMA)

- Convert/Retro-fit existing code-compliant structure
- Hotel, dorm, or apartment building
- Enable conversion of facility to support an ICU-like capability
- Main Functions - supply power (+ auxiliary), remove carpet, modify HVAC for negative pressure, install nurse's station, enable/configure IT infrastructure, etc…
- Stafford Act – emergency contracting authorities, utilizing local, capable business(es); Construction contracts. Cost per Patient = ~$145K or ~$35M for 250-Bed hotel. (minimum, constr. + equip, not including restoration or lease) (Rough Order)

3. SUPPLY – FEMA Mission

- Procure, Install, and Configure medically unique equipment
- Meets end-state requirements
- FEMA would task to either HHS or DLA to procure and install

4. STAFF – STATE Responsibility

- Clearly a state function with available staff
- Expect to be critical path

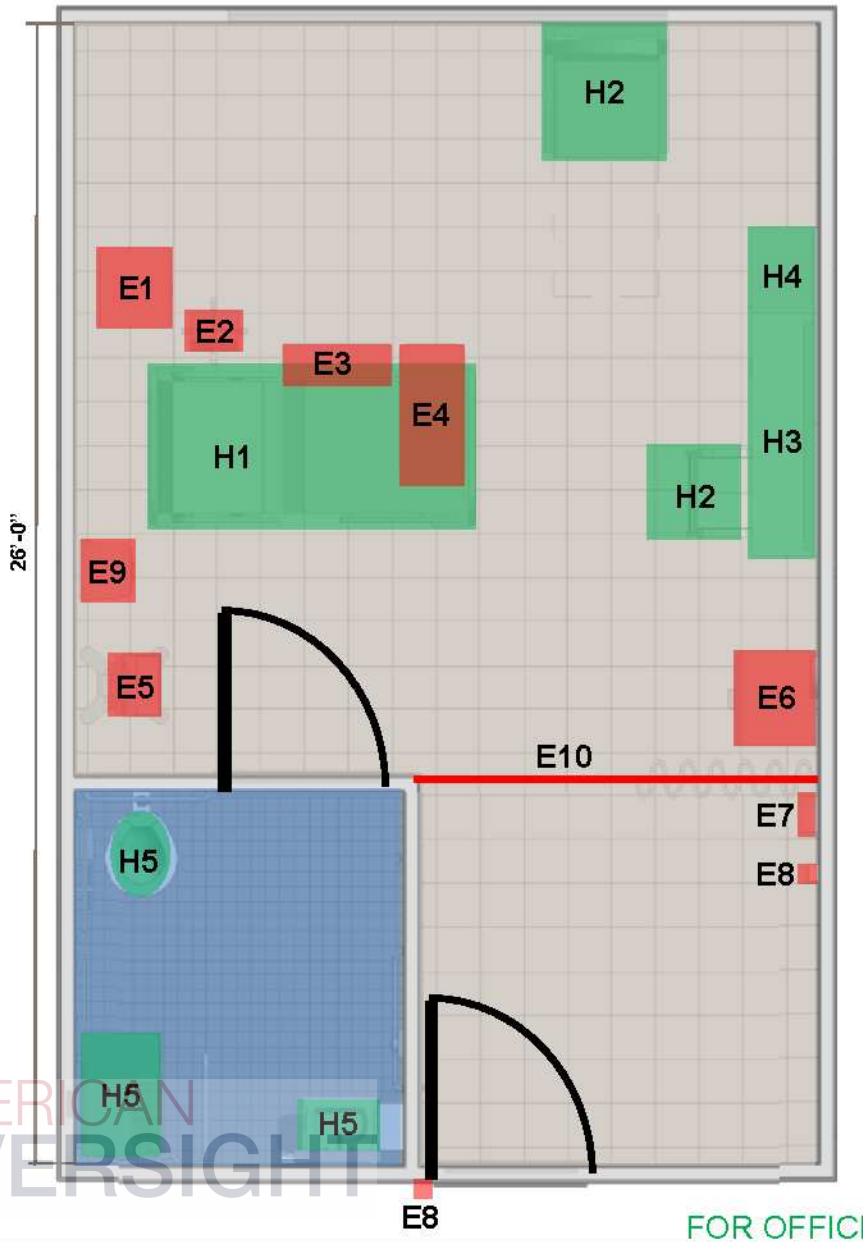
BUSINESS RULES

- Proximity to existing, permanent medical hospital (10 mile/30 min)
- Readily available (10 mile/30 min) HazWaste disposal, linen/laundry, pharmacy
- Will not be fully ADA compliant; only to extent of existing facility
- USACE Cost estimates will not include real estate or lease acquisition, nor restoration costs post-medical use.
- USACE costs for renovation/construction work and IO&T are minimum costs. Actual cost must be developed when site adapting actual facility
- Facility templates and standards are adapted from DoD UFC criteria.
- Local municipality/county/state standards should be discussed and agreed upon by municipality and the Construction Agent.
- State or City Owned Property Preferred...eases leasing and permitting.
- Built/Renovated after 1990 to mitigate lead paint/asbestos.
- Already has redundant power or emergency power
- Building already Sprinklered and meets Fire Code
- Should be Single Room with attached Bathroom
- Meet Modern Power 3-Phase, 3-Wire
- Utilize exterior wall to install exhaust if needed

FL-DOH-20-0673-A-003900

AMERICAN OVERSIGHT

NOTIONAL HOTEL ROOM to HEALTHCARE ROOM



ENGINEERING CHANGES

- REMOVE CARPET
- INSTALL VINYL FLOORING OR EPOXY
- REVISE HVAC DUCTING AND HEPA FILTERING
- ADD EMERGENCY BACK-UP POWER & UPS
- ADD PRIVACY CURTAIN
- ADD ELECTRICAL OUTLETS

REUSE

H1. HOTEL BED *WITH MEDICAL LINENS
H2. HOTEL/RECLINING CHAIR
H3. HOTEL DESK
H4. HOTEL WARDROBE
H5. HOTEL PLUMBING FIXTURES

NEW EQUIPMENT

E1. VENTILATOR CAPABLE; STORAGE CABINET
E2. TELEMETRY/PUMP ON IV STAND
E3. STOOL
E4. OVER BED TABLE
E5. MOBILE WORK STATION
E6. LINEN HAMPER
E7. SHARPS/GLOVES
E8. HAND SANITIZER STATION
E9. INFECTIOUS WASTE
E10. CUBICLE CURTAIN

KEY POINTS

- ALTERNATE CARE (Contingency) Standards
- WAIVERS Required for Unified Facilities Criteria and Typical Medical Facility Standards, as agreed upon between state and construction agent
- ABA ACCESSIBILITY All rooms may not be ABA compliant or wheel chair accessible
- TYPICAL PATIENT ROOM LAYOUT: 420 SF
- TYPICAL HOTEL ROOM LAYOUT:
  SINGLE ROOM: 275 SF
  DOUBLE ROOM: 325 SF

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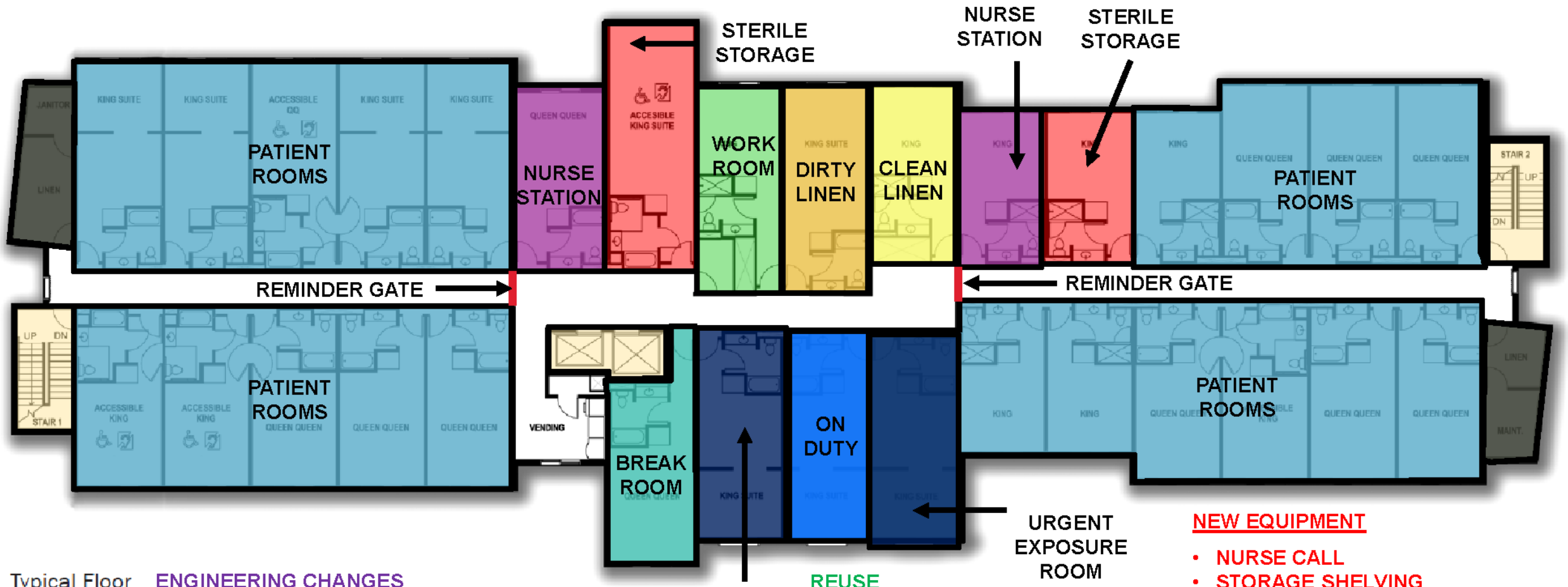
FL-DOH-20-0673-A-003901

H2HC - TYPICAL FLOOR PLAN



Typical Floor

ENGINEERING CHANGES

- INSTALL PRESSURE MONITORING
- MODIFY HVAC TO ACHEIVE NEGATIVE PRESSURE (BY FLOOR)
- MODIFIED ELEVATOR CONTROLS

REUSE

- HOTEL WIFI
- HOTEL PHONE SYSTEM
- HOTEL INHOUSE NETWORK/TVS
- HOTEL ICE MACHINE/VENDING
- HOTEL PACKAGED HVAC

NEW EQUIPMENT

- NURSE CALL
- STORAGE SHELVING
- WORKSTATIONS
- MED DISPENSING UNITS
- #TBD VENTILATORS / FLOOR
- “CRASH” CART / FLOOR
- REMINDER GATES
- EYE/HAND WASH STATIONS

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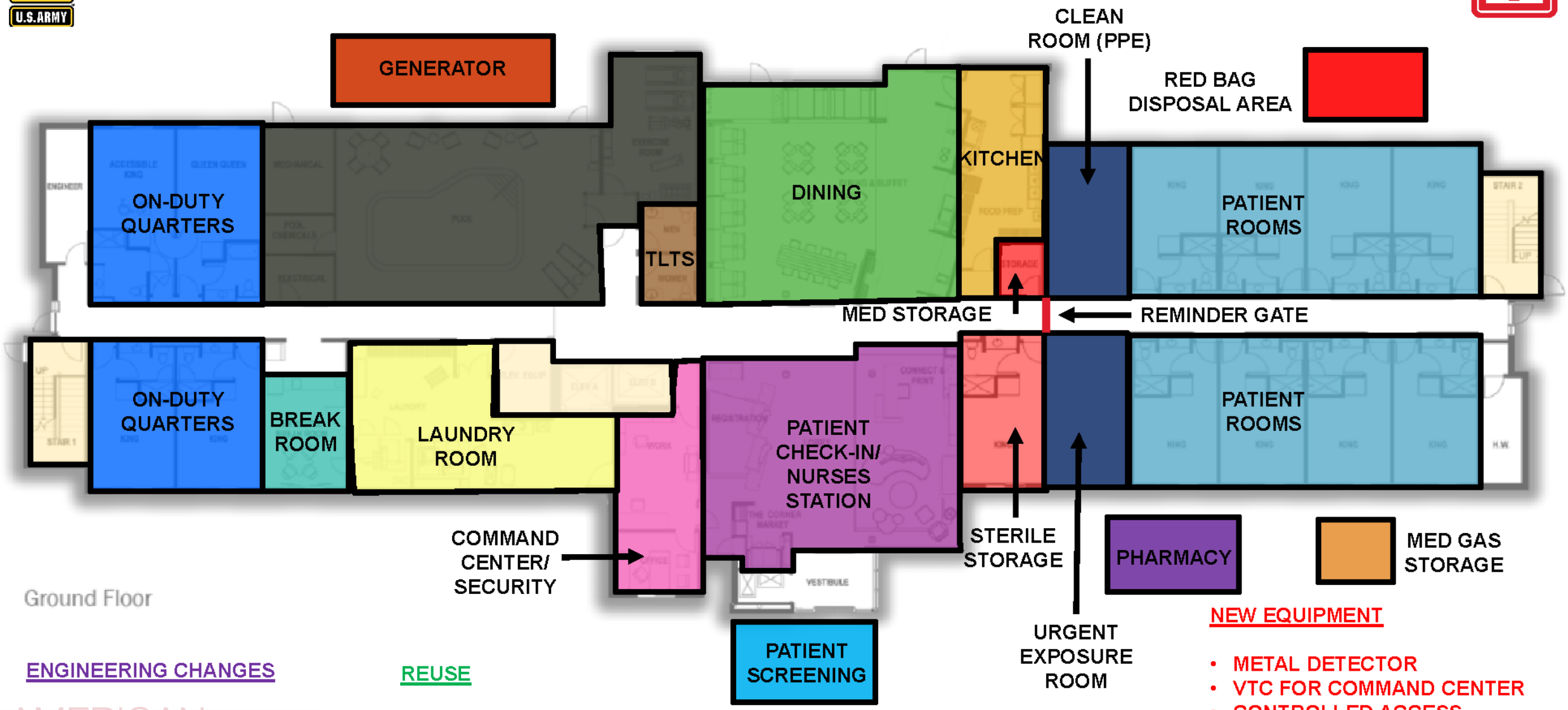
H2HC - GROUND FLOOR PLAN



ENGINEERING CHANGES

- ALL TYPICAL FLOOR PLAN ADDITIONS
- PLUS GENERATOR

REUSE

- HOTEL FURNITURE FOR STAFF QUARTERS
- HOTEL KITCHEN
- HOTEL DINING
- HOTEL VESTIBULE
- HOTEL CCTV FOR SECURITY
- HOTEL CARD READERS

NEW EQUIPMENT

- METAL DETECTOR
- VTC FOR COMMAND CENTER
- CONTROLLED ACCESS
- INFECTIOUS/CLEAN REMINDER GATES
- EYE HANDWASH STATIONS

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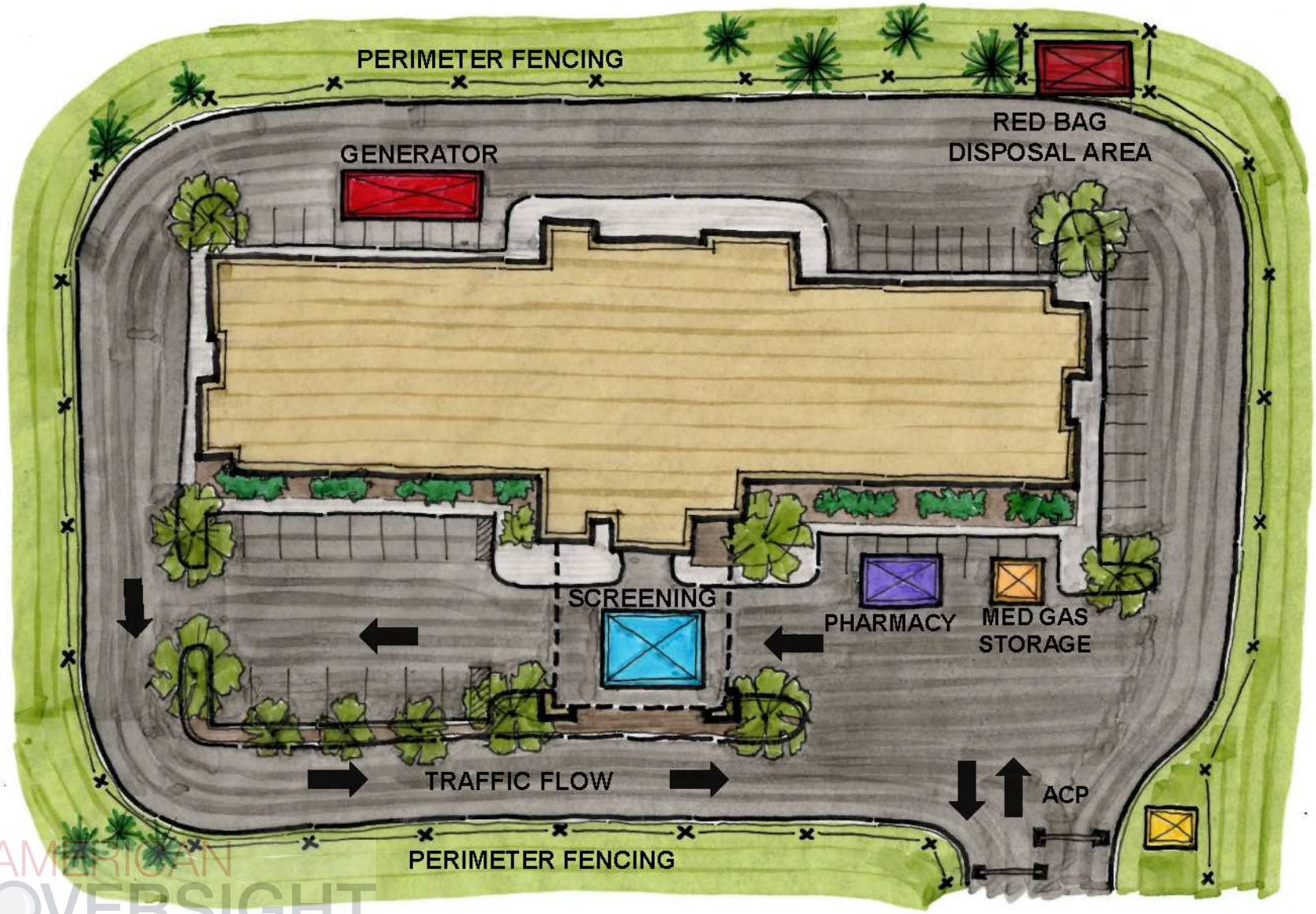
H2HC – SITE IMPROVEMENT PLAN



ENGINEERING CHANGES

- ADD PERIMETER FENCING
- ADD GENERATOR
- ADD PATIENT SCREENING TENT
- ADD EXTERIOR PHARMACY
- ADD MED GAS STORAGE
- ADD ACCESS CONTROL POINT (ACP)
- ADD RED BAG DISPOSAL AREA

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ARENA TO HEALTHCARE CONCEPT (A2HC)

ALTERNATE HEALTHCARE FACILITY



19 March 2020





US Army Corps of Engineers®

AMERICAN OVERBRIGHT

A2HC – CONCEPT OF THE OPERATION

PHASES

1. SITE – STATE Responsibility

- Identify existing, available facility
- Assess for suitability
- Technical advice/assistance from USACE under FEMA MA – Critical Public Facilities PRT
- Existing utilities and infrastructure (electric, power, water, HVAC, IT,…)
- Lease facility
- Transfer authority to USACE to convert and retrofit facility

2. BUILD – USACE Mission (MA from FEMA)

- Convert/Retro-fit existing structure
- Arena or convention center
- Enable conversion of facility to support an ICU-like capability
- Main Functions - supply power (+ auxiliary), cover flooring, modify HVAC for negative pressure, install nurse's station, enable/configure IT infrastructure, temp utilities, etc…
- Stafford Act – emergency contracting authorities, utilizing local, capable business(es); Construction Contract; Cost per Patient = ~$135K or ~$16M for Football Field Scale at 120 beds. (minimum, not including restoration or lease) (Rough Order)

3. SUPPLY – FEMA Mission

- Procure, Install, and Configure medically unique equipment
- Meets end-state requirements
- FEMA would task to either HHS or DLA to procure and install

4. STAFF – STATE Responsibility

- Clearly a state function with available staff
- Expect to be critical path

BUSINESS RULES

- Proximity to existing, permanent medical hospital (10 mile/30 min)
- Readily available (10 mile/30 min) HazWaste disposal, linen/laundry, pharmacy
- Will not be fully ADA compliant; only to extent of existing facility
- USACE Cost estimates will not include real estate or lease acquisition, nor restoration costs post-medical use.
- USACE costs for renovation/construction work and IO&T are minimum costs. Actual cost must be developed when site adapting actual facility
- Facility templates and standards are adapted from DoD UFC criteria.
- Local municipality/county/state standards should be discussed and agreed upon by municipality and the Construction Agent.
- State or City Owned Property Preferred...eases leasing and permitting.
- Already has redundant power or emergency power
- Building modified or supplemented to meet Fire Code.
- Temp Facilities will be staged on perimeter, includes med waste, sanitary, soiled linen, hand washing, med supply/pharmacy
- Meet Modern Power 3-Phase, 3-Wire – Temp Power supplemented to patient care areas on floor.

FL-DOH-20-0673-A-003906

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A2HC PATIENT CONTAINMENT EXAMPLE







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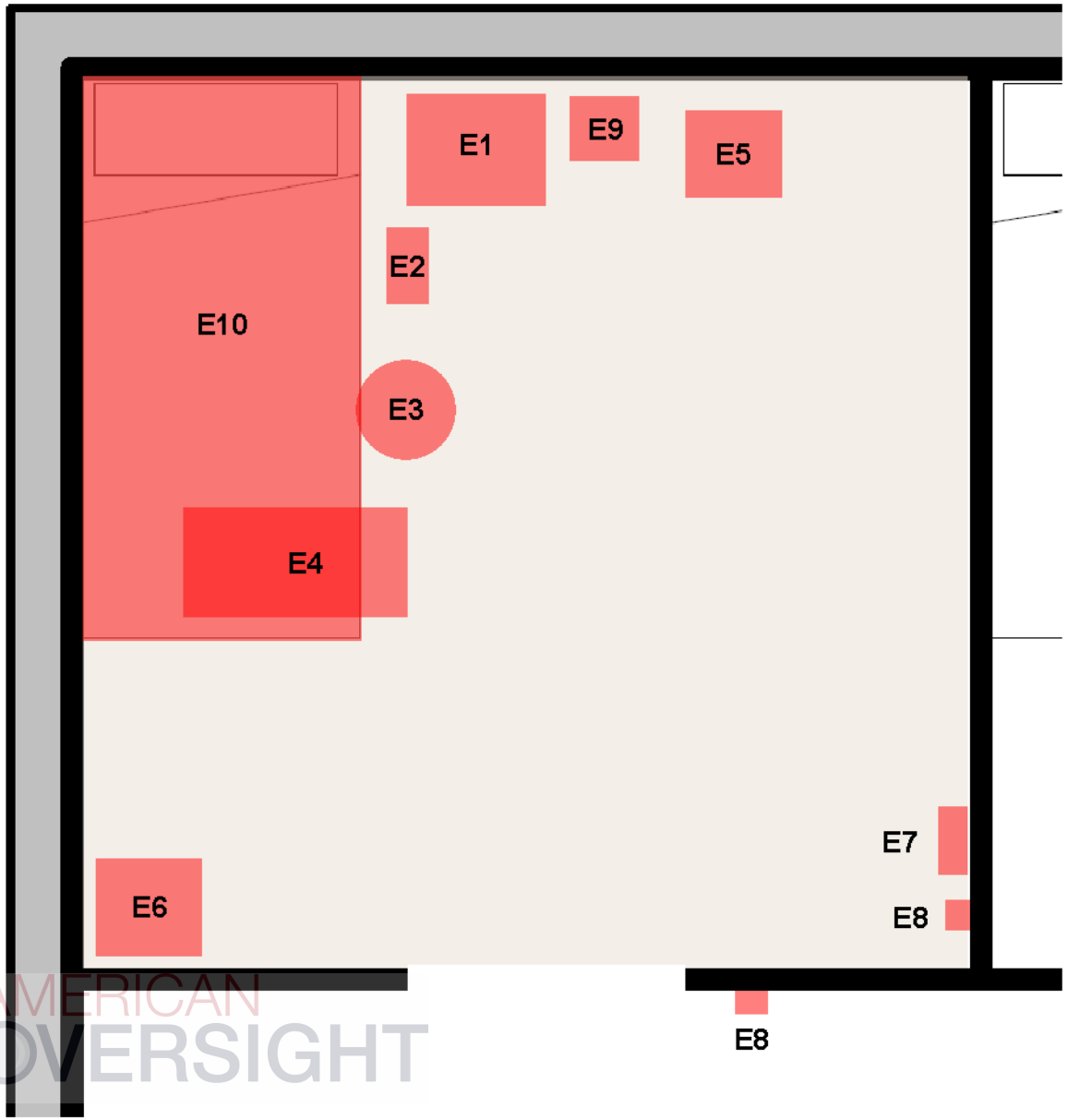
A2HC TYPICAL POP-UP CARE SPACES



ENGINEERING CHANGES

- ADD HVAC DUCTING AND HEPA FILTERING
- ADD EMERGENCY BACK-UP POWER
- ADD ELECTRICAL OUTLETS
- ADD DATA OUTLETS
- ADD PLUMBING

NEW EQUIPMENT

E1. VENTILATOR CAPABLE; STORAGE CABINET
E2. TELEMETRY/PUMP ON IV STAND
E3. STOOL
E4. OVER BED TABLE
E5. MOBILE WORK STATION
E6. LINEN HAMPER
E7. SHARPS/GLOVES
E8. HAND SANITIZER STATION
E9. INFECTIOUS WASTE
E10. PATIENT BED



Bedside Toilet

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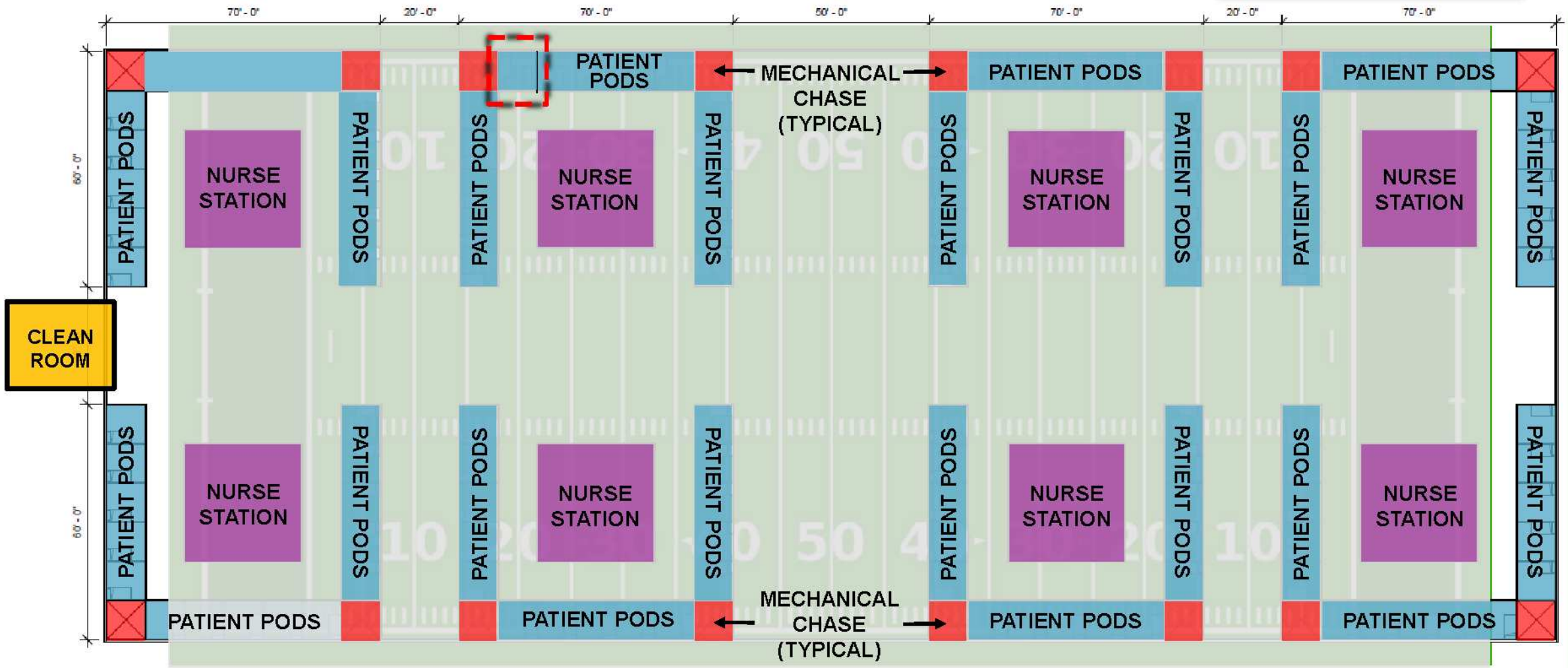
A2HC TYPICAL LAYOUT

- 1 NURSE STATION FOR EACH 15 PATIENTS
- TOTAL OF 120 PODS



ENGINEERING CHANGES

- ALL TYPICAL FLOOR PLAN ADDITIONS
- ADD GENERATOR

REUSE

- FIELD HOUSE ICE MACHINE

NURSE STATION | NURSE STATION | NURSE STATION

NEW EQUIPMENT

- ALL TYPICAL FLOOR PLAN ADDITIONS
- NURSE CALL
- STORAGE
- WORKSTATIONS
- MED DISPENSING UNITS

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Medical Support Planning Task Force Initial Questions:

Primary POC: _____
POC E-mail: _____
POC Phone: _____

Responses to the below questions should be based on what your respective State EM/Public Health are using for Planning Factors at this time.

1. What Planning Factors/Assumptions have your respective States developed in regard to providing medical care to individuals who have or are presumed to have a COVID-19 diagnosis or respiratory like illness?

2. Do you anticipate the need for Alternate Care Sites in your State?
    a. If so, how many of these facilities do you anticipate needing and what patient capacity would you like to see?
    b. Potential locations (cities/regions) that may be considered for Alternate Care Facilities?
    c. ACS use with “known positive’ COVID patients with mild symptoms or no symptoms that are not eligible for hospital admission.

3. Would you prefer the site to be any of the following?
    a. Rental of existing hotel facility?
    b. Retrofit of an existing building (Closed hospital, Nursing home, school, dorm, strip-mall, etc.)?
    c. Ambulatory Care/Surgical Centers?
    d. Soft-side/tent like facility?

4. From the below list, what level of care would you like these facilities to provide?
    a. Basic (i.e. In patient basic supportive care including administration of medications and IV fluids)
    b. Medium (Basic care in addition to in-room oxygen delivery)
    c. High (i.e. Ventilator/ICU capable facility)

5. Would you like a dedicated USACE Medical Facility Planner assigned to your State?

6. Based on the number of facilities and capacity requirements from question 2a, what do you expect your needs will be related to medical equipment? Please provide estimated quantities if possible.
    a. Consumable Medical Equipment
    b. Durable Medical Equipment

7. Based on the number of facilities and capacity requirements from question 2a, what do you expect your needs will be related to medical staff? Please provide estimated quantities if possible.
    a. Physicians (MD/DO):
    b. Registered Nurses (RN/ARNP):
    c. Licensed Practical Nurses (LPN):
    d. Respiratory Therapist (RT/RRT):
    e. Medical Assistants (MA):
    f. Case Mangers (CM):
    g. Social Workers (SW):

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Andy.Mullins@adph.state.al.us; Tim.Hatch@adph.state.al.us; (Jcraig@msdh.state.ms.us); wayne.vaughn@msdh.ms.gov; Brian.Combs@dhhs.nc.gov; Clement, Kimberly D; Blair, Jamie D.; Dawona.Hough@dph.ga.gov; christie.craft@msdh.ms.gov; amanda.b.williford@dhhs.nc.gov; paul.petersen@tn.gov; peter.koonz@tn.gov; sean.j.kice@tn.gov; john.hooper@adph.state.al.us; Stephanie Anspaugh-Naples (Stephanie.Anspaugh-Naples@flhealth.gov); Leah Hoffacker (Leah.Hoffacker@dph.ga.gov); Johnson, Rick D (CHFS DPH EPB); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Cc:	R4 PHUL (FEMA.DHS.GOV); ASPR Region 4 (HHS/ASPR/OEM)
Subject:	FOUO FW: COVID 19 Update dated 22 Mar at (FMS Fact Sheet, A1 Medcom Guidance, Alt Healthcare Facilities)
Date:	Monday, March 23, 2020 7:15:12 PM
Attachments:	FMS Fact Sheet.pdf H2HC and A2HC - HOTEL+ ARENA COAs 191930Mar20 (002).pdf Corporate Partners Items-Equipment.xlsx Medical Support Task Force Initial Questions.docx

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UPC team

This is some of what I was speaking to on the phone today about alternate care sites and isolation facilities. More to coma as the days continue.
Thank you Rick for sending.

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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	A	B	C	D	E
1	CORPORATE PARTNERS ITEMS/EQUIPMENT				
2	COMPANY	ITEMS/EQUIPMENT	POC	CELL PHONE	E-MAIL ADDRESS
3					
4	ADS, Inc	PPE, Disinfectant Wipes, Isolation & Hospital Shelters, Field Hospital Beds, Full Spectrum Germicidal Wipes, One Step Cleaner & Disinfector, Micro ULV Cold Sprayer/Fogger, Combat One Sin Wipes, Bathing Wipes, Disinfectant Robot, Individual Decontamination Kits, Tyvec Suits, SCBA's Electrolyte Hydration Packs, Portable Ultrasound, Portable Ventilator, Portable X-Ray, Therm-App Thermal Imaging Cameras to Measure Skin Temperature, Blue Med Field Hospital, Portable Hand-Washing Stations, KAMS Medical Module, Beds, Cots, Litters	Brad Smith Benny Brown Mike Matthews	(757) 319-0600 (757) 274-7319 (757) 793-5733	bradsmith@adsinc.com bbrown@adsinc.com mmatthews@adsinc.com
5					
6	Air Shelter USA, LLC (ZUMRO)	Rapidly Deployable Shelters - Infection Control/Isolation/Quarantine; Medical Surge/Triage; Drive-Thru Screening; Field Hospital	Trent Baer	(254) 247-8236	tbaer@bfxfire.com
7		Air Handling - Scrubbers/Filtration; Climate Control			
8		Power Generation			
9					
10	Arbill	Through our comprehensive safety offerings - comprising nearly 60 safety services and technology tools to reduce incidents and more than 200,000 stocked safety products (800 items manufactured under our Turline brand). Arbill makes it easy for safety conscious agencies to provide their team members with the tools they need to create a culture of safety throughout their organization and reduce injuries. NOTE: the COVID-19 requirements and our existing relationships with DHS, CDC, USDA, States and City agencies have put some product lines on back order with long lead times. Recommend visiting our website at Arbill.com to determine your safety needs.	Mike Bobeck	(703) 314-0858	mbobeck@arbill.com
11					
12	BOH FPU Systems, a division of BOH Environmental, LLC	BOH Mobile Patient Isolation Unit. Government Pricing Qty 1-24 - $146,153.84 Qty 25+ - $141,538.42	Ronald Riling	(256) 425-4235	rriling@bohfpusystems.com
13					
14	Brief Relief a Division of American Innotek, Inc	Portable disposable sanitation facilities when normal facilities are not available (WAG BAGS). All products are in stock. Can ship in 48 hours.	Lou Ortego	(858) 354-5034	lortego@briefrelief.com
15					
16	Caliburn Intl (acquired Comprehensive Health Services)	Rapid Response Medical Capabilities - Rapid transition including all medical facilitites up to Level III, logistics, supply chain, and equipment; 210+ medical Professionals, 24/7 Medical Support, 10,000+ Population at Risk (PAR), 730+ Patients Monthly;	Kathleen Cyphert	(571) 318-4227	Kathleen.Cyphert@caliburnintl.com
17		Modular Medical Facilities - Fully equipped to isolate and treat COVID-19 patients, Negative pressure units meets CDC's airborne infection isolation (AII) requirements, with HEPA and UV filtration, based on standard modular containers, U.S. MADE.			
18		Medical Staffing - Qualified medical professionals, registered nurses, nursse practitioners, physicians, we analyze the population at risk, the expected pathology, patient load and acuity, then tailor a staffing plan.			
19					
20	Cambium Networks	Cambium Connectivity Kits securely extend communications from a Command Post to other locations using point to point and point to multi point technologies in NATO Band IV, Unlicensed, and NTIA7 & 8GHz, for Voice/Data Command & Control, Surveillance, & C4ISR backhaul. The kits provide rapidly deployagble capabilities configured in a self-contained 450 Mbps ultra-wide band radio & 18M antenna mask. They are also available in Vehicle Platform configurations. The kits have been deployed in disaster responses such as the Puerto Rico Hurricance Response, CBP Mobile Border Ops, US Marshall Prison Breakout in NY, FEMA Mobile response, & Teams with US DoD Force Protection missions. Multiple States with the National guard have purchased these units. Unit price is $110,000. Available today.	Mike Bristol	(703) 472-1940	Michael.Bristol@fairwinds-tech.com
21					
22	Canadus Power Systems	Canadus HD-1224 Battery Desulfator - this inexpensive item will help your trucks and equipment start when you need them to. Easily bolts onto the battery terminals in 10-15 minutes & will help keep your Lead-Acid and AGM batteries in top performing condition. Can be purchased with Government credit card direct from manufacturer or for orders above $10,000 through GSA.	Andy VanElzen	(330) 858-8850	avanelzen@canadus.com
23		https://www.gsaadvantage.gov/advantage/s/search.do?q=0:2canadus&db=0&searchType=0			
24					
25	Carcoon America, LLC	The CARCOON product line helps with shelters, medical & organizational facilities, decontamination chambers, Rapidly Deployable Mobile Isolation Chambers, and Personal Units. These shelters range in size from one person unit to one big enough to hold a freight train or 747 aircraft. (Economically Disadvantaged Woman Owned Small Business) CAGE Code 8G7Z7	Janet Bernard David Bernard	(904) 567-3825 (904) 910-0336	info@carcoonamerica.com
26		www.carcoonmedical.com			
27					
28	Cascade Designs	Emergency Shelter and Pop-Up Clinic Pads; Emergency Shelter & Po-Up Clinic Water Treatment and Decontamination; Field Sanitation	Tim Davis	(206) 963-4343	Tim.Davis@CascadeDesigns.com
29					

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	A	B	C	D	E
30	Cerego	Rapid development of world-class remote training for immediate applications. State-of-the-art adaptive learning, with one-of-a-kind feedback and monitoring capabilities.	Ron Houle	(914) 806-3775	ron.houle76@gmail.com
31					
32	Climb2Glory LLC (SDVOSB certified)	Protective Masks: N95 (30 types), N99 (4 types) NIOSH certified; Anti-Microbial Liquid Super Durable Cleaner; Emergency power Supplies w/wind or solar backup charging capabilities - from 3,000 to 10,000W/hour range.	Ted Reich	(719)447-7749	treich@climb2glory.com
33					
34	Cobham	Cobham RT-7000 radio - 3 transceivers in an 8.9 lb box; ability to step down to first responder frequencies (and civilian hospitals); has input jacks for hand-held radios allowing first responders to hop in the aircraft and plug-in and simulcast across whatever frequencies desired.	Garrett Jensen	(571) 970-8669	garrett.jensen@peduzziassociates.com
35					
36	DripDrop Hydration Inc	DripDrop ORS is DoD and AMEDD approved Oral Rehydration Solution with NSNs. The class VII part #s are 61406 Lemon; 61407 Berry; 61408 Watermelon; and 61410 Orange. DripDrop ORS has a great taste while having half the sugar and three times the electrolytes than a sports drink. it works as well as an IV and is infinitely more useful because it is easily transported and can be administered by anyone (pour powder into 16 oz water and drink). DripDrop ORS consequently reduces IV need. Has been used in the US by prominent institutions including UCSF, Mayo Clinic, Stanford, Boston Childrfen's and all branches of the US Military 9as well as both professional and collegiate sports teeams). It has been used in the US and around the globe in disaster situations as well. The CDC used DripDrop in Sierra leone and Liberia in the treatment of Ebola and it is currently being used in the Congo for the same. DripDrop has been used for Cholera in Haiti. In the US, medical professionals and consumers use DripDrop ORS to treat dehydration from the cold and flu and it can be used the same in connection with COVID-19.	Steve Duran	(724) 513-4692	steve.duran@dripdropors.com
37					
38	Eureka! (A Division of Johnson Outdoor Gear)	Tents & sidewalls available for immediate shipment	Tim Cronk	(607) 972-1814	tim.cronk@johnsonoutdoors.com
39					
40	ForceProtector Gear	Deployments Bags (including medical kit bags); ThermalShield (clean environment for medics to work on/thermal barrier). We are 100% Berry and 100% material sourced in the United States. We have not only a warehouse of raw goods, but also have finished products available for immediate shipment.	John Carswell	(818) 439-6261	john@forceprotector.com
41					
42	Galls	PPE/Infection Control: Sanitizer, Antiseptic wipes, N95 Surgucal Masks, Nitrile Gloves, TyChem/Healthcare Coveralls, Goggles/Eyewear, Protective/Chemical Resistant Footwear, Protective Headwear, Shoe Covers.	Earl Wilder	(859) 800-1038	wilder-earl@galls.com
43		Medical/Emergency Gear: IFAK, Medical bags/Kits, Emergency blankets, Spine Board, Diagnostic equipment, CPR, Oxygen equipment, First Aid supplies, Medical gloves, Shears, AEDS, sleeping cots.			
44		Rescue Mission Gear: Tents, Sleeping bags, Tactical bags/Backpacks, Flashlights, Flares, MRE's, Camelbaks/Canteens, Knives, Multitools, Nightvision, Optics/scopes.			
45		Civil Disturbance Operations Gear: Emergency power sources, Area lighting, Riot gear/suits/shields, Face shields, Traffic signs, Portable Traffic barriers, OC spray, Megaphone, Batons, Body armor, Molle pouches, Plate carriers & Plat3es, Ballistic helmets, Assault packs, Weapon slings, Active shooter kits, metal detectors, traffic spikes, Inspection mirror, Hi Vis traffic vests, Restraints/handcuffs/flex cuffs, Pelican cases.			
46		Operational Clothing: OCP uniforms, BDUs, SFS/police Class A uniforms, Fire/EMS uniforms & Stationwear, Jackets/outerwear, ECWCS system clothing, Tactical pants, Polos, base layers, Custom patches/embroidery/Screen print/heat press.			
47		Footwear: Military boots, Fire & EMS boots, Tactical/Duty boots, Athletic & Training boots, Socks.			
48		http://www.galls.com/govops/index.html			
49					
50	Genasys Inc (also known as LRAD)	LRAD 100X Portable Long Range Communication System. We currently have 196 100X units in stock ready to be shipped. We also have six 450XLs, Tripod Kits and 24V Power Packs readily available. We have already helped National Guard units with communicating to the public from long and safe distances. These systems are already MILSPEC'd items being purchased by all our Military Services and First Responders.	Jeff Palmer	(858) 204-8514	jpalmer@genasys.com
51					
52	Gordian	We provide a service that would be a great assset to the States as they start to receive and execute large amounts of SRM dollars in response to the stimulus packages. We are industry leader in construction cost data and job order contracting. We hhave established job order contracts in several States that the Guard would be able to quickly find contractors.	Lisa Cooley	(505) 239-3446	L.cooley@gordian.com
53					
54	Hughes Network Systems	Hughes Cellular On-Demand ManPack creates an independent LTE wireless network with a wide radius to keep teams connected to each other via smartphones and other devices. Offers an ultra-small, completely virtualized 3GPP LTE core network to deliver fully functional cellular communications which can be deployed for operations around the world. Light and energy-efficient LTE network core creat3es a cellular and Wi-Fi bubble in just minues to meet mission-critical wireless connectivity requirements. With the option to add satellite for backhaul, Hughes can provide an agile, turnkey communications solution for resilient, time-sensitive military and disaster response. Unit price $180,000.	Janie Robinson	(703) 785-7618	Janie.Robinson@hughes.com
55					

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	A	B	C	D	E
56	ibvi Industries - for the Blind & Visually Impaired	We can kit nearly anything needed. Eamples - Direct Responde Aid Kits (DRAK), Vertical Skills Engineering and Construction Kits (VSECK) and more. Cotton masks available.	Martin Brill	(414) 405-0341	Martin.Brill@ibvi.org
57		https://ibvi.org			
58					
59	isf	Enterprise wide Personnel and Logistical Tracking Software that allows States to manage, track and report on SAD and long-term standing missions. Gives States a centgralized system that allows them to work more efficiently when preparing for an activation or emergency. It enables States to manage the events & expedite the recovery and reimbursement process in a fashion not available with any other software.	Lawrence Salerno	(850) 212-7130	lsalerno@isf.com
60					
61	Kimball Midwest	Cleaners, Hand-Sanitation, MRO, etc	Shane Steele	(254) 577-0337	shane.steele@kimballmidwest.com
62					
63	Laerdal Medical	Laerdal Medical Simulator Scenariofor COVID-19 Training of Medical Personnel; Human patient Simulators (adult, toddler & infant); Laerdal Silicone Resuscitator; The Bag Disposable Resuscitator; Laerdal Compact Suction Unit 4	Steve Parrish	(845) 514-8737	Steve.Parrish@laerdal.com
64					
65	Leonardo DRS	We have an M1152 HMMWV outfitted with the On Board Vehcile Power (OBVP) system (30kW, 120/208 VAC) that is ready to roll as an Emergency Power Source. It is currently located in our DRS facility in Huntsville, AL.	Carlos Aguirre	(256) 653-6604	carlos.aguirre@drs.com
66					
67	LiteFighter Systems, LLC	Litefighter 1 (NSN 8340-01-628-8855) Individual Shelter Systems for Tactical "Social Distancing"	Rich Coachys	(404) 718-9818	rcoachys@litefighter.com
68		Olympus Emergency Response Mobility Bags (NSN 8465-01-679-7717) in OCP Camouflage			
69		Olympus Emergency Response Mobility Bags (NSN 8465-01-679-7709) in Coyote Tan			
70		Olympus Emergency Response Mobility Bags (NSN 8465-01-679-7698) in Black			
71					
72	Mack Defense	All GSA Class 8 truck options are available & simple parts.	Rob Gordon	(484) 695-2086	robert.gordon@mackdefense.com
73					
74	Mahaffey Fabric Structures	Complete shelter and life support solutions that can be rented! Leasing arrangements are flexible & customer-driven.	Ron Houle	(914) 806-3775	ron.houle76@gmail.com
75					
76	MASSIF	Massif fire resistant base layers - lightweight, midweight, and heavyweight tops and bottoms. Also beanies and balaclavas.	Sarah Rehfeldt	(541) 531-0558	sarah@massif.com
77		https://www.massif.com/shop/light-mid-heavy-layers.html			
78					
79	McFall Consulting	ZONO Sanitizing Cabinet - Ready to Ship! The ZONO cabinet is recognized by CDC and WHO as an efficient sanitizing agent and eco-friendly solution to wiping out 99.9% of common bacteria and 99.99% of common viruses (under EPA regs, ZONO cannot say it kills COVID 19 until it is able to test with the virus. However, ZONO has tested with Norovirus, widely known as one of the hardest type of virus to kill, and the ZONO kills 99.99% (disinfecting level) of Norovirus. ZONO plans to test with COVID-19 ASAP.) ZONO sanitizes items safely and as effectively as bleach or other chemicals without compromising their integrity:	Davis Murphy	(504) 813-9574	davis@mcfallconsulting.com
80		Tactical Communities (military, LE/Fire, First Responders): body armor, vests, helmets, boots, shoes, physical training gear, radios, anything that is checked out daily, etc.			
81		Fitness/Strength & Conditioning/Physical Therapy: group X equipment, yoga mats/blocks/bands/med ball, Ab mats, cable crossover attachments, bands, collars, etc.			
82		Parks & Rec/Campus Rec: In addition to above, anthyhhing that is checked out on a daily basis or use in general play.			
83		Office/Front Desk/Corporate Wellness Lounges: computers, keyboards, mouse, mousepads, power-nap mats, etc.			
84		ISDs/Daycare/Kids Zones in Fitness Ccenters: PE equipment, sports equipment, toys, arts & craft supplies, crayons, sleep mats, etc.			
85					
86	Military Battery Systems, Inc	Rugged COTS portable (emergency) power sources. Quiet power for charging/powering laptops, tablets, comms gear, lighting, etc. Portable,powered cellular/WiFi hotspots. Dual sim portable routers that work on AT&T, Verizon, FirstNet, etc. For up to 128 uswers.	Jim Wagner	(303) 641-1845	jim@milbatteries.com
87					
88	Motel 6 & Studio 6	Discount on Lodging	Kirsten Jenkins	(214) 641-8969	k jenkins@g6hospitality.com
89					
90	Motorola Solutions, Inc	Portable radios & accessories, mobile radios, transportable repeater systems, transportable LTE (broadband) solutions, hardened and secure Android smartphones, video solutions, video analytics, body worn cameras, professional communication services.	Bob Nosenchuk Chris Sarantos	(201) 874-9104 (434) 258-1676	bob.nosenchuk@motorolasolutions.com chris.sarantos@motorolasolutions.com
91					

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	A	B	C	D	E
92	MulePAC	Portable All-mode Container is a system of lightweight, plastic, collapsible, modular, intermodal, nearly indestructible secondary containers designed specifically for the U.S. Military for transporting and storing all classes of military supplies to, from and within theater all the way to the last tactical mile. Built to withstand the toughest environments, MulePAC saves time, money and lives! They are on Army Standing Resolution ARNG-5, Item "V" and all sizes/configurations have noth NSNs and MulePAC Part Numbers. These contgainers wll be of great value to store and transport both Emergency Supplies as well as Mobilized Unit Equipment.	Rick Segeleon	(502) 608-8400	rick@getmulepac.com
93					
94	North American Rescue	All medical items from point of injusry through hospital, dental & veterinary.	Matt Westra	(864) 293-2468	mwestra@narescue.com
95					
96	Pelican Products	Protective Cases along with Lighting Solutions	Jason Russell Mike Thompson	(757) 285-6883 (757) 372-3065	jason.russell@pelican.com mike.thompson@pelican.com
97	Phantom Products, Inc	Flashlights (safety, MP/SF, and covert); tent lights, traffic control lighting (wands and road flares), vehicle marking lights (rotary/steady and flashing-all sizes); crowd control lighting; emergency lighting.	Victoria McDermott	(703) 906-2066	vmcdermott@phantomlights.com
98					
99	PowerFlare	Safety Lighting	Tricia Callahan	(703) 599-9514	tricia@pfdci.com
100					
101	Progressive Expert Consulting, Inc	Online Virtual Platform for Training, Instruction & Meetings - on GSA schedule.	Michael Feng	(315) 5603364	michael.feng@peinc.com
102					
103	Proksi Systems	Pharmacy Consultation in VIRGINIA ONLY	Pragnay Choski	(215) 588-8374	pragnay@proksisystems.com
104					
105	PTS-Inc	Emergency Operations Center Communications Systems - Expeditionary Communications that require NO generator or vehicle power to operate SINCGARS, all Harris radios to include the ANPRC 150, ANPRC 117G, ANPRC 117F, PSC 5, and the ANPRC 160.	Keith Hudson	(757) 641-7435	khudson@pts-inc.com
106					
107	Rite in the Rain	Weatherproof Paper/Card Stock, to be used for outdoor emergency signage; Weatherproof Medic Cards; Emergency Medical Response Notebooks; CERT Field Operating Guide Notebooks; All Weather Pens.	Debra Johnson Pierson	(360) 550-5519	debra@riteintherain.com
108					
109	Robertson Fuel Systems	Army Aviation: Internal Auxiliary Fuel Tank Systems (IAFTS) for the Guard's UH-60M Black Hawks. Currently,this is the only airframe that does not have IAFTS. Both the Guards UH-60As & UH-60Ls have IAFTS capability to extend range. At this time, the Guard would likely use their UH-60A/Ls in lieu of the newer UH-60M, as these aircraft are operationally better equipped to extend time and range. NGB has listed IAFTS for UH-60M on their 2020 Buy List, but the funding has been reprogrammed by the Big Army.	Chip Lunn	(480) 298-5684	chip.lunn@robbietank.com
110					
111	Sikorsky/A Lockheed Company	The company is available to assist, but need to know what is needed. Please call.	Tom Nicolett	(703) 851-9280	tom.v.nicolett@lmco.com
112					
113	Stanley Black and Decker Storage Solutions (Vidmar Lista)	In the increased cimate of medical testing and laboratory facility volumes, Stanley Black and Decker provides a product that will allow for efficiency of work and work place solutions. Our work benching and storage cabinets can be a viable source to help with any medical process in support of the COVID-19 virus.	Darin Gilderoy	(678) 316-0972	darin.gilderoy@sbdinc.com
114		https://www.listaintl.com/industry-solutions/healthcare			
115		https://www.listaintl.com/industry-solutions/dental-labs			
116					
117	Freedom Surveillance, dba Strongwatch	In support of DOMOPS, Homeland Security, Installation Security, and FEMA ESFs' 3, 4, 5, 9 and 10 missions. This ground system is a fully mobile and on the move, stabilized zoom cameria system with Thermal infrared, High Definition Color, Laser Range Finder, and Laser Illuminator that can record video, snapshot pictures, designate grid coordinates (LAT/LOG & MGRS) & human detection up to 12,000 meters (7 miles) that includes interoperability capability to simultaneously live stream into multiple agencies Command Posts, computers, smart phone, and tablets significantly increasing info sharing & accuracy of the common operating picture. The J3's, NGAUS and ANG 5/7 Domestic Capabilities Priorities are in support of this system in multiple areas of priorities.	Robert Mouw	(360) 524-5542	robert.mouw@strongwatch.com
118		https://strongwatch.com			
119					
120	SyTech Corp	SyTech Corps's communication product, RIOS, in an interoperative gateway that connects all types of communication devices, including radio, smartphone and computers. RIOS is immediately deployable to the most challenging environments. RIOS connects networks anywhere in the world with ethernet, satellie or wireless IP. This product has been completely vetted by NGB HQ staff and State representatives. It is currently the number-one priorityfor communication equipment for the ANG for somestic operations. Unit price is $58,000.	Aaron Armendariz	(703) 268-1561	aarmendariz@sytechcorp.com
121					

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	A	B	C	D	E
122	TeleSwivel LLC	Emergency Lighting Equipment; portable LED light sets - same orbetter performance as big diesel generator sets at 1/3 to 1/2 the cost. Probiotic Disinfectant for vehicles & equipment. Non-chemical disinfectant, highly effective on a range of bacteria and allergans. We are working on trials to show efficacy onr espiratory (Corona) viruses).	Dave Woolf	(919) 623-2031	dwoolf@teleswivel.com
123					
124	The Last US Bag Company	Medical Bags, Nylon or Polyester for kitting and transport; reusable protective shoe covers; reusable protective masks.	Will Macia	(503) 816-4001	will@lastusbag.com
125					
126	Unifire, Inc	Medical, Clothing, Tents/Shelters, Cleaning Supplies, PPE, Rescue Equipment, Decon Stations, Crown Control, Helmets, Footwear, etc. We hold multiple GSA schedules, are a TLS Prime Contractor and sub-contractor under the FES contract.	Bryan Mills	(336) 417-1699	govsales@unifireusa.com
127					
128	Vizsafe	Geoaware COVID-19 Information Sharing & Monitoring Solution. Solutions available immediately that can help improve information sharing, communications, incident reporting, monitoring and response to the COVID-19 crisis for healthcare and public safety organizations. Theis application would enable the National Guard to securely communicate and track their teams in the field, as well as share actionable intelligence with local, state and Federal partners/resources.	Peter Mottur	(401) 862-2029	pmottur@vizsafe.com
129					
130	Weatherhaven	Mobile negative pressure isolation units; turnkey base camps; mobile power; environmental control units (ECUs); mobile billeting; mobile field hospitals.	Ron Houle	(914) 806-3775	ron.houle76@gmail.com
131					
132	XGO	Ag47 Silver Anti-Microbial/Anti-Fungal clothing & accessories.	Mackenzie Huston	(859) 492-2675	Mackenzie.huston@proxgo.com
133					
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AMERICAN OVERSIGHT

Federal Medical Stations

From 2005-2012, DSNS deployed FMS aid to victims of Hurricanes Katrina, Rita, Dean, Gustav, Ike, and Sandy.



Managed by the Division of Strategic National Stockpile (DSNS), federal medical stations (FMS) are rapidly deployable caches containing beds, supplies, and medicines which can quickly turn a pre-identified building into a temporary medical shelter during a national emergency. Care can be provided for 50-250 displaced people for three days before resupply is necessary. The FMS offers health and medical surge capability and capacity for short-term inpatient persons who have sub-acute medical, mental health, or other healthcare needs that cannot be accommodated or provided for in a general shelter.

Each FMS has the ability to increase local healthcare capabilities in mass casualty incidents or potential public health threats. They are flexible, modular, scalable, and tailored to meet the requirements of each incident. The FMS operates in cooperation with federal, state and local authorities.

Use of an FMS requires pre-planning, and prior to an event, state, local, tribal, and territorial (SLTT) jurisdictions collaborate with Health and Human Services' (HHS) Regional Emergency Coordinators (REC) to identify anticipated requirements for FMS support (e.g., conduct FMS site surveys to ensure logistical wraparound services are appropriate and to identify any gaps requiring resolution during a response.) FMS site selection criteria should be met for all potential FMS facilities. Pre-identification of possible FMS sites should be included in SLTT or regional jurisdiction emergency plans.

To assist stakeholders, DSNS deploys an FMS Strike Team (FMSST) to facilitate FMS cache set-up, conduct training for volunteers, and provide subject matter expertise, which can include among others, assessing the facility's limiting factors, providing advice and assistance in support of the FFMS internal set-up, and conducting recovery procedures. FMSST members do not operate the FMS; this is done by teams from the United States Public Health Service Rapid Deployment Force, or the Department of Veterans Affairs, or a combination of other designated groups. FMS deployment for specific locations is organized through the REC.

Federal Medical Stations Minimum Requirements

One FMS requires approximately 40,000 square feet of enclosed, climate-controlled space with the following features:

- Loading dock/ramps, forklifts, pallet jacks, and parking
- Sufficient existing communications/IT support and power supply with back-up
- Availability of support services including, food and water, waste disposal, medical oxygen, laundry, and mortuary services
- Refrigeration and locked storage
- Bathroom and shower capability

Quick Facts
Federal Medical Stations

- Each FMS has a base, treatment, and pharmacy module.
- Each FMS can quickly turn a building into a temporary medical shelter.
- Each FMS is modeled for all age populations.
- Each FMS can be transported by air, water, or ground for maximum geographic distribution.

For additional information, email sns_opcext@cdc.gov.

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HOTEL TO HEALTHCARE CONCEPT (H2HC)

ALTERNATE HEALTHCARE FACILITY



19 March 2020





US Army Corps of Engineers®

AMERICAN MEDBRIGHT

FL-DOH-20-0673-A-003918

H2HC – CONCEPT OF THE OPERATION

PHASES

1. SITE – STATE Responsibility

- Identify existing, available facility
- Assess for suitability
- Technical advice/assistance from USACE under FEMA MA – Critical Public Facilities PRT
- Existing utilities and infrastructure (electric, power, water, HVAC, IT,…)
- Lease facility
- Transfer authority to USACE to convert and retrofit facility

2. BUILD – USACE Mission (MA from FEMA)

- Convert/Retro-fit existing code-compliant structure
- Hotel, dorm, or apartment building
- Enable conversion of facility to support an ICU-like capability
- Main Functions - supply power (+ auxiliary), remove carpet, modify HVAC for negative pressure, install nurse's station, enable/configure IT infrastructure, etc…
- Stafford Act – emergency contracting authorities, utilizing local, capable business(es); Construction contracts. Cost per Patient = ~$145K or ~$35M for 250-Bed hotel. (minimum, constr. + equip, not including restoration or lease) (Rough Order)

3. SUPPLY – FEMA Mission

- Procure, Install, and Configure medically unique equipment
- Meets end-state requirements
- FEMA would task to either HHS or DLA to procure and install

4. STAFF – STATE Responsibility

- Clearly a state function with available staff
- Expect to be critical path

BUSINESS RULES

- Proximity to existing, permanent medical hospital (10 mile/30 min)
- Readily available (10 mile/30 min) HazWaste disposal, linen/laundry, pharmacy
- Will not be fully ADA compliant; only to extent of existing facility
- USACE Cost estimates will not include real estate or lease acquisition, nor restoration costs post-medical use.
- USACE costs for renovation/construction work and IO&T are minimum costs. Actual cost must be developed when site adapting actual facility
- Facility templates and standards are adapted from DoD UFC criteria.
- Local municipality/county/state standards should be discussed and agreed upon by municipality and the Construction Agent.
- State or City Owned Property Preferred...eases leasing and permitting.
- Built/Renovated after 1990 to mitigate lead paint/asbestos.
- Already has redundant power or emergency power
- Building already Sprinklered and meets Fire Code
- Should be Single Room with attached Bathroom
- Meet Modern Power 3-Phase, 3-Wire
- Utilize exterior wall to install exhaust if needed

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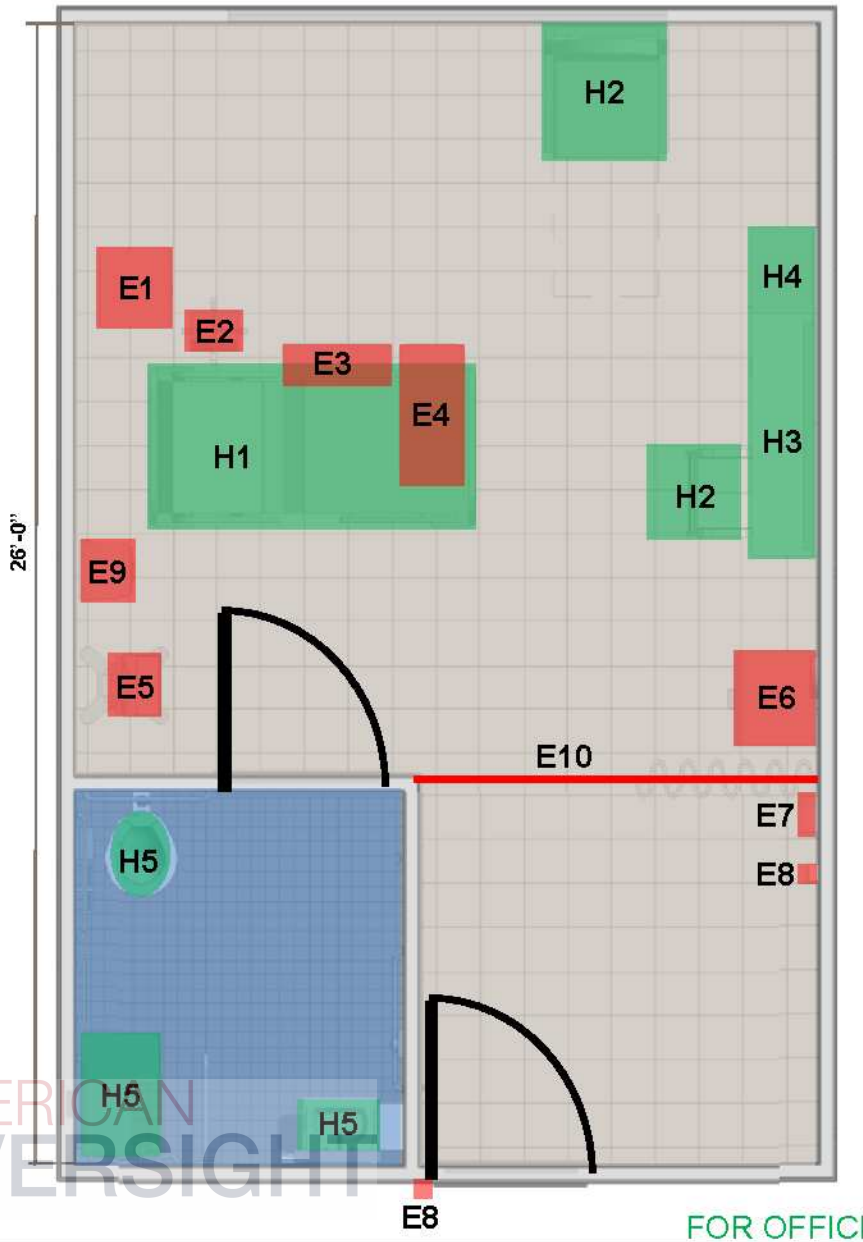
NOTIONAL HOTEL ROOM to HEALTHCARE ROOM



ENGINEERING CHANGES

- REMOVE CARPET
- INSTALL VINYL FLOORING OR EPOXY
- REVISE HVAC DUCTING AND HEPA FILTERING
- ADD EMERGENCY BACK-UP POWER & UPS
- ADD PRIVACY CURTAIN
- ADD ELECTRICAL OUTLETS

REUSE

H1. HOTEL BED *WITH MEDICAL LINENS
H2. HOTEL/RECLINING CHAIR
H3. HOTEL DESK
H4. HOTEL WARDROBE
H5. HOTEL PLUMBING FIXTURES

NEW EQUIPMENT

E1. VENTILATOR CAPABLE; STORAGE CABINET
E2. TELEMETRY/PUMP ON IV STAND
E3. STOOL
E4. OVER BED TABLE
E5. MOBILE WORK STATION
E6. LINEN HAMPER
E7. SHARPS/GLOVES
E8. HAND SANITIZER STATION
E9. INFECTIOUS WASTE
E10. CUBICLE CURTAIN

KEY POINTS

- ALTERNATE CARE (Contingency) Standards
- WAIVERS Required for Unified Facilities Criteria and Typical Medical Facility Standards, as agreed upon between state and construction agent
- ABA ACCESSIBILITY All rooms may not be ABA compliant or wheel chair accessible
- TYPICAL PATIENT ROOM LAYOUT: 420 SF
- TYPICAL HOTEL ROOM LAYOUT:
  SINGLE ROOM: 275 SF
  DOUBLE ROOM: 325 SF

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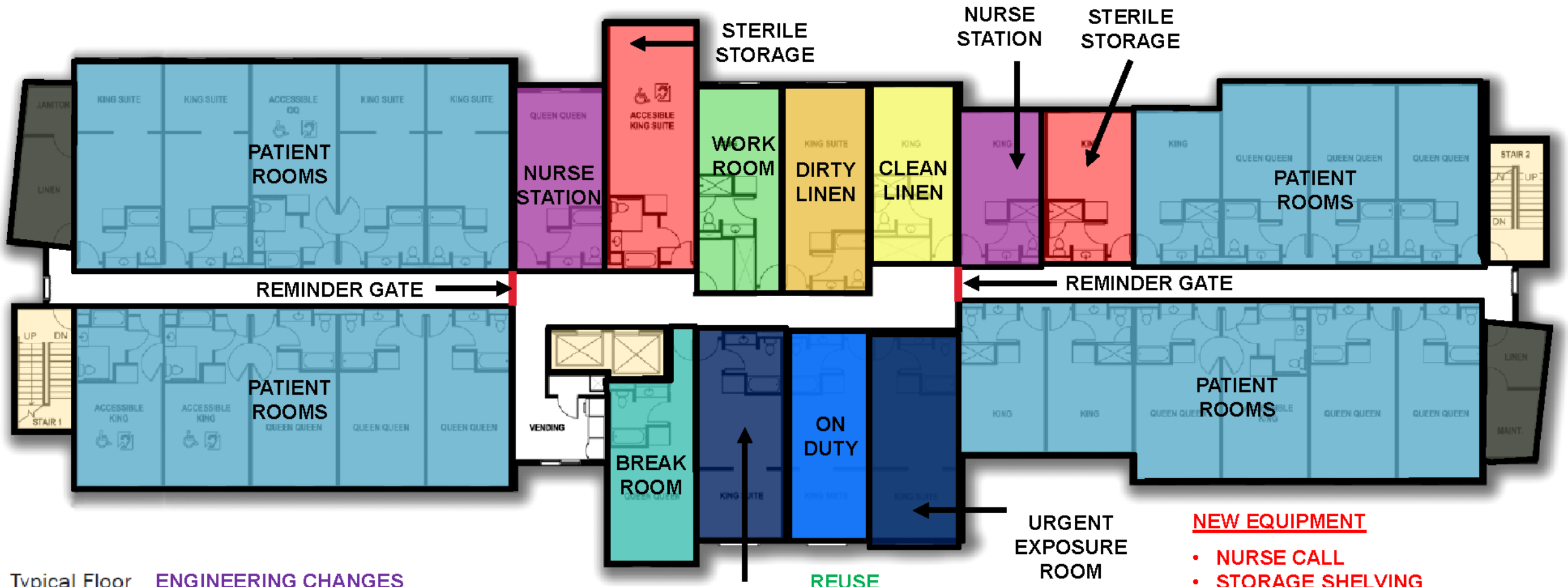
H2HC - TYPICAL FLOOR PLAN



Typical Floor

ENGINEERING CHANGES

- INSTALL PRESSURE MONITORING
- MODIFY HVAC TO ACHEIVE NEGATIVE PRESSURE (BY FLOOR)
- MODIFIED ELEVATOR CONTROLS

REUSE

- HOTEL WIFI
- HOTEL PHONE SYSTEM
- HOTEL INHOUSE NETWORK/TVS
- HOTEL ICE MACHINE/VENDING
- HOTEL PACKAGED HVAC

NEW EQUIPMENT

- NURSE CALL
- STORAGE SHELVING
- WORKSTATIONS
- MED DISPENSING UNITS
- #TBD VENTILATORS / FLOOR
- “CRASH” CART / FLOOR
- REMINDER GATES
- EYE/HAND WASH STATIONS

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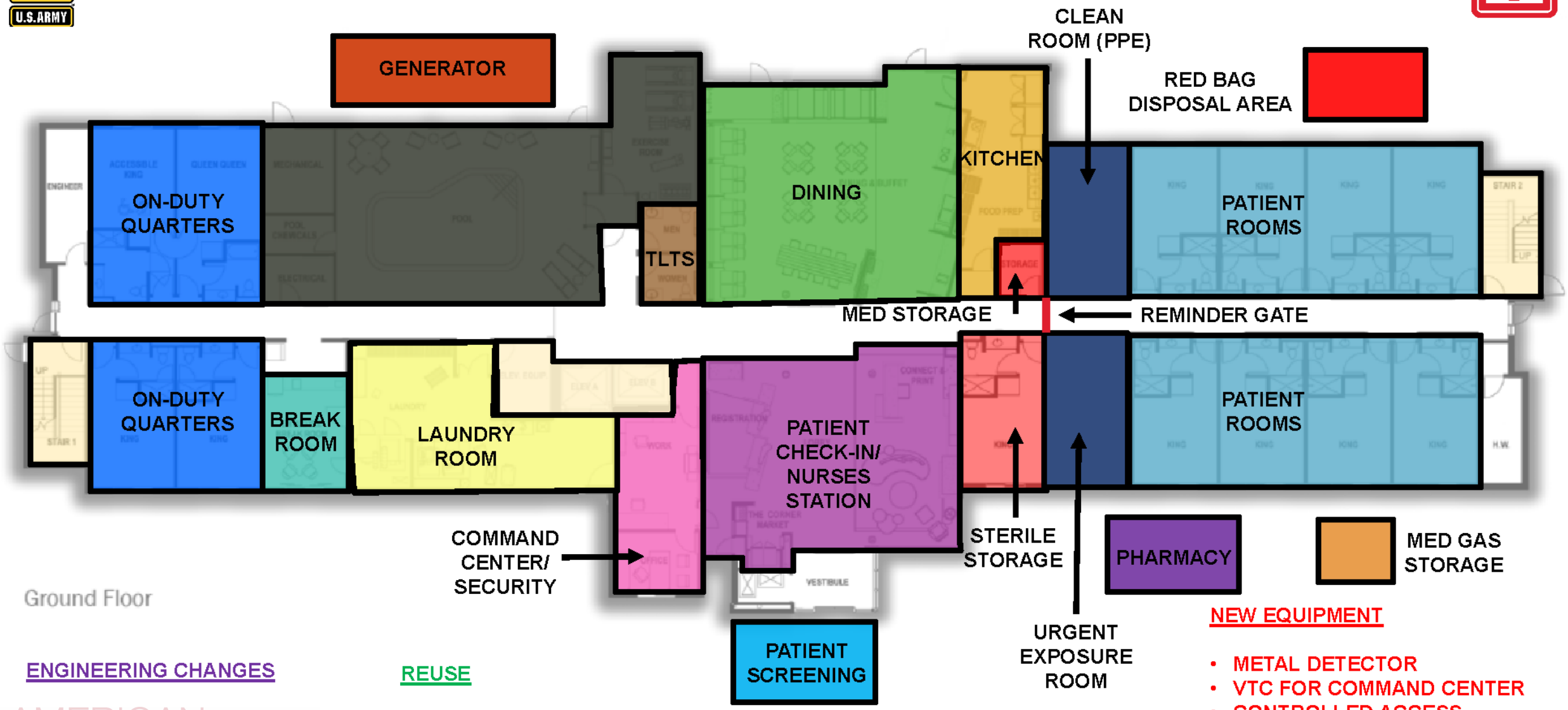
FL-DOH-20-0673-A-003921

H2HC - GROUND FLOOR PLAN



ENGINEERING CHANGES

- ALL TYPICAL FLOOR PLAN ADDITIONS
- PLUS GENERATOR

REUSE

- HOTEL FURNITURE FOR STAFF QUARTERS
- HOTEL KITCHEN
- HOTEL DINING
- HOTEL VESTIBULE
- HOTEL CCTV FOR SECURITY
- HOTEL CARD READERS

NEW EQUIPMENT

- METAL DETECTOR
- VTC FOR COMMAND CENTER
- CONTROLLED ACCESS
- INFECTIOUS/CLEAN REMINDER GATES
- EYE HANDWASH STATIONS

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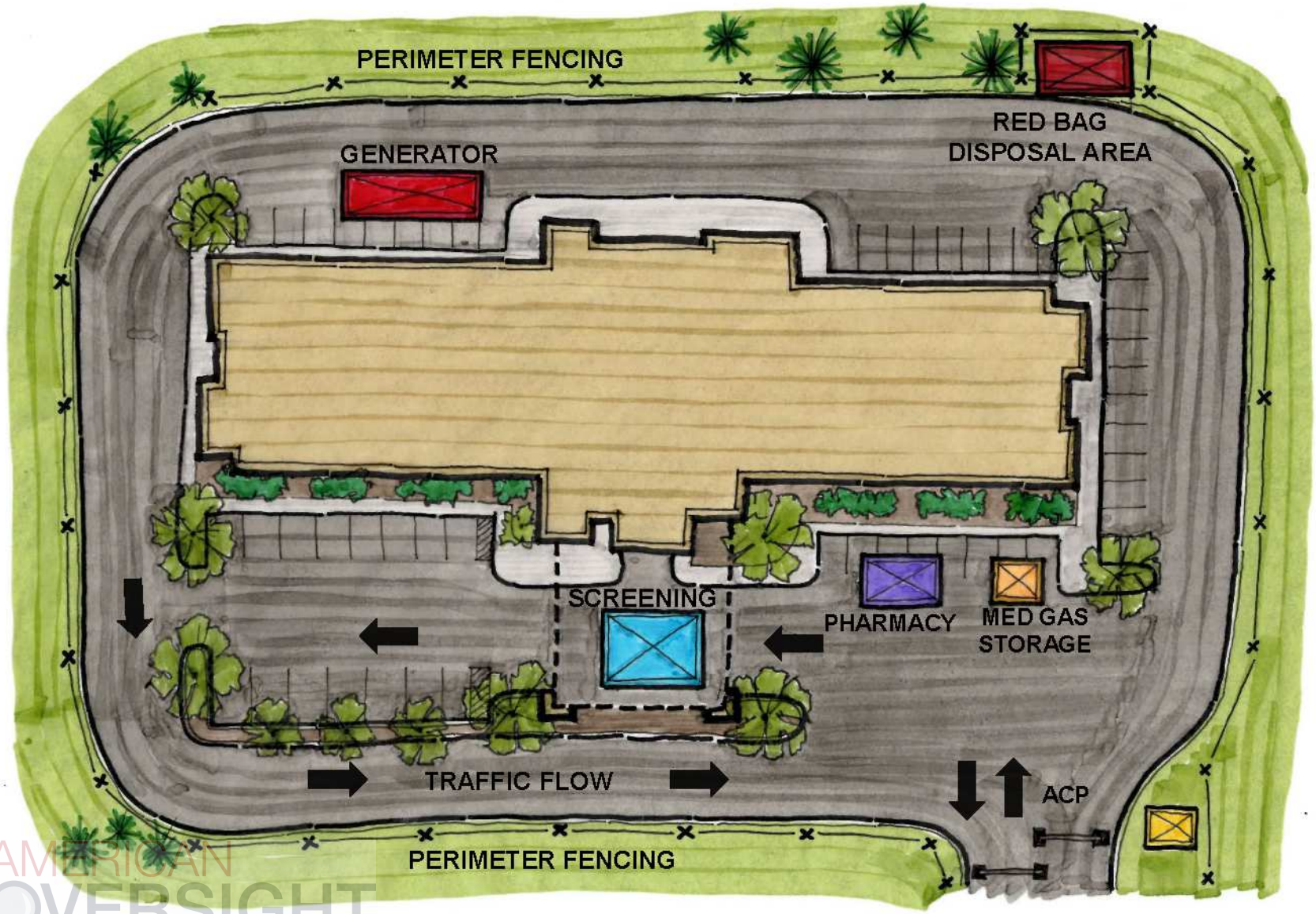
H2HC – SITE IMPROVEMENT PLAN



ENGINEERING CHANGES

- ADD PERIMETER FENCING
- ADD GENERATOR
- ADD PATIENT SCREENING TENT
- ADD EXTERIOR PHARMACY
- ADD MED GAS STORAGE
- ADD ACCESS CONTROL POINT (ACP)
- ADD RED BAG DISPOSAL AREA

AMERICAN OVERSIGHT

ARENA TO HEALTHCARE CONCEPT (A2HC)

ALTERNATE HEALTHCARE FACILITY



19 March 2020





US Army Corps of Engineers®

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A2HC – CONCEPT OF THE OPERATION

PHASES

1. SITE – STATE Responsibility

- Identify existing, available facility
- Assess for suitability
- Technical advice/assistance from USACE under FEMA MA – Critical Public Facilities PRT
- Existing utilities and infrastructure (electric, power, water, HVAC, IT,…)
- Lease facility
- Transfer authority to USACE to convert and retrofit facility

2. BUILD – USACE Mission (MA from FEMA)

- Convert/Retro-fit existing structure
- Arena or convention center
- Enable conversion of facility to support an ICU-like capability
- Main Functions - supply power (+ auxiliary), cover flooring, modify HVAC for negative pressure, install nurse's station, enable/configure IT infrastructure, temp utilities, etc…
- Stafford Act – emergency contracting authorities, utilizing local, capable business(es); Construction Contract; Cost per Patient = ~$135K or ~$16M for Football Field Scale at 120 beds. (minimum, not including restoration or lease) (Rough Order)

3. SUPPLY – FEMA Mission

- Procure, Install, and Configure medically unique equipment
- Meets end-state requirements
- FEMA would task to either HHS or DLA to procure and install

4. STAFF – STATE Responsibility

- Clearly a state function with available staff
- Expect to be critical path

BUSINESS RULES

- Proximity to existing, permanent medical hospital (10 mile/30 min)
- Readily available (10 mile/30 min) HazWaste disposal, linen/laundry, pharmacy
- Will not be fully ADA compliant; only to extent of existing facility
- USACE Cost estimates will not include real estate or lease acquisition, nor restoration costs post-medical use.
- USACE costs for renovation/construction work and IO&T are minimum costs. Actual cost must be developed when site adapting actual facility
- Facility templates and standards are adapted from DoD UFC criteria.
- Local municipality/county/state standards should be discussed and agreed upon by municipality and the Construction Agent.
- State or City Owned Property Preferred...eases leasing and permitting.
- Already has redundant power or emergency power
- Building modified or supplemented to meet Fire Code.
- Temp Facilities will be staged on perimeter, includes med waste, sanitary, soiled linen, hand washing, med supply/pharmacy
- Meet Modern Power 3-Phase, 3-Wire – Temp Power supplemented to patient care areas on floor.

FL-DOH-20-0673-A-003925

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A2HC PATIENT CONTAINMENT EXAMPLE







FL-DOH-20-0673-A-003926

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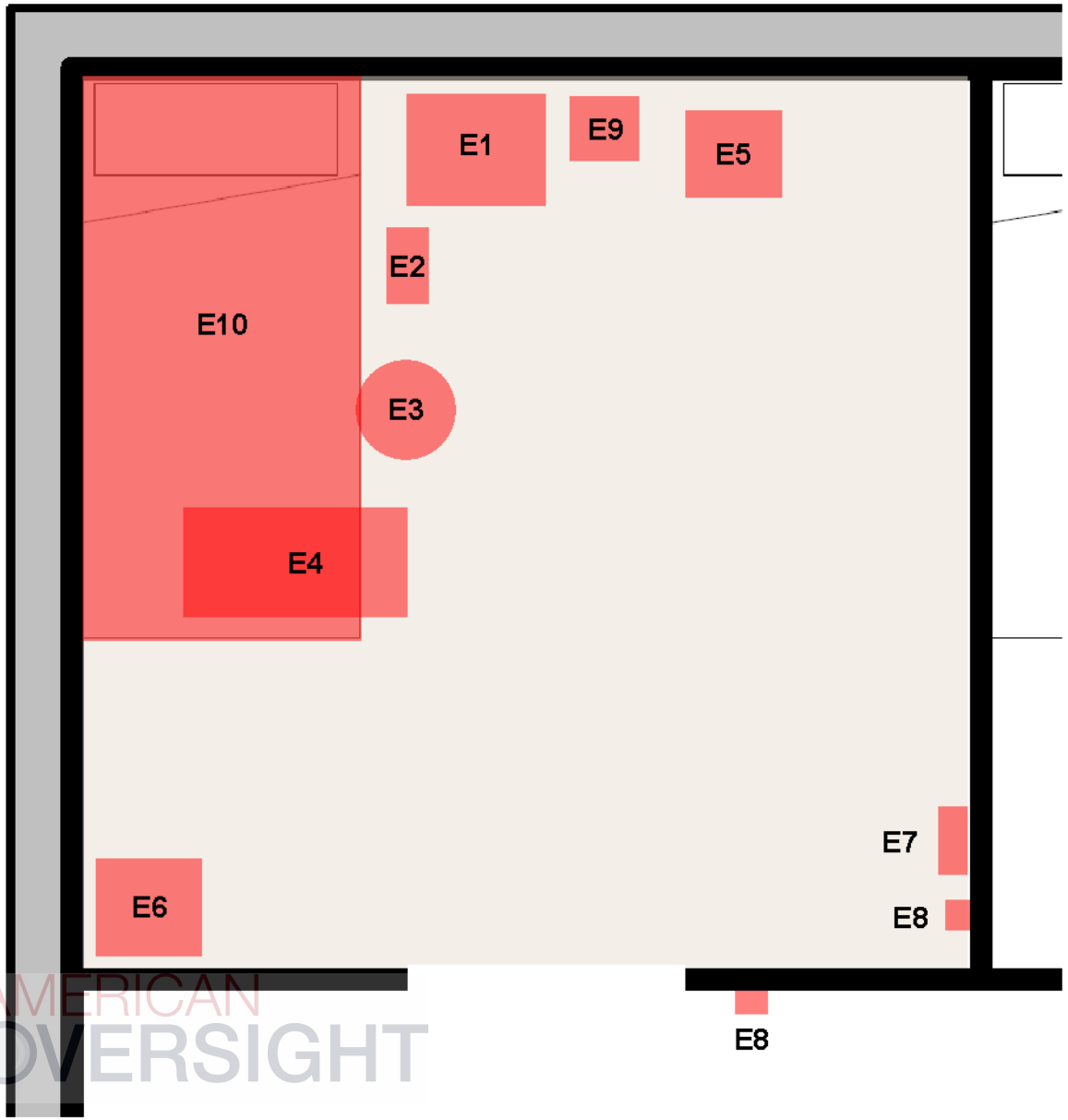
A2HC TYPICAL POP-UP CARE SPACES



ENGINEERING CHANGES

- ADD HVAC DUCTING AND HEPA FILTERING
- ADD EMERGENCY BACK-UP POWER
- ADD ELECTRICAL OUTLETS
- ADD DATA OUTLETS
- ADD PLUMBING

NEW EQUIPMENT

E1. VENTILATOR CAPABLE; STORAGE CABINET
E2. TELEMETRY/PUMP ON IV STAND
E3. STOOL
E4. OVER BED TABLE
E5. MOBILE WORK STATION
E6. LINEN HAMPER
E7. SHARPS/GLOVES
E8. HAND SANITIZER STATION
E9. INFECTIOUS WASTE
E10. PATIENT BED



Bedside Toilet

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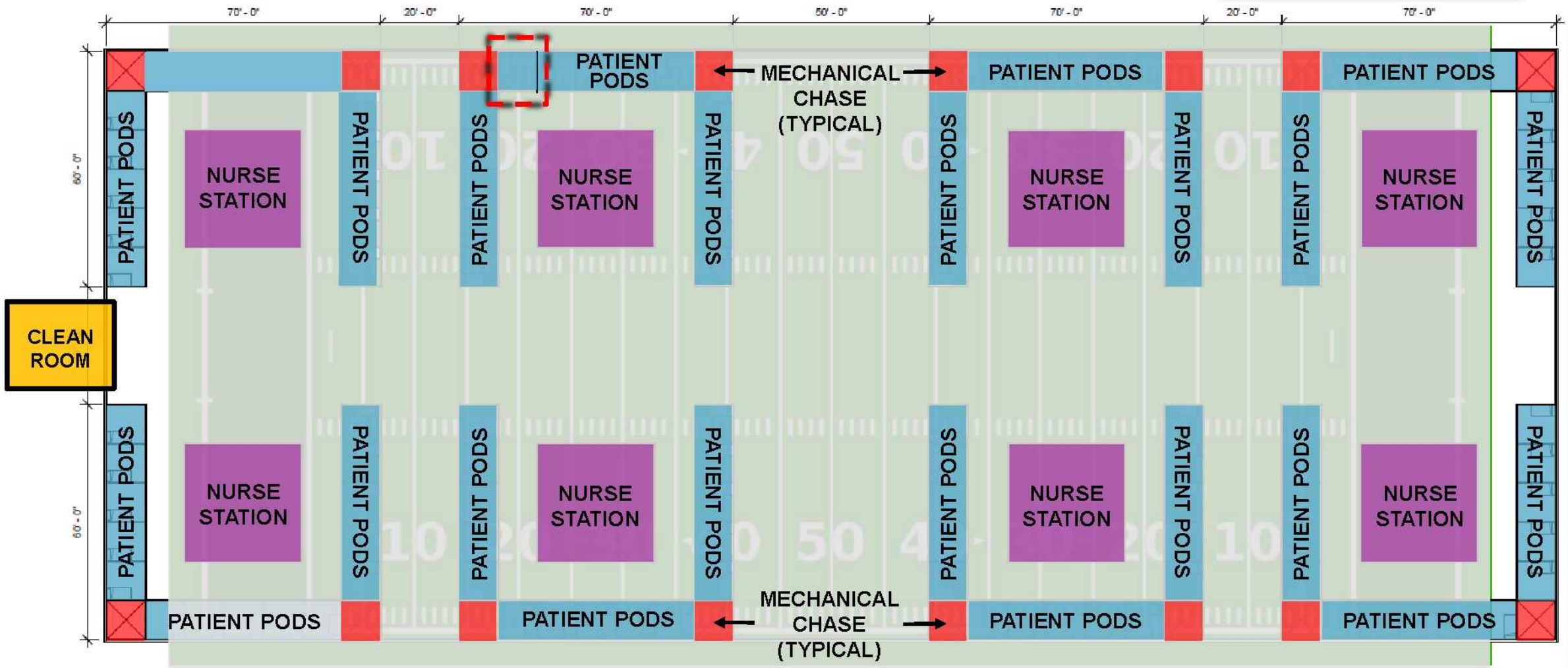
A2HC TYPICAL LAYOUT

- 1 NURSE STATION FOR EACH 15 PATIENTS
- TOTAL OF 120 PODS



ENGINEERING CHANGES

- ALL TYPICAL FLOOR PLAN ADDITIONS
- ADD GENERATOR

REUSE

- FIELD HOUSE ICE MACHINE

NURSE STATION | NURSE STATION | NURSE STATION

NEW EQUIPMENT

- ALL TYPICAL FLOOR PLAN ADDITIONS
- NURSE CALL
- STORAGE
- WORKSTATIONS
- MED DISPENSING UNITS

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Medical Support Planning Task Force Initial Questions:

Primary POC: _____
POC E-mail: _____
POC Phone: _____

Responses to the below questions should be based on what your respective State EM/Public Health are using for Planning Factors at this time.

1. What Planning Factors/Assumptions have your respective States developed in regard to providing medical care to individuals who have or are presumed to have a COVID-19 diagnosis or respiratory like illness?

2. Do you anticipate the need for Alternate Care Sites in your State?
    a. If so, how many of these facilities do you anticipate needing and what patient capacity would you like to see?
    b. Potential locations (cities/regions) that may be considered for Alternate Care Facilities?
    c. ACS use with “known positive’ COVID patients with mild symptoms or no symptoms that are not eligible for hospital admission.

3. Would you prefer the site to be any of the following?
    a. Rental of existing hotel facility?
    b. Retrofit of an existing building (Closed hospital, Nursing home, school, dorm, strip-mall, etc.)?
    c. Ambulatory Care/Surgical Centers?
    d. Soft-side/tent like facility?

4. From the below list, what level of care would you like these facilities to provide?
    a. Basic (i.e. In patient basic supportive care including administration of medications and IV fluids)
    b. Medium (Basic care in addition to in-room oxygen delivery)
    c. High (i.e. Ventilator/ICU capable facility)

5. Would you like a dedicated USACE Medical Facility Planner assigned to your State?

6. Based on the number of facilities and capacity requirements from question 2a, what do you expect your needs will be related to medical equipment? Please provide estimated quantities if possible.
    a. Consumable Medical Equipment
    b. Durable Medical Equipment

7. Based on the number of facilities and capacity requirements from question 2a, what do you expect your needs will be related to medical staff? Please provide estimated quantities if possible.
    a. Physicians (MD/DO):
    b. Registered Nurses (RN/ARNP):
    c. Licensed Practical Nurses (LPN):
    d. Respiratory Therapist (RT/RRT):
    e. Medical Assistants (MA):
    f. Case Mangers (CM):
    g. Social Workers (SW):

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Friday, February 14: CDC Media Telebriefing: Update on COVID-19
Date:	Friday, February 14, 2020 11:44:47 AM

Media Advisory

For Immediate Release
Friday, February 14, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:30 p.m. ET Friday, February 14, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

CDC works 24/7protecting America's health, safety and security. Whether diseases start at

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home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Sent by BCC to PHEP Directors, State Health Officials, State Epidemiologists, and Non-Governmental Partners

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: FW: 3-23-20 CDC COVID-19 Weekly Key Messages and Updated Website Guidance
Date: Monday, March 23, 2020 9:26:41 AM
Attachments: CDC_COVID-19 Weekly Key Messages__3.22.2020_FINAL.pdf

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FYI…apologize if dupe

Attached please find the CDC COVID-19 weekly key messages for Sunday, March 22, 2020. Feel free to share with your staff and other partners.

In addition, CDC released/updated several guidance documents on the CDC COVID-19 webpage.

- New People who are at higher risk for severe illness (consumer page)
- New COVID-19 and Underlying Medical Conditions (healthcare professional page)
- New Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness
- Updates to Information for Health Departments on Reporting Cases of COVID-19
    - COVID-19 Case Report Form Instructions
    - Completing a CRF and Specimen guidance

- New FAQs for consumers on Higher Risk & Underlying Conditions

You can also keep up with CDC updates on Coronavirus Disease 2019 by signing up for email updates, syndicating available content, and subscribing to Coronavirus Disease 2019 RSS Feed.

Regards,
Jeanne

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CDC WEEKLY KEY MESSAGES

Coronavirus Disease 2019 (COVID-19) Pandemic

March 22, 2020 as of 11:40pm

This document summarizes key messages about the COVID-19 outbreak and the response. It will be updated and distributed regularly. For the most current information, visit www.cdc.gov/COVID19.
All content updated since March 17 is shown in colored text.

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CORONAVIRUS DISEASE 2019 (COVID-19) NAMING

- The International Committee on Taxonomy of Viruses named the novel coronavirus causing an outbreak of respiratory illness that was first detected in Wuhan, Hubei Province, China, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
    - Due to potential for confusion with SARS-CoV, where possible, public communications will use “the virus that causes COVID-19.”
- On February 11, 2020, the World Health Organization (WHO) named the disease caused by this virus Coronavirus Disease 2019 (COVID-19).
    - **Disease name:** COVID-19

OUTBREAK SUMMARY

- There is an expanding outbreak of COVID-19 caused by a novel (new) coronavirus.
    - The outbreak began in China but is spreading worldwide and is now considered a pandemic.

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- Initially, many of the patients reportedly had some link to a large seafood and animal market, suggesting animal-to-person spread. Since then, sustained (ongoing) person-to-person spread in the community is occurring in some international locations.
- The newly-emerged COVID-19 is a respiratory disease that seems to be spreading much like flu. It can spread from person to person.
- The new virus can cause illness varying from mild to severe, including potentially resulting in death.
- Outbreaks like this — when a new virus has emerged to infect people and spread between people — are especially concerning.

International

- Global case numbers are reported by WHO in their COVID-19 situation reports.
    - As of **March 21, 292,142** cases have been confirmed worldwide. More than **210,644** of these cases have occurred outside of China.
- On January 30, WHO declared this outbreak a Public Health Emergency of International Concern (PHEIC). A PHEIC is declared if an event poses a public health threat to other nations through the spread of disease and potentially requires a coordinated international response.
- On March 11, 2020, WHO announced that the outbreak of COVID-19 can be characterized as a pandemic.

Domestic

- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.
- This is a very serious public health threat and the federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to minimize introductions of this virus, detect new cases quickly, and reduce community spread of this new coronavirus in the US.
- As the virus continues to spread internationally and in the United States, it becomes harder and harder contain its spread.
- What is currently known about the potential cases of community spread has raised the level of concern about the immediate threat for COVID-19 for certain communities.
- The coming days and weeks are likely to bring more confirmed cases of COVID-19 in the United States and globally, but strong public health measures now may blunt the impact of the virus in the United States.
- Pandemics of respiratory disease follow a certain progression outlined in the Pandemic Intervals Framework, part of the National Pandemic Strategy.
    - Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases.

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    - The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses.
    - Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.
    - Nationally, the United States is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase.
    - The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- Public health partners are encouraged to review their pandemic preparedness plans at this time. Selected pandemic preparedness materials are available online.
- On March 13, the President of the United States declared the COVID-19 outbreak a national emergency.
- On March 16, the White House announced a program called "15 Days to Slow the Spread." This is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.

U.S. OUTBREAK STATISTICS

Cases in the United States as of **March 20, 2020:**

- **Travel-related: 337**
- **Close contact: 321**
- **Under investigation: 14,561**
- **Total cases: 15,219**
- **Deaths: 201**
- **Jurisdictions reporting cases: All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19**

For global cases, please see the WHO daily situation reports.

SITUATION IN THE U.S.

- The number of cases of COVID-19 being reported in the United States is rising quickly.
    - This increase is expected given an increase in testing and ongoing rapid spread of disease across communities in the United States.
    - While these numbers are concerning, the increase is not unexpected.
    - More robust data will allow us to better understand and track the size and scope of the outbreak and strengthen prevention and response efforts.
- Different parts of the country are seeing different levels of COVID-19 activity. The United States nationally is currently in the initiation phase, but states where community spread is occurring are in the acceleration phase. The duration and severity of each phase can vary depending on the characteristics of the virus and the public health response.
- CDC and state and local public health laboratories are testing for the virus that causes COVID-19.
- More and more states are reporting cases of COVID-19 to CDC.
- U.S. COVID-19 cases include:
    - Imported cases in travelers
    - Cases among close contacts of a known case

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    - Community-acquired cases where the source of the infection is unknown.
- Twenty-seven U.S. states are reporting some community spread of COVID-19.

CORONAVIRUS BACKGROUND

- Coronaviruses are a group of viruses that have a halo or crown-like (corona) appearance when viewed under a microscope. They are common in many different species of animals, including camels, cattle, cats, and bats.
- It is rare for animal coronaviruses to become capable of infecting humans and then spreading between people.
    - Severe acute respiratory syndrome (SARS-CoV) and Middle East respiratory syndrome (MERS-CoV) are examples of coronaviruses that originated in animals and spread to people.
    - That is what is suspected happened with the virus that causes the current outbreak of COVID-19.
- Human coronaviruses are a common cause of mild to moderate upper-respiratory illness. But three coronaviruses have emerged to cause more severe illness: Severe Acute Respiratory Syndrome (SARS-CoV), Middle East Respiratory Syndrome (MERS-CoV), and now the virus that causes COVID-19.

TRANSMISSION

- Much is unknown about how the new coronavirus that causes COVID-19 spreads. Current knowledge is largely based on what is known about similar coronaviruses.
- Most often, person-to-person spread is thought to happen among people in close contact (about 6 feet) with each other.
- Person-to-person spread is thought to occur mainly through respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- How easily a virus spreads person-to-person can vary. Some viruses are highly contagious (like measles), while other viruses are less so.
- It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- Typically, with most respiratory viruses, people are thought to be most contagious when they are most symptomatic (sickest).
- Mother-to-child transmission during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- There is no reason at this time to think that any animals, including pets, in the United States might be a source of infection with the new coronavirus that causes COVID-19.

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    - On February 28, the Hong Kong Agriculture, Fisheries and Conservation Department (AFCD) reported a pet dog had tested "weak positive" to COVID-19 through nose and mouth samples. The dog had contact with a person infected with COVID-19.
        - CDC is working with human and animal health partners to monitor this situation and will continue to provide updates as information becomes available.
        - It's important to remember that dogs have their own coronaviruses, which cannot spread to people.
            - *AFCD official report available*
- At this time, CDC has no data to suggest that this new coronavirus or other similar coronaviruses are spread by mosquitoes or ticks.
    - Mosquitoes and ticks cannot spread all types of viruses. For a virus to pass to a person through a mosquito or tick bite, the virus must be able to replicate inside the mosquito or tick.
- There is much more to learn about the spread of this new coronavirus, severity of the disease, and other features associated with this outbreak and investigations are ongoing. This information will further inform the risk assessment.

DIAGNOSIS AND TREATMENT

Diagnostics

- CDC developed a real time Reverse Transcription-Polymerase Chain Reaction (rRT-PCR) test to detect SARS-CoV-2 (the virus that causes COVID-19) in respiratory samples from clinical specimens.
- On January 24, CDC publicly posted the assay protocol for this test.
- CDC submitted an Emergency Use Authorization (EUA) package to the U.S. Food and Drug Administration on February 3 for its test.
- FDA approved the Emergency Use Authorization on February 4.
- The first manufactured batch of CDC test kits were made available for ordering by domestic and international partners through the agency's International Reagent Resource (IRR) on February 5.
- Upon arrival at public health laboratories, when laboratories began trying to verify the assay, several laboratories reported issues.
    - Specifically, some laboratories found sporadic reactivity in the negative control of one of the three assay components.
    - This sporadic activity resulted in an inconclusive test result.
- Routine quality control (QC) measures aim to identify these types of issues. It is unclear why QC did not detect this issue before the kits were sent out to states.
- On February 18, CDC stood up a new surge laboratory to support testing for COVID-19. This expanded capacity to 350 samples per day
- On February 20, CDC completed contracts with 2 large commercial manufacturers to ensure reagent availability for the public health laboratories

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- On February 26, CDC, in conjunction with FDA, determined how to move forward and shared this information immediately with public health labs through the Association of Public Health Laboratories (APHL):
    - CDC is remanufacturing the test kits to ensure that laboratories have effective and reliable kits. The new kits include the two components (e.g., reagents) that are specific to novel coronavirus.
    - Before new test kits were available:
        - States that were able to validate all three assays should continue to test in this manner.
        - States that were able to validate the other two assays (N1 and N2) can test using these two assays.
    - FDA granted CDC "enforcement discretion," which means that testing in this manner was able to move forward while an updated EUA is officially completed.
    - CDC distributed updated instructions for use through APHL.
- On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure these health departments are able to verify the assay. An additional 40 test kits were hand-carried to IRR for repackaging and distribution to additional public health labs.
- On February 29, IRR began to distribute new test kits to the additional 40 laboratories.
- On March 16, FDA reauthorized the EUA for the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel.
- As of March 21, 91 public health labs are running the CDC test, representing all 50 states, as well as the District of Columbia, Guam, and Puerto Rico.
- Commercial manufacturers are now producing their own tests.
- As of March 22, CDC has tested over 4,607 samples.
- Overall, CDC and public health labs have tested 71,870 samples as of March 22.

Treatment

- There is no specific antiviral treatment for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms.
- Most people have mild illness and are able to recover at home.
- For severe cases, treatment should include care to support vital organ functions.
- *See more in Management of Patients Guidance for Healthcare Providers section*

PREVENTION

- There is currently no vaccine to prevent COVID-19. The best way to prevent infection is to avoid being exposed to the virus.
- CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:
    - Avoid touching your eyes, nose, and mouth with unwashed hands.
    - Avoid close contact with people who are sick.

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- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.

PEOPLE AT RISK FOR SERIOUS ILLNESS

- Older adults and people who have severe underlying medical conditions are at higher risk for more serious COVID-19 illness.
- Eight out of 10 deaths reported in the United States have been in adults aged 65 years or older.
- Based upon available information to date, those most at risk include—
    - People 65 years and older
    - People who live in a nursing home or long-term care facility
    - People of any age with the following underlying medical conditions, particularly those that are not well controlled
        - Heart disease
        - Diabetes
        - Lung disease
- Severe illness leading to hospitalization, including ICU admission and death, can occur in adults of any age with COVID-19.
- The risk for serious disease and death from COVID-19 in the United States increases with age.
- Preliminary data in the United States indicate fatality is highest among persons aged 85 years or older, ranging from 10% to 27%.
- Early data suggest older people are twice as likely to have serious COVID-19 illness.
- If you are at increased risk for COVID-19 complications due to age or because you have a serious underlying medical condition, it is especially important for you to take actions to reduce your risk of exposure.
- If you are a person with a serious underlying medical condition that can put you at higher risk, stay home and away from other people.
    - Stock up on supplies.
    - Make a plan with family members, friends, caregivers, and/or healthcare providers and consider including the following in your plan:
        - Alternate caregiver in case your caregiver is sick or paid service is limited or unavailable—it's a good idea to have at least three alternate caregivers
        - A 30-day supply of medications and a checklist to monitor usage
        - Nonperishable food items for at least 14 days

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        - Phone bank plan in case of quarantine (this reduces feelings of loneliness and isolation)
    - If you feel sick, use these guidelines to reduce the risk of spread:
        - Stay home.
        - Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
        - If you need emergency help, call 911.
        - If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.

What people at higher risk can do to prepare

- Have supplies on hand
    - Contact your healthcare professional to ask about obtaining extra necessary medications to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home.
    - If you cannot get extra medications, consider using mail-order for medications.
    - Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
    - Have enough household items and groceries on hand so that you will be prepared to stay at home for at least 14 days.
- Take everyday precautions
    - Avoid close contact with people who are sick.
    - Take everyday preventive actions.
        - Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing, or having been in a public place.
        - If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol.
        - To the extent possible, avoid touching high-touch surfaces in public places – elevator buttons, door handles, handrails, handshaking with people, etc. Use a tissue or your sleeve to cover your hand or finger if you must touch something.
        - Wash your hands after touching surfaces in public places.
        - Avoid touching your face, nose, eyes, etc.
        - Clean and disinfect your home to remove germs. Practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks and cell phones).
        - Avoid crowds, especially in poorly ventilated spaces. Your risk of exposure to respiratory viruses like COVID-19 may increase in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.

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- If COVID-19 is spreading in your community, take extra measures to put distance between yourself and other people.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks.
- Have a plan for if you get sick.
    - **Consult with your healthcare provider for more information about** monitoring your health for symptoms suggestive of COVID-19**.**
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick.
    - Plan for how you will get more supplies if you need them before you recover.
- Watch for symptoms and emergency warning signs.
    - Pay attention for potential COVID-19 symptoms including, fever, cough, and shortness of breath. If you feel like you are developing symptoms, call your doctor.
    - If you develop emergency warning signs for COVID-19 get medical attention immediately. In adults, emergency warning signs*:
        - Difficulty breathing or shortness of breath
        - Persistent pain or pressure in the chest
        - New confusion or inability to arouse
        - Bluish lips or face

          *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

What to do if you are at higher risk and get sick

- Stay home and call your doctor.
- Call your healthcare provider and let them know about your symptoms. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- If you are not sick enough to be hospitalized, you can recover at home. Follow CDC instructions for how to take care of yourself at home.
- Know when to get emergency help.
- Get medical attention immediately if you have any of the emergency warning signs listed above.

Community Support for Older Adults

- Community preparedness planning for COVID-19 should include older adults and people with disabilities, and the organizations that support them in their communities, to ensure their needs are taken into consideration.
    - Many of these people live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.

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- Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. Information for long-term care facilities can be found here.

Family and Caregiver Support

- Know what medications your loved one is taking and see if you can help them have extra on hand.
- Monitor food and other medical supplies (hearing aid batteries, oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- Stock up on non-perishable food items to have on hand in your home to minimize trips to stores.
- If you care for a loved one living in a care facility, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

Coping for People at Risk for Serious Illness and Caregivers

- People at higher risk for COVID-19 (including older people and people with severe underlying medical conditions), as well as the people who care for and about them, may feel especially stressed, worried, or anxious.
    - Things you can do to take care of yourself and help the people you care for:
        - Take breaks from watching, reading, or listening to news stories, including social media. Remind others that you care for to do the same.
        - Stay connected to others through calls (audio or video), instant messaging, email, letters, or other forms of communication, even if you cannot be together in person.
        - Talk with people you trust about your concerns and how you are feeling.
- If you, or someone you care about, is feeling overwhelmed with emotions like sadness, depression, or anxiety, or if you are concerned about harming yourself or others, call 911 or the SAMHSA Disaster Distress Helpline: 1-800-985-5990 or text TalkWithUs to 66746 (TTY 1-800-846-8517).

Tribal Elders and Multi-generational Tribal Families

- Tribal communities and Urban American Indians and Alaska Natives are particularly vulnerable to COVID-19 because of unique characteristics of health that impact tribal members.
- Any exposure to COVID-19 can pose a threat to tribal and urban American Indian and Alaska Native communities.
- Many tribal communities are made up of interdependent multi-generational families that house many Elders. These families may be both geographically and socially close. For tribal families, avoiding sick children or Elders may not seem practical or desirable.
- Families can take steps to protect the health and safety of Elders.
    - Consider limiting visitation except for caregivers or healers.
    - Avoid communing at social tribal events or gatherings, supermarkets, or casinos.

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- Consider seeking out other partners in the community to help with housing accommodations or optional caregiving, in case of illness.

Rural Communities

- Rural communities face some COVID-19 challenges that are different from urban and suburban communities. These differences warrant additional guidance.
- Many rural communities have experienced multiple closings of hospitals and healthcare facilities. This can leave an already vulnerable population without immediate access to healthcare, should an outbreak occur in the community.
- People living in rural communities can take steps to prepare.
    - Identify the two closest healthcare facilities to contact in case of an outbreak
    - Create an information card with the numbers and addresses of healthcare facilities and the family and friends who are physically nearest to you.
    - Locate state, local, or tribal health centers in advance to identify available resources
    - Create a phone tree system (activating a group of people by telephone to get a message out quickly) with family, friends, and neighbors

People with Asthma

- People with asthma may be at higher risk of getting infected with COVID-19. COVID-19 can affect your respiratory tract (nose, throat, lungs), cause an asthma attack, and possibly lead to pneumonia and acute respiratory disease.
- If you have asthma, you should prepare for COVID-19 and follow your Asthma Action Plan.
    - Take your asthma medication exactly as prescribed.
        - Talk to your healthcare provider, insurer, and pharmacist about creating an emergency supply of prescription medications, such as asthma inhalers.
        - Make sure that you have 30 days of non-prescription medications and supplies on hand too, in case you need to stay home for a long time.
    - Know how to use your inhaler.
    - Avoid your asthma triggers.
    - Clean and disinfect frequently touched surfaces like tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks daily to protect yourself against COVID-19.
        - Avoid disinfectants that can cause an asthma attack.
    - As more cases of COVID-19 are discovered and our communities take action to combat the spread of disease, it is natural for some people to feel concerned or stressed. Strong emotions can trigger an asthma attack. Take steps to help yourself cope with stress and anxiety.
- If you have symptoms
    - Contact your health care provider to ask about your symptoms.

Pregnant People

- Pregnant people may be at higher risk for having severe illness from COVID-19.

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- CDC has limited information on adverse pregnancy outcomes in pregnant people with COVID-19.
    - Pregnancy loss, including miscarriage and stillbirth, has been observed in cases of infection with other related coronaviruses [SARS-CoV and MERS-CoV] during pregnancy.
    - There is limited information on infant outcomes of COVID-19 illness during pregnancy.
    - Other respiratory viral infections during pregnancy, such as influenza, have been associated with adverse neonatal outcomes, including low birth weight and preterm birth.
    - High fevers during the first trimester of pregnancy can increase the risk of certain birth defects.
- It is especially important for pregnant people to take actions to reduce their risk of exposure.

MINIMIZING STIGMA AND MISINFORMATION

- Minimizing stigma and misinformation is important, especially during contagious disease outbreaks.
- **Everyone:** Know the facts about COVID-19 and help prevent the spread of rumors:
    - Fight stigma by supporting people who are coming back to school or work after completing their quarantine or isolation period for COVID-19 exposure or illness.
    - Someone who has completed their quarantine or met the requirements to discontinue infection control measures does not pose a risk of spreading COVID-19.
    - People of Asian descent, including Chinese Americans, are not more likely to get coronavirus than anyone else. Let people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.
    - Viruses cannot target people from specific populations, ethnicities, or racial backgrounds.
        - People who have not been in contact with a person who is a confirmed or suspected case are not at greater risk of acquiring and spreading this new virus than others.
- People who returned more than 14 days ago from an area with widespread or ongoing community spread and do not have symptoms of coronavirus do not put others at risk.
- To help counter stigma, public health professionals can:
    - Maintain privacy and confidentiality of those seeking health care and those who may be part of any contact investigation.
    - Communicate the risk or lack of risk from associations with products, people, and places in a timely manner.
    - Raise awareness of COVID-19 while showing empathy for people's concerns and fears.
    - Share accurate information about how the virus spreads.
    - Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
        - Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
        - Engage with stigmatized groups in person and through media channels including news media and social media.

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- Share with others the need for social support for people who have returned from an area with ongoing spread or are worried about friends or relatives in the affected areas.

TRAVEL

Presidential Proclamations announcing travel restrictions for travelers from China, Iran, United Kingdom, Republic of Ireland, and most of Europe

- On January 31, President Trump issued the first Presidential Proclamation implementing temporary measures to increase our abilities to detect and contain the novel coronavirus proactively and aggressively.
    - The proclamation suspends entry to the United States of foreign nationals who have been in China (excluding Hong Kong and Macau) in the past 14 days.
- On March 2, a Presidential Proclamation suspended entry to the United States of foreign nationals who have been in Iran in the past 14 days.
    - For more information, consult the notice published in the Federal Register.
- On March 11, a Presidential Proclamation suspended entry to the United States of foreign nationals who have been in 26 countries in Europe (known as the Schengen Area) in the past 14 days.
    - The order suspends the entry of foreign nationals for 30 days from these European states: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland.
- On March 14, a Presidential proclamation suspended entry to the United States of foreign nationals who have been in the United Kingdom (excluding overseas territories outside of Europe) or the Republic of Ireland in the past 14 days.
- Exemptions to these travel restrictions include American citizens, legal permanent residents, and immediate family members of US citizens and legal permanent residents. (Hereafter referred to as "American citizens and exempted persons.")
- **Under the Presidential Proclamations:** All American citizens and exempted persons coming from
    - **China, and Iran** will be directed to ("**funneled to"**) one of 11 US airports (the first 11 airports in the list below).
    - **Europe, the United Kingdom, and the Republic of Ireland** will be directed to ("funneled to") one of 13 US airports (including the last 2 airports in the list below).
- American citizens and exempted persons who have been in **China or Iran** in the previous 14 days will have an additional health assessment (screened for fever, cough, or difficulty breathing).
    - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
    - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.

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- American citizens and exempted persons who have been to the **Schengen area of Europe, UK and Ireland** in the previous 14 days will screened by Department of Homeland Security and receive a Travelers' Health Alert Notice.
    - If symptomatic, American citizens and exempted persons will be transferred for medical evaluation. (They will not be able to complete their itinerary at that time.)
    - If asymptomatic, American citizens and exempted persons will be allowed to reach their final destination and, after arrival, will be asked to stay home and self-monitor for 14 days.
- The 13 airports where travelers are being funneled include:
    - John F. Kennedy International Airport (JFK), New York
    - Chicago O'Hare International Airport (ORD), Illinois
    - San Francisco International Airport (SFO), California
    - Seattle-Tacoma International Airport (SEA), Washington
    - Daniel K. Inouye International Airport (HNL), Hawaii
    - Los Angeles International Airport (LAX), California
    - Hartsfield-Jackson Atlanta International Airport (ATL), Georgia
    - Washington-Dulles International Airport (IAD), Virginia
    - Newark Liberty International Airport (EWR), New Jersey
    - Dallas/Fort Worth International Airport (DFW), Texas
    - Detroit Metropolitan Airport (DTW), Michigan
    - Boston Logan International Airport (BOS), Massachusetts
    - Miami International Airport (MIA), Florida
- As of March 18, about 60,000 people have been screened at U.S. airports.

CDC Travel Health Notices and Other Travel Guidance

- CDC has issued Level 3 Travel Health Notices (Avoid Nonessential Travel) for Australia, Brazil, Canada, China, Iran, Israel, Japan, most of Europe (Schengen Area), the United Kingdom and the Republic of Ireland, Malaysia, South Korea, and cruise travel worldwide.
- CDC has issued Level 2 Travel Health Notices (Practice Enhanced Precautions) for the global outbreak.
- CDC has posted after-travel precautions for Travelers from Countries with Widespread Sustained (Ongoing) Transmission Arriving in the United States.
- CDC has posted a webpage about COVID-19 and considerations for travel in the United States.
- On March 19, the U.S. State Department posted a Level 4 Global Health Advisory, warning travelers Do Not Travel.

Repatriation flights and quarantine orders

- CDC has supported the Department of State in the safe and expedient ordered departure of US citizens and residents affected by outbreaks of COVID-19.
- Chartered flights returned passengers from Wuhan City, China and passengers from a cruise ship docked in Japan. (See section: Diamond Princess).

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- The Department of Health and Human Services (DHHS) Secretary, under statutory authority, issued federal quarantine orders to all such passengers entering the United States.
    - The quarantine period is for 14 days.
    - The quarantine is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
    - This quarantine order also serves to protect the health of the repatriated persons, their families, and their communities.
- Based on what is known about this virus and other coronaviruses, CDC believes the risk to the communities temporarily housing these people is low.
- At the end of the 14-day period, people who have not developed symptoms have their quarantine order lifted and are free to return home.
- As of March 18th, everyone from the Wuhan and Diamond Princess repatriation flights who were quarantined or isolated under federal orders has been released and returned home.
    - A small number of people are still isolated or quarantined under state orders

Cruise Ships and River Cruises*

- The U.S. Government's priority is to protect the health of passengers and crew, their loved ones, the traveling public, and communities within the US.
- CDC recommends all persons defer any travel on cruise ships, including river cruises, worldwide because of the increased risk of COVID-19 on board ships.
- CDC is continuously tracking cruise ships that are coming into domestic ports that may have confirmed, suspected, or no cases of COVID-19.
    - Cruise ships, both domestic and international, carrying American citizens are being assessed and documented.
    - The situation in the United States is evolving, both with increasing community transmission and an increasing number of cruise ships coming into port. CDC is continuing to reevaluate its approach to returning cruise ships.
    - As CDC reevaluates the approach to returning cruise ships, CDC's priority is to protect passengers' and crews' health while helping them get home as quickly and safely as possible.
- On March 13, the Cruise Lines International Association voluntarily suspended cruise travel out of U.S. ports.
    - Many cruise ships will soon be ending their voyages and coming into port in the U.S. and other countries. New cruise voyages will be postponed.
- On March 15, CDC released a Health Alert Network (HAN) Update providing information and guidance about global travel on cruise ships, including river cruises, due to COVID-19.
    - The HAN provides broad information and recommendations for clinicians seeing patients who have recently traveled by cruise ship or river cruise.
    - State and local health departments should check the Epidemic Information Exchange (Epi-X) notification system for information on COVID-19 cases on cruise ships and river cruises. If a ship has one or more confirmed COVID-19 cases on board, CDC will send an Epi-X alert to state health departments alerting them to these cases.

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- On March 17, CDC posted a Global Level 3 Travel Health Notice for Cruise Ship Travel recommending travelers defer all cruise ship travel worldwide.
    - Cruise travelers should stay home for 14 days after returning from travel, monitor their health, and practice social distancing.
- In an effort to make sure returning passengers and crew members without symptoms can get home as quickly and safely as possible, CDC will not hold ships in port and will not prevent disembarking passengers and crew from onward travel. They will be treated like other travelers returning from areas with widespread ongoing transmission, such as Europe.
    - Passengers without symptoms will be allowed to travel home immediately via commercial carrier.
    - Cruise line passengers and crew members are advised to stay home for 14 days, monitor their health, and practice social distancing.
        - Social distancing means staying out of crowded places and keeping a distance of about 6 feet (2 meters) from others as much as possible.
        - Cruise lines will give disembarking passengers details about how to monitor themselves at home and practice social distancing.
        - These recommendations are consistent with CDC recommendations for travelers returning from countries with widespread ongoing transmission.
    - Any passengers who get sick with fever, new or worsening cough, or shortness of breath during their cruise should isolate themselves in their cabin and notify the onboard medical center immediately.
        - Crew members who get sick should follow any instructions from the cruise line.
    - If an ill passenger or crew member is identified on board the ship, the cruise line will report to the CDC Quarantine Station responsible for the port. CDC staff will determine if further action is needed.
- If a ship has one or more confirmed COVID-19 cases on board, CDC will send an Epi-X alert to state health departments alerting them to these cases.
- CDC will also alert WHO per the International Health Regulations to ensure non-US citizen travelers are aware of their risk.

Diamond Princess

- CDC supported the Department of State-led mission to repatriate US citizens returning to the United States from Japan who were aboard the *Diamond Princess* cruise ship.
- On February 16, 329 American citizens returned by flights chartered by the State Department.
- Americans returned by flights chartered by the State Department are subject to a 14-day federal quarantine and were housed at two existing federal quarantine sites for repatriated travelers:
    - Travis Air Force Base in California
    - Joint Base San Antonio-Lackland in Texas
- The passengers were screened before leaving the ship and were monitored and evaluated by medical and public health personnel during the trip and after arrival. They were monitored by medical and public health personnel throughout the 14-day quarantine period. All of these individuals completed their quarantine.

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- 11 Americans who were on board the *Diamond Princess* remain in Japan, including some who are still hospitalized.

Grand Princess*

- CDC has been working with the California Department of Public Health, other federal, state, and local partners and the Princess Cruise Line to investigate a cluster of COVID-19 cases connected with a Grand Princess voyage from February 11-21. Additionally, CDC worked with the same partners to assess the risk for passengers currently aboard the Grand Princess.
    - CDC notified states about the risk and management of passengers aboard the Grand Princess between February 11 and 21 who might have COVID-19 symptoms.
- The U.S. Department of Health and Human Services (HHS) is continuing to work with state and local partners in California to support the return of passengers from the Grand Princess.
- On March 9, the Grand Princess docked in the Port of Oakland.
    - Passengers were transferred to federal military installations across the United States for medical screening, COVID-19 testing, and a 14-day quarantine.
    - Nearly 1,000 passengers who are California residents are completing the mandatory quarantine at Travis Air Force Base.
    - Additional residents of California and residents of other states are completing the mandatory quarantine at Marine Corps Air Station Miramar in San Diego, Lackland Air Force Base in San Antonio, or Dobbins Air Reserve Base in Georgia.
    - Throughout the quarantine, passengers will be monitored for symptoms of COVID-19.
    - The Department of State is working closely with the home countries of several hundred foreign national passengers to arrange for repatriation to their countries.

**Please continue to look for updates in CDC's Daily Key Points and in next week's Key Messages document. The situation is rapidly evolving and CDC will provide updates as they become available.*

Nile River Cruises

- As of March 14, 2020, 16 state health departments have notified CDC of **62** COVID-19 cases and **42** patients under investigation (PUIs) associated with cruise boats on the Nile River in Egypt. Those 16 states are California, Colorado, Delaware, Florida, Iowa, Illinois, Maryland, North Carolina, New Mexico, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, and Wisconsin.
    - Most of these American citizens have returned to the United States.
    - Three American citizens remain in Egypt, 1 of whom is in the hospital.
- The affected cruise boats on the Nile River include at least the following ships:
    - M/S A'sara
    - M.S. Esplanade
    - M.S. Queen of Hansa
    - M.S. Sun Goddess
    - Crown Empress
    - M.S. Mayfair
- As of March 12, the Pilgrim tour agency suspended all Egyptian river cruise tours.

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- On March 19, Cairo, Egypt temporarily halted all flights to its airports as a further measure against the spread of COVID-19. The suspension of air traffic will continue until March 31.
- The M/S A'sara took at least four voyages.
    - Cruise 1 had 9 confirmed cases among American passengers and was associated with a cluster of cases in Texas.
    - Cruise 2 had 2 confirmed cases among American passengers.
    - Cruise 3 had 6 confirmed cases among American passengers.
    - Cruise 4 had 29 confirmed cases among American passengers.
- The M.S/ Queen Hansa sailed February 28–March 2. It had at least 1 confirmed case among American passengers.
- The M.S. Esplanade sailed February 24–February 27. As of March 11, it had 7 cases among American passengers and was associated with a cluster in Iowa.

WHAT CDC IS DOING

CDC Response in the US:

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The goal of the ongoing US public health response is to detect new cases quickly and prevent further spread of COVID-19 in this country.
- CDC established a COVID-19 Incident Management Structure on January 7. On January 21, CDC activated its Emergency Operations Center to better provide ongoing support to the COVID-19 response.
    - The US government has taken unprecedented steps with respect to travel in response to the growing public health threat posed by this new coronavirus.
    - Effective February 2, at 5pm, the US government suspended entry of foreign nationals who have been in China within the past 14 days.
        - US citizens, residents, and their immediate family members who have been in mainland China are allowed to enter the United States, but they are subject to health monitoring for up to 14 days.
    - On February 29, the U.S. government announced it was suspending entry of foreign nationals who have been in Iran within the past 14 days.
    - As of March 13, all American citizens and exempted persons coming from most of Europe (knows as the Schengen Area) will be funneled through 13 airports (listed in the above Travel section). As of March 16, all American citizens and exempted persons coming from the United Kingdom (excluding overseas territories outside of Europe) or the Republic of Ireland will also be funneled through those 13 airports.
        - CDC and partners will conduct enhanced illness response at these points of entry.
    - CDC has issued the following travel guidance related to COVID-19:
        - China — Level 3, Avoid Nonessential Travel — updated February 22;
        - Iran — Level 3, Avoid Nonessential Travel — updated February 28;

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    - South Korea — Level 3, Avoid Nonessential Travel — updated February 24;
    - Most of Europe (Schengen Area) — Level 3, Avoid Nonessential Travel – updated March 12;
    - Global Outbreak — Level 2, Practice Enhanced Precautions — posted March 11.
    - United Kingdom and Ireland — Level 3, Avoid Nonessential Travel — posted March 15.
    - COVID-19 and Cruise Ship Travel — Level 3, Avoid Nonessential Travel — posted March 17.
    - Malaysia — Level 3, Avoid Nonessential Travel — posted March 18.
    - Australia— Level 3, Avoid Nonessential Travel — posted March 21.
    - Brazil— Level 3, Avoid Nonessential Travel — posted March 21.
    - Canada — Level 3, Avoid Nonessential Travel — posted March 21.
    - Israel — Level 3, Avoid Nonessential Travel — posted March 21.
    - Japan — Level 3, Avoid Nonessential Travel — posted March 21.
- CDC is issuing clinical guidance, including clinical care guidance and healthcare infection control guidance.
- On March 2, FDA announced that commercial companies may sell test kits under CDC's EUA.
- CDC has deployed multidisciplinary teams to support state health departments with clinical management, contact tracing, and communications.
- CDC has helped mobilize state health departments to receive returned repatriated travelers.
- Through the Public Health Emergency Preparedness (PHEP) cooperative agreement, 62 state PHEP programs across the country are part of the multi-agency infrastructure working on quarantine, isolation, case finding, protecting health care workers and assuring medical supply chains.
- On March 16, CDC awarded nearly $570 million in funding to 65 state, local, territorial, and tribal jurisdictions to provide resources to prevent, prepare for, and respond to the COVID-19 outbreak.
    1. CDC made these awards 10 days after the President signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123)
    2. CDC has authorized recipients to begin spending their funds immediately.
- CDC activated the Cooperative Agreement for Emergency Response: Public Health Crisis Response (CDC-RFA-TP18-1802) to award a total of $569,822,380 to the 65 eligible jurisdictions on the approved but unfunded (ABU) list for the cooperative agreement.
    1. The 65 jurisdictions include the 50 states; eight U.S. territories and freely associated states; six directly funded localities (Chicago, Houston, Los Angeles County, New York City, Philadelphia, and the District of Columbia); and one tribal nation (Cherokee Nation).

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- This funding gives state and local health departments the flexibility to implement response actions based on the disease characteristics and priorities in their communities.
- The funding supports two required activities:
    1. Accelerated laboratory testing, data collection, and real-time reporting to CDC for identification and tracking of COVID-19 cases in the community; and
    2. Implementation of COVID-19 community intervention plans.
- The supplemental funding is in addition to funding in the amount of $35 million to 21 jurisdictions for immediate COVID-19 response activities.
    - CDC awarded that initial funding on March 6.
    - For the 21 jurisdictions that received the initial funding, CDC has combined their initial funding with the new supplemental funding to reduce the administrative burden of managing two awards.
- CDC has worked with the Department of State, supporting the safe return of Americans who have been stranded as a result of the ongoing outbreaks of COVID-19 and related travel restrictions. CDC has worked to assess the health of passengers as they return to the United States and provided continued daily monitoring of people who are quarantined.
- An important part of CDC's role during a public health emergency is to develop a test for the pathogen and equip state and local public health labs with testing capacity. CDC developed a molecular test to detect COVID-19 from human clinical specimens and distributed this test to state and local health laboratories.
- After distribution of a CDC rRT-PCR test to diagnose COVID-19 to state and local public health labs started, performance issues were identified related to a problem in the manufacturing of one of the reagents. Laboratories were not able to verify the test performance.
- CDC worked on two potential resolutions to this problem.
    - CDC developed a new protocol that uses two of the three components of the original CDC test kit to detect the virus that causes COVID-19 after establishing that the third component, which was the problem with the original test, can be excluded from testing without affecting accuracy.
        - CDC worked with FDA to amend the existing Emergency Use Authorization (EUA) for the test.
    - Further, newly manufactured kits were provided to the International Reagent Resource for distribution.
        - On February 27, CDC distributed new test kits to 7 laboratories to serve as evaluation sites to ensure health departments are able to verify the assay. On February 29, 6 of 7 pilot laboratories reported successful completion of the verification panel.
        - An additional 40 test kits were hand carried to IRR for repackaging and distribution to additional public health labs.

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        - On February 28, IRR began to distribute new test kits to the additional 40 laboratories.
        - As of March 19th, 91 public health labs are running the CDC test, representing all 50 states, as well as the District of Columbia, Guam, and Puerto Rico.
        - Commercial manufacturers are now producing their own tests.
    - Combined with other reagents that CDC has procured, there are enough testing kits to test more than 75,000 people.
    - In addition, CDC is conducting laboratory testing in two of its laboratories at its headquarters in Atlanta. CDC can test approximately 350 specimens per day.
    - CDC has been uploading the entire genome of the viruses from reported cases in the United States to GenBank as sequencing was completed.
    - CDC has grown the virus in cell culture, which is necessary for further studies, including for additional genetic characterization. The cell-grown virus was sent to NIH's BEI Resources Repository for use by the broad scientific community.
    - CDC has deployed staff to assist in local areas experiencing clusters of COVID-19.

CDC International Response

Note: Due to the rapidly changing situation, any statements on CDC involvement in China need case-by-case clearance.

- CDC is working diligently and closely with partners to support the response to this novel coronavirus outbreak.
- CDC has staff stationed in more than 60 countries across the globe. CDC has offices in China, in a number of the countries reporting cases of COVID-19, and in countries that have not yet reported cases of COVID-19 but are busy with planning and preparedness efforts.
    - CDC and the government of China have collaborated for the past 30 years addressing public health priorities affecting the US, China, and the world.
- In addition to working with host country officials, CDC staff are working in coordination with Department of State and other agencies within US embassies.
- CDC is mobilizing Atlanta-based staff to support the response. Many of these staffers have extensive experience responding to global outbreaks.
- CDC has identified experts who are prepared to join a planned WHO mission to support efforts to better understand the severity and transmissibility of the virus.
- CDC is providing technical assistance to the Government of Italy for exit screening flights departing from Italy to the United States.
- In China, CDC is an important technical partner for the Chinese Field Epidemiology Training Program (FETP). and has been involved in the program since 2004.
    - More than 800 FETP-trained residents or graduates of FETP are supporting ongoing COVID-19 response efforts.
    - In 2019 specialized FETP training tracks were established in non-communicable diseases and tuberculosis.

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- CDC has supported China CDC's national influenza laboratory for more than 20 years.
- CDC works in close partnership with the China CDC's National Influenza Epidemiology, Virology, and Pandemic Preparedness Centers, China's provincial and local CDCs, hospitals, and academic institutions.
- CDC supports Chinese partners in monitoring seasonal and novel influenza viruses, as well as enhancing efforts to detect and respond to seasonal, avian, and other novel influenza viruses with pandemic potential. CDC's key supporting activities include:
    - Strengthening influenza surveillance for seasonal and novel influenza viruses
    - Conducting research to estimate disease burden and vaccine effectiveness among populations at greatest risk (including young children, older adults, and pregnant women)
    - Promoting influenza vaccination policy development and coverage
    - Supporting novel virus risk assessments
    - Establishing pandemic influenza preparedness in China
    - Maintaining close ties between US and China influenza experts
- In other countries, CDC is collaborating with WHO to support Ministries of Health to prepare and respond to the epidemic.
    - CDC is helping to support countries to implement WHO recommendations related to the diagnosis and care of patients, tracking the epidemic, and identifying people who might have COVID-19.
    - CDC staff are also starting to work together with country colleagues to conduct investigations that will help inform response efforts going forward.
    - CDC works closely with countries to establish FETPs that train a workforce of field epidemiologists —or disease detectives— to identify and contain outbreaks close to the source.
    - For country-specific information, please contact CDCglobal@cdc.gov.

RECOMMENDATIONS

- CDC routinely advises that people help protect themselves from respiratory illnesses by washing their hands often, avoiding touching their face with unwashed hands, avoiding close contact with people who appear sick, and cleaning frequently touched surfaces.
    - CDC defines close contact as—
        - Being within about 6 feet (2 meters) of someone with COVID-19 for a prolonged period of time, such as living with, visiting, caring for or sharing a room in a healthcare facility

          - or –
        - By having direct contact with infectious secretions from a patient, such as being coughed on.

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- If you are a resident in a community where person-to-person spread of COVID-19 has been detected and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms.
- If you have symptoms of COVID-19 and want to get tested, try calling your state or local health department or a medical provider. While supplies of these tests are increasing, it may still be difficult to find a place to get tested.
- Most people have mild illness and are able to recover at home.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.

Recent International Travelers

- If you have traveled internationally, watch your health, and limit interactions with others for 14 days after returning to the United States.
- If you feel sick with fever, cough, or difficulty breathing during this time, you should:
    - Seek medical advice. Before you go to a doctor's office or emergency room, call ahead and tell them about your recent travel and your symptoms.
    - Avoid contact with others.
    - Not travel while sick.
    - Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
    - Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains at least 60% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
    - If you were in a country with widespread sustained (ongoing) transmission—China, Iran, South Korea, most of Europe (known as the Schengen Area), the United Kingdom, or the Republic of Ireland—stay home, monitor yourself, and practice social distancing for 14 days after you left that country.

People Confirmed to Have, or Being Evaluated for, COVID-19

- Your doctors and public health staff will evaluate whether you can be cared for at home. If it is determined that you can be isolated at home, you will be monitored by staff from your local or state health department. You should follow the prevention steps below until a healthcare professional or local or state health department says you can return to your normal activities. Detailed information is available at Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities.
    - Stay home except to get medical care.
    - Separate yourself from other people in your home.
    - Call ahead before visiting your doctor.
    - Wear a facemask.

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- Cover your coughs and sneezes with a tissue or cough or sneeze into your sleeve.
- Wash your hands often with soap and water for at least 20 seconds.
- Avoid sharing household items like eating utensils, cups, or linens.
- Monitor your symptoms and seek prompt medical attention if your symptoms worsen.

On February 27, CDC updated interim guidance for state and local public health officials on how to assess and manage the risks posed by patients who may have been exposed to this new coronavirus.

- This guidance establishes four risk categories: High, Medium, Low and No Identifiable Risk.
- The categories are based on a person's travel history and possible contact with patients who have laboratory-confirmed infections.
- The guidance **offers recommendations** for movement restrictions and public health evaluations for people in different risk categories.
- **In most cases, state and local authorities will make these decisions. Federal public health authority primarily extends to international arrivals at ports of entry and preventing interstate communicable disease threats.**
- These guidelines are subject to change as the situation requires. They do not apply retroactively to people who have been in an affected area with sustained transmission during the previous 14 days and are already in the United States, or those being managed as part of a contact investigation.
- CDC will provide separate guidance for healthcare settings.

Close Contacts of Patients Under Investigation

People who have had close contact with someone who is confirmed to have, or being evaluated for, COVID-19, should:

- Monitor your health starting from the day you first had close contact with the person and continue for 14 days after you last had close contact with the person. Watch for these signs and symptoms:
  - Fever—take your temperature twice a day.
  - Coughing.
  - Shortness of breath or difficulty breathing.
  - Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea, vomiting, and runny nose.
- **If you develop fever or any of these symptoms, call your healthcare professional right away.**
  - **Before** going to your medical appointment, be sure to tell your healthcare professional about your close contact with someone who is confirmed to have, or being evaluated for, COVID-19. This notification will help the healthcare professional's office take steps to keep other people from getting infected. Ask your healthcare professional to call the local or state health department.
- On March 16, the White House recommended that if someone in your household has tested positive for COVID-19, the entire household should stay home and you should contact your medical provider.

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- Detailed information for caregivers and household members can be found on the Interim Guidance for Preventing COVID-19 from Spreading to Others in Homes and Communities web page.

Healthcare Professionals

- As availability of diagnostic testing for COVID-19 increases, clinicians will be able to access laboratory tests for diagnosing COVID-19 through clinical laboratories performing tests authorized by FDA under an Emergency Use Authorization (EUA).
    - Clinicians will also be able to access laboratory testing through public health laboratories in their jurisdictions.
- This expands testing to a wider group of symptomatic patients. Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested.
    - Decisions on which patients receive testing should be based on the local epidemiology of COVID-19, as well as the clinical course of illness.
    - Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing).
    - Clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Epidemiologic factors that may help guide decisions on whether to test include: any persons, including healthcare workers, who have had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset, or a history of travel from affected geographic areas within 14 days of symptom onset.

Recommendations for Reporting, Testing, and Specimen Collection

- Clinicians should immediately implement recommended infection prevention and control practices if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19.
- State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website.
- State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays.
- Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.
- On March 13, CDC updated its guidance for specimen collection for testing for COVID-19to to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).

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- For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended.
- For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen.
- Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs.
- Clinical specimens should be collected from PUIs for routine testing of respiratory pathogens at either clinical or public health labs. Note that clinical laboratories should NOT attempt viral isolation from specimens collected.
- Maintain proper infection control when collecting specimens.
- Additional guidance for collection, handling, and testing of clinical specimens is available on CDC's website.
- Detailed information on specimen types and shipping can be found on the Information for Laboratories web page

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Protect yourself and your community from getting and spreading respiratory illnesses like coronavirus disease 2019. Everyone has a role to play in getting ready and staying healthy.
    - For most people in the U.S., the immediate risk of being exposed to the virus that causes COVID-19 is thought to be low. The virus is not currently widespread in the U.S.
    - In places where ongoing community spread of the virus that causes COVID-19 has been reported, people are at elevated risk of exposure.
- Currently a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as temporary school dismissals, postponing or cancelling large events, social distancing (i.e. limiting face-to-face contact) can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for disease outbreaks, like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local public health departments, the healthcare sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs in their local communities.
- Community-based interventions can be grouped in three categories:
    - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, respiratory and cough etiquette, using facemasks in community settings when ill, practicing hand hygiene)

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- Community measures aimed at increasing social distancing (e.g., temporary school dismissals, social distancing in workplaces (like working remotely), postponing or cancelling mass gatherings)
- Environmental measures (e.g., routine cleaning of frequently touched objects or surfaces)

Household/Personal Protective Measures

- Everyone can do their part to help plan for, prepare, and respond to this emerging public health threat.
- CDC recommends that individuals/households create an emergency plan of action, practice good personal health habits and plan for home-based care (if needed), be prepared for your child's school or childcare facility to be temporarily dismissed, and plan for changes at your workplace.
- During an outbreak in your community, **stay home when you are sick** with COVID-19 symptoms, keep away from others who are sick, and limit face-to-face contact with others.

Community Measures

- **Mass gatherings:**
  - Mass gatherings and events, such as concerts, festivals, conferences, worship services, and sporting events, increase the chance of a virus, like COVID-19, to spread and infect people crowded together within a close proximity.
  - On March 16, the White House recommended avoiding social gatherings in groups of more than 10 people.
- **Community and faith-based organizations:**
  - Local leaders and community organizers play a vital role to bring the community together to help plan for and reduce the impact of a potential COVID-19 outbreak. Since you know your community members the best, you can ensure groups most vulnerable to COVID-19 are considered and included in the planning process.
  - CDC recommends finding out if your local government has a private-public emergency planning group that meets regularly that you can join. If not, suggest one that should be set up. Building strong alliances before an outbreak can help provide your organization with the support and resources needed.
  - CDC has created interim guidance to help you create an emergency plan for your community and faith-based organization.
- **Administrators of U.S. childcare programs and K-12 schools and administrators of institutions of higher education:**
  - Schools should plan for and prepare for a potential community-level outbreak of COVID-19. Fortunately, many of the steps to plan and prepare for COVID-19 are the same steps schools take to keep students healthy and safe from the flu.
  - The decision to dismiss a school should be made locally. CDC recommends working with local health officials to determine if, when, and for how long schools may need to be

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dismissed in the event of an outbreak. (NOTE: The U.S. Department of Education does not recommend using "school closure" terminology.)

- School administrators should plan to provide critical support services, such as continuity of education and continuity of school meal programs, if schools are dismissed.
- CDC has posted guidance for childcare and K-12 school settings on its website.
- CDC has posted recommendations of considerations for school dismissals.
- CDC has posted guidance for institutions of higher education (IHE) on its website.
    - This guidance includes considerations about addressing campus housing. Guidance for IHE with students participating in international travel or study abroad programs is also available.

- **Homeless shelters:**
    - People experiencing homelessness may be at risk for infection during an outbreak of COVID-19.
        - CDC has created interim guidance for homeless shelters that address planning for and responding to COVID-19 in these settings.
        - CDC has also posted Interim Guidance for Responding to COVID-19 among People Experiencing Unsheltered Homelessnessv.

Information for Law Enforcement

- For law enforcement personnel performing daily routine activities, the immediate health risk is low.
- CDC has developed recommendations for law enforcement to protect themselves from exposure.
    - Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS.
    - Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
    - Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Different styles of PPE may be necessary to perform operational duties.
    - These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.
- If close contact occurs during apprehension:
    - Clean and disinfect duty belt and gear prior to reuse. Use a household cleaning spray or wipe, according to the product label.
    - Follow standard operating procedures for the containment and disposal of used PPE.
    - Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

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HAND HYGIENE IN COMMUNITY SETTINGS (ENVIRONMENTAL MEASURES)

- Handwashing is one of the best ways to protect yourself and your family from getting sick.
- Clean hands can stop germs from spreading from one person to another and throughout an entire community—from your home and workplace to childcare facilities.
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Always wash hands with soap and water if hands are visibly dirty.
- Follow these steps to make sure you wash your hands properly:
    1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
    2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
    3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
    4. Rinse your hands well under clean, running water.
    5. Dry your hands using a clean towel or air dry them.

INFECTION PREVENTION AND CONTROL FOR HEALTHCARE SETTINGS

- Healthcare facilities are increasingly unable to procure reliable and sufficient supplies for infection control, including N95 respirators.
- Because of demands associated with the COVID-19 response, CDC has updated the current national COVID-19 infection control guidance for healthcare in the midst of supply realities and growing insight about the spread of COVID-19.
- Protection of healthcare personnel is a priority. CDC's updated guidance on infection control aims to prioritize the use of N95 respirators and other respiratory protection devices for use during high-risk procedures while still protecting health care personnel with facemasks and eye protection during other routine patient care activities, in the setting of respirator shortages.
- CDC's updated, interim IPC guidance also aims to support health care facilities in practical decision-making at the local level to maintain a functional health care system while protecting healthcare workers.
- The guidance also outlines multiple interventions that can be implemented to enhance protection of health care personnel
- CDC has updated guidance on the PPE healthcare personnel should use when caring for patients with known or suspected COVID-19:
    - Eye protection, gown, and gloves continue to be recommended.
    - While respirators remain preferred, facemasks are an acceptable alternative until the supply chain is restored.
        - Facemasks protect the wearer from splashes and sprays.

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        - Respirators, which filter inspired air, offer respiratory protection.
    - Respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to healthcare professionals.
- The risk of transmission can be reduced by several types of actions, like prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- CDC reminds all employers and healthcare personnel about the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
- All healthcare facilities should continuously review their infection control supply inventories and taking steps to optimize supplies.
    - This is particularly true for areas in facilities where aerosol-generating procedures are performed, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
- The anticipated timeline for return to routine levels of PPE is not known.
    - CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available.
    - CDC has also posted a companion checklist to help healthcare facilities prioritize the implementation of the strategies is available.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not typically procure N-95 respirators, currently have respiratory protection programs, nor fit-tested HCP. Therefore, they would not be able to implement all the recommended infection control interventions for care of COVID-19 patients.
    - Without respiratory protection programs and fit testing, unnecessary transfer of stable patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.
- Healthcare personnel (HCP) are on the front lines of caring for patients with confirmed or possible COVID-19. HCP caring for these patients have an increased risk of exposure to this virus.
- HCP can minimize their risk of exposure when caring for confirmed or possible COVID-19 patients by following CDC infection prevention and control (IPC) guidelines, including use of recommended personal protective equipment (PPE).
- Infection control procedures and appropriate use of PPE are necessary to prevent infections from spreading while caring for patients. CDC reminds all employers and HCP that PPE is only one aspect of safe care of patients with COVID-19.

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    - Focusing only on PPE gives a false sense of security of safe care and worker safety.
    - It is critical to focus on other strategies to prevent spread of COVID-19 in healthcare settings. Examples include prompt screening and triage of patients and limiting the numbers of healthcare personnel entering the patient room.
- CDC's current guidelines are designed to prevent the spread of COVID-19 within healthcare facilities to healthcare personnel, visitors, and other patients who may be exposed to a patient with COVID-19.
- Healthcare personnel caring for patients with confirmed or suspected COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):
    - Assess and triage patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure. Care for patients with known or suspected COVID-19 in a single-person room with the door closed. Reserve Airborne Infection Isolation Rooms (AIIRs) for patients undergoing aerosol-generating procedures.
    - Use Standard, Contact, and Airborne Precautions, including eye protection, when caring for patients with confirmed or possible COVID-19.
    - Perform hand hygiene with alcohol-based hand sanitizer before and after all patient contact, before and after contact with potentially infectious materials, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
    - Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
    - Perform aerosol-generating procedures (e.g., sputum induction, open suctioning of airways) in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.
    - The collection of respiratory specimens (e.g., nasopharyngeal swabs) are not considered aerosol generating procedures. These procedures should take place in an examination room with the door closed.
    - Healthcare facilities can minimize the chance for exposures by ensuring facility policies and practices are in place and implemented before patient arrival, upon patient arrival, and throughout the duration of the affected patient's time in the healthcare setting.
    - CDC has created Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings
- Healthcare facilities should promptly notify state or local public health authorities of patients with known or possible COVID-19 (i.e., persons under investigation or PUIs), and should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
- All healthcare facilities should ensure that their healthcare personnel are correctly trained and capable of implementing infection control procedures. Individual healthcare personnel should ensure they understand and can adhere to infection control requirements.

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- Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2, the virus that causes COVID-19.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures. Federal, state, and local guidelines and regulations specify the categories of medical waste that are subject to regulation and outline the requirements associated with treatment and disposal.
- CDC recommends that employees who are confirmed to have COVID-19, those who appear to have acute respiratory illness symptoms upon arrival to work, and persons who become sick during the work day promptly put on a facemask, be separated from other people, and be sent home immediately.
- If facemasks are not available, sick healthcare personnel should cover their noses and mouths with a tissue when coughing or sneezing (or an elbow or shoulder if no tissue is available), prior to leaving the facility.

Long-term care facilities

- The general strategies CDC recommends to prevent the spread of COVID-19 in long-term care facilities (LTCF) are the same strategies these facilities use every day to detect and prevent the spread of other respiratory viruses like influenza. View Strategies to Prevent the Spread of COVID-19 in LTCF for more information.
- All healthcare facilities can take steps now to prepare for COVID-19 and protect both their patients and staff.
- In late February, there was an outbreak of COVID-19 in a long-term care facility in Washington state infecting patients and a healthcare professionals.
- CDC deployed a team to Washington to support the ongoing investigation to find and identify how the patients were exposed and do extensive contact tracing of people who were exposed or might have been exposed to the patients.

WHAT CDC IS DOING TO PROTECT HEALTHCARE PERSONNEL

- CDC is providing regular communication to the US healthcare community through targeted outreach activities.
- CDC is rapidly developing guidance and resources to protect US healthcare personnel. Current guidance and recommendations are designed to protect healthcare personnel and prevent the spread of the virus that causes COVID-19 within US healthcare facilities.
- CDC has deployed field teams to provide onsite infection control assessment and consultation to the US healthcare facilities currently treating confirmed COVID-19 patients and the passengers returning from China.
- CDC is preparing first responders, healthcare providers, and health systems, by:

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    - Establishing visibility across healthcare systems to understand healthcare use, particularly surges in demand for medical care and associated resources.
    - Conducting extensive outreach to clinical and hospital professional organizations to ensure health system preparedness.
    - Producing guidance documents on infection control, hospital clinical evaluation and patient management.
    - Working closely with healthcare facilities and providers to reinforce infection control principles that recognize PPE is one component of a larger set of practices that help to limit the spread of disease.
    - Developing a range of respirator conservation strategies, including strategies to make supplies last longer (such as using alternative products like reusable respirators) and extending the use of disposable respirators.
    - Leveraging existing telehealth tools to direct people to the right level of care.
    - Working with supply chain partners to understand supply usage, what products are available, and when more aggressive measures may need to be taken to ensure that HCPs at highest risk have access to PPE.
    - Sharing information with stakeholders to help them recognize when to shift the strategies they are using.
- The first report of an infected healthcare provider occurred on February 29 in a long-term care facility in Washington.
- Healthcare personnel (HCP) often have prolonged close contact with patients in healthcare settings and may come in contact with a person infected with COVID-19. HCPs can protect themselves by properly following recommended infection control practices, including the appropriate use of PPE when caring for patients with COVID-19.
- CDC recommends evaluating asymptomatic HCPs with close contact or a potential exposure to COVID-19 by assessing risk, monitoring symptoms, and determining the need for appropriate work restrictions.

OPTIMIZING THE SUPPLY OF N95 RESPIRATORS

- Protection of healthcare workers is a priority. CDC's Strategies for Optimizing the Supply of N95 Respirators offers a series of strategies or options to optimize supplies of disposable N95 filtering facepiece respirators (commonly called "N95 respirators") in healthcare settings where there is limited supply.
- It also includes considerations for use by federal, state, and local public health officials, respiratory protection program managers, occupational health service leaders, infection prevention and control program leaders, and other leaders in healthcare settings who are responsible for developing and implementing policies and procedures for preventing pathogen transmission in healthcare settings.
- CDC has provided additional resources related to these strategies:
    - Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response is intended to help healthcare facilities

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prioritize the implementation of the strategies presented in the Strategies for Optimizing the Supply for N95 Respirators guidance.

- Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response
    - In times of increased demand and decreased supply, consideration can be made to use the N95s listed in the guidance past their manufacturer-designated shelf life when responding to COVID-19.
    - This preliminary information from the NIOSH study suggests certain N95 models beyond their manufacturer-designated shelf life will be protective. CDC recommends that N95s that have exceeded their manufacturer-designated shelf life should be used only as outlined in the Strategies for Optimizing the Supply of N95 Respirators.

MANAGEMENT OF PATIENTS GUIDANCE FOR HEALTHCARE PROVIDERS

Clinical Presentation

- Most frequently reported symptoms of COVID-19 include fever, cough, sore throat, myalgia, or fatigue. Less commonly reported symptoms include sputum production, headache, hemoptysis, and diarrhea. Older patients and people with chronic medical conditions may be at higher risk of severe illness.
    - Possible risk factors for progressing to severe illness may include, but are not limited to, older age and people of any age with underlying chronic medical conditions such as heart disease, lung disease and diabetes.

Clinical Course

- Symptoms among reported cases of COVID-19 vary in severity from mild illness to severe or fatal illness.
- Some reports suggest the potential for clinical deterioration during the second week of illness.
- Among hospitalized patients with confirmed COVID-19, some will develop complications:
    - Acute respiratory distress syndrome (ARDS)
    - Intensive care for respiratory support
    - Pneumonia resulting in death
    - Secondary infection

Laboratory and Radiographic Findings

- SARS-CoV-2 RNA has been detected from upper and lower respiratory tract specimens, and the virus has been isolated from bronchoalveolar lavage fluid.
- The duration of shedding of SARS-CoV-2 RNA in the upper and lower respiratory tracts is not yet known but may be several weeks or longer.

Clinical Management and Treatment

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- There are no U.S. Food and Drug Administration (FDA)-approved drugs specifically for the treatment of patients with COVID-19.
- At present, clinical management includes infection prevention and control measures and supportive care, including supplementary oxygen and mechanical ventilatory support when indicated.
- Patients with mild clinical presentation may not initially require hospitalization.
- The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis.

Therapeutic Options for COVID-19 Patients

- There are two approved drugs (chloroquine and hydroxychloroquine) and one investigational agent (remdesivir) currently in use in the United States.
    - The two approved drugs have not been approved specifically for the treatment of patients with COVID-19.
    - For full information on therapeutic options and obtaining these drugs, visit Information for Clinicians on Therapeutic Options for COVID-19 Patients.
- Remdesivir is an investigational intravenous drug with broad antiviral activity that inhibits viral replication through premature termination of RNA transcription. It has in-vitro activity against SARS-CoV-2 and in-vitro and in-vivo activity against related betacoronaviruses.
    - It is available through three clinical trials or on an uncontrolled compassionate use basis.
- Hydroxychloroquine and chloroquine are oral prescription drugs that have been used for treatment of malaria and certain inflammatory conditions.
    - Based upon limited in-vitro and anecdotal data, chloroquine or hydroxychloroquine are currently recommended for treatment of hospitalized COVID-19 patients in several countries.

INTERIM GUIDANCE FOR BUSINESSES AND EMPLOYERS (NON-HEALTHCARE SETTINGS)

- Interim guidance for businesses and employers to plan for and respond to COVID-19 is now available on CDC's website. This interim guidance may help prevent workplace exposures to acute respiratory illnesses, including COVID-19, in non-healthcare settings.
- Employers can use strategies now to prevent workplace exposures to acute respiratory illness:
    - Actively encouraging sick employees to stay home
    - Separating sick employees
    - Emphasizing staying home when sick, respiratory etiquette, and hand hygiene by all employees
    - Performing routine environmental cleaning
    - Advising employees before traveling to take certain steps
    - Checking the CDC's Traveler's Health Notices website for the latest guidance and recommendations for each country to which you will travel
- Some people, like healthcare workers caring for COVID-19 patients and other close contacts of COVID-19 patients, will have an increased risk of infection.

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    - Employees who are well but who have a sick family member at home with COVID-19 should notify their supervisor and refer to CDC guidance for how to conduct a risk assessment of their potential exposure. Recommendations released March 16 state that if someone in a household has tested positive, keep the entire household at home.
    - If an employee is confirmed to have COVID-19, employers should inform fellow employees of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act. Employees exposed to a co-worker with confirmed COVID-19 should refer to CDC guidance for how to conduct a risk assessment of their potential exposure.
- Employers should be ready to implement strategies to protect the workforce from COVID-19 while ensuring the continuity of operations.
    - An infectious disease outbreak response plan should include possible work-related exposures and health risks to employees. The plan should also explore flexible worksites (e.g., telecommuting) and work hours in accordance with human resource policies.
    - Determine how you will operate if absenteeism spikes from increases in sick employees, those who stay home to care for sick family members, and those who must stay home to watch their children dismissed from childcare programs and K-12 schools.

AMERICAN OVERSIGHT

From: Sayler, Erik
To: St Laurent, Louise R; Grow, Stefan
Cc: Larson, Bradford U (Brad) Col USAF NG FLANG (USA); Deleon, Melissa (FLNG)
Subject: FW: [EXTERNAL] FW: MOA for CST testing lab (UNCLASSIFIED)
Date: Wednesday, March 25, 2020 5:18:42 PM
Attachments: MOA FLARNG CST and DOH 20200324.docx

Louise & Stefan,
Attached is the FLNG MOA for the testing machine between DOH and FLNG. Col. Bradford's team drafted it. Are these the right state parties to the MOA? The Colonel said the lab comes with some NG personnel, but they are not currently CLIA certified. Also, supplies and wrap-around services will need to be procured. Do you have any edits? If you have any questions, please let me know.

All,
Some logistics items to be addressed/questions to be answered about the lab, but don't necessarily need to be addressed in the MOA. These are logs/finc/management questions but worth noting and sharing internally.

1. Staffing the lab
    a. How many lab techs are needed to operate the lab at full capacity.
    b. The Colonel says the lab can test 500 samples per day, but is that in an 8, 12, or 24 hour period?
    c. Currently the NG personnel are not CLIA certified; so lab techs will need to be procured – who pays for the lab techs (DOH, AHCA, DEM)
2. Testing materials
    a. What materials are included with the lab (what not included)
    b. What materials are needed to operate the lab at full capacity
    c. Procuring those material that help the lab operate – who procures/pays for these material
3. Wrap-around services
    a. What services are needed (ie, 24-hr security, food for staff, maintenance of lab, etc.)
    b. Who pays for the wrap-around services (DOH, AHCA, DEM)?
4. Timing – It will take at least a week to get the lab.
5. Location – where to stage the lab – that's a logs/mgt decision
6. Other items??

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

Florida has a very broad public records law. Written communications to or from state officials regarding state business constitute public records. Public records are available to the public and media upon request, unless the information is subject to a specific statutory exemption. Therefore, any information that you send to this address, including your contact information, may be subject to public disclosure.

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-----Original Message-----
From: Larson, Bradford U (Brad) Col USAF NG FLANG (USA) <bradford.u.larson.mil@mail.mil>
Sent: Wednesday, March 25, 2020 4:25 PM
To: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: [EXTERNAL] FW: MOA for CST and DOH (UNCLASSIFIED)

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

CLASSIFICATION: UNCLASSIFIED

Erik

Attached is the draft MOA we discussed. Please let me know if you have any suggestions. I contacted LTC Eastman and asked what we would need and what we may receive to run this machine. The National Guard Bureau is still working those details as far as what PPE, pipets, kits, etc. may come with the machine. He will get back with me. NGB is sending 2 to NY, so we will have a good idea of what to expect based on what they receive. He did say this would not get to us for about a week even if we do get one.

V/R
Brad

BRADFORD U. LARSON, Col, FLANG
Command Judge Advocate
Florida National Guard
Work: 904-823-0683
Cell: 850-774-3000

CLASSIFICATION: UNCLASSIFIED

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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MEMORANDUM OF AGREEMENT
BETWEEN
FLORIDA NATIONAL GUARD
44th WEAPONS OF MASS DESTRUCTION - CIVIL SUPPORT TEAM
AND
FLORIDA DEPARTMENT OF HEALTH
AGREEMENT NO.: DOH-03-24-2020

I. PURPOSE

The purpose of this Memorandum of Agreement (MOA) is to enable the Florida National Guard (FLNG) 44th Weapons of Mass Destruction Civil Support Team (WMD-CST) to provide assistance to the State of Florida, Department of Health (DOH) in relation to the COVID-19 Pandemic.

It is understood by the parties to this MOA that requests by DOH for the support of the WMD-CST to assist in response to the response to the COVID-19 Pandemic may include multi-agency, federal, state, and local cooperative agencies and law enforcement activities (Governmental Entities). It is further understood that each party's participation in these activities is limited as specified in Paragraph II, Scope of Work, of this MOA and that each party will bear their own expenses related to execution of this MOA.

II. SCOPE OF WORK

For the purposes of this agreement, the WMD-CST will:

1. **Work under the Command and Control of Military leadership while assisting the FL DOH to accomplish the objectives outlined by FL DOH.**
2. **Provide any NGB CST program issued ABI 7500 PCR machine for use by the FL DOH, provide maintenance of such machinery, and provide non-medical/non-laboratory certified personnel to assist, as necessary.**

Commented [LBUCMN1]: Please fill in with real name.

For purposes of this agreement, the FL DOH will:

1. **Define objectives FL DOH and WMD-CST are working to accomplish.**
2. **Provide CLIA certified personnel to collect and analyze specimens as needed during the COVID-19 Pandemic using the NGB CST program issued ABI 7500 PCR machine.**
3. **Provide any necessary training to WMD-CST members.**

III. AUTHORITY AND COMPLIANCE WITH RELEVANT LAWS AND REGULATIONS

DOH shall not request, and the WMD-CST shall not provide, any services not in compliance with all state and federal laws. Any support provided by WMD-CST under this MOA is done in the performance of those members' duty under the provisions of Florida Statute 250.31.

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In the event that WMD-CST is assisting an entity and comes into contact with protected information, the parties will ensure proper controls and protections are in place and such information is managed in accordance with applicable law.

IV. FLORIDA NATIONAL GUARD POINT OF CONTACT

The Point of Contact for the FLNG is:
Lieutenant Colonel Troy M. Eastman,
Commander, FLARNG 44th Weapons of Mass Destruction – Civil Support Team (WMD-CST) Florida
Phone: 904-682-2401 (direct); 904-813-4043 (mobile)
E-mail: troy.m.eastman.mil@mail.mil

V. STATE OF FLORIDA POINT OF CONTACT

The Point of Contact for the DOH is:

_____
_____
Phone: _____
E-mail: _____

V. NOTIFICATIONS BY FLNG OF SERVICES

DOH acknowledges that the FLNG may notify the National Guard Bureau was about tasks performed under this MOA. Any information provided will be limited to a general categorization of the service provided, general client classification, and will not include specific details or outcomes. No further details will be disclosed to ensure client confidentiality.

VI. TERM

This MOA shall commence on the date of the last signature below, and shall end on August 31, 2020, or sooner if the State emergency in response to COVID-19 Pandemic ends, services as contemplated by this MOA are completed and accepted by DOH, or if this MOA is terminated as set forth in paragraph VII below.

VII. MODIFICATIONS TO THIS AGREEMENT

Any amendments or changes to this to this Agreement must be in writing and executed by all parties hereto.

VIII. TERMINATION

Either party may terminate this MOA by giving written notice to all parties hereto. Early termination of support must provide a minimum of 48 hours' notice, and such notice shall be delivered by email. Such termination notice period shall not commence until receipt of delivery is obtained.

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IX. COMPENSATION

The parties understand and agree that all parties bear their own cost associated with services provided pursuant to this MOA.

X. DISCLAIMER OF LIABILITY

Pursuant to Florida Statute 250.31, in no event shall the DOH, the FLNG or its members be liable to DOH or any third parties affected by the services provided by FLNG for any damages of any kind whatsoever, arising out of services provided pursuant to this Agreement, or for special, indirect, consequential, incidental, or punitive damages however caused, and regardless of the theory of liability, arising out of the services provided by the FLNG. Any claims by any person against the FLNG will be directed to the Florida Department of Legal Affairs.

XI. SEVERABILITY

In the event that any provision or section herein is held invalid or unenforceable, the remaining provisions and sections shall remain in full force and effect.

Florida Department of Health	**Florida National Guard**
??????	Major General James Eifert
Executive Director	The Adjutant General
Date:_____	Date:_____

AMERICAN OVERSIGHT

From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Roberson, Shamarial (CDC flhealth.gov); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE)
Subject:	FW: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:36:52 PM

Dear Dr. Roberson,
Here is the latest update that we received from Royal Caribbean.
I understand that my team lead, Cindy Friedman, has just spoken with Dr. Rivkees who reported that the plan has not been approved by the state at this time.

Best,
Michelle

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 7:25 PM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

Until then, I will arrange for Dr. Green to receive 60 Quest Novel Coronavirus (2019-nCoV)/COVID-19 test kits from my office, so that he can make final determinations on those who are ill. Ms. Stephanie Buchler will follow Quest collection instructions and will ensure courier specimen pickup, if necessary.

Dr. Green will direct his Medical staff to triage the arrival of these patients to either Jackson Memorial Hospital or Hotel St. Michel in Coral Gables, depending on their physical condition.

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Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 2:17 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

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Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.

AMERICAN OVERSIGHT

c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.

d. Passengers who are not ill will be allowed to continue their travel on commercial flights.

6. After arrival
   a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.

   b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.

7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
   a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

      i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

      ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

   b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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<yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Tyler

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
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AMERICAN OVERSIGHT

Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
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All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

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Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Roberson, Shamarial (CDC flhealth.gov); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject:	FW: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:37:42 PM

Further information from Royal Caribbean

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
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AMERICAN OVERSIGHT

Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
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AMERICAN OVERSIGHT

added Rachel , Michelle and Shannon

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329

470-487-4373

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Subject:	FW: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 5:28:57 PM
Attachments:	SCREENINGFORM_v4.docx SOP for disembarking international cruise ships with passengers arriving in charter flights (ver 3_17_2020).docx 20_316043-A_FS_Guide_disembark_ship_March17.pdf

Here is the earlier correspondence that I mentioned. Dr. Rivkees was copied but not sure that he has had time to review.

Best,
Michelle
Mobile: 1 404 456 4559

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Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 1:57 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>

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Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
> **To:** Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
> **Subject:** Royal Caribbean Ships off Brazil/Chile

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All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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Health Alert:
Coronavirus Disease 2019 (COVID-19)

You have recently been on a cruise ship or river cruise.

COVID-19 is a respiratory illness that can spread from person to person.

Stay home for 14 days from the time you left the cruise ship or river cruise and practice social distancing

Take these steps to monitor your health and practice social distancing:

1. Take your temperature with a thermometer two times a day and monitor for fever. Also watch for cough or trouble breathing.

2. Stay home and avoid contact with others. Do not go to work or school for this 14-day period. Discuss your work situation with your employer before returning to work.

3. Do not take public transportation, taxis, or ride-shares during the time you are practicing social distancing.

4. Avoid crowded places (such as shopping centers and movie theaters) and limit your activities in public.

5. Keep your distance from others (about 6 feet or 2 meters).

What To Do If You Get Sick

If you get sick with fever (100.4°F/38°C or higher), cough, or have trouble breathing:

- Seek medical care. Call ahead before you go to a doctor's office or emergency room.

- Tell your doctor about your recent travel and your symptoms.

- Avoid contact with others.

If you need to seek medical care for other reasons, such as dialysis, call ahead to your doctor and tell them about your recent travel on a cruise ship or river cruise.

For additional questions on monitoring your health, contact your local public health officials.

Visit the website for more information on monitoring your health and how to contact local public health officials. Visit: www.cdc.gov/COVIDtravel

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FL-DOH-20-0673-A-003991
CS 316043A March 17, 2020 9:56 AM

ONE FORM PER TRAVELER **Form filled by:** _____

UNITED STATES: PRE-BOARDING PUBLIC HEALTH SCREENING FOR US RETURNING PASSENGERS

Family name: _____

First (given) name: _____

Birth date: ___ /___ / ___ (Day/Month/Year)

SPECIMEN ID # _____

Cabin number _____

INSTRUCTIONS: Read out loud the text in italics and check the corresponding boxes

I am going to ask you a few questions about your health. It will take less than five minutes.

Were you sharing a cabin with someone who has tested positive for novel coronavirus (COVID-19)?

☐ Yes, ☐ No, ☐ Don't know

1. *Today or in the past 72 hours did you have fever?* (Check all that apply)
   ☐ Yes
   If yes,
   ☐ *was this a subjective temperature (feeling feverish) without measuring*?
   ☐ was temperature *measured and 100°F (37.8°C) or higher?*
   ☐ No fever
   ☐ Don't know

2. *In the past 72 hours did you have any of the following respiratory symptoms? If you have a pre-existing condition that causes coughing or shortness of breath, please tell me if these symptoms are worse than usual* (Check all that apply)

   a) New onset or worsening cough, ☐ yes ☐ no

   b) New onset or worsening shortness of breath ☐ yes ☐ no

3. *In the past 72 hours did you have any of the following gastrointestinal symptoms:*
   a) *Diarrhea* (*3 or more loose stools in 24 hrs*) ☐ yes ☐ no

   b) *Vomiting* ☐ yes ☐ no

To be filled out by the health screening staff

4. Measured temperature: _____☐°C ☐°F
5. Visible signs of cough or difficulty breathing ☐ yes ☐no
6. Appears obviously unwell

INSTRUCTIONS

REFER TO TEAM LEAD IF traveler responds yes to any of the criteria in questions 1, 2, or 3 **OR** has a measured temperature of ≥100 °F (37.8 °C) **OR** has visible signs of cough or difficulty breathing (question 5) **OR** appears obviously unwell (question 6)

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Proposed SOP for Disembarking International Cruise Ships With Passengers Arriving In US On Charter Flights (Working Draft As Of 3/16/20)

1) Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2) At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3) Passengers without any symptoms can board charter flights.
4) During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5) Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6) After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7) If there is an air ambulance flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf
    b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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From:	FieldSupport (CDC)
To:	Bennett, Siiri (CDC maine.gov); lohff@snhd.org; Blackmore, Carina (CDC flhealth.gov); Lawrence, Jean JML (CDC kp.org); Dunn, John (CDC tn.gov); Thoroughman, Douglas (CDC ky.gov); Longenberger, Allison (CDC pa.gov); Lutterloh, Emily (CDC health.ny.gov); Huston, Sarah L., PhD (CDC maine.gov); zhangy@snhd.org; Tartof, Sara SYT (CDC kp.org); Jones, Tim F. (CDC tn.gov); Robeson, Sara (CDC ky.gov); Waller, Kirsten (CDC pa.gov); Blog, Debra (CDC health.ny.gov); Robinson, Sara (CDC maine.gov); Stanek, Danielle (CDC flhealth.gov); Jacobsen, Steven SJJ (CDC kp.org); Fill, Margaret (CDC tn.gov); Bicking_Kinsey, Cara (CDC pa.gov); Newman, Alexandra (CDC health.ny.gov)
Cc:	Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD); Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD); Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD)
Subject:	FW: Cancellation of EIS conference – next steps
Date:	Monday, March 16, 2020 3:07:00 PM

Dear prematched supervisors, many of you have already received the message below. For those who do not have a current officer, in light of the ongoing response we have made the difficult decision to cancel EIS conference this year. If you have made travel arrangements, please go ahead and cancel those. For those who have the time, consider dropping a note to your incoming officer to touch base in lieu of seeing them at conference.

If you have any questions, please reach out to us. Thank you for all you are doing and for hosting an incoming EISO.

Thank you – Jennifer

From: EIS (CDC) <eisepo@cdc.gov>
Sent: Monday, March 16, 2020 12:41 PM
To: CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>
Cc: CDC CSELS DSEPD EWB <OSELSSEPDPOEISStaff@cdc.gov>; Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD) <hld0@cdc.gov>; Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD) <tbn9@cdc.gov>; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) <mai9@cdc.gov>; Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) <pms6@cdc.gov>; Black, Erin (CDC/DDPHSS/CSELS/DSEPD) <epm7@cdc.gov>
Subject: Cancellation of EIS conference – next steps

EISOs,

I am writing to inform you of the cancellation of the EIS conference scheduled for May 4–7th. As of March 15, 2020, CDC is recommending the cancellation or postponement of in-person events consisting of 50 people or more throughout the U.S. We have been working on contingency planning for weeks and we determined that even a virtual conference is not feasible given the presenters and audience are needed for the COVID-19 response. During this time, response priorities take precedence over developing presentations for EIS Conference.

We understand that cancelling conference has broad implications for all of you, especially the 2nd year EISOs. We are cognizant of the potential impacts on CAL completion, job searching, graduation,

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and other elements that are important to all of you and the program. We want you to know the following:

- The match for the incoming class will be conducted virtually with an extended recruitment period starting on March 23, 2020 and an extended period for virtual interviewing from April 20 – May 8.

- We will work with 2nd year officers on a case-by-case basis if your COVID-19 response involvement might compromise your ability to complete your CALs. We do not want CAL completion to be a deterrent to your involvement. If you have concerns, please reach out to your EWB supervisor or CIO liaison to discuss your situation.

- We are working to plan a 2-day EIS presentation and graduation event for June. The event would include presentations from 2nd year EISOs who needed conference to fulfill the CAL requirement, a graduation ceremony, and the EIS satirical review.

- We know that EIS conference is a time when many of you were planning to network and interview for jobs. We are working to identify alternative ways to support your search for CDC jobs.

For all of you currently or preparing to deploy, we hope that the cancellation of the conference alleviates any tension you might have been experiencing regarding how to prepare your presentation in the midst of COVID-19, Ebola, and polio responses.

EISO's are playing a vital role in supporting this nation's public health response, at the local, state, and federal level. Thank you for your service. Your dedication and contributions are valued and appreciated. At this time, we expect every EISO to contribute to the response in some way. We expect most field EISOs are supporting the response within their assigned jurisdiction and do not expect you to deploy elsewhere. If you are not already involved in response activities, please volunteer now. If you need guidance on how to find a deployment role, please contact us at EpiAid@cdc.gov. If you have had difficulty obtaining supervisory approval to support the response, please contact your CIO liaison or EWB supervisor so that we can assist.

Please reserve time on your schedules for a **call on March 18, 2020 at 12 pm EST** to answer your questions and discuss planning for an EIS presentation and graduation event for all EISOs tentatively scheduled for June. We will be sending the link for the Skype Meeting ASAP.

Respectfully,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.

please consider the environment before printing this e-mail.

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From: Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
To: Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
Subject: FW: CDC COCA Call: COVID-19 Update—Information for Clinicians Caring for Children and Pregnant Women
Date: Tuesday, March 10, 2020 12:39:47 PM
Attachments: image004.png

Dear USZPIR and SET-NET partners,

We wanted to share this information about the COCA call this Thursday.

Best,
Megan

Megan Reynolds, MPH, MDiv, CPH
Coordinator, US Zika Pregnancy and Infant Registry
Emerging Threats Team
Infant Outcomes Monitoring, Research, and Prevention Branch
Division of Birth Defects and Infant Disorders
National Center on Birth Defects and Developmental Disabilities
Email: xah6@cdc.gov
Phone: 404-498-0604

From: Centers for Disease Control and Prevention <no-reply@emailupdates.cdc.gov>
Sent: Tuesday, March 10, 2020 11:59 AM
To: Polen, Kara N. (CDC/DDNID/NCBDDD/DBDID) <fvc1@cdc.gov>
Subject: CDC COCA Call: COVID-19 Update—Information for Clinicians Caring for Children and Pregnant Women

National Center on Birth Defects and Developmental Disabilities Partner Alert

March 10, 2020

Special Edition

CDC COCA Call: COVID-19 Update—Information for Clinicians Caring for Children and Pregnant Womenr

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Pregnant woman with doctor



Join us for this week's COCA call, which focuses on current information about COVID-19 as it relates to children and pregnant women. Topics will include infection prevention and control measures in inpatient obstetric healthcare settings (CDC's Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings) and resources available to care for pediatric patients.

When: Thursday March 12, 2020
Time: 2:00-3:00 pm (ET)

How to join?
Please click the link below:
https://zoom.us/j/200932054

Or iPhone one-tap:
US: +16468769923,,200932054# or +16699006833,,200932054#

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

Webinar ID: 200 932 054
International numbers available: https://zoom.us/u/anixAVgIV
If you are unable to attend this live COCA Call, it will be available to view on-demand a few hours after the call.

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

Watch on Facebook: You may also participate in this COCA Call by joining COCA's Facebook Live.

Continuing Education will not be offered for this COCA Call.

For more information on this call, visit CDC's COCA website:
https://emergency.cdc.gov/coca/calls/2020/callinfo_031220.asp

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Please also consider following us on Twitter at @CDC_NCBDDD and @CDCgov and on Facebook at @CDC in addition to sharing this news with your respective networks.

Get NCBDDD'sd 2018 Annual Report here.



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Centers for Disease Control and Prevention

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

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov)
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: FW: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Friday, March 6, 2020 10:16:10 AM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Good morning Carina,

We are following up on the email below. At your earliest, could you please confirm the COVID-19 case counts for March 5? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit

eocevent118@cdc.gov

CDC 2019-nCoV Response

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Thursday, March 5, 2020 7:22 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

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https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
    - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
    - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0

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New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; and 6) major avoidable issues we hope to overcome with your assistance. We plan for the noted changes to go into effect at **5 pm ET, Sunday, March 1.**

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **we anticipate that all jurisdictions will be onboarded to 'Phase 2' during the week of March 2.** As soon as your jurisdiction is able to confirm its 'Phase 2' status, please email eocevent118@cdc.gov.

As part of the 'Phase 2' rollout, CDC needs to better understand each jurisdiction's plan for providing data to CDC for the PUI and Case Report Form via DCIPHER, an electronic PUI and case reporting system. We request that each jurisdiction provides a list of ≤5 DCIPHER users before **Monday, March 2 at 5pm ET,** if they have not already done so. In addition, we ask that jurisdictions confirm their intent to input data on PUI and case-patients directly into the DCIPHER platform (preferred option) or if alternative arrangements need to be made to send data to CDC. Please email eocevent118@cdc.gov with the requested information by **March 2 at 5pm ET**.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

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- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings

For reporting jurisdictions that have the capacity to do their own testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs or Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.

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2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

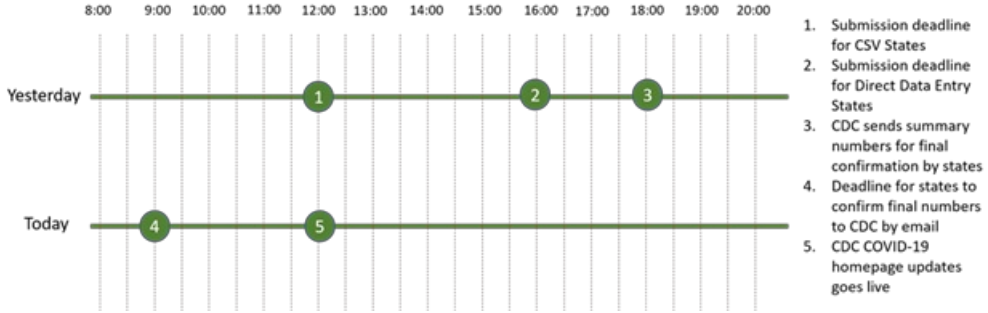
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
>
>
> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: FW: CDC COVID-19 Daily Key Points for 24Mar20
Date: Tuesday, March 24, 2020 10:26:45 PM
Attachments: CDC_COVID-19_Daily Key Points__3_24_2020_FINAL.pdf

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UNCLASSIFIED // FOR OFFICIAL USE ONLY

Good evening,

Please see the attached CDC COVID-19 Daily Key Points for **24Mar20**.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 24, 2020 as of 9:30pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 44,183 confirmed and presumptive positive cases of COVID-19
  - 544 COVID-19-related deaths
  - All 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands have reported cases of COVID-19.

MAIN KEY POINTS

- On March 16, 2020 President Trump and the White House Coronavirus Task Force issued new guidelines to help protect Americans during the Coronavirus pandemic.
  - The initiative, called 15 Days to Slow the Spread, lays out guidelines for a nationwide effort to slow the spread of COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society.
  - This is a massive proactive, preventive response to COVID-19. It aims to slow the spread and blunt the impact of this disease on the United States.
- All segments of U.S. society have a role to play at this time:
  - People across the country are asked to stay home as much as much as possible and otherwise practice social distancing.
  - This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas as determined by local and state governments.
  - It also includes special measures to protect those people who are most vulnerable to this disease.
  - People who are sick are asked to follow CDC guidance on recovering at home and follow the new guidance for when it's OK to interact with other people again.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- There is a body of evidence—based on about 200 journal articles—that supports the effectiveness of social distancing measures, both when used alone and in combination with other measures.
  - Much of this data is outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza — United States, 2017.
  - These recommendations work better when implemented in concert.
- While the new guidelines are recommended for the 15-day period ending March 30, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified or extended for additional periods of time.
- This is a historic, unprecedented outbreak, the likes of which have not been seen since the influenza pandemic of 1918.
- The White House Task Force on Coronavirus has established www.coronavirus.gov as the centralized website for the Federal government.
  - CDC continues to maintain www.cdc.gov/covid19.

AMERICAN OVERSIGHT

CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 24, 2020 as of 9:30pm

SITUATION UPDATE

- 44,183 reported cases of COVID-19 have been detected in all 50 states.
- 569 of these cases occurred through close contact with another case.
- 479 cases occurred in people who had traveled to international areas with sustained (ongoing) transmission and among their close contacts.
- 43,135 cases are either still being investigated to determine the source of exposure, or have an unknown source of exposure and are therefore assumed to be a result of community spread.
- The number of cases of COVID-19 being reported in the United States is rising quickly.
    - Early on, most cases in the United States were among travelers returning from affected countries or close contacts of people who had COVID-19.
    - Now, more and more cases are resulting from community spread where the source of the exposure is unknown.
- As COVID-19 activity continues to increase, it will be possible to track activity using some existing surveillance systems that track respiratory illnesses, including flu.
- CDC's most recent FluView showed that the percent of specimens testing positive for influenza at clinical laboratories is decreasing. At the same time, levels of influenza-like-illness (ILI)—as measured by people seeking care for fever, cough, and sore throat—increased for the second week in a row after declining for three weeks.
    - This means that more people are seeking care for respiratory illness than usual at this time of year and that the increase is not due to increasing influenza activity.
    - There are likely multiple factors that contribute to this increase. These may include concern over COVID-19 causing people to seek treatment for respiratory illness when they otherwise would not have, delayed or cancelled visits for routine healthcare, and the ILI surveillance system picking up COVID-19 illness activity.
- CDC and partners that collaborate on surveillance are adapting many of the surveillance systems that routinely collect information on viruses, illnesses, hospitalizations and deaths to better track COVID-19.
    - They are additionally creating new systems to track COVID-19.
    - All sources of information will be made available in one place on the web to facilitate tracking of COVID-19
    - The agency plans to roll out COVID-19 surveillance data on the website this week.
- As of March 23, 91 state and local public health labs in 50 states, the District of Columbia, Guam, and Puerto Rico verified they are successfully using COVID-19 diagnostic tests. See map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
- As of March 23, 2020, CDC and local and state public health laboratories had tested a total of 88,042 specimens.
- Private laboratories are increasing their testing capacity. In addition to the approximately 2,500 tests per day currently done nationally, it is projected that:
    - Roche will increase their capacity up to 10,000 tests per day by end of this week
    - BioReference will increase their capacity by an additional 3,000 tests per day.

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Pandemic
March 24, 2020 as of 9:30pm

- In addition, the Food and Drug Administration has issued a number of Emergency Use Authorizations for commercial manufacturers to develop other COVID-19 tests, including a point-of-care test that could deliver results in as short as 30 minutes.,

CDC GUIDANCE UPDATES

- On March 23, 2020 CDC posted additional guidance for specific community settings including:
  - Management of COVID-19 in Correctional and Detention Facilities,
  - Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings, and
  - Infection Control Guidance for Personnel at Blood and Plasma Collection Facilities.
- On March 22, CDC posted COVID-19 information specific to children including:
  - Tips for parents during school dismissal,
  - Guidance for Schools and Childcare Programs, and
  - Updated FAQs related to children and COVID-19
- On March 22, CDC posted Guidance for Retirement Communities and Independent Living to help them plan, prepare, and respond to COVID-19.
- On March 19, CDC updated technical guidance and consumer information about cleaning and disinfecting your home when someone is sick.
- On March 17, updates were made to CDC guidance on alternate non-95 PPE guidance: Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies.
- CDC is reviewing and updating travel notices almost on a daily basis.
  - On March 23, CDC issued 9 additional Level 3 Travel notices for Ecuador, India, Indonesia, Philippines, Qatar, Romania, Saudi Arabia, Singapore, and South Africa.
- CDC updated its guidance for specimen collection for testing for COVID-19 to collect a single upper respiratory nasopharyngeal swab (NP) instead of an NP and oropharyngeal swab (OP).
- CDC also posted new guidance on when people who have had COVID-19 and have been isolating at home can discontinue isolating in Discontinuation of Home Isolation for Persons with COVID-19.
  - People with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation if:
    - At least 3 days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
    - At least 7 days have passed since symptoms first appeared.
- CDC posted Guidance for child care settings, including a decision tree on when schools should close.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
  - On March 16, the White House announced a program called 15 Days to Slow the Spread, which is a nationwide effort to slow the spread of COVID-19 through the implementation of social distancing at all levels of society.

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    - CDC developed print resources to promote this message, including a Stay at home if you are sick! poster.
- Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
- If you are a healthcare provider, use your judgement to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Factors to consider, in addition to clinical symptoms, may include:
    - Does the patient have recent travel from an affected area?
    - Has the patient been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause?
    - Does the patient reside in an area where there has been community spread of COVID-19?
- If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
- CDC and federal partners recommend that people postpone routine medical or dental care at this time. This will help to reduce the burden on the healthcare system.
    - If you cannot postpone medical treatment, call your provider before visiting to see if they offer consultations by phone or telemedicine.
- People who get a fever or cough should consider whether they might have COVID-19, depending on where they live, their travel history, or other exposures.
    - More than half of the United States is seeing some level of community spread of COVID-19.
    - Testing for COVID-19 may be accessed through medical providers or public health departments, but there is no treatment for this virus.
    - Most people have mild illness and are able to recover at home without medical care.
- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	Amy Chang
To:	chris.rustin@dph.ga.gov; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Kurylo, Elizabeth (CDC/OID/NCEZID); Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman
Subject:	FW: CIFOR Promote DT - February Meeting
Attachments:	Promote DT Meeting_Agenda_02-18-20.docx CIFOR Guidelines Third Edition Postcard Draft 11Feb2020.pdf

Hi everyone, just sending this out as a reminder of our call this afternoon. Hope everyone can be on the call.

Scott

-----Original Appointment-----
From: Amy Chang <Achang@naccho.org>
Sent: Monday, February 3, 2020 7:36 AM
To: Amy Chang; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Hainstock, Lisa (MDARD); kristin.holt@fsis.usda.gov; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Michelle Shapiro; Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc: Collaro, Thomas - FSIS
Subject: CIFOR Promote DT - February Meeting
When: Tuesday, February 18, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://naccho.zoom.us/j/507646459

Achang@naccho.org <mailto:Achang@naccho.org> is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/507646459

Meeting ID: 507 646 459

One tap mobile
+19292056099,,507646459# US (New York)
+16699006833,,507646459# US (San Jose)

Dial by your location
+1 929 205 6099 US (New York)
+1 669 900 6833 US (San Jose)
Meeting ID: 507 646 459
Find your local number: https://naccho.zoom.us/u/ahhDdSCQg

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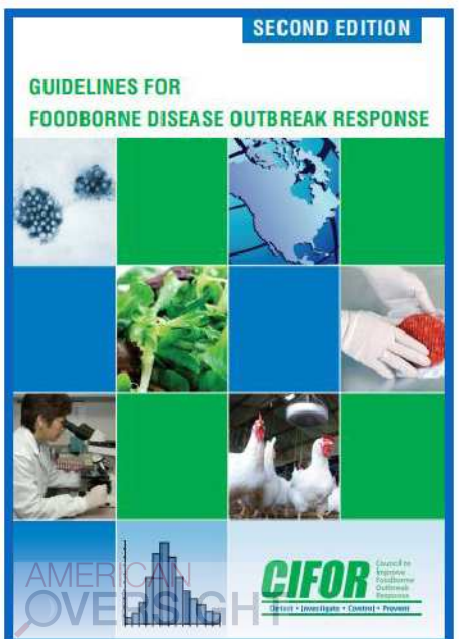
NEW!

Third Edition of the CIFOR

Guidelines for Foodborne Disease Outbreak Response



The CIFOR Guidelines are a comprehensive source of information on foodborne disease investigation and control for local, state and federal health agencies.

The Guidelines describe:

- the overall approach to addressing foodborne disease outbreaks, including preparation, detection, investigation, control and follow-up.
- the roles of key organizations in foodborne disease outbreaks.

Download the new Guidelines for free: https://cifor.us

FL-DOH-20-0673-A-004015

Flip to see what's new in the Third Edition

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NEW in the CIFOR Guidelines Third Edition

Extremely streamlined and easy to read

Provides information on the value and use of complaint systems

Highlights Whole Genome Sequencing and Culture-Independent Diagnostic Testing)

Highlights expanded importance of epi data:

- Recommends routine interviewing to collect detailed exposure information
- Expands effective models of sub-cluster investigations and product tracebacks

Better illustrates how epi, lab, and environmental data come together

Highlights importance of environmental assessments



CIFOR is a multidisciplinary collaboration of national associations and federal agencies working together since 2006 to improve methods to detect, investigate, control and prevent foodborne disease outbreaks. **Learn more at https://cifor.us.**

FDA OVERSIGHT

CIFOR Council to Improve Foodborne Outbreak Response

FL-DOH-20-0673-A-004016

Detect • Investigate • Control • Prevent

CIFOR Promote Development Team Agenda
February 10, 2020 @ 3:00pm ET

Discussion Item(s)	Person Responsible	Due Date
Updates: • Website updates and input/requests • Website sign-ups • Revisiting the Guidelines Printing Needs survey • Shipping options and number of Guidelines to order? • Cover page of new Guidelines • Promote DT Co-Chair Nominations	NACCHO India All	

Upcoming Promotions:
• 3rd Ed. Guidelines Promotion Plan
  ○ Promotion Plan
  § National Conferences
  § Postcard Flyers
 	
• Discussion: Chapter authors and coordinated effort to request info (learning modules and promotional outreach)
 	
• CIFOR Banners
  ○ Banner status update (India)
  ○ Process to request banner at events
• Other Items?
	Scott Holmes	

Analytics & Tracking • Review from Michelle: ○ New analytics are available on Basecamp.	Michelle All	

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	FW: COVID-19 CONCOPs and Process Flow
Date:	Thursday, March 19, 2020 4:11:36 PM
Attachments:	image001.png 16Mar20 - HHS COVID-19 Process Flow.pptx COVID_CBTS_SOP_03 17 2020.docx

May be a dupe email

Regards,
Jeanne

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Sent: Tuesday, March 17, 2020 5:55 PM
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Subject: COVID-19 CONCOPs and Process Flow

Hi All,

Please find attached the final COVID-19 CONOPs and Process Flow for the community-based drive thru testing sites. Please share with regional and state partners. The ASH planning team is establishing regional POCs for questions. More to come on how information will flow.

Artensie

Artensie Flowers, PhD, MPH
CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

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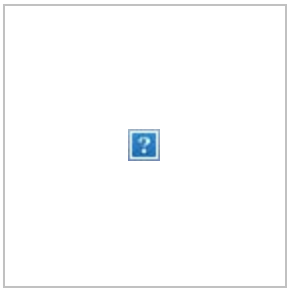

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OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

COVID-19 COMMUNITY-BASED TESTING SITES PROCESS AND STAFFING FLOW

Commissioned Corps Headquarters

March 16, 2020

DELIBERATIVE AND PRE-DECISIONAL COMMUNICATION

1

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COVID-19 COMMUNITY-BASED TESTING SITES

PRE-SCREENING PROCESS AND INSTRUCTIONS:

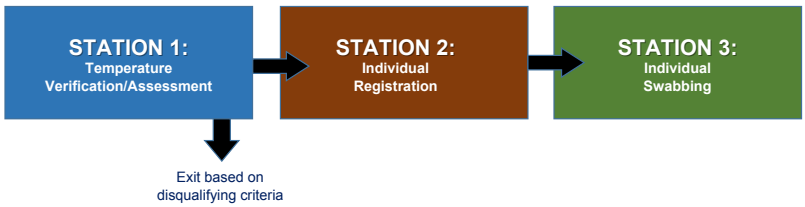
- Individual visits website to determine need for testing at **[URL TBD]**
- Instructed to Bring:
  - Photo ID for all adults needing testing
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare or first responder ID
- Instructed not to take fever-reducing medicine prior to testing (such as Tylenol [acetaminophen] or Advil [ibuprofen]) for at least 6-8hrs prior to arrival

ESTIMATED TESTING SITE CAPACITY:

(per hour):

- 1 Lane Operation (for vehicles with 1 individual):
  12-24 individuals screened
  12 vehicles
- 2 Lane Operation (for vehicles with 2-4 individuals):
  48 individuals screened
  24 vehicles

PROCESS FLOW:



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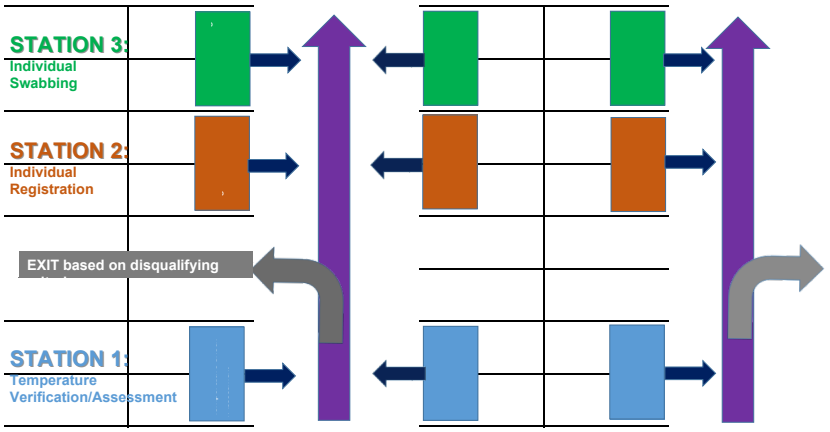
COMMUNITY-BASED TESTING SITES

CBTS FLOW



Security: Greeting and confirm windows can roll down and that persons are seated next to a window

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COMMUNITY-BASED TESTING SITES

STATION 1: Temperature Verification/Assessment

Personnel Roles:

1. **Runners:** Take and document temperature on collection form (form holds patient ID number)
2. **Assessors:** Provide a document to vehicle providing public health information to include:
   - What should you do while you wait for test results?
   - Monitoring symptoms
   - If you test positive for COVID-19, continue to monitor your symptoms and manage appropriately
   - When can you stop isolating at home?

Individuals Must Meet one of these Criteria:

Criteria 1:	65 years of age and older with temperature of 99.6F or greater and respiratory symptoms
Criteria 2:	First responders, Healthcare workers* (regardless of symptoms)

Individuals not meeting criteria are asked to leave the line

If you develop symptoms after leaving the site, visit **[URL TBD]** to check if you qualify for testing

**Healthcare workers = personnel who are currently working in a healthcare facility, including long-term care facilities.*

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EAD: added “Criteria 3: Any person with respiratory symptoms and a temperature over 100.4F”

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COMMUNITY-BASED TESTING SITES

STATION 2: Individual Registration

Personnel Roles:

- **Recorder (1):** Document on written form demographic information for patient(s). Record unique identifier (barcode), site, date and lane number.

First	**Email**	**Form of Identification**
Last	**Address**	**Healthcare or First Responder ID**
Phone	**License Plate**	**Insurance Information**

Note: information collected may change based on testing company requirements

- **Recorder (2):** Registers document in electronic data collection tool capturing demographic information for patients to be tested

Unique Identifier (Barcode), Site, Date and Lane Info

Information flow dependent upon state requirements and processes

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COVID-19 **COMMUNITY-BASED TESTING SITES**

STATION 3: Individual Swabbing

Personnel Roles:

Primary Swabber	Decon Staff	Secondary Swabber	Quality Control Staff	Runner
• Issue individual tissue (clear nasal passage) • Use pen light to check for nasal obstructions. Do not force swab – if an obstruction is encountered, try the other nostril. If both nostrils are obstructed, contact on-site medical provider. • Receive collection tube/swab • Take swab of patient(s) in car • Return swab back into tube • Label tube with patient ID • Insert tube into secondary containment (sample bag) • Receive decon wipe to decon sample bag • Place sample bag onto temporary sample bag staging table • Work with decon staff to doff top layer PPE • Remove PPE: Gloves, Sleeves	• Observe swabbing operation for safety/occupational contamination • Provide decon wipes without touching swabber(s) • Assist the swabber during doffing	• Don PPE (i.e., replace gloves and sleeves) to prepare for next vehicle • Becomes primary swabber for next vehicle	• Collects deconned sample bag to ensure sample ID is on the sample tube • Collects collection form from the runner • Verifies patient ID on tube and form is the same • Places form and sample bag in envelope, signs form as chain of custody, places envelope in shipping container • Confirms temperature in cooler stays within range	• Documents temperature on collection form and relevant demographic data • Stays with vehicle throughout all 3 stations • Returns to station 1 to prepare for next vehicle after donning clean PPE

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EAD: added to QC Staff: “confirms temperature in cooler stays within range” and added under runner, “ after donning clean PPE”

NOTE: identified need for Swabber to have either: a table to put bag/tube on, so they can provide tissue/gauze and also check nares for any obstruction prior to conducting swab or an “assistant swabber” to facilitate the nares review prior to swabbing

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COMMUNITY-BASED TESTING SITES

STATION 3: Individual Swabbing

Swab Processing:

Collection:

1. ***Swabber confirms verbal authorization from passenger***
2. ***Swabber confirms no obstruction in nares of person being swabbed (using pen light)***
3. ***Swabber collects sample***
4. ***Swabber bags collected sample***
    1. ***Offers tissue or gauze to person being swabbed***
    2. ***Conducts swab***
    3. ***Places swab into proper collection tube and breaks swab as needed***
    4. ***Caps sample tube***
    5. ***Places sealed tube in corresponding sample bag***
    6. ***Places tube, form, and sample bag into a second bag***
5. ***QC officer verifies that all UNIs match on sample tube, bag, and paperwork***
6. ***Sample is deposited in the refrigerator and then transferred to the insulated shipping container with cold pack and telatemp [must be packed by trained personnel]***
7. ***Samples are mailed to corresponding lab within 48 hours***
    1. ***Plan is to mail samples twice daily to appropriate lab***

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COMMUNITY-BASED TESTING SITES

STAFFING RECOMMENDATIONS

TESTING STATIONS	STATE CBTS (1-lane operation)	STATE CBTS (2-lane operation)
Assessment	Assessor: 2 Runners: 1	Assessor: 4 Runner: 2
Registration	Registration: 2 Runner: 1	Registration: 4 Runner: 2
Sampling/Decon	Samplers: 4 Runner: 1 Decon: 2	Samplers: 8 Runner: 2 Decon: 4
Admin	Logistics: 2 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1	Logistics: 4 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1
Other Staff	Facilitator: 1	Facilitator: 1 Water/Sanitation: 3
Estimated Personnel	20	38

2-lane operation for vehicles with driver and 1+ passenger(s): 12 (min) – 48 (max) individuals/hour

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**make sure there is a note/slide that includes # position type per hour, because while assessment and/or registration pax can stay for ~4-8hrs, swabber swill need to rotate more often, which ultimately requires more swabbers

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COMMUNITY-BASED TESTING SITES

CBTS OPERATION CONSIDERATIONS

OTHER CONSIDERATIONS FOR LOCAL DECISION:

- Security
- Local Fire/EMS Support
- Traffic Control
- Operator Communications
  - Including training and signage at each tent
- Linguistics / Interpreters
- Public Communication
- Water / Feeding for Operators
- Sanitation / Safety
- Training – Safety Officer
- Training – Quality Control Officer
- Recommendations for change of clothes/laundering of clothes worn during operations
- Access and Functional Capability Requirements
- Daily tracking and reporting mechanism for results

For additional information about Community-Based Testing Sites, please contact your FEMA Regional Administrator.

DELIBERATIVE AND PRE-DECISIONAL COMMUNICATION

EAD: added Local Fire/EMS support and Quality Control officer Training, recommendations for change of clothes/laundering of clothes work during operations

Should we also add:

1. handwashing stations/protocol?
2. How to mix/check bleach/sanitizing solution protocol
3. QC/temp monitoring protocol (including cold-pack storage overnight protocol)

to this slide?

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OFFICE OF THE
ASSISTANT SECRETARY FOR HEALTH

COVID-19 COMMUNITY-BASED TESTING SITES (CBTS) CONCEPT OF OPERATIONS

March 17, 2020

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Pre-Screening Process and Instructions

- CALL or EMAIL a health care provider first. If the provider recommends obtaining a test or seek care, follow the provider's advice **BEFORE** going into any health care facility.
- **DO NOT** go to an emergency room to get a test for COVID-19 unless you are having a medical emergency. For COVID-19, that means severe respiratory symptoms, such as shortness of breath or breathing difficulties.
- DO call 911 or go to an emergency room if you are having a medical emergency. Tell the dispatcher your symptoms and proceed as advised.
- Instruct individuals to visit website, determining need for drive-thru testing at <URL TBD>.
- Instructed to bring to any CBTS:
  - Photo ID for all adults needing testing
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare or first responder ID
- Instructed not to take fever-reducing medicine within 6-8 hours prior to testing [such as Tylenol (acetaminophen) or Advil (ibuprofen)]
- If eligible, patients will be provided a list of available times and testing center(s) for their visit.
- People who come to be tested at the CBTS must bring:
  - Photo Identification (does not need to be government issued).
- If the CBTS personnel determine an individual meets the testing criteria, they will be tested. If the person does **NOT** meet the criteria to be tested, they will **NOT** be tested.

Other Considerations:

- Be prepared for longer wait times. No restrooms may be available.
- For the safety of all personnel, testing sites will only be operational contingent upon safe weather (testing sites may have to close unexpectedly as needed)

Media Presence

Be prepared for media personnel and/or live coverage. Although this may be discouraged by the community sites, it is a possibility. (Collaborate with State Health Department to protect patient privacy and discourage media coverage).

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Language/Translators

Telephone interpretation may be available for speakers of other languages or anyone requesting translation. Phone call-in translation is available. Local health systems have such partnerships and resources and can utilize what is currently used within local healthcare system networks.

Pre-Screening Criteria

1. **Criteria 1**: Anyone ≥65 years of age with on-site confirmed temperature of 99.6^{0}F **and** with respiratory symptoms
2. **Criteria 2:** First responders, Healthcare workers* (regardless of presence of symptoms). *This includes only staff with direct contact with patients (not those in administrative roles) or as determined at the state level.

Definition of First Responder: Any individual responding to the public health task or mission, as determined by the jurisdiction.

Definition of Healthcare Worker: any individual working or providing direct patient care in acute or critical settings (hospitals, clinics, long-term care facilities, emergency medicine).

Regional/State sites can clarify or expand this classification based on needs/demand and adjust accordingly.

Pre-Arrival to Testing Site Instructions

1. Ensure pre-screening completed online (highly recommended)
2. If there are multiple people in one vehicle, each person will be individually registered and be tested if they meet the testing criteria.
3. Passenger Capacity: 3 - Max of 4 individuals per vehicle
    a. Must be sitting at an operating/usable window
    b. additional passengers to be tested will have to start at the front of the line after moving to operational window
4. Every person(s) must remain in the vehicle from time of arrival to departure of testing area
5. Testing will be done via open vehicle window. Ensure windows are operational.

At Arrival to Testing Site Instructions

1. Pull forward slowly, as instructed until arriving to first station.
2. Place car into park.
3. Roll down window.
4. Shut off engine.

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Testing Flow- See Appendix A for 3-Station Personnel Role Details

Station 1 – Temperature verification/Assessment (est. time: 3-5 min)

- Assessors use infrared thermometers to verify individual temperature
  - Preference for laser thermometers to reduce any potential contact
- Assessor should verbalize date to the Runner assigned to each vehicle
  - Follow criteria guidelines to determine if individual should proceed or exit
    - If no temperature based on criteria (below), person should exit
    - If temperature noted according to guidelines below, the person should proceed with drive-thru testing
- Individuals must meet one of these 2 criteria:
  - **Criteria 1**: Anyone ≥65 years of age with on-site confirmed temperature of 99.6^{0}F or greater **and** with respiratory symptoms
  - **Criteria 2:** First responders, Healthcare workers* (regardless of presence of symptoms).
  - Individuals who do NOT meet testing criteria will exit the drive thru via a dedicated exit point
- Assessors provide an information packet to vehicle telling patients public health information to include contact information
- Assessors should disinfect or remove sleeves/outer gloves at decon station in station 1, according to their level of contact
  - No contact = disinfect
  - Contact = remove and replace outer layer of sleeves/gloves
- Runners document temperature on collection form and follow car through the entire site
  - Form holds patient ID number and other demographic information
  - Awaits confirmation from Assessor/Temp Checker that vehicle/individual will proceed to station 2
  - Follows each vehicle through entire process

Station 2 – Individual Registration (est.time: ~5 min per person)

- Recorders complete paper form with demographic information for each patient to be tested (information relayed to Recorders via the Runner for each car):
  - First Name
  - Last Name

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- Phone
- Email
- Address
- Insurance (Carrier, Plan ID, Group ID)
- Recorders enter patient information from form in electronic data collection tool

Station 3 – Swabbing and Decontamination (est. time: 6-8 min)

- **Primary Swabber**
  - Confirm verbal authorization from person being swabbed for swab collection (ask runner)
  - Issue individual tissue (clear nasal passage/cover cough/sneeze post collection)
  - Use pen light to check nares for obstructions
  - Receive collection tube/swab from runner
  - Take swab of individual(s) in car
  - Return swab back into tube
  - Label tube with patient ID
  - Insert tube into secondary containment (sample bag)
  - Receive decon wipe to decon sample bag
  - Place sample bag into temporary sample bag staging table
  - Places form and sample bag in envelope, signs form as chain of custody, places envelope in shipping container
  - Have QC officer verify all labels match, and place sample into sample cooler
    - Samples must stay at temperature between 2 -8 C
    - Samples must be shipped in less than 48 hours from collection
  - Work with decon staff to doff top layer PPE
- Runner should now doff all PPE/decon as appropriate, and then rehab, and get fresh PPE for next car. Please note if runner used clipboard as a writing surface, they would need to sanitize it.
- Remove PPE: Gloves, Sleeves, Decon staff (at least one decon staff at all times)
  - Observe swabbing operation for safety/occupational contamination
  - Provide decon wipes without touching swabber(s)

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    - Assist the swabber during doffing, following listed steps on signage in decon area
- **Secondary Swabber**
    - Don PPE (i.e., replace gloves and sleeves) PPE to prepare for next vehicle
    - Becomes primary swabber for next vehicle
- **Quality Control Staff**
    - Collects deconned sample bag to ensure sample ID is on the sample tube
    - Collects collection form from the runner
    - Verifies patient ID on tube and form is the same
    - Verifies temperature of samples from collection until shipping
        - Samples will be moved to refrigeration until shipping
        - Shipping should be arranged for at least 2x per day

        [add shipping and storage guidelines]
- **Insurance**
    - Billing to be done when request for lab results are submitted; if they do not have insurance that's acceptable
- Call Center (for results):
    - Contracted call center will be calling each individual/custodian with test results.
    - 3 scenarios have been predetermined with scripting to be given to those calling (THIS IS NOT FINALIZED/AVAILBLE)
- Provider Credentialing:
    - Registered Nurse (minimum), Advanced Practice Providers (Nurse Practitioner or Physician Assistant), Pharmacists trained on swabbing procedures, or Physicians. Provider must have a current and valid license as required by state operating in.

- **Laboratory Processing**
    - All labs will be processed using LabCorp or Quest.

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Staffing Recommendations

*consider multi-lane operations to expedite sample collection and minimize wait times in the event of increased surge

- Station 5 – Individual Swabbing

TESTING STATIONS	Fully Federal or private partner (1-lane operation)	Fully Federal or private partner (2-lane operation)
TEMP CHECK	Assessor: 2 Runners: 1	Assessor: 4 Runner: 2
REGISTRATION	Registration: 2 Runner: 1	Registration: 4 Runner: 2
SAMPLING/DECON	Samplers: 4 Runner: 1 Decon: 2	Samplers: 8 Runner: 2 Decon: 4
Admin	Logistics: 2 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1	Logistics: 4 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1 (P
Other Staff	Team Leader(Provider) : 1	Team Leader(provider): 1 Water/Sanitation: 3
Total Count	**20**	**38**

- Please note that security and EMS need to be discussed with the local community

Individual Roles

Role	PPE
Temp checker	N95, Scrubs, Gown, Double Gloves, Faceshield, Apron, Ear Loop Mask, Sleeves
Security	Gloves, Faceshield, N95, Gown
HCP	PAPR, Tyvek, Apron, Double glove, Booties, Shroud, Scrubs, Sleeves

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Runner / Documentation	Goggles, Gown, Double Gloves, Scrubs, N95, Sleeves
Decontamination	Tyvek, Booties, Double Glove, N95, Shroud, Scrubs
Logs	Work Gloves, Surgical Mask, Faceshield
Safety Officer	Faceshield, N95, Gloves, Scrubs, Gown
Admin / Finance	Computer, Faceshield, Gloves, Scrubs
Team Lead	Faceshield, Ear Loop Mask, Gloves, Apron, Scrubs
Data Entry	Computer, Faceshield, Ear Loop Mask, Gloves, Scrubs
Quality Control / Sample Processing	N95, Scrubs, Gown, Gloves, Faceshield, Apron, Ear Loop Mask

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Estimated Community Based Testing Site (CBTS) Capacity

- 1-lane operation:
  - 12-24 (max) individuals screened per hour
- 2-lane operation for vehicles with driver and 1+passenger(s):
  - 48 (max) individuals screened per hour
  - ~24 vehicles per hour at each station
  - 12 hours a day operational period

Recommended Training

All team members:

- Personal Protective Equipment (PPE) Types (per role requirement), Donning and Doffing, PPE usage, PPE decontamination between patients, PPE disposal
- Respiratory Protection / Fit Testing
- Role-specific training (process, communications to team and persons being tested)
- Drive Through Site Operations, Safety, Clean Boundaries, PPE requirements in potentially contaminated areas, Leadership and Chain of Command, Emergency Procedures

Additional Training for Specific Site Roles:

Temp checker (Assessor)	Temperature monitoring equipment training; crowd control, standard greetings (script)
Security	NA
HCP	Scope of Practice, Code Procedures, Data Reporting Plan to Local Health
Runner	NA
Decontamination	Spill cleanup
Logs	Inventory, Resupply ordering procedures
Safety Officer	ICS 215, 208, HASP/HERA for site/region
Admin / Finance / Data entry	Electronic record procedures, site personnel (accountability), end of shift screening data
Team Lead	Public Information / Talking Points
Quality Control / Sample Processing	Sample processing form completion (site specific), chain of custody procedures, sample handling, processing, storage, packaging for transfer

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Site Request / Site Suitability Requests

- Physical Address
- Spacing Recommendations
  - 2-lane drive-through set up: 80 ft x 50 ft (44 personnel)
  - 1-lane drive-through set up: 80 ft x 25 ft (20 personnel)
- Traffic flow pattern / map in and around site
- ICS 206 Medical Plan Completion (to best of ability)
- Points of Contact for Security (local law enforcement), , Local and/or State Health Department, Local Fire/EMS services, Biohazard Waste Services (e.g., Local Health Department)
- Other anticipated requirements (e.g., gaps in supply list, personnel augmentation)

Other Operations Considerations

- Security
- Local Fire/EMS standby
- Communications for site operations
- Linguistics/
- Public Communication
- Water/Sanitation
    - Define hazardous waste and who will collect
- Training – Safety Officer
- Training – Quality Control Officer
- Report mechanism for results
    - Lab reports results to local public health department for contact screening
    - Call center for patients test results (being established)
- Equipment storage
    - Refrigeration of samples/ice packs
    - Tents (if applicable)
    - PPE
    - Other equipment
- Handwashing stations

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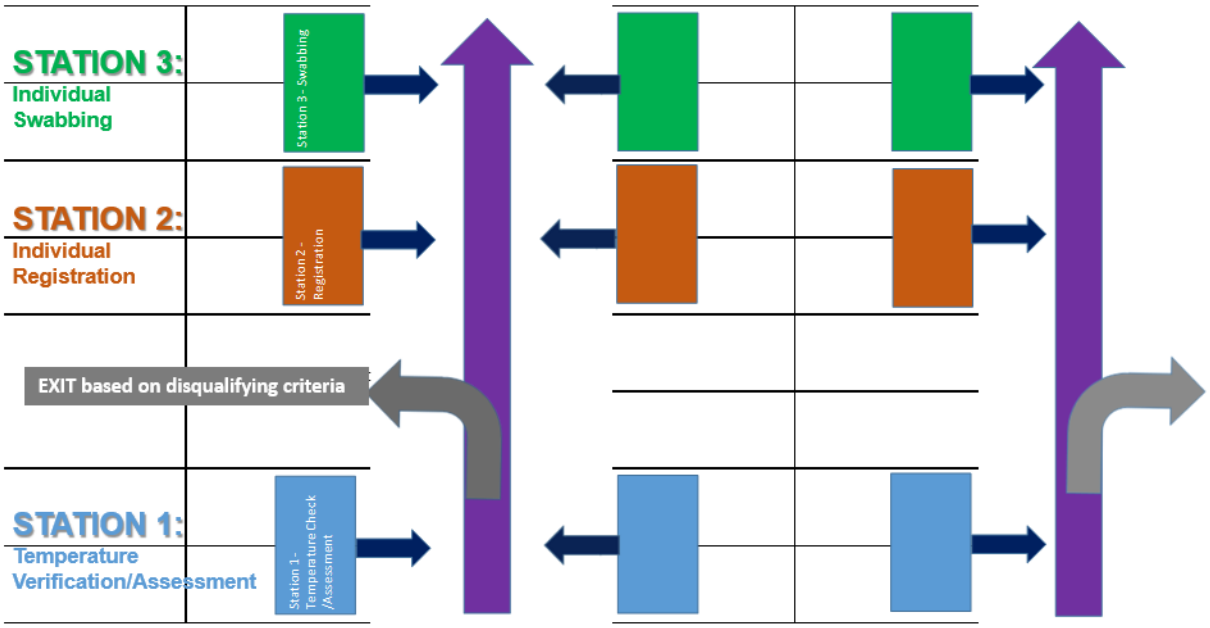
CBTS Staff Participation – Post Operation

- All participants involved in the CBTS will be followed up in accordance with local and state Department of Public Health requirements and ideally, would be consistent with healthcare worker protocols in that designated area.

Appendix A: Community-Based Testing Sites (CBTS) Supply List (see attached "Complete CBTS Supply List 17Mar2020 1130hrs")

Appendix B: Example CBTS Flow Map



Appendix C: CBTS Station 3 Individual Swabbing

Personnel Roles:

Primary Swabber	Decon Staff	Secondary Swabber	Quality Control Staff	Runner
• Issue individual tissue (clear nasal passage) • Use pen light to check for nasal obstructions • Receive collection tube/swab • Take swab of patient(s) in car • Return swab back into tube • Label tube with patient ID • Insert tube into secondary containment (sample bag) • Receive decon wipe to decon sample bag • Place sample bag onto temporary sample	• Observe swabbing operation for safety/occupational contamination • Provide decon wipes without touching swabber(s) • Assist the swabber during doffing	• Don PPE (i.e., replace gloves and sleeves) to prepare for next vehicle • Becomes primary swabber for next vehicle	• Collects deconned sample bag to ensure sample ID is on the sample tube • Collects collection form from the runner • Verifies patient ID on tube and form is the same • Places form and sample bag in bag, seals form as chain of custody, places envelope in shipping container	• Documents temperature on collection form and relevant demographic data • Stays with vehicle throughout all 3 stations • Returns to station 1 to

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FL-DOH-20-0673-A-004040



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Subject:	FW: COVID-19 CONCOPs and Process Flow
Date:	Thursday, March 19, 2020 4:10:11 PM
Attachments:	image001.png 16Mar20 - HHS COVID-19 Process Flow.pptx COVID_CBTS_SOP_03 17 2020.docx

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May be a dupe email

Regards,
Jeanne

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Sent: Tuesday, March 17, 2020 5:55 PM
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Subject: COVID-19 CONCOPs and Process Flow

Hi All,

Please find attached the final COVID-19 CONOPs and Process Flow for the community-based drive thru testing sites. Please share with regional and state partners. The ASH planning team is establishing regional POCs for questions. More to come on how information will flow.

Artensie

Artensie Flowers, PhD, MPH
CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

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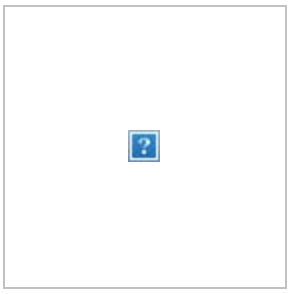

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OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

COVID-19 COMMUNITY-BASED TESTING SITES PROCESS AND STAFFING FLOW

Commissioned Corps Headquarters

March 16, 2020

DELIBERATIVE AND PRE-DECISIONAL COMMUNICATION

1

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COVID-19 COMMUNITY-BASED TESTING SITES

PRE-SCREENING PROCESS AND INSTRUCTIONS:

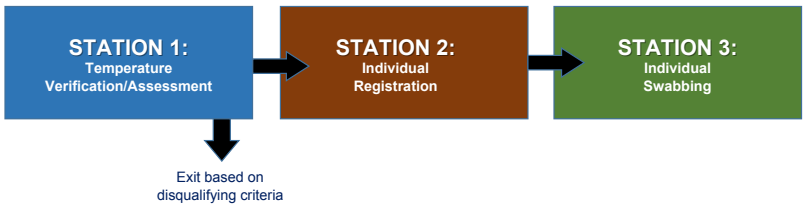
- Individual visits website to determine need for testing at **[URL TBD]**
- Instructed to Bring:
  - Photo ID for all adults needing testing
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare or first responder ID
- Instructed not to take fever-reducing medicine prior to testing (such as Tylenol [acetaminophen] or Advil [ibuprofen]) for at least 6-8hrs prior to arrival

ESTIMATED TESTING SITE CAPACITY:

(per hour):

- 1 Lane Operation (for vehicles with 1 individual):
  12-24 individuals screened
  12 vehicles
- 2 Lane Operation (for vehicles with 2-4 individuals):
  48 individuals screened
  24 vehicles

PROCESS FLOW:



DELIBERATIVE AND PRE-DECISIONAL COMMUNICATION

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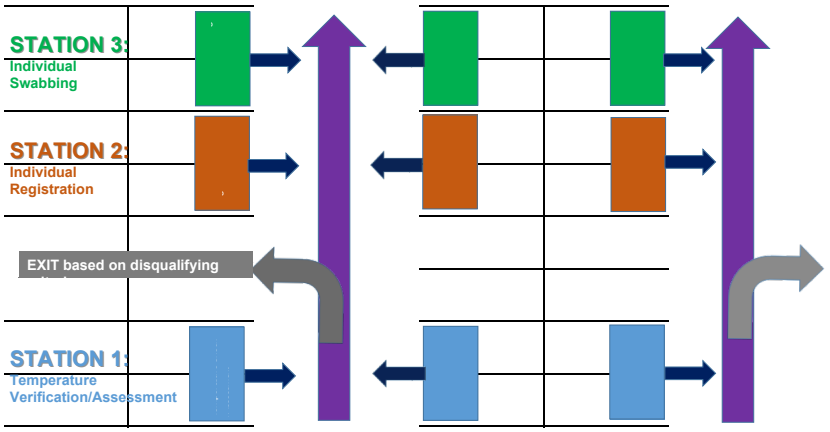
COVID-19

COMMUNITY-BASED TESTING SITES

CBTS FLOW



Security: Greeting and confirm windows can roll down and that persons are seated next to a window

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COMMUNITY-BASED TESTING SITES

STATION 1: Temperature Verification/Assessment

Personnel Roles:

1. **Runners:** Take and document temperature on collection form (form holds patient ID number)
2. **Assessors:** Provide a document to vehicle providing public health information to include:
   - What should you do while you wait for test results?
   - Monitoring symptoms
   - If you test positive for COVID-19, continue to monitor your symptoms and manage appropriately
   - When can you stop isolating at home?

Individuals Must Meet one of these Criteria:

Criteria 1:	65 years of age and older with temperature of 99.6F or greater and respiratory symptoms
Criteria 2:	First responders, Healthcare workers* (regardless of symptoms)

Individuals not meeting criteria are asked to leave the line

If you develop symptoms after leaving the site, visit **[URL TBD]** to check if you qualify for testing

**Healthcare workers = personnel who are currently working in a healthcare facility, including long-term care facilities.*

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EAD: added “Criteria 3: Any person with respiratory symptoms and a temperature over 100.4F”

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COMMUNITY-BASED TESTING SITES

STATION 2: Individual Registration

Personnel Roles:

- **Recorder (1):** Document on written form demographic information for patient(s). Record unique identifier (barcode), site, date and lane number.

First	**Email**	**Form of Identification**
Last	**Address**	**Healthcare or First Responder ID**
Phone	**License Plate**	**Insurance Information**

Note: information collected may change based on testing company requirements

- **Recorder (2):** Registers document in electronic data collection tool capturing demographic information for patients to be tested

Unique Identifier (Barcode), Site, Date and Lane Info

Information flow dependent upon state requirements and processes

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COVID-19 **COMMUNITY-BASED TESTING SITES**

STATION 3: Individual Swabbing

Personnel Roles:

Primary Swabber	Decon Staff	Secondary Swabber	Quality Control Staff	Runner
• Issue individual tissue (clear nasal passage) • Use pen light to check for nasal obstructions. Do not force swab – if an obstruction is encountered, try the other nostril. If both nostrils are obstructed, contact on-site medical provider. • Receive collection tube/swab • Take swab of patient(s) in car • Return swab back into tube • Label tube with patient ID • Insert tube into secondary containment (sample bag) • Receive decon wipe to decon sample bag • Place sample bag onto temporary sample bag staging table • Work with decon staff to doff top layer PPE • Remove PPE: Gloves, Sleeves	• Observe swabbing operation for safety/occupational contamination • Provide decon wipes without touching swabber(s) • Assist the swabber during doffing	• Don PPE (i.e., replace gloves and sleeves) to prepare for next vehicle • Becomes primary swabber for next vehicle	• Collects deconned sample bag to ensure sample ID is on the sample tube • Collects collection form from the runner • Verifies patient ID on tube and form is the same • Places form and sample bag in envelope, signs form as chain of custody, places envelope in shipping container • Confirms temperature in cooler stays within range	• Documents temperature on collection form and relevant demographic data • Stays with vehicle throughout all 3 stations • Returns to station 1 to prepare for next vehicle after donning clean PPE

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EAD: added to QC Staff: “confirms temperature in cooler stays within range” and added under runner, “ after donning clean PPE”

NOTE: identified need for Swabber to have either: a table to put bag/tube on, so they can provide tissue/gauze and also check nares for any obstruction prior to conducting swab or an “assistant swabber” to facilitate the nares review prior to swabbing

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COMMUNITY-BASED TESTING SITES

STATION 3: Individual Swabbing

Swab Processing:

Collection:

1. ***Swabber confirms verbal authorization from passenger***
2. ***Swabber confirms no obstruction in nares of person being swabbed (using pen light)***
3. ***Swabber collects sample***
4. ***Swabber bags collected sample***
    1. ***Offers tissue or gauze to person being swabbed***
    2. ***Conducts swab***
    3. ***Places swab into proper collection tube and breaks swab as needed***
    4. ***Caps sample tube***
    5. ***Places sealed tube in corresponding sample bag***
    6. ***Places tube, form, and sample bag into a second bag***
5. ***QC officer verifies that all UNIs match on sample tube, bag, and paperwork***
6. ***Sample is deposited in the refrigerator and then transferred to the insulated shipping container with cold pack and telatemp [must be packed by trained personnel]***
7. ***Samples are mailed to corresponding lab within 48 hours***
    1. ***Plan is to mail samples twice daily to appropriate lab***

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COMMUNITY-BASED TESTING SITES

STAFFING RECOMMENDATIONS

TESTING STATIONS	STATE CBTS (1-lane operation)	STATE CBTS (2-lane operation)
Assessment	Assessor: 2 Runners: 1	Assessor: 4 Runner: 2
Registration	Registration: 2 Runner: 1	Registration: 4 Runner: 2
Sampling/Decon	Samplers: 4 Runner: 1 Decon: 2	Samplers: 8 Runner: 2 Decon: 4
Admin	Logistics: 2 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1	Logistics: 4 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1
Other Staff	Facilitator: 1	Facilitator: 1 Water/Sanitation: 3
Estimated Personnel	20	38

2-lane operation for vehicles with driver and 1+ passenger(s): 12 (min) – 48 (max) individuals/hour

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**make sure there is a note/slide that includes # position type per hour, because while assessment and/or registration pax can stay for ~4-8hrs, swabber swill need to rotate more often, which ultimately requires more swabbers

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COMMUNITY-BASED TESTING SITES

CBTS OPERATION CONSIDERATIONS

OTHER CONSIDERATIONS FOR LOCAL DECISION:

- Security
- Local Fire/EMS Support
- Traffic Control
- Operator Communications
  - Including training and signage at each tent
- Linguistics / Interpreters
- Public Communication
- Water / Feeding for Operators
- Sanitation / Safety
- Training – Safety Officer
- Training – Quality Control Officer
- Recommendations for change of clothes/laundering of clothes worn during operations
- Access and Functional Capability Requirements
- Daily tracking and reporting mechanism for results

For additional information about Community-Based Testing Sites, please contact your FEMA Regional Administrator.

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EAD: added Local Fire/EMS support and Quality Control officer Training, recommendations for change of clothes/laundering of clothes work during operations

Should we also add:

1. handwashing stations/protocol?
2. How to mix/check bleach/sanitizing solution protocol
3. QC/temp monitoring protocol (including cold-pack storage overnight protocol)

to this slide?

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OFFICE OF THE
ASSISTANT SECRETARY FOR HEALTH

COVID-19 COMMUNITY-BASED TESTING SITES (CBTS) CONCEPT OF OPERATIONS

March 17, 2020

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Appendix A: Community-Based Testing Sites (CBTS) Supply List (see attached "Complete CBTS Supply List 17Mar2020 1130hrs") 11

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Pre-Screening Process and Instructions

- CALL or EMAIL a health care provider first. If the provider recommends obtaining a test or seek care, follow the provider's advice **BEFORE** going into any health care facility.
- **DO NOT** go to an emergency room to get a test for COVID-19 unless you are having a medical emergency. For COVID-19, that means severe respiratory symptoms, such as shortness of breath or breathing difficulties.
- DO call 911 or go to an emergency room if you are having a medical emergency. Tell the dispatcher your symptoms and proceed as advised.
- Instruct individuals to visit website, determining need for drive-thru testing at <URL TBD>.
- Instructed to bring to any CBTS:
  - Photo ID for all adults needing testing
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare or first responder ID
- Instructed not to take fever-reducing medicine within 6-8 hours prior to testing [such as Tylenol (acetaminophen) or Advil (ibuprofen)]
- If eligible, patients will be provided a list of available times and testing center(s) for their visit.
- People who come to be tested at the CBTS must bring:
  - Photo Identification (does not need to be government issued).
- If the CBTS personnel determine an individual meets the testing criteria, they will be tested. If the person does **NOT** meet the criteria to be tested, they will **NOT** be tested.

Other Considerations:

- Be prepared for longer wait times. No restrooms may be available.
- For the safety of all personnel, testing sites will only be operational contingent upon safe weather (testing sites may have to close unexpectedly as needed)

Media Presence

Be prepared for media personnel and/or live coverage. Although this may be discouraged by the community sites, it is a possibility. (Collaborate with State Health Department to protect patient privacy and discourage media coverage).

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Language/Translators

Telephone interpretation may be available for speakers of other languages or anyone requesting translation. Phone call-in translation is available. Local health systems have such partnerships and resources and can utilize what is currently used within local healthcare system networks.

Pre-Screening Criteria

1. **Criteria 1**: Anyone ≥65 years of age with on-site confirmed temperature of 99.6^{0}F **and** with respiratory symptoms
2. **Criteria 2:** First responders, Healthcare workers* (regardless of presence of symptoms). *This includes only staff with direct contact with patients (not those in administrative roles) or as determined at the state level.

Definition of First Responder: Any individual responding to the public health task or mission, as determined by the jurisdiction.

Definition of Healthcare Worker: any individual working or providing direct patient care in acute or critical settings (hospitals, clinics, long-term care facilities, emergency medicine).

Regional/State sites can clarify or expand this classification based on needs/demand and adjust accordingly.

Pre-Arrival to Testing Site Instructions

1. Ensure pre-screening completed online (highly recommended)
2. If there are multiple people in one vehicle, each person will be individually registered and be tested if they meet the testing criteria.
3. Passenger Capacity: 3 - Max of 4 individuals per vehicle
    a. Must be sitting at an operating/usable window
    b. additional passengers to be tested will have to start at the front of the line after moving to operational window
4. Every person(s) must remain in the vehicle from time of arrival to departure of testing area
5. Testing will be done via open vehicle window. Ensure windows are operational.

At Arrival to Testing Site Instructions

1. Pull forward slowly, as instructed until arriving to first station.
2. Place car into park.
3. Roll down window.
4. Shut off engine.

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Testing Flow- See Appendix A for 3-Station Personnel Role Details

Station 1 – Temperature verification/Assessment (est. time: 3-5 min)

- Assessors use infrared thermometers to verify individual temperature
  - Preference for laser thermometers to reduce any potential contact
- Assessor should verbalize date to the Runner assigned to each vehicle
  - Follow criteria guidelines to determine if individual should proceed or exit
    - If no temperature based on criteria (below), person should exit
    - If temperature noted according to guidelines below, the person should proceed with drive-thru testing
- Individuals must meet one of these 2 criteria:
  - **Criteria 1**: Anyone ≥65 years of age with on-site confirmed temperature of 99.6^{0}F or greater **and** with respiratory symptoms
  - **Criteria 2:** First responders, Healthcare workers* (regardless of presence of symptoms).
  - Individuals who do NOT meet testing criteria will exit the drive thru via a dedicated exit point
- Assessors provide an information packet to vehicle telling patients public health information to include contact information
- Assessors should disinfect or remove sleeves/outer gloves at decon station in station 1, according to their level of contact
  - No contact = disinfect
  - Contact = remove and replace outer layer of sleeves/gloves
- Runners document temperature on collection form and follow car through the entire site
  - Form holds patient ID number and other demographic information
  - Awaits confirmation from Assessor/Temp Checker that vehicle/individual will proceed to station 2
  - Follows each vehicle through entire process

Station 2 – Individual Registration (est.time: ~5 min per person)

- Recorders complete paper form with demographic information for each patient to be tested (information relayed to Recorders via the Runner for each car):
  - First Name
  - Last Name

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- Phone
- Email
- Address
- Insurance (Carrier, Plan ID, Group ID)
- Recorders enter patient information from form in electronic data collection tool

Station 3 – Swabbing and Decontamination (est. time: 6-8 min)

- **Primary Swabber**
  - Confirm verbal authorization from person being swabbed for swab collection (ask runner)
  - Issue individual tissue (clear nasal passage/cover cough/sneeze post collection)
  - Use pen light to check nares for obstructions
  - Receive collection tube/swab from runner
  - Take swab of individual(s) in car
  - Return swab back into tube
  - Label tube with patient ID
  - Insert tube into secondary containment (sample bag)
  - Receive decon wipe to decon sample bag
  - Place sample bag into temporary sample bag staging table
  - Places form and sample bag in envelope, signs form as chain of custody, places envelope in shipping container
  - Have QC officer verify all labels match, and place sample into sample cooler
    - Samples must stay at temperature between 2 -8 C
    - Samples must be shipped in less than 48 hours from collection
  - Work with decon staff to doff top layer PPE
- Runner should now doff all PPE/decon as appropriate, and then rehab, and get fresh PPE for next car. Please note if runner used clipboard as a writing surface, they would need to sanitize it.
- Remove PPE: Gloves, Sleeves, Decon staff (at least one decon staff at all times)
  - Observe swabbing operation for safety/occupational contamination
  - Provide decon wipes without touching swabber(s)

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    - Assist the swabber during doffing, following listed steps on signage in decon area
- **Secondary Swabber**
    - Don PPE (i.e., replace gloves and sleeves) PPE to prepare for next vehicle
    - Becomes primary swabber for next vehicle
- **Quality Control Staff**
    - Collects deconned sample bag to ensure sample ID is on the sample tube
    - Collects collection form from the runner
    - Verifies patient ID on tube and form is the same
    - Verifies temperature of samples from collection until shipping
        - Samples will be moved to refrigeration until shipping
        - Shipping should be arranged for at least 2x per day

        [add shipping and storage guidelines]
- **Insurance**
    - Billing to be done when request for lab results are submitted; if they do not have insurance that's acceptable
- Call Center (for results):
    - Contracted call center will be calling each individual/custodian with test results.
    - 3 scenarios have been predetermined with scripting to be given to those calling (THIS IS NOT FINALIZED/AVAILBLE)
- Provider Credentialing:
    - Registered Nurse (minimum), Advanced Practice Providers (Nurse Practitioner or Physician Assistant), Pharmacists trained on swabbing procedures, or Physicians. Provider must have a current and valid license as required by state operating in.

- **Laboratory Processing**
    - All labs will be processed using LabCorp or Quest.

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Staffing Recommendations

*consider multi-lane operations to expedite sample collection and minimize wait times in the event of increased surge

- Station 5 – Individual Swabbing

TESTING STATIONS	Fully Federal or private partner (1-lane operation)	Fully Federal or private partner (2-lane operation)
TEMP CHECK	Assessor: 2 Runners: 1	Assessor: 4 Runner: 2
REGISTRATION	Registration: 2 Runner: 1	Registration: 4 Runner: 2
SAMPLING/DECON	Samplers: 4 Runner: 1 Decon: 2	Samplers: 8 Runner: 2 Decon: 4
Admin	Logistics: 2 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1	Logistics: 4 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1 (P
Other Staff	Team Leader(Provider) : 1	Team Leader(provider): 1 Water/Sanitation: 3
Total Count	**20**	**38**

- Please note that security and EMS need to be discussed with the local community

Individual Roles

Role	PPE
Temp checker	N95, Scrubs, Gown, Double Gloves, Faceshield, Apron, Ear Loop Mask, Sleeves
Security	Gloves, Faceshield, N95, Gown
HCP	PAPR, Tyvek, Apron, Double glove, Booties, Shroud, Scrubs, Sleeves

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Runner / Documentation	Goggles, Gown, Double Gloves, Scrubs, N95, Sleeves
Decontamination	Tyvek, Booties, Double Glove, N95, Shroud, Scrubs
Logs	Work Gloves, Surgical Mask, Faceshield
Safety Officer	Faceshield, N95, Gloves, Scrubs, Gown
Admin / Finance	Computer, Faceshield, Gloves, Scrubs
Team Lead	Faceshield, Ear Loop Mask, Gloves, Apron, Scrubs
Data Entry	Computer, Faceshield, Ear Loop Mask, Gloves, Scrubs
Quality Control / Sample Processing	N95, Scrubs, Gown, Gloves, Faceshield, Apron, Ear Loop Mask

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Estimated Community Based Testing Site (CBTS) Capacity

- 1-lane operation:
  - 12-24 (max) individuals screened per hour
- 2-lane operation for vehicles with driver and 1+passenger(s):
  - 48 (max) individuals screened per hour
  - ~24 vehicles per hour at each station
  - 12 hours a day operational period

Recommended Training

All team members:

- Personal Protective Equipment (PPE) Types (per role requirement), Donning and Doffing, PPE usage, PPE decontamination between patients, PPE disposal
- Respiratory Protection / Fit Testing
- Role-specific training (process, communications to team and persons being tested)
- Drive Through Site Operations, Safety, Clean Boundaries, PPE requirements in potentially contaminated areas, Leadership and Chain of Command, Emergency Procedures

Additional Training for Specific Site Roles:

Temp checker (Assessor)	Temperature monitoring equipment training; crowd control, standard greetings (script)
Security	NA
HCP	Scope of Practice, Code Procedures, Data Reporting Plan to Local Health
Runner	NA
Decontamination	Spill cleanup
Logs	Inventory, Resupply ordering procedures
Safety Officer	ICS 215, 208, HASP/HERA for site/region
Admin / Finance / Data entry	Electronic record procedures, site personnel (accountability), end of shift screening data
Team Lead	Public Information / Talking Points
Quality Control / Sample Processing	Sample processing form completion (site specific), chain of custody procedures, sample handling, processing, storage, packaging for transfer

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Site Request / Site Suitability Requests

- Physical Address
- Spacing Recommendations
  - 2-lane drive-through set up: 80 ft x 50 ft (44 personnel)
  - 1-lane drive-through set up: 80 ft x 25 ft (20 personnel)
- Traffic flow pattern / map in and around site
- ICS 206 Medical Plan Completion (to best of ability)
- Points of Contact for Security (local law enforcement), , Local and/or State Health Department, Local Fire/EMS services, Biohazard Waste Services (e.g., Local Health Department)
- Other anticipated requirements (e.g., gaps in supply list, personnel augmentation)

Other Operations Considerations

- Security
- Local Fire/EMS standby
- Communications for site operations
- Linguistics/
- Public Communication
- Water/Sanitation
    - Define hazardous waste and who will collect
- Training – Safety Officer
- Training – Quality Control Officer
- Report mechanism for results
    - Lab reports results to local public health department for contact screening
    - Call center for patients test results (being established)
- Equipment storage
    - Refrigeration of samples/ice packs
    - Tents (if applicable)
    - PPE
    - Other equipment
- Handwashing stations

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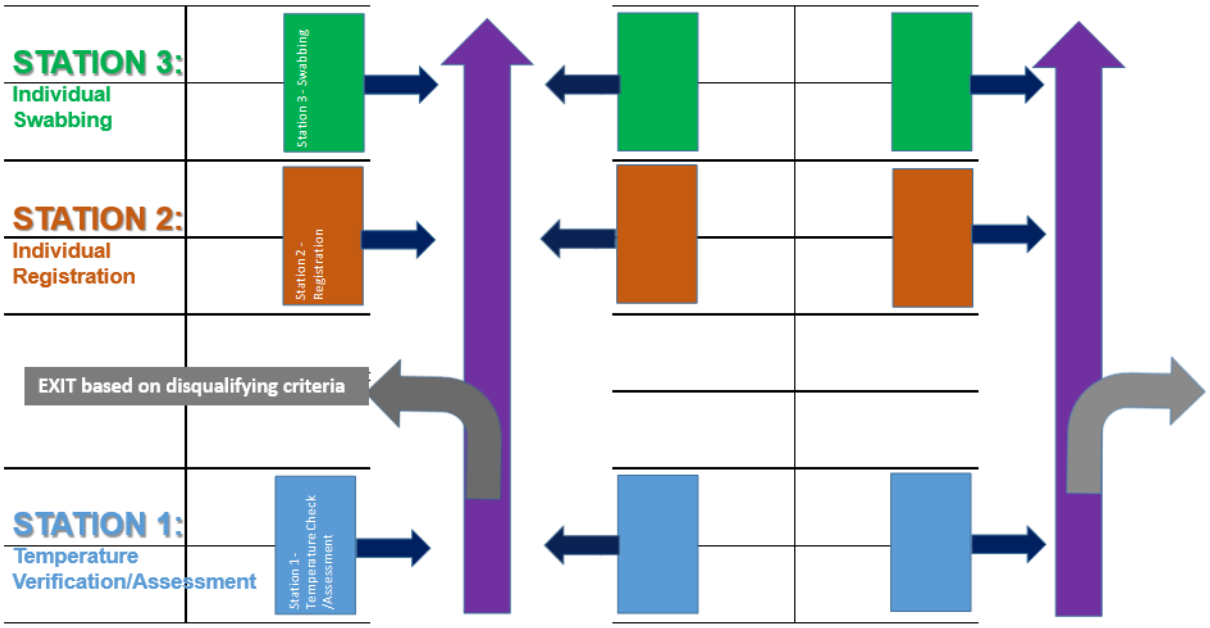
CBTS Staff Participation – Post Operation

- All participants involved in the CBTS will be followed up in accordance with local and state Department of Public Health requirements and ideally, would be consistent with healthcare worker protocols in that designated area.

Appendix A: Community-Based Testing Sites (CBTS) Supply List (see attached "Complete CBTS Supply List 17Mar2020 1130hrs")

Appendix B: Example CBTS Flow Map



Appendix C: CBTS Station 3 Individual Swabbing

Personnel Roles:

Primary Swabber	Decon Staff	Secondary Swabber	Quality Control Staff	Runner
• Issue individual tissue (clear nasal passage) • Use pen light to check for nasal obstructions • Receive collection tube/swab • Take swab of patient(s) in car • Return swab back into tube • Label tube with patient ID • Insert tube into secondary containment (sample bag) • Receive decon wipe to decon sample bag • Place sample bag onto temporary sample	• Observe swabbing operation for safety/occupational contamination • Provide decon wipes without touching swabber(s) • Assist the swabber during doffing	• Don PPE (i.e., replace gloves and sleeves) to prepare for next vehicle • Becomes primary swabber for next vehicle	• Collects deconned sample bag to ensure sample ID is on the sample tube • Collects collection form from the runner • Verifies patient ID on tube and form is the same • Places form and sample bag in bag and seals form as chain of custody, places envelope in shipping container	• Documents temperature on collection form and relevant demographic data • Stays with vehicle throughout all 3 stations • Returns to station 1 to

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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: FW: COVID-19 information and updated guidances
Date: Friday, March 6, 2020 5:52:26 PM

From our partners in Georgia. Thank you Georgia.
Forgive any duplication.

Colleagues,
Here are some information links that may be helpful and have been recently updated. We heard that an updated Health Alert Network notice is being prepared, so we will send that along as soon as it is available.

CDC Guidance for People at Higher Risk for COVID-19 Complications
https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html

CDC Healthcare Supply of Personal Protective Equipment
https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html
CDC PPE Poster
https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19-PPE.pdf

CDC Guidance for Travelers from Countries with Widespread Sustained (ongoing) Transmission Arriving in the United States
https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

CDC Communication Resources
https://www.cdc.gov/coronavirus/2019-ncov/communication/index.html

NETEC coronavirus page includes PPE validation checklists and video resource, in addition to many other great resources.
https://protect2.fireeye.com/url?k=6bb14ce2-37e445f1-6bb17ddd-0cc47adb5650-2ae2ceb528ee1b58&u=https://repository.netecweb.org/exhibits/show/ncov/ncov

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
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United States Department of Health & Human Services (HHS)
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From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Eckes, Jeanne (OS/ASPR/EMMO)
Subject: FW: COVID-19 Stakeholder Call to Acton
Date: Monday, March 2, 2020 5:57:18 PM
Attachments: COVID-19 Healthcare Planning Checklist.pdf
Importance: High

Sorry for the dupe and short notice

From: BHPP Medical Directors and Coordinators <BHPPGRANTEES@LIST.NIH.GOV> **On Behalf Of** Hannah, Jennifer (OS/ASPR/EMMO)
Sent: Monday, March 2, 2020 5:19 PM
To: BHPPGRANTEES@LIST.NIH.GOV
Subject: COVID-19 Stakeholder Call to Acton
Importance: High

Office of the Assistant Secretary for Preparedness and Response hosts COVID-19 stakeholder call

The United States is currently responding to an outbreak of respiratory disease caused by a novel (new) coronavirus. Our public health and medical response is aggressive and multi-layered, with the goal of detecting introductions of this virus in the United States, understanding virus transmission, and reducing potential spread and impact.

We know that planning for an emerging infectious disease outbreak, like COVID-19, is critical to protecting the health and welfare of our nation. As such, we invite you to join a call with representatives from the U.S. Department of Health and Human Services to discuss emerging developments in the COVID-19 response and to learn about activities your jurisdictions can do now to prepare for, respond to, and be resilient in the face of COVID-19.

Invited participants include Health Care Coalitions; National Hospital Preparedness Program participants; and nongovernmental associations serving the needs of long term care facilities and vulnerable populations.

What: COVID-19 Stakeholder Call to Action
When: Monday, March 2, 2020 (6:00-7:00 pm ET)
Dial-in Number: 1-800-369-1924
Passcode: 8652907

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COVID-19 Healthcare Planning Checklist

Hover over form fields for instructions.

Planning for a potential emerging infectious disease pandemic, like COVID-19, is critical to protecting the health and welfare of our nation. To assist state, local, tribal, and territorial partners in their planning efforts, the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response has developed the following checklist. It identifies specific activities your jurisdiction can do now to prepare for, respond to, and be resilient in the face of COVID-19. Many of the activities in this checklist are specific for COVID-19, however many, pertain to any public health emergency.

This checklist is adapted from a variety of HHS Pandemic Influenza Pandemic Planning resources. It is not intended to set forth mandatory requirements by the Federal government. Each jurisdiction should determine for itself whether it is adequately prepared for disease outbreaks in accordance with its own laws and authorities. We strongly encourage continued review of HHS' Centers for Disease Control (CDC) COVID-19 guidance which is available on their website for the most current information.

1. **Safety / Infection Control Activities**

Completed	In Progress	Not Started	Activities
○	○	○	1.1 Develop a pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.2 Develop an agency/facility pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.3 Provide staff education about COVID-19 infection control and update polices as required.
○	○	○	1.4 Support N95 respirator fit-testing for all agency/facility employees and just-in-time education on recommended infection control precautions including fit checking, applying simple mask to patients with cough, and hand hygiene.
○	○	○	1.5 Monitor availability of N95 respirators/powered air purifying respirators (PAPRs) and other supplies including alcohol-based hand disinfectants, gloves, etc., and watch and alert coalition members to supply shortages. Make recommendations on possible alternatives.
○	○	○	1.6 Prepare guidelines for conservative and re-use of N95 respirators/PAPRs if severe shortages are imminent (ideally regionally and in conjunction with local public health, occupational safety, and infection prevention providers and agencies - for example, consider use by only the highest-risk staff, re-use in selected situations, continued use while working on cohorted units, etc.).
○	○	○	1.7 Plan contingencies if appropriate levels of respiratory protection are unavailable.
○	○	○	1.8 Develop guidance for staff monitoring for signs of illness (including self-reporting, self-quarantine, and start/end of shift evaluation) and create a mechanism for reporting both illness and absenteeism.
○	○	○	1.9 Develop a return to work post illness policy for health care workers. This should be as consistent as possible across the coalition.
○	○	○	1.10 Encourage HCFs to plan for staff access to medical care for themselves and their families; determine whether illness will be handled as workers' compensation or personal insurance depending on situation/criteria and share best practices.
○	○	○	1.11 Determine contingency plan for at-risk staff (e.g., pregnant, other defined risk groups) including job expectations and potential alternate roles and locations.
○	○	○	1.12 Evaluate the need for family support to enable staff to work (e.g., childcare, pet care). Provide information for family care plans.

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2. **EMS Activities**

Completed	In Progress	Not Started	Activities
○	○	○	2.1 Determine coordination mechanisms, scope, and likely authorities between coalition EMS agencies including information sharing, resource monitoring/assistance, and policy coordination. Work with local intelligence fusion centers to assist with information sharing and coordination.
○	○	○	2.2 Determine actions that the state EMS agency is likely to take including: • Suspension or modification of operational requirements for EMS agencies • Specific emergency orders or actions that may limit liability and/or expand scope of operations
○	○	○	2.3 Determine local ordinances or laws that may affect EMS disaster operations and the authorities or ability to suspend or modify if needed to support non-traditional operations.
○	○	○	2.4 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., EEI such as number of transports, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	2.5 Evaluate indicators that have effects on EMS and coordinate access through the health care coalition (e.g., status of emergency departments, alternate care sites, epidemiologic information/ forecasting, weather (e.g., snowstorms), availability of staff, availability of supplies).
○	○	○	2.6 Determine vulnerable supplies and coordinate with vendors and the health care coalition to develop contingency plans/allocation plans.
○	○	○	2.7 Develop public messages that emphasize using 911 only for life-threatening emergencies and coordinate with the joint information system.
○	○	○	2.8 Develop information sharing process both for internal staff and between EMS agencies.
○	○	○	2.9 Develop just-in-time education for EMS personnel relative to infection prevention and control, self-care, transmission and family protection, and normal stress responses.
○	○	○	2.10 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	2.11 Determine virtual coordination mechanisms that will enable remote engagement of senior staff to prevent exposures and maximize ability to engage in both daily and incident operations.
○	○	○	2.12 Determine how agency/regional EMS incident action plans will be managed.
○	○	○	2.13 Prepare to initiate auto-answer/recorded answering of 911 calls including diversion of information or non-emergency calls to another call center (e.g., public health hotline). Consider activating a community hotline if such a call center does not exist.
○	○	○	2.14 Evaluate protocols for conducting call screening to recognize COVID-19 -like symptoms (e.g., cough and fever) and advise the responding EMS personnel of a potentially infectious patient.

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2. EMS Activities (cont'd)

Completed	In Progress	Not Started	Dispatch Activities
○	○	○	2.15 Adjust response configurations to allow flexibility including: • Prioritization of calls for service (for services that do not currently use priority dispatch systems) including basic algorithms for non-medically trained dispatchers or referring calls to recorded information, nurse triage hotlines, public health information lines, or other technology-based systems • Recommending self-transport or referral to primary care if appropriate (may need to triage calls to medical provider to evaluate if this capability is available) • Assignment of less than usual resources (e.g., assign law enforcement only on injury accidents unless and until clear information that non-ambulatory/critical injuries a represent) • Assignment of non-traditional resources (e.g., using `jump' cars, community paramedicine, and other responses) • Diversion to an alternate care site • Increasing interpretive service assistance

Completed	In Progress	Not Started	Response Activities
○	○	○	2.16 Develop triggers for implementing closest hospital transport - ideally done regionally.
○	○	○	2.17 Develop triggers for implementing `batch' transports (e.g., answering another call immediately if your current patient is stable) - ideally regionally.
○	○	○	2.18 Determine indicators and triggers for changing staff shifts and crew configuration - ideally this should be implemented consistently in the region.
○	○	○	2.19 Provide criteria for patient assessment and emphasis on cough/respiratory and hand hygiene as well as strict adherence to appropriate infection control precautions per Centers for Disease Control and Prevention (CDC) guidance.
○	○	○	2.20 Develop criteria for on-scene denial of transport by EMS personnel for COVID-19 -like illness and other patients - with or without on-line medical control - ideally regional rather than agency-based criteria and process.
○	○	○	2.21 Develop/provide patient information sheets on homecare for COVID-19 -like illness including usual clinical symptoms and course, infection prevention, treatment, and when to seek additional medical care.
○	○	○	2.22 Develop/provide patient information sheets for other conditions that may be left without transport if the service volume suggests a relevant need (e.g., minor injuries).
○	○	○	2.23 Determine alternate transport resources and triggers to utilize them, e.g., private ambulance, wheelchair, contract/courier, for hire vehicles, military assets, buses.
○	○	○	2.24 Evaluate available staff vs. available transport units to determine ability to meet other non-transport missions (e.g., community paramedicine, EMS personnel staffing alternate care locations or providing hospital support).
○	○	○	2.25 Determine necessary changes to record-keeping including use of templates.

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3. **Hospitals and Health Care Activities**

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.1 Determine coordination mechanisms, scope, and likely authorities between coalition hospitals and health care systems including information sharing, resource monitoring/assistance, and policy coordination. This should include the role of the coalition to engage with vendors of PPE, pharmaceuticals, and other medical supplies that may be in shortage. Conduct a coordination conference call with healthcare facilities to ensure awareness and consistency.
○	○	○	3.2 Determine mechanism to engage outpatient settings (homecare, ambulatory care) in information sharing and policy/response coordination.
○	○	○	3.3 Determine mechanisms to engage skilled nursing facilities in information sharing and policy/ response coordination.
○	○	○	3.4 Determine actions that the state of emergency management or public health agency is likely to take that affect health care including: • Suspension or modification of requirements for hospitals or clinics • Specific emergency orders or actions that may limit liability or expand scope of operations (for facilities and providers, including volunteers) • Requests for 1135 waivers from the Centers for Medicare & Medicaid Services (CMS) • Crisis standards of care activation • Issuance of clinical guidelines for care and resource allocation • 'Taking powers' of the state relative to medical materials and staff (i.e., does the state have ability to commandeer resources under their emergency powers and does this include medical materials?) • Promulgation or enforcement of legal obligations of medical staff to provide care
○	○	○	3.5 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., number ED visits available beds, available ventilators, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	3.6 Evaluate indicators that have effects on hospitals and coordinate access through the health care coalitions (e.g., status of EMS agencies, alternate care sites, epidemiologic information/ forecasting, availability of supplies).
○	○	○	3.7 Determine a process for expedited credentialing of supplemental staff and for the orientation/ mentoring of supplemental or shared staff.
○	○	○	3.8 Determine threshold for use and priority list for supplemental staff (e.g., first shared health care system staff, then similarity credentialed and licensed staff, then Medical Reserve Corps, etc.)
○	○	○	3.9 Determine indicators and potential triggers for implementation of alternate care systems in conjunction with public health.
○	○	○	3.10 Develop public messages that emphasize using emergency departments only for life-threatening emergencies and coordinate with the joint information system. Be prepared to manage the expectations of the public relative to scarce resources (what is the shortage, what is being done, who are the priority groups, etc.).
○	○	○	3.11 Determine common visitor policies for coalition hospitals.
○	○	○	3.12 Develop just-in-time education for health care personnel relative to COVID-19 transmission, clinical course, at-risk populations, complications, treatment prevention and control, self-care, transmission and family protection, and normal stress responses.

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Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.13 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	3.14 Determine how facility/regional hospital incident action plans will be managed.
○	○	○	3.15 Determine how awareness of retail pharmacy stocks will be maintained and shared with ambulatory/emergency care workers.
○	○	○	3.16 Determine behavioral health support plan that includes use of individual HCF staff as well as local, regional, state and federal assistance for meeting patients and staff needs (including those in a leadership role.)
○	○	○	3.17 Determine direction for tracking response cost and lost revenue implications associated with response.

Completed	In Progress	Not Started	Health Care Facility Activities
○	○	○	3.18 Determine incident management activation/configuration based on impact (phased approach) as well as incident action plan cycle and development process.
○	○	○	3.19 Identify SMEs to inform operational decisions and potential resource allocation decisions.
○	○	○	3.20 Determine methods for patient/family information provision including alternate languages/ interpretive services.
○	○	○	3.21 Determine staff communication mechanisms and redundant information management process.
○	○	○	3.22 Determine indicators and potential triggers for changing services provided (e.g., limit elective services).
○	○	○	3.23 Determine strategies to maintain services for at-risk patients during outbreak period (e.g., pregnant, dialysis) but unrelated to COVID-19.
○	○	○	3.24 Determine likely resource shortages and identify relevant vendor, cache, and coalition options for managing shortages.
○	○	○	3.25 Develop service restriction plans in case of staff shortages or increased demand (e.g., respiratory care, nutritional support, pharmacy, laboratory, radiology, elective surgeries/ procedures).
○	○	○	3.26 Develop/update crisis standard of care language in emergency operations plan including the potential for triage decision-making (who, process, communication, considerations) and staff management (how will staff expertise be maximally utilized vs. add additional training for some staff.
○	○	○	3.27 Evaluate the plan for providing just-in-time staff education via electronic and other non-classroom means including information about the COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, risk factors, and complications.
○	○	○	3.28 Establish connection with homecare and long-term care partners to facilitate rapid discharge process from the hospital.

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Completed	In Progress	Not Started	
○	○	○	3.29 Develop indicators and possible triggers for implementing alternate systems of care (including phone and web-based assessments as well as in-person care) including establishing health care system-based alternate care sites (e.g., on-site or managed completely by health care entity at owned and re-purposed site).
○	○	○	3.30 Develop indicators and possible triggers for establishing community alternate care sites in conjunction with public health and emergency management including what support may be required from the health care system.
○	○	○	3.31 Develop demand staffing plans for all categories of staff. Modify staff responsibilities and shifts as required (supervisory staff work clinically, suspend most education and other administrative burdens, determine where less-trained staff can safely provide support and the extent of family member support).
○	○	○	3.32 Engage union/labor leaders in relevant discussions of staff responsibilities and hours during pandemics.
○	○	○	3.33 Anticipate supply shortages and coordinate with vendors, the health care coalition, and emergency management to coordinate resource supply, distribution, and scarce resource strategies.
○	○	○	3.34 Develop a plan for implementing a supplemental facility security/controlled access plan (which may be phased) particularly during the peak pandemic weeks to assure controlled campus ingress and egress and monitoring.
○	○	○	3.35 Provide patients and staff with information about stress responses, resilience, and available professional mental health resources. Develop staff monitoring for those exposed to high levels of cumulative stress or specific severe stressors (death of co-worker, etc.).
○	○	○	3.36 Consider ways to maintain staff resilience and morale when congregate gatherings and close physical contact are discouraged. This may need to include memorial services for staff members.
○	○	○	3.37 Determine if the fatality management plan is sufficient for an increased volume of decedents at the facility.
○	○	○	3.38 Develop procedure for notifying the state agency for healthcare administration if licensed bed availability/capacity changes as a result of COVID-19.
Completed	**In Progress**	**Not Started**	**Emergency Department Activities**
○	○	○	3.39 Determine screening process and location (e.g., curb side screening prior to entry, supplemental screening at intake, etc.).
○	○	○	3.40 Determine how suspect cases will be isolated from other waiting patients and during ED care.
○	○	○	3.41 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.42 Develop referral plans for patients that do not need emergency care.

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Completed	In Progress	Not Started	
○	○	○	3.59 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.60 Adjust daily nursing expectations/duties as required to meet demand.
○	○	○	3.61 Develop environmental services room decontamination and waste stream plans.
○	○	○	3.62 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.63 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.64 Develop palliative care plans for implementation when needed.

Completed	In Progress	Not Started	**Outpatient Services/Community Health Centers/Free Standing Health Facilities Activities**
○	○	○	3.65 Develop staffing plan to allow for expanded service hours when needed. Determine if outpatient locations and services should remain open if the threat is too great to staff and patients.
○	○	○	3.66 Determine screening process and location (e.g., curbside screening prior to entry, supplemental screening at intake, separate well/ill clinics, etc.).
○	○	○	3.67 Develop telemedicine service plan for use for patients with special needs or general population.
○	○	○	3.68 Develop a plan to expedite medication refills, obstetrician visits, and other office visits prior to the arrival of COVID-19 cases in the community. The practice should have days to weeks to pre-emptively manage its workload in anticipation of limited elective services during the outbreak period.
○	○	○	3.69 Develop a process for screening and triage of phone and email requests for care to limit office visits to those that require an in-person provider evaluation.
○	○	○	3.70 Develop a process to limit/cancel non-essential visits which can `flex' with the demands of the COVID-19 outbreak.
○	○	○	3.71 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies. Develop patient movement and transportation route plans.
○	○	○	3.72 Evaluate maximal use of space. Convert specialty clinics to acute care, extend hours, etc.
○	○	○	3.73 Consider which clinics may be converted into in-patient units (e.g., surgicenters).
○	○	○	3.74 Develop referral/deferral plans for patients that do not need acute care (e.g., perform virtual/ telephone medication management, automate prescription refills).
○	○	○	3.75 Assure administrative engagement in decision-making/use of incident management to assure continuity and consistency between providers and agencies/facilities.

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Completed	In Progress	Not Started	
○	○	○	3.76 Develop infection prevention plan for the clinic specific to COVID-19 and conduct education and develop signage and other necessary materials.
○	○	○	3.77 Create templated charts for COVID-19 patients including discharge instructions and prescriptions.
○	○	○	3.78 Create `fast-track' or other methods for rapid evaluation and prescribing for minor illness.
○	○	○	3.79 Determine how suspect cases will be isolated from other patients in the clinic space.
○	○	○	3.80 Consider specific clinics designated for suspect cases, or specific hours for acute illness clinics.
○	○	○	3.81 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.82 Determine at-risk and functional needs populations that may be impacted and assure access to care.
○	○	○	3.83 Plan to provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19 transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.84 Determine potential indicators/triggers for alternate care systems (including telephone prescribing/encounters and early evaluation and treatment locations as needed).
○	○	○	3.85 Provide or develop patient resources on COVID-19 including transmission, prevention, usual clinical course, risks for more severe disease, and when to seek medical care. These materials should also encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.86 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.87 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.

Completed	In Progress	Not Started	**Homecare Activities**
○	○	○	3.88 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.89 Establish prioritization process for homecare intake or ongoing services including denial and referral to other services. Adjust home visit schedules and responsibilities as required.
○	○	○	3.90 Establish liaison process with hospitals to share information on current and projected capacity and needs.
○	○	○	3.91 Establish liaison process with health care coalition to provide updates on capacity and assist with resource and staffing issues including the process for requesting additional resources from coalition partners or emergency management.

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Completed	In Progress	Not Started	
○	○	○	3.92 Determine contingency staffing plan.
○	○	○	3.93 Address staff transportation-related issues that may be anticipated such as reduced access to fuel.
○	○	○	3.94 Develop/provide education to homecare professionals about COVID-19 transmission, and complications (in addition to infection control/staff safety information as outlined above).
○	○	○	3.95 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.96 Develop/provide just-in-time training to staff taking on non-traditional roles as required to maintain critical services. Coordinate with health care coalition to determine potential options.
○	○	○	3.97 Obtain or develop printed materials (including at appropriate reading level and in relevant languages) for clients including information about COVID-19 (including infection prevention measures and clinical disease), service modifications due to COVID-19, and resources. These materials should encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.98 Determine how volunteer/other staff could contribute to homecare activities.
○	○	○	3.99 Establish telephone/virtual support for clients to provide information and `check in' status.
○	○	○	3.100 Monitor clients for mental health related issues and provide information on normal stress responses.
○	○	○	3.101 Provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.102 Assure that at-risk individuals serviced (e.g., on home oxygen, dialysis patients, etc.) have ongoing access to appropriate services and are listed in an agency database for easy reference.
○	○	○	3.103 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.

Completed	In Progress	Not Started	**Long-term Care/Skilled Nursing Activities**
○	○	○	3.104 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.105 Liaison with the health care coalition/hospitals to assure maximal available residential beds.
○	○	○	3.106 Determine potential supply shortages and work with vendors and the health care coalition if resource availability is limited.
○	○	○	3.107 Develop a process to address shortages of supplies at the facility level including administration, nursing, medical direction, and subject matter expert input - ideally this can be a regional construct rather than at each facility.

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Completed	In Progress	Not Started	
○	○	○	3.108 Develop a plan for more advanced care at the facility if hospital capacity is unavailable. This should involve nursing, medical direction, administrative representatives, and include consideration of telemedicine.
○	○	○	3.109 Determine any potential regulatory relief (CMS 1135 or other waivers, state regulations relief, staffing requirements, etc.) that may be needed to effectively respond to COVID-19 as well as issues regarding staff licensure/certification.
○	○	○	3.110 Determine with medical director and nursing director changes in thresholds for emergency department referral. These may vary across the period according to demand.
○	○	○	3.111 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.112 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.113 Develop a process for rapid credentialing and training of non-facility supplemental health care staff.
○	○	○	3.114 Develop infection detection process at the facility to promptly detect and isolate residents and staff with suspected COVID-19 and monitor their close contacts.
○	○	○	3.115 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.116 Develop visitor policies designed to minimize potential exposures (ideally consistent across the coalition) and communicate via physical (signs at entrances and on units) and electronic means. Determine if visitation should be restricted or stopped if threat is too high for patients and staff.
○	○	○	3.117 Communicate any change in services or policies to staff, residents, families, and the health care coalition.
○	○	○	3.118 Designate a point of contact for the health care coalition.
○	○	○	3.119 Designate a point of contact for family/resident information or questions.
○	○	○	3.120 Develop infection control/isolation plan for ill suspect or confirmed cases.
○	○	○	3.121 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.122 Assure fatality management plans are appropriate to address potentially increased numbers of deaths during a COVID-19 outbreak.
○	○	○	3.123 Plan for providing just-in-time staff education via electronic and other non-classroom means including information about COVID-19 , transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.

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Completed	In Progress	Not Started	Alternate Care Site/System Activities
○	○	○	3.124 Assure integration with public health and other health systems regarding consistent scripts for web and telephone based nurse triage lines/9-1-1 public safety answering points/ poison control centers/locally generated "apps" and integration with additional telephone/virtual prescribing - particularly for at-risk populations.
○	○	○	3.125 Determine support needed from the health care system for `flu clinics' for early screening and treatment as planned by public health.
○	○	○	3.126 Understand/assist with plan for alternate care site(s) for hospital overflow - roles, responsibilities, authorities, staffing, material resources, criteria, level of clinical care (understanding that this may not be feasible if staff absenteeism is high at the hospitals).
○	○	○	3.127 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.128 Assure enough staff, supplies, prophylaxis, and logistical support are on hand before opening the site.
○	○	○	3.129 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.

Comments:

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From: Garcia, Macarena (CDC/DDPHSS/CSELS/OD)

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Subject: FW: DCIPHER DEMO: COVID-19 Traveler Health Screening Data

Attachments: COVID-19 Response Travel Training Document.pdf

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-----Original Appointment-----
From: Garcia, Macarena (CDC/DDPHSS/CSELS/OD) <kou3@cdc.gov>
Sent: Friday, February 28, 2020 3:59 PM
To: Garcia, Macarena (CDC/DDPHSS/CSELS/OD); Burdyshaw, Serena (CDC/DDID/NCEZID/OD) (CTR); Soroka, Stephen (CDC/DDID/NCEZID/OD); Hemby, Taylor (CDC/DDID/NCEZID/OD) (CTR); Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR)
Cc: Roush, Sandra (CDC/DDID/NCIRD/OD); Lichtenstein, Meredith (CDC cste.org); CDC IMS State Coordination Task Force (SCTF) Operations; Shah, Dhara (CDC cste.org); 'hemby_taylor@bah.com'; Williams, Ian (CDC/DDID/NCEZID/DFWED); CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject: DCIPHER DEMO: COVID-19 Traveler Health Screening Data
When: Friday, March 6, 2020 1:30 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Skype Meeting - CDC Blgd 21, Room 4118

Please join us at the next demonstration of how to access COVID-19 Traveler Health Screening Data in the Data Collation & Integration for Public Health Event Response (DCIPHER) platform. This demo is similar to the first demo held last week, and appropriate for new DCIPHER users, or users who would like a refresher. Please forward to relevant members of your state teams, as necessary.

This demo will be facilitated by CDC DCIPHER technical staff, and CDC DGMQ staff.

Please note The demo will be live, however, participants are not required or expected to log into DCIPHER and follow along. If participants do not currently have access to DCIPHER, the demo is still a beneficial introduction to how the system is being utilized in the CDC COVID-19 Response.

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Join Skype Meeting <https://webconf.cdc.gov/kou3/M2P83N1H>

Trouble Joining? Try Skype Web App <https://webconf.cdc.gov/kou3/M2P83N1H?sl=1>

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[!OC([1033])!]

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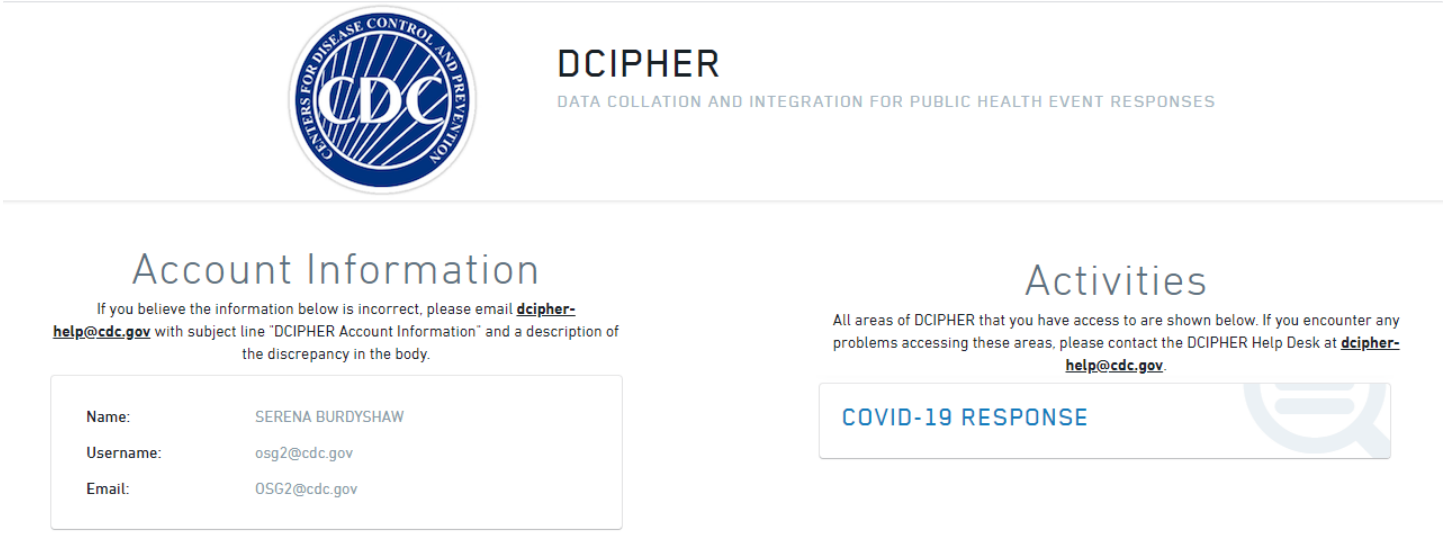
COVID-19 Response Travel Training Document

This training guide will take you through the process to enter data into DCIPHER, update data within DCIPHER and view Reports. This guide is intended for users that are viewing the EpiX travel data and completing the Aggregate State Monitoring Form for the 2019 Novel Coronavirus Response.

Platform Navigation

After logging into DCIPHER users will see the below DCIPHER Homepage. Under activities users can select the "COVID-19 Response" button.



After clicking the COVID-19 Response button, users will see the below landing page for the Coronavirus Disease 2019 Response. The key features are the "Entering Data" section and the "Edit and Search Data" button. The tutorial will focus on these two areas.

If the landing page does not load correctly (e.g., missing buttons), please reference the troubleshooting tips at the end of this tutorial)

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Entering data in the Aggregate State Monitoring form

To enter data into the aggregate state monitoring form, go to the 2019-nCoV Response landing page at

https://dcipher.cdc.gov/workspace/home

On the landing page click the "Add aggregate travel data" button (indicated by a green box below) to open the Aggregate State Monitoring form.

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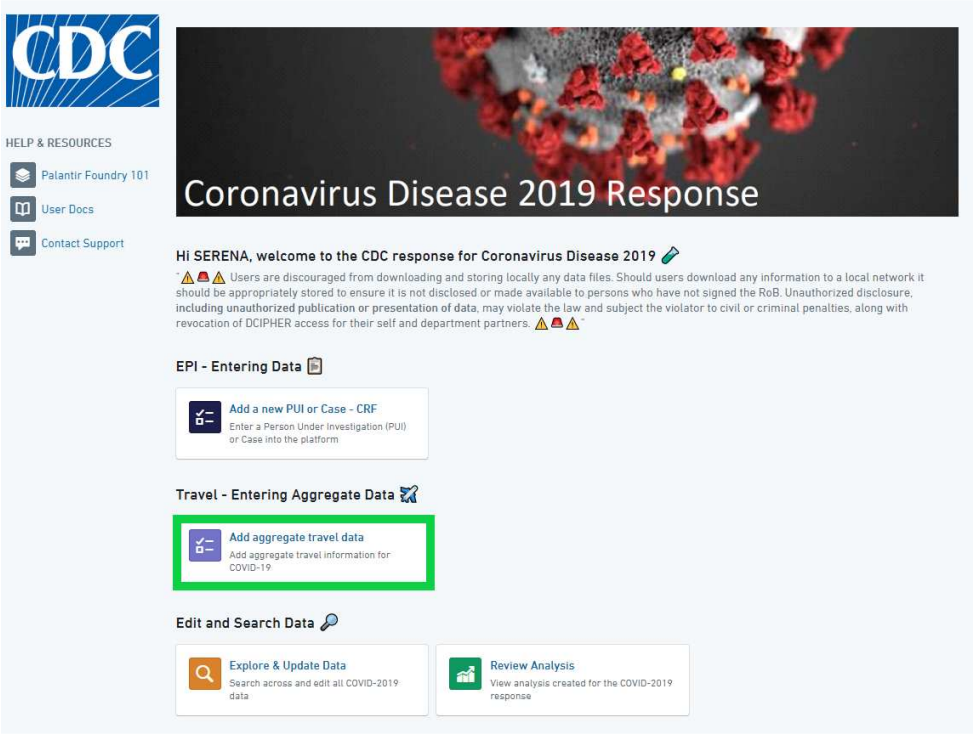
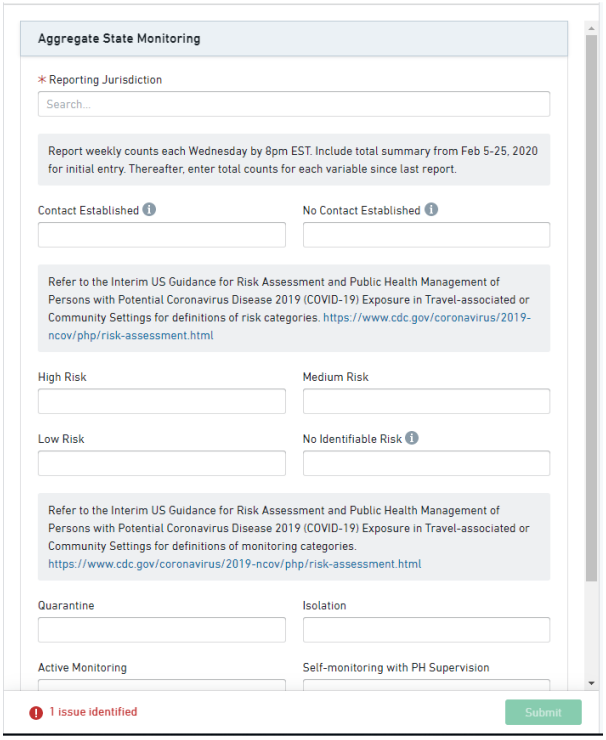


This will open the Aggregate State Monitoring form. Please enter all appropriate information and click the submit button. Fields that are required are indicated by a red asterisk.



Viewing EpiX Travel Data

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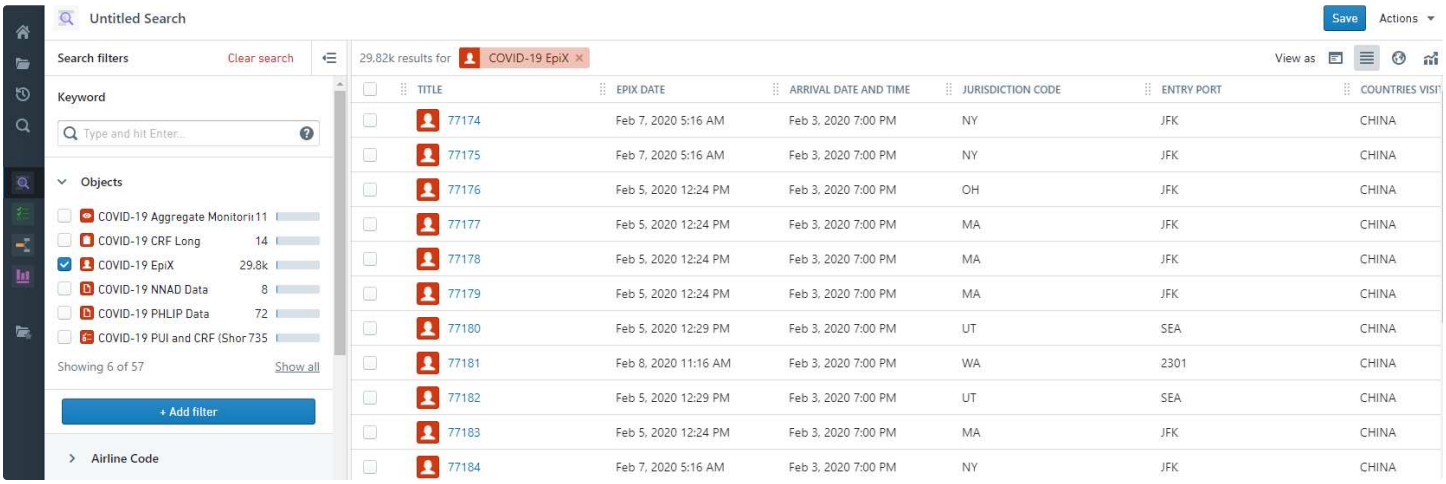
Data that was entered via EpiX can be viewed within the platform. To view this data navigate back to the landing page after



You will be taken to a list of travelers for your state that have been submitted. You can then search and click on the travelers of interest. The travelers are listed by their DGMQ ID.



After opening the traveler of interest, you will be shown the Traveler View. This provides summary information on the traveler including a timeline, personal information, temporary contact information, medical information, and travel information.

Troubleshooting Tips

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This sections covers a few troubleshooting steps for users to follow should they encounter an issue.

COVID-19 Landing Page does not load correctly:

If the landing page is missing the main buttons (Add a New Case, Explore & Update Cases, View National Report) please follow the steps below:

1. Clear your browser history including cookies and cached images/files and close your browser
2. Open Chrome and go to the following url: https://dcipher.cdc.gov/workspace/home
3. If you still do not see buttons to "Add aggregate travel data" and "Explore & Update Data," please restart your computer
4. Open Chrome and go to the following url: https://dcipher.cdc.gov/workspace/home

If the landing page still does not load, users can reach the main buttons using the below links:

1. Add Aggregate Data: https://dcipher.cdc.gov/workspace/fforms/f/new/ri.fforms.main.form.6e026126-e26d-4560-a69e-5cfebb981cae
2. Explore & Update Cases: https://dcipher.cdc.gov/workspace/hubble/search/N4Ig1gpgng7g9gJwCYgFwhAGhHARgKwgGMAXAFSgAcIBnNAbQF1sAzASwBsSIE7UmAvkA?searchId=a4aaf1b4-a6ac-4a51-b9b7-90367b9ec046

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From: EIS (CDC)
To: CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC EIS EAC Roster 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Gaertner, Sonnet Jeong Im (CDC/DDPHSS/CSELS/OD); Blackstock, Anna J. (CDC/DDID/NCEZID/DFWED); McColloch, Caitlin (CDC/DDPHSS/CSELS/DSEPD); Wilson, Kendra (CDC/DDPHSS/CSELS/DSEPD); DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Owens, Kevin (CDC/OCOO/OCIO) (CTR); Bauer, Darrell (CDC/DDPHSS/CSELS/DSEPD)
Subject: FW: EIS Supervisor Seminar: EIS Conference and Match Orientation
Importance: High

This seminar is primarily for supervisors who have been approved to match for the EIS Class of 2020; however, all supervisors are welcome to participate.

EIS Supervisors –

With the cancellation of the EIS Conference, the match for the incoming EIS class will now be conducted virtually. Please join us for this important supervisor seminar on the EIS virtual match.

During this EIS virtual match orientation, we will go over

* Cancellation of EIS Conference considerations
* Virtual match timeline
* Overview of logistics
* Virtual match host site support
* Q&A

For those unable to attend, this session will be recorded.

Thank you,

EIS Program

Adobe Connect Webinar Information

https://adobeconnect.cdc.gov/ruqnt1n2uhla

If you have never attended an Adobe Connect meeting before:

Test your connection: https://virtualsepd.adobeconnect.com/common/help/en/support/meeting_test.htm

Get a quick overview: http://www.adobe.com/products/adobeconnect.html

Phone Line Information

(770) 488-3600

Conference ID: 3183827

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From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Roberson, Shamarial (CDC flhealth.gov)
Cc:	Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ)
Subject:	FW: Florida Cruise Ship Summary 3.17.20 4 pm
Date:	Tuesday, March 17, 2020 5:22:23 PM
Attachments:	Florida Cruise Ship Summary 3.17.20 4 pm.docx

Dear Dr. Roberson,
It was good to talk to you just now about the arriving charter flights expected from the 2 cruise ships in Brazil and Chile. Please find the attached summary from the earlier call. As I mentioned, Dr. Cindy Friedman, the CDC Cruise Ship Task Force Lead, spoke to Dr. Rivkees earlier today.

I am copying Cindy, Paul (co-lead of the Task Force). I am part of their team and assisting with these two ships. I am also copying Michelle Decenteceo, Officer-in-Charge at the Miami Quarantine Station, and Andy Klevos, Regional Officer in Charge – both from the CDC Division of Global Migration and Quarantine.

Please feel free to contact me with any questions.

I will forward the correspondence with the cruise line to you.

Kindly,
Michelle

Michelle Weinberg, MD, MPH
Detailed to Cruise Ship Task Force/COVID-19 Response
Mobile: 1 404 456 4559

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 4:08 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: Florida Cruise Ship Summary 3.17.20 4 pm

Dear Mr. McGough,

Attached please find a summary of our phone call with the Florida Governor's Deputy Chief of Staff regarding two Royal Caribbean cruise ships and pending charter flights to Miami from both Brazil and Chile. Please let me know if you have any other questions.

Kind regards,

AMERICAN OVERSIGHT

Cindy

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

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For Internal Use Only

Florida Cruise Ship Summary: 3/17/2020

On March 16th CDC was notified about two Royal Caribbean cruise ships with at least one confirmed COVID-19 case on each ship. Each ship had American citizens on board; one was in Recife, Brazil and the other in Puerto Montt, Chile. Royal Caribbean is chartering flights to transport the American passengers back to the United States. Below is a summary of what the cruise line plans to do to return the 148 persons to the United States. A total of three charter flights are expected to depart South America and arrive at Miami International airport. The date and time of arrival has not been confirmed, but Royal Caribbean have indicated a possible departure time during the evening of March 17. All asymptomatic persons on charter flights to Miami will be treated as if they are arriving from Level 3 countries. They will be screened by CBP staff with secondary screenings provided by CDC quarantine officer as necessary. All returning travelers on these charter flights will be instructed to self-quarantine and self-monitor for symptoms for 14 days per CDC guidance.

Silver Shadow (Brazil)

- 103 AMCITS (20 of these are Florida residents)
- Two confirmed COVID-19 cases were on ship (non-AMCITS)
- Plans for charter flight
    - One charter flight to Miami International Airport
    - Asymptomatic travelers to return to their homes from Miami to self-quarantine for 14 days

Silver Explorer (Chile)

- 45 AMCITS (8 of these are Florida residents)
- At least one confirmed COVID-19 case was on the cruise ship (non-AMCIT)
- Plans for charter flights
    - Two charter flights to Miami International Airport
        - First flight with 37 asymptomatic persons
        - Second flight is a medical ambulance with 8 persons who either have reported influenza-like illness or were at higher risk for exposure (cabinmate of person with symptoms); none of these persons have been tested for COVID-19 and all are reported to be medically stable to fly to Miami.
            - The eight persons with symptoms are residents of California (3), Florida (1), Georgia(2), Oregon (1), Pennsylvania (1)

Points of Contact

Royal Caribbean Cruises
Eleni P. Kalish, Vice President of Federal Relations
Ph: 305.539.6799; Cell: 786.253.5305
ekalisch@rccl.com

Florida Department of Health Miami-Dade County
Yesenia D. Villalta, Administrator/Health Officer
Ph: 786.336.1260
Yesenia.Villalta@flhealth.gov

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From: Rivkees, Scott A

To: ABaiken; bbarash; Abhall; Abojo; AdamMayle Aventura Hospital; admin@cgrehab.net; admin@keysready.org; andrewchecchia01@gmail.com; administration@homedcareinc.com; admwgh; Agatha Samuel; agomez@chsfla.com; agency@integralhomehealth.com; Alicia Horner; ailynferrera@yahoo.com; Aklevos; Alara Select Specialty Hospital; Alazandria Cruze; Albert.Howe@flhealth.gov; Alejandro.Nossar; alliancehcmb@gmail.com; Alinag; ALOPEZ6; Amemon; amooss@bsrinstitute.org; amy.polanco@Hcr-manorcare.com; Ana Cladera; Ana Mederos; AndreaBl@baptisthealth.net; Angel Colon; Angel Pallin Mount Sinai Medical Center; Angela Ren; Ann Schmitz; annamoor@uco-ucpsfl.org; Anne.m.gonzalez@fmc-na.com; April Hoyt Mount Sinai Medical Center; Arelyr; Arlene.Mayo-Davis@ahca.myflorida.com; Arlene Merrill Aventura Hospital; arusso2@jhsmiami.org; Asolar@plazahealthnetwork.org; Aupadhyay; avaldes@larkinhospital.com; barbaras Baptist Hospital of Miami; bcabrera; Benjamin.Davis; betty.mendez Kindred Hospital; betterlivinghome@bellsouth.net; Beverlin.Allen Sister Emmanuel Hospital; bhartley; BHernandez; bhavarth.shukla@med.miami.edu; BillD Homestead Hospital; bing.wood; bkiedrowski; blanca.alfonso@mch.com; bobbi; bpelaez@fiu.edu; bpol@lifelinehomehealthcare.com; bpreter@plazahealthnetwork.org; BrandonRO@baptisthealth.net; CAceves; caja University of Miami; camilletapper@uco-ucpsfl.org; CardonL; Carlos.Aja; Carlos.Cuevas@flhealth.gov; carlos.saborio@tenethealth.com; carlosfeliciano; Carmen.Tejada; CarmenR1; Casey.Canny@vitas.com; Catherine.Torres; Cathyd@mactown.org; cbauer; ccamacho@larkinhospital.com; centuryhomecare@aol.com; Cgarcia3; cguzman; charles1.rodriguez Hialeah Hospital; charlesm@allianceforaging.org; chris.gutierrez@opuscare.org; christian.goss; Christopher.Morando@amr.net; Christopher.pidgeon Christopher.pidgeon@hcahealthcare.com; Christina.Chao@flhealth.gov; chughes; Claude.Augustine; claudiam@firstcareservices.com; Cleo.Reynolds; cmedinamd; cristina.jimenez Coral Gables Hospital; csabayton; CSepulveda West Gables Rehabilitation; curlyg; cvargas; dalbisa Select Specialty Hospital; dalbisa2; Dale.Milner; Damon.Barrett@hcahealthcare.com; Darren Caprara; Darryl.stevenson@va.gov; David.Daley Jackson Memorial Hospital; Dawn.stevenson2@va.gov; dbencomo Select Specialty Hospital; Deborah.Cooper; Debra.McCray; deniseh; diego0414@gmail.com; djamie; dmiller; DON@cgrehab.net; dougj Doctors Hospital; dreiff@fbi.gov; DVonderCrone University of Miami; dzambrana University of Miami; EdBustillo West Gables Rehabilitation; eddy.ballester@miamidade.gov; Edelarosa; EdgarF Baptist Hospital of Miami; Eduardo.Bustillo; eduardo@lumars.com; Edward.borrego Jackson South Community Hospital; Edward.Rundle; EdwinG; edwinru; egonzalez; eklundmd; elaine.robinson; elderlyhhc@gmail.com; eduardo.leon Larkin Hospital; EllenS Homestead Hospital; elsaf; emartinez7@miami.edu; emoultri@jhsmiami.org; emoultri; enrique.morales@nicklaushealth.org; Eortiz@plazahealthnetwork.org; EPretto; errol.douglas; erundle; esoler@gastrohealth.com; Estela.Carmona Kendall Regional Medical Center; 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KABrown; KandyU; karin.dipiero@jhsmiami.org; Kathleen.Lavergne; KCapezzuto; kevenj; Kiara.Serrano@msmc.com; keyh; kgoodman; KimdasheNS Doctors Hospital; Kelly Keys; Kmanni University of Miami; Kmiller; labreceptionpsgh; lalcure Miami Jewish Health Systems; Lani.Ferro@mch.com; laura.kim@mch.com; lazg@baptisthealth.net; Lbenitez@miamigov.com; lee.chaykin; Lgranata; lgwynn@med.miami.edu; Liana.Calvo@Bristolhospice.com; Liliana.Cabal; Linda; lisa.brunner@va.gov; lise; lisia@firstcareservices.com; lissysanchez@faithhealthcare.com; Loma.kernizan@hcahealthcare.com; Lorenzo.Gutierrez Aventura Hospital; lorigrn Westchester General/Southern; LourdesBou West Kendall Baptist Hospital; low@plazahealthnetwork.org; Luis.Derosa@jhsmiami.org; LPagan University of Miami Hospital and Clinics; lseff; LuisCol West Kendall Baptist Hospital; LuisRod; lumars4@bellsouth.net; LynnDick; m.varona@caretechhhs.com; MAWorts@jtchs.org; madison.workman@tenethealth.com; Maricela.Sweeney@tenethealth.com; Maite.Cordero@encompasshealth.com; Manuella.Janvier-Anglade; ManuelR@ThePalace.org; maprigliano Jackson Memorial Hospital; marcg; MCarrasco@plazahealthnetwork.org; marcos.olivarez@mch.com; maria.villa; mariarego@uco-ucpsfl.org; maribelru; mario; mario.gomez@usa.g4s.com; martamorin@uco-ucpsfl.org; mdelgado@epworthrc.com; Martha-Hia.Wright; Martha.Garci; Maria.Mayor@jhsmiami.org; mary.ibarra; mary.valero; Mathai.Vempala; matthew.ganley@leonmedicalcenters.com; Mayi.ramirez; mccreadj@bellsouth.net; mdamavandi sariel@mjhha.org; mdelarosa; mdiaz@turn-keyhealth.com; mejerl14@gmail.com; mercedesp Larkin Community Hospital; mercyb@baptisthealth.net; MFermin@hscmd.org; michael.rogers; Michele.Thoman@tenethealth.com; Michelle.Steele@miamidade.gov; migdaliasantiago@uco-ucpsfl.org; Miguel.Vasquez Sister Emmanuel Hospital; migueldi; Miriam.Garcia@tenethealth.com; MMoore@miamigov.com; MollyV; mountauburnhomehealth@gmail.com; mapalacios@mdpd.com; mrabinovich@westchesterhospital.com; mrousseau@chsfla.com; Msevillano; mshpiner; Mworts; Nancy.Humbert; 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Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

---

Good Morning MDCHPC Partners,

This is a reminder and future calendar reminder for the FDOH Stakeholder call on COVID-19.

Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

AMERICAN OVERSIGHT

From: Rivkees, Scott A

To: ABaiken; bbarash; Abhall; Abojo; AdamMayle Aventura Hospital; admin@cgrehab.net; admin@keysready.org; andrewchecchia01@gmail.com; administration@homedcareinc.com; admwgh; Agatha Samuel; agomez@chsfla.com; agency@integralhomehealth.com; Alicia Horner; ailynferrera@yahoo.com; Aklevos; Alara Select Specialty Hospital; Alazandria Cruze; Albert.Howe@flhealth.gov; Alejandro.Nossar; alliancehcmb@gmail.com; Alinag; ALOPEZ6; Amemon; amooss@bsrinstitute.org; amy.polanco@Hcr-manorcare.com; Ana Cladera; Ana Mederos; AndreaBl@baptisthealth.net; Angel Colon; Angel Pallin Mount Sinai Medical Center; Angela Ren; Ann Schmitz; annamoor@uco-ucpsfl.org; Anne.m.gonzalez@fmc-na.com; April Hoyt Mount Sinai Medical Center; Arelyr; Arlene.Mayo-Davis@ahca.myflorida.com; Arlene Merrill Aventura Hospital; arusso2@jhsmiami.org; Asolar@plazahealthnetwork.org; Aupadhyay; avaldes@larkinhospital.com; barbaras Baptist Hospital of Miami; bcabrera; Benjamin.Davis; betty.mendez Kindred Hospital; betterlivinghome@bellsouth.net; 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Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

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Good Morning MDCHPC Partners,

This is a reminder and future calendar reminder for the FDOH Stakeholder call on COVID-19.

Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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From: Rivkees, Scott A

To: "Smith, Todd"; "Woodard, Steven"; Schaudel, James; David Castleman; "Blanton, Jake"; "Moreland, Charles"; "Elias, Bradley"; "Maxwell Ervanian"; "Peterson, Brian"; "Johnson, Belinda"; "Cichowlas, Monica"; "Hastings, Annette"; "Hilbrant, Paul"; "Wishard, Randy"; lrosie1965@gmail.com; Arrindell, Aja L; Zaheer, Saad MD; "chad.neilsen@jax.ufl.edu"; "jennifer.silvey@jax.ufl.edu"; "vkoelebryan@visitjacksonville.com"; "Meaghan Smalley"; "soaresp@duvalschools.org"; "Kimbleton, Nikki"; Davis, Terri C; "Ronald Lendvay"; "Rowley, Mark"; "Viafora Ray, Laura"; Wilsey, Leigh; Eric Anderson; "Arthur, Scott"; Auguste, Rachel A; "Ayoub, Andre E."; "Barth, Micah"; "Bates, Kari"; "marion.a.gregg2.mil@mail.mil"; "Berlinghoff, Jim"; "Bethea John"; Boutte, Mary J.; "Bradford, Keithe"; "Brown, Tawana"; "Burch, Yvette"; "Chapman, David"; "Cipriani, Joe"; "Coffey, John"; "Copeland, Shanti"; "Cowan, Leigh"; "DeGennaro, Donna"; "Devin, Tim"; "Dixon, James"; "Durgin, Kevin"; "Elliott, Billy"; "Geraci, Chris"; Gibbs, Winston E; "Hemmingway, Tammy L."; Higginbotham, Ken; "Hillyard Steve"; "Jacobs, Diann"; "Jolivette, Lawana"; "Kingery, Jenny"; "Knight, Danny"; "Kotsis, Kevin"; "Lichtman, Joe"; Wesley Marsh; "McDonald, Sandra"; Danny McPhaul; Miller, Jason S; Payne, Elizabeth; "Pendley, James A."; "Pereira, Carolina"; "Peterson, Larry"; "Reynolds, John"; "Roberts, Scott"; Rodgers, Sonny J; "Saftner, Marissa"; "Shay, Brittny"; "Shropshire, Dana"; "Stores, Joe"; "Torrence, Theo"; Ward, Richard; "Williams, Bob"; "Wolff, Mark"; "Young Sam"; "Hooten, Tracy"; "Fine, Brent"; "eweisz@pruitthealth.com"; "COJEPD"; "HSEPD - Executive Conference RM"; "Hall, Shawn"; "McManus, Richard"; "Southall, Brian"; "Ray, Noah"; "Ervanian, Maxwell"; "Jeff Winkler"; "Johnson, Zandra"; "Smith, Timothy"; "Amy.Riley@hcahealthcare.com"; "Sharron.Seitz@hcahealthcare.com"; "Patricia Winters"; "Sherriff, Autumn"; "Brown, Adam"; "Ricks, James D."; "Meysenburg, David"; "Durham, Karen"; Hipps, Angie; "Hellum, Cody"; "Young, Sam"; "Norton, Miller"; Turner, Scott M; "Nelson, Shannon"; "Thompson, Jeffrey - OASAM ATL"; "chad.neilsen@jax.ufl.edu"; "Ramos, Joseph F - OASAM ATL"

Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

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-----Original Appointment-----
From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Monday, March 2, 2020 1:20 PM
To: Rivkees, Scott A; Turner, Scott M; Arrindell, Aja L; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
Cc: Rolle, Pauline J; Boswell, Patricia; James-Glasgow, Olivia N.; Moffses, Thomas P; Villalta, Yesenia D; Wegener-Vitani, Carol A; Myers, Paul D; Lander, Mark S; Vick, Stephanie; Waldron, Kerry S; Hawker, Miranda C; Durden, Tammy M; Danyluk, Gregory M; Harvey, James D; Snyder, Robert E; Conklin, Kelly H; Grabelle, Dorothy A; Singer, Keith A; Ming, Randy S; Jergens, Christy M; Duncan, Sherry L; Pepe, Joseph D; Speedling, Sandon S.; Johnson, Karen S (HolmesCHD); Smith, Angela M; Hess, Erin E; Cooksey, Adrian; Pino, Raul; Danielle Sorrentino-Brightman; Park-O'Hara, Sandra L; Johns, Amie G; Bill VanHelden; Amy Perez; CERULLO, TIMOTHY; HAWLEY, WILLIAM; WILLIAMS, RAYMOND; Martin, Sandy K; Henry, Charles H; Stahl, Maria A; Pierce, Bruce; Street, Karen K; Inman, Barry; Medlin, Helen K; Choe, Ulyee; Prosser, Kimberly; DL CHD46 ICSR; Chapman, Karen A; Allbritton, Kimberly; Napier, Mike J.; Baker, Lisa A; Nicholson, Garik A; Zelnick, Sanford D; Jena Glantz; Winn, Jason Esq ; Matt Jordan; 'William Hightower'; 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Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

From: Rivkees, Scott A
Sent: Tuesday, February 11, 2020 2:36:19 PM (UTC-05:00) Eastern Time (US & Canada)
To: Rivkees, Scott A; Arrindell, Aja L; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
Cc: Rolle, Pauline J; Boswell, Patricia; James-Glasgow, Olivia N.; Moffses, Thomas P; Villalta, Yesenia D; Wegener-Vitani, Carol A; Myers, Paul D; Lander, Mark S; Vick, Stephanie; Waldron, Kerry S; Hawker, Miranda C; Durden, Tammy M; Danyluk, Gregory M; Harvey, James D; Snyder, Robert E; Conklin, Kelly H; Grabelle, Dorothy A; Singer, Keith A; Ming, Randy S; Jergens, Christy M; Duncan, Sherry L; Pepe, Joseph D; Speedling, Sandon S.; Johnson, Karen S (HolmesCHD); Smith, Angela M; Hess, Erin E; Cooksey, Adrian; Pino, Raul; Danielle Sorrentino-Brightman; Park-O'Hara, Sandra L; Johns, Amie G; Bill VanHelden; Amy Perez; CERULLO, TIMOTHY; HAWLEY, WILLIAM; WILLIAMS, RAYMOND; Martin, Sandy K; Henry, Charles H; Stahl, Maria A; Pierce, Bruce; Street, Karen K; Inman, Barry; Medlin, Helen K; Choe, Ulyee; Prosser, Kimberly; DL CHD46 ICSR; Chapman, Karen A; Allbritton, Kimberly; Napier, Mike J.; Baker, Lisa A; Nicholson, Garik A; Zelnick, Sanford D; Jena Glantz; Winn, Jason Esq ; Matt Jordan; 'William Hightower'; Robinson, Lynn; Wadsworth, Lynn; Curt Sommerhoff; nmcdonald@uwf.edu; Courson, Sandi C; Foster, Kena K; Fleischman, Jennifer; Gray, Jennifer; Syfrett, Christine M; Bohaboy-Walby, Madalaine I; Byrge, Treasure L; Carmichael, Megan; Crumpton, Greg T; Etzel, Patricia L; Exline, Timothy; Hensley, Deborah S; Maguire, Ken G; Mullens, Donna J; Pavone, David; Pell, Jennie B; Snead, Jordan A; Watson, George F; Watts, Melissa E; alexandergolden@comcast.net; Sandoval, Randi C; Bailey, William H; Hodges, Zachary L; Cook, Helen M; Hogan, Lisa C; Hinds, Sarah JQ; Sentman, Michael L; Sperber, Clint J.; Rubio, Tito G.; Central Florida Disaster Medical Coalition; Eric.Alberts@orlandohealth.com; Rogers, Jon; Rodrigues, Ruth; Phillipine, Kristin; Holt, Holly; Barley, Kathryn C; Portis, Alan L; Locke, Barbara L; Alonso, Alina M; Kissler, Aaron X; Medved, Daniel T; Matos, Nathaly; Cherry, Georgianne M; Juarez, Padraic R; Holtzclaw, Rhonda; janetkinney@calhounlibertyhospital.com; jannamatautia@calhounlibertyhospital.com; BAKER, JOANN; jennifer.cloud@doctorsmemorialhospital.com; Sarah Catalanotto; janet.smith@doctorsmemorial.org; Long, Tracey; FREEBURG, RICHARD; davidab@baptisthealth.net; dstanger@baptisthealth.net; denise.grimsley@ahss.org; rosalie.oliver@ahss.org; cathy.jaco@ahss.org; matthew.l.smith@adventhealht.com; dwalker@emmsmemorial.com; bstorck@weemsmemorial.com; rspringer@hrmc.us; hhuron@weemsmemorial.com; jbeltz@hhrmc.us; tblackman@hrmc.us; mcorbo@hrmc.us; Pam Howard; pwebb@lakebutlerhospital.com; jthomas@lakebutlerhospital.com; jfulgham@lakebutlerhospital.com; brett.mcclung@bmcjax.com; martha.oakley@bmcjax.com; heidi.schaffer@hcahealthcare.com; dhogan@dmh.org; tconerly@dmh.org; STONE, THOMAS; doug.faircloth@doctorsmemorial.com; david.ottati@fhms.org; jermaine.bucknor@ahss.org; jthompson@healthmarkregional.com; lmeese@jackhosp.org; Krovito@jackhosp.org; HUTCHINS, MICHAEL; keith.strickling@bhcpns.org; brandy.call@bhcpns.org; rroche@lmcpbc.org; briley@lmcpbc.org; dan.mcLean@lpnt.net; debra.noyes@lpnt.net; 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Walsh, Donna; PLATT, CARROL; Moscoso, Alberto; SHERROD, RHONDA; Brown, Richard; Perez, Ellis E; Asim Jani; Struble,Wayne Gordon; Matt Meyers; peterpappas52@gmail.com; Crowe, David R; Jonathan Lord; Baker, Kevin M; Bencie, Jennifer L; Poniatowski, Michael; Klein, Jason L.; Rutledge, Laura X; Napier, Robin; Ziegler, Carolyn H; McDaniel, Allison L; Smith, Rita M; Ashley Beigle; Melyssa Callahan; DiFede, Matthew; MacDonell, Sam; Blevins, Allison M; Jenkins Kelley; Burns, Mary K; Lewis, Susan M.; Welter, Bonnie J; Stewart, Lewis Shayne; rhambrick@ncf.edu; Brafford, Melba G.; Loftin, Edwin; Schuffert, Michael; Andrews, Phil; Jo.Alverson@Steward.org; REED, PAMELA; Mann, William; Johns, Paul M.; Abbasi, Muhammad J; Harder, Terri A; Hollingsworth, Kristine M; Marr, Kathleen J; Mercado, Carlos A.; Pedigo, Ryan J.; Miller, Brian L.; Gordon, Leslene E.; Lanza, John J; Bolton, Beate H; Georgine Kruedelbach; Marcia Catania; Hendershot, Jeri; Albert, Michele M; Burns, David; Clincea, Radu; Moore, Valarie E; 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Bailey, Bobby; Rowe, Ann; Kelley, Debbie A; Stenberg, Christina; James, Susan; Alonso, Zuzel; Ngo-Seidel, Eugenia J; Zayas, Maribel A; Keyes, Becky (County Health Systems); Smith, Thomas M; Alison Doeing; Foerster, Lisa R.; Peggy Brown; Quigley, Jacob B; Harris, Nicole E.; Morris, Cindy K.; Hill, Ann; Weller, Karen; Yow, Annmarie; Bielling, Jeffery; acburke8@gmail.com; Luce, Christie; Nelson, Joanna; Robinson, Eriko M; Davis, Ashley; Vaughn, Freda G; Shedlock, Andrew (AndrewShedlock@fdle.state.fl.us); Woodlief, Douglas; Jackson, Iris F; Tracey Vause; Ciereck, Christina M.; HSU MD, Vincent; Taryn Kryzda; Steve Wolfberg; ddyess@ci.stuart.fl.us; commissioners@ci.stuart.fl.us; William Schobel; Gaylord, Laurie; comish@martin.fl.us; wdsnyder@sheriff.martin.fl.us; jtummine@ci.stuart.fl.us; Michelle Miller; Rouse, Renay C; Bowzer, Leah F; Powell, Sheryl L; Doug Smith; Watkins, Shirley; Kevin Herndon; Don Donaldson; Domenica Labbate; George Stokus; Meier, Mike; Katelyn White; Reinhold, Todd A; County Health Systems; Mich Mongel; Ronnie Daves; David Whalen; Darrel Welborn; Matthew D. Abbott (mabbott@sheriff-okaloosa.org); BonicaLauren; SummersDan; ShawMichael; Kevin Gingras; Astrid Ramirez;

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Scuteri, Ana C; EmergencyManagementEmployees; Manuel Cela; Connor, Olga; zannett@thearpc.com; Eneida Roldan; Ashley Krutz; Smoak, Kimberly; Best, Jay; William Johnston - Northbay; brian.cook@hcahealthcare.com; ray@healthmarkregional.com; becky.washler@ascension.org; llamarche@mywakulla.com; adamms@hendryfla.net; Morell, Venita W; YOUNG, Brenna; Dominguez, Orlando J; Debra Boyce; Clark, Heath; Pokryfke, John; Glass Leighton, Kelli; Harold Jenkins; Amy Aiken
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday from 2:00 PM to 3:00 PM effective 2/12/2020.
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with interested parties as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

Best,

Aja L. Arrindell, M.P.H., M.S.

Surveillance Epidemiologist

Florida Department of Health in Duval County

515 W 6th St
Jacksonville, FL 32206

Office: (904) 253-1855

Cell: (904) 627-0647

Fax: (904) 253-1851

Aja.Arrindell@flhealth.gov<mailto:Aja.Arrindell@flhealth.gov>

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FLORIDA HEALTH PERFORMS

INCREASE CHILDHOOD VACCINES
Increase vaccination of children to prevent disease and keep all of Florida's children protected from health threats.

DECREASE HIV INFECTIONS
Reduce the incidence of HIV infections to allow more Floridians to live longer healthier lives.

DECREASE INFANT MORTALITY
Reduce infant mortality to improve health outcomes for all infants.

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail, therefore, may be subject to public disclosure.

From: Rolle, Pauline J <Pauline.Rolle@flhealth.gov> on behalf of Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Wednesday, February 26, 2020 2:44 PM
To: Arrindell, Aja L
Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday from 2:00 PM to 3:00 PM effective 2/12/2020.
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

From: Rivkees, Scott A
Sent: Tuesday, February 11, 2020 2:36:19 PM (UTC-05:00) Eastern Time (US & Canada)
To: Rivkees, Scott A; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
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eddieh@suwgov.org; swilliams@panhandleareahealthnetwork.com; Susan Grich; melissa.thibodeau@hrhn.org; lynn.witt@hma.com; garyowens@nwfrhn.com; Rpearson@rhnmc.org; HALL, ROGER; Reich, Debbie A; Dunn, Nathan P; Beedie, Katherine A; psparks@uwf.edu; Kirsch, Holly S; Stewart, Gail; DAlessio, Rebecca; Smith, Kathy J; Oliver, Rosalie; Walsh, Donna; PLATT, CARROL; Moscoso, Alberto; SHERROD, RHONDA; Brown, Richard; Perez, Ellis E; Asim Jani; Struble,Wayne Gordon; Matt Meyers; peterpappas52@gmail.com; Crowe, David R; Jonathan Lord; Baker, Kevin M; Bencie, Jennifer L; Poniatowski, Michael; Klein, Jason L.; Rutledge, Laura X; Napier, Robin; Ziegler, Carolyn H; McDaniel, Allison L; Smith, Rita M; Ashley Beigle; Melyssa Callahan; DiFede, Matthew; MacDonell, Sam; Blevins, Allison M; Jenkins Kelley; Burns, Mary K; Lewis, Susan M.; Welter, Bonnie J; Stewart, Lewis Shayne; rhambrick@ncf.edu; Brafford, Melba G.; Loftin, Edwin; Schuffert, Michael; Andrews, Phil; Jo.Alverson@Steward.org; REED, PAMELA; Mann, William; 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From: Rivkees, Scott A
To: DL DEPCS00 BPR HCCTF
Subject: FW: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus

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FYI

-----Original Appointment-----
From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov <mailto:Scott.Rivkees@flhealth.gov> >
Sent: Tuesday, February 11, 2020 2:36 PM
To: Rivkees, Scott A; DL DOH CHD Administrators_Directors; Molly.McKinstry@ahca.myflorida.com <mailto:Molly.McKinstry@ahca.myflorida.com> ; Laura MacLafferty; Kinsley, Chris; mary.mayhew@ahca.myflorida.com <mailto:mary.mayhew@ahca.myflorida.com> ; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; jeanetta.stalcup@uhsinc.com <mailto:jeanetta.stalcup@uhsinc.com> ; steve winn; michelle@foma.org <mailto:michelle@foma.org> ; andrew@foma.org <mailto:andrew@foma.org> ; govaffairs@foma.org <mailto:govaffairs@foma.org> ; Shepard, Lela; mcarter@flmedical.org <mailto:mcarter@flmedical.org> ; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; MThomas@flmedical.org <mailto:MThomas@flmedical.org> ; CPrine@flmedical.org <mailto:CPrine@flmedical.org>
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AMERICAN OVERSIGHT

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
To: Wallace, Marla D.; Clark, Marah
Cc: DSLRCrisisCoag (CDC); Stanek, Danielle R; Morrison, Andrea; Blackmore, Carina; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project
Date: Monday, February 24, 2020 2:25:27 PM
Importance: High

Good Afternoon Marla, Marah,

After speaking with OGS, the recommendation is for the State of FL to move forward with submitting the request as an official amendment in GrantSolutions.

Using official state letterhead, a process which you should be familiar, I would strongly advise breaking down the following:

- Show what the prior activities and amounts were (and why they are no longer feasible)
- Show what the new activities and amounts are (and how they are supported under the NOFO)
    - For the trailers, please be sure to provide ample justification and if possible necessary specs, quotes, and vendors. The more thoroughly tied to the NOFO, the more helpful it will be.

If you need any assistance, or would like me to view the official draft prior to submission, I would be happy to review.

Kind regards,
Kevin Sevak

From:
Sent: Monday, February 24, 2020 1:59 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Good Afternoon,

In order for CDC To make an informed decision regarding their proposed request an official request should be submitted to CDC via grant solutions.

Damond

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Friday, February 21, 2020 1:54 PM
To: Barnes, Damond (CDC/OCOO/OFR/OGS) <xhp5@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project
Importance: High

Good afternoon Damond,

I am reaching out to you on behalf of Sabrina Hansen, who is the Project Officer for Florida under Hurricane Crisis CoAg TP18-1802. Sabrina is currently supporting Coronavirus response activities.

Her jurisdiction has requested a redirection of funds for two activities. Prior to submission into GMM we were wanting to get some feedback. The first of which is straight forward, but the second may require more attention.

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The request entails that funds would actually be staying in the same budget category, however they are proposing a chance in two activities.

1. The first is to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control. The justification they provided aligns with Domain 5 of approved activities under the grant. I found this to be an allowable use of funds, but wanted to get your concurrence. More information on this can be found highlighted in this color below.

2. Secondly, FL is proposing to purchase two trailers: One trailer to move equipment around the county, increasing their capacity in post storm treatment response. The other is interested in using the trailer to educate their constituents. Detailed justification and estimates can be found attached. I have requested quotes and further information already, but sought your advice on such a purchase. Further justification on this can be found **attached** and below in this color.

Thank you for all your help!

Kind regards,

Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@freshfromflorida.com>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) [mailto:ydh1@cdc.gov]
Sent: Friday, February 14, 2020 1:13 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing **LA**'s vector project needs and are proposing some alternative use of funds. **Do you means FL?**

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

In other words, we need to see clearly see what the money was originally approved for, and how much, and where the money is going toward now, how much, justifications, and associated quotes… Based on that, we will review and get the necessary prior approval, and if approved, have the appropriate changes documented in GMM.

Please let me know if this makes sense. Thank you!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the

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CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

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Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: Fw: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 10:21:15 PM
Attachments: image001.png

From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Thursday, March 12, 2020 12:51 PM
To: State and Local Readiness (CDC) <preparedness@cdc.gov>
Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our

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office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs
The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the

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Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.

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- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
    - In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
    - In February, the President restricted travel for individuals recently traveling from Iran.
    - The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
    - Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.
- Today, the President directed his Administration to make general-use face masks available to our healthcare workers.
    - The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.
- President Trump signed into law more than $8 billion to fund response efforts.
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
- The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to

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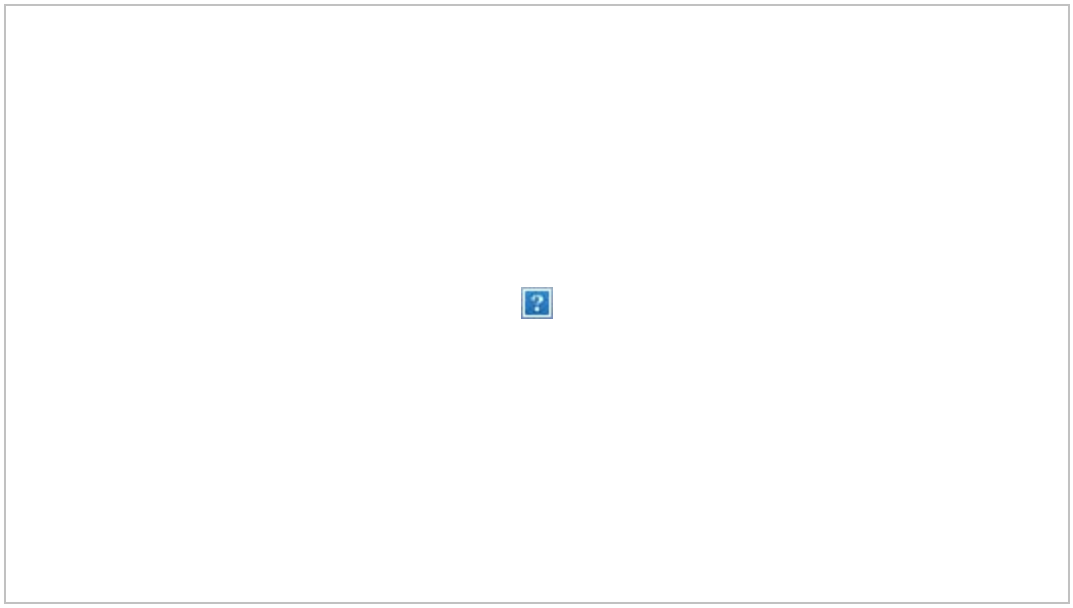
combat the coronavirus.

ON ABC's GOOD MORNING AMERICA



WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

> "The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities

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where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE.

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's

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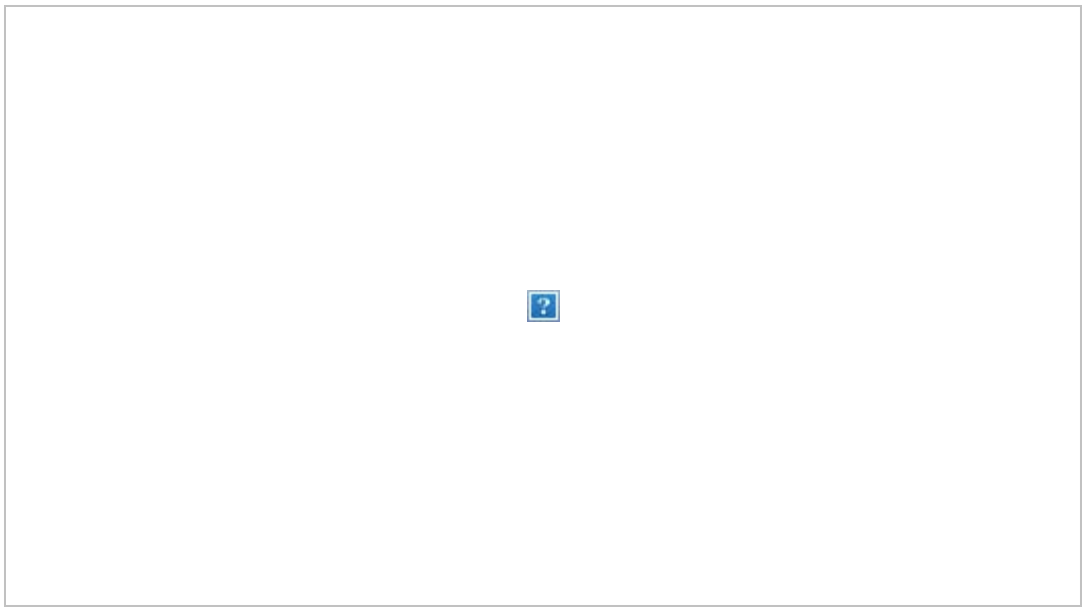
direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no higher priority than the health, safety and well-being of the American people.

"The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country. You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS



WATCH HERE AND HERE.

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

"The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus.

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And we will get through this.

> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

> "Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

> "I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

> "For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

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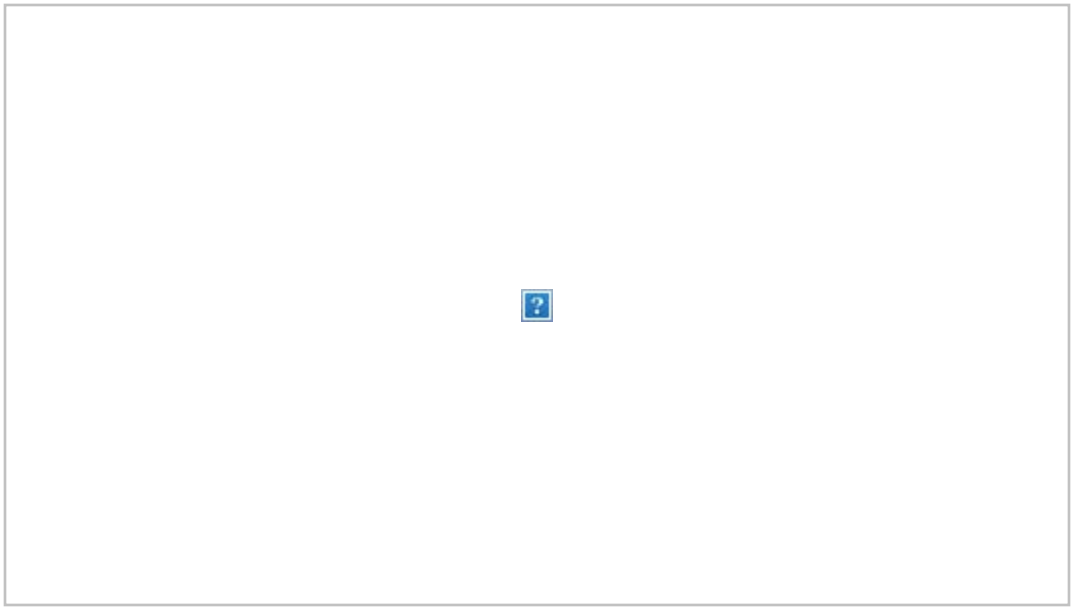

WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

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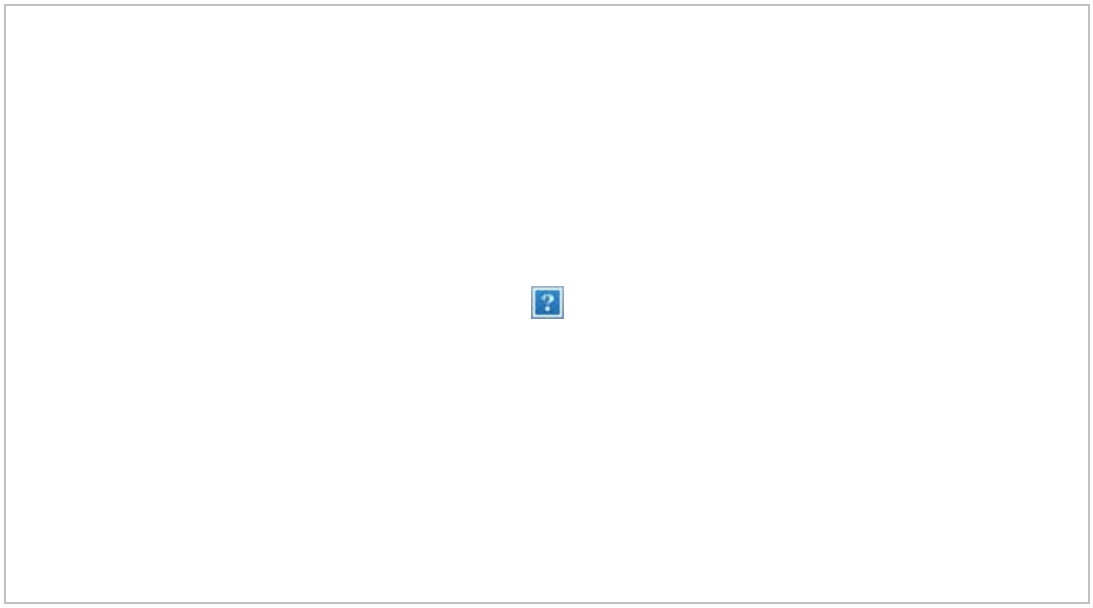
want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: Fw: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 12:53:45 PM
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Sent: Thursday, March 12, 2020 12:51 PM
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Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our

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office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs
The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the

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Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.

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- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
    - In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
    - In February, the President restricted travel for individuals recently traveling from Iran.
    - The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
    - Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.
- Today, the President directed his Administration to make general-use face masks available to our healthcare workers.
    - The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.
- President Trump signed into law more than $8 billion to fund response efforts.
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
- The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to

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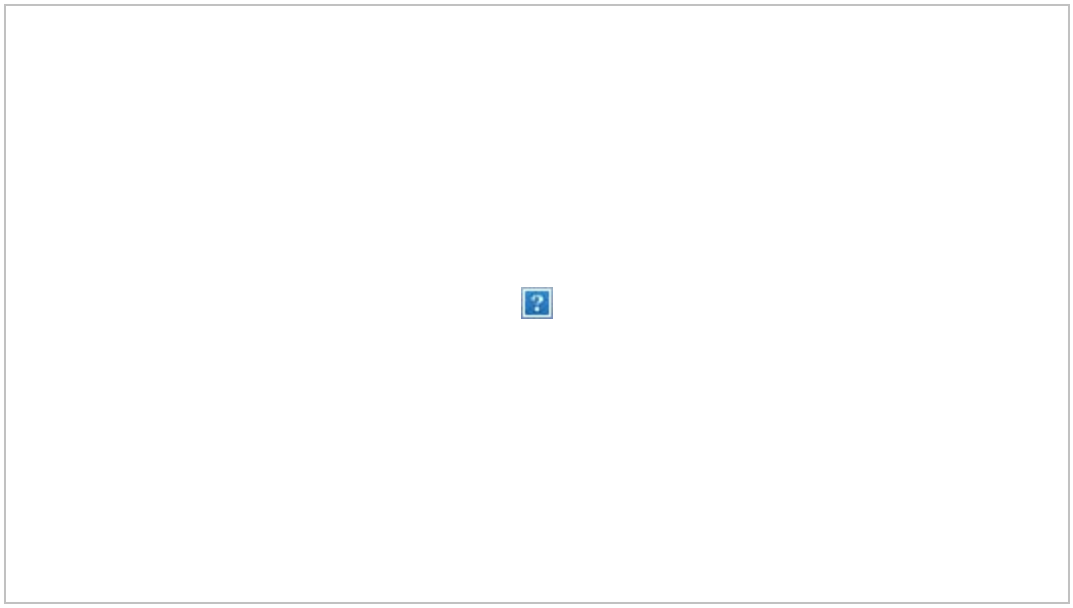
combat the coronavirus.

ON ABC's GOOD MORNING AMERICA



WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

> "The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities

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where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE.

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's

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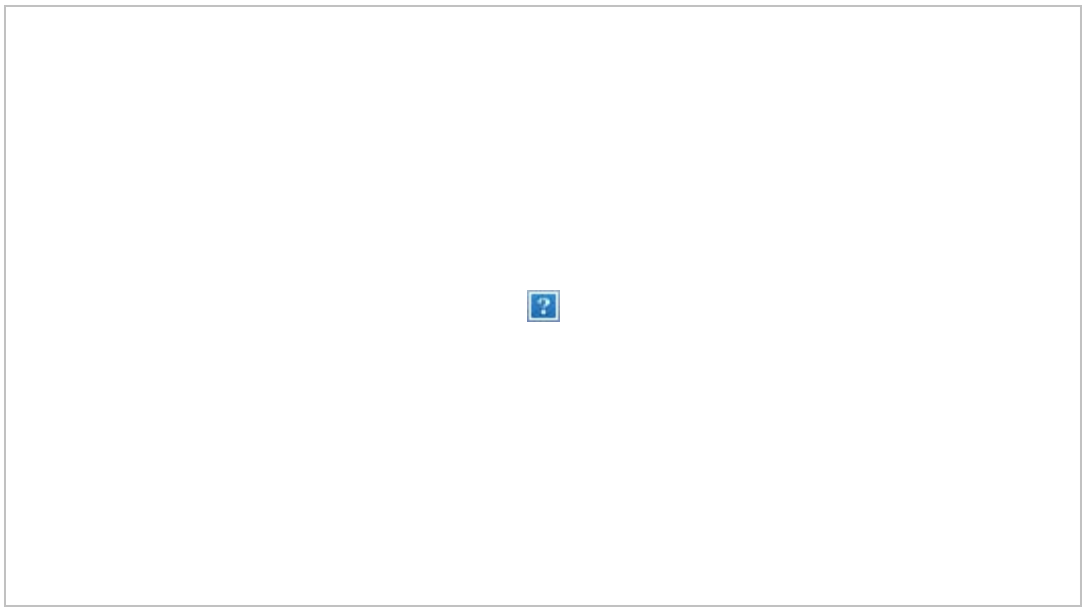
direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no higher priority than the health, safety and well-being of the American people.

"The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country. You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS



WATCH HERE AND HERE.

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

"The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus.

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And we will get through this.

> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

> "Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

> "I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

> "For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

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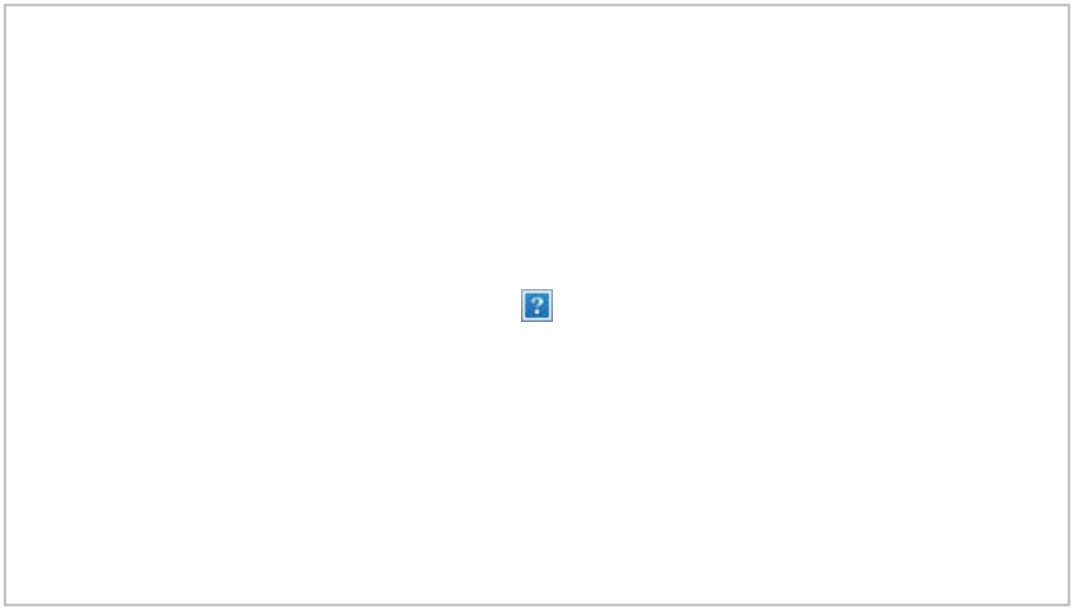

WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

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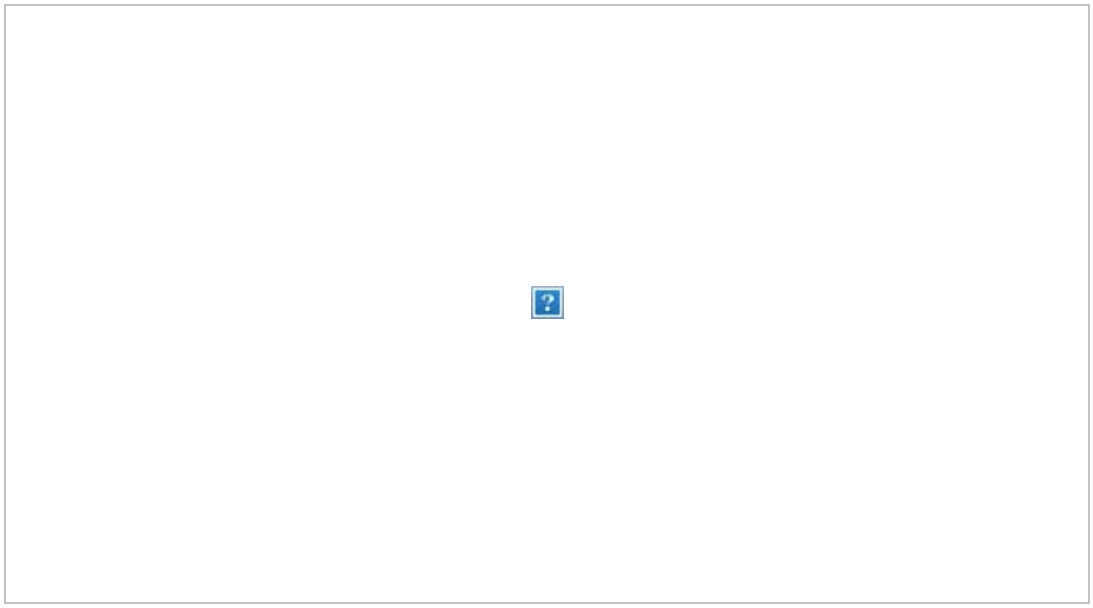
want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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From:	Scott, John
To:	jacqueline.s.zuluaga.mil@mail.mil; yesenia.villalta@flhealth.gov; eddie.borrego@jhsmiami.org
Cc:	McWhorter, Linda; Kincaid, Brooke
Subject:	FW: LAB FORMS AND PROCESS DOCUMENTS
Date:	Friday, March 20, 2020 8:20:26 PM
Attachments:	image001.png Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Black and White.pdf Greeting Script and Process 3_18_v2.docx Lab Process Guidelines_17 MAR.docx Informed Consent Instructional_17 MAR.docx COVID-19 Testing Center Requisition Form 2020.03.17_v13 for private partners.docx 3_Community-Based Testing Sites_Test and Result Info Sheet_3_19 v GENERAL_Black and White.pdf
Importance:	High

Good Evening

Attached are the updated versions to Emil I sent to you all earlier. They currently have been sent to print and I will let you know when they are ready….

Please disregard the previous email…….

v/r

John "JW" Scott III, EMT-P, CFI
Hazardous Materials Coordinator
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, FL 32399
Cell: (850) 567-4795

From: Kincaid, Brooke <Brooke.Kincaid@em.myflorida.com>
Sent: 20 March, 2020 20:14
To: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Cc: Scott, John <JohnW.Scott@em.myflorida.com>
Subject: RE: LAB FORMS AND PROCESS DOCUMENTS

Linda,

They have updated 1 of the forms and pushed it out to DOH at 6:52. This new version is the one I am pushing out to the printer for Miami and Orlando, and all the stuff being printed be found attached/who gets which printout and quantities can be found below:

- 3,000- What to Expect
- 3,000- Test Result Info Sheets
- 3,000- Requisition Form, that citizens should be filling out and handing back during the screening process. (Station 2) - The recommendation is **3,000 of each.**

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- 10,000-Info Sheet for Not Meeting Criteria
- 150- Scripts for those who will be doing initial greetings with the citizens arriving for testing. (Station 1)
- 150- Lab Processing Instructions for those doing the sample collection. (Station 3)
- 150- Informed Consent Instructions, for staff working at station 2.

If you have any more questions, please let me know .

Brooke Kincaid, MPA | Recovery Regional Manager and Region 2
Bureau of Recovery
Florida Division of Emergency Management
Rebuilding Together
(850)-567-6197 (c)
(850) 815-4437 (o)
Email: Brooke.Kincaid@em.myflorida.com

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.

From: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Sent: Friday, March 20, 2020 5:57 PM
To: Kincaid, Brooke <Brooke.Kincaid@em.myflorida.com>
Cc: Scott, John <JohnW.Scott@em.myflorida.com>
Subject: FW: LAB FORMS AND PROCESS DOCUMENTS
Importance: High

Brooke,

Please make sure these are the correct forms

Linda J. McWhorter
Preparedness Bureau Chief
2555 Shumard Oak Blvd
Tallahassee, FL 32399-21000
Office: (850) 815-4301
Mobile: (850) 528-7528
Linda.mcwhorter@em.myflorida.com

From: Scott, John <JohnW.Scott@em.myflorida.com>
Sent: Friday, March 20, 2020 5:56 PM
To: yesenia.villalta@flhealth.gov; eddie.borrego@jhsmiami.org
Cc: nicholas.m.fasanella.mil@mil.mil; McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Subject: LAB FORMS AND PROCESS DOCUMENTS
Importance: High

Attached are the forms you requested.

Please contact me directly with any questions you may have.

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John "JW" Scott III, EMT-P, CFI
Incident Commander, Hard Rock Stadium Complex
Hazardous Materials Coordinator
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Cell: (850) 567-4795



Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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Coronavirus

COVID-19

INSTRUCTIONS

While awaiting test results

You will receive a call from 1-833-447-0001 (Caller ID: Results Center) with test results in 3-5 days.

What should you do about work while you wait for test results?

- If you <u>are experiencing symptoms</u>: Stay home and, if applicable, notify your supervisor and note the date of testing.
- If you <u>are not experiencing symptoms</u>: Follow recommendations below to protect yourself. If you are a healthcare facility worker or first responder, request guidance from your supervisor on any potential work and patient care restrictions until you know your test results.
- Avoid using public transportation, ride-sharing or taxis when commuting.

What should you do to protect yourself while you wait for test results?

- Wash your hands often with soap and water for at least 20 seconds. Clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid close contact with people who are sick. Put distance between yourself and others when possible.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all “high-touch” surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

When you receive a call from 1-833-447-0001 (Caller ID: Results Center), please answer.
Due to privacy considerations, we are unable to leave a message. We will attempt two follow up calls.
If you have not received your test **result in 7 days**, contact your state or local health department.

Monitor any symptoms:

- Note the day any new symptoms begin.
- Check your temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or an in-person if your symptoms get worse. **Call ahead before visiting your doctor** and tell them you have been tested for COVID-19.
- Even if you don’t experience symptoms, you <u>might</u> make others sick.

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won’t stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **<u>call 911</u>** & notify the dispatch personnel that you may have COVID-19.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

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Coronavirus

COVID-19

TEST RESULTS

If you test positive for COVID-19

- Most cases can be cared for at home.
  - Do not go to the hospital to seek care unless you have a medical emergency.
- Do not go to work. Notify your employer of your positive test result. Begin home isolation.
- **Continue to monitor your symptoms at home as described on the opposite side.**
- Seek medical attention if you develop ANY of the following:
  - ❑ Extreme difficulty breathing
  - ❑ Bluish lips or face
  - ❑ Constant pain or pressure in the chest
  - ❑ Severe constant dizziness or lightheadedness
  - ❑ Difficult to wake up
  - ❑ Slurred speech (new or worsening)
  - ❑ New seizures or seizures that won't stop

What should you expect?

- Most people experience minor symptoms such as fever and cough.
- Over-the-counter medications that lesson symptoms of fever and cough may help. It is important to get rest and drink plenty of fluids.
- There is currently no vaccine or medication to treat or prevent COVID-19.

When does home isolation end?

- If you test positive for COVID-19, stay home and limit contact with others until:
  - You have been fever-free for at least 3 days without using medicine that reduces fevers

    AND
  - Your other symptoms have improved

    AND
  - At least 7 days have passed since your symptoms first appeared
- In all cases, follow the guidance of your healthcare provider and local health department.

If you test negative for COVID-19

- You are probably not infected at this time. However, you could have been exposed and test positive later. You must continue to practice all the protective measures to keep yourself and others negative.
- As long as the virus that causes COVID-19 is spreading in your community, continue to follow recommendations to protect yourself, including:
  - practice social distancing, wash your hands often, avoid touching your face, and avoid social gatherings according to local guidance.
- Follow guidance from your healthcare provider and your state and local health departments.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

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FL-DOH-20-0673-A-004134

Coronavirus

COVID-19 INFORMATION

At this time, this Community-based Testing Site is only testing healthcare facility workers and first responders or has reached capacity.

If you are experiencing COVID-19 symptoms or may have been exposed, contact your state or local health department for additional testing sites.

Continue to take steps to protect yourself

- Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all “high-touch” surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.

Continue to take steps to protect others

- Stay home if you’re sick.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

Monitor any symptoms:

- Note the day your symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or in-person if your symptoms get worse. **Call ahead before visiting your doctor.**

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won’t stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

Coronavirus

COVID-19

WHAT TO EXPECT AT COMMUNITY-BASED TESTING SITES

For Healthcare Facility Workers & First Responders

- **You must arrive in a personal vehicle**
- **Items to bring:**
  - Photo ID
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare facility employee or first responder ID/Badge (if applicable)

THINGS TO CONSIDER

- There are **no** bathrooms;
- Each person who needs testing must be seated next to a **working window**;
- All passengers must **stay inside** vehicles from arrival to departure;
- Try to **limit** the people in your vehicle to those needing testing; and
- There may be **significant wait times**.

ARRIVAL

- Each vehicle will be greeted and directed by personnel in full medical protective gear.

TEMPERATURE CHECK

- Your temperature will be checked using a no touch thermometer.

REGISTRATION

- Each person needing testing will be asked to provide the following:
  - Photo ID
  - First and last name
  - Healthcare facility employee or first responder ID/badge (if applicable)
  - Current address (where you are staying)
  - Best phone number to reach you (indicate mobile/landline)
  - Insurance card (if available)

TESTING

- A healthcare provider in personal protective equipment will provide you with instructions.
- You will be given a tissue to blow your nose and will need to keep your tissue to dispose on your own.
- A soft swab will be inserted deep into your nose to get the necessary sample. This may be slightly uncomfortable; however, the test is quick and should take less than a minute.

INFORMATION & DEPARTURE

- Once the test is complete, you will move to the final station.
- You will be given information to take with you on what to do while awaiting test results. **Please keep this paper until you get your test results.**
- Depart/Exit Community-based Testing Site.
- Follow the instructions on the paper provided by the Community-based Testing Site. Continue to monitor and record symptoms. You will receive test results via telephone.

For medical emergencies, call 911 and notify the dispatch that you may have COVID-19.

AMERICAN OVERSIGHT

Site Organization and ID Number:
Site Location:
Site Address:

COVID-19 by PCR Requisition Form

No other test may be ordered on this COVID-19 by PCR requisition form

Ordering Physician: Dr. Erica Schwartz, MD **Ordering Physician NPI:** 1427034826 **Quest Account Number:** 73916469 **LabCorp Account Number:** 32044780 **Result to:** Maximus	**CPT Code:** 87635 **Test Name:** COVID-19 by PCR **Sample Type:** Nasopharyngeal **ICD-10 Code:** Z03.818

1. DATE of Collection (MM/DD/YYYY) **2.TIME of Collection** **3. Language** (if not English)

/ / 2020 MM / DD / YYYY		

4. LAST NAME **5. FIRST NAME** **6. DOB** (MM/DD/YYYY)

		/ / MM / DD / YYYY

7. ADDRESS **8. CITY**

9. STATE **10. ZIP CODE** **11. PHONE (primary)**

		Cell / Home

12. Insurance Carrier Name 13. Group Number

14. Member/Individual Number

Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode or Unique Identifier affixed below

AMERICAN OVERSIGHT

SCRIPT FOR WEDNESDAY, MARCH 18:**

Script 1: Greeting

Good morning/afternoon, are you here for COVID-19 testing? Today we are only testing healthcare facility workers and first responders. Are you a healthcare facility worker or first responder?

“I am a healthcare facility work or first responder”

Here is what to expect at the testing site today. The registration team will verify that you meet these criteria. <*Provide “What to Expect” handout and number.*>

“I don’t meet that criteria”

We will not be able to test you today at this location. Here is some useful information that may be helpful about COVID-19 and other resources for testing. <*Provide “Information” handout.*>

Script 2: Not in an enclosed personal vehicle

I’m sorry, you must be in an enclosed personal vehicle for your safety. We will not be able to test you at this location. Here is some useful information that may be helpful about COVID-19 and other resources for testing. <*Provide “Information” handout.*>

Script 3: Site has reached capacity

We have reached the maximum number of vehicles that we can accommodate today. Here is some useful information that may be helpful about COVID-19 and other resources for testing. As a reminder, this site is only for healthcare facility workers and first responders today. If you meet the criteria; please come back tomorrow.

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PRIVACY ACT STATEMENT AND INFORMED CONSENT

Community Based Testing Sites are recommended to:

1. Print the attached 1-page “Informed Consent” verbiage.
2. Both English and Spanish versions are provided.
3. Recommend print multiple copies (double-sided printing)
4. Laminate if possible (for ease of sanitizing, as needed)
5. Identify the personnel at the registration site who will verbally read this to each individual proceeding for testing.
6. Recommended: hold up the Informed Consent for individuals to follow along while it is being verbally read.
7. For any individual requesting translation, utilize resources available, including telephonic. Collaborate with local healthcare network systems if necessary.

Verbal Informed Consent to be read out loud to each individual (see page 2):

AMERICAN OVERSIGHT

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PRIVACY ACT STATEMENT

Collection of this information is authorized by the Public Readiness and Emergency Preparedness Act (PREP Act), Pub. L. No. 109-148, and the President's Proclamation of a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. Your information will be used to notify you of your test results and to seek reimbursement from your health insurance provider, if applicable. Providing this information is voluntary, however failure to do so will make it impossible for us to notify you of your results. We will share this information with a diagnostics lab that will test your sample, with a call center that will notify you of your results, and with your health insurance provider.

"You have agreed, by coming to this test site, to participate in testing designed to identify whether you have been infected by the novel coronavirus and have developed COVID-19, the disease caused by the novel coronavirus. Your participation in this process is voluntary. Should you decide not to participate, you will not suffer any penalty or loss of benefits to which you are otherwise entitled. In addition, you should be aware of the following: This test involves the administration of a nasal swab that will capture mucus and secretions from your nose. This procedure is called a nasopharyngeal swab and is used to identify upper respiratory infections. Administering the swab is a low risk procedure, but there is a small risk that the swab could cause damage to the posterior nasopharynx. Your participation in this process and any records developed as a result of your participation that could be used to identify you are confidential and will be maintained in confidence.

Please indicate verbally that I have read this statement to you and that you give your informed consent to participate in this testing."

AMERICAN OVERSIGHT

Pre-Sampling Lab Process Instructions

Sample Test Medium Instructions:

- Your sampling kits contain Universal Transport Medium (UTM); please read this **CRITICAL** information:
  - **Storage Considerations**:
    This product must be stored in its original packaging at a temperature between 2-25^{0}C (35.6 - 77^{0}F) until the time of use. Do not overheat or freeze prior to use.
  - After collection, the specimen should be stored at 2-8°C (35.6-46.4°F) and processed within 48 hours.
  - When shipped, sample must remain at 2-8°C (35.6-46.4°F).
    For full product package insert instruction: https://www.copanusa.com/wp-content/uploads/2020/02/UTM-Package-Insert.pdf

Requisition Form Instructions for Sites:

- Recommend sites update certain fields within the form (before printing on-site):
  - **Site ID/Number**: Add organization name and ID as applicable (i.e. CVS #2100)
  - **Site Location**: If Community Based Testing Site (CBTS) has a specific name, input this here and keep it consistent throughout duration of testing. Labs will associate samples with this site specifically.
  - **Site Address**: Physical location must be added within header to include city, state, zip code.
  - Consider pre-populate the month and year within the form. Only date will need to be entered manually on-site
  - Print estimated amount needed for operations for the week.
- **Every field** on the attached form **is required** for the labs to be able to successfully process samples (including the fields within the header).
  - LABS WILL NOT PROCESS SAMPLE IF ANY PORTION OF THIS FORM IS NOT FILLED OUT.
- Sites must identify and designate a personnel member to verbally **read** the informed consent and privacy language to individuals (*verbiage is below*) before proceeding with registration and accurately identifying responses at the bottom of the form. Both ENGLISH/SPANISH versions are provided.

- **SAMPLE BARCODES**

  - Each individual being tested will receive a unique sample identification from the contract lab company.

AMERICAN OVERSIGHT

- Two (2) unique adhesive **matched barcodes** will be placed on 1) the sample tube and 2) on the requisition form.
- All samples will be identified with **two items**: a unique barcode and a label with written DOB of individual being tested.
- The barcodes must meet the following specifications:

  - Must have a human readable string (16 character max)
  - Must be Code 128 (barcode standard)

- Required supplies have been put on state supply list: paper/printers for forms, barcodes, labels (for DOB on sample), pens

  - Note: Quest has recommended a company called Standard Register who is ready to assist with form printing and would be able to print forms with barcodes pre-attached. If states want to procure forms and barcodes through them, the contact is Kevin Witte, cell phone: 973-723-1317, email: kevin.witte@taylorcommunications.com

*if community based testing sites are in collaboration with local health networks, and already have pre-existing electronic intake process(es) or a pre-existing hardcopy intake forms that includes all information that needs to be identified, please utilize those.

The attached intake form is **highly recommended,** as it includes ALL necessary components for labs to successfully process samples as intended. If using other private sector forms, but intending to send sample results to either LabCorp or Quest, ensure the required fields within the requisition form here are also populated on the other (private sector) form.

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: LAB Requisition Form and Process Guideline docs
Date:	Thursday, March 19, 2020 4:09:31 PM
Attachments:	image001.png COVID-19 Testing Center Requisition Form 2020.03.17_v13 for private partners.docx COVID-19 Testing Center Requisition Form 2020.03.17_vCVSBoston5.docx Informed Consent Instructional_17 MAR.docx Lab Process Guidelines_17 MAR.docx

More than likely a dupe email

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
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NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Tuesday, March 17, 2020 9:59 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA) <Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>;

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Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Fw: LAB Requisition Form and Process Guideline docs

Hi All,

Additional guidance for the community-based testing sites is attached. Please share with your regional, state, and local partners.

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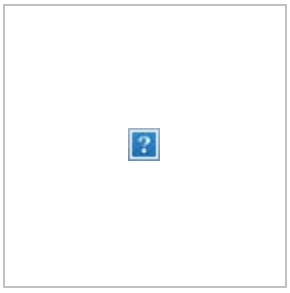
Artensie Flowers, PhD, MPH
CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



AMERICAN OVERSIGHT

Site Organization and ID Number: CVS 10596
Site Location: Massachusetts COVID-19 Testing Site
Site Address: 720 Boston Turnpike, Shrewsbury, MA 01545

COVID-19 by PCR Requisition Form

No other test may be ordered on this COVID-19 by PCR requisition form

Ordering Physician: Dr. Erica Schwartz, MD **Ordering Physician NPI:** 1427034826 **Quest Account Number:** 73916469 **LabCorp Account Number:** 32044780 **Result to:** Maximus	**CPT Code:** 87635 **Test Name:** COVID-19 by PCR **Sample Type:** Nasopharyngeal **ICD-10 Code:** Z03.818

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/ / 2020 MM / DD / YYYY		

4. LAST NAME **5. FIRST NAME** **6. DOB** (MM/DD/YYYY)

		/ / MM / DD / YYYY

7. ADDRESS **8. CITY**

9. STATE **10. ZIP CODE** **11. PHONE (primary)**

		Cell / Home

12. Insurance Carrier Name 13. Group Number

14. Member/Individual Number

Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode or Unique Identifier affixed below

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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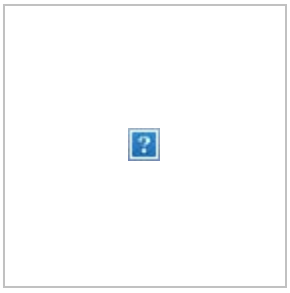
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



AMERICAN OVERSIGHT

Site Organization and ID Number: CVS 10596
Site Location: Massachusetts COVID-19 Testing Site
Site Address: 720 Boston Turnpike, Shrewsbury, MA 01545

COVID-19 by PCR Requisition Form

No other test may be ordered on this COVID-19 by PCR requisition form

Ordering Physician: Dr. Erica Schwartz, MD **Ordering Physician NPI:** 1427034826 **Quest Account Number:** 73916469 **LabCorp Account Number:** 32044780 **Result to:** Maximus	**CPT Code:** 87635 **Test Name:** COVID-19 by PCR **Sample Type:** Nasopharyngeal **ICD-10 Code:** Z03.818

1. DATE of Collection (MM/DD/YYYY) **2.TIME of Collection** **3. Language** (if not English)

/ / 2020 MM / DD / YYYY		

4. LAST NAME **5. FIRST NAME** **6. DOB** (MM/DD/YYYY)

		/ / MM / DD / YYYY

7. ADDRESS **8. CITY**

9. STATE **10. ZIP CODE** **11. PHONE (primary)**

		Cell / Home

12. Insurance Carrier Name 13. Group Number

14. Member/Individual Number

Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode or Unique Identifier affixed below

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Site Organization and ID Number:
Site Location:
Site Address:

COVID-19 by PCR Requisition Form

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		/ / MM / DD / YYYY

7. ADDRESS **8. CITY**

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		Cell / Home

12. Insurance Carrier Name 13. Group Number

14. Member/Individual Number

Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode or Unique Identifier affixed below

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PRIVACY ACT STATEMENT AND INFORMED CONSENT

Community Based Testing Sites are recommended to:

1. Print the attached 1-page “Informed Consent” verbiage.
2. Both English and Spanish versions are provided.
3. Recommend print multiple copies (double-sided printing)
4. Laminate if possible (for ease of sanitizing, as needed)
5. Identify the personnel at the registration site who will verbally read this to each individual proceeding for testing.
6. Recommended: hold up the Informed Consent for individuals to follow along while it is being verbally read.
7. For any individual requesting translation, utilize resources available, including telephonic. Collaborate with local healthcare network systems if necessary.

Verbal Informed Consent to be read out loud to each individual (see page 2):

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PRIVACY ACT STATEMENT

Collection of this information is authorized by the Public Readiness and Emergency Preparedness Act (PREP Act), Pub. L. No. 109-148, and the President's Proclamation of a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. Your information will be used to notify you of your test results and to seek reimbursement from your health insurance provider, if applicable. Providing this information is voluntary, however failure to do so will make it impossible for us to notify you of your results. We will share this information with a diagnostics lab that will test your sample, with a call center that will notify you of your results, and with your health insurance provider.

"You have agreed, by coming to this test site, to participate in testing designed to identify whether you have been infected by the novel coronavirus and have developed COVID-19, the disease caused by the novel coronavirus. Your participation in this process is voluntary. Should you decide not to participate, you will not suffer any penalty or loss of benefits to which you are otherwise entitled. In addition, you should be aware of the following: This test involves the administration of a nasal swab that will capture mucus and secretions from your nose. This procedure is called a nasopharyngeal swab and is used to identify upper respiratory infections. Administering the swab is a low risk procedure, but there is a small risk that the swab could cause damage to the posterior nasopharynx. Your participation in this process and any records developed as a result of your participation that could be used to identify you are confidential and will be maintained in confidence.

Please indicate verbally that I have read this statement to you and that you give your informed consent to participate in this testing."

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Pre-Sampling Lab Process Instructions

Sample Test Medium Instructions:

- Your sampling kits contain Universal Transport Medium (UTM); please read this **CRITICAL** information:
  - **Storage Considerations**:
    This product must be stored in its original packaging at a temperature between 2-25^{0}C (35.6 - 77^{0}F) until the time of use. Do not overheat or freeze prior to use.
  - After collection, the specimen should be stored at 2-8°C (35.6-46.4°F) and processed within 48 hours.
  - When shipped, sample must remain at 2-8°C (35.6-46.4°F).
    For full product package insert instruction: https://www.copanusa.com/wp-content/uploads/2020/02/UTM-Package-Insert.pdf

Requisition Form Instructions for Sites:

- Recommend sites update certain fields within the form (before printing on-site):
  - **Site ID/Number**: Add organization name and ID as applicable (i.e. CVS #2100)
  - **Site Location**: If Community Based Testing Site (CBTS) has a specific name, input this here and keep it consistent throughout duration of testing. Labs will associate samples with this site specifically.
  - **Site Address**: Physical location must be added within header to include city, state, zip code.
  - Consider pre-populate the month and year within the form. Only date will need to be entered manually on-site
  - Print estimated amount needed for operations for the week.
- **Every field** on the attached form **is required** for the labs to be able to successfully process samples (including the fields within the header).
  - LABS WILL NOT PROCESS SAMPLE IF ANY PORTION OF THIS FORM IS NOT FILLED OUT.
- Sites must identify and designate a personnel member to verbally **read** the informed consent and privacy language to individuals (*verbiage is below*) before proceeding with registration and accurately identifying responses at the bottom of the form. Both ENGLISH/SPANISH versions are provided.

- **SAMPLE BARCODES**

  - Each individual being tested will receive a unique sample identification from the contract lab company.

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- Two (2) unique adhesive **matched barcodes** will be placed on 1) the sample tube and 2) on the requisition form.
- All samples will be identified with **two items**: a unique barcode and a label with written DOB of individual being tested.
- The barcodes must meet the following specifications:

  - Must have a human readable string (16 character max)
  - Must be Code 128 (barcode standard)

- Required supplies have been put on state supply list: paper/printers for forms, barcodes, labels (for DOB on sample), pens

  - Note: Quest has recommended a company called Standard Register who is ready to assist with form printing and would be able to print forms with barcodes pre-attached. If states want to procure forms and barcodes through them, the contact is Kevin Witte, cell phone: 973-723-1317, email: kevin.witte@taylorcommunications.com

*if community based testing sites are in collaboration with local health networks, and already have pre-existing electronic intake process(es) or a pre-existing hardcopy intake forms that includes all information that needs to be identified, please utilize those.

The attached intake form is **highly recommended,** as it includes ALL necessary components for labs to successfully process samples as intended. If using other private sector forms, but intending to send sample results to either LabCorp or Quest, ensure the required fields within the requisition form here are also populated on the other (private sector) form.

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From:	Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
To:	Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
Cc:	Lewis, Elizabeth L. (CDC/DDNID/NCBDDD/DBDID) (CTR); Akosa, Amanda (CDC/DDNID/NCBDDD/DBDID) (CTR); Castillo, Keila (CDC/DDNID/NCBDDD/DBDID) (CTR); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Lessely O BrownShuler; Ysaias E Presas
Subject:	FW: March 5: COCA Call on COVID-19
Date:	Thursday, March 5, 2020 7:39:00 AM

Good morning USZPIR and SET-NET partners,

We wanted to make sure that you were all aware of the below resources for the novel coronavirus, COVID-19.

This **Thursday, March 5, at 2:00pm Eastern**, there will be a Clinician Outreach and Communication Activity (COCA) call where clinicians "will learn what they can do to prepare for COVID-19 including identifying persons under investigation, applying infection prevention and control measures, assessing risks for exposures, optimizing the use of personal protective equipment supplies, and managing and caring for patients (inpatient and at home)."

Call information is found at the link below. Participants are asked to access the call in a group format due to high demand. Target audience is physicians, nurses, pharmacists, veterinarians, physician assistants, health educators, and other clinicians.
https://emergency.cdc.gov/coca/calls/2020/callinfo_030520.asp

The following page has everything in one place from CDC:
https://www.cdc.gov/coronavirus/2019-ncov/index.html

Within that site, there is also a specific page with information on pregnancy, breastfeeding, and children:
https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/pregnant-women.html

Just sharing in case it is helpful for you or your colleagues.

Please let us know if you have any questions.

Best,
Megan

Megan Reynolds, MPH, MDiv, CPH
Coordinator, US Zika Pregnancy and Infant Registry
Emerging Threats Team
Infant Outcomes Monitoring, Research, and Prevention Branch
Division of Birth Defects and Infant Disorders
National Center on Birth Defects and Developmental Disabilities
Email: xah6@cdc.gov
Phone: 404-498-0604

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From:	Borrego, Eddie
To:	jimmy.arias.mil@mail.mil; sdean@miamigov.com
Cc:	Villalta, Yesenia D; lilianriv@gmail.com
Subject:	FW: Marlins Park Collection Site
Date:	Monday, March 23, 2020 4:24:58 PM
Attachments:	image001.png PreTesting Instructions or Guidelines03.23.2020.FINAL.pdf Where to Get Tested (3-23-2020).FINAL.pdf COVID19 SCREENING TOOL - MARLINS (002).pdf COVID19TESTINGSITE 03.23.2020.pdf
Importance:	High

See attached documents developed for this project.

From: Villalta, Yesenia D <Yesenia.Villalta@flhealth.gov>
Sent: Monday, March 23, 2020 3:53 PM
To: Borrego, Eddie <edward.borrego@jhsmiami.org>; inson.kim@miamidade.gov; Liz.silva@miamidade.gov
Cc: Rivera, Lillian <Lillian.Rivera@flhealth.gov>; Jackson, Iris F <Iris.Jackson@flhealth.gov>; Suarez, Sarah B <Sarah.Suarez@flhealth.gov>; Paterniti, Beth A <Beth.Paterniti@flhealth.gov>
Subject: Marlins Park Collection Site
Importance: High

WARNING: This email originated outside of Jackson Health System. Do not click links or attachments unless you recognize the sender and know the content is safe.

Good afternoon,

Please find the latest documents. Please let me know if you have any questions.

1. Script for Call Center
2. Pre-Specimen collection information (internal reference only)
3. COVID-Screening tool
4. Post specimen collection brochure

Thank you,

Yesenia D. Villalta, APRN, DNP, MSN
Florida Department of Health in Miami-Dade County
Administrator/Health Officer
Email: Yesenia.Villalta@flhealth.gov
Phone:(786)336-1260
Address: 8323 NW 12th Street Floor:02 Room:212
Miami, FL 33126

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How is my customer service? Please let me know by taking our survey at www.FDOHMDCares.com

Our Mission is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has very broad public records law. Most written communication to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

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FLORIDA HEALTH IN MIAMI-DADE COUNTY
COVID-19 SCREENING TOOL

SITE: Marlins Stadium ☐ **Date:** **Time:**

Last Name:

First Name: **Age:**

Date of birth: M M (MONTH) – D D (DAY) – Y Y Y Y (YEAR) **Sex:** Male: ☐ Female: ☐ Other: ☐

Race: White ☐ Black ☐ Asian / Pacific Islander ☐ Amarican Indian/ Alaskan ☐ Other: ☐ Unknown:: ☐

Ethnicity: Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Not specified ☐

Language: English ☐ Spanish ☐ Creole ☐ Other: ☐

Home Address:

City: **State:** **Zip Code:**

Telephone: – –

Email Address:

↓ IS THE PATIENT EXHIBITING THE FOLLOWING SYMPTOMS? ↓

Cough: YES ☐ NO ☐ **Or Shortness of Breath:** YES ☐ NO ☐

IN ADDITION TO THE ABOVE SYMPTOMS - PATIENT MEETS ONE OF THE FOLLOWING CRITERIAS

1) Are you 65 years old or greater?
YES ☐ NO ☐

2) Are you Immunocompromised?
YES ☐ NO ☐

3) Do you verbally consent to COVID-19 testing?
YES ☐ NO ☐

4) Are you driving yourself?
YES ☐ NO ☐

NOTE: If NO, only you and your driver are allowed in the vehicle at the specimen collection site and the driver will also be registered and tested.

5) Do you understand: you will be turned away if there are more than 2 persons in your vehicle.
YES ☐ NO ☐

Primary Doctor's Name: **Telephone Number:**

Name of Employee Completing Form:

Content Source: CDC

ONLY individuals that meet the above criteria are eligible for COVID-19 testing.

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10 ways to manage respiratory symptoms at home

Continue to monitor and record symptoms. The Florida Department of Health in Miami-Dade County will be contacting you with results within 7 days of testing.

1. **Stay home** from work, school, and away from other public places. If you must go out, avoid using any kind of public transportation, ridesharing, or taxis.



2. **Monitor your symptoms** carefully. If your symptoms get worse, call your healthcare provider immediately.



3. **Get rest and stay hydrated.**



4. If you have a medical appointment, **call the healthcare provider** ahead of time and tell them that you have or may have COVID-19.



5. For medical emergencies, call 911 and **notify the dispatch personnel** that you have or may have COVID-19.



6. **Cover your cough and sneezes.**



7. **Wash your hands often** with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.



8. As much as possible, **stay** in a specific room and **away from other people** in your home. Also, you should use a separate bathroom, if available. If you need to be around other people in or outside of the home, wear a facemask.



9. **Avoid sharing personal items** with other people in your household, like dishes, towels, and bedding.



10. **Clean all surfaces** that are touched often, like counters, tabletops, and doorknobs. Use household cleaning sprays or wipes according to the label instructions.



For more information:
Visit: www.cdc.gov/COVID19 Call: 305-470-5660

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[redacted]

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INTERNAL REFERENCE ONLY

Pre-Arrival to Testing Site Instructions

1. Vehicle Capacity: 2 – (1 Driver and 1 Passenger)
    a. The passenger must be sitting at an operating window
2. If there are two (2) people in one (1) vehicle, each person is individually registered and tested if they meet the testing criteria.
    a. A vehicle with more than two (2) people will be turned away from the testing site.
    b. If a vehicle arrives with more than two (2) people, the onsite lead Charge Nurse will make a clinical decision to proceed.
    c. If a person arrives with no appointment, the onsite lead Charge Nurse will make a clinical decision to proceed.
3. Each person(s) must remain in the vehicle from time of arrival to departure of the testing area
4. Testing is done via an open vehicle window. Ensure windows are operational.

THINGS TO CONSIDER ·There are no bathrooms; · Each person needing a test must be seated next to a working window; · All passengers must remain in the vehicle from arrival to departure; ·Try to limit the people in your vehicle to those needing a test; · Eat prior to appointment or bring snacks and water. There may be significant wait times (expect several hours)

At Arrival to Testing Site Instructions

1. Pull forward slowly, as instructed until arriving to first station.
2. Place car into park.
3. Slightly roll down window and speak loudly.

Testing Flow

Station 1 – Appointment Validation

- Assessors will ask for person(s) ID and confirm individual's name and the assigned code matches the appointment list
- Assessors provide an information packet to vehicle informing person(s) of public health information, including contact information

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Station 2 – Lab Registration (est. time: ~5 min per person)

- Scribers complete paper form with demographic information for each person to be tested (information relayed to Scribers via the Runner for each car):
    - First Name
    - Last Name
    - Phone
    - Email
    - Address
    - Date of Birth
    - Sex
    - Race & Ethnicity
- Scriber places lab requisition bag under the wiper of the front vehicle window.

Station 3 – Swabbing and Decontamination (est. time: 5 min)

- **Primary Swabber**
    - Confirm verbal authorization from person being swabbed for swab collection (ask runner)
    - Receive collection tube and swab from runner
    - Label collection tube with person's ID
    - Take swab of person(s) in car
    - Immediately place specimen swab into specimen collection tube
    - Insert specimen collection tube into secondary containment (specimen bag)
    - Place specimen bag on to temporary specimen bag staging table
    - Place form and sample bag in envelope, signs form as chain of custody, and places envelope in shipping container
    - Quality Control officer verifies all labels match and places specimen into sample cooler
        - Specimens must be maintained at a temperature between 2˚ -8˚ C (35.6˚F to 46.4˚F)
        - Specimens must be shipped in less than 48 hours of collection

VEHICLE EXITS

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Laboratory Processing

- All labs are processed using LabCorp

- **Results**
  - Participants are called by a Florida Department of Health in Miami-Dade employee to receive results.
  - Results may take up to 7 days depending on lab processing.

- **Negative Results**

Encourage individual to practice proper hygiene techniques, maintain social distancing measures as well as monitoring for signs and symptoms of COVID-19. Proper hygiene measures include washing the hands before meals and after using the bathroom, avoiding touching their face, proper covering of cough and sneeze.

- **Positive Results**

Monitor for signs and symptoms of complications such as:

- Difficulty breathing or shortness of breath,
- Persistent pain or pressure in the chest,
- new confusion or inability to arouse
- Blush lips or face

If this occurs, person is to immediately go to the nearest hospital or call 911. Currently, there is no treatment or vaccine for COVID-19. The best treatment available is based on the individuals' symptoms. Get plenty of rest, fluids, and use fever reducing and pain medication if needed. A Florida Department of Health in Miami-Dade employee will be reaching out all positive COVID-19 individuals daily either by telephone or via text messaging.

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Testing Request from Community

Agent: Thank you for contacting the _____. My name is _____. How can I assist you today?

Caller: I would like a COVID-19 test.

Agent: Are you or a family member experiencing any **severe** acute lower respiratory illness? The emergency warning signs include, but not limited to:

- Difficulty breathing or shortness of breath,
- Persistent pain or pressure in the chest,
- New confusion or inability to arouse
- Bluish lips or face

Caller Answers "Yes," then direct the person to seek emergency care immediately or call 911 for assistance. Caller answers "no" continue with the script.

Agent: Before directing you to a testing site, I will need to determine if you meet the criteria for COVID-19 testing.

Agent: Do you have a cough or shortness of breath

Caller Answers "Yes" to either cough or shortness of breath continue with the script.

Caller Answers "No". Then caller does not meet criteria.

AND the individual meets one or more of the following criteria

Agent: Are you age 65 or greater?

Caller Answers "Yes" continue script caller meets criteria.

Caller Answers "No" caller does not meet criteria.

Agent: Are you immunocompromised?

Caller Answers "Yes" continue script caller meets criteria.

Caller Answers "No" caller does not meet criteria.

CALLER MEETS CRITERIA:

Agent: You have met the criteria for COVID-19 testing. Miami-Dade County has a COVID-19 drive thru specimen collection site. Are you interested in scheduling an appointment?

Caller: Yes

Agent: *Proceed to make an appointment. Collect caller's demographic information, provide caller with address, special code and time of appointment. They should plan on arriving early as wait times will be long.*

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AGENT INFORMS CALLER

THINGS TO CONSIDER ·There are no bathrooms; · Each person needing a test must be seated next to a working window; · All passengers must remain in the vehicle from arrival to departure; ·Try to limit the people in your vehicle to those needing a test; · Eat prior to arriving to the specimen collection site; · Bring snacks and beverages as there may be significant wait times (expect several hours).

Agent: Only people with an appointment, special code and a valid Florida ID, license, passport, etc. will be tested.

Agent: Will you be driving yourself to the COVID-19 test collection site?

Caller Answers "Yes"

Agent: Upon arrival to the specimen collection site, you are to remain in your vehicle from the time of arrival to departure of the testing area. Testing will be done via an open vehicle window. Please ensure your window is operable.

Caller Answers "No"

Agent: Only you and your driver should be in the car upon arrival at the test site. Your driver will be registered and tested. Both windows of the vehicle should be operable. If you bring anyone other than yourself and a designated driver, you will be turned away and your appointment will be canceled.

Agent: Please confirm verbally that you understand this.

Caller: How soon can I get my test results?

Agent: Your results should be available within 7 days of testing. A Florida Department of Health in Miami-Dade employee will call you. Please do not call the state lab, the state health department or the local health department to get your results.

CALLER DOES NOT MEET CRITERIA:

Agent: I am sorry but based on the criteria for the specimen collection site you do not meet criteria for testing at this time. You may reach out to your medical provider for additional medical guidance. Please continue to take steps to protect yourself • Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. • Avoid close contact with people who are sick. • Avoid touching your eyes, nose, and mouth with unwashed hands. • Clean all "high-touch" surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Continue to take steps to protect others • Stay home if you're sick. • Cover coughs and sneezes. • If available, wear a facemask if you are sick.

Always reach out and **c**ontact your medical provider for guidance.

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Monitor for any symptoms:

- Note the day your symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or in-person if your symptoms get worse. Always call before visiting your doctor's office.
- Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies **Call 911 in case of an emergency**: - Extreme difficulty breathing - Bluish lips or face - Constant pain or pressure in the chest - Severe constant dizziness or lightheadedness - Acting confused - Difficult to wake up - Slurred speech (new or worsening).

For medical emergencies, call 911 and notify the dispatch personnel that you may have COVID-19.

If you have no insurance or a medical provider, I can direct you to the Florida Department of Health in Miami-Dade website for a list of Federally Qualified Health Centers. Please visit Miamidade.floridahealth.gov

If you have additional questions, you can call the Department of Health 24/7 COVID-19 Call Center The number to call is **1 (866) 779-6121** or visit http://miamidade.floridahealth.gov/

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From:	Moulton, Diane
To:	Rivkees, Scott; Eifert, James; Moskowitz, Jared; Swearingen, Rick; Mayhew, Mary; Corcoran, Richard
Cc:	Coppola, Courtney; Oglesby, Mark; Guthrie, Kevin; Philpot, Toby; Kelly, Alex; Lukis, Adrian
Subject:	FW: Meeting TODAY @ 3:30
Date:	Wednesday, February 19, 2020 10:29:56 AM

The meeting will be held in our large conference room (next to our reception area). Please let me know if you plan to attend in person or if you plan to participate via phone. The conference line is listed below. Also, please provide me with a list of your staff who plan to attend. Thank you!

1-888-585-9008
Conference room 260-782-751

From: Moulton, Diane
Sent: Wednesday, February 19, 2020 7:25 AM
To: Rivkees. Scott <scott.rivkees@flhealth.gov>; Eifert, James <James.o.eifert.mil@mail.mil>; Moskowitz, Jared <jared.moskowitz@em.myflorida.com>; Swearingen, Rick <rickswearingen@fdle.state.fl.us>; Mayhew, Mary <mary.mayhew@ahca.myflorida.com>; Corcoran, Richard <Richard.Corcoran@fldoe.org>
Subject: Meeting TODAY @ 3:30

The Governor would like to have a briefing regarding the Coronavirus today at 3:30. The briefing will be held in our small conference room. Please let me know if you can attend in person. If some of you can't attend in person, I will provide a conference line. Thank you all!

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

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From:	Ernst, Colleen
To:	StLaurent, Louise; Grow, Stefan; Carbone, Francis; Enriquez, Javier; Faircloth, Chuck; Montfort, Kerven; Tritschler, Richard
Subject:	FW: MEMORANDUM: Executive Orders 20-82 and 20-83
Date:	Wednesday, March 25, 2020 9:21:47 AM
Attachments:	20-82.pdf 20-83.pdf

From: Governor's Press Office <Governor'sPressOffice@eog.myflorida.com>
Sent: Tuesday, March 24, 2020 9:49 PM
Subject: MEMORANDUM: Executive Orders 20-82 and 20-83

MEMORANDUM

TO: Members of the Press

FROM: Helen Aguirre Ferré, Director of Communications, Governor Ron DeSantis

DATE: March 24, 2020

RE: Executive Orders 20-82 and 20-83

Good evening:

Today, Governor Ron DeSantis issued Executive Order 20-82, directing all persons who enter the State of Florida from an area with substantial community spread, to include the New York Tri-State Area (Connecticut, New Jersey and New York), to isolate or quarantine for a period of 14 days from the time of entry into the State of Florida or the duration of the person's presence in the State of Florida, whichever is shorter.

The Governor also issued Executive Order 20-83, directing the State Surgeon General and State Health Officer to issue a public health advisory to all persons over 65 years of age urging them to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

PDF copies of the Executive Orders are attached to this email and provided below.

Sincerely,

Helen Aguirre Ferré
Director of Communications
Governor Ron DeSantis

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STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-82

(Emergency Management - COVID-19 –Isolation of Individuals Traveling to Florida)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 9, 2020, I issued Executive Order 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19; and

WHEREAS, many cases of COVID-19 in Florida have resulted from individuals coming into the State of Florida from international travel and other states, posing great risk to Florida residents; and

WHEREAS, on March 23, 2020, I issued Executive Order 20-80 requiring the screening, isolation and quarantine of individuals whose point of departure originated outside the State of Florida in an area with substantial community spread, to include the New York Tri-State Area; and

WHEREAS, Florida is experiencing an increase in individuals fleeing to Florida from states where "shelter-in-place" orders are being implemented, including from the New York Tri-State Area; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, Chapter 252,

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Florida Statutes, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1.

A. I hereby direct all persons who enter the State of Florida from an area with substantial community spread, to include the New York Tri-State Area (Connecticut, New Jersey and New York), to isolate or quarantine for a period of 14 days from the time of entry into the State of Florida or the duration of the person's presence in the State of Florida, whichever is shorter. This Order shall not apply to persons employed by the airlines and those performing military, emergency or health response. This Order shall take effect immediately and apply retroactively to all persons who have entered Florida after being in any area with substantial community spread within the previous 14 days. All persons isolating or quarantining under this Section shall be responsible for all costs associated with their isolation or quarantine, including transportation, lodging, food, medical care and any other expenses to sustain the person during the period of isolation or quarantine.

B. I hereby direct all persons covered under Section 1(A) of this Order to inform any individual in Florida with whom they have had direct physical contact in the past 21 days that they traveled from an area with substantial community spread.

Section 2. Failure to follow Section 1 of this Order is a second-degree misdemeanor pursuant to section 252.50, Florida Statutes, and is punishable by imprisonment not to exceed 60 days, a fine not to exceed $500, or both.

Section 3.

A. Pursuant to section 252.47, Florida Statutes, I hereby direct all state, county and local law enforcement authorities to enforce this Order. Any law enforcement authority that interacts with a person in violation of Section 1(A) of

AMERICAN OVERSIGHT

this Order shall immediately report the individual, along with personal identifying and contact information, to the Florida Department of Health.

B. Pursuant to section 381.0012(5), Florida Statutes, "it shall be the duty of every state and county attorney, sheriff, police officer, and other appropriate city and county officials upon the request to assist the Department of Health" in enforcing any isolation or quarantine, state health law and order of the Department of Health issued pursuant to this Order.

Section 4. This Executive Order shall expire upon the expiration of Executive Order 20-52, including any extensions, or upon an Executive Order lifting the isolation or quarantine after advice from the State Health Officer and Surgeon General.

STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-83

(Emergency Management - COVID-19 –Protective Measures for Vulnerable Populations, Gatherings of Private Citizens and Density of the Workforce)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 9, 2020, I issued Executive Order 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19; and

WHEREAS, according to the Centers for Disease Control and Prevention (CDC), older adults and people of any age with serious underlying medical conditions are particularly

AMERICAN OVERSIGHT

at risk for severe illness or death due to COVID-19; and

WHEREAS, on March 16, 2020, President Donald J. Trump and the CDC issued "15 Days to Slow the Spread" guidance advising individuals to avoid social gatherings in groups of more than 10 people and advising older persons and persons with serious underlying health conditions to stay home and away from others; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, Chapter 252, Florida Statutes, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1.

A. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory to all persons over 65 years of age urging them to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

B. I further direct the State Surgeon General and State Health Officer to issue a public health advisory to persons that have a serious underlying medical condition that places them at a high risk of severe illness from COVID-19. Consistent with CDC guidance, such conditions include, but not limited to, chronic lung disease or moderate to severe asthma; serious heart conditions; immunocompromised status, including those in cancer treatment; and severe obesity. The Surgeon General's advisory must urge these persons to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

Section 2. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory against all social or recreational gatherings of 10 or more people.

Section 3. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory to those who can work remotely urging them to do so.

Section 4. Any action(s) taken or document(s) issued by the State Surgeon General

AMERICAN OVERSIGHT

and State Health Officer pursuant to this Executive Order shall not constitute a rule as defined in section 120.52(16), Florida Statutes, and are specifically exempted from any and all requirements or procedures outlined in chapter 120 and section 252.46, Florida Statutes.

Section 5. This Executive Order shall expire upon the expiration of Executive Order 20-52, including any extensions.

###

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

AMERICAN OVERSIGHT

STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-82

(Emergency Management - COVID-19 –Isolation of Individuals Traveling to Florida)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 9, 2020, I issued Executive Order 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19; and

WHEREAS, many cases of COVID-19 in Florida have resulted from individuals coming into the State of Florida from international travel and other states, posing great risk to Florida residents; and

WHEREAS, on March 23, 2020, I issued Executive Order 20-80 requiring the screening, isolation and quarantine of individuals whose point of departure originated outside the State of Florida in an area with substantial community spread, to include the New York Tri-State Area; and

WHEREAS, Florida is experiencing an increase in individuals fleeing to Florida from states where "shelter-in-place" orders are being implemented, including from the New York Tri-State Area; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

AMERICAN OVERSIGHT

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, Chapter 252, Florida Statutes, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1.

A. I hereby direct all persons who enter the State of Florida from an area with substantial community spread, to include the New York Tri-State Area (Connecticut, New Jersey and New York), to isolate or quarantine for a period of 14 days from the time of entry into the State of Florida or the duration of the person's presence in the State of Florida, whichever is shorter. This Order shall not apply to persons employed by the airlines and those performing military, emergency or health response. This Order shall take effect immediately and apply retroactively to all persons who have entered Florida after being in any area with substantial community spread within the previous 14 days. All persons isolating or quarantining under this Section shall be responsible for all costs associated with their isolation or quarantine, including transportation, lodging, food, medical care and any other expenses to sustain the person during the period of isolation or quarantine.

B. I hereby direct all persons covered under Section 1(A) of this Order to inform any individual in Florida with whom they have had direct physical contact in the past 21 days that they traveled from an area with substantial community spread.

Section 2. Failure to follow Section 1 of this Order is a second-degree misdemeanor pursuant to section 252.50, Florida Statutes, and is punishable by imprisonment not to exceed 60 days, a fine not to exceed $500, or both.

Section 3.

A. Pursuant to section 252.47, Florida Statutes, I hereby direct all state, county and local law enforcement authorities to enforce this Order. Any law enforcement authority that interacts with a

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004186

person in violation of Section 1(A) of this Order shall immediately report the individual, along with personal identifying and contact information, to the Florida Department of Health.

B. Pursuant to section 381.0012(5), Florida Statutes, "it shall be the duty of every state and county attorney, sheriff, police officer, and other appropriate city and county officials upon the request to assist the Department of Health" in enforcing any isolation or quarantine, state health law and order of the Department of Health issued pursuant to this Order.

Section 4. This Executive Order shall expire upon the expiration of Executive Order 20-52, including any extensions, or upon an Executive Order lifting the isolation or quarantine after advice from the State Health Officer and Surgeon General.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 24th day of March, 2020.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2020 MAR 24 PM 9:28
DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA

AMERICAN OVERSIGHT

STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-83

(Emergency Management - COVID-19 –Protective Measures for Vulnerable Populations, Gatherings of Private Citizens and Density of the Workforce)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 9, 2020, I issued Executive Order 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19; and

WHEREAS, according to the Centers for Disease Control and Prevention (CDC), older adults and people of any age with serious underlying medical conditions are particularly at risk for severe illness or death due to COVID-19; and

WHEREAS, on March 16, 2020, President Donald J. Trump and the CDC issued "15 Days to Slow the Spread" guidance advising individuals to avoid social gatherings in groups of more than 10 people and advising older persons and persons with serious underlying health conditions to stay home and away from others; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

AMERICAN OVERSIGHT

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B. I further direct the State Surgeon General and State Health Officer to issue a public health advisory to persons that have a serious underlying medical condition that places them at a high risk of severe illness from COVID-19. Consistent with CDC guidance, such conditions include, but not limited to, chronic lung disease or moderate to severe asthma; serious heart conditions; immunocompromised status, including those in cancer treatment; and severe obesity. The Surgeon General's advisory must urge these persons to stay home and to take such other measures as necessary to limit their risk of exposure to COVID-19.

Section 2. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory against all social or recreational gatherings of 10 or more people.

Section 3. I hereby direct the State Surgeon General and State Health Officer to issue a public health advisory to those who can work remotely urging them to do so.

Section 4. Any action(s) taken or document(s) issued by the State Surgeon General and State Health Officer pursuant to this Executive Order shall not constitute a rule as defined in section 120.52(16), Florida Statutes, and are specifically exempted from any and all requirements or procedures outlined in chapter 120 and section 252.46, Florida Statutes.

AMERICAN OVERSIGHT

Section 5. This Executive Order shall expire upon the expiration of Executive Order 20-52, including any extensions.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 24th day of March, 2020.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2020 MAR 24 PM 9:28
DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: Please Disseminate: Handouts for Community-based Testing Sites
Date:	Thursday, March 19, 2020 4:08:12 PM
Attachments:	image001.png Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Color.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Black and White.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Color.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Color.pdf

FYI

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
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NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Wednesday, March 18, 2020 10:09 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA)

AMERICAN OVERSIGHT

<Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>; Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Please Disseminate: Handouts for Community-based Testing Sites

PLEASE DISSEMINATE TO YOUR STATES AND LOCAL HEALTH PARTNERS PARTICIPATING IN THE CBTS INITIATIVE

Intended Use of the Handouts Provided to Community-based Testing Sites:

These 3 documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below our capacity numbers. (Note: When the website is launched, the same information will also be available in text format with a print option.)

2) Information:

Purpose: To provide individuals who will not be tested because of capacity issues or because they do not meet testing criteria at that site have useful information on what to do next.

Instructions:

Hand out this document to the following:

- people who are in line but will not receive testing because we have exceeded capacity
- people who are in line but will not receive testing because they are not healthcare facility workers or first-responders

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested instructions on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

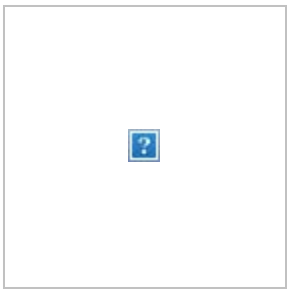
Hand out this document at the final station and instruct people to keep the paper until they receive the test results.

Artensie Flowers, PhD, MPH

AMERICAN OVERSIGHT

CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
Phone: 202-836-2406 | Email: artensie.flowers@hhs.gov



AMERICAN OVERSIGHT

Coronavirus
COVID-19

INFORMATION

At this time, this Community-based Testing Site is only testing healthcare facility workers and first responders or has reached capacity.

If you are experiencing COVID-19 symptoms or may have been exposed, contact your state or local health department for additional testing sites.

Continue to take steps to protect yourself

- Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all "high-touch" surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.

Continue to take steps to protect others

- Stay home if you're sick.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

Monitor any symptoms:

- Note the day your symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or in-person if your symptoms get worse. **Call ahead before visiting your doctor.**

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won't stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004194

Coronavirus

COVID-19 INFORMATION

At this time, this Community-based Testing Site is only testing healthcare facility workers and first responders or has reached capacity.

If you are experiencing COVID-19 symptoms or may have been exposed, contact your state or local health department for additional testing sites.

Continue to take steps to protect yourself

- Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all “high-touch” surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.

Continue to take steps to protect others

- Stay home if you’re sick.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

Monitor any symptoms:

- Note the day your symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or in-person if your symptoms get worse. **Call ahead before visiting your doctor.**

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- Extremely difficult breathing
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- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won’t stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

Coronavirus

COVID-19

INSTRUCTIONS

For Tested Healthcare Facility Workers & First Responders

You will receive a call from 1-833-447-0001 with test results in 3-5 days.

What should you do about work while you wait for test results?

- Please inform your supervisor at work that you have been tested for COVID-19 and note the date of testing.
- If you are experiencing symptoms: Notify your supervisor and stay home.
- If you are not experiencing symptoms: Request guidance from your supervisor on any potential work and patient care restrictions until you know your test results.
- Avoid using public transportation, ride-sharing or taxis when commuting.

What should you do to protect yourself while you wait for test results?

- Wash your hands often with soap and water for at least 20 seconds. Clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all "high-touch" surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

When you receive a call from 1-833-447-0001 (Caller ID: Results Center), please answer.
Due to privacy considerations, we are unable to leave a message. We will attempt two follow up calls.
If you have not received your test **result in 7 days**, contact your state or local health department.

Monitor any symptoms:

- Note the day any new symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or an in-person if your symptoms get worse. **Call ahead before visiting your doctor** and tell them you have been tested for COVID-19.
- Even if you don't experience symptoms, you might make others sick.

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won't stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you have COVID-19.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004196

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

Coronavirus

COVID-19

TEST RESULTS

For Healthcare Facility Workers & First Responders

If you test positive for COVID-19, keep your entire household home

- Most cases can be cared for at home.
  - Do not go to the hospital to seek care unless you have a medical emergency.
- Do not go to work. Notify your employer of your positive test result.
- **Continue to monitor your symptoms at home as described on the opposite side.**
- Seek medical attention if you develop ANY of the following:
  - ❑ Extreme difficulty breathing
  - ❑ Bluish lips or face
  - ❑ Constant pain or pressure in the chest
  - ❑ Severe constant dizziness or lightheadedness
  - ❑ Difficult to wake up
  - ❑ Slurred speech (new or worsening)
  - ❑ New seizures or seizures that won't stop

What should you expect?

- Most people experience minor symptoms such as fever and cough.
- Over-the-counter medications that lesson symptoms of fever and cough may help. It is important to get rest and drink plenty of fluids.
- There is currently no vaccine or medication to treat or prevent COVID-19.

When does home isolation end?

- If you test positive for COVID-19, stay home and limit contact with others until:
  - You have been fever-free for at least 3 days without using medicine that reduces fevers

    AND
  - Your other symptoms have improved

    AND
  - At least 7 days have passed since your symptoms first appeared
- You will need to consult your employer prior to returning to work.

If you test negative for COVID-19

- You are probably not infected at this time. However, you could have been exposed and test positive later. You must continue to practice all the protective measures to keep yourself and others negative.
- As long as the virus that causes COVID-19 is spreading in your community, continue to follow recommendations to protect yourself, including:
  - practice social distancing, wash your hands often, avoid touching your face, and avoid social gatherings according to local guidance.
- Follow guidance from your healthcare provider and your state and local health departments.

AMERICAN OVERSIGHT

Coronavirus

COVID-19

INSTRUCTIONS

For Tested Healthcare Facility Workers & First Responders

You will receive a call from 1-833-447-0001 with test results in 3-5 days.

What should you do about work while you wait for test results?

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- If you are experiencing symptoms: Notify your supervisor and stay home.
- If you are not experiencing symptoms: Request guidance from your supervisor on any potential work and patient care restrictions until you know your test results.
- Avoid using public transportation, ride-sharing or taxis when commuting.

What should you do to protect yourself while you wait for test results?

- Wash your hands often with soap and water for at least 20 seconds. Clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all “high-touch” surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.
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- Even if you don’t experience symptoms, you might make others sick.

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

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- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won’t stop

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For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

Coronavirus

COVID-19

TEST RESULTS

For Healthcare Facility Workers & First Responders

If you test positive for COVID-19, keep your entire household home

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  - Do not go to the hospital to seek care unless you have a medical emergency.
- Do not go to work. Notify your employer of your positive test result.
- **Continue to monitor your symptoms at home as described on the opposite side.**
- Seek medical attention if you develop ANY of the following:
  - ❑ Extreme difficulty breathing
  - ❑ Bluish lips or face
  - ❑ Constant pain or pressure in the chest
  - ❑ Severe constant dizziness or lightheadedness
  - ❑ Difficult to wake up
  - ❑ Slurred speech (new or worsening)
  - ❑ New seizures or seizures that won't stop

What should you expect?

- Most people experience minor symptoms such as fever and cough.
- Over-the-counter medications that lesson symptoms of fever and cough may help. It is important to get rest and drink plenty of fluids.
- There is currently no vaccine or medication to treat or prevent COVID-19.

When does home isolation end?

- If you test positive for COVID-19, stay home and limit contact with others until:
  - You have been fever-free for at least 3 days without using medicine that reduces fevers

    AND
  - Your other symptoms have improved

    AND
  - At least 7 days have passed since your symptoms first appeared
- You will need to consult your employer prior to returning to work.

If you test negative for COVID-19

- You are probably not infected at this time. However, you could have been exposed and test positive later. You must continue to practice all the protective measures to keep yourself and others negative.
- As long as the virus that causes COVID-19 is spreading in your community, continue to follow recommendations to protect yourself, including:
  - practice social distancing, wash your hands often, avoid touching your face, and avoid social gatherings according to local guidance.
- Follow guidance from your healthcare provider and your state and local health departments.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004199

Coronavirus

COVID-19

WHAT TO EXPECT AT COMMUNITY-BASED TESTING SITES

For Healthcare Facility Workers & First Responders

- **You must arrive in a personal vehicle**
- **Items to bring:**
  - Photo ID
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare facility employee or first responder ID/Badge (if applicable)

THINGS TO CONSIDER

- There are **no** bathrooms;
- Each person who needs testing must be seated next to a **working window**;
- All passengers must **stay inside** vehicles from arrival to departure;
- Try to **limit** the people in your vehicle to those needing testing; and
- There may be **significant wait times**.

ARRIVAL

- Each vehicle will be greeted and directed by personnel in full medical protective gear.

TEMPERATURE CHECK

- Your temperature will be checked using a no touch thermometer.

REGISTRATION

- Each person needing testing will be asked to provide the following:
  - Photo ID
  - First and last name
  - Healthcare facility employee or first responder ID/badge
  - Current address (where you are staying)
  - Best phone number to reach you (indicate mobile/landline)
  - Insurance card (if available)

TESTING

- A healthcare provider in personal protective equipment will provide you with instructions.
- You will be given a tissue to blow your nose and will need to keep your tissue to dispose on your own.
- A soft swab will be inserted deep into your nose to get the necessary sample. This may be slightly uncomfortable; however, the test is quick and should take less than a minute.

INFORMATION & DEPARTURE

- Once the test is complete, you will move to the final station.
- You will be given information to take with you on what to do while awaiting test results. **Please keep this paper until you get your test results.**
- Depart/Exit Community-based Testing Site.
- Follow the instructions on the paper provided by the Community-based Testing Site. Continue to monitor and record symptoms. You will receive test results via telephone.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004200

For medical emergencies, call 911 and notify the dispatch that you may have COVID-19.

Coronavirus

COVID-19

WHAT TO EXPECT AT COMMUNITY-BASED TESTING SITES

For Healthcare Facility Workers & First Responders

- **You must arrive in a personal vehicle**
- **Items to bring:**
  - Photo ID
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare facility employee or first responder ID/Badge (if applicable)

THINGS TO CONSIDER

- There are **no** bathrooms;
- Each person who needs testing must be seated next to a **working window**;
- All passengers must **stay inside** vehicles from arrival to departure;
- Try to **limit** the people in your vehicle to those needing testing; and
- There may be **significant wait times**.

ARRIVAL

- Each vehicle will be greeted and directed by personnel in full medical protective gear.

TEMPERATURE CHECK

- Your temperature will be checked using a no touch thermometer.

REGISTRATION

- Each person needing testing will be asked to provide the following:
  - Photo ID
  - First and last name
  - Healthcare facility employee or first responder ID/badge (if applicable)
  - Current address (where you are staying)
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  - Insurance card (if available)

TESTING

- A healthcare provider in personal protective equipment will provide you with instructions.
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INFORMATION & DEPARTURE

- Once the test is complete, you will move to the final station.
- You will be given information to take with you on what to do while awaiting test results. **Please keep this paper until you get your test results.**
- Depart/Exit Community-based Testing Site.
- Follow the instructions on the paper provided by the Community-based Testing Site. Continue to monitor and record symptoms. You will receive test results via telephone.

For medical emergencies, call 911 and notify the dispatch that you may have COVID-19.

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	FW: Please Disseminate: Handouts for Community-based Testing Sites
Date:	Thursday, March 19, 2020 4:06:35 PM
Attachments:	image001.png Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Info Sheet for Not Meeting Criteria_3_18_FINAL_Color.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Black and White.pdf Community-Based Testing Sites_What to Expect_3_18_FINAL_Color.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Blank and White.pdf Community-Based Testing Sites_Test and Result Info Sheet_3_18_FINAL_Color.pdf

FYI

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
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From: Flowers, Artensie (OS/ASPR/EMMO) <Artensie.Flowers@hhs.gov>
Sent: Wednesday, March 18, 2020 10:09 PM
To: Baker, Matthew (HHS/IEA) <Matthew.Baker@hhs.gov>; Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>; Beckman, Susan (HHS/IEA) <Susan.Beckman@hhs.gov>; DFOR Regional Operations Branch <ASPR.DFOR.RegionalOps@hhs.gov>; Ferreri, Anthony (HHS/IEA)

AMERICAN OVERSIGHT

<Anthony.Ferreri@hhs.gov>; Gonzalez, Dennis (HHS/IEA) <Dennis.Gonzalez@HHS.GOV>; Graham, John (HHS/IEA) <John.Graham@hhs.gov>; Heidig, Edward (HHS/IEA) <Edward.Heidig@hhs.gov>; Kahrs, Jeff (HHS/IEA) <Jeff.Kahrs@hhs.gov>; Lincoln, Carol (OS/ASPR/EMMO) <Carol.Lincoln@hhs.gov>; Mccreary, Kenneth (OS/ASPR/SPPR) <Kenneth.Mccreary@hhs.gov>; McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; O'brien, Douglas (OS/IEA) <Douglas.Obrien@hhs.gov>; Pereira, Esmeralda (OS/ASPR/EMMO) <esmeralda.pereira@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Schuster, Fred (HHS/IEA) <Fred.Schuster@hhs.gov>; tiffany.r.bilderback.mil@mail.mil; Vineyard, Michael (OS/ASPR/IO) <Michael.Vineyard@HHS.GOV>
Subject: Please Disseminate: Handouts for Community-based Testing Sites

****PLEASE DISSEMINATE TO YOUR STATES AND LOCAL HEALTH PARTNERS PARTICIPATING IN THE CBTS INITIATIVE****

Intended Use of the Handouts Provided to Community-based Testing Sites:

These 3 documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below our capacity numbers. (Note: When the website is launched, the same information will also be available in text format with a print option.)

2) Information:

Purpose: To provide individuals who will not be tested because of capacity issues or because they do not meet testing criteria at that site have useful information on what to do next.

Instructions:

Hand out this document to the following:

- people who are in line but will not receive testing because we have exceeded capacity
- people who are in line but will not receive testing because they are not healthcare facility workers or first-responders

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested instructions on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

Hand out this document at the final station and instruct people to keep the paper until they receive the test results.

Artensie Flowers, PhD, MPH

AMERICAN OVERSIGHT

CDR, US Public Health Service
Regional Emergency Coordinators Program Manager

U.S. Department of Health and Human Services | Assistant Secretary for Preparedness and Response
Division of Field Operations and Response (DFOR)
200 C Street, SW | O'Neil Federal Building | Washington, DC 20515
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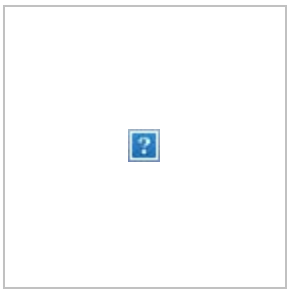

AMERICAN OVERSIGHT

Coronavirus
COVID-19

INFORMATION

At this time, this Community-based Testing Site is only testing healthcare facility workers and first responders or has reached capacity.

If you are experiencing COVID-19 symptoms or may have been exposed, contact your state or local health department for additional testing sites.

Continue to take steps to protect yourself

- Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all "high-touch" surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.

Continue to take steps to protect others

- Stay home if you're sick.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

Monitor any symptoms:

- Note the day your symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or in-person if your symptoms get worse. **Call ahead before visiting your doctor.**

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won't stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004206

Coronavirus

COVID-19 INFORMATION

At this time, this Community-based Testing Site is only testing healthcare facility workers and first responders or has reached capacity.

If you are experiencing COVID-19 symptoms or may have been exposed, contact your state or local health department for additional testing sites.

Continue to take steps to protect yourself

- Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all “high-touch” surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.

Continue to take steps to protect others

- Stay home if you’re sick.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

Monitor any symptoms:

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- Bluish lips or face
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- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won’t stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

Coronavirus

COVID-19

INSTRUCTIONS

For Tested Healthcare Facility Workers & First Responders

You will receive a call from 1-833-447-0001 with test results in 3-5 days.

What should you do about work while you wait for test results?

- Please inform your supervisor at work that you have been tested for COVID-19 and note the date of testing.
- If you are experiencing symptoms: Notify your supervisor and stay home.
- If you are not experiencing symptoms: Request guidance from your supervisor on any potential work and patient care restrictions until you know your test results.
- Avoid using public transportation, ride-sharing or taxis when commuting.

What should you do to protect yourself while you wait for test results?

- Wash your hands often with soap and water for at least 20 seconds. Clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all "high-touch" surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

When you receive a call from 1-833-447-0001 (Caller ID: Results Center), please answer.
Due to privacy considerations, we are unable to leave a message. We will attempt two follow up calls.
If you have not received your test **result in 7 days**, contact your state or local health department.

Monitor any symptoms:

- Note the day any new symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or an in-person if your symptoms get worse. **Call ahead before visiting your doctor** and tell them you have been tested for COVID-19.
- Even if you don't experience symptoms, you might make others sick.

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won't stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you have COVID-19.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004208

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

Coronavirus

COVID-19

TEST RESULTS

For Healthcare Facility Workers & First Responders

If you test positive for COVID-19, keep your entire household home

- Most cases can be cared for at home.
  - Do not go to the hospital to seek care unless you have a medical emergency.
- Do not go to work. Notify your employer of your positive test result.
- **Continue to monitor your symptoms at home as described on the opposite side.**
- Seek medical attention if you develop ANY of the following:
  - ❑ Extreme difficulty breathing
  - ❑ Bluish lips or face
  - ❑ Constant pain or pressure in the chest
  - ❑ Severe constant dizziness or lightheadedness
  - ❑ Difficult to wake up
  - ❑ Slurred speech (new or worsening)
  - ❑ New seizures or seizures that won't stop

What should you expect?

- Most people experience minor symptoms such as fever and cough.
- Over-the-counter medications that lesson symptoms of fever and cough may help. It is important to get rest and drink plenty of fluids.
- There is currently no vaccine or medication to treat or prevent COVID-19.

When does home isolation end?

- If you test positive for COVID-19, stay home and limit contact with others until:
  - You have been fever-free for at least 3 days without using medicine that reduces fevers

    AND
  - Your other symptoms have improved

    AND
  - At least 7 days have passed since your symptoms first appeared
- You will need to consult your employer prior to returning to work.

If you test negative for COVID-19

- You are probably not infected at this time. However, you could have been exposed and test positive later. You must continue to practice all the protective measures to keep yourself and others negative.
- As long as the virus that causes COVID-19 is spreading in your community, continue to follow recommendations to protect yourself, including:
  - practice social distancing, wash your hands often, avoid touching your face, and avoid social gatherings according to local guidance.
- Follow guidance from your healthcare provider and your state and local health departments.

AMERICAN OVERSIGHT

Coronavirus

COVID-19

INSTRUCTIONS

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- If you are experiencing symptoms: Notify your supervisor and stay home.
- If you are not experiencing symptoms: Request guidance from your supervisor on any potential work and patient care restrictions until you know your test results.
- Avoid using public transportation, ride-sharing or taxis when commuting.

What should you do to protect yourself while you wait for test results?

- Wash your hands often with soap and water for at least 20 seconds. Clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid close contact with people who are sick.
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- Clean all “high-touch” surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.
- Cover coughs and sneezes.
- If available, wear a facemask if you are sick.

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Due to privacy considerations, we are unable to leave a message. We will attempt two follow up calls.
If you have not received your test **result in 7 days**, contact your state or local health department.

Monitor any symptoms:

- Note the day any new symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or an in-person if your symptoms get worse. **Call ahead before visiting your doctor** and tell them you have been tested for COVID-19.
- Even if you don’t experience symptoms, you might make others sick.

Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies:

- Extremely difficult breathing
- Bluish lips or face
- Constant pain or pressure in the chest
- Severe constant dizziness or lightheadedness
- Acting confused
- Difficult to wake up
- Slurred speech (new or worsening)
- New seizure or seizures that won’t stop

This list is not all-inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

For medical emergencies, **call 911** & notify the dispatch personnel that you may have COVID-19.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

Coronavirus

COVID-19

TEST RESULTS

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  - ❑ Severe constant dizziness or lightheadedness
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If you test negative for COVID-19

- You are probably not infected at this time. However, you could have been exposed and test positive later. You must continue to practice all the protective measures to keep yourself and others negative.
- As long as the virus that causes COVID-19 is spreading in your community, continue to follow recommendations to protect yourself, including:
  - practice social distancing, wash your hands often, avoid touching your face, and avoid social gatherings according to local guidance.
- Follow guidance from your healthcare provider and your state and local health departments.

FOR MORE INFORMATION VISIT: WWW.CORONAVIRUS.GOV

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004211

Coronavirus
COVID-19

WHAT TO EXPECT AT COMMUNITY-BASED TESTING SITES

For Healthcare Facility Workers & First Responders

- **You must arrive in a personal vehicle**
- **Items to bring:**
  - Photo ID
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare facility employee or first responder ID/Badge (if applicable)

THINGS TO CONSIDER

- There are **no** bathrooms;
- Each person who needs testing must be seated next to a **working window**;
- All passengers must **stay inside** vehicles from arrival to departure;
- Try to **limit** the people in your vehicle to those needing testing; and
- There may be **significant wait times**.

ARRIVAL

- Each vehicle will be greeted and directed by personnel in full medical protective gear.

TEMPERATURE CHECK

- Your temperature will be checked using a no touch thermometer.

REGISTRATION

- Each person needing testing will be asked to provide the following:
  - Photo ID
  - First and last name
  - Healthcare facility employee or first responder ID/badge
  - Current address (where you are staying)
  - Best phone number to reach you (indicate mobile/landline)
  - Insurance card (if available)

TESTING

- A healthcare provider in personal protective equipment will provide you with instructions.
- You will be given a tissue to blow your nose and will need to keep your tissue to dispose on your own.
- A soft swab will be inserted deep into your nose to get the necessary sample. This may be slightly uncomfortable; however, the test is quick and should take less than a minute.

INFORMATION & DEPARTURE

- Once the test is complete, you will move to the final station.
- You will be given information to take with you on what to do while awaiting test results. **Please keep this paper until you get your test results.**
- Depart/Exit Community-based Testing Site.
- Follow the instructions on the paper provided by the Community-based Testing Site. Continue to monitor and record symptoms. You will receive test results via telephone.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004212

For medical emergencies, call 911 and notify the dispatch that you may have COVID-19.

Coronavirus

COVID-19

WHAT TO EXPECT AT COMMUNITY-BASED TESTING SITES

For Healthcare Facility Workers & First Responders

- **You must arrive in a personal vehicle**
- **Items to bring:**
  - Photo ID
  - Health insurance card (everyone will be tested regardless if they have insurance)
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THINGS TO CONSIDER

- There are **no** bathrooms;
- Each person who needs testing must be seated next to a **working window**;
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ARRIVAL

- Each vehicle will be greeted and directed by personnel in full medical protective gear.

TEMPERATURE CHECK

- Your temperature will be checked using a no touch thermometer.

REGISTRATION

- Each person needing testing will be asked to provide the following:
  - Photo ID
  - First and last name
  - Healthcare facility employee or first responder ID/badge (if applicable)
  - Current address (where you are staying)
  - Best phone number to reach you (indicate mobile/landline)
  - Insurance card (if available)

TESTING

- A healthcare provider in personal protective equipment will provide you with instructions.
- You will be given a tissue to blow your nose and will need to keep your tissue to dispose on your own.
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For medical emergencies, call 911 and notify the dispatch that you may have COVID-19.

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

From:	Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)
To:	Heinzerling, Amy (CDC cdph.ca.gov); Blau, Erin (CDC ky.gov); Blau, Erin (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo (CDC adph.state.al.us); Heinzerling, Amy Patricia (CDC/DDPHSS/CSELS/DSEPD); Sanchez, Guillermo Vincent (CDC/DDPHSS/CSELS/DSEPD); Szablewski, Christine (CDC dph.ga.gov); Szablewski, Christine (CDC/DDPHSS/CSELS/DSEPD); Torres, Yaritbel (CDC flhealth.gov); Torres-Mendoza, Yaritbel (CDC/DDPHSS/CSELS/DSEPD); James, Allison (CDC arkansas.gov); James, Allison (CDC/DDPHSS/CSELS/DSEPD); Ghinai, Isaac; Ghinai, Isaac (CDC/DDPHSS/CSELS/DSEPD); Steinberg, Jonathan (CDC state.sd.us); Feder, Kenneth (CDC/DDPHSS/CSELS/DSEPD); Kenneth Feder -MDH-; Steinberg, Jonathan (CDC/DDPHSS/CSELS/DSEPD)
Cc:	Blackmore, Carina (CDC flhealth.gov); Davidson, Sherri (CDC adph.state.al.us); Drenzek, Cherie (CDC dhr.state.ga.us); Edison, Laura (CDC dph.ga.gov); Materna, Barbara (CDC cdph.ca.gov); Robeson, Sara (CDC ky.gov); Stanek, Danielle (CDC flhealth.gov); Thoroughman, Douglas (CDC/DDPHSIS/CPR/DSLR); Wilken, Jason (CDC cdph.ca.gov); Wortley, Pascale (CDC dph.ga.gov); Balamurugan, Appathurai (CDC arkansas.gov); Clayton, Joshua (CDC state.sd.us); Austin, Connie (CDC illinois.gov); Blythe, David (CDC maryland.gov); Crum, David (CDC maryland.gov); Soda, Elizabeth (CDC illinois.gov); Layden, Jennifer (CDC illinois.gov); Duwell, Monique MD (CDC maryland.gov); Rothfeldt, Laura (CDC arkansas.gov); Tarkhashvili, Nato (CDC state.sd.us)
Subject:	FW: Protecting Your Health and Safety During the COVID-19 Response
Date:	Thursday, March 5, 2020 2:54:35 PM

Hi everyone,

Please be aware of the highlighted sentence in the email from CDC OD pertaining to cancellation of travel, copied here.

To ensure CDC maintains its response readiness, CDC/ATSDR is canceling all travel except mission-critical and response-related travel.

Thanks,

Suzanne

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)
Epidemic Intelligence Service | Epidemiology Workforce Branch
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

From: Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD) <dhe0@cdc.gov>
Sent: Thursday, March 5, 2020 2:49 PM
To: Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD) <dwi4@cdc.gov>; Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD) <kmb6@cdc.gov>; Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD) <gii5@cdc.gov>; Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD) <cbu1@cdc.gov>; Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD) <vie0@cdc.gov>; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD) <osk0@cdc.gov>; Priest, Priscilla (CDC/DDPHSS/CSELS/DSEPD) (CTR) <fys8@cdc.gov>; Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD) <pzw5@cdc.gov>
Subject: FW: Protecting Your Health and Safety During the COVID-19 Response

Just wanted to make sure you saw the highlighted sentence below.

AMERICAN OVERSIGHT

From: CDC OD Announcements <CDCODANNOUNCE@cdc.gov>
Sent: Thursday, March 5, 2020 2:41 PM
To: CDC OD Announcements <CDCODANNOUNCE@cdc.gov>
Subject: Protecting Your Health and Safety During the COVID-19 Response

As Dr. Redfield has said, CDC's efforts to respond to the novel coronavirus disease 2019 (COVID-19) are a remarkable demonstration of your commitment to public health and to those whom we serve. As we continue to see the spread of COVID-19 in communities across the country, including recent cases in Georgia, I wanted to share what we're doing to both protect your health and safety and to ensure CDC's ability to respond to this global outbreak.

Health and Safety for CDC Staff
The health and safety of our staff are critically important. While the immediate health risk for most Americans is considered low, current events have raised the risk in some communities. We should all practice everyday preventive actions to help prevent the person-to-person and community spread of COVID-19, including staying home when you are sick.

Inside CDC, our DeployCDC site is an excellent resource. Whether you're preparing to deploy, returning from a deployment, or supporting a deployer, I encourage you to check this site regularly for important information.

The Office of Personnel Management Tuesday released preliminary guidance for federal agencies. I encourage all supervisors to take advantage of workplace flexibilities like telework to ensure the health and safety of CDC staff. If CDC is forced to alter operations, we will follow CDC's recently updated Pandemic Workforce Protection Plan and our Continuity of Operations Plan. CDC also has a number of preparedness resources, including how you can prepare your health for an emergency.

Ensuring CDC's Ability to Respond
CDC has moved quickly to secure the resources needed for this evolving response. In addition to using our Infectious Diseases Rapid Response Reserve Fund, CDC recently received a transfer from HHS and Congress is expected to act this week on a supplemental funding request. We continue to see positive support for CDC's work and hope we receive the supplemental funding to support this complex, fast-moving response.

To ensure CDC maintains its response readiness, CDC/ATSDR is canceling all travel except mission-critical and response-related travel. Please work with members of your CIO leadership team, who are reviewing current travel plans as we have done in the past. We will evaluate this and other guidance as this response evolves.

Whether you're involved directly with the response or helping to keep all our other important work going, thank you for all you're doing to keep Americans safe and healthy.

Sherri Berger, MSPH
Chief Operating Officer, CDC

AMERICAN OVERSIGHT

From: Stanek, Danielle R
To: Amador, Nelly; Asmita Gupta; Blackmore, Carina; Bommineni, Reddy; Carlos Risco (riscoc@ufl.edu); "Cherabuddi,Kartik"; Clark-Curtiss,Josephine; Clemons, Bambi; Cunningham, Mark; Daniel Wolf (Daniel.Wolf@fdacs.gov); Diane Kitchen (Diane.Kitchen@fdacs.gov); Dix Harrell (cdix.harrell@usda.gov); Doblecki-Lewis, Susanne; Gibbs, Paul; Gibbs, Samantha; Gillis, Karen; Greg Gray; Gregory Christy (Gregory.Christy@fdacs.gov); Gregory Glass; Hall, Parker T - APHIS; hernandezja@ufl.edu; Hooker, Kara; Hunter, Pamela; Iovine,Nicole Marie; jeremy.d.butts@aphis.usda.gov; Johnson, David (Bay Pines); Landsberg, Jan; Lanza, John J; leahdgillis@gmail.com; Lichtenberger, Paola; Lisa Conti; Marc Engel; Mary Gessert; Mary Leigh Merrill; Mary Moore (Mary.E.Moore@aphis.usda.gov); MAUNSELL,FIONA PAULINE; Michael Whicker; Michael.P.Milleson@aphis.usda.gov; Morrison, Andrea; Progulske, Barbara A; Ramira, Isaza; Rehme, Paul A; Richard Austin; Sayler,Katherine A; "Shender, Lisa"; Short, Mike; Stauffer, Kendra E. (CDC/CGH/DGHP); Loerzel, Susan; Teresa Chapman; Terry Doonan (terry.doonan@myfwc.com); Thomas Holt; Tom Belcuore; Tuanyok,Apichai; Vittor,Amy Yomiko; william.fisch@freshfromflorida.com; Wisely,Samantha M; Torres, Yari
Subject: FW: TODAY! CDC ZOHU Call March 4, 2020
Date: Wednesday, March 4, 2020 11:09:42 AM

ZOHU Calls are 1-hour monthly webinars that provide timely education on zoonotic and infectious diseases, One Health, antimicrobial resistance, food safety, vector-borne diseases, recent outbreaks, and related health threats at the animal-human-environment interface.

Join us for the next ZOHU Call on March 4, 2020 - 2-3 pm ET.

Please note that we now use Zoom to present ZOHU Call webinars.

Simply click this link https://zoom.us/j/697892934 to see and hear the presentations.
All questions will now be submitted online instead of by phone.
Information to listen only by phone is available on the March 4 ZOHU Call webpage.

Presentations

One Health News from CDC
Casey Barton Behravesh, MS, DVM, DrPH, DACVPM
Captain, U.S. Public Health Service
Director, One Health Office
Centers for Disease Control and Prevention
dlx9@cdc.gov

Mammal decline, linked to invasive Burmese python, shifts host use of vector mosquito towards reservoir hosts of a zoonotic disease
Nathan Burkett-Cadena, PhD
Assistant Professor
University of Florida
Florida Medical Entomology Laboratory
nburkettcadena@ufl.edu

Companion Animals and Domestic Violence as a One Health Issue

AMERICAN OVERSIGHT

Melinda D. Merck, DVM
Forensic Veterinarian
Veterinary Forensics Consulting, LLC
catdvm@drmerck.com

Psittacosis Outbreak among Workers at Chicken Slaughter Plants, Virginia and Georgia, USA, 2018
Julia M. Murphy, DVM, MS, DACVPM
State Public Health Veterinarian
Virginia Department of Health
julia.murphy@vdh.virginia.gov

Join the Next ZOHU Call

Free Continuing Education is available for **physicians, nurses, health educators, veterinarians, and others.**

- The ZOHU Call course number is **2962**, and access code is **onehealth2020**.
- If you were unable to attend a live call, archived ZOHU Calls are available online.

Get Free CE for ZOHU Call

One Health News from CDC - March 2020

HIGHLIGHTS

- Coronavirus Disease 2019 (COVID-19) outbreak - Check CDC's website for the latest information about this response, including FAQs about animals. See CDC's Pet Disaster Preparedness Kit for pet preparedness info.
- Patient Stories Show Seriousness of Foodborne Illness
- Pool Inspection Training for Environmental Health Professionals
- CDC's One Health Office has created an email newsletter for the Healthy Pets, Healthy People program. Subscribe

Events & Observances

- March 9-12 - CANCELED InFORM (Integrated Foodborne Outbreak Response and Management) 2020 Conference, Atlanta, Georgia.
- March 31-April 3 - 2020 Preparedness Summit - Dallas, Texas
- May 4-7 - 2020 Epidemic Intelligence Service (EIS) Conference, Atlanta, Georgia.
- June 14-18 - World One Health Congress, Edinburgh, Scotland.

PUBLICATIONS

- Health Security Supplement (2020) What Works? Lessons Learned in Global Health Security Implementation
- Preliminary Evaluation of Human Personal Protective Measures Against the Nymphal Stage of the Asian Longhorned Tick (Acari: Ixodidae)
- The March 2020 issue of *EID Journal* has articles relevant to One Health.

Morbidity and Mortality Weekly Report (MMWR)

- Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak — United States, December 31, 2019–February 4, 2020
- Persons Evaluated for 2019 Novel Coronavirus — United States, January 2020
- Autochthonous Chagas Disease — Missouri, 2018
- Anhydrous Ammonia Chemical Release — Lake County, Illinois, April 2019
- Travel-Associated and Locally Acquired Dengue Cases — United States, 2010–2017
- Human Rabies — Utah, 2018

AMERICAN OVERSIGHT

US OUTBREAKS
New

- Outbreak of *E. coli* Infections Linked to Clover Sprouts

Updated

- Coronavirus Disease 2019 (COVID-19)
- Outbreak of *Salmonella* Infections Linked to Cut Fruit

See a selected list of ongoing and past US outbreaks of zoonotic diseases on the Healthy Pets, Healthy People website.

See the CDC Current Outbreak List, including foodborne outbreaks, at cdc.gov/outbreaks.

One Health uses a collaborative, multisectoral, and trans-disciplinary approach — working at the local, regional, national, and global levels — with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment.

Email topic suggestions or provide feedback to ZOHUCall@cdc.gov.

Centers for Disease Control and Prevention
1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348
Questions or Problems | Unsubscribe

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayceterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdalelivng.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angiamrcompanies.com; Betsy Schatt; Betty Scott; bfmaint@southernltc.com; Bil Stock; Bitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Renew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@mc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cori; D. 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Subject: Fwd: 2019 Novel Coronavirus Guidance

Date: Thursday, March 12, 2020 11:59:12 AM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Thu, Mar 12, 2020 at 10:05 AM
Subject: 2019 Novel Coronavirus Guidance
To: <ann.echcc@gmail.com>

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MLN Connects Header Graphic

Thursday, March 12, 2020

News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

Compliance

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Open Payments: Your Role in Health Care Transparency Call — March 19
- Medicare Promoting Interoperability Program Call for Measures Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- Interoperability and Patient Access Final Rule Call — April 7
- LTCH and IRF Quality Reporting Programs: SPADEs Webinar — April 14

MLN Matters® Articles

- NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
- Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1
- Proper Use of Modifier 59 — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

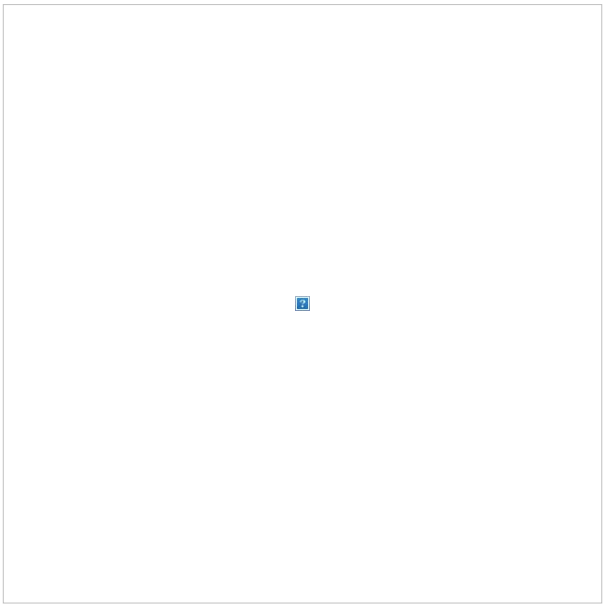
Publications

- Evacuating and Receiving Patients in the Midst of a Wildfire
- Administrative Simplification: Eligibility and Benefits Transaction Basics

Multimedia

AMERICAN OVERSIGHT

- Dementia Care Call: Audio Recording and Transcript



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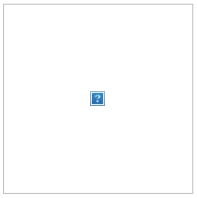

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayceterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdalelivng.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/ SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angiamrcompanies.com; Betsy Schatt; Betty Scott; bfmaint@southernltc.com; Bil Stock; Bitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Renew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurniak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brookgrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstorn; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr. Drawdy, Lynne; Duane Bridges; duane@manoratlwb.com; Dustin Wooten; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@hhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@hhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegat; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medvacelfnl.com; Gerry Pierce; gmeade@hhhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Bawus; james.edwards@brookgrehab.org; james.nutt@hhcpns.org; Jamie Carmichael; Jamie Tutnievic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/ SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Ohleon; John.Hatfield; John.Lanza@lhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@lhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skallitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pitsey; Lauritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehs; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@gchrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; Rajackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@safey.us; Ron Morley; Ros Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@hhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: Fwd: 2019 Novel Coronavirus Guidance

Date: Thursday, March 12, 2020 11:59:12 AM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Thu, Mar 12, 2020 at 10:05 AM
Subject: 2019 Novel Coronavirus Guidance
To: <ann.echcc@gmail.com>

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MLN Connects Header Graphic

Thursday, March 12, 2020

News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

Compliance

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Open Payments: Your Role in Health Care Transparency Call — March 19
- Medicare Promoting Interoperability Program Call for Measures Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- Interoperability and Patient Access Final Rule Call — April 7
- LTCH and IRF Quality Reporting Programs: SPADEs Webinar — April 14

MLN Matters® Articles

- NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
- Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1
- Proper Use of Modifier 59 — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

- Evacuating and Receiving Patients in the Midst of a Wildfire
- Administrative Simplification: Eligibility and Benefits Transaction Basics

Multimedia

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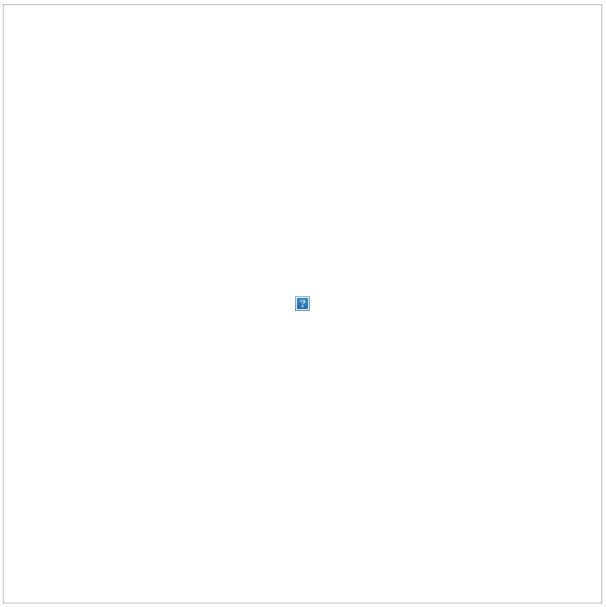
- Dementia Care Call: Audio Recording and Transcript



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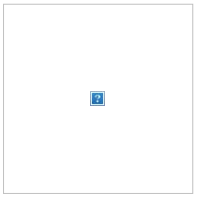

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Torres, Yari
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Stanek, Danielle R; Blackmore, Carina
Subject: Fwd: Action Required: COVID-19 impact on your polio TDY
Date: Friday, March 13, 2020 3:13:35 AM

FYI- At the moment my new return date is March 24th which is within that time frame, I will let you know if that changes.

Thank you and see you soon!

Yari
Get Outlook for iOS

From: Vertefeuille, John F. (CDC/DDPHSIS/CGH/GID) <dki4@cdc.gov>
Sent: Friday, March 13, 2020 3:23:29 AM
To: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP) <pja5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>
Cc: Frank, Daniel (CDC/DDPHSIS/CGH/GID) <fcd3@cdc.gov>; Rouse, Edward N. (CDC/DDPHSIS/CPR/DEO) <dmz0@cdc.gov>; Taylor, Bryan (CDC/DDPHSIS/CPR/DEO) <yzi8@cdc.gov>; Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>; Wiesen, Eric (CDC/DDPHSIS/CGH/GID) <ejw2@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>
Subject: Action Required: COVID-19 impact on your polio TDY

Hi everyone,

Let me first say that we appreciate everyone's effort on the polio surge and your flexibility in these uncertain and rapidly changing times with the COVID-19 response. We in the polio EOC, as well as CDC as whole, have your safety and health as our top priority.

You are receiving this email because you are currently set to return home from your polio TDY between 7-14 days from now. **We ask that you work with the EOC to immediately curtail your travel and return to the US.**

If you believe that anything may impact your date for return to work at your home office, please let us know and we can reach out to your supervisory chain. New agency guidance regarding post-deployment telework and monitoring policies should be coming out by the end of the week and will be sent to you.

Please continue to monitor all information you receive from the post where you are located which may impact your travel, as well as any guidance you receive from the EOC. Thank you for your contributions to polio eradication, the contributions you may be being asked to make regarding COVID-19 in your TDY location, and your commitments to CDC's mission.

John F. Vertefeuille, PhD, MHS
Incident Manager

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CDC Polio Activation

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From:	Thaqi, Paula M
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Subject:	Fwd: ALF NH Info
Date:	Sunday, March 22, 2020 5:58:40 PM
Attachments:	ALF Outreach Questionnaire Short Form 3_21.docx Facility Inspection.docx

---

Sent from my Verizon, Samsung Galaxy smartphone
Get Outlook for Android

From: Podolsky, Renee C <Renee.Podolsky@flhealth.gov>
Sent: Sunday, March 22, 2020 5:26:34 PM
To: Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: FW: ALF NH Info

Renee Podolsky, MBA
Community Health Director
Florida Department of Health in Broward County
780 S.W. 24th Street
Ft Lauderdale FL 33315
(954) 847-8188
Renee.Podolsky@flhealth.gov
Visit our website: http://broward.floridahealth.gov

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Vision: To be the **Healthiest State** in the Nation

Values: (ICARE)

Innovation: We search for creative solutions and manage resources wisely.
Collaboration: We use teamwork to achieve common goals & solve problems.
Accountability: We perform with integrity & respect.
Responsiveness: We achieve our mission by serving our customers& engaging our partners.
Excellence: We promote quality outcomes through learning & continuous performance improvement.
****
Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request.

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ALF Outreach Questionnaire

Facility Name: _____Date of Visit: _____

Facility Address:_____

Contact Person at Facility Name:_____

Office Number: _____Cell Number:_____

Email Address for best contact to receive emailed information:_____

Name of Persons Visiting Facility:_____

GENERAL INFORMATION

- Call facility and advise them you are coming and to meet you outside.
  - Record name and number of person you are meeting
  - Provide them a timeframe in which you will be arriving

- Once you arrive call contact person and have them meet you outside
  - Stand 6 feet away
  - Avoid physical contact – no hand shaking

- Provide them Instruction.

QUESTIONS

1. Is anyone in the facility in acute distress? If yes, does that person have fever, cough or shortness of breath? _____
   Call 911. If cough, fever or SOB are reported, please make sure you tell the 911 operator and advise that EMS use PPE.

2. Does anyone have fever, cough or shortness of breath? _____
   If anyone has acute distress or respiratory symptoms, please call DOH-Broward Epidemiology at 954-270-8905 (during the day).

3. Does your facility have any critical unmet needs?

   If so, please record below:

   _____

   _____

REMIND THEM TO CALL 911 IF ANY PERSON IS IN ACUTE DISTRESS. CALL EPIDEMIOLOGY AT: 954-847-8039 if any resident develops or is admitted to the hospital with fever, cough or shortness of breath.

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Facility Visit

Face Sheet

Facility Name:_____

Facility Address:_____

Contact Person at Facility Name:_____

Office Number:_____Cell Number:_____

Email Address:_____

Facility Type	Number of Resident Rooms	Maximum Number of Residents Per Room

Date of Visit_____

Staff Name (s):_____

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Resident Room To Room Checks (Make copies per Number of Residents)

General Guidelines:

- See every resident. Make sure no resident is in acute distress. If so, immediately call 911.
- Ask each resident: How are you feeling? Do you have a cough? Do you have a fever? Do you have any trouble breathing?

Room Number	# of People in Room	Any showing symptoms of COVID19	What symptoms	Did you call 911

Facility Question (Make additional copies as needed)

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FACILITY NAME_____

DATE_____

Type of Staff	Total Number	Total Non-Contract	Contract	Name of Contract Agency
MD				
RN				
CNA				
MA				
Home Health				
LPN				
Kitchen				
Maintenance				
Janitorial				
Drivers				
Administrative				
Entertainment				
Volunteers				
Clergy				
Other: (List below) Ex: Salon Services, Fitness, Classes				

Staff Questionnaire

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Staff Name	Staff Occupation and Yes/No Direct Patient Contact	Traveled (Yes/No) If yes, where?	Dates traveled	Are they Working? If yes when did they return to work?	Is the staff showing symptoms of any illness? (LIST)

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Have staff been trained on PPE?	Yes	No
Have all employees been trained on hand hygiene?	Yes	No
What is the COVID-19 screening process for employees?		
Were the employees trained on the COVID-19 screening process?		
What date did you start COVID-19 screening?		

Facility Questions

What's the schedule for the residents? Congregation areas – eating, entertainment…		
What is the screening process for any visitors?		
Who are your maintenance staff and what is the cleaning schedule? What products do they use? Do you have a list? Can we see the controls/cleaning products? Do you have a visitor log? Please provide. Are the people who drop off and pick up deliveries on that list?		
Do you have a sick leave log, volunteer log? Please provide?		
What is the staff to patient ratio? How often do the nurses visit the residents? What do they do when they visit?		
Do you keep shift change reports? Please provide those.		
Do you have a medical director? Who is that and how often does he visit the facility? What does he do when he visits? Do you have a schedule? Please provide.		
What are your procedures and protocols for handling infectious disease control? Do you have an isolation room? How do you handle a potential outbreak? Do you mark the room?		
Do any other agencies come in and provide services, ie. Hospice? Who? Names and phone numbers		

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From:	Cheryl Stroud
To:	Bruce Kaplan (bkapdvm@verizon.net); Carter, Craig; Keith Goldman; King, Lonnie; Laura H. Kahn; Lisa Conti; William Stokes; wrdehaven@comcast.net; alex.thiermann@gmail.com; at97@cornell.edu; biosburn@ucdavis.edu; bdunham@email.gwu.edu; bkapdvm@verizon.net; Carter, Craig; prof.grossklaus@gmx.de; dnoah21@gmail.com; famurphy@UTMB.EDU; hmm2@cdc.gov; hmainzer@cdc.gov; isabel.kantor@gmail.com; jack.a.shere@usda.gov; jrcliffordjr@aol.com; kelley-donham@uiowa.edu; konradeugster@gmail.com; lkahn@Princeton.EDU; LXC2001@gmail.com; Lonnie.King@cvm.osu.edu; mpappa1821@gmail.com; primoarambulo@gmail.com; racran@juno.com; bgjorgydvm@yahoo.com; robert.whitney@comcast.net; ruscurrier@yahoo.com; srjenkins@comcast.net; tfm@vetmed.wsu.edu; tpmonath@gmail.com; wrdehaven@comcast.net; Huest001@umn.edu; billmacdvm@comcast.net; williamstokes.asg@gmail.com; yoshi-oz@h07.itscom.net; abeck@purdue.edu; Amaccabe@aavmc.org; aehill@ucdavis.edu; b.olugasa@ui.edu.ng; bernadette.dunham@fda.hhs.gov; bonniebuntain@calgary.ca; e-pi-vet@hotmail.com; bakey@tvmdl.tamu.edu; candacejacobs99@gmail.com; Carina.Blackmore@FLHealth.gov; Chr1@CDC.gov; CBartonBehravesh@cdc.gov; cmuscop@umn.edu
Subject:	Fwd: Announcing Dr. Jack Shere, the AVES Pres-Elect to the AVES Board of Directors and the full membership!
Date:	Tuesday, February 11, 2020 9:14:26 PM
Attachments:	meclgeeachkbohkk.png

Craig, Jack and Harz Mountain:

Thank you for your continued service to AVES and for your belief in and support of One Health.

May we all continue our efforts to implement it at all levels of academia, research, government and policy. Had it been fully in place we just might not be dealing with Covid-19 now??

Warmly,

Cheryl Stroud, DVM, PhD
Executive Director, One Health Commission
cstroud@onehealthcommission.org
Direct Phone: 224-622-1839

http://bit.ly/2k7NPSe
Connect, Create, Educate for One Health

"Never underestimate the power of a few committed people to change the world. Indeed, it is the only thing that ever has". – Margaret Meade
"We have the choice to use the gift of our life to make the world a better place--or not to bother" Jane Goodall

-------- Forwarded Message --------
Subject: Announcing Dr. Jack Shere, the AVES Pres-Elect to the AVES Board of Directors and the full membership!
Date: Tue, 11 Feb 2020 18:14:48 +0000
From: Carter, Craig <craig.carter@uky.edu>
To: Bruce Kaplan (bkapdvm@verizon.net) <bkapdvm@verizon.net>, Carter, Craig <craig.carter@uky.edu>, Keith Goldman <kgoldman@hartz.com>, King, Lonnie <king.1518@osu.edu>, Laura H. Kahn <lkahn@Princeton.EDU>, Lisa Conti <lxc2001@gmail.com>, William Stokes <williamstokes.asg@gmail.com>,

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CC: Shere, Jack A - APHIS (jack.a.shere@usda.gov) <jack.a.shere@usda.gov>

All:

I am very proud to announce that Dr. Jack Shere has accepted his elected role of President-Elect in the American Veterinary Epidemiology Society and will be inducted at the end of the AVMA awards breakfast meeting in San Diego on Monday, Aug 3rd, location TBD. He will serve for three years in this position. I have pasted in Dr. Shere's bio below. Most recently, he was appointed the Associate Administrator of the USDA Animal Plant Health Inspection Service (APHIS). He has had a long and very productive career with ever-increasing responsibilities and has led the response to many important animal disease outbreaks in US history.

Dr. Jack Shere, Associate Administrator, APHIS



Dr. Jack Shere was appointed Associate Administrator in August 2019. He works in partnership with Administrator Kevin Shea and fellow Associate Administrators Dr. Mike Watson and Dr. Mark Davidson to carry out the Agency's day-to-day operations, represent APHIS on Departmental-level and cross-Agency working groups, and oversee the activities of every APHIS program area and support unit on behalf of employees and stakeholders. Particularly, Dr. Shere will concentrate on emergency preparedness and planning, as well as homeland and national security issues. Among his duties will be a special focus on the emerging African swine fever threat throughout the world.

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Dr. Shere was Veterinary Services' (VS) Deputy Administrator since March 2016, where he served as the nation's Chief Veterinary Officer and led VS in protecting and improving the health, quality, and marketability of U.S. agricultural animals, animal products, and veterinary biologics. Dr. Shere joined VS in 1990 as a field veterinary medical officer in Nebraska and Wisconsin and has held many leadership positions since then, including VS' Associate Deputy Administrator, Eastern Regional Director, and Associate Western Regional Director.

Dr. Shere has extensive experience with animal disease outbreaks, including salmonella enteritidis, foot-and-mouth disease in England, low pathogenic avian influenza, Exotic Newcastle Disease (END), and highly pathogenic avian influenza. During the extensive 2002-2003 END outbreak in California, Texas, New Mexico, and Utah, Dr. Shere served as the Joint Area Commander and Incident Commander, leading a massive federal and state eradication effort for nine months until the disease was eradicated from the United States.

Dr. Shere received a Bachelor of Science in Biology and Chemistry in 1981, a Doctor of Veterinary Medicine in 1987, and a Master of Science in Education with a minor in Counseling in 1988 – all from Iowa State University. He received PhD's in Poultry Science and Microbiology in 2001 from the University of Wisconsin. He also practiced veterinary clinical medicine for 3 years in Georgia.

From the entire Board of Directors of the AVES, we send hearty congratulations—we know that your mentors Drs. Jim Steele and Charles Thoen are smiling down on you! We all look forward to working with you to help take the AVES from its early beginnings by Jim in 1964 on into the future!

Many thanks as always to Hartz Mountain for the sole sponsorship of the AVES all the way back to 1964. We also want to thank Mr. Keith Goldman, our Hartz liaison for all of his efforts to help us sustain the AVES and to recognize our awardees for their contributions to animal health, human health and One Health!

Sincerely,

Craig

CRAIG N. CARTER
President, AVES

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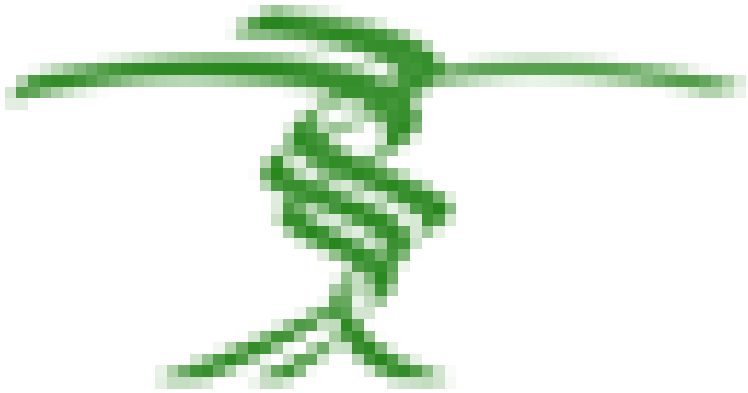



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Subject: Fwd: CDC - Prevent Spread - Long Term Care Facilities
Date: Monday, March 16, 2020 3:54:50 PM

---------- Forwarded message ---------
From: **Verlaan, Thomas D** <Thomas.Verlaan@flhealth.gov>
Date: Mon, Mar 16, 2020 at 2:41 PM
Subject: CDC - Prevent Spread - Long Term Care Facilities
To: Margie Hobbs <margie.hobbs@hcahealthcare.com>, Aleta <aleta.hoodless@hma.com>, Anne <paceasc@gmail.com>, Anthony Brown <anbrown@gchc.com>, April Gilmore - Berryhill Manor <berryhillmanor@aol.com>, April Parsons - Covenant Hospice <April.Parsons@covenanthospice.org>, Ary Habig <ary.habig@bhcpns.org>, McMillion, Barbara J <Barbara.McMillion@flhealth.gov>, Beata Kundera <beata.kundera@fmc-na.com>, Beau Pollard - Administrator GB Hosp <bpollard@bhcpns.org>, Bonnie Hunter - Navarre Gardens <Elizabeth_Black@hotmail.com>, Brad Baker - Santa Rosa County EM <BradB@santarosa.fl.gov>, Carol Belitsos - Veritas <cbelitsos@veritasincare.com>, Carol Ettelson <carolettelson@gmail.com>, Cathy Blanchard - Gentiva <Cathy.blanchard@gentiva.com>, Charity Bailey - Pruitt Health <CHBailey@pruitthealth.com>, Cheryl Pence - Davita <Cheryl.Pence@davita.com>, Cheryl Whisman <cwhisman@gchc.com>, Christopher Kennison - Lifeguard Ambulance <Christopher.Kennison@amr.net>, Cindy Almand <cindy.almand@bhcpns.org>, Cindy Westergard - Baptist Healthcare Systems <cwestergard@bhcpns.org>, Corey Lofton - Kindred Hospice Care <Corey.Lofton@kindredhospicecare.com>, CRISTIN CARR-PETERSON <admin@sandyridgehealthandrehab.com>, Daniel Hahn - Santa Rosa County District Schools <Hahnd@santarosa.k12.fl.us>, Darline Earl - Watermark of Gulfbreeze <dearl@watermarkofgulfbreeze.com>, David Kauffman - Sacred Heart Hospital <david.kauffman@ascension.org>, Dawn Mann - Baptist Healthcare Systems <dawn.mann@bhcpns.org>, Deanna Edwards-Walton - Emerald Coast Hospice <Deanna.EdwardsWalton@kindredhospicecare.com>, Debra Burr <Debra.Burr@fmc-na.com>, Denice Curtis - UWF <dcurtis@uwf.edu>, Diane McKeon <diane.mckeon@hma.com>, dluongo@bhcpns.org <dluongo@bhcpns.org>, Dobson, Roger M <Roger.Dobson@flhealth.gov>, Don Russell - Baptist Healthcare Systems <don.russell@bhcpns.org>, Dr. Landry - Lifeguard Ambulance <klandry@mchsi.com>, Dwayne Tullos - Lifeguard Ambulance <Dwayne.Tullos@amr.net>, Eamonn Wheelock - Baptist Healthcare Systems <eamonn.wheelock@bhcpns.org>, Elizabeth Foster - Santa Rosa Medical Center <Elizabeth.Foster@srmcfl.com>, Enid Sisskin - UWF <esisskin@uwf.edu>, Fletcher Forte - Bureau of Parole <Fletcher.Forte@fdc.myflorida.com>, Fran Rohling - Baptist Healthcare Systems <fran.rohling@bhcpns.org>, Frank Daniel <fdanielmpt@aol.com>, Genny Holley - Kindred <genny.holley@kindred.com>, Ginny Palmer - Santa Rosa County EM <GinnyP@santarosa.fl.gov>, Grissom, Dana L <Dana.Grissom@flhealth.gov>, Heather Cornett - Santa Rosa Medical Center <Heather.Cornett@srmcfl.com>, Hill, Ann <ann.echcc@gmail.com>, Howard Clinic <howardclinic1354@att.net>, HUTCHINS, MICHAEL <mike.hutchins@bhcpns.org>, Isaac Newlin <itnewlin@gmail.com>, Jaimie Hudson - Gentiva <jaimie.hudson@gentiva.com>, Jana Lynder - Santa Rosa Medical Center <jana.lyner@srmcfl.com>, Jeffrey Walters - Santa Rosa Medical Clinic <jeffrey.waltersjr@srmcfl.com>, Jennefer Melnyk - Sandy Ridge Health & Rehab <don@sandyridgehealthandrehab.com>, Jessie Stafford - Lifeguard Ambulance <jessie.stafford@amr.net>, Jody Massey - White-Wilson <jmassey@white-wilson.com>, Joyce Amor - SRMC <Joyce.amor@hma.com>, Julie Gaither - Bureau of Parole <Julie.Gaither@fdc.myflorida.com>, JUSTIN GIBSON <jgibson@gchc.com>, Karen

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Here's a good informational link from the CDC:

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Thank you,

Tom

Thomas D. Verlaan

Planner IV

Santa Rosa County Health Department

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FX: 850.983.5278

State iPhone: 850.291.8329 (no texts)

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: CDC - Prevent Spread - Long Term Care Facilities
Date: Monday, March 16, 2020 3:54:50 PM

---------- Forwarded message ---------
From: **Verlaan, Thomas D** <Thomas.Verlaan@flhealth.gov>
Date: Mon, Mar 16, 2020 at 2:41 PM
Subject: CDC - Prevent Spread - Long Term Care Facilities
To: Margie Hobbs <margie.hobbs@hcahealthcare.com>, Aleta <aleta.hoodless@hma.com>, Anne <paceasc@gmail.com>, Anthony Brown <anbrown@gchc.com>, April Gilmore - Berryhill Manor <berryhillmanor@aol.com>, April Parsons - Covenant Hospice <April.Parsons@covenanthospice.org>, Ary Habig <ary.habig@bhcpns.org>, McMillion, Barbara J <Barbara.McMillion@flhealth.gov>, Beata Kundera <beata.kundera@fmc-na.com>, Beau Pollard - Administrator GB Hosp <bpollard@bhcpns.org>, Bonnie Hunter - Navarre Gardens <Elizabeth_Black@hotmail.com>, Brad Baker - Santa Rosa County EM <BradB@santarosa.fl.gov>, Carol Belitsos - Veritas <cbelitsos@veritasincare.com>, Carol Ettelson <carolettelson@gmail.com>, Cathy Blanchard - Gentiva <Cathy.blanchard@gentiva.com>, Charity Bailey - Pruitt Health <CHBailey@pruitthealth.com>, Cheryl Pence - Davita <Cheryl.Pence@davita.com>, Cheryl Whisman <cwhisman@gchc.com>, Christopher Kennison - Lifeguard Ambulance <Christopher.Kennison@amr.net>, Cindy Almand <cindy.almand@bhcpns.org>, Cindy Westergard - Baptist Healthcare Systems <cwestergard@bhcpns.org>, Corey Lofton - Kindred Hospice Care <Corey.Lofton@kindredhospicecare.com>, CRISTIN CARR-PETERSON <admin@sandyridgehealthandrehab.com>, Daniel Hahn - Santa Rosa County District Schools <Hahnd@santarosa.k12.fl.us>, Darline Earl - Watermark of Gulfbreeze <dearl@watermarkofgulfbreeze.com>, David Kauffman - Sacred Heart Hospital <david.kauffman@ascension.org>, Dawn Mann - Baptist Healthcare Systems <dawn.mann@bhcpns.org>, Deanna Edwards-Walton - Emerald Coast Hospice <Deanna.EdwardsWalton@kindredhospicecare.com>, Debra Burr <Debra.Burr@fmc-na.com>, Denice Curtis - UWF <dcurtis@uwf.edu>, Diane McKeon <diane.mckeon@hma.com>, dluongo@bhcpns.org <dluongo@bhcpns.org>, Dobson, Roger M <Roger.Dobson@flhealth.gov>, Don Russell - Baptist Healthcare Systems <don.russell@bhcpns.org>, Dr. Landry - Lifeguard Ambulance <klandry@mchsi.com>, Dwayne Tullos - Lifeguard Ambulance <Dwayne.Tullos@amr.net>, Eamonn Wheelock - Baptist Healthcare Systems <eamonn.wheelock@bhcpns.org>, Elizabeth Foster - Santa Rosa Medical Center <Elizabeth.Foster@srmcfl.com>, Enid Sisskin - UWF <esisskin@uwf.edu>, Fletcher Forte - Bureau of Parole <Fletcher.Forte@fdc.myflorida.com>, Fran Rohling - Baptist Healthcare Systems <fran.rohling@bhcpns.org>, Frank Daniel <fdanielmpt@aol.com>, Genny Holley - Kindred <genny.holley@kindred.com>, Ginny Palmer - Santa Rosa County EM <GinnyP@santarosa.fl.gov>, Grissom, Dana L <Dana.Grissom@flhealth.gov>, Heather Cornett - Santa Rosa Medical Center <Heather.Cornett@srmcfl.com>, Hill, Ann <ann.echcc@gmail.com>, Howard Clinic <howardclinic1354@att.net>, HUTCHINS, MICHAEL <mike.hutchins@bhcpns.org>, Isaac Newlin <itnewlin@gmail.com>, Jaimie Hudson - Gentiva <jaimie.hudson@gentiva.com>, Jana Lynder - Santa Rosa Medical Center <jana.lyner@srmcfl.com>, Jeffrey Walters - Santa Rosa Medical Clinic <jeffrey.waltersjr@srmcfl.com>, Jennefer Melnyk - Sandy Ridge Health & Rehab <don@sandyridgehealthandrehab.com>, Jessie Stafford - Lifeguard Ambulance <jessie.stafford@amr.net>, Jody Massey - White-Wilson <jmassey@white-wilson.com>, Joyce Amor - SRMC <Joyce.amor@hma.com>, Julie Gaither - Bureau of Parole <Julie.Gaither@fdc.myflorida.com>, JUSTIN GIBSON <jgibson@gchc.com>, Karen

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AMERICAN OVERSIGHT

Here's a good informational link from the CDC:

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Thank you,

Tom

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Ann Hill, Executive Director
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AMERICAN OVERSIGHT

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To: Blackmore, Carina (CDC flhealth.gov)
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: Fwd: cdc consult
Date: Wednesday, March 11, 2020 8:55:46 AM

Dr. Blackmore,

We are more than happy to assist and roster a group of CDC SMEs for a call. Just let us know where things land internally for you and what needs, if any, remain.

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Wednesday, March 11, 2020 8:18 AM
To: CDC IMS 2019 NCOV Response Clinical On-Call Unit
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Subject: FW: cdc consult

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 6:44 AM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Yes I believe we do need to circle back. What you describe didn't address the issues at the port itself. Let me check with the health officer first thing

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

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I communicated to our morning team that there was follow up needed with you all. Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: Re: cdc consult

Did you not hear from anyone today?

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

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Caroline Schrodt

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Date: Friday, March 6, 2020 10:16:46 AM

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To: <ann.echcc@gmail.com>

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Special Edition – Friday, March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

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"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million

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beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

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Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

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On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

Like our newsletter? Have suggestions? Please let us know!

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

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On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayceterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdalelivng.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angiamarcompanies.com; Betsy Schatt; Betty Scott; bfmaint@southernltc.com; Bil Stock; Bitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Renew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject:	Fwd: COVID-19 EO
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Attachments:	EO 20-52.pdf

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Cc: Sayler, Erik <erik.sayler@em.myflorida.com>
Subject: COVID-19 EO

Attached. Please send to your agency GC.

Nicholas A. Primrose
Deputy General Counsel
Executive Office of the Governor
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Office: (850) 717-9310
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AMERICAN OVERSIGHT

STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-52

(Emergency Management - COVID-19 Public Health Emergency)

WHEREAS, Novel Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, in late 2019, a new and significant outbreak of COVID-19 emerged in China; and

WHEREAS, the World Health Organization previously declared COVID-19 a Public Health Emergency of International Concern; and

WHEREAS, in response to the recent COVID-19 outbreak in China, Iran, Italy, Japan and South Korea, the Centers for Disease Control and Prevention ("CDC") has deemed it necessary to prohibit or restrict non-essential travel to or from those countries; and

WHEREAS, on March 1, 2020, I issued Executive Order number 20-51 directing the Florida Department of Health to issue a Public Health Emergency; and

WHEREAS, on March 1, 2020, the State Surgeon General and State Health Officer declared a Public Health Emergency exists in the State of Florida as a result of COVID-19; and

WHEREAS, on March 7, 2020, I directed the Director of the Division of Emergency Management to activate the State Emergency Operations Center to Level 2 to provide coordination and response to the COVID-19 emergency; and

WHEREAS, as of March 9, 2020, eight counties in Florida have positive cases for COVID-19, and COVID-19 poses a risk to the entire state of Florida; and

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WHEREAS, the CDC currently recommends community preparedness and everyday prevention measures be taken by all individuals and families in the United States, including voluntary home isolation when individuals are sick with respiratory symptoms, covering coughs and sneezes with a tissue and disposal of the tissue immediately thereafter, washing hands often with soap and water for at least 20 seconds, using of alcohol-based hand sanitizers with 60%-95% alcohol if soap and water are not readily available and routinely cleaning frequently touched surfaces and objects to increase community resilience and readiness for responding to an outbreak; and

WHEREAS, the CDC currently recommends mitigation measures for communities experiencing an outbreak including staying at home when sick, keeping away from others who are sick, limiting face-to-face contact with others as much as possible, consulting with your healthcare provider if individuals or members of a household are at high risk for COVID-19 complications, wearing a facemask if advised to do so by a healthcare provider or by a public health official, staying home when a household member is sick with respiratory disease symptoms if instructed to do so by public health officials or a health care provider; and

WHEREAS, as Governor, I am responsible for meeting the dangers presented to this state and its people by this emergency.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, Chapter 252, Florida Statutes, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1. Because of the foregoing conditions, I declare a state of emergency exists in the State of Florida.

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Section 2. I designate the Director of the Division of Emergency Management ("Director") as the State Coordinating Officer for the duration of this emergency and direct him to execute the State's Comprehensive Emergency Management Plan and other response, recovery, and mitigation plans necessary to cope with the emergency. Additionally, I designate the State Health Officer and Surgeon General as a Deputy State Coordinating Officer and State Incident Commander.

Pursuant to section 252.36(1)(a), Florida Statutes, I delegate to the State Coordinating Officer the authority to exercise those powers delineated in sections 252.36(5)-(10), Florida Statutes, which he shall exercise as needed to meet this emergency, subject to the limitations of section 252.33, Florida Statutes. In exercising the powers delegated by this Order, the State Coordinating Officer shall confer with the Governor to the fullest extent practicable. The State Coordinating Officer shall also have the authority to:

A. Seek direct assistance and enter into agreements with any and all agencies of the United States Government as may be needed to meet the emergency.

B. Designate additional Deputy State Coordinating Officers, as necessary.

C. Suspend the effect of any statute, rule, or order that would in any way prevent, hinder, or delay any mitigation, response, or recovery action necessary to cope with this emergency.

D. Enter orders as may be needed to implement any of the foregoing powers; however, the requirements of sections 252.46 and 120.54(4), Florida Statutes, do not apply to any such orders issued by the State Coordinating Officer; however, no such order shall remain in effect beyond the expiration of this Executive Order, to include any extension.

Section 3. I order the Adjutant General to activate the Florida National Guard, as needed, to deal with this emergency.

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Section 4. I find that the special duties and responsibilities resting upon some State, regional, and local agencies and other governmental bodies in responding to the emergency may require them to suspend the application of the statutes, rules, ordinances, and orders they administer. Therefore, I issue the following authorizations:

A. Pursuant to section 252.36(1)(a), Florida Statutes, the Executive Office of the Governor may suspend all statutes and rules affecting budgeting to the extent necessary to provide budget authority for state agencies to cope with this emergency. The requirements of sections 252.46 and 120.54(4), Florida Statutes, do not apply to any such suspension issued by the Executive Office of the Governor; however, no such suspension shall remain in effect beyond the expiration of this Executive Order, to include any extension.

B. Each State agency may suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders or rules of that agency, if strict compliance with the provisions of any such statute, order, or rule would in any way prevent, hinder, or delay necessary action in coping with the emergency. This includes, but is not limited to, the authority to suspend any and all statutes, rules, ordinances, or orders which affect leasing, printing, purchasing, travel, and the condition of employment and the compensation of employees. For the purposes of this Executive Order, "necessary action in coping with the emergency" means any emergency mitigation, response, or recovery action: (1) prescribed in the State Comprehensive Emergency Management Plan ("CEMP"); or (2) ordered by the State Coordinating Officer. The requirements of sections 252.46 and 120.54, Florida Statutes, shall not apply to any such suspension issued by a State agency; however, no such suspension shall remain in effect beyond the expiration of this Executive Order, to include any extensions.

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C. In accordance with section 465.0275, Florida Statutes, pharmacists may dispense up to a 30-day emergency prescription refill of maintenance medication to persons who reside in an area or county covered under this Executive Order and to emergency personnel who have been activated by their state and local agency but who do not reside in an area or county covered by this Executive Order.

D. In accordance with section 252.38, Florida Statutes, each political subdivision within the State of Florida may waive the procedures and formalities otherwise required of the political subdivision by law pertaining to:

1) Performance of public work and taking whatever prudent action is necessary to ensure the health, safety, and welfare of the community;

2) Entering into contracts; however, political subdivisions are cautioned against entering into time and materials contracts without ceiling as defined by 2 CFR 200.318(j) or cost plus percentage contracts as defined by 2 CFR 200.323(d);

3) Incurring obligations;

4) Employment of permanent and temporary workers;

5) Utilization of volunteer workers;

6) Rental of equipment;

7) Acquisition and distribution, with or without compensation, of supplies, materials, and facilities; and,

8) Appropriation and expenditure of public funds.

E. All State agencies responsible for the use of State buildings and facilities may close such buildings and facilities in those portions of the State affected by this emergency, to the extent necessary to meet this emergency. I direct each State agency to report the closure of any State

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building or facility to the Secretary of the Department of Management Services. Under the authority contained in section 252.36, Florida Statutes, I direct each County to report the closure of any building or facility operated or maintained by the County or any political subdivision therein to the Secretary of the Department of Management Services. Furthermore, I direct the Secretary of the Department of Management Services to:

1) Maintain an accurate and up-to-date list of all such closures; and,

2) Provide that list daily to the State Coordinating Officer.

Section 5. I find that the demands placed upon the funds appropriated to the agencies of the State of Florida and to local agencies are unreasonably great and the funds currently available may be inadequate to pay the costs of coping with this emergency. In accordance with section 252.37(2), Florida Statutes, I direct that sufficient funds be made available, as needed, by transferring and expending moneys appropriated for other purposes, moneys from unappropriated surplus funds, or from the Budget Stabilization Fund.

Section 6. All State agencies entering emergency final orders or other final actions in response to this emergency shall advise the State Coordinating Officer contemporaneously or as soon as practicable.

Section 7. Medical professionals and workers, social workers, and counselors with good and valid professional licenses issued by states other than the State of Florida may render such services in Florida during this emergency for persons affected by this emergency with the condition that such services be rendered to such persons free of charge, and with the further condition that such services be rendered under the auspices of the American Red Cross or the Florida Department of Health.

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Section 8. All activities taken by the Director of the Division of Emergency Management and the State Health Officer and Surgeon General with respect to this emergency before the issuance of this Executive Order are ratified. This Executive Order shall expire sixty days from this date unless extended.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 9th day of March, 2020.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2020 MAR -9 PM 5:52
DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Date: Monday, March 23, 2020 4:13:47 PM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Mon, Mar 23, 2020 at 2:46 PM
Subject: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment
To: <ann.echcc@gmail.com>

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Special Edition – Monday, March 23, 2020

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

COVID-19 Provider Enrollment Relief FAQs

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

On March 22, CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration's response to 2019 Novel Coronavirus (COVID-19).

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CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for several CMS programs. For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report.

CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions, and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

CMS will continue monitoring the developing COVID-19 situation and assess options to provide additional relief to clinicians, facilities, and their staff so they can focus on caring for patients.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Webpage on CMS.Gov.

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COVID-19 Provider Enrollment Relief FAQs

On March 22, CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19, including the toll-free hotlines available to provide expedited enrollment and answer questions related to COVID-19 enrollment requirements.

A copy of the FAQs can be found here: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the Current Emergencies Website.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
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From: Hill, Ann

To: 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Date: Monday, March 23, 2020 4:13:53 PM

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From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Mon, Mar 23, 2020 at 2:46 PM
Subject: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment
To: <ann.echcc@gmail.com>

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Special Edition – Monday, March 23, 2020

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You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. 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Subject: Fwd: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Date: Monday, March 23, 2020 4:13:47 PM

---------- Forwarded message ---------
From: **CMS MLN Connects** <cmslists@subscriptions.cms.hhs.gov>
Date: Mon, Mar 23, 2020 at 2:46 PM
Subject: COVID-19: Relief for Quality Reporting Programs and Provider Enrollment
To: <ann.echcc@gmail.com>

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MLN Connects Header Graphic



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Special Edition – Monday, March 23, 2020

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

COVID-19 Provider Enrollment Relief FAQs

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Blackmore, Carina
To: Vuong, Nga (CDC/OID/NCEZID) <ypg2@cdc.gov>
Cc: Clark, Marah
Subject: Fwd: Florida Hurricane Crisis CoAg Vector Control Project
Date: Friday, February 28, 2020 12:07:12 PM

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From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Monday, February 24, 2020 12:25 PM
To: Wallace, Marla D.; Clark, Marah
Cc: DSLRCrisisCoag (CDC); Stanek, Danielle R; Morrison, Andrea; Blackmore, Carina; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project

Good Afternoon Marla, Marah,

After speaking with OGS, the recommendation is for the State of FL to move forward with submitting the request as an official amendment in GrantSolutions.

Using official state letterhead, a process which you should be familiar, I would strongly advise breaking down the following:

- Show what the prior activities and amounts were (and why they are no longer feasible)
- Show what the new activities and amounts are (and how they are supported under the NOFO)
    - For the trailers, please be sure to provide ample justification and if possible necessary specs, quotes, and vendors. The more thoroughly tied to the NOFO, the more helpful it will be.

If you need any assistance, or would like me to view the official draft prior to submission, I would be happy to review.

Kind regards,
Kevin Sevak

From:
Sent: Monday, February 24, 2020 1:59 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Good Afternoon,

In order for CDC To make an informed decision regarding their proposed request an official request should be submitted to CDC via grant solutions.

Damond

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Friday, February 21, 2020 1:54 PM
To: Barnes, Damond (CDC/OCOO/OFR/OGS) <xhp5@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>

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Subject: FW: Florida Hurricane Crisis CoAg Vector Control Project
Importance: High

Good afternoon Damond,

I am reaching out to you on behalf of Sabrina Hansen, who is the Project Officer for Florida under Hurricane Crisis CoAg TP18-1802. Sabrina is currently supporting Coronavirus response activities.

Her jurisdiction has requested a redirection of funds for two activities. Prior to submission into GMM we were wanting to get some feedback. The first of which is straight forward, but the second may require more attention.

The request entails that funds would actually be staying in the same budget category, however they are proposing a chance in two activities.

1. The first is to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control. The justification they provided aligns with Domain 5 of approved activities under the grant. I found this to be an allowable use of funds, but wanted to get your concurrence. More information on this can be found highlighted in this color below.

2. Secondly, FL is proposing to purchase two trailers: One trailer to move equipment around the county, increasing their capacity in post storm treatment response. The other is interested in using the trailer to educate their constituents. Detailed justification and estimates can be found attached. I have requested quotes and further information already, but sought your advice on such a purchase. Further justification on this can be found **attached** and below in this color.

Thank you for all your help!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@freshfromflorida.com>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

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Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) [mailto:ydh1@cdc.gov]
Sent: Friday, February 14, 2020 1:13 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing **LA**'s vector project needs and are proposing some alternative use of funds. **Do you means FL?**

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

In other words, we need to see clearly see what the money was originally approved for, and how much, and where the money is going toward now, how much, justifications, and associated quotes… Based on that, we will review and get the necessary prior approval, and if approved, have the appropriate changes documented in GMM.

Please let me know if this makes sense. Thank you!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

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From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share

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best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: AAP News OnCall--March 9, 2020

Date: Monday, March 9, 2020 11:18:39 AM

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Date: Mon, Mar 9, 2020 at 9:24 AM
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More for pediatric practices

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From: aapnewsoncall@aap.org <aapnewsoncall@aap.org>
Sent: Monday, March 9, 2020 9:21 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: AAP News OnCall--March 9, 2020

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March 9, 2020 · Volume 4 Issue 42

CDC HPV Vaccine

COVID-19 resources and updates for pediatricians

The American Academy of Pediatrics is advising members of the steps they can take now to prepare as the outbreak continues to spread. Visit the *AAP News* Coronavirus disease outbreak page for regular COVID-19 news updates. Here are some additional resources on COVID-19:

- AAP Red Book Online: 2019 Novel Coronavirus (COVID-19) Infections
- CDC: COVID-19 Information for healthcare professionals
- CDC: Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children
- AAP: Preparedness Checklist for Pediatric Practices
- World Health Organization: Coronavirus
- HealthyChildren.org: 2019 Novel Coronavirus (COVID-19)

Top stories in *AAP News*

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COVID-19 testing criteria expanded
As the availability of diagnostic tests increases, the CDC is telling clinicians to use their judgment when deciding whether to test someone for COVID-19.

CDC: 136 children have died of flu; virus activity still high

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Deaths among children are higher than during the same period in every other season since reporting started in 2004-'05 with the exception of the 2009 H1N1 pandemic.

Prioritizing children in national disaster preparedness planning
Since 9/11, greater focus has been placed on the impact of disasters on children, which influenced national and local preparedness and planning efforts. As a result, pediatricians may be asked to advise on preparing for disasters.

FDA strengthens warning about mental health side effects linked to montelukast
The FDA implemented a boxed warning for Montelukast (Singulair and generics) following continued reports of neuropsychiatric events such as agitation, depression, sleeping problems and suicidal thoughts and actions.

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This week from the AAP

RadioMD: Infant Safe Sleep

Having a new baby is exciting, and parents want to do everything right. RadioMD has just released a HealthyChildren.org podcast "Infant Safe Sleep" to help answer questions of young parents about how to keep babies snug and safe at night. Dr. Elizabeth Murray joins host Melanie Cole, MS to discuss safe infant sleeping practices.

Pediatric Dermatology Case of the Month feature

The AAP Section on Dermatology (SOD) continues to sponsor a Pediatric Dermatology Case of the Month feature. This online, educational tool was created to address pediatric dermatology knowledge gaps among practicing pediatricians and pediatric trainees. Cases of interest and those that address the American Board of Pediatrics content specifications are presented each month in vignette form. Please contact jgorlewski@aap.org if you would like to be notified when a new case is posted or if you would like to contribute a case.

Webinar: Achieving Optimal Nutrition
The Important Role of Schools and Pediatricians

Tuesday, March 17
12:00 PM (Eastern) | 11:00 AM (Central) | 10:00 AM (Mountain) | 9:00 AM (Pacific)

Reese Pinworm Meds

The American Academy of Pediatrics, with support from National Dairy Council, is hosting a Webinar on the importance of school meals. Join us for a lunchtime discussion on the vital role school meals play in child growth and development as well as helping children learn about and practice healthy eating.

- Robert Murray, MD, FAAP, will share opportunities to help pediatricians work effectively with schools on practical approaches to address nutrition during the office visit.
- Donna Martin, EdS, RD, LD, School Nutrition Director for Burke County Schools in Georgia will share a case study about practical implementation approaches of the school meal program.

Register today

New from ShopAAP

Pediatric Education for Prehospital Professionals (PEPP), Fourth Edition Now Available!

Celebrating its 20th anniversary, PEPP is an evidence-based resource of essential medical content for the assessment and management of infants and children in the field. This respected and ground-breaking program paired physicians and EMS providers together to ensure the content reflects current best practices and the realities of the field. Developed by the American Academy of Pediatrics, PEPP is designed to give prehospital professionals the knowledge, skills, and confidence they need to effectively assess and manage pediatric patients. Visit shop.aap.org for more information and to order PEPP, Fourth Edition.

Take advantage of early-bird pricing for the 2020 Diagnosis and Treatment of Common Pediatric Mental Health Disorders Course

Register by March 24, 2020 and save $150. This course is designed to enable participants to learn critical concepts in the recognition of pediatric mental health disorders and apply evidence-based strategies to manage patients' illnesses

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effectively and efficiently. Earn a maximum of 16.5 *AMA PRA Category 1 Credits* . Visit shop.aap.org/mentalhealth2020 for more information and to register.

Effectively diagnose and treat various skin conditions with AAP resources

Save $15 when you purchase together *Pediatric Dermatology: A Quick Reference Guide* and *Pediatric Dermatology: A Quick Diagnosis Deck*. Effectively identify and treat more than 100 pediatric and adolescent skin conditions with the aid of these handy resources. Includes 300+ high-quality images. Visit shop.aap.org for more information and to order.

Your membership makes a difference for children everywhere, thank you!

The AAP's ability to advocate on behalf of children is only as strong as the support we receive from our members. Encourage your colleagues to join today by visiting the **AAP website** or calling 866-THE-AAP1 (843-2271).

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Ann Hill, Executive Director
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From: Ann Hill

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Subject: Fwd: FW: AAP News OnCall--March 9, 2020

Date: Monday, March 9, 2020 11:18:38 AM

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From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 9:24 AM
Subject: FW: AAP News OnCall--March 9, 2020
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com)

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More for pediatric practices

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
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From: aapnewsoncall@aap.org <aapnewsoncall@aap.org>
Sent: Monday, March 9, 2020 9:21 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: AAP News OnCall--March 9, 2020

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March 9, 2020 · Volume 4 Issue 42

CDC HPV Vaccine

COVID-19 resources and updates for pediatricians

The American Academy of Pediatrics is advising members of the steps they can take now to prepare as the outbreak continues to spread. Visit the *AAP News* Coronavirus disease outbreak page for regular COVID-19 news updates. Here are some additional resources on COVID-19:

- AAP Red Book Online: 2019 Novel Coronavirus (COVID-19) Infections
- CDC: COVID-19 Information for healthcare professionals
- CDC: Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children
- AAP: Preparedness Checklist for Pediatric Practices
- World Health Organization: Coronavirus
- HealthyChildren.org: 2019 Novel Coronavirus (COVID-19)

Top stories in *AAP News*

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COVID-19 testing criteria expanded
As the availability of diagnostic tests increases, the CDC is telling clinicians to use their judgment when deciding whether to test someone for COVID-19.

CDC: 136 children have died of flu; virus activity still high

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Deaths among children are higher than during the same period in every other season since reporting started in 2004-'05 with the exception of the 2009 H1N1 pandemic.

Prioritizing children in national disaster preparedness planning
Since 9/11, greater focus has been placed on the impact of disasters on children, which influenced national and local preparedness and planning efforts. As a result, pediatricians may be asked to advise on preparing for disasters.

FDA strengthens warning about mental health side effects linked to montelukast
The FDA implemented a boxed warning for Montelukast (Singulair and generics) following continued reports of neuropsychiatric events such as agitation, depression, sleeping problems and suicidal thoughts and actions.

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This week from the AAP

RadioMD: Infant Safe Sleep

Having a new baby is exciting, and parents want to do everything right. RadioMD has just released a HealthyChildren.org podcast "Infant Safe Sleep" to help answer questions of young parents about how to keep babies snug and safe at night. Dr. Elizabeth Murray joins host Melanie Cole, MS to discuss safe infant sleeping practices.

Pediatric Dermatology Case of the Month feature

The AAP Section on Dermatology (SOD) continues to sponsor a Pediatric Dermatology Case of the Month feature. This online, educational tool was created to address pediatric dermatology knowledge gaps among practicing pediatricians and pediatric trainees. Cases of interest and those that address the American Board of Pediatrics content specifications are presented each month in vignette form. Please contact jgorlewski@aap.org if you would like to be notified when a new case is posted or if you would like to contribute a case.

Webinar: Achieving Optimal Nutrition
The Important Role of Schools and Pediatricians

Tuesday, March 17
12:00 PM (Eastern) | 11:00 AM (Central) | 10:00 AM (Mountain) | 9:00 AM (Pacific)

Reese Pinworm Meds

The American Academy of Pediatrics, with support from National Dairy Council, is hosting a Webinar on the importance of school meals. Join us for a lunchtime discussion on the vital role school meals play in child growth and development as well as helping children learn about and practice healthy eating.

- Robert Murray, MD, FAAP, will share opportunities to help pediatricians work effectively with schools on practical approaches to address nutrition during the office visit.
- Donna Martin, EdS, RD, LD, School Nutrition Director for Burke County Schools in Georgia will share a case study about practical implementation approaches of the school meal program.

Register today

New from ShopAAP

Pediatric Education for Prehospital Professionals (PEPP), Fourth Edition Now Available!

Celebrating its 20th anniversary, PEPP is an evidence-based resource of essential medical content for the assessment and management of infants and children in the field. This respected and ground-breaking program paired physicians and EMS providers together to ensure the content reflects current best practices and the realities of the field. Developed by the American Academy of Pediatrics, PEPP is designed to give prehospital professionals the knowledge, skills, and confidence they need to effectively assess and manage pediatric patients. Visit shop.aap.org for more information and to order PEPP, Fourth Edition.

Take advantage of early-bird pricing for the 2020 Diagnosis and Treatment of Common Pediatric Mental Health Disorders Course

Register by March 24, 2020 and save $150. This course is designed to enable participants to learn critical concepts in the recognition of pediatric mental health disorders and apply evidence-based strategies to manage patients' illnesses

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effectively and efficiently. Earn a maximum of 16.5 *AMA PRA Category 1 Credits* . Visit shop.aap.org/mentalhealth2020 for more information and to register.

Effectively diagnose and treat various skin conditions with AAP resources

Save $15 when you purchase together *Pediatric Dermatology: A Quick Reference Guide* and *Pediatric Dermatology: A Quick Diagnosis Deck*. Effectively identify and treat more than 100 pediatric and adolescent skin conditions with the aid of these handy resources. Includes 300+ high-quality images. Visit shop.aap.org for more information and to order.

Your membership makes a difference for children everywhere, thank you!

The AAP's ability to advocate on behalf of children is only as strong as the support we receive from our members. Encourage your colleagues to join today by visiting the **AAP website** or calling 866-THE-AAP1 (843-2271).

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Ann Hill, Executive Director
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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: CDC COVID Tips for Everyday

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Date: Tuesday, March 10, 2020 4:15:04 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:04 PM
Subject: FW: CDC COVID Tips for Everyday
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matroni, Michael <Mike.Matroni@medxcelfm.com>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch

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Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
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regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 1:34 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: CDC COVID Tips for Everyday

CDC posted some new resources last night regarding simple things Americans can do every day to protect themselves from COVID-19. They target families, schools, and workplaces. Please find these resources online at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/workplace-school-and-home-guidance.pdf

Samantha Cooksey Strickland

COVID-19 Response Team

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: CDC COVID Tips for Everyday

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Date: Tuesday, March 10, 2020 4:15:04 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:04 PM
Subject: FW: CDC COVID Tips for Everyday
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matroni, Michael <Mike.Matroni@medxcelfm.com>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. 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Subject: Fwd: FW: COVID-19 - Updated Provider Algorithm

AMERICAN OVERSIGHT

Date: Monday, March 2, 2020 5:59:06 PM
Attachments: nCoVProviderAlgorithm2020-02-28.pdf
nCoVProviderAlgorithmCHD2020-02-28.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Fri, Feb 28, 2020 at 3:02 PM
Subject: FW: COVID-19 - Updated Provider Algorithm
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Dan Flynn <dflynn@cityofpensacola.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Steven Barry <district5@myescambia.com>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A

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<Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

Latest, easy to follow algorithm for decision making for clinical staff at your locations.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, February 28, 2020 2:53 PM
To: DL DCBE Primary Epi CHD Contacts <DLDCBEPrimaryEpiCHDContacts@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Riggen, Amy <Amy.Riggen@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>; DL DOH CHD Administrators_Directors <DLDOHCHDAdministrators_Directors@flhealth.gov>
Subject: COVID-19 - Updated Provider Algorithm
Importance: High

Please see the updated COVID-19 algorithm to be shared with health care providers.

An updated provider letter is currently being routed and will be shared as soon as possible.

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Sincerely,

Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

Clinician Screening Tool for Identifying Persons Under Investigation for Coronavirus Disease 2019 (COVID-19)

Version 2 | February 28, 2020

Only consider persons with travel to an affected geographic area[1] or close contact[2] with a laboratory-confirmed[3,4] COVID-19 patient within 14 days of symptom onset or persons with severe respiratory illness[5] without an alternative diagnosis.

- Ask the patient to wear a surgical mask.
- Evaluate the patient in a private room with the door closed, ideally an airborne isolation room, if available.
- Initiate contact and airborne precautions, including use of eye protection (e.g., goggles or a face shield) for all health care professionals and other staff entering the room.
- Visit **www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html** for additional recommendations on infection control recommendations for patients under investigation for COVID-19 in health care settings.

A. Person traveled to or from an **affected geographic area[1]** with widespread or sustained community transmission.

Does the person have fever[6] **and** symptoms of lower respiratory illness (e.g., cough, shortness of breath)?

YES / NO

B. Person had **close contact[2]** with a laboratory-confirmed[3,4] COVID-19 patient

Does the person have fever[6] **or** symptoms of lower respiratory illness (e.g., cough, shortness of breath)?

YES / NO

C. Person with **severe acute lower respiratory illness[5]** and fever requiring hospitalization.

Does the person have an alternative explanatory diagnosis (e.g., influenza)?

YES / NO

STOP: No COVID-19 testing needed
Continue to treat patient normally.

This patient meets the criteria for a patient under investigation for COVID-19. The Florida Department of Health asks that you **immediately** notify both infection control personnel at your health care facility and your county health department (**FloridaHealth.gov/CHDEpiContact**).

[1]Affected areas are defined as geographic regions where sustained community transmission has been identified. Countries with CDC Level 2 or 3 Travel Health Notices include: China, South Korea, Iran, Italy, and Japan (as of February 28,2020). A current list of affected areas can be found at **www.cdc.gov/coronavirus/2019-ncov/travelers/**.

[2]Close contact is defined as: (1) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, or (2) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings

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

[4]For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation.

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

[6]Fever may be subjective or confirmed.

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Content source: Centers for Disease Control and Prevention

Clinician Screening Tool for Identifying Persons Under Investigation for Coronavirus Disease 2019 (COVID-19)

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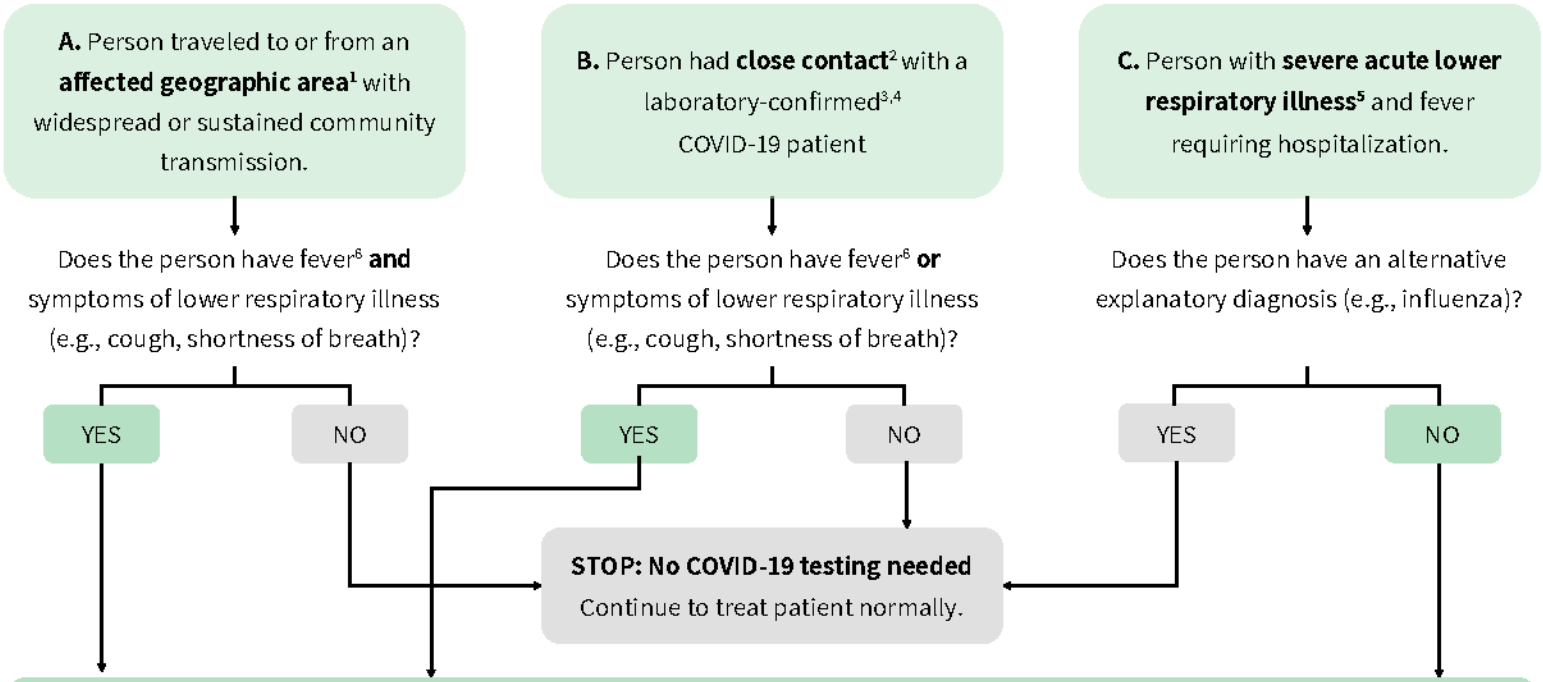

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Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. 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Subject: Fwd: FW: COVID-19 - Updated Provider Algorithm

AMERICAN OVERSIGHT

Date: Monday, March 2, 2020 5:59:03 PM
Attachments: nCoVProviderAlgorithm2020-02-28.pdf
nCoVProviderAlgorithmCHD2020-02-28.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Fri, Feb 28, 2020 at 3:02 PM
Subject: FW: COVID-19 - Updated Provider Algorithm
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Dan Flynn <dflynn@cityofpensacola.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Steven Barry <district5@myescambia.com>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A

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<Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

Latest, easy to follow algorithm for decision making for clinical staff at your locations.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts."
Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, February 28, 2020 2:53 PM
To: DL DCBE Primary Epi CHD Contacts <DLDCBEPrimaryEpiCHDContacts@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Riggen, Amy <Amy.Riggen@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>; DL DOH CHD Administrators_Directors <DLDOHCHDAdministrators_Directors@flhealth.gov>
Subject: COVID-19 - Updated Provider Algorithm
Importance: High

Please see the updated COVID-19 algorithm to be shared with health care providers.

An updated provider letter is currently being routed and will be shared as soon as possible.

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Sincerely,

Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

Clinician Screening Tool for Identifying Persons Under Investigation for Coronavirus Disease 2019 (COVID-19)

Version 2 | February 28, 2020

Only consider persons with travel to an affected geographic area[1] or close contact[2] with a laboratory-confirmed[3,4] COVID-19 patient within 14 days of symptom onset or persons with severe respiratory illness[5] without an alternative diagnosis.

- Ask the patient to wear a surgical mask.
- Evaluate the patient in a private room with the door closed, ideally an airborne isolation room, if available.
- Initiate contact and airborne precautions, including use of eye protection (e.g., goggles or a face shield) for all health care professionals and other staff entering the room.
- Visit **www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html** for additional recommendations on infection control recommendations for patients under investigation for COVID-19 in health care settings.

A. Person traveled to or from an **affected geographic area[1]** with widespread or sustained community transmission.

Does the person have fever[6] **and** symptoms of lower respiratory illness (e.g., cough, shortness of breath)?

YES

NO

B. Person had **close contact[2]** with a laboratory-confirmed[3,4] COVID-19 patient

Does the person have fever[6] **or** symptoms of lower respiratory illness (e.g., cough, shortness of breath)?

YES

NO

C. Person with **severe acute lower respiratory illness[5]** and fever requiring hospitalization.

Does the person have an alternative explanatory diagnosis (e.g., influenza)?

YES

NO

STOP: No COVID-19 testing needed
Continue to treat patient normally.

This patient meets the criteria for a patient under investigation for COVID-19. The Florida Department of Health asks that you **immediately** notify both infection control personnel at your health care facility and your county health department (**FloridaHealth.gov/CHDEpiContact**).

[1]Affected areas are defined as geographic regions where sustained community transmission has been identified. Countries with CDC Level 2 or 3 Travel Health Notices include: China, South Korea, Iran, Italy, and Japan (as of February 28,2020). A current list of affected areas can be found at **www.cdc.gov/coronavirus/2019-ncov/travelers/**.

[2]Close contact is defined as: (1) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, or (2) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met. Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings

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

[4]For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation.

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

[6]Fever may be subjective or confirmed.

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Content source: Centers for Disease Control and Prevention

Clinician Screening Tool for Identifying Persons Under Investigation for Coronavirus Disease 2019 (COVID-19)

Version 2 | February 28, 2020

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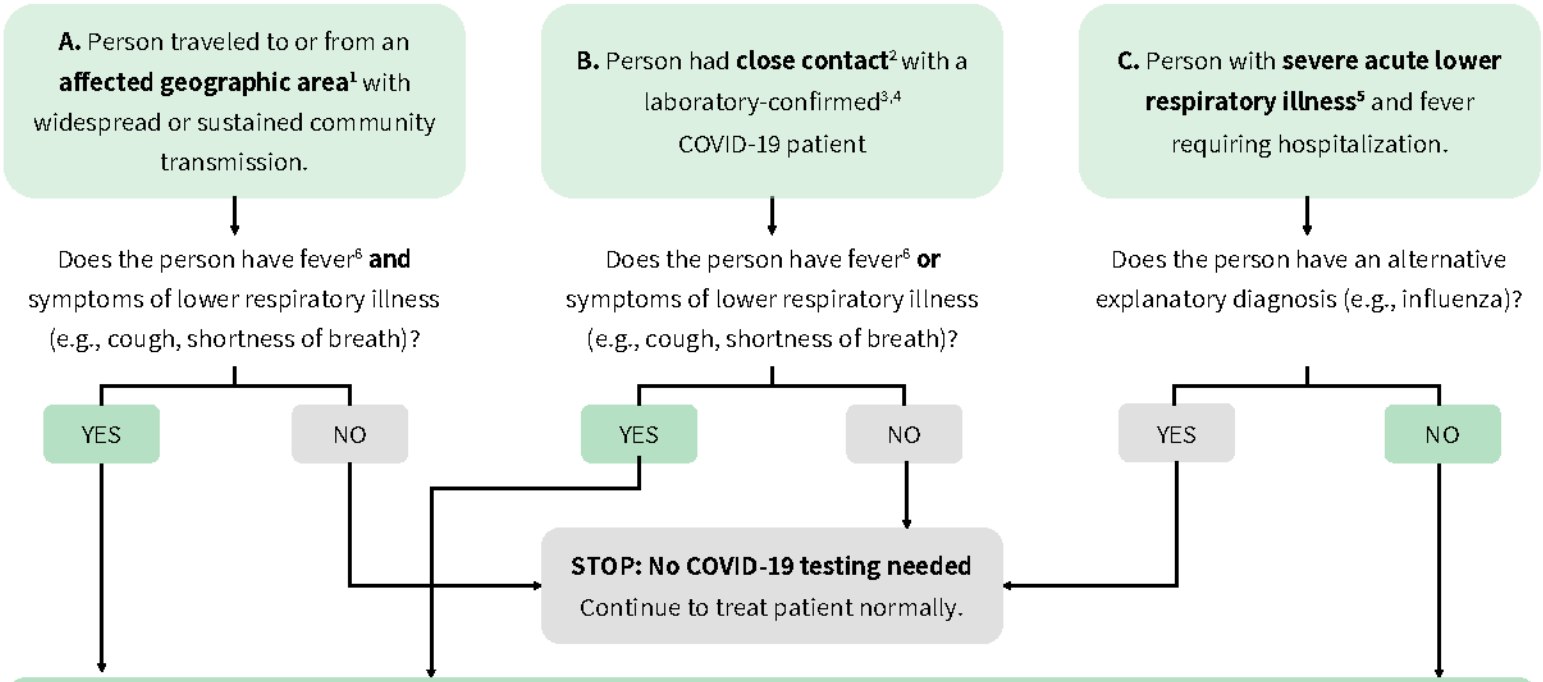

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Content source: Centers for Disease Control and Prevention

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services

AMERICAN OVERSIGHT

Date: Thursday, March 5, 2020 1:13:17 PM
Attachments: QSO-20-14-NH.pdf
QSO-20-13-Hospitals.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:51 AM
Subject: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com

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latest

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Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

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regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Thursday, March 5, 2020 11:39 AM

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To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
Importance: High

CHDs,

For your situational awareness, please find newly released standards for hospitals and nursing homes related to COVID-19 from Centers for Medicaid & Medicare Services. These are being distributed by AHCA directly to providers. They both include guidance for screening visitors and employees for these facilities.

Please distribute locally as appropriate.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-13-Hospitals

DATE: **March 4, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- ***Coordination with the Centers for Disease Control (CDC) and local public health departments*** - We encourage all hospitals to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).
- ***Hospital Guidance and Actions*** **-** CMS regulations and guidance support hospitals taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, discharge and transfers from the hospital, and visitation.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for hospitals and critical access hospitals (CAH's) in addressing the COVID-19 outbreak and minimizing transmission to other individuals. Specifically, we address FAQs related to optimizing patient placement, with the goal of addressing the needs of the individual patient while protecting other patients and healthcare workers.

Guidance

Hospitals should monitor the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) for up to date information and resources. They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Additional information about monitoring healthcare personnel

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is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Guidance for Addressing Patient Triage and Placement of Patients with known or suspected COVID-19

Which patients are at risk for severe disease for COVID-19?
Based upon CDC data, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

How should facilities screen visitors and patients for COVID-19?

Hospitals should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:

1. Fever or symptoms of a respiratory infection, such as a cough and sore throat.
2. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
3. Contact with someone with known or suspected COVID-19.

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for hospital staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

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    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the hospital's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Hospitals should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

What are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for a patients with known or suspected COVID-19?

Recommendations for patient placement and other detailed infection prevention and control recommendations regarding hand hygiene, Transmission-Based Precautions, environmental cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel are available in the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons under Investigation for COVID-19 in Healthcare Settings.

Do all patients with known or suspected COVID-19 infection require hospitalization?
Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

Are there specific considerations for patients requiring diagnostic or therapeutic interventions?
Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some procedures create high risks for transmission (e.g., intubation) additional precautions include: 1) HCP should wear all recommended PPE, 2) the number of HCP present should be limited to essential personnel, and 3) the room should be cleaned and disinfected in accordance with environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

When is it safe to discontinue Transmission-based Precautions for hospitalized patients with COVID-19?
The decision to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens

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More detailed information about criteria to discontinue Transmission-Based Precautions are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Can hospitals restrict visitation of patients?
Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

What are the considerations for discharge to a subsequent care location for patients with COVID-19?
The decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

What are the implications of the Medicare Hospital Discharge Planning Regulations for Patients with COVID-19?
Medicare's Discharge Planning Regulations (which were updated in November 2019) requires that hospital assess the patient's needs for post-hospital services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

Can hospitals restrict visitation of patients?
Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control

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concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

Important CDC Resources:

- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID19) or Persons Under Investigation for COVID-19 in Healthcare Settings.: **https://www.cdc.gov/coronavirus/2019-ncov/infection-control/controrecommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html**

CDC Updates:
https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

CMS Resources
CMS has additional guidance which may be beneficial to hospitals related to EMTALA requirements and other topics surrounding the health and safety standards during emergencies. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Contact: Questions about this memorandum should be addressed to QSOG_EmergencyPrep@cms.hhs.gov. Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

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cc: Survey and Operations Group Management

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH

DATE: **March 4, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19 -** CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments -** We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).

Background

CMS is responsible for ensuring the health and safety of nursing homes by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we're providing additional guidance to nursing homes to help control and prevent the spread of the virus.

Guidance

Facilities should monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and

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CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with patients, patient representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

Guidance for Limiting the Transmission of COVID-19 for Nursing Homes

How should facilities monitor or limit visitors?
Facilities should screen visitors for the following:

1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.
3. Has had contact with someone with or under investigation for COVID-19.

If visitors meet the above criteria, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident's right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of Appendix PP of the State Operations Manual. Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, "restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident's risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication)."

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above).

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

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Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?
Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms maybe mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the patient assuming: 1) the patient does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html)

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the patient does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the patient and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?
A nursing home can accept a patient diagnosed with COVID-19 and still under Transmission-based Precautions for COVID-19 as long as it can follow CDC guidance for transmission-based precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19. Information on the duration of infectivity is limited, and the interim guidance has been developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.

Other considerations for facilities:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- Increase the availability and accessibility of alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

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    - Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).

What other resources are available for facilities to help improve infection control and prevention?
CMS urges providers to take advantage of several resources that are available:

CDC Resources:
- Infection preventionist training: https://www.cdc.gov/longtermcare/index.html
- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html

CMS Resources:
- Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf
- Infection control toolkit for bedside licensed nurses and nurse aides ("Head to Toe Infection Prevention (H2T) Toolkit"): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

Contact: Email DNH_TriageTeam@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services

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Date: Thursday, March 5, 2020 1:13:16 PM
Attachments: QSO-20-14-NH.pdf
QSO-20-13-Hospitals.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:51 AM
Subject: FW: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com

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latest

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
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regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Thursday, March 5, 2020 11:39 AM

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To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Standards for Hospitals & Nursing Homes from Centers for Medicaid & Medicare Services
Importance: High

CHDs,

For your situational awareness, please find newly released standards for hospitals and nursing homes related to COVID-19 from Centers for Medicaid & Medicare Services. These are being distributed by AHCA directly to providers. They both include guidance for screening visitors and employees for these facilities.

Please distribute locally as appropriate.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

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Ann Hill, Executive Director
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DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-13-Hospitals

DATE: **March 4, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- ***Coordination with the Centers for Disease Control (CDC) and local public health departments*** - We encourage all hospitals to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).
- ***Hospital Guidance and Actions*** **-** CMS regulations and guidance support hospitals taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, discharge and transfers from the hospital, and visitation.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. This memorandum responds to questions we have received and provides important guidance for hospitals and critical access hospitals (CAH's) in addressing the COVID-19 outbreak and minimizing transmission to other individuals. Specifically, we address FAQs related to optimizing patient placement, with the goal of addressing the needs of the individual patient while protecting other patients and healthcare workers.

Guidance

Hospitals should monitor the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/index.html) for up to date information and resources. They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Additional information about monitoring healthcare personnel

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is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Guidance for Addressing Patient Triage and Placement of Patients with known or suspected COVID-19

Which patients are at risk for severe disease for COVID-19?
Based upon CDC data, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

How should facilities screen visitors and patients for COVID-19?

Hospitals should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:

1. Fever or symptoms of a respiratory infection, such as a cough and sore throat.
2. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
3. Contact with someone with known or suspected COVID-19.

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for hospital staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

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    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the hospital's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Hospitals should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

What are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for a patients with known or suspected COVID-19?

Recommendations for patient placement and other detailed infection prevention and control recommendations regarding hand hygiene, Transmission-Based Precautions, environmental cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel are available in the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons under Investigation for COVID-19 in Healthcare Settings.

Do all patients with known or suspected COVID-19 infection require hospitalization?
Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

Are there specific considerations for patients requiring diagnostic or therapeutic interventions?
Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some procedures create high risks for transmission (e.g., intubation) additional precautions include: 1) HCP should wear all recommended PPE, 2) the number of HCP present should be limited to essential personnel, and 3) the room should be cleaned and disinfected in accordance with environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

When is it safe to discontinue Transmission-based Precautions for hospitalized patients with COVID-19?
The decision to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens

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More detailed information about criteria to discontinue Transmission-Based Precautions are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Can hospitals restrict visitation of patients?
Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

What are the considerations for discharge to a subsequent care location for patients with COVID-19?
The decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

What are the implications of the Medicare Hospital Discharge Planning Regulations for Patients with COVID-19?
Medicare's Discharge Planning Regulations (which were updated in November 2019) requires that hospital assess the patient's needs for post-hospital services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

Can hospitals restrict visitation of patients?
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Important CDC Resources:

- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID19) or Persons Under Investigation for COVID-19 in Healthcare Settings.: **https://www.cdc.gov/coronavirus/2019-ncov/infection-control/controrecommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html**

CDC Updates:
https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

CMS Resources
CMS has additional guidance which may be beneficial to hospitals related to EMTALA requirements and other topics surrounding the health and safety standards during emergencies. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Contact: Questions about this memorandum should be addressed to QSOG_EmergencyPrep@cms.hhs.gov. Questions about COVID-19 guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

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cc: Survey and Operations Group Management

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Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH

DATE: **March 4, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19 -** CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19.
- **Coordination with the Centers for Disease Control (CDC) and local public health departments -** We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html).

Background

CMS is responsible for ensuring the health and safety of nursing homes by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we're providing additional guidance to nursing homes to help control and prevent the spread of the virus.

Guidance

Facilities should monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and

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CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with patients, patient representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

Guidance for Limiting the Transmission of COVID-19 for Nursing Homes

How should facilities monitor or limit visitors?
Facilities should screen visitors for the following:

1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.
3. Has had contact with someone with or under investigation for COVID-19.

If visitors meet the above criteria, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident's right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of Appendix PP of the State Operations Manual. Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, "restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident's risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication)."

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above).

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
    - Immediately stop work, put on a facemask, and self-isolate at home;
    - Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
    - Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

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Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?
Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms maybe mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the patient assuming: 1) the patient does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html)

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the patient does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the patient and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?
A nursing home can accept a patient diagnosed with COVID-19 and still under Transmission-based Precautions for COVID-19 as long as it can follow CDC guidance for transmission-based precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19. Information on the duration of infectivity is limited, and the interim guidance has been developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.

Other considerations for facilities:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- Increase the availability and accessibility of alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

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    - Ensure ABHS is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.).

What other resources are available for facilities to help improve infection control and prevention?
CMS urges providers to take advantage of several resources that are available:

CDC Resources:
- Infection preventionist training: https://www.cdc.gov/longtermcare/index.html
- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html

CMS Resources:
- Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf
- Infection control toolkit for bedside licensed nurses and nurse aides ("Head to Toe Infection Prevention (H2T) Toolkit"): https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

Contact: Email DNH_TriageTeam@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19: Declaration of Public Health Emergency In Florida

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Date: Monday, March 2, 2020 5:28:10 PM
Attachments: SLG-BIZHUB20030109040.pdf
Declaration of Public Health Emergency COVID-19 3.1.20.pdf

---------- Forwarded message ---------
From: **StateESF8.Planning** <StateESF8.Planning@flhealth.gov>
Date: Sun, Mar 1, 2020 at 9:28 PM
Subject: FW: COVID-19: Declaration of Public Health Emergency In Florida
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>

FYI

The Governor has issued Executive Order 20-51, directing a Public Health Emergency and establishing Florida's Response Protocol for COVID-19. As a result, the State Surgeon General has issued a Declaration of Public Health Emergency for the State of Florida. Please review the attached Executive Order and Declaration.

Thank you for your continued support of our public health preparedness and response.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email | Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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STATE OF FLORIDA
DEPARTMENT OF HEALTH
DECLARATION OF PUBLIC HEALTH EMERGENCY

WHEREAS, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that appears to occur through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, as of February 29, 2020, COVID-19 has spread throughout China and to 67 other countries and territories, including 62 cases within the United States; and

WHEREAS, the Centers for Disease Control and Prevention recommends that all states and territories implement aggressive measures to slow and contain transmission of COVID-19 in the United States; and

WHEREAS, on January 30, 2020, the World Health Organization declared a public health emergency of international concern related to COVID-19; and

WHEREAS, on January 31, 2020, the United States Department of Health and Human Services declared that a public health emergency exists nationwide as a result of confirmed cases of COVID-19 in the United States; and

WHEREAS, one Hillsborough County resident and one Manatee County resident have tested presumptively positive for COVID-19; and

WHEREAS, on March 1, 2020, Governor Ron DeSantis issued Executive Order 20-51, declaring that appropriate measures to control the spread of COVID-19 in the State of Florida are necessary, and therefore directed that a Public Health Emergency be declared in the State of Florida; and

WHEREAS, implementation of basic precautions of infection control and prevention, including staying at home when ill and practicing respiratory and hand hygiene are necessary to slow or prevent the spread of COVID-19; and

WHEREAS, COVID-19 is a communicable disease with significant morbidity and mortality, and presents a severe danger to public health; and

WHEREAS, COVID-19 is a threat to public health in Florida.

NOW, THEREFORE, I, Scott A. Rivkees, M.D., State Surgeon General and State Health Officer, by virtue of Executive Order Number 20-51 issued by Governor Ron DeSantis, the authority vested in me by section 381.00315, Florida Statutes, and after consultation with

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Governor Ron DeSantis and public health officials within the Department of Health, do hereby declare that a public health emergency exists in the State of Florida. In order to respond to this emergency, the following shall commence:

Section 1. In order to protect public health, I find it is necessary for the Florida Department of Health to request assistance from the Centers for Disease Control and Prevention to address this public health emergency.

Section 2. In order to protect public health, I find it is necessary to advise individuals in the State of Florida that have traveled to an area that the Centers for Disease Control and Prevention has issued a Warning Level 3 or Alert Level 2 Travel Health Notice, or have been in close contact with an individual that has traveled to such an area, that develop symptoms of fever, cough, shortness of breath, or difficulty breathing within 14 days of such travel or close contact should immediately contact the Florida Department of Health in their current county and self-isolate until cleared by the Florida Department of Health.

Section 3. In order to protect public health, I find it is necessary to advise any individuals who believe they may have been exposed to COVID-19 to contact their local county health department **prior to** travelling to any physician's office, emergency department, hospital, or urgent care center, to ensure proper protective measures are taken to prevent further risk of spread to others.

Section 4. In order to protect public health, I find it is necessary to remind health care providers, hospitals, and labs that they are required to immediately report all suspected cases of COVID-19 to the local county health department to ensure a prompt public health response to prevent disease among close contacts.

Section 5. In order to protect public health, the Florida Department of Health will maintain an Incident Management Team to coordinate the public health response for the State of Florida.

Section 6. In order to protect public health, the Florida Department of Health, at such time when necessary, may take actions to protect the public health, pursuant to the authority of section 381.00315, Florida Statutes, including quarantine, isolation and other interventions.

Issued this 1st day of March 2020, in Department of Health offices, Tallahassee, Leon County, Florida.

Scott A. Rivkees, M.D.
State Surgeon General

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STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-51

(Establishes COVID-19 Response Protocol and Directs Public Health Emergency)

WHEREAS, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, in late 2019, a new and significant outbreak of COVID-19 emerged in China; and

WHEREAS, the World Health Organization declared COVID-19 a Public Health Emergency of International Concern; and

WHEREAS, in response to the recent COVID-19 outbreak in China, Iran, Italy and South Korea, the Centers for Disease Control and Prevention ("CDC") has deemed it necessary to prohibit or restrict non-essential travel to or from those countries; and

WHEREAS, in response to the recent COVID-19 outbreak in Japan, the CDC has advised older travelers and those with chronic medical conditions to avoid nonessential travel and all travelers to exercise enhanced precautions; and

WHEREAS, the CDC currently recommends community preparedness and everyday prevention measures be taken by all individuals and families in the United States, including voluntary home isolation when individuals are sick with respiratory symptoms, covering coughs and sneezes with a tissue and disposal of the tissue immediately thereafter, washing hands often with soap and water for at least 20 seconds, use of alcohol-based hand sanitizers with 60%-95%

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alcohol if soap and water are not readily available and routinely cleaning frequently touched surfaces and objects to increase community resilience and readiness for responding to an outbreak; and

WHEREAS, two individuals in the State of Florida tested presumptively positive for COVID-19, including a resident of Manatee County and a resident of Hillsborough County; and

WHEREAS, the CDC currently recommends mitigation measures in communities with COVID-19 cases, including staying at home when sick, keeping away from others who are sick and staying at home when a household member is sick with respiratory disease symptoms or if instructed to do so by public health officials or a health care provider; and

WHEREAS, it is necessary and appropriate to take action to ensure that COVID-19 remains controlled and that residents and visitors in Florida remain safe and secure;

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1. Because of the foregoing conditions, I direct the State Health Officer and Surgeon General, Dr. Scott Rivkees, to declare a public health emergency in the State of Florida, pursuant to his authority in section 381.00315, Florida Statutes. The State Health Officer is authorized and directed to use his judgment as to the duration of this public health emergency.

Section 2. In accordance with section 381.0011(7), Florida Statutes, I direct the State Health Officer to take any action necessary to protect the public health.

Section 3. I direct the State Health Officer to follow the guidelines established by the CDC in establishing protocols to control the spread of COVID-19 and educate the public on prevention.

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Section 4. In accordance with section 381.0011(7), Florida Statutes, I designate the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments. The State Health Officer, or his designee, shall advise the Executive Office of the Governor on the implementation of these emergency response activities.

Section 5. All actions taken by the State Health Officer with respect to this emergency before the issuance of this Executive Order are ratified.

Section 6. The Florida Department of Health will actively monitor, at a minimum, all persons meeting the definition of a Person Under Investigation ("PUI") as defined by the CDC for COVID-19 for a period of at least 14 days or until the PUI tests negative for COVID-19. Active monitoring by the Florida Department of Health will include at least the following:

A. Risk assessment within 24 hours of learning an individual meets the criteria for a PUI.

B. Twice-daily temperature checks.

Section 7. The Florida Department of Health, pursuant to its authority in section 381.00315, Florida Statutes, will ensure that all individuals meeting the CDC's definition of a PUI are isolated or quarantined for a period of 14 days or until the person tests negative for COVID-19.

Section 8. I hereby direct the Florida Department of Health to make its own determinations as to quarantine, isolation and other necessary public health interventions as permitted under Florida law.

Section 9. I direct all agencies under the direction of the Governor to fully cooperate with the Florida Department of Health, and any representative thereof in furtherance of this Order.

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Agencies not under the direction of the Governor are requested to provide such assistance as is required.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 1st day of March, 2020.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2020 MAR -1 PM 9:31
TALLAHASSEE, FLORIDA

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19: Declaration of Public Health Emergency In Florida

AMERICAN OVERSIGHT

Date: Monday, March 2, 2020 5:28:10 PM
Attachments: SLG-BIZHUB20030109040.pdf
Declaration of Public Health Emergency COVID-19 3.1.20.pdf

---------- Forwarded message ---------
From: **StateESF8.Planning** <StateESF8.Planning@flhealth.gov>
Date: Sun, Mar 1, 2020 at 9:28 PM
Subject: FW: COVID-19: Declaration of Public Health Emergency In Florida
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>

FYI

The Governor has issued Executive Order 20-51, directing a Public Health Emergency and establishing Florida's Response Protocol for COVID-19. As a result, the State Surgeon General has issued a Declaration of Public Health Emergency for the State of Florida. Please review the attached Executive Order and Declaration.

Thank you for your continued support of our public health preparedness and response.

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email| Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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STATE OF FLORIDA
DEPARTMENT OF HEALTH
DECLARATION OF PUBLIC HEALTH EMERGENCY

WHEREAS, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that appears to occur through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, as of February 29, 2020, COVID-19 has spread throughout China and to 67 other countries and territories, including 62 cases within the United States; and

WHEREAS, the Centers for Disease Control and Prevention recommends that all states and territories implement aggressive measures to slow and contain transmission of COVID-19 in the United States; and

WHEREAS, on January 30, 2020, the World Health Organization declared a public health emergency of international concern related to COVID-19; and

WHEREAS, on January 31, 2020, the United States Department of Health and Human Services declared that a public health emergency exists nationwide as a result of confirmed cases of COVID-19 in the United States; and

WHEREAS, one Hillsborough County resident and one Manatee County resident have tested presumptively positive for COVID-19; and

WHEREAS, on March 1, 2020, Governor Ron DeSantis issued Executive Order 20-51, declaring that appropriate measures to control the spread of COVID-19 in the State of Florida are necessary, and therefore directed that a Public Health Emergency be declared in the State of Florida; and

WHEREAS, implementation of basic precautions of infection control and prevention, including staying at home when ill and practicing respiratory and hand hygiene are necessary to slow or prevent the spread of COVID-19; and

WHEREAS, COVID-19 is a communicable disease with significant morbidity and mortality, and presents a severe danger to public health; and

WHEREAS, COVID-19 is a threat to public health in Florida.

NOW, THEREFORE, I, Scott A. Rivkees, M.D., State Surgeon General and State Health Officer, by virtue of Executive Order Number 20-51 issued by Governor Ron DeSantis, the authority vested in me by section 381.00315, Florida Statutes, and after consultation with

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Governor Ron DeSantis and public health officials within the Department of Health, do hereby declare that a public health emergency exists in the State of Florida. In order to respond to this emergency, the following shall commence:

Section 1. In order to protect public health, I find it is necessary for the Florida Department of Health to request assistance from the Centers for Disease Control and Prevention to address this public health emergency.

Section 2. In order to protect public health, I find it is necessary to advise individuals in the State of Florida that have traveled to an area that the Centers for Disease Control and Prevention has issued a Warning Level 3 or Alert Level 2 Travel Health Notice, or have been in close contact with an individual that has traveled to such an area, that develop symptoms of fever, cough, shortness of breath, or difficulty breathing within 14 days of such travel or close contact should immediately contact the Florida Department of Health in their current county and self-isolate until cleared by the Florida Department of Health.

Section 3. In order to protect public health, I find it is necessary to advise any individuals who believe they may have been exposed to COVID-19 to contact their local county health department **prior to** travelling to any physician's office, emergency department, hospital, or urgent care center, to ensure proper protective measures are taken to prevent further risk of spread to others.

Section 4. In order to protect public health, I find it is necessary to remind health care providers, hospitals, and labs that they are required to immediately report all suspected cases of COVID-19 to the local county health department to ensure a prompt public health response to prevent disease among close contacts.

Section 5. In order to protect public health, the Florida Department of Health will maintain an Incident Management Team to coordinate the public health response for the State of Florida.

Section 6. In order to protect public health, the Florida Department of Health, at such time when necessary, may take actions to protect the public health, pursuant to the authority of section 381.00315, Florida Statutes, including quarantine, isolation and other interventions.

Issued this 1st day of March 2020, in Department of Health offices, Tallahassee, Leon County, Florida.

Scott A. Rivkees, M.D.
State Surgeon General

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STATE OF FLORIDA

OFFICE OF THE GOVERNOR
EXECUTIVE ORDER NUMBER 20-51

(Establishes COVID-19 Response Protocol and Directs Public Health Emergency)

WHEREAS, Coronavirus Disease 2019 (COVID-19) is a severe acute respiratory illness that can spread among humans through respiratory transmission and presents with symptoms similar to those of influenza; and

WHEREAS, in late 2019, a new and significant outbreak of COVID-19 emerged in China; and

WHEREAS, the World Health Organization declared COVID-19 a Public Health Emergency of International Concern; and

WHEREAS, in response to the recent COVID-19 outbreak in China, Iran, Italy and South Korea, the Centers for Disease Control and Prevention ("CDC") has deemed it necessary to prohibit or restrict non-essential travel to or from those countries; and

WHEREAS, in response to the recent COVID-19 outbreak in Japan, the CDC has advised older travelers and those with chronic medical conditions to avoid nonessential travel and all travelers to exercise enhanced precautions; and

WHEREAS, the CDC currently recommends community preparedness and everyday prevention measures be taken by all individuals and families in the United States, including voluntary home isolation when individuals are sick with respiratory symptoms, covering coughs and sneezes with a tissue and disposal of the tissue immediately thereafter, washing hands often with soap and water for at least 20 seconds, use of alcohol-based hand sanitizers with 60%-95%

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alcohol if soap and water are not readily available and routinely cleaning frequently touched surfaces and objects to increase community resilience and readiness for responding to an outbreak; and

WHEREAS, two individuals in the State of Florida tested presumptively positive for COVID-19, including a resident of Manatee County and a resident of Hillsborough County; and

WHEREAS, the CDC currently recommends mitigation measures in communities with COVID-19 cases, including staying at home when sick, keeping away from others who are sick and staying at home when a household member is sick with respiratory disease symptoms or if instructed to do so by public health officials or a health care provider; and

WHEREAS, it is necessary and appropriate to take action to ensure that COVID-19 remains controlled and that residents and visitors in Florida remain safe and secure;

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, and all other applicable laws, promulgate the following Executive Order to take immediate effect:

Section 1. Because of the foregoing conditions, I direct the State Health Officer and Surgeon General, Dr. Scott Rivkees, to declare a public health emergency in the State of Florida, pursuant to his authority in section 381.00315, Florida Statutes. The State Health Officer is authorized and directed to use his judgment as to the duration of this public health emergency.

Section 2. In accordance with section 381.0011(7), Florida Statutes, I direct the State Health Officer to take any action necessary to protect the public health.

Section 3. I direct the State Health Officer to follow the guidelines established by the CDC in establishing protocols to control the spread of COVID-19 and educate the public on prevention.

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Section 4. In accordance with section 381.0011(7), Florida Statutes, I designate the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments. The State Health Officer, or his designee, shall advise the Executive Office of the Governor on the implementation of these emergency response activities.

Section 5. All actions taken by the State Health Officer with respect to this emergency before the issuance of this Executive Order are ratified.

Section 6. The Florida Department of Health will actively monitor, at a minimum, all persons meeting the definition of a Person Under Investigation ("PUI") as defined by the CDC for COVID-19 for a period of at least 14 days or until the PUI tests negative for COVID-19. Active monitoring by the Florida Department of Health will include at least the following:

A. Risk assessment within 24 hours of learning an individual meets the criteria for a PUI.

B. Twice-daily temperature checks.

Section 7. The Florida Department of Health, pursuant to its authority in section 381.00315, Florida Statutes, will ensure that all individuals meeting the CDC's definition of a PUI are isolated or quarantined for a period of 14 days or until the person tests negative for COVID-19.

Section 8. I hereby direct the Florida Department of Health to make its own determinations as to quarantine, isolation and other necessary public health interventions as permitted under Florida law.

Section 9. I direct all agencies under the direction of the Governor to fully cooperate with the Florida Department of Health, and any representative thereof in furtherance of this Order.

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Agencies not under the direction of the Governor are requested to provide such assistance as is required.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 1st day of March, 2020.

RON DESANTIS, GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2020 MAR -1 PM 9:31
TALLAHASSEE, FLORIDA

AMERICAN OVERSIGHT
FL-DOH-20-0673-A-004375

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP

Date: Monday, March 9, 2020 11:21:30 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:40 AM
Subject: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com)

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For pediatric providers

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From: American Academy of Pediatrics <information@aap.org>
Sent: Friday, March 6, 2020 5:01 PM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: COVID-19: Message from AAP President Sally Goza, MD, FAAP

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Message from AAP President Sally Goza, MD, FAAP

As COVID-19 continues to spread in communities, pediatricians can prepare to handle suspected cases in their patient population in the same way they prepare for other infectious disease outbreaks, such as influenza or RSV. The same principles apply:

- Keep children out of the health care system if it's not necessary
- Advise individuals to stay home if they are sick.
- Review infection-control measures. This can include asking patients with symptoms to call ahead, so they can be evaluated in isolation from other patients.
- Collaborate with hospitals and health systems on local response and to prepare for surges.
- Check with local and state health departments for information on specific local and state responses.

We have also heard from members that children and adolescents in their practice have expressed fear and anxiety about the outbreak. Pediatricians can be a calm, reassuring voice that can help alleviate these fears.

As a general pediatrician myself who has been in practice through especially severe RSV and flu outbreaks, I understand how important it is to remain reassuring to worried parents, clear in my guidance and practical and transparent in my approach to talking to patients who are old enough to understand what's going on.

David Schonfeld, MD, FAAP, a member of the AAP Council on Disaster Preparedness and Recovery, recommends keeping the conversation straightforward and direct, while avoiding graphic details. More information is available in the HealthyChildren.org article on talking to children about disasters and other events in the news. He also offers advice specific to COVID-19 in this interview for CNN.

AAP also offers general information for parents on COVID-19 in the HealthyChildren.org article authored by H. Cody Meissner, M.D., FAAP. This article will be updated to reflect the most recent information as the outbreak evolves.

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AAP continues to be in close communication with leaders at the Centers for Disease Control & Prevention. We are committed to providing you with updates and information about practice recommendations and infection-control measures as it is developed.

Updated information will also be posted on the Red Book Online Outbreaks page and in *AAP News*.

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From: Ann Hill

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Subject: Fwd: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP

Date: Monday, March 9, 2020 11:21:30 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:40 AM
Subject: FW: COVID-19: Message from AAP President Sally Goza, MD, FAAP
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com)

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For pediatric providers

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As COVID-19 continues to spread in communities, pediatricians can prepare to handle suspected cases in their patient population in the same way they prepare for other infectious disease outbreaks, such as influenza or RSV. The same principles apply:

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Department of Education Information

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Date: Tuesday, March 10, 2020 4:17:22 PM
Attachments: COVID-19 University Travel Precaution.pdf
COVID-19 DOE Preparedness Spanish.pdf
COVID-19 DOE Preparedness_2-28-20.pdf
COVID-19 DOE Preparedness_3-3-20.pdf
COVID-19 DOE Travel Precaution.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:02 PM
Subject: FW: Department of Education Information
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>,

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Education related travel precautions

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”

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Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 12:42 PM
Subject: Department of Education Information

Please see attached Department of Education information which has been sent to all Florida School Districts.

Please Note: BCC recipients include CHD Administrators, Nursing Directors, Primary Epi Contacts and Preparedness Planners.

Jefferson Welle, R.N., FPEM

Planning Analyst, FDOH ESF-8
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support
4052 Bald Cypress Way,
Tallahassee, FL 32399

Phone: 850-617-1546

Mobile: 239-206-6329

http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html

On Twitter: @healthyfla

Mission of the Department of Health:

To protect, promote & improve the health of all people in Florida through integrated state, county & community

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efforts.

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--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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State Board of Education

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FLORIDA DEPARTMENT OF EDUCATION
fldoe.org

Richard Corcoran
Commissioner of Education

Información de contacto:
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850-245-4444
DiseaseControl@flhealth.gov

Departamento de Educación de Florida
Dra. Dianne Mennitt
850-245-0475
Dianne.Mennitt@fldoe.org

MEMORÁNDUM

PARA: Superintendentes del distrito escolar, Administradores y Educadores

DE: Jacob Oliva

FECHA: 3 de marzo de 2020

ASUNTO: **Preparación de Florida para COVID-19 (Coronavirus)**

Recientemente se confirmaron dos casos de COVID-19 (coronavirus) en Florida, lo que llevó al gobernador Ron DeSantis y al cirujano general estatal Scott Rivkees a declarar una emergencia de salud pública (Orden Ejecutiva 20-51). **Actualmente, todavía hay un bajo riesgo en Florida. La planificación y la preparación siempre son importantes, y el Departamento de Educación de Florida (FDOE) entiende que las preocupaciones sobre la salud y la seguridad son primordiales para todas las comunidades educativas.** Se alienta a las escuelas, los distritos escolares, los colegios y las universidades a comunicarse con su departamento de salud local para obtener la información y asistencia más actualizada sobre COVID-19. Los departamentos de salud del condado están completamente integrados con el Departamento de Salud de Florida (FDOH) y el Centro para el Control de Enfermedades (CDC), y están bien equipados para responder si es necesario. El CDC también ha publicado una guía provisional para administradores de programas de cuidado infantil de EE. UU. y escuelas K-12 para planificar, preparar y responder a COVID-19.

COVID-19 se propaga de manera similar a la gripe, principalmente a través del contacto de un individuo infectado y se transmite al toser y estornudar. Los síntomas comunes incluyen fiebre, tos, dificultad para respirar y problemas respiratorias inferiores y superiores. Es más probable que ocurra en las personas ancianas y aquellos con condiciones de salud subyacentes, y la mayoría de las personas con el virus tendrán un caso leve y podrán ser tratados en el hogar.

A medida que COVID-19 evoluciona, lo más importante para las escuelas es **planificar y prepararse:**

- Revisar, actualizar e implementar planes de operaciones de emergencia. Esto debe hacerse en colaboración con los departamentos de salud locales.
- Asegurarse de que las estrategias de lavarse las manos incluyan **lavarse con agua y jabón durante al menos 20 segundos o usar desinfectante para manos que contenga al menos 60% de alcohol.**
- Desarrollar sistemas de intercambio de información con padres y socios locales.

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- **Realice una limpieza de rutina**, incluidas las superficies tocadas con frecuencia.

El Departamento de Salud de Florida puede realizar una prueba de COVID-19 en los laboratorios de Jacksonville, Miami y Tampa, lo que permite que los resultados de las pruebas estén disponibles dentro de las 24 a 48 horas. Si entra en contacto con un individuo que ha viajado recientemente a un área donde el CDC ha emitido un aviso de salud de viaje de nivel 2 o nivel 3 como China, Italia, Corea del Sur y Japón, existen protocolos:

- **Comuníquese de inmediato con el departamento de salud de su condado local al desarrollar síntomas, antes de visitar un médico.**
- Las personas pueden ser evaluadas en cualquier hospital local. **CUALQUIER** hospital local está equipado para manejar COVID-19. Las pruebas se realizarán en Jacksonville, Miami o Tampa.
- El objetivo es **contención** para detener cualquier transmisión**.**

Actualmente es la temporada de gripe, y lo alentamos a que continúe enfatizando estas directrices comunes con todos los miembros de la comunidad escolar, estudiantes, personal y padres:

- Vacúnese contra la gripe y tome antivirales contra la gripe si se lo recetan.
- Si está enfermo, quédese en casa**.**
- Lávese las manos a menudo con agua y jabón durante al menos 20 segundos.
- Lleve y use desinfectante de manos a base de alcohol que contenga al menos 60% de alcohol.
- Evite tocarse los ojos, la nariz y la boca con las manos sucias.
- Llame con anticipación antes de visitar a su médico.
- Cúbrase la boca y la nariz con un pañuelo cuando tosa o estornude. Deseche inmediatamente el pañuelo usado.
- Controle sus síntomas.

Por último, una tendencia emergente a nivel nacional es que las instituciones educativas tomen precauciones adicionales con respecto a los estudiantes, el personal y los administradores que pueden regresar de viajes al extranjero a China, Irán, Italia, Corea del Sur y Japón. Las universidades y los colegios estatales de Florida ahora requieren que esos estudiantes se auto aíslen por 14 días, antes de regresar al campus, y que cancelen los viajes patrocinados por universidades y colegios a estos países. Nuestro equipo en el Departamento de Educación de Florida estaría encantado de discutir estrategias con usted para implementar mejores prácticas similares a fin de reducir los riesgos para sus estudiantes.

Se puede encontrar información útil en los siguientes sitios web:

- Departamento de Salud de Florida: http://www.floridahealth.gov/
- Centro de Control de Enfermedades: https://www.cdc.gov/
- Departamento de Educación de Florida: http://fldoe.org/em-response/
- Consulte este folleto útil del CDC relacionado con el lavado de manos y el desinfectante de manos.
- Consulte este folleto útil del CDC sobre como detener la propagación de gérmenes.

Florida está haciendo todo lo posible para prepararse y responder a COVID-19 y el Departamento de Educación de Florida está disponible para asistir según sea necesario. Las actualizaciones diarias se publicaran en el sitio web del DOH, y tenga la seguridad de que FDOE le proporcionará actualizaciones a medida que las tengamos.

JACOB OLIVA
CHANCELLOR OF PUBLIC SCHOOLS

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FL-DOH-20-0673-A-004390

Para reiterar, todavía hay un bajo riesgo en Florida. Florida está totalmente preparado para responder a COVID-19. Continuaremos proporcionando actualizaciones periódicas.

JACOB OLIVA
CHANCELLOR OF PUBLIC SCHOOLS

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FLORIDA DEPARTMENT OF EDUCATION
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Richard Corcoran
Commissioner of Education

MEMORANDUM

TO: School District Superintendents, School Administrators, and Educators

FROM: Jacob Oliva

DATE: February 28, 2020

Contact Information:
Florida Department of Health
850-245-4444
DiseaseControl@flhealth.gov

Florida Department of Education
Dr. Dianne Mennitt
School Nurse Consultant
850-245-0475
Dianne.Mennitt@fldoe.org
DPS: 2020-36

SUBJECT: Florida Preparedness for COVID-19 (Coronavirus)

Yesterday, Governor Ron DeSantis hosted a press conference regarding COVID-19 (Coronavirus), and announced **there are no confirmed cases in Florida**. **Currently there is a low risk in Florida.** However, planning and preparing is always important and the Florida Department of Education (FDOE) understands that concerns about health and safety are paramount for all education communities. In response to such concerns, we encourage you to access up-to-date information and resources from the Florida Department of Health (FDOH) website or the Centers for Disease Control and Prevention (CDC) website.

FDOH has been closely monitoring COVID-19 since November 2019, and emphasizes that there is low health risk in the United States. The FDOH Incident Management Team has been working in lockstep with the CDC on daily updates, and hundreds of dedicated FDOH professionals are positioned to respond if the need arises in each county. In addition, county health departments are fully integrated with FDOH and CDC, and are well equipped to respond if necessary.

This virus is spread mostly through contact from an infected individual and transmitted by coughing and sneezing. Common symptoms include fever, coughing, shortness of breath, and lower and upper respiratory issues. It is more likely to occur in the elderly and those with underlying health conditions.

If there is an individual with a suspected case of COVID-19, there are protocols in place with **ALL** Florida health care providers and practitioners:

- Immediately contact your health care practitioner or any local hospital. **ANY** local hospital is equipped to handle COVID-19.
- Individuals will be evaluated at any local hospital, and tests will be sent to the CDC for evaluation.
- The goal is **containment** to stop any transmission.

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It is currently flu season, and FDOH recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed. We encourage you to continue to stress these common guidelines with all members of the school community, students, staff and parents:

- If you are sick, stay home.
- Wash your hands often with soap and warm water for at least 20 seconds.
- Carry and use alcohol-based hand sanitizer.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Call ahead before visiting your doctor.
- Cover your mouth and nose with a tissue when you cough or sneeze.
- Monitor your symptoms.

Please see this helpful flier from the CDC related to handwashing and the use of alcohol based sanitizer.

Florida is doing everything in its power to prepare and respond to COVID-19 and the FDOE is available to assist as needed. Daily updates will be posted on the FDOH website, and rest assured FDOE will provide you with updates as we have them.

JO/tf

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Ryan Petty
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FLORIDA DEPARTMENT OF EDUCATION
fldoe.org

Richard Corcoran
Commissioner of Education

Contact Information:
Florida Department of Health
850-245-4444
DiseaseControl@flhealth.gov

Florida Department of Education
Dr. Dianne Mennitt
850-245-0475
Dianne.Mennitt@fldoe.org
DPS: 2020-39

MEMORANDUM

TO: School District Superintendents, Administrators, and Educators

FROM: Chancellor Jacob Oliva

DATE: March 3, 2020

SUBJECT: Florida Preparedness for COVID-19 (Coronavirus)

Two cases of COVID-19 (coronavirus) were recently confirmed in Florida, leading to Governor Ron DeSantis and State Surgeon General Scott Rivkees declaring a public health emergency (Executive Order 20-51). **Currently, there is still a low risk in Florida. Planning and preparing is always important, and the Florida Department of Education (FDOE) understands that concerns about health and safety are paramount for all education communities.** Schools, school districts, colleges and universities are encouraged to contact their local health department for the most up-to-date information and assistance regarding COVID-19. County health departments are fully integrated with the Florida Department of Health (FDOH) and the Center for Disease Control (CDC), and are well equipped to respond if necessary. The CDC has also published Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to COVID-19.

COVID-19 is spread similarly to the flu, mostly through contact from an infected individual and transmitted by coughing and sneezing. Common symptoms include fever, coughing, shortness of breath, and lower and upper respiratory issues. It is more likely to occur in the elderly and those with underlying health conditions, and most individuals with the virus will have a mild case and will be able to be treated at home.

As COVID-19 evolves, the most important thing for schools to do is **plan and prepare:**

- Review, update and implement emergency operations plans. This should be done in collaboration with local health departments.
- Ensure handwashing strategies include **washing with soap and water for at least 20 seconds or using hand sanitizer that contains at least 60% alcohol.**
- Develop information-sharing systems with parents and local partners.
- **Perform routine cleaning**, including frequently touched surfaces.

The Florida Department of Health is able to test for COVID-19 in labs in Jacksonville, Miami and Tampa, allowing tests results to be available within 24 to 48 hours. If you come into contact with an individual who has recently traveled to an area that the CDC has issued a level 2 or level 3 travel health notice such as China, Italy, South Korea and Japan, there are protocols in place:

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- **Immediately contact your local county health department upon developing symptoms, before visiting a doctor.**
- Individuals will be evaluated at any local hospital. **ANY** local hospital is equipped to handle COVID-19. Testing will be conducted in Jacksonville, Miami or Tampa.
- The goal is **containment** to stop any transmission.

It is currently flu season, and we encourage you to continue to stress these common guidelines with all members of the school community, students, staff, and parents:

- Get a flu shot, and take flu antivirals if prescribed.
- If you are sick, stay home**.**
- Wash your hands often with soap and warm water for at least 20 seconds.
- Carry and use alcohol-based hand sanitizer.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Call ahead before visiting your doctor.
- Cover your mouth and nose with a tissue when you cough or sneeze. Immediately dispose of used tissue.
- Monitor your symptoms.

Lastly, an emerging trend nationally is for educational institutions to take additional precautions regarding students, staff and administrators who may be returning from overseas travel to China, Iran, Italy, South Korea and Japan. Florida's state universities and colleges are now requiring those students to self-isolate for 14 days, before returning to campus, as well as cancelling university- and college-sponsored travel to these countries. Our team at the Florida Department of Education would be happy to discuss strategies with you around implementing similar best practices, in order to reduce the risks to your students.

Helpful information can be found at the following websites:

- Florida Department of Health: http://www.floridahealth.gov/
- Centers for Disease Control: https://www.cdc.gov/
- Florida Department of Education: http://fldoe.org/em-response/
- Please see this helpful flier from the CDC related to handwashing and hand sanitizer.
- Please see this helpful flier from the CDC related to stopping the spread of germs.

Florida is doing everything in their power to prepare and respond to COVID-19 and the Florida Department of Education is available to assist as needed. Daily updates will be posted on the DOH website, and rest assured FDOE will provide you with updates as we have them.

To reiterate, there is still a low risk in Florida. Florida is fully prepared to respond to COVID-19. We will continue to provide regular updates.

JO/tf

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State Board of Education

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Joe York

FLORIDA DEPARTMENT OF EDUCATION
fldoe.org

Richard Corcoran
Commissioner of Education

MEMORANDUM

TO: College Presidents

FROM: Kathy Hebda

DATE: March 2, 2020

SUBJECT: **COVID-19 Travel Precaution**

Following guidance from Governor Ron DeSantis and State Surgeon General Dr. Scott Rivkees, we request that each college take immediate action to request all employees and students who return from travel to China, Iran, Italy, Japan and South Korea to self-isolate and not return to campus for 14 days after their return. Consistent with this guidance, we recommend canceling all college-sponsored travel to these countries.

We encourage you to continue to be in regular contact with your local Department of Health officials and to review any of your college's relevant procedures.

KH

KATHRYN S. HEBDA
FLORIDA COLLEGE SYSTEM CHANCELLOR

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Florida Board of Governors
State University System of Florida
325 West Gaines Street, Suite 1614
Tallahassee, FL 32399
Phone 850.245.0466
Fax: 850.245.9685
www.flbog.edu

MEMORANDUM

TO: State University Presidents and Provosts

FROM: Sydney Kitson, Chair, Board of Governors
Marshall M. Criser III, Chancellor, Board of Governors

DATE: March 2, 2020

RE: COVID-19 Travel Precaution

Following guidance from Governor Ron DeSantis and State Surgeon General Dr. Scott Rivkees, we request that each University take immediate action to request all faculty employees and students who return from travel to China, Iran, Italy, Japan and South Korea to self-quarantine and not return to campus for fourteen days after their return. Consistent with this guidance, we recommend canceling all university sponsored travel to these countries.

Sydney Kitson, Chair
Board of Governors

Marshall M. Criser III, Chancellor
Board of Governors

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. 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Subject: Fwd: FW: Department of Education Information

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Date: Tuesday, March 10, 2020 4:17:22 PM
Attachments: COVID-19 University Travel Precaution.pdf
COVID-19 DOE Preparedness Spanish.pdf
COVID-19 DOE Preparedness_2-28-20.pdf
COVID-19 DOE Preparedness_3-3-20.pdf
COVID-19 DOE Travel Precaution.pdf

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 10, 2020 at 3:02 PM
Subject: FW: Department of Education Information
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce (Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>,

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Education related travel precautions

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”

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Vision: "To be the Healthiest State in the Nation"
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Tuesday, March 10, 2020 12:42 PM
Subject: Department of Education Information

Please see attached Department of Education information which has been sent to all Florida School Districts.

Please Note: BCC recipients include CHD Administrators, Nursing Directors, Primary Epi Contacts and Preparedness Planners.

Jefferson Welle, R.N., FPEM

Planning Analyst, FDOH ESF-8
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support
4052 Bald Cypress Way,
Tallahassee, FL 32399

Phone: 850-617-1546

Mobile: 239-206-6329

http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html

On Twitter: @healthyfla

Mission of the Department of Health:

To protect, promote & improve the health of all people in Florida through integrated state, county & community

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efforts.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to disclosure.



PLEASE NOTE: *Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to disclosure.*

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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State Board of Education

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Members
Ben Gibson
Tom Grady
Michael Olenick
Ryan Petty
Joe York

FLORIDA DEPARTMENT OF EDUCATION
fldoe.org

Richard Corcoran
Commissioner of Education

MEMORÁNDUM

PARA: Superintendentes del distrito escolar, Administradores y Educadores

DE: Jacob Oliva

FECHA: 3 de marzo de 2020

ASUNTO: **Preparación de Florida para COVID-19 (Coronavirus)**

Información de contacto:
Departamento de Salud de Florida
850-245-4444
DiseaseControl@flhealth.gov

Departamento de Educación de Florida
Dra. Dianne Mennitt
850-245-0475
Dianne.Mennitt@fldoe.org

Recientemente se confirmaron dos casos de COVID-19 (coronavirus) en Florida, lo que llevó al gobernador Ron DeSantis y al cirujano general estatal Scott Rivkees a declarar una emergencia de salud pública (Orden Ejecutiva 20-51). **Actualmente, todavía hay un bajo riesgo en Florida. La planificación y la preparación siempre son importantes, y el Departamento de Educación de Florida (FDOE) entiende que las preocupaciones sobre la salud y la seguridad son primordiales para todas las comunidades educativas.** Se alienta a las escuelas, los distritos escolares, los colegios y las universidades a comunicarse con su departamento de salud local para obtener la información y asistencia más actualizada sobre COVID-19. Los departamentos de salud del condado están completamente integrados con el Departamento de Salud de Florida (FDOH) y el Centro para el Control de Enfermedades (CDC), y están bien equipados para responder si es necesario. El CDC también ha publicado una guía provisional para administradores de programas de cuidado infantil de EE. UU. y escuelas K-12 para planificar, preparar y responder a COVID-19.

COVID-19 se propaga de manera similar a la gripe, principalmente a través del contacto de un individuo infectado y se transmite al toser y estornudar. Los síntomas comunes incluyen fiebre, tos, dificultad para respirar y problemas respiratorias inferiores y superiores. Es más probable que ocurra en las personas ancianas y aquellos con condiciones de salud subyacentes, y la mayoría de las personas con el virus tendrán un caso leve y podrán ser tratados en el hogar.

A medida que COVID-19 evoluciona, lo más importante para las escuelas es **planificar y prepararse:**

- Revisar, actualizar e implementar planes de operaciones de emergencia. Esto debe hacerse en colaboración con los departamentos de salud locales.
- Asegurarse de que las estrategias de lavarse las manos incluyan **lavarse con agua y jabón durante al menos 20 segundos o usar desinfectante para manos que contenga al menos 60% de alcohol.**
- Desarrollar sistemas de intercambio de información con padres y socios locales.

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- **Realice una limpieza de rutina**, incluidas las superficies tocadas con frecuencia.

El Departamento de Salud de Florida puede realizar una prueba de COVID-19 en los laboratorios de Jacksonville, Miami y Tampa, lo que permite que los resultados de las pruebas estén disponibles dentro de las 24 a 48 horas. Si entra en contacto con un individuo que ha viajado recientemente a un área donde el CDC ha emitido un aviso de salud de viaje de nivel 2 o nivel 3 como China, Italia, Corea del Sur y Japón, existen protocolos:

- **Comuníquese de inmediato con el departamento de salud de su condado local al desarrollar síntomas, antes de visitar un médico.**
- Las personas pueden ser evaluadas en cualquier hospital local. **CUALQUIER** hospital local está equipado para manejar COVID-19. Las pruebas se realizarán en Jacksonville, Miami o Tampa.
- El objetivo es **contención** para detener cualquier transmisión**.**

Actualmente es la temporada de gripe, y lo alentamos a que continúe enfatizando estas directrices comunes con todos los miembros de la comunidad escolar, estudiantes, personal y padres:

- Vacúnese contra la gripe y tome antivirales contra la gripe si se lo recetan.
- Si está enfermo, quédese en casa**.**
- Lávese las manos a menudo con agua y jabón durante al menos 20 segundos.
- Lleve y use desinfectante de manos a base de alcohol que contenga al menos 60% de alcohol.
- Evite tocarse los ojos, la nariz y la boca con las manos sucias.
- Llame con anticipación antes de visitar a su médico.
- Cúbrase la boca y la nariz con un pañuelo cuando tosa o estornude. Deseche inmediatamente el pañuelo usado.
- Controle sus síntomas.

Por último, una tendencia emergente a nivel nacional es que las instituciones educativas tomen precauciones adicionales con respecto a los estudiantes, el personal y los administradores que pueden regresar de viajes al extranjero a China, Irán, Italia, Corea del Sur y Japón. Las universidades y los colegios estatales de Florida ahora requieren que esos estudiantes se auto aíslen por 14 días, antes de regresar al campus, y que cancelen los viajes patrocinados por universidades y colegios a estos países. Nuestro equipo en el Departamento de Educación de Florida estaría encantado de discutir estrategias con usted para implementar mejores prácticas similares a fin de reducir los riesgos para sus estudiantes.

Se puede encontrar información útil en los siguientes sitios web:

- Departamento de Salud de Florida: http://www.floridahealth.gov/
- Centro de Control de Enfermedades: https://www.cdc.gov/
- Departamento de Educación de Florida: http://fldoe.org/em-response/
- Consulte este folleto útil del CDC relacionado con el lavado de manos y el desinfectante de manos.
- Consulte este folleto útil del CDC sobre como detener la propagación de gérmenes.

Florida está haciendo todo lo posible para prepararse y responder a COVID-19 y el Departamento de Educación de Florida está disponible para asistir según sea necesario. Las actualizaciones diarias se publicaran en el sitio web del DOH, y tenga la seguridad de que FDOE le proporcionará actualizaciones a medida que las tengamos.

JACOB OLIVA
CHANCELLOR OF PUBLIC SCHOOLS

AMERICAN OVERSIGHT
FL-DOH-20-0673-A-004404

Para reiterar, todavía hay un bajo riesgo en Florida. Florida está totalmente preparado para responder a COVID-19. Continuaremos proporcionando actualizaciones periódicas.

JACOB OLIVA
CHANCELLOR OF PUBLIC SCHOOLS

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FLORIDA DEPARTMENT OF EDUCATION
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Richard Corcoran
Commissioner of Education

MEMORANDUM

TO: School District Superintendents, School Administrators, and Educators

FROM: Jacob Oliva

DATE: February 28, 2020

Contact Information:
Florida Department of Health
850-245-4444
DiseaseControl@flhealth.gov

Florida Department of Education
Dr. Dianne Mennitt
School Nurse Consultant
850-245-0475
Dianne.Mennitt@fldoe.org
DPS: 2020-36

SUBJECT: Florida Preparedness for COVID-19 (Coronavirus)

Yesterday, Governor Ron DeSantis hosted a press conference regarding COVID-19 (Coronavirus), and announced **there are no confirmed cases in Florida**. **Currently there is a low risk in Florida.** However, planning and preparing is always important and the Florida Department of Education (FDOE) understands that concerns about health and safety are paramount for all education communities. In response to such concerns, we encourage you to access up-to-date information and resources from the Florida Department of Health (FDOH) website or the Centers for Disease Control and Prevention (CDC) website.

FDOH has been closely monitoring COVID-19 since November 2019, and emphasizes that there is low health risk in the United States. The FDOH Incident Management Team has been working in lockstep with the CDC on daily updates, and hundreds of dedicated FDOH professionals are positioned to respond if the need arises in each county. In addition, county health departments are fully integrated with FDOH and CDC, and are well equipped to respond if necessary.

This virus is spread mostly through contact from an infected individual and transmitted by coughing and sneezing. Common symptoms include fever, coughing, shortness of breath, and lower and upper respiratory issues. It is more likely to occur in the elderly and those with underlying health conditions.

If there is an individual with a suspected case of COVID-19, there are protocols in place with **ALL** Florida health care providers and practitioners:

- Immediately contact your health care practitioner or any local hospital. **ANY** local hospital is equipped to handle COVID-19.
- Individuals will be evaluated at any local hospital, and tests will be sent to the CDC for evaluation.
- The goal is **containment** to stop any transmission.

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It is currently flu season, and FDOH recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed. We encourage you to continue to stress these common guidelines with all members of the school community, students, staff and parents:

- If you are sick, stay home.
- Wash your hands often with soap and warm water for at least 20 seconds.
- Carry and use alcohol-based hand sanitizer.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Call ahead before visiting your doctor.
- Cover your mouth and nose with a tissue when you cough or sneeze.
- Monitor your symptoms.

Please see this helpful flier from the CDC related to handwashing and the use of alcohol based sanitizer.

Florida is doing everything in its power to prepare and respond to COVID-19 and the FDOE is available to assist as needed. Daily updates will be posted on the FDOH website, and rest assured FDOE will provide you with updates as we have them.

JO/tf

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State Board of Education

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FLORIDA DEPARTMENT OF EDUCATION
fldoe.org

Richard Corcoran
Commissioner of Education

Contact Information:
Florida Department of Health
850-245-4444
DiseaseControl@flhealth.gov

Florida Department of Education
Dr. Dianne Mennitt
850-245-0475
Dianne.Mennitt@fldoe.org
DPS: 2020-39

MEMORANDUM

TO: School District Superintendents, Administrators, and Educators

FROM: Chancellor Jacob Oliva

DATE: March 3, 2020

SUBJECT: Florida Preparedness for COVID-19 (Coronavirus)

Two cases of COVID-19 (coronavirus) were recently confirmed in Florida, leading to Governor Ron DeSantis and State Surgeon General Scott Rivkees declaring a public health emergency (Executive Order 20-51). **Currently, there is still a low risk in Florida. Planning and preparing is always important, and the Florida Department of Education (FDOE) understands that concerns about health and safety are paramount for all education communities.** Schools, school districts, colleges and universities are encouraged to contact their local health department for the most up-to-date information and assistance regarding COVID-19. County health departments are fully integrated with the Florida Department of Health (FDOH) and the Center for Disease Control (CDC), and are well equipped to respond if necessary. The CDC has also published Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to COVID-19.

COVID-19 is spread similarly to the flu, mostly through contact from an infected individual and transmitted by coughing and sneezing. Common symptoms include fever, coughing, shortness of breath, and lower and upper respiratory issues. It is more likely to occur in the elderly and those with underlying health conditions, and most individuals with the virus will have a mild case and will be able to be treated at home.

As COVID-19 evolves, the most important thing for schools to do is **plan and prepare:**

- Review, update and implement emergency operations plans. This should be done in collaboration with local health departments.
- Ensure handwashing strategies include **washing with soap and water for at least 20 seconds or using hand sanitizer that contains at least 60% alcohol.**
- Develop information-sharing systems with parents and local partners.
- **Perform routine cleaning**, including frequently touched surfaces.

The Florida Department of Health is able to test for COVID-19 in labs in Jacksonville, Miami and Tampa, allowing tests results to be available within 24 to 48 hours. If you come into contact with an individual who has recently traveled to an area that the CDC has issued a level 2 or level 3 travel health notice such as China, Italy, South Korea and Japan, there are protocols in place:

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- **Immediately contact your local county health department upon developing symptoms, before visiting a doctor.**
- Individuals will be evaluated at any local hospital. **ANY** local hospital is equipped to handle COVID-19. Testing will be conducted in Jacksonville, Miami or Tampa.
- The goal is **containment** to stop any transmission.

It is currently flu season, and we encourage you to continue to stress these common guidelines with all members of the school community, students, staff, and parents:

- Get a flu shot, and take flu antivirals if prescribed.
- If you are sick, stay home**.**
- Wash your hands often with soap and warm water for at least 20 seconds.
- Carry and use alcohol-based hand sanitizer.
- Avoid touching your eyes, nose and mouth with unwashed hands.
- Call ahead before visiting your doctor.
- Cover your mouth and nose with a tissue when you cough or sneeze. Immediately dispose of used tissue.
- Monitor your symptoms.

Lastly, an emerging trend nationally is for educational institutions to take additional precautions regarding students, staff and administrators who may be returning from overseas travel to China, Iran, Italy, South Korea and Japan. Florida's state universities and colleges are now requiring those students to self-isolate for 14 days, before returning to campus, as well as cancelling university- and college-sponsored travel to these countries. Our team at the Florida Department of Education would be happy to discuss strategies with you around implementing similar best practices, in order to reduce the risks to your students.

Helpful information can be found at the following websites:

- Florida Department of Health: http://www.floridahealth.gov/
- Centers for Disease Control: https://www.cdc.gov/
- Florida Department of Education: http://fldoe.org/em-response/
- Please see this helpful flier from the CDC related to handwashing and hand sanitizer.
- Please see this helpful flier from the CDC related to stopping the spread of germs.

Florida is doing everything in their power to prepare and respond to COVID-19 and the Florida Department of Education is available to assist as needed. Daily updates will be posted on the DOH website, and rest assured FDOE will provide you with updates as we have them.

To reiterate, there is still a low risk in Florida. Florida is fully prepared to respond to COVID-19. We will continue to provide regular updates.

JO/tf

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State Board of Education

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FLORIDA DEPARTMENT OF EDUCATION
fldoe.org

Richard Corcoran
Commissioner of Education

MEMORANDUM

TO: College Presidents

FROM: Kathy Hebda

DATE: March 2, 2020

SUBJECT: **COVID-19 Travel Precaution**

Following guidance from Governor Ron DeSantis and State Surgeon General Dr. Scott Rivkees, we request that each college take immediate action to request all employees and students who return from travel to China, Iran, Italy, Japan and South Korea to self-isolate and not return to campus for 14 days after their return. Consistent with this guidance, we recommend canceling all college-sponsored travel to these countries.

We encourage you to continue to be in regular contact with your local Department of Health officials and to review any of your college's relevant procedures.

KH

AMERICAN OVERSIGHT

Florida Board of Governors
State University System of Florida
325 West Gaines Street, Suite 1614
Tallahassee, FL 32399
Phone 850.245.0466
Fax: 850.245.9685
www.flbog.edu

MEMORANDUM

TO: State University Presidents and Provosts

FROM: Sydney Kitson, Chair, Board of Governors
Marshall M. Criser III, Chancellor, Board of Governors

DATE: March 2, 2020

RE: COVID-19 Travel Precaution

Following guidance from Governor Ron DeSantis and State Surgeon General Dr. Scott Rivkees, we request that each University take immediate action to request all faculty employees and students who return from travel to China, Iran, Italy, Japan and South Korea to self-quarantine and not return to campus for fourteen days after their return. Consistent with this guidance, we recommend canceling all university sponsored travel to these countries.

Sydney Kitson, Chair
Board of Governors

Marshall M. Criser III, Chancellor
Board of Governors

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. 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Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: Fwd: FW: FCOVID-19 Information Toolkit

AMERICAN OVERSIGHT

Date: Monday, March 9, 2020 11:20:45 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:44 AM
Subject: FW: FCOVID-19 Information Toolkit
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Paul A. McLeod (paul.mcleod@med.fsu.edu) <paul.mcleod@med.fsu.edu>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph

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<Ralph.Schofield@flhealth.gov>, RAYNES, SCOTT <Scott.Raynes@bhcpns.org>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson <tanderson@healthcarewithinreach.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A <Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

This has lots of pictographs for display purposes.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
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therefore be subject to public disclosure.

AMERICAN OVERSIGHT

may therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Friday, March 6, 2020 2:00 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Information Toolkit

CHDs,

Attached please find a link to our public facing toolkit with a variety of information resources for COVID-19. Numerous new resources have been added today and more will be added throughout the day, of particular interest is a visitor screening tool for healthcare facilities. Please share these with your local partners and continue to check this link for updated resources.

Link: http://ww11.doh.state.fl.us/comm/_partners/action/

Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email| Samantha.Cooksey@flhealth.gov

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AMERICAN OVERSIGHT

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. 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Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: Fwd: FW: FCOVID-19 Information Toolkit

AMERICAN OVERSIGHT

Date: Monday, March 9, 2020 11:20:45 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 9, 2020 at 7:44 AM
Subject: FW: FCOVID-19 Information Toolkit
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Paul A. McLeod (paul.mcleod@med.fsu.edu) <paul.mcleod@med.fsu.edu>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph

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<Ralph.Schofield@flhealth.gov>, RAYNES, SCOTT <Scott.Raynes@bhcpns.org>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson <tanderson@healthcarewithinreach.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A <Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

This has lots of pictographs for display purposes.

John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director
Florida Department of Health in
Escambia County
www.EscambiaHealth.com
Office: 850-595-6500 xt1001

Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

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may therefore be subject to public disclosure.

From: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Sent: Friday, March 6, 2020 2:00 PM
To: StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Subject: COVID-19 Information Toolkit

CHDs,

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Samantha Cooksey Strickland

COVID-19 Incident Management Team

Bureau of Preparedness & Response

Florida Department of Health

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Mobile | 850.251.2553

Email| Samantha.Cooksey@flhealth.gov

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AMERICAN OVERSIGHT

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayecenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Baines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eadis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: Fwd: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

Date: Thursday, March 19, 2020 1:11:51 PM

---------- Forwarded message ---------
From: **Mooney, Dayle** <Dayle.Mooney@flhealth.gov>
Date: Thu, Mar 19, 2020 at 12:10 PM
Subject: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
To: DL DEPCS00 BPR HCCTF <DLDEPCS00BPRHCCTF@flhealth.gov>

Sincerely,

Dayle D. Mooney

Manager, Community Preparedness Section

Bureau of Preparedness and Response

Division of Emergency Preparedness and Community Support

Logo

Some or all of the information contained within this message may be confidential pursuant to sections 381.003 and 381.0031(6), Florida Statutes, Rule 64D-3.036, Florida Administrative Code, or other applicable state or federal privacy laws.

From: Joint Information Center on COVID-19 for the State of Florida <FLSERT@public.govdelivery.com>
Sent: Thursday, March 19, 2020 11:17 AM
To: Mooney, Dayle <Dayle.Mooney@flhealth.gov>
Subject: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

Banner

AMERICAN OVERSIGHT

FOR IMMEDIATE RELEASE March 19, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

~360 positive cases in Florida Residents and 30 positive cases in non-Florida residents~

TALLAHASSEE — To keep Florida residents and visitors safe, informed and aware about the status of the virus, The Florida Department of Health has launched a COVID-19 dashboard that will be updated twice daily. Today, as of 10 a.m., there are 390 total** Florida cases.

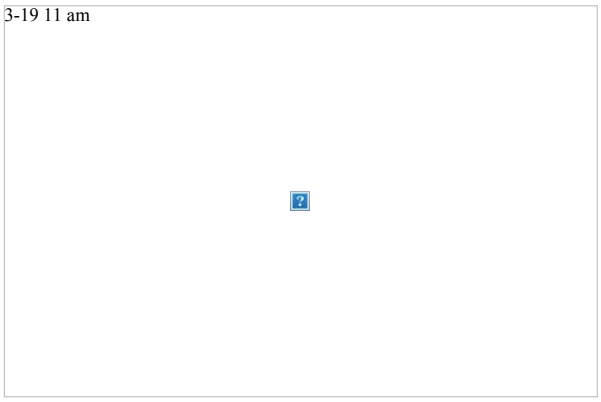
New Florida cases include:

- 62 additional positive COVID-19 cases (61 Florida residents and 1 non-Florida resident) reported to the Florida Department of Health.
- There are currently 360 positive cases in Florida residents and 30 positive cases in non-Florida residents.

Florida recently partnered with private laboratories around the state to expand COVID-19 laboratory testing capacity. This partnership will increase the number of tests conducted each day and ensure Floridians receive the critical health information they need in a timely manner.

Expansion to private laboratories changes the COVID-19 testing landscape in Florida. Private laboratories will run tests as they receive swab samples from practitioners. Testing and reporting times will vary among commercial and DOH laboratories. Demographic information may be updated during investigations. These twice daily reports reflect the state's efforts to accurately and transparently share information.

More information on a case-by-case basis can also be found here.



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About the Florida Department of Health

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AMERICAN OVERSIGHT

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Hill, Ann
To: 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gil, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Pauley, Codie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey Dobridnia; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; CRISTIN CARR-PETERSON; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. 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Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Luka, Greg; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwen Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Carmichael, Jamie B; Jamie Tutnjevic; KINNEY, JANET; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Arant, Jennifer S; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; Ard, John; John Dosh; John Gainous; John Hatfield; Ottesen, John P; John.Hatfield; Lanza, John J; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Milligan, Joseph D; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Chapman, Karen A; Karen Urquhart; Beedie, Katherine A; Kathlyn Campbell White; Kathrine Lee; Scott, Katie E; Kayla Henderson; Kay Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Lonas, Kim; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Webb, Robert K; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Bridgeway Center, Inc.; Larry Petty; Laura Messer; Laura Pistey; 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Subject: Fwd: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
Date: Thursday, March 19, 2020 1:11:58 PM

---------- Forwarded message ---------
From: **Mooney, Dayle** <Dayle.Mooney@flhealth.gov>
Date: Thu, Mar 19, 2020 at 12:10 PM
Subject: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
To: DL DEPCS00 BPR HCCTF <DLDEPCS00BPRHCCTF@flhealth.gov>

Sincerely,

Dayle D. Mooney

Manager, Community Preparedness Section

Bureau of Preparedness and Response

Division of Emergency Preparedness and Community Support

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From: Joint Information Center on COVID-19 for the State of Florida <FLSERT@public.govdelivery.com>
Sent: Thursday, March 19, 2020 11:17 AM
To: Mooney, Dayle <Dayle.Mooney@flhealth.gov>
Subject: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

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AMERICAN OVERSIGHT

FOR IMMEDIATE RELEASE March 19, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

~360 positive cases in Florida Residents and 30 positive cases in non-Florida residents~

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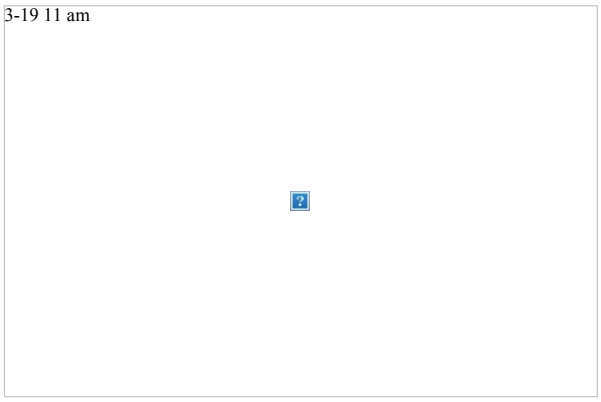

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AMERICAN OVERSIGHT

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@bayscenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belle Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Baines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eadis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

Date: Thursday, March 19, 2020 1:11:51 PM

---------- Forwarded message ---------
From: **Mooney, Dayle** <Dayle.Mooney@flhealth.gov>
Date: Thu, Mar 19, 2020 at 12:10 PM
Subject: FW: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update
To: DL DEPCS00 BPR HCCTF <DLDEPCS00BPRHCCTF@flhealth.gov>

Sincerely,

Dayle D. Mooney

Manager, Community Preparedness Section

Bureau of Preparedness and Response

Division of Emergency Preparedness and Community Support

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From: Joint Information Center on COVID-19 for the State of Florida <FLSERT@public.govdelivery.com>
Sent: Thursday, March 19, 2020 11:17 AM
To: Mooney, Dayle <Dayle.Mooney@flhealth.gov>
Subject: Florida Department of Health Updates New COVID-19 Cases, 11 a.m. Update

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AMERICAN OVERSIGHT

FOR IMMEDIATE RELEASE March 19, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

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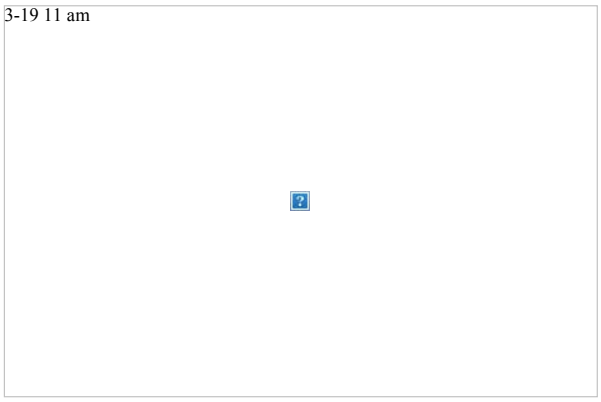

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. 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Subject: Fwd: FW: Guidance from AHCA
Date: Thursday, March 19, 2020 11:16:50 AM
Attachments: ATT00001.htm
Guidance_and_Clarification for EO 20-006.pdf
ATT00002.htm

---------- Forwarded message ---------
From: **Smith, Thomas M** <Thomas.Smith@flhealth.gov>
Date: Thu, Mar 19, 2020 at 6:59 AM
Subject: FW: Guidance from AHCA
To: Hill, Ann <ann.echcc@gmail.com>, Bobby Martin (marbobby@co.walton.fl.us) <marbobby@co.walton.fl.us>, Catie Feeney (catie@visitsouthwalton.com) <catie@visitsouthwalton.com>, Charlie Morse (morsec@walton.k12.fl.us) <morsec@walton.k12.fl.us>, Christopher Mitchell <grants@defuniaksprings.net>, Cory Webster (cwebster@waltonso.org) <cwebster@waltonso.org>, Eddie (Eddie.PathofGrace@AOL.com) <Eddie.PathofGrace@aol.com>, Fletcher Forte (Fletcher.forte@FDC.myflorida.com) <Fletcher.forte@fdc.myflorida.com>, Gabrielle Kilgore (gabrielle@waltonareachamber.com) <gabrielle@waltonareachamber.com>, Gina Waddell (wadgina@co.walton.fl.us) <wadgina@co.walton.fl.us>, Hurley James (hurleyjw@dfspd.net) <hurleyjw@dfspd.net>, James McMillan (mcmjames@waltonso.org) <mcmjames@waltonso.org>, Jeff Infinger (infingej@walton.k12.fl.us) <infingej@walton.k12.fl.us>, Jerry Hall (jhall@defuniaksprings.net) <jhall@defuniaksprings.net>, Julie Gaither (Julie.Gaither@FDC.myflorida.com) <Julie.Gaither@fdc.myflorida.com>, Lindsey Darby (darlindsey@waltonso.org) <darlindsey@waltonso.org>, Svehla, Louis <svelouis@co.walton.fl.us>, Mell Smigielski (citymanager@defuniaksprings.net) <citymanager@defuniaksprings.net>, Nathan Kervin <kernathan@co.walton.fl.us>, Philip Austin (austinpj@dfspd.net) <austinpj@dfspd.net>, Sarah Eailey (earsarah@waltonso.org) <earsarah@waltonso.org>, Shayne Betts (shaynebetts@yahoo.com) <shaynebetts@yahoo.com>, Stephanie King (stephanie.king@chhealthcare.org) <stephanie.king@chhealthcare.org>, Sterling Strickland (sstrickland@swfd.org) <sstrickland@swfd.org>, Tim Orenic (torenic@swfd.org) <torenic@swfd.org>, Tom Baker <baktom@co.walton.fl.us>, Trish Meadows <meadowst@walton.k12.fl.us>, Barley, Kathryn C <Kathryn.Barley@flhealth.gov>, Carmichael, Jamie B <Jamie.Carmichael@flhealth.gov>, Drummond, Robert D <Robert.Drummond@flhealth.gov>, Gill, Brandi N <Brandi.Gill@flhealth.gov>, Holt, Holly <Holly.Holt@flhealth.gov>, Mims, Ryan E <Ryan.Mims@flhealth.gov>, Morell, Venita W <Venita.Morell@flhealth.gov>, Ottesen, John P <John.Ottesen@flhealth.gov>, Roberts, Missy <Missy.Roberts@flhealth.gov>, Roberts, Patricia J <Patricia.Roberts@flhealth.gov>, Simmons, Harriet A <Harriet.Simmons@flhealth.gov>, Smith, Marissa <Marissa.Smith@flhealth.gov>, Smith, Thomas M <Thomas.Smith@flhealth.gov>, Steele, Crystal C <Crystal.Steele@flhealth.gov>, Alma Solano (asolano@elc-ec.org) <asolano@elc-ec.org>, Ann McCannon (amccannon@somerbyliving.com) <amccannon@somerbyliving.com>, CHrissy Howell (chrissy.howell@gentiva.com) <chrissy.howell@gentiva.com>, Connie Zuraff <CZuraff@gchc.com>, Daniel Shearn (daniel_shearn@chs.net) <daniel_shearn@chs.net>, Daniela (dmejia@pancarefl.org) <dmejia@pancarefl.org>, Danny Wilkins (dwilkins@healthmarkregional.com) <dwilkins@healthmarkregional.com>, Darren M. Staggers (darren.staggers@medxcelfm.com) <darren.staggers@medxcelfm.com>, Graham Campbell (admin.chautauqua@shccs.com) <admin.chautauqua@shccs.com>, Gwen Cobb (cobbg@elderaffairs.org)

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Updated information from ACHA on Long-term and residential care facilities.

Respectfully,

Tom Smith

Planning Consultant II

Florida Department of Health Walton County

356 State Highway 83 N

DeFuniak Springs, FL. 32433

Thomas.smith@flhealth.gov

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Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Vision: To be the Healthiest State in the Nation

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From: Jeff Goldberg <jeff@waltoncountyem.org>
Sent: Thursday, March 19, 2020 6:47 AM
To: Holt, Holly <Holly.Holt@flhealth.gov>; Smith, Thomas M <Thomas.Smith@flhealth.gov>; Roberts, Patricia J <Patricia.Roberts@flhealth.gov>; Donna Free <donna@waltoncountyem.org>; Chris Eliadis <chris@waltoncountyem.org>; Svehla, Louis <svelouis@co.walton.fl.us>
Subject: Fwd: Guidance from AHCA

Thanks!

Jeff

Jeffrey M. Goldberg, FPEM, FMI, CHS-III
Director
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Sent from my iPhone

Begin forwarded message:

> **From:** "Guthrie, Kevin" <Kevin.Guthrie@em.myflorida.com>
> **Date:** March 19, 2020 at 06:38:35 CDT
> **To:** County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
> **Subject: FW: Guidance from AHCA**

Kevin Guthrie | Deputy Director

Office: (850) 815-4101

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Kevin.Guthrie@em.myflorida.com

From: Twomey, Stephanie <Stephanie.Twomey@em.myflorida.com>
Sent: Wednesday, March 18, 2020 11:49 AM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>
Cc: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: Guidance from AHCA

Good Afternoon,

Please see attached AHCA guidance released regarding DEM No.20-006

Very Respectfully,

Stephanie Twomey

Stephanie Twomey

Senior Attorney

Florida Division of Emergency Management

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AGENCY FOR HEALTH CARE ADMINISTRATION

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

Guidance and Clarification on Division of Emergency Management (DEM) Emergency Order No. 20-006

An Emergency Order was recently issued to create broad limitations on visitation at long-term care and residential facilities to protect residents from COVID-19. To assist with clarifying this directive, the Agency for Health Care Administration has started a list of the most commonly asked questions.

1. **What are necessary health care services as allowed by the Emergency Order?**

   Medically necessary health care includes health services as well as support services such as activities of daily living and assistance with resident self-administration of medication. This exception applies to individuals who previously performed them on a regular basis.

   For example, any family member or sitter who provided assistance with activities of daily living, such as feeding a resident or assisting with bathing, prior to the Emergency Order issued on March 15, 2020, may continue to provide these services.

2. **Can staff who have been on a flight within the last 14 days enter a facility?**

   Yes. Facility staff are exempt from the 14-day air travel prohibition if the individual does not meet any of the other screening criteria. The facility must still follow the required documentation criteria.

3. **Can hospice workers enter the facility?**

   Yes. Hospice workers are allowed to see a resident with hospice

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orders so long as the hospice workers meet the other screening criteria in the Emergency Order.

The full Emergency Order is available here: https://ahca.myflorida.com/docs/DEM_ORDER_NO.20-006_In_re_COVID-19_Public_Health_Emergency_Issued_March_15_2020.pdf

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 44,000 health care facilities and 53 health plans, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

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From: Hill, Ann

To: 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Smith, Thomas M; Verlaan, Thomas D; Tim Orenic; Timothy A. 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Subject: Fwd: FW: Guidance from AHCA
Date: Thursday, March 19, 2020 11:16:56 AM
Attachments: ATT00001.htm
Guidance_and_Clarification for EO 20-006.pdf
ATT00002.htm

---------- Forwarded message ---------
From: **Smith, Thomas M** <Thomas.Smith@flhealth.gov>
Date: Thu, Mar 19, 2020 at 6:59 AM
Subject: FW: Guidance from AHCA
To: Hill, Ann <ann.echcc@gmail.com>, Bobby Martin (marbobby@co.walton.fl.us) <marbobby@co.walton.fl.us>, Catie Feeney (catie@visitsouthwalton.com) <catie@visitsouthwalton.com>, Charlie Morse (morsec@walton.k12.fl.us) <morsec@walton.k12.fl.us>, Christopher Mitchell <grants@defuniaksprings.net>, Cory Webster (cwebster@waltonso.org) <cwebster@waltonso.org>, Eddie (Eddie.PathofGrace@AOL.com) <Eddie.PathofGrace@aol.com>, Fletcher Forte (Fletcher.forte@FDC.myflorida.com) <Fletcher.forte@fdc.myflorida.com>, Gabrielle Kilgore (gabrielle@waltonareachamber.com) <gabrielle@waltonareachamber.com>, Gina Waddell (wadgina@co.walton.fl.us) <wadgina@co.walton.fl.us>, Hurley James (hurleyjw@dfspd.net) <hurleyjw@dfspd.net>, James McMillan (mcmjames@waltonso.org) <mcmjames@waltonso.org>, Jeff Infinger (infingej@walton.k12.fl.us) <infingej@walton.k12.fl.us>, Jerry Hall (jhall@defuniaksprings.net) <jhall@defuniaksprings.net>, Julie Gaither (Julie.Gaither@FDC.myflorida.com) <Julie.Gaither@fdc.myflorida.com>, Lindsey Darby (darlindsey@waltonso.org) <darlindsey@waltonso.org>, Svehla, Louis <svelouis@co.walton.fl.us>, Mell Smigielski (citymanager@defuniaksprings.net) <citymanager@defuniaksprings.net>, Nathan Kervin <kernathan@co.walton.fl.us>, Philip Austin (austinpj@dfspd.net) <austinpj@dfspd.net>, Sarah Eailey (earsarah@waltonso.org) <earsarah@waltonso.org>, Shayne Betts (shaynebetts@yahoo.com) <shaynebetts@yahoo.com>, Stephanie King (stephanie.king@chhealthcare.org) <stephanie.king@chhealthcare.org>, Sterling Strickland (sstrickland@swfd.org) <sstrickland@swfd.org>, Tim Orenic (torenic@swfd.org) <torenic@swfd.org>, Tom Baker <baktom@co.walton.fl.us>, Trish Meadows <meadowst@walton.k12.fl.us>, Barley, Kathryn C <Kathryn.Barley@flhealth.gov>, Carmichael, Jamie B <Jamie.Carmichael@flhealth.gov>, Drummond, Robert D <Robert.Drummond@flhealth.gov>, Gill, Brandi N <Brandi.Gill@flhealth.gov>, Holt, Holly <Holly.Holt@flhealth.gov>, Mims, Ryan E <Ryan.Mims@flhealth.gov>, Morell, Venita W <Venita.Morell@flhealth.gov>, Ottesen, John P <John.Ottesen@flhealth.gov>, Roberts, Missy <Missy.Roberts@flhealth.gov>, Roberts, Patricia J <Patricia.Roberts@flhealth.gov>, Simmons, Harriet A <Harriet.Simmons@flhealth.gov>, Smith, Marissa <Marissa.Smith@flhealth.gov>, Smith, Thomas M <Thomas.Smith@flhealth.gov>, Steele, Crystal C <Crystal.Steele@flhealth.gov>, Alma Solano (asolano@elc-ec.org) <asolano@elc-ec.org>, Ann McCannon (amccannon@somerbyliving.com) <amccannon@somerbyliving.com>, CHrissy Howell (chrissy.howell@gentiva.com) <chrissy.howell@gentiva.com>, Connie Zuraff <CZuraff@gchc.com>, Daniel Shearn (daniel_shearn@chs.net) <daniel_shearn@chs.net>, Daniela (dmejia@pancarefl.org) <dmejia@pancarefl.org>, Danny Wilkins (dwilkins@healthmarkregional.com) <dwilkins@healthmarkregional.com>, Darren M. Staggers (darren.staggers@medxcelfm.com) <darren.staggers@medxcelfm.com>, Graham Campbell (admin.chautauqua@shccs.com) <admin.chautauqua@shccs.com>, Gwen Cobb (cobbg@elderaffairs.org)

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Updated information from ACHA on Long-term and residential care facilities.

Respectfully,

Tom Smith

Planning Consultant II

Florida Department of Health Walton County

356 State Highway 83 N

DeFuniak Springs, FL. 32433

Thomas.smith@flhealth.gov

Phone: 850-401-6364

Cell: 850-259-9989

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Vision: To be the Healthiest State in the Nation

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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From: Jeff Goldberg <jeff@waltoncountyem.org>
Sent: Thursday, March 19, 2020 6:47 AM
To: Holt, Holly <Holly.Holt@flhealth.gov>; Smith, Thomas M <Thomas.Smith@flhealth.gov>; Roberts, Patricia J <Patricia.Roberts@flhealth.gov>; Donna Free <donna@waltoncountyem.org>; Chris Eliadis <chris@waltoncountyem.org>; Svehla, Louis <svelouis@co.walton.fl.us>
Subject: Fwd: Guidance from AHCA

Thanks!

Jeff

Jeffrey M. Goldberg, FPEM, FMI, CHS-III
Director
Walton County Emergency Management
75 South Davis Lane
DeFuniak Springs, FL 32435
Work: (850) 892-8530
Mobile: (850) 307-4121

Sent from my iPhone

Begin forwarded message:

> **From:** "Guthrie, Kevin" <Kevin.Guthrie@em.myflorida.com>
> **Date:** March 19, 2020 at 06:38:35 CDT
> **To:** County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
> **Subject: FW: Guidance from AHCA**

Kevin Guthrie | Deputy Director

Office: (850) 815-4101

Cell: (850) 294-8250

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Kevin.Guthrie@em.myflorida.com

From: Twomey, Stephanie <Stephanie.Twomey@em.myflorida.com>
Sent: Wednesday, March 18, 2020 11:49 AM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>
Cc: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: Guidance from AHCA

Good Afternoon,

Please see attached AHCA guidance released regarding DEM No.20-006

Very Respectfully,

Stephanie Twomey

Stephanie Twomey

Senior Attorney

Florida Division of Emergency Management

Cell: (850)-815-5762

Direct: (850) 815-4160

Stephanie.Twomey@em.myflorida.com

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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AGENCY FOR HEALTH CARE ADMINISTRATION

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

Guidance and Clarification on Division of Emergency Management (DEM) Emergency Order No. 20-006

An Emergency Order was recently issued to create broad limitations on visitation at long-term care and residential facilities to protect residents from COVID-19. To assist with clarifying this directive, the Agency for Health Care Administration has started a list of the most commonly asked questions.

1. **What are necessary health care services as allowed by the Emergency Order?**

   Medically necessary health care includes health services as well as support services such as activities of daily living and assistance with resident self-administration of medication. This exception applies to individuals who previously performed them on a regular basis.

   For example, any family member or sitter who provided assistance with activities of daily living, such as feeding a resident or assisting with bathing, prior to the Emergency Order issued on March 15, 2020, may continue to provide these services.

2. **Can staff who have been on a flight within the last 14 days enter a facility?**

   Yes. Facility staff are exempt from the 14-day air travel prohibition if the individual does not meet any of the other screening criteria. The facility must still follow the required documentation criteria.

3. **Can hospice workers enter the facility?**

   Yes. Hospice workers are allowed to see a resident with hospice

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orders so long as the hospice workers meet the other screening criteria in the Emergency Order.

The full Emergency Order is available here: https://ahca.myflorida.com/docs/DEM_ORDER_NO.20-006_In_re_COVID-19_Public_Health_Emergency_Issued_March_15_2020.pdf

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 44,000 health care facilities and 53 health plans, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

Agency for Health Care Administration | 2727 Mahan Drive, Tallahassee, FL 32308 | http://ahca.myflorida.com

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Guidance from AHCA
Date: Thursday, March 19, 2020 11:16:50 AM
Attachments: ATT00001.htm
Guidance_and_Clarification for EO 20-006.pdf
ATT00002.htm

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From: **Smith, Thomas M** <Thomas.Smith@flhealth.gov>
Date: Thu, Mar 19, 2020 at 6:59 AM
Subject: FW: Guidance from AHCA
To: Hill, Ann <ann.echcc@gmail.com>, Bobby Martin (marbobby@co.walton.fl.us) <marbobby@co.walton.fl.us>, Catie Feeney (catie@visitsouthwalton.com) <catie@visitsouthwalton.com>, Charlie Morse (morsec@walton.k12.fl.us) <morsec@walton.k12.fl.us>, Christopher Mitchell <grants@defuniaksprings.net>, Cory Webster (cwebster@waltonso.org) <cwebster@waltonso.org>, Eddie (Eddie.PathofGrace@AOL.com) <Eddie.PathofGrace@aol.com>, Fletcher Forte (Fletcher.forte@FDC.myflorida.com) <Fletcher.forte@fdc.myflorida.com>, Gabrielle Kilgore (gabrielle@waltonareachamber.com) <gabrielle@waltonareachamber.com>, Gina Waddell (wadgina@co.walton.fl.us) <wadgina@co.walton.fl.us>, Hurley James (hurleyjw@dfspd.net) <hurleyjw@dfspd.net>, James McMillan (mcmjames@waltonso.org) <mcmjames@waltonso.org>, Jeff Infinger (infingej@walton.k12.fl.us) <infingej@walton.k12.fl.us>, Jerry Hall (jhall@defuniaksprings.net) <jhall@defuniaksprings.net>, Julie Gaither (Julie.Gaither@FDC.myflorida.com) <Julie.Gaither@fdc.myflorida.com>, Lindsey Darby (darlindsey@waltonso.org) <darlindsey@waltonso.org>, Svehla, Louis <svelouis@co.walton.fl.us>, Mell Smigielski (citymanager@defuniaksprings.net) <citymanager@defuniaksprings.net>, Nathan Kervin <kernathan@co.walton.fl.us>, Philip Austin (austinpj@dfspd.net) <austinpj@dfspd.net>, Sarah Eailey (earsarah@waltonso.org) <earsarah@waltonso.org>, Shayne Betts (shaynebetts@yahoo.com) <shaynebetts@yahoo.com>, Stephanie King (stephanie.king@chhealthcare.org) <stephanie.king@chhealthcare.org>, Sterling Strickland (sstrickland@swfd.org) <sstrickland@swfd.org>, Tim Orenic (torenic@swfd.org) <torenic@swfd.org>, Tom Baker <baktom@co.walton.fl.us>, Trish Meadows <meadowst@walton.k12.fl.us>, Barley, Kathryn C <Kathryn.Barley@flhealth.gov>, Carmichael, Jamie B <Jamie.Carmichael@flhealth.gov>, Drummond, Robert D <Robert.Drummond@flhealth.gov>, Gill, Brandi N <Brandi.Gill@flhealth.gov>, Holt, Holly <Holly.Holt@flhealth.gov>, Mims, Ryan E <Ryan.Mims@flhealth.gov>, Morell, Venita W <Venita.Morell@flhealth.gov>, Ottesen, John P <John.Ottesen@flhealth.gov>, Roberts, Missy <Missy.Roberts@flhealth.gov>, Roberts, Patricia J <Patricia.Roberts@flhealth.gov>, Simmons, Harriet A <Harriet.Simmons@flhealth.gov>, Smith, Marissa <Marissa.Smith@flhealth.gov>, Smith, Thomas M <Thomas.Smith@flhealth.gov>, Steele, Crystal C <Crystal.Steele@flhealth.gov>, Alma Solano (asolano@elc-ec.org) <asolano@elc-ec.org>, Ann McCannon (amccannon@somerbyliving.com) <amccannon@somerbyliving.com>, CHrissy Howell (chrissy.howell@gentiva.com) <chrissy.howell@gentiva.com>, Connie Zuraff <CZuraff@gchc.com>, Daniel Shearn (daniel_shearn@chs.net) <daniel_shearn@chs.net>, Daniela (dmejia@pancarefl.org) <dmejia@pancarefl.org>, Danny Wilkins (dwilkins@healthmarkregional.com) <dwilkins@healthmarkregional.com>, Darren M. Staggers (darren.staggers@medxcelfm.com) <darren.staggers@medxcelfm.com>, Graham Campbell (admin.chautauqua@shccs.com) <admin.chautauqua@shccs.com>, Gwen Cobb (cobbg@elderaffairs.org)

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Updated information from ACHA on Long-term and residential care facilities.

Respectfully,

Tom Smith

Planning Consultant II

Florida Department of Health Walton County

356 State Highway 83 N

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Vision: To be the Healthiest State in the Nation

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AMERICAN OVERSIGHT

From: Jeff Goldberg <jeff@waltoncountyem.org>
Sent: Thursday, March 19, 2020 6:47 AM
To: Holt, Holly <Holly.Holt@flhealth.gov>; Smith, Thomas M <Thomas.Smith@flhealth.gov>; Roberts, Patricia J <Patricia.Roberts@flhealth.gov>; Donna Free <donna@waltoncountyem.org>; Chris Eliadis <chris@waltoncountyem.org>; Svehla, Louis <svelouis@co.walton.fl.us>
Subject: Fwd: Guidance from AHCA

Thanks!

Jeff

Jeffrey M. Goldberg, FPEM, FMI, CHS-III
Director
Walton County Emergency Management
75 South Davis Lane
DeFuniak Springs, FL 32435
Work: (850) 892-8530
Mobile: (850) 307-4121

Sent from my iPhone

Begin forwarded message:

> **From:** "Guthrie, Kevin" <Kevin.Guthrie@em.myflorida.com>
> **Date:** March 19, 2020 at 06:38:35 CDT
> **To:** County Emergency Management Directors <CountyEmergencyManagementDirectors@em.myflorida.com>
> **Subject: FW: Guidance from AHCA**

Kevin Guthrie | Deputy Director

Office: (850) 815-4101

Cell: (850) 294-8250

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Kevin.Guthrie@em.myflorida.com

From: Twomey, Stephanie <Stephanie.Twomey@em.myflorida.com>
Sent: Wednesday, March 18, 2020 11:49 AM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Bussey, Jon <Jon.Bussey@em.myflorida.com>; Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>
Cc: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: Guidance from AHCA

Good Afternoon,

Please see attached AHCA guidance released regarding DEM No.20-006

Very Respectfully,

Stephanie Twomey

Stephanie Twomey

Senior Attorney

Florida Division of Emergency Management

Cell: (850)-815-5762

Direct: (850) 815-4160

Stephanie.Twomey@em.myflorida.com

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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AGENCY FOR HEALTH CARE ADMINISTRATION

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

Guidance and Clarification on Division of Emergency Management (DEM) Emergency Order No. 20-006

An Emergency Order was recently issued to create broad limitations on visitation at long-term care and residential facilities to protect residents from COVID-19. To assist with clarifying this directive, the Agency for Health Care Administration has started a list of the most commonly asked questions.

1. **What are necessary health care services as allowed by the Emergency Order?**

   Medically necessary health care includes health services as well as support services such as activities of daily living and assistance with resident self-administration of medication. This exception applies to individuals who previously performed them on a regular basis.

   For example, any family member or sitter who provided assistance with activities of daily living, such as feeding a resident or assisting with bathing, prior to the Emergency Order issued on March 15, 2020, may continue to provide these services.

2. **Can staff who have been on a flight within the last 14 days enter a facility?**

   Yes. Facility staff are exempt from the 14-day air travel prohibition if the individual does not meet any of the other screening criteria. The facility must still follow the required documentation criteria.

3. **Can hospice workers enter the facility?**

   Yes. Hospice workers are allowed to see a resident with hospice

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orders so long as the hospice workers meet the other screening criteria in the Emergency Order.

The full Emergency Order is available here: https://ahca.myflorida.com/docs/DEM_ORDER_NO.20-006_In_re_COVID-19_Public_Health_Emergency_Issued_March_15_2020.pdf

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 44,000 health care facilities and 53 health plans, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

Agency for Health Care Administration | 2727 Mahan Drive, Tallahassee, FL 32308 | http://ahca.myflorida.com

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; David Keighley; David Morrison; David Prescott; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Lanny Odom; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; Lisa Guthrie; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. 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Subject: Fwd: FW: PPE Clarification

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Date: Wednesday, March 11, 2020 2:56:48 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Wed, Mar 11, 2020 at 1:33 PM
Subject: FW: PPE Clarification
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, dale simmons (dsimmons@hillcrestchurch.com) <dsimmons@hillcrestchurch.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Glenn, Amy <AGlenn@pcci.edu>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, julie gaither (julie.gaither@FDC.myflorida.com) <julie.gaither@fdc.myflorida.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lanza1@cox.net <lanza1@cox.net>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce

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(Lynn.pierce@southernoaks-cc.com) <Lynn.pierce@southernoaks-cc.com>, M Sartain (msartain@healthcarewithinreach.org) <msartain@healthcarewithinreach.org>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matroni, Michael <Mike.Matroni@medxcelfm.com>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Paul A. McLeod (paul.mcleod@med.fsu.edu) <paul.mcleod@med.fsu.edu>, paul Glisson (paul.glisson@bhcpns.org) <paul.glisson@bhcpns.org>, Pennie Sparks <psparks@uwf.edu>, Peter Jennings (peter.jennings@ascension.org) <peter.jennings@ascension.org>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, RAYNES, SCOTT <Scott.Raynes@bhcpns.org>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, tammi bassette (Tami.Bassette@bhcpns.org) <Tami.Bassette@bhcpns.org>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson <tanderson@healthcarewithinreach.org>, Tom Gilliam (tgilliam@pensacolastate.edu) <tgilliam@pensacolastate.edu>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shehee, Patrick M <Patrick.Shehee@flhealth.gov>, Shoulders, Barbara A <Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

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Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

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regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Smith, Rita M <Rita.Smith@flhealth.gov>
Sent: Wednesday, March 11, 2020 12:53 PM
To: DL DOH CHD Nursing Directors <DLCHDND@flhealth.gov>; DL CHD Medical Directors <DLCHDMedicalDirectors@flhealth.gov>
Cc: Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject: PPE Clarification

The attached poster covers the minimum standards recommended by CDC for PPE use in COVID-19 test collection.

If a CHD includes additional equipment to the PPE list, that is acceptable.

Hopefully this clears any confusion.

Rita Smith, DNP, APRN, NP-C

Statewide Nursing Director

Public Health Practice Unit

Florida Department of Health

Office of the Deputy Secretary for County Health Systems

4052 Bald Cypress Way

Tallahassee, Florida 32399
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--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: PPE Clarification

AMERICAN OVERSIGHT

Date: Wednesday, March 11, 2020 2:56:48 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Wed, Mar 11, 2020 at 1:33 PM
Subject: FW: PPE Clarification
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, Alain Espinosa <aespinosa@myescambia.com>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, brian wyer (bwyer@gcmcc.info) <bwyer@gcmcc.info>, Byron Burkhart <bburkhart@cityofpensacola.com>, casey richards (casey.richards@navyfederal.org) <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, dale simmons (dsimmons@hillcrestchurch.com) <dsimmons@hillcrestchurch.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, debbieray kings (debbieray.kings@medicalcenterclinic.com) <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, gay Nord (gay.nord@HCAhealthcare.com) <gay.nord@hcahealthcare.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, Glenn, Amy <AGlenn@pcci.edu>, Jennifer.Grove@bhcpns.org <Jennifer.Grove@bhcpns.org>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, john Lands (jlands@pcci.edu) <jlands@pcci.edu>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Julette Saussy MD (jmsaussy@gmail.com) <jmsaussy@gmail.com>, julie gaither (julie.gaither@FDC.myflorida.com) <julie.gaither@fdc.myflorida.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, katie Glaze (katie.glaze@brookdale.com) <katie.glaze@brookdale.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lanza1@cox.net <lanza1@cox.net>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, Lynn Pierce

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Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email communication may
therefore be subject to public disclosure.

From: Smith, Rita M <Rita.Smith@flhealth.gov>
Sent: Wednesday, March 11, 2020 12:53 PM
To: DL DOH CHD Nursing Directors <DLCHDND@flhealth.gov>; DL CHD Medical Directors <DLCHDMedicalDirectors@flhealth.gov>
Cc: Otis, Aaron <Aaron.Otis@flhealth.gov>
Subject: PPE Clarification

The attached poster covers the minimum standards recommended by CDC for PPE use in COVID-19 test collection.

If a CHD includes additional equipment to the PPE list, that is acceptable.

Hopefully this clears any confusion.

Rita Smith, DNP, APRN, NP-C

Statewide Nursing Director

Public Health Practice Unit

Florida Department of Health

Office of the Deputy Secretary for County Health Systems

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Baines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eadis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: The State of Florida Issues Updates on COVID-19

Date: Tuesday, March 17, 2020 11:03:08 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 17, 2020 at 7:28 AM
Subject: FW: The State of Florida Issues Updates on COVID-19
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Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

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From: CHD17, PIO <PIO.CHD17@flhealth.gov>
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Subject: The State of Florida Issues Updates on COVID-19

Banner

FOR IMMEDIATE RELEASE March 16, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

The State of Florida Issues Updates on COVID-19

TALLAHASSEE, Fla. — The State of Florida is responding to COVID-19. In an effort to keep Florida residents and visitors safe and aware regarding the status of the virus, the Florida Department of Health will issue this update every day, seven days per week.

Governor Ron DeSantis is in constant communication with Florida Division of Emergency Management Director Jared Moskowitz and State Surgeon General Dr. Scott Rivkees as the State of Florida continues to monitor and respond to the threat of COVID-19.

Today, in a briefing at the State Emergency Operations Center, Governor DeSantis announced the following:

- Governor DeSantis announced he is going to supplement federal Small Business Administration (SBA) loans. The Governor activated the Florida Small Business Emergency Loan Program. Up to $50 million has been allocated for the program.
- Governor Ron DeSantis directed the Department of Revenue to provide flexibility on the deadlines of taxes due such as corporate income tax and sales tax to assist businesses that are adversely impacted from COVID-19 mitigation measures.
- Floridians throughout the state are lending a hand to stop the spread of COVID-19:
  - Members of the Florida House of Representatives have been activated to their National Guard units**,**
  - The Players Championship donated thousands of pounds of food to Feeding Northeast Florida**,**
  - Miami-Dade County school administrators are handing out computers and mobile devices, and
  - Comcast agreed to provide free WiFi for the next 60 days to kids who do not have it.

- The Miami Dolphins, Jacksonville Jaguars and the Orange County Convention Center have agreed to open their parking lots to stage supplies and locate testing sites.
- Restaurants throughout the state including Jimmy John’s in Tallahassee and Toasted Restaurant in Orange County are providing children with free lunch throughout the week.
- Drive through testing sites are expected to open, throughout the state, in addition to the first proposed state site at Memorial Healthcare System in Broward. So far, sites are being developed in in Myers, Pensacola, West Palm Beach and Tallahassee.
- The Floridians who were at held at the Dobbins Air Reserve Base are on their way back to Florida; 15 Floridians have elected to stay at the base to care for their family members.
- On March 9, Governor DeSantis issued Executive Order 20-52, declaring a State of Emergency for COVID-19. By declaring a State of

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Emergency, Governor DeSantis is ensuring that state and local governments have the resources and flexibility they need to prepare and respond.

More Information on COVID-19

To find the most up-to-date information and guidance on COVID-19, please visit the Department of Health's dedicated COVID-19 webpage. For information and advisories from the Centers for Disease Control (CDC), please visit the CDC COVID-19 website. For more information about current travel advisories issued by the U.S. Department of State, please visit the travel advisory website.

For any other questions related to COVID-19 in Florida, please contact the Department's dedicated COVID-19 Call Center by calling **(866) 779-6121. The Call Center is available 24 hours per day**. Inquiries may also be emailed to **COVID-19@flhealth.gov.**

What you Should Know

COVID-19 can spread from person to person through small droplets from the nose or mouth, including when an individual coughs or sneezes. These droplets may land on objects and surfaces. Other people may contract COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth.

Symptoms of COVID-19 are fever, cough and shortness of breath. Symptoms may appear in as few as two days or as many as 14 days following exposure. Most people recover from COVID-19 without needing special treatment. The elderly and those with underlying medical problems like high blood pressure, heart problems and diabetes are more likely to develop serious illness.

There is currently no vaccine to prevent COVID-19. The best way to prevent illness is to avoid being exposed to the virus. The Department recommends everyday preventive actions to help stop the spread of respiratory diseases, including:

- Avoiding close contact with people who are sick;
- Staying home when you are sick and avoiding contact with persons in poor health;
- Avoiding touching your eyes, nose and mouth with unwashed hands;
- Covering your cough or sneezing into a tissue, then disposing of the tissue;
- Washing your hands often with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, after blowing your nose, coughing or sneezing;
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty; and
- Cleaning and disinfecting frequently touched objects and surfaces using a regular household cleaning spray or wipe.

The CDC does not recommend that asymptomatic, healthy people wear a facemask to protect themselves from respiratory diseases, including COVID-19. Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).
A person that experiences a fever and symptoms of respiratory illness, such as fever, cough or shortness of breath, within 14 days after travel from any other destination with community transmission should call ahead to their health care provider and local CHD and mention their recent travel or close contact.

If a person has had close contact with someone showing these symptoms who has recently traveled from this area or been in contact with a person with laboratory-confirmed COVID-19, he or she should call ahead to a health care professional and the CHD. The health care provider will work with the Department to determine if the person should be tested for COVID-19.

Actions the state has taken to prepare for and respond to COVID-19:

DEPARTMENT OF HEALTH

- At the direction of Governor DeSantis, State Surgeon General Dr. Scott Rivkees declared a Public Health Emergency for COVID-19 in Florida.
- Governor DeSantis announced that the State ordered an additional 2,500 test kits to supplement the adequate resources already available to test for COVID-19. These additional test kits will enable the Department of Health, working with Florida health care providers, to test up to an additional 625,000 individuals. The Governor also suspended non-essential in state and all out-of-state travel for state employees for 30 days.
- Established an Incident Management Team to coordinate response operations.
- Defined a high-level phased response strategy for COVID-19.
- Activated a dedicated incident command post for on-site response activities.
- Conducted three public health and health care stakeholder conference calls to provide statewide updates on the current outbreak situation, response actions and guidance for pandemic planning. Over five hundred participants joined the calls.
- Established a public call center for questions regarding COVID-19. The call center launched Monday, March 2.
- Developed and distributed COVID-19 presentation materials to County Health Departments (CHD) for use at community meetings.
- Activated the Joint Information Center in coordination with the Division of Emergency Management.
- Developed and implemented protocols for investigation, surveillance and monitoring for COVID-19 to rapidly detect and contain cases.
- Established mechanisms for monitoring and coordination with the Centers for Disease Control and Prevention (CDC) regarding epidemiological activities.
- Distributed CDC Interim Guidance for public health personnel evaluating Persons Under Investigation (PUI) and asymptomatic close contacts of confirmed cases at their home or non-home residential settings to CHDs.
- Approved and disseminated an updated Clinician Screening Tool for identifying COVID-19 PUIs.
- Distributed a health care provider letter regarding enhanced surveillance and preparedness for COVID-19 to associations, licensed providers, Health Care Coalitions and CHDs.
- Implemented testing at all three State Public Health Laboratories.
- Distributed updated CDC guidance for schools to CHDs and the Department of Education.
- Distributed updated laboratory guidance regarding implementation of testing at State Public Health Laboratories.
- Developing a laboratory surge plan.
- Developing a clinician-level briefing for medical audiences.
- Identifying and monitoring close contacts of presumptive cases. Any close contacts with symptoms will be tested.
- Implemented private lab testing.
- Developed and disseminated pandemic planning guidance.
- Advised CHDs and HCCs to retain expired personal protective equipment until further until further notice.
- Continued development of public information resources.
- Developing infographics for first responders (fire, law enforcement and EMS) regarding infection control and personal protection for COVID-19.
- At the Governor's direction, a public-private partnership has been put in place between Memorial Healthcare in Broward and the National

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Guard to set up a mobile testing unit.
- At the direction of Governor DeSantis hiring additional epidemiologists from university health programs to help with workload.
- Governor DeSantis directed the Agency for Health Care Administration (AHCA) to extend all existing nursing home and assisted living facility licenses for 90 days to remove distraction from patient care.

AGENCY FOR HEALTH CARE ADMINISTRATION

- AHCA distributed a provider alert to licensed health care providers regarding the Division of Emergency Management's new Emergency Order tightening visitation restrictions at residential and long-term care facilities.
- AHCA, in coordination with the DEM and the Department, is hosting ongoing statewide calls for nursing homes, assisted living facilities, intermediate care facilities, the Agency for Persons with Disabilities, group homes, and adult family care homes in conjunction with the Florida Health Care Association. Secretary Mayhew and Surgeon General Rivkees are continuing to address critical issues impacting these providers such as restricting visitors and providing updates.
- AHCA, in coordination with DEM and the Department, is hosting ongoing statewide calls for hospitals in conjunction with the Florida Hospital Association. Secretary Mayhew and Surgeon General Rivkees to provide the most up-to-date information to hospital partners and residential facilitates caring for aging and vulnerable populations.
- After previously opening an event on the Emergency Status System (ESS) for hospitals to enter census information, emergency room status updates and isolation beds, AHCA expanded the ESS event to track nursing homes and assisted living facility bed capacity, effective March 15.
- The Agency for Health Care Administration (AHCA) will be granting a 90-day extension to all licenses for health care providers and regulated facilities.
- AHCA is distributing information regarding regulatory flexibilities created by waivers from the Centers for Medicare and Medicaid Services (CMS) related to skilled nursing facilities, critical access hospitals, home health agencies, durable medical equipment, provider enrollment, etc.
- AHCA participated in a collaborative call with the Florida Health Care Association, Florida Hospital Association and LeadingAge Florida to discuss patient transfer arrangements between health care facilities such as nursing homes and hospitals.
- The Florida Medicaid Program announced coverage of commercial testing for COVID-19 for dates of service back to February 4.
- AHCA submitted requests to CMS for flexibility for Florida's program under the federal declaration of a state of emergency.

AGENCY FOR PERSONS WITH DISABILITIES

- The agency's three state-run centers in Marianna, Gainesville and Chattahoochee, as well as APD-licensed group homes, are restricting visitors in compliance with the Executive Order to protect the health and safety of our customers.
- APD Adult Day Training programs across the state are screening visitors for possible exposure to COVID-19 using a visitor questionnaire. The questionnaire is also being used to screen visitors coming into APD Regional Offices.
- APD continues to provide an up-to-date status on COVID-19, best practices, preventative tips, and CDC guidance to APD providers, Waiver Support Coordinators, Stakeholders and APD employees.

DEPARTMENT OF ELDER AFFAIRS

- The Department of Elder Affairs (DOEA), in coordination with the Administration for Community Living (ACL), facilitated a virtual Town Hall meeting at the request of Hallandale Beach Mayor Joy Cooper. More than 2,700 seniors were online for the meeting. Charlotte Mather Taylor, Executive Director of the Aging and Disability Resource Center (ADRC) of Broward County, led the discussion with participation from ACL Representative Constantino Miskos, Chen Senior Medical Center, and representatives from Emergency Medical Services. Their primary topics of conversation centered on the work being done, specifically by the Area Agency on Aging, to continue to provide people resources and services to maximize support during COVID-19.
- Through Departmental Leadership and the Area Agency on Aging contract managers, DOEA provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the safe delivery of home-delivered meals to prevent spread of respiratory infection.
- DOEA continues to provide updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, they are provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.
- "The Vision 2020: Looking Towards Your Age-Friendly Future Tour" to five communities across Florida originally planned for April 20th - April 24th and co-hosted by the Department and AARP has been postponed to protect the health and wellness of seniors, volunteers and staff.
- All Serving Health Insurance Needs of Elders (SHINE) participation in scheduled outreach events, presentations, and in-person SHINE/Senior Medicare Patrol (SMP) counseling has been suspended until further notice. SHINE volunteers and staff will continue to provide counseling services, but the services will be conducted over-the-phone with future considerations for the use of webinars and Facebook LIVE.
- DOEA Secretary Prudom held a conference call with The Comprehensive Assessment and Review for Long-term Care Services (CARES) supervisors to discuss the suspension of face-to-face assessments. CARES assessors will provide reviews through phone or tele-technology to reduce client/staff exposure and reduce spread.
- Through Departmental Leadership and the Area Agency on Aging contract managers, we provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the provision on completing assessments for multiple program types, specifically for clients who have chosen to self-isolate.
- DOEA provided updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers, and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.

DEPARTMENT OF CHILDREN AND FAMILIES

- The Department of Children and Families' (DCF) Office of Child Welfare is sending regular communication about COVID-19 specifically to licensed child care providers, directing them to follow the CDC's Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19). An FAQ document for providers was also posted prominently on DCF's Child Care webpage.
- DCF's Office of Child Welfare is disseminating a survey to licensed child care providers to assess closures throughout the state. Currently, the decision to close is at the discretion of each individual facility.
- DCF Secretary Chad Poppell sent thorough communication to all DCF staff, contracted partners, and licensed facilities (including child care providers) about COVID-19, including precautionary measures (as outlined by the CDC) and temporary policy updates.
- DCF is working with AHCA, DOEA, and APD to compile and develop guidance for agency staff and stakeholders who work directly with Florida's elderly population and have a higher risk of being exposed to COVID-19.
- DCF is leading status update calls with both internal leadership and leadership from external contracted partners. For the time being, these calls will take place twice weekly, every Tuesday and Friday.

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- DCF General Services staff throughout the state are working with lessors and janitorial contractors to increase sanitizing measures in office buildings, especially restrooms and common areas. They also began taking inventory of sanitizing supplies (disinfecting wipes, Lysol spray, hand-sanitizer, etc.) and are ordering more as needed.
- DCF established strategies for COVID-19 prevention at all three state mental health treatment facilities, as well as the South Florida mental health facilities run by Wellpath Recovery Solutions, a contracted partner. They are reporting daily updates to ensure compliance with virus prevention and monitor potential outbreaks.
- DCF has established a visitation protocol for all state-owned and contracted mental health treatment facilities, as well as vendors and patient families, requiring all outside parties to complete a Visitors Viral Symptoms Screening prior to entering a facility. At this time, there are no cases of patients or facility staff testing positive for COVID-19.
- DCF's Office of Economic Self-Sufficiency is communicating with DEO regarding work requirements and CareerSource operations and availability.
- DCF's Office of Economic Self-Sufficiency implemented screening procedures, including a set of questions that must be asked prior to entry, at all economic self-sufficiency storefronts.

FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

- Effective March 11, 2020, FDVA is restricting visitor access to its State Veterans' Nursing Homes and Domiciliary until further notice, with the exception of essential visitors, such as family members of those residents undergoing end-of-life care.
- The U.S. Department of Veterans Affairs (VA) has also temporarily restricted access to their nursing and community living center facilities to only essential visitors until further notice.
- All VA Medical Centers in Florida are implementing enhanced screening protocols at their facilities. VA Outpatient Clinics are also implementing enhanced screening protocols. Please plan to arrive at the facility well in advance of your appointment to allow additional time for the screening process.
- Veterans who are concerned they may have symptoms of Coronavirus (COVID-19) are encouraged to contact the VISN 8 Clinical Contact Center at 1-877-741-3400 (toll free). Clinical staff provide 24/7 virtual care and support, including nurse advice and triage. The service is available at no cost to veterans enrolled for care in the VA Sunshine Healthcare Network (VISN 8).
- All FDVA and VA facilities remain fully operational.

DEPARTMENT OF MILITARY AFFAIRS

- There have been over 200 Florida National Guardsmen placed on state active duty in support of COVID-19.
- The Florida National Guard is activating all of their medical professionals (Army Combat medic specialists and Air Force medical technicians) to support Florida Department of Health's drive-through screening operations. Guardsmen have reported in and formed Task Force Medical already.
- The Florida National Guard has activated soldiers to augment the State Logistics Readiness Center in Central Florida.

VOLUNTEER FLORIDA

- Volunteer Florida is working with state counterparts and FEMA to develop volunteer plans.
- Volunteer Florida's National Service Department has discussed using AmeriCorps members in food banks as feeding needs increase.
- Volunteer Florida is having conversations with Mass Care on the anticipated needs of volunteers. Together, we are working on a plan for volunteers with volunteer safety guidelines to ensure that we are protecting our service providers (volunteers and clients).
- Volunteer Florida has asked all Voluntary Organizations Active in Disaster (VOAD) partners to review their continuity of operations so that there is no service delivery disruption.

FLORIDA DEPARTMENT OF EDUCATION

- Commissioner of the Florida Department of Education (FDOE) Richard Corcoran provided strong recommendations for extending spring break following Centers for Disease Control and Prevention (CDC) issuing guidance specific to COVID-19 in Florida. As all Florida school districts and public charter schools have different schedules, please click here to see the recommended spring break changes for each district. In addition, the department also announced that the start of state testing will be delayed by a minimum of two weeks. To stay up to date on school closure information, visit: org/em-response.
- FDOE sent updated guidance to school districts and superintendents ahead of spring break. To view that memo, visit: fldoe.org/em-response.
- In an effort to be proactive, and only as a precautionary measure if COVID-19 evolves in Florida, Florida Virtual School (FLVS) has partnered with the Florida Department of Education to offer all school districts student support and teacher professional development tailored to the online learning environment. The Florida Department of Education in partnership with FLVS is training an additional 10,000 teachers statewide on the Virtual Teacher Training for COVID-19. Superintendents who are interested in offering their teachers the Virtual Teacher Training for COVID-19 should work with their County Virtual Principals to provide a list of teachers to FLVS through: https://www.flvs.net/FLVSTeacherTraining.
- Education Commissioner Corcoran is in constant communication with Florida Superintendents and districts to provide guidance on COVID-19 preparedness and response and will be holding weekly calls to update districts on preparation efforts.
- FDOE has sent weekly memos providing updates to school districts, superintendents, Florida Colleges, parents, teachers and stakeholders.
- FDOE launched a survey to school districts and public charter schools about their preparations, policies, and their capacity to serve their students virtually to help meet and determine any preparedness needs.

STATE UNIVERSITY SYSTEM

- The State University System will continue to evaluate the effectiveness of remote learning and the need to teach remotely in order to protect our students and the university community.
- The State University System will continue to work with the Florida Department of Health and the Emergency Operations Center to determine if the initial two weeks of remote learning is sufficient.
- Effective immediately, all universities will make plans to transition to remote instruction as soon as possible.
- State universities with students who have returned from spring break, which includes Florida Gulf Coast University, Florida International University, Florida Polytechnic University, and the University of Florida, should implement a process to transition to remote instruction immediately and encourage students to return home for at least 2 weeks. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- State universities with students who are currently on spring break or about to be on break should direct their students to NOT return to campus for at least 2 weeks following the conclusion of spring break. This includes students at Florida Agricultural and Mechanical University, Florida Atlantic University, Florida State University, New College of Florida, the University of North Florida, the University of Central Florida, the University of South Florida, and the University of West Florida. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- RESIDENTIAL HOUSING - While students are encouraged to remain off-campus, each university should develop a plan for providing

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residential accommodations for students who need assistance or must remain in place.
- All state universities have implemented campus-wide critical incident or emergency management teams that are meeting regularly to prepare for the impacts of the COVID-19 virus.
- All universities are preparing to transition to remote instructional delivery for a two-week period during March and early April, depending on each institution's Spring Break, and are informing students not to return to campus during this period.
- The Board of Governors will be conducting its March meeting via conference call and will not have a face-to-face meeting at USF as was originally scheduled.
- For more information visit: https://www.flbog.edu/2020/03/11/state-university-system-statement-on-covid-19/.

FLORIDA DEPARTMENT OF CORRECTIONS

- Florida Department of Corrections (FDC) has no known or suspected cases of COVID-19 within its correctional institutions at this time.
- FDC Community Corrections officers are working with offenders on supervision to adjust reporting schedules to minimize congregating at probation offices and prevent the spread of COVID-19.
- FDC's Office of Health Services coordinates with the Department for guidance on any type of outbreak and is closely monitoring new information as it is disseminated from the Department and the CDC.
- FDC has suspended visitation at all correctional institutions statewide through April 5, 2020. The decision to reinstate the normal visitation schedule will be evaluated in consultation with the Department.
    - Inmates will continue to have access to mail, email, phone calls and video visitation.
    - Legal visits will not be impacted.
    - FDC has partnered with vendors to provide some complimentary phone and video visitation services.
- Anyone entering a correctional institution will be screened, and entrance will be restricted if they:
    - Have traveled internationally or on a cruise within the last 14 days.
    - Have signs or symptoms of a respiratory infection such as fever, cough or shortness of breath.
    - Have had contact with someone who has been or is under investigation for COVID-19.
- All non-critical inmate transfers have been suspended.
- FDC has a plan in place and dedicated staff members trained in the prevention and containment of infectious diseases.
- FDC initiated its Incident Command System in response to COVID-19.
- Education has been provided to staff, inmates and visitors to prevent the spread of any infectious disease, including COVID-19.
- Precautions are in place at facilities to protect inmates and staff from exposure to flu, COVID-19 or any other respiratory illness; preventative measures are being followed per CDC recommendations.

FLORIDA DEPARTMENT OF STATE

- The Division of Elections offers a toll-free Voter Assistance Hotline, 1.866.308.6739 (in English and Español), available Monday - Friday, 8:00 am - 5:00 pm ET, with extended hours during statewide elections. For hearing or speech impaired, please contact the Division using the Florida Relay Service, 1.800.955.8771 (TDD), 1.800.955.8770 (Voice), or 1.877.955.8773 (Español). Voters can also contact their local Supervisor of Elections
- The Florida Department of State is in constant communication with Supervisors of Elections regarding Tuesday's Presidential Preference Primary Election and is providing guidance and information to voters through traditional and social media messages:
- The Florida Department of State been informing voters of the various options Florida provides in order to cast their ballot ahead of Tuesday's election and on Election Day. Further, we have assured Florida's voters that otherwise healthy poll workers can work on Election Day. DOS has notified voters who have been ordered to self-isolate or who are experiencing symptoms of COVID-19 and who have not yet voted, of the option to have someone pick up their ballot for them.
    - As with any election, before a voter goes to the polls on Tuesday, they should check with their local Supervisor of Elections. Now more than ever, it is critical that we continue to provide voters with clear and consistent information regarding polling place locations. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be on the voter's respective **Supervisor of Elections website**.
    - The Division of Elections website provides prominent placement of the Voter Information Lookup where voters can check their voter status and find their polling place information. This polling place information is linked to the voters' respective Supervisor of Elections database. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be from the voter's respective **Supervisor of Elections.**
- The Florida Department of State continues to support and work with local Supervisors of Elections and Emergency Management officials to ensure the Supervisors needs are met regarding sanitization and cleaning needs for the Presidential Preference Primary Election on Tuesday.

FLORIDA DEPARTMENT OF TRANSPORTATION

- FDOT is coordinating with other state and local agencies to help ensure mobility around the temporary testing site in Broward County. Once the site is open, FDOT plans to publicize testing site information on highway advisory radio.
- FDOT completed a request to provide necessary supplies to harbor pilots working at seaports.
- At the direction of Governor DeSantis, Florida Department of Transportation (FDOT) Secretary Kevin J. Thibault, along with Surgeon General Dr. Scott Rivkees, hosted a conference call with all Florida ports and their governing bodies as well as all public use airports to discuss Florida's ongoing response to the COVID-19 virus.
- FDOT Secretary Thibault and staff from the department will host weekly conference calls with all passenger seaports and public use airports to provide updates related to COVID-19.
- FDOT is monitoring temporary lane closures near hospitals and Department of Health facilities. If congestion near these facilities and lane closures occur, FDOT will remove lane restrictions to help ensure mobility within the area.
- Pursuant to Executive Order 20-52 issued by Governor DeSantis, FDOT Secretary Thibault has suspended size and weight restrictions for divisible loads on any vehicles transporting emergency equipment, services, supplies, and necessary agricultural commodities on state roads.
- COVID-19 educational materials have been posted in FDOT facilities, which include welcome centers, service plazas and rest areas across the state.
- COVID-19 materials have been posted at all FDOT work sites across the state to help educate contractors, vendors, and stakeholders.
- FDOT toll collectors have been given additional training and are required to wear gloves as well as continue with enhanced cleansing.
- SunRail has posted COVID-19 educational materials inside all trains and on all platforms, focusing on areas near entrances and bathrooms.
- SunRail trains are being cleaned and sanitized daily and SunRail staff have been provided sanitizing towelettes and encouraged to wash their hands frequently throughout the day.

FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

- At the direction of Governor Ron DeSantis, Florida Department of Highway Safety and Motor Vehicles Executive Director Terry L. Rhodes has issued an Emergency Order extending all Florida driver licenses and identification cards that will expire in the next 30 days.
- Pursuant to Executive Order 20-52, FLHSMV Executive Director Rhodes waived commercial truck hours of service regulations and other related regulations so that emergency supplies, equipment, commodities and resources can be moved more quickly and efficiently throughout the state.
- FLHSMV continues to encourage Floridians through social media and other channels to use convenient online options, rather than visiting an

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office location, to complete transactions for driver licenses, ID cards, motor vehicle or vessel registrations, and more.
- FLHSMV has been in regular communication with the Florida Tax Collectors Association as well as Tax Collectors across the state to provide the latest COVID-19 information and guidance from the Florida Department of Health and other state partners.

DEPARTMENT OF ECONOMIC OPPORTUNITY

- Governor DeSantis has requested the federal Small Business Administration (SBA) make the Economic Injury Disaster Loan program available for Florida's small businesses impacted by COVID-19. The Florida Department of Economic Opportunity (DEO) stands ready to assist Florida's small businesses in accessing this funding when available.
- Governor Ron DeSantis has activated the Business Damage Assessment survey to assess the impact of COVID-19 on Florida's local business operations. The survey, managed by DEO, will evaluate businesses affected by COVID-19 and the impacts the virus has had on the local economy so actions to implement appropriate relief programs can begin. The survey can be taken online at https://floridadisaster.biz/.

VISIT FLORIDA

- VISIT FLORIDA is wholly focused on providing health and safety information to travelers and Floridians. This includes the activation of Florida Now, which includes the latest updates from state emergency response professionals hosted on VisitFlorida.com.
- VISIT FLORIDA is planning for future marketing campaigns to ensure that Florida's tourism industry has a strong, unified voice following COVID-19
- To protect the health and safety of the traveling public and staff, VISIT FLORIDA's four welcome centers will be closed until further notice.
- VISIT FLORIDA is tracking traveler sentiment across online platforms and social media to monitor how COVID-19 may impact travel and travel booking to Florida.
- VISIT FLORIDA remains in close contact with industry partners and travel organizations and is communicating all new information as it becomes available.

DEPARTMENT OF REVENUE

- The Department of Revenue is advising child support customers who are scheduled for court hearings related to their child support cases to check with the local courts where the hearings are scheduled in case the courts have new requirements, such as appearing telephonically.
- The Department of Revenue's Child Support Program is working to reduce when customers are required to visit a local child support office and is providing new connect/customer service options.
- Efforts include rescheduling genetic testing sample collection appointments and postponing other types of appointments. The Program will soon be implementing the ability for parents to enter into written agreements over the phone, and the Program will be providing new fax, email and form drop-off processes.
- The Department of Revenue's General Tax Administration (GTA) program is working with its tax processing vendor to ensure continuity in tax data and payment processing.
- GTA is closely monitoring any future guidance issued by the Internal Revenue Service for potential corporate income tax due date extensions.
- The Department has increased messaging on preventative measures through the deployment of DOH/CDC posters, ensured hand sanitizer is available, and increased cleaning of high-traffic areas in our public areas of our service centers.

OFFICE OF INSURANCE REGULATION

- The Office of Insurance Regulation (OIR) Insurance Commissioner David Altmaier is actively engaged with insurers and key partners at the state and national level regarding COVID-19. Commissioner Altmaier is collaborating with other state insurance commissioners and the National Association of Insurance Commissioners to share information and resources.
- OIR has issued Informational Memorandum OIR-20-01M to all health insurers and health maintenance organizations, directing them to:
  - Use every channel available to them to communicate with their policyholders and share official CDC and Department of Health information;
  - Devote resources to inform consumers of available benefits, quickly respond to inquiries, and avoid and dispel misinformation;
  - Work with public health officials to do everything possible to prepare and respond; and
  - Consider all practicable options to reduce the barriers of cost-sharing for testing and treatment of COVID-19.
- OIR is reaching out to insurers regarding their response to COVID-19 and working with insurers to make sure they are properly communicating to consumers.
- OIR has activated its incident management team and has met to review disaster response procedures.
- OIR has issued Informational Memorandum OIR-20-02M as a reminder to all health insurers, health maintenance organizations and other health entities to allow for early prescription refills following the Governor's Executive Order 20-52 declaring a state of emergency in Florida.
- OIR has spoken with multiple insurers who are voluntarily waiving cost-sharing for consumers in an effort to remove barriers to testing for COVID-19.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

- Florida Department of Law Enforcement (FDLE) is working with state and local agencies and the Florida National Guard to set up testing collection sites in multiple locations across Florida.

- The Florida Department of Law Enforcement (FDLE) Regional Operations Centers are working with Regional Domestic Security Task Forces to prepare for any responses needed.

- FDLE's Office of Mutual Aid prepared and distributed a law enforcement guide on COVID-19 for law enforcement partners and state agencies and FDLE's General Counsel prepared a law enforcement guide for protocols in a quarantine.

- FDLE Commissioner Rick Swearingen sent an email to all members outlining simple ways to prevent the spread of COVID-19 as well as links to the Florida Department of Health and CDC websites. Signs have been posted in all FDLE Regions and at Headquarters with prevention information.

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

- The Florida Department of Juvenile Justice's Office of Health Services developed COVID-19 guidance for all facilities serving DJJ youth. This guidance included Center for Disease Control criteria on how to assess and care for youth who are exhibiting fever and respiratory symptoms and environmental cleaning and disinfection recommendations.

- The Florida Department of Juvenile Justice has modified screening protocols and procedures for youth taken into custody by law enforcement who are brought to juvenile assessment centers and detention screening units to now include precautionary coronavirus screening questions and protocols. This modified screening protocol was shared with law enforcement partners statewide.

- The Florida Department of Juvenile Justice has developed a visitor screening tool which is now mandatory to use inside of our juvenile detention centers and residential commitment programs to ensure both the safety of the youth and staff in these programs. The

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Florida Department of Juvenile Justice has sent a notice to parents and guardians of youth in programs regarding the new visitor screening requirements.

- The Florida Department of Juvenile Justice has instituted additional screening measures for outside vendors who work within juvenile facilities and non-essential travel of staff members has been stopped. Visitors are limited to business-related visitors only (i.e., vendors, no personal visitors, no volunteers at this time). The department will work with these entities on alternatives to visiting programs to ensure critical services are not interrupted. Clinical personnel, however, are still permitted to visit youth for treatment purposes, and attorneys are still permitted to conduct legal visits with youth.

FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

- Governor DeSantis directed all agencies to suspend for 30 days licensing and registration renewal requirements for existing processional licenses (e.g. realtors).
- Governor DeSantis has directed the Department of Business and Professional Regulation Secretary Halsey Beshears, in coordination with the Florida Department of Health, to issue social distancing guidance to restaurants and bars.
- Governor DeSantis sent a letter to the federal Small Business Administration to turn on the SBA loan program for small businesses.
- The Florida Department of Business and Professional Regulation (DBPR) has suspended all official business visits, including inspections, that involve licenses located at a facility covered under the visitation restrictions implemented pursuant to FDEM Emergency Order 20-002.
- DBPR is incorporating informational comments on all on-site inspection reports issued to public lodging, public food service, and alcohol and tobacco license holders that will promote situational awareness of the current public health emergency and will direct parties to the FDOH COVID-19 webpage for guidance and resources related to prevention best practices. Copies of informational flyers from the FDOH COVID-19 toolkit will also be available for inspectors to distribute when interacting with managers of these premises.

FLORIDA DEPARTMENT OF MANAGEMENT SERVICES

- Governor DeSantis directed the Department of Management Services Secretary Jonathan Satter to allow state employees to donate and transfer their available leave time to other state employees to mitigate the impacts of school closures.
- The Florida Department of Management Services' (DMS) Emergency Support Function-7 (ESF-7) Logistics team continues to coordinate with the Department of Health and the Division of Emergency Management on identifying the equipment or supplies that may be necessary for a mass response to COVID-19.
- DMS' Division of Human Resource Management has provided guidance to agencies on implementing preventive actions in the workplace, reporting symptoms, using leave, utilizing health insurance benefits, and applying travel restrictions and telework policies.
- DMS' Division of State Group Insurance continues to coordinate with health plan providers to ensure that state employee health plan members receive the health benefits that can assist them and their dependents if needed.
- DMS' Division of Real Estate Development and Management (REDM) continues to provide guidance to agency facility managers across the state on steps to take to prevent workplace contamination and to pre-position environmental vendors to mobilize in the event a viricidal cleaning is needed.
- DMS' Division of Real Estate Development and Management continues to identify, purchase, and distribute additional hand sanitizing gel and cleaning supplies to state-maintained facilities.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with users and vendor of the Statewide Law Enforcement Radio System (SLERS) vendors to ensure the continuation of mission critical services if a reduction of staffing resources occurs.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with statewide public safety communications personnel on their plans to ensure emergency communications systems are not impacted by potential reductions in staffing resources.

FLORIDA DEPARTMENT OF ENVIRONMENTAL PROTECTION

- All State Parks have adjusted their operating hours to 8 a.m. to 5 p.m. daily. The Department continues to monitor new developments closely and will make further adjustments as necessary based on any new Department of Health or CDC guidance received to ensure protection of our staff and visitors. For the latest information on park operating hours and operational status, please visit floridastateparks.org.
- Currently all Florida State Parks and campgrounds, and Office of Resilience and Coastal Protection facilities (aquatic preserves and National Estuarine Research Reserves), remain open to the public. However, in an abundance of caution and consistent with Center for Disease Control and Prevention (CDC) guidance, DEP announced on March 13 that it is cancelling all events and activities at these facilities effective immediately and until further notice.
  - This includes DEP events and includes activities such as tours and visitor centers that involve large groups and/or or people in close proximity to others. People with questions regarding any privately scheduled event should check with the host of the event or the facility directly. For the latest closure and cancellation information, please visit floridastateparks.org.
- If your travel plans have changed and you need to modify camping or cabin reservations, please visit ReserveAmerica.com, call Reserve America at 1-800-326-3521 or TDD 888-433-0287 or text to 904-204-3216.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

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Subject: Fwd: FW: The State of Florida Issues Updates on COVID-19

Date: Tuesday, March 17, 2020 11:03:08 AM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 17, 2020 at 7:28 AM
Subject: FW: The State of Florida Issues Updates on COVID-19
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Mission: “To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

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From: CHD17, PIO <PIO.CHD17@flhealth.gov>
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Subject: The State of Florida Issues Updates on COVID-19

Banner

FOR IMMEDIATE RELEASE March 16, 2020

Contact: Joint Information Center on COVID-19 for the State of Florida (850) 815-4940, ESF14@em.myflorida.com

The State of Florida Issues Updates on COVID-19

TALLAHASSEE, Fla. — The State of Florida is responding to COVID-19. In an effort to keep Florida residents and visitors safe and aware regarding the status of the virus, the Florida Department of Health will issue this update every day, seven days per week.

Governor Ron DeSantis is in constant communication with Florida Division of Emergency Management Director Jared Moskowitz and State Surgeon General Dr. Scott Rivkees as the State of Florida continues to monitor and respond to the threat of COVID-19.

Today, in a briefing at the State Emergency Operations Center, Governor DeSantis announced the following:

- Governor DeSantis announced he is going to supplement federal Small Business Administration (SBA) loans. The Governor activated the Florida Small Business Emergency Loan Program. Up to $50 million has been allocated for the program.
- Governor Ron DeSantis directed the Department of Revenue to provide flexibility on the deadlines of taxes due such as corporate income tax and sales tax to assist businesses that are adversely impacted from COVID-19 mitigation measures.
- Floridians throughout the state are lending a hand to stop the spread of COVID-19:
  - Members of the Florida House of Representatives have been activated to their National Guard units**,**
  - The Players Championship donated thousands of pounds of food to Feeding Northeast Florida**,**
  - Miami-Dade County school administrators are handing out computers and mobile devices, and
  - Comcast agreed to provide free WiFi for the next 60 days to kids who do not have it.

- The Miami Dolphins, Jacksonville Jaguars and the Orange County Convention Center have agreed to open their parking lots to stage supplies and locate testing sites.
- Restaurants throughout the state including Jimmy John’s in Tallahassee and Toasted Restaurant in Orange County are providing children with free lunch throughout the week.
- Drive through testing sites are expected to open, throughout the state, in addition to the first proposed state site at Memorial Healthcare System in Broward. So far, sites are being developed in in Myers, Pensacola, West Palm Beach and Tallahassee.
- The Floridians who were at held at the Dobbins Air Reserve Base are on their way back to Florida; 15 Floridians have elected to stay at the base to care for their family members.
- On March 9, Governor DeSantis issued Executive Order 20-52, declaring a State of Emergency for COVID-19. By declaring a State of

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Emergency, Governor DeSantis is ensuring that state and local governments have the resources and flexibility they need to prepare and respond.

More Information on COVID-19

To find the most up-to-date information and guidance on COVID-19, please visit the Department of Health's dedicated COVID-19 webpage. For information and advisories from the Centers for Disease Control (CDC), please visit the CDC COVID-19 website. For more information about current travel advisories issued by the U.S. Department of State, please visit the travel advisory website.

For any other questions related to COVID-19 in Florida, please contact the Department's dedicated COVID-19 Call Center by calling **(866) 779-6121. The Call Center is available 24 hours per day**. Inquiries may also be emailed to **COVID-19@flhealth.gov.**

What you Should Know

COVID-19 can spread from person to person through small droplets from the nose or mouth, including when an individual coughs or sneezes. These droplets may land on objects and surfaces. Other people may contract COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth.

Symptoms of COVID-19 are fever, cough and shortness of breath. Symptoms may appear in as few as two days or as many as 14 days following exposure. Most people recover from COVID-19 without needing special treatment. The elderly and those with underlying medical problems like high blood pressure, heart problems and diabetes are more likely to develop serious illness.

There is currently no vaccine to prevent COVID-19. The best way to prevent illness is to avoid being exposed to the virus. The Department recommends everyday preventive actions to help stop the spread of respiratory diseases, including:

- Avoiding close contact with people who are sick;
- Staying home when you are sick and avoiding contact with persons in poor health;
- Avoiding touching your eyes, nose and mouth with unwashed hands;
- Covering your cough or sneezing into a tissue, then disposing of the tissue;
- Washing your hands often with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, after blowing your nose, coughing or sneezing;
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty; and
- Cleaning and disinfecting frequently touched objects and surfaces using a regular household cleaning spray or wipe.

The CDC does not recommend that asymptomatic, healthy people wear a facemask to protect themselves from respiratory diseases, including COVID-19. Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for health workers and people who are taking care of someone in close settings (at home or in a health care facility).
A person that experiences a fever and symptoms of respiratory illness, such as fever, cough or shortness of breath, within 14 days after travel from any other destination with community transmission should call ahead to their health care provider and local CHD and mention their recent travel or close contact.

If a person has had close contact with someone showing these symptoms who has recently traveled from this area or been in contact with a person with laboratory-confirmed COVID-19, he or she should call ahead to a health care professional and the CHD. The health care provider will work with the Department to determine if the person should be tested for COVID-19.

Actions the state has taken to prepare for and respond to COVID-19:

DEPARTMENT OF HEALTH

- At the direction of Governor DeSantis, State Surgeon General Dr. Scott Rivkees declared a Public Health Emergency for COVID-19 in Florida.
- Governor DeSantis announced that the State ordered an additional 2,500 test kits to supplement the adequate resources already available to test for COVID-19. These additional test kits will enable the Department of Health, working with Florida health care providers, to test up to an additional 625,000 individuals. The Governor also suspended non-essential in state and all out-of-state travel for state employees for 30 days.
- Established an Incident Management Team to coordinate response operations.
- Defined a high-level phased response strategy for COVID-19.
- Activated a dedicated incident command post for on-site response activities.
- Conducted three public health and health care stakeholder conference calls to provide statewide updates on the current outbreak situation, response actions and guidance for pandemic planning. Over five hundred participants joined the calls.
- Established a public call center for questions regarding COVID-19. The call center launched Monday, March 2.
- Developed and distributed COVID-19 presentation materials to County Health Departments (CHD) for use at community meetings.
- Activated the Joint Information Center in coordination with the Division of Emergency Management.
- Developed and implemented protocols for investigation, surveillance and monitoring for COVID-19 to rapidly detect and contain cases.
- Established mechanisms for monitoring and coordination with the Centers for Disease Control and Prevention (CDC) regarding epidemiological activities.
- Distributed CDC Interim Guidance for public health personnel evaluating Persons Under Investigation (PUI) and asymptomatic close contacts of confirmed cases at their home or non-home residential settings to CHDs.
- Approved and disseminated an updated Clinician Screening Tool for identifying COVID-19 PUIs.
- Distributed a health care provider letter regarding enhanced surveillance and preparedness for COVID-19 to associations, licensed providers, Health Care Coalitions and CHDs.
- Implemented testing at all three State Public Health Laboratories.
- Distributed updated CDC guidance for schools to CHDs and the Department of Education.
- Distributed updated laboratory guidance regarding implementation of testing at State Public Health Laboratories.
- Developing a laboratory surge plan.
- Developing a clinician-level briefing for medical audiences.
- Identifying and monitoring close contacts of presumptive cases. Any close contacts with symptoms will be tested.
- Implemented private lab testing.
- Developed and disseminated pandemic planning guidance.
- Advised CHDs and HCCs to retain expired personal protective equipment until further until further notice.
- Continued development of public information resources.
- Developing infographics for first responders (fire, law enforcement and EMS) regarding infection control and personal protection for COVID-19.
- At the Governor's direction, a public-private partnership has been put in place between Memorial Healthcare in Broward and the National

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Guard to set up a mobile testing unit.
- At the direction of Governor DeSantis hiring additional epidemiologists from university health programs to help with workload.
- Governor DeSantis directed the Agency for Health Care Administration (AHCA) to extend all existing nursing home and assisted living facility licenses for 90 days to remove distraction from patient care.

AGENCY FOR HEALTH CARE ADMINISTRATION

- AHCA distributed a provider alert to licensed health care providers regarding the Division of Emergency Management's new Emergency Order tightening visitation restrictions at residential and long-term care facilities.
- AHCA, in coordination with the DEM and the Department, is hosting ongoing statewide calls for nursing homes, assisted living facilities, intermediate care facilities, the Agency for Persons with Disabilities, group homes, and adult family care homes in conjunction with the Florida Health Care Association. Secretary Mayhew and Surgeon General Rivkees are continuing to address critical issues impacting these providers such as restricting visitors and providing updates.
- AHCA, in coordination with DEM and the Department, is hosting ongoing statewide calls for hospitals in conjunction with the Florida Hospital Association. Secretary Mayhew and Surgeon General Rivkees to provide the most up-to-date information to hospital partners and residential facilitates caring for aging and vulnerable populations.
- After previously opening an event on the Emergency Status System (ESS) for hospitals to enter census information, emergency room status updates and isolation beds, AHCA expanded the ESS event to track nursing homes and assisted living facility bed capacity, effective March 15.
- The Agency for Health Care Administration (AHCA) will be granting a 90-day extension to all licenses for health care providers and regulated facilities.
- AHCA is distributing information regarding regulatory flexibilities created by waivers from the Centers for Medicare and Medicaid Services (CMS) related to skilled nursing facilities, critical access hospitals, home health agencies, durable medical equipment, provider enrollment, etc.
- AHCA participated in a collaborative call with the Florida Health Care Association, Florida Hospital Association and LeadingAge Florida to discuss patient transfer arrangements between health care facilities such as nursing homes and hospitals.
- The Florida Medicaid Program announced coverage of commercial testing for COVID-19 for dates of service back to February 4.
- AHCA submitted requests to CMS for flexibility for Florida's program under the federal declaration of a state of emergency.

AGENCY FOR PERSONS WITH DISABILITIES

- The agency's three state-run centers in Marianna, Gainesville and Chattahoochee, as well as APD-licensed group homes, are restricting visitors in compliance with the Executive Order to protect the health and safety of our customers.
- APD Adult Day Training programs across the state are screening visitors for possible exposure to COVID-19 using a visitor questionnaire. The questionnaire is also being used to screen visitors coming into APD Regional Offices.
- APD continues to provide an up-to-date status on COVID-19, best practices, preventative tips, and CDC guidance to APD providers, Waiver Support Coordinators, Stakeholders and APD employees.

DEPARTMENT OF ELDER AFFAIRS

- The Department of Elder Affairs (DOEA), in coordination with the Administration for Community Living (ACL), facilitated a virtual Town Hall meeting at the request of Hallandale Beach Mayor Joy Cooper. More than 2,700 seniors were online for the meeting. Charlotte Mather Taylor, Executive Director of the Aging and Disability Resource Center (ADRC) of Broward County, led the discussion with participation from ACL Representative Constantino Miskos, Chen Senior Medical Center, and representatives from Emergency Medical Services. Their primary topics of conversation centered on the work being done, specifically by the Area Agency on Aging, to continue to provide people resources and services to maximize support during COVID-19.
- Through Departmental Leadership and the Area Agency on Aging contract managers, DOEA provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the safe delivery of home-delivered meals to prevent spread of respiratory infection.
- DOEA continues to provide updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, they are provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.
- "The Vision 2020: Looking Towards Your Age-Friendly Future Tour" to five communities across Florida originally planned for April 20th - April 24th and co-hosted by the Department and AARP has been postponed to protect the health and wellness of seniors, volunteers and staff.
- All Serving Health Insurance Needs of Elders (SHINE) participation in scheduled outreach events, presentations, and in-person SHINE/Senior Medicare Patrol (SMP) counseling has been suspended until further notice. SHINE volunteers and staff will continue to provide counseling services, but the services will be conducted over-the-phone with future considerations for the use of webinars and Facebook LIVE.
- DOEA Secretary Prudom held a conference call with The Comprehensive Assessment and Review for Long-term Care Services (CARES) supervisors to discuss the suspension of face-to-face assessments. CARES assessors will provide reviews through phone or tele-technology to reduce client/staff exposure and reduce spread.
- Through Departmental Leadership and the Area Agency on Aging contract managers, we provided ongoing technical assistance to the entire Aging Network regarding allowable flexibilities within programs to ensure continuity of services and the safety of elders. For example, we provided guidance to all Executive Directors regarding the provision on completing assessments for multiple program types, specifically for clients who have chosen to self-isolate.
- DOEA provided updated information on current closures and possible future temporary closures of specific services at Congregate Meal Sites, Senior Centers, and Adult Day Care Centers on our website homepage and all corresponding program pages. Clients are guided to contact the specific location for alternative services, provided the Area Agency on Aging helpline, and directed to the DOH website with any additional questions on COVID-19.

DEPARTMENT OF CHILDREN AND FAMILIES

- The Department of Children and Families' (DCF) Office of Child Welfare is sending regular communication about COVID-19 specifically to licensed child care providers, directing them to follow the CDC's Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19). An FAQ document for providers was also posted prominently on DCF's Child Care webpage.
- DCF's Office of Child Welfare is disseminating a survey to licensed child care providers to assess closures throughout the state. Currently, the decision to close is at the discretion of each individual facility.
- DCF Secretary Chad Poppell sent thorough communication to all DCF staff, contracted partners, and licensed facilities (including child care providers) about COVID-19, including precautionary measures (as outlined by the CDC) and temporary policy updates.
- DCF is working with AHCA, DOEA, and APD to compile and develop guidance for agency staff and stakeholders who work directly with Florida's elderly population and have a higher risk of being exposed to COVID-19.
- DCF is leading status update calls with both internal leadership and leadership from external contracted partners. For the time being, these calls will take place twice weekly, every Tuesday and Friday.

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- DCF General Services staff throughout the state are working with lessors and janitorial contractors to increase sanitizing measures in office buildings, especially restrooms and common areas. They also began taking inventory of sanitizing supplies (disinfecting wipes, Lysol spray, hand-sanitizer, etc.) and are ordering more as needed.
- DCF established strategies for COVID-19 prevention at all three state mental health treatment facilities, as well as the South Florida mental health facilities run by Wellpath Recovery Solutions, a contracted partner. They are reporting daily updates to ensure compliance with virus prevention and monitor potential outbreaks.
- DCF has established a visitation protocol for all state-owned and contracted mental health treatment facilities, as well as vendors and patient families, requiring all outside parties to complete a Visitors Viral Symptoms Screening prior to entering a facility. At this time, there are no cases of patients or facility staff testing positive for COVID-19.
- DCF's Office of Economic Self-Sufficiency is communicating with DEO regarding work requirements and CareerSource operations and availability.
- DCF's Office of Economic Self-Sufficiency implemented screening procedures, including a set of questions that must be asked prior to entry, at all economic self-sufficiency storefronts.

FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

- Effective March 11, 2020, FDVA is restricting visitor access to its State Veterans' Nursing Homes and Domiciliary until further notice, with the exception of essential visitors, such as family members of those residents undergoing end-of-life care.
- The U.S. Department of Veterans Affairs (VA) has also temporarily restricted access to their nursing and community living center facilities to only essential visitors until further notice.
- All VA Medical Centers in Florida are implementing enhanced screening protocols at their facilities. VA Outpatient Clinics are also implementing enhanced screening protocols. Please plan to arrive at the facility well in advance of your appointment to allow additional time for the screening process.
- Veterans who are concerned they may have symptoms of Coronavirus (COVID-19) are encouraged to contact the VISN 8 Clinical Contact Center at 1-877-741-3400 (toll free). Clinical staff provide 24/7 virtual care and support, including nurse advice and triage. The service is available at no cost to veterans enrolled for care in the VA Sunshine Healthcare Network (VISN 8).
- All FDVA and VA facilities remain fully operational.

DEPARTMENT OF MILITARY AFFAIRS

- There have been over 200 Florida National Guardsmen placed on state active duty in support of COVID-19.
- The Florida National Guard is activating all of their medical professionals (Army Combat medic specialists and Air Force medical technicians) to support Florida Department of Health's drive-through screening operations. Guardsmen have reported in and formed Task Force Medical already.
- The Florida National Guard has activated soldiers to augment the State Logistics Readiness Center in Central Florida.

VOLUNTEER FLORIDA

- Volunteer Florida is working with state counterparts and FEMA to develop volunteer plans.
- Volunteer Florida's National Service Department has discussed using AmeriCorps members in food banks as feeding needs increase.
- Volunteer Florida is having conversations with Mass Care on the anticipated needs of volunteers. Together, we are working on a plan for volunteers with volunteer safety guidelines to ensure that we are protecting our service providers (volunteers and clients).
- Volunteer Florida has asked all Voluntary Organizations Active in Disaster (VOAD) partners to review their continuity of operations so that there is no service delivery disruption.

FLORIDA DEPARTMENT OF EDUCATION

- Commissioner of the Florida Department of Education (FDOE) Richard Corcoran provided strong recommendations for extending spring break following Centers for Disease Control and Prevention (CDC) issuing guidance specific to COVID-19 in Florida. As all Florida school districts and public charter schools have different schedules, please click here to see the recommended spring break changes for each district. In addition, the department also announced that the start of state testing will be delayed by a minimum of two weeks. To stay up to date on school closure information, visit: org/em-response.
- FDOE sent updated guidance to school districts and superintendents ahead of spring break. To view that memo, visit: fldoe.org/em-response.
- In an effort to be proactive, and only as a precautionary measure if COVID-19 evolves in Florida, Florida Virtual School (FLVS) has partnered with the Florida Department of Education to offer all school districts student support and teacher professional development tailored to the online learning environment. The Florida Department of Education in partnership with FLVS is training an additional 10,000 teachers statewide on the Virtual Teacher Training for COVID-19. Superintendents who are interested in offering their teachers the Virtual Teacher Training for COVID-19 should work with their County Virtual Principals to provide a list of teachers to FLVS through: https://www.flvs.net/FLVSTeacherTraining.
- Education Commissioner Corcoran is in constant communication with Florida Superintendents and districts to provide guidance on COVID-19 preparedness and response and will be holding weekly calls to update districts on preparation efforts.
- FDOE has sent weekly memos providing updates to school districts, superintendents, Florida Colleges, parents, teachers and stakeholders.
- FDOE launched a survey to school districts and public charter schools about their preparations, policies, and their capacity to serve their students virtually to help meet and determine any preparedness needs.

STATE UNIVERSITY SYSTEM

- The State University System will continue to evaluate the effectiveness of remote learning and the need to teach remotely in order to protect our students and the university community.
- The State University System will continue to work with the Florida Department of Health and the Emergency Operations Center to determine if the initial two weeks of remote learning is sufficient.
- Effective immediately, all universities will make plans to transition to remote instruction as soon as possible.
- State universities with students who have returned from spring break, which includes Florida Gulf Coast University, Florida International University, Florida Polytechnic University, and the University of Florida, should implement a process to transition to remote instruction immediately and encourage students to return home for at least 2 weeks. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- State universities with students who are currently on spring break or about to be on break should direct their students to NOT return to campus for at least 2 weeks following the conclusion of spring break. This includes students at Florida Agricultural and Mechanical University, Florida Atlantic University, Florida State University, New College of Florida, the University of North Florida, the University of Central Florida, the University of South Florida, and the University of West Florida. Each university will provide detailed information to their students, faculty, and staff at the earliest possible time regarding this transition.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- All universities will continue to provide essential services, such as dining, counseling, health services, library services, etc., potentially on a limited basis or remotely. Each university with clinical and other non-classroom based programs will communicate directly with those students.
- RESIDENTIAL HOUSING - While students are encouraged to remain off-campus, each university should develop a plan for providing

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residential accommodations for students who need assistance or must remain in place.

- All state universities have implemented campus-wide critical incident or emergency management teams that are meeting regularly to prepare for the impacts of the COVID-19 virus.
- All universities are preparing to transition to remote instructional delivery for a two-week period during March and early April, depending on each institution's Spring Break, and are informing students not to return to campus during this period.
- The Board of Governors will be conducting its March meeting via conference call and will not have a face-to-face meeting at USF as was originally scheduled.
- For more information visit: https://www.flbog.edu/2020/03/11/state-university-system-statement-on-covid-19/.

FLORIDA DEPARTMENT OF CORRECTIONS

- Florida Department of Corrections (FDC) has no known or suspected cases of COVID-19 within its correctional institutions at this time.
- FDC Community Corrections officers are working with offenders on supervision to adjust reporting schedules to minimize congregating at probation offices and prevent the spread of COVID-19.
- FDC's Office of Health Services coordinates with the Department for guidance on any type of outbreak and is closely monitoring new information as it is disseminated from the Department and the CDC.
- FDC has suspended visitation at all correctional institutions statewide through April 5, 2020. The decision to reinstate the normal visitation schedule will be evaluated in consultation with the Department.
    - Inmates will continue to have access to mail, email, phone calls and video visitation.
    - Legal visits will not be impacted.
    - FDC has partnered with vendors to provide some complimentary phone and video visitation services.
- Anyone entering a correctional institution will be screened, and entrance will be restricted if they:
    - Have traveled internationally or on a cruise within the last 14 days.
    - Have signs or symptoms of a respiratory infection such as fever, cough or shortness of breath.
    - Have had contact with someone who has been or is under investigation for COVID-19.
- All non-critical inmate transfers have been suspended.
- FDC has a plan in place and dedicated staff members trained in the prevention and containment of infectious diseases.
- FDC initiated its Incident Command System in response to COVID-19.
- Education has been provided to staff, inmates and visitors to prevent the spread of any infectious disease, including COVID-19.
- Precautions are in place at facilities to protect inmates and staff from exposure to flu, COVID-19 or any other respiratory illness; preventative measures are being followed per CDC recommendations.

FLORIDA DEPARTMENT OF STATE

- The Division of Elections offers a toll-free Voter Assistance Hotline, 1.866.308.6739 (in English and Español), available Monday - Friday, 8:00 am - 5:00 pm ET, with extended hours during statewide elections. For hearing or speech impaired, please contact the Division using the Florida Relay Service, 1.800.955.8771 (TDD), 1.800.955.8770 (Voice), or 1.877.955.8773 (Español). Voters can also contact their local Supervisor of Elections
- The Florida Department of State is in constant communication with Supervisors of Elections regarding Tuesday's Presidential Preference Primary Election and is providing guidance and information to voters through traditional and social media messages:
- The Florida Department of State been informing voters of the various options Florida provides in order to cast their ballot ahead of Tuesday's election and on Election Day. Further, we have assured Florida's voters that otherwise healthy poll workers can work on Election Day. DOS has notified voters who have been ordered to self-isolate or who are experiencing symptoms of COVID-19 and who have not yet voted, of the option to have someone pick up their ballot for them.
    - As with any election, before a voter goes to the polls on Tuesday, they should check with their local Supervisor of Elections. Now more than ever, it is critical that we continue to provide voters with clear and consistent information regarding polling place locations. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be on the voter's respective **Supervisor of Elections website**.
    - The Division of Elections website provides prominent placement of the Voter Information Lookup where voters can check their voter status and find their polling place information. This polling place information is linked to the voters' respective Supervisor of Elections database. The most current and up-to-date polling place information (per 71, Florida Statutes) is going to be from the voter's respective **Supervisor of Elections.**
- The Florida Department of State continues to support and work with local Supervisors of Elections and Emergency Management officials to ensure the Supervisors needs are met regarding sanitization and cleaning needs for the Presidential Preference Primary Election on Tuesday.

FLORIDA DEPARTMENT OF TRANSPORTATION

- FDOT is coordinating with other state and local agencies to help ensure mobility around the temporary testing site in Broward County. Once the site is open, FDOT plans to publicize testing site information on highway advisory radio.
- FDOT completed a request to provide necessary supplies to harbor pilots working at seaports.
- At the direction of Governor DeSantis, Florida Department of Transportation (FDOT) Secretary Kevin J. Thibault, along with Surgeon General Dr. Scott Rivkees, hosted a conference call with all Florida ports and their governing bodies as well as all public use airports to discuss Florida's ongoing response to the COVID-19 virus.
- FDOT Secretary Thibault and staff from the department will host weekly conference calls with all passenger seaports and public use airports to provide updates related to COVID-19.
- FDOT is monitoring temporary lane closures near hospitals and Department of Health facilities. If congestion near these facilities and lane closures occur, FDOT will remove lane restrictions to help ensure mobility within the area.
- Pursuant to Executive Order 20-52 issued by Governor DeSantis, FDOT Secretary Thibault has suspended size and weight restrictions for divisible loads on any vehicles transporting emergency equipment, services, supplies, and necessary agricultural commodities on state roads.
- COVID-19 educational materials have been posted in FDOT facilities, which include welcome centers, service plazas and rest areas across the state.
- COVID-19 materials have been posted at all FDOT work sites across the state to help educate contractors, vendors, and stakeholders.
- FDOT toll collectors have been given additional training and are required to wear gloves as well as continue with enhanced cleansing.
- SunRail has posted COVID-19 educational materials inside all trains and on all platforms, focusing on areas near entrances and bathrooms.
- SunRail trains are being cleaned and sanitized daily and SunRail staff have been provided sanitizing towelettes and encouraged to wash their hands frequently throughout the day.

FLORIDA DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

- At the direction of Governor Ron DeSantis, Florida Department of Highway Safety and Motor Vehicles Executive Director Terry L. Rhodes has issued an Emergency Order extending all Florida driver licenses and identification cards that will expire in the next 30 days.
- Pursuant to Executive Order 20-52, FLHSMV Executive Director Rhodes waived commercial truck hours of service regulations and other related regulations so that emergency supplies, equipment, commodities and resources can be moved more quickly and efficiently throughout the state.
- FLHSMV continues to encourage Floridians through social media and other channels to use convenient online options, rather than visiting an

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office location, to complete transactions for driver licenses, ID cards, motor vehicle or vessel registrations, and more.
- FLHSMV has been in regular communication with the Florida Tax Collectors Association as well as Tax Collectors across the state to provide the latest COVID-19 information and guidance from the Florida Department of Health and other state partners.

DEPARTMENT OF ECONOMIC OPPORTUNITY

- Governor DeSantis has requested the federal Small Business Administration (SBA) make the Economic Injury Disaster Loan program available for Florida's small businesses impacted by COVID-19. The Florida Department of Economic Opportunity (DEO) stands ready to assist Florida's small businesses in accessing this funding when available.
- Governor Ron DeSantis has activated the Business Damage Assessment survey to assess the impact of COVID-19 on Florida's local business operations. The survey, managed by DEO, will evaluate businesses affected by COVID-19 and the impacts the virus has had on the local economy so actions to implement appropriate relief programs can begin. The survey can be taken online at https://floridadisaster.biz/.

VISIT FLORIDA

- VISIT FLORIDA is wholly focused on providing health and safety information to travelers and Floridians. This includes the activation of Florida Now, which includes the latest updates from state emergency response professionals hosted on VisitFlorida.com.
- VISIT FLORIDA is planning for future marketing campaigns to ensure that Florida's tourism industry has a strong, unified voice following COVID-19
- To protect the health and safety of the traveling public and staff, VISIT FLORIDA's four welcome centers will be closed until further notice.
- VISIT FLORIDA is tracking traveler sentiment across online platforms and social media to monitor how COVID-19 may impact travel and travel booking to Florida.
- VISIT FLORIDA remains in close contact with industry partners and travel organizations and is communicating all new information as it becomes available.

DEPARTMENT OF REVENUE

- The Department of Revenue is advising child support customers who are scheduled for court hearings related to their child support cases to check with the local courts where the hearings are scheduled in case the courts have new requirements, such as appearing telephonically.
- The Department of Revenue's Child Support Program is working to reduce when customers are required to visit a local child support office and is providing new connect/customer service options.
- Efforts include rescheduling genetic testing sample collection appointments and postponing other types of appointments. The Program will soon be implementing the ability for parents to enter into written agreements over the phone, and the Program will be providing new fax, email and form drop-off processes.
- The Department of Revenue's General Tax Administration (GTA) program is working with its tax processing vendor to ensure continuity in tax data and payment processing.
- GTA is closely monitoring any future guidance issued by the Internal Revenue Service for potential corporate income tax due date extensions.
- The Department has increased messaging on preventative measures through the deployment of DOH/CDC posters, ensured hand sanitizer is available, and increased cleaning of high-traffic areas in our public areas of our service centers.

OFFICE OF INSURANCE REGULATION

- The Office of Insurance Regulation (OIR) Insurance Commissioner David Altmaier is actively engaged with insurers and key partners at the state and national level regarding COVID-19. Commissioner Altmaier is collaborating with other state insurance commissioners and the National Association of Insurance Commissioners to share information and resources.
- OIR has issued Informational Memorandum OIR-20-01M to all health insurers and health maintenance organizations, directing them to:
  - Use every channel available to them to communicate with their policyholders and share official CDC and Department of Health information;
  - Devote resources to inform consumers of available benefits, quickly respond to inquiries, and avoid and dispel misinformation;
  - Work with public health officials to do everything possible to prepare and respond; and
  - Consider all practicable options to reduce the barriers of cost-sharing for testing and treatment of COVID-19.
- OIR is reaching out to insurers regarding their response to COVID-19 and working with insurers to make sure they are properly communicating to consumers.
- OIR has activated its incident management team and has met to review disaster response procedures.
- OIR has issued Informational Memorandum OIR-20-02M as a reminder to all health insurers, health maintenance organizations and other health entities to allow for early prescription refills following the Governor's Executive Order 20-52 declaring a state of emergency in Florida.
- OIR has spoken with multiple insurers who are voluntarily waiving cost-sharing for consumers in an effort to remove barriers to testing for COVID-19.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

- Florida Department of Law Enforcement (FDLE) is working with state and local agencies and the Florida National Guard to set up testing collection sites in multiple locations across Florida.

- The Florida Department of Law Enforcement (FDLE) Regional Operations Centers are working with Regional Domestic Security Task Forces to prepare for any responses needed.

- FDLE's Office of Mutual Aid prepared and distributed a law enforcement guide on COVID-19 for law enforcement partners and state agencies and FDLE's General Counsel prepared a law enforcement guide for protocols in a quarantine.

- FDLE Commissioner Rick Swearingen sent an email to all members outlining simple ways to prevent the spread of COVID-19 as well as links to the Florida Department of Health and CDC websites. Signs have been posted in all FDLE Regions and at Headquarters with prevention information.

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

- The Florida Department of Juvenile Justice's Office of Health Services developed COVID-19 guidance for all facilities serving DJJ youth. This guidance included Center for Disease Control criteria on how to assess and care for youth who are exhibiting fever and respiratory symptoms and environmental cleaning and disinfection recommendations.

- The Florida Department of Juvenile Justice has modified screening protocols and procedures for youth taken into custody by law enforcement who are brought to juvenile assessment centers and detention screening units to now include precautionary coronavirus screening questions and protocols. This modified screening protocol was shared with law enforcement partners statewide.

- The Florida Department of Juvenile Justice has developed a visitor screening tool which is now mandatory to use inside of our juvenile detention centers and residential commitment programs to ensure both the safety of the youth and staff in these programs. The

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Florida Department of Juvenile Justice has sent a notice to parents and guardians of youth in programs regarding the new visitor screening requirements.

- The Florida Department of Juvenile Justice has instituted additional screening measures for outside vendors who work within juvenile facilities and non-essential travel of staff members has been stopped. Visitors are limited to business-related visitors only (i.e., vendors, no personal visitors, no volunteers at this time). The department will work with these entities on alternatives to visiting programs to ensure critical services are not interrupted. Clinical personnel, however, are still permitted to visit youth for treatment purposes, and attorneys are still permitted to conduct legal visits with youth.

FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

- Governor DeSantis directed all agencies to suspend for 30 days licensing and registration renewal requirements for existing processional licenses (e.g. realtors).
- Governor DeSantis has directed the Department of Business and Professional Regulation Secretary Halsey Beshears, in coordination with the Florida Department of Health, to issue social distancing guidance to restaurants and bars.
- Governor DeSantis sent a letter to the federal Small Business Administration to turn on the SBA loan program for small businesses.
- The Florida Department of Business and Professional Regulation (DBPR) has suspended all official business visits, including inspections, that involve licenses located at a facility covered under the visitation restrictions implemented pursuant to FDEM Emergency Order 20-002.
- DBPR is incorporating informational comments on all on-site inspection reports issued to public lodging, public food service, and alcohol and tobacco license holders that will promote situational awareness of the current public health emergency and will direct parties to the FDOH COVID-19 webpage for guidance and resources related to prevention best practices. Copies of informational flyers from the FDOH COVID-19 toolkit will also be available for inspectors to distribute when interacting with managers of these premises.

FLORIDA DEPARTMENT OF MANAGEMENT SERVICES

- Governor DeSantis directed the Department of Management Services Secretary Jonathan Satter to allow state employees to donate and transfer their available leave time to other state employees to mitigate the impacts of school closures.
- The Florida Department of Management Services' (DMS) Emergency Support Function-7 (ESF-7) Logistics team continues to coordinate with the Department of Health and the Division of Emergency Management on identifying the equipment or supplies that may be necessary for a mass response to COVID-19.
- DMS' Division of Human Resource Management has provided guidance to agencies on implementing preventive actions in the workplace, reporting symptoms, using leave, utilizing health insurance benefits, and applying travel restrictions and telework policies.
- DMS' Division of State Group Insurance continues to coordinate with health plan providers to ensure that state employee health plan members receive the health benefits that can assist them and their dependents if needed.
- DMS' Division of Real Estate Development and Management (REDM) continues to provide guidance to agency facility managers across the state on steps to take to prevent workplace contamination and to pre-position environmental vendors to mobilize in the event a viricidal cleaning is needed.
- DMS' Division of Real Estate Development and Management continues to identify, purchase, and distribute additional hand sanitizing gel and cleaning supplies to state-maintained facilities.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with users and vendor of the Statewide Law Enforcement Radio System (SLERS) vendors to ensure the continuation of mission critical services if a reduction of staffing resources occurs.
- DMS' Division of State Technology-Public Safety Unit continues to coordinate with statewide public safety communications personnel on their plans to ensure emergency communications systems are not impacted by potential reductions in staffing resources.

FLORIDA DEPARTMENT OF ENVIRONMENTAL PROTECTION

- All State Parks have adjusted their operating hours to 8 a.m. to 5 p.m. daily. The Department continues to monitor new developments closely and will make further adjustments as necessary based on any new Department of Health or CDC guidance received to ensure protection of our staff and visitors. For the latest information on park operating hours and operational status, please visit floridastateparks.org.
- Currently all Florida State Parks and campgrounds, and Office of Resilience and Coastal Protection facilities (aquatic preserves and National Estuarine Research Reserves), remain open to the public. However, in an abundance of caution and consistent with Center for Disease Control and Prevention (CDC) guidance, DEP announced on March 13 that it is cancelling all events and activities at these facilities effective immediately and until further notice.
  - This includes DEP events and includes activities such as tours and visitor centers that involve large groups and/or or people in close proximity to others. People with questions regarding any privately scheduled event should check with the host of the event or the facility directly. For the latest closure and cancellation information, please visit floridastateparks.org.
- If your travel plans have changed and you need to modify camping or cabin reservations, please visit ReserveAmerica.com, call Reserve America at 1-800-326-3521 or TDD 888-433-0287 or text to 904-204-3216.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

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Subject: Fwd: FW: Updated HCP Risk Assessment

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Date: Thursday, March 5, 2020 12:08:35 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:03 AM
Subject: FW: Updated HCP Risk Assessment
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson

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FYI for health care facilities. Latest CDC guidance on health care worker exposures.

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Sent: Thursday, March 5, 2020 8:25 AM
To: Lanza, John J <JohnJ.Lanza@flhealth.gov>
Subject: FW: Updated HCP Risk Assessment

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Scott Pritchard, MPH

Interim Director

Infectious Disease Prevention and Investigations Section

Bureau of Epidemiology

850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Wednesday, March 04, 2020 7:22 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>
Subject: Updated HCP Risk Assessment

Hi Scott,

We want to alert you to the release of CDC's updated **Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)** now available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

There are several changes we want to highlight in the new guidance compared to the old guidance:

1. **In regards to conducting risk assessments for healthcare personnel (HCP) for areas with community transmission**: For areas within the U.S. that are demonstrating community transmission, all healthcare personnel (HCP) are considered at some risk for COVID-19 whether through patient interactions or from general community interactions. In these instances, devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities. Instead, facilities may decide to shift their emphasis to more routine

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practices, which includes asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not reporting to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP.

2. **In regards to HCP furlough:** The old guidance recommended work restrictions for HCP with medium or high risk exposure. In the new guidance, facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.
3. **If a risk assessment is pursued for exposed HCP:**

    a. Table 1. *Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations* has been simplified with a focus on presence/absence of source control measures; use of personal protective equipment (PPE) by HCP; and degree of contact with the patient (i.e., prolonged versus brief).
    b. In addition, for those who are assessed as requiring "self-monitoring with delegated supervision" the requirement to actively verify absence of fever and respiratory symptoms when healthcare personnel (HCP) report for work is now optional.
    c. The category of HCP who fully adhered to recommended PPE was removed from Table 1. but is still addressed under section III, #3. These HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

Please let us know if you have any questions. We are always happy to chat.

Best,

Elizabeth, Shelley, and Sarah

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: FW: Updated HCP Risk Assessment

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Date: Thursday, March 5, 2020 12:08:34 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Thu, Mar 5, 2020 at 11:03 AM
Subject: FW: Updated HCP Risk Assessment
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, John P Albano (john.p.albano.civ@mail.mil) <john.p.albano.civ@mail.mil>, John Salvaggio (john.salvaggio@medicalcenterclinic.com) <john.salvaggio@medicalcenterclinic.com>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Cathy White <Robin.Wright@flcourts1.gov>, Sara Peat (speat@healthcarewithinreach.org) <speat@healthcarewithinreach.org>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, Sean Fagan (sfagan@pensacolastate.edu) <sfagan@pensacolastate.edu>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Todd Thomson (tthomson@pensacolachamber.com) <tthomson@pensacolachamber.com>, Tom Anderson

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Scott Pritchard, MPH

Interim Director

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    a. Table 1. *Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations* has been simplified with a focus on presence/absence of source control measures; use of personal protective equipment (PPE) by HCP; and degree of contact with the patient (i.e., prolonged versus brief).
    b. In addition, for those who are assessed as requiring "self-monitoring with delegated supervision" the requirement to actively verify absence of fever and respiratory symptoms when healthcare personnel (HCP) report for work is now optional.
    c. The category of HCP who fully adhered to recommended PPE was removed from Table 1. but is still addressed under section III, #3. These HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

Please let us know if you have any questions. We are always happy to chat.

Best,

Elizabeth, Shelley, and Sarah

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AMERICAN OVERSIGHT



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: Long Term Care Resources for Pandemic Planning

AMERICAN OVERSIGHT

Date: Friday, February 21, 2020 12:58:30 PM

please see attached information and checklist on pandemic preparedness
thank you

---------- Forwarded message ---------
From: **Cooksey, Samantha** <Samantha.Cooksey@flhealth.gov>
Date: Thu, Feb 20, 2020 at 2:35 PM
Subject: Long Term Care Resources for Pandemic Planning
To: Melanie Motiska <MMotiska@fhca.org>, Bob Asztalos <basztalos@fhca.org>, Laura MacLafferty <Laura.MacLafferty@ahca.myflorida.com>, StateESF8.Planning <StateESF8.Planning@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>, Pritchard, Scott <Scott.Pritchard@flhealth.gov>

Long Term Care Partners,

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AMERICAN OVERSIGHT

Can you all share with long term care facilities and/or post this resource on your websites? Thank you.

Samantha Cooksey Strickland

Alternate Emergency Coordination Officer

State ESF8 Planning & Operations Section Manager

Bureau of Preparedness & Response

Florida Department of Health

Office | 850.617.1506

Mobile | 850.251.2553

Email | Samantha.Cooksey@flhealth.gov

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

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Subject: Fwd: More COVID-19 references

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Date: Tuesday, March 3, 2020 2:44:14 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 3, 2020 at 12:14 PM
Subject: More COVID-19 references
To: Hill, Ann <ann.echcc@gmail.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, Alexander Nettles (Frederick.Nettles@va.gov) <Frederick.Nettles@va.gov>, Amanda Armstrong (aArmstrong@pcci.edu) <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Brenda Van Brussel (COC) <BVANBRUSSEL@escambiaclerk.com>, Byron Burkhart <bburkhart@cityofpensacola.com>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh (CLeigh@escambiaclerk.com) <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Dan Flynn <dflynn@cityofpensacola.com>, David Conkle (missbabbie@att.net) <missbabbie@att.net>, Denise Seabert <dseabert@uwf.edu>, Devin Simmons (Dsimmons@waterfrontmission.org) <Dsimmons@waterfrontmission.org>, Diane Wilkinson (dmw101@ufl.edu) <dmw101@ufl.edu>, district1@myescambia.com <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, doctorkelli@live.com <doctorkelli@live.com>, Doug Underhill <district2@myescambia.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric W. Gilmore <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Esc County Administrator (admin@myescambia.com) <admin@myescambia.com>, George Smith M.D. <gsmith@healthcarewithinreach.org>, Ginny Cranor <GCranor@cityofpensacola.com>, jim.frost@medicalcenterclinic.com <jim.frost@medicalcenterclinic.com>, jmbizo@uwf.edu <jmbizo@uwf.edu>, John A. Robinson <JAROBINSON@co.escambia.fl.us>, John Johnson <johnj@openingdoorsnwfl.org>, Karen Urquhart <Karen.Urquhart@hcahealthcare.com>, Keith Wilkins (kwilkins@cityofpensacola.com) <kwilkins@cityofpensacola.com>, kim settle <ksettle@ascension.org>, Lanza, John J <JohnJ.Lanza@flhealth.gov>, lewis garvin (lgarvin@cityofpensacola.com) <lgarvin@cityofpensacola.com>, Lisa Lavoie <Lisa.Lavoie@bhcpns.org>, luman may <district3@myescambia.com>, malcolm Thomas <mthomas@escambia.k12.fl.us>, Matt Coughlin <mcoughlin@cityofpensacola.com>, Michelle Grier-Hall (pmgrierhall@gmail.com) <pmgrierhall@gmail.com>, Nicole McDonald <nmcdonald@uwf.edu>, Patrick lynch <patrick.lynch@ascension.org>, Pennie Sparks <psparks@uwf.edu>, Quetheline Lanza (qlanza@healthcarewithinreach.org) <qlanza@healthcarewithinreach.org>, Rayme Edler (RMEDLER@myescambia.com) <RMEDLER@myescambia.com>, robert Bender <district4@myescambia.com>, Schofield, Ralph <Ralph.Schofield@flhealth.gov>, ssukstorf@medquestmail.com <ssukstorf@medquestmail.com>, Steven Barry <district5@myescambia.com>, Tammy Pruse <Tammy.Pruse@bhcpns.org>, Taylor Lewis <Taylor.Lewis@bhcpns.org>, Veenhuis, David A CDR USN NAVHOSP PENSACOLA FL (US) (david.a.veenhuis.mil@mail.mil) <david.a.veenhuis.mil@mail.mil>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>,

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https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-for-schools.html

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html

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Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

“Children are one third of our population and all of our future.” The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

“I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character.” Martin Luther King, Jr.

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regarding state business are public records available to the public and media upon request. Your email

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communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Fwd: More COVID-19 references

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Date: Tuesday, March 3, 2020 2:44:13 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Tue, Mar 3, 2020 at 12:14 PM
Subject: More COVID-19 references
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https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-for-schools.html

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html

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“Children are one third of our population and all of our future.” The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

“I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character.” Martin Luther King, Jr.

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communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Ann Hill

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Subject: Fwd: Note Coronavirus self-checker at this URL
Date: Monday, March 23, 2020 4:14:10 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 23, 2020 at 1:55 PM
Subject: Note Coronavirus self-checker at this URL
To: (m.brandhorst@yahoo.com) <m.brandhorst@yahoo.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, abe singh <execdir@areahousing.org>, PRINCIPE, ADAM <aprincipe@selectmedical.com>, Alain Espinosa <aespinosa@myescambia.com>, Alex Nettles <Frederick.Nettles@va.gov>, Amanda Armstrong <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Andy Hobbs (anhobbs@escambiaso.com) <anhobbs@escambiaso.com>, Angela.Strumeyer@myflfamilies.com <Angela.Strumeyer@myflfamilies.com>, Anges Rivers <arivers@healthcarewithinreach.org>, Hill, Ann <ann.echcc@gmail.com>, Anthony Manning <dc18@myescambia.com>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brad Hattaway <Brad_Hattaway@co.escambia.fl.us>, Brenda Van Brussel (CDC) <BVANBRUSSEL@escambiaclerk.com>, Brian Allen Waters <bwaters@waterfrontmission.org>, Brian Wyer <bwyer@gcmcc.info>, Brittany Johnson <b.n.johnson@cox.net>, Brock Dester <hdester@cityofpensacola.com>, Bruce Watson (Bwatson@elcescambia.org) <Bwatson@elcescambia.org>, Byron Burkhart <bburkhart@cityofpensacola.com>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Casey Boatwright <ccboatwright@myescambia.com>, Casey Richards <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, charlotte mccorvey <mccorveycx@gmail.com>, Chip Campbell <chip.campbell2@gmail.com>, Christine Crespo <cmcrespo@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Craig Ammons <cammons@myescambia.com>, d. Marcus <dmarcus@bop.gov>, Dale Flynn <dflynn@cityofpensacola.com>, Dale Simmons <dsimmons@hillcrestchurch.com>, Danny Marcus <danny.marcus123@yahoo.com>, David Conkle <missbabbie@att.net>, David Stafford <soe@escambiavotes.com>, Dawn Engel <dengel@elcescambia.org>, Debbie Chavers <dchavers@pediatricassociatespa.com>, Debbieray Kings <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Derek Pratt <dpratt@cityofpensacola.com>, Devin Simmons <Dsimmons@waterfrontmission.org>, Diane Wilkinson <dmw101@ufl.edu>, District 1 <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, Doug Underhill <district2@myescambia.com>, Dr. Kelli Wells <doctorkelli@live.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric Gilmore (egilmore@myescambia.com) <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Erin Jeffreys <erinejeffreys@gmail.com>, Esc County Administrator <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, Frederick Henderson <fhenderson@waterfrontmission.org>, Freer, Christine M <Christine.Freer@flhealth.gov>, gay Nord <gay.nord@hcahealthcare.com>, George Smith, MD <gsmith@healthcarewithinreach.org>, Ginny Carnor <gcraner@cityofpensacola.com>, Giny Cranor <GCranor@cityofpensacola.com>, Gordon, David D

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https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html

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Mission: “To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

“Children are one third of our population and all of our future.” The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

“I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character.” Martin Luther King, Jr.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email

communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Hill, Ann

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Subject: Fwd: Note Coronavirus self-checker at this URL
Date: Monday, March 23, 2020 4:14:18 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 23, 2020 at 1:55 PM
Subject: Note Coronavirus self-checker at this URL
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https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html

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Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

“Children are one third of our population and all of our future.” The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

“I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character.” Martin Luther King, Jr.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email

communication may therefore be subject to public disclosure.

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Ann Hill, Executive Director
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From: Ann Hill

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Subject: Fwd: Note Coronavirus self-checker at this URL
Date: Monday, March 23, 2020 4:14:10 PM

---------- Forwarded message ---------
From: **Lanza, John J** <JohnJ.Lanza@flhealth.gov>
Date: Mon, Mar 23, 2020 at 1:55 PM
Subject: Note Coronavirus self-checker at this URL
To: (m.brandhorst@yahoo.com) <m.brandhorst@yahoo.com>, Hanna, Martha <mhanna@escambia.k12.fl.us>, A Trammell (Gatordentist@cox.net) <Gatordentist@cox.net>, abe singh <execdir@areahousing.org>, PRINCIPE, ADAM <aprincipe@selectmedical.com>, Alain Espinosa <aespinosa@myescambia.com>, Alex Nettles <Frederick.Nettles@va.gov>, Amanda Armstrong <aArmstrong@pcci.edu>, Andrea Levitt <alevitt@cityofpensacola.com>, Andy Hobbs (anhobbs@escambiaso.com) <anhobbs@escambiaso.com>, Angela.Strumeyer@myflfamilies.com <Angela.Strumeyer@myflfamilies.com>, Anges Rivers <arivers@healthcarewithinreach.org>, Hill, Ann <ann.echcc@gmail.com>, Anthony Manning <dc18@myescambia.com>, Bolton, Beate H <Beate.Bolton@flhealth.gov>, Brad Hattaway <Brad_Hattaway@co.escambia.fl.us>, Brenda Van Brussel (CDC) <BVANBRUSSEL@escambiaclerk.com>, Brian Allen Waters <bwaters@waterfrontmission.org>, Brian Wyer <bwyer@gcmcc.info>, Brittany Johnson <b.n.johnson@cox.net>, Brock Dester <hdester@cityofpensacola.com>, Bruce Watson (Bwatson@elcescambia.org) <Bwatson@elcescambia.org>, Byron Burkhart <bburkhart@cityofpensacola.com>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Casey Boatwright <ccboatwright@myescambia.com>, Casey Richards <casey.richards@navyfederal.org>, Chandra Smiley (csmiley@healthcarewithinreach.org) <csmiley@healthcarewithinreach.org>, Charlette Gardner <cegardner@myescambia.com>, charlotte mccorvey <mccorveycx@gmail.com>, Chip Campbell <chip.campbell2@gmail.com>, Christine Crespo <cmcrespo@myescambia.com>, Cindy Almand <cindy.almand@bhcpns.org>, Codey Leigh <CLeigh@escambiaclerk.com>, Community & Media Relations <CMR@myescambia.com>, Craig Ammons <cammons@myescambia.com>, d. Marcus <dmarcus@bop.gov>, Dale Flynn <dflynn@cityofpensacola.com>, Dale Simmons <dsimmons@hillcrestchurch.com>, Danny Marcus <danny.marcus123@yahoo.com>, David Conkle <missbabbie@att.net>, David Stafford <soe@escambiavotes.com>, Dawn Engel <dengel@elcescambia.org>, Debbie Chavers <dchavers@pediatricassociatespa.com>, Debbieray Kings <debbieray.kings@medicalcenterclinic.com>, DeDe Flounlacker (dede@mannahelps.org) <dede@mannahelps.org>, Denise Seabert <dseabert@uwf.edu>, Derek Pratt <dpratt@cityofpensacola.com>, Devin Simmons <Dsimmons@waterfrontmission.org>, Diane Wilkinson <dmw101@ufl.edu>, District 1 <district1@myescambia.com>, DL CHD17 EMT <CHD17-EMT@flhealth.gov>, Doug Underhill <district2@myescambia.com>, Dr. Kelli Wells <doctorkelli@live.com>, Elliot, Jonathan N CDR USN (USA) <jonathan.n.elliot.mil@mail.mil>, Eric Gilmore (egilmore@myescambia.com) <egilmore@myescambia.com>, Erica Laxson Huffman <director@escambiacms.org>, Erin Jeffreys <erinejeffreys@gmail.com>, Esc County Administrator <admin@myescambia.com>, fletcher Forte (fletcher.forte@fdc.myflorida.com) <fletcher.forte@fdc.myflorida.com>, Frederick Henderson <fhenderson@waterfrontmission.org>, Freer, Christine M <Christine.Freer@flhealth.gov>, gay Nord <gay.nord@hcahealthcare.com>, George Smith, MD <gsmith@healthcarewithinreach.org>, Ginny Carnor <gcraner@cityofpensacola.com>, Giny Cranor <GCranor@cityofpensacola.com>, Gordon, David D

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Angela <apmintz@bellsouth.net>, mlogrady29@gmail.com <mlogrady29@gmail.com>, mtacro@yahoo.com <mtacro@yahoo.com>, mwctullus@gmail.com <mwctullus@gmail.com>, okan.elidemir@nemours.org <okan.elidemir@nemours.org>, paul.larose@floridawomancare.com <paul.larose@floridawomancare.com>, pdavenpo@nemours.org <pdavenpo@nemours.org>, pedsbenny@yahoo.com <pedsbenny@yahoo.com>, pedspulmry@gmail.com <pedspulmry@gmail.com>, rafahaflak@yahoo.com <rafahaflak@yahoo.com>, Regina.McCutcheon.MD@gmail.com <Regina.McCutcheon.MD@gmail.com>, rlewismd@me.com <rlewismd@me.com>, robert.andrews@floridawomancare.com <robert.andrews@floridawomancare.com>, robert.dillard@uky.edu <robert.dillard@uky.edu>, robert.patterson2@ascension.org <robert.patterson2@ascension.org>, rpriche@cox.net <rpriche@cox.net>, rsbenson@bellsouth.net <rsbenson@bellsouth.net>, rsstuart@cox.net <rsstuart@cox.net>, sarahwaite@yahoo.com <sarahwaite@yahoo.com>, schwartzj@ufl.edu <schwartzj@ufl.edu>, SHALINI.GOLLA@ASCENSION.ORG <SHALINI.GOLLA@ascension.org>, shanemedlock@yahoo.com <shanemedlock@yahoo.com>, sharon_parnell@thewomensgroup.org <sharon_parnell@thewomensgroup.org>, sharonlseidel@gmail.com <sharonlseidel@gmail.com>, stalnakerb@aol.com <stalnakerb@aol.com>, suzanne.bush@med.fsu.edu <suzanne.bush@med.fsu.edu>, svn@dr.com <svn@dr.com>, swfert@aol.com <swfert@aol.com>, taylor.obgyn@comcast.net <taylor.obgyn@comcast.net>, tbrooks@cerainc.com <tbrooks@cerainc.com>, ted.mathew@gmail.com <ted.mathew@gmail.com>, temignerey@aol.com <temignerey@aol.com>, timbeiswenger@gmail.com <timbeiswenger@gmail.com>, trineyjr@yahoo.com <trineyjr@yahoo.com>, VANDENE.MILLER@ASCENSION.ORG <VANDENE.MILLER@ascension.org>, wjschwartz3@gmail.com <wjschwartz3@gmail.com>, wwhite@ecc-clinic.org <wwhite@ecc-clinic.org>, yurttutancigdem@gmail.com <yurttutancigdem@gmail.com>, Baurberg, Traci M <Traci.Baurberg@flhealth.gov>, Berrian, Gregory M <Gregory.Berrian@flhealth.gov>, Brown, James K <James.Brown@flhealth.gov>, Chmiel, J David <John.Chmiel@flhealth.gov>, DeCarolis, Margaret J <Margaret.DeCarolis@flhealth.gov>, Donado, Louviminda P <Louviminda.Donado@flhealth.gov>, Dwiggins, Patty C <Patty.Dwiggins@flhealth.gov>, Gibbs, CheBreia D <CheBreia.Gibbs@flhealth.gov>, Hammonds, Patricia A <Patricia.Hammonds@flhealth.gov>, Kent, Linda H <Linda.Kent@flhealth.gov>, Luciano-Green, Candy <Candy.Luciano-Green@flhealth.gov>, Mignerey, Thomas G <Thomas.Mignerey@flhealth.gov>, Mott, Marie B <Marie.Mott@flhealth.gov>, Phillips, Vanessa L <Vanessa.Phillips@flhealth.gov>, Schofield, Ralph <Ralph.Schofield@ssa.gov>, Shoulders, Barbara A <Barbara.Shoulders@flhealth.gov>, Willis, Wayne S <Wayne.Willis@flhealth.gov>, Willoughby, Rebecca L <Rebecca.Willoughby@flhealth.gov>, Chris Williams <ChrisWilliams@fdle.state.fl.us>, Palumbo, Meaghan <MeaghanPalumbo@fdle.state.fl.us>, White, Daniel <DanielWhite@fdle.state.fl.us>

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html

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John J. Lanza, MD, PhD, MPH, FAAP, FHPS
Director and Health Officer
Florida Department of Health in
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Follow us on Twitter: @HealthyEscambia

Mission: “To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.”
Vision: "To be the Healthiest State in the Nation”
Values: ICARE (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

“Children are one third of our population and all of our future.” The Report of the Select Panel for the Promotion of Child Health to the United States Congress, 1981

“I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character.” Martin Luther King, Jr.

PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from state officials
regarding state business are public records available to the public and media upon request. Your email

communication may therefore be subject to public disclosure.

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To: andy.mullins@adph.state.al.us; Christopher.Shields@cityofchicago.org; Provenzano, Francesca; patrick.ashley@dc.gov; Christie.Luce@flhealth.gov; Scott.Minarcine@dph.ga.gov; Dudley, Matthew - EMS; Lytle, Megan; Denise L. Kelly [KDHE]; RickD.Johnson@ky.gov; Stella Fogleman; Doris Brown; Sherry.adams@maryland.gov; kerin.milesky@state.ma.us; Macqueen, Mary (DHHS); RPongliyab@fsmhealth.fm; cheryl.petersen-kroeber@state.mn.us; Nickelson, Paula; O"Loughlin, Kevin; warren.villagomez@dph.gov.mp; eric.sergeant@nebraska.gov; Malinda Southard; Daly, Elizabeth; Dana.johnson@doh.nj.gov; Christopher.emory@state.nm.us; Primeau, Michael J (HEALTH); bmaldin@health.nyc.gov; jsickler@nd.gov; scotts@health.ok.gov; ritter.udui@palauhealth.org; jcabrera@salud.gov.pr; paul.petersen@tn.gov; jeff.hoogheem@dshs.state.tx.us; Kevin Mcculley; Francine.lang@doh.vi.gov; Halvorson, Clark (CDC doh.wa.gov); donnie.w.haynes@wv.gov; Davidson, Sherri (CDC adph.state.al.us); Aifili Tufa; Louie, Shirley (CDC arkansas.gov); Watt, James (CDC cdph.ca.gov); Abdo, Mark (HHS/); Rachel-Philip, Disney (IHS/ABR/BCH); Davies-Cole, John (CDC dc.gov); Blackmore, Carina (CDC flhealth.gov); Drenzek, Cherie (CDC dph.ga.gov); ann.pobutksy@dphss.guam.gov; Park, Sarah Y., MD; Hahn, Christine G. <ID> (CDC dhw.idaho.gov); Pedati, Caitlin; farah.ahmed@ks.gov; Ratard, Raoult (CDC la.gov); Abdo, Mark (HHS/); Brown, Catherine (DPH); LyonCallo, Sarah (DHHS); Eliaser Johnson; Lynfield, Ruth (CDC state.mn.us); Tan, Christina (CDC doh.state.nj.us); Landen, Michael (CDC state.nm.us); Blog, Debra (CDC health.ny.gov); Layton, Marci (CDC health.nyc.gov); Burnsed, Laurence (CDC health.ok.gov); Dunn, John (CDC tn.gov); Gaul, Linda (CDC dshs.state.tx.us); Ellis, Esther (CDC doh.vi.gov); Lindquist, Scott SL (CDC doh.wa.gov); Dudley, Matthew - EMS; Francine.lang@doh.vi.gov; Louie, Shirley (CDC arkansas.gov); Eliaser Johnson; Williamson, Laura (CDC mt.gov)
Cc: CDC IMS State Coordination Task Force (SCTF) MCCM LNO; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date: Tuesday, March 3, 2020 3:09:00 PM

Good Afternoon, We are following up with you on the request below. This is a gentle reminder to provide the outlined information by COB today, March 3, 2020. You can send all responses to **eocsctfmccmlno@cdc.gov .**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at **eocsctfmccmlno@cdc.gov .**

We appreciate all you are doing to support COVID-19!

Thank you, Devi Hawkins-Prather

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

> **From:** Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
> **Sent:** Friday, February 28, 2020 1:31 PM
> **To:** CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>
> **Cc:** CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
> **Subject:** Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
>
> Greetings PHEP Directors & State Epidemiologists –
>
> The outbreak of COVID-19 in China has led to a disruption in the global supply chain of personal

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protective equipment (PPE). CDC recognizes that healthcare facilities may experience temporary shortages even if they do not care for patients with COVID-19. CDC has released guidance for optimizing the use of N95 respirators, which includes some recommendations that may be applicable to other types of PPE, including surgical masks. CDC also has guidance regarding who needs and does not need PPE to help prevent excessive use of PPE.

As you are aware, this is a delicate system with many factors. When CDC receives notifications from healthcare systems about supply chain shortages, we encourage the Healthcare Coalition Partners to work together to problem solve within the coalition and/or wider state system. Further we encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

We have heard from the healthcare system partners that have contacted us that they are unsure whom to contact in the state health department about supply chain shortages in their facilities. As a way to help mitigate this, **we are asking you to reply to eocsctfmccmlno@cdc.gov no later than March 3, 2020, with an identified primary and secondary point of contact for any supply chain issues within your state.**
Please provide the following information:

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

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From:	Jacobi, Amy (CDC/DDID/NCEZID/DFWED)
To:	PetersS6@michigan.gov; Stobierski, Mary Grace (CDC michigan.gov); Rebecca.Fugitt@odh.ohio.gov; Bryce.Kerr@odh.ohio.gov; Amanda.Koch@dhs.wisconsin.gov; Irving, Roy (CDC dhs.wisconsin.gov); Jordan.Mason@dhs.wisconsin.gov; Sarah.Koske@dhs.wisconsin.gov; Andy.Reich@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); Goff, Kendra (CDC flhealth.gov); Monika.Pitts@flhealth.gov; Michael.Balda@flhealth.gov; Michael.Mitchell@flhealth.gov; Elke.Ursin@flhealth.gov; Rick.Clark@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Dawn.Blackburn@flhealth.gov; CURTIS.G.CUDE@dhsoha.state.or.us; Rebecca.Hillwig@dhsoha.state.or.us; Fill, Margaret (CDC tn.gov); Jane.Yackley@tn.gov; Judy.Manners@tn.gov
Cc:	Roberts, Virginia (CDC/DDID/NCEZID/DFWED); Vigar, Marissa (CDC/DDID/NCEZID/DFWED); Luyindula, Dema (CDC/DDID/NCEZID/DFWED) (CTR)
Subject:	HAB Communication Survey from CDC
Date:	Monday, March 2, 2020 12:22:20 PM
Attachments:	HAB Risk Communicaiton Partner Survey_FINAL.docx

Dear colleagues,

We want to hear from you as we plan and develop HAB communication resources to support your work! **Please respond to this survey by March 13** to provide input on the HAB topics, audiences, and communication materials you are most interested in:
https://www.surveymonkey.com/r/Q6FLRY9

Please limit your response to one per state. We would like to hear from everyone that is interested in responding, but we ask that each state compile input from multiple people into one response to the survey. I've attached a Word document version of the survey in case that makes compiling your input easier. The survey should take about 10 minutes or less, and your insight is much appreciated.

Please feel free to reach out with any questions or comments.

Thank you,

Amy Jacobi, MPH
Health Communication Specialist
Waterborne Disease Prevention Branch
Division of Foodborne, Waterborne, and Environmental Diseases
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention
Email: puw6@cdc.gov | Office: 404.718.3715

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1. Please put a checkmark next to each audience you are interested in communicating with about HAB health risks.

☐General public

☐ Recreational water users

☐ People who fish

☐ People who harvest shellfish

☐ People who wade and swim

☐ People who participate in water sports (boating, jet skiing, kayaking, etc.)

☐ Dog owners

☐ Livestock owners

☐ One Health partners – professionals working in human health, animal health, or environmental fields

☐ Health care providers

☐ Veterinarians

☐ Water utility managers

☐ Recreational water mangers

☐ Public health department staff

☐ Policymakers

☐ Community leaders

☐ Tribal leaders

☐ People whose source of drinking water is surface water

☐ People served by public water systems

☐ People served by private surface water systems

☐ Media outlets and journalists

☐ Homeowner Associations

☐ Other (please specify)

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2. Please list the top three audiences you are most interested in communicating with about HAB health risks, with **1 being the audience you are most interested in** communicating with.

    1.
    2.
    3.

3. Please put a checkmark next to each channel you use to disseminate HAB messages.

    ☐ Websites

    ☐ Social media (Facebook, Twitter, Instagram, etc.)

    ☐ Webinars

    ☐ Email newsletters

    ☐ Fact sheets

    ☐ Posters

    ☐ Brochures

    ☐ Advisory signs near water bodies

    ☐ Radio

    ☐ Newspapers

    ☐ TV

    ☐ Training or conferences

    ☐ Other (please specify)

4. Please list the top 3 channels you are most interested in using to disseminate HAB health risk messages, with **1 being the channel you are most interested in using.**
    1.
    2.
    3.

5. Please put a checkmark next to each topic you are interested in CDC developing messages and communication resources for.

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☐ HABs in recreational water

☐ HABs in drinking water

☐ HABs and private surface water

☐ Marine HABs

☐ Freshwater HABs

☐ HABs as a One Health issue

☐ Identification, diagnosis, and treatment of HAB-associated illnesses

☐ Easily understandable information about HABs and health impacts

☐ HAB-associated pet illnesses

☐ HAB-associated livestock illnesses

☐ Key HAB-associated illness prevention messages

☐ HAB-associated foodborne illness

☐ Long-term health risks of HAB exposure

☐ Benthic HABs

☐ BMAA and neurodegenerative diseases

☐ HABs and irrigation water

☐ One Health Harmful Algal Bloom System (OHHABS) surveillance

☐ Social and economic impacts of HABs

☐ Current public health work and research related to HABs

☐ Other (please specify)

6. Please list the top 3 health-related HAB topics you are most interested in disseminating information about, with **1 being the topic you are most interested in** disseminating information about.
   1.
   2.
   3.

7. Please put a checkmark next to each type of risk communication resource you would find useful.

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☐ **General information** about the health impacts of HABs for all audiences.

☐ **Information** about the health impacts of HABs for **specific audiences** such as healthcare providers, veterinarians, animal owners, media, community leaders, and One Health partners.

☐ **Communication planning tools** such as guidance on identifying and analyzing audiences, setting communication goals, and choosing communication channels for HAB messaging.

☐ **Risk communication coordination tools** such as guidance on defining roles and responsibilities and requesting support from federal agencies during a HAB event.

☐ **HAB risk identification tools** such as guidance for the public on possible signs of a HAB, a list of labs that can test for HAB toxins, and decision matrices on when to issue and lift advisories.

☐ **Message and channel recommendations by audience**, such as for animal owners, veterinarians, healthcare providers, media, community leaders, and One Health partners.

☐ **Outreach templates and resources**, such as advisory templates, press release templates, sample news article, social media graphics and messages, fact sheets, posters, presentation templates, PSAs, and reference cards.

☐ **Tools for developing HAB messages** such as message development worksheets and scoring guides for communication materials.

☐ **Tools for evaluating HAB advisories and messages** such as evaluation planning guides, survey templates, and discussion guides.

☐ Other (please specify)

8. Please list the top 3 risk communication resources you are most interested in, with 1 being the resource you are most interested in.
   1.
   2.
   3.

9. Which format would you prefer HAB communication resources from CDC be available in?

   ☐ HTML - content available on a website without needing to download documents

   ☐ PDF - downloadable and printable documents

   ☐ Both HTML and PDF

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10. **How can CDC best support you with HAB risk communications?** Please include any risk communication needs you have and ideas about the types of messages, materials, or tools that may be helpful. Your suggestions on how to improve existing CDC materials and risk communication support are also welcome and appreciated.

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From:	Bowen, Virginia B. (CDC/DDID/NCHHSTP/DSTDP)
To:	Heather.Rubino@flhealth.gov
Cc:	Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott; Curns, Aaron (CDC/DDID/NCIRD/DVD); Anderson, Kayla (CDC/DDNID/NCBDDD/DBDID); Roguski, Katherine (CDC/DDID/NCEZID/DFWED); CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Epi TF Data Team; Chow, Nancy Ann Marie (CDC/DDID/NCHHSTP/DTE); Whitham, Hilary (CDC/DDID/NCEZID/DFWED)
Subject:	Helpful documents for submitting COVID-19 cases via CSV upload
Date:	Tuesday, March 3, 2020 2:55:18 PM
Attachments:	Instructions on Submission of CSV Files_2020Feb25.docx PUI_CRF_Short_Form_CSV_Template.csv Copy of 2019-nCoV Data Dictionary PUI and CRF_2020Feb29v2_highlight.xlsx

Hi, Dr. Rubino,

I got your name from Scott Pritchard and wanted to email you proactively to provide a few helpful documents as you prepare to format your first CSV file for COVID-19 case reporting. These attachments provide helpful information about where and how frequently to send your file, and the attached template provides a clear picture of how your file should formatted. The attached data dictionary in Excel format may also be helpful as you develop your own data collection module.

We would love to schedule a quick 20-minute call with you to discuss these documents and answer any questions you may have.

Please let me know if you might have time to chat tomorrow, **March 4th**.

Regards,
Ginny Bowen

Virginia B. (Ginny) Bowen, PhD, MHS
Lieutenant Commander, U.S. Public Health Service
Deputy Team Lead, Case-Tracking Team
Epidemiology Task Force, CDC COVID-19 Response
Mail: 1600 Clifton Rd., NE; US 12-2; Atlanta, GA 30329

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	A	B
1	2019-nCoV PUI and CRF Data Dictionary Form used: 03_2019-nCoV_PUI_Case ReportForm_2020Feb29.docx Last updated 20200229_11.00am	
2	Questions	Variable Name
3	Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form	
4	Reporting jurisdiction	state
5	Reporting health department	healthdept
6	Contact ID	contact_id
7	Case state/local ID	local_id
8	CDC 2019-nCoV ID	cdc_ncov2019_id
9	NNDSS loc. Rec. ID/ Case ID	nndss_id
10	Interviewer Information	
11	Last name of interviewer	interviewer_ln
12	First name of interviewer	interviewer_fn
13	Affilliation/ Organization	interviewer_org
14	Telephone number	interviewer_tele
15	Email	interviewer_email
16	Basic Case Information	
17	What is the current status of this person?	current_status
18	Report date of PUI to CDC (MM/DD/YYYY)	pui_cdcreport_dt
19	Report date of case to CDC (MM/DD/YYYY)	case_cdcreport_dt
20	County of residence	res_county
21	State of residence	res_state
22	Ethnicity	ethnicity
23	Sex	sex
24	*Race (Check all that apply)*	
25	Asian	race_asian
26	American Indian/ Alaska Native	race_aian
27	Black	race_black
28	Native Hawaiian/ Other Pacific Islander	race_nhpi
29	White	race_white
30	Unknown	race_unk
31	Other	race_other
32	Other specified race	race_spec
33	Date of birth (MM/DD/YYYY)	dob
34	Age	age
35	Age units (yr/mo/days):	ageunit
36	Date of first positive specimen collection (MM/DD/YYYY)	pos_spec_dt
37	Check if date unknown	pos_spec_unk
38	Check if date not applicable	pos_spec_na
39	Did the patient develop pneumonia?	pna_yn
40	Did the patient have acute respiratory distress syndrome?	acuterespdistress_yn

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	C	D
1		
2	Values, Labels	Type
3		
4		Character
5		Character
6		Character
7		Character
8		Character
9		Character
10		
11		Character
12		Character
13		Character
14		Character
15		Character
16		
17	1, PUI testing pending 2, PUI tested negative 3, Presumptive case (positive local test), confirmatory testing pending 4, Presumptive case (positive local test), confirmatory tested negative* 5, Laboratory-confirmed case*	Number
18		Date (mm/dd/yyyy)
19		Date (mm/dd/yyyy)
20		Character
21		Character
22	1, Hispanic/Latino 0, Non-Hispanic/Latino 9, Not specified	Number
23	1, Male 2, Female 9,Unknown 3, Other	Number
24		
25	1, Yes	Number
26	1, Yes	Number
27	1, Yes	Number
28	1, Yes	Number
29	1, Yes	Number
30	1, Yes	Number
31	1, Yes	Number
32		Character
33		Date (mm/dd/yyyy)
34		Number
35	1, Years 2, Months 3, Days	Number
36		Date (mm/dd/yyyy)
37	1, Yes	Number
38	1, Yes	Number
39	1, Yes 0, No 9, Unknown	Number
40	1, Yes 0, No 9, Unknown	Number

AMERICAN OVERSIGHT

	A	B
41	Did the patient have another diagnosis/etiology for their illness?	diagother
42	Did the patient have an abnormal chest X-ray?	abxchest_yn
43	Symptoms present during course of illness:	sympstatus
44	If symptomatic, onset date (MM/DD/YYYY)	onset_dt
45	If symptomatic, onset date - unknown	onset_unk
46	If symptomatic, date of symptom resolution (MM/DD/YYYY)	symp_res_dt
47	If symptomatic, state of resolution	symp_res_yn
48	Was the patient hospitalized?	hosp_yn
49	If yes, admission date 1 (MM/DD/YYYY)	adm1_dt
50	If yes, discharge date 1 (MM/DD/YYYY)	dis1_dt
51	Was the patient admitted to an intensive care unit (ICU)?	icu_yn
52	Did the patient receive mechanical ventilation (MV)/intubation?	mechvent_yn
53	If yes, total days with MV (days)	mechvent_dur
54	Did the patient receive extracorporeal membrane oxygenation (ECMO)?	ecmo_yn
55	Did the patient die as a result of this illness?	death_yn
56	Date of Death (MM/DD/YYYY)	death_dt
57	Date of Death Unknown	death_unk
58	Is the patient a health care worker in the United States?	hc_work_yn
59	Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China?	hc_work_china_yn
60	***In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):***	
61	Travel to Wuhan	exp_wuhan
62	Travel to Hubei	exp_hubei
63	Travel to mainland China	exp_china
64	Travel to other non-US country	exp_othcountry
65	If yes, specify	exp_othcountry_spec
66	Household contact with another lab-confirmed COVID-19 case-patient	exp_house
67	Community contact with another lab-confirmed COVID-19 case-patient	exp_community
68	Any healthcare contact with another lab-confirmed COVID-19 case-patient	exp_health
69	Healthcare contact with another lab-confirmed COVID-19 case-patient -- patient	exp_health_pt
70	Healthcare contact with another lab-confirmed COVID-19 case-patient -- visitor	exp_health_vis
71	Healthcare contact with another lab-confirmed COVID-19 case-patient -- healthcare worker	exp_health_hcw
72	Animal exposure	exp_animal
73	Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology	exp_cluster
74	Other	exp_other
75	If other, specify	exp_other_spec
76	Unknown	exp_unk
77	If the patient had contact with another COVID-19 case, was this person a U.S. case?	cont_lab_us
78	If yes, specify nCoV ID of source case	cdc_ncov2019_sourceid_2

AMERICAN OVERSIGHT

	C	D
41	1, Yes 0, No 9, Unknown	Number
42	1, Yes 0, No 9, Unknown	Number
43	1, Symptomatic 0, Asymptomatic 9, Unknown	Number
44		Date (mm/dd/yyyy)
45	1, Yes	Number
46		Date (mm/dd/yyyy)
47	1, Still symptomatic 0, Symptoms resolved, unknown date 9, Unknown symptom status	Number
48	1, Yes 0, No 9, Unknown	Number
49		Date (mm/dd/yyyy)
50		Date (mm/dd/yyyy)
51	1, Yes 0, No 9, Unknown	Number
52	1, Yes 0, No 9, Unknown	Number
53		Number
54	1, Yes 0, No 9, Unknown	Number
55	1, Yes 0, No 9, Unknown	Number
56		Date (mm/dd/yyyy)
57	1, Yes	Number
58	1, Yes 0, No 9, Unknown	Number
59	1, Yes 0, No 9, Unknown	Number
60		
61	1, Yes	Number
62	1, Yes	Number
63	1, Yes	Number
64	1, Yes	Number
65		Character
66	1, Yes	Number
67	1, Yes	Number
68	1, Yes	Number
69	1, Yes	Number
70	1, Yes	Number
71	1, Yes	Number
72	1, Yes	Number
73	1, Yes	Number
74	1, Yes	Number
75		Character
76	1, Yes	Number
77	1, Yes 0, No 9, Unknown 5, NA	Number
78		Character

AMERICAN OVERSIGHT

	A	B
79	*Under what process was the PUI or case first identified? (check all that apply):*	
80	Clinical evaluation leading to PUI determination	process_pui
81	Contact tracing of case patient	process_cont
82	Routine surveillance	process_surv
83	EpiX notification of travelers	process_epix
84	If checked, DGMQID	process_dgmqid
85	Unknown	process_unk
86	Other	process_other
87	If other, specify	process_other_spec
88	Symptoms, clinical course, past medical history and social history	
89	*Collected from (check all that apply):*	
90	Patient interview	collect_ptinterview
91	Medical record review	collect_medchart
92	*During this illness, did the patient experience any of the following symptoms?*	
93	Fever >100.4F (38C)	fever_yn
94	Subjective fever (felt feverish)	sfever_yn
95	Chills	chills_yn
96	Muscle aches (myalgia)	myalgia_yn
97	Runny nose (rhinorrhea)	runnose_yn
98	Sore throat	sthroat_yn
99	Cough (new onset or worsening of chronic cough)	cough_yn
100	Shortness of breath (dyspnea)	sob_yn
101	Nausea or Vomiting	nauseavomit_yn
102	Headache	headache_yn
103	Abdominal pain	abdom_yn
104	Diarrhea (≥3 loose/looser than normal stools/24hr period)	diarrhea_yn
105	Other symptoms - 1	othsym1_yn
106	Other symptoms - 1, specify:	othsym1_spec
107	Other symptoms - 2	othsym2_yn
108	Other symptoms - 2, specify:	othsym2_spec
109	Other symptoms - 3	othsym3_yn
110	Other symptoms - 3, specify:	othsym3_spec
111	Pre-existing medical conditions?	medcond_yn
112	Chronic lung disease (asthma/emphysema/COPD)	cld_yn
113	Diabetes Mellitus	diabetes_yn

AMERICAN OVERSIGHT

	C	D
79		
80	1, Yes	Number
81	1, Yes	Number
82	1, Yes	Number
83	1, Yes	Number
84		Character
85	1, Yes	Number
86	1, Yes	Number
87		Character
88		
89		
90	1, Yes	Number
91	1, Yes	Number
92		
93	1, Yes 0, No 9, Unknown	Number
94	1, Yes 0, No 9, Unknown	Number
95	1, Yes 0, No 9, Unknown	Number
96	1, Yes 0, No 9, Unknown	Number
97	1, Yes 0, No 9, Unknown	Number
98	1, Yes 0, No 9, Unknown	Number
99	1, Yes 0, No 9, Unknown	Number
100	1, Yes 0, No 9, Unknown	Number
101	1, Yes 0, No 9, Unknown	Number
102	1, Yes 0, No 9, Unknown	Number
103	1, Yes 0, No 9, Unknown	Number
104	1, Yes 0, No 9, Unknown	Number
105	1, Yes	Number
106		Character
107	1, Yes	Number
108		Character
109	1, Yes	Number
110		Character
111	1, Yes 0, No 9, Unknown	Number
112	1, Yes 0, No 9, Unknown	Number
113	1, Yes 0, No 9, Unknown	Number

AMERICAN OVERSIGHT

	A	B
114	Cardiovascular disease	cvd_yn
115	Chronic renal disease	renaldis_yn
116	Liver disease	liverdis_yn
117	Immunocompromised condition	immsupp_yn
118	Neurologic/neurodevelopmental/intellectual disability	neuro_yn
119	If yes, specify	neuro_spec
120	Other chronic diseases	otherdis_yn
121	If yes, specify	otherdis_spec
122	If female, currently pregnant	pregnant_yn
123	Current smoker	smoke_curr_yn
124	Former smoker	smoke_former_yn
125	Respiratory Diagnostic Testing	
126	Influenza A Rapid Ag	resp_flua_ag
127	Influenza B Rapid Ag	resp_flub_ag
128	Influenza A PCR	resp_flua_pcr
129	Influenza B PCR	resp_flub_pcr
130	RSV	resp_rsv
131	H. metapneumovirus	resp_hm
132	Parainfluenza (1-4)	resp_pi
133	Adenovirus	resp_adv
134	Rhinovirus/enterovirus	resp_rhino
135	Coronavirus (OC43, 229E, HKU1, NL63)	resp_cov

AMERICAN OVERSIGHT

	C	D
114	1, Yes 0, No 9, Unknown	Number
115	1, Yes 0, No 9, Unknown	Number
116	1, Yes 0, No 9, Unknown	Number
117	1, Yes 0, No 9, Unknown	Number
118	1, Yes 0, No 9, Unknown	Number
119		Character
120	1, Yes 0, No 9, Unknown	Number
121		Character
122	1, Yes 0, No 9, Unknown	Number
123	1, Yes 0, No 9, Unknown	Number
124	1, Yes 0, No 9, Unknown	Number
125		
126	1, Positive 2, Negative 3, Pending 4, Not Done	Number
127	1, Positive 2, Negative 3, Pending 4, Not Done	Number
128	1, Positive 2, Negative 3, Pending 4, Not Done	Number
129	1, Positive 2, Negative 3, Pending 4, Not Done	Number
130	1, Positive 2, Negative 3, Pending 4, Not Done	Number
131	1, Positive 2, Negative 3, Pending 4, Not Done	Number
132	1, Positive 2, Negative 3, Pending 4, Not Done	Number
133	1, Positive 2, Negative 3, Pending 4, Not Done	Number
134	1, Positive 2, Negative 3, Pending 4, Not Done	Number
135	1, Positive 2, Negative 3, Pending 4, Not Done	Number

AMERICAN OVERSIGHT

	A	B
136	M. pneumoniae	resp_mp
137	C. pneumoniae	resp_rcp
138	Other positive pathogens	othrp
139	If yes, specify	othrp_spec
140	Specimens for COVID-19 Testing	
141	NP Swab: Local Specimen ID - 1	spec_npswab1id
142	NP Swab: Collection date - 1	spec_npswab1_dt
143	NP Swab: State Lab Tested - 1	spec_npswab1state
144	NP Swab: State Result - 1	spec_npswab1Stateresult
145	NP Swab: Sent to CDC - 1	spec_npswab1cdc
146	NP Swab: CDC Result - 1	spec_npswab1CDCresult
147	NP Swab: Local Specimen ID - 2	spec_npswab2id
148	NP Swab: Collection date - 2	spec_npswab2_dt
149	NP Swab: State Lab Tested - 2	spec_npswab2state
150	NP Swab: State Result - 2	spec_npswab2Stateresult
151	NP Swab: Sent to CDC - 2	spec_npswab2cdc
152	NP Swab: CDC Result - 2	spec_npswab2CDCresult
153	NP Swab: Local Specimen ID - 3	spec_npswab3id
154	NP Swab: Collection date - 3	spec_npswab3_dt
155	NP Swab: State Lab Tested - 3	spec_npswab3state
156	NP Swab: State Result - 3	spec_npswab3Stateresult
157	NP Swab: Sent to CDC - 3	spec_npswab3cdc
158	NP Swab: CDC Result - 3	spec_npswab3CDCresult
159	OP Swab: Local Specimen ID - 1	spec_opswab1id
160	OP Swab: Collection date - 1	spec_opswab1_dt
161	OP Swab: State Lab Tested - 1	spec_opswab1state
162	OP Swab: State Result - 1	spec_opswab1Stateresult
163	OP Swab: Sent to CDC - 1	spec_opswab1cdc

AMERICAN OVERSIGHT

	C	D
136	1, Positive 2, Negative 3, Pending 4, Not Done	Number
137	1, Positive 2, Negative 3, Pending 4, Not Done	Number
138	1, Positive 2, Negative 3, Pending 4, Not Done	Number
139		Character
140		
141		Character
142		Date (mm/dd/yyyy)
143	1, Yes	Number
144	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
145	1, Yes	Number
146	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
147		Character
148		Date (mm/dd/yyyy)
149	1, Yes	Number
150	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
151	1, Yes	Number
152	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
153		Character
154		Date (mm/dd/yyyy)
155	1, Yes	Number
156	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
157	1, Yes	Number
158	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
159		Character
160		Date (mm/dd/yyyy)
161	1, Yes	Number
162	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
163	1, Yes	Number

AMERICAN OVERSIGHT

	A	B
164	OP Swab: CDC Result - 1	spec_opswab1CDCresult
165	OP Swab: Local Specimen ID - 2	spec_opswab2id
166	OP Swab: Collection date - 2	spec_opswab2_dt
167	OP Swab: State Lab Tested - 2	spec_opswab2state
168	OP Swab: State Result - 2	spec_opswab2Stateresult
169	OP Swab: Sent to CDC - 2	spec_opswab2cdc
170	OP Swab: CDC Result - 2	spec_opswab2CDCresult
171	OP Swab: Local Specimen ID - 3	spec_opswab3id
172	OP Swab: Collection date - 3	spec_opswab3_dt
173	OP Swab: State Lab Tested - 3	spec_opswab3state
174	OP Swab: State Result - 3	spec_opswab3Stateresult
175	OP Swab: Sent to CDC - 3	spec_opswab3cdc
176	OP Swab: CDC Result - 3	spec_opswab3CDCresult
177	Sputum: Local Specimen ID - 1	spec_sputum1id
178	Sputum: Collection date - 1	spec_sputum1_dt
179	Sputum: State Lab Tested - 1	spec_sputum1state
180	Sputum: State Result - 1	spec_sputum1Stateresult
181	Sputum: Sent to CDC - 1	spec_sputum1cdc
182	Sputum: CDC Result - 1	spec_sputum1CDCresult
183	Sputum: Local Specimen ID - 2	spec_sputum2id
184	Sputum: Collection date - 2	spec_sputum2_dt
185	Sputum: State Lab Tested - 2	spec_sputum2state
186	Sputum: State Result - 2	spec_sputum2Stateresult
187	Sputum: Sent to CDC - 2	spec_sputum2cdc
188	Sputum: CDC Result - 2	spec_sputum2CDCresult
189	Sputum: Local Specimen ID - 3	spec_sputum3id
190	Sputum: Collection date - 3	spec_sputum3_dt
191	Sputum: State Lab Tested - 3	spec_sputum3state

FLORIDA OVERSIGHT

	C	D
164	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
165		Character
166		Date (mm/dd/yyyy)
167	1, Yes	Number
168	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
169	1, Yes	Number
170	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
171		Character
172		Date (mm/dd/yyyy)
173	1, Yes	Number
174	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
175	1, Yes	Number
176	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
177		Character
178		Date (mm/dd/yyyy)
179	1, Yes	Number
180	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
181	1, Yes	Number
182	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
183		Character
184		Date (mm/dd/yyyy)
185	1, Yes	Number
186	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
187	1, Yes	Number
188	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
189		Character
190		Date (mm/dd/yyyy)
191	1, Yes	Number

AMERICAN OVERSIGHT

	A	B
192	Sputum: State Result - 3	spec_sputum3Stateresult
193	Sputum: Sent to CDC - 3	spec_sputum3cdc
194	Sputum: CDC Result - 3	spec_sputum3CDCresult
195	Other specimen type - 1	spec_otherspecimen1_yn
196	If yes, specify type - 1	spec_otherspecimen1_spec
197	Other: Local Specimen ID - 1	spec_otherspecimen1id
198	Other: Collection date - 1	spec_otherspecimen1_dt
199	Other: State Lab Tested - 1	spec_otherspecimen1state
200	Other: State Result - 1	spec_otherspecimen1Stateresult
201	Other: Sent to CDC - 1	spec_otherspecimen1cdc
202	Other: CDC Result - 1	spec_otherspecimen1CDCresult
203	Other specimen type - 2	spec_otherspecimen2_yn
204	If yes, specify type - 2	spec_otherspecimen2_spec
205	Other: Local Specimen ID - 2	spec_otherspecimen2id
206	Other: Collection date - 2	spec_otherspecimen2_dt
207	Other: State Lab Tested - 2	spec_otherspecimen2state
208	Other: State Result - 2	spec_otherspecimen2Stateresult
209	Other: Sent to CDC - 2	spec_otherspecimen2cdc
210	Other: CDC Result - 2	spec_otherspecimen2CDCresult
211	Other specimen type - 3	spec_otherspecimen3_yn
212	If yes, specify type - 3	spec_otherspecimen3_spec
213	Other: Local Specimen ID - 3	spec_otherspecimen3id
214	Other: Collection date - 3	spec_otherspecimen3_dt
215	Other: State Lab Tested - 3	spec_otherspecimen3state
216	Other: State Result - 3	spec_otherspecimen3Stateresult
217	Other: Sent to CDC - 3	spec_otherspecimen3cdc
218	Other: CDC Result - 3	spec_otherspecimen3CDCresult
219	Additional State/local Specimen IDs:	lab_local_id1
220	Any additional comments/notes?	final_notes

AMERICAN OVERSIGHT

	C	D
192	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
193	1, Yes	Number
194	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
195	1, Yes	Number
196		Character
197		Character
198		Date (mm/dd/yyyy)
199	1, Yes	Number
200	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
201	1, Yes	Number
202	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
203	1, Yes	Number
204		Character
205		Character
206		Date (mm/dd/yyyy)
207	1, Yes	Number
208	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
209	1, Yes	Number
210	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
211	1, Yes	Number
212		Character
213		Character
214		Date (mm/dd/yyyy)
215	1, Yes	Number
216	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
217	1, Yes	Number
218	1, Positive 2, Negative 3, Pending 4, Not Done 5, Indeterminate	Number
219		Character
220		Character

AMERICAN OVERSIGHT

Instructions on Submission of CSV Files for the 'Human Infection of 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form' to CDC

While data on persons under investigation and laboratory-confirmed cases are most expediently provided to CDC through direct data entry in DCIPHER, CDC is able to receive exported data from other data management systems via a comma delimited file (CSV) if the following conditions are met:

1. The data contained within the CSV file are directly mapped and aligned to the data dictionary provided by CDC for the PUI and Case Report Form (available here). This includes:
    a. Naming conventions of data elements must match
    b. Variable types and response sets must match
    c. The number and order of variables. All variables must be included in the jurisdiction-provided CSV file in the same order as the CDC-provided CSV template;[a] extra variables not included in the CDC-provided template or data dictionary should not be sent to CDC

2. Data are sent as a CSV file by 9am Eastern Time daily to CDC via SAMs. If data are sent by 9am EST, and meet the criteria in #1, above, data will be imported into DCIPHER by 2pm EST daily.[b]
    a. If data are sent after 9am Eastern Time, they will not be included in any DCIPHER imports until the following day. This may result in laboratory testing delays, as CDC may not test laboratory samples without the priority PUI or case data (defined below). The priority PUI and case data are needed in order to identify samples for laboratory testing, and link samples and their results back to specific PUIs or cases.
    b. If data are not sent in the format outlined in #1, above, data will be returned to the reporting jurisdiction to correct the CSV formatting. This may result in laboratory testing delays, as CDC may not test laboratory samples without the priority PUI or case data (defined below).

3. Data should include cumulative PUI and case data, such that each day, the number of submitted records represents the full universe of PUIs and cases for the reporting jurisdiction.

4. Once it is determined that a jurisdiction has provided the CSV file in the correct format, there should be no changes to the CSV format for any future submissions of this file. Any changes to the format of the CSV file may result in return of the submitted data to the reporting jurisdiction, and subsequent delays in laboratory testing of samples. Consistency is key.

Instructions on how to submit data via SAMS are as follows:
Please upload the CSV file to the folder "COVID-19-Upload" at https://transfer2.cdc.gov or sams.cdc.gov. This upload requires level 2 SAMS access.

Please name your file as following: **NCOV2019_PUICASELIST_ST _YYYYMMDDHHMM**, where ST is the jurisdictional abbreviation; YYYYMMDD is the Date format for year, month, day; HHMM is the military time (24:00) of upload.

Please let eocevent333@cdc.gov know which SAMS box you will be sending your CSV file to.

AMERICAN OVERSIGHT

While CDC encourages reporting jurisdictions to provide all updated information on PUIs and cases as it becomes available, the following variables should be prioritized for submission at the time at which a PUI or laboratory-confirmed case is first reported. Please note that even if only information on the priority dataset are populated, the submitted CSV file must contain all data elements in the correct order, as noted in #1, above.

The priority dataset includes the following data elements (variable names in parentheses):

- CDC 2019-nCoV ID (cdc_ncov2019_id) **(required field)**
- Reporting jurisdiction (state) **(required field)**
- Current status of the person as PUI or laboratory-confirmed case (current_status)
- Report date of PUI to CDC (pui_cdcreport_dt)
- Report date of case to CDC (case_cdcreport_dt)
- Sex (sex)
- Age (age) and Age Units (ageunit)
- Symptoms present during course of illness (sympstatus)
- If symptomatic, onset date (onset_dt)
- Hospitalization status (hosp_yn)
- ICU Admission status (icu_yn)
- Death (death_yn)
- If female, currently pregnant (pregnant_yn)
- Travel to mainland China (exp_China)
- Travel to other non-US country (exp_othcountry)
- Travel to other non-US country, specify (exp_othcountry_spec)
- Household contact with a COVID-19 case patient (exp_house)
- Community contact with a COVID-19 case patient (exp_community)
- Any healthcare contact with a COVID-19 case patient (exp_health)
- Healthcare contact with a COVID-19 case patient, healthcare worker (exp_health_hcw)
- Exposure to a cluster of patients with ARDS with unknown etiology (exp_cluster)
- Specimen type (see series on specimen type)
- Specimen ID (see series on specimen ID)
- Specimen sent to CDC (see series on specimen sent to CDC)

CDC is available to answer questions about correct CSV formatting and data import into DCIPHER. For inquiries, please email eocevent118@cdc.gov and eocevent333@cdc.gov.

[a]Please note that the order of variables in the data dictionary may vary slightly from the order of variables in the CSV provided template. The data dictionary is necessary in order to identify appropriate naming conventions, variable types, and response sets, but the CDC-provided CSV template should be used to determine order of variables in the CSV file containing jurisdictional data sent to CDC.
[b]The initial data submission may take some additional processing time to assess the match between the jurisdictionally-provided CSV file and the CDC-provided data dictionary. Once the mapping has been confirmed to be accurate, CDC will operate on the schedule noted for data uploads.

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cdc_ncov2019_id,state,local_id,healthdept,nndss_id,contact_id,interviewer_ln,interviewer_fn,interviewer_org,interviewer_tele,interviewer_email,current_status,pui_cdcreport_dt,case_cdcreport_dt,res_county,res_state,ethnicity,sex,race_asian,race_aian,race_black,race_nhpi,race_white,race_unk,race_other,race_spec,dob,age,ageunit,pos_spec_dt,pos_spec_unk,pos_spec_na,pna_yn,acuterespdistress_yn,diagother,abxchest_yn,sympstatus,onset_dt,onset_unk,symp_res_dt,symp_res_yn,hosp_yn,adm1_dt,dis1_dt,icu_yn,mechvent_yn,mechvent_dur,ecmo_yn,death_yn,death_dt,death_unk,hc_work_yn,hc_work_china_yn,exp_wuhan,exp_hubei,exp_china,exp_othcountry,exp_othcountry_spec,exp_house,exp_community,exp_health,exp_health_pt,exp_health_vis,exp_health_hcw,exp_animal,exp_cluster,exp_other,exp_other_spec,exp_unk,cont_lab_us,cdc_ncov2019_sourceid_2,process_pui,process_cont,process_surv,process_epix,process_dgmqid,process_unk,process_other,process_other_spec,collect_ptinterview,collect_medchart,fever_yn,sfever_yn,chills_yn,myalgia_yn,runnose_yn,sthroat_yn,cough_yn,sob_yn,nauseavomit_yn,headache_yn,abdom_yn,diarrhea_yn,othsym1_yn,othsym1_spec,othsym2_yn,othsym2_spec,othsym3_yn,othsym3_spec,medcond_yn,cld_yn,diabetes_yn,cvd_yn,renaldis_yn,liverdis_yn,immsupp_yn,neuro_yn,neuro_spec,otherdis_yn,otherdis_spec,pregnant_yn,smoke_curr_yn,smoke_former_yn,resp_flua_ag,resp_flub_ag,resp_flua_pcr,resp_flub_pcr,resp_rsv,resp_hm,resp_pi,resp_adv,resp_rhino,resp_cov,resp_mp,resp_rcp,othrp,othrp_spec,spec_npswab1id,spec_npswab1_dt,spec_npswab1cdc,spec_npswab1state,spec_npswab2id,spec_npswab2_dt,spec_npswab2cdc,spec_npswab2state,spec_npswab3id,spec_npswab3_dt,spec_npswab3cdc,spec_npswab3state,spec_opswab1id,spec_opswab1_dt,spec_opswab1cdc,spec_opswab1state,spec_opswab2id,spec_opswab2_dt,spec_opswab2cdc,spec_opswab2state,spec_opswab3id,spec_opswab3_dt,spec_opswab3cdc,spec_opswab3state,spec_sputum1id,spec_sputum1_dt,spec_sputum1cdc,spec_sputum1state,spec_sputum2id,spec_sputum2_dt,spec_sputum2cdc,spec_sputum2state,spec_sputum3id,spec_sputum3_dt,spec_sputum3cdc,spec_sputum3state,spec_otherspecimen1_yn,spec_otherspecimen1_spec,spec_otherspecimen1id,spec_otherspecimen1_dt,spec_otherspecimen1cdc,spec_otherspecimen1state,spec_otherspecimen2_yn,spec_otherspecimen2_spec,spec_otherspecimen2id,spec_otherspecimen2_dt,spec_otherspecimen2cdc,spec_otherspecimen2state,spec_otherspecimen3_yn,spec_otherspecimen3_spec,spec_otherspecimen3id,spec_otherspecimen3_dt,spec_otherspecimen3cdc,spec_otherspecimen3state,lab_local_id1,final_notes,spec_npswab1Stateresult,spec_npswab1CDCresult,spec_npswab2Stateresult,spec_npswab2CDCresult,spec_npswab3Stateresult,spec_npswab3CDCresult,spec_opswab1Stateresult,spec_opswab1CDCresult,spec_opswab2Stateresult,spec_opswab2CDCresult,spec_opswab3Stateresult,spec_opswab3CDCresult,spec_sputum1Stateresult,spec_sputum1CDCresult,spec_sputum2Stateresult,spec_sputum2CDCresult,spec_sputum3Stateresult,spec_sputum3CDCresult,spec_otherspecimen1Stateresult,spec_otherspecimen1CDCresult,spec_otherspecimen2Stateresult,spec_otherspecimen2CDCresult,spec_otherspecimen3Stateresult,spec_otherspecimen3CDCresult

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From: Montgomery, Martha (CDC/DDID/NCHHSTP/DVH)

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Subject: Hepatitis A - all impacted states call

Date: Tuesday, February 18, 2020 3:11:10 PM

Hi everyone,

Just a quick reminder that the hepatitis A call for all impacted states is scheduled for this **Friday, February 21 at 2pm ET**. We don't have a specific topic scheduled. We want to give you an opportunity to have an open forum to discuss and share any recent questions, challenges, or successes you've had in your outbreaks. If you have any topics that you know you'd like to discuss, please email in advance.

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If you're busy with COVID-19, we understand if you're unable to join. However, we want to continue to support the hepatitis A response however is most helpful. Please let us know if you have any questions or concerns.

Thanks,

Hepatitis A Outbreak Response Team

Agenda

Roll call – Due to the large size, please have one representative from each jurisdiction to say "present". We will **not** be asking for case counts, hospitalizations, and deaths on this call.
CDC announcements
State announcements & questions
Action items

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From: Hofmeister, Megan (CDC/DDID/NCHHSTP/DVH)

To: Lesinger, Cindy (CDC adph.state.al.us); Nakema.Moss@adph.state.al.us; Michael.Cima@arkansas.gov; McCartney, Kellye (CDC arkansas.gov); Aaron Otis (CDC flhealth.gov); Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); Mark.ONeill@flhealth.gov; Andrea.Leapley@flhealth.gov; Wendy.Sweigert@flhealth.gov; Amy.Riggen@flhealth.gov; Ben.Sloat@dph.ga.gov; Ami.Gandhi@dph.ga.gov; Tracy.Kavanaugh@dph.ga.gov; Lovett, Sheila (CDC dph.ga.gov); Thoroughman, Douglas (CDC ky.gov); Robeson, Sara (CDC ky.gov); Amanda.Hunt@ky.gov; Johnson, Tisha (CDC ky.gov); jennifer.khoury@ky.gov; Schweitzer, Jody (CDC ky.gov); Kristy.Royalty@ky.gov; Anderson, Emily A. (CDC ky.gov); Sokol, Theresa (CDC la.gov); stacy.hall@la.gov; Jenna.IbergJohnson@la.gov; Frank Welch; Paul.Byers@msdh.ms.gov; Jannifer.Anderson@msdh.ms.gov; Kittle, Theresa (CDC msdh.ms.gov); Shipp, Rebecca; erica.wilson@dhhs.nc.gov; christina.caputo@dhhs.nc.gov; natalie.bontrager@dhhs.nc.gov; justin.albertson@dhhs.nc.gov; susan.sullivan@dhhs.nc.gov; Holmes, Wendy (CDC dhhs.nc.gov); Drociuk, Dan (CDC dhec.sc.gov); White, Stephen (CDC dhec.sc.gov); Cassandra.Jones@tn.gov; SHOC.Epidemiologist@tn.gov; Michelle.Fiscus@tn.gov; Haralson, Catherine (CDC tn.gov); Latoya.Antoine@tn.gov; John.Benitez@tn.gov; SHOC.Planning@tn.gov; Amy.Cox@tn.gov; Shavetta.Conner@tn.gov; Sean.J.Kice@tn.gov; Peter Koonz; Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Montgomery, Martha (CDC/DDID/NCHHSTP/DVH); Weng, Mark (CDC/DDID/NCHHSTP/DVH); Augustine, Ryan (CDC/DDID/NCHHSTP/DVH); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Teshale, Eyasu H. (CDC/DDID/NCHHSTP/DVH); Cooley, Laura A. (CDC/DDID/NCHHSTP/DVH); Chappell, Shauntrelle L. (CDC/DDID/NCIRD/ISD); Awwad, Hanan (CDC/DDID/NCIRD/ISD); Schwartz-Kitchens, Tricia (CDC/DDID/NCIRD/ISD); Crawford, Nathan E. (CDC/DDID/NCIRD/ISD); mschroeder@cste.org; Hamilton, Janet (CDC cste.org); Shah, Dhara (CDC cste.org); Danila, Richard (CDC state.mn.us); traxlelb@dhec.sc.gov; Sanders.Kelsey (DSHS); Leos.Greg (DSHS); Salinas.Andrea (DSHS); Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)

Cc: william.ledford@arkansas.gov

Subject: Hepatitis A Regional Call - HHS Regions 4 & 6

Date: Monday, February 3, 2020 12:14:56 PM

Hi Everyone,

We're still planning to hold the hepatitis A regional call this week, but understand that health departments may be overwhelmed with responding or preparing to respond to the novel Coronavirus. Please let me know today or tomorrow if a representative from your health department is planning to call in on Thursday. We want to be respectful of your time and competing priorities, so if there's not a "quorum" I'm happy to cancel the call and talk to anyone individually if specific issues have come up.

Thanks,
Megan

Megan Hofmeister, MD, MS, MPH
Division of Viral Hepatitis
Centers for Disease Control and Prevention
LXN7@cdc.gov
404-718-5458

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From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Announces Initial Funding to Jurisdictions Supporting COVID-19 Response
Date: Wednesday, March 4, 2020 2:23:12 PM

Dear Partner –

Today, the U.S. Department of Health and Human Services (HHS), through the Centers for Disease Control and Prevention (CDC) is announcing upcoming action to provide initial resources to a limited number of state and local jurisdictions in support of our nation's response to the coronavirus disease 2019 (COVID-19).

"State and local governments are the backbone of our public health system. They have been essential partners in the ongoing work to contain and mitigate the spread of COVID-19 in the United States," said HHS Secretary Alex Azar. "The Trump Administration is acting swiftly through every avenue we have to ensure state and local governments have the support they need to combat this outbreak."

"CDC is committed to working with state, local, tribal and territorial public health departments to mitigate community spread of novel coronavirus in this nation," said CDC Director Robert R. Redfield, M.D. "Our partners are on the front lines of this response and we support their efforts to increase needed public health capacity to confront the challenges this virus presents."

Using funds provided to CDC through the HHS Secretary's Transfer, CDC will:

- Award an initial $25 million cooperative agreement to the states and local jurisdictions who have borne the largest burden of response and preparedness activities to date. This is an initial award for those jurisdictions who require immediate assistance for activities such as monitoring of travelers, data management, lab equipment, supplies, staffing, shipping, infection control, and surge staffing. Once supplemental funding is provided, support will be provided to all states and local jurisdictions for a variety of critical public health activities.
- Award an initial $10 million cooperative agreement to state and local jurisdictions to begin implementation of coronavirus surveillance across the U.S., building on existing influenza activities and other surveillance systems. This initial award is for a limited number of jurisdictions. Once supplemental funding is provided, additional support will be provided to all states and local jurisdictions to enhancing testing and surveillance.

CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding.

For more information about COVID-19, please visit CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs

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U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

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From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Announces Initial Funding to Jurisdictions Supporting COVID-19 Response
Date: Wednesday, March 4, 2020 2:22:52 PM

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For more information about COVID-19, please visit CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs

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U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

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From:	Mariani, Lisa (HRSA)
To:	Rivkees, Scott A
Cc:	Mariani, Lisa (HRSA); McGough, John (HHS/IEA)
Subject:	HHS Awards Health Centers Funds to Support COVID-19 Response in Florida
Date:	Wednesday, March 25, 2020 2:54:35 PM

Dear Dr. Rivkees,

Yesterday, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), awarded **$4,518,410** to **47** health centers in Florida with funding provided by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. Health center recipients in Florida may use these awards to address screening and testing needs, acquire medical supplies and boost their telehealth capacity in response to the Coronavirus Disease 2019 (COVID-19) pandemic. Recognizing the urgency of the situation, and the important role health centers play in their communities, HHS is making funding for health center recipients in Florida available immediately.

Thank you for your critically important work in responding to the COVID-19 pandemic. The HRSA Office of Regional Operations and HHS Office of the Regional Director are committed to supporting your COVID-19 response efforts. Please do not hesitate to reach out to us with questions, concerns or requests for support and engagement.

Best,

Lisa Mariani
HRSA Regional Administrator, Region 4

John McGough
HHS Regional Director, Region 4

See the HHS press release for more information on these awards:
https://www.hhs.gov/about/news/2020/03/24/hhs-awards-100-million-to-health-centers-for-covid-19-response.html

For a list of all award recipients, visit https://bphc.hrsa.gov/emergency-response/coronavirus-covid19-FY2020-awards.

For more information about COVID-19, visit http://coronavirus.gov/ and https://www.hrsa.gov/coronavirus.

For more information about HRSA's Office of Regional Operations Region 4 visit https://www.hrsa.gov/about/organization/bureaus/oro/region-4.html

For more information about HHS' Regional Offices Region 4 visit https://www.hhs.gov/about/agencies/iea/regional-offices/region-4/index.html

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From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: HHS COVID-19 Update, 3-25
Date: Wednesday, March 25, 2020 6:47:19 PM

Dear Governor and State Health Officials:

The federal government continues to take aggressive and proactive steps to address the coronavirus (COVID-19) pandemic. The health and safety of the American people is our top priority.

Many of you have been asking how your companies can assist in meeting the needs imposed by this pandemic. This includes everyone from individuals and families, to companies who want to manufacture, donate, or sell PPE and other materials to help the effort.

We have the answer!

How Can You Help? FEMA released information for how to help via donations, volunteering and for the private sector. Their specific guidance includes:

- **Businesses that have medical supplies or equipment to donate** are asked to go to www.fema.gov and provide of the offer through our online medical supplies and equipment form. The direct web link is www.fema.gov/coronavirus/covid-19-donations.
- **Businesses that want to sell medical supplies or equipment** to the federal government, please email specifics to covidsupplies@fema.dhs.gov.
- **Licensed medical volunteers can offer their services** by registering with the Emergency System for Advance Registration of Volunteer Health Professionals. You can access a direct link to do so through fema.gov
- **Donate Blood**: One thing people can do to help is to donate blood. Many blood drives have been cancelled, impacting the supply. Blood donation centers have the highest standards of safety and infection control. To find where you can donate blood, visit redcross.org.

Here are other items released today:

CMS Lessening Provider Financial Burdens: CMS announced modifications to its accelerated /advanced payment programs for health care providers and suppliers experiencing cash flow concerns due to COVID-19. This guidance allows CMS to streamline the payment calculations and eliminates regional office approval and review of supporting documents in an effort to further help providers and lessen their financial hardships.

How to Manage COVID-19 in Correctional and Detention Facilities: CDC published interim guidance to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors.

1.

What to Do If You are A Traveler Returning from a High-Risk Country? CDC has released information on guidance for recommended actions to take upon returning from a high-risk country in terms of isolation procedures and what to do if you are sick.

How to Ensure Your Hospital is Prepared: CDC posted a comprehensive hospital preparedness checklist to help hospitals assess and improve their preparedness for responding to a community-wide outbreak of COVID-19.

Help for Facilities to Assess When to Discontinue Transmission-Based Precautions: To help prevent the spread of the virus that causes COVID-19 in healthcare facilities, CDC released a reference to guide healthcare regarding discontinuing transmission-based precautions and discharging hospitalized patients with COVID-19.

CMS Continues to Approve 1135 Waivers: CMS announced the approval of seven additional state Medicaid 1135 waivers bringing the total to 23 states with approved waivers. The list of states and waivers can be found here.

Updates on How to Collect, Handle, and Test Clinical Specimens: CDC updated their guidance for handling specimens to

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allow for only nasal swabs if a nasopharyngeal is not available when collecting specimens to test for COVID-19. FDA also released new FAQs on diagnostic testing for labs, manufacturers and general questions.

Watch Public Health Leaders Answer Your Public Health Questions:

- How Can You Keep the Most Vulnerable Safe from Coronavirus? (VIDEO)
- How Can You Engage in Social Distancing? (VIDEO)
- Is It Still Safe to Donate Blood? (VIDEO)
- Dr. Deborah Birx: If You Feel Sick, Stay Home (VIDEO)

Stay safe and keep 6 feet away!

Laura

Laura Trueman, Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
(202) 690-6060

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From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Releases Funding and Other Resources for COVID-19
Date: Wednesday, March 11, 2020 3:56:42 PM

Dear Partner –

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19. We highly value our strong ongoing partnership, and hope to continue to be a resource to you as you implement community mitigation techniques. As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

Funding for States to Address COVID-19
Perhaps of keenest interest to you and your health officials is an update on funding for states and communities to address mitigation of COVID-19. Today, the Department of Health and Human Services (HHS) is announcing upcoming action by the Centers for Disease Control and Prevention (CDC) to provide resources to state and local jurisdictions in support of our nation's response to the coronavirus disease 2019 (COVID-19).

The $8.3 billion dollar Supplemental passed by Congress included statutory language which prescribed the exact formula for disbursing the money: states will receive 90% of their 2019 CDC PHEP grants. This marks the first tranche of funding to states from the $8.3 billion supplemental. Today, CDC is contacting State Health Officers to move forward with awarding over $560 million to states, localities, territories, and tribes. CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding. To view the list of CDC funding actions to jurisdictions, click here.

Helping Communities Know Mitigation Strategies
Yesterday, CDC released their "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission." Essentially, this is a guide for communities describing possible mitigation strategies for communities dealing with transmission at three different levels: (1) None/Minimal, (2) Moderate, or (3) Substantial. Community mitigation strategies, which are non-pharmaceutical interventions, are often the most available interventions to help slow the transmission of COVID-19 in communities. The Mitigation Plans include a set of actions that persons and communities can take to slow the spread of respiratory virus infections. The Community Mitigation Plan can be found here.

Guidance on Infection Control For Healthcare Workers
Yesterday, CDC released updated guidance on infection prevention and control recommendations. Healthcare workers are fighting this outbreak on the front lines, and this guidance is intended to provide assistance to healthcare settings that are handling suspected or confirmed cases of COVID-19. This guidance is applicable to all U.S. healthcare settings, but not for non-healthcare settings. There is separate guidance for that. The new guidance on infection control can be found here.

Guidance on Laboratories
The CDC has been actively working to address the need for testing across the country. In addition to public health laboratories, private labs are doing testing. In addition to reviewing

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the Updated Guidance on Evaluating and Testing Persons for Coronavirus Disease 2019, the CDC recently updated the FAQ website for laboratories, and we encourage you to read through the site to answer preliminary questions, though we stand ready to answer other questions that you may have.

OMB Flexibilities

On March 9, 2020, OMB issued a memo that provides administrative relief for recipients and applicants of Federal financial assistance who are directly impacted by COVID-19. The grant flexibilities include 10 actions that HHS can take to provide short-term administrative and financial management relief, allowing funds to be awarded quicker and giving grantees the ability to focus on their critical response, research, or services. More information can be found here.

General Preparation Information

On March 9, 2020, the White House Coronavirus Task Force released practical steps that we recommend posting and sharing to keep workplaces, school, home and commercial establishments safe. This information can be found here.

As the President, the Vice President, and the entire White House team continue to stress, the COVID-19 response is a whole-of-government effort. Each department has a number of specific resources. We encourage you to explore those resources as necessary to respond to the situation in your communities.

If you have any questions on these items or other issues, please feel free to reach out.

Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Releases Funding and Other Resources for COVID-19
Date: Wednesday, March 11, 2020 3:55:51 PM

Dear Partner –

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19. We highly value our strong ongoing partnership, and hope to continue to be a resource to you as you implement community mitigation techniques. As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

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Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: HHS Statement on Coronavirus Supplemental Request
Date: Monday, February 24, 2020 10:04:25 PM

Dear Partner –

Please find below HHS's statement on the coronavirus supplemental request.

"The Administration has been effectively utilizing all available resources to protect the American people from COVID-19. Today, the White House sent a supplemental request to Congress to make $2.5 billion available for COVID-19 response efforts, including an emergency supplemental appropriation of $1.25 billion. HHS will also use the Secretary's transfer authority to provide needed resources to continue the Department's robust and multi-layered public health preparedness and response efforts – including public health surveillance, epidemiology, laboratory testing, support for state and local governments and other key partners, advanced research and development of new vaccines, therapeutics and diagnostics, advanced manufacturing enhancements, and support for the Strategic National Stockpile."

Read the letter here: https://www.whitehouse.gov/wp-content/uploads/2020/02/Coronavirus-Supplemental-Request-Letter-Final.pdf

Please let us know if there are any questions.

Sincerely,
Darcie

Darcie Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

From:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019; Brower, Melissa (CDC/DDPHSS/CSELS/OD); Smith, Teresa M. (CDC/DDPHSS/CSELS/DSEPD); Duggan, Natalie (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD); Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD); Duncan, Heather (CDC/DDPHSS/CSELS/DSEPD); Olivares, Dagny (CDC/DDPHSIS/CPR/DEO)
Subject:	how to handle any COVID-19 speaking requests
Date:	Friday, February 28, 2020 5:04:54 PM
Attachments:	Dr Schuchat_COVID-19_2020.jpg

Dear EISOs and LLS Fellows,

As the response to COVID-19 continues to evolve, it is increasingly likely that many of you (especially EISOs and LLS assigned to states) will be approached to participate in media interviews. During any emergency response that requires the activation of CDC's EOC, all communication functions are handed through the Joint Information Center (JIC) in the EOC. Decisions about who may serve as a CDC spokesperson with regard to media interviews are made by the public affairs specialists working in the JIC in collaboration with the Indecent Manager and CDC leadership. Those decisions are also guided by HHS's Office of the Assistant Secretary for Public Affairs (ASPA).

During EOC-led responses, a very limited number of spokespeople are approved to speak to media on behalf of CDC. In a rapidly evolving emergency response, it is critical that our messages remain as consistent as possible, are based on the most current information, and include important framing and nuances. The staff best positioned to deliver these nuanced messages are on all the calls, involved in all the conversations, and briefed on every aspect of the response = senior leaders at CDC (picture attached of EIS alum delivering key messages).

Please understand we want you to have as many opportunities as possible to talk with media about your work. This is a time when it's in the best interest of the agency and the public to limit the number of people talking to media for the reasons described above. This is also in your best interest, as it helps ensure that you will not be put in the position of being asked to speak and comment about things that are beyond the scope of your specific work. When media quote a CDC employee, that employee is invariably presented as speaking on behalf of the entire agency. Asking you to speak now offers far more risk than benefit given the fast-moving and politically complicated nature of the response.

Guidance is being developed and will be issued soon for all staff deployed to the field. **Any requests to speak about COVID-19 should be directed to the following address** eocjicmedia2@cdc.gov. Thanks for your cooperation and contributions to a complicated and ever evolving response.

For those of you that get a good weekend, have a good weekend. For those of you working – thanks for your service on behalf of EIS/LLS and CDC.

Regards,
Eric

Eric Pevzner, PhD, MPH

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CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.


please consider the environment before printing this e-mail.

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Dr Schuchat White house - Goog | CDC's Dr. Anne Schuchat on

cnbc.com/video/2020/02/26/cdcs-dr-anne-schuchat-on-preventing-the-spread-of-coronavirus.html

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President Trump: Coronavirus risk to American people remains very low



Alex Azar, HHS Secretary on US coronavirus cases so far



What's behind the sudden coronavirus fear



'This is not a time to be a fiscal

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From: Pritchard, Scott
To: eocevent185@cdc.gov
Cc: Blackmore, Carina
Subject: ID Provider Request - PUI 0001106
Date: Wednesday, February 12, 2020 12:48:38 PM

See a note from the ID doc treating PUI 0001106, who tested negative for nCoV (NP/OP/sputum) yesterday. If a clinical expert on coronavirus could talk to Dr. Hsu we would appreciate it. Please call me on my cell to coordinate.

Thanks for informing us about the negative coronavirus result and appreciate you sending the written documentation to us when you receive. Even though the test result came after our conversation below, his condition is not improving. He remains febrile, and yesterday patient had some desats and transient hypotension with worsening R lung infiltrate, not responding to antimicrobials, increasing bands and LFTs as well, although he is a bit more stable now. We've elected to keep him on airborne / contact at this point as we don't know what pathogen he might have. Dr. Levent (the treating peds ID physician) & I discussed last night and we have a few questions:

1. While RT-PCR is clearly very sensitive, there could be some factors that could suggest false negative – the quality of the swabs collected and also the timing of swab collection within the natural course of this disease. For most viral diseases, I would expect positive PCR early during his febrile illness (which he was), but not sure. In other words, clinically he remains ill without a diagnosis. What is the likelihood of a false negative in this setting and would CDC be agreeable to recollecting a sample?
2. Would it still be possible to talk with the coronavirus CDC expert?

We're not doubting CDC's result, but as clinicians we are trained to put the puzzle pieces together and so far not successful. We recognize epidemiologically he neither fit the close contact with nCoV nor was he from Hubei, but despite all our commercial PCR tests / urine antigen, etc everything has come back negative so no alternative diagnoses. We will keep searching & managing him appropriately.

Vincent Hsu

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
Division of Disease Control and Health Protection

Phone: 850-245-4406
Cell: 850-251-5558
Fax: 850-414-6894

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24/7 EPI Hotline: (850) 245-4401
Email: scott.pritchard@flhealth.gov

Physical Address:
4025 Esplanade Way, Room 240-H
Tallahassee, FL 32399-1720

Mailing Address:
4052 Bald Cypress Way, Bin A-12
Tallahassee, FL 32399-1720

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From: DNPAO Comm TA (CDC)
To: DNPAO Comm TA (CDC)
Subject: Important Updates to April-June 2020 sample social media packet
Date: Monday, March 16, 2020 2:01:32 PM

Dear State and Community Health Media/Communication Contacts,

In the sample social media packet we sent last week, we included posts regarding April 18 physical activity events. See below for an update on those. Please feel free to edit these posts-- and all the posts-- to reflect what is taking place in your location and to be sensitive to what is happening related to COVID-19 locally.

- National Park Week's Junior Ranger Day and Fee Free Day – Some site are temporarily closed; this may impact National Park Week activities. Visit the National Park Service website for more information.

- Rails to Trails Opening Day – Rails-to-Trails Conservancy has postponed the event.

- YMCA Healthy Kids Day® – Visit the web page or contact your local YMCA for updates.

Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

AMERICAN OVERSIGHT

From: DNPAO Comm TA (CDC)
To: DNPAO Comm TA (CDC)
Subject: Important Updates to April-June 2020 sample social media packet
Date: Monday, March 16, 2020 2:01:23 PM

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AMERICAN OVERSIGHT

From:	Gellis, Sean
To:	Brian.Berkowitz@djj.state.fl.us; Francis.Carbone@apdcares.org; bill.chorba@deo.myflorida.com; dunsonda@flalottery.com; javier.enriquez@myflfamilies.com; fairclothc@fdva.state.fl.us; Erik.Fenniman@dot.state.fl.us; terrence.a.gorman@us.army.mil; stefan.grow@ahca.myflorida.com; mark.hamilton@floridarevenue.com; jasonjones@fdle.state.fl.us; lisamartin@fcor.state.fl.us; Brad.Mcvay@dos.myflorida.com; Matthew.Mears@fldoe.org; kerven.l.montfort.mil@mail.mil; Norton.Emily; erik.sayler@em.myflorida.com; kenneth.Steely@fdc.myflorida.com; StLaurent, Louise; Craig Thomas; Ray.treadwell@myfloridalicense.com; christieutt@flhsmv.gov; Justin.g.wolfe@dep.state.fl.us; tritschlerr@elderaffairs.org
Cc:	Jacquot, Joe; Primrose, Nicholas; Uthmeier, James; Colleen.Ernst@eog.myflorida.com; Pratt, Joshua; O"Connor, Kasey
Subject:	IMPORTANT: Telework Guidance and Template Agreement for Consideration for Employees of the State Personnel System (COVID-19)
Date:	Friday, March 13, 2020 3:33:25 PM
Attachments:	image001.png image003.png image005.png image007.png DMS Telework Agreement Template.doc
Importance:	High

Good afternoon,

Telework can be an effective and useful tool for supporting an agency's Continuity of Operations Plan (COOP) during a declared health emergency such as COVID-19.

The purpose of this document is to aid and guide state agencies as telework is being evaluated and considered as part of each agency's response to COVID-19 to ensure required staffing levels are maintained while addressing employee health concerns.

- Telework connected with a declared health emergency must be evaluated on a case by case basis. Not all positions will be eligible for telework nor will all employees be suited for telework due to a variety of reasons. However, telework is a viable option to assist agencies in maintaining continuity of operations during a health emergency.

- If not already determined, agencies should evaluate if the duties of a given position/job or a portion of the work can be effectively performed away from the regular work location.

- If the nature of an employee's work responsibilities can be accomplished away from the regular work location and if any necessary technological/equipment needs can be satisfied, the agency may permit and encourage employees to telework as a way to reduce the face-to-face contacts between employees (social distancing).

- Agencies should identify available equipment (laptops, telephones, etc.) to be assigned to employees for the purpose of teleworking. Consideration should be given to which positions are essential to operations when prioritizing the use of appropriate equipment for telework.

- Agencies should review their telework policies to ensure they are current and consider whether any component of their policies should be modified to allow broader use of telework as appropriate.

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If a position is deemed eligible for telework, the manager and employee will need to complete a written agreement that specifies the terms and conditions of the arrangement and provides for the termination of the telework arrangement upon the agency's determination that it is no longer necessary.
    - Agencies may want to prepare a telework agreement that includes the basic components for short-term telework arrangements associated with the current health emergency. (See attached template)

- In evaluating telework eligibility, considerations should include:
    - Is the position essential to the agency's required responsibilities?
    - Although an essential position, can the duties be performed away from the official worksite for a defined, short period of time? If so, how long?
    - Are there significant portions of the job that can be done away from the official worksite?
    - Does the position need continual supervision or input from others that is only available from the official worksite?
    - Is contact with other employees/customers required every day? Can contacts be accomplished through various forms of technology?
    - Are needed reference materials to perform the work available/accessible?
    - Is data security maintained?
    - Is specialized equipment or technology available at the employee's home?
    - Is the home workspace appropriate for telework?

- Although a position or job class may be identified by the agency as telework eligible, an evaluation of whether a given employee is an appropriate candidate for telework should be conducted. Agencies should consider individual employee factors such as the employee's:
    - Ability to work independently;
    - Comfort level with the required technology;
    - Past performance levels;
    - Dependability and trustworthiness; and
    - Level of self-motivation.

- Employees who are unable to work due to illness or who have sick family members under their care will not be good candidates for telework.

- Employees who are caring for well children due to school or day care closures may be able to perform portions of their work from home, depending on individual circumstances (e.g., the age and level of independence of the child).

- For additional guidance on telework, please refer to the DMS-HRM policy guideline titled *Identifying Positions Appropriate for Telework and Determining Employee Eligibility*.

Thank you!

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Sean W. Gellis | Interim General Counsel
Office of the General Counsel
850-922-6617 (office) | 850-508-9219 (mobile)
Florida Department of Management Services
We Serve Those Who Serve Florida



How Are We Doing? Click Here to Take the DMS Customer Satisfaction Survey

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Additionally, please note that Florida has a very broad public records law. Unless expressly exempt, this or any other written communication with this office may be subject to public disclosure.

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AGREEMENT FOR TEMPORARY TELEWORK ARRANGEMENT TEMPLATE
Insert Agency Name
(For use when telework is associated with a health emergency
in support of an agency's Continuity of Operations Plan)

This is a telework agreement between _____ (agency) and _____ (employee).

Period covered: From _____ through _____.

The noted employee agrees to participate in the telework program and to follow all applicable statutes, rules, policies, procedures, and guidelines. The agency approves the employee's participation in telework as specifically outlined in this agreement.

Duration: This agreement will be valid for the period outlined above or as extended or otherwise modified by the agency.

Pay and Attendance: All pay and leave will be based on the employee's established work schedule. The employee's time and attendance will be recorded based on actual hours worked in accordance with the Fair Labor Standards Act.

Overtime: An employee working overtime will be compensated in accordance with applicable law and rules. Overtime must be approved in advance in accordance with agency policy, and although compensated, unauthorized overtime may be subject to disciplinary action.

Leave: Employees must obtain supervisory approval before taking leave in accordance with established agency procedures. The employee agrees to follow established procedures for requesting and obtaining approval of leave.

Equipment: The supervisor and the employee must agree upon the equipment, if applicable, to be used in telework. The State is not required to provide equipment for the home office; however, with the approval of the supervisor, the teleworker may be provided State-owned equipment necessary to perform work assignments.

Maintenance of Equipment: Equipment provided by the agency must be protected against damage and unauthorized use. Agency-owned equipment will be serviced and maintained by the agency. Equipment provided by the employee will be at no cost to the agency and will be maintained by the employee.

Costs: The agency will not be responsible for operating costs, home maintenance, or any other incidental costs (e.g., utilities, internet, etc.), associated with the use of the employee's residence for telework.

Workers' Compensation: The employee is covered by workers' compensation if injured in the course of performing official duties at the telework location.

Liability: The agency will not be liable for damages to the employee's property resulting from participation in the telework program. In signing this document, the employee agrees to hold the State harmless against any and all claims, excluding workers' compensation claims.

Verification of Home Safety: In signing this agreement, the employee verifies that the home office provides workspace that is free of safety and fire hazards. In addition, the employee will not conduct face-to-face business at his or her residence.

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Data Security: While teleworking, the employee will apply safeguards which are approved by the agency to protect records and electronic data from unauthorized disclosure or damage.

Termination of Agreement: It is understood by the employee that teleworking is a privilege. The Department reserves the right to terminate this agreement at any time and require the employee to report to work in-person.

Work Hours and Location: The working hours and work location agreed to as a part of the Telework Agreement, which may be modified as needed by agency management, are as follows:

Telework Location: _____

General Work Hours:

	(Hours)
Monday:	_____
Tuesday:	_____
Wednesday:	_____
Thursday:	_____
Friday:	_____
Saturday:	_____
Sunday:	_____

This agreement establishes the terms and conditions applicable for this period of telework.

Employee: _____ Date: _____

Supervisor: _____ Date: _____

Approving Authority: _____ Date: _____

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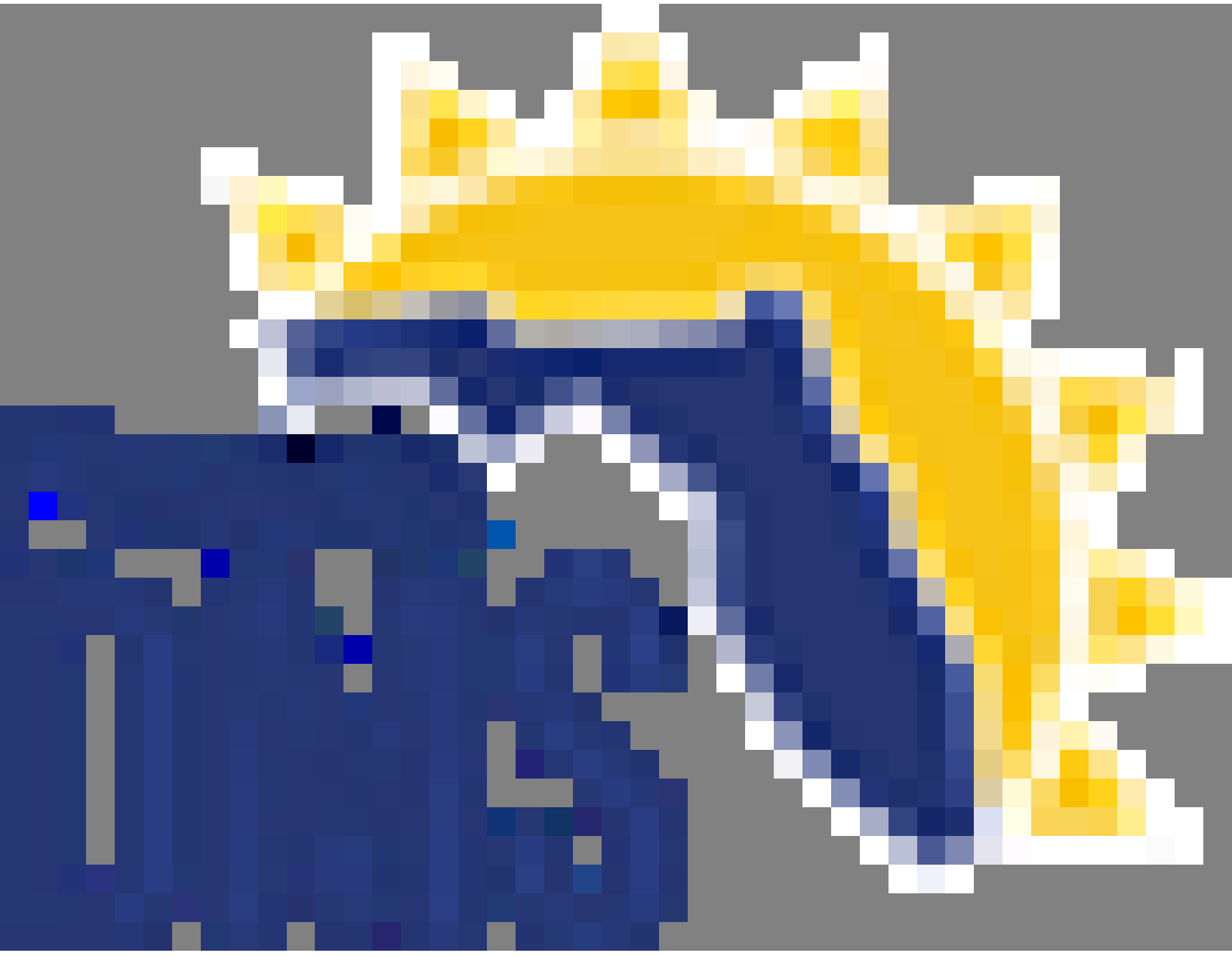

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From:	Gellis, Sean
To:	Brian.Berkowitz@djj.state.fl.us; Francis.Carbone@apdcares.org; bill.chorba@deo.myflorida.com; dunsonda@flalottery.com; javier.enriquez@myflfamilies.com; fairclothc@fdva.state.fl.us; Erik.Fenniman@dot.state.fl.us; terrence.a.gorman@us.army.mil; stefan.grow@ahca.myflorida.com; mark.hamilton@floridarevenue.com; jasonjones@fdle.state.fl.us; lisamartin@fcor.state.fl.us; Brad.Mcvay@dos.myflorida.com; Matthew.Mears@fldoe.org; kerven.l.montfort.mil@mail.mil; Norton.Emily; erik.sayler@em.myflorida.com; kenneth.Steely@fdc.myflorida.com; StLaurent, Louise; Craig Thomas; Ray.treadwell@myfloridalicense.com; christieutt@flhsmv.gov; Justin.g.wolfe@dep.state.fl.us; tritschlerr@elderaffairs.org
Cc:	Jacquot, Joe; Primrose, Nicholas; Uthmeier, James; Colleen.Ernst@eog.myflorida.com; Pratt, Joshua; O"Connor, Kasey
Subject:	IMPORTANT: Use of Sick Leave and Emergency Leave Transfer (COVID-19)
Date:	Monday, March 16, 2020 2:11:03 PM
Attachments:	image001.png image003.png image005.png image007.png 63 DMS Suspension of Rules 3-16-2020.pdf EmergencyLeaveDonationForm.docx COVID-19 Emergency Leave Transfer Program.docx

---

Good afternoon,

In response to our public health emergency and to help contain the spread of COVID-19, the Governor is allowing state employees the flexibility to donate and transfer available leave (sick, annual, special compensatory, and regular compensatory leave) to other state employees (intra- and inter-agency). This flexibility will also help mitigate the impacts of school closures and observe the Centers for Disease Control and Prevention and the Florida Department of Health's social distancing recommendations.

In order to assist employees who may not have enough leave to cover necessary absences, the Department of Management Services (DMS) is suspending the administrative rule provisions governing the existing sick leave transfer program to expand the opportunities for employees to transfer sick, annual, special compensatory, and regular compensatory leave to fellow employees.

Under this temporary COVID-19 Emergency Leave Transfer program, employees will have the ability to donate sick, annual, special compensatory leave, or regular compensatory leave to employees in need. The following requirements will govern this program:

- Employees who donate must retain at least 80 hours of sick leave.
- Employees who donate must transfer at least eight hours of leave to the recipient.
- Employees eligible for disability leave may not receive donations.
- Intra-agency and inter-agency donations are allowed.
- Unused leave donations will be returned to donating employees once Executive Order 20-52 expires.

Employees in need of leave donations and employees willing to donate leave should work directly with their agency HR offices. DMS has created the attached form that can be used to facilitate the leave donation process.

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In addition, DMS has suspended Rule 60L-34.0042(3), Florida Administrative Code for the particular purpose of allowing State Personnel System employees the flexibility to utilize sick leave for childcare or dependent care purposes.

If you have any questions regarding this temporary COVID-19 Emergency Leave Transfer program, please contact Matt Gregory at 850-921-4618, John Apthorp at 850-922-1274, or Mark Helms at 850-487-1508.

This message is being cascaded to Chiefs of Staff, Administration Directors, HR Directors, Communications Directors, and Legislative Directors.

Thank you!!

Sean W. Gellis | Interim General Counsel
Office of the General Counsel
850-922-6617 (office) | 850-508-9219 (mobile)
Florida Department of Management Services
We Serve Those Who Serve Florida



How Are We Doing? Click Here to Take the DMS Customer Satisfaction Survey

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Additionally, please note that Florida has a very broad public records law. Unless expressly exempt, this or any other written communication with this office may be subject to public disclosure.

AMERICAN OVERSIGHT

STATE OF FLORIDA
DEPARTMENT OF MANAGEMENT SERVICES

IN RE: SUSPENSION OF RULES, PURSUANT TO EXECUTIVE ORDER NUMBER 20-52, MADE NECESSARY BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

DMS EO 20-01

_____/

EMERGENCY ORDER

WHEREAS, the Governor of the State of Florida issued Executive Order No. 20-52 in response to the COVID-19 Public Health Emergency which poses a severe threat to the entire State of Florida and requires that timely precautions are taken to protect the communities, critical infrastructure, and general welfare of this State;

WHEREAS, Section 4(B) of Executive Order No. 20-52 provides that each State agency may suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the order or rules of that agency, if strict compliance with the provisions of any such statute, order, or rule would in any way prevent, hinder, or delay necessary action in coping with the emergency, including rules affecting the conditions of employment and the compensation of employees; and

WHEREAS, Rule 60L-34.0042(5), Florida Administrative Code, currently allows intra-agency and inter-agency transfers of sick leave only when an employee has completely exhausted all of their personal leave balances.

NOW THEREFORE, I hereby find that the Department of Management Services' timely performance of disaster response functions related to the COVID-19 Public Health Emergency is hindered by the application of procedures imposed by Rule 60L-34.0042(5), Florida Administrative Code.

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Therefore, pursuant to Section 4(B) of Executive Order No. 20-52, I hereby issue the following authorization(s):

1. Suspend Rule 60L-34.0041, Florida Administrative Code, and Rule 60L-34.0042(5), Florida Administrative Code, for the particular purpose of allowing state employees of the State Personnel System the flexibility to donate and transfer leave (sick, annual and personal) to other state employees of the State Personnel System (intra and inter-agency) to mitigate the impacts of school closures and adopt Centers for Disease Control and Department of Health social distancing recommendations, within the following parameters:
    a. A donating employee must retain at least 80 hours of sick leave in case of future illness;
    b. A donating employee must transfer at least eight hours of leave to a receiving employee;
    c. The provisions of Rule 60L-34.0042(5)(e)3., Florida Administrative Code remain in effect, meaning that any state employee who is eligible for disability leave is not eligible to receive donated or transferred leave.
2. Suspend Rule 60L-34.0042(3), Florida Administrative Code, for the particular purpose of allowing state employees of the State Personnel System the flexibility to utilize sick leave for childcare or dependent care purposes.

The effective dates of this Order shall correspond with the effective dates of Executive Order No. 20-52.

(Signature Page Follows)

AMERICAN OVERSIGHT

By Order of the Secretary of the Department of Management Services executed this 16th day of March, 2020, in Tallahassee, Leon County, Florida.

JONATHAN R. SATTER, Agency Secretary
Department of Management Services
4050 Esplanade Way, Suite 285
Tallahassee, Florida 32399

Certificate of Clerk:

Filed in the office of the Clerk of
the Department of Management Services
on this 16th day of March, 2020.

Agency Clerk

AMERICAN OVERSIGHT

Department of MANAGEMENT SERVICES
Division of State Human Resource Management

COVID-19: Emergency Leave Transfer Program Instructions for SPS HR Offices

March 16, 2020

In response to our public health emergency and to help contain the spread of COVID-19, the Governor is allowing state employees the flexibility to donate and transfer available leave (sick, annual, special compensatory, and regular compensatory leave) to other state employees (intra- and inter-agency). This flexibility will also help mitigate the impacts of school closures and observe the Centers for Disease Control and Prevention and the Florida Department of Health's social distancing recommendations.

In order to assist employees who may not have enough leave to cover necessary absences, the Department of Management Services (DMS) is suspending the administrative rule provisions governing the existing sick leave transfer program to expand the opportunities for employees to transfer sick, annual, special compensatory, and regular compensatory leave to fellow employees.

Under this temporary COVID-19 Emergency Leave Transfer program, employees will have the ability to donate sick, annual, special compensatory leave, or regular compensatory leave to employees in need. The following requirements will govern this program:

- Employees who donate must retain at least 80 hours of sick leave.
- Employees who donate must transfer at least eight hours of leave to the recipient.
- Employees eligible for disability leave may not receive donations.
- Intra-agency and inter-agency donations are allowed.
- Unused leave donations will be returned to donating employees once Executive Order 20-52 expires.

Employees in need of leave donations and employees willing to donate leave should work directly with their agency HR offices. DMS has created the attached form that can be used to facilitate the leave donation process.

In addition, DMS has suspended Rule 60L-34.0042(3), Florida Administrative Code for the particular purpose of allowing State Personnel System employees the flexibility to utilize sick leave for childcare or dependent care purposes.

If you have any questions regarding this temporary COVID-19 Emergency Leave Transfer program, please contact Matt Gregory at 850-921-4618, John Apthorp at 850-922-1274, or Mark Helms at 850-487-1508.

AMERICAN OVERSIGHT

State of Florida — State Personnel System

COVID-19 EMERGENCY LEAVE TRANSFER

REQUEST TO DONATE

Part I - Request to Donate Leave Hours - Donor Information

I certify that I am eligible and willing to donate my personal sick, annual, special compensatory, or regular compensatory leave credits as specified below and that I will maintain at least 80 hours of sick leave and will transfer at least 8 hours to the recipient.

Print Name: _____ People First Employee ID#: _____

Agency/Division/Bureau or District/Region/Institution: _____

Work Telephone Number: (_____) _____

I authorize my employer to transfer _____ hours of sick leave, _____ hours of annual leave, _____ hours of special compensatory leave, and _____ hours of regular

_____ _____

Signature Date

RECIPIENT INFORMATION

Recipient's Name: People First Employee ID# (if known):

Agency/Division/Bureau or District/Region/Institution:

Part II - For Personnel Office(s) Use

Recipient's Agency

Date: ____/____/_____

Send To:

Leave Administrator

Personnel Office/Human Resources

Department of _____

Telephone: Fax: _____

Hours Credited: PPE: ____/____/_____

Hours Credited: PPE: ____/____/_____

Hours Credited: PPE: ____/____/_____

Hours Credited: PPE: ____/____/_____

☐ Approved Per ☐ Disapproved Per

Leave Administrator's Signature:

Donor's Agency

Date: ____/____/_____

Send To:

Leave Administrator

Personnel Office/Human Resources

Department of _____

Telephone: _____

Fax: _____

Hours Charged: PPE:

☐ Approved ☐ Disapproved

Leave Administrator's Signature:

Print Leave Administrator's Name: _____

AMERICAN OVERSIGHT

Print Leave Administrator's Name: _____	To return unused leave to the donor, complete Part III of this form.

Rev. 3/15/2020

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Part III - Return of Unused Leave Hours

To:

_____
Agency

_____
Leave Administrator

_____
Address

From:

_____
Agency

_____
Leave Administrator

_____
Signature

Please credit _____ hours back to:

_____
Employee Name

People First Employee ID#: _____

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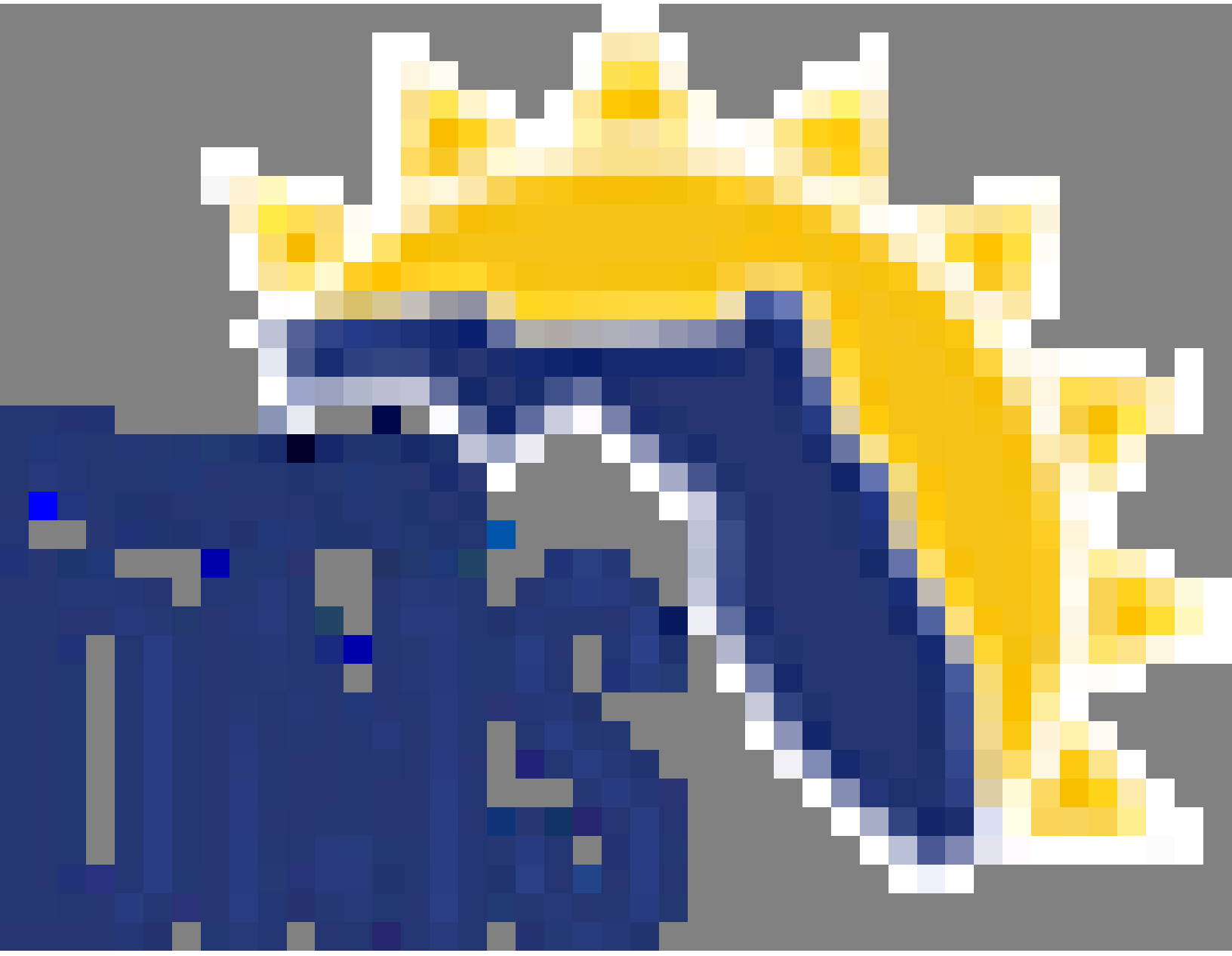

AMERICAN OVERSIGHT



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AMERICAN OVERSIGHT

From: Ann Hill

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AMERICAN OVERSIGHT

Subject: information received from one of our SME"s
Date: Monday, March 16, 2020 9:53:58 AM

To all of the fine health care providers and emergency management professionals that we have had the opportunity to train, coach and interact with during the past several years. Please be assured that we appreciate the very critical work you are doing and know that you are in our thoughts and prayers as we go through the coronavirus pandemic. We realize that we had seen an increase in health care providers and emergency managers in our region of the state for incident management classes. We commend you for your interest and participation in these classes and hope that you will be able to utilize the information that we have given you.

As you go through the next several weeks, we wanted to remind you of some of the lessons that we stress on lengthy incidents:

1) Take care of your personal health and well being first and foremost. Get appropriate rest and if you are traveling to areas away from home to work be sure your kit is ready to go with any needed supplies.

2) If you are working with a group **watch out for each other**. Remember that your team is only as strong as the weakest member. There will be long hours, stressful situations and different team members may be struggling at different times. Get them help to overcome the issues that they are having at the time.

3) Watch vehicle travel when you are tired. Carpool when you can and pull over and rest if you are sleepy. We don't want to lose you on the highway.

4) Meet with your group periodically to discuss issues that can potentially help your team members function more efficiently. What are the alligators out there that may affect us today, tomorrow, and next week? Stay ahead of the situation.

5) Maintain your situational awareness. Be aware of what is happening in the vicinity you are working. Constantly reassess the information you are receiving and determine what is important and what isn't.

6) Communication is critical to being successful on a team of responders. Communicate often and openly and get the critical information to those who need it.

7) Fill out the necessary positions on you teams so that those in Command and General Staff positions are not overwhelmed doing tasks that should be accomplished by subordinates.

8) Have a plan and share it with all of the team members, get buy-in and look at all options. Remember to avoid groupthink.

Your work over the next weeks is going to be critical to the communities that we live and work in. Should you feel the need for mentoring or have open task books that need to be

AMERICAN OVERSIGHT

signed off we would be pleased to help you with these tasks. Again, please know that we appreciate each of you and look forward to our next opportunity visit again. Please reach out to us if we can help you with any Incident Management Resources.

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

From: Ann Hill

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3) Watch vehicle travel when you are tired. Carpool when you can and pull over and rest if you are sleepy. We don't want to lose you on the highway.

4) Meet with your group periodically to discuss issues that can potentially help your team members function more efficiently. What are the alligators out there that may affect us today, tomorrow, and next week? Stay ahead of the situation.

5) Maintain your situational awareness. Be aware of what is happening in the vicinity you are working. Constantly reassess the information you are receiving and determine what is important and what isn't.

6) Communication is critical to being successful on a team of responders. Communicate often and openly and get the critical information to those who need it.

7) Fill out the necessary positions on you teams so that those in Command and General Staff positions are not overwhelmed doing tasks that should be accomplished by subordinates.

8) Have a plan and share it with all of the team members, get buy-in and look at all options. Remember to avoid groupthink.

Your work over the next weeks is going to be critical to the communities that we live and work in. Should you feel the need for mentoring or have open task books that need to be

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signed off we would be pleased to help you with these tasks. Again, please know that we appreciate each of you and look forward to our next opportunity visit again. Please reach out to us if we can help you with any Incident Management Resources.

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Garcia, Vicky (Aviation)
To:	"CHRISTOPHER.D.MASTON@CBP.DHS.GOV"; "MPH, MBA Andrew D. Klevos (Aklevos@cdc.gov)"; "yesenia.villalta@flhealth.gov"
Cc:	Sola, Lester (Aviation); Rull Valenciaga, Arlyn (Aviation); Pyatt, Ken (Aviation); Hatfield Jr., Mark O. (Aviation)
Subject:	Interim revision: Miami International Airport Communicable Disease Emergency Response Plan
Date:	Friday, February 28, 2020 5:09:54 PM
Attachments:	image001.png image002.png image003.png MIA Communicable Disease Plan - 02.2020.pdf

---

Attached is an updated copy of the Interim Update of the Communicable Disease Emergency Response Plan. Please advice as soon as possible, of any changes you would like to make to this interim document. Once your changes have been incorporated, we will send the revised document, along with a signature page for your respective agencies to sign.

Thank you,

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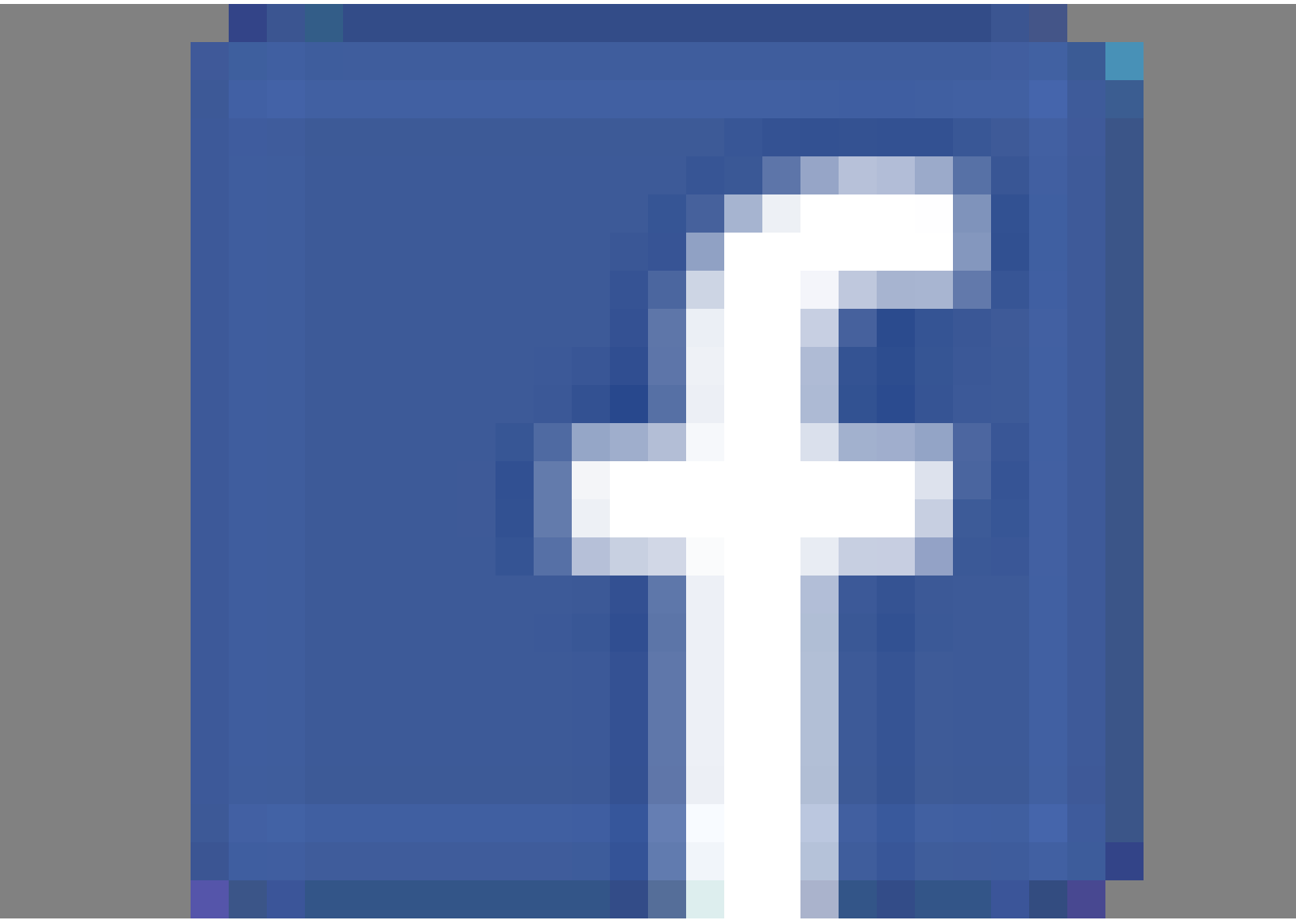

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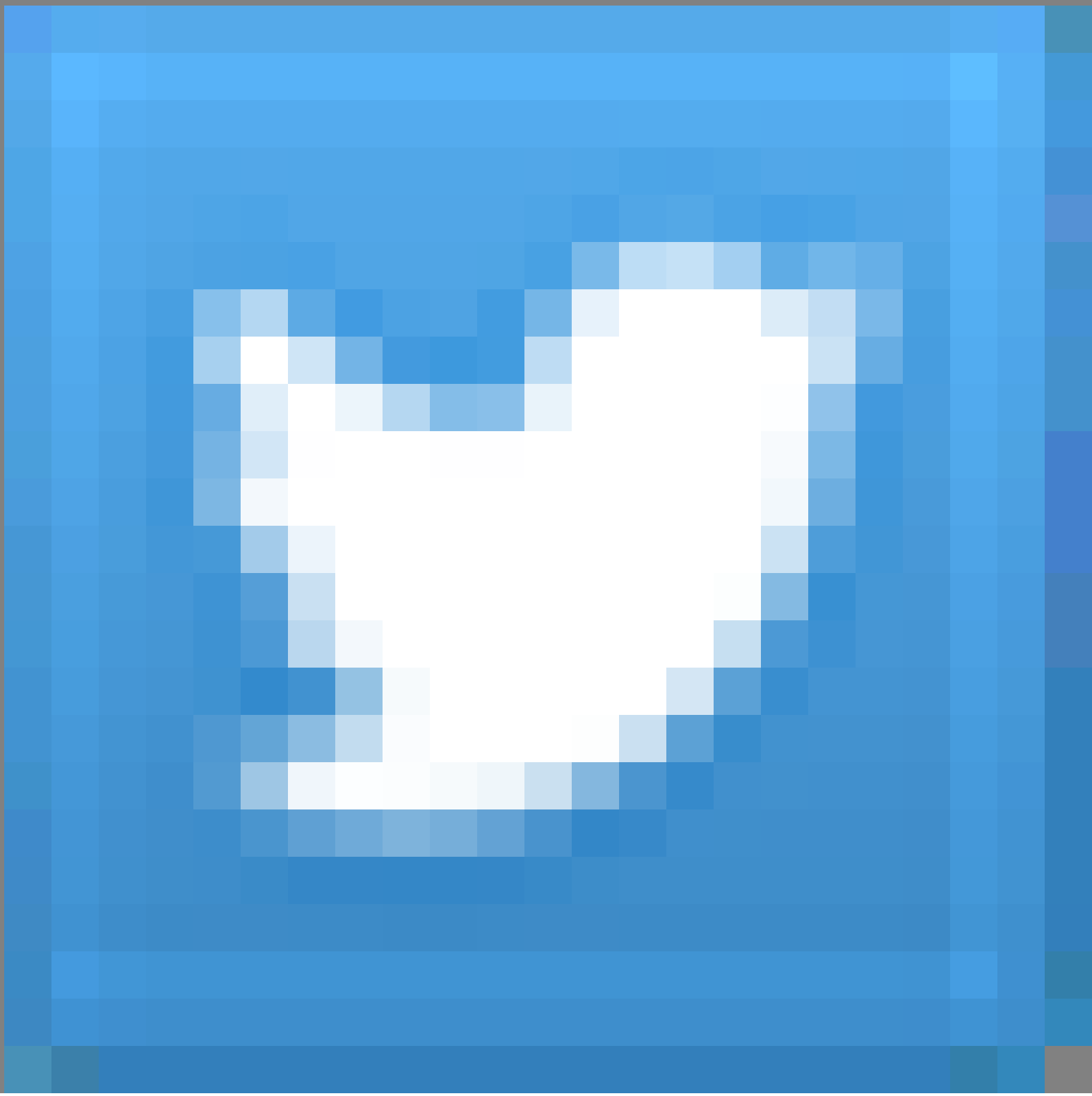

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Miami International Airport

Interim Update
Communicable Disease Emergency Response Plan

Revised: 02/2020

Guidelines for Preventing the Introduction, Transmission and Spread of Communicable Diseases from Foreign Countries into the United States

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This plan was developed by a consortium of federal, state, county, airport and local agencies as well as private stakeholders. The principal parties responsible for the approval and maintenance of the plan are the CDC Miami Quarantine Station, Customs and Border Protection, the Florida Department of Health in Miami-Dade County and the Miami-Dade Aviation Department. This plan will be reviewed and updated as needed or on an annual basis.

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Revised Date: November 2014

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I. Introduction

The vast, interconnected and complex system of transportation moves people and essential goods, and supports our critical infrastructure. As a decentralized network, the transportation sector is predominantly owned and operated by State and local governments and the private sector.

Each day, more than 371,000 international travelers arrive in the United States at international airports and preclearance stations. Our Nation's 328 international ports of entry represent the intersection of the transportation industry, public health, and homeland security.

Because of the sheer volume of traffic flowing through this and other international ports of entry, the potential exists for the rapid and widespread dissemination of a communicable disease within the U.S. Therefore, expeditious implementation of public health measures at our borders provides an opportunity to prevent the introduction of communicable diseases into the United States.

II. Purpose

Ensuring 24/7 public health capability to prevent or mitigate the introduction, transmission, and interstate spread of communicable diseases in the United States and territories.

The triggers for implementation of this plan include, but are not limited to: 1) Response to a quarantinable illness at a Port of Entry (POE), and 2) Response to any disease of public health significance at a POE.

III. Legal Authorities

Title 42 United States Code Section 264 (Section 361 of the Public Health Service Act) gives the Secretary of HHS responsibility for preventing the introduction, transmission, and spread of communicable diseases from foreign countries into the United States and from one state or U.S. possession into another. This statute is implemented through regulations found at 42 CFR Parts 70 and 71. Under its delegated authority, CDC, through the Division of Global Migration and Quarantine (DGMQ), is empowered to apprehend, detain, medically examine, or conditionally release persons suspected of carrying a quarantinable disease. By mutual agreement, U.S. Customs and Border Protection and the U.S. Coast Guard are required to aid in the enforcement of quarantine rules and regulations. Violation of federal quarantine rules and regulations constitutes a criminal misdemeanor, punishable by fine and/or imprisonment.

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It is incumbent on each CDC quarantine station to communicate with state and local public health officials to coordinate efforts related to the response to the introduction of diseases of public health significance.

State, local, territorial, and tribal governments are responsible for the health and safety of the people within their jurisdictional boundaries. Specific rules and regulations will vary by state. Upon request, the CDC is authorized to assist these agencies in their efforts to prevent disease transmission.

A. Florida Department of Health in Miami-Dade (DOH) Miami-Dade PUBLIC HEALTH: GENERAL PROVISIONS

- Per §381.0315, the State Health Officer is responsible for declaring public health emergencies and quarantines and issuing public health advisories. Ordering an individual to be examined, tested, vaccinated, treated, or quarantined for communicable diseases that have significant morbidity or mortality and present a severe danger to public health. Individuals who are unable or unwilling to be examined, tested, vaccinated, or treated for reasons of health, religion, or conscience may be subjected to quarantine. §381.0315(1)(b)(4)

B. Enforcement Authority:

- Authority and power are two different things: Power is the force by means of which you can oblige others to obey you. Authority is the right to direct and command, to be listened to or obeyed by others..."[1] The Florida Legislature has given broad authority to Health Departments to handle a bioterrorism event through use of quarantine. However, the force of local law enforcement and the National Guard is the means by which the Health Departments will be able to oblige the citizenry to obey its quarantine orders.

C. International vs. Domestic Flights:

- The origin of a flight dictates which agency is primarily responsible for responding to a disease event.

- Under CFR Title 42 sec 71.21, the Centers for Disease Control and Prevention Miami Quarantine Station (CDC MQS) or the nearest quarantine station is primarily responsible for responding to disease events on international flights.

---

[1] Maritain, Jacques (1882-1973), French philosopher. "The Democratic Charter," Man and the State, University of Chicago Press (1951).

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Under CFR Title 42 sec 70.4, the Florida Department of Health in Miami-Dade County (DOH Miami-Dade), or the local county health department is primarily responsible for responding to suspected communicable diseases on domestic flights.

The CDC MQS shall act as the primary contact point for all airlines (international and domestic origin) to report suspected communicable diseases or syndromes.

It is the responsibility of the airline to report to the CDC MQS all international flights, destined to arrive at MIA, in which the crew has reported to the captain the presence of "ill persons," as defined in CFR Title 42 sec 71.1 on board.

In addition CFR Title 42 sec 70.4 requires airlines engaged in domestic travel, to report to the "local health authority", suspected cases of communicable diseases on all flights. The CDC MQS will serve as a point of contact for DOH Miami-Dade and receive reports of suspected communicable diseases from domestic carriers, and in turn notify DOH Miami-Dade.

IV. Definitions

Communicable Disease – A disease that is transmitted through direct contact with an infected individual or indirectly through a vector.

Conditional Release – Release of a traveler from a public health restriction, such as quarantine and/or isolation under 42 C.F.R. part 71, provided that the traveler agrees to certain conditions. Conditional release can be accomplished through an order that is enforceable to the same extent as an order for quarantine or isolation.

Contact – A person who has been in such association with an infected person, animal, or contaminated environment as to have had an opportunity to acquire that infection.

Contact Tracing – Identification and diagnosis of persons who may have come into contact with an infected source.

Detention – The temporary holding of ill or exposed travelers and crew at a POE while the threat to public health is being determined by the Director of CDC, or while transportation to a medical or quarantine facility is being arranged, or the quarantine facility is being established.

Epidemic – The occurrence, in a defined community, of cases of an illness with a frequency clearly in excess of normal expectancy.

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Incubation Period – The time interval between initial contact with an infectious agent and the first appearance of symptoms associated with an infection.

Isolation – The separation of an individual or group infected with a communicable disease from those who are healthy in such a place and manner as determined by the Director of CDC to prevent the spread of communicable disease.

Pandemic – An epidemic occurring over a very wide area, crossing international boundaries and usually affecting a large number of people; a global epidemic.

Public Health Assessment – The initial interview of persons who were possible exposed to a given disease due to proximity to symptomatic person or other established criteria. This may be limited to providing well passengers contact forms and instructions for actions to take if symptoms occur.

Quarantinable Disease - Any of the communicable diseases listed in an Executive Order of the President, as provided under section 361(b) of the Public Health Service Act (42 USC 264). The current list of quarantinable diseases as set forth in Executive Order 13295 of April 4, 2003, as amended, is provided in section VI.

Quarantine – The separation of an individual or group that has been exposed to a communicable disease, but is not yet ill, from others who have not been so exposed, in such a manner and place as determined by the Director of CDC to prevent the possible spread of the communicable disease.

Screening – Active steps to identify the existence of disease in an individual or group of individuals through visual examinations, physical examinations, laboratory tests or other methods.

Surveillance – The ongoing systematic collection and analysis of data and the provision of information which leads to action being taken to prevent and control a disease.

Suspect – An ill person whose history and symptoms suggest that he or she may have or is developing a communicable disease.

Transmission – Mechanism by which an infectious agent is spread from a source to a person.

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V. Abbreviations

1. AOC Airport Operations Center
2. ARC American Red Cross
3. CBP Customs and Border Protection
4. CDC Centers For Disease Control And Prevention
5. DGMQ Division of Global Migration and Quarantine
6. EMS Emergency Medical Services/Miami-Dade Fire Rescue
7. EOC Emergency Operations Center
8. FBI Federal Bureau of Investigation
9. FDOH Florida Department of Health
10. HHS Department of Health and Human Services
11. IC Incident Commander
12. ICE Immigration and Customs Enforcement
13. HSI Homeland Security Investigations (Under ICE)
14. ICP Incident Command Post
15. ICS Incident Command System
16. LHD Local Health Department
17. MDAD Miami-Dade Aviation Department
18. MDFR Miami-Dade Fire Rescue
19. MDHD Miami-Dade Health Department
20. MDPD Miami-Dade Police Department
21. MDTA Miami-Dade Transit Authority
22. MIA Miami International Airport
23. MOA Memorandum of Agreement
24. MOU Memorandum of Understanding
25. POE Port of Entry
26. PIO Public Information Officer
27. PPE Personal Protective Equipment
28. SHD State Health Department
29. TSA Transportation Security Administration
30. THAN Traveler's Health Alert Notice
31. UC Unified Command
32. FAA Federal Aviation Administration

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VI. Participating Agencies

1. Airline – In flight, airside representative
2. Airport Authority – Miami-Dade Aviation Department (MDAD)
3. American Red Cross (ARC)
4. Centers for Disease Control and Prevention (CDC) – Miami Quarantine Station
5. Customs and Border Protection (CBP)
6. Emergency Medical Services (EMS) – Miami-Dade Fire Rescue Department (MDFR)
7. Federal Aviation Administration (FAA)
8. Federal Bureau of Investigation (FBI)
9. Florida Department of Transportation (FDOT)
10. Local Health Department – Florida Department of Health in Miami-Dade (DOH Miami-Dade)
11. Local Law Enforcement – Miami-Dade Police Department (MDPD)
12. Local Emergency Management Authority – Miami-Dade Office of Emergency Management (OEM)
13. Local Transit Authority – Miami-Dade Transit Authority (MDTA)
14. Local Healthcare Facilities – Jackson Memorial Hospital, Miami Children's Hospital and others
15. State Health Department – Florida Department of Health (FLDOH)
16. United States Department of State (DOS)
17. Transportation Security Administration (TSA)

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VII. Background and Overview

Under Section 361(b) of the Public Health Service Act, DGMQ has the authority to isolate and quarantine individuals or groups of individuals who are known, or suspected of being ill with, or exposed to the following diseases:

- Cholera and suspected Cholera
- Diphtheria
- Infectious Tuberculosis
- Plague
- Smallpox
- Yellow Fever
- Viral Hemorrhagic Fevers
- Severe Acute Respiratory Syndrome (SARS)
- Influenza (novel strain with the potential for a pandemic)

Current federal regulations (42CFR71.21) require aircraft commanders to immediately report death and illness of passengers or crew onboard inbound international flights to the nearest CDC Quarantine Station.

A. Required Reporting

Ill persons displaying any of these conditions must be reported under federal regulations:

1.Fever (has a measured temperature of 100.4 °F [38 °C]† or greater, or feels warm to the touch, or gives a history of feeling feverish) accompanied by one or more of the following:
◦skin rash
◦difficulty breathing
◦persistent cough
◦decreased consciousness or confusion of recent onset
◦new unexplained bruising or bleeding (without previous injury)
◦persistent diarrhea
◦persistent vomiting (other than air sickness)
◦headache with stiff neck, or
◦appears obviously unwell;

OR
2.Fever that has persisted for more than 48 hours

OR
3.Symptoms or other indications of communicable disease, as the CDC may announce through posting of a notice in the Federal Register

B. Requested Reporting

In addition to the required reporting above, CDC Quarantine Stations also request reports from aircraft commanders of ill persons with the following conditions, which

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may also indicate a serious, communicable disease:

- Fever (a measured temperature of 100° F/37.8° C or greater) of any duration plus any one of the following:
  - difficulty breathing, or
  - headache with stiff neck, or reduced level of consciousness, or
  - unexplained bleeding
  - persistent cough
  - persistent vomiting

CDC recommends the following to help quarantine station personnel quickly act:

- Upon learning of a possible communicable illness or a death on board, the pilot, or designee, should immediately notify their land-based point of contact (for example, Operations Center, Flight Control, airline station manager) and provide the ill person's name, seat number (and seat changes, if any), symptoms, approximate age, point of origin, travel itinerary, and additional information about the ill person that may have been collected by volunteer, airline, or contract medical staff. See Appendix 2 for cockpit cards for reference on airplane.

- The CDC Quarantine Station staff can help evaluate an ill person and answer other questions regarding reporting requirements. **If contact cannot be made with the nearest station, please contact the Atlanta, Georgia CDC HQ Quarantine Duty Officer on call at 404-639-1220.**

- CDC Quarantine Stations, their contact information, and areas of jurisdiction are found at: http://www.cdc.gov/quarantine/QuarantineStationContactListFull.html.

- A flowchart on the response to arrival of an international flight with a suspected communicable disease is provided in the Agency Notification List (Appendix 3). Primary response agencies must be contacted **within 15 minutes** of notification by the pilot/captain of an arriving international conveyance of a suspect quarantinable disease or illness of public health significance.

- The Florida Department of Health in Miami-Dade County will be notified by the CDC MQS for domestic flights.

- The CDC Quarantine Station Manual of Operations provides case definitions and internal response protocols for illnesses of public health significance/threat onboard arriving flights. These internal protocols are updated periodically as more information regarding emerging/re-emerging infectious diseases is obtained.

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VIII. Emergency Operations

Emergency Response Steps:

A. Parking and Gate Procedures

Using the scenarios described in the previous section parking and gate procedures are:

Timing of Notification	Report of Ill Traveler	Parking / Gate	Public Health/ EMS Access to Aircraft
Pre-Arrival	Illness and travel description meets criteria to suspect public health threat	Park at scheduled gate or Penalty Box	Air stairs truck
Pre-Arrival	Not enough information to determine potential public health threat	Park at scheduled gate	Jet bridge

B. Possible Scenarios of Ill Traveler Notification

Preparers of this document have identified four (4) possible scenarios of ill traveler notification. Parking and gate procedures will depend on the timing of notification and the information provided regarding an arriving ill passenger.

- Pre-arrival notification- The following triggers will call for CDC to be called to evaluate a potential public health situation.
    - Passenger/s exhibiting signs and symptoms listed for required or requested reporting.
    - Passenger/s is coming from an area with confirmed or suspect outbreak of disease of public health importance.

Pre-arrival notification- Report of ill traveler without enough information to determine cause of illness (may or may not include signs and symptoms of a communicable disease).

Post-arrival notification- Report of ill traveler prior to aircraft disembarkation- triggers for isolation activated upon evaluation on aircraft at gate.

Post-arrival notification- Report of ill traveler after disembarkation-triggers for isolation activated up after aircraft disembarkation. Notifications of a suspect communicable disease on an aircraft can come from the FAA control tower, the airport's operations center, or EMS.

- Once notification is made, the receiving office notifies the Miami Quarantine Station by calling the 24-hour phone number (305-526-2910).

- After regular office hours the phone is answered by a central answering system [the Director's Emergency Operations Center (DEOC)]; a voice message will play and the caller should select **option 0** for emergencies. The phone will be answered by staff at the DEOC who will obtain specifics about the emergency and connect the caller by phone to the on-call officer for the CDC Miami Quarantine Station.

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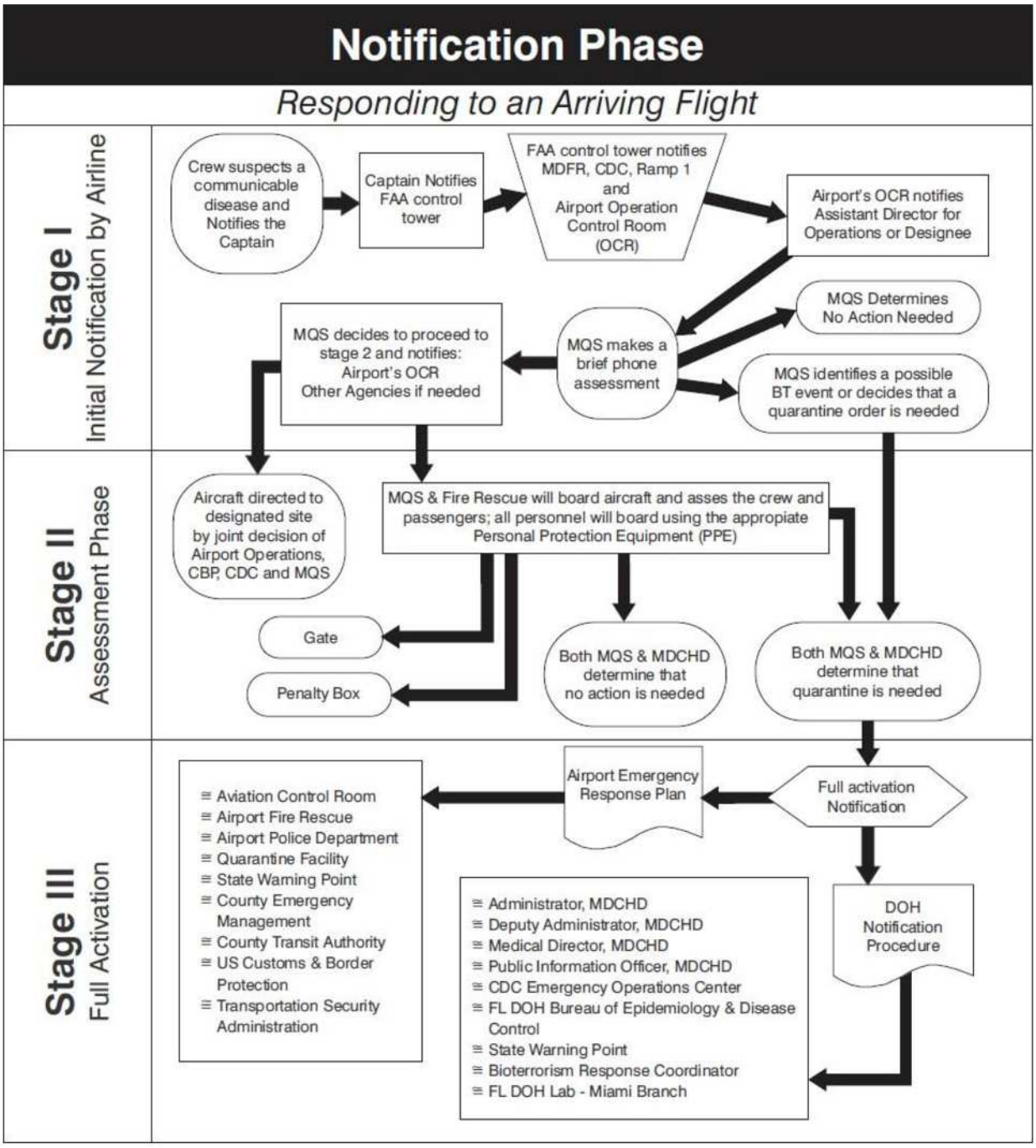

Pre-Designated Isolation Areas

- **Gate –** To be used in most circumstances. If a quarantinable disease emergency is suspected, the captain of the arriving aircraft will be directed by FAA or Airport AOC to secure the doors of the plane until emergency medical response/CDC MQS personnel arrive. See Appendix 4 for Memorandum outlining this NOTAM .

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- **Penalty Box** – Extreme circumstance. To be used for remote parking of aircraft, safe EMS / CDC response personnel access, isolation of aircraft, passenger, and crew from main terminals. Hard stand near this terminal can facilitate ill passenger/s evaluation and transport to medical facility.

- **Satellite (Upper E)** – In rare circumstance that an entire aircraft needs to be quarantined.

- Air conditioning to the aircraft cabins is to be maintained at all times.

- Everyone on board aircraft must remain onboard until public health assessment is complete.

- EMS/CDC personnel, with assistance from airline cabin crew will inform the crew and passengers as to the nature of the situation and the sequence of events.

C. Planeside Response

- The composition of an initial response group to a quarantinable disease emergency at the MIA should include the following:
  - CDC Quarantine Public Health Officer
  - MDFR
  - CBP Officer
  - MDPD Law Enforcement Officer
  - MDAD Operations
  - Airline Representative
  - Additional responders may include local public health authorities

- All agencies that interact with ill or exposed passengers will use appropriate personal protective equipment (PPE).

- Everyone on board aircraft must remain seated until the symptomatic person and identified close contacts are removed from the aircraft. Remaining passengers will be given contact form by CDC for completion prior to deplaning or directed to identified location within terminal for public health assessment.

- MDFR/ CDC personnel, with assistance from airline cabin crew, will inform the crew and passengers about the situation and the expected sequence of events. (See Appendix 5 for Public Health Announcement Scripts)

- The CDC MQS will board the aircraft with MDFR to perform an initial assessment, to rule out the presence of a bioterrorism event or a quarantinable disease that would constitute a public health threat.

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- If a quarantinable disease emergency is suspected, the CDC MQS personnel or their designated alternates will lead the illness response investigation, provide personal protection equipment (PPE) guidance, and direct the activities of all response staff present. If CDC MQS is not on site, MDFR will board the flight and consult with CDC MQS on-call officer by phone.

- CDC MQS and DOH Miami-Dade may undertake one or more of the following in response to a report of a quarantinable/communicable disease among passengers on an inbound aircraft:
  - The CDC MQS and DOH Miami-Dade will interview all passengers regarding symptoms, travel and exposure history.
  - The cases, i.e. passengers who are acutely ill with signs and symptoms, will be interviewed first utilizing the appropriate CDC form.
  - The CDC MQS/ DOH Miami-Dade will obtain passenger information from all contact passengers utilizing the "Passenger Locator Information Form".
  - Those passengers who will require epidemiologic follow-up will be given the "DOH Miami-Dade Possible Exposure Instructions" (Appendix 6) and the CDC Traveler's Health Alert Notice (if indicated).
  - Duty Officers, in consultation with the Quarantine Medical Officer and possibly the CDC-Division of Global Migration and Quarantine/Florida Department of Health- Bureau of Epidemiology, will make a decision about the disposition of all the passengers.
  - Transport will be done to the designated isolation or treating hospital if the passenger is suspected for a quarantinable disease. MDFR will be requested for transport.
  - If the communicable disease is not quarantinable under federal regulations a recommendation will be made to the passenger to seek immediate medical attention.
  - CDC MQS may notify DOH Miami-Dade of the case of suspect communicable disease so that the Health Department can determine action at the local/state level is needed.
  - It is anticipated that a single flight arriving at the MIA will be within the response capabilities of these agencies. However, a massive event, involving a single flight carrying large numbers of sick passengers, multiple flights carrying ill passengers arriving during a condensed time period, or a single case of smallpox or another suspected bioterrorism agent would require a large scale response, coordinated through the Miami-Dade Office of Emergency Management (OEM) and the State Warning Point (SWP).

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D. **POSSIBLE DISPOSITION OF PASSENGERS** (after all passengers have been assessed):

1. Persons will be released at the scene with no follow-up needed

- This scenario would occur, if no quarantinable disease, communicable disease of public health significance, or bioterrorism were suspected, and passengers are considered non-contacts.

- Passengers and/or crew members will be released and would be free to continue their trips. There will be no follow-up action.

- In collaboration with the DOH Miami-Dade, the CDC MQS will manage passengers wanting access to a physician after being told that they are safe to continue their trip.

2. Persons released but under epidemiological surveillance

- This would occur if there were a suspicion for a communicable disease of public health significance, which requires post exposure prophylaxis or observation for the development of symptoms. These passengers would be asymptomatic for the suspected disease, and conditionally released to continue on their journey to their final destination if they can arrive prior to the minimum incubation period.

- These passengers would be followed-up by the DOH Miami-Dade or local health authorities having jurisdiction over the individual during the incubation period.

3. Persons requiring quarantine

- This scenario would occur if there were a suspicion of the presence of a quarantinable disease and a communicable disease of public health significance. If a passenger is considered a close contact and depending on the phase, transmissibility and nature of the virus, close contacts may be quarantined in place, or alternatively released for home quarantine.

- In the event that quarantine is required to protect the public's health, onsite facilities will be used for a limited time until DOH Miami-Dade, Miami-Dade OEM or CDC MQS make arrangements for off-site facilities.

- The CDC Miami Quarantine Station will follow DGMQ protocols to activate the standing Memorandum of Understanding (MOU) with a designated hospital. NOTE: Activation of MOA with hospitals must be approved by headquarters.

- Examples of situations that may require quarantine of potentially exposed person(s) include smallpox, SARS, Ebola and other emerging infectious diseases considered to be a threat to public's health.

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- These passengers would be asymptomatic or not meet the case definition.

- Passengers would be transported to a temporary quarantine facility (priority will be given to the Concourse E in the Satellite Building for up to 72 hours, while DOH Miami-Dade and Miami-Dade ESF6 partners prepare the designated community quarantine facility.

- Passengers would be transported to the designated community quarantine facility once initial public health assessment was complete.

- After assessment, if the CDC MQS determines the presence of a quarantinable communicable disease or a bioterrorism event, CDC MQS will initiate full notification to the following CDC Emergency Operations Center (EOC). See Appendix 8 for Emergency Response Contact Database.

    - American Red Cross of Greater Miami and the Keys (ARC)
    - Federal Bureau of Investigation (FBI)
    - MIA's Airport Operations Center (AOC)
    - Miami-Dade County Fire Rescue (MDFR)
    - Miami-Dade Police Department (MDPD)
    - Florida Department of Health in Miami-Dade County (DOH)
    - State Warning Point (SWP)
    - Transportation Security Administration (TSA)
    - Customs & Border Protection (CBP)
    - US Department of State (DOS)
    - Miami-Dade Transit Authority (MDTA)

- Consideration will be given to contacting the designated isolation or treatment facility/hospital, as soon as there is any indication that passenger(s) will require airborne isolation or acute medical care. The facility must be notified once absolute determination is made that an ill passenger is to be transported to it.

NOTE: *The order of notifications will be determined by the event and flight origin. The Miami-Dade Aviation Department will activate the Airport's Emergency Response Plan in consultation with CDC, CBP and health authorities.*

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- In the event that quarantine is required for any passengers, a quarantine order will be obtained by the following steps:

  - **Step 1:** The CDC MQS will contact the DOH Miami-Dade Legal Counsel at the DOH main number: 305-324-2400 to notify the need of having a quarantine order issued.

  - **Step 2:** The DOH Miami-Dade Legal Counsel will contact the Director/ Administrator of the DOH Miami-Dade and have him/her complete the Quarantine Order and fax it to the CDC MQS.

  - **Step 3:** The MQS will copy the Quarantine Order and provide copies to the passenger(s), MDFR, MDPD and/or CBP and the hospital at which the passenger(s) will be quarantined.

- Depending on the type and extent of the situation, if needed, the local and/or state EOCs will be activated and one or more of the following agencies will be requested to provide additional response support:
  - Florida Department of Health in Miami-Dade County (DOH)
  - Miami-Dade Office of Emergency Management (OEM)
  - Florida Department of Emergency Management (FDEM)
  - Florida Department of Health (FDOH)
  - Federal Bureau of Investigation (FBI)
  - Transportation Security Administration (TSA)
  - Local Hospitals (alerted at World Health Organization Phase 4, 5, and 6 of Pandemic Alert)

E. Incident Command

- This plan follows protocols and guidelines established within the National Incident Management System (NIMS). An Incident Command System (ICS) will be implemented upon the activation of this plan and used to coordinate response activities. See Appendix 9 (**Incident Command Triggers for EOC Activation)**, for triggers for EOC activation, and transition of authority from federal to state and local agencies.

F. Screening/Detention

- **Operations/Logistics**
  - The Miami-Dade Aviation Department will secure screening and additional facilities for passengers when detention, restriction of movement, or quarantine is warranted.
  - Concourse H, fourth floor (formerly Club America) will be considered for use for up to 400 people for up to 72 hours.

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- For restriction of movement beyond 72 hours, a suitable off-site facility designated by the Florida Department of Health in Miami-Dade will be set up to house individuals.

- A suitable off-site facility designated by the DOH Miami-Dade collaboration with the Miami-Dade OEM will be set up to house individuals.

- Legal/Administration
  - Additional information about points of contact, procedures and timelines for seeking local/state, and/or federal orders to restrict movement is included in section above (C.3.) and Appendix 10 (Port of Entry Quarantine Response Timeline).

G. Conditional Release

- Under certain circumstances, the CDC MQS may conditionally release those passengers not deemed as close contacts of the index case(s), allowing them to continue their travel.

- For example, co-travelers who are not travel companions of the ill person(s) and who will complete travel within 24 hours of first exposure may be conditionally released to continue travel. These individuals will be asked to self-quarantine for up to five days.

- Passenger locator information will be collected, health information cards may be distributed, prophylaxis medications, if available, may be administered, and state and local health departments will be notified for tracking of the released persons.

H. Surge Capacity

- In the event of a large scale public health emergency, the CDC MQS will request the help of outside mutual response agencies to assist with medical screening and triage, public health screening of ill and exposed persons, distribution of health alert notices, administration of prophylaxis, and collection of personal locator information.

- The deployment of federal surge response staff to MQS may take 48 hours or longer. An effective response may require a two-tiered approach. CDC MQS will have a need for surge response by local public health officials and other members of the immediate health care community who can arrive at the airport immediately upon notification. Long-term (beyond 48 hours) sustainability of operations will require a federal response following the arrival of national assets.

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- Federal surge capacity resources that will be requested may include CDC deployed staff, United States Public Health Service (USPHS) commissioned corps officers, Health and Human Services (HHS), National Disaster Medical System (NDMS) staff, Regional Emergency Coordinators (REC) and other regional HHS personnel.

- CDC Miami Quarantine Station has the responsibility for providing training, equipment and overall management of surge personnel.

- Department of Homeland Security and MDAD Security Division has responsibility for badging of surge staff.

- Transportation of surge staff to and from deployment is the responsibility of each agency.

I. Decontamination

- Any aircraft and/or facility deemed to need decontamination will be prohibited for use until designated as safe. For additional information see Appendix 11 through 14.
- All costs for decontamination are the responsibility of the airline/facility manager.

J. Health Communication/Education

- All passengers, flight crew, travelers in the airport will be provided information specific to the incident at hand by CDC. This information will be in writing and in a language appropriate to the audience. Travel alerts, THANs, electronic notifications, posters and handouts may be sufficient for these purposes.

- Quarantine staff will be on hand to answer questions for those affected by the incident.

- Regular communication between federal officials and individuals in quarantine is important to ensuring that those in quarantine understand the situation and are informed of what they can expect during their time in quarantine. It may be useful to have social workers and health educators on site to serve as a resource to those in quarantine.

K. Media Communications

- When the Aviation Department is notified of a Level 1 Medical Emergency, MDAD Communications and social media staff will provide information to the news media and to the public only as it relates to the event's effect on airport operations (i.e. flights, terminal, landside). If the Aviation Department's AOC is activated, Communications and social media staff will report to the Operations Center and notify PIOs from Miami-Dade Fire Rescue and the

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- Miami-Dade Health Department to report as well. The PIOs will coordinate talking points for press releases and social media postings through the lead PIO as designated by the Incident Commander. Depending on the magnitude of the event, a joint information conference call line and conference call schedule will also be established for further coordination between agencies.

- Triggers for activation of the Communication Plan includes the disease being on the President's list of quarantinable diseases and one of the following:
  - Political implications
  - Involvement of three or more agencies
  - Of media interest

- Media inquiries will also be referred to the State of Florida Joint Information Center: ESF14@em.myflorida.com: (850) 921-0217. Media inquires for the Miami Quarantine Station will be referred to the CDC-INFO: 1-800-232-4636: CDCINFO@cdc.gov

L. International Communications

- Communication with international public health partners will be coordinated by the CDC quarantine stations.

- The U.S. Department of State will be notified whenever any international flight or person is legally detained or quarantined, to verify the status of the passenger(s), and to confirm those claiming diplomatic affiliations. If a diplomatic pouch is present on board the aircraft, its disposition will be determined by the U.S. Department of State in consultation with the Incident Commander.

M. The Quarantine Facilities

- Should quarantine of passengers be required, Florida Department of Health in Miami-Dade will work with the various response agencies planning for and activating a temporary care facility and quarantine facility.

- The public health aspect of the incident will be under the Miami Quarantine Station jurisdiction until longer term quarantine facilities are warranted. In a quarantine event beyond 72 hours, the authority will be handed to the Florida Department of Health in Miami-Dade.

- Consult "CDC Guidelines for Establishing Quarantine Facilities at U.S. Ports of Entry and in Community Settings."

- In some instances, home quarantine may be a more desirable option than quarantine in a designated facility.

- For more information on Community Mitigation Guidelines, please see: http://pandemicflu.gov/professional/community/. Written specifically for a pandemic influenza event, many of these guidelines may apply to other communicable diseases of public health significance.

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IX. Assignment of Responsibilities

Primary agency roles and responsibilities to staff a quarantine facility response

Miami-Dade Aviation Department: passenger logistics post deplaning
Aircraft Operator: aircraft hygiene and decontamination
MDFR: incident support
DOH Miami-Dade: support preliminary screening assessments
CDC MQS: subject matter experts
CBP: passive observation and security
MDPD: security
ICE or HSI: enforcement and security of detained individuals
FAA: aircraft communications
State and Local Emergency Management Authorities: planning and preparation support
MDTA: transportation to long term quarantine facilities
FBI: jurisdiction for terrorist threats and events
Local support and NGOs: support services for quarantined individuals
US DOS: diplomat liaison

A. Pilot-in-Command of Aircraft

- Immediately report to the nearest CDC Quarantine Station any death or illness among passengers or crew during the flight.

- Seek assistance from medical professionals on board the aircraft and on the ground (e.g. airline medical staff, contract medical consultants, CDC Quarantine Medical Officer, etc.) to make an initial assessment of the situation and communicate pertinent information to CDC Quarantine Station personnel who will coordinate the ground response upon arrival.

- Determine, in consultation with medical professionals, CDC, and other governmental entities, whether to proceed to the scheduled destination or divert to another airport. (Depending on the medical situation and current national transportation concerns, CDC, DOT, FAA, CBP, and TSA may directly influence the decision to divert.)

- Recommend what services may be needed at the POE upon arrival.

- Maintain contact with the FAA, airport operations center and air carrier operations center which will establish and maintain contact with the CDC Quarantine Station of jurisdiction.

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- Direct the cabin crew to isolate the ill person or relocate surrounding passengers, to the extent possible, covering any rash and providing masks if available and appropriate.

- Provide periodic updates to passengers and cabin crew on recommendations from authorities and agencies on the ground.

B. Air Carrier Operations Center/On-Airport Representative

- Coordinate operations and maintain communications between the captain of the conveyance and CDC to monitor the status of the ill person(s).

- Provide instructions to the crew, in consultation with airport authorities, CBP, and CDC Quarantine Station officials.

- Coordinate with CDC and state and local health departments on media relations and press management.

- Assist travelers in making alternative travel arrangements due to any delays caused by a public health incident.

- Instruct ground crews to delay off-loading baggage and cargo until authorized to do so by the unified command/incident commander.

- Recover and forward baggage of travelers delayed by a public health incident, subject to the necessary processing by CBP, TSA or other entities as appropriate.

- Ensure air circulation is maintained and functional hygiene facilities are available on the aircraft.

- Provide/coordinate for appropriate conveyance decontamination when necessary.

- Ensure food and beverages are available on the aircraft.

- Ensure that the pilot-in-command receives approved public health communication messaging.

- Offer language interpreters, when needed.

- Provide transportation to remote pads for CDC Quarantine Station officials, when needed.

- Coordinate sanitization of aircraft if needed.

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C. Miami-Dade Aviation Department (MDAD)

- Notify CDC, MDFR, CBP, MDPD and TSA personnel of any inbound conveyance with reported ill person(s) on board.
- Assist in deciding when and where the aircraft should park.
- Coordinate with the FAA to provide a parking area for the aircraft.
- Make appropriate notifications about the incident.
- Work with state/local public health to activate the quarantine facility, as needed.
- Arrange transportation for individuals who will be quarantined off site working with MDTA.
- In conjunction with CDC, maintain and periodically update the POE's Communicable Disease Response Plan to properly reflect responder organization, responsibilities and resources.
- In conjunction with CDC and other stakeholders, periodically exercise the POE's Communicable Disease Response Plan.
- Coordinate through the MIA PIO with federal, state, and local authorities on media relations, social media and press management.

D. Emergency Medical Services (MDFR) – Miami-Dade Fire Rescue

- When requested, assist public health personnel in conducting a preliminary public health assessment on-scene to determine if the individual requires medical treatment and if the person is ill with a quarantinable disease or disease of public health importance.
- Miami-Dade Fire Rescue will assume command of the incident, unless a bioterrorism event is suspected, in which case the FBI may assume command.
- The Incident Command Post (ICP) will be identified by a beacon light on top of the vehicle (if it is situated on the airport tarmac).
- The Incident Commander (IC) will request the dispatch of the Mobile Command Post (MCP), if needed.
- Once the MCP arrives on the scene, it will become the ICP.
- All arriving responders will report to the ICP and check in with the IC (*see* Incident Command Structure – Appendix 9).

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- If a determination to transport a passenger with a suspect quarantinable disease of public health importance/threat is made by CDC (or designee), MDFR and CDC (or designee) shall notify appropriate isolation and/or medical treatment facility.

- Remove ill person from the conveyance and transport by ambulance to the designated medical facility after CBP clearance or medical parole.

- The transportation vehicle(s) (ambulance and/or rescue vehicle) and its staff, must be adequately prepared and follow appropriate infection control precautions, in transporting a patient with a communicable disease such as smallpox:[2]
    - Remove unnecessary items from the ambulance(s) to avoid contamination and facilitate decontamination.
    - The ambulance should be equipped with a working 2-way communication device (e.g., two-way radio or cellular telephone).
    - Equip ambulance with all necessary equipment to permit adherence to appropriate isolation precautions.
    - The ambulance driver and attendant should wear appropriate PPE.
    - The ambulance driver and attendant(s) should remove their gloves and other personal protective equipment and dispose of them according to proper infection control practices as soon as the patient is placed in the ambulance and the doors are closed.
    - The patient should be covered in a linen sheet (to prevent contact with and potential contamination of objects in the area) and his nose and mouth should be covered with a disposable surgical mask (to decrease potential for droplet exposure of other individuals).
    - The patient should be transported directly to the appropriate isolation facility and stay in the vehicle until he or she can be taken into the isolation facility.

Infection Control and Ambulance Decontamination

- After the patient(s) have been transported and admitted into an appropriate receiving facility, the driver and attendant must, while in the ambulance, remove and place all protective clothing (gowns, gloves, masks, etc.) in biohazard bags, and replace them with clean protective clothing (gowns, gloves, masks, etc.).

- The bagged materials should be autoclaved or incinerated as medical waste.

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[2] Adapted and reprinted from the CDC –Smallpox response Plan and Guidelines (version 3.0), Guide C, Part 1. Available at: http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-c-part-1.doc

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- For certain suspected infectious agents such as smallpox, the ambulance(s) should not be used to transport non-smallpox cases after transportation of a suspected smallpox case until a full decontamination has been completed[3]:
    a. *Variola* virus (smallpox) is sensitive to chemical disinfection because of its envelope structure.
    b. The nature and extent of surface contamination will dictate the level of disinfection (i.e. low-level or intermediate-level) needed to make the surface safe to handle or use.
    c. However, use of high-level disinfectants or liquid chemical sterilants on large environmental surfaces (e.g., table tops, floors, walls) is not indicated under any circumstances.
    d. Environmental surfaces can be cleaned and subjected to low- to intermediate-level disinfection with an EPA-registered chemical germicide according to label instructions. There is no evidence for the transmission of *Variola* virus from nonporous surfaces. Therefore, there is no indication to use extraordinary procedures to clean and disinfect the interior surfaces of ambulances or other spaces occupied by smallpox patients. Routine approaches for cleaning and disinfection are adequate in these areas.
    e. There is no evidence to support air space decontamination of rooms, facilities, or vehicles (e.g. fumigation). Therefore, fumigation is not indicated for environmental control of the *Variola* virus.
    f. The surfaces of reusable medical equipment should be cleaned and then subjected to either low- or intermediate-level disinfection with an EPA-registered chemical germicide in accordance with label instructions.

E. State and Local Public Health Departments

- Specific Response Guidelines:

- For suspected communicable diseases on domestic flights, investigation will be led by the **Florida Department of Health in Miami-Dade (DOH).**

NOTE: *The CDC Miami Quarantine Station (CDC MQS) will be the initial point of contact for suspected communicable diseases on arriving flights (domestic and international), based on the pre-existing MOU between CDC MQS and the DOH Miami-Dade.*

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[3] Adapted and reprinted from the CDC –Smallpox response Plan and Guidelines (version 3.0), Guide F, http://www.bt.cdc.gov/agent/smallpox/response-plan/files/guide-f.doc

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- Once the Office of Epidemiology and Disease Control (OEDC) at the DOH Miami-Dade is notified by the CDC MQS of a potential quarantinable communicable disease or a bioterrorism event, it will notify the following (Appendix K):
- Administrator, DOH Miami-Dade
- Public Health Preparedness, DOH Miami-Dade
- Medical Director, DOH Miami-Dade
- Public Information Officer, DOH Miami-Dade
- Florida DOH Bureau of Epidemiology and Disease Control
- State Warning Point (SWP)
- Office of Emergency Management (OEM)
- Bioterrorism Response Coordinator
- State Public Health Laboratory-Miami

– The DOH Miami-Dade will report to a pre-determined area and be escorted to the Incident Command Post (ICP) by the Miami-Dade County Aviation Department personnel.

– If the flight is blocked at a gate**,** the DOH Miami-Dade will respond to the appropriate Transportation Security Administration (TSA) checkpoint. TSA personnel will escort responders to the appropriate gate.

– The CDC MQS and the DOH Miami-Dade will respond to the ICP at the Penalty Box or other designated area and check in with the Incident Commander (IC).

– The IC is in charge of the entire incident.

– For an international flight, the CDC MQS Medical Officer is in charge of the epidemiological investigation of the crew and passengers.

– For a domestic flight, the designated DOH Miami-Dade staff will coordinate with CDC MQS to conduct epidemiological investigation of the crew and passengers.

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General Responsibilities:

- Provide support (upon CDC request) in the preliminary assessment of ill person(s).
- In the event of travelers' potential exposure to a person infected with a quarantinable disease or disease of public health importance, coordinate contact tracing and notification with CDC.
- Notify state and local medical examiner or coroner, as required.
- Coordinate with CDC and other federal entities, as necessary, in the issuance of quarantine and isolation orders, and the management of quarantine and isolation.
- Work with the Miami-Dade Aviation Department to activate the quarantine facility, as needed. Provide guidance to designated hospitals and/or the quarantine site medical clinic on the evaluation, diagnosis and clinical management of ill people, including assisting with arrangements for laboratory testing at local or state public health laboratories or at CDC.
- Provide clinical and public health information to local healthcare providers and the public.
- Provide public health information and recommendations to local and state authorities.
- Coordinate with CDC Quarantine Station on public health recommendations and implementation of protective measures, as needed.
- Collaborate with the Public Information Officer (PIO)/Joint Information Center (JIC) to develop and authorize information for the detained individuals, responders, the media and the public.

F. State and Local Law Enforcement Agencies

- Upon aircraft arrival, establish a security perimeter, secure the aircraft, and perform crowd control, as needed.
- Ensure that law enforcement responders have access to appropriate PPE.
- Enforce required actions (e.g., detention) for ill person or persons who have been exposed to an illness if any such persons are uncooperative.

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- Provide escort to ensure the security and enforcement of appropriate isolation and quarantine orders.[4]

Actions applicable to a report of illness on arriving aircraft

- Miami-Dade Police Department (MDPD) will be notified of an arriving flight by the CDC MQS and the airport's AOC. Once notified, they will do the following:
  - Dispatch a security team consisting of two Miami-Dade County Police Officers with the appropriate personal protective equipment (PPE).
  - Report to the Incident Command Post.

- **MDPD:**
  - Board the plane with CDC MQS and DOH Miami-Dade to provide security. Appropriate PPE will be provided to MDPD by CDC MQS if necessary.
  - Secure the perimeter of the aircraft in conjunction with CBP.
  - Provide security both in, and around any facilities used while assessment of passengers is being conducted. Appropriate PPE will be provided to MDPD officers if necessary.
  - MDPD will provide escort for the MDFR if transportation of patients to a designated hospital is required, in addition to CBP guarding and following the ambulance and providing security for international passengers.
  - Follow behind MDFR if a passenger from a domestic flight needs transportation to the hospital. MDPD officer(s) will remain in the hospital 24/7 until the ill passenger is cleared by the lead agencies, found not to have criminal intent, and is medically cleared for communicable disease. Security at the hospital may be provided in conjunction with the local sheriff's office. If a passenger from an international flight requires transportation to the hospital, a MDPD officer will follow behind MDFR. MDPD will provide additional escort. The MDPD officer would then remain in the hospital 24/7, until the ill passenger is cleared by the lead agencies to not have a quarantinable disease and found by the Federal Bureau of Investigation (FBI), not to have criminal intent.
  - Take over the surveillance of the passenger in the hospital, if required (due to noncompliance with isolation/quarantine), thereby enforcing the authority of the Health Department under Fla. Stat. 381.00315(1)(b)(4) This states that in the event of "communicable diseases that have significant morbidity or mortality and present a severe danger to public health" the State Health officer, after declaring a public health emergency, has the ability to order an individual who is unwilling to be examined, tested, vaccinated, or treated to be subjected to quarantine.

[4] State and local officials may not have authorities to enforce federal isolation and quarantine orders.

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Actions applicable when quarantine is considered

- After the initial public health assessment period is complete, and if a quarantinable disease is suspected, the aircraft will be towed to the temporary quarantine facility. MDPD will perform the following actions as the plane is transported to designated area and once the temporary quarantine facility is established:
    - Provide security on the airfield while the plane is towed from the Penalty Box to designated temporary facility.
    - In collaboration with CBP and TSA, provide security at all entrances and exits of the temporary quarantine facility.
    - Provide security on the airfield if quarantined passengers need access to their luggage for medical reasons.

G. Local Healthcare Facilities

- The isolation or treating hospital must be notified prior to transport so that they can make arrangements to accept the patient safely.
- The appropriate law enforcement agency having jurisdiction over the isolation facility will provide "quarantine" enforcement for all patients transported to isolation facilities with a "quarantine order" but refuse to be "quarantined."[5]
- Receive, isolate, evaluate and treat ill persons, as medically indicated.
- Maintain infection control measures to limit the spread of quarantinable diseases. This may include isolation of ill persons and use of PPE by staff and visitors, as medically indicated (See Appendixs 16 and 17 for Standard and Droplet Precautions).
- Obtain specified diagnostic specimens and ensure the specimens are promptly and safely transported to designated laboratories.
- Monitor exposed persons, and evaluate those who develop illness signs or symptoms while in quarantine.

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[5] 381.0012 Enforcement authority – (5) It **shall be the duty** of every state and county attorney, **sheriff**, **police officer**, and other appropriate city and county officials **upon request to assist** the department or any of its agents in enforcing the state health laws and the rules adopted under this chapter. (**Emphasis supplied**)

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- Report cases, suspect cases, laboratory confirmation, and/or diagnoses immediately to appropriate public health authorities.

- Coordinate with public health authorities on media relations.

- Coordinate with local law enforcement for ill travelers placed under isolation orders or quarantine orders.

- Provide clinical and laboratory diagnostic information to federal, state, and local public health authorities.

- The hospital would proceed with the following steps for requesting a Quarantine Order from DOH Miami-Dade for a non-compliant patient(s):

  - **Step 1:** The hospital will contact the Florida Department of Health in Miami-Dade Legal Office at 305-324-2400 to request a Quarantine Order for non-compliant patients.

  - **Step 2:** The DOH Miami-Dade Legal Counsel will draft an order for the Director or Administrator of DOH Miami-Dade to sign.

  - **Step 3:** The DOH Miami-Dade Director/Administrator will execute the order and have it delivered to the hospital (via fax).

  - Work with public health authorities on media relations.

H. Centers for Disease Control and Prevention (CDC)

- Conduct public health assessments and arrange medical examinations of ill travelers and crew to determine the need for public health interventions.

- Authorize the temporary detention or quarantine, through federal order as necessary, of travelers and animals/cargo for appropriate public health evaluation and response to reports of illness, in consultation with other relevant federal entities.

- Notify and collaborate with other federal, state, and local agencies when ill travelers have been detained or paroled into the United States for evaluation or treatment for communicable diseases.

- Provide advice and guidance to the public health responders, including state and local public health authorities, in caring for ill and exposed persons.

- Provide training for CBP officers and other port and community partners regarding public health response at U.S. ports of entry.

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- Obtain information on ill and exposed travelers (e.g., demographics, contact information, travel itinerary, illness history, and medical status) and the conveyance (number of passengers, manifest availability), in accordance with the law and existing information sharing agreements.

- Rescind federal quarantine orders when the public health situation allows.

- Provide access to a medical review in instances where travelers challenge federal isolation or quarantine orders.

- Advise F/S/L/P officials potentially exposed to a quarantinable disease or disease of public health importance throughout the course of the epidemiological investigation and upon the final medical determination of the nature of the illness.

- Provide guidance to aircraft and airport operators on cleaning areas and conveyances potentially contaminated with communicable disease organisms.

- Coordinate with the Department of State and World Health Organization (WHO) to provide information about ill international travelers to ministries of health at their place of origin and at intermediate destinations.

- Coordinate with the Department of State, as necessary, to notify applicable foreign consulates or embassies that their foreign nationals have been detained for evaluation or treatment of a quarantinable disease.

- Participate in the management of media relations, in collaboration with state and local health departments and information officers from other response partners.

- In conjunction with the Miami-Dade Aviation Department and other stakeholders, maintain and periodically update the POE's Communicable Disease Response Plan to properly reflect responder organization, responsibilities and resources.

- In conjunction with the Miami-Dade Aviation Department and other stakeholders, periodically exercise the POE's Communicable Disease Response Plan.

- Collaborate with PIO/JIC to develop and authorize information for the detained, responders, the media, and the public.

I. U.S. Customs and Border Protection (CBP)

- For international arrivals with a potential ill person on board, meet the conveyance and prevent disembarkation until CDC or their designated alternate arrives.

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- Conduct passive observation of arriving international travelers and crew (using up-to-date information provided by CDC) during the routine performance of inspection duties through visual observations and questioning with a specific set of questions, for the purposes of identifying travelers and crew.

- To the extent necessary, provide on-site security escort of ill or potentially ill travelers and crew to ensure their separation from the general public.

- To the extent necessary, provide escort to ensure the security and enforcement on-site at the POE of individuals being detained pending their public health disposition, to include federal isolation and/or quarantine orders.

- Assist CDC in determining an on-site area appropriate for short-term detention and short-term quarantine.

- When CDC is not present, consult with the appropriate CDC Quarantine Station or Director's Emergency Operations Center to determine the public health disposition of ill or potentially ill travelers and crew.

- Assist CDC in identifying travelers at risk and those suspected of having been in contact with an ill person by reviewing passenger customs declarations (CBP Form 6059B), Advance Passenger Information System (APIS) data, and other sources of traveler information in response to a specific request by CDC, in a manner consistent with current information sharing arrangements, policies and laws.

- Parole or otherwise establish the correct immigration status for ill non-U.S. citizens and non-permanent residents (e.g. non-immigrant students, workers, etc.) if public health interventions are indicated.

- Assist CDC in distributing Traveler Health Alert Notices (THANs) and other public health information as well as posting traveler health information, as requested.

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J. Immigration and Customs Enforcement (ICE)

- To the extent necessary, provide off-POE escort and continued presence at the facility to ensure the security and enforcement for individuals being detained pending their public health disposition, to include federal isolation and/or quarantine orders.

- Assure that individuals who are cleared of public health orders are processed in accordance with the immigration or other laws (i.e., enforcement of warrants, detaining persons under Title 8 as needed, etc.).

K. Federal Aviation Administration (FAA)

- Provide air traffic control services and handling priority as required to permit safe and expeditious aircraft arrival and landing at the destination airport.

- Maintain communications between the aircraft pilot-in-command, the airport operating authority and CDC to advise on the progress of the flight and status of the ill person(s).

- Establish and assist with enforcement of temporary flight restrictions where requested by competent authority in the interest of public health and safety.

- Provide taxi instructions to a parking location designated by competent authority to effectively implement public health intervention in response to illnesses on board.

- At the request of TSA, divert a flight destined for the U.S. from landing in the U.S. or direct the flight to land at a specified airport in the U.S. that is equipped to examine and process a suspected infectious person on the aircraft.

L. State and Local Emergency Management Authorities

- Assist and support state and local public health authorities with supportive measures if temporary care and quarantine facilities are activated.

- Work with state and local health departments to support the planning and preparation activities to operate temporary care and quarantine facilities at each international and domestic airport, seaport, and land border crossing.

- Seek assistance from the Federal Emergency Management Agency (FEMA) when appropriate.

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M. Federal Bureau of Investigation (FBI)

- The FBI has jurisdiction over all terrorist threats and events. If a public health incident bears the potential to be an act of terrorism, the FBI will immediately be notified.

N. Local Support (and Non-Governmental) Organizations

- Miami-Dade OEM (ESF 6-Mass Care), ARC and the DOH Miami-Dade will provide support services to people exposed to the illness (quarantined individuals), as well as to service providers (See Appendix 18 American Red Cross Standard Operating Procedures). Such support services may be modified. Support services include, but are not limited to:

    - Meals (including special meals for those under dietary restrictions)
    - Beverages (including sterile water and formula for infants)
    - Eating utensils, plates and napkins
    - Tables and chairs
    - Cots and bedding
    - Space heaters and fans
    - Portable toilet facilities and toiletries
    - Hand-washing facilities
    - Portable showering facilities
    - Parent-child needs (e.g., diapers)
    - Telephones
    - Means of communicating with family
    - Television, movies, and radio
    - Internet access and email
    - Reading materials and games
    - Public address system
    - Interpreter services
    - Spiritual support
    - Mental health support

- The ARC will be responsible for providing support services during all phases of the event (initial assessment and temporary quarantine phases). Duties will include:

  Support Items/Infrastructure:

  – In collaboration with DOH Miami-Dade, supply and deliver support items for passengers during both the initial public health assessment and temporary quarantine phases of the event (*see* Appendix 19 for list of items).

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- Delivery of support materials to the Penalty Box or Satellite building during the initial public health assessment phase, should be within 1-2 hours of receiving notification of the arriving aircraft.

- Delivery of support materials to the temporary quarantine facility should be within 4-6 hours of receiving notification of the arriving aircraft.

Staff/Volunteer Duties: (See Appendix 20 for a Detailed List)

– ARC personnel will provide mental health and crisis management assistance if needed, to passengers in the temporary quarantine facility.

– ARC will coordinate and manage all organizations and personnel providing crisis counseling, food services, administrative assistance, and other support services to family members and support organizations.

– ARC will coordinate with other staff in the temporary quarantine facility to appropriately stage the facility, including arrangement of sleeping, eating, and recreation areas.

Family Assistance:

– In collaboration with the airline, ARC will establish a family waiting/receiving area in the airport to provide support to waiting family and friends of passengers requiring quarantine.

– ARC will coordinate on site child care services if necessary for waiting family members and friends with young children.

– ARC personnel will provide mental health and crisis management assistance if needed, to waiting family members and friends.

O. Miami-Dade Transit Authority (MDTA)

– Once the community quarantine facility is readied (up to 72 hours after initiation of quarantine), Miami-Dade Transit Authority (MDTA) buses will be used to transport passengers to temporary quarantine facilities throughout the County.

NOTE: *MDTA buses must have a police escort while they are transporting passengers from MIA to a community quarantine site.*

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P. U.S. Department of State (DOS)

- On international flights, if foreign diplomats, consular officials, or their dependents are on board, the U.S. Department of State (DOS), Bureau of Diplomatic Security should be notified so that they can contact consulates to verify the diplomatic status of passenger(s) claiming diplomatic affiliations.

- In the event that a quarantine order is issued, the DOS' Diplomatic Security Law Enforcement Center should be notified immediately at 571- 345-3146. This office will be responsible for notifying the home country of diplomats, consular officials, or their dependents and assisting in the handling of these individuals.

- If a diplomatic pouch is present on board the aircraft, its disposition will be determined by the DOS in consultation with the lead agency depending on the event (FBI or the CDC MQS or the DOH Miami-Dade).

- In the event that a quarantine order is issued, and foreign nationals (i.e. non-U.S. citizens or permanent residents) are on board, the DOS, Office of Foreign Missions should be contacted at 571-345-3146. This office will be responsible for notifying the home country of foreign nationals and assist in the handling of these individuals.

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X. APPENDIX

1. Memorandum of Agreement between FAA and CDC

MEMORANDUM OF AGREEMENT
BETWEEN
THE FEDERAL AVIATION ADMINISTRATION
AND
THE CENTERS FOR DISEASE CONTROL AND PREVENTION

1. PURPOSE.

The purposes of this Memorandum of Agreement (MOA) are to set forth the terms, conditions, and understandings by which the Federal Aviation Administration (FAA) of the U.S. Department of Transportation (DOT) and the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) (collectively the Parties and, individually, a Party) will relay notifications of reports that they receive of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft and to establish other actions that the Parties agree to take to prepare for and respond to contingencies involving deaths, suspected cases of communicable disease, or other public health risks, on board aircraft. Note 1 to Paragraph 8.15 of Annex 9 to the Convention on International Civil Aviation (the Chicago Convention) provides some possible examples of when a communicable disease might be suspected and require further evaluation.

2. PARTIES.

The Parties to this MOA are the FAA and the CDC.

3. BACKGROUND.

HHS has the authority to make and enforce regulations necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States or from one U.S. state or possession into another. This authority is implemented through HHS's Interstate and Foreign Quarantine Regulations, promulgated in Title 42, Code of Federal Regulations (CFR), Part 70 (Interstate) and Part 71 (Foreign), respectively. With respect to the activities contemplated under this MOA, the Division of Global Migration and Quarantine (DGMQ), is the office of primary responsibility within the CDC.

Title 42 CFR requires the commander of an aircraft to report deaths or suspected cases of communicable disease in circumstances defined by CDC. Paragraph 8.15 of Annex 9 to the Chicago Convention requires that "[t]he pilot-in-command of an aircraft shall ensure that a suspected communicable disease is reported promptly to air traffic control, in order to facilitate provision for the presence of any special medical personnel and equipment necessary for the management of public health risks on arrival." ICAO Document 4444

1

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provides guidance to ICAO Member States (including the United States) on the implementation of this requirement.

Specifically, ICAO Document 4444 sets forth, in paragraph 16.6.1, the items of information that the flight crew is expected to provide to the Air Traffic Services (ATS) unit with which the pilot is communicating regarding suspected cases of communicable disease, or other public health risks, on board an aircraft and further states that:

> 16.6.2 The ATS unit, upon receipt of information from a pilot regarding suspected case(s) of communicable disease, or other public health risk, on board the aircraft, shall forward a message as soon as possible to the ATS unit serving the destination/departure, unless procedures exist to notify the appropriate authority designated by the State and the aircraft operator or its designated representative.
>
> 16.6.3 When a report of a suspected case(s) of communicable disease, or other public health risk, on board an aircraft is received by an ATS unit serving the destination/departure, from another ATS unit, or from an aircraft or aircraft operator, the unit concerned shall forward a message as soon as possible to the public health authority (PHA) or the appropriate authority designated by the State as well as the aircraft operator or its designated representative, and the aerodrome authority.

In the United States, the FAA's Air Traffic Organization (ATO) provides air traffic services, and the CDC is the authority designated by the United States to arrange for any necessary public health response to reports of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft.

This MOA establishes the terms, conditions, and understandings by which the FAA and the CDC will exchange notifications of reports that they receive of deaths, suspected cases of communicable disease, and other public health risks, on board aircraft and establishes other actions that the Parties will take to prepare for and respond to such contingencies. The primary mechanism by which FAA and CDC will exchange notifications of reports that they receive of deaths, suspected cases of communicable disease, and other public health risks, on board aircraft is the FAA's Domestic Events Network (DEN). The DEN is an FAA-sponsored, 24/7 telephonic conference call network that includes all the FAA Air Route Traffic Control Centers (ARTCCs) in the United States. It also includes various other governmental agencies that monitor the DEN, including the CDC Emergency Operations Center (EOC). The purpose of the DEN is to provide timely notification to the appropriate departments or agencies that there is an emerging aviation-related problem or incident. The DEN is managed and facilitated by FAA Air Traffic Security Coordinators (ATSCs) under the direction of ATO System Operations Security. All interagency communication regarding real-time aviation security concerns and other events with potential operational impacts on the National Airspace System should be initiated and coordinated on the DEN. The premise of the DEN is a "need to share" versus a "need to know." The DEN is an open mode of communication and is not to be used for classified information.

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A diagram illustrating the intended pathways for many of the potential government and industry communications regarding reports of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft is included as Appendix 1 to this MOA. Appendix 1 does not form part of this MOA, and the Parties recognize that, in an actual event, reporting pathways may differ from what is depicted in Appendix 1 and that there are additional potential reporting pathways that are not depicted.

4. AUTHORITY.

A. The CDC is authorized to enter into this MOA pursuant to section 361 of the Public Health Service Act (42 United States Code (U.S.C.) § 264).

B. The FAA is authorized to enter into this MOA pursuant to 49 U.S.C. § 106(m).

5. RESPONSIBILITIES.

A. The FAA agrees to:

1. Develop procedures for ATSCs and ATS staff to use to notify the CDC EOC of any reports of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft destined for or departing from the United States, transiting U.S. airspace, or operating in other airspace in which the FAA provides air traffic services, that are received by an FAA ATS unit.

2. Notify the CDC EOC of any reports of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft destined for or departing from the United States, transiting U.S. airspace, or operating in other airspace in which the FAA provides air traffic services, that are received by any FAA ATS unit. The FAA will relay such reports to the CDC EOC using the DEN. To the extent that the report made to the FAA includes the information listed in Paragraph 16.6.1 of ICAO Document 4444, the FAA shall provide this information to the CDC EOC.

3. If an FAA ATS unit receives a report of a death, suspected case of communicable disease, or other public health risk, on board an aircraft that departed from or is destined for a location outside the United States, the FAA will, in addition to notifying the CDC EOC, forward a message as soon as possible to the ATS unit(s) serving the departure or destination outside the United States to notify said ATS unit(s) of the report of a death, suspected case of communicable disease, or other public health risk, unless procedures exist to notify the appropriate authority designated by the foreign country and the aircraft operator or its designated representative.

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B. The CDC agrees to:

1. Develop procedures to be used by watch officers in the CDC EOC to document receipt of notifications and actions taken when the FAA or another source notifies the CDC of a report of a death, suspected case of communicable disease, or other public health risk, on board an aircraft destined for or departing from the United States, transiting U.S. airspace, or operating in other airspace in which the FAA provides air traffic services. The CDC EOC will verbally acknowledge receipt from the DEN of reports of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft.

2. Develop procedures to communicate directly with aircraft operators or their designated representatives and airport operators regarding notifications received by the CDC of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft, whether from the FAA or another source.

3. In response to a notification from the FAA or another source of a report of a death, suspected case of communicable disease, or other public health risk, on board an aircraft, the CDC agrees to notify the aircraft operator or its designated representative, and the departure and destination airport operators (where such airports are located within the United States), as well as to arrange for an appropriate public health response at departure or destination airports located within the United States. The CDC agrees to communicate directly with the aircraft operator or its designated representative and the airport operator(s), if applicable, for subsequent coordination with the aircraft concerning clinical details, airport preparation, and other aspects of the public health response. The CDC agrees that it will not request that ATC channels be used for any such subsequent coordination unless no other reasonable alternative exists.

4. The CDC EOC, via the DEN, will provide the FAA with follow-up information concerning CDC's actions in response to a notification from the FAA or another source of a report of a death, suspected case of communicable disease, or other public health risk, on board an aircraft.

5. The CDC EOC will notify FAA, via the DEN, of any reports that the CDC receives from sources other than the FAA of deaths, suspected cases of communicable disease, or other public health risks, on board aircraft destined for or departing from the United States, transiting U.S. airspace, or operating in other airspace in which the FAA provides air traffic services, that may require action by the CDC or by other federal, state, local, tribal, or foreign authorities that the CDC has received from sources other than the FAA.

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6. POINTS OF CONTACT.

A. FAA.

a. System Operations Security
Manager, Strategic Operations Security
800 Independence Ave, SW, BLDG 10A, Room 300
Washington, D.C. 20591
Office: 202-267-7382

b. Domestic Events Network
Manager, Tactical Operations Security
800 Independence Ave, SW, BLDG 10A, Room 300
Washington, D.C. 20591
Office: 202-493-4528

B. CDC.

a. Division of Global Migration and Quarantine (DGMQ)
1600 Clifton Road, NE, MS E-03
Atlanta, GA 30333
404-498-1600

b. CDC Emergency Operations Center
Office of the Director
1600 Clifton Road, NE
Atlanta, GA 20332
770-488-7100

7. RELATIONSHIP TO OTHER PROVISIONS.

Nothing in this MOA is intended to conflict with any applicable U.S. law or regulation. If any provision of this MOA is found to conflict with any applicable U.S. law or regulation or any obligation of the United States under an international agreement, then such law or regulation shall control, but the remaining provisions of this MOA shall remain in full force and effect.

8. FUNDS.

It is not anticipated that funds from either Party will be specifically required to implement this MOA. If such expenditures do occur, the expenditures by each Party are subject to its budgetary processes and to the availability of funds and resources pursuant to applicable

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laws, regulations, and policies. Each Party will be responsible for any expenditures it may make to implement this MOA.

Any transfer of funds between the Parties relating to this MOA shall be made in accordance with the Economy Act (31 U.S.C. §§ 1535, et seq.) or the authority provided to the FAA at 49 U.S.C § 106(m) and shall be subject to the availability of appropriations.

9. LIABILITY

Each party to this MOA will be solely responsible for its own acts and omissions and those of its officers, employees and agents.

10. AMENDMENTS

The Parties may amend this MOA at any time and shall document the details of any such amendment in a written agreement signed by both Parties.

11. NO PRIVATE RIGHTS CREATED & NO EFFECT ON LEGAL AUTHORITIES

This MOA is an interagency agreement between the CDC and the FAA and does not create or confer any right, benefit, or cause of action on any other person or party, private or public. Nothing in this MOA is intended to restrict the authority of either Party to act as provided by law or regulation, or to restrict any agency from enforcing any laws or regulations within its authority or jurisdiction.

12. EFFECTIVE DATE.

This MOA enters into force on the date of the last signature and shall remain in force until terminated in accordance with Article 13 of this MOA.

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13. TERMINATION.

Either Party may terminate this MOA upon thirty (20) business days' written notice to the other Party.

APPROVED BY:

F. D. Hatfield
Director,
System Operations Security
Air Traffic Organization
Federal Aviation Administration
Department of Transportation

10/26/10
(date)

Martin S. Cetron, M.D.
Director, Division of Global Migration
and Quarantine
Centers for Disease Control
and Prevention
Department of Health and Human Services

25 October 2010
(date)

Phillip X. Navin, Jr.
Director,
Emergency Operations Center
Centers for Disease Control
and Prevention
Department of Health and Human Services

10/25/10
(date)

Appendix A – Selected Communication Paths for Aircraft Reporting A Death, Suspected Case of Communicable Disease, Or Other Public Health Risk

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2. Cockpit Card Notifying Public Health about Ill Passengers or Crew on Flights Arriving in the United States

Federal regulations require that the captain of an aircraft destined for a U.S. airport report, before landing, any death on board or illnesses that may indicate a communicable disease.

Conditions <u>requiring</u> reporting to the Centers for Disease Control and Prevention (CDC):

- **Fever*** that has lasted more than 48 hours;
- **Fever*** of any duration **plus** any of the following:
  - o **rash,** or
  - o **swelling of the lymph glands**, or
  - o **jaundice (yellowing of skin or eyes);**
- **Persistent Diarrhea** (more than 3 stools within 24 hours)

Conditions that CDC <u>requests</u> be reported:

- **Fever*** of any duration **plus** any of the following:
  - **difficulty breathing**, or
  - **headache with stiff neck**, or
  - **reduced level of consciousness**, or
  - **unexplained bleeding**
  - **persistent vomiting**
  - **persistent cough**

- Contact your airline's point of contact (for example, Operations Center, Flight Control, airline station manager) as soon as you learn of an ill person or death. Provide the ill person's name, seat number, symptoms, approximate age, and point of origin.
- Tell the airline point of contact to immediately notify the CDC Quarantine Station at or closest to the airport where you are arriving to ensure a prompt ground response so the ill person can receive timely care and the risk for spreading disease will be minimized.

** Fever means a temperature of 100° F (37.8° C) or greater. Flight crew should consider someone to have a fever if the ill person feels warm to the touch, gives a history of feeling feverish, or has an actual measured temperature of 100° F (37.8° C) or greater.*

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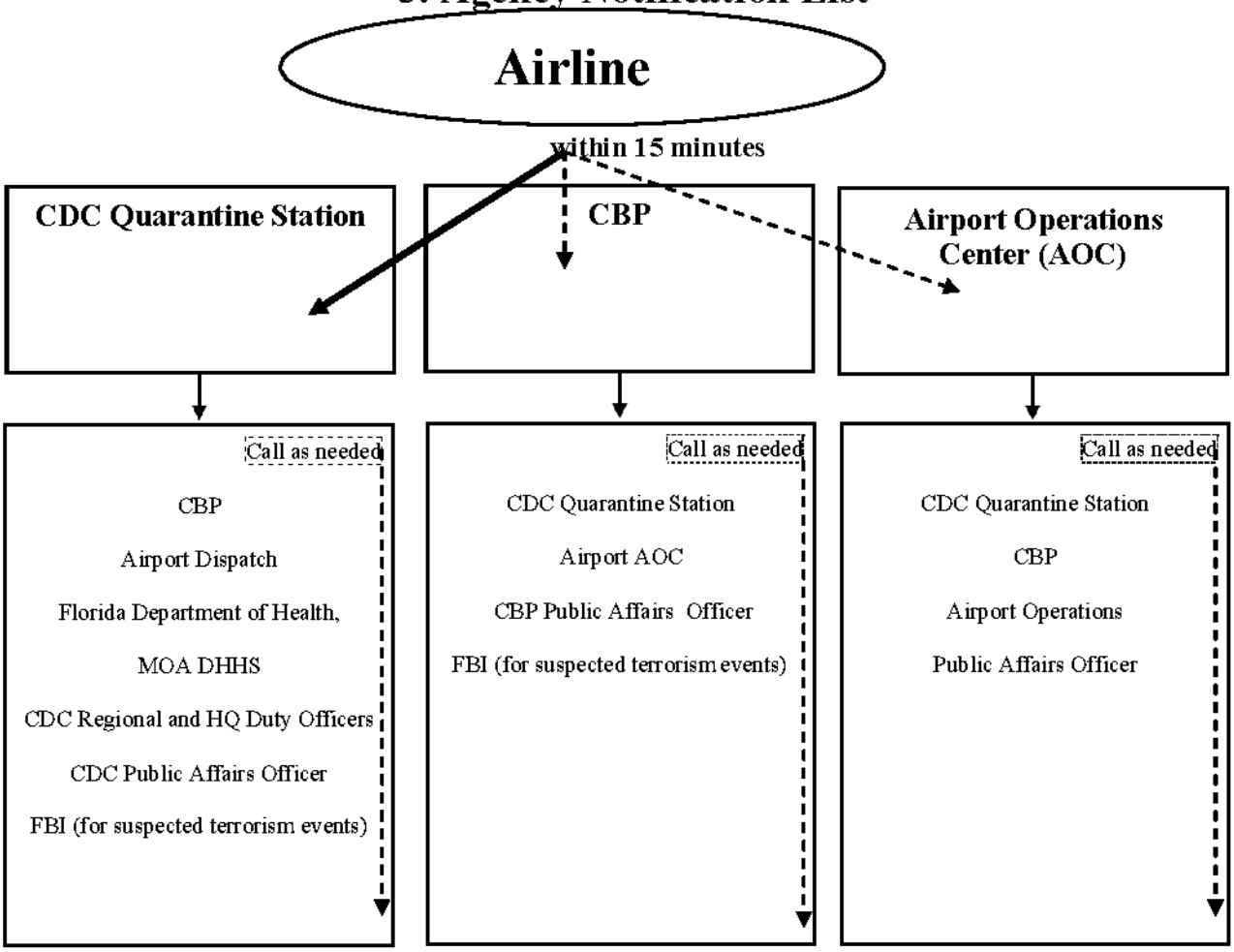
3. Agency Notification List



Notifications among responding agencies to a communicable disease incident on an international aircraft should be timely and redundant. In particular, designated healthcare facilities/hospitals should be notified prior to transport and treatment of suspected ill persons.

Depending on the nature of the communicable disease event and the scope of the response (high public health significance vs. low public health significance), in addition to the responders listed in the notifications above, the entities listed below may also be notified.

- Miami Dade County Office of Emergency Management
- Florida Department of Health
- Florida Department of Emergency Management

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4. NOTAM

MIAMI-DADE COUNTY
AVIATION DEPARTMENT
P. O. Box 025504

Miami, FL 33102-5504
(305) 876.7484 or 7359

To: Federal Aviation Administration (Telephone (800) 662.6470 or (305) 233.2610)
International Flight Service Station
14715 S.W. 128th Street, Miami, FL

From: Ken Pyatt
Deputy Director for Operations
Miami International Airport

FAA Received: ____
MDADNumber:080119

Subject: **NOTAM**.

MIA ALL MED EMERG ARR EXCLD AIR AMBULANCE FLT MUST SECURE DOORS TIL MED EMERG RESP ARR, WIE/UFN

ALL MEDICAL EMERGENCY ARRIVALS, EXCLUDING AIR AMBULANCE FLIGHTS, MUST SECURE DOORS UNTIL MEDICAL EMERGENCY RESPONSE ARRIVES, with immediate effect and **UNTIL FURTHER NOTICE**.

Reason for NOTAM:
Medical Emergency Response Procedure

MDAD Coordination Information:
Ramp One (305) 876.7001

For Lonny Craven

NOTAM issued per Telecon ( )
FSS Reference Number ( )
Date: (01/14/08) Time: ( )
NOTAM terminated per Telecon ( )
Date: ( ) Time: ( )

cc: JMurphy; LCraven; GAC; GAC Ramp 1; E-Tower; B-Tower; RCR; Ramp One; Miami Tower; FAA Front Office; Darryl Roberts; FAA-A.F. Section; Access Control; Maintenance; JBunting.

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FL-DOH-20-0673-A-004665

5. Public Health Announcement Scripts

These messages should be read **after** a report of an ill person has been made to the Centers for Disease Control and Prevention (CDC) Quarantine Station, and/or if requested by the Quarantine Station. If possible, the public health announcement (PHA) should be made before landing or while taxiing to the gate to ensure that passengers remain in their seats once the plane has landed.

Situation 1: Ill person is still on the plane, and medical assistance is needed. Read PHA 1.

Situation 2: Ill person has been taken off the plane, and CDC has asked that Travel Health Alert Notices be handed out to everyone. Read PHA 2.

Situation 3: Ill person has been taken off the plane. CDC has asked that certain passengers sitting near the ill person receive Travel Health Alert Notices and provide their contact information by filling out a Passenger Locator Form. Read PHA 3.

Situation 4: There are no ill people on board. CDC has asked that a PHA be read because the flight is coming from an area of risk for a disease. Travel Health Alert Notices will be handed out to everyone on the plane. Read PHA 4.

Situation 5: There are no ill people on board. CDC has asked that a PHA be read and that passengers fill out the Passenger Locator Form. Travel Health Alert Notices will be handed out to everyone on the plane. Read PHA 5.

PHA 1
Please remain seated for an announcement. A person on board requires medical attention. This should take only a few minutes. Please remain seated while emergency medical team and public health staff are on board. We will provide more information as soon as possible. Thank you very much for your cooperation.

PHA 2
Please remain seated for an announcement. An ill person has been taken off the plane to receive medical treatment. As a precaution, public health officials have asked us to give you information about the illness and what to do if you become ill. Flight attendants will hand you a Travel Health Alert Notice as you leave the plane. Please read this card carefully and keep it for the time specified on the card. Thank you very much for your cooperation.

PHA 3
Please remain seated for an announcement. An ill person has been taken off the plane to receive medical treatment. As a precaution, we are collecting information on how to contact passengers who sat near the ill person. In case public health authorities need to contact you, we are asking you to provide information about how you can be reached in the next 3 weeks. Flight attendants are passing out the forms now. Please fill out the form completely and hand it back to a flight attendant before you leave the plane. We will also give you a Travel Health Alert Notice to

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inform you about the illness and what to do if you become ill. Please read the card carefully and keep it for the time specified on the card. Thank you very much for your cooperation.

PHA 4
Please remain seated for an announcement. This flight is returning from an area where cases of [*insert name of the infectious disease*] have been reported. There is a slight risk that travelers may have been around people ill with the disease while in the country. As a precaution, public health officials have asked us to give you information about the illness and what to do if you become ill. Flight attendants will hand you a Travel Health Alert Notice as you leave the plane. Please read this card carefully and keep it for the time specified on the card. Thank you very much for your cooperation.

PHA 5
Please remain seated for an announcement. This flight is returning from an area where cases of [*insert name of the infectious disease*] have been reported. There is a slight risk that travelers may have been around people ill with the disease while in the country. As a precaution, public health officials have asked us to give you information about the disease and what to do if you become ill. Flight attendants will hand you a Travel Health Alert Notice as you leave the plane. Please read this card carefully and keep it for the time specified on the card.

Public health officials may need to contact you, so we are asking you to provide information about how you can be reached in the next 3 weeks. Flight attendants are passing out the forms now. Please fill out the form completely and hand it back to a flight attendant before you leave the plane. Thank you very much for your cooperation.

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6. DOH Miami-Dade Possible Exposure Instructions

POSSIBLE EXPOSURE TO A CONTAGIOUS DISEASE

The DOH Miami-Dade has been notified of illness in a passenger who was on this flight. The cause of illness is being investigated but is not yet known. The following information is being requested in case the illness is a communicable disease, which could have been spread to other passengers. Any information you provide will be kept confidential and used only for health department follow-up if needed.

If you need any follow-up or preventive treatment, the DOH Miami-Dade will be contacting you. However, you should notify your health care provider and call the DOH Miami-Dade if, during the incubation period you develop symptoms such as:

- **Temperature of 100°F (38°C) or greater accompanied by rash;**
- **Temperature of 100°F (38°C) or greater accompanied by glandular swelling;**
- **Temperature of 100°F (38°C) or greater accompanied by jaundice;**
- **Temperature of 100°F (38°C) or greater which has persisted for more than 48 hours; or**
- **Diarrhea defined as the occurrence in a 24-hour period of three or more loose stools or a greater than normal amount of loose stools.**

In addition, it is recommended that a report be made for the following conditions which may indicate a reportable illness:

- **Hemorrhagic fever syndrome (persistent fever accompanied by abnormal bleeding from any site);**
- **Acute respiratory syndrome (severe cough or severe respiratory disease of less than 3 weeks duration); or**
- **Acute neurological syndrome (severe nervous system problem of less than 3 weeks duration)**

The DOH Miami-Dade 24 hour phone number is (305) 324-2400.

The attached form should be completed by / for each passenger. If you need assistance completing this form, please ask a health department or airline representative.

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7. Memorandum Of Agreement Between DOH Miami-Dade and Miami-Dade County

MEMORANDUM OF AGREEMENT
Between
MIAMI-DADE COUNTY HEALTH DEPARTMENT
And
MIAMI-DADE COUNTY

RECITALS

THIS MEMORANDUM OF AGREEMENT, entered into between Miami-Dade County, (hereinafter referred to as the "County") and the **Miami-Dade County Health Department**, (hereinafter referred to as "MDCHD").

WHEREAS, it is the intent of the Florida Legislature that the Department of Health provide public health services through the 67 county health departments in partnership with county governments, as specified in part I of §154.001 Florida Statutes (2006), and in so doing make every attempt possible to solicit the support and involvement of federal, state, and local government and the public and private sectors to achieve its mission; and

WHEREAS, the Florida Legislature has directed the Florida Department of Health to exercise quarantine authority, stating, "It is the duty of the Department of Health to declare, enforce, modify, and abolish quarantine of persons, animals, and premises as the circumstances indicate for controlling communicable diseases or providing protection from unsafe conditions that pose a threat to public health." (Florida Statute §381.0011(6)); and

WHEREAS, pursuant to Rule 64-D-3.005(1), Florida Administrative Code, authority to give notice of a quarantine is delegated to the County Health Department Directors and Administrators; and

WHEREAS, upon request, it is the duty of every city and county official of Miami-Dade County to assist the MDCHD in enforcing the state health laws and rules (Florida Statute §381.0012(5)); and

WHEREAS, it is the MDCHD's intent, in collaboration with the County, to house persons, when suspected of having contracted or having been exposed to an infectious disease, in order to keep them out of the community, or to confine them to a given place, and to prevent interaction between them and people generally of the community; and

WHEREAS, the County owns and manages the Miami-Dade County Auditorium located at 2901 W. Flagler Street, Miami, Florida that has been identified as an appropriate quarantine facility.

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the recipient and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

I. **RECITALS**

The parties mutually agree that the foregoing recitals are true and correct and incorporated herein by reference.

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II. DEFINITIONS

1. Human quarantine: the act of segregating, handling, disinfecting, testing, transporting, treating, caring for, and managing fatalities of humans, to eliminate and control exposure of disease-causing agents (and to identify, contain and control chemical and/or radiological contamination) that pose hazards to the health of all Miami-Dade county visitors and residents.
2. Minor event: This is characterized by a biological, radiological, and/or terrorist attack that affects less than 100 individuals, who are then transported to a C facility. The most prominent features of the minor event are that the number of affected individuals remains under 100 and that these individuals are transported to the Q facility.
3. Major event: This is characterized by a biologic, radiological, and/or terrorist attack that affects 101 or more persons, who are quarantined in a specific area. The most prominent features of the major event are that the number of individuals affected remains over 101 and the entire area is quarantined.
4. Responders:

    - First Responders: This refers to the personnel with direct contact with victims and the event working within the quarantine area.

    - Second Responders: This refers to personnel with direct contact with suspected cases working outside of the quarantine area, i.e. personnel in an X Facility.

    - Third Responders: The public's response to the event. This refers to all personnel assisting the public and people in R Facilities, as well as people living within the county or the region.

5. Type C Facility: (C=Contagious) Isolation-Infectious individuals confirmed, probable and suspected smallpox cases, i.e. hospital.
6. Type R Facility: Residential-Asymptomatic contacts (not infectious), i.e. private home.
7. Type R-2 Facility: Asymptomatic contacts (not infectious) with mental health issues, homeless individuals who refuse to obey quarantine, i.e. arena or stadium.
8. Type R-3: Asymptomatic contacts (not infectious); these are tourists or visitors, i.e. hotel or motel.
9. Type X Facility: Isolation of persons with uncertain diagnosis-Vaccinated febrile contact without rash-(2 successive temperatures greater than 101F (38C) i.e. dormitory.

III. County Agrees to the Following:

1. During a critical health event and/or a declared state of emergency, the County shall provide access and usage of the Miami-Dade County Auditorium ("Facility") for purposes of enacting a Human Quarantine. The County understands that the Facility will be used as a Type X or Type R Facility and not as a Type C Facility.

2. The County shall provide the Facility for quarantine purposes to the MDCHD for no cost.

3. The Facility shall be able to accommodate large numbers of people (100 or more) at one time.

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4. The Facility shall have adequate utilities (i.e., water, electricity, and restrooms). MDCHD will be responsible for the cost of utilities while utilizing the Facility for quarantine purposes.

5. The County will allow the MDCHD to monitor and inspect the Facilities once a year upon reasonable notice.

IV. MDCHD Agrees to the Following:

1. If possible, MDCHD agrees to provide the County at least 24 hours notice of its intent to use the Facility.

2. Provide, or coordinate with other agencies to provide, all necessary medical equipment, such as IV fluids, antibiotics, skin care, oxygen monitoring (pulse ox) and oxygen (in-line or portable), medical vital signs monitoring, cardiac and respiratory resuscitation, ventilatory support, suctioning equipment, basic laboratory evaluations (blood chemistries, CBC), radiology (portable chest x-ray), etc.

3. Provide, or coordinate with other agencies to provide, all bedding, linens, and food service.

4. Determine the staffing configuration for this collaboration in the event of a decision to quarantine.

5. Oversee and maintain quality control/quality assurance at the quarantine site.

6. Coordinate physical security with the County and other agencies as deemed necessary.

7. Respond to operational issues and challenges as they occur in an event.

8. Monitor and inspect the facilities at least once a year.

9. Give the County reasonable notice and site location for any inspection of the Facility prior to initiating such inspection.

10. Coordinate the decontamination of the facilities once the Facility is no longer being used for quarantine. MDCHD will be responsible for payment of decontamination.

V. HIPPA

Where applicable, the County will comply with the Health Insurance Portability Accountability Act as well as all regulations promulgated thereunder (45CFR Parts 160, 162, and 164).

VI. Termination

This agreement may be terminated by either party upon no less than thirty (30) calendar days notice in writing to the other party, without cause, unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

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VII. Agreement to Follow Florida Governing Law

This Agreement is executed and entered into in the State of Florida, and shall be construed, performed and enforced in all respects in accordance with the laws, rules and regulations of the State of Florida. Each party shall perform its obligations in accordance with the terms and conditions of this Agreement.

VIII. All Terms and Conditions Included

This agreement contains all the terms and conditions agreed upon by both parties. There are no provisions, terms, conditions, or obligations other than those contained herein, and this agreement shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of the agreement is found to be illegal or unenforceable, the remainder of the agreement shall remain in full force and effect and such term or provision shall be stricken.

The term of this agreement shall be from November 1, 2007 or on the date on which the agreement has been signed by both parities, whichever is later. It shall remain in effect until either party terminates this Agreement.

This Agreement shall not be changed, modified or amended in any respect except by a written instrument signed by the parties hereto.

I have read the above Memorandum of Agreement and understand each section and paragraph.

IN WITNESS THEREOF, the parties hereto have caused this 4 page Agreement to be executed by their undersigned officials as duly authorized.

MIAMI-DADE COUNTY

Jack Kardys
Interim Director

10/13/07
Date

MIAMI-DADE COUNTY
HEALTH DEPARTMENT

Maribel Zayas
Interim Administrator

10/28/07
Date

Approved as to form and legal sufficiency:

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8. Emergency Contact Database

Miami International Airport and Port of Miami Emergency Contacts

MIA:

Dan Agostino, MDAD Assistant Director for Operations
Office: (305) 876-7138; Cell: (305) 979-9662; email: dagostino@miami-airport.com

Mark O. Hatfield Jr., MDAD Assistant Director for Security
Office: (305) 876-0127; Cell: (786) 602-3093; email: mhatfield@miami-airport.com

Ken Pyatt, MDAD Deputy Director – Supervisor
Office: (305) 876-7129, Cell: 305-608-1587; email: kpyatt@miami-airport.com

David Bello, CBP- Assistant Port Director, PAX
Office: (786) 476-3817, Cell: (305) 747-5057 email: salvador.flores@cbp.dhs.gov

John Gardner, Chief, Miami-Dade Fire Rescue, MIA
Office: (305) 869-2705; Cell: 347-366-4880; email: john.gardner@miamidade.gov

Reynald C. Jean MD, DOH-Miami-Dade - Director Tuberculosis & Epidemiology, Disease Control, Immunization Services
Office: (305) 575-5402; 305-470-6827; Cell (786) 412-4024 email: reynald.jean@flhealth.gov

PortMiami:

Franklin Roig, Jr., Chief Operating Officer/Safety and Security
Office 305-329-4059; email:feroigjr@mdpd.com

Chester W. "Bill" Olejasz, CBP- Assistant Port Director (Tactical)
Office: (305) 305-536-4989; e-mail: chester.w.olejasz@cbp.dhs.gov

State of Florida:
Laura Rutledge, Executive Health Nurse Consultant- Florida Bureau of Immunization
Office: 850-245-4444 X 2384; e-mail: laura.rutledge@flhealth.gov

Valerie Shipley, Community Health Nursing Consultant- Florida Bureau of Immunization
Office: (850) 245-4444 X 2385; e-mail: valerie.shipley@flhealth.gov

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Airport			
Title	**Name**	**1st Phone**	**2nd Phone**
Aviation Director	Lester Sola	305-876-7066	305-308-9285
Deputy Director	Ken Pyatt	305-876-7129	305-608-1587
Chief of Staff to the Director	Arlyn Rull-Valenciaga	305-876-7066	305-877-8129
Assistant Aviation Director for Operations	Dan Agostino	305-876-7138	305-979-9662
Assistant Aviation Director for Security and Public Safety	Mark O. Hatfield Jr.	305-876-0127	786-602-3093
MIA Communications Director	Greg Chin	305-869-3809	786-251-0588
MIA Public Information Officer	24 Hr. Duty Officer	305-342-1849	
CDC-Miami Quarantine Station			
Acting Officer In Charge	Michelle Decenteceo	305-526-2910	786-459-3831
Quarantine Public Health Officer	CDR Andrew Ganzon	305-526-2910	404-617-8357
Quarantine Public Health Officer	Emily Davenport	305-526-2910	305-407-5118
Quarantine Public Health Officer	Gabriella Wuyke	305-526-2910	305-323-0015
Regional Officer in Charge	CDR Andrew Klevos	305-526-2910	617-455-8749
Florida Department of Health in Miami-Dade County			
Administrator DOH Miami-Dade	Yesenia Villalta, APRN, DNP, MSN	786-336-1260	305-970-2507
Director, Epidemiology and Disease Control & TB Control and Prevention	Reynald C. Jean, MD, MPH	305-575-5402 305-470-6827	786-412-4024
Florida Department of Health			
Epidemiology Investigation Unit	Scott Pritchard, MPH	850-245-4406	850-251-5558
Laboratory Liaison	Ann Schmitz, DVM, MA	305-325-2547	305-324-2415
State Warning Point			
Ask for duty officer		800-320-0519	850-413-9900
United States Coast Guard			
Captain of the Port Operations		786-295-9083	305-535-4472 305-535-4454
Law Enforcement Agencies			
CBP	Passenger Operations Control Center (POCC)	305-874-5403	
Police MIA, Major	Jesus Ramirez	305-876-7373	786-229-1530
TSA Federal Security Director	Dan Ronan	305-421-2443	347-461-4129
FBI, WMD Coordinator	Stephanie Viegas	954-818-4433	
Fire Rescue - Contact Information			
MIA, Chief	John Gardner	786-256-9132	786-36-6592
Other Agencies - Contact Information			
Red Cross	Carlos Castillo	305-644-1200 #2541	305-807-3588
Miami-Dade Office of Emergency Management EOC	Duty Officer	305-468-5800	

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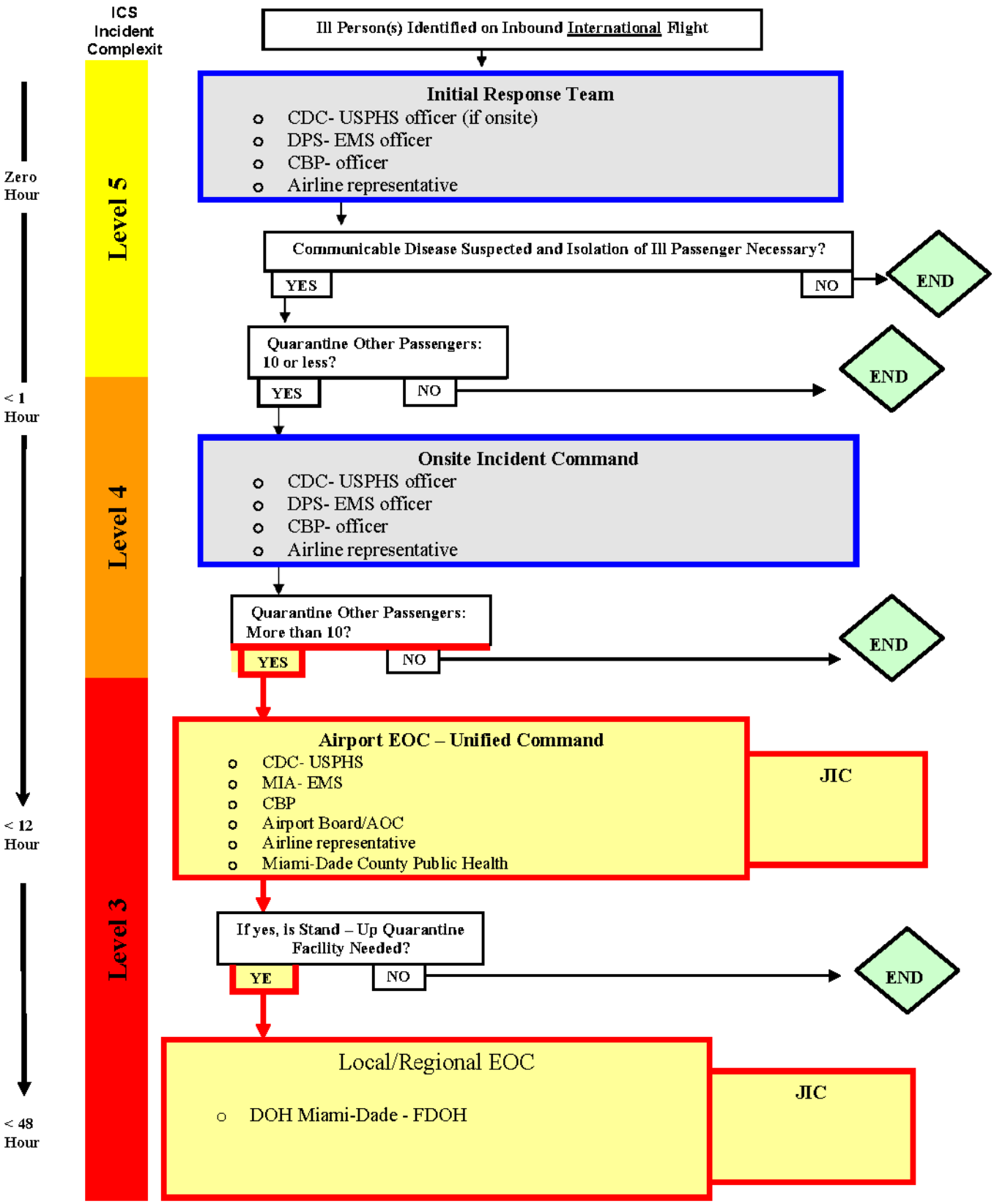
9. Incident Command Structure for EOC Activation



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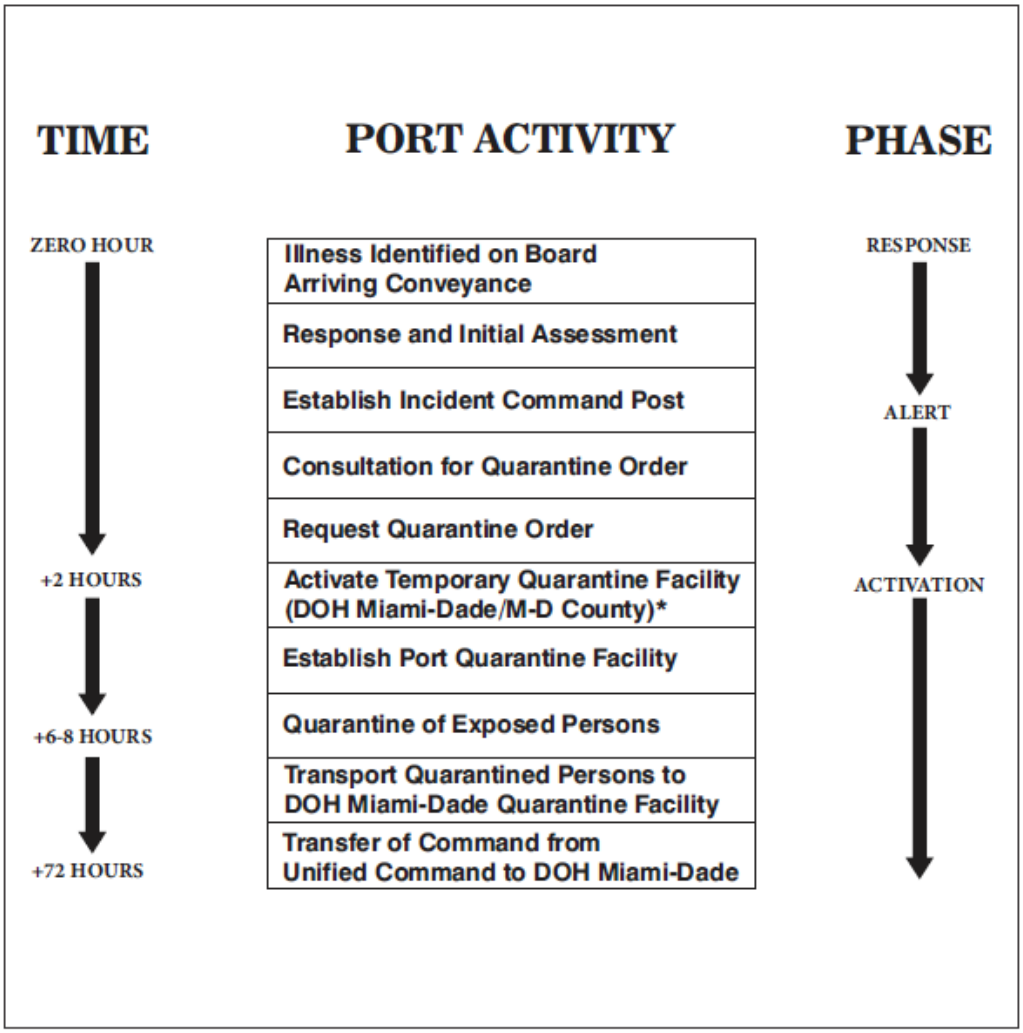
10. Port of Entry Quarantine Response Timeline



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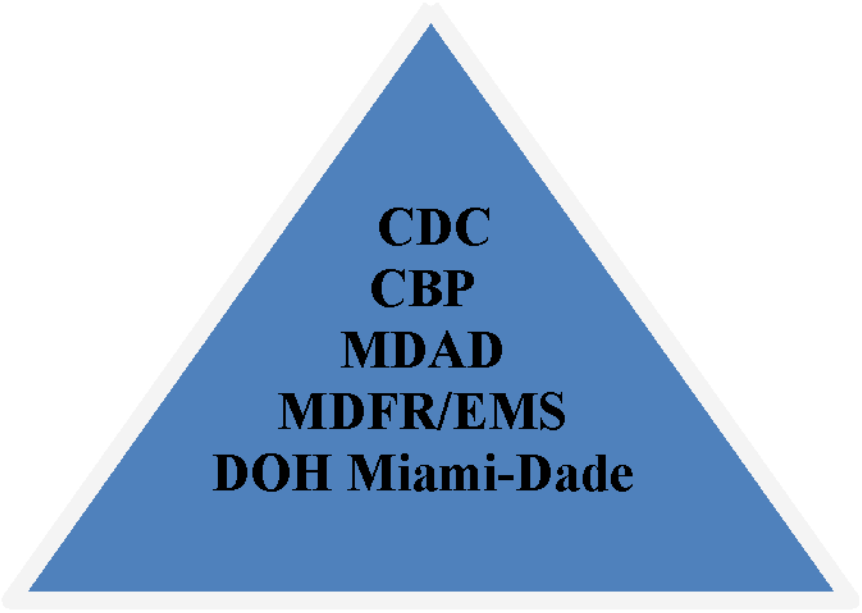
11. Unified Command Structure*



*A Unified Command Structure will be utilized during a response for up to 72 hours from a determination for a quarantine order. For Incident Command Structure beyond 72 hrs, see Appendix 9, **Procedure for Transfer of Command.**

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12. Guidance for Commercial Aircraft Operators: Seasonal Influenza

Commercial air travel involves the movement of large numbers of people in closed and semi-closed settings. As with other close contact environments, these settings may facilitate the transmission of influenza viruses from person to person or through contact with contaminated environmental surfaces. The Centers for Disease Control and Prevention (CDC) recommends that efforts to reduce the spread of influenza virus on commercial aircraft focus on encouraging airline employees and passengers to:

•Get vaccinated (http://www.cdc.gov/flu/protect/vaccine/)
•Postpone travel when sick (http://www.flu.gov/individualfamily/travelers/index.html)
•Take everyday steps to protect themselves and others while traveling (http://www.cdc.gov/flu/protect/covercough.htm)

Management of Passengers and Crew Members with ILI Influenza-Like Illness (ILI)

Flight crew should consider someone to have a fever if the ill person feels warm to the touch, gives a history of feeling feverish, or has an actual measured temperature of 100° F (37.8° C) or higher. ILI has been defined as an illness with fever or feverishness, plus either cough or sore throat; however, not all ILI is influenza, and not all influenza illnesses fit the definition of ILI. Anyone with a respiratory illness should exercise good hand and respiratory hygiene, as noted above, to reduce the chance of spreading respiratory illnesses to others.

Steps to take on board

Crew members should take the following actions if a person has ILI during a flight:

- Keep interactions with the ill person as brief as possible.
- Ask the ill person to wear a face mask, if it can be tolerated and one is available.
- If a face mask cannot be tolerated, provide tissues and ask the ill person to cover his or her mouth and nose when coughing or sneezing.
- If the ill person is a passenger, move her or him to a seat that is separated from other passengers, if possible (≥6 feet of separation is ideal).
- Provide a plastic bag for proper disposal of used masks and tissues.
- Practice good hand hygiene and encourage others, including the ill person, to do the same:
    - Hands should be washed with soap and water or an alcohol-based hand rub especially after coughing or sneezing, after using the restroom, or after touching potentially contaminated surfaces or items (e.g., faucets, door handles, or someone's mobile phone).

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- Persons who are experiencing more severe illness (e.g., high fever, shortness of breath, difficulty breathing, rapid breathing, chest pain, altered mental status, dehydration, or worsening of chronic underlying medical conditions) should be reported to the airline in-flight medical consultant, according to airline protocols.

- If possible, continue operating the aircraft air-conditioning or ventilation system until all passengers and crew have disembarked to maximize air circulation in the cabin and thus the filtering of virus particles. Safety concerns may preclude this step on some aircrafts.

- If the ill person is a crew member, CDC recommends, in addition to the actions listed above, that the ill crew member.

- Follow individual company policy for onset of illness or incapacitation during flight operations.

- Discontinue work as soon as possible without affecting flight safety.

- See his or her health care provider, or a company-recommended health care provider if away from home base, and take antiviral medication for treatment of influenza if prescribed by the health care provider.

- Return to work only after fever has resolved for at least 24 hours without the use of fever-reducing medications.

Personal Protective Measures

- **Hand Hygiene**
  Routine hand hygiene is an important line of defense against infection with influenza viruses, as well as other viruses and bacteria. Wash hands with soap and water for 15-20 seconds or use an alcohol-based hand rub. Hands should always be washed before donning and after removing gloves and other personal protective items.

- **Gloves**
  Crew members should wear impermeable, disposable gloves if they are assisting an ill passenger or have contact with potentially contaminated surfaces or lavatories. Crew members should avoid touching their faces with gloved or unwashed hands. Hands should be washed with soap and water or with an alcohol-based hand rub after removing gloves. Improper use or disposal of gloves may actually increase transmission of infectious pathogens.

- **Face Masks and Respirators**
  Routine use of face masks and N95 respirators is NOT recommended for airline crew members. Crew members who wish to voluntarily wear face masks or N95 respirators while tending to an ill person should follow their airline's policy on the use of personal protective equipment during flight. To best ensure maximum protection from an N95 respirator, fit testing and training on proper technique is required

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Cleaning and Disinfection

Environmental management of influenza and other respiratory viral diseases should include routine cleaning and disinfection strategies, as well as more frequent cleaning of commonly touched hard surfaces, such as food trays, lavatory surfaces, and door handles. Commonly used environmental cleaners certified for use in the aircraft cabin are sufficient.
For more detailed information regarding these recommendations, please see http://www.cdc.gov/quarantine/travel-industry/air/guidance-seasonal-influenza-commerical-aircraft-operators.html

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13. Infection Control Guidelines for Cabin Crew Members on Commercial Aircraft

CDC Infection Control Guidelines or Cabin Crew Members on Commercial Aircraft can be found at http://wwnc.cdc.gov/travel/page/infection-control-guidelines -cabin-crew.htm

*All agencies will abide by their internal infection control guidelines.

PURPOSE

These guidelines provide cabin crew members (flight attendants) with practical measures to protect themselves, passengers, and other crew members when someone onboard is ill with a possible contagious infection. The practical measures for protecting yourselves and others include personal protection, management of an ill traveler, targeted clean-up measures, and post- flight measures. Since whether an illness is contagious is usually not known at the time, any body fluid (such as phlegm, diarrhea, vomit, or blood) must be treated as potentially infectious.

This guideline provides information on general infection control measures, as well as specific measures according to three infection categories: respiratory, gastrointestinal, and blood-borne.

As a general preventive measure, airline crew should be up to date on all recommended immunizations and other preventive health measures for their destination. Many infectious diseases can be prevented by vaccines!

ILLNESS CATEGORIES

Respiratory infections:

Symptoms: Germs (viruses or bacteria) in the respiratory system (such as measles, tuberculosis, influenza, whooping cough, or some pneumonias) can cause symptoms including coughing, sneezing, fever, rash, and difficulty breathing. Similar symptoms may also be caused by noninfectious conditions, such as asthma, allergic reactions, or reactions to irritating substances.

How infection spreads: Coughing, sneezing, or even singing or talking may spread respiratory germs. Depending on what is causing the infection, germs may be spread when another person inhales them from droplets or aerosols expelled into the air by a cough or sneeze. Another way of spreading these germs is by touching contaminated surfaces with your hands, then touching your mouth, eyes, or nose, before washing your hands. Some infections, such as tuberculosis (TB), do not spread easily without close and prolonged contact, while others, such as measles, can be transmitted after brief contact

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Gastrointestinal Infections:

Symptoms: Germs in the stomach or intestines, such as norovirus, can cause symptoms including nausea, abdominal pain, vomiting, diarrhea, or fever. Similar symptoms may also be triggered by a sensitivity or allergy to a food or food additive.

How infection spreads: Vomiting or diarrhea may spread germs to surfaces that other people may touch and then touch their mouth with contaminated hands. Infection may also be spread through contaminated food or liquids, for example, if an ill person prepares food or drink for other people.

Blood-borne Infections:

Symptoms: Certain infections, such as HIV/AIDS, hepatitis B and C, and viral hemorrhagic fevers, are carried in the bloodstreams of infected people. A person with one of these infections may have symptoms such as jaundice (a yellow appearance of the skin or white parts of the eyes) in the case of hepatitis B or C; or, in the case of hemorrhagic fevers, unexplained bleeding of the skin, eyes, or gums. However, a person with some of these diseases may not have any symptoms at all, yet still be contagious.

How infection spreads: Some of these infections can be spread when body surfaces that can easily absorb blood-borne pathogens, such as open cuts, scrapes, or mucous membranes (lining of mouth, eyes, or nose) come into direct contact with infectious bodily fluids.

INFECTION CONTROL MEASURES

- **Personal protection**
  - Treat any body fluid as though it is infectious
    - Hand hygiene is the single most important infection control measure. Wash hands with soap and water for at least 20 seconds after assisting ill travelers or coming in contact with body fluids or surfaces that may be contaminated.
    - An alcohol-based hand cleaner is an alternative to hand-washing but will not be effective if hands are visibly soiled.
    - Avoid touching your mouth, eyes, and nose with unwashed or gloved hands.
  - Disposable gloves (gloves do not replace proper hand hygiene) ◦Wear impermeable, disposable gloves when:
    - Physically tending to an ill traveler
    - Coming in contact with body fluids (such as used tissues, blood, vomit, or diarrhea), potentially contaminated surfaces or lavatories
    - Remove gloves carefully to avoid contaminating yourself or your clothing.
    - Properly dispose of soiled gloves after use into a plastic bag, and do not re-use.
    - Wash your hands with soap and water or with an alcohol-based hand cleaner after removing gloves.

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- Face masks: Surgical-type face masks worn by an ill person may help reduce the spread of respiratory germs from coughing, sneezing or talking; however, surgical facemasks are not recommended for use by a person who is not ill.

- Management of ill person:
  - Minimize the number of persons directly exposed to the ill traveler
  - Keep interactions with the ill traveler as brief as possible
  - Respiratory infections*:
    - Ask the ill traveler to cover his or her mouth with a tissue when coughing or sneezing. Provide tissues, if necessary.
    - Provide a plastic bag for disposing of used tissues.
    - Ask the ill traveler to wear a face mask particularly for persistent cough, if it can be tolerated and one is available.
    - Encourage the ill traveler to wash hands and/or use alcohol-based hand cleaner (if available).
    - Separate the ill traveler from others by 6 feet, if possible, and without compromising flight safety or exposing additional passengers.
    - Follow the instructions in "Targeted Clean-Up" below, as necessary.

***Note: measles and rubella (German measles) are caused by respiratory viruses with rash and fever being prominent signs. Therefore, follow these respiratory illness infection control measures if the ill traveler has a fever and rash.**

- Gastrointestinal infections:
  - Seat the ill traveler(s) close to a lavatory, if possible.
  - If possible, restrict the use of that lavatory to only the ill traveler(s).
  - If traveler is vomiting, provide air-sickness bags.
  - Provide a plastic bag for disposing of used air-sickness bags.
  - Encourage the ill traveler to wash hands and/or use alcohol-based hand cleaner (if available).
  - Follow the instructions in "Targeted Clean-Up" below as necessary.

- Blood-borne infections:
  - If the ill traveler is actively bleeding, such as from an injury or nosebleed, provide first aid according to your airline's guidelines.
  - Separate the ill traveler from others far enough to reduce the likelihood of blood splattering on other people, if possible.
  - Provide a plastic bag for disposing soiled tissues or towels.
  - Follow the instructions in "Targeted Clean-Up" below as necessary.

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- Targeted Clean-Up*
    - Hard (nonporous) surfaces, such as tray tables, TV monitors, seat arms, windows and walls that are visibly soiled: remove visible contaminations, then clean with a cleaning or disinfectant agent approved by your airline.
    - Soft (porous) surfaces, such as carpeted floor or seat cushions that are obviously soiled, such as with vomit or diarrhea: first remove as much of the contaminant as possible, then cover the area with an absorbent substance, followed by an impermeable material, such as plastic, to reduce the risk of spread beyond the immediate area or into the air.
    - If a contaminated item can be easily removed, is small enough to fit inside a plastic bag (such as a pillow, blanket or small cushion), and will not cause significant disruption to passengers by removing it (such as in a full flight), carefully place it inside a plastic bag** and tie or tape the bag shut securely to avoid leaking.
    - Dispose of used cleaning materials in a plastic bag** immediately after use**.

*Note: actions should be consistent with company policy.

**Biohazard bag if available; otherwise secure in plastic bag and label as biohazard.

- Post-Flight Measures
    - Properly dispose of contaminated items:
        - Place all receptacles that have been used by the ill traveler, as well as all bags containing materials used to clean up, in a plastic bag and tie it securely (see ** above).
        - Notify cleaning crew of areas that have been contaminated (specify respiratory, gastrointestinal, and/or blood-borne body fluids) which may need more than routine cleaning or possible removal such as:
            - visibly soiled soft materials (e.g., seat cushion)
            - hard surfaces like arm rests and tray tables
            - lavatory used by ill traveler(s)
        - Remind cleaning crew that this may require additional personal protective equipment and that they should follow company policy for such situations
            - Note: If ill traveler(s) changed seats, ensure that both areas are adequately cleaned.

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- When to see a health care provider after exposure to ill travelers:
  - Cabin crew members who have been exposed to travelers with known or suspected contagious infections should consult their health care providers shortly after the flight in question if they develop symptoms that concern them (such as fever, rash, persistent cough, vomiting, or diarrhea). Risk of infection depends on many factors, including the type of disease, flight duration, level of exposure, and level of immunity.
  - To avoid exposing others, crew members who are ill with a contagious infection should not report to work until they have recovered. Crew members who develop symptoms consistent with a contagious infection during flight should discontinue their work duties as soon as it is safe to do so and follow procedures as outlined for ill passengers. Crew members with gastrointestinal symptoms should not prepare or serve food or beverages.

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14. Standard Precautions

Excerpted from Guideline for Isolation Precautions in Hospitals (January 1996)

Background

Standard Precautions synthesize the major features of UP (Blood and Body Fluid Precautions) (**27,28**) (designed to reduce the risk of transmission of bloodborne pathogens) and BSI (body substance isolation)(**29,30**) (designed to reduce the risk of transmission of pathogens from moist body substances) and applies them to all patients receiving care in hospitals, regardless of their diagnosis or presumed infection status. Standard Precautions apply to 1) blood; 2) all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood; 3) non-intact skin; and 4) mucous membranes. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

II. Standard Precautions

Use Standard Precautions, or the equivalent, for the care of all patients. *Category IB*

A. Hand washing

1. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites. Category IB
2. Use a plain (non-antimicrobial) soap for routine hand washing. *Category IB*
3. Use an antimicrobial agent or a waterless antiseptic agent for specific circumstances (e.g., control of outbreaks or hyper endemic infections), as defined by the infection control program. *Category IB* (See Contact Precautions for additional recommendations on using antimicrobial and antiseptic agents.)

B. Gloves

Wear gloves (clean, non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments.

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C. Mask, Eye Protection, Face Shield

Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.
Category IB

D. Gown

Wear a gown (a clean, non-sterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments. *Category IB*

E. Patient-Care Equipment

Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately. Ensure that single-use items are discarded properly. Category IB

F. Environmental Control

Ensure that the hospital has adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces, and ensure that these procedures are being followed.
Category IB

G. Linen

Handle, transport, and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures and contamination of clothing and that avoids transfer of microorganisms to other patients and environments. *Category IB*

H. Occupational Health and Bloodborne Pathogens

1. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Never recap used needles, or otherwise manipulate them using both hands, or use any other technique that involves directing the point of a needle toward any part of the body; rather, use either a one-handed "scoop" technique or a mechanical device designed for holding the needle sheath. Do not remove used needles from disposable syringes by hand, and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate

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puncture-resistant containers, which are located as close as practical to the area in which the items were used, and place reusable syringes and needles in a puncture-resistant container for transport to the reprocessing area. *Category IB*

2. Use mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable. *Category IB*

I. Patient Placement

Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is not available, consult with infection control professionals regarding patient placement or other alternatives. *Category IB*

Date last modified: April 1, 2005 **Content source: Division of Healthcare Quality Promotion (DHQP)**

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15. Droplet Precautions

Excerpted from Guideline for Isolation Precautions in Hospitals (January 1996)

Background

Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and bronchoscopy. Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 3 ft or less, through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission. Droplet Precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplets.

IV. Droplet Precautions

In addition to Standard Precautions, use Droplet Precautions, or the equivalent, for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 µm in size] that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures). *Category IB*

In addition to Standard Precautions, use Droplet Precautions, or the equivalent, for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 µm in size] that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures). *Category IB*

A. Patient Placement

Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, maintain spatial separation of at least 3 ft between the infected patient and other patients and visitors. Special air handling and ventilation are not necessary, and the door may remain open. *Category IB*

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B. Mask

In addition to wearing a mask as outlined under Standard Precautions, wear a mask when working within 3 ft of the patient. (Logistically, some hospitals may want to implement the wearing of a mask to enter the room.) *Category IB*

C. Patient Transport

Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplets by masking the patient, if possible. *Category IB*

Date last modified: April 1, 2005 **Division of DHQP**

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16. American Red Cross of Greater Miami and the Keys Standard Operating Procedure

American Red Cross Procedures

Issue Date:
Effective Date:
ORIGINATOR:
Amends:
Rescinds:

Subject: Staffing, Staging, and Coordination
Temporary Quarantine Facility
Reference: Miami International Airport
Communicable Disease Response Plan

16.01 PURPOSE

To establish guidance for the care and feeding of passengers, crew and staff, housed in a temporary quarantine facility for 72 hours.

16.02 GENERAL

I. The American Red Cross is a humanitarian organization led by volunteers. Their focus includes helping communities prepare and respond to disasters or emergencies.

II. The American Red Cross has a local branch located in Miami, Florida and has responded to emergencies affecting the Miami Dade County population.

III. Local contacts for the American Red Cross include :

a. Carlos Castillo, Director of Emergency Services: carlos.castillo@redcross.org 305-807-3588, 305-644-1200 #2541 (see Appendix 18 for additional contacts)

IV. Upon notification by the Miami Dade Airport Administration and the CDC Miami Quarantine Station (CDC MQS) that a temporary quarantine facility is necessary, American Red Cross (ARC) will begin its staging process.

V. ARC will coordinate their response actions and receive direction from DOH Miami-Dade.

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VI. The American Red Cross will be responsible for :
   a. The provision of personnel to provide meals for the temporary quarantine facility.
   b. The provision of meals, personal care and sleeping provisions for the temporary quarantine facility.

16.03 PROCEDURE

I. Within two hours American Red Cross will have a team onsite to coordinate with DOH Miami-Dade and the airport. Team members will park in long-term parking, and deploy to the quarantine area, where they will receive security badges and access to the pre-determined temporary quarantine facility.

II. Within four hours, American Red Cross will have an operational Family Assistance Center with a Mental Health counseling presence, and snacks and water for family members of the quarantined passengers in a facility provided.

III. In a period off approximately 8-12 hours, which may change as condition warrant, provide the following:
   a. Begin delivery of food items (three meals and snacks for each 24 hour day provided on a daily basis) for up to 300 passengers and crew
   b. Palettes of water for three - 24 hour day time period
   c. Cots – 350 total
   d. Blankets - 700 total
   e. Comfort kits – personal toiletries: one/person/day – 900 total
   f. Infant supplies including disposable bottles, infant formula, multi-sized diapers, diaper wipes - amount dependent on need
   g. Children's coloring books and crayons

IV. Within five hours, American Red Cross will deploy Tables (XX) and Chairs (XX) to the pre-determined temporary quarantine facility. These will be used for a variety of needs including feeding stations, mental health counseling area, health assessments.

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17. Infrastructure Items for Public Health Assessment Area and Temporary Quarantine Facility

Infrastructure Needs:

Initial public health assessment area (where passengers would be screened for signs/symptoms of illness of public health importance before transport to the temporary quarantine facility at the airport)

Please note: Estimation of the quantity of material needed is based on the full capacity of a 777 aircraft (i.e. 400 people). The Florida Department of Health in Miami-Dade stores PPE and supplies in very limited quantities. Requests for supplies will be submitted to the local Office of Emergency Management for support and/or via e-constellation requests to the Sate ESF6.

Item	Description	Quantity	Providing Agency	Time to deliver item (in hours)
Infrastructure				
Tables		10	MDAD (5)	1
Chairs		10-12	MDAD	1
Cots		10	Red Cross	2
Fans		5	MDAD	1
Portable toilets		3	MDAD (via contract with APS)	1.5
Alcohol-based hand gel	Gallon containers w/ hand pumps	4	DOH Miami-Dade	3
Nourishment				
Food (snack only)			Red Cross	2
Water		1.5 pallets	Red Cross	2
Child Care				
Baby formula		As needed	Red Cross	3
Baby bottles w/ nipples	Disposable	As needed	Red Cross	3
Diapers	Infant, small and large	As needed	Red Cross	3
Diaper wipes	Box	As needed	Red Cross	3
Personal Protective Equipment (PPE)				
Alcohol-based hand gel	4 oz. bottle	200	DOH Miami-Dade	3
Alcohol-based hand gel	Gallon w/ hand pump - 2 liter	8	DOH Miami-Dade	3
Exam gloves, latex	Small, 1000/case	2 cases	DOH Miami-Dade	3
Exam gloves, latex	Medium, 1000/case	2 cases	DOH Miami-Dade	3
Exam gloves, latex	Large, 1000/case	2 cases	DOH Miami-Dade	3
Exam gloves, latex	X-large, 1000/case	2 cases	DOH Miami-Dade	3
Exam gloves, nitrile	Small, 1000/case	2 cases	DOH Miami-Dade	3
Exam gloves, nitrile	Medium, 1000/case	2 cases	DOH Miami-Dade	3

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Exam gloves, nitrile	Large, 1000/case	2 cases	DOH Miami-Dade	3
Exam gloves, nitrile	X-large, 1000/case	2 cases	DOH Miami-Dade	3
N-95 masks	120/case	2 cases	DOH Miami-Dade	Not Currently Stocked
Surgical masks	250/case	8 cases	DOH Miami-Dade	3
Medical Equipment/Supplies				
Adhesive strips	Assort. sizes, hypo-allergenic, 100/box	12 boxes	DOH Miami-Dade	Not Currently Stocked
Alcohol prep pads	100, box	200 boxes	DOH Miami-Dade	Not Currently Stocked
Facial tissue	30 boxes/case	3 cases	DOH Miami-Dade	Not Currently Stocked
Gauze bandage	1", non-sterile, 12/pkg.	8 packages	DOH Miami-Dade	Not Currently Stocked
Gauze bandage	3", non-sterile, 12/pkg.	8 packages	DOH Miami-Dade	Not Currently Stocked
Gauze pads	2x2, non-sterile	4 boxes	DOH Miami-Dade	Not Currently Stocked
Gauze pads	4", non-sterile	8 cases	DOH Miami-Dade	Not Currently Stocked
Gauze pads	4", sterile, 12/pkg.	8 packages	DOH Miami-Dade	Not Currently Stocked
Pen lights				Not Currently Stocked
Tongue depressors	Wooden	4 boxes	DOH Miami-Dade	Not Currently Stocked
Tempa Dots	Disposable	16 boxes	DOH Miami-Dade	Not Currently Stocked
Medications				
See below				
Waste Disposal				
Biohazard waste disposal services			DOH Miami-Dade (via existing contract)	
Biohazard bags	Large	40	DOH Miami-Dade	3
Biohazard bags	Small	40	DOH Miami-Dade	3
Non-biohazard waste disposal services			MDAD	1
Garbage cans and bags			MDAD	1
Special Services				
Wheelchairs		1-2	Airline	1
Wheelchairs	Oversized	8	DOH Miami-Dade	Not Currently Stocked
Wheelchairs	Standard	16	DOH Miami-Dade	Not Currently Stocked

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Interpretive services (non-English language and hearing impaired)	Non-English language interpretation via phone		MDAD	1
Mental health professionals/ Services			Red Cross	2
Entertainment				
Books/magazines			Red Cross	1
Office Supplies				
Clipboards	Letter size	60	DOH Miami-Dade	3
Dry erase markers	Multicolor	4 boxes	DOH Miami-Dade	3
Name tags, self-adhesive	100/box	4 boxes	DOH Miami-Dade	3
Note pads	Letter size	60	DOH Miami-Dade	3
Pens, ballpoint	Black ink, 12/box	12 boxes	DOH Miami-Dade	3
Pens, ballpoint	Red ink, 12/box	24 boxes	DOH Miami-Dade	3
Poster board	White	24	DOH Miami-Dade	3

Miami-Dade County Auditorium Temporary Quarantine Facility (Airport facility where passengers will be temporarily held for up to 72 hours, or until a community quarantine facility can become operational)

Please note: Estimation of the quantity of material needed is based on the full capacity of a 777 aircraft (i.e. 400 people)

Item	**Description**	**Quantity**	**Providing Agency**	**Time to deliver item (in hours)**
Infrastructure				
Tables			Red Cross	5
Chairs			Red Cross	5
Cots		450	Red Cross	5
Blankets (also used as pillows)	Disposable	900	Red Cross	5
Hygiene				
Personal comfort kits		450	Red Cross	24
Towels	Disposable	450	Red Cross	24
Clothing	Various sizes/styles		Red Cross	24
Child Care				
Baby formula		As needed	Red Cross	5
Baby bottles w/ nipples	Disposable	As needed	Red Cross	5
Diapers	Infant, various sizes	As needed	Red Cross	5
Diaper Wipes		As needed	Red Cross	5
Coloring books/crayons		As needed	Red Cross	5

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Personal Protective Equipment (PPE)				
Alcohol-based hand gel	Gallon w/ hand pump - 2 liter	8	DOH Miami-Dade	5
Alcohol-based hand gel	4 oz. squeeze bottle	400	DOH Miami-Dade	5
Antibacterial hand soap	12/case	4 cases	DOH Miami-Dade	5
Exam gloves, latex	Small, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, latex	Medium, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, latex	Large, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, latex	X-large, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, nitrile	Small, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, nitrile	Medium, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, nitrile	Large, 1000/case	2 cases	DOH Miami-Dade	5
Exam gloves, nitrile	X-large, 1000/case	2 cases	DOH Miami-Dade	5
Face masks	Universal size	600	DOH Miami-Dade	5
Face shields	Disposable, w/head band, 100/case	1 case	DOH Miami-Dade	5
Gowns	Disposable, 100/case	2 cases	DOH Miami-Dade	5
N-95 masks	120/case	2 cases	DOH Miami-Dade	Not Currently Stocked
Pants	Barrier, small, 48/cs.	3 cases	DOH Miami-Dade	5
Pants	Barrier, medium, 48/cs/	3 cases	DOH Miami-Dade	5
Pants	Barrier, large, 48/cs.	3 cases	DOH Miami-Dade	5
Pants	Barrier, X-large, 48/cs.	3 cases	DOH Miami-Dade	5
Shoe covers	Ankle cover, 270/case	1 case	DOH Miami-Dade	5
Surgical hoods	200/case	1 case	DOH Miami-Dade	Not Currently Stocked
Surgical masks	250/case	8 cases	DOH Miami-Dade	5
Medical Equipment/supplies				
AED	W/ 2 sets of pads	4	DOH Miami-Dade	Not Currently Stocked
Adhesive strips	Assort. sizes, hypo-allergenic, 100/box	12 boxes	DOH Miami-Dade	Not Currently Stocked
Adhesive strips	Assort. sizes, hypo-allergenic, 100/box	12 boxes	DOH Miami-Dade	Not Currently Stocked
Adhesive strips	Assort. sizes, hypo-allergenic, 100/box	12 boxes	DOH Miami-Dade	Not Currently Stocked
Adhesive tape	1", paper	16 rolls	DOH Miami-Dade	Not Currently Stocked
Adhesive tape	2", paper	8 rolls	DOH Miami-Dade	Not Currently Stocked

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Alcohol prep pads	100, box	200 boxes	DOH Miami-Dade	Not Currently Stocked
AMBU bag	Adult, disposable	8	DOH Miami-Dade	Not Currently Stocked
AMBU bag	Pediatric, disposable	8	DOH Miami-Dade	Not Currently Stocked
Applicators	Cotton-tipped, wood, 100/box	4 boxes	DOH Miami-Dade	Not Currently Stocked
Bacterial throat culturettes*			DOH Miami-Dade (*Time sensitive– budget for but purchase later)	Not Currently Stocked
Bedpans w/ covers	Disposable	40	DOH Miami-Dade	Not Currently Stocked
Bedside commode		40	DOH Miami-Dade	Not Currently Stocked
Blood glucometer		8	DOH Miami-Dade	Not Currently Stocked
Blood glucose test strips	50/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Blood pressure cuff set	Adult	16	DOH Miami-Dade	Not Currently Stocked
Blood pressure cuff set	Pediatric	4	DOH Miami-Dade	Not Currently Stocked
Blood pressure cuff set	Thigh	8	DOH Miami-Dade	Not Currently Stocked
Bulb syringe	3oz.	8	DOH Miami-Dade	Not Currently Stocked
Chux underpads (bed pads)	Disposable, 50/case	12 cases	DOH Miami-Dade	Not Currently Stocked
Cotton balls				Not Currently Stocked
CPR face mask		20	DOH Miami-Dade	Not Currently Stocked
Disposable diapers	Adult, small	4 packages	DOH Miami-Dade	Not Currently Stocked
Disposable diapers	Adult, large	4 cases	DOH Miami-Dade	Not Currently Stocked
Dressing, abdominal pad	Sterile, 20/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Dressing, non-adherent	Adaptic, sterile	40 packages	DOH Miami-Dade	Not Currently Stocked
Elastic bandage, Ace	3”	24	DOH Miami-Dade	Not Currently Stocked
Air sick bag	Disposable	10	DOH Miami-Dade	Not Currently Stocked
Exam tables			DOH Miami-Dade	Not Currently Stocked
Exam table changing paper			DOH Miami-Dade	Not Currently Stocked

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Eye pads	50/box	4 boxes	DOH Miami-Dade	Not Currently Stocked
Gauze bandage	1", non-sterile, 12/pkg.	8 packages	DOH Miami-Dade	Not Currently Stocked
Gauze bandage	3", non-sterile, 12/pkg.	8 packages	DOH Miami-Dade	Not Currently Stocked
Gauze pads	2x2, non-sterile	4 boxes	DOH Miami-Dade	Not Currently Stocked
Gauze pads	4", non-sterile	8 cases	DOH Miami-Dade	Not Currently Stocked
Gauze pads	4", sterile, 12/pkg.	8 packages	DOH Miami-Dade	Not Currently Stocked
Gowns	Disposable	100	DOH Miami-Dade	Not Currently Stocked
Ice packs	Instant	24	DOH Miami-Dade	Not Currently Stocked
ID bands	500/box	6 boxes	DOH Miami-Dade	Not Currently Stocked
Irrigation kit		40	DOH Miami-Dade	Not Currently Stocked
Lancets	100/box	4 boxes	DOH Miami-Dade	Not Currently Stocked
Medication cups	Plastic, 1oz.	4 boxes	DOH Miami-Dade	Not Currently Stocked
Obstetrical kit	Disposable	12	DOH Miami-Dade	Not Currently Stocked
Opthalmoscopes		2	DOH Miami-Dade	Not Currently Stocked
Otoscopes		2	DOH Miami-Dade	Not Currently Stocked
Oxygen w/ oxygen supplies		20	DOH Miami-Dade	Not Currently Stocked
Pen lights			DOH Miami-Dade	Not Currently Stocked
Portable privacy curtains			DOH Miami-Dade	Not Currently Stocked
Scissors, bandage	Stainless steel	4	DOH Miami-Dade	Not Currently Stocked
Sharps container	Gallon size	16	DOH Miami-Dade	Not Currently Stocked
Sling	Arm	20	DOH Miami-Dade	Not Currently Stocked
Splints	Leg/arm	16	DOH Miami-Dade	Not Currently Stocked
Sponges	General	48	DOH Miami-Dade	Not Currently Stocked
Stethoscope	Spraig style	20	DOH Miami-Dade	Not Currently Stocked
Syringes	Insulin	4 boxes	DOH Miami-Dade	Not Currently Stocked

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Syringes	3cc 25g 5/8", 100/box	4 boxes	DOH Miami-Dade	Not Currently Stocked
Syringes	5cc	48	DOH Miami-Dade	Not Currently Stocked
Syringes	60cc	48	DOH Miami-Dade	Not Currently Stocked
Tape	Hypoallergenic, 1"	4 boxes	DOH Miami-Dade	Not Currently Stocked
Tape	Paper, 1"	8 boxes	DOH Miami-Dade	Not Currently Stocked
Tape	Silk, 1"	4 boxes	DOH Miami-Dade	Not Currently Stocked
Tempa Dots	Disposable	16 boxes	DOH Miami-Dade	Not Currently Stocked
Tongue depressors	Wooden	4 boxes	DOH Miami-Dade	Not Currently Stocked
Triangular bandage	Cloth	24	DOH Miami-Dade	Not Currently Stocked
Tweezers	Small	8	DOH Miami-Dade	Not Currently Stocked
Urinals with lids	Disposable	96	DOH Miami-Dade	Not Currently Stocked
Venous puncture equip. – butterfly needles				Not Currently Stocked
Venous puncture equip. – tourniquets				Not Currently Stocked
Venous puncture equip. – Vacutainers				Not Currently Stocked
Viral throat culturettes*			DOH Miami-Dade (*Time sensitive – budget for but purchase later)	Not Currently Stocked
Medications & Equipment				
A&D Ointment/Desitin	4oz. tubes	8	DOH Miami-Dade	Not Currently Stocked
Acetaminophen	Adult, individual pkg, 100/bottle	8 bottles	DOH Miami-Dade	Not Currently Stocked
Acetaminophen	Liquid, pediatric	8 bottles	DOH Miami-Dade	Not Currently Stocked
Albuterol Inhaler	Adult	16	DOH Miami-Dade	Not Currently Stocked
Albuterol Inhaler	Pediatric	16	DOH Miami-Dade	Not Currently Stocked
Isopropyl alcohol	Pint	8	DOH Miami-Dade	Not Currently Stocked
Ammonia Inhalants	6/box	4 boxes	DOH Miami-Dade	Not Currently Stocked
Anaphylactic kit		8	DOH Miami-Dade	Not Currently Stocked

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Antacid	Low sodium,500/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Antibiotic Ointment	100/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Antihistamine	Liquid	8 bottles	DOH Miami-Dade	Not Currently Stocked
Antihistamine	Tablets, 24/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Aspirin	Adult, 2/package	400 packages	DOH Miami-Dade	Not Currently Stocked
Benadryl	Adult, 120/bottle	4 bottles	DOH Miami-Dade	Not Currently Stocked
Benadryl	Pediatric, 8oz./bottle	4 bottles	DOH Miami-Dade	Not Currently Stocked
Calamine lotion	6oz./bottle	4 bottles	DOH Miami-Dade	Not Currently Stocked
Epinephrine pen	Adult	4	DOH Miami-Dade	Not Currently Stocked
Epinephrine pen	Pediatric	16	DOH Miami-Dade	Not Currently Stocked
Eye drops	Normal saline, 4oz.	100 bottles	DOH Miami-Dade	Not Currently Stocked
Glucose tabs		4 bottles	DOH Miami-Dade	Not Currently Stocked
Glucose, instant		8 tubes	DOH Miami-Dade	Not Currently Stocked
Hydrocortisone Ointment	0.5%	20 tubes	DOH Miami-Dade	Not Currently Stocked
Hydrogen peroxide	Pint	50 bottles	DOH Miami-Dade	Not Currently Stocked
Ibuprofen	200mg, 100/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Ibuprofen	Pediatric, 10mg	20 bottles	DOH Miami-Dade	Not Currently Stocked
Imodium	100/box	8 boxes	DOH Miami-Dade	Not Currently Stocked
Insulin	70/30	8 vials	DOH Miami-Dade	Not Currently Stocked
Insulin	NPH, 10Ml	8 vials	DOH Miami-Dade	Not Currently Stocked
Insulin	Regular, 10mL	8 vials	DOH Miami-Dade	Not Currently Stocked
Ketosis sticks		8 bottles	DOH Miami-Dade	Not Currently Stocked
KY lubricant		8 tubes	DOH Miami-Dade	Not Currently Stocked
Lock box (med storage)		4	DOH Miami-Dade	Not Currently Stocked
Lotrimin cream	100/box	4 boxes	DOH Miami-Dade	Not Currently Stocked

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Nicotine patches			DOH Miami-Dade	Not Currently Stocked
Normal saline (irrigation)	500cc/bottle	16 bottles	DOH Miami-Dade	Not Currently Stocked
Pepto Bismol	Chewables	40 boxes	DOH Miami-Dade	Not Currently Stocked
Refrigerator (med storage)	Dorm size	4	DOH Miami-Dade	Not Currently Stocked
Throat lozenges	20/bag	12 bags	DOH Miami-Dade	Not Currently Stocked
Tums, chewable	200/bottle	4 bottles	DOH Miami-Dade	Not Currently Stocked
Communications				
Telephones (w/ TTY capacity)			MDAD	5
PA system/facility communication system			MDAD	5
Waste Disposal/Facility Environment				
Biohazard waste disposal services			DOH Miami-Dade (via existing contract)	5
Biohazard bags	Red, large	40	DOH Miami-Dade	5
Biohazard bags	Red, small	40		5
Non-biohazard waste disposal services			MDAD	5
Garbage cans and bags			MDAD	5
Janitorial services			MDAD	5
Sanitation inspection services			DOH Miami-Dade	5
Decontamination kit		8	DOH Miami-Dade	5
Special Services				
Wheelchairs	Oversized	8	DOH Miami-Dade	5
Wheelchairs	Standard	16	DOH Miami-Dade	5
Interpretive services (non-English language and hearing impaired)	Non-English language interpretation via phone		MDAD	5
Mental health professionals/services			Red Cross	5
Nutrition				
Food (3 meals + snack)	Food (3 meals + snack)		Red Cross	5
Water			Red Cross	5
Entertainment				
Books			DOH Miami-Dade	Not Currently

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				Stocked
Games			DOH Miami-Dade	Not Currently Stocked
Magazines			DOH Miami-Dade	Not Currently Stocked
Radio, portable, AM/FM	+ ext. batteries	4	DOH Miami-Dade	Not Currently Stocked
TVs		1-2	MDAD	5
TV/DVD/VCR	Combo	3 in stock	DOH Miami-Dade	5
Office Supplies				
Clipboards	Letter size	60	DOH Miami-Dade	5
Dry erase markers	Multicolor	4 boxes	DOH Miami-Dade	5
Duct tape	3”	24 rolls	DOH Miami-Dade	5
Envelopes	9” x 12”, 50/box	4 boxes	DOH Miami-Dade	5
Extension cords	100’ length	8	DOH Miami-Dade	5
Extension cords	50’ length	8	DOH Miami-Dade	5
Extension cords	25’ length	40	DOH Miami-Dade	5
File folders	100/box	4 boxes	DOH Miami-Dade	5
Flashlights	+ ext. batteries	40	DOH Miami-Dade	5
Headlights	+ ext. batteries	40	DOH Miami-Dade	Not Currently Stocked
Lantern	Fluorescent, + ext. batteries	16	DOH Miami-Dade	5
Masking tape	2”	20 rolls	DOH Miami-Dade	5
Name tags, self-adhesive	100/box	4 boxes	DOH Miami-Dade	5
Note pads	Letter size	60	DOH Miami-Dade	Not Currently Stocked
Paperclips	Large	4 boxes	DOH Miami-Dade	5
Pens, ballpoint	Black ink, 12/box	12 boxes	DOH Miami-Dade	5
Pens, ballpoint	Red ink, 12/box	24 boxes	DOH Miami-Dade	
Posterboard	White	24	DOH Miami-Dade	5
Post-it notes	3” x 5”, lined	24	DOH Miami-Dade	5
Rubber bands	Medium	4 boxes	DOH Miami-Dade	5
Personnel Resources				
Fax/printer/copier	Portable	4	DOH Miami-Dade	5
Laptop computers		16	DOH Miami-Dade	5
Lippincott	Reference	4	DOH Miami-Dade	5
Merck Manual	18th edition	4	DOH Miami-Dade	5
PDR	Pocket edition	4	DOH Miami-Dade	5
Red Book	29th edition	4	DOH Miami-Dade	5
Vests to identify staff	Bright color	120	DOH Miami-Dade	5
Walkie-talkie w/ recharger	+ Extra batteries	24	DOH Miami-Dade	Not Currently Stocked
Miscellaneous				
Can/bottle opener	Manual	8	DOH Miami-Dade	Not Currently Stocked
Drinking straws, bendable	500/case	6 cases	DOH Miami-Dade	Not Currently

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				Stocked
Insect repellent w/ DEET	6oz. can	40 cans	DOH Miami-Dade	Not Currently Stocked
Paper Towels (emerg. use)	20 rolls/case	4 cases	DOH Miami-Dade	Not Currently Stocked
Safety pins	Large, 25/pack	4 packs	DOH Miami-Dade	Not Currently Stocked

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18. AMERICAN RED CROSS – CONTRIBUTIONS/DUTIES AND RESPONSIBILITIES DURING COMMUNICABLE DISEASE AND/OR BT EVENT

In accordance with **Florida Statutes §252.34(3) and §119.07(3)(d)**, the information contained within this document is confidential information intended only for the use of those individuals and agencies to which this document is issued. This document is exempt from the provisions of **§(1) and §24(a), Article 1 of the State Constitution** and unavailable for inspection except for authorized personnel. Unauthorized dissemination, distribution, or reproduction of this document is strictly prohibited and subject to criminal and civil penalties.

AMERICAN RED CROSS – CONTRIBUTIONS/DUTIES AND RESPONSIBILITIES DURING COMMUNICABLE DISEASE AND/OR BT EVENT

Who & contact info (24/7/365)	What	Where	How	When
Carlos Castillo (primary) 305-807-3588 305-644-1200 (#2541) 305-644-1368(f) carlos.castillo@redcross.org Shel Seidman (Chair, Emergency Services) 954-931-4540 shel.seidman@redcross.org Robert Page (Program Services Manager) 954-826-2551 robert.page@redcross.org	All items found in Infrastructure needs matrix- CDC Quarantine Station & DOH Miami-Dade Quarantinee & Isolation SOP	Penalty Box, Concourse E, Coconut Grove Convention Center	ARC personnel shall deliver all food and supplies to CDC and DOH Miami-Dade personnel (in cold zone);	Snacks and other truck items: 0-1 hr.
	Food items to be obtained from dedicated ARC contracted vendor	ARC to provide list of alternate long-term care facilities**	ARC has sufficient personnel to work in 3 physical areas simultaneously: penalty box, Concourse E, Convention Ctr.(2 min. drive from ARC facility)	ARC vendor delivery : 1 – 3hrs

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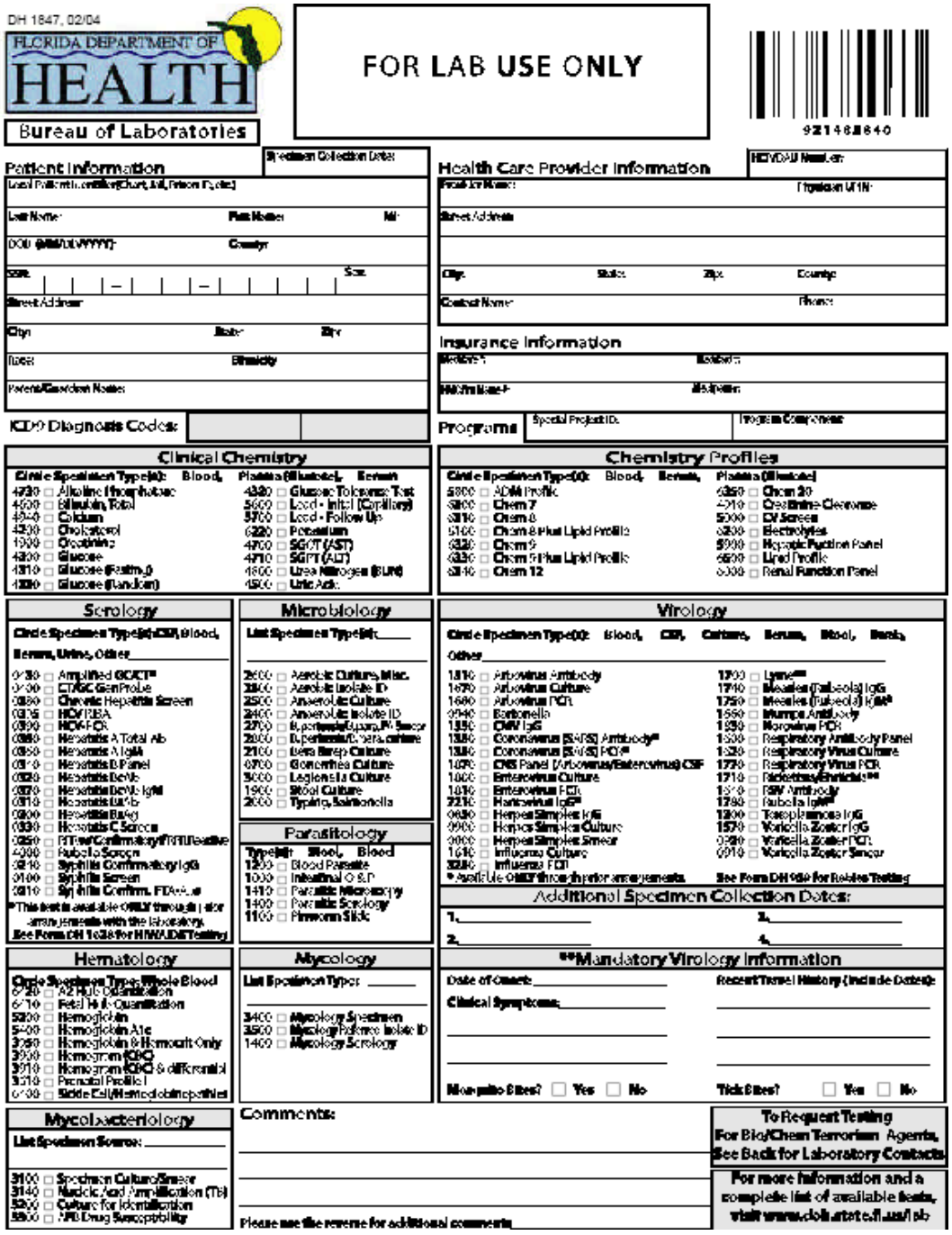
19. FDOH Lab Request Form



DH 1847, 02/04

FLORIDA DEPARTMENT OF HEALTH

Bureau of Laboratories

FOR LAB USE ONLY

921468840

Patient Information — Specimen Collection Date:

Local Patient Identifier (Chart, Jail, Prison, Etc.):

Last Name: First Name: MI:

DOB (MM/DD/YYYY): County:

SSN: Sex:

Street Address:

City: State: Zip:

Race: Ethnicity:

Parent/Guardian Name:

ICD9 Diagnosis Codes:

Health Care Provider Information — HCV/DAU Number:

Provider Name: Physician UPIN:

Street Address:

City: State: Zip: County:

Contact Name: Phone:

Insurance Information

Medicare: Medicaid:

HMO/Ins Name: Medicaid:

Programs — Special Project ID: Program Component:

Clinical Chemistry

Circle Specimen Type(s): Blood, Plasma (Glucose), Serum

4730 ☐ Alkaline Phosphatase
4600 ☐ Bilirubin, Total
4940 ☐ Calcium
4200 ☐ Cholesterol
4900 ☐ Creatinine
4300 ☐ Glucose
4310 ☐ Glucose (Fasting)
4320 ☐ Glucose (Random)
4320 ☐ Glucose Tolerance Test
5600 ☐ Lead - Initial (Capillary)
5700 ☐ Lead - Follow Up
6220 ☐ Potassium
4700 ☐ SGOT (AST)
4710 ☐ SGPT (ALT)
4800 ☐ Urea Nitrogen (BUN)
4500 ☐ Uric Acid

Chemistry Profiles

Circle Specimen Type(s): Blood, Serum, Plasma (Glucose)

5800 ☐ ADM Profile
6200 ☐ Chem 7
6310 ☐ Chem 8
6100 ☐ Chem 8 Plus Lipid Profile
6320 ☐ Chem 9
6330 ☐ Chem 9 Plus Lipid Profile
6340 ☐ Chem 12
6350 ☐ Chem 20
4910 ☐ Creatinine Clearance
5000 ☐ CV Screen
6200 ☐ Electrolytes
5900 ☐ Hepatic Function Panel
6500 ☐ Lipid Profile
6000 ☐ Renal Function Panel

Serology

Circle Specimen Type(s): CSF, Blood, Serum, Urine, Other

0430 ☐ Amplified GC/CT*
0400 ☐ CT/GC GenProbe
0380 ☐ Chronic Hepatitis Screen
0305 ☐ HCV RIBA
0390 ☐ HCV-PCR
0380 ☐ Hepatitis A Total Ab
0350 ☐ Hepatitis A IgM
0310 ☐ Hepatitis B Panel
0320 ☐ Hepatitis BcAb
0370 ☐ Hepatitis BcAb IgM
0310 ☐ Hepatitis BcAb
0300 ☐ Hepatitis BsAg
0330 ☐ Hepatitis C Screen
0350 ☐ RTF w/Confirmatory/RTF Reactive
4000 ☐ Rubella Screen
0240 ☐ Syphilis Confirmatory IgG
0100 ☐ Syphilis Screen
0210 ☐ Syphilis Confirm. FTA-Abs

*This test is available ONLY through prior arrangements with the laboratory.

See Form DH 1038 for HIV/AIDS Testing

Microbiology

List Specimen Type(s):

2600 ☐ Aerobic Culture, Misc.
2800 ☐ Aerobic Isolate ID
2500 ☐ Anaerobic Culture
2400 ☐ Anaerobic Isolate ID
2700 ☐ B.pertussis/B.para.P. Smear
2800 ☐ B.pertussis/B.para. culture
2100 ☐ Beta Strep Culture
0700 ☐ Gonorrhea Culture
3000 ☐ Legionella Culture
1900 ☐ Stool Culture
2000 ☐ Typing, Salmonella

Parasitology

Type(s): Stool, Blood

1200 ☐ Blood Parasite
1000 ☐ Intestinal O & P
1410 ☐ Parasitic Microscopy
1400 ☐ Parasitic Serology
1100 ☐ Pinworm Slide

Virology

Circle Specimen Type(s): Blood, CSF, Culture, Serum, Stool, Burn, Other

1810 ☐ Arbovirus Antibody
1670 ☐ Arbovirus Culture
1680 ☐ Arbovirus PCR
0940 ☐ Bartonella
1350 ☐ CMV IgG
1380 ☐ Coronavirus (SARS) Antibody*
1380 ☐ Coronavirus (SARS) PCR*
1870 ☐ CNS Panel (Arbovirus/Enterovirus) CSF
1800 ☐ Enterovirus Culture
1810 ☐ Enterovirus PCR
7210 ☐ Hantavirus IgG*
0630 ☐ Herpes Simplex IgG
0900 ☐ Herpes Simplex Culture
0900 ☐ Herpes Simplex Smear
1610 ☐ Influenza Culture
3280 ☐ Influenza PCR
1700 ☐ Lyme**
1740 ☐ Measles (Rubeola) IgG
1750 ☐ Measles (Rubeola) IgM*
1660 ☐ Mumps Antibody
1930 ☐ Norovirus PCR
1600 ☐ Respiratory Antibody Panel
1620 ☐ Respiratory Virus Culture
1770 ☐ Respiratory Virus PCR
1710 ☐ Rickettsia/Ehrlichia**
1610 ☐ RSV Antibody
1780 ☐ Rubella IgM*
1200 ☐ Toxoplasmosis IgG
1570 ☐ Varicella Zoster IgG
0920 ☐ Varicella Zoster PCR
0910 ☐ Varicella Zoster Smear

*Available ONLY through prior arrangements.

See Form DH 950 for Rabies Testing

Additional Specimen Collection Dates:

1. _____ 3. _____
2. _____ 4. _____

Hematology

Circle Specimen Type: Whole Blood

6720 ☐ A2 Hgb Quantitation
6710 ☐ Fetal Hgb Quantitation
5200 ☐ Hemoglobin
5400 ☐ Hemoglobin A1c
3950 ☐ Hemoglobin & Hemocrit Only
3900 ☐ Hemogram (CBC)
3910 ☐ Hemogram (CBC) & differential
3510 ☐ Prenatal Profile I
6100 ☐ Sickle Cell/Hemoglobinopathies

Mycology

List Specimen Type:

3400 ☐ Mycology Specimen
3500 ☐ Mycology Reference Isolate ID
1400 ☐ Mycology Serology

****Mandatory Virology Information**

Date of Onset: _____ Recent Travel History (Include Dates):

Clinical Symptoms: _____

Mosquito Bites? ☐ Yes ☐ No Tick Bites? ☐ Yes ☐ No

Mycobacteriology

List Specimen Source:

3100 ☐ Specimen Culture/Smear
3140 ☐ Nucleic Acid Amplification (TB)
5200 ☐ Culture for Identification
5300 ☐ AFB Drug Susceptibility

Comments:

Please use the reverse for additional comments

To Request Testing For Bio/Chem Terrorism Agents, See Back for Laboratory Contacts

For more information and a complete list of available tests, visit www.doh.state.fl.us/lab

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 12:51:40 PM
Attachments: image001.png



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

- **Date: Today,** Thursday, March 11
- **Time:** 2:00 PM ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**
- **Note:** You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs

AMERICAN OVERSIGHT

The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

- President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.
    - Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.
- The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.

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- Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
- There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

- The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.

- President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.
    - These loans will help overcome disruptions caused by the coronavirus.
    - The President is calling on Congress to increase funding for this program by an additional $50 billion.
- The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.
    - This action will provide more than $200 billion of additional liquidity to the economy.
- President Trump is calling on Congress to immediately pass payroll tax relief.
- The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.
    - The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

- The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
- The Trump Administration declared a public health emergency in January to bolster response efforts.
- President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.
    - In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
    - In February, the President restricted travel for individuals recently

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traveling from Iran.
    - The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
    - Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.
- Today, the President directed his Administration to make general-use face masks available to our healthcare workers.
    - The Administration's actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.
- President Trump signed into law more than $8 billion to fund response efforts.
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
- The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

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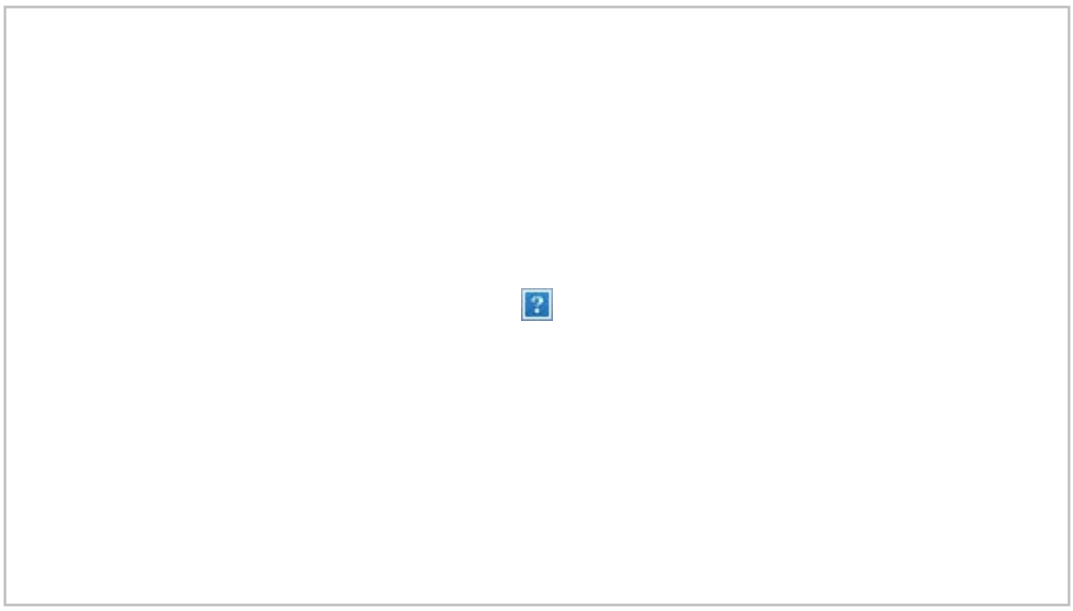

WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

> "The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American

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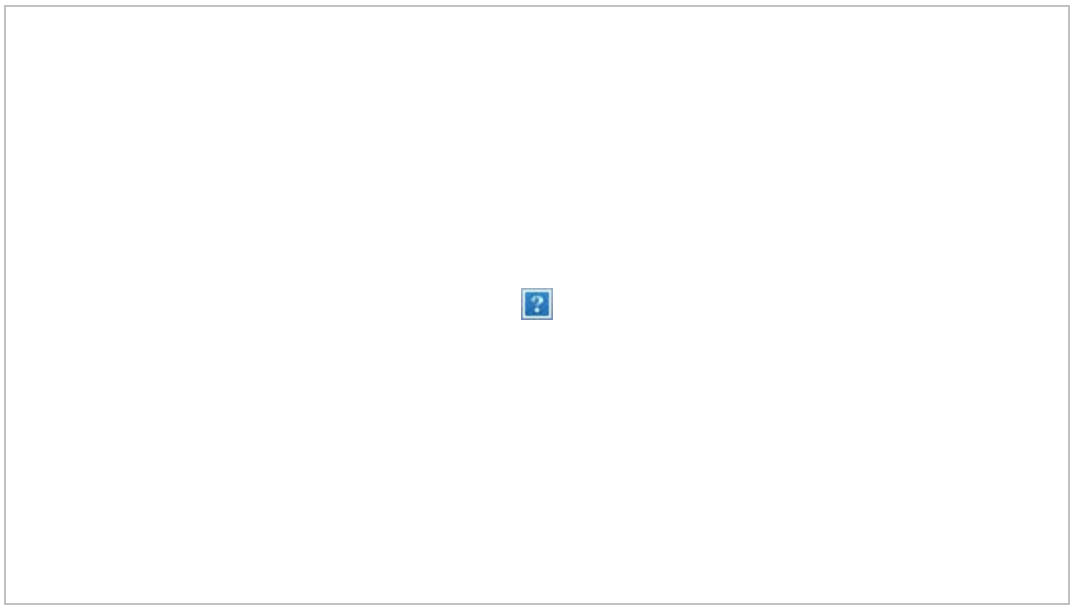
people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW



WATCH HERE.

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

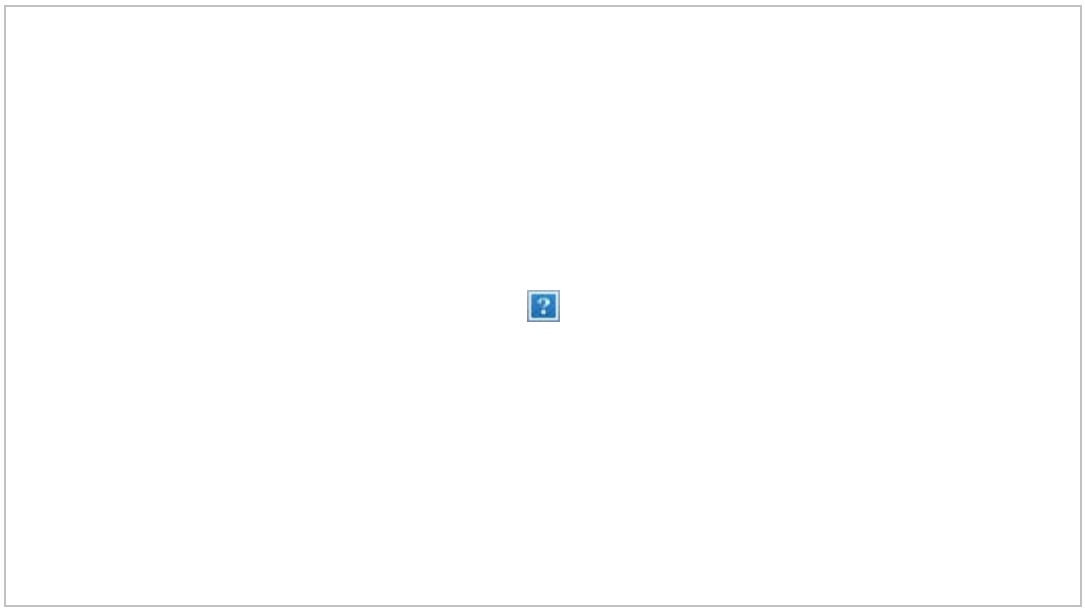
The American people should know that President Trump has no

AMERICAN OVERSIGHT

higher priority than the health, safety and well-being of the American people.

> "The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country. You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS



WATCH HERE AND HERE.

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

> "The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as

AMERICAN OVERSIGHT

possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

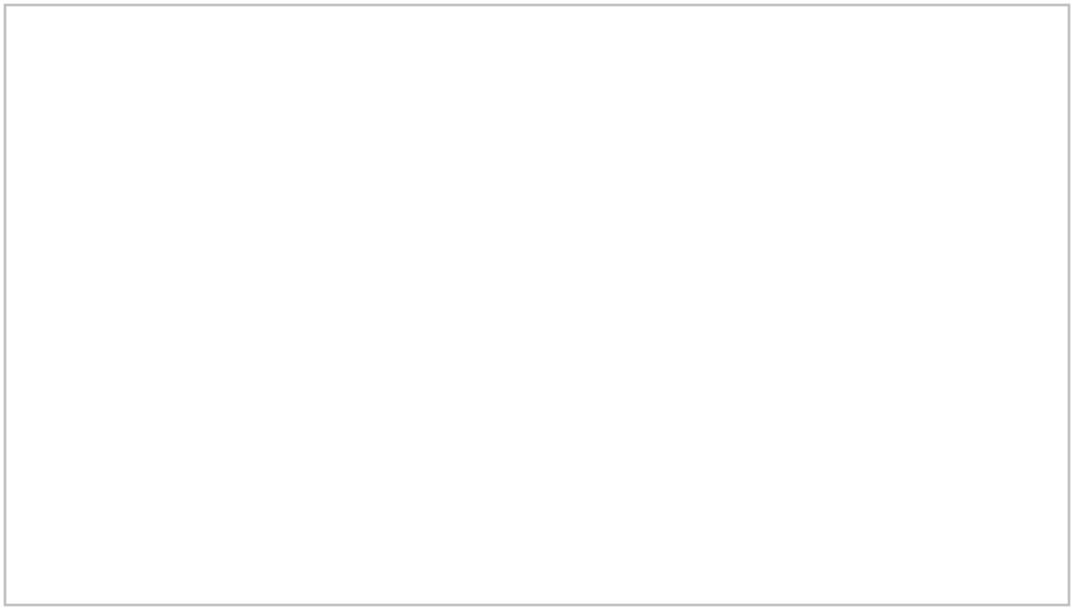
"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

AMERICAN OVERSIGHT



WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

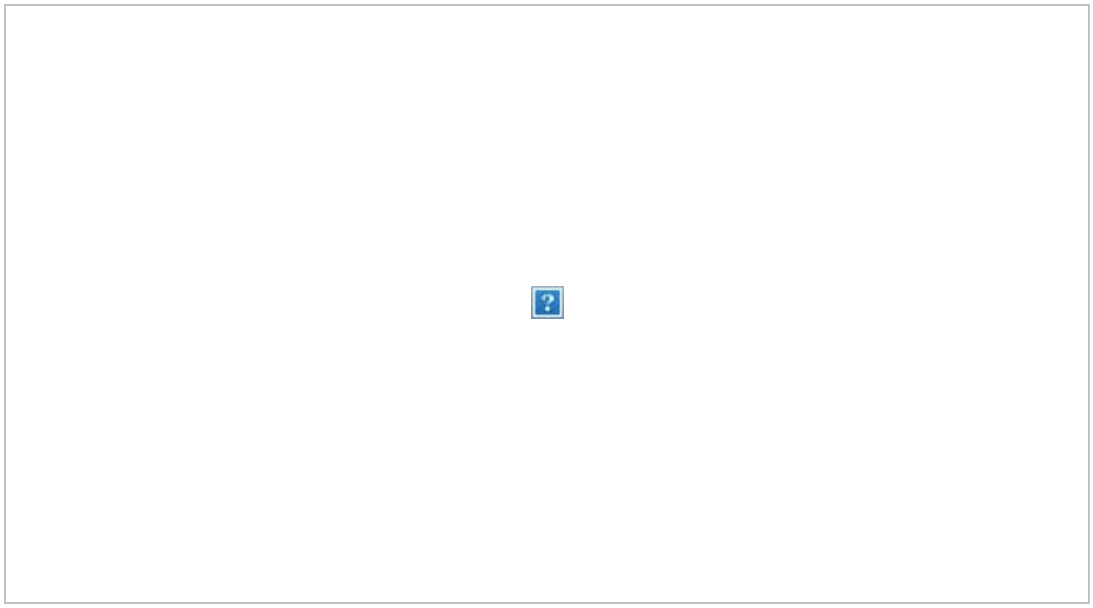
AMERICAN OVERSIGHT

want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: INVITATION: Briefing Call on COVID-19 TODAY (March 12) at 2:00 p.m. ET
Date: Thursday, March 12, 2020 12:49:34 PM
Attachments: image001.png



State and Local Leaders,

On **Thursday, March 12, at 2:00 p.m. Eastern Time**, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission).

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Sincerely,
Zach

The White House Office of Intergovernmental Affairs

Zach Swint
Office of Intergovernmental Affairs
The White House
C: (202) 881-6717 | E: Zachariah.D.Swint2@who.eop.gov

AMERICAN OVERSIGHT

President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

"Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!" – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: "Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures."

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travelers coming into the country from Italy and South Korea.
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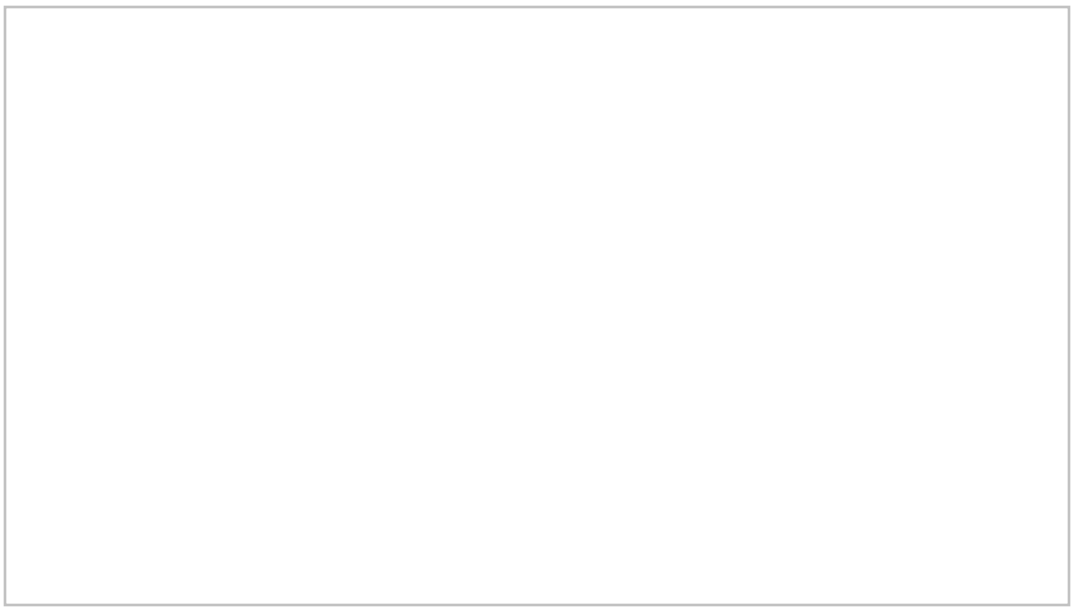
- The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
- Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.
    - More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
    - Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.
- The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.
    - From the start, President Trump has made keeping the public informed a top priority.
- The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

AMERICAN OVERSIGHT



WATCH HERE.

From very early on, President Trump took decisive action to put the health of the American people first.

> "We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

> "The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American

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people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE.

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

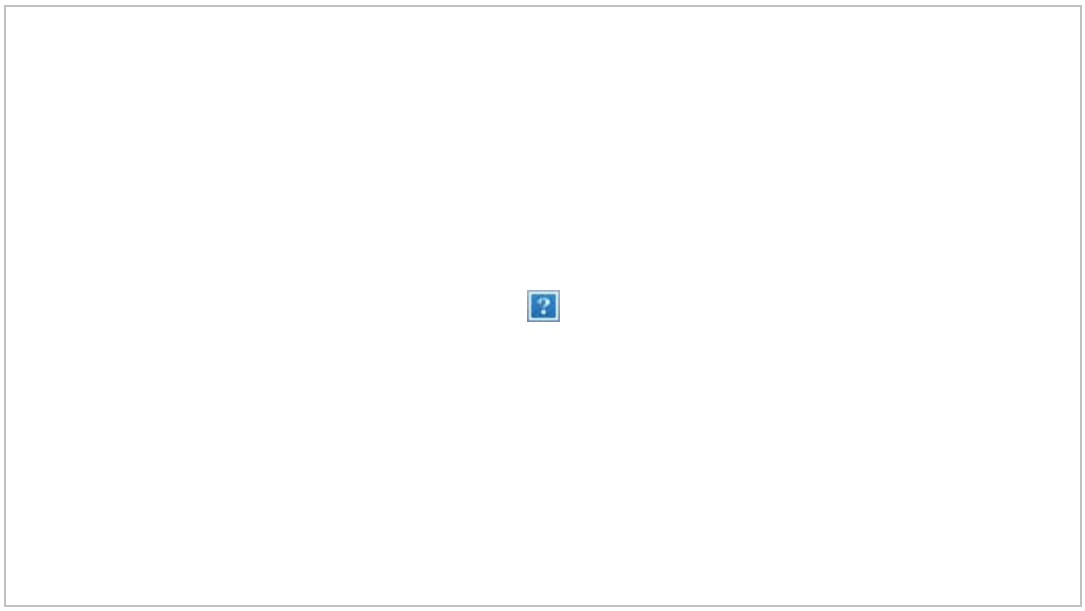
The American people should know that President Trump has no

AMERICAN OVERSIGHT

higher priority than the health, safety and well-being of the American people.

> "The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country. You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS



WATCH HERE AND HERE.

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

> "The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

> "Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as

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possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

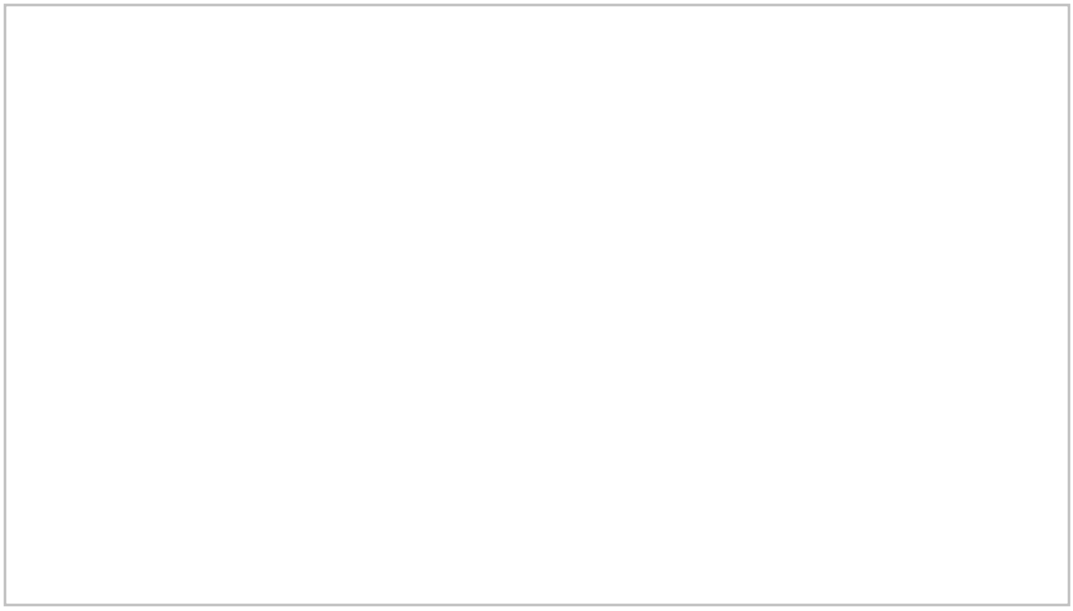
"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

AMERICAN OVERSIGHT



WATCH HERE AND HERE.

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

> "We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

> "Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

> "But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't

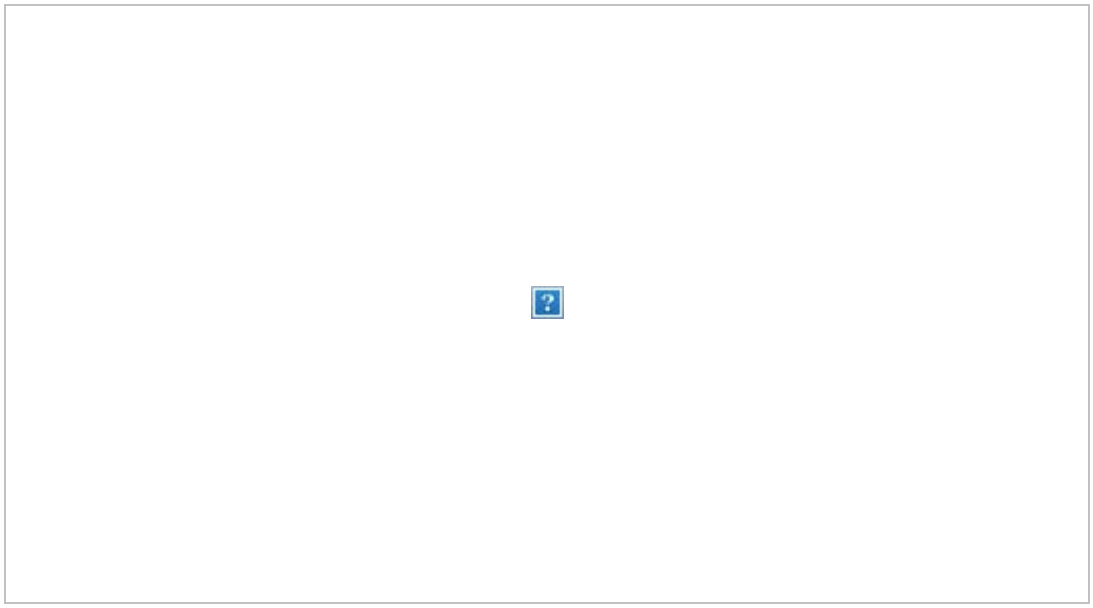
AMERICAN OVERSIGHT

want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

ON CBS This Morning



WATCH HERE.

We are going to continue to put in every effort in place to protect the health and safety of the American people.

"The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people."

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

"Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which

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they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand."

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

"Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days."

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From:	Torres, Yari
To:	FieldSupport (CDC); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Blackmore, Carina; Stanek, Danielle R; Sanchez, Guillermo Vincent (CDC/DDPHSS/CSELS/DSEPD); lgz9@cdc.gov; Blau, Erin (CDC/DDPHSS/CSELS/DSEPD); Browne, Springer (CDC/DDPHSS/CSELS/DSEPD)
Subject:	January Monthly Report
Date:	Tuesday, February 4, 2020 9:12:58 AM
Attachments:	TorresY202001.docx

Good morning,

I hope everyone is having a great week so far. Attached you will find my monthly report.

V/r

Yari

Yaritbel Torres-Mendoza, DVM, MPH
Lieutenant, U.S. Public Health Service
CDC Epidemic Intelligence Service Officer
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Phone: 850 -901-6933
Mobile: 850 -815-0059
E-mail: Yari.Torres@flhealth.gov | hvb0@cdc.gov

DOH Mission: To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Please Note: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

AMERICAN OVERSIGHT

Date: 2/4/2020

From: Yaritbel Torres Mendoza

Subject: Field EISO Monthly Report – [January, 2020]

To: FieldSupport@cdc.gov; Suzanne Beavers (fgx5@cdc.gov); Carina Blackmore (carina.blackmore@FLhealth.gov); Danielle Stanek (Danielle.Stanek@FLhealth.gov); AL EISO Guillermo Sanchez (xkv4); GA EISO Christine Szablewski (lqz9); KY EISO Erin Blau (okl2) and USVI EISO Springer Browne (okl4).

I. New Activities

- EWB supervisor field site visit 1/29–1/30.
- PHS VetPAC All Partners Access Network (APAN) website development, will be meeting biweekly.
- Attended webinar on Feline leukemia virus and feline immunodeficiency virus.
- Attended a Florida USDA accreditation training.
- 2019 novel corona virus
    - Attended FDOH and CDC meetings on 2019 nCoV.
    - Assisted with 2019 nCoV on-call calls from health care providers.
    - Attended COCA call on 2019 nCoV

II. Ongoing Activities

- **Syphilis reinfection**. (HSR: 2019-00170). A retrospective cohort study from patients who were diagnosed, reported, and met syphilis case definition with a novel and initial syphilis infection between 2012 and 2015 in Florida. The objectives of the study are to 1) determine how many patients had one or more follow-up serology tests performed over two years from their first syphilis diagnosis; 2) to identify how many reinfections occurred among patients that had a novel syphilis infection and had follow-up serology; and 3) to determine if age, gender, HIV status, pregnancy status, or self-reported sexual orientation influences the likelihood of follow-up serology tests or reinfection.
- **Community Assessment of Monroe County post-Hurricane Irma.** (HSR: 2019-00105, 70 days). On September 10, 2017, Monroe County experienced a direct hit from Hurricane Irma, a category 4 hurricane. As of January 25, 2019 the number of suicides for 2018 (35 suicides) have exceeded the 2013 record (31 suicides) for the annual number of suicides recorded in the last ten years. Because of the increase in suicides, the Florida Department of Health (FL DOH) in Monroe County contacted the FL DOH requesting support for a Community Assessment for Public Health Emergency Response (CASPER). The objectives of the CASPER are to: 1) To assess the economic, and physical and mental health impact of Monroe County residents post-Hurricane Irma; and 2) to assess the knowledge of and perceived barriers to accessing health resources among Monroe County residents post-Hurricane Irma. CASPER took place from May 20th to May 25th, 2019, approximately over 200 surveys were completed. Analysis is stil pending.
- Tuesday Monthly Seminar
- Biweekly EWB supervisory meeting

AMERICAN OVERSIGHT

- US PHS Veterinary Pac meeting
- On call
- Followed up with the high risk *B. suis* exposures for follow up serology and retesting of their pet dog.
- Submitted Monroe County CASPER report for FDOH clearance.
- Dengue thrombocytopenia syndromic surveillance.

III. Miscellaneous

A. Annual leave taken (with dates): MLK

B. Upcoming annual leave and official travel planned (with dates):

Polio deployment to Ghana: 2/8–3/21

C. Upcoming conferences (with dates and locations): None

IV. Pictures (optional)

AMERICAN OVERSIGHT

From:	Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE)
To:	courtney.coppola@flhealth.gov
Cc:	alberto.moscoso@flhealth.gov; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
Subject:	Letters from Princess Cruise Line to passengers and crew of Sky Princess
Date:	Saturday, March 14, 2020 6:57:36 PM
Attachments:	YP Y008A Y009 - Health Advisory PEL - Debark.pdf YP Y010 Y010A - Health Advisory PEL - Embark.pdf

Good evening Ms. Coppola,

Dr. Rivkees gave me your name and email to forward these letters sent by Princess Cruise Line to passengers and crew of the Sky Princess voyages on 2/22 and 2/29. Alberto Moscoso (cc'd here) was involved with the crafting of the letters.

Thank you and please acknowledge receipt.

On Detail to COVID-19 Response

Paul J. Weidle, PharmD, MPH, CAPT USPHS
Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30329
404-639-6155
pweidle@cdc.gov

From: Peyton, Dennis (PCL) <dpeyton@hagroup.com>
Sent: Saturday, March 14, 2020 6:14 PM
To: Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; alberto.moscoso@flhealth.gov
Cc: Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; White, Stefanie B. (CDC/DDID/NCEZID/DGMQ) <ixy3@cdc.gov>; Poser, Sarah (CDC/DDID/NCEZID/OD) <wzk8@cdc.gov>; Rinker, Robin (CDC/OD/OADPS) <vqb2@cdc.gov>; Brooks, Ashley (CDC/DDID/NCIRD/OD) <ylo5@cdc.gov>; Tarling, Grant (PCL) <gtarling@hagroup.com>; Howard, Daniel (PCL) <dhoward@hagroup.com>; Drumalds, Aleks (PCL) <adrumalds@hagroup.com>
Subject: RE: Connection - Princess with State of Florida Comms

Good Day Paul and Kara,

Thank you kindly for reaching out today.

As per telephonic guidance received the evening of 12 March 2020 from Alberto Moscoso and team at Florida Department of Health, as well as Cindy Friedman and Paul Weidle from US CDC, it was recommended that an email notification to be sent to individuals with travel history aboard Sky Princess voyage A [22-29 February 2020] and voyage B [29 February – 7 March]. Attached are the email notifications sent on 13 March 2020.

Thanks,

_____

Dennis Peyton Jr., MPH, CIC

AMERICAN OVERSIGHT

Epidemiologist | Health Services
Holland America Group | Princess Cruises, Holland America Line, Seabourn, P&O Australia, & HAP Alaska
+1 (661) 753-2353 office | +1 (661) 645-4013 mobile | dpeyton@hagroup.com
24/7 Emergency Line: +1-661-753-2355

AMERICAN OVERSIGHT

PRINCESS CRUISES

IMPORTANT NOTICE REGARDING YOUR CRUISE

Sky Princess - Voyages Y008A & Y009

March 13, 2020

Dear Princess Guest,

We have been notified by the Florida Department of Health of three positive COVID-19 cases associated with Port Everglades in Broward County, Florida. All three cases are connected to, or employed by, Metro Cruise Services – an external company that operates at Port Everglades. We have been informed that these external contractors worked in the disembarkation area of terminal 2 in Port Everglades on February 29, 2020. Only one individual reported illness symptom onset before February 29.

The Florida Department of Health is working closely with Metro Cruise Services to provide appropriate guidance and monitoring to their employees with potential close contact.

The Florida Department of Health is in close consultation with the CDC on this investigation and is working to connect other employees at Metro Cruise Services who may have come into contact with the three individuals. The Florida Department of Health believes the risk of exposure to cruise ship guests from these individuals is generally low.

CDC recommends that all individuals with recent travel history on a cruise ship, monitor their health for 14 days after they return to the United States. If you develop symptoms, immediately self-isolate and contact your county Health Department or health care provider. CDC advice for cruise ship guests can be found here: https://wwwnc.cdc.gov/travel/page/covid-19-cruise-ship.

Updated information on COVID-19 can be found at the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/index.html.

Thank you for taking the time to read this important information.

Grant Tarling, MD, MPH
Chief Medical Officer

AMERICAN OVERSIGHT

PRINCESS CRUISES

IMPORTANT NOTICE REGARDING YOUR CRUISE

Sky Princess - Voyages Y010 & Y010A

March 13, 2020

Dear Princess Guest,

We have been notified by the Florida Department of Health of three positive COVID-19 cases associated with Port Everglades in Broward County, Florida. All three cases are connected to, or employed by, Metro Cruise Services – an external company that operates at Port Everglades. We have been informed that these external contractors worked in the embarkation area of terminal 2 in Port Everglades on February 29, 2020. Only one individual reported illness symptom onset before February 29.

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Updated information on COVID-19 can be found at the CDC website:https://www.cdc.gov/coronavirus/2019-ncov/index.html.
Thank you for taking the time to read this important information.

Grant Tarling, MD, MPH
Chief Medical Officer

AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	Melanie Motiska; Bob Asztalos; Laura MacLafferty; StateESF8.Planning
Cc:	Blackmore, Carina; Pritchard, Scott
Subject:	Long Term Care Resources for Pandemic Planning
Date:	Thursday, February 20, 2020 3:35:13 PM

Long Term Care Partners,

Hope things are well with you all. As I am sure you are aware, the Department has activated an incident management team for responding to the novel coronavirus COVID-19. While we have no cases in Florida, we are taking this opportunity to review pandemic preparedness plans should this outbreak escalate to a global pandemic.

Older populations and people with underlying health issues appear to be at increased risk for this virus. We believe it is important that long-term care facilities begin planning now and ensuring they have protocols in place for a pandemic scenario. Specific actions include:

- Criteria and protocols for closing units or the entire facility to new admissions when the pandemic virus is in the facility
- Criteria and protocols for enforcing visitor limitations
- A plan for cohorting symptomatic residents or groups
- An occupational health plan for addressing staff absences
- Plans for increased cleaning of common surfaces

The linked checklist is an excellent resource for long-term care and other residential facilities to assist them with pandemic planning. While the document references influenza, coronavirus is a respiratory disease and most of the same activities apply. Link: https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf

Can you all share with long term care facilities and/or post this resource on your websites? Thank you.

Samantha Cooksey Strickland
Alternate Emergency Coordination Officer
State ESF8 Planning & Operations Section Manager
Bureau of Preparedness & Response
Florida Department of Health
Office | 850.617.1506
Mobile | 850.251.2553
Email | Samantha.Cooksey@flhealth.gov

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From:	Borrego, Eddie
To:	patricia.abril@miamidade.gov; tere.florin@miamidade.gov; Leets, Tania; myriam.marquez@miamidade.gov; jesse.o.manzano.mil@mail.mil; icarroll@miamigov.com
Cc:	Silva, Liz (COM); Villalta, Yesenia D; sdean@miamigov.com; jimmy.arias.mil@mail.mil; Steigman, Don S; Kim, Inson (COM)
Subject:	Marlins Park Collection Site
Date:	Monday, March 23, 2020 5:05:42 PM
Attachments:	image002.png PreTesting Instructions or Guidelines03.23.2020.FINAL.pdf Where to Get Tested (3-23-2020).FINAL.pdf COVID19 SCREENING TOOL - MARLINS (002).pdf COVID19TESTINGSITE 03.23.2020.pdf
Importance:	High

PIOs,

This email is to link in all the PIOs on the relevant details of this drive through. Please note that the PreTesting Instructions document is for internal use only and not authorized to be shared.

All the best,

Eddie

--
Edward (Eddie) Borrego
Vice President & Chief Executive Officer
Jackson West Medical Center
786-999-2977 Mobile

From: Villalta, Yesenia D <Yesenia.Villalta@flhealth.gov>
Sent: Monday, March 23, 2020 3:53 PM
To: Borrego, Eddie <edward.borrego@jhsmiami.org>; inson.kim@miamidade.gov; Liz.silva@miamidade.gov
Cc: Rivera, Lillian <Lillian.Rivera@flhealth.gov>; Jackson, Iris F <Iris.Jackson@flhealth.gov>; Suarez, Sarah B <Sarah.Suarez@flhealth.gov>; Paterniti, Beth A <Beth.Paterniti@flhealth.gov>
Subject: Marlins Park Collection Site
Importance: High

WARNING: This email originated outside of Jackson Health System. Do not click links or attachments unless you recognize the sender and know the content is safe.

Good afternoon,

Please find the latest documents. Please let me know if you have any questions.

1. Script for Call Center
2. Pre-Specimen collection information (internal reference only)
3. COVID-Screening tool

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4. Post specimen collection brochure

Thank you,

Yesenia D. Villalta, APRN, DNP, MSN
Florida Department of Health in Miami-Dade County
Administrator/Health Officer
Email: Yesenia.Villalta@flhealth.gov
Phone:(786)336-1260
Address: 8323 NW 12th Street Floor:02 Room:212
Miami, FL 33126



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FLORIDA HEALTH IN MIAMI-DADE COUNTY
COVID-19 SCREENING TOOL

SITE: Marlins Stadium ☐ **Date:** **Time:**

Last Name:

First Name: **Age:**

Date of birth: M M (MONTH) – D D (DAY) – Y Y Y Y (YEAR) **Sex:** Male: ☐ Female: ☐ Other: ☐

Race: White ☐ Black ☐ Asian / Pacific Islander ☐ Amarican Indian/ Alaskan ☐ Other: ☐ Unknown:: ☐

Ethnicity: Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Not specified ☐

Language: English ☐ Spanish ☐ Creole ☐ Other: ☐

Home Address:

City: **State:** **Zip Code:**

Telephone: – –

Email Address:

↓ IS THE PATIENT EXHIBITING THE FOLLOWING SYMPTOMS? ↓

Cough: YES ☐ NO ☐ **Or Shortness of Breath:** YES ☐ NO ☐

IN ADDITION TO THE ABOVE SYMPTOMS - PATIENT MEETS ONE OF THE FOLLOWING CRITERIAS

1) Are you 65 years old or greater?
YES ☐ NO ☐

2) Are you Immunocompromised?
YES ☐ NO ☐

3) Do you verbally consent to COVID-19 testing?
YES ☐ NO ☐

4) Are you driving yourself?
YES ☐ NO ☐

NOTE: If NO, only you and your driver are allowed in the vehicle at the specimen collection site and the driver will also be registered and tested.

5) Do you understand: you will be turned away if there are more than 2 persons in your vehicle.
YES ☐ NO ☐

Primary Doctor's Name: **Telephone Number:**

Name of Employee Completing Form:

Content Source: CDC

ONLY individuals that meet the above criteria are eligible for COVID-19 testing.

AMERICAN OVERSIGHT

Florida HEALTH

10 ways to manage respiratory symptoms at home

Continue to monitor and record symptoms. The Florida Department of Health in Miami-Dade County will be contacting you with results within 7 days of testing.

1. **Stay home** from work, school, and away from other public places. If you must go out, avoid using any kind of public transportation, ridesharing, or taxis.



2. **Monitor your symptoms** carefully. If your symptoms get worse, call your healthcare provider immediately.



3. **Get rest and stay hydrated.**



4. If you have a medical appointment, **call the healthcare provider** ahead of time and tell them that you have or may have COVID-19.



5. For medical emergencies, call 911 and **notify the dispatch personnel** that you have or may have COVID-19.



6. **Cover your cough and sneezes.**



7. **Wash your hands often** with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.



8. As much as possible, **stay** in a specific room and **away from other people** in your home. Also, you should use a separate bathroom, if available. If you need to be around other people in or outside of the home, wear a facemask.



9. **Avoid sharing personal items** with other people in your household, like dishes, towels, and bedding.



10. **Clean all surfaces** that are touched often, like counters, tabletops, and doorknobs. Use household cleaning sprays or wipes according to the label instructions.



For more information:
Visit: www.cdc.gov/COVID19 Call: 305-470-5660

AMERICAN LEGIBILITY LIGHT

MIAMI-DADE COUNTY

THE CITY OF MIAMI FLORIDA

Jackson HEALTH SYSTEM

Health UNIVERSITY OF MIAMI HEALTH SYSTEM

FL-Data-20-0673-A-004741



AMERICAN OVERSIGHT

INTERNAL REFERENCE ONLY

Pre-Arrival to Testing Site Instructions

1. Vehicle Capacity: 2 – (1 Driver and 1 Passenger)
    a. The passenger must be sitting at an operating window
2. If there are two (2) people in one (1) vehicle, each person is individually registered and tested if they meet the testing criteria.
    a. A vehicle with more than two (2) people will be turned away from the testing site.
    b. If a vehicle arrives with more than two (2) people, the onsite lead Charge Nurse will make a clinical decision to proceed.
    c. If a person arrives with no appointment, the onsite lead Charge Nurse will make a clinical decision to proceed.
3. Each person(s) must remain in the vehicle from time of arrival to departure of the testing area
4. Testing is done via an open vehicle window. Ensure windows are operational.

THINGS TO CONSIDER ·There are no bathrooms; · Each person needing a test must be seated next to a working window; · All passengers must remain in the vehicle from arrival to departure; ·Try to limit the people in your vehicle to those needing a test; · Eat prior to appointment or bring snacks and water. There may be significant wait times (expect several hours)

At Arrival to Testing Site Instructions

1. Pull forward slowly, as instructed until arriving to first station.
2. Place car into park.
3. Slightly roll down window and speak loudly.

Testing Flow

Station 1 – Appointment Validation

- Assessors will ask for person(s) ID and confirm individual's name and the assigned code matches the appointment list
- Assessors provide an information packet to vehicle informing person(s) of public health information, including contact information

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Station 2 – Lab Registration (est. time: ~5 min per person)

- Scribers complete paper form with demographic information for each person to be tested (information relayed to Scribers via the Runner for each car):
    - First Name
    - Last Name
    - Phone
    - Email
    - Address
    - Date of Birth
    - Sex
    - Race & Ethnicity
- Scriber places lab requisition bag under the wiper of the front vehicle window.

Station 3 – Swabbing and Decontamination (est. time: 5 min)

- **Primary Swabber**
    - Confirm verbal authorization from person being swabbed for swab collection (ask runner)
    - Receive collection tube and swab from runner
    - Label collection tube with person's ID
    - Take swab of person(s) in car
    - Immediately place specimen swab into specimen collection tube
    - Insert specimen collection tube into secondary containment (specimen bag)
    - Place specimen bag on to temporary specimen bag staging table
    - Place form and sample bag in envelope, signs form as chain of custody, and places envelope in shipping container
    - Quality Control officer verifies all labels match and places specimen into sample cooler
        - Specimens must be maintained at a temperature between 2˚ -8˚ C (35.6˚F to 46.4˚F)
        - Specimens must be shipped in less than 48 hours of collection

VEHICLE EXITS

AMERICAN OVERSIGHT

Laboratory Processing

- All labs are processed using LabCorp

- **Results**
  - Participants are called by a Florida Department of Health in Miami-Dade employee to receive results.
  - Results may take up to 7 days depending on lab processing.

- **Negative Results**

Encourage individual to practice proper hygiene techniques, maintain social distancing measures as well as monitoring for signs and symptoms of COVID-19. Proper hygiene measures include washing the hands before meals and after using the bathroom, avoiding touching their face, proper covering of cough and sneeze.

- **Positive Results**

Monitor for signs and symptoms of complications such as:

- Difficulty breathing or shortness of breath,
- Persistent pain or pressure in the chest,
- new confusion or inability to arouse
- Blush lips or face

If this occurs, person is to immediately go to the nearest hospital or call 911. Currently, there is no treatment or vaccine for COVID-19. The best treatment available is based on the individuals' symptoms. Get plenty of rest, fluids, and use fever reducing and pain medication if needed. A Florida Department of Health in Miami-Dade employee will be reaching out all positive COVID-19 individuals daily either by telephone or via text messaging.

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Testing Request from Community

Agent: Thank you for contacting the _____. My name is _____. How can I assist you today?

Caller: I would like a COVID-19 test.

Agent: Are you or a family member experiencing any **severe** acute lower respiratory illness? The emergency warning signs include, but not limited to:

- Difficulty breathing or shortness of breath,
- Persistent pain or pressure in the chest,
- New confusion or inability to arouse
- Bluish lips or face

Caller Answers "Yes," then direct the person to seek emergency care immediately or call 911 for assistance. Caller answers "no" continue with the script.

Agent: Before directing you to a testing site, I will need to determine if you meet the criteria for COVID-19 testing.

Agent: Do you have a cough or shortness of breath

Caller Answers "Yes" to either cough or shortness of breath continue with the script.

Caller Answers "No". Then caller does not meet criteria.

AND the individual meets one or more of the following criteria

Agent: Are you age 65 or greater?

Caller Answers "Yes" continue script caller meets criteria.

Caller Answers "No" caller does not meet criteria.

Agent: Are you immunocompromised?

Caller Answers "Yes" continue script caller meets criteria.

Caller Answers "No" caller does not meet criteria.

CALLER MEETS CRITERIA:

Agent: You have met the criteria for COVID-19 testing. Miami-Dade County has a COVID-19 drive thru specimen collection site. Are you interested in scheduling an appointment?

Caller: Yes

Agent: *Proceed to make an appointment. Collect caller's demographic information, provide caller with address, special code and time of appointment. They should plan on arriving early as wait times will be long.*

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AGENT INFORMS CALLER

THINGS TO CONSIDER ·There are no bathrooms; · Each person needing a test must be seated next to a working window; · All passengers must remain in the vehicle from arrival to departure; ·Try to limit the people in your vehicle to those needing a test; · Eat prior to arriving to the specimen collection site; · Bring snacks and beverages as there may be significant wait times (expect several hours).

Agent: Only people with an appointment, special code and a valid Florida ID, license, passport, etc. will be tested.

Agent: Will you be driving yourself to the COVID-19 test collection site?

Caller Answers "Yes"

Agent: Upon arrival to the specimen collection site, you are to remain in your vehicle from the time of arrival to departure of the testing area. Testing will be done via an open vehicle window. Please ensure your window is operable.

Caller Answers "No"

Agent: Only you and your driver should be in the car upon arrival at the test site. Your driver will be registered and tested. Both windows of the vehicle should be operable. If you bring anyone other than yourself and a designated driver, you will be turned away and your appointment will be canceled.

Agent: Please confirm verbally that you understand this.

Caller: How soon can I get my test results?

Agent: Your results should be available within 7 days of testing. A Florida Department of Health in Miami-Dade employee will call you. Please do not call the state lab, the state health department or the local health department to get your results.

CALLER DOES NOT MEET CRITERIA:

Agent: I am sorry but based on the criteria for the specimen collection site you do not meet criteria for testing at this time. You may reach out to your medical provider for additional medical guidance. Please continue to take steps to protect yourself • Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. • Avoid close contact with people who are sick. • Avoid touching your eyes, nose, and mouth with unwashed hands. • Clean all "high-touch" surfaces every day. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Continue to take steps to protect others • Stay home if you're sick. • Cover coughs and sneezes. • If available, wear a facemask if you are sick.

Always reach out and **c**ontact your medical provider for guidance.

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Monitor for any symptoms:

- Note the day your symptoms begin.
- Check your own temperature two times a day.
- Keep a daily record of fever, cough, and additional respiratory symptoms.
- Seek further evaluation from a healthcare provider via telemedicine or in-person if your symptoms get worse. Always call before visiting your doctor's office.
- Seek medical attention immediately if you develop any of the following emergency warning signs for COVID-19 or other medical emergencies **Call 911 in case of an emergency**: - Extreme difficulty breathing - Bluish lips or face - Constant pain or pressure in the chest - Severe constant dizziness or lightheadedness - Acting confused - Difficult to wake up - Slurred speech (new or worsening).

For medical emergencies, call 911 and notify the dispatch personnel that you may have COVID-19.

If you have no insurance or a medical provider, I can direct you to the Florida Department of Health in Miami-Dade website for a list of Federally Qualified Health Centers. Please visit Miamidade.floridahealth.gov

If you have additional questions, you can call the Department of Health 24/7 COVID-19 Call Center The number to call is **1 (866) 779-6121** or visit http://miamidade.floridahealth.gov/

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Materials from 2-18-2020 SHO & State Epi Touchbase webinar (COVID-19)
Date:	Wednesday, February 19, 2020 2:16:36 PM
Attachments:	COVID_19 Leaders_Intent (002) JW Final.pdf Novel CoV_2_14_20 Health Care Pre-Meeting.pdf CSC SHO Call 2.18.2020 UPDATED SP.pdf SRC_Respirator 2020-2-13 DRAFT (002).pdf CSC SHO Call 2.18.2020 UPDATED_updated.pptx 7 Key Questions_MCCM_2.18.20.pptx public-health-management-decision-making algorithm feb 18 2020.pdf

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Dear Colleagues,

This email contains materials from the 2-18-2020 SHO & State Epi Touchbase webinar (COVID-19) .

Attached:

- Considerations for Crisis Standards of Care Slides
- WA DOH SHO's leader's intent document to the IMT on leaning into community readiness
- WA DOH slide set: Health Care Readiness Pre-Planning
- MCCM "7 Key Questions"
- Strategies for Scare Resource Situations
- Webinar Slides
- COVID-19 Risk Assessment and PH Management Decision Making Algorithm

Thank you for attending,

State Coordination Task Force

Sent by BCC to State Health Officials and State Epidemiologists

AMERICAN OVERSIGHT

The “7 Key Questions”

Priority Information Requirement	Measure
1. Significant reporting of increasing demand for patient care service? a) Urgent Care/ER b) ICU	**Facility Impact and Ability to Meet Demand**
2. Ability to meet demand for increasing patient care services? a) Urgent Care/ER b) ICU	
3. Significant reporting of strategies to augment facility/hospital operations?	
4. Significant reporting of staffing shortages impacting patient care services? a) Urgent Care/ER b) ICU	
5. Impact on need for ventilators/ventilator ancillary supplies? a) Increased demand of ventilators/ventilator ancillary supplies? b) Decreased availability of ventilators/ventilator ancillary supplies?	**Supply Chain (Facility Demand and Supply)**
6. Impact on key pharmaceuticals? a) Increased demand of key pharmaceuticals b) Decreased availability of key pharmaceuticals	
7. Impact on PPE? a) Increased demand of PPE b) Decreased availability of PPE	

AMERICAN OVERSIGHT

Washington State Department of Health Incident Management Team

COVID-19 Leader's Intent

Phase 2

February 14, 2020

The novel coronavirus outbreak has required the Department of Health Incident Management Team to enhance several significant foundational public health capabilities, in order to effectively detect cases of disease, conduct laboratory analysis for the virus, share information between local, state and federal public health agencies, provide the public with information about what they can do to stay healthy, monitor people at risk of developing the disease, and if necessary quarantine individuals when other locations are not available.

At this time, the operationalization of the containment strategies are fairly well established and there is much concern that as the virus has spread to many countries, that this event is evolving and containment in the US may not be feasible in the medium to long term. Therefore, the Department of Health must focus its planning and preparation work to strategies for broader personal, community, and environmental mitigation and readying systems to reduce impact.

Task

Relying on existing emergency response plans where developed, the DOH IMT will focus on engaging partners in standing up and implementing community mitigation efforts to slow the spread of COVID-19 in communities, and simultaneously facilitate the preparation of multiple sectors for impact and minimizing that impact. Community mitigation efforts, are by definition a set of layered approaches to create social barriers to the transmission of the disease.

<u>Health Care Sector Work</u>

The work here must be to decrease demand on the health care system and increase supply of health care COVID-19 healthcare services.

- Stand up systems to track and maintain awareness of the health care system stressors (staffing, space, and "stuff"—materials) and to the extent possible, rely on existing data and systems capabilities. Health care supply chain information must be incorporated with epidemiologic and health care stress indicators to inform a real-time common operating picture. With these systems we will engage partners to identify thresholds and operational strategies for implementing community mitigation measures.

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- Coordinate with health care partners and health plans to support them, in their efforts, to develop and implement strategies for a) reducing demand (e.g., increase use of nurse advice lines, telemedicine, home self-assessments and home care guidelines), b) conserving scarce health care resources (staffing, personal protective equipment, ventilators, and medical supplies, and c) expanding surge capacity/output.
- Assist them with tools such as planning checklists.
- Keep local public health informed of this work and assist them in connecting with and supporting their local health care delivery partners.
- Assist EMS in their readiness.

Schools/Universities

- In collaboration with OSPI, Washington State Board for Community and Technical Colleges, and Washington Student Achievement Council, assist schools and universities (public, private, and religious) with implementation of school guidelines. Keep local public health informed of this work and assist them in connecting with and supporting their local public and private schools.
- Engage school leadership and health officers in environmental and community mitigation efforts to slow the spread of COVID-19. Assist them in understanding social distancing measures and the potential use of school closures and dismissals (staff work but students not in attendance). Assist them in understanding decision making processes and legal authorities for school closures and dismissals, including health officer role/authority.
- Encourage their pre-planning for how schools may continue educational learning via home-based instruction.
- Identify "secondary" impacts and consider options for mitigating those impacts of other services provided at school (e.g., meal programs, counseling services, etc).

Businesses

(To be developed next week after a 5pm planning meeting today). Include surveillance of supply systems and engagement of emergency management.

Chinese American and Other Asian Communities

- In collaboration with Commission on Pacific American Affairs, other Asian/Pacific led Islander organizations, Public Health: Seattle & King County, engage in comprehensive efforts to educate them on COVID-19, mitigation efforts, monitoring of COVID-19 related discrimination, and stigma/discrimination reduction efforts.

Elected Officials (Must be done in tight coordination with Secretary Wiesman)

- Identify organizations representing elected officials and engage them in education on community mitigation tools, when those tools may be recommended for use, their role and legal authorities in implementing those. Include local public health in this effort.

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- These key partners must be enrolled in systems for sharing information about the outbreak and notification of changes in the situation.

Purpose

The Washington State's Department of Health must fulfill our responsibility to prevent disease spread, promote health, and protect the public's health. Additionally, our state's healthcare system operates at full capacity on a daily basis. Since our state is still experiencing health care surge with respect to the current influenza season this system is under considerable stress. The COVID-19 presents an additional burden as well as an additional demand on the supply chain. Overall, the burden on the health care system impedes their ability to care for critically injured and ill patients on a daily basis. This response must support their ability to care for people in our communities when they need that care, which involves both mitigating spread of COVID-19 and building health care capacity.

End State

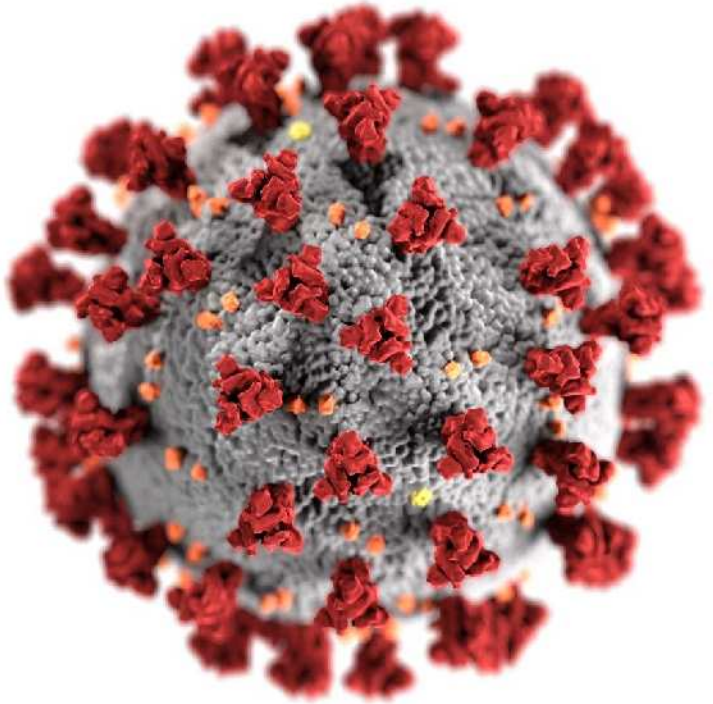
Our public health actions will prevent the spread of disease long enough for our state (country) to emerge from influenza season. With that, our health care partners will have built systems to decrease demand and conserve their resources, space, and personnel, in order to effectively care for those who require medical care. Our other sectors, especially schools and businesses will have leaned into preparations to minimize impacts.

AMERICAN OVERSIGHT

COVID 19
CORONAVIRUS DISEASE

Considerations for Crisis Standards of Care

Senior Health Official and State Epidemiologist Touchbase Call



February 18, 2020

CDC

For more information: www.cdc.gov/COVID19

AMERICAN OVERSIGHT
FL-DOH-20-0673-A-004754

COVID-19 Health System Concerns

- Medical system
  - Current concerns: increasing stress on PPE supply
  - Depending on intensity of outbreak: insufficient staff and staff safety, appropriate patient triage and care, medical countermeasure use, prioritization of laboratory testing
- Emergency Medical Services
  - Responding to suspect COVID cases
- Communicating to the public and community resilience

AMERICAN OVERSIGHT

Continuum of Care

Incident demand/resource imbalance increases →

Patient-level of care → Population-level of care

← Recovery

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[a]

Normal operating conditions

Extreme operating conditions

Indicator(s): Potential for contingency care[b]

Indicator(s): Potential for crisis standards of care[d]

Trigger(s): Decision point for contingency care[c]

Crisis care trigger(s): Decision point for crisis standards of care[e]

AMERICAN OVERSIGHT

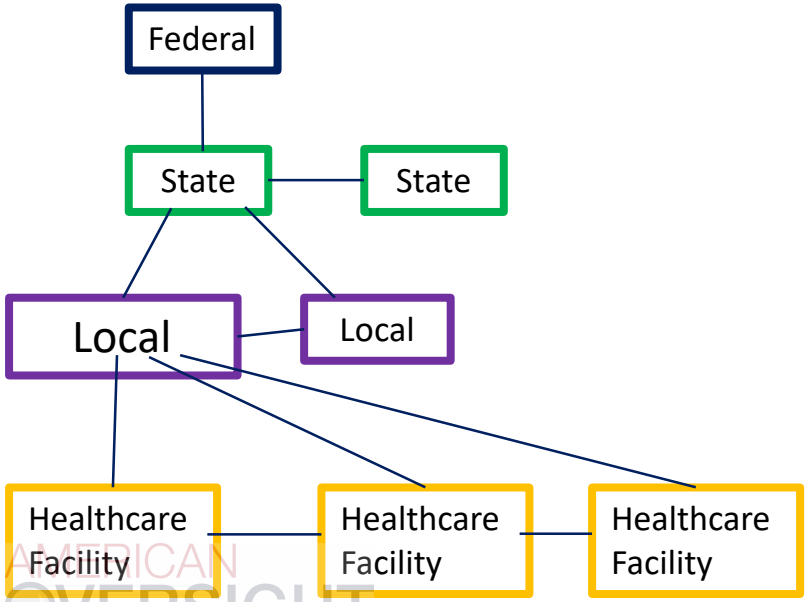
What is Crisis Standards of Care (CSC)?

- Crisis Standards of Care (CSC) guidelines help public health and healthcare personnel determine how to utilize resources during a public health emergency
- Why is it necessary?
  - During catastrophic events, there may not be enough resources to give all patients the level of care they would normally receive.
  - A substantial change in usual healthcare operations and level of care it is possible to deliver due to a catastrophic disaster (e.g., pandemic influenza, earthquake, hurricane) (IOM 2012).

AMERICAN OVERSIGHT

How does CSC fit into response structure?

Emergency Response Activities



CSC Guidance, Policies, and Authorities

HHS/others

State Disaster Medical Advisory Committee (SDMAC)

Regional Disaster Medical Advisory Committee (RDMAC)

Clinical Care Committee

Triage Team

AMERICAN OVERSIGHT

Federal Role in CSC (examples)

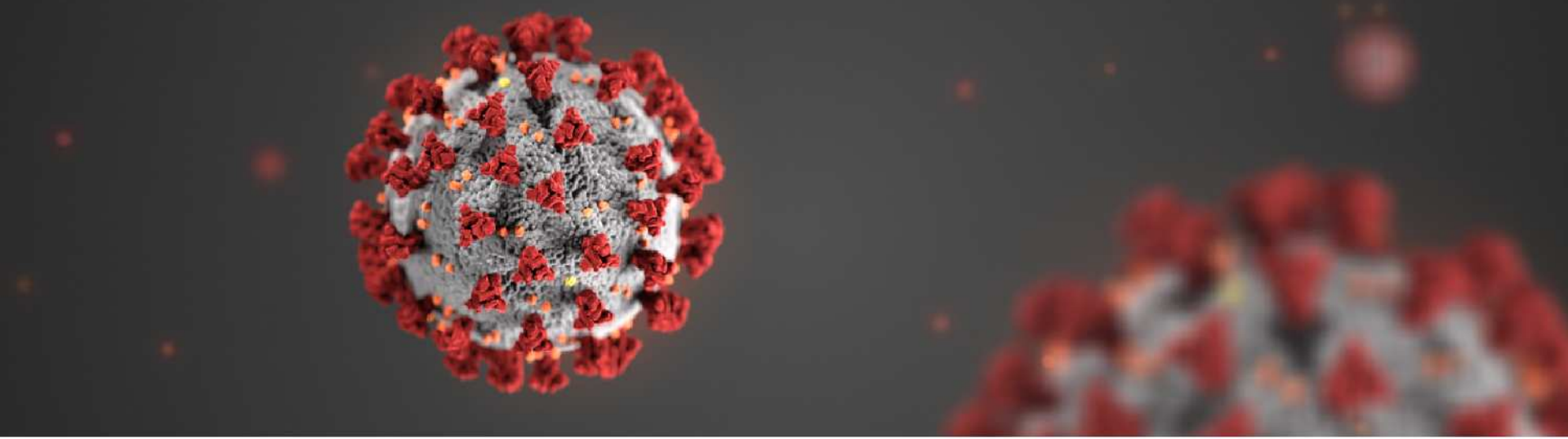
1. **Provision of staff/stuff/space**
   - Is there a role for personnel (deployments)
   - Possible utilizing alternative care strategies (e.g., scripts for telemedicine, nurse triage lines)
2. **Technical assistance**
   - Clinical and operational guidance for ventilator allocation, respirator use, or other scarce resource
   - Facilitate standardization of CSC approach across country (sharing best practices)
3. **Use of federal authorities to support jurisdictional efforts**

AMERICAN OVERSIGHT

Planning from a State Perspective

Kathy Lofy, MD
State Health Officer, Chief Science Officer
Washington State

AMERICAN OVERSIGHT



For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

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

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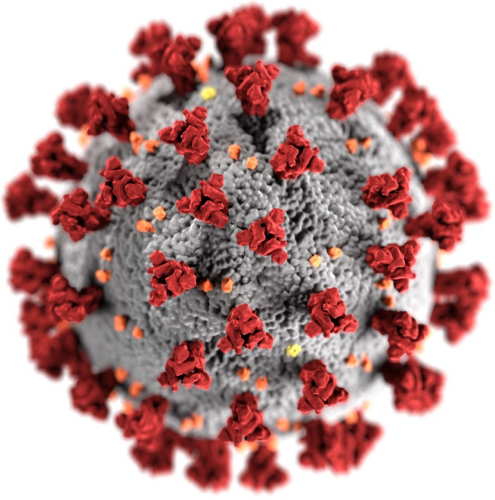
Considerations for Crisis Standards of Care

Senior Health Official and State Epidemiologist Touchbase Call



February 18, 2020

For more information: **www.cdc.gov/COVID19**

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AMERICAN OVERSIGHT

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Extreme operating conditions

AMERICAN OVERSIGHT

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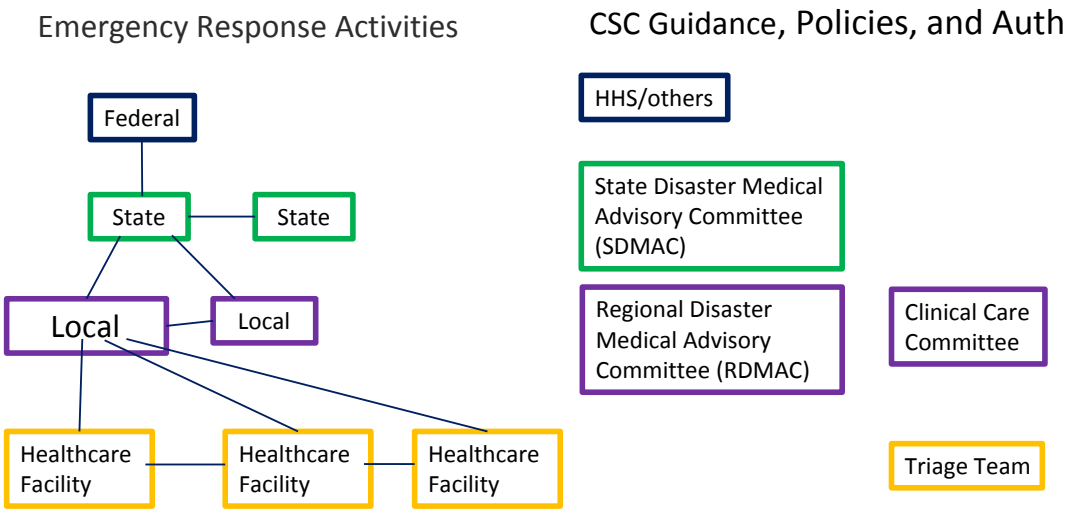
How does CSC fit into response structure?



Emergency response breaks down into specific roles for feds, states and locals. CSC implementation requires guidance, policies and authorities at the federal, state/local and facility level.

CSC guidance can be developed at the federal, state and local level. As are medical decisions. Question is, can we do more at the Federal guidance and Medical decision making levels to help state and locals?

AMERICAN OVERSIGHT

Federal Role in CSC (examples)

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   - Is there a role for personnel (deployments)
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AMERICAN OVERSIGHT

Planning from a State Perspective

Kathy Lofy, MD
State Health Officer, Chief Science Officer
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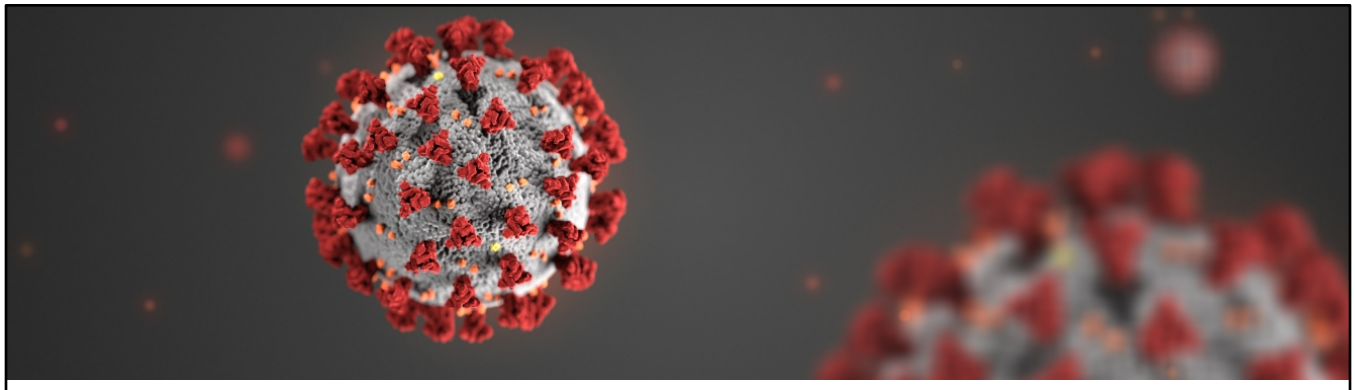

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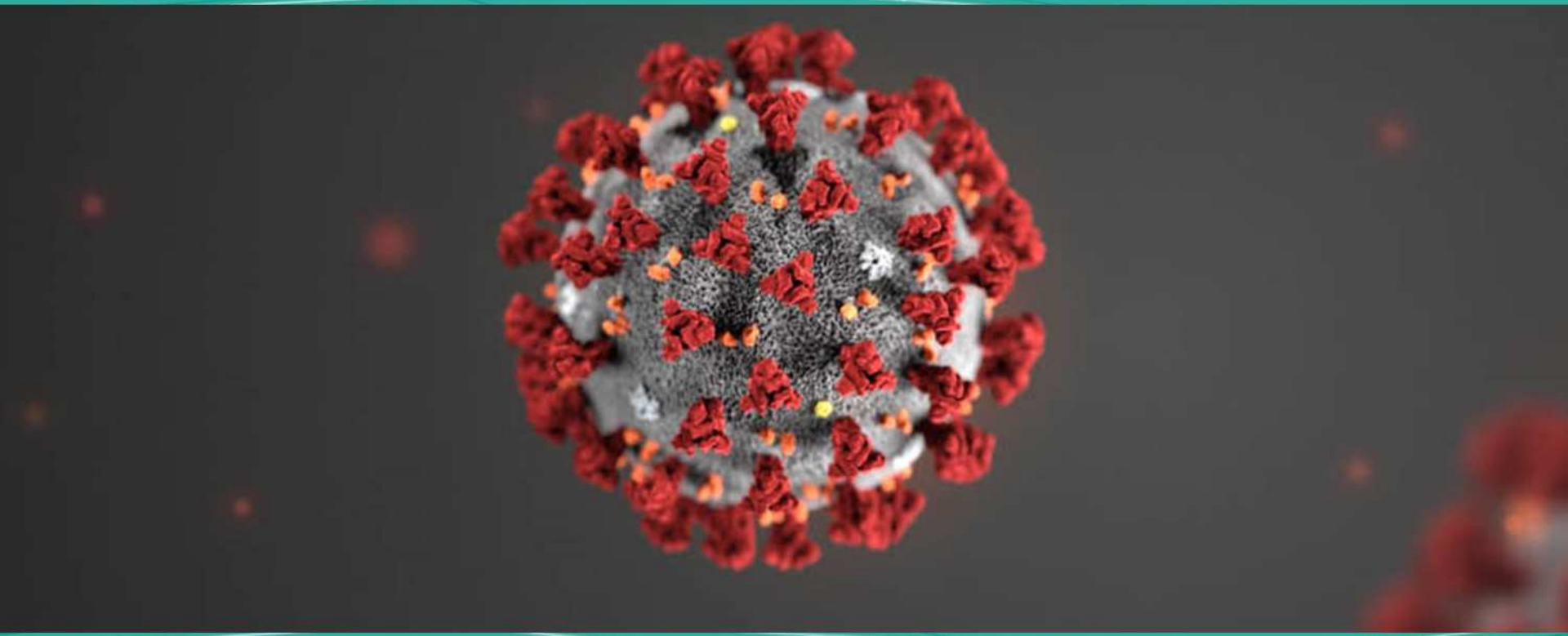

2019 Novel Coronavirus (COVID-19) Infection

Health Care Readiness Pre-Planning

February 14, 2020

Washington State Department of Health

AMERICAN OVERSIGHT

Current Work with Healthcare System

- Provider alerts
- Infection control webinars
- Readiness survey completed
- Establishment of Home Assessment Team at Harborview Medical Center
- PPE supply chains

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Healthcare System Planning

- Pre-call with health care associations/key leaders to join in a healthcare “call to action”. Discuss roles/responsibilities and aproach
- Call to Action Webinar
  - “Call to Action” letter to healthcare executives from Secretary of Health followed by webinar for healthcare executives
  - Accelerating planning efforts in 4 key areas
    - Assessment of the healthcare systems (e.g., PPE, ICU beds)
    - Maximizing and expanding capacity (e.g., med surge plans, triage lines, COOP, alternate care systems)
    - Conservation strategies / Crisis Standard of Care guidelines (DMAC = policy group)
    - Fatality management

AMERICAN OVERSIGHT

Assessment of the Healthcare System

HEALTH PULSE

The "7 Key Questions"

PRIORITY INFORMATION REQUIREMENT	MEASURE
1. Significant reporting of increasing demand for patient care services? a) Urgent Care/ER b) ICU	Facility Impact and Ability to Meet Demand
2. Ability to meet demand for increasing patient care services? a) Urgent Care/ER b) ICU	
3. Significant reporting of strategies to augment facility/hospital operations?	
4. Significant reporting of staffing shortages impacting patient care services? a) Urgent Care/ER b) ICU	
5. Impact on need for ventilators/ventilator ancillary supplies? a) Increased demand of ventilator/ ventilator ancillary supplies b) Decreased availability of ventilator/ ventilator ancillary supplies	Supply Chain (Facility Demand and Supply)
6. Impact on key pharmaceuticals? a) Increased demand of key pharmaceuticals b) Decreased availability of key pharmaceuticals	
7. Impact on PPE? a) Increased demand of PPE b) Decreased availability of PPE	

CDC

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Maximizing Capacity

- Decrease demand of services (PRIMARY FOCUS)
  - Online self-assessment
  - Protocols for nurse triage lines
  - Telemedicine

  We need to get our payers thinking about paying for these services.

- Increase supply of services for COVID-19 (HARD TO DO)
  - Health Care System Service/Operational Modficiations
  - Alternate care systems

Conservation Strategies/Crisis Standards of Care

- Need to prepare for:
  - Limited PPE
    - PPE conservation strategies (https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html)
  - Limited bed space
  - Limited ICU space
  - Limited ventilators

Resources for the Healthcare System

- Hospital checklist: https://www.cdc.gov/flu/pandemic-resources/pdf/hospitalchecklist.pdf
- Medical Office checklist: https://www.cdc.gov/flu/pandemic-resources/pdf/medofficesclinics.pdf
- CDC's COVID-19 Business Guidance: https://www.cdc.gov/coronavirus/2019-ncov/guidance-business-response.html

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Washington State Department of Health

Washington State Department of Health is committed to providing customers with forms and publications in appropriate alternate formats. Requests can be made by calling 800-525-0127 or by email at civil.rights@doh.wa.gov. TTY users dial 711.

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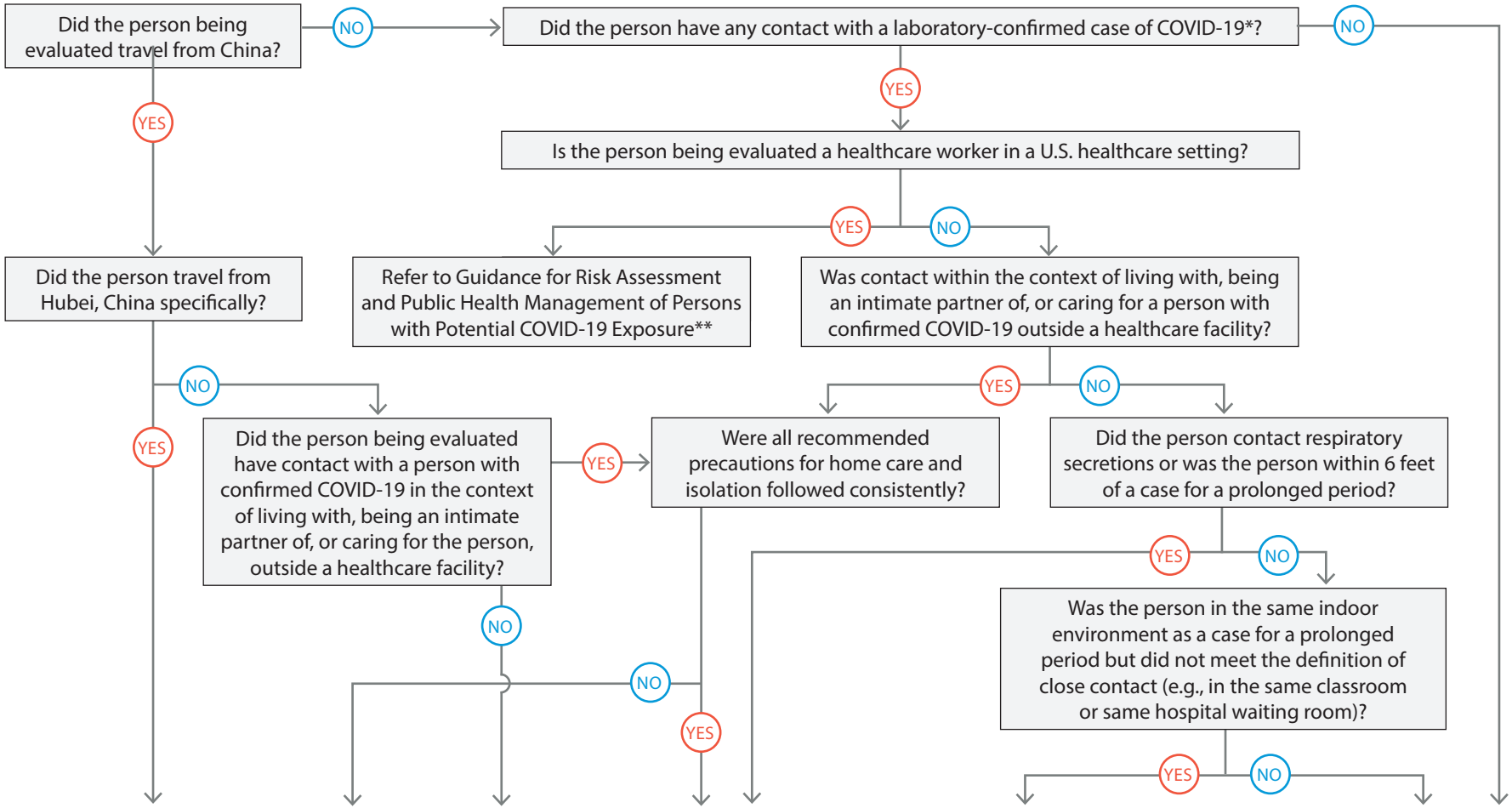
Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making *Each question refers to within the past 14 days*

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



	High Risk	Medium Risk	Low Risk	No identifiable risk
Actions for people without symptoms consistent with COVID-19	Remain under quarantine authority; no public activities; daily active monitoring; controlled travel	Stay home; active monitoring or self-monitoring with public health supervision; recommend to not travel	Self observation	None
Actions for people with symptoms consistent with COVID-19	Immediate isolation; medical evaluation guided by PUI definition; pre-notify healthcare services; controlled travel	Immediate isolation; medical evaluation guided by PUI definition; pre-notify healthcare services; controlled travel	Stay home from work or school, avoid contact with others, don't travel. Seek health advice	None; routine medical care

These examples may not cover all potential exposures to laboratory confirmed case of COVID-19. If you are concerned about an exposure that does not align with these categories, please contact the CDC Emergency Operations Center at 1-800-232-4636

*Or a case diagnosed clinically with COVID-19 infection outside of the United States who did not have laboratory testing
**Healthcare provider (HCP) guidance outlines risk categories to determine work exclusion and monitoring procedures. After identifying risk category in the HCP guidance, use the categories outlined here to determine quarantine requirements.

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02/14/20

FL-DOH-20-0673-A-004778

PARTICULATE RESPIRATORS and General PPE (N95, Elastomeric, PAPR, CAPR)[1]

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

2020 UPDATE DRAFT for REVIEW

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
General Infection Control Procedures • 1. Establish procedures for managing visitors and ill healthcare personnel. • 2. Establish triage procedures and separate areas for ill and well patients. • 3. Assign dedicated staff to minimize exposure. • 4. Require, when possible, or strongly encourage vaccination of primary personnel and first responders, according to vaccine schedule as recommended for existing circumstances by the CDC and the Advisory Committee for Immunization Practices (ACIP). • 5. Seriously consider creation of a registry to reflect the vaccination status of primary personnel and first responders to aid in decisions regarding service assignments. • 6. Educate and routinely train all staff regarding use and proper handling of particulate respirators. • 7. Maintain good hand hygiene procedures including gloves, hand washing with soap and water and/or alcohol based hand sanitizers depending on the current recommendations. • 7a) Maintain proficiency in N95 Fit Testing **Cache/ Increase Supply Levels** • 8. Clarify current CDC and OSHA guidelines for respirator use; monitor for updates and recommendations.[2] • 9. Cache additional supplies of respirators and their functional components (e.g. fit testing supplies, batteries, cartridges, filters, hoods etc.). • 10. Review vendor agreements, contingencies for delivery and production, including alternate vendors. • 11. Maintain a reserve sufficient to meet estimated needs for respiratory protection for all respiratory infectious diseases.	*Prepare*			
• 12. Obtain masks and cartridges from alternate sources such as industrial suppliers and companies – welding, manufacturing, etc. – as indicated. • 13. Request Strategic National Stockpile of respirators with the knowledge that they may be from different manufacturers. They may not be functional in all situations (i.e. surgical use) and they may require additional fit testing before deployment.	*Substitute*			
Decrease Use of Respirators • 14. Clarify current CDC and OSHA guidelines for respirator use; monitor for updates and recommendations.[2] • 15. Medical/surgical masks can be reused by infected patients until the masks are no longer useable due to moisture or damage.	*Substitute & Conserve*			
• 16. When Respirators are in short supply, aerosol-generating procedures should only be performed on patients when medically necessary and cannot be postponed. • 17. Limit the number of healthcare personnel with patient contact to only those essential for patient care and support, especially during aerosol generating procedures. • 17a) Consider limiting all visitors • 17(b): Consider changes in staffing (i.e. unimmunized staff given assignments that would not require significant PPE use)	*Conserve*			
Extended Use[3] • 18. Clarify current CDC and OSHA guidelines for respirator use; monitor for updates and recommendations.[2] • 19. Policies and recommendations around "extended use" or "re-use" of respirators should include input from occupational health,	*Re-use*			

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infection control, infectious disease specialists, state and local public health and any national recommendations around the situation at hand. • 20. For N95, consider wearing a loose-fitting barrier that does not interfere with fit or seal (e.g., surgical mask, face shield) over the respirator to extend its use.[3] • 21. In general, wearing an N95 respirator over multiple serial patient encounters (while minimizing touching) is favored over removing and re-donning between encounters (i.e. extended use is favored over re-use of N95).[3] • 22. Cleaning and filter replacement procedures and extended use of filters and/or hoods/shields on all other mechanical respirators (i.e. elastomeric respirators, PAPRs , CAPRs etc.) should be done according to manufacturer's protocols and guidelines.				
Re-use Respirator After Removal[3] • 23. Clarify current CDC and OSHA guidelines for respirator use; monitor for updates and recommendations.[2] • 24. Policies and recommendations around "extended use" or "re-use" of respirators should include input from occupational health, infection control, infectious disease specialists, state and local public health and any national recommendations around the situation at hand.	*Re-use* *Re-allocate*			
• 25. Use and store used respirators (hood, mask, shield) individually in such a way that the physical integrity and efficacy of the respirator will not be compromised.[3] • 26. Label respirator with a user's name before use to prevent inadvertent use by another individual.[3] • 27. Practice appropriate hand hygiene before and after removal of the respirator and, if necessary and possible, appropriately disinfect the object used to store it.[3] • 28. Respirators should be discarded if visibly damaged or contaminated.[3] • 29. Five (5) is the recommended number of donning of a re-used N95-type respirator.[3] • 30. Consider N95 decontamination with ultraviolet germicidal irradiation (UVGI), or other tested method of decontamination to extend the use of respirators.[4] **Re-allocate/ prioritize** • 31. Respirators use should be prioritized only to those healthcare providers identified as highest risk. • 32. Identify medical personnel and caregivers with documented vaccination, immunity after an illness or lower risk of complicated infection to provide direct patient contact without a respirator.	*Re-use* *Re-allocate*			

[1]Refers to any device such as N95, elastomeric respirators, Powered Air Purifying respirators (PAPRs), Controlled Air Purifying Respirator (CAPRs) or equivalent. NIOSH approved particulate respirators can be found at: https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/RespSource.html; https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html

[2]CDC and NIOSH overview of respirators: https://www.cdc.gov/niosh/topics/respirators/default.html

[3]"Extended use" is defined as wearing the same respirator for repeated close contact encounters with multiple patients without removing the respirator between patients (e.g. triage area, dedicated waiting rooms or wards, etc). "Reuse" is defined as using the same respirator for multiple encounters but removing it after each encounter. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3respreuse.html

[4]Current research on the decontamination of N95 Respirators: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4699414/pdf/nihms747549.pdf, https://academic.oup.com/annweh/article/53/8/815/154763 https://academic.oup.com/annweh/article/56/1/92/166111

FINAL APPROVED: 12/6/2017

Next Revision due: 2020

DRAFT

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Media Advisory: CDC Media Telebriefing: Update on COVID-19
Date:	Wednesday, February 12, 2020 10:32:34 AM

Media Advisory

For Immediate Release
Wednesday, February 12, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 11:30 am. ET Wednesday, February 12, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 2684824

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

U.S. Department of Health and Human Services

CDC works 24/7protecting America's health, safety and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is

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headquartered in Atlanta and has experts located throughout the United States and the world.

Sent by BCC to PHEP directors, State Health Officials, State Epidemiologists, Lab Directors, and Non-Governmental partners

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From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: Media Statement: CDC Confirms 15th Case of Coronavirus Disease (COVID-19)
Date: Thursday, February 13, 2020 10:38:19 AM

Media Statement

For Immediate Release
Thursday, February 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Confirms 15th Case of Coronavirus Disease (COVID-19)

CDC today confirmed another infection with Coronavirus Disease (COVID-19) in the United States. The patient is among a group of people under a federal quarantine order at JBSA-Lackland in Texas because of their recent return to the U.S. on a State Department-chartered flight that arrived on February 7, 2020.

All people who lived or travelled in Hubei Province, China, are considered at high risk of having been exposed to this virus and are subject to a temporary 14-day quarantine upon entry into the United States. This is the first person under quarantine at JBSA-Lackland who had symptoms and tested positive for COVID-19. The individual is currently isolated and receiving medical care at a designated hospital nearby.

This brings the total number of COVID-19 cases in the United States to 15. There will likely be additional cases in the coming days and weeks, including among other people recently returned from Wuhan. While 195 people were discharged from quarantine on Tuesday, more than 600 people who returned on chartered flights from Wuhan remain under federal quarantine and are being closely monitored to contain the spread of the virus.

For the latest information on the outbreak, visit CDC's Novel Coronavirus 2019 website.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

Sent by BCC to PHEP directors, State Health Officials, State Epidemiologists, Lab Directors, and Non-Governmental partners

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From:	Moulton, Diane
To:	Rivkees, Scott; Eifert, James; Moskowitz, Jared; Swearingen, Rick; Mayhew, Mary; Corcoran, Richard
Subject:	Meeting TODAY @ 3:30
Date:	Wednesday, February 19, 2020 7:25:24 AM

The Governor would like to have a briefing regarding the Coronavirus today at 3:30. The briefing will be held in our small conference room. Please let me know if you can attend in person. If some of you can't attend in person, I will provide a conference line. Thank you all!

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

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From:	Dobson, Jolie T
To:	Burger, Ron; Cicerrella, Richard; Connor, Olga; Cyrille, Charles; Davis, Joanna; Disbrow, Scott; Jeanne Eckes-Roper; Elmir, Samir; Erase, Romualde X; Franco, Benjamin; Frost, Matthew; Garcia, Maikel; Gomez, Tatiana ; Hernandez, Richard; Horner, Alicia; Jean, Reynald; Kelly Keys; Lara, William; Lewandowski, Patty A; Loo, Georgina; Lopez, Jose M; Mejia-Echeverry, Alvaro; Milian, Victor ; Nunez, R. Jaime; Presmanes, Cristina; Quaye, Elesi A; Rafky, Brian; Schmitz, Ann; Senyshyn, William; Serrano, Maria; Steele, Michelle; Sudden, Terri M; Toñanez, Alvaro Lt.; Trim, Anthony Capt.; Vaughn, Freda G; Villalta, Yesenia D; White, Stephen L; Chao Morales, Christina A; Castillo, Klelia S; Celorio, Oscar; Villamil, Vanessa
Cc:	Suarez, Ana; Pognon, Monica; Jaime Hernandez; jzambella@icerif.com; John Antapasis; Chambliss, James; James Russo; Franco, Benhamin; Davis, Joanna S - APHIS; Lara, William (RER); Bello, Joel; vmmilian@gmail.com; Zambella, Joseph; Serrano, Maria (ASD)
Subject:	Miami-area BAC Quarterly Meeting
Attachments:	image001.jpg Agenda_031220.pdf 20200102 BWNCC Framework_022020.pdf Super Bowl 54 Miami BAC.pptx 2019-COVID BioWatch.pptx

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Please find the updated COVID-19 ppt.

Thank you.

Jolie Dobson

Biological Scientist IV
Florida Department of Health in Miami-Dade County

Email: Jolie.Dobson@flhealth.gov <mailto:Jolie.Dobson@flhealth.gov>

Phone: (305) 470-5558

How is my customer service? Please let me know by taking our survey at www.FDOHMDCares.com <http://www.FDOHMDCares.com>

Our Mission is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

Please note: Florida has very broad public records law. Most written communication to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

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Department of Health

NOVEL CORONAVIRUS 2019 (COVID-19)

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Presentation Overview

- COVID-19 outbreak
- Transmission and symptoms
- Prevention
- Treatment and testing
- Travel advisories
- Public health monitoring
- Influenza

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COVID-19 OUTBREAK

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Number of Confirmed Cases

More public health laboratories can test for the virus that causes COVID-19, and they are reporting their results publicly. Because states are reporting publicly directly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting

- **Worldwide**
  - 127,820 confirmed cases
  - 4,717 deaths

  Last updated at 9:38 AM on 3/12/2020; John Hopkins CSSE GIS map
- **U.S**
  - 1,000 positive cases and 70 positive repatriated cases (46 cases from Diamond Princess; 21 cases from Grand Princess; and 3 cases from Wuhan, China)
  - 31 deaths

  Last updated at ~1:55PM on 3/11/2020; CNN
- **Florida**
  - 33 positive cases (26 Florida residents; 5 repatriated; 3 non-Florida resident)
  - 2 deaths

  Last updated 9:40 AM on 3/12/2020; FL DOH



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TRANSMISSION AND SYMPTOMS

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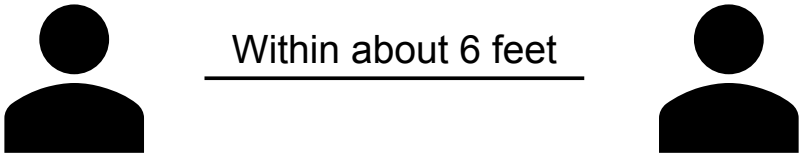
COVID-19 Most Often Spreads from Person to Person

- Spread through respiratory droplets from an infected person who coughs or sneezes
- Spread among close contacts



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Most often, spread from person-to-person happens among close contacts (about 6 feet). Person-to-person spread is thought to occur mainly by respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. It's currently unclear if a person can get 2019-nCoV by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes.

With most respiratory viruses, people are expected to be most contagious while they have symptoms.

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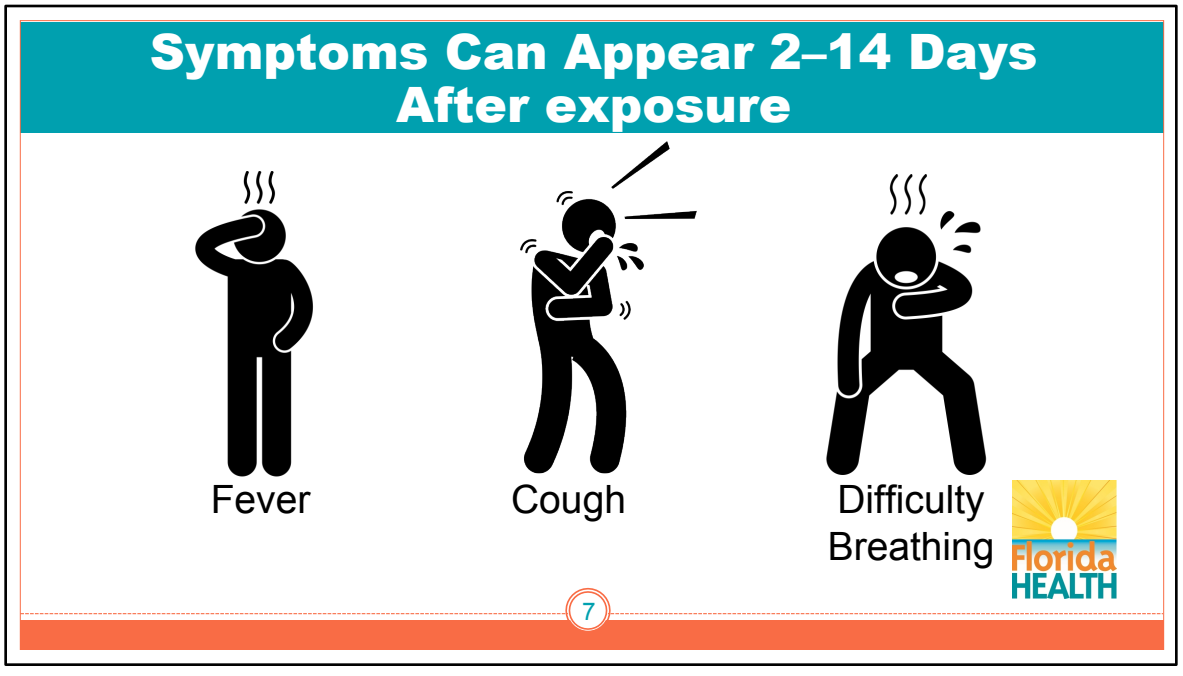

Symptoms may be mild to severe and may appear 2-14 days after exposure.

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PREVENTION

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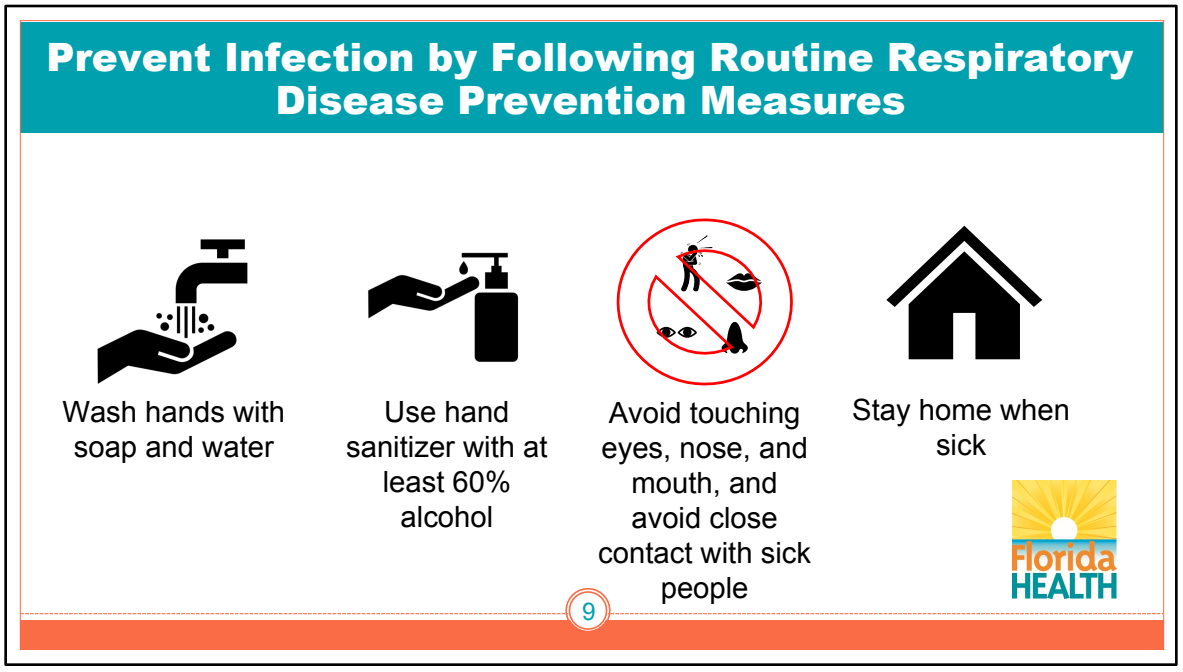

There is currently no vaccine to prevent 2019-nCoV infection. The best way to prevent infection is to avoid being exposed to this virus. CDC & DOH always recommend these actions to help prevent the spread of respiratory viruses, including:

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe

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People at risk and have symptoms of fever, cough or difficulty breathing, please take these steps:

- Call ahead to your health care provider and tell them about your travel or exposure and your symptoms.
- Avoid contact with others.
- Do not travel while sick.
- Cover your mouth and nose when coughing or sneezing.
- Wash hands often with soap and water for at least 20 seconds, especially after coughing, sneezing or blowing your nose.
- If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal.

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Suspected or Confirmed COVID-19 Cases are Asked to Take Precautions

- Immediately isolate at home or health care facility.
- Do not participate public activities such as work or school.
- Only travel by ambulance or private car and avoid public transportation.
- Always wear a mask when around other people or pets at home.
- Always cover your coughs and sneezes and clean your hands often.

www.cdc.gov/coronavirus/index.html

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TREATMENT AND TESTING

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There is No Specific Treatment for COVID-19 at This Time

The CDC recommends people who think they may have been exposed to COVID-19 should call their county health department immediately and self-isolate.

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There is no specific antiviral treatment recommended for 2019-nCoV infection. People infected with 2019-nCoV should receive supportive care to help relieve symptoms. For severe cases, treatment should include care to support vital organ functions.

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Testing

- The CDC developed a test for COVID-19.
- The DOH Bureau of Public Health Laboratories are testing with CDC's test kits.
- Some commercial labs can test for COVID-19

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TRAVEL ADVISORIES

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CDC Travel Advisories

Countries with sustained community or widespread transmission

- China (level 3)
- Iran (level 3)
- South Korea (level 3)
- Italy (level 3)
- Japan (level 2)

https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

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COVID-19 Travel Updates

- It is recommended that travelers from affected areas who are sick delay or avoid travel.
- General recommendations for personal hygiene, cough etiquette and keeping a distance of at least six feet from persons showing symptoms remain particularly important for all travelers.

- **Level 3 travelers**: CDC recommends 14-day self-isolation and social distancing upon return to the United States. Social distancing includes avoiding going out in public and close personal interactions. If you become symptomatic, immediately self-isolate and contact your County Health Department (CHD) or health care provider.
- **Level 2 travelers and cruises**: FL DOH and CDC recommends that travelers should monitor their health and limit interactions with others for 14 days after returning to the United States.

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important for travelers who are sick to delay or avoid travel

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COVID-19 Travel Updates

- **Nile Cruise Advisory**: FL DOH is advising all individuals who traveled on a river cruise on the Nile River in Egypt in February 2020 to self-isolate for 14 days following their date of return to the United States.
- **Port Everglades Advisory:**

  FL DOH recommends:
  - All individuals experiencing symptoms who have recently traveled through Port Everglades to immediately contact their CHD or health care provider and self-isolate for 14 Days
  - Employees of Metro Cruise Services at Port Everglades with any association to the three positive cases self-isolate at home

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PUBLIC HEALTH MONITORING

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DOH is Monitoring those Possibly Exposed

- Personnel at the agency's 67 county health departments (CHDs) and central office in Tallahassee are working together to protect Floridians from emerging diseases.
- DOH receives information from CDC on U.S. citizens/residents/family returning from impacted areas.
- CHDs work with travelers to restrict their movement, monitor for illness, isolate persons with symptoms, and ensure health care providers use proper infection control techniques.

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DOH Monitoring Process

For people who may have been exposed, but do not have symptoms:



- Monitor for symptoms for 14 days.
- Self isolate for 14 days.
  - Stay home as much as possible.
  - Avoid travel on publicly used vehicles, gathering with groups of people, and going out in public.
  - Excluded from work, school, and other public places.
- Follow provided education on prevention of spread.



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Immediate Risk to Americans Remains Low

- More cases in the U.S. are likely to be identified in the coming days.
- There is currently limited person-to-person spread in the community, but this may change.
- Everyone can do their part to prevent the spread of COVID-19 and other respiratory viruses.

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If you have any questions, please contact the Florida Department of Health in Miami-Dade County at

305-470-5660

You can also visit the CDC's website for updates regarding COVID-19
https://www.cdc.gov/coronavirus/COVID-19/index.html

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Any Questions?



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Department of Homeland Security

FOR OFFICIAL USE ONLY

THE ATTACHED MATERIALS CONTAIN DEPARTMENT OF HOMELAND SECURITY INFORMATION THAT IS "FOR OFFICIAL USE ONLY," OR OTHER TYPES OF SENSITIVE BUT UNCLASSIFIED INFORMATION REQUIRING PROTECTION AGAINST UNAUTHORIZED DISCLOSURE. THE ATTACHED MATERIALS WILL BE HANDLED AND SAFEGUARDED IN ACCORDANCE WITH OHS MANAGEMENT DIRECTIVES GOVERNING PROTECTION AND DISSEMINATION OF SUCH INFORMATION.

AT A MINIMUM, THE ATTACHED MATERIALS WILL BE DISSEMINATED ONLY ON A "NEED-TO-KNOW" BASIS AND WHEN UNATTENDED, WILL BE STORED IN A LOCKED CONTAINER OR AREA OFFERING SUFFICIENT PROTECTION AGAINST THEFT, COMPROMISE, INADVERTENT ACCESS AND UNAUTHORIZED DISCLOSURE.

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BioWatch National Conference Call (BWNCC) Framework

PURPOSE

The purpose of the BioWatch National Conference Call (BWNCC) is for information sharing and situational assessment following a BioWatch Actionable Result (BAR) in order to develop a common operating picture. This framework guides that discussion.

FORMAT AND USE

- The items in each section provide an outline for discussion. They should not be regarded as discussion requirements or limitations.
- The BWNCC Framework can be used with one or multiple jurisdictions.
- Throughout the BWNCC Framework, information presented as *(blue, italicized, and in parentheses)* denotes areas where a speaker will provide situation-specific information. If you may be a speaker during the BWNCC, you are encouraged to review the BWNCC Framework section(s) during which you might speak and be prepared to provide situation-specific information.
- The BWNCC Framework includes several questions the BWNCC Facilitator may ask participants. The BWNCC Facilitator may ask additional questions or omit questions based on the scope of the incident.
- For additional information on the content discussed in each BWNCC Framework section, reference the *BioWatch National Conference Call (BWNCC) Framework Overview*, which is available on the BioWatch Toolbox.

SECTION 1. INTRODUCTION

Hello everyone and welcome to this BioWatch National Conference Call. The current time is *(Time Eastern)*. To limit background noise and feedback, please mute your phone now and remember to unmute before you speak.

My name is *(Name)*, I am the *(Title)*, of the BioWatch Program, Countering Weapons of Mass Destruction Office, Department of Homeland Security. I am the facilitator of this call. Information

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FL-DOH-20-0673-A-004811

discussed on this call is sensitive to United States national security. Parties who are not affiliated with this subject matter must leave now.

The BWNCC Facilitator will pause to allow people to leave

The purpose of this call is for information sharing and situational assessment following a BioWatch Actionable Result (BAR) in order to develop a common operating picture. Participants in the BWNCC are federal, state, and local government subject matter experts from a multitude of disciplines and emergency support functions.

This call does not constitute a formal declaration of emergency by the local, state, or federal government nor is it a forum to request federal emergency response resources. However, BioWatch specific resources are available and will be addressed later in this call. The jurisdiction has chosen to *(use/not use)* the decision support tool (DST).

If the jurisdiction is using the DST, the BWNCC Facilitator will ask the jurisdictional coordinator to provide the HSIN link here and ask who will be running the DST.

Please mute your phone now and remember to unmute before you speak.

SECTION 2. ROLL CALL

If more than one BioWatch jurisdiction is participating on the BWNCC, the BWNCC Facilitator will specify the order in which each will present their information.

We will begin the roll call with state and local representatives, including locally deployed federal representatives in the field offices. The Jurisdictional Coordinator will conduct the local roll call and I will follow with the roll call for federal representatives at national headquarters.

Please identify yourself by name and agency. In the interest of time, please identify a single representative to speak on behalf of each agency.

I will now turn it over to the JC.

JURISDICTIONAL ROLL CALL – FACILITATED BY THE JURISDICTIONAL COORDINATOR:

Jurisdictional Coordinator: Roll call for state and local officials, including Federal Partners at Local Field Offices:

- ❒ Public Health (ESF #6 and ESF #8)
- ❒ Emergency Management (ESF #5)
- ❒ Law Enforcement / Intelligence (ESF #13)
- ❒ BioWatch Laboratory

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- ❒ Field Operations
- ❒ Veterinarian (ESF #8 and ESF #11)
- ❒ Hazardous Materials / Environmental Sampling (ESF #10)
- ❒ Public Affairs / External Affairs (ESF #15)
- ❒ FBI Weapons of Mass Destruction (WMD) Coordinators
- ❒ EPA On-Scene Coordinators (OSCs)
- ❒ Military Installation(s)
- ❒ For any other agencies not previously identified representing the jurisdiction - please identify your speaking representatives now.

FEDERAL HEADQUARTERS ROLL CALL – FACILITATED BY THE BWNCC FACILITATOR:

BWNCC Facilitator: We have completed the state and local roll call; I will now conduct the Federal Headquarters roll call.

- ❒ National Operations Center (NOC)
- ❒ BioWatch Program
- ❒ DHS National Biosurveillance Integration Center (NBIC)
- ❒ DHS Intelligence and Analysis (I&A)
- ❒ DHS Public Affairs
- ❒ CWMD Public Affairs
- ❒ HHS / Assistant Secretary for Preparedness and Response (ASPR)
- ❒ HHS / Centers for Disease Control and Prevention (CDC)
- ❒ EPA Office of Emergency Management (OEM)
- ❒ FBI WMD Directorate (Operations Response Unit and Biological Countermeasures Unit)
- ❒ Department of Defense (DoD) Office of the Secretary of Defense / USNORTHCOM
- ❒ For any other agencies not previously identify - please identify your speaking representatives now

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SECTION 3. JURISDICTIONAL BRIEF

If applicable, the BWNCC Facilitator should share information on any recent BARs for the same agent and any other critical information that will help BWNCC participants develop a common operating picture.

Thank you everyone. We are here today to discuss a BAR declared by the *(Jurisdiction)* jurisdiction. There *(was/were) (Number of collectors)* collector(s) that tested positive for *(Agent)*. *(Number)* positive collector(s) are located at outdoor site(s) and *(Number)* positive collectors are located at indoor sites. *(Jurisdiction)* has had *(Number)* previous BARs for *(Agent[s])* in *(Year[s])*. The most recent BAR was for *(Agent)* in *(Year)*.

3.1: LABORATORY SUMMARY

We will now discuss key findings regarding laboratory and field data. *If the DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction if there are any Laboratory Operations resources (BAR Data Form, Laboratory Results Summary Sheet etc.) available on HSIN.*

It is our understanding that a Technical Laboratory Consultation Call *(did/did not)* occur. Is that correct?

- ❒ What is the range for the Ct values detected?
- ❒ Has the laboratory processed any other samples (i.e., QA samples) in the past week in which this agent was tested for or results were generated for?
- ❒ Did any work with *(Agent)* recently occur in the laboratory space where BioWatch samples are processed?
- ❒ Did any other collector filters under analysis generate reactive results not meeting the algorithm in the screening or verification panels for *(Agent)*?

3.2 FIELD SUMMARY

The *(Jurisdiction)*'s array consists of *(Number)* of collectors with *(Number)* outdoor collectors and *(Number)* indoor collectors. Is that correct? *If DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction if there are any Field Operations resources available (maps, etc.) on HSIN.*

- ❒ What was the sampling period for the collector(s) that reported the BAR?
- ❒ Can you briefly describe approximately where each collector that tested positive is located and provide us with a general understanding of the area?
- ❒ Did your team report any unusual activity around these collector(s)?

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- ❒ Did the collector(s) have any mechanical problems that may have compromised sampling capacity?
- ❒ What were the weather conditions during the sampling period?
- ❒ What are the weather conditions today?
- ❒ Do you have any other relevant environmental information to share?
- ❒ Are there any questions or comments from the jurisdictional or federal partners regarding this information?

3.3: LAW ENFORCEMENT AND INTELLIGENCE SUMMARY

LOCAL LAW ENFORCEMENT AND INTELLIGENCE

We will now discuss key local law enforcement findings and intelligence findings. *If DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction if there are any Law Enforcement resources available on HSIN.*

- ❒ Are you aware of any credible threats to the jurisdiction or intelligence about potential threats?
- ❒ Have there been any recent applicable criminal or suspicious activities near or relevant to the area in question that you are free to discuss?
- ❒ Have there been any special events, large gatherings, VIP visits, etc.?
- ❒ Does the local Fusion Center have anything to add?
- ❒ Does the Local FBI WMD Coordinator have anything to add?
- ❒ Any other items for discussion?

FEDERAL LAW ENFORCEMENT AND INTELLIGENCE

We will now discuss key law enforcement and intelligence findings from federal representatives.

- ❒ Does FBI HQ have anything to add about their threat credibility evaluation at this stage?
- ❒ Does DHS Intelligence and Analysis have any information to share?
- ❒ Does the DHS National Operations Center have any information to share?
- ❒ Are there any questions or additional comments from the jurisdictional or federal partners regarding the law enforcement and intelligence information provided?

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LAW ENFORCEMENT ASSESSMENT

Based on the available information:

- ❒ Do current conditions warrant a law enforcement investigation for the possibility of an intentional release?

  If Yes:

  - ❒ Has the jurisdiction already begun a law enforcement investigation? What current steps are being taken?
  - ❒ Do any other state, local, and federal participants have additional perspectives to add?

3.4: PUBLIC HEALTH SUMMARY

LOCAL HUMAN AND ANIMAL HEALTH – FACILITATED BY THE JC

We will now discuss key human and animal health surveillance data from local representatives. I will turn this portion over to the JC. *If DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction to describe any public health resources available on HSIN.*

- ❒ Has there been any recent *human* health surveillance data that could be related to the disease caused by (*Agent*)?
- ❒ Has there been any recent *animal* health surveillance data that could be related to the disease caused by (*Agent*)?
- ❒ Is there any other relevant public health information for discussion?

FEDERAL HUMAN AND ANIMAL HEALTH

We will now discuss key findings from the federal representatives regarding human and animal health surveillance data.

- ❒ Does HHS/CDC have anything to add?
- ❒ Does HHS/ASPR have anything to add?
- ❒ Does the DHS NBIC have anything to add?

QUESTIONS AND OTHER INFORMATION

- ❒ Is there any other agency on the call with public health information to share?

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- ❒ Are there any questions or additional comments from the jurisdictional or federal partners regarding the public health and veterinary surveillance data provided?

PUBLIC HEALTH ASSESSMENT

Based on the public health information available:

- ❒ Does a public health risk exist based on this BWNCC discussion?

  If Yes:

  - ❒ Has the jurisdiction already taken public health response actions?

    If Yes: What current actions are being taken?

- ❒ Do the circumstances of the incident warrant a public health investigation?

  If Yes:

  - ❒ Has the jurisdiction already begun a public health investigation?

    If Yes:

    - ❒ What current actions are being taken?
    - ❒ Do the circumstances of the incident warrant additional public health response beyond an investigation?

SECTION 4. JURISDICTIONAL NEXT STEPS

The questions in this section are open for group discussion. If BWNCC participants are not sharing feedback to the questions, the BWNCC Facilitator may have to call on agencies/individuals.

IF THERE IS **NO** PUBLIC HEALTH OR LAW ENFORCEMENT THREAT/INVESTIGATION

We will now discuss the jurisdiction's next steps based on the assessment of the situation. Please note that it may be deemed appropriate to take no further action in response to this BAR.

- ❒ Given the current situational assessment, will the jurisdiction take any additional actions that we have not yet discussed?

  If Yes:

  - ❒ What actions will be taken?

IF THERE **IS** A PUBLIC HEATH OR LAW ENFORCEMENT THREAT/INVESTIGATION

We will now discuss the jurisdiction's next steps. These may include emergency management operations, risk communication activities, public health operations, and briefings to elected officials. Conversely, it may be deemed appropriate to take no further action in response to this

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BAR. Given the current situational assessment, (*JC/Jurisdiction Facilitator*) please highlight your jurisdiction's next steps.

The BWNCC Facilitator may prompt discussion if no actions are identified. Some actions the jurisdiction may decide to take include the following:

- *No action*
- *BioWatch-specific actions*
  - *Change filter retrieval frequencies*
  - *Modify the collector array (e.g., additional collectors)*
  - *Activate Phase I/II sampling*
- *Emergency Management Operations*
  - *Transition to response framework to include emergency declaration*
  - *Requests for Federal assistance (e.g., expecting to request Federal assistance, in the process of requesting federal assistance, etc.)*
  - *Activate and staff local Emergency Operations Center*
- *Risk Communication Activities*
  - *Risk Communication Conference Call*
  - *Media and/or public inquiries*
  - *Press releases*
- *Public Health Operations*
  - *Enhanced passive surveillance*
  - *Active surveillance*
  - *Continued syndromic surveillance*
  - *Joint public health/law enforcement investigation of agent-related disease*
  - *Strategic National Stockpile (SNS) action (e.g., considering/requested SNS)*
  - *Points of Distribution (PODs) actions (e.g., considering/activated PODs)*
- *Communications with elected officials*
  - *Briefings made or planned to be made to elected political leadership*

SECTION 5. REQUEST FOR RESOURCES

Given the situational assessment, does the jurisdiction wish to receive or continue to receive the following BioWatch Program-managed resources?

- ❒ Rapidly Deployable Laboratory (RDL) (or elements of) consumables, reagents, or surge laboratory staff
- ❒ Environmental sampling supplies
- ❒ DHS/CWMD Public Affairs risk communication / messaging support

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If resources are requested:

The BioWatch Program will coordinate the delivery of the BioWatch resources as well as any on-site control or access issues through the Jurisdictional Coordinator following this conference call.

SECTION 6. FEDERAL AGENCY ACTIONS

We will now highlight next steps from our federal agencies. I will call you by agency for your response.

Federal Agencies (*BWNCC Facilitator will call on participating components, directorates and offices based on the roll call*)**:**

- ❒ DHS NBIC
- ❒ DHS I&A
- ❒ DHS Public Affairs
- ❒ CWMD Public Affairs
- ❒ HHS / ASPR
- ❒ HHS / CDC
- ❒ EPA
- ❒ FBI WMD Directorate
- ❒ Department of Defense (DoD) / USNORTHCOM
- ❒ Others – Do any other federal representatives on the call have next steps to report?

SECTION 7. CLOSING THE CALL

Are there any additional comments at this time before we close this conference call?

Is there need for another BWNCC? *If DST was used, the BWNCC Facilitator will ask if it will be used again on any subsequent BWNCCs.*

If Needed: The date and time for the next BioWatch National Conference Call will be at: *(Date/Time)* and the phone number is 1-855-852-7677; the access code is 498-9534.

Thank you everyone for your contributions to this BioWatch National Conference Call. The time is now (*Time Eastern*) and this call is adjourned.

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Miami-area BioWatch Advisory Committee Meeting - Agenda

Date: March 12, 2020
Time: 10:00 AM - 12:00 PM
Location: MICC Building - 3rd Floor
8175 NW 12 Street
Miami, FL 33126

10:00 AM	**Welcome & Announcements** ☐ **Sign-in**	Álvaro Mejia-Echeverry
	New Business	
10:05 AM	☐ Call-down chart review	All
10:10 AM	☐ COVID-19 Overview	Vanessa Villamil
10:20 AM	☐ Updated BWNCC Agenda/Script - January 2020	Álvaro Mejia-Echeverry/ Ron Burger
	Old Business	
10:30 AM	☐ Super Bowl LIV SEM	Ron Burger
10:45 AM	☐ Super Bowl LIV Hot Wash	"
11:00 AM ***(Please keep updates to 2 minutes per program)***	**Updates** - RDSTF - Field (RER/DERM) - Laboratory (Miami LRN) - Public Health (Preparedness, Epidemiology, Communications, Training) - Law Enforcement (FBI, Local PD) - HazMat (MDFR, City of Miami, City of Hialeah) Emergency Management - Broward BAC (Broward Liaison) - Other Jurisdictions/BioWatch Program Office	All
12:00 PM	**Meeting Adjourned** **Next Scheduled Quarterly Meeting:** **June 18, 2020**	Álvaro Mejia-Echeverry

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Super Bowl 54
Miami and BioWatch

January 25-February 2, 2020



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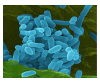
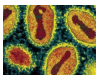
The BioWatch Target Organisms



Biological Agent	Disease
Bacillus anthracis	**Anthrax**
Francisella tularensis	**Tularemia**
Yersinia pestis	**Plague**
Burkholderia mallei/ B. pseudomallei	**Glanders/Melioidosis**
Variola virus	**Smallpox**

FOUO

[THIS SLIDE IS FOUO]

Talking Points

- The BioWatch program currently monitors the air for the 5 biological agents: *Bacillus anthracis, Francisella tularensis, Yersinia pestis, Burkholderia* species and Variola virus.
- As shown, this list includes some agents that are rarely seen or have been eradicated in the United States as well as some agents that exist naturally in our environment.
- Four of the BioWatch agents are Category A agents. These are: *B. anthracis*, *Y. pestis*, *F. tularensis*, and Variola virus.
- According to the CDC, Category A bioterrorism agents pose a risk to national security because they: Can be easily disseminated or transmitted from person to person, result in high death rates and have the potential for major public health impact, might cause public panic and social disruption and require special action for public health preparedness.
- The BioWatch agents categorized as Category B agents, the second highest priority agents, are the *Burkholderia* species *Burkholderia mallei* and *B. pseudomallei*. These agents are moderately easy to disseminate, result in moderate death rates and low illness and injury rates.

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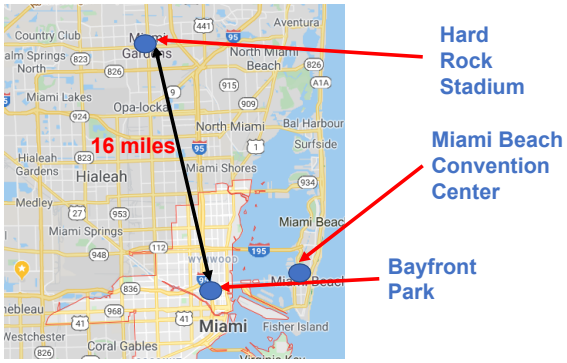
Venues for BioWatch Deployment

- **Miami Beach Convention Center:** NFL Experience
- **Bayfront Park:** Super Bowl Live
- **Hard Rock Stadium:** Game



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Laboratory and Field Support

- **Florida Department of Health; Bureau of Public Health Laboratories: Miami**

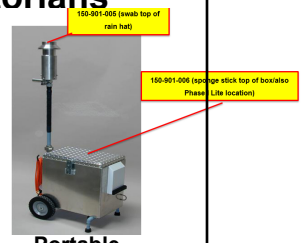




- **Miami-Dade Regulatory and Economic Resources; Environmental Section**

- **Miami BioWatch Lab Team = 5 laboratorians**
- **Surge support from PAE/Atek = 6 laboratorians**

- **Field Staff from DHS For Filter Retrieval**



Portable Sampling Unit

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Modeling for Number of PSUs

- Los Alamos National Laboratory
- Outside area for Hard Rock, Bayfront Park and Miami Beach Convention Center
- Probability of Detection (P_d) vs Fraction of Population (F_p)





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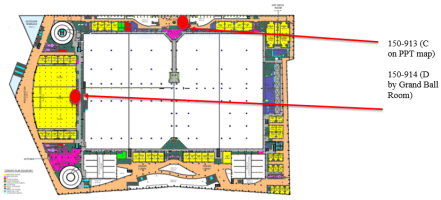
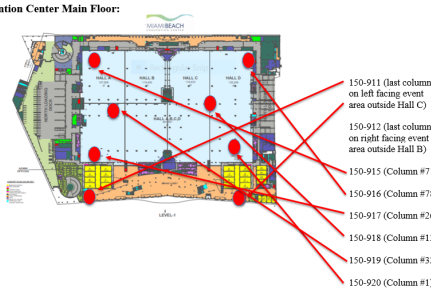
PSU Deployment

- **Miami Beach Convention Center: 10 indoor; 10 outdoor**

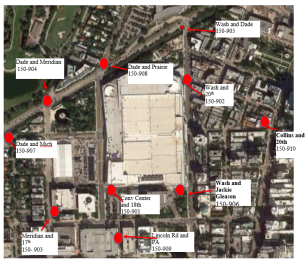
Convention Center Second Floor Ballrooms:



Convention Center Main Floor:



Miami Beach Convention Center





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PSU Deployment

- **Bayfront Park: 3 inside; 5 outside**



Bayfront Park Area:



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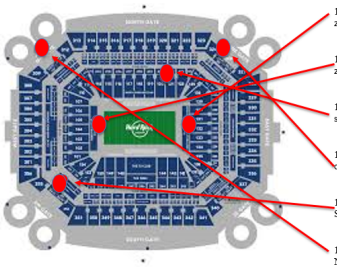
PSU Deployment

- **Hard Rock Stadium: 6 inside; 16 outside**

Hard Rock Stadium Inside:



150-928 (East end zone event level)

150-929 (West end zone event level)

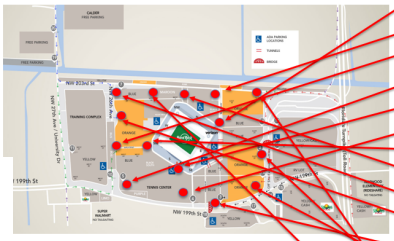
150-930 (100 level by seats 119-118)

150-931 (300 level NE corner)

150-932 (300 level SW corner)

150-933 (300 level NW corner)

Hard Rock Stadium Outside:



150-934 (NE gate planter)

150-935 (near helipad)

150-936 (near Gate 5 & 6 off Carl Barger Blvd)

150-937 (tennis courts near Gate 5)

150-938 (tennis courts SE)

150-939 (tennis courts SW)

150-940 (SW Gate; planter)

150-941 (Media entry)

150-942 (Staff, golf cart entry NW)

150-943 (at Gate 6)

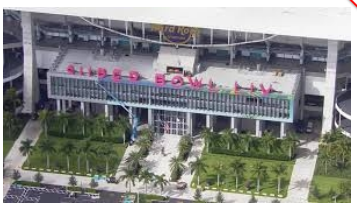
150-944 (Near main entrance C)

150-945 (SE parking Shula Dr area)

150-946 (B Entry)

150-947 (NE corner parking lot NFL compound)

150-948 (between 941 and 942)



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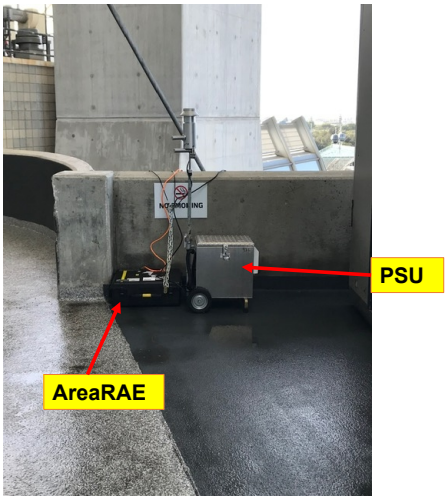
EPA's Chemical/Rad Detection Co-Located with 17 PSUs

- AreaRAE Portable Detection System
- Real Time
- Photoionization Detector (PID)
- Tests for:
  - Volatile Organic Compounds (VOCs)
  - Other gases
  - Gamma radiation



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Schedule for Filter Exchange

- **Convention Center and Bayfront Park:** activated January 24 twice a day to February 1 then once on Game Day February 2
- **Pickup Times/Results**
  - 0630 and 1800 hours
  - Lab results mostly 1500 and 0300 hours
- **Hard Rock Stadium:** activated January 30 once on January 31; twice a day February 1 and Game Day February 2; final retrieval was post game about 2300 hours

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Number of Filters Tested Per Day

- Including Network of 30 PSUs
  - Jan 25: 86
  - Jan 26: 86
  - Jan 27: 86
  - Jan 28: 86
  - Jan 29: 86
  - Jan 30: 86
  - Jan 31: 108
  - Feb 01: 130
  - Feb 02: 102



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Getting Power: Even in Sun Drenched Miami, Solar Power is Out





- Traffic Control Signal Boxes
- Outlets Available on Street
- Portable Outlets in the Park



NFL and COVID-19

- Query from NFL Sports Medical Group Lead, Saturday February 1st
- PUI at a local Hollywood hospital
- Follow up: NFL Security and others obtained from social media trolling
- See Pembroke Pines Police Department's Media Release

No Image

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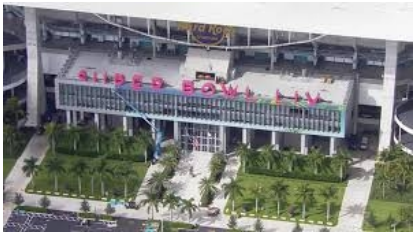
20











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Now onto TAMPA: 2021 Super Bowl 55







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From:	Dobson, Jolie T
To:	Burger, Ron; Cicerrella, Richard; Connor, Olga; Cyrille, Charles; Davis, Joanna; Disbrow, Scott; Jeanne Eckes-Roper; Elmir, Samir; Erase, Romualde X; Franco, Benjamin; Frost, Matthew; Garcia, Maikel; Gomez, Tatiana ; Hernandez, Richard; Horner, Alicia; Jean, Reynald; Kelly Keys; Lara, William; Lewandowski, Patty A; Loo, Georgina; Lopez, Jose M; Mejia-Echeverry, Alvaro; Milian, Victor ; Nunez, R. Jaime; Presmanes, Cristina; Quaye, Elesi A; Rafky, Brian; Schmitz, Ann; Senyshyn, William; Serrano, Maria; Steele, Michelle; Sudden, Terri M; Toñanez, Alvaro Lt.; Trim, Anthony Capt.; Vaughn, Freda G; Villalta, Yesenia D; White, Stephen L; Chao Morales, Christina A; Castillo, Klelia S; Celorio, Oscar; Villamil, Vanessa
Cc:	Suarez, Ana; Pognon, Monica; Jaime Hernandez; jzambella@icerif.com; John Antapasis; Chambliss, James; James Russo; Franco, Benhamin; Davis, Joanna S - APHIS; Lara, William (RER); Bello, Joel; vmmilian@gmail.com; Zambella, Joseph; Serrano, Maria (ASD)
Subject:	Miami-area BAC Quarterly Meeting
Attachments:	image001.jpg Agenda_031220.pdf 2019-COVID BioWatch.pptx 20200102 BWNCC Framework_022020.pdf Super Bowl 54 Miami BAC.pptx

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Hello,

Please see attached agenda and documents which will be discussed in tomorrow's meeting. We anticipate that this meeting will end earlier than 12pm.

See you tomorrow!

Jolie Dobson

Biological Scientist IV
Florida Department of Health in Miami-Dade County

Email: Jolie.Dobson@flhealth.gov <mailto:Jolie.Dobson@flhealth.gov>

Phone: (305) 470-5558

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Department of Health

NOVEL CORONAVIRUS 2019 (COVID-19)



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Presentation Overview

- COVID-19 outbreak
- Transmission and symptoms
- Prevention
- Treatment and testing
- Travel advisories
- Public health monitoring
- Influenza



2

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COVID-19 OUTBREAK

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Number of Confirmed Cases as of 4:30PM on March 10, 2020

More public health laboratories can test for the virus that causes COVID-19, and they are reporting their results publicly. Because states are reporting publicly directly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting

- **Worldwide**
  - 121,564 confirmed cases
  - 4,373 deaths

  Last updated at 1:55 PM on 3/11/2020; John Hopkins CSSE GIS map
- **U.S**
  - 1,000 positive cases and 70 positive repatriated cases (46 cases from Diamond Princess; 21 cases from Grand Princess; and 3 cases from Wuhan, China)
  - 31 deaths

  Last updated at ~1:55PM on 3/11/2020; CNN
- **Florida**
  - 28 positive cases (21 Florida residents; 5 repatriated; 2 non-Florida resident)
  - 2 deaths

  Last updated 2:00 PM on 3/11/2020; FL DOH

Florida HEALTH

4

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TRANSMISSION AND SYMPTOMS

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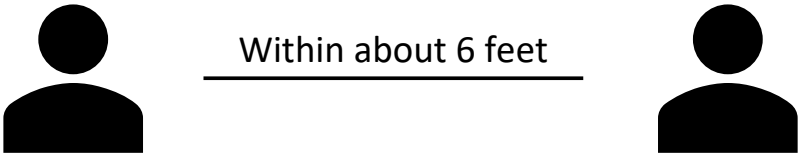
COVID-19 Most Often Spreads from Person to Person

- Spread through respiratory droplets from an infected person who coughs or sneezes
- Spread among close contacts



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Most often, spread from person-to-person happens among close contacts (about 6 feet). Person-to-person spread is thought to occur mainly by respiratory droplets produced when an infected person coughs or sneezes, similar to how influenza and other respiratory pathogens spread. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. It's currently unclear if a person can get 2019-nCoV by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes.

With most respiratory viruses, people are expected to be most contagious while they have symptoms.

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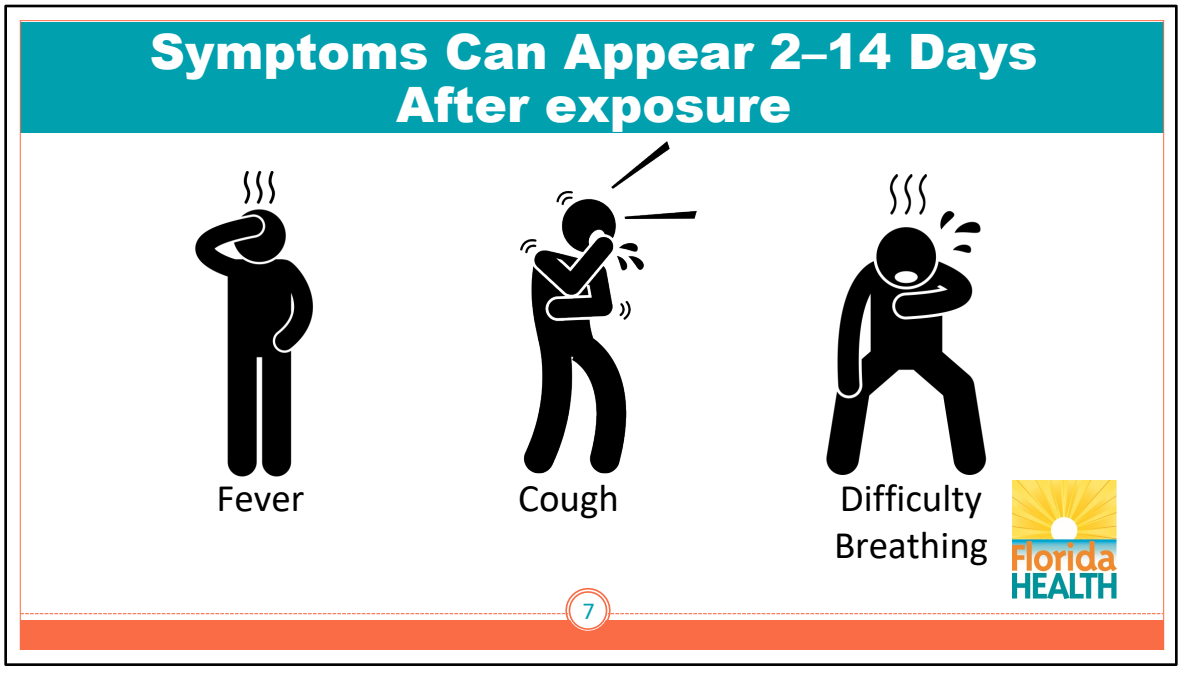

Symptoms may be mild to severe and may appear 2-14 days after exposure.

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PREVENTION

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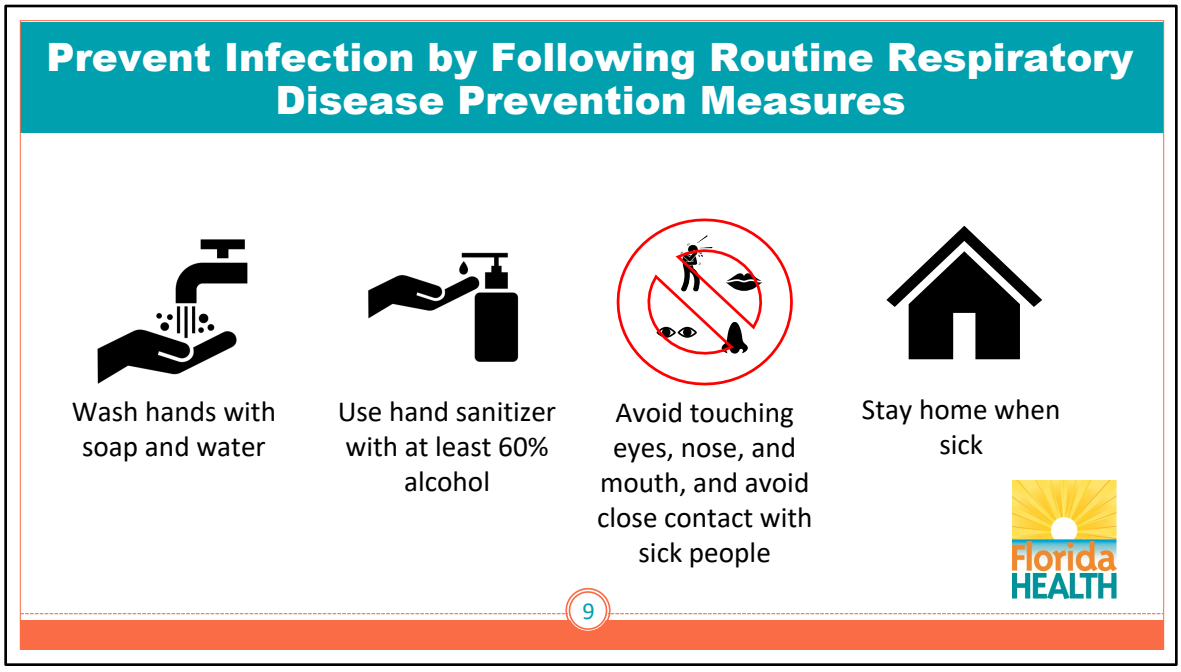

There is currently no vaccine to prevent 2019-nCoV infection. The best way to prevent infection is to avoid being exposed to this virus. CDC & DOH always recommend these actions to help prevent the spread of respiratory viruses, including:

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe

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People at risk and have symptoms of fever, cough or difficulty breathing, please take these steps:

- Call ahead to your health care provider and tell them about your travel or exposure and your symptoms.
- Avoid contact with others.
- Do not travel while sick.
- Cover your mouth and nose when coughing or sneezing.
- Wash hands often with soap and water for at least 20 seconds, especially after coughing, sneezing or blowing your nose.
- A medical mask is not required if exhibiting no symptoms
  - If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal.

Florida HEALTH

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Suspected or Confirmed COVID-19 Cases are Asked to Take Precautions

- Immediately isolate at home or health care facility.
- Do not participate public activities such as work or school.
- Only travel by ambulance or private car and avoid public transportation.
- Always wear a mask when around other people or pets at home.
- Always cover your coughs and sneezes and clean your hands often.

www.cdc.gov/coronavirus/index.html

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TREATMENT AND TESTING

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There is No Specific Treatment for COVID-19 at This Time

The CDC recommends people who think they may have been exposed to COVID-19 should call their county health department immediately and self-isolate.



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There is no specific antiviral treatment recommended for 2019-nCoV infection. People infected with 2019-nCoV should receive supportive care to help relieve symptoms. For severe cases, treatment should include care to support vital organ functions.

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Testing is Only Available through Public Health Currently

- The CDC developed a test for COVID-19.
- The DOH Bureau of Public Health Laboratories are testing with CDC's test kits.
- Some commercial labs can test for COVID-19

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TRAVEL ADVISORIES

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COVID-19 Travel Updates

- It is recommended that older adults and those who have chronic medical conditions consider postponing travel to places with sustained community transmission.
- General recommendations for personal hygiene, cough etiquette and keeping a distance of at least six feet from persons showing symptoms remain particularly important for all travelers.
- Level 3 travelers: FL DOH recommends travelers to self-isolation for 14 days and practice social distancing upon return to the United States.
- Level 2 travelers and cruises: FL DOH recommends that travelers should monitor their health and limit interactions with others for 14 days after returning to the United States.
- Nile Cruise Advisory: FL DOH is advising all individuals who traveled on a river cruise on the Nile River in Egypt in February 2020 to self-isolate for 14 days following their date of return to the United States.

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important for travelers who are sick to delay or avoid travel or if travelers are immunocompromised avoid travel to affected areas

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CDC Travel Advisories

To countries with sustained community or wide spread transmission.

As of March 2, 2020:

- China
- Iran
- South Korea
- Italy
- Japan

https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html



Please monitor the CDC's website for updated travel advisories

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PUBLIC HEALTH MONITORING

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DOH is Monitoring those Possibly Exposed

- Personnel at the agency's 67 county health departments (CHDs) and central office in Tallahassee are working together to protect Floridians from emerging diseases.
- DOH receives information from CDC on U.S. citizens/residents/family returning from impacted areas.
- CHDs work with travelers to restrict their movement, monitor for illness, isolate persons with symptoms, and ensure health care providers use proper infection control techniques.

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DOH Monitoring Process

For people who may have been exposed, but do not have symptoms:



- Monitor for symptoms for 14 days.
- Self isolate for 14 days.
  - Stay home as much as possible.
  - Avoid travel on publicly used vehicles, gathering with groups of people, and going out in public.
  - Excluded from work, school, and other public places.
- Follow provided education on prevention of spread.



Florida HEALTH

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Immediate Risk to Americans Remains Low

- More cases in the U.S. are likely to be identified in the coming days.
- There is currently limited person-to-person spread in the community, but this may change.
- Everyone can do their part to prevent the spread of COVID-19 and other respiratory viruses.

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If you have any questions, please contact the
Florida Department of Health in Miami-Dade County
at

305-470-5660

You can also visit the CDC's website for
updates regarding COVID-19
https://www.cdc.gov/coronavirus/COVID-19/index.html

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Any Questions?



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Department of Homeland Security

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THE ATTACHED MATERIALS CONTAIN DEPARTMENT OF HOMELAND SECURITY INFORMATION THAT IS "FOR OFFICIAL USE ONLY," OR OTHER TYPES OF SENSITIVE BUT UNCLASSIFIED INFORMATION REQUIRING PROTECTION AGAINST UNAUTHORIZED DISCLOSURE. THE ATTACHED MATERIALS WILL BE HANDLED AND SAFEGUARDED IN ACCORDANCE WITH OHS MANAGEMENT DIRECTIVES GOVERNING PROTECTION AND DISSEMINATION OF SUCH INFORMATION.

AT A MINIMUM, THE ATTACHED MATERIALS WILL BE DISSEMINATED ONLY ON A "NEED-TO-KNOW" BASIS AND WHEN UNATTENDED, WILL BE STORED IN A LOCKED CONTAINER OR AREA OFFERING SUFFICIENT PROTECTION AGAINST THEFT, COMPROMISE, INADVERTENT ACCESS AND UNAUTHORIZED DISCLOSURE.

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BioWatch National Conference Call (BWNCC) Framework

PURPOSE

The purpose of the BioWatch National Conference Call (BWNCC) is for information sharing and situational assessment following a BioWatch Actionable Result (BAR) in order to develop a common operating picture. This framework guides that discussion.

FORMAT AND USE

- The items in each section provide an outline for discussion. They should not be regarded as discussion requirements or limitations.
- The BWNCC Framework can be used with one or multiple jurisdictions.
- Throughout the BWNCC Framework, information presented as *(blue, italicized, and in parentheses)* denotes areas where a speaker will provide situation-specific information. If you may be a speaker during the BWNCC, you are encouraged to review the BWNCC Framework section(s) during which you might speak and be prepared to provide situation-specific information.
- The BWNCC Framework includes several questions the BWNCC Facilitator may ask participants. The BWNCC Facilitator may ask additional questions or omit questions based on the scope of the incident.
- For additional information on the content discussed in each BWNCC Framework section, reference the *BioWatch National Conference Call (BWNCC) Framework Overview*, which is available on the BioWatch Toolbox.

SECTION 1. INTRODUCTION

Hello everyone and welcome to this BioWatch National Conference Call. The current time is *(Time Eastern)*. To limit background noise and feedback, please mute your phone now and remember to unmute before you speak.

My name is *(Name)*, I am the *(Title)*, of the BioWatch Program, Countering Weapons of Mass Destruction Office, Department of Homeland Security. I am the facilitator of this call. Information

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discussed on this call is sensitive to United States national security. Parties who are not affiliated with this subject matter must leave now.

The BWNCC Facilitator will pause to allow people to leave

The purpose of this call is for information sharing and situational assessment following a BioWatch Actionable Result (BAR) in order to develop a common operating picture. Participants in the BWNCC are federal, state, and local government subject matter experts from a multitude of disciplines and emergency support functions.

This call does not constitute a formal declaration of emergency by the local, state, or federal government nor is it a forum to request federal emergency response resources. However, BioWatch specific resources are available and will be addressed later in this call. The jurisdiction has chosen to *(use/not use)* the decision support tool (DST).

If the jurisdiction is using the DST, the BWNCC Facilitator will ask the jurisdictional coordinator to provide the HSIN link here and ask who will be running the DST.

Please mute your phone now and remember to unmute before you speak.

SECTION 2. ROLL CALL

If more than one BioWatch jurisdiction is participating on the BWNCC, the BWNCC Facilitator will specify the order in which each will present their information.

We will begin the roll call with state and local representatives, including locally deployed federal representatives in the field offices. The Jurisdictional Coordinator will conduct the local roll call and I will follow with the roll call for federal representatives at national headquarters.

Please identify yourself by name and agency. In the interest of time, please identify a single representative to speak on behalf of each agency.

I will now turn it over to the JC.

JURISDICTIONAL ROLL CALL – FACILITATED BY THE JURISDICTIONAL COORDINATOR:

Jurisdictional Coordinator: Roll call for state and local officials, including Federal Partners at Local Field Offices:

- ❒ Public Health (ESF #6 and ESF #8)
- ❒ Emergency Management (ESF #5)
- ❒ Law Enforcement / Intelligence (ESF #13)
- ❒ BioWatch Laboratory

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- ❒ Field Operations
- ❒ Veterinarian (ESF #8 and ESF #11)
- ❒ Hazardous Materials / Environmental Sampling (ESF #10)
- ❒ Public Affairs / External Affairs (ESF #15)
- ❒ FBI Weapons of Mass Destruction (WMD) Coordinators
- ❒ EPA On-Scene Coordinators (OSCs)
- ❒ Military Installation(s)
- ❒ For any other agencies not previously identified representing the jurisdiction - please identify your speaking representatives now.

FEDERAL HEADQUARTERS ROLL CALL – FACILITATED BY THE BWNCC FACILITATOR:

BWNCC Facilitator: We have completed the state and local roll call; I will now conduct the Federal Headquarters roll call.

- ❒ National Operations Center (NOC)
- ❒ BioWatch Program
- ❒ DHS National Biosurveillance Integration Center (NBIC)
- ❒ DHS Intelligence and Analysis (I&A)
- ❒ DHS Public Affairs
- ❒ CWMD Public Affairs
- ❒ HHS / Assistant Secretary for Preparedness and Response (ASPR)
- ❒ HHS / Centers for Disease Control and Prevention (CDC)
- ❒ EPA Office of Emergency Management (OEM)
- ❒ FBI WMD Directorate (Operations Response Unit and Biological Countermeasures Unit)
- ❒ Department of Defense (DoD) Office of the Secretary of Defense / USNORTHCOM
- ❒ For any other agencies not previously identify - please identify your speaking representatives now

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SECTION 3. JURISDICTIONAL BRIEF

If applicable, the BWNCC Facilitator should share information on any recent BARs for the same agent and any other critical information that will help BWNCC participants develop a common operating picture.

Thank you everyone. We are here today to discuss a BAR declared by the *(Jurisdiction)* jurisdiction. There *(was/were) (Number of collectors)* collector(s) that tested positive for *(Agent)*. *(Number)* positive collector(s) are located at outdoor site(s) and *(Number)* positive collectors are located at indoor sites. *(Jurisdiction)* has had *(Number)* previous BARs for *(Agent[s])* in *(Year[s])*. The most recent BAR was for *(Agent)* in *(Year)*.

3.1: LABORATORY SUMMARY

We will now discuss key findings regarding laboratory and field data. *If the DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction if there are any Laboratory Operations resources (BAR Data Form, Laboratory Results Summary Sheet etc.) available on HSIN.*

It is our understanding that a Technical Laboratory Consultation Call *(did/did not)* occur. Is that correct?

- ❒ What is the range for the Ct values detected?
- ❒ Has the laboratory processed any other samples (i.e., QA samples) in the past week in which this agent was tested for or results were generated for?
- ❒ Did any work with *(Agent)* recently occur in the laboratory space where BioWatch samples are processed?
- ❒ Did any other collector filters under analysis generate reactive results not meeting the algorithm in the screening or verification panels for *(Agent)*?

3.2 FIELD SUMMARY

The *(Jurisdiction)*'s array consists of *(Number)* of collectors with *(Number)* outdoor collectors and *(Number)* indoor collectors. Is that correct? *If DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction if there are any Field Operations resources available (maps, etc.) on HSIN.*

- ❒ What was the sampling period for the collector(s) that reported the BAR?
- ❒ Can you briefly describe approximately where each collector that tested positive is located and provide us with a general understanding of the area?
- ❒ Did your team report any unusual activity around these collector(s)?

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- ❒ Did the collector(s) have any mechanical problems that may have compromised sampling capacity?
- ❒ What were the weather conditions during the sampling period?
- ❒ What are the weather conditions today?
- ❒ Do you have any other relevant environmental information to share?
- ❒ Are there any questions or comments from the jurisdictional or federal partners regarding this information?

3.3: LAW ENFORCEMENT AND INTELLIGENCE SUMMARY

LOCAL LAW ENFORCEMENT AND INTELLIGENCE

We will now discuss key local law enforcement findings and intelligence findings. *If DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction if there are any Law Enforcement resources available on HSIN.*

- ❒ Are you aware of any credible threats to the jurisdiction or intelligence about potential threats?
- ❒ Have there been any recent applicable criminal or suspicious activities near or relevant to the area in question that you are free to discuss?
- ❒ Have there been any special events, large gatherings, VIP visits, etc.?
- ❒ Does the local Fusion Center have anything to add?
- ❒ Does the Local FBI WMD Coordinator have anything to add?
- ❒ Any other items for discussion?

FEDERAL LAW ENFORCEMENT AND INTELLIGENCE

We will now discuss key law enforcement and intelligence findings from federal representatives.

- ❒ Does FBI HQ have anything to add about their threat credibility evaluation at this stage?
- ❒ Does DHS Intelligence and Analysis have any information to share?
- ❒ Does the DHS National Operations Center have any information to share?
- ❒ Are there any questions or additional comments from the jurisdictional or federal partners regarding the law enforcement and intelligence information provided?

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LAW ENFORCEMENT ASSESSMENT

Based on the available information:

- ❒ Do current conditions warrant a law enforcement investigation for the possibility of an intentional release?

  If Yes:

  - ❒ Has the jurisdiction already begun a law enforcement investigation? What current steps are being taken?
  - ❒ Do any other state, local, and federal participants have additional perspectives to add?

3.4: PUBLIC HEALTH SUMMARY

LOCAL HUMAN AND ANIMAL HEALTH – FACILITATED BY THE JC

We will now discuss key human and animal health surveillance data from local representatives. I will turn this portion over to the JC. *If DST is being used, the BWNCC Facilitator will ask the JC/jurisdiction to describe any public health resources available on HSIN.*

- ❒ Has there been any recent *human* health surveillance data that could be related to the disease caused by (*Agent*)?
- ❒ Has there been any recent *animal* health surveillance data that could be related to the disease caused by (*Agent*)?
- ❒ Is there any other relevant public health information for discussion?

FEDERAL HUMAN AND ANIMAL HEALTH

We will now discuss key findings from the federal representatives regarding human and animal health surveillance data.

- ❒ Does HHS/CDC have anything to add?
- ❒ Does HHS/ASPR have anything to add?
- ❒ Does the DHS NBIC have anything to add?

QUESTIONS AND OTHER INFORMATION

- ❒ Is there any other agency on the call with public health information to share?

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- ❒ Are there any questions or additional comments from the jurisdictional or federal partners regarding the public health and veterinary surveillance data provided?

PUBLIC HEALTH ASSESSMENT

Based on the public health information available:

- ❒ Does a public health risk exist based on this BWNCC discussion?

  If Yes:

  - ❒ Has the jurisdiction already taken public health response actions?

    If Yes: What current actions are being taken?

- ❒ Do the circumstances of the incident warrant a public health investigation?

  If Yes:

  - ❒ Has the jurisdiction already begun a public health investigation?

    If Yes:

    - ❒ What current actions are being taken?
    - ❒ Do the circumstances of the incident warrant additional public health response beyond an investigation?

SECTION 4. JURISDICTIONAL NEXT STEPS

The questions in this section are open for group discussion. If BWNCC participants are not sharing feedback to the questions, the BWNCC Facilitator may have to call on agencies/individuals.

IF THERE IS **NO** PUBLIC HEALTH OR LAW ENFORCEMENT THREAT/INVESTIGATION

We will now discuss the jurisdiction's next steps based on the assessment of the situation. Please note that it may be deemed appropriate to take no further action in response to this BAR.

- ❒ Given the current situational assessment, will the jurisdiction take any additional actions that we have not yet discussed?

  If Yes:

  - ❒ What actions will be taken?

IF THERE **IS** A PUBLIC HEATH OR LAW ENFORCEMENT THREAT/INVESTIGATION

We will now discuss the jurisdiction's next steps. These may include emergency management operations, risk communication activities, public health operations, and briefings to elected officials. Conversely, it may be deemed appropriate to take no further action in response to this

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BAR. Given the current situational assessment, (*JC/Jurisdiction Facilitator*) please highlight your jurisdiction's next steps.

The BWNCC Facilitator may prompt discussion if no actions are identified. Some actions the jurisdiction may decide to take include the following:

- *No action*
- *BioWatch-specific actions*
  - *Change filter retrieval frequencies*
  - *Modify the collector array (e.g., additional collectors)*
  - *Activate Phase I/II sampling*
- *Emergency Management Operations*
  - *Transition to response framework to include emergency declaration*
  - *Requests for Federal assistance (e.g., expecting to request Federal assistance, in the process of requesting federal assistance, etc.)*
  - *Activate and staff local Emergency Operations Center*
- *Risk Communication Activities*
  - *Risk Communication Conference Call*
  - *Media and/or public inquiries*
  - *Press releases*
- *Public Health Operations*
  - *Enhanced passive surveillance*
  - *Active surveillance*
  - *Continued syndromic surveillance*
  - *Joint public health/law enforcement investigation of agent-related disease*
  - *Strategic National Stockpile (SNS) action (e.g., considering/requested SNS)*
  - *Points of Distribution (PODs) actions (e.g., considering/activated PODs)*
- *Communications with elected officials*
  - *Briefings made or planned to be made to elected political leadership*

SECTION 5. REQUEST FOR RESOURCES

Given the situational assessment, does the jurisdiction wish to receive or continue to receive the following BioWatch Program-managed resources?

- ❒ Rapidly Deployable Laboratory (RDL) (or elements of) consumables, reagents, or surge laboratory staff
- ❒ Environmental sampling supplies
- ❒ DHS/CWMD Public Affairs risk communication / messaging support

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If resources are requested:

The BioWatch Program will coordinate the delivery of the BioWatch resources as well as any on-site control or access issues through the Jurisdictional Coordinator following this conference call.

SECTION 6. FEDERAL AGENCY ACTIONS

We will now highlight next steps from our federal agencies. I will call you by agency for your response.

Federal Agencies (*BWNCC Facilitator will call on participating components, directorates and offices based on the roll call*)**:**

- ❒ DHS NBIC
- ❒ DHS I&A
- ❒ DHS Public Affairs
- ❒ CWMD Public Affairs
- ❒ HHS / ASPR
- ❒ HHS / CDC
- ❒ EPA
- ❒ FBI WMD Directorate
- ❒ Department of Defense (DoD) / USNORTHCOM
- ❒ Others – Do any other federal representatives on the call have next steps to report?

SECTION 7. CLOSING THE CALL

Are there any additional comments at this time before we close this conference call?

Is there need for another BWNCC? *If DST was used, the BWNCC Facilitator will ask if it will be used again on any subsequent BWNCCs.*

If Needed: The date and time for the next BioWatch National Conference Call will be at: *(Date/Time)* and the phone number is 1-855-852-7677; the access code is 498-9534.

Thank you everyone for your contributions to this BioWatch National Conference Call. The time is now (*Time Eastern*) and this call is adjourned.

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Miami-area BioWatch Advisory Committee Meeting - Agenda

Date: March 12, 2020
Time: 10:00 AM - 12:00 PM
Location: MICC Building - 3rd Floor
8175 NW 12 Street
Miami, FL 33126

10:00 AM	**Welcome & Announcements** - **Sign-in**	Álvaro Mejia-Echeverry
	New Business	
10:05 AM	- Call-down chart review	All
10:10 AM	- COVID-19 Overview	Vanessa Villamil
10:20 AM	- Updated BWNCC Agenda/Script - January 2020	Álvaro Mejia-Echeverry/ Ron Burger
	Old Business	
10:30 AM	- Super Bowl LIV SEM	Ron Burger
10:45 AM	- Super Bowl LIV Hot Wash	"
11:00 AM ***(Please keep updates to 2 minutes per program)***	**Updates** - RDSTF - Field (RER/DERM) - Laboratory (Miami LRN) - Public Health (Preparedness, Epidemiology, Communications, Training) - Law Enforcement (FBI, Local PD) - HazMat (MDFR, City of Miami, City of Hialeah) Emergency Management - Broward BAC (Broward Liaison) - Other Jurisdictions/BioWatch Program Office	All
12:00 PM	**Meeting Adjourned** **Next Scheduled Quarterly Meeting:** **June 18, 2020**	Álvaro Mejia-Echeverry

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Super Bowl 54
Miami and BioWatch

January 25-February 2, 2020



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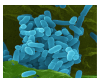
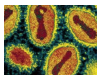
The BioWatch Target Organisms



Biological Agent	Disease
Bacillus anthracis	**Anthrax**
Francisella tularensis	**Tularemia**
Yersinia pestis	**Plague**
Burkholderia mallei/ B. pseudomallei	**Glanders/Melioidosis**
Variola virus	**Smallpox**

FOUO

[THIS SLIDE IS FOUO]

Talking Points

- The BioWatch program currently monitors the air for the 5 biological agents: *Bacillus anthracis, Francisella tularensis, Yersinia pestis, Burkholderia* species and Variola virus.
- As shown, this list includes some agents that are rarely seen or have been eradicated in the United States as well as some agents that exist naturally in our environment.
- Four of the BioWatch agents are Category A agents. These are: *B. anthracis*, *Y. pestis*, *F. tularensis*, and Variola virus.
- According to the CDC, Category A bioterrorism agents pose a risk to national security because they: Can be easily disseminated or transmitted from person to person, result in high death rates and have the potential for major public health impact, might cause public panic and social disruption and require special action for public health preparedness.
- The BioWatch agents categorized as Category B agents, the second highest priority agents, are the *Burkholderia* species *Burkholderia mallei* and *B. pseudomallei*. These agents are moderately easy to disseminate, result in moderate death rates and low illness and injury rates.

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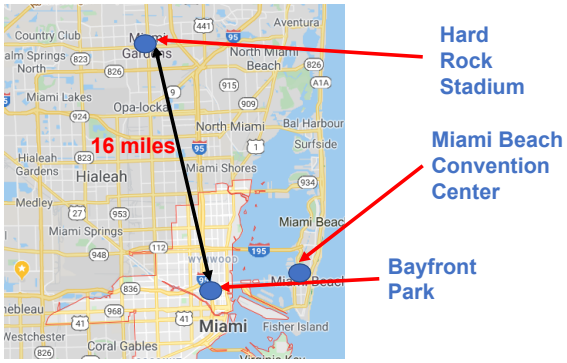
Venues for BioWatch Deployment

- **Miami Beach Convention Center:** NFL Experience
- **Bayfront Park:** Super Bowl Live
- **Hard Rock Stadium:** Game



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Laboratory and Field Support

- **Florida Department of Health; Bureau of Public Health Laboratories: Miami**

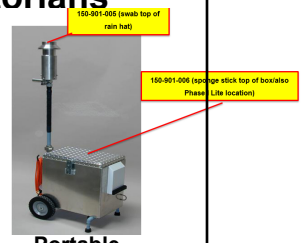




- **Miami-Dade Regulatory and Economic Resources; Environmental Section**

- **Miami BioWatch Lab Team = 5 laboratorians**
- **Surge support from PAE/Atek = 6 laboratorians**

- **Field Staff from DHS For Filter Retrieval**



Portable Sampling Unit

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Modeling for Number of PSUs

- Los Alamos National Laboratory
- Outside area for Hard Rock, Bayfront Park and Miami Beach Convention Center
- Probability of Detection (P_d) vs Fraction of Population (F_p)





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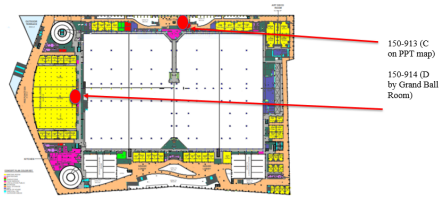
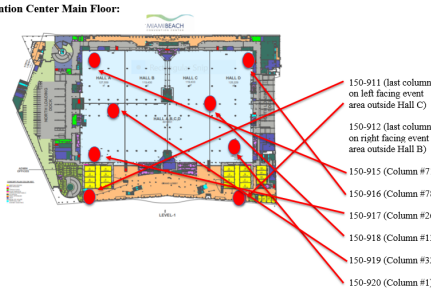
PSU Deployment

- **Miami Beach Convention Center: 10 indoor; 10 outdoor**

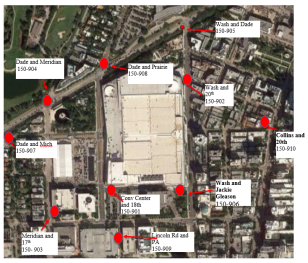
Convention Center Second Floor Ballrooms:



Convention Center Main Floor:



Miami Beach Convention Center





AMERICAN OVERSIGHT

PSU Deployment

- **Bayfront Park: 3 inside; 5 outside**



Bayfront Park Area:

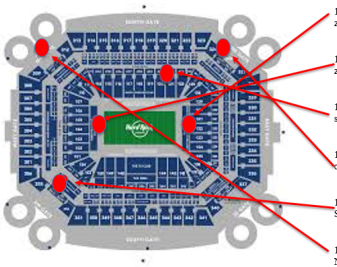


AMERICAN OVERSIGHT

PSU Deployment

- **Hard Rock Stadium: 6 inside; 16 outside**

Hard Rock Stadium Inside:



150-928 (East end zone event level)

150-929 (West end zone event level)

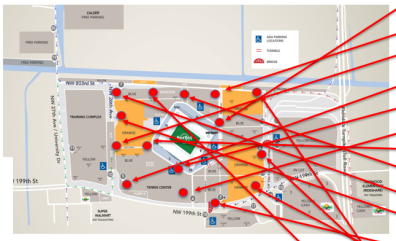
150-930 (100 level by seats 119-118)

150-931 (300 level NE corner)

150-932 (300 level SW corner)

150-933 (300 level NW corner)

Hard Rock Stadium Outside:



150-934 (NE gate planter)

150-935 (near helipad)

150-936 (near Gate 5 & 6 off Carl Barger Blvd)

150-937 (tennis courts near Gate 5)

150-938 (tennis courts SE)

150-939 (tennis courts SW)

150-940 (SW Gate; planter)

150-941 (Media entry)

150-942 (Staff, golf cart entry NW)

150-943 (at Gate 6)

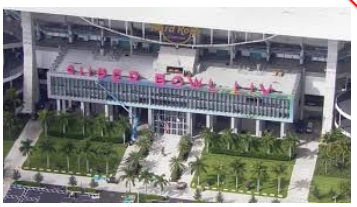
150-944 (Near main entrance C)

150-945 (SE parking Shula Dr area)

150-946 (B Entry)

150-947 (NE corner parking lot NFL compound)

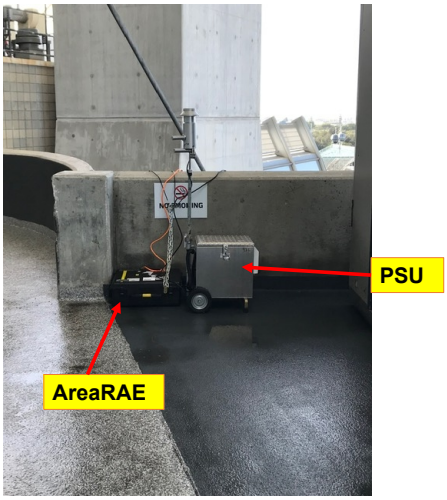
150-948 (between 941 and 942)



AMERICAN OVERSIGHT

EPA's Chemical/Rad Detection Co-Located with 17 PSUs

- AreaRAE Portable Detection System
- Real Time
- Photoionization Detector (PID)
- Tests for:
  - Volatile Organic Compounds (VOCs)
  - Other gases
  - Gamma radiation



AMERICAN OVERSIGHT

Schedule for Filter Exchange

- **Convention Center and Bayfront Park:** activated January 24 twice a day to February 1 then once on Game Day February 2
- **Pickup Times/Results**
  - 0630 and 1800 hours
  - Lab results mostly 1500 and 0300 hours
- **Hard Rock Stadium:** activated January 30 once on January 31; twice a day February 1 and Game Day February 2; final retrieval was post game about 2300 hours

AMERICAN OVERSIGHT

Number of Filters Tested Per Day

- Including Network of 30 PSUs
  - Jan 25: 86
  - Jan 26: 86
  - Jan 27: 86
  - Jan 28: 86
  - Jan 29: 86
  - Jan 30: 86
  - Jan 31: 108
  - Feb 01: 130
  - Feb 02: 102



AMERICAN OVERSIGHT

Getting Power: Even in Sun Drenched Miami, Solar Power is Out





- Traffic Control Signal Boxes
- Outlets Available on Street
- Portable Outlets in the Park



AMERICAN OVERSIGHT

NFL and COVID-19

- Query from NFL Sports Medical Group Lead, Saturday February 1st
- PUI at a local Hollywood hospital
- Follow up: NFL Security and others obtained from social media trolling
- See Pembroke Pines Police Department's Media Release



AMERICAN OVERSIGHT

31



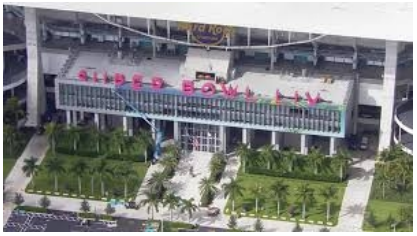


20











AMERICAN OVERSIGHT

Now onto TAMPA: 2021 Super Bowl 55







AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc: Pritchard, Scott; Rubino, Heather
Subject: Monday
Date: Sunday, March 1, 2020 10:26:24 PM

Hi Tim, The good news is you are coming right at the best time. Expect to be plugged into the Coronavirus response from day one. The bad news is that tomorrow morning will likely be a tad chaotic. We may have our two first cases confirmed tomorrow and we have just declared an emergency. I have a meeting between 830-9 am. It may drag out a little. I will try to meet you at 8 and we will get your badge and computer etc set up started. Then we will all get together as soon as we have a chance. Hopefully shortly after 9. Just wanted to give you a heads up and wish you a warm welcome :). Carina

Get Outlook for iOS

AMERICAN OVERSIGHT

From:	Fitzgerald, John M CDR
To:	"Davis, Ashley"; "Guthrie, Kevin"
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:00:08 PM

Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald
D7 LNO to the FL EOC

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
Division of Global Migration and Quarantine

AMERICAN OVERSIGHT

Centers for Disease Control and Prevention
Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

AMERICAN OVERSIGHT

From:	Fitzgerald, John M CDR
To:	"Davis, Ashley"; "Guthrie, Kevin"
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 1:59:54 PM

Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

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Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:25:29 PM

Sam/Ashley

This is the string I got below and why I asked if you had this ship on the radar. Let me know if you find something out. HHS has no ask….we just want to make sure you are aware this may be headed to Miami.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

NOTICE: This communication contains information intended for the addressees only, in the conduct of official business of the federal government, and which may be exempt from mandatory disclosure under the Freedom of Information Act 5 U.S.C. § 552. If you received this communication in error, please do not print, copy, forward, disseminate, or otherwise use the information. Please immediately notify the sender and delete the copy.

Jeanne,

See below. Is FL DOH tracking this?

Joe

AMERICAN OVERSIGHT

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

18MAR: Indications that an Oceania cruise ship will be arriving at Port of Miami sometime next week with various COVID-19 positives on it. Consular Affairs from the Australian Embassy contacted to say they had been notified overnight that the MS Marina (Oceania) is returning to Miami from South America via the Panama Canal after it was denied docking by several countries. The latest advice the Embassy has is that it is passing through the Canal could take 5 or 6 days. Australian Embassy in Mexico and Honorary Consul in Panama are trying to assist at least 49 Australians on board - some of whom are starting to run short of medications etc. - but are having difficulty contacting the crew and Oceania's agents in Panama. CONS provided them with the contact for Norwegian cruise lines which is a parent company of Oceania. OFM indicates Port of Miami is not aware of the ship coming to Miami and questioned where it would even dock as all available ports are occupied. OFM in touch with Norwegian.

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:25:19 PM

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Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
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Assistant Secretary for Preparedness and Response (ASPR)
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AMERICAN OVERSIGHT

From:	Public Health Leadership and Practice
To:	Candice McDaniel; Jennie Hefelfinger; Abby Lowe-Wilson; Hahn, Jamie K; lea.ojamaa@state.ma.us; Lisa.Sanders@msdh.ms.gov; Samaha Hodges; DeShara Johnson; lisa.mccooey@ct.gov; kathleen.arnold-lewis@doh.vi.gov; Kelly McCracken; Kathleen Lewis-Arnold; aflaherty@pa.gov; Emily.Moores@maine.gov; lrp0@cdc.gov; dlw7@cdc.gov; nhh1@cdc.gov; flw2@cdc.gov; cwu9@cdc.gov; hri0@cdc.gov; hcc3@cdc.gov; prs5@cdc.gov; kuv7@cdc.gov; rnh2@cdc.gov; Anya Karavanov; Julie Dudley; Amanda Martinez; Ann Forburger; Ann Marie Shields; Kimberly Miller; lhelzer@health.nv.gov
Cc:	Candice McDaniel; Tari O"Connor; Sondra Reese; Appathurai Balamurugan; teresa.manygoats; Caroline Peck; laurie.schneider; Monica Morales; Gabriel Kaplan; Mehul Dalal; Robin Diggs Outlaw; helen.arthur@state.de.us; Shamarial Roberson; Kia Toodle; lola.irvin; Jack Miller; J Myers-Geadelmann; tiffanie.pressley@illinois.gov; Ann Alley; Ryan Lester; Thomas-Cox, Sue (CHFS PH); melissa.r.martin; Kristi Pier; Linda Scarpetta; Mary Manning; Steve Cramer; victor.sutton@healthyMS.com; Campbell, Stacy; Susan Kansagra; jlpastir@nd.gov; Hurst, Gwen; whitney.hammond@dhhs.nh.gov; Melita Jordan; Catron, Britt, DOH; Judith Gabriele; Wallace, Barbara J (HEALTH); Michele Shough; Stephanie U"Ren; Girard Karen E; Sutton, Nancy (RIDOH); Kiley.hump; Charlotte Woods; Nimisha Bhakta; Antonio L. Cases Rosario; Daguise, Virginie; Janae Duncan; heather.board@vdh.virginia.gov; Julie.Arel; pama.joyner; Pesik, Mary J - DHS; Jessica.G.Wright; Lisa Wordeman; Jeanne Alongi; victor.sutton@msdh.ms.gov; Kristi Robusto; Arthur, Helen (DHSS); Nancy Sutherland; Thompson, Carolyn; Robin Rhodes; Levine, Britt, DOH; John Robitscher
Subject:	NACDD Chronic Disease Directors Forum First Thursday Webinar

Dear Colleagues,

Update to our 3/5 webinar speaker line up: In addition to the speakers listed below, Dr. Karen Hacker and Dr. Peter Briss will be providing an update on coronavirus on the webinar this Thursday.

For our March 2020 webinar we are looking at leading to address upstream factors. We are excited to have the following speakers join us:

* Carol Hall Walker and Deborah Garneau (Rhode Island Department of Health) to discuss the Rhode Island Health Equity Measures.

* Shamarial Roberson (Florida) as our Chronic Disease Director respondent.

* Karla Sneegas from CDC's Office on Smoking and Health to share information on Tips 2020.

Please join us and bring your questions, comments, and experiences to share.

Register in advance for upcoming webinars with this link: https://chronicdisease.zoom.us/meeting/register/uJYvc-urpjwrOcPx6hOXeJ3eSfuM4yRpSA <https://chronicdisease.zoom.us/meeting/register/uJYvc-urpjwrOcPx6hOXeJ3eSfuM4yRpSA> . After registering, you will receive a confirmation email containing information about joining the meeting. Note that you will need to register each month.

Slides and webinar recordings are available here: https://www.chronicdisease.org/page/CDDF_First_Thursday.

For more information please contact Abby Lowe-Wilson at alwilson@chronicdisease.org <mailto:alwilson@chronicdisease.org> .

Jeanne Alongi, DrPH, MPH (she/her)
Senior Public Health Consultant - Public Health Leadership & Practice
National Association of Chronic Disease Directors
jalongi@chronicdisease.org
www.chronicdisease.org
916-452-2440 (pacific time zone)

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: National Briefing 2 PM EST - Coronavirus Task Force
Date: Friday, February 7, 2020 12:31:45 PM

Please join us at 2 PM EST at www.hhs.gov/live for a national press briefing from the Coronavirus Task Force. *Link will be live shortly before the event.*

U.S. Department of Health and Human Services

**Friday,
February
7, 2020**

Today, the Department of Health and Human Services (HHS) will host a press briefing by members of President Trump's Coronavirus Task Force.

2:00 PM EST: Press Conference Begins. www.HHS.gov/live

###

Follow @SecAzar on Twitter, like HHS on Facebook, and sign up for HHS Email Updates

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: National Briefing 2 PM EST - Coronavirus Task Force
Date: Friday, February 7, 2020 12:28:22 PM

Please join us at 2 PM EST at www.hhs.gov/live for a national press briefing from the Coronavirus Task Force. *Link will be live shortly before the event.*

U.S. Department of Health and Human Services

**Friday,
February
7, 2020**

Today, the Department of Health and Human Services (HHS) will host a press briefing by members of President Trump's Coronavirus Task Force.

2:00 PM EST: Press Conference Begins. www.HHS.gov/live

###

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Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From: NCHS NVSS News (CDC)
Cc: Brown, Kelly D. (CDC/DDPHSS/NCHS/DVS); Tolson, George C. (CDC/DDPHSS/NCHS/DVS)
Subject: National Vital Statistics System Newsletter - February 2020
Date: Monday, March 2, 2020 9:11:01 AM



Division of Vital Statistics Newsletter — February 2020

-

Click here to view the full NVSS newsletter online

This month, we're focused on improvements. To begin, we will be proposing improvements to the next VSCP contract, and will be seeking your input. Please take a moment to read and find out how you can contribute your ideas. This issue also highlights our newest VSCP Special Project, Address Data for Geocoding, which is collecting data from every jurisdiction to improve our ability to calculate life expectancy and mortality at more local levels. You'll also find out how Iowa is improving data quality and timeliness through a new birth registration facility report card. Additionally, we connect you to upcoming NAPHSIS trainings that may be of interest, and to information on how jurisdictions can work with NCHS to test newly implemented data systems.

Whether it's by joining our projects, attending a training, or sharing your own ideas for the future, we encourage you to stay connected with us and be a part of making the National Vital Statistics System better.

Enjoy!
Steve

Steven Schwartz, PhD
Director – Division of Vital Statistics
National Center for Health Statistics
3311 Toledo Rd | Hyattsville, MD 20782

AMERICAN OVERSIGHT

From:	Lushbaugh, Justin (CDC/DDNID/NCBDDD/DHDD)
To:	Claudia.Johnson@ky.gov; Pier, Kristi (CDC maryland.gov); Cramer, Steve (CDC health.mo.gov); Paras, Kathy (CDC utah.gov); Kamp, Susan (CDC vermont.gov); Laurie.Eldridge-Auffant@adph.state.al.us; Roberson, Shamarial (CDC flhealth.gov); bryan.russell@flhealth.gov; maggie.ferguson@idph.iowa.gov; jhall@ku.edu; Kbruns@ku.edu; hoffmana5@michigan.gov; Manning, Mary (CDC state.mn.us); Bluhm, Jim JB (CDC state.mn.us); Meg.Traci@mso.umt.edu; Susan.havercamp@osumc.edu; vanessas@uark.edu; Rodrigo.Monterrey@MassMail.State.MA.US; Barbara.wallace@health.ny.gov; weaverro@ohsu.edu; SMCDERMO@mailbox.sc.edu; devlinj@mailbox.sc.edu; Barb.Locker@ky.gov; Allison.perline@vermont.gov; Wimberley, Richard (CDC michigan.gov); HWelch@mt.gov; erin.ashinghurst@maryland.gov; bdkilpat@uark.edu; ann.robinson@osumc.edu; Kimberly.Phillips@unh.edu; holly.teal@health.ny.gov; Brenda.Maley@health.mo.gov; Kimberley.Warsett@state.ma.us; hornerjo@ohsu.edu; nettie.romanzo-smith@health.ny.gov; Evan.England@unh.edu; nassira.d.nicola@state.ma.us; aBraner@utah.gov; ctamayo@phhp.ufl.edu; Rachael.Austin@health.ny.gov; Patrick.Hodge@flhealth.gov; Casey, Margaret MC (CDC health.ny.gov); maureen.spence@health.ny.gov; rodrigo.monterrey@state.ma.us; LeeC@michigan.gov; anna.fuller@uky.edu; lindsey.c.mullis@uky.edu; chithra.adams@uky.edu; David.Ellsworth@odh.ohio.gov; Edward.Clark@flhealth.gov; FrameA@michigan.gov; Bishop, Susan (CDC state.mn.us); emily.smoak@state.mn.us; Mackenzie.Jones@mt.gov; Schulte, Ann (MDH); Crotty, Anne E
Cc:	Tilahun, Selam (MDH); Erin Taylor; Vincent-Mark, Arlene (CDC/DDNID/NCBDDD/DHDD)
Subject:	NCHPAD Home workout toolkit
Date:	Friday, March 20, 2020 8:58:54 AM
Attachments:	Inclusive Home Workout Toolkit.pdf Inclusive Home Workout_Landscape.jpeg Inclusive Home Workout_Square.jpeg

---

Good morning, all:

Please find attached NCHPAD's Inclusive Home Workout Toolkit, and please feel free to share the content with your networks.

Thanks, and please let me know if you have any questions.

Stay happy and healthy!

-Justin

Justin Lushbaugh
Public Health Analyst
Disability Science and Program Team ¦ Disability & Health Promotion Branch
Division of Human Development and Disability
National Center on Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
4770 Buford Hwy MS-S101-3
Chamblee, GA 30341-3717
Xko0@cdc.gov
(404) 498-3036 Office
(470) 421-0183 Mobile
(770) 488-0270 Fax

AMERICAN OVERSIGHT

WORKOUT FROM HOME

Options for People with Disability and Chronic Health Conditions



It is especially important for people to stay active during this time. Exercise can help boost immunity and keep us in good physical and mental health. The National Center on Health, Physical Activity and Disability (NCHPAD) has curated a playlist of the top exercise from home videos on their YouTube channel for kids and adults. The playlist includes 32 options for all abilities to choose an exercise mode that works and is enjoyable to them. Example exercise videos include: inclusive yoga class, standing and seated cardio workouts, strength activities using household items, high intensity workouts and much more!

Sample Newsletter Blurb

> Given the severity of COVID-19, people with disabilities and chronic health conditions are some of the most at risk populations. While staying home, practicing social distancing and good hygiene are of upmost importance it is also imperative that we stay active through exercise options at home. Exercise can help boost immunity and keep us in good physical and mental health. The National Center on Health, Physical Activity and Disability (NCHPAD) has curated a playlist of the top exercise from home videos on their YouTube channel for kids and adults. The playlist includes 32 options for all abilities to choose an exercise mode that works and is enjoyable to them. Get ready, set and move ->https://bit.ly/2Qoliao.

Watch & Move

> Link to get moving from home with inclusive exercise video options:
> https://www.youtube.com/watch?list=PLwMObYmlSHaPlArTOC4JBZfeuU7LN7KVJ&v=eLClKvN9Qag
>
> Short link:
> https://bit.ly/2Qoliao.

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Social Media Sample Posts

Facebook

Let's not forget about our physical and mental health during the COVID-19 pandemic! Staying active at home is important to keep our immunity levels up and @NCHPAD has curated a playlist of the top exercise from home videos on their YouTube channel for kids and adults. The playlist includes 32 options for all abilities to choose an exercise mode that works and is enjoyable to them. Check it out and get moving today! https://bit.ly/2Qoliao

Looking for an exercise program that is inclusive and can be done at home? Look no further! @NCHPAD's 14 Week Program to a Healthier You might be just what you need. This program is a FREE, personalized, web-based physical activity and nutrition program for individuals with disabilities and chronic health conditions. Remember to stay active at home during #COVID-19! https://www.nchpad.org/14weeks/

Calling all athletes with a disability! Need some new options to stay active while at home? Check out @NCHPAD's Champion's Rx program. This is a FREE, high-intensity daily workout program designed to challenge all ability levels. https://www.nchpad.org/CRx

Twitter

During #COVID-19, let's not forget about our physical & mental health! Staying active at home is very important to keep immunity high. Check out a video playlist from @NCHPAD with over 30 workout from home options for everyone. https://bit.ly/2Qoliao

People with #disabilities and chronic health conditions are some of the most at risk populations for #COVID-19. Remember to stay active from home during this time and use inclusive exercise videos from @NCHPAD to help you do so. https://bit.ly/2Qoliao

Calling all #athletes with a #disability! Need some new options to stay active while at home? Check out @NCHPAD's Champion's Rx program. https://www.nchpad.org/CRx

Looking for an exercise program that is inclusive and can be done at home? Look no further! @NCHPAD's 14 Week Program to a Healthier You might be just what you need. https://www.nchpad.org/14weeks/

Instagram

Let's not forget about our physical and mental health during the COVID-19 pandemic! Staying active at home is important to keep our immunity levels up and @NCHPAD has curated a playlist of the top exercise from home videos on their YouTube channel for kids and adults. The playlist includes 32 options for all abilities to choose an exercise mode that works and is enjoyable to them. Check it out and get moving today! https://bit.ly/2Qoliao

Looking for an exercise program that is inclusive and can be done at home? Look no further! @NCHPAD's 14 Week Program to a Healthier You might be just what you need. This program is a FREE, personalized, web-based physical activity and nutrition program for individuals with disabilities and chronic health conditions. Remember to stay active at home during #COVID-19! https://www.nchpad.org/14weeks/

For questions about this resource, please contact NCHPAD at email@nchpad.org.

NCHPAD

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NCHPAD
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WORKOUT FROM HOME

Options for People with Disability and Chronic Health Conditions



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WORKOUT FROM HOME

Options for People with Disability and Chronic Health Conditions

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	New CDC COVID-19 Check and Record Everyday (CARE) Booklet
Date:	Wednesday, February 26, 2020 8:09:25 AM
Attachments:	2019nCoV_CARE_EngChinese_Feb25.pdf
Importance:	High

Dear Colleagues:

Attached is CDC's new COVID-19 Check and Record Everyday (CARE) booklet. Here is what to know:

- **Who gets a CARE booklet? And when?** Every traveler referred by CBP from mainland China, whenever they get released during the screening process or the completion of secondary screening. This is the same process as the current T-HAN and Temperature and Symptom log. If the traveler is an unaccompanied minor, a booklet will be provided to the person in charge of picking them up at their final destination

- **What language is the booklet in?** English on one side and Simplified Chinese on the other for the print version. A Spanish version will be available online in the coming weeks.

- **When will CDC staff at quarantine stations start handing out the new booklet?** Distribution of the booklets will start by **Friday, February 28th.**

- **What is the role of CDC/QS staff?** The role of CDC/QS staff is to ensure every traveler referred from mainland China by CBP receives a CARE booklet in an envelope. Booklets are shipped pre-assembled in a labeled envelope.

- **What is the role of State and Local Health Departments?**Travelers are advised to connect with the State and Local Health Departments at their destination; these numbers are listed in the booklet.

- **How many CARE booklets will quarantine stations receive?**Each station will receive a different number of booklets every week based on the number of travelers entered in QARS the previous week. Because this is an estimate, we've added an additional 10% of booklets to each shipment.

- **What if the information in the booklet changes?**Information is quickly and frequently changing. If the CARE booklet changes, we will print and ship a new version of the booklet. The new version will have a different color on the outside label of the envelope containing the booklet. If this happens, quarantine stations will receive an email with the new information and outdated materials will be discarded. The first and current shipment contains ayellow outline on the label.

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- **Does the shipment contain thermometers and phones?**No, we will not be supplying thermometers or phones at this time.

- **Will the booklet be available online?** Yes, we plan on having an online version of the booklet available in the coming weeks.

Thank you,

State Coordination Task Force

Sent by BCC to State Health Officials, State Epidemiologists, PHEP Directors, and COVID-19 Primary/Secondary Contacts

AMERICAN OVERSIGHT

C A R E

Check and Record Everyday

简体中文版请翻转

VERSION: 02.21.2020



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

COVID 19 CORONAVIRUS DISEASE

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004910

You have received this booklet of important health information because you traveled from the People's Republic of China. There is an ongoing outbreak of coronavirus disease 2019 (COVID-19) in China. COVID-19 is a respiratory illness caused by a virus that can spread from person to person.

If you have returned from Hubei Province within the last 14 days, you will be monitored by the public health department in your destination state. Monitoring will include agreements or legal orders such as a quarantine order.

Under these agreements or quarantine orders:

- You must stay at your home, or at a location chosen by your state or local health department or the U.S. government for a 14-day period from the time you left Hubei Province.
- Follow the directions in the quarantine order and the directions provided by your health department and the U.S. government.

If you have returned from China (other than Hubei Province), CDC strongly recommends you protect yourself and others by self-monitoring at home for 14 days from the time you left China. Take these steps to monitor your health:

1. Take your temperature with a thermometer two times a day and watch for cough or difficulty breathing (see instructions in this booklet).
2. Stay home from school.
3. Employees: Discuss your work situation with your employer before returning to work.
4. Do not take public transportation, taxis, or ride-shares.
5. Avoid crowded places (such as shopping centers and movie theaters) and limit your activities in public.
6. Keep your distance from others (about 6 feet or 2 meters).
7. If you get sick with fever, cough, or trouble breathing, follow instructions on page 3.
8. If you need to seek medical care for other reasons, such as dialysis, call ahead to your doctor and tell them about your recent travel to China.

Your health department may have specific instructions for you to follow that may be more restrictive than described above.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004911

Connect with your health department upon return from travel (phone list included in this booklet). They will let you know:

- How you should report your health checks to the health department
- How often you should report your health checks
- Who to contact if you get sick with symptoms of fever, cough, or trouble breathing
- What else you should do if you develop symptoms
- Who to contact if you have questions



When you connect with the health department, ask them for the following contact information. Keep track of this important information by writing it below.

The contact information for staff at the health department is:



Name(s):

Phone Number:

After-hours phone number:

Email or website:

Other method:

Use the space below to write important information given to you.

How do I report my health checks?

How often should I report my health checks?

If I get sick, what does the health department want me to do?

Who do I contact if I have additional questions?

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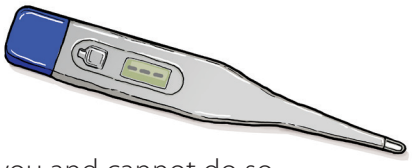
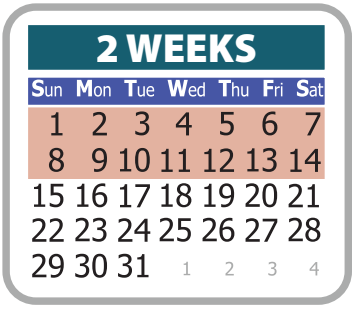
If you have been exposed to a person with COVID-19, it may take up to 14 days to know if you will get sick. It is important to check your health two times each day for 14 days after you leave China. Follow the steps below to check and record your health.



Step 1 Do health checks every morning and every night:

- Take your temperature and/or that of family members who traveled with you and cannot do so themselves.
- In addition to fever, be alert for any other symptoms of COVID-19, including cough or difficulty breathing.
- Write your temperature and any symptoms in the log included in this booklet.
- Write family members' temperatures and symptoms in their own booklets.

Family members who did not travel with you do not need to be monitored.



Step 2 If your health department asks you to report your temperature and any symptoms, follow their instructions.

Step 3 If you have fever (fever is 100.4°F/38°C or higher), cough, or trouble breathing:

1. Do not go out in public.
2. Call the phone number listed for your health department in this booklet. Remind them that you are self-monitoring.
3. If you can't reach your health department, seek medical advice – call ahead before you go to a doctor's office or emergency room. Tell them about your recent travel, your symptoms, and guidance received from the health department.
4. Avoid contact with others.
5. Do not travel while sick.
6. Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
7. Wash hands often with soap and water for at least 20 seconds to avoid spreading the virus to others.
8. Wash your hands with soap and water immediately after coughing, sneezing, or blowing your nose. If soap and water are not readily available, you can use an alcohol-based hand sanitizer that contains 60%-95% alcohol. Always wash hands with soap and water if hands are visibly dirty.

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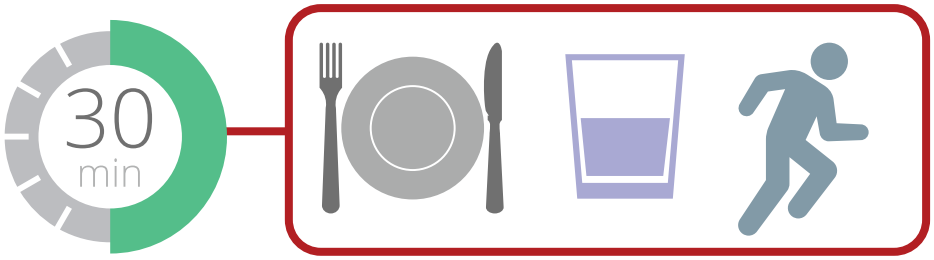
FL-DOH-20-0673-A-004913

If you have a medical emergency, call 911. Tell them your symptoms and that you traveled from China.

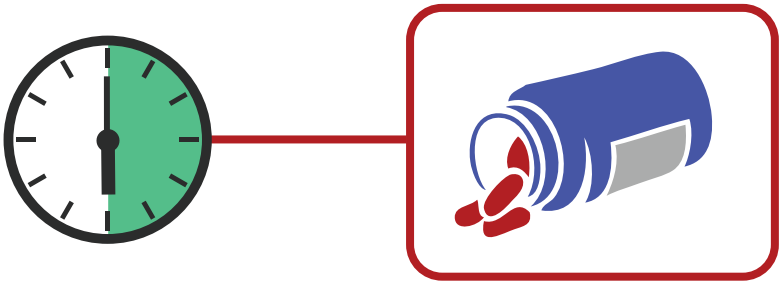
Before you take your temperature:

Wait 30 minutes after eating, drinking, or exercising.



Wait at least 6 hours after taking medicines that can lower your temperature, like:

- Acetaminophen, also called paracetamol
- Ibuprofen
- Aspirin



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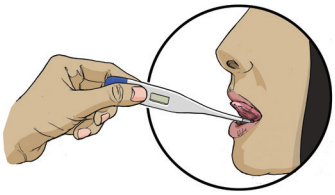
1. Turn the thermometer on by pressing the button near the screen.



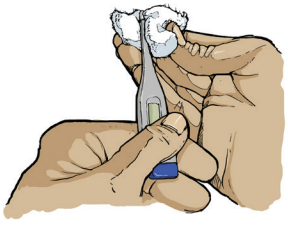
2. Hold the tip of the thermometer under your tongue until it beeps. Do not bite the thermometer.



3. Read your temperature on the screen. If your temperature is 100.4°F/38°C or higher, you have a fever.



4. Write your temperature in the 14-Day Symptom and Temperature Log in this booklet.



5. Clean the top of your thermometer with soap and water and dry it well.

PLEASE NOTE: For infants and children younger than 4 years old, use an age-appropriate thermometer such as an ear thermometer. If you do not have one, use a regular thermometer by placing it under the child's arm in the center of the armpit.

For the armpit method, if the child's temperature is 99.4°F/37.4°C or higher, they have a fever. Tell the public health worker that you are taking the child's temperature this way.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004915

Two times a day (morning and night), write down your temperature and any COVID-19 symptoms you may have: feeling feverish, coughing, or difficulty breathing. Do this every day for 14 days after you left China.

1. Fill in the dates on the log, starting with Day 0 and ending with Day 14. Day 0 is the day you left China.
2. Start recording your temperature and symptoms, beginning with today's date. **Fever is 100.4°F/38°C or higher.**
3. If you get sick, contact your health department. Be sure to tell them you were in China, your symptoms, and that you are self-monitoring.
4. Your daily health checks are complete 14 days after you left China, or as indicated by public health authorities.

DAY	DATE	SYMPTOMS	TEMP
DAY 0	Feb 1, 2020	Day 0 is the day you left the China.	
DAY 1	Feb 2, 2020	No Symptoms	97.4 F
		No Symptoms	98.6 F
DAY 2	Feb 3, 2020	No Symptoms	96.9 F
		No Symptoms	98.6 F
DAY 3	Feb 4, 2020	No Symptoms	98.0 F
		No Symptoms	98.6 F
DAY 4	Feb 5, 2020	No Symptoms	97.3 F
		No Symptoms	98.6 F
DAY 5	Feb 6, 2020	No Symptoms	96.5 F
		No Symptoms	98.6 F

SAMPLE

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Symptom and Temperature Log

COVID 19 CORONAVIRUS DISEASE

Write your symptoms and temperature in the space below every day for 14 days.

DAY	DATE	SYMPTOMS	TEMP
DAY 0		Day 0 is the day you left China.	
DAY 1			
DAY 2			
DAY 3			
DAY 4			
DAY 5			
DAY 6			
DAY 7			
DAY 8			
DAY 9			
DAY 10			
DAY 11			
DAY 12			
DAY 13			
DAY 14			

If you get sick, contact your health department as instructed and remind them you were in China, your symptoms, and that you are self-monitoring. Your daily health checks are complete at 14 days after you left China, or as indicated by public health authorities.

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004917

If you have a medical emergency, call 911. Tell them your symptoms and that you traveled from China.

Phone Numbers for State and Local Health Departments

CARE

This is a list of telephone numbers for health departments across the United States that travelers can use to connect with the health department in their destination state or the state they are in. These phone lines are monitored at all times, and travelers may call 24 hours a day and 7 days a week unless noted. Members of the public with general questions about COVID-19 should call their state health department's main daytime telephone number or they can contact CDC at www.cdc.gov/cdc-info or 1-800-CDC-INFO (800-232-4636) or TTY 888-232-6348.

State	Phone Number
Alabama	1-800-338-8374
Alaska	1-800-478-0084 or 1-907-269-8000
Arizona	1-602-747-7099
Arkansas	1-800-554-5738
California *If you are in L.A. County, call:*	1-800-852-7550 *Ask for the CDPH Duty Officer* 1-213-974-1234
Colorado	1-303-370-9395 *Available until 10:00pm MT*
Connecticut	1-860-509-8000
Delaware	1-888-295-5156
District of Columbia	1-202-576-1117
Florida	1-850-245-4401
Georgia	1-866-782-4584
Hawaii	1-808-586-4586
Idaho	1-208-334-5939
Illinois *If you are in Chicago, call:*	1-800-889-3931 1-312-744-5000 *Available from 9:00am-5:00pm CT*
Indiana	1-317-233-1325
Iowa	1-800-362-2736
Kansas	1-877-427-7317
Kentucky	1-888-973-7678
Louisiana	1-800-256-2748
Maine	1-800-821-5821
Maryland	1-410-795-7365
Massachusetts	1-617-983-6800
Michigan	1-517-335-9030
Minnesota	1-877-676-5414
Mississippi	1-601-576-7725
Missouri	1-800-392-0272, Ext.1
Montana	1-406-444-0273

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FL-DOH-20-0673-A-004918

State	Phone Number
Nebraska	1-402-444-3400 *Available from 8:30am-4:00pm CT*
Nevada	1-775-400-0333
New Hampshire	1-603-271-44961
New Jersey	1-800-222-1222
New Mexico	1-505-827-0006
New York *If you are in New York City, call:*	1-888-364-3065 *Available from 9:00am-6:00pm* 1-866-692-3641, Ext.1
North Carolina	1-866-462-3821
North Dakota	1-701-328-2270
Ohio	1-614-722-7221
Oklahoma	1-405-271-4060
Oregon	1-971-673-0977
Pennsylvania *If you are in Philadelphia, call* *If you are in Pittsburgh, call*	1-877-724-3258 1-215-686-4514 1-412-687-2243
Puerto Rico	1-787-765-2929, Ext.3552 or 3551
Rhode Island	1-401-222-2577
South Carolina	1-888-847-0902
South Dakota	1-800-592-1861
Tennessee	1-615-741-7247
Texas	1-512-776-7111
Utah	1-888-374-8824
Vermont	1-802-863-7240
Virgin Islands *If you are in St. Thomas, call:* *If you are in St. Croix, call:*	See below. 1-340-774-9000 *Available from 9:00am-5:00pm* 1-340-718-1311 *Available from 9:00am-5:00pm*
Virginia	1-877-ASK-VDH3 (1-877-275-8343)
Washington	1-800-525-0127 *Available from 6:00am-10:00pm*
West Virginia	1-304-558-5358, Ext. 1
Wisconsin	1-608-258-0099
Wyoming	1-888-996-9104
Northern Marian Islands	1-670-234-8950

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FL-DOH-20-0673-A-004919

If you have a medical emergency, call 911. Tell them your symptoms and that you traveled from China.

C·A·R·E

Check and Record Everyday

简体中文版请翻转

VERSION: 02.21.2020



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

COVID 19 CORONAVIRUS DISEASE

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004920

日常检查并记录

COVID 19 CORONAVIRUS DISEASE

您收到这份重要的健康信息手册是因为您的航班来自中华人民共和国。在中国, 2019 冠状病毒疾病（COVID-19）疫情持续蔓延。COVID-19 是一种由病毒引起的呼吸系统疾病，并且可以在人与人之间传播。

如果您在过去的14天内从湖北省返回， 您目的地州的公共卫生部门将对您进行监测。监测将包括协议或法律条令，例如检疫条令。

根据这些协议或检疫条令:

- 从您离开湖北省开始的14天内，您必须呆在家中，或待在您所在州或地方卫生部门，或美国政府所指定的地点。
- 请遵循检疫条令，您卫生部门还有美国政府提供的指示。

如果您从中国返回 (湖北省除外), CDC 强烈建议您在离开中国的14天内，通过在家自我监测来保护自己与他人。请采取以下步骤来监测您的健康:

1. 每日两次用体温计测量您的体温，并且密切关注咳嗽，或呼吸困难 (请参见手册中的指示)。
2. 呆在家中，请不要去学校。
3. 雇员：请在返回工作之前和您的雇主讨论您的工作情况。
4. 请不要乘坐公共交通，出租车，或与他人共同乘车。
5. 避免去拥挤的地点 (例如，购物中心和电影院) 并且限制您在公共场所的活动。
6. 与他人保持距离 (大约 6 英尺 或 2 米).
7. **如果您生病并伴有发烧，咳嗽，或呼吸困难，请遵循第三页的指示。**
8. 如果因为其他的原因需要就医，如透析，请提前打电话联系您的医生并且告知他们您最近去中国的旅行。

您当地的卫生部门可能会有更严格的具体指示供您遵循。

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004921

*** 如果您需要急诊，请拨打911。告知他们您的症状，并且您曾去过中国。**

在您旅行返回后，请与您的卫生部门联系 (手册中包含电话列表). 他们会告知您:

- 如何向卫生部门报告您的健康检查?
- 应该多久报告一次您的健康检查?
- 如果生病并伴有发烧，咳嗽，或呼吸困难的症状，您该联系谁?
- 如果出现症状，您还应该做什么?
- 如果有疑问，您应该询问谁?



当您与卫生部门联系时，请寻求以下联系方式。
请在下方填写并记录重要信息。

卫生部门的工作人员联系方式:

姓名:

电话号码:

非办公时间电话号码:

邮箱或网址:

其他方式:



请使用以下空白处填写提供给您的重要信息。

如何报告我的健康检查?

我应该多久报告一次我的健康检查?

如果我生病了，卫生部门希望我怎么做?

如果有其他的疑问，我应该联系谁?

AMERICAN OVERSIGHT

每日检测并记录您的健康

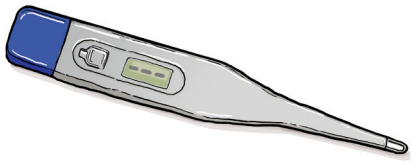
COVID 19 CORONAVIRUS DISEASE



如果您曾接触过感染2019 冠状病毒疾病(COVID-19)的人，可能需要14天的时间得知您是否会生病。在您离开中国后的14天内，每天2次检测您的健康是十分重要的。请按照以下步骤来监测和记录您的健康。







第一步 请每日早，晚检测您的健康.

- 请测量您的体温，并/或帮助其他与您同行但无法自行测量的家庭成员。
- 除了发烧，请警惕其他2019冠状病毒疾病的症状，包括咳嗽，或呼吸困难。
- 请在此手册的日志中填写您的体温和其他任何症状。
- 请将家庭成员的体温和症状填写在他们的手册中。

未与您同行的家庭成员无需被检测。



第二步 如果您的卫生部门要求您报告您的体温和任何症状，请遵循他们的指示。

第三步 如果您发烧 (发烧为100.4˚ F/38˚ C 或更高)，咳嗽，或呼吸困难:

1. 请不要去公共场所。
2. 请拨打本手册中列出的您当地卫生部门的电话号码，提醒他们您在自我监测。
3. 如果无法联系到您的卫生部门，请寻求医生建议 — 请在去医生办公室或急诊室之前先打电话咨询。告知他们您最近的旅行，您的症状，和卫生部门给您的指示。
4. 避免与他人接触。
5. 请不要生病时旅行。
6. 在咳嗽或打喷嚏时请用纸巾或您的衣袖 (不要用手)掩盖口鼻。
7. 避免传播病毒给他人，请用肥皂和水洗手，至少20秒。
8. 请在咳嗽，打喷嚏，或擦鼻涕后，立即用肥皂和水洗手。如果没有肥皂和水，您可以使用酒精含量60%-95% 的酒精类洗手液进行手部消毒。如果手看起来脏，请经常用肥皂和水洗手。

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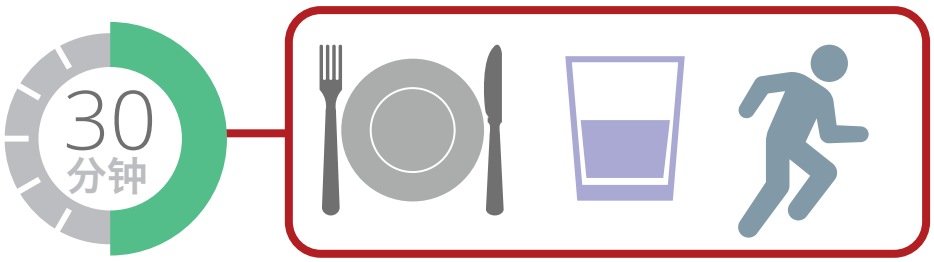
FL-DOH-20-0673-A-004923

*** 如果您需要急诊，请拨打911。告知他们您的症状，并且您曾去过中国。**

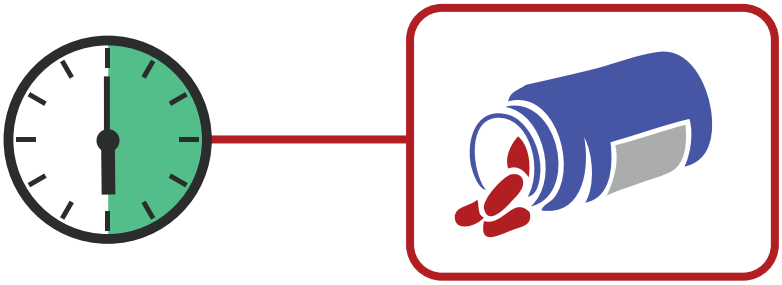
在您测量体温之前:

饭后，饮水后，或运动后，请等待30 分钟



在服用退烧药后，请等待至少6小时，比如:

- 对乙酰氨基酚，又称为扑热息痛，
- 布洛芬
- 阿司匹林



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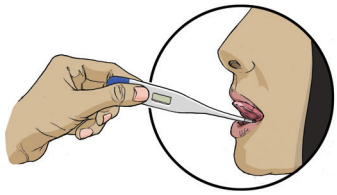
如何测量您的体温

COVID 19 CORONAVIRUS DISEASE



1. 通过按压屏幕旁边的按钮来打开体温计。



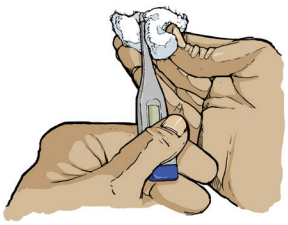
2. 把体温计的尖端放在舌头下面，直到它发出哔哔声。不要咬体温计。



3. 在屏幕上读取您的体温。如果您的体温为 100.4˚ F/38˚ C 或更高，您已发烧。



4. 请在手册内，在14天症状和体温日志中写下您测量的体温。



5. 用肥皂和水清洗体温计的尖端，并晾干。

请注意: 对于4岁以下婴幼儿，请使用适龄的体温计测量，比如耳温枪。如果您没有此类体温计，请将常规体温计放置在儿童的腋窝中央。

使用腋窝测量的方式，如果孩子的体温为 **99.4˚ F/37.4˚ C 或更高**，孩子已发烧。请告知公共卫生工作人员，您用此方法为您的孩子测量体温。

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FL-DOH-20-0673-A-004925

*** 如果您需要急诊，请拨打911。告知他们您的症状，并且您曾去过中国。**

如何使用您的症状和体温日志

CARE

每天两次（早上和晚上），写下您的体温和任何2019冠状病毒疾病的症状：感觉发热，咳嗽，或呼吸困难。请在离开中国后的14天内，每天都要这样记录。

1. 在日志中填写日期，从第0天开始到第14天结束。第0天是您离开中国的时间。
2. 从今日起开始记录您的体温和症状。发烧为100.4° F/38° C 或更高.
3. 如果您生病了，联系您的卫生部门。请一定告知他们您曾去过中国，您的症状，并且您正在自我监测。
4. 您的日常健康检查会在您离开中国后的14天完成，或根据公共卫生官员的指示。

日	日期	症状	体温(°C摄氏度)
第0天	2020年2月1日	第0天是您离开中国的日期。	
第1天	2020年2月2日	无症状	36.3
		无症状	37
第2天	2020年2月3日	无症状	36
		无症状	37
第3天	2020年2月4日	无症状	36.7
		无症状	37
第4天	2020年2月5日	无症状	36.4
		无症状	37
第5天	2020年2月6日	无症状	35.8
		无症状	37

范例

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症状和体温日志

COVID 19 CORONAVIRUS DISEASE

请您在之后的14天内，每天都在下列表格中记录下您的症状和体温。

日	日期	症状	体温（°C摄氏度）
第0天		**第0天是您离开中国的日期。**	
第1天			
第2天			
第3天			
第4天			
第5天			
第6天			
第7天			
第8天			
第9天			
第10天			
第11天			
第12天			
第13天			
第14天			

如果您生病了，请依照指示联系您的卫生部门，告知他们您曾去过中国，您的症状，并且您在自我监测中。您的日常健康检查在您离开中国后的14天完成，或根据公共官员的指示 。

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FL-DOH-20-0673-A-004927

*** 如果您需要急诊，请拨打911。告知他们您的症状，并且您曾去过中国。**

州和地方卫生部门的电话号码

这是美国各地卫生部门的电话号码列表，旅客可以使用这些号码与目的地州或所在州的卫生部门联系。这些电话线路全天受到监控，除有特别说明外，旅客可以全天24小时，一周7天电话联系。有关COVID-19 的普遍问题，公众可以拨打州卫生部门的日间办公电话或通过网址 www.cdc.gov/cdc-info 与CDC取得联系，电话号码为 1-800-CDC-INFO (800-232-4636) 或 TTY 888-232-6348。

州	电话号码
Alabama	1-800-338-8374
Alaska	1-800-478-0084 or 1-907-269-8000
Arizona	1-602-747-7099
Arkansas	1-800-554-5738
California 如果您在 L.A. County, 致电:	1-800-852-7550 寻求CDPH执勤官 1-213-974-1234
Colorado	1-303-370-9395 办公时间至 10:00pm 山地时间
Connecticut	1-860-509-8000
Delaware	1-888-295-5156
District of Columbia	1-202-576-1117
Florida	1-850-245-4401
Georgia	1-866-782-4584
Hawaii	1-808-586-4586
Idaho	1-208-334-5939
Illinois 如果您在 Chicago, 致电:	1-800-889-3931 1-312-744-5000 办公时间 9:00am-5:00pm 中部时间
Indiana	1-317-233-1325
Iowa	1-800-362-2736
Kansas	1-877-427-7317
Kentucky	1-888-973-7678
Louisiana	1-800-256-2748
Maine	1-800-821-5821
Maryland	1-410-795-7365
Massachusetts	1-617-983-6800
Michigan	1-517-335-9030
Minnesota	1-877-676-5414
Mississippi	1-601-576-7725
Missouri	1-800-392-0272, Ext.1
Montana	1-406-444-0273

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州和地方卫生部门的电话号码

COVID 19 CORONAVIRUS DISEASE

州	电话号码
Nebraska	1-402-444-3400 办公时间8:30am-4:00pm 中部时间
Nevada	1-775-400-0333
New Hampshire	1-603-271-44961
New Jersey	1-800-222-1222
New Mexico	1-505-827-0006
New York 如果您在 New York City, 致电:	1-888-364-3065 办公时间 9:00am-6:00pm 1-866-692-3641, Ext.1
North Carolina	1-866-462-3821
North Dakota	1-701-328-2270
Ohio	1-614-722-7221
Oklahoma	1-405-271-4060
Oregon	1-971-673-0977
Pennsylvania 如果您在 Philadelphia, 致电 如果您在 in Pittsburgh, 致电	1-877-724-3258 1-215-686-4514 1-412-687-2243
Puerto Rico	1-787-765-2929, Ext.3552 or 3551
Rhode Island	1-401-222-2577
South Carolina	1-888- 847-0902
South Dakota	1-800-592-1861
Tennessee	1-615-741-7247
Texas	1-512-776-7111
Utah	1-888-374-8824
Vermont	1-802-863-7240
Virgin Islands 如果您在 St. Thomas, 致电: 如果您在 St. Croix, 致电:	See below. 1-340-774-9000 办公时间9:00am-5:00pm 1-340-718-1311 办公时间 9:00am-5:00pm
Virginia	1-877-ASK-VDH3 (1-877-275-8343)
Washington	1-800-525-0127 办公时间6:00am-10:00pm
West Virginia	1-304-558-5358, Ext. 1
Wisconsin	1-608-258-0099
Wyoming	1-888-996-9104
Northern Marian Islands	1-670-234-8950

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FL-DOH-20-0673-A-004929

* 如果您需要急诊，请拨打911。告知他们您的症状，并且您曾去过中国。

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: NEW Ventilator Guidance - COVID-19
Date: Monday, March 23, 2020 2:22:26 PM

Dear Governor and State Health Officials-

Below please find new FDA guidance to expand the availability of ventilators as well as other respiratory devices:

What Types of Ventilators Can be Used to Expand Supply? The FDA issued guidance to expand the availability of ventilators as well as other respiratory devices and their accessories during this pandemic. Wherever possible, health care facilities should use FDA-cleared conventional/standard full featured ventilators when necessary to support patients with respiratory failure. However, to expand availability, FDA will not object to limited modifications to the *indications, claims, functionality, or to the hardware, software, or materials of FDA-cleared devices used* to support patients with respiratory failure or respiratory insufficiency. This policy applies only during the public health emergency.

Examples of changes to the indications could include a significant change or modification in *design, material, chemical composition, energy source, or manufacturing process*. Specific examples of products FDA will allow include:

- The use of powered emergency ventilators and anesthesia gas machines for patients needing mechanical ventilation;
- The use of ventilators outside of their cleared environment for use (use of a ventilators in a health care facility when it is only cleared for use at home or during transport);
- the use of devices indicated for sleep apnea (including CPAP and BiPAP), provided that appropriate design mitigations are in place to minimize aerosolization; or
- The use of oxygen concentrators for primary supply when medically necessary and clinically appropriate.

FDA will also allow for modifications to the FDA-cleared *indications, claims, or functionality* of these devices, without a prior submission of a premarket notification. Examples of circumstances where FDA currently believes a modification would be allowable include:

- Modifications to motors, batteries, or other electrical components;
- Material changes to components in the gas pathway or with other patient tissue contact;
- Introduction of filtration to minimize aerosolization;
- Software modifications intended to modify the ventilation parameters including inspiratory pressure, tidal volumes, flow rates, positive end-expiratory pressure (PEEP) in accordance with any applicable device standard;
- Software modifications implementing physiological closed loop (automated)

AMERICAN OVERSIGHT

algorithms for oxygen titration where the algorithms/devices are the subject of an FDA-approved Investigational Device Exemption (IDE); and
- Hardware and/or software modifications implementing the capability for remote monitoring and remote adjustment of ventilator parameters (i.e., adjustment of parameters by trained health care providers from outside an isolation unit to avoid unnecessary exposures).

FDA is interested in interacting with manufacturers of ventilatory support devices that are not currently legally marketed in the U.S. as well as manufacturers who have not previously been engaged in medical device manufacturing with capabilities to increase supply of these devices. FDA will work interactively with these manufacturers through its Emergency Use Authorization (EUA) process. The guidance includes specific information to send to FDA and all information and questions can be sent to: CDRH-COVID19-Ventilators@fda.hhs.gov.

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc: Pritchard, Scott; Rubino, Heather
Subject: Next week
Date: Wednesday, February 26, 2020 6:23:53 PM

We are excited to have you on site next week. Coronavirus is the first item on the menu as you can imagine. But we are also engaged in hep A and legionella response. Not to forget flu. What time do you think you will be in the office? We would like to sit down sometimes early in the day to discuss scientific on boarding. Carina

Get Outlook for iOS

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From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response PUI; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Monday, March 2, 2020 8:40:28 AM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2783039
FL2783057

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response PUI; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Monday, March 2, 2020 12:46:58 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2785091
FL2785125

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response PUI
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Friday, March 6, 2020 5:06:11 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2786318

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Clinical On-Call Unit; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Monday, March 9, 2020 6:09:39 PM

Dear Blackmore

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2785091
FL2787169

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Tuesday, March 10, 2020 4:05:21 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL 2789590
FL 2789655
FL27889624

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Clinical On-Call Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Wednesday, March 11, 2020 10:50:50 AM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2785091
FL2787619

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Clinical On-Call Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Friday, March 13, 2020 5:50:49 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID
FL2789656
FL2791177

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	CDC IMS 2019 NCOV Response Clinical On-Call Unit; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject:	Notification regarding Novel Coronavirus Disease-2019 (COVID-19) Test Results
Date:	Tuesday, March 17, 2020 7:59:48 PM

Dear Dr. Blackmore,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCOV#
FL2792229
FL2792320
FL2792316
FL2792718
FL2792318
FL2786318
FL2785125

Thanks,

Clinical On-call Unit & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov)
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response PUI
Subject: Notification regarding Novel Coronavirus Disease-2019 (COVID-19)
Date: Friday, February 21, 2020 7:14:59 PM

Dear Carina,

We are emailing to alert you that laboratory testing results for a Novel Coronavirus Disease-2019 (COVID-19) Person Under Investigation (PUI) or PUIs in your jurisdiction have been sent to your State Public Health Laboratory from the CDC testing laboratory. We are unable to share test results in this email, but they are available. Please contact your State Public Health Laboratory for additional information on these test results.

Test results for the following IDs should be available:

nCov ID	Submitter Specimen ID
0001283	MRF20000027
0001283	MRF20000028

Thanks,

Persons Under Investigation (PUI) Team & State Coordination Unit
Epidemiology Task Force
CDC Novel Coronavirus Disease-2019 (COVID-19) Response

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Office for Civil Rights (OCR) Announces Notification: Enforcement Discretion for Telehealth Remote Communications During the COVID-19
Date:	Thursday, March 19, 2020 11:33:59 AM

OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html

Today, the Office for Civil Rights (OCR) at the U.S Department of Health and Human Services (HHS) announced, effective immediately, that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency.

This exercise of discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.

In support of this action, OCR will be providing further guidance explaining how covered health care providers can use remote video communication products and offer telehealth to patients responsibly.

"We are empowering medical providers to serve patients wherever they are during this national public health emergency," said Roger Severino, OCR Director. "We are especially concerned about reaching those most at risk, including older persons and persons with disabilities," Severino added.

The Notification of Enforcement Discretion on telehealth remote communications may be found at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

For more information on HIPAA and COVID-19, see OCR's February 2020 Bulletin: https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf - PDF

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health

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laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	Gilliard, Deric (HHS/IEA)
To:	Jade.Tindle@FLHealth.gov
Cc:	Coppola, Courtney (Courtney.Coppola@flhealth.gov); Cales, Natalia (HHS/ORD)
Subject:	Office of the Secretary in Region IV reaching out for county health directors" contact list
Date:	Tuesday, March 24, 2020 2:15:17 PM
Attachments:	BIO - John McGough HHS Regional Director - Region 1 Boston & Region 4 Atlanta.pdf

Hello Jade.

I work for HHS Region IV Director John McGough, who has oversight of the eight southeastern states. He held a call with SG Rivkees that was coordinated by Courtney back in November to discuss the HHS priorities as they relate to the Florida county health directors. John has asked me to acquire contact information for all of the county health directors, in the event an emergency or fast-developing COVID-19 situation, either involving testing, PPEs, staffing, cruise ship arrivals, etc., requires him to reach someone on the weekends, or in the evening. Believe me, because he also leads the six Region I states, which include Boston, his plate is full and he would not be making a call unless there were no other options.

Courtney returned my call Friday evening and told me she would provide me with the list. Since I see that she is now deployed and out of pocket, I will refer the request to you, per her instructions.

Thanks in advance.

Sincerely,

Deric

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Public Affairs Specialist
U.S. Department of Health and Human Services
Atlanta Federal Center
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Atlanta, GA 30303-8909
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404-562-7910 Office
202-868-9202 Cell

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John G. McGough
U.S. Department of Health and Human Services
Regional Director for New England & the Southeast

John G. McGough was appointed by the White House in January of 2018 to serve as Regional Director of the U.S. Department of Health & Human Services for Region 1 in New England. As a Presidential Appointee, Mr. McGough provides executive leadership as the primary representative for the Secretary of Health and Human Services. The office of the Regional Director is tasked with intergovernmental and external affairs bringing together federal, state, local and tribal government organizations, along with other external partners. In his role, Mr. McGough is responsible for the six New England states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, as well as the Region's 10 federally recognized Tribes.

In July of 2019, McGough was additionally tasked with serving as Regional Director for Region 4 in the Southeast including the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee, as well as the Region's 6 federally recognized Tribes.

Prior to his appointment with HHS, McGough served as Chief of Staff for Maine's Republican Governor Paul R. LePage for seven years. During the 2010 gubernatorial campaign, he served as Deputy Chief of Staff and Policy Director. Prior to joining the campaign, McGough was the Director of Human Resources for the City of South Portland, Maine. McGough previously served as Assistant City Administrator/Human Resources Officer for the City of Waterville, Maine. He is also the former Chief of Staff for the House Republican Leader in the Maine House of Representatives.

McGough earned a Bachelor's and Master's Degree in Public Administration from the University of Maine system. He resides in Brunswick, Maine and attends the Pathway Vineyard Church. He has one daughter, Molly, who attends college.

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From: omni

To: Abra Greenberg; Abra.Greenberg@odh.ohio.gov; abross@acog.org; achaudhry@amchp.org; Aflagg@aphsa.org; ailis.clyne@health.ri.gov; Alane.oconnor@mainegeneral.org; Alda.Osinaga@health.ny.gov; Alexandra Kearly; Alexia Harrist; alexis.tucey@dhcfp.nv.gov; allen.brenzel@ky.gov; amanda.c.bennett@illinois.gov; amy.acton@odh.ohio.gov; amy@pachc.org; angelaw.parker@ky.gov; ann.zerr@fssa.in.gov; Anna Bartels; anne.zink@alaska.gov; antraneise.jackson@ahca.myflorida.com; ANussbaum@marchofdimes.org; aogushi@health.nv.gov; apeterson2@roseman.edu; april_henry@mednax.com; arvind.goyal@illinois.gov; ashley.berliner@vermont.gov; ashley.busacker@wyo.gov; Ashley.Jeans@tn.gov; Ashley.Swarowski@uhc.com; atolliver@wvperinatal.org; aushry@acog.org; avelonis@uic.edu; bberry@southcentralfoundation.com; Benedetta.Bernardo@uhsinc.com; beverly.mason@dcfs.nv.gov; bki@hrpregnancy.com; borders.ann@gmail.com; Breena.Holmes@vermont.gov; brenda.barker@tipqc.org; buffingtona@unce.unr.edu; caitlin.cross-barnet@cms.hhs.gov; constantinis@thewrightcenter.org; carolyn.drazinic@myflfamilies.com; catherine.friedman@bhddh.ri.gov; Catherine Slemp, MD, MPH; cchance@indianapca.org; c-dakelley@pa.gov; cdf1@cdc.gov; chamilton@hsc.wvu.edu; charissa.fotinos@hca.wa.gov; choots@iphca.org; Christi Mackie; cio8@cdc.gov; cjohn@hsc.wvu.edu; ckendell@kyha.com; ckroelinger@cdc.gov; cmcdaniel@health.nv.gov; cmclachlan@dhcfp.nv.gov; coloradobabydoc@gmail.com; Connie White; cpaoli@washoecounty.us; cphinney@dhcfp.nv.gov; Cynthia.A.Parsons@wv.gov; Cynthia.Wohlford-Lotas@medicaid.ohio.gov; czj5@cdc.gov; danielle.howes@vermont.gov; danielle.kirby@illinois.gov; danielle.marks@wyo.gov; dcorritore@washoecounty.us; ddurham@uwyo.edu; Debbie.Croshaw@ClarkCountyNV.gov; deepa.sonpatki@gmail.com; denise.a.smith@wv.gov; Denise.Werner@tn.gov; dlevinson@hrsa.gov; DMadole@washoecounty.us; dmeador@kyha.com; dnp7@cdc.gov; Donna.L.PauleyWilson@wv.gov; DRab@hrsa.gov; drael@health.nv.gov; drbbartholomew@whasn.com; drdmiller@whasn.com; dshargo@mepca.org; dvn1@cdc.gov; DWeiss@northshore.org; dwz8@cdc.gov; dyoung@dhcfp.nv.gov; EBezy@isdh.IN.gov; edunlevey@pa.gov; ekk5@cdc.gov; elizabeth.conrey@odh.ohio.gov; elizabeth.harvey@tn.gov; Ellen Pliska; emma.white@wvpca.org; eon1@cdc.gov; erin.lynch@dhcfp.nv.gov; evonda.thomas-smith@illinois.gov; fkamyar@hrpregnancy.com; fob1@cdc.gov; ftaylor@adsd.nv.gov; fvc1@cdc.gov; Gabriela Garcia; gbaroi@cdc.gov; gina.pierotti-buthman@uhsinc.com; glen.klinkhart@alaska.gov; Gordon.smith@maine.gov; gstoner@geisinger.edu; gzander@pa.gov; henrietta.bada@ky.gov; Hilary.Daugherty@tn.gov; hjarolimek@dcfs.nv.gov; iazzam@health.nv.gov; ile4@cdc.gov; ilisa.stalberg@vermont.gov; j.thompson@cms.hhs.gov; jaimie.evins@dhcfp.nv.gov; james.b.becker@wv.gov; james.e.jeffries@wv.gov; jan@wypca.org; janiner@wsha.org; Javier.Betancourt@flhealth.gov; jbreyel@hsc.wvu.edu; JBuerlein@hrsa.gov; jdavies@dhcfp.nv.gov; Jean.Blankenship@acf.hhs.gov; jeanine.evenden@dignityhealth.org; Jennifer Somdahl; Jennifer.brown2@anthem.com; jennifer.epstein@illinois.gov; Jennifer.Johnson@flhealth.gov; jevins@dhcfp.nv.gov; jill.marano@clarkcountynv.gov; jim.walsh@swedish.org; joan.chappell@hca.wa.gov; Joanna.Bacon@uhsinc.com; johnfirestone@tlccreno.org; joyce.starr@mha.ohio.gov; jpatton@dhcfp.nv.gov; jpgoslin@alaska.gov; jschoolmeester@dhcfp.nv.gov; jsteinberg@hrsa.gov; jtonkin@dhcfp.nv.gov; judy.theriot@ky.gov; jwo4@cdc.gov; jwolf@lacsn.org; kara.miller@medicaid.ohio.gov; Kari.Ellis@hcahealthcare.com; kariearle@gmail.com; Kat Patterson; kathryn.chapman@alaska.gov; katie.eilers@doh.wa.gov; Katie.Letcher@uhc.com; kbox@isdh.in.gov; kcraig2@renown.org; KDavis-Coelho@renown.org; kelly.boyle@dcyf.wa.gov; Kelly.Dougherty@vermont.gov; KFarrell@hrsa.gov; kharris997@aol.com; khx2@cdc.gov; kim.connolly@centerforbehavioralhealth.com; kims@fha.org; klayosa@step2reno.org; kmarschall@socialent.com; kmoran3@thehealthplan.com; Lawless, Kristen L (HEALTH); Kristen.Zycherman@cms.hhs.gov; kristi.pebley@centerforbehavioralhealth.com; Kristina.West@hhs.gov; kristine.campagna@health.ri.gov; kristine@symplexityconsulting.com; kroussos@ufl.edu; ktrocin@hrsa.gov; kuesugi@uic.edu; lamalinalovell@dhhs.nv.gov; laura.dobler@wyo.gov; laura.rooney@odh.ohio.gov; Lauren.Tobias@health.ny.gov; Laurin.Kasehagen@partner.vermont.gov; lhale@socialent.com; LHorlamus@hrsa.gov; libby.bunzli@ohhs.ri.gov; Lily.lou@alaska.gov; linda.mahoney@bhddh.ri.gov; linda.mccorkle@tn.gov; linda.streitfeld1@cms.hhs.gov; lindsaya@unce.unr.edu; lisa.cohen@illinois.gov; Lisa.Mantkus@uhc.com; llee@forrecovery.org; lmosier@uwyo.edu; lnv1@cdc.gov; Lori Reeves; Lori.Dorsey@bhddh.ri.gov; lori.reeves@flhealth.gov; lpaul@aap.org; lstapleton@hrsa.org; Luciana.Blosz@dignityhealth.org; Lusine Ghazaryan; LWaddell@marchofdimes.org; mackr2@unlv.nevada.edu; maggie.schroeder@ky.gov; Margo.Katz@health.ri.gov; maria.delrio@ascension.org; maria.mclay@dignityhealth.org; Maria.Morris@oasas.ny.gov; marid@uic.edu; Marietta.Scholten@partner.vermont.gov; Marilyn.Kacica@health.ny.gov; marissa@nvha.net; mark.hurst@mha.ohio.gov; mark.hurst@odh.ohio.gov; Mark Levine; Mary.Applegate@Medicaid.ohio.gov; Maryann.harakall@maine.gov; Maya.Zamir@anthem.com; mberry@casat.org; mcampbell@rihca.org; mclouse@ky.gov; mdygert@aphsa.org; Megan.Mitchell@vermont.gov; Mekell.L.Golden@wv.gov; Melissa.A.Baker@wv.gov; melissa.jordan@flhealth.gov; Mesfin_Woldesenbet@mednax.com; mhmgreer@aol.com; mhutchinson@step2reno.org; Michele Walsh; Michelle.probert@maine.gov; michelle.shepard@med.uvm.edu; Miranda.J.Scott@illinois.gov; mlawler@hrsa.gov; mmeaney@renown.org; moira.crowley@uhhospitals.org; Monica Clouse; morgan.mcdonald@tn.gov; mrh7@cdc.gov; mrice@cdc.gov; mterplan@gmail.com; muw1@cdc.gov; nadine@doylestrategies.com; nancy.miller@vermont.gov; nancy@alaskapca.org; Natalie Foster; Natalie.Norberg@alaska.gov; nbowen@nvpca.org; Neodoc1124@gmail.com; Newja@clarkcountynv.gov; nhu4@cdc.gov; Nicole.L.Figles@silversummithealthplan.com; nirav.shah@maine.gov; njn6@cdc.gov; nlamboley@renown.org; nmulho2@uic.edu; ntyus@hrsa.gov; Pamela.england@dignityhealth.org; pap5@cdc.gov; patricia.king@northwestern.edu; patsy.kelso@vermont.gov; pblank@pa.gov; PCarlston@marchofdimes.org; peter.slom@dcyf.ri.gov; Philip_Vaughn@mednax.com; pmaris@ric.edu; PMasonMarti@marchofdimes.org; pmorphew@indianapca.org; rachael.comeau@uvm.edu; rammon@hrsa.gov; Ramya Dronamraju; Rebecca.Buhner@fssa.IN.gov; Rebecca.e.roth@wv.gov; Reena.Oza-Frank@odh.ohio.gov; Renee.Fox@cms.hhs.gov; rgustafson@washoecounty.us; Richa Ranade; Richard.Massatti@mha.ohio.gov; Robert Morrison; Robert.H.Hansen@wv.gov; rschultz@kypca.net; rutu.ezhuthachan@uhc.com; ryan.erickson@governor.ri.gov; sali@health.nv.gov; SAmatetti@hrsa.gov; Sanaa Akbarali; Sarah.Beard@flhealth.gov; Sarah.bowman@health.ri.gov; Sarah.E.Fox@silversummithealthplan.com; sarah.mansouri@tn.gov; sarah.pine@hca.wa.gov; sashmore@iphca.org; saylem.m.depasquale@wv.gov;

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Cc:	Barker, Brenda; Kari Earle; Berube, Jayne (HRSA); Radford, Dora L; Elizabeth Ruebush; Anne R Lindsay; McGown, Molly Frances; Charles Damon; cduarte@socialent.com; Kindle Craig; Eustice, Sarah M (CHFS DPH); Jill Martin; Marks, Katie (BHDID)
Subject:	OMNI ASTHOConnects: PCA Involvement
Attachments:	image001.png OMNI_ASTHOConnect_Agenda_2.4.20.pdf OMNI_ASTHOConnects Slides_2.4.20.pdf OMNI_ASTHOConnects_ Speaker Bios_2.4.20.pdf

Please join us for our OMNI ASTHOConnects on Primary Care Associations and Federally Qualified Health Centers, and how to best engage them in your work. Attached you'll find the agenda, slides, and speaker bios for today's webinar.

To access the webinar, please use the following:

Zoom Link: https://astho.zoom.us/j/290202789

Phone Number: 646-876-9923
Access Code: 290 202 789

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OMNI Learning Community ASTHO*Connects*:
Engaging Primary Care Associations and Federally Qualified Health Centers
February 4, 2020
Time: 1:00 – 2:00 PM EDT
Phone: 646-876-9923; 290 202 789
URL: https://astho.zoom.us/j/290202789

Cohort 1: Alaska✧Florida✧Illinois✧Kentucky✧Nevada✧Ohio✧Pennsylvania✧
Rhode Island✧Tennessee✧Vermont✧Washington✧West Virginia
Cohort 2: Indiana✧New York✧Wyoming

Desired Outcomes:

- Provide the federal perspective on engaging primary care associations and leveraging federally qualified health centers for OMNI related work.
- Highlight two FQHCs on their role providing services to pregnant and postpartum women affected by opioid use disorder and infants prenatally exposed to substances.

Agenda:

1:00 PM EST	**Welcome –** ASTHO • Welcome from ASTHO • Overview of agenda and objectives
1:05 PM EST	**Overview of Efforts to Engage PCAs** • *Sue Lin, PhD, MS, Director, Quality Division, Office of Quality Improvement, HRSA Bureau of Primary Health Care*
1:15 PM EST	**State Highlight on Engaging PCAs –** *Pennsylvania* • *Scott Constantini, Director of Behavioral Health, The Wright Center for Community Health*
1:30 PM EST	**State Highlight on Engaging PCAs –** *Colorado* • *Jessica Cram, Licensed Addiction Counselor, Denver Health*
1:45 PM EST	**Q&A and Discussion**
1:55 PM EST	**Wrap-up and Next Steps** • Next state share call
2:00 PM EST	**Adjourn**

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ASTHOConnects

A virtual learning series for public health leaders.

OMNI ASTHO*Connect:* Engaging Primary Care Associations and Federally Qualified Health Centers

Tuesday, February 4, 2020

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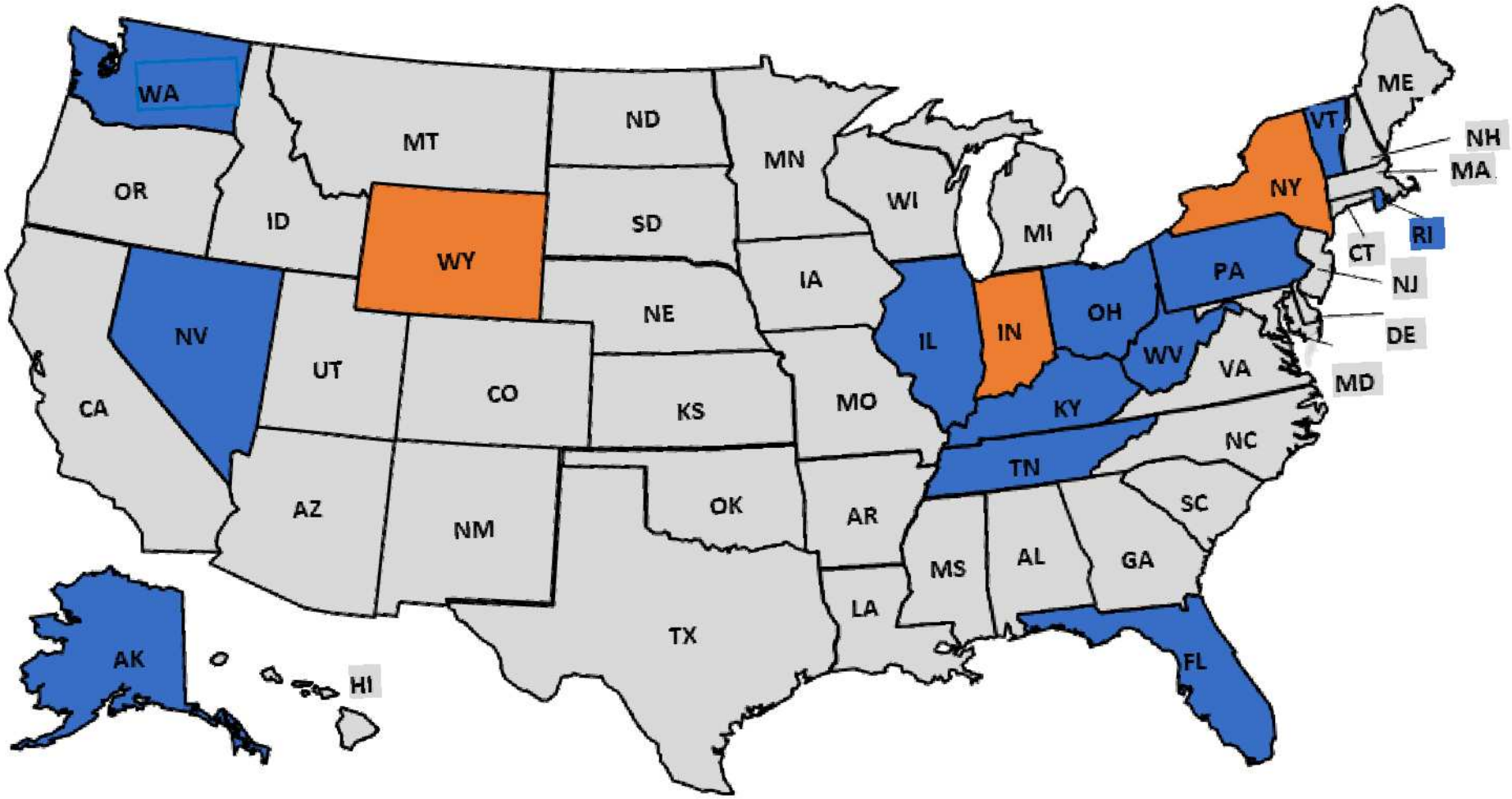
FL-DOH-20-0673-A-004950

OMNI Learning Community:

Cohort One and Cohort Two States



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FL-DOH-20-0673-A-004951

Agenda

1:00 Welcome and Introductions

1:05 HRSA Bureau of Primary Health Care

1:15 The Wright Center for Community Health

1:30 Denver Health

1:45 Q&A

1:55 What's next?

2:00 Adjourn

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FL-DOH-20-0673-A-004952

Webinar Objectives

- Provide the federal perspective on engaging primary care associations and leveraging federally qualified health centers for OMNI related work.
- Highlight two FQHCs on their role providing services to pregnant and postpartum women affected by opioid use disorder and infants prenatally exposed to substances.

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ASTHOConnects

A virtual learning series for public health leaders.



Sue Lin, PhD, MS

Director, Quality Division, Office of Quality Improvement, HRSA Bureau of Primary Health Care

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FL-DOH-20-0673-A-004954




HRSA
Health Resources & Services Administration

ASTHOConnects Webinar
Health Center Program Update

February 4, 2020

Sue Lin, PhD, MS
Director, Quality Division, Office of Quality Improvement
Bureau of Primary Health Care (BPHC)

Vision: Healthy Communities, Healthy People




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Health Center Program Highlights



Source: Uniform Data System, 2018

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HRSA Health Center Program

Behavioral Health Integration



In 2018, health centers provided over **10.8 million** mental health clinic visits

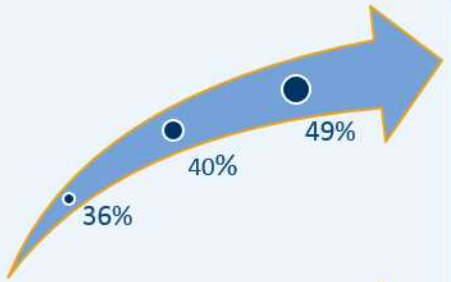
Over 11,700 mental health FTEs **10.5%** ↑

70.6% of patients screened for depression with a documented follow-up plan

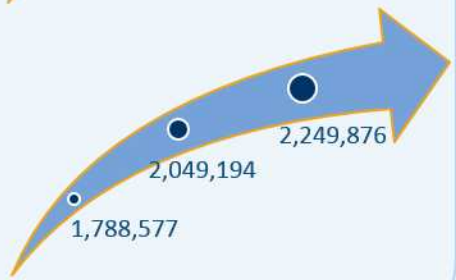


2016-2018 Progress

SBIRT implementation increased to **49%**



Mental health patients served increased by **26%**



Strategies to Enhance Integrated Behavioral Health Services (2019-2020)

- Increase access to high quality, integrated behavioral health services including the prevention or treatment of mental health conditions and substance use disorders, including opioid use disorder
- Improve provider awareness of clinical strategies to address behavioral health needs of special populations (e.g., women, adolescents, LGBT)
- Enhance behavioral health capacity in health centers through sharing promising practices in workforce recruitment, training, and integration

Training and Technical Assistance (T/TA)

- SBIRT, Depression Screening, and Trauma-Informed Care Communities of Practice
- Promising Practices and Resource Sharing on:
  - ✓ Maternal Depression and Substance Use
  - ✓ Suicide Prevention and Treatment

T/TA Resources: https://bphc.hrsa.gov/qualityimprovement/clinicalquality/behavioralhealth/index.html

Source: Uniform Data System, 2016-2018

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HRSA Health Center Program

Substance Use Disorder Services

1,748 health center providers (FTEs) delivering SUD services: **23.4%** ↑

Nearly **1.5 million** SUD clinic visits: **20.9%** ↑

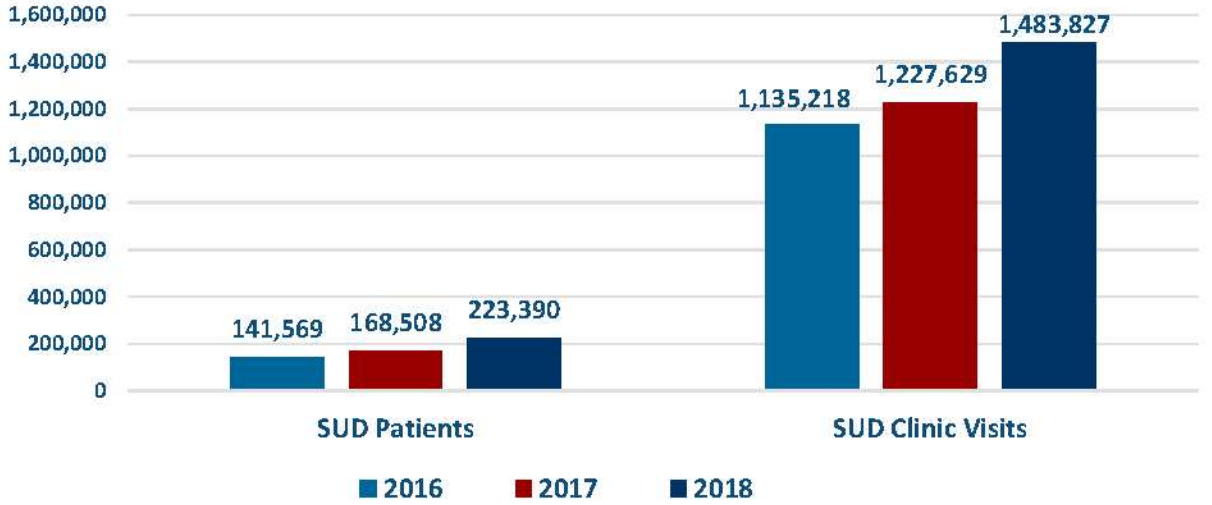
223,390 patients receiving SUD services: **32.6%** ↑

Medication-Assisted Treatment (MAT) Expansion

64.7% increase in the number of health center providers with a DATA 2000 Waiver in 2018

46.3% increase in the number of patients receiving MAT services

Health Center Program SUD Services, 2016-2018



Training and Technical Assistance (T/TA) Resources

- **HRSA SUD and Primary Care Integration Webpage**: https://bphc.hrsa.gov/qualityimprovement/clinicalquality/substance-use-disorder-primary-care-integration
- **Webinars** (http://www.astho.org/Webinars/): ASTHO's **O**pioid Use Disorder, **M**aternal Outcomes, and **N**eonatal Abstinence Syndrome **I**nitiative (OMNI) Learning Community discusses state-level approaches to addressing NAS (https://www.astho.org/generickey/GenericKeyDetails.aspx?contentid=21095&folderid=5162&catid=7254)
- **UCSF National Clinician Consultation Center's Substance Use Warmline** (http://nccc.ucsf.edu/clinical-resources/substance-use-resources/) provides clinician-to-clinician expert consultation addressing integrated behavioral health treatment & chronic pain management; M-F, 9 am to 8 pm ET by phone at 855-300-3595, or by submitting patient cases online (https://nccc.ucsf.edu/clinician-consultation/substance-use-management/)

Source: Uniform Data System, 2016-2018

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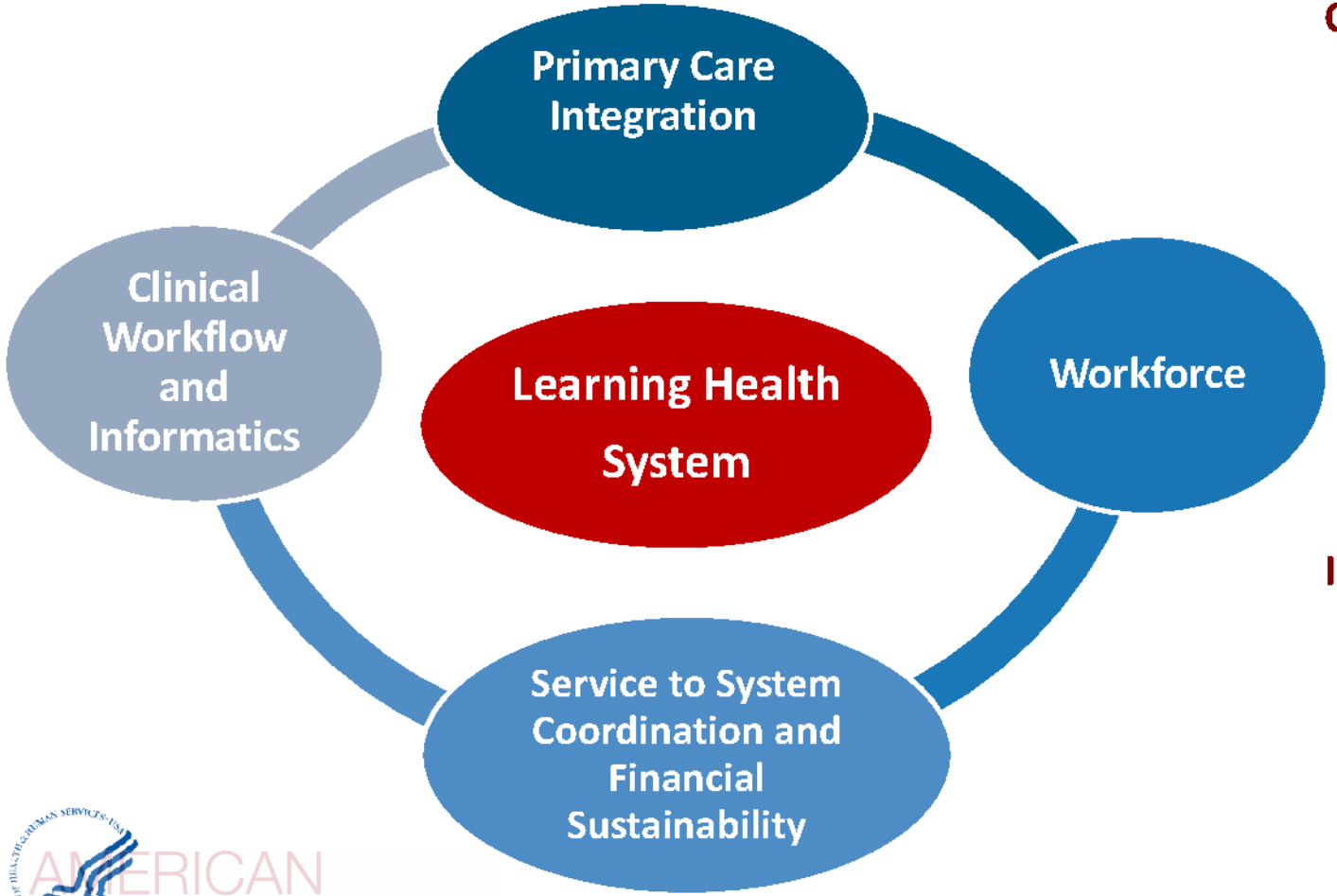
HRSA Health Center Program

HRSA Center of Excellence (COE) for Behavioral Health Technical Assistance

The COE provides Training and Technical Assistance (T/TA) on evidence-based interventions and best practices to support the integration of behavioral health in HRSA funded programs.



COE Key Functions

- To share promising practices and support behavioral health integration (BHI) in primary care
- To support the initiation of SUD/MAT programs
- To build grantee capacities on the financial sustainability of integrated behavioral health programs
- To leverage innovative, real-time T/TA modalities

IBHS T/TA Requested Topics

- Enhance BHI service delivery
- Prevention & treatment of opioid use disorder
- Medication-assisted treatment
- Tele-behavioral health
- Pain management

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HRSA Health Center Program

Health Center and Home Visiting Program Collaboration

In 2018, health centers provided care for over **563,000** prenatal care patients

74% of prenatal care patients entered prenatal care during their first trimester

8% of newborns had Low Birth Weight (< 2,500 grams)

Strategies to Enhance Collaboration and Integration (2019-2020)

- Improve awareness and knowledge on evidence-based home visiting programs
- Build sustainable partnerships to enhance pregnancy, child health and development, and other family outcomes
- Share promising practices for home visiting service coordination and primary care integration
- Disseminate resources that promote community-level engagement
- Encourage connections and resource sharing around Substance Use Disorder and Mental Health to address gaps in care
- Primary Care and Home Visiting Partnerships to Promote Maternal and Child Health T/TA Webinar

Through Complimentary Services, Health Centers and Home Visiting Programs can:



Resource: HRSA's Maternal and Child Health Bureau's Home Visiting webpage (https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview)

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HRSA Health Center Program

PCAs: Supporting State/Regional Value Transformation

1. Accelerate **Value-Based Care** Delivery
2. Increase **Access** to Comprehensive Primary Health Care
3. Strengthen the Health Center **Workforce**
4. Enhance Health Center **Emergency Preparedness**
5. Advance Health Center **Clinical Quality and Performance**



AMERICAN OVERSIGHT

Thank You!

Sue Lin, PhD, MS

Director, Quality Division, Office of Quality Improvement

Bureau of Primary Health Care (BPHC)

Health Resources and Services Administration (HRSA)

slin@hrsa.gov

bphc.hrsa.gov

Sign up for the *Primary Health Care Digest*

AMERICAN OVERSIGHT

ASTHOConnects

A virtual learning series for public health leaders.



Scott Constantini, BS

Director of Behavioral Health, The Wright Center for Community Health

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THE WRIGHT CENTER for COMMUNITY HEALTH | THE WRIGHT CENTER for GRADUATE MEDICAL EDUCATION

At a Glance:

- **Our Level 3 Patient-Centered Medical Homes** (PCMH), which hold the **FQLA designation**, integrate Primary Medical, Dental, Behavioral Health, Addiction Medicine, Ryan White Infectious Disease, and School-Based Health Center services, providing inclusive access to a seven-county radius in Northeast Pennsylvania.

- **The Wright Center's Graduate Medical Education Safety-Net Consortium** (GME-SNC) has a dual mission to improve the health and welfare of the communities we serve through inclusive and responsive health services and the sustainable renewal of an inspired and competent workforce that is privileged to serve.



AMERICAN OVERSIGHT

Pennsylvania Opioid Use Disorder Center of Excellence

- **Our designations as a Pennsylvania Opioid Use Disorder Center of Excellence** in 2016 and **PacMAT** in 2018 have transformed all of our care delivery service lines and our organizational culture toward recovery.
- We currently have 22 **waivered providers** and 3 who are board-certified in Addiction Medicine.
- 739 total patients served in our OUD-COE since 2016.





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Healthy MOMS (Maternal Opiate Medical Support)

82 total moms served since program began in 2018

54 moms currently in the program

To date, **38 babies** have delivered in Healthy MOMS Program.





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Warm Hand-off Initiative

- Built Collaborative Relationships with Local Partners
- TWCCH Residents Rounding at Local Hospitals
- Educated Hospital Teams / Didactics



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Our Partnership with the State

- We're grateful for the funding and legislative support of **Gov. Wolf, Sec. Dr. Levine, Sec. Miller and Sec. Smith.**
- **State Grants:** PacMAT ($1.75M); PADHS OUD Support Services and Housing ($2.6M); AllOne Opioid Pregnancy Recovery ($500,000); DDAP Pregnancy Support Services ($382,441)
- **Federal Grants:** USDA Distance Learning and Telemedicine ($463,223); HRSA Rural Communities Opioid Response ($1M); SAMHSA MAT-PDOA ($1.5M)





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Jessica Cram, MA, LAC, LPCC
Licensed Addiction Counselor, Denver Health



Sean Buck, MD
Family Physician, Denver Health

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FL-DOH-20-0673-A-004969

OUD, Maternal Outcomes, & Neonatal Abstinence Syndrome

Jessica Cram, MA, LAC, LPCC
&
Sean Buck, MD

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Objectives

- Integrated addiction counselor 2014
- MAT 2016
  - First OB MAT patient in 2019
- Integrated addiction services?
- Case Study
  - Medical perspective
  - Counselor perspective
  - Treatment outcomes

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Medication Assisted Treatment

- Medication
  - Stops cravings
  - Blocks withdrawal
  - Obstructs the effectiveness of opioids/heroin
- Behavioral Support
  - Addiction Counselor
  - Peer support



Success

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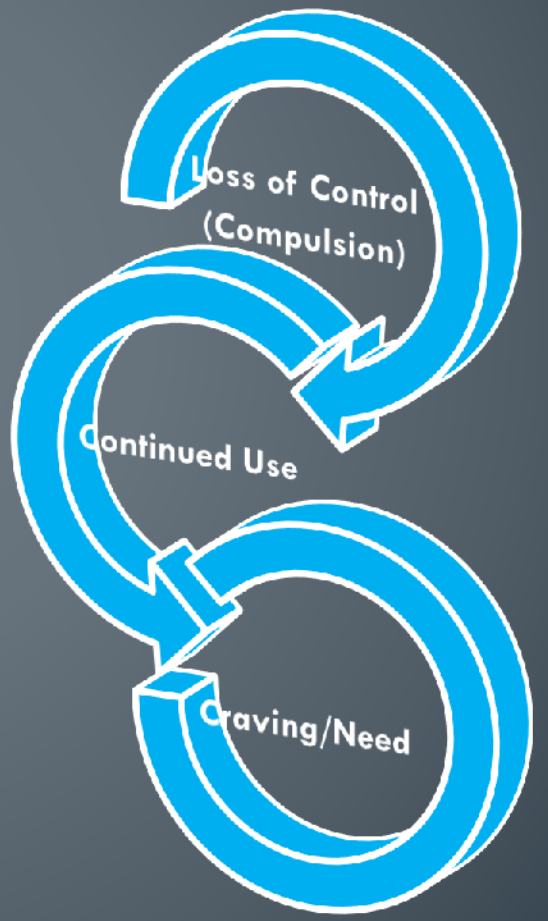
Addiction Considerations?

- Interest in Treatment
- Understand risks/benefits
- No contra-indications (allergy)
- Can follow safety precautions
- Reasonably adherent
- Pregnant or Child-bearing age
- Liver Disease
- Drug-drug interactions
- Detox
- Prior treatment experience
- Psychiatric Stability
- Psychosocial Circumstances
- Co-morbid substance use disorder: alcohol and benzodiazepines
- Readiness?



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Pregnancy Considerations

- NAS counseling (likely 5d stay)
- Likely CPS report
- Drug testing expectations
- Extra US around 32w (nonstandard)
- Many visits, the patient was able to see BH, psych, and LAC or BH, LAC, and MD.
- Many FQHCs are able to provide this integrated care! MDs can counsel specifically on risks of medications and risks to baby of continued use. A few of her MAT visits were converted to OB visits with FHT and size measurements completed.

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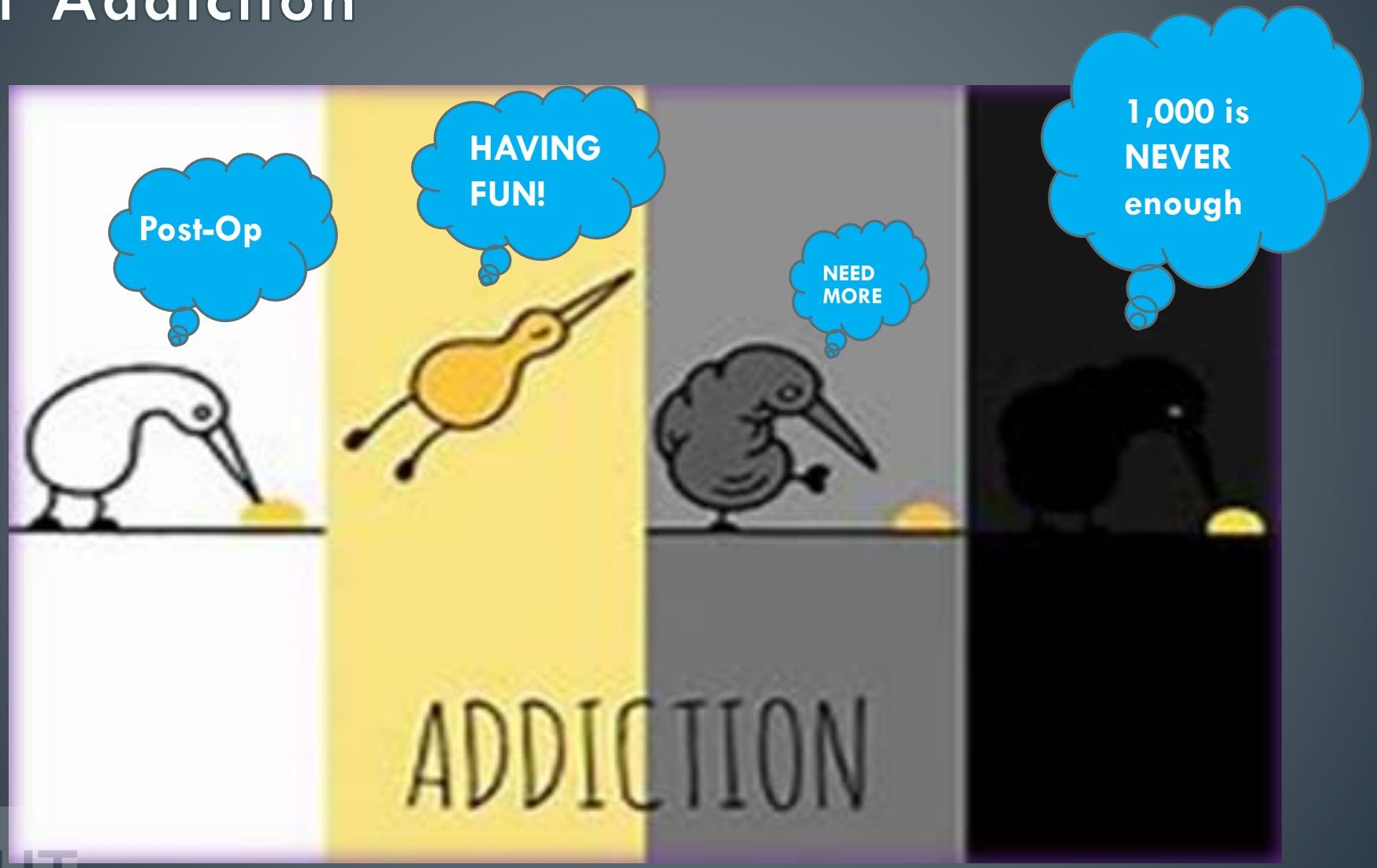
Cycle of Addiction



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Patient-Centered Care

DON'Ts

- Require/Force Treatment
- Offensive language
  - Dirty/clean
  - Junky
  - Addict

DO's

- Chief Complaint??
- Motivational Interviewing
- Educate
- Offer Resources
- Follow DH opioid prescribing guidelines

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Case Presentation

- 31yo G1P0 presents at 8w1d due to missed period. Reports nearly daily opioid (Percocet and IV heroin), methamphetamine (smoking), and cocaine (smoking) use as well as occasional EtOH and daily tobacco use. Reports some IPV (though out relationship) + legal troubles.
- Medical history:
  - ADHD
  - PCOS (on metformin)
  - Generalized anxiety
  - No PSH. SHx: In college for behavioral health BA, reports some IPV (though out of relationship), + legal troubles.

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Continued

- Presents for OBI at 12w3d and due to proximity to Lowry clinic, transitioned care to Lowery for MAT. Also referred to psychiatry at this time. Started on Subutex at this visit and then with fu in six days. No opioid use, no recent meth use, + cocaine use. Engaged in MAT clinic. Fu at 16w3d with MD without concerns. Then some e-cig and MJ use. No return to opioid treatment since starting MAT. Still with consistent cocaine use and + meth at around 14-16w.
- At about 18w, saw psychiatry, who started bupropion (due to h/o ADHD and stimulant use), increase sertraline. Trialed PRN hydroxyzine. At this time, started talking a lot about her guilt surrounding using in pregnancy. Still with + cocaine. First negative utox at around 24w! Continued to be negative and then positive for cocaine around 26w, then negative until + around 36w twice. Socially, she was having lots of conflict with her brother (who she lived with), then moved out to live in a hostel with boyfriend (positive influence).

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Outcome

- Delivered sober at 40w0d due to IOL due to gHTN. Uncomplicated delivery, baby with uncomplicated newborn nursery course with minimal to no NAS (kept for 5d for observation). DH has NAS babies in well-baby nursery, though many placed send to NICU.

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ASTHOConnects

A virtual learning series for public health leaders.

QUESTIONS

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FL-DOH-20-0673-A-004980

What's next?

- State Share TA Calls – March 2020
- Send TA related to your action plan to omni@astho.org

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FL-DOH-20-0673-A-004981

astho™

TELL US WHAT YOU THINK >>

Help ASTHO evaluate
OMNI Learning Community's ASTHO*Connect*
by visiting http://bit.ly/omnipca
on your device now!

AMERICAN OVERSIGHT

FL-DOH-20-0673-A-004982

OMNI Learning Community ASTHOConnects: Engaging Primary Care Associations and Federally Qualified Health Centers

February 4, 2020
Presenter Bios

Sue Lin, PhD, MS



Sue Lin is the Director of the Quality Division in the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, Office of Quality Improvement. She directs HRSA's Advance in Precision Medicine Initiative and oversees the Health Center Program clinical quality initiatives in patient centered medical home transformation and comprehensive primary care integration with behavioral health, substance use disorder, oral health, HIV care, and public health. Sue received her PhD in Epidemiology from the University of Maryland, College Park and MS in Biomedical Engineering from the University of Michigan, Ann Arbor.

Scott Constantini, BS



Scott Constantini is the Director of Behavioral Health at The Wright Center for Community Health and aims to ensure that patients receive comprehensive treatment for behavioral health and addiction issues within the Patient-Centered Medical Home setting. He has over 20 years' experience working directly with individuals with substance abuse challenges and behavioral health disorders and has implemented unique programs and specialized treatment services to effectively treat our community's high-risk population. He oversees The Wright Center's behavioral health service line integration into daily primary care workflow, including the daily operations of planning, organization, direction and controls of services provided. Scott oversaw The Wright Center for Community Health's Opioid Use Disorder Center of Excellence (OUD-COE) startup and implementation in 2017 and actively coordinates with community resources, including inpatient and outpatient providers. He is responsible for distribution and dissemination of the Medically Assisted Treatment (MAT) and community-based case management workflow within the OUD-COE and ensures all required COE data is collected and reported monthly to the state. Scott looks at recovery as a full circle, helping patients change their lifestyle, their thinking and their habits to engage them on the journey to taking better care of themselves.

AMERICAN OVERSIGHT

Jessica Cram, MA, LAC, LPCC



Jessica Cram is a PhD candidate, licensed addiction counselor, and licensed professional counselor candidate. She grew up in the Upper Peninsula of Michigan, moved to Denver in 2010 and doesn't plan on moving. She enjoys the outdoors, mountain hikes, and time with her daughter. Jessica has compassionately cared for individuals with a use disorder since 2010 and does not see an end in sight.

Sean Buck, MD



Dr. Buck is a family physician working in Denver, Colorado. He grew up in Denver, attended the University of Wisconsin School of Medicine and Public Health. He studied addiction medicine, anthropology, and health care administrator. Dr. Buck has a passion for treating patients with a use disorder. He enjoys trail running, skiing, and backpacking.

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: Opportunity for "drive-through" testing site synergy
Date: Tuesday, March 17, 2020 4:41:17 PM

State Health Official –

First, let me thank you for all the work that you are currently doing to respond to COVID-19. We value your dedication to this.

As we continue to monitor and respond to the ongoing COVID-19 outbreak, we are working to drastically increase the number of sites that are testing for coronavirus around the country. As you are aware from the communications from Admiral Brett Giroir, FEMA, and ASPR throughout the past few days, we – in partnership with state and local health authorities – are standing up a number of "drive-through" testing sites across the nation for populations that are most in need of testing. While we are working to operationalize these, we know that there are a number of independent or private sites that are simultaneously opening their own "drive-through" testing operations.

If you are aware of sites in your state that are doing this testing, and are comfortable with sharing those with HHS for publication on the website that we are developing for this response, please share those with the U.S. Health and Human Services team. We want to amplify the availability of these testing operations to connect individuals to testing. You can reply to this email, or call me at the number below.

Please let me know the locations of these operations as soon possible. We are hoping for the location, address, and contact information for those sites. We thank you for your continued partnership and support during this outbreak. The leadership that you provide in your state is invaluable, and we look forward to continuing to work together to protect the health and well-being of the nation.

Thank you,

Michael Baker
Office of Intergovernmental and External Affairs
Office of the Secretary
U.S. Department of Health and Human Services
202-439-7829

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please Register - COVID 19- National Call, Feb. 14th
Date: Thursday, February 13, 2020 5:39:01 PM

State and Local Leaders,

Please join us for a national briefing call **TOMORROW, Friday, February 14 at 1:45 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Additional Information

- You can find more information and resources at the CDC website here: https://www.cdc.gov/coronavirus/.
- ICYMI – USA Today: Our Coronavirus Response Is Protecting Americans (see full Op-Ed below)

Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

ICYMI - Our Coronavirus Response Is Protecting Americans
USA Today
By Secretary of State Mike Pompeo and HHS Secretary Alex Azar
February 11, 2020
Link to op-ed here.

The first duty of the federal government is to keep our citizens safe. Since the United States first became aware on Dec. 30 of what has become known as the novel coronavirus, America's public health officials have closely monitored the situation, worked to understand the virus and taken steps to limit Americans' exposure to it.

Our task force is ensuring that our whole of government, layered, public health plan has the resources necessary to protect Americans. We've treated the sick, and traced back their travel

AMERICAN OVERSIGHT

history and contacts to minimize the spread of the virus. We've worked swiftly to screen and safely receive American travelers returning from China, and bar foreign travelers who have recently visited the epicenter of the outbreak.

Consistent with the World Health Organization International Health Regulations, our travel restrictions were intentionally devised to complement the Chinese government's policy of isolating approximately 50 million of its own citizens in Hubei province. Other nations, such as Italy and South Korea, have taken similar measures.

Our efforts in China

Thus far, the United States has only had 12 confirmed cases of the virus. We were saddened to hear last week that one American, a 60-year-old woman in Wuhan, China, has died. But we're undeterred in our vigilance to protect our people. And we're mobilizing resources around the world to help other nations fight the disease, too. This is American altruism at its finest.

Let's start with our efforts focused on the country where the virus first appeared — China. In the words of President Donald Trump, "We're offering them tremendous help." During the first week of January, the Centers for Disease Control and Prevention made an offer of assistance in order to understand the disease and help bolster response efforts.

The Department of Health and Human Services subsequently provided to the WHO a list of world-class medical professionals ready to deploy their skills in China and learn from China's efforts to combat this new coronavirus. In the last week of January, Secretary Azar personally extended an offer of help to Health Minister Ma Xiaowei; Secretary Pompeo did the same with Chinese State Councilor Yang Jiechi. We hope the mission will commence immediately, whether bilaterally or under the auspices of the WHO.

We've also facilitated the delivery of vast amounts of medical supplies to the Chinese people. Just last week, the State Department helped transport 17.8 tons of relief supplies to Hubei. And more assistance will continue to be offered — the United States is prepared to spend up to $100 million in existing State and U.S. Agency for International Development funds to assist China and other impacted countries to contain and combat the virus.

While State managed the logistics, the donations themselves were provided by Samaritan's Purse, Boeing, Intermountain Healthcare and The Church of Jesus Christ of Latter-day Saints, and coordinated by a nongovernmental organization called Project HOPE. Time and again, when diseases and disasters strike, the American people have stepped up to help citizens of other countries without being asked. Our robust charitable giving and enthusiastic civil society groups are channeling the American people's concern for their fellow man.

Cooperation with other nations

Then there are America's actions to help the citizens of other countries, beyond China. CDC staff based in more than 60 countries are working closely with ministries of health and other health partners, often in conjunction with their colleagues at the State Department and other federal agencies.

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For instance, the United States has made coronavirus test kits available to 191 qualified laboratories around the world; so far, labs from 36 countries have put in orders. We've deployed staff to train health professionals in 15 hospitals in Vietnam. In Kenya, health experts at the U.S. Embassy in Nairobi, as part of our Infectious Diseases Task Force, engaged the government early on to recommend best practices in airport screening and public health.

Our quick and effective reaction abroad is facilitated by partnerships that America has carefully nurtured over decades — long before the latest outbreak.

We believe our actions will slow the transmission of the virus to and within the United States and other countries, solidify our ties of friendship with our allies and partners, and help save lives by giving us more time to refine preparedness measures and better understand the virus.

We all hope that our concerted efforts will control the virus and cause it to subside. But the world doesn't need to wait for that day to see how America remains a force for good throughout the globe.

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please Register - COVID 19- National Call, Feb. 14th
Date: Thursday, February 13, 2020 5:39:29 PM

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Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
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Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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February 11, 2020
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AMERICAN OVERSIGHT

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To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please Register - COVID 19- National Call, Feb. 14th
Date: Thursday, February 13, 2020 5:38:57 PM

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AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject: Please Register: National Briefing Call TODAY, February 3rd; 12 PM EST
Date: Monday, February 3, 2020 9:22:10 AM

State and Local Leaders,

Please join us for a national briefing call **TODAY, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Briefing Call
Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
Call-In Information: CLICK HERE *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject: Please Register: National Briefing Call TODAY, February 3rd; 12 PM EST
Date: Monday, February 3, 2020 9:28:47 AM

State and Local Leaders,

Please join us for a national briefing call **TODAY, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Briefing Call
Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
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Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Stevens, Lee (OS/IEA)
Subject: Please Register: National Briefing Call TODAY, February 3rd; 12 PM EST
Date: Monday, February 3, 2020 9:18:25 AM

State and Local Leaders,

Please join us for a national briefing call **TODAY, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Briefing Call
Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
Call-In Information: CLICK HERE *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

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From:	Ashley Vineyard
To:	FBD3@CDC.GOV; CSZ5@CDC.GOV; SFV1@CDC.GOV; cnd8@cdc.gov; CUE0@cdc.gov; Carina Blackmore; Elizabeth.Dykstra@DOH.WA.GOV; Christine Scott-Waldron; elizabeth.schiffman@state.mn.us; Sally Slavinski; Jen Brown; Esther Ellis; krymason@pa.gov; Catherine Brown; Abelardo Moncayo; John Dunn; Melissa.Kretschmer@Maricopa.gov; jennifer.house@state.co.us; conlonamcata@gmail.com; coridley-smith@naccho.org; mgustafson@neha.org; BHess@neha.org; Courtney Youngbar; kelly.wroblewski@aphl.org
Cc:	Justin Snair
Subject:	Please Review: Draft VBD Program Core Components Manuscript
Date:	Tuesday, March 3, 2020 9:29:31 AM
Attachments:	image001.png SGNL VBD Program Components Project_Draft Project Summary_final.docx

Good morning all,

Please review the attached draft "Defining the Components and Minimal Capabilities of Comprehensive State and Local Vector-Borne Disease Prevention and Control Programming" manuscript and submit any suggested edits, comments, and questions to Justin Snair (jsnair@sgnl.solutions) by **COB Friday, March 13th.**

Please also complete this doodle poll to indicate your availability for an upcoming webinar to present the final manuscript and discuss implementation.

Thanks,

Ashley Vineyard, MPH
Program Analyst II

CSTE

Council of State and Territorial Epidemiologists
"Using the power of epidemiology to improve the public's health"
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Documents with personal data and/or confidential information must be sent to CSTE's national office only through a secure ShareFile request and not through regular email.

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DEFINING THE COMPONENTS AND MINIMAL CAPABILITIES OF COMPREHENSIVE STATE AND LOCAL VECTOR-BORNE DISEASE PREVENTION AND CONTROL PROGRAMMING

PROJECT SUMMARY

2019 – 2020

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EXECUTIVE SUMMARY

In 2019 – 2020, SGNL Solutions (SGNL), in consultation with the Council of State and Territorial Epidemiologists (CSTE) and with the financial support from the Centers for Disease Control and Prevention (CDC), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Vector-Borne Diseases (DVBD), facilitated a consensus process with local, state, and national level stakeholders to identify the components and capabilities of a comprehensive approach framework (the framework) to reduce illness and death from vector-borne diseases (VBD). SGNL also analyzed available data to attempt to determine the cost of resources needed to support a comprehensive approach in VBD programs at both the minimal and optimal performance levels. SGNL employed an iterative, consensus-based, mixed-methods approach involving five conference calls with an expert working group, two in-person workshops, an online self-assessment, key informant interviews, and an extensive information gathering and analysis process. Through this process, six components with numerous sub-components and associated minimal capabilities were developed. The process also revealed several challenges, namely an absence of necessary measures and data needed to conduct a cost analysis. SGNL also sought to coordinate the framework with CDC's effort to develop a national strategy for VBD prevention, but given the timing of CDC's strategy development, this coordination was not accomplished. Future alignment between efforts could help strengthen the national VBD strategy and further improve the framework.

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ACKNOWLEDGEMENTS

We would like to acknowledge and thank the following people and organizations for their contributions to this project:

Justin Snair, MPA, SGNL Solutions; Megan Snair, MPH, SGNL Solutions; Laura Runnels, MPH, LAR Consulting; Jordan Peart, MPH and the Council of State and Territorial Epidemiologists; Chris Duggar and the Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Vector-Borne Diseases (DVBD); and the workgroup members and stakeholders who dedicated their time to speaking with us.

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BACKGROUND

Vector-borne diseases (VBDs) are caused by infective pathogens that are transmitted by living organisms (e.g., ticks, mosquitos, fleas) between humans or from animals to humans. VBDs are a major public health concern in the United States. Between 2004 and 2016, more than 640,000 cases of VBDs were reported in the United States, and 9 new germs spread by bites from infected mosquitoes and ticks were discovered or introduced domestically.[1] Disease cases from mosquito, tick, and flea bites tripled in the United States during this period. Since 2014, major outbreaks of dengue, malaria, chikungunya, yellow fever, and Zika have afflicted populations, claimed lives, and overwhelmed health systems across the globe. While the United States has not yet experienced this level of VBD outbreak, recent reports by the Centers for Disease Control and Prevention (CDC) indicate that the number of cases of domestic VBDs has increased, emerging VBDs pose a rising threat, and jurisdictions have limited capacity to respond.[2] In an assessment conducted by the National Association of County and City Health Officials (NACCHO), 84% of state and local health departments and vector control organizations (the nation's main defense against VBDs) need improvement in at least one core competency area based on the standards for vector control competency developed and promoted by the CDC and American Mosquito Control Association (AMCA).[3] In most jurisdictions across the United States, a comprehensive approach to VBD prevention requires a system in which multiple partners (private, public, and academic) contribute resources and perform mutually reinforcing activities to meet common goals. However, consensus over what constitutes such a comprehensive, jurisdiction-wide approach has not yet been reached.

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[1] CDC Vital Signs. May 2018. https://www.cdc.gov/vitalsigns/pdf/vs-0518-vector-borne-H.pdf
[2] Ibid.
[3] Mosquito Control Capabilities in the U.S. October 2017. https://www.naccho.org/uploads/downloadable-resources/Mosquito-control-in-the-U.S.-Report.pdf

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PROJECT APPROACH

In 2019, SGNL Solutions (SGNL), in consultation with the Council of State and Territorial Epidemiologists (CSTE) and with the financial support from the CDC's National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Vector-Borne Diseases (DVBD), facilitated a consensus process with local, state, and national level stakeholders to identify the components and capabilities of a comprehensive approach framework (the framework) to reduce illness and death from vector-borne diseases. SGNL also analyzed available data to determine the cost of resources needed to support a comprehensive vector-borne disease program at both the minimal and optimal performance levels. The original Scope of Work can be found in Box 1.

Timeline

The initial project timeframe was February 15, 2019 to July 31, 2019. However, the contract was extended to December 31, 2019 to provide additional time to coordinate with and be informed by CDC's effort to develop a national strategy for VBD. The project was extended a second time to July 31, 2020 to allow for time to present the findings to the workgroup.

Key Terms

Burden of Disease	Disease burden is the impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators.
Components	Elements and structures that make up a vector-borne disease (VBD) system within a jurisdiction (e.g., city, county, territory, state)
Capabilities	Specific activities/functions within each component that entities of a VBD system within a jurisdiction should be able to collectively perform
Competencies	The specific knowledge, skills, and abilities needed or possessed by individuals within entities of a VBD system within a jurisdiction

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Disability-Adjusted Life Year (DALY)	the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences
Quality-adjusted life years (QALYs)	a measure of disease burden, including both the quality and the quantity of life lived

BOX 1 – SCOPE OF WORK

SGNL Solutions will develop a consensus definition of the key elements for a comprehensive state and local vector-borne disease program. This definition will define the core components and competencies needed for each key element to include a range from minimal to optimal performance. SGNL Solutions will lead a workgroup with relevant stakeholders, including federal, state, and local epidemiologists and members of partner organizations to assess existing vector-borne disease programs of varying sizes and vector-borne disease burden. SGNL Solutions will also analyze available data and complete a cost analysis of the resources needed to support a comprehensive vector-borne disease program at both the minimal and optimal performance levels. SGNL Solutions will develop a report, a manuscript suitable for publication in a peer-reviewed journal, and a webinar presentation with key findings.

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ACTIVITIES, METHODS, AND PROCESS

SGNL designed and undertook an iterative, consensus-based, mixed-methods process to achieve the project goals. SGNL enlisted the support of the CSTE Vector-Borne Diseases (VBD) Subcommittee and additional national partners (together constituting "the workgroup") and CDC to inform the project activities. Activities included an environmental scan, workgroup conference calls, in-person stakeholder workshops, and an assessment. Descriptions of each activity are provided below. After the process, most workgroup members agreed that components in the framework represented a comprehensive VBD prevention approach and that the minimal capabilities could be considered appropriate as minimal performance.

Workgroup Calls

SGNL conducted five conference calls (see Appendix A for workgroup member list). During each call, the workgroup provided feedback on the current draft of the framework. Audio recordings of the workgroup calls are included with the submission of this report. The first and second workgroup calls oriented the workgroup members to the project goals and offered an opportunity to ask clarifying questions to CDC. The following questions were explored:

- What is CDC's vision for VBD control and prevention?
- What is the vision for VBD control and prevention from the perspective of workgroup members? Does this match CDC's vision?
- What is the purpose of the comprehensive VBD program core components and capabilities?
- What is the mission of a comprehensive VBD program?
    - What are the desired outcomes?
- How do we define comprehensive?

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    - Do we include public, private, and academic?
- What factors influence variability in VBD programs?
- What costs are involved with various program components and are data available to be shared?

The third and fourth workgroup calls focused reviewing revisions to the framework and gaining a better understanding of VBD program costs in local and state jurisdictions. The following questions were explored:

- Is the component done by the health department (HD), another governmental entity, or by an external party?
- If done by HD or governmental entity, how many FTEs support the component?
- What is/are the funding source(s) for the component?

The objective of the fifth workgroup call was to validate the revised framework and core capabilities.

Environmental Scan

SGNL conducted an extensive discovery and analysis process based on available reports, data, and evaluations of domestic VBD prevention programming, VBD burden, and associated resource costs. SGNL also provided the workgroup access to an online document repository to submit relevant documents. The environment scan aimed to answer the following questions.

- How do we define vector and VBD?
- What do we know about VBD programs? Have descriptive studies of state or local programs been conducted?

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- Have assessments of state or local program capabilities occurred (surveillance, epi, prevention, mitigation)?
- Do related comprehensive components or core capabilities exist?
- What else might we need to align with (federal guidelines, existing standards from Association for Public Health Laboratories, CSTE, Public Health Accreditation Board)?
- What are examples of standards/core components/capabilities that are adaptable?

In-Person Workshops

SGNL held two in-person stakeholder workshops (see Appendix C) for agendas and facilitation guides). The first in-person exploratory workshop was with stakeholders at NACCHO's 2019 Vector Summit. The workshop objectives were to:

- Identify components of a comprehensive VBD program
- Identify capabilities, or specific activities and functions, for various components
- Determine the extent to which components and capabilities are essential or adaptable (can be changed to meet local needs without compromising effectiveness)?

Approximately 15 attendees from local, state, and private/semi-private organizations participated in the workshop. Attendees were provided context and led through a concept mapping process. Although SGNL staff used the then current draft of the Framework to design the discussion, attendees were not asked to review and respond to the draft in order to gather unbiased reactions. Following this workshop, SGNL organized and facilitated a second

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in-person workshop with personnel from CDC DVBD. Objectives for this workshop were to:

- Identify the vectors of concern, categorized by core, enhanced, and comprehensive
- Identify the vector borne diseases of concern, categorized by core, enhanced, and comprehensive
- Explore the possible program components employed to address the vectors and VBDs of concern, categorized by core, enhanced, and comprehensive

This workshop resulted in a more refined definition of the minimal capabilities within the comprehensive framework that should be exercised in state and local jurisdictions.

Online Self-Assessment

SGNL designed and administered an online self-assessment based on the framework to determine to what extent the components and capabilities were present in range of jurisdictions and to understand the resources and funding associated with those components and capabilities. Nineteen workgroup members responded to the online assessment. The full instrument and findings can be found in Appendix B. The assessment was designed to explore the following questions.

- Did the respondent's organization perform any surveillance, prevention, or control activities related to six vectors of concern (mosquitoes, ticks, and fleas, and triatominae/kissing bugs, lice, and deer flies)?
- Did the respondent's organization perform any surveillance, prevention, or control activities related to 30 VBDs?

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- To what extent were the framework components present in their jurisdiction through the work of the health departments or other organizations?
- Who in their jurisdiction (whether their organization or another organization) was primarily responsible for the core capabilities?
- How did their organization fund the VBD-related efforts performed in the current budget year?
- What were the sources of funding, number of FTEs, types of activities, and infrastructure supported by the funding?

It should also be noted that throughout this project, SGNL made an effort to coordinate our findings and products with CDC's effort to develop a national strategy for VBD prevention. However, the national strategy development process is still underway, so we were not able to align the framework with that effort in the given timeline.

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FRAMEWORK OF COMPONENTS AND MINIMAL CAPABILITIES OF COMPREHENSIVE STATE AND LOCAL VBD PREVENTION AND CONTROL PROGRAMMING

Through the activities, methods, and processes undertaken by SGNL, the following framework of the components and minimal capabilities within a comprehensive approach to state and local VBD prevention and control was developed. Our findings indicate that in most jurisdictions across the United States, a comprehensive approach to VBD prevention requires a system in which multiple partners (private, public, and academic) contribute resources and perform mutually reinforcing activities to meet common (though possibly uncoordinated) VBD prevention and control goals. Therefore, rather than focusing entirely on the activities of state and local health departments, this framework reflects the components and minimal capabilities of a system of stakeholders jointly contributing towards VBD prevention and control.

Key Terms

- Components are elements and structures that make up a VBD system within a jurisdiction (e.g., city, county, territory, state).
- Minimal capabilities are specific activities and functions within each component that entities of a VBD system within a jurisdiction should be able to collectively perform.

These components and minimal capabilities are not listed in order of priority.

COMPONENT 1: A designated, functioning mechanism for convening system partners to coordinate VBD efforts.

1.1: Leadership that is knowledgeable and supportive of efforts to address VBD
1.2: A convening entity or mechanism (e.g., program, multi-partner collaborative)
1.3: A plan to address VBD in jurisdiction

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Minimal Capabilities

- Identify, access, and educate leaders within the jurisdiction.
- Identify priorities based on surveillance data and public perceptions.
- Include VBD in an all hazards planning process within the jurisdiction.
- Identify and interact with other VBD stakeholders within the jurisdiction.
- Develop a comprehensive and coordinated strategy for VBD efforts within the jurisdiction.

COMPONENT 2: Resources (e.g., facilities, staffing, partnerships, and funding) that can be used and leveraged to support and sustain VBD prevention efforts.

2.1: Facilities, infrastructure, and materials necessary to address VBD
2.2: Staff that possess the core competencies and qualifications necessary to effectively address VBD
2.3: Sustainable, right-sized funding to support VBD prevention
2.4: Partnerships, collaborations, and/or agreements with key local, regional, and state, national, and private sector organizations

Minimal Capabilities

- Maintain a database for VBD related data (e.g., case reporting, surveillance, and analysis).
- Utilize a data transmission mechanism (e.g., HL7).
- Assign epidemiology staffing to support VBD programming.
- Assign laboratory staffing to support VBD programming.
- Assign communications staffing to support VBD programming.

COMPONENT 3: Surveillance system aimed at the accurate and timely measurement of vector ecology and patterns of disease.

3.1: Data collection mechanisms (e.g., pathogen, serological, clinical, syndromic, ecology, vector, risk factors)
3.2: Analysis mechanisms (e.g., laboratory, informatics, GIS)
3.3: Staff that possess the core competencies and qualifications to interpret analysis outputs
3.4: Established mechanisms for disseminating surveillance information to leadership, collaborators, and the public

Minimal Capabilities

- Maintain general awareness of vector distribution
- Collect VBD case reports from providers.

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- Confirm VBD cases.
- Transmit case information as required by local, state, and national regulations.
- Conduct routine surveillance activities at local, state, and national levels.

COMPONENT 4: System that makes use of mutually reinforcing, data-driven, evidence-based actions to reduce VBD morbidity and mortality.

4.1: Routine review of local data regarding ecology, disease transmission, and other factors (e.g., resistance, public perceptions, resources) to select appropriate prevention and control strategies
4.2: Evidence-based practices related to communication, education, and outreach to the public regarding risk and preventive strategies
4.3 Evidence-based practices related to vector control including environmental alterations (improved design or operation of infrastructure), chemical, physical and cultural control
4.4 Consideration of the public health and ecological impacts on VBD of established and proposed laws, regulations, and infrastructure development, and the enforce laws and regulations that affect VBD

Minimal Capabilities

- Provide timely information about specific risks and comprehensive mitigation strategies to the public, partners, and decision makers.
- Ensure use of a comprehensive menu of evidence-based interventions and adaptation considerations options across social ecological model.

COMPONENT 5: Prepared to react to novel VBD situations (e.g., outbreak).

5.1: Defined risk scenarios based on local data (e.g., jurisdictional characteristics, stakeholder perceptions)
5.2: An early warning system in which reception of predefined signals (e.g. novel vector, novel VBD above norm for place or time, unexpected increase of known vector or VBD, situation exceeding capacity to respond) triggers interventions
5.3: Authorities and collaborators prepared for outbreaks of diseases prior to their arrival

Minimal Capabilities

- Identify risks (vectors, diseases, ecology, public perceptions).

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- Determine thresholds for response.
- Activate communication mechanism when response is triggered.

COMPONENT 6: Evaluation and continuous improvement of VBD processes, programs, and interventions.

6.1: Evaluation of interventions and technologies in practice
6.2: Development and testing of possible new interventions and technologies
6.3: Dissemination of findings from evaluation for local improvements
6.4: Contribution of findings to the evidence base of the field

Minimal Capabilities

- Formally evaluate VBD processes, outputs, and outcomes.
- Use evaluation findings to improve VBD efforts.

CHALLENGES TO DEFINING A COMPREHENSIVE APPROACH

Reaching agreement over several key project concepts and definitions presented significant challenges to the workgroup and slowed the framework development process. Most difficult was reaching consensus on the breadth of a comprehensive VBD prevention approach. Specifically, is a comprehensive approach exclusive to state and local health departments or is it inclusive of the entire system (i.e., state and local health departments and other stakeholders)? Similarly, the workgroup heavily debated the meaning of the term core components. For example, the inclusion of academic research and product development and testing (e.g., field testing and evaluating new mitigation products by private entities) was a point of contention. Some workgroup members agreed that this element was essential, or core, to a comprehensive approach while others were reluctant to include an activity that their health departments did not currently include in their VBD prevention efforts. However, it is our belief, and one that was confirmed through discussions with CDC, that in most jurisdictions across the United States, a comprehensive approach to VBD prevention requires a system in which multiple partners (private, public, and academic) contribute resources and perform mutually reinforcing (though not necessarily coordinated or through formal partnerships) activities to meet common

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goals. We understood this to mean that our charge was to define all the components that could be done in a jurisdiction, or affected by, public, private, and academic partners as core. The proposed framework reflects this.

These difficulties may be related to the composition of the workgroup itself, which included mostly state (75%) and local (6%) VBD health department stakeholders and national association representatives (19%). Also, because VBD concerns are variable by geographic area, needs can differ widely state to state. Therefore, consensus about what should be considered a comprehensive VBD prevention approach could be better framed regionally, rather than nationally. Furthermore, if academic or private sector partners were also involved, we may have found more agreement with a system wide approach.

Interestingly, when polled individually via an online self-assessment, most workgroup members indicated that all the framework components were either primarily performed by their organization or by another organization within their jurisdiction, confirming a system of stakeholders providing reinforcing activities. There are limitations in the findings from the online self-assessment. Because the respondents were all members of the workgroup, the state health department perspectives were most dominant. Greater representation of local public health, academic, and private sector respondents in the self-assessment may have yielded more diverse results.

Another challenge involved determining which capabilities constituted minimal to optimal performance. Workgroup agreement over what should be considered minimal or optimal performance was not reached, nor were we able to achieve clarity from CDC on what constitutes “optimal”. This reluctance within the workgroup could be related to perceived negative undertones related to the terms “minimal” and “optimal”, and possible future judgments or consequences (i.e. financial). With the help of CDC, we did define minimum desired capabilities within the components. Again, when

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polled individually via the online self-assessment, most workgroup members indicated that nearly all the minimum capabilities in the framework were done in their jurisdictions. However, without a clearly defined definition of “optimal”, we were unable to derive the upper end of this performance range.

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CHALLENGES PREVENTING A COST ANALYSIS

SGNL was charged with analyzing available data and completing a retrospective cost analysis of the resources needed to support a comprehensive vector-borne disease program at both the minimal and optimal performance levels. However, a cost analysis was not possible given the information available at the time of this project.

A cost analysis involves the systematic collection, categorization, and analysis of costs (resources and inputs) associated with a public health program or intervention. Resources and inputs include the labor, buildings, supplies, and equipment used in the delivery of a program. A cost analysis must also consider both the financial and economic costs. Financial costs are those most easily ascertained, such as those in included in a program budget or department expenditure data. Economic costs are costs that exist but may not involve a direct exchange of funding from the program or is provided by another partner in the system. These costs have monetary value but are often hidden. Considering both types costs in a cost analysis is important, doing otherwise will result in an incomplete picture of the resources involved in a program. Such an analysis is not meant to include the change in health outcomes (e.g., morbidity and mortality) and whether the program was effective (e.g., cost benefit analysis). A cost analysis answers the following questions:

1. How much does it cost to implement a program or intervention?
2. Where do the resources to cover the cost come from (the state and local public health system, CDC's, or all parties involved in a comprehensive approach to VBD prevention)?
3. What are the program and cost categories involved?

We undertook several data gathering methods to gather the information needed for the cost analysis. We dedicated large portions of five workgroup calls to discussing program costing and asked cost and funding specific questions in the online self-assessment. SGNL also gathered publicly available VBD program budget documents for some states (California and

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Florida) and local jurisdictions. We made multiple requests to workgroup members for cost-related data but received none. We also reviewed the Epidemiology and Laboratory Capacity (ELC) funding amounts provided by CDC, but that data only showed what was awarded by CDC to the jurisdictions, not the total cost of jurisdiction VBD programming. We gathered data on vector prevalence and disease cases across jurisdictions of various sizes and sought VBD programming budgets for those jurisdictions. While this information and data gathered afforded some insight into costing of individual VBD programs, these efforts did not provide enough data to reveal a pattern to programming cost consistent across jurisdictions and states. No discernable pattern or indicators, such vector prevalence, disease prevalence, cost of the diseases, mortality, morbidity, jurisdiction spending per capita, or FTEs per $100,000 in funding, emerged to help us understand costs or budgeted amounts that could be compared across jurisdictions as part of a cost analysis. Funding for VBD programming seemed to be determined less by measurable, outcome-driven factors and more by perception of risk and political motives and pressures. Our task was further complicated in that it involved not only an accounting of the actual costs associated with a single jurisdiction’s VBD prevention programming, but also an analysis of the costs of a proposed comprehensive VBD approach that had not been fully vetted by all system stakeholders at minimal and optimal performance levels, which had not yet been defined.

A cost analysis is an important undertaking and could help ensure adequate and strategic funding of VBD prevention programs. While a cost analysis was not possible at this time given the information available to SGNL, an effort could be made in the future once program performance levels are defined and the comprehensive approach components (an output of this project) are better socialized and used within program budgets and CDC funding opportunities. In addition, a cost benefit analysis that involves correlated costs to benefits or outcomes (e.g., population size, vector and

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disease prevalence, mortality, morbidity, disability adjusted life years, quality of life years) would further support the CDC's mission.

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RECOMMENDATIONS

Overall, workgroup members, in-person workshop participants, and other consulted stakeholders seemed supportive of the effort to define the components of comprehensive VBD prevention approaches. Furthermore, we found that most agreed with the current framework as drafted. However, additional steps could be taken to improve upon the framework and to conduct a cost analysis. The following recommendations are not listed in order of priority and can be completed independent of other recommendations.

Components of a Comprehensive VBD Prevention Approach

- Define "optimal" capabilities for each component.
- Define metrics necessary to assess performance across a minimal to optimal capability range.
- Conduct additional pilot tests, especially with local, academic, and private sector representatives, to collect feedback on and further refine the framework.
- Use the framework to inform CDC's effort to develop a national strategy for VBD to ensure alignment of concepts and consistency of terminology.
- Make use of the framework components as programming categories within CDC's ELC funding opportunity.

Costs of a Comprehensive VBD Approach

- Define indicators beyond case incidence, such as DALYs and QALYs associated with VBD in the United States, that could be compared across jurisdictions.
- Develop and require/encourage the use of a standard approach (which includes the costs of all involved parties in the VBD prevention

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systems) to conduct a cost analysis for use by local and state VBD programs receiving ELC funding.

- Make use of such a standard cost analysis as part of the ELC funding process.

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APPENDIX A: WORK GROUP MEMBERS

Vector-Borne Disease Program Core Components Workgroup Roster

Members

Nicole Lindsey	CDC
Roxanne Connelly	CDC
Sue Visser	CDC
Chris Duggar	CDC
Alison Hinckley	CDC
Carina Blackmore	Florida Department of Health and CSTE VBD Subcommittee Co-chair
Elizabeth Dykstra	Washington State Department of Health and CSTE VBD Subcommittee Co-chair
Christine Scott-Waldron	Louisiana Department of Health
Elizabeth Schiffman	Minnesota Department of Health
Sally Slavinski	New York City Department of Health and Mental Hygiene
Jennifer Brown	Indiana State Department of Health
Esther Ellis	USVI Department of Health
Krystal Mason	Pennsylvania Department of Health
Catherine Brown	Massachusetts Department of Public Health
Abelardo Moncayo	Tennessee Department of Health
John Dunn	Tennessee Department of Health
Melissa Kretschmer	Maricopa County Department of Public Health
Jennifer House	Colorado Department of Public Health and Environment
Joe Conlon	AMCA
Chelsea Gridley-Smith	NACCHO
Sandra Whitehead	NEHA
Ayana Jones	NEHA
Courtney Youngbar	ASTHO
Kelly Wroblewski	APHL

Staff

Justin Snair	SGNL Solutions (Project Lead)
Laura Runnels	LAR Consulting (Facilitator and Process Designer)
Jordan Peart	CSTE

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APPENDIX B: VBD PROGRAM SELF-ASSESSMENT AND FINDINGS

ONLINE SELF-ASSESSMENT INSTRUMENT

Thank you for agreeing to take part in this assessment exploring the components, capabilities, and resourcing of state and local approaches to reduce illness and death from vector-borne diseases (VBD).

We recognize that in most jurisdictions, VBD prevention requires a system in which multiple partners contribute resources and perform mutually reinforcing activities to meet common goals. As such, you will be asked questions related to your own organization and your partners. Your responses will be compiled and used only in the aggregate with no individual attribution. The assessment is expected to take approximately 30 minutes to complete.

If you have questions about this assessment, please contact the project director, Justin Snair, at jsnair@sgnl.solutions. Please click the red button below to begin the assessment.

Page Break

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Q3 Select the options that best matches your organization.

- ○ State Government
- ○ Local or County Government
- ○ Territorial Government
- ○ Non-Profit Organization
- ○ Corporation

Q4 Enter the name of your organization/program.

_____

Q5 Enter the name of your jurisdiction.

_____

Q6 Enter your jurisdiction’s population size.

_____

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Q7 Does your **organization** perform any surveillance, prevention, or control activities related to the following vectors?

	Yes	No	Don't Know
Mosquitoes	○	○	○
Ticks	○	○	○
Fleas	○	○	○
Lice	○	○	○
Triatominae/Kissing Bugs	○	○	○
Deer Flies	○	○	○
Other	○	○	○
Other	○	○	○

Page Break

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Q8 Does your **organization** perform any surveillance, prevention, or control activities related to the following diseases?

	Yes	No	Don't Know
Rocky Mountain Spotted Fever	○	○	○
Lyme	○	○	○
Tularemia	○	○	○
West Nile	○	○	○
Babesia	○	○	○
Plague	○	○	○
Anaplasmosis	○	○	○
Western Equine Encephalitis	○	○	○
Colorado Tick Fever	○	○	○
Jamestown Canyon	○	○	○
Eastern Equine Encephalitis	○	○	○
Powassan	○	○	○
Japanese Encephalitis	○	○	○
Yellow Fever	○	○	○
Zika	○	○	○

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Dengue	○	○	○
LaCrosse	○	○	○
Ehrlichia	○	○	○
Saint Louis Encephalitis	○	○	○
Tick-borne Relapsing Fever	○	○	○
Q Fever	○	○	○
Chikungunya	○	○	○
Bourbon	○	○	○
Heartland	○	○	○
B. miyamotoi	○	○	○
Tick Paralysis	○	○	○
Leishmaniasis	○	○	○
Chagas	○	○	○
Other	○	○	○
Other	○	○	○

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Q10
We recognize that in most jurisdictions a comprehensive approach requires a system in which multiple partners contribute resources and perform mutually reinforcing activities to meet common goals.

Components are the elements and structures that make up a vector-borne disease (VBD) system within a jurisdiction (e.g., city, county, territory, state). Capabilities are the specific activities/functions within each component that entities of a VBD system within a jurisdiction should be able to collectively perform.

Consider **all of the organizations and programs in your jurisdiction**

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that work to reduce VBD morbidity and mortality. Indicate the extent to

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which you agree with each component statement.

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
My jurisdiction has a designated, functioning mechanism for convening partners to plan and coordinate VBD efforts.	○	○	○	○	○
My jurisdiction has resources (e.g., facilities, staffing, partnerships, and funding) that can be used and leveraged to support and sustain VBD prevention efforts	○	○	○	○	○
My jurisdiction has a surveillance system aimed at the accurate and timely measurement of the introduction of vectors and pathogens and the incidence of disease.	○	○	○	○	○

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My jurisdiction makes use of mutually reinforcing, data-driven, evidence-based actions to reduce VBD morbidity and mortality	○	○	○	○	○
My jurisdiction is prepared to react to novel VBD situations (e.g., outbreak).	○	○	○	○	○
My jurisdiction evaluates and continuously improve its VBD processes, programs, and interventions.	○	○	○	○	○

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Q11 COMPONENT 1: A designated, functioning mechanism for convening partners to coordinate VBD efforts

1.1: Leadership that is knowledgeable and supportive of efforts to address VBD
1.2: A convening entity or mechanism (e.g., program, multi-partner collaborative)
1.3: A plan to address VBD in jurisdiction

Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

	Primarily supported by my organization	Primarily supported by other organizations	Not present in my jurisdiction	Don't know
Identify, access, and educate leaders within the jurisdiction.	○	○	○	○
Identify priorities based on surveillance data and public perceptions.	○	○	○	○
Include VBD in an all hazards planning process within the jurisdiction.	○	○	○	○
Identify and interact with other VBD stakeholders within the jurisdiction.	○	○	○	○
Develop a comprehensive and coordinated strategy for VBD efforts within the jurisdiction.	○	○	○	○

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Q13 COMPONENT 2: Resources (e.g., facilities, staffing, partnerships, and funding) that can be used and leveraged to support and sustain VBD prevention efforts.

2.1: Facilities, infrastructure, and materials
2.2: Staff that possess the core competencies, qualifications, knowledge, and skills necessary to effectively address VBD
2.3: Sustainable, right-sized funding
2.4: Partnerships, collaborations, and/or agreements with key local, regional, and state, national, and private sector organizations

Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

	Primarily supported by my organization	Primarily supported by other organizations	Not present in my jurisdiction	Don't know
A database for VBD related data (e.g., case reporting, surveillance, and analysis).	○	○	○	○
A data transmission mechanism (e.g., HL7).	○	○	○	○
Dedicated epidemiology staffing for VBD. Enter the FTE in the text box.	○	○	○	○
Dedicated laboratory staffing for VBD. Enter the FTE in the text box.	○	○	○	○
Dedicated communications staffing for VBD. Enter the FTE in the text box.	○	○	○	○

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Q14 COMPONENT 3: Surveillance system aimed at the accurate and timely measurement of vector ecology and patterns of disease.

3.1: Data collection (e.g., pathogen, serological, clinical, syndromic, ecology, vector, risk factors)
3.2: Analysis (e.g., laboratory, informatics, GIS)
3.3: Interpretation of analysis outputs
3.4: Dissemination of surveillance information to leadership, collaborators, and the public

Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

	Primarily supported by my organization	Primarily supported by other organizations	Not present in my jurisdiction	Don't know
Collect VBD case reports from providers.	○	○	○	○
Confirm VBD cases.	○	○	○	○
Transmit case information as required by local, state, and national regulations.	○	○	○	○
Conduct routine surveillance activities at local, state, and national levels.	○	○	○	○

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Q15 COMPONENT 4: System that makes use of mutually reinforcing, data-driven, evidence-based actions to reduce VBD morbidity and mortality

4.1: Routine review of local data regarding ecology, disease transmission, and other factors (e.g., resistance, public perceptions, resources) to select appropriate prevention and control strategies
4.2: Evidence-based practices related to communication, education, and outreach to the public regarding risk and preventive strategies
4.3 Evidence-based practices related to vector control including environmental alterations (improved design or operation of infrastructure), chemical, physical and cultural control
4.4 Consideration of the public health and ecological impacts on VBD of established and proposed laws, regulations, and infrastructure development, and the enforce laws and regulations that affect VBD

Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

	Primarily performed by my organization	Primarily supported by other organizations	Not present in my jurisdiction	Don't know
Provide timely information about specific risks and comprehensive mitigation strategies to the public, partners, and decisionmakers.	○	○	○	○
Ensure use of a comprehensive menu of evidence-based interventions and adaptation considerations options across social ecological model.	○	○	○	○

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Q16 COMPONENT 5: Prepared to react to novel VBD situations (e.g., outbreak).

5.1: Defined risk scenarios based on local data (e.g., jurisdictional characteristics, stakeholder perceptions)
5.2: An early warning system in which reception of predefined signals (e.g. novel vector, novel VBD above norm for place or time, unexpected increase of known vector or VBD, situation exceeding capacity to respond) triggers interventions
5.3: Authorities and collaborators prepared for outbreaks of diseases prior to their arrival

Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

	Primarily performed by my organization	Primarily supported by other organizations	Not present in my jurisdiction	Don't know
Identify risks (vectors, diseases, ecology, public perceptions).	○	○	○	○
Determine thresholds for response.	○	○	○	○
Activate communication mechanism when response is triggered.	○	○	○	○

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Q17 COMPONENT 6: Evaluation and continuous improvement of VBD processes, programs, and interventions.

6.1: Evaluation of interventions and technologies in practice
6.2: Development and testing of possible new interventions and technologies
6.3: Dissemination of findings from evaluation for local improvements
6.4: Contribution of findings to the evidence base of the field

Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

	Primarily performed by my organization	Primarily supported by other organizations	Not present in my jurisdiction	Don't know
Formally evaluate VBD processes, outputs, and outcomes.	○	○	○	○
Use evaluation findings to improve VBD efforts.	○	○	○	○

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Q22 Indicate which funding sources support VBD-related efforts performed by your organization.

- ☐ Local government budget (e.g., taxes, assessments, fees)
- ☐ State government budget (e.g., taxes, assessments, fees)
- ☐ Federal sources (routine/core funding direct or passed through state)
- ☐ Federal sources (supplemental/emergency funding direct or passed through state)
- ☐ Private foundations (e.g., grants)
- ☐ Other _____

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Q23 To the best of your ability, provide information about each type of funding that you receive or leverage for VBD-related efforts.

	Source Description	$ Amount	# FTE Supported	Activities Supported	Infrastructure/ Materials Supported
Q22 = Local government budget (e.g., taxes, assessments, fees) Local government budget (e.g., taxes, assessments, fees)					
Q22 = State government budget (e.g., taxes, assessments, fees) State government budget (e.g., taxes, assessments, fees)					
Q22 = Federal sources (routine/core funding direct of passed through state) Federal sources (routine/core funding direct or passed through state)					

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Q22 = Federal sources (supplemental/emergency funding direct or passed through state) Federal sources (supplemental/emergency funding direct or passed through state)					
Q22 = Private foundations (e.g., grants) Private foundations (e.g., grants)					
Q22 = Other Other					

End of Block: Default Question Block

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SELF-ASSESSMENT FINDINGS

(Responses are unedited, however typographical errors were corrected)

Q3 - Select the options that best matches your organization.

#	Answer	%	Count
1	State Government	73.68%	14
2	Local or County Government	5.26%	1
3	Territorial Government	0.00%	0
4	Non-Profit Organization	21.05%	4
5	Corporation	0.00%	0
	Total	100%	19

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Q4 - Enter the name of your organization/program.
Responses removed to maintain anonymity of respondents.

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Q5 - Enter the name of your jurisdiction.
Responses removed to maintain anonymity of respondents.

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Q6 - Enter your jurisdiction’s population size.

Enter your jurisdiction’s population size.
n/a
40,000,000
3,000
N/A
7,500,000
4.66 million
3 million
12,800,000
8.9 million
2.912 million
5.69 million
339 million
5.611 million
40 million
4 million
6.8 million
268,597 mi²
~6.8 million
7.2 million

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Q7 - Does your organization perform any surveillance, prevention, or control activities related to the following vectors?

#	Question	Yes		No		Don't Know		Total
1	Mosquitoes	89.47%	17	10.53%	2	0.00%	0	19
2	Ticks	84.21%	16	15.79%	3	0.00%	0	19
3	Fleas	10.53%	2	78.95%	15	10.53%	2	19
4	Lice	5.26%	1	89.47%	17	5.26%	1	19
5	Triatominae/Kissing Bugs	26.32%	5	68.42%	13	5.26%	1	19
6	Deer Flies	0.00%	0	89.47%	17	10.53%	2	19
7	Other	5.26%	1	73.68%	14	21.05%	4	19
8	Other	0.00%	0	78.95%	15	21.05%	4	19

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Q8 - Does your organization perform any surveillance, prevention, or control activities related to the following diseases?

#	Question	Yes		No		Don't Know		Total
1	Rocky Mountain Spotted Fever	72.22%	13	27.78%	5	0.00%	0	18
2	Lyme	66.67%	12	33.33%	6	0.00%	0	18
3	Tularemia	66.67%	12	27.78%	5	5.56%	1	18
4	West Nile	94.44%	17	5.56%	1	0.00%	0	18
5	Babesia	61.11%	11	33.33%	6	5.56%	1	18
6	Plague	72.22%	13	27.78%	5	0.00%	0	18
7	Anaplasmosis	61.11%	11	33.33%	6	5.56%	1	18
8	Western Equine Encephalitis	66.67%	12	33.33%	6	0.00%	0	18
9	Colorado Tick Fever	50.00%	9	50.00%	9	0.00%	0	18
10	Jamestown Canyon	66.67%	12	33.33%	6	0.00%	0	18
11	Eastern Equine Encephalitis	61.11%	11	38.89%	7	0.00%	0	18
12	Powassan	50.00%	9	50.00%	9	0.00%	0	18
13	Japanese Encephalitis	66.67%	12	33.33%	6	0.00%	0	18
14	Yellow Fever	72.22%	13	27.78%	5	0.00%	0	18
15	Zika	88.89%	16	11.11%	2	0.00%	0	18
16	Dengue	88.89%	16	11.11%	2	0.00%	0	18
17	LaCrosse	61.11%	11	38.89%	7	0.00%	0	18
18	Ehrlichia	66.67%	12	33.33%	6	0.00%	0	18
19	Saint Louis Encephalitis	88.89%	16	11.11%	2	0.00%	0	18
20	Tick-borne Relapsing Fever	44.44%	8	55.56%	10	0.00%	0	18
21	Q Fever	61.11%	11	27.78%	5	11.11%	2	18
22	Chikungunya	88.89%	16	11.11%	2	0.00%	0	18
23	Bourbon	27.78%	5	72.22%	13	0.00%	0	18

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24	Heartland	33.33%	6	66.67%	12	0.00%	0	18
25	B. miyamotoi	55.56%	10	38.89%	7	5.56%	1	18
26	Tick Paralysis	27.78%	5	61.11%	11	11.11%	2	18
27	Leishmaniasis	27.78%	5	72.22%	13	0.00%	0	18
28	Chagas	50.00%	9	50.00%	9	0.00%	0	18
29	Other	11.11%	2	72.22%	13	16.67%	3	18
30	Other	11.11%	2	72.22%	13	16.67%	3	18

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Q10 - We recognize that in most jurisdictions a comprehensive approach requires a system in which multiple partners contribute resources and perform mutually reinforcing activities to meet common goals. Components are the elements and structures that make up a vector-borne disease (VBD) system within a jurisdiction (e.g., city, county, territory, state). Capabilities are the specific activities/functions within each component that entities of a VBD system within a jurisdiction should be able to collectively perform. Consider all of the organizations and programs in your jurisdiction that work to reduce VBD morbidity and mortality. Indicate the extent to which you agree with each component statement.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Component 1: My jurisdiction has a designated, functioning mechanism for convening partners to plan and coordinate VBD efforts.	1.00	5.00	1.72	1.04	1.09	18
2	Component 2: My jurisdiction has resources (e.g., facilities, staffing, partnerships, and funding) that can be used and leveraged to support and sustain VBD prevention efforts	1.00	4.00	1.83	0.76	0.58	18

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3	Component 3: My jurisdiction has a surveillance system aimed at the accurate and timely measurement of the introduction of vectors and pathogens and the incidence of disease.	1.00	4.00	1.83	0.96	0.92	18
4	Component 4: My jurisdiction makes use of mutually reinforcing, data-driven, evidence-based actions to reduce VBD morbidity and mortality.	1.00	4.00	1.61	0.83	0.68	18
5	Component 5: My jurisdiction is prepared to react to novel VBD situations (e.g., outbreak).	1.00	4.00	1.78	0.85	0.73	18
6	Component 6: My jurisdiction evaluates and	1.00	4.00	1.83	0.83	0.69	18

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	continuously improve its VBD processes, programs, and interventions.										

#	Question	Strongly agree		Somewhat agree		Neither agree nor disagree		Somewhat disagree		Strongly disagree		Total
1	Component 1: My jurisdiction has a designated, functioning mechanism for convening partners to plan and coordinate VBD efforts.	55.56%	10	27.78%	5	11.11%	2	0.00%	0	5.56%	1	18
2	Component 2: My jurisdiction has resources (e.g., facilities, staffing, partnerships, and funding)	33.33%	6	55.56%	10	5.56%	1	5.56%	1	0.00%	0	18

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	that can be used and leveraged to support and sustain VBD prevention efforts										
3	Component 3: My jurisdiction has a surveillance system aimed at the accurate and timely measurement of the introduction of vectors and pathogens and the incidence of disease.	44.44%	8	38.89%	7	5.56%	1	11.11%	2	0.00%	0	18
4	Component 4: My jurisdiction makes use of mutually reinforcing, data-driven, evidence-based	55.56%	10	33.33%	6	5.56%	1	5.56%	1	0.00%	0	18

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	actions to reduce VBD morbidity and mortality.											
5	Component 5: My jurisdiction is prepared to react to novel VBD situations (e.g., outbreak).	44.44 %	8	38.89 %	7	11.11 %	2	5.56%	1	0.00 %	0	18
6	Component 6: My jurisdiction evaluates and continuously improve its VBD processes, programs, and interventions.	38.89 %	7	44.44 %	8	11.11 %	2	5.56%	1	0.00 %	0	18

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Q11 - COMPONENT 1: A designated, functioning mechanism for convening partners to coordinate VBD efforts 1.1: Leadership that is knowledgeable and supportive of efforts to address VBD 1.2: A convening entity or mechanism (e.g., program, multi-partner collaborative)1.3: A plan to address VBD in jurisdiction Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Identify, access, and educate leaders within the jurisdiction.	1.00	4.00	1.76	1.11	1.24	17
2	Identify priorities based on surveillance data and public perceptions.	1.00	4.00	1.29	0.75	0.56	17
3	Include VBD in an all hazards planning process within the jurisdiction.	1.00	4.00	1.47	0.85	0.72	17
4	Identify and interact with other VBD stakeholders within the jurisdiction.	1.00	2.00	1.12	0.32	0.10	17
5	Develop a comprehensive and coordinated strategy for VBD efforts within the jurisdiction.	1.00	2.00	1.18	0.38	0.15	17

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#	Question	Primarily supported by my organization		Primarily supported by other organizations		Not present in my jurisdiction		Don't know		Total
1	Identify, access, and educate leaders within the jurisdiction.	58.82%	10	23.53%	4	0.00%	0	17.65%	3	17
2	Identify priorities based on surveillance data and public perceptions.	82.35%	14	11.76%	2	0.00%	0	5.88%	1	17
3	Include VBD in an all hazards planning process within the jurisdiction.	70.59%	12	17.65%	3	5.88%	1	5.88%	1	17
4	Identify and interact with other VBD stakeholders within the jurisdiction.	88.24%	15	11.76%	2	0.00%	0	0.00%	0	17
5	Develop a comprehensive and coordinated strategy for VBD efforts within the jurisdiction.	82.35%	14	17.65%	3	0.00%	0	0.00%	0	17

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Q13 - COMPONENT 2: Resources (e.g., facilities, staffing, partnerships, and funding) that can be used and leveraged to support and sustain VBD prevention efforts. 2.1: Facilities, infrastructure, and materials2.2: Staff that possess the core competencies, qualifications, knowledge, and skills necessary to effectively address VBD2.3: Sustainable, right-sized funding2.4: Partnerships, collaborations, and/or agreements with key local, regional, and state, national, and private sector organizations Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	A database for VBD related data (e.g., case reporting, surveillance, and analysis).	1.00	2.00	1.12	0.32	0.10	17
2	A data transmission mechanism (e.g., HL7).	1.00	4.00	1.47	0.85	0.72	17
3	Dedicated epidemiology staffing for VBD. Enter the FTE in the text box.	1.00	3.00	1.24	0.55	0.30	17
4	Dedicated laboratory staffing for VBD. Enter the FTE in the text box.	1.00	3.00	1.29	0.67	0.44	17
5	Dedicated communications staffing for VBD. Enter the FTE in the text box.	1.00	4.00	1.94	1.00	1.00	17

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#	Question	Primarily supported by my organization		Primarily supported by other organizations		Not present in my jurisdiction		Don't know		Total
1	A database for VBD related data (e.g., case reporting, surveillance, and analysis).	88.24%	15	11.76%	2	0.00%	0	0.00%	0	17
2	A data transmission mechanism (e.g., HL7).	70.59%	12	17.65%	3	5.88%	1	5.88%	1	17
3	Dedicated epidemiology staffing for VBD. Enter the FTE in the text box.	82.35%	14	11.76%	2	5.88%	1	0.00%	0	17
4	Dedicated laboratory staffing for VBD. Enter the FTE in the text box.	82.35%	14	5.88%	1	11.76%	2	0.00%	0	17
5	Dedicated communications staffing for VBD. Enter the FTE in the text box.	47.06%	8	17.65%	3	29.41%	5	5.88%	1	17

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Q14 - COMPONENT 3: Surveillance system aimed at the accurate and timely measurement of vector ecology and patterns of disease. 3.1: Data collection (e.g., pathogen, serological, clinical, syndromic, ecology, vector, risk factors)3.2: Analysis (e.g., laboratory, informatics, GIS)3.3: Interpretation of analysis outputs3.4: Dissemination of surveillance information to leadership, collaborators, and the public Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Collect VBD case reports from providers.	1.00	3.00	1.53	0.70	0.48	17
2	Confirm VBD cases.	1.00	3.00	1.35	0.68	0.46	17
3	Transmit case information as required by local, state, and national regulations.	1.00	3.00	1.35	0.68	0.46	17
4	Conduct routine surveillance activities at local, state, and national levels.	1.00	3.00	1.47	0.61	0.37	17

#	Question	Primarily supported by my organization		Primarily supported by other organizations		Not present in my jurisdiction		Don’t know		Total
1	Collect VBD case reports from providers.	58.82%	10	29.41%	5	11.76%	2	0.00%	0	17

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2	Confirm VBD cases.	76.47%	13	11.76%	2	11.76%	2	0.00%	0	17
3	Transmit case information as required by local, state, and national regulations.	76.47%	13	11.76%	2	11.76%	2	0.00%	0	17
4	Conduct routine surveillance activities at local, state, and national levels.	58.82%	10	35.29%	6	5.88%	1	0.00%	0	17

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Q15 - COMPONENT 4: System that makes use of mutually reinforcing, data-driven, evidence-based actions to reduce VBD morbidity and mortality. 4.1: Routine review of local data regarding ecology, disease transmission, and other factors (e.g., resistance, public perceptions, resources) to select appropriate prevention and control strategies 4.2: Evidence-based practices related to communication, education, and outreach to the public regarding risk and preventive strategies 4.3 Evidence-based practices related to vector control including environmental alterations (improved design or operation of infrastructure), chemical, physical and cultural control 4.4 Consideration of the public health and ecological impacts on VBD of established and proposed laws, regulations, and infrastructure development, and the enforce laws and regulations that affect VBD Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Provide timely information about specific risks and comprehensive mitigation strategies to the public, partners, and decisionmakers.	1.00	4.00	1.44	0.79	0.62	16
2	Ensure use of a comprehensive menu of evidence-based interventions and adaptation considerations options across social ecological model.	1.00	4.00	2.25	1.20	1.44	16

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#	Question	Primarily performed by my organization		Primarily supported by other organizations		Not present in my jurisdiction		Don't know		Total
1	Provide timely information about specific risks and comprehensive mitigation strategies to the public, partners, and decisionmakers.	68.75%	11	25.00%	4	0.00%	0	6.25%	1	16
2	Ensure use of a comprehensive menu of evidence-based interventions and adaptation considerations options across social ecological model.	37.50%	6	25.00%	4	12.50%	2	25.00%	4	16

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Q16 - COMPONENT 5: Prepared to react to novel VBD situations (e.g., outbreak). 5.1: Defined risk scenarios based on local data (e.g., jurisdictional characteristics, stakeholder perceptions)5.2: An early warning system in which reception of predefined signals (e.g. novel vector, novel VBD above norm for place or time, unexpected increase of known vector or VBD, situation exceeding capacity to respond) triggers interventions5.3: Authorities and collaborators prepared for outbreaks of diseases prior to their arrival Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Identify risks (vectors, diseases, ecology, public perceptions).	1.00	2.00	1.13	0.33	0.11	16
2	Determine thresholds for response.	1.00	2.00	1.25	0.43	0.19	16
3	Activate communication mechanism when response is triggered.	1.00	4.00	1.38	0.78	0.61	16

#	Question	Primarily performed by my organization		Primarily supported by other organizations		Not present in my jurisdiction		Don’t know		Total
1	Identify risks (vectors, diseases, ecology, public perceptions).	87.50%	14	12.50%	2	0.00%	0	0.00%	0	16

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2	Determine thresholds for response.	75.00%	12	25.00%	4	0.00%	0	0.00%	0	16
3	Activate communication mechanism when response is triggered.	75.00%	12	18.75%	3	0.00%	0	6.25%	1	16

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Q17 - COMPONENT 6: Evaluation and continuous improvement of VBD processes, programs, and interventions. 6.1: Evaluation of interventions and technologies in practice6.2: Development and testing of possible new interventions and technologies6.3: Dissemination of findings from evaluation for local improvements6.4: Contribution of findings to the evidence base of the field Indicate who in your jurisdiction is primarily responsible for each capability statement listed below.

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Formally evaluate VBD processes, outputs, and outcomes.	1.00	4.00	1.69	0.85	0.71	16
2	Use evaluation findings to improve VBD efforts.	1.00	4.00	1.63	0.86	0.73	16

#	Question	Primarily performed by my organization		Primarily supported by other organizations		Not present in my jurisdiction		Don’t know		Total
1	Formally evaluate VBD processes, outputs, and outcomes.	50.00%	8	37.50%	6	6.25%	1	6.25%	1	16
2	Use evaluation findings to improve	56.25%	9	31.25%	5	6.25%	1	6.25%	1	16

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VBD efforts.							

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Q22 - Indicate which funding sources support VBD-related efforts performed by your organization in the current budget year.

#	Answer	%	Count
1	Local government budget (e.g., taxes, assessments, fees)	11.76%	4
2	State government budget (e.g., taxes, assessments, fees)	23.53%	8
3	Federal sources (routine/core funding direct or passed through state)	41.18%	14
4	Federal sources (supplemental/emergency funding direct or passed through state)	20.59%	7
5	Private foundations (e.g., grants)	2.94%	1
6	Other	0.00%	0
	Total	100%	34

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Q23 - To the best of your ability, provide information about each type of funding that your organization receives or leverages for VBD-related efforts in the current budget year.

Q23_1_1 - Local government budget (e.g., taxes, assessments, fees) - Source Description

Local government budget (e.g., taxes, assessments, fees) - Source Description
assessments
unknown
Municipalities collect fees to support VBD activities (e.g., Memphis-Shelby county)

Q23_1_2 - Local government budget (e.g., taxes, assessments, fees) - $ Amount

Local government budget (e.g., taxes, assessments, fees) - $ Amount
N/A
unknown
?

Q23_1_3 - Local government budget (e.g., taxes, assessments, fees) - # FTE Supported

Local government budget (e.g., taxes, assessments, fees) - # FTE Supported
N/A
unknown
Unknown

Q23_1_4 - Local government budget (e.g., taxes, assessments, fees) - Activities Supported

Local government budget (e.g., taxes, assessments, fees) - Activities Supported
surveillance and control
unknown
Mosquito trapping and abatement

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Q23_1_5 - Local government budget (e.g., taxes, assessments, fees) - Infrastructure/Materials Supported

Local government budget (e.g., taxes, assessments, fees) - Infrastructure/Materials Supported
equipment and chemical
unknown
Traps, equipment, trucks, treatments

Q23_2_1 - State government budget (e.g., taxes, assessments, fees) - Source Description

State government budget (e.g., taxes, assessments, fees) - Source Description
General fund
Lyme money
State funds
State General fund
general fund
One-time funds to support local vector control

Q23_2_2 - State government budget (e.g., taxes, assessments, fees) - $ Amount

State government budget (e.g., taxes, assessments, fees) - $ Amount
2,500,000
$550,000
as needed
$500,000
500,000

Q23_2_3 - State government budget (e.g., taxes, assessments, fees) - # FTE Supported

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State government budget (e.g., taxes, assessments, fees) - # FTE Supported
0
0
4.0
0.5
20
5.25
None

Q23_2_4 - State government budget (e.g., taxes, assessments, fees) - Activities Supported

State government budget (e.g., taxes, assessments, fees) - Activities Supported
~20
Human TBD surveillance, human and mosquito lab testing
Entomologist's time
epi, surveillance, lab
surveillance, lab testing, outreach
Supported trapping and equipment, local jurisdictions could use for staff as well

Q23_2_5 - State government budget (e.g., taxes, assessments, fees) - Infrastructure/Materials Supported

State government budget (e.g., taxes, assessments, fees) - Infrastructure/Materials Supported
Tick surveillance and materials, supports lots of materials for educational outreach activities
Lab testing supplies
lab equipment, supplies, IT infrastructure, vehicles
Equipment for trapping and shipment, abatement

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Q23_3_1 - Federal sources (routine/core funding direct or passed through state) - Source Description

Federal sources (routine/core funding direct or passed through state) - Source Description
ELC
CDC ELC
ELC
CDC ELC
ELC grant
CDC ELC
ELC grant
ELC and EIP grant funds
routine
ELC
ELC
ELC
CDC ELC

Q23_3_2 - Federal sources (routine/core funding direct or passed through state) - $ Amount

Federal sources (routine/core funding direct or passed through state) - $ Amount
250,000
500,000
$584,000
297000
150,000
~ 1 million
$700,000
$125,000
350,000

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~200K
500,000

Q23_3_3 - Federal sources (routine/core funding direct or passed through state) - # FTE Supported

Federal sources (routine/core funding direct or passed through state) - # FTE Supported
2.5
3.2
4
2.5
3.0
2.4
1.5
7
2
5
3
4

Q23_3_4 - Federal sources (routine/core funding direct or passed through state) - Activities Supported

Federal sources (routine/core funding direct or passed through state) - Activities Supported
Surveillance
surveillance and laboratory capacity
All activities
Surveillance, reporting, education and outreach
Human VBD surveillance, prevention/outreach, tick surveillance, travel to national/regional VBD meetings
235000

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epi/lab time, supplies for testing
all/everything
surveillance, laboratory testing, outreach
Lab, Epi, Ento
Entomologist, Microbiologist, Epidemiologist
Lab and Epi

Q23_3_5 - Federal sources (routine/core funding direct or passed through state) - Infrastructure/Materials Supported

Federal sources (routine/core funding direct or passed through state) - Infrastructure/Materials Supported
don't understand the question
small portion toward education materials
lab testing supplies, GIS and statistical analysis software
62000
Arboviral testing reagents
all/everything
Laboratory supplies
reagents for clinical and mosquito testing
Laboratory supplies
Testing and other vector supplies.

Q23_4_1 - Federal sources (supplemental/emergency funding direct or passed through st... - Source Description

Federal sources (supplemental/emergency funding direct or passed through state) - Source Description
ELC Zika supp, CDC hurricane crisis response grant
Hurricane
EIP grant
Crisis Cooperative Agreement
ELC - Zika carryover

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Q23_4_2 - Federal sources (supplemental/emergency funding direct or passed through st... - $ Amount

Federal sources (supplemental/emergency funding direct or passed through state) - $ Amount
unsure
variable
6,000,000
~500K

Q23_4_3 - Federal sources (supplemental/emergency funding direct or passed through st... - # FTE Supported

Federal sources (supplemental/emergency funding direct or passed through state) - # FTE Supported
1
usually none
6
3

Q23_4_4 - Federal sources (supplemental/emergency funding direct or passed through st... - Activities Supported

Federal sources (supplemental/emergency funding direct or passed through state) - Activities Supported
additional study objectives
depends - often epidemiology plus laboratory
local mosquito control and state medical entomology expertise
Environmental Health capacity

Q23_4_5 - Federal sources (supplemental/emergency funding direct or passed through st... - Infrastructure/Materials Supported

Federal sources (supplemental/emergency funding direct or passed through state) - Infrastructure/Materials Supported
variable - may be lab supplies, IT or informatics systems, educational materials

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Testing, trapping, training of vector borne disease programs

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APPENDIX C: WORKSHOP AGENDAS AND FACILITATION GUIDES

Exploring the Core Components of a Comprehensive Vector-Borne Disease Program

Vector Summit | Facilitated Session | 1:00 – 4:00 pm | April15, 2019 |

Session Objectives

- Identify key components of a comprehensive vector-borne disease program
- Identify capabilities, or specific activities and functions, for various components
- Determine the extent to which components and capabilities are essential or adaptable (can be changed to meet local needs without compromising effectiveness)?

Agenda-in-Brief

Day 1	
1:00 PM	Welcome & Introductions
1:15 PM	Context
1:30 PM	Components
2:15 PM	Break
2:30 PM	Capabilities
3:45 PM	Next Steps
4:00 PM	Adjourn

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Facilitation Guide

Block	Activity/Talking Points	Notes/Supplies
12:00 PM (60 minutes)	<u>Final Prep</u> ● Sign in sheet ● Materials (packets) ● Check AV ● Queue slides ● Position facilitation supplies ● Table/chair set up	
1:00 PM (15 minutes) Aims ● Orient participants to the space and agenda ● Prepare participants for interactions ● Set expectations for day	<u>Welcome and Introductions</u> ● Welcome – **Justin Snair** with support from **Jordan Peart** ● **Laura Runnels** introduces herself and leads a round of introductions with participants ● **Laura** orients participants to the day of work ○ Amenities: parking, breaks, bathrooms, private space, water, food, wifi, outlets, suitcases ○ Emergency Procedures: shelter in place, evaluation ○ Meeting Objectives (flip chart) ○ Format: Combination of presentations and discussions ○ Agenda Review (flip chart) ○ Materials Provided: ○ Outputs: Meeting proceedings ○ Ground Rules (flip chart) ▪ WAIT (Why Am I Talking) ▪ Be present (limit device use & side conversations; participate) ▪ Be transparent (share information openly) ▪ Be curious (limit gut	Flip chart Markers

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	reactions; ask questions; listen to other people to understand their perspective) ▪ Speak one person at the time, one idea at a time	
1:15 PM (15 minutes) Aims ● To reach shared understanding of the project background	<u>Context</u> • Overview – **Justin** with support from **Jordan** ○ What is a vector-borne disease program? ○ What is the CDC's vision for vector-borne disease control and prevention? ○ Why are we creating the comprehensive vector-borne disease program core components and capabilities?	Slidedeck queued
1:30 PM (45 minutes) Aims • To identify key components of a comprehensive vector-borne diseases program	<u>Work Session 1 – Components</u> • **Laura** leads the group through a concept mapping activity using the sticky wall to identify the components of a comprehensive VBD program ○ Potential components from workgroup to validate include: Laboratory, Surveillance (Case and Outbreak Investigation), Vector Control, Public Education, Policy	Sticky wall Halfsheets Markers
2:15 PM (15 minutes)	<u>Break</u>	
2:30 PM (75 minutes) Aims ● To identify capabilities, or specific activities and functions, for	<u>Work Session 2 – Capabilities</u> • **Laura** leads the group through a concept mapping activity using the sticky wall to identify the capabilities for each of the identified components of a comprehensive VBD program • (time permitting) **Laura** leads a discussion about the extent to	Sticky wall Halfsheets Markers

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various components ● To determine the extent to which components and capabilities are essential or adaptable (can be changed to meet local needs without compromising effectiveness)	which components/capabilities are core vs adaptable. ○ Which jurisdiction(s) would the components/capabilities apply to? State, Territorial, Local, Tribal	
3:45 PM (15 minutes)	<u>Next Steps</u> ● **Justin** prompts participants to share how they use a VBD core components and capabilities document in their work. ● **Justin** provides information about next steps: ○ Meeting documentation ○ Follow up requests ○ Travel reimbursements	
4:00 PM (30 minutes)	<u>Adjourn</u> ● Staff will complete documentation of activities	

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Exploring the Components of a Comprehensive Approach to Vector-Borne Disease Prevention and Control

DVBD Fort Collins | Facilitated Session |8:30 am – 12:00 pm | May 14, 2019

Session Objectives

- Identifying the vectors of concern, categorized by core, enhanced, and comprehensive
- Identifying the vector borne diseases of concern, categorized by core, enhanced, and comprehensive
- Exploring the possible program components employed to address the vectors and VBDs of concern, categorized by core, enhanced, and comprehensive

Agenda-in-Brief

Day 1	
8:30 AM	Welcome & Introductions
8:45 AM	Context Setting
9:10 AM	Work Session 1
10:15 AM	Break
10:25 AM	Work Session 2
11:30 PM	Closing Conversation
12:00 PM	Adjourn

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Facilitation Guide

Block	Activity/Talking Points	Notes/Supplies
8:00 AM (30 minutes)	<u>Final Prep</u> ● Check AV ● Queue slides ● Position facilitation supplies ● Table/chair set up	
8:30 AM (15 minutes) Aims ● Orient participants to the space and agenda ● Prepare participants for interactions ● Set expectations for day	<u>Welcome and Introductions</u> ● Welcome and Intros – **Chris Duggar** & **Justin Snair** ● **Laura Runnels** orients participants to the day of work ○ Agenda Review ○ Format: Discussions ○ Materials Provided: ○ Outputs: Information to inform final report ○ Ground Rules (flip chart) ▪ WAIT (Why Am I Talking) ▪ Be present (limit device use & side conversations; participate) ▪ Be transparent (share information openly) ▪ Be curious (limit gut reactions; ask questions; listen to other people to understand their perspective) ▪ Speak one person at the time, one idea at a time	Flip chart Markers
8:45 PM (25 minutes) Aims ● To reach shared understanding of	<u>Context Setting</u> ● Opening Remarks – **Dr, Chris Gregory** (10 min) • Project Overview – **Justin Snair and Laura Runnels** ○ RFP call to action	Slidedeck queued

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the project background	○ Proposed process and where we are today ○ Highlights from discussions with working groups and stakeholders so far	
9:10 AM (45 minutes) Aims • To describe a comprehensive approach to vector-borne diseases prevention/control	<u>Work Session 1 – Vectors and Diseases</u> • **Laura** leads the group through a concept mapping activity using the sticky wall to identify the components of a comprehensive approach VBD prevention/control • **Note:** We first need to zoom out and describe a true comprehensive approach (in terms of vectors, pathogens, resources, partners, strategies) before we define the role of governmental public health in VBD prevention. • Key Definitions ○ Components – elements and structures (see draft below) ○ Capabilities – activities/functions of components (to be determined) ○ Levels § Core – minimum viability § Enhanced - § Comprehensive – • Discussion to list and refine ○ The Vector(s) of Concern ○ The Vector Borne Disease(s) of Concern	Sticky wall Halfsheets Markers
10:15 AM (10 minutes)	<u>Break</u>	

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10:25 AM (65 minutes) Aims ● To identify capabilities, or specific activities and functions, for various components ● To determine the extent to which components and capabilities are essential or adaptable (can be changed to meet local needs without compromising effectiveness)	<u>Work Session 2 – Components</u> • **Laura** leads the group through a concept mapping activity using the sticky wall to identify the components of a comprehensive approach VBD prevention/control • Discussion to list and refine ○ The Program Component(s) Employed to Address the Vectors and VBDs of Concern ○ The Resources Available to Address the Vectors and VBDs of Concern Using the Employed Program Components	Sticky wall Halfsheets Markers
11:30 PM (30 minutes)	<u>Closing Conversation</u> ● **Justin** prompts participants to what value this might to the field (for LHDs, SHDs, Federal programs, others)? ● **Justin** provides information about next steps: ○ Meeting documentation ○ Follow up requests	
12:00 PM (30 minutes)	<u>Adjourn</u> ● Staff will complete documentation of activities	

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please RSVP: National Briefing Call Monday, February 3rd; 12 PM EST
Date: Sunday, February 2, 2020 8:27:25 PM

State and Local Leaders,

Please join us for a national briefing call on **Monday, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force. The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Briefing Call
Date: Monday, February 3, 2020
Time: 12:00 p.m. Eastern Time
Call-In Information: CLICK HERE *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Stevens, Lee (OS/IEA)
To:	Stevens, Lee (OS/IEA); Johnston, Darcie (HHS/IEA)
Subject:	Please RSVP: National Briefing Call Monday, February 3rd; 12 PM EST
Date:	Sunday, February 2, 2020 8:31:47 PM

State and Local Leaders,

Please join us for a national briefing call on **Monday, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force. The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

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Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Please RSVP: National Briefing Call Monday, February 3rd; 12 PM EST
Date: Sunday, February 2, 2020 8:20:34 PM

State and Local Leaders,

Please join us for a national briefing call on **Monday, February 3 at 12:00 p.m. Eastern Time** on the President's Coronavirus Task Force. The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

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Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CDC ky.gov)
Subject:	Please see the note below from Eric Hargarten
Date:	Wednesday, March 18, 2020 6:07:38 PM

****

From Eric Hargarten- HHS

Hi all -

We wanted to notify you that the provided supplies will arrive at the shipping locations you provided as early as 8 AM EST and as late as 8 PM EST today (Wednesday March 18th). Upon arrival the driver will contact the shipping point of contact you provided.

A few other important notes about the shipments and what to expect:

- **Shipment details**: Testing kits are coming from Henry Schein and other supplies will come from the following companies: McKesson, Medline (FedEx), Uline (UPS), Grainger (UPS), DuPont (UPS), Taylor Communications (UPS)
    - Some deliveries will be on pallets or skids, smaller shipments will not (for example, bar code labels will not be on skids)
- **Delivery timelines:** all **ESTIMATES** based on latest information:
    - By COB Wednesday: Henry Schein, McKesson, Uline, Grainger, DuPont, Medline
    - By 10:30 am Thurs: Taylor Communications (bar code labels)

Please note that due to the extraordinary circumstances we are trying to provide the most accurate and comprehensive information, but things are subject to change. We will provide updates in the morning and evening on Wednesday.

Thank you

Eric Hargarten
316-209-6279
Special Assistant, Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

AMERICAN OVERSIGHT

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov); Gillis, Rebecca L (CHFS DPH EPB); jamesr.house@ky.gov; Hume, Robbie ; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHFS DPH EPB); Kik, Angela M ; Mattingly, Jay; White, Connie (CHFS PH) (Connie.White@ky.gov)
Subject:	Please see the note below from Eric Hargarten
Date:	Wednesday, March 18, 2020 6:07:27 PM

****

From Eric Hargarten- HHS

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Please note that due to the extraordinary circumstances we are trying to provide the most accurate and comprehensive information, but things are subject to change. We will provide updates in the morning and evening on Wednesday.

Thank you

Eric Hargarten
316-209-6279
Special Assistant, Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

AMERICAN OVERSIGHT

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Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	POSTPONED: 3-13-14 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, March 13, 2020 12:37:53 PM

Telebriefing postponed until tomorrow at 1pm.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When UPDATED: 1:00 p.m. ET Saturday, March 14, 2020

Dial-In

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

###

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U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	POSTPONED: 3-13-14 CDC Media Telebriefing: Update on COVID-19
Date:	Friday, March 13, 2020 12:40:15 PM

Telebriefing postponed until tomorrow at 1pm.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When UPDATED: 1:00 p.m. ET Saturday, March 14, 2020

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TRANSCRIPT
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AMERICAN OVERSIGHT

###

U.S. Department of Health and Human Services

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

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: POSTPONED: 3-13-14 CDC Media Telebriefing: Update on COVID-19
Date: Friday, March 13, 2020 12:34:21 PM

Telebriefing postponed until tomorrow at 1pm.

Media Advisory

For Immediate Release
Friday, March 13, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When UPDATED: 1:00 p.m. ET Saturday, March 14, 2020

Dial-In

Media:800-857-9756
International: 1-212-287-1647
PASSCODE:CDC MEDIA

Non-Media:888-795-0855
International: 1-630-395-0498
PASSCODE: 2125064

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

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U.S. Department of Health and Human Services

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

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; D"Angelo, Joseph ; Dellamura, Joseph ; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; RRCC LOGS Supply Box
Subject:	PPE Burn Rate Calculator, Excel Spreadsheet Model
Date:	Wednesday, March 25, 2020 8:23:11 PM
Attachments:	R8 Ventilator Estimates 2020-03-25 11_44_23.xlsx 200324 Determining PPE Requirements 2020-03-25 11_42_05.pptx

All

One of our regions did some calculations on PPE burn rate and staffing estimate. It is one of the modeling opportunities out there. Please use if you like.
I also attached a sample document to review

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

Number of Full Time Staff per Bed Estimate: https://www.beckershospitalreview.com/lists/200-hospital-benchmarks-october-2012.html

Regards,
Jeanne

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(please cc all correspondence to this ESF 8 desk address)

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Determining PPE Requirements

POC: Thomas J. Swint, Reg

State	Cases 24MAR	Hospitalizations (20% of Cases)	Doctors 2/bed	Nurses 2/bed	Other (4/bed)	Periodicity	Gown Disp Impervious	Coverall	Glove, ex cuff	Glove Exam	Boot/shoe cover	Plastic Apron	PAPR^^	PAPR Shroud	PAPR Battery	PAPR Filter#	N95	Surgical Hood	Face Shield
CO	716	144	288	288	576	7 day	24192	16128	88704	56448	56448	16128	2592	16128	5184	16128	16128	16128	24192
						14 day	48384	32256	177408	112896	112896	32256	2592	32256	5184	32256	32256	32256	48384
						31 day	107136	71424	392832	249984	249984	71424	2592	71424	5184	71424	71424	71424	107136
MT	46	10	20	20	40	7 day	1680	1120	6160	3920	3920	1120	180	1120	360	1120	1120	1120	1680
						14 day	3360	2240	12320	7840	7840	2240	180	2240	360	2240	2240	2240	3360
						31 day	7440	4960	27280	17360	17360	4960	180	4960	360	4960	4960	4960	7440
WY	28	6	12	12	24	7 day	1008	672	3696	2352	2352	672	108	672	216	672	672	672	1008
						14 day	2016	1344	7392	4704	4704	1344	108	1344	216	1344	1344	1344	2016
						31 day	4464	2976	16368	10416	10416	2976	108	2976	216	2976	2976	2976	4464
SD	27	6	12	12	24	7 day	1008	672	3696	2352	2352	672	108	672	216	672	672	672	1008
						14 day	2016	1344	7392	4704	4704	1344	108	1344	216	1344	1344	1344	2016
						31 day	4464	2976	16368	10416	10416	2976	108	2976	216	2976	2976	2976	4464
ND	33	7	14	14	28	7 day	1176	784	4312	2744	2744	784	126	784	252	784	784	784	1176
						14 day	2352	1568	8624	5488	5488	1568	126	1568	252	1568	1568	1568	2352
						31 day	5208	3472	19096	12152	12152	3472	126	3472	252	3472	3472	3472	5208
UT	256	52	104	104	208	7 day	8736	5824	32032	20384	20384	5824	936	5824	1872	5824	5824	5824	8736
						14 day	17472	11648	64064	40768	40768	11648	936	11648	1872	11648	11648	11648	17472
						31 day	38688	25792	141856	90272	90272	25792	936	25792	1872	25792	25792	25792	38688

The above chart depicts the types and amounts of PPE required per 7 day, 14 day, and 31 da

Walkthrough:

- **Current hospitalization rates are holding at ~ 20% of positive cases. (Currently, CO is below 100)**
- **CDC default estimate is 2 Drs, 2 Nurses, and 4 other associated personnel (Techs, etc…). Beckers Hospital statistics indicate between 7-8 Full Time Employees per bed and reinforces the number of staff used.**
- **CDC PPE Calculator (for Ebola) is a usable approximation of PPE for COVID cases.**

The above numbers can serve as a "recurring" supply requirement based on "burn rate" calculations largely established by CDC standards. Recommend re-running the calculator with updated data as needed.

Recommend: Establish PPE recurring resupply at a 14 or 31 day frequency which would allow the State to both adjust to increasing requirements as well as redistribute quantities to meet dynamic need.

FL-DOH-20-0673-A-005101

CDC PPE Calculator: https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/calculator.html

Number of Full Time Staff per Bed Estimate: https://www.beckershospitalreview.com/lists/200-hospital-benchmarks-october

	A	B	C	D	E	F	G	H
1		20% AR, low severity,	20% AR, low severity,	30% AR, low severity,	30% AR, low severity,	20% AR, high severity,	20% AR, high severity	30% AR, high severity
2	Colorado	119	185	178	277	400	693	600
3	Montana	22	34	33	52	74	129	112
4	North Dakota	16	25	24	37	53	93	80
5	South Dakota	19	29	28	44	63	109	94
6	Utah	66	103	99	155	223	387	335
7	Wyoming	12	18	18	27	40	69	59
8	Total	254	394	380	592	853	1479	1280
9								
10	0.0172	6909	10,747	10,363	16,120	23,250	40,300	34,875
11	0.0032							
12	0.0023							
13	0.0027							
14	0.0096							
15	0.0017							
16								
17	Reference: Meltzer, M. I., Patel, A., Ajao, A., Nystrom, S. V., & Koonin, L. M. (2015). Estimates of the demand for mechanical ventilation in the United States during an influenza pander							
18								
19		Lowest estimate						
20		Highest estimate						

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	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1	30% AR, high severity, max													
2	1040													
3	193													
4	139													
5	163													
6	580													
7	103													
8	2219													
9														
10	60,450													
11														
12														
13														
14														
15														
16														
17	mic. Clinical infectious diseases : an official publication of the Infectious Diseases Society of America, 60 Suppl 1(Suppl 1), S52–S57. https://doi.org/10.1093/cid/civ089													
18														
19														
20														

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Subject:	PPE Manufacturing Expertise and swab sample kits
Date:	Sunday, March 22, 2020 12:43:55 PM
Attachments:	FDA Hand Sanitizers Immediately in Effect Guidance Other Firms FINAL_0.pdf Strategies for Optimizing the Supply of N95 Respirators_ COVID-19 _ CDC.pdf Masks - cloth and common fabrics AOH 2010.pdf Simple resp mask EID 05-1468.pdf
Importance:	High

Here is additional information I just got from CDC regarding PPE. Several more attachments too. I'm sending this to much wider audience.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Swab sample test kit suppliers (unvetted)

Here are some suppliers you may want to contact for supplies:
Copan Diagnostics
26055 Jefferson Avenue Murrieta, CA 92562

Thermo Fisher Scientific
168 Third Avenue | Waltham, MA 02451

Princeton BioMeditech Corporation
P.O. Box 7139, Princeton, New Jersey 08543-7139 U.S.A. Tel: (732) 274-1000
4242 U.S. Route 1, Monmouth Junction, New Jersey 08852-1905 U.S.A. Fax: (732) 274-1010
Internet E-mail: info@pbmc.com
World Wide Web: http://www.pbmc.com/

Regards,
Jeanne

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Temporary Policy for Preparation of Certain Alcohol-Based Hand Sanitizer Products During the Public Health Emergency (COVID-19[1])

Guidance for Industry

U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)

March 2020
Pharmaceutical Quality/Manufacturing Standards (CGMP)/Over-the-Counter (OTC)

[1] This guidance was implemented immediately without prior comment.

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Temporary Policy for Preparation of Certain Alcohol-Based Hand Sanitizer Products During the Public Health Emergency (COVID-19)

Guidance for Industry

Public Comment

Comments may be submitted at any time for Agency consideration. Submit written comments to the Dockets Management Staff (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852. Submit electronic comments to https://www.regulations.gov. All comments should be identified with the docket number FDA-2020-D-1106 and complete title of the guidance in the request.

Additional Copies

Additional copies are available from the FDA webpage titled "Coronavirus Disease 2019 (COVID-19)," *available at* https://www.fda.gov/emergency-preparedness-and-response/mcm-issues/coronavirus-disease-2019-covid-19 and from the FDA webpage titled "Search for FDA Guidance Documents" *available at* https://www.fda.gov/regulatory-information/search-fda-guidance-documents. You may also send an e-mail request to druginfo@fda.hhs.gov to receive a copy of the guidance. Please include the document number FDA-2020-D-1106 and complete title of the guidance in the request.

Questions

For questions regarding this document, contact FDA at: CDERCompliance@fda.hhs.gov.

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U.S. Department of Health and Human Services
Food and Drug Administration
Center for Drug Evaluation and Research (CDER)

March 2020
Pharmaceutical Quality/Manufacturing Standards (CGMP)/Over-the-Counter (OTC)

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Contains Nonbinding Recommendations

Temporary Policy for Preparation of Certain Alcohol-Based Hand Sanitizer Products During the Public Health Emergency (COVID-19) Guidance for Industry[2]

This guidance represents the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. To discuss an alternative approach, contact the FDA office responsible for this guidance as listed on the title page.

I. INTRODUCTION

The Food and Drug Administration (FDA or Agency) plays a critical role in protecting the United States from emerging infectious diseases, such as the Coronavirus Disease 2019 (COVID-19) pandemic. FDA is committed to providing timely guidance to support continuity and response efforts to this pandemic.

FDA is issuing this guidance in response to a number of queries from entities that are not currently licensed or registered drug manufacturers that would like to prepare alcohol-based hand sanitizers, either for public distribution or for their own internal use. The Agency is issuing this guidance to communicate its policy for the temporary preparation of certain alcohol-based hand sanitizer products by firms that register as over-the-counter (OTC) drug manufacturers to prepare alcohol-based hand sanitizers under the circumstances described in this guidance ("firms") for the duration of the public health emergency declared by the Secretary of Health and Human Services (HHS) on January 31, 2020.[3] At such time when the public health emergency is over, as declared by the Secretary, FDA intends to discontinue this enforcement discretion policy and withdraw this guidance.

[2] This guidance has been prepared by the Center for Drug Evaluation and Research at the Food and Drug Administration. FDA has issued a separate guidance for industry entitled Policy for Temporary Compounding of Certain Alcohol-Based Hand Sanitizer Products During the Public Health Emergency (March 2020), that describes the Agency's policy for the temporary compounding of certain alcohol-based hand sanitizer products by pharmacists in State licensed pharmacies or Federal facilities and registered outsourcing facilities. The compounding guidance is available at https://www.fda.gov/regulatory-information/search-fda-guidance-documents/policy-temporary-compounding-certain-alcohol-based-hand-sanitizer-products-during-public-health. We update guidances periodically. For the most recent version of a guidance, check the FDA guidance web page at https://www.fda.gov/regulatory-information/search-fda-guidance-documents.

[3] The HHS Public Health Emergency Declaration is available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

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FL-DOH-20-0673-A-005110

Given this public health emergency, this guidance is being implemented without prior public comment because the FDA has determined that prior public participation for this guidance is not feasible or appropriate (see section 701(h)(1)(C)(i) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. § 371(h)(1)(C)(i)) and 21 CFR § 10.115(g)(2)). This guidance document is being implemented immediately, but it remains subject to comment in accordance with the Agency's good guidance practices.

In general, FDA's guidance documents do not establish legally enforceable responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should be viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in Agency guidances means that something is suggested or recommended, but not required.

II. BACKGROUND

There is currently an outbreak of respiratory disease caused by a novel coronavirus that was first detected in Wuhan City, Hubei Province, China, and that has now spread globally, to include the United States. The virus has been named "SARS-CoV-2" and the disease it causes has been named "Coronavirus Disease 2019" (COVID-19). On January 31, 2020, the Department of Health and Human Services (HHS) issued a declaration of a public health emergency related to COVID-19 and mobilized the Operating Divisions of HHS.[4] In addition, on March 13, 2020, the President declared a national emergency in response to COVID-19.[5]

Hand hygiene is an important part of the U.S. response to COVID-19. Washing hands often with soap and water for at least 20 seconds is essential, especially after going to the bathroom; before eating; and after coughing, sneezing, or blowing one's nose. If soap and water are not readily available, the Centers for Disease Control and Prevention (CDC) recommends consumers use an alcohol-based hand sanitizer that contains at least 60 percent alcohol (also referred to as ethanol or ethyl alcohol).[6]

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[4] Secretary of Health and Human Services Alex M Azar, Determination that a Public Health Emergency Exists. (Jan. 31, 2020), *available at* https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

[5] Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (Mar. 13, 2020), *available at* https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

[6] Isopropyl alcohol and ethyl alcohol are two of the active ingredients currently being evaluated by FDA as part of its review of over-the-counter (OTC) monographs for hand sanitizers for use in reducing bacteria on the skin that potentially can cause disease or decreasing bacteria on the skin. See "Safety and Effectiveness of Consumer Antiseptic Rubs; Topical Antimicrobial Drug Products for Over-the-Counter Human Use," Final Rule, 84 FR 14847 (April 12, 2019); "Safety and Effectiveness of Health Care Antiseptics; Topical Antimicrobial Drug Products for Over-the-Counter Human Use," Final Rule, 82 FR 60474 (December 20, 2017); "Topical Antimicrobial Drug Products for Over-the-Counter Human Use; Tentative Final Monograph for Health-Care Antiseptic Drug Products," Proposed Rule, 59 FR 31402 (June 17, 1994) (1994 TFM).

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III. DISCUSSION

We understand that some consumers and health care professionals are currently experiencing difficulties accessing alcohol-based hand sanitizers. We are also aware of reports that some consumers are producing hand sanitizers for personal use in their homes; the Agency lacks verifiable information on the methods being used to prepare such products and whether they are safe for use on human skin.

In response to the demand for alcohol-based sanitizers, certain entities that are not currently regulated by FDA as drug manufacturers have requested guidance on the preparation and distribution of hand sanitizer products for the public's use.

Because of the public health emergency posed by COVID-19, FDA does not intend to take action against firms[7] that prepare alcohol-based hand sanitizers for consumer use and for use as health care personnel hand rubs for the duration of the public health emergency declared by the Secretary of HHS on January 31, 2020, provided the following circumstances are present:

1. The hand sanitizer is manufactured using only the following United States Pharmacopoeia (USP) grade ingredients in the preparation of the product (percentage in final product formulation) consistent with World Health Organization (WHO) recommendations:[8]
    a. Alcohol (ethanol) (USP or Food Chemical Codex (FCC) grade) (80%, volume/volume (v/v)) in an aqueous solution denatured according to Alcohol and Tobacco Tax and Trade Bureau regulations in 27 CFR part 20; **or** Isopropyl Alcohol (75%, v/v) in an aqueous solution.[9]
    b. Glycerol (1.45% v/v).[10]
    c. Hydrogen peroxide (0.125% v/v).
    d. Sterile distilled water or boiled cold water.

    The firm does not add other active or inactive ingredients. Different or additional ingredients may impact the quality and potency of the product.

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[7] Specifically, FDA does not intend to take action against firms, for the duration of the public health emergency declared by the Secretary of HHS on January 31, 2020, for violations of sections 501(a)(2)(B), 502(f)(1), 505, or 582 of the FD&C Act (21 U.S.C. §§ 351(a)(2)(B), 352(f)(1), 355, and 360eee-1).

[8] The 1994 TFM is available at https://www.gpo.gov/fdsys/pkg/FR-1994-06-17/html/94-14503.htm. WHO's recommendations, titled "Guide to Local Production: WHO-recommended Handrub Formulations," are available at https://www.who.int/gpsc/5may/Guide_to_Local_Production.pdf.

[9] Consistent with the 1994 TFM, alcohol should be used in a final product concentration between 60-95% (v/v) in an aqueous solution denatured according to Alcohol and Tobacco Tax and Trade Bureau regulations in 27 CFR part 20; isopropyl alcohol should be used in a concentration between 70-91.3% (v/v). This guidance is consistent with WHO's recommended formulation specifications of 80% alcohol and 75% isopropyl alcohol.

[10] Although WHO's recommended formulation includes glycerol 1.45% (v/v), reports indicate that glycerol negatively impacts effectiveness of isopropyl alcohol (https://www.ncbi.nlm.nih.gov/pubmed/28670452), and reports studying the effectiveness of WHO's formulation have suggested a reduction from 1.45% to 0.725% (https://www.ncbi.nlm.nih.gov/pubmed/23388358/).

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2. The firm pays particular attention to ensure the ethanol or isopropyl alcohol active ingredient is correct and the correct amount of the active ingredient is used. A simple record should be used to document key steps and controls to assure each batch matches the formula developed for the drug product.

3. The hand sanitizer is prepared under sanitary conditions and equipment utilized is well maintained and fit for this purpose.[11]

4. The firm uses the most accurate method of analysis available at the site for verification of alcohol content in samples of the finished drug product before each batch is released for distribution. Methods can include gas chromatography (GC), alcoholmeter, hydrometer, or other chemical analysis of at least equivalent accuracy. The sample tested can be performed on in-process material before filling into the final containers to be distributed.

5. The hand sanitizer is labeled consistent with the attached labeling in Appendix A (Labeling for Ethyl Alcohol Formulation Consumer Use), Appendix B (Labeling for Isopropyl Alcohol Formulation Consumer Use), Appendix C (Labeling for Ethyl Alcohol Formulation Health Care Personnel Handrub Use), or Appendix D (Labeling for Isopropyl Alcohol Formulation Health Care Personnel Handrub Use).

6. Firms register their facility and list these products in the FDA Drug Registration and Listing System (DRLS, https://www.fda.gov/drugs/guidance-compliance-regulatory-information/drug-registration-and-listing-system-drls-and-edrls). Upon completion of registration and listing, firms receive automatic confirmation from the FDA and do not need to wait for a further communication from FDA before they begin to manufacture and distribute these products. FDA relies on registration and listing information to help manage drug shortages, monitor safety issues that may arise with product distributed to the public, and manage product recalls, among other important FDA public safety activities. Our help desk is standing by to assist with facilitating this process and can be contacted by sending an email to: edrls@fda.hhs.gov.

This policy does not extend to other types of products, such as: products (1) that use different active ingredients; (2) whose potency falls above or below the formulation described above; (3) that are marketed with claims that do not conform to the "Topical Antimicrobial Drug Products for Over-the-Counter Human Use; Tentative Final Monograph for Health-Care Antiseptic Drug Products," Proposed Rule, 59 FR 31402 (June 17, 1994) (e.g., pathogen-specific disease claims): (4) that are surgical hand rubs; or (5) whose labeling is false or misleading in any particular.

Firms will need to have a way to accept adverse event reports for any products they manufacture, and submit adverse event reports to FDA (for more information, please see FDA's guidance on adverse event reporting requirements, https://www.fda.gov/media/77193/download).[12]

[11] Facilities must prevent insanitary conditions under section 501(a)(2)(A) of the FD&C Act (21 U.S.C. § 351(a)(2)(A)).
[12] See Section 760 of the FD&C Act (21 U.S.C. § 379aa).

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FDA encourages consumers and health care professionals to report adverse events experienced with the use of hand sanitizers to FDA's MedWatch Adverse Event Reporting program:

- Complete and submit the report online; or
- Download and complete the form, then submit it via fax at 1-800-FDA-0178.

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Appendix A. Labeling for Ethyl Alcohol Formulation Consumer Use

PRINCIPAL DISPLAY PANEL (FRONT OF PACKAGE):

Alcohol Antiseptic 80%
Topical Solution

Hand Sanitizer
Non-sterile Solution

[Insert Volume of Product in mL]

DRUG FACTS LABEL

Drug Facts

Active ingredient[s] ***Purpose***

Alcohol 80% v/v..... Antiseptic

Use[s]

Hand Sanitizer to help reduce bacteria that potentially can cause disease. For use when soap and water are not available.

Warnings

For external use only. Flammable. Keep away from heat or flame

Do not use

- in children less than 2 months of age
- on open skin wounds

When using this product keep out of eyes, ears, and mouth. In case of contact with eyes, rinse eyes thoroughly with water.

Stop use and ask a doctor if irritation or rash occurs. These may be signs of a serious condition.

Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions

- Place enough product on hands to cover all surfaces. Rub hands together until dry.
- Supervise children under 6 years of age when using this product to avoid swallowing.

Other information

- Store between 15-30C (59-86F)
- Avoid freezing and excessive heat above 40C (104F)

Inactive ingredients glycerin, hydrogen peroxide, purified water USP

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Appendix B. Labeling for Isopropyl Alcohol Formulation Consumer Use

PRINCIPAL DISPLAY PANEL (FRONT OF PACKAGE):

Isopropyl Alcohol Antiseptic 75%
Topical Solution

Hand Sanitizer
Non-sterile Solution

[Insert Volume of Product in mL]

DRUG FACTS LABEL

Drug Facts

Active ingredient[s] ***Purpose***

Isopropyl alcohol 75% v/v.....Antiseptic

Use[s]

Hand sanitizer to help reduce bacteria that potentially can cause disease. For use when soap and water are not available.

Warnings

For external use only. Flammable. Keep away from heat or flame

Do not use

- in children less than 2 months of age
- on open skin wounds

When using this product keep out of eyes, ears, and mouth. In case of contact with eyes, rinse eyes thoroughly with water.

Stop use and ask a doctor if irritation or rash occurs. These may be signs of a serious condition.

Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions

- Place enough product on hands to cover all surfaces. Rub hands together until dry.
- Supervise children under 6 years of age when using this product to avoid swallowing.

Other information

- Store between 15-30C (59-86F)
- Avoid freezing and excessive heat above 40C (104F)

Inactive ingredients glycerin, hydrogen peroxide, purified water USP

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Appendix C. Labeling for Ethyl Alcohol Formulation Health Care Personnel Handrub Use

PRINCIPAL DISPLAY PANEL (FRONT OF PACKAGE):

Alcohol Antiseptic 80%
Topical Solution

Antiseptic Hand Rub
Non-sterile Solution

[Insert Volume of Product in mL]

DRUG FACTS LABEL

Drug Facts

Active ingredient[s] ***Purpose***

Alcohol 80% v/v..... Antiseptic

Use[s]

Health care personnel hand rub to help reduce bacteria that potentially can cause disease.

Warnings

For external use only. Flammable. Keep away from heat or flame

Do not use

- in children less than 2 months of age
- on open skin wounds

When using this product keep out of eyes, ears, and mouth. In case of contact with eyes, rinse eyes thoroughly with water.

Stop use and ask a doctor if irritation or rash occurs. These may be signs of a serious condition.

Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions

- Place enough product on hands to cover all surfaces. Rub hands together until dry.
- Supervise children under 6 years of age when using this product to avoid swallowing.

Other information

- Store between 15-30C (59-86F)
- Avoid freezing and excessive heat above 40C (104F)

Inactive ingredients glycerin, hydrogen peroxide, purified water USP

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Appendix D. Labeling for Isopropyl Alcohol Formulation Health Care Personnel Handrub Use

PRINCIPAL DISPLAY PANEL (FRONT OF PACKAGE):

Isopropyl Alcohol Antiseptic 75% Topical Solution

Antiseptic Hand Rub
Non-sterile Solution

[Insert Volume of Product in mL]

DRUG FACTS LABEL

Drug Facts

Active ingredient[s] ***Purpose***

Isopropyl alcohol 75% v/v.....Antiseptic

Use[s]

Hand sanitizer to help reduce bacteria that potentially can cause disease.

Warnings

For external use only. Flammable. Keep away from heat or flame

Do not use

- in children less than 2 months of age
- on open skin wounds

When using this product keep out of eyes, ears, and mouth. In case of contact with eyes, rinse eyes thoroughly with water.

Stop use and ask a doctor if irritation or rash occurs. These may be signs of a serious condition.

Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away.

Directions

- Place enough product on hands to cover all surfaces. Rub hands together until dry.
- Supervise children under 6 years of age when using this product to avoid swallowing.

Other information

- Store between 15-30C (59-86F)
- Avoid freezing and excessive heat above 40C (104F)

Inactive ingredients glycerin, hydrogen peroxide, purified water USP

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Simple Respiratory Protection—Evaluation of the Filtration Performance of Cloth Masks and Common Fabric Materials Against 20–1000 nm Size Particles

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A shortage of disposable filtering facepiece respirators can be expected during a pandemic respiratory infection such as influenza A. Some individuals may want to use common fabric materials for respiratory protection because of shortage or affordability reasons. To address the filtration performance of common fabric materials against nano-size particles including viruses, five major categories of fabric materials including sweatshirts, T-shirts, towels, scarves, and cloth masks were tested for polydisperse and monodisperse aerosols (20–1000 nm) at two different face velocities (5.5 and 16.5 cm s^{-1}) and compared with the penetration levels for N95 respirator filter media. The results showed that cloth masks and other fabric materials tested in the study had 40–90% instantaneous penetration levels against polydisperse NaCl aerosols employed in the National Institute for Occupational Safety and Health particulate respirator test protocol at 5.5 cm s^{-1}. Similarly, varying levels of penetrations (9–98%) were obtained for different size monodisperse NaCl aerosol particles in the 20–1000 nm range. The penetration levels of these fabric materials against both polydisperse and monodisperse aerosols were much higher than the penetrations for the control N95 respirator filter media. At 16.5 cm s^{-1} face velocity, monodisperse aerosol penetrations slightly increased, while polydisperse aerosol penetrations showed no significant effect except one fabric mask with an increase. Results obtained in the study show that common fabric materials may provide marginal protection against nanoparticles including those in the size ranges of virus-containing particles in exhaled breath.

Keywords: fabric material; H1N1; H5N1; infectious aerosol; influenza; pandemic; particle penetration; respiratory protection

INTRODUCTION

The outbreaks of avian influenza A (H5N1) and the recent novel influenza virus A (H1N1) pandemic are major health problems (WHO, 2006, 2009). To reduce exposure to infectious influenza aerosols, several government agencies and nongovernment organizations have recommended a number of nonpharmaceutical interventions, including respiratory protection. The Centers for Disease Control and Prevention (CDC) recommends the use of National Institute for Occupational Safety and Health (NIOSH)-approved respirators for reducing exposure to infectious aerosols such as those that cause severe acute respiratory syndrome (SARS) and novel influenza (H1N1) (CDC, 2001, 2003, 2004, 2009). The use of large number of respirators created a demand during the spread of SARS in the USA (Srinivasan *et al.*, 2004). Recently, CDC predicted that the need for disposable N95 respirators could exceed 90 million for the protection of healthcare

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workers for an outbreak of 42 days of influenza A (H5N1), indicating a possible shortage of respirators (Bailar *et al.*, 2006; CDC, 2006).

The issue of a respirator shortage during a widespread influenza pandemic was addressed by the Institute of Medicine (IOM), which released a report entitled 'Reusability of Facemasks during an Influenza Pandemic. Facing the flu' (Bailar *et al.*, 2006). One of the recommendations was to conduct research on the effectiveness of woven cloth masks for the transmission of influenza virus because cloth masks may be the only option available for some individuals during a pandemic. Research on alternative respiratory protective materials, including common fabric materials such as T-shirts, handkerchiefs, and scarves, was also recommended (Bailar *et al.*, 2006). In the absence of respirators, some individuals may use improvised common fabric materials for respiratory protection while entering a contaminated environment, such as when caring for an infected family member at home. These household materials are not designed for respiratory protection and their use may provide a false sense of protection because their effectiveness against larger and $<$1000 nm size particles including viruses is not well understood. This indicates that further studies are needed to better understand the filtration performance of cloth masks and common fabric materials against a wide range of particle sizes, including the size of many viruses.

The knowledge on the filtration performance of improvised materials for particulates is limited, however. Previous studies challenged the improvised materials with large-size biological and inert particles and reported varying levels of protection for different size particles (Guyton *et al.*, 1959; Cooper *et al.*, 1983a,b). In one study, the filtration efficiency of a number of fabric materials was tested using human subjects. The authors reported that the filtration efficiency of single layer of bath towel, cotton shirt, handkerchief, and other materials was in the 28–73% range against *Bacillus globigii* aerosols of 2000 nm mass median diameter (Guyton *et al.*, 1959). Another study measured the effectiveness factor obtained from filtration efficiency and pressure drop for different common fabric materials using a manikin (Cooper *et al.*, 1983a). Fabric materials were challenged with mineral oil aerosol particles of 410–4800 nm diameter size and the effectiveness factor calculated. For many fabric materials including shirt, sheet, towel, and handkerchief, the effectiveness factor decreased with decreasing particle size from 4800 to 410 nm, indicating further decrease in the respiratory protection for virus-containing particles $<$410 nm (Cooper *et al.*, 1983a).

Recent studies showed that patients, as well as control subjects, generate significant levels of submicron as well as larger size particles including the size of many viruses during breathing, coughing, and talking (Fairchild and Stampfer, 1987; Papineni and Rosenthal, 1997; Edwards *et al.*, 2004; Yang *et al.*, 2007; Fabian *et al.*, 2008; Blachere *et al.*, 2009; Lindsley *et al.*, 2010). Although some viruses can be quite small ($\sim$20 nm), they are often generated by humans as larger size particles (e.g. attached to mucus secretions). For example, one study (Fabian *et al.*, 2008) showed 87% of particles in exhaled breath of influenza-infected patients were under 1000 nm in diameter and the rest of the particles larger than that size. Similarly, the transmission of infectious diseases through exposure to smaller and $>$1000 nm size aerosols has been reviewed (Fiegel *et al.*, 2006; Hall, 2007). Although much debate still exists on the relative contributions of the various routes of disease transmission (e.g. inhalation, contact, and droplet) (IOM, 2009), infected individuals produce smaller size particles ($<$1000 nm) that can travel long distances and larger size particles ($\sim$10000 nm) capable of reaching shorter distances. Some individuals may improvise fabric materials for emergency respiratory protection to reduce inhalation of infectious aerosols, indicating the need for further studies to assess their filtration performance against a wide range of particle sizes. In this study, household fabric materials and cloth masks were challenged with polydisperse as well as monodisperse particles in the 20–1000 nm size range, which include the size of many viruses and initial penetration levels measured and compared with those values obtained for N95 respirator filter media. In this study, we hypothesized that cloth masks and fabric materials would capture some aerosol but would exhibit high variability because they were not designed for that purpose.

MATERIALS AND METHODS

Fabric materials

Common fabric materials of five major categories including sweatshirts, T-shirts, towels, scarves, and cloth masks were selected for aerosol penetration tests (Table 1). Table 1 also shows the fiber composition of fabric materials and the resistance levels measured at 5.5 cm s^{-1} face velocity. The fiber composition for cloth masks is not available. Fabric materials for each category were randomly selected

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Table 1. Fabric materials tested for particle penetration measurements

Fabric material	Description	Model 1	Model 2	Model 3
Cloth mask	Brand name	Respro	Breathe Health	Breathe Health
		Bandit Mask	Cloth Mask	Fleece Mask
	Fiber composition	Not available	Not available	Not available
	Resistance (mm water)	2.0 ± 0.3	3.2 ± 0.7	1.2 ± 0.1
Sweatshirt	Brand name	Norma Kamali Tunic	Hanes	Faded Glory
	Fiber composition	85% Cotton/ 15% polyester	70% Cotton/ 30% polyester	60% Cotton/ 40% polyester
	Resistance (mm water)	2.0 ± 0.1	1.1 ± 0.1	0.4 ± 0.1
T-shirt	Brand name	Dickies	Hanes	Faded Glory
	Fiber composition	99% Cotton/ 1% polyester	100% Cotton	60% Cotton/ 40% polyester
	Resistance (mm water)	1.6 ± 0.2	1.6 ± 0.1	0.9 ± 0.1
Towel	Brand name	Pem America	Pinzon	Aquis
	Fiber composition	100% Cotton	100% Cotton	80% Polyester/ 20% nylon
	Resistance (mm water)	3.8 ± 0.2	7.9 ± 0.8	3.7 ± 0.2
Scarf	Brand name	Today's Gentleman	Walmart	Seed Supply
		Pocket square	Fleece	Cotton
	Fiber composition	100% Cotton	100% Polyester	100% Cotton
	Resistance (mm water)	5.9 ± 0.1	2.0 ± 0.1	1.4 ± 0.1

Fabric material composition and airflow resistance measured at 5.5 cm s^{-1} face velocity. 1 mm water gauge = 0.133 kPa.

from three different manufacturers based on availability. The commercial cloth masks were advertised as pollution and allergen masks and did not make any claim as to their effectiveness for submicron-size particles. It should be noted that none of the other fabric materials was designed to be used as a filtering media. N95 respirator filter media was tested in parallel with the fabric materials for comparison of the filtration performance against submicron-size aerosol particles.

Polydisperse aerosol penetration test method

Three samples from each fabric materials were tested for polydisperse NaCl aerosol (75 ± 20 nm count median diameter and a geometric standard deviation not exceeding 1.86) penetrations with a TSI 8130 Automated Filter Tester (TSI 8130) used for NIOSH particulate respirator certification (NIOSH, 2007). Penetration levels for 100 cm^2 samples were measured at two different face velocities 5.5 and 16.5 cm s^{-1} corresponding to 33 and 99 l min^{-1} flow rates. A standard face velocity of 5.3 cm s^{-1} is employed for testing various filter media. In this study, a face velocity closer to this value, i.e. 5.5 cm s^{-1}, and a relatively higher face velocity, 16.5 cm s^{-1}, were employed for testing the filtration performance of fabric materials. The flow rates are based on the area of the fabric material tested to achieve the face velocities employed in the study. Initial penetration levels of NaCl particles were measured for 1 min with no loading as conducted in the NIOSH 42 CFR 84 test protocol. Percentage penetration was determined as the ratio of particle concentration downstream to upstream multiplied by 100. Polydisperse aerosol is commonly used for filtration performance testing and allows comparison to standard filters made (N95, P2, P3, high efficiency particulate air, etc.).

Monodisperse aerosol penetration test method

Another set of three samples from each group of the same fabric models was tested against monodisperse NaCl particles using a TSI 3160 Fractional Efficiency Tester (TSI 3160) as described previously (Rengasamy *et al.*, 2007). Similar to polydisperse aerosols, penetration levels for 100 cm^2 samples were measured at face velocities 5.5 and 16.5 cm s^{-1}. Initial percentage penetration levels

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for 10 different monodisperse aerosols (20, 30, 40, 50, 60, 80, 100, 200, 300, and 400 nm) were measured for each sample. These monodisperse aerosol tests were conducted to better understand the filtration performance against <400 nm size particles. This size range is necessary to determine the aerosol size range of minimum efficiency.

Penetration of NaCl particles as a function of particle size from 500 to 1000 nm

Penetration levels for larger size particles (500–1000 nm) were measured as a function of particle size. Polydisperse NaCl aerosols were generated using a constant output atomizer (Model 3076; TSI, Inc.) and passed through a dryer, a ^{85}Kr neutralizer, and then into the Plexiglas box containing the test fabric material. The upstream and downstream aerosol number concentrations and size distributions (500–1000 nm range) were measured for 2 min alternately using a scanning mobility particle sizer (SMPS 3080; TSI, Inc.) in scanning mode and an ultrafine condensation particle counter as described previously (Rengasamy *et al.*, 2009a). Percentage penetration was calculated from the ratio of the particle number concentration downstream to the concentration upstream. These monodisperse aerosol tests were conducted to better understand the filtration performance against 500–1000 nm size particles.

Data analysis

The data were analyzed using the SigmaPlot® (Jandel Corporation) computer program. Average penetration values and 95% confidence intervals were calculated for each model.

RESULTS

Polydisperse aerosol penetrations

Average penetration levels for the three different cloth masks were between 74 and 90%, while N95 filter media controls showed 0.12% at 5.5 cm s^{-1} face velocity (Fig. 1). The penetration levels increased significantly for the N95 control filter media but remained <5%, while none of the fabric materials showed any significant increase at 16.5 cm s^{-1} face velocity. Figure 2 shows polydisperse aerosol penetration levels for sweatshirts and T-shirts. Of the three sweatshirts, one model (Hanes) showed 40% penetration level at 5.5 cm s^{-1}, which increased to 57% at 16.5 cm s^{-1} face velocity. The other two models (Norma Kamali and Faded Glory) showed penetration levels in the 70–82% range at both

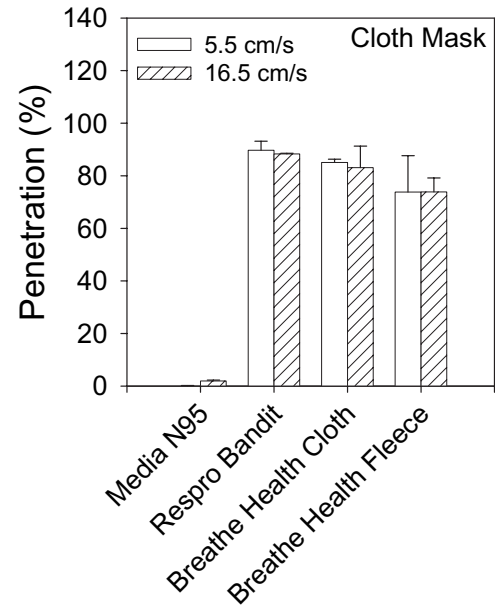

Fig. 1. Polydisperse NaCl aerosol penetration levels for cloth masks at two different face velocities. Error bars indicate 95% confidence level.

5.5 and 16.5 cm s^{-1} face velocities (Fig. 2a). At the same time, T-shirts showed penetration levels >86% at 5.5 cm s^{-1} with no significant increase at 16.5 cm s^{-1} (Fig. 2b). Average penetration levels for the three different model towels and scarves were in the 60–66% and 73–89% ranges, respectively, with no significant increase at 16.5 cm s^{-1} (Fig. 3a,b). Table 1 shows airflow resistance (in millimeter water) at 5.5 cm s^{-1} face velocity. In general, the resistance levels were less than or comparable to N95 filter material employed in the study (9.8 ± 0.2 cm water gauge; 1 cm water gauge = 1.33 kPa). A cotton towel model (Pinzon) and a scarf material (Today's Gentleman) showed slightly higher resistance levels than the other fabric materials. Slightly higher airflow resistance levels were obtained at 16.5 cm s^{-1}.

Monodisperse aerosol penetrations

Penetration levels for monodisperse aerosol particle (20–400 nm range) were combined with those for 500–1000 nm range particles measured as a function of particle size. For the cloth masks, monodisperse aerosol penetration levels (35–68%) for 20 nm size particles increased steadily, reached maximum (73–82%) at 100 nm range, plateaued up to 400 nm, and increased slightly up to 1000 nm at 5.5 cm s^{-1} face velocity (Fig. 4a). Slightly higher penetration levels were obtained at 16.5 cm s^{-1} face

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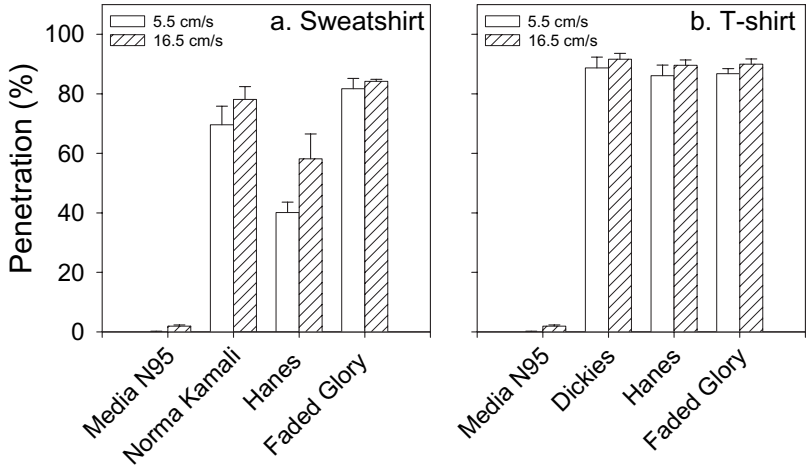

Fig. 2. Polydisperse NaCl aerosol penetration levels for sweatshirts and T-shirts at two different face velocities. Error bars indicate 95% confidence level.

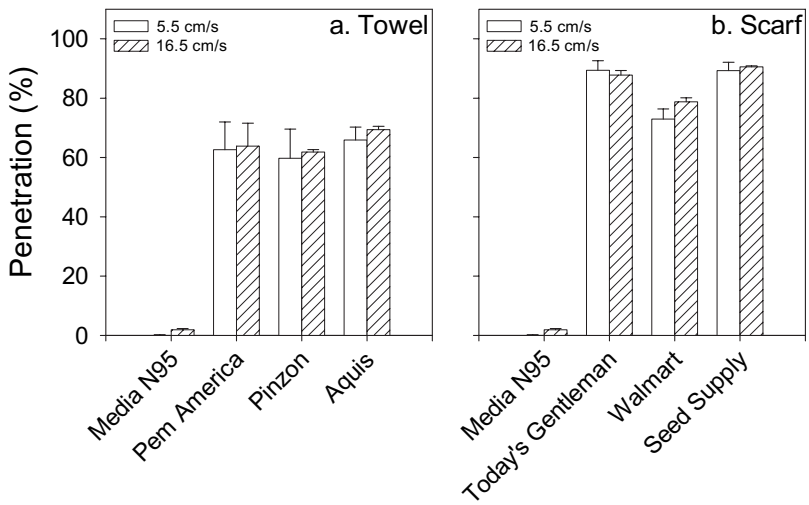

Fig. 3. Polydisperse NaCl aerosol penetration levels for towels and scarves at two different face velocities. Error bars indicate 95% confidence level.

velocity for the different size particles (20–1000 nm range) (Fig. 4b). Penetration levels for the three sweatshirt and T-shirt models were, respectively, in the 30–61% and 56–79% ranges for 20-nm size particles and increased to 80–93% and 89–97% for 1000 nm particles (Fig. 5a,c). A slight increase in penetration levels was obtained for 20–1000 nm size particles, which remained the same or decreased slightly with increasing particle sizes at 16.5 cm s^{-1} face velocity (Fig. 5b,d). In the case of towels and scarves, penetration levels varied from 9 to 74% for 20 nm size particles and increased monotonically at 5.5 cm s^{-1} face velocity (Fig. 6a,c). Penetration levels of different size particles increased at 16.5 cm s^{-1} face velocity at varying levels (Fig. 6b,d).

DISCUSSION

The results obtained in the study showed that cloth masks and other fabric materials tested in the study had 40–90% instantaneous penetration levels when challenged with polydisperse NaCl aerosols employed in the NIOSH particulate respirator test protocol at a face velocity of 5.5 cm s^{-1}. Similarly, varying levels of penetrations (9–98%) were

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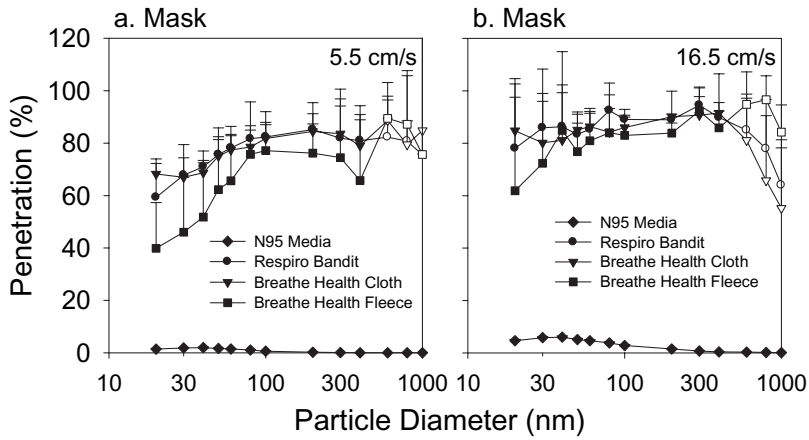

Fig. 4. Monodisperse aerosol penetration levels for cloth masks at two different face velocities. Error bars indicate 95% confidence level (closed symbols, TSI 3160 and open symbols, SMPS).

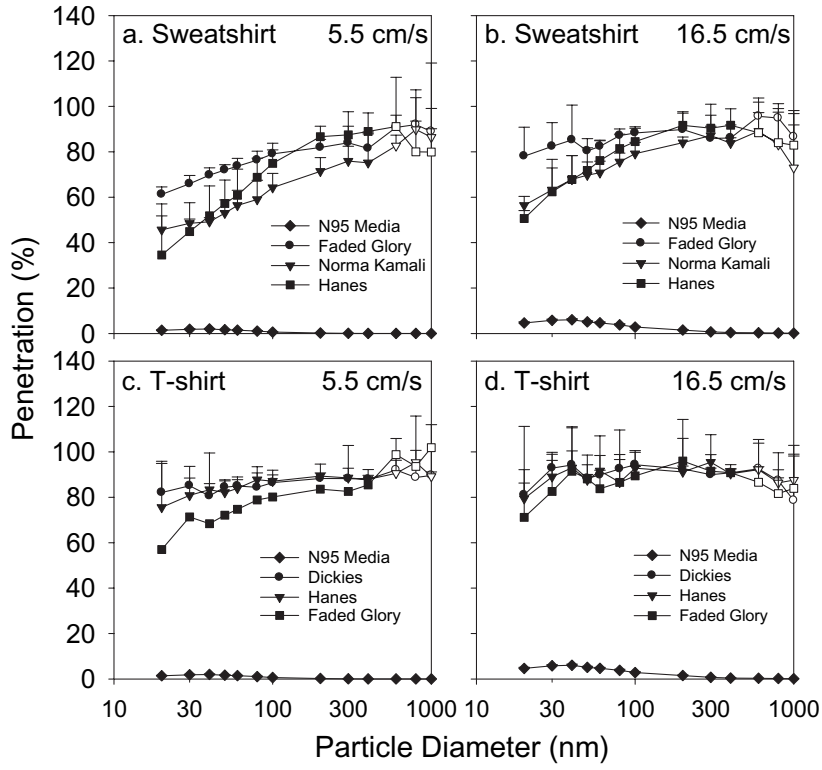

Fig. 5. Monodisperse aerosol penetration levels at two different face velocities for sweatshirts (a and b) and T-shirts (c and d). Error bars indicate 95% confidence level. (closed symbols, TSI 3160 and open symbols, SMPS).

obtained for different size monodisperse NaCl aerosol particles in the 20–1000 nm range. Monodisperse aerosol penetration curves for many fabric materials were similar to the curve for a mechanical filter indicating that electret charge was not incorporated in the fabric materials tested in the study. The penetration levels for these fabric materials against polydisperse, as well as monodisperse aerosols, were much higher than the values for the control N95 respirator filter media. A poor filtration performance is

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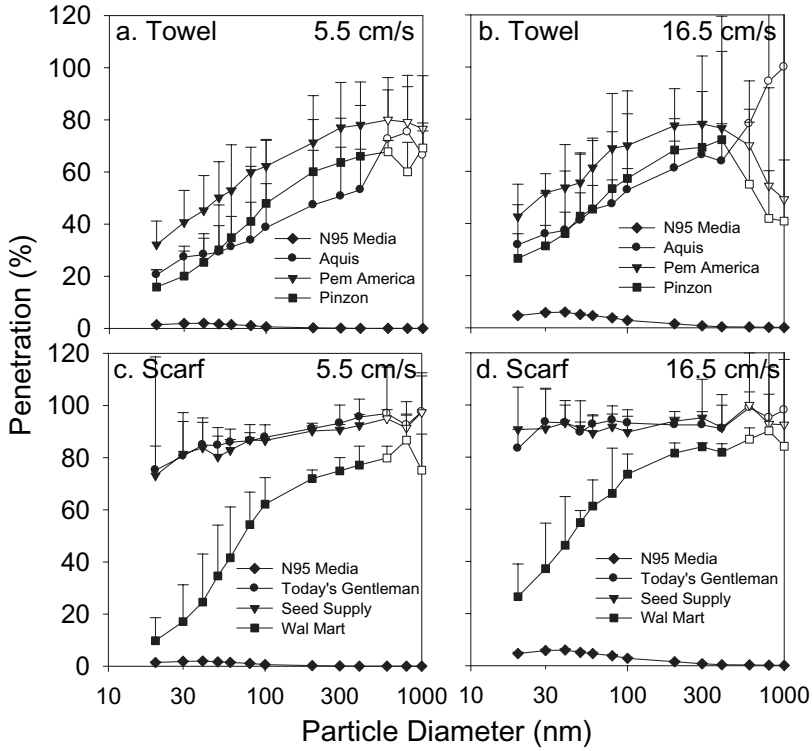

Fig. 6. Monodisperse aerosol penetration levels at two different face velocities for towels (a and b) and scarves (c and d). Error bars indicate 95% confidence level. (closed symbols, TSI 3160 and open symbols, SMPS).

expected for improvised fabric materials because these materials are not designed for respiratory protection.

The wide variation in penetration levels obtained for many fabric materials tested in our study agree with the penetration results reported previously (Guyton *et al.*, 1959; Cooper *et al.*, 1983a). For example, the filtration efficiency (i.e. inverse of the penetration) of fabric materials was in the range of 3–33% (penetration range 67–97%) for 1000 nm particles at 5.5 cm s^{-1} face velocity that is comparable to the filtration efficiency (27–73%) of single-layer fabric materials against *B. globigii* particles (2000 nm) at a breathing flow rate of 10 l min^{-1} (Guyton *et al.*, 1959). The increase in efficiency can be attributed to the efficient capturing of larger size *B. globigii* particles. Similarly, the penetration values measured in our study 56–94% and 67–97% for 400 and 1000 nm size particles, respectively, at 5.5 cm s^{-1} face velocity are similar compared to 54 and 59% penetrations for 400 and 1000 nm size particles, respectively, at 1.5 cm s^{-1} face velocity reported previously (Cooper *et al.*, 1983a).

The filtration efficiency of improvised fabric materials is comparable to some commonly used Federal Drug Agency-cleared surgical masks and unapproved dust masks (Oberg and Brosseau, 2008; Rengasamy *et al.*, 2008; Rengasamy *et al.*, 2009b). For example, previous studies showed that some surgical masks had high penetration levels against similar size polydisperse as well as monodisperse aerosols at a similar face velocity (Rengasamy *et al.*, 2009b). Two of the five surgical masks showed 51–89% penetration levels against polydisperse aerosols. Similarly, three dust mask models had high penetration levels (81–89%) for polydisperse aerosol particles (Rengasamy *et al.*, 2008). Thus, the penetration results obtained in the study indicate that the filtration performance of fabric materials is similar in some aspects to some surgical masks to reduce the transmission of infectious diseases. However, this study did not evaluate the fabric materials for protection against droplets and liquid splashes.

The use of fabric materials may provide only minimal levels of respiratory protection to a wearer against virus-size submicron aerosol particles (e.g. droplet nuclei). This is partly because fabric materials show only marginal filtration performance against virus-size particles when sealed around the edges. Face seal leakage will further decrease the

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respiratory protection offered by fabric materials. As expected, a previous study using a manikin showed greater particle penetration for loosely held fabric materials than fully sealed materials around edges (Guyton *et al.*, 1959). Interestingly, however, some studies have reported that improvised fabric materials can provide a good fit and measurable protection level against test aerosols (Dato *et al.*, 2006; Sandee *et al.*, 2009). In one study, fit factors between 13 and 67 were obtained for three subjects using hand-fashioned masks out of a Hanes T-shirt, a modest level of protection to the wearer (Dato *et al.*, 2006). Similarly, home-made face masks made of tea cloths tested on human subjects provided marginal protection as measured by a PortaCount® Plus (TSI, Inc.) that also uses 20–1000 nm size ambient air particles compared to surgical and CE-marked FFP2 masks (Sandee *et al.*, 2009). The authors reported protection factor levels of 2–3, 4–6, and 66–141 for tea cloths, surgical masks, and FFP2 masks, respectively, under various test conditions. The fabric materials tested in our study might also be expected to provide marginal levels of respiratory protection for 20–1000 nm aerosols (droplet nuclei). Fabric materials may provide respiratory protection levels (i.e. total inward leakage) similar to the levels obtained using some surgical masks, which have been measured to be <10 (Oberg and Brosseau, 2008). Thus, the use of improvised fabric materials may be of some value compared to no protection at all when respirators are not available. Moreover, fabric materials would not suffer from limited supplies unlike respirators and surgical masks for emergency protection.

Some of the fabric materials tested in this study had relatively better filtration performance than others. For example, the Hanes sweatshirt showed less penetration levels against polydisperse aerosols at 5.5 cm s^{-1} face velocity compared to other fabric materials. Similarly, monodisperse aerosol penetration values for particles <60 nm size were less for Hanes sweatshirt. However, the penetration values for >60 nm size particles were higher similar to the penetrations for other sweatshirts and the reason for the discrepancy is not clear. The filtration performance of the towels (Aquis, Pinzon, and Pem America) and one scarf (Walmart) against <100 nm size monodisperse aerosol particles was relatively better than the other fabric materials. Moreover, filtration performance of the fabric materials showed no correlation with the airflow resistance levels. Filtration of polydisperse aerosol particles was effective by 100% cotton fabrics in one case, while 100% polyester, 100% cotton, or cotton/polyester combination was better for nanoparticle (<100 nm) range. Filtration performance of the fabric material cannot be estimated *a priori* from material composition because it is mostly dependent on fiber characteristics, including diameter, charge, and packing density. Moreover, the finished fabric products do not carry information on fiber properties involved in particle filtration. Thus, the selection process for a better performing improvised fabric material may be difficult for a common user. In spite of the poor performance, fabric materials may provide some level of protection against the transmission of infectious aerosols when used in combination with other protective measures. Recently, a review paper analyzed the data obtained from seven case–control studies on the intervention measures of SARS transmission (Jefferson *et al.*, 2009). The authors concluded that a combination of several measures including the use of respiratory protection devices, gloves, and other hygienic practices may reduce the spread of infectious diseases considerably than by a single method. Moreover, cloth masks and fabric materials covering the mouth and nose may serve as a reminder to not touch those areas with the hands serving to minimize contact transmission and reduce exposure to liquid splashes and droplets, although these premises would need to be confirmed experimentally.

The limitations of our study include that only a few types of fabric materials were tested in the study. Some fabric materials not tested in the study may perform better. None of the materials had been worn or laundered, which could also affect filtration performance. Moreover, face seal leakage of aerosol particles was not measured, which is a critical component of respiratory protection. Further studies on respiratory protection of common fabric materials on human subjects for an even wider size range (20–5000 nm) of aerosol particles (e.g. to include more data on filtration performance against droplets) would be helpful to better assess the value of common fabric materials to reduce exposure to infectious aerosols.

CONCLUSION

Common fabric materials and cloth masks showed a wide variation in penetration values for polydisperse (40–90%) as well as monodisperse aerosol particles in the 20–1000 nm range (40–97%) at 5.5 cm s^{-1} face velocity. The penetration levels obtained for fabric materials against both polydisperse and monodisperse aerosols were much higher than the value for the control N95 respirator filter media but were in the range found for some surgical masks

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in previous studies. Penetrations of monodisperse aerosol particles slightly increased at 16.5 cm s^{-1} face velocity, while polydisperse aerosols showed no significant effect except one fabric mask with an increase. The penetration values obtained for common fabric materials indicate that only marginal respiratory protection can be expected for submicron particles taking into consideration face seal leakage.

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Disclaimer—Mention of commercial product or trade name does not constitute endorsement by the NIOSH. The findings and conclusions of this report are those of the authors and do not necessarily represent the views of the NIOSH.

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Simple Respiratory Mask

To the Editor: The US Department of Labor recommends air-purifying respirators (e.g., N95, N99, or N100) as part of a comprehensive respiratory protection program for workers directly involved with avian influenza–infected birds or patients (*1*). N95 respirators have 2 advantages over simple cloth or surgical masks; they are ≥95% efficient at filtering 0.3-μm particles (smaller than the 5-μm size of large droplets—created during talking, coughing, and sneezing—which usually transmit influenza) and are fit tested to ensure that infectious droplets and particles do not leak around the mask (*2–4*). Even if N95 filtration is unnecessary for avian influenza, N95 fit offers advantages over a loose-fitting surgical mask by eliminating leakage around the mask.

The World Health Organization recommends protective equipment including masks (if they not available, a cloth to cover the mouth is recommended) for persons who must handle dead or ill chickens in regions affected by H5N1 (*5*). Quality commercial masks are not always accessible, but anecdotal evidence has showed that handmade masks of cotton gauze were protective in military barracks and in healthcare workers during the Manchurian epidemic (*6,7*). A simple, locally made, washable mask may be a solution if commercial masks are not available. We describe the test results of 1 handmade, reusable, cotton mask.

For material, we choose heavyweight T-shirts similar to the 2-ply battle dress uniform T-shirts used for protective masks against ricin and saxitoxin in mouse experiments (*8*). Designs and T-shirts were initially screened with a short version of a qualitative Bitrex fit test (*9*) (Allegro Industries, Garden Grove, CA, USA). The best were tested by using a standard quantitative fit test, the Portacount Plus Respirator Fit Tester with N95-Companion (TSI, Shoreview, MN, USA) (*10*). Poor results from the initial quantitative fit testing on early prototypes resulted in the addition of 4 layers of material to the simplest mask design. This mask is referred to as the prototype mask (Figure).

A Hanes Heavyweight 100% preshrunk cotton T-shirt (made in Honduras) was boiled for 10 minutes and air-dried to maximize shrinkage and sterilize the material in a manner available in developing countries. A scissor, marker, and ruler were used to cut out 1 outer layer (≈37 × 72 cm) and 8 inner layers (≤18 cm^2). The mask was assembled and fitted as shown in the Figure.

A fit factor is the number generated during quantitative fit testing by simulating workplace activities (a series of exercises, each 1 minute in duration). The Portacount Plus Respirator Fit Tester with N95-Companion used for the test is an ambient aerosol instrument that measures aerosol concentration outside and inside the prototype mask. The challenge agent used is the ambient microscopic dust and other aerosols that are present in the air.

A commercially available N95 respirator requires a fit factor of 100 to be considered adequate in the workplace. The prototype mask achieved a fit factor of 67 for 1 author with a Los Alamos National Laboratory (LANL) panel face size of 4, a common size. Although insufficient for the workplace, this mask offered substantial protection from the challenge aerosol and showed good fit with minimal leakage. The other 2 authors with LANL panel face size 10, the largest size, achieved fit factors of 13 and 17 by making the prototype mask inner layers slightly larger (22 cm^2).

We do not advocate use of this respirator in place of a properly fitted commercial respirator. Although subjectively we did not find the work of breathing required with the prototype mask to be different from that required with a standard N95 filtering facepiece, persons with respiratory compromise of any type should not use this mask. While testers wore the mask for an hour without difficulty, we cannot comment on its utility during strenuous work or adverse environmental conditions.

We showed that a hand-fashioned mask can provide a good fit and a measurable level of protection from a challenge aerosol. Problems remain. When made by naive users, this mask may be less effective because of variations in material, assembly, facial structure, cultural practices, and

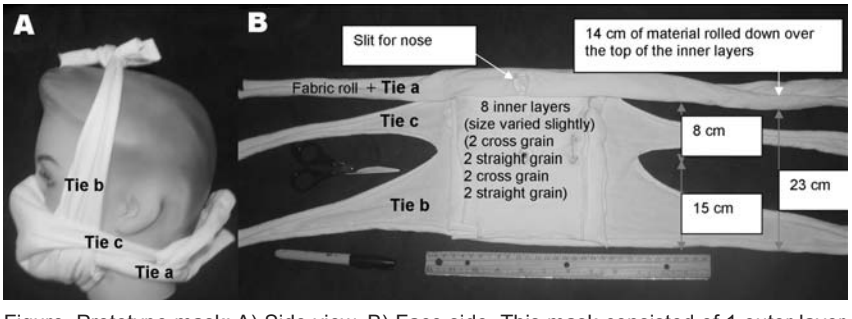

Figure. Prototype mask: A) Side view, B) Face side. This mask consisted of 1 outer layer (≈37cm × 72 cm) rolled and cut as in panel B with 8 inner layers (≤18 cm^2) placed inside (against the face). The nose slit was first placed over the bridge of the nose, and the roll was tied below the back of the neck. The area around the nose was adjusted to eliminate any leakage. If the seal was not tight, it was adjusted by adding extra material under the roll between the cheek and nose and/or pushing the rolled fabric above or below the cheekbone. Tie b was tied over the head. A cloth extension was added if tie b was too short. Finally tie c was tied behind the head. The mask was then fit tested.

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handling. No easy, definitive, and affordable test can demonstrate effectiveness before each use. Wearers may find the mask uncomfortable.

We encourage innovation to improve respiratory protection options. Future studies must be conducted to determine levels of protection achieved when naive users, following instructions, produce a similar mask from identical or similar raw materials. Research is needed to determine the minimal level of protection needed when resources are not available for N95 air-purifying respirators since the pandemic threat from H5N1 and other possible influenza strains will exist for the foreseeable future.

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Linguatuliasis in Germany

To the Editor: Pentastomids or tongue worms are a unique group of vermiform parasites, phylogenetically related to arthropods (*1*). Of the many pentastomid species, only a few, including *Linguatula serrata*, infect humans. The adult parasites are long, flat, or annulated and have 4 hooks surrounding a central mouth. Adult *L. serrata* inhabit the nasal passages and paranasal sinuses of wild and domestic canids, which serve as definitive hosts. Infective eggs containing larvae are discharged into the environment by nasopharyngeal secretions and are ingested by herbivores, the natural intermediate hosts. Humans can become dead-end intermediate hosts; visceral linguatuliasis then develops (*2*) if infective eggs are ingested. The liver is the organ most often involved (*3–5*), but the lung (*4,6,7*) or other organs (*4,8*) may be affected. Parasites may also be found in lymph nodes. In the viscera, the primary 4-legged larva molts several times and eventually forms the legless nymph. Lesions due to *Linguatula* may be confused with malignancy, particularly in the lung (*6*).

We describe a recent infection with *L. serrata* in Germany in a patient who had pulmonary symptoms and in whom malignancy was suspected. The patient was a 39-year-old man of Russian origin who had been living in Germany since 1999. He was admitted to the hospital with weight loss, night sweats, chest pain, and coughing. He had been a smoker for 20 years, and his past medical history included pneumonia and sinusitis in 1989 during his military service at Lake Baikal, Russia. The patient had been living in a farmhouse in Karaganda, Kazakhstan, until he immigrated to Germany.

A chest radiograph and computed tomographic scan showed multiple, small lesions in both lungs. Malignancy was suspected, and a bronchoscopy was performed. Numerous granulomatous nodules were discovered. Thoracotomy was performed, and stringlike nodules on the pleural surface were resected. Except for a mild eosinophilia (7%, 500 cells/μL), the leukocyte count was normal. All other parameters, including C-reactive protein levels, angiotensin-converting enzyme, and tumor markers were normal. Histologic examination of the nodules showed a targetoid appearance with a sharp demarcation from the surrounding lung tissue by a thick fibrocollagenous capsule. In the center of the nodules, a transverse section (Figure, right inset) and a longitudinal section (Figure, main panel) of a parasite were visible. The parasite had a chitinous cuticle 2.5 μm thick and cuticular

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Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies

Crisis/Alternate Strategies

These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are *not* commensurate with current U.S. standards of care. However, individual measures or a combination of these measures may need to be considered during periods of expected or known N95 respirator shortages. It is important to consult with entities that include some combination of: local healthcare coalitions, federal, state, or local public health officials, appropriate state agencies that are managing the overall emergency response related to COVID-19, and state crisis standards of care committees. Even when state/local healthcare coalitions or public health authorities can shift resources between health care facilities, these strategies may still be necessary.

When N95 Supplies are Running Low

Personal Protective Equipment and Respiratory Protection

Use of respirators beyond the manufacturer-designated shelf life for healthcare delivery

Consideration can be made to use N95 respirators beyond the manufacturer-designated shelf life for care of patients with COVID-19, tuberculosis, measles, and varicella. However, respirators beyond the manufacturer-designated shelf life may not perform to the requirements for which they were certified. Over time, components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal. Many models found in U.S. stockpiles and stockpiles of healthcare facilities have been found to continue to perform in accordance with NIOSH performance standards. However, fluid resistance and flammability were not assessed. Use of the N95 respirators recommended in Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response can be considered. It is optimal to use these respirators in the context of a respiratory protection program that includes medical evaluation, training, and fit testing. If used in healthcare delivery, it is particularly important that HCP perform the expected seal check, prior to entering a patient care area. CDC does not recommend using N95s beyond the manufacturer-designated shelf life in surgical settings.

Use of respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators

Other countries approve respirators for occupational use and approve respirators to these standards. These products are evaluated using some methods similar to those used by NIOSH, and some methods that are different, but are expected to protect HCPs. These respirators are expected to provide protection to workers. Those with equivalent or similar protection to NIOSH-approved respirators may be available to provide respiratory protection to workers exposed to harmful airborne particulate matter. These devices are expected to be suitable alternatives to provide protection during the COVID-19 response when supplies are short. The country, conformity assessment standards, acceptable product classifications, standards and guidance documents, and protection factor determination are provided in alphabetical order. All of these respirators have protection factors of at least 10 in the countries listed below, as outlined in the standards and guidance documents specified.

Country	Performance Standard	Acceptable product classifications	Standards/Guidance Documents	Protection Factor ≥ 10
Australia	AS/NZS 1716:2012	P3 P2	AS/NZS 1715:2009	YES

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Country	Performance Standard	Acceptable product classifications	Standards/Guidance Documents	Protection Factor ≥ 10
Brazil	ABNT/NBR 13698:2011	PFF3 PFF2	Fundacentro CDU 614.894	YES
China	GB 2626-2006	KN 100 KP100 KN95 KP95	GB/T 18664—2002	YES
Europe	EN 149-2001	FFP3 FFP2	EN 529:2005	YES
Japan	JMHLW-2000	DS/DL3 DS/DL2	JIS T8150: 2006	YES
Korea	KMOEL-2017-64	Special 1st	KOSHA GUIDE H-82-2015	YES
Mexico	NOM-116-2009	N100, P100, R100 N99, P99, R99 N95, P95, R95	NOM-116	YES
US NIOSH Requirements	**NIOSH approved 42 CFR 84**	**N100, P100, R100 N99, P99, R99 N95, P95, R95**	**OSHA 29CFR1910.134**	**YES**

Limited re-use of N95 respirators for COVID-19 patients

Limited re-use of N95 respirators when caring for patients with COVID-19 might become necessary. However, it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, and caution should be used. Re-use should be implemented according to CDC guidance. Re-use has been recommended as an option for conserving respirators during previous respiratory pathogen outbreaks and pandemics. It may also be necessary to re-use N95 respirators when caring for patients with varicella or measles, although contact transmission poses a risk to HCP who implement this practice.

Use of additional respirators beyond the manufacturer-designated shelf life for healthcare delivery

Use of additional N95 respirators beyond the manufacturer-designated shelf life for care of patients with COVID-19, tuberculosis, measles, and varicella can be considered. However, respirators beyond the manufacturer-designated shelf life may not perform to the requirements for which they were certified. Over time, components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal. Some models have been found NOT to perform in accordance with NIOSH performances standards, and consideration may be given to use these respirators as identified in Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response. In addition, consideration can be given to use N95 respirators beyond the manufacturer-designated shelf life that have not been evaluated by NIOSH. It is optimal to use these respirators in the context of a respiratory protection program that includes medical evaluation, training, and fit testing. It is particularly important that HCP perform the expected seal check, prior to entering a patient care area.

Prioritize the use of N95 respirators and facemasks by activity type

The number of infectious particles required to cause an infection (infectious dose) is often uncertain or unknown for respiratory pathogens. Further, there is often uncertainty about the influence of factors such as exposure duration and nature of clinical symptoms on the likelihood of infection transmission from person-to-person. When facemasks must be used by HCP entering a patient care area, source control (i.e. masking of symptomatic patients) and maintaining distance from the patient are particularly important to reduce the risk of transmission.

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This prioritization approach to conservation is intended to be used when N95 respirators are so limited that routinely practiced standards of care for all HCP wearing N95 respirators when caring for a COVID-19 patient are no longer possible. N95 respirators beyond their manufacture-designated shelf life, when available, are preferable to use of facemasks. The use of N95s or elastomeric respirators or PAPRs should be prioritized for HCP with the highest potential exposures including being present in the room during aerosol generating procedures performed on symptomatic persons.

Suggested facemask or respirator use, based upon distance from a patient with suspected or known COVID-19 and use of source control*

HCP planned proximity to the case patient during encounter	**Facemask or respirator determination**	
	Patient masked for entire encounter (i.e., with source control)	**Unmasked patient or mask needs to be removed for any period of time during the patient encounter**
HCP will remain at greater than 6 feet from symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator
HCP will be within 3 to 6 feet of symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask
HCP will be within 3 feet of symptomatic patient, including providing direct patient care	Facemask	N95 respirator/ elastomeric /PAPR, based on availability
HCP will be present in the room during aerosol generating procedures performed on symptomatic persons	N95 respirator/ elastomeric /PAPR, based on availability	N95 respirator/ elastomeric /PAPR, based on availability

*Based on availability, organizations may require and/or individuals may voluntarily choose to utilize higher levels of protection

When No Respirators are Left

Administrative Controls

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients

During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients

It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Engineering Controls

Expedient patient isolation rooms for risk-reduction

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Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a “clean” larger ventilated zone. In the absence of any remaining supply of N95 respirators, it may be possible to use this technology in conjunction with HCP wearing facemasks.

Ventilated Headboards

NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters. In the absence of any remaining supply of N95 respirators, it may be possible to use this technology in conjunction with HCP and/or patients wearing facemasks.

Personal Protective Equipment and Respiratory Protection

HCP use of non-NIOSH approved masks or homemade masks

In settings where N95 respirators are so limited that routinely practiced standards of care for wearing N95 respirators and equivalent or higher level of protection respirators are no longer possible, and surgical masks are not available, as a last resort, it may be necessary for HCP to use masks that have never been evaluated or approved by NIOSH or homemade masks. It may be considered to use these masks for care of patients with COVID-19, tuberculosis, measles, and varicella. However, caution should be exercised when considering this option.[1,2]

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Subject:	PPE RFI
Date:	Saturday, March 21, 2020 9:46:43 AM
Attachments:	Strategies for Optimizing the Supply of N95 Respirators_ COVID-19 _ CDC.pdf

Below are the CDC links reference reusable materials that you requested.

The last paragraph of the pdf covers homemade masks.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Regards,
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Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

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When N95 Supplies are Running Low

Personal Protective Equipment and Respiratory Protection

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Use of respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators

Other countries approve respirators for occupational use and approve respirators to these standards. These products are evaluated using some methods similar to those used by NIOSH, and some methods that are different, but are expected to protect HCPs. These respirators are expected to provide protection to workers. Those with equivalent or similar protection to NIOSH-approved respirators may be available to provide respiratory protection to workers exposed to harmful airborne particulate matter. These devices are expected to be suitable alternatives to provide protection during the COVID-19 response when supplies are short. The country, conformity assessment standards, acceptable product classifications, standards and guidance documents, and protection factor determination are provided in alphabetical order. All of these respirators have protection factors of at least 10 in the countries listed below, as outlined in the standards and guidance documents specified.

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AMERICAN OVERSIGHT

Country	Performance Standard	Acceptable product classifications	Standards/Guidance Documents	Protection Factor ≥ 10
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China	GB 2626-2006	KN 100 KP100 KN95 KP95	GB/T 18664—2002	YES
Europe	EN 149-2001	FFP3 FFP2	EN 529:2005	YES
Japan	JMHLW-2000	DS/DL3 DS/DL2	JIS T8150: 2006	YES
Korea	KMOEL-2017-64	Special 1st	KOSHA GUIDE H-82-2015	YES
Mexico	NOM-116-2009	N100, P100, R100 N99, P99, R99 N95, P95, R95	NOM-116	YES
US NIOSH Requirements	**NIOSH approved 42 CFR 84**	**N100, P100, R100 N99, P99, R99 N95, P95, R95**	**OSHA 29CFR1910.134**	**YES**

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Limited re-use of N95 respirators when caring for patients with COVID-19 might become necessary. However, it is unknown what the potential contribution of contact transmission is for SARS-CoV-2, and caution should be used. Re-use should be implemented according to CDC guidance. Re-use has been recommended as an option for conserving respirators during previous respiratory pathogen outbreaks and pandemics. It may also be necessary to re-use N95 respirators when caring for patients with varicella or measles, although contact transmission poses a risk to HCP who implement this practice.

Use of additional respirators beyond the manufacturer-designated shelf life for healthcare delivery

Use of additional N95 respirators beyond the manufacturer-designated shelf life for care of patients with COVID-19, tuberculosis, measles, and varicella can be considered. However, respirators beyond the manufacturer-designated shelf life may not perform to the requirements for which they were certified. Over time, components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal. Some models have been found NOT to perform in accordance with NIOSH performances standards, and consideration may be given to use these respirators as identified in Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response. In addition, consideration can be given to use N95 respirators beyond the manufacturer-designated shelf life that have not been evaluated by NIOSH. It is optimal to use these respirators in the context of a respiratory protection program that includes medical evaluation, training, and fit testing. It is particularly important that HCP perform the expected seal check, prior to entering a patient care area.

Prioritize the use of N95 respirators and facemasks by activity type

The number of infectious particles required to cause an infection (infectious dose) is often uncertain or unknown for respiratory pathogens. Further, there is often uncertainty about the influence of factors such as exposure duration and nature of clinical symptoms on the likelihood of infection transmission from person-to-person. When facemasks must be used by HCP entering a patient care area, source control (i.e. masking of symptomatic patients) and maintaining distance from the patient are particularly important to reduce the risk of transmission.

AMERICAN OVERSIGHT

This prioritization approach to conservation is intended to be used when N95 respirators are so limited that routinely practiced standards of care for all HCP wearing N95 respirators when caring for a COVID-19 patient are no longer possible. N95 respirators beyond their manufacture-designated shelf life, when available, are preferable to use of facemasks. The use of N95s or elastomeric respirators or PAPRs should be prioritized for HCP with the highest potential exposures including being present in the room during aerosol generating procedures performed on symptomatic persons.

Suggested facemask or respirator use, based upon distance from a patient with suspected or known COVID-19 and use of source control*

HCP planned proximity to the case patient during encounter	**Facemask or respirator determination**	
	Patient masked for entire encounter (i.e., with source control)	**Unmasked patient or mask needs to be removed for any period of time during the patient encounter**
HCP will remain at greater than 6 feet from symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator
HCP will be within 3 to 6 feet of symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask
HCP will be within 3 feet of symptomatic patient, including providing direct patient care	Facemask	N95 respirator/ elastomeric /PAPR, based on availability
HCP will be present in the room during aerosol generating procedures performed on symptomatic persons	N95 respirator/ elastomeric /PAPR, based on availability	N95 respirator/ elastomeric /PAPR, based on availability

*Based on availability, organizations may require and/or individuals may voluntarily choose to utilize higher levels of protection

When No Respirators are Left

Administrative Controls

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients

During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients

It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Engineering Controls

Expedient patient isolation rooms for risk-reduction

AMERICAN OVERSIGHT

Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a “clean” larger ventilated zone. In the absence of any remaining supply of N95 respirators, it may be possible to use this technology in conjunction with HCP wearing facemasks.

Ventilated Headboards

NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters. In the absence of any remaining supply of N95 respirators, it may be possible to use this technology in conjunction with HCP and/or patients wearing facemasks.

Personal Protective Equipment and Respiratory Protection

HCP use of non-NIOSH approved masks or homemade masks

In settings where N95 respirators are so limited that routinely practiced standards of care for wearing N95 respirators and equivalent or higher level of protection respirators are no longer possible, and surgical masks are not available, as a last resort, it may be necessary for HCP to use masks that have never been evaluated or approved by NIOSH or homemade masks. It may be considered to use these masks for care of patients with COVID-19, tuberculosis, measles, and varicella. However, caution should be exercised when considering this option.[1,2]

References

1. Dato, VM, Hostler, D, and Hahn, ME. Simple Respiratory Mask , *Emerg Infect Dis*. 2006;12(6):1033–1034.
2. Rengasamy S, Eimer B, and Shaffer R. Simple respiratory protection-evaluation of the filtration performance of cloth masks and common fabric materials against 20-1000 nm size particles , *Ann Occup Hyg*. 2010;54(7):789-98.

Page last reviewed: March 17, 2020

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	PPE RFI
Date:	Saturday, March 21, 2020 9:47:42 AM
Attachments:	Strategies for Optimizing the Supply of N95 Respirators_ COVID-19 _ CDC.pdf

Below are the CDC links reference reusable materials that you requested.

The last paragraph of the pdf covers homemade masks.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Regards,
Jeanne

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AMERICAN OVERSIGHT

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies

Crisis/Alternate Strategies

These crisis capacity or alternate strategies accompany and build on the conventional and contingency capacity strategies. The following measures are *not* commensurate with current U.S. standards of care. However, individual measures or a combination of these measures may need to be considered during periods of expected or known N95 respirator shortages. It is important to consult with entities that include some combination of: local healthcare coalitions, federal, state, or local public health officials, appropriate state agencies that are managing the overall emergency response related to COVID-19, and state crisis standards of care committees. Even when state/local healthcare coalitions or public health authorities can shift resources between health care facilities, these strategies may still be necessary.

When N95 Supplies are Running Low

Personal Protective Equipment and Respiratory Protection

Use of respirators beyond the manufacturer-designated shelf life for healthcare delivery

Consideration can be made to use N95 respirators beyond the manufacturer-designated shelf life for care of patients with COVID-19, tuberculosis, measles, and varicella. However, respirators beyond the manufacturer-designated shelf life may not perform to the requirements for which they were certified. Over time, components such as the straps and nose bridge material may degrade, which can affect the quality of the fit and seal. Many models found in U.S. stockpiles and stockpiles of healthcare facilities have been found to continue to perform in accordance with NIOSH performance standards. However, fluid resistance and flammability were not assessed. Use of the N95 respirators recommended in Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response can be considered. It is optimal to use these respirators in the context of a respiratory protection program that includes medical evaluation, training, and fit testing. If used in healthcare delivery, it is particularly important that HCP perform the expected seal check, prior to entering a patient care area. CDC does not recommend using N95s beyond the manufacturer-designated shelf life in surgical settings.

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China	GB 2626-2006	KN 100 KP100 KN95 KP95	GB/T 18664—2002	YES
Europe	EN 149-2001	FFP3 FFP2	EN 529:2005	YES
Japan	JMHLW-2000	DS/DL3 DS/DL2	JIS T8150: 2006	YES
Korea	KMOEL-2017-64	Special 1st	KOSHA GUIDE H-82-2015	YES
Mexico	NOM-116-2009	N100, P100, R100 N99, P99, R99 N95, P95, R95	NOM-116	YES
US NIOSH Requirements	**NIOSH approved 42 CFR 84**	**N100, P100, R100 N99, P99, R99 N95, P95, R95**	**OSHA 29CFR1910.134**	**YES**

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HCP will be within 3 feet of symptomatic patient, including providing direct patient care	Facemask	N95 respirator/ elastomeric /PAPR, based on availability
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References

1. Dato, VM, Hostler, D, and Hahn, ME. Simple Respiratory Mask , *Emerg Infect Dis*. 2006;12(6):1033–1034.
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Page last reviewed: March 17, 2020

AMERICAN OVERSIGHT

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To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	PPE RFI
Date:	Saturday, March 21, 2020 9:46:41 AM
Attachments:	Strategies for Optimizing the Supply of N95 Respirators_ COVID-19 _ CDC.pdf

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https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
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AMERICAN OVERSIGHT

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

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Mexico	NOM-116-2009	N100, P100, R100 N99, P99, R99 N95, P95, R95	NOM-116	YES
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The number of infectious particles required to cause an infection (infectious dose) is often uncertain or unknown for respiratory pathogens. Further, there is often uncertainty about the influence of factors such as exposure duration and nature of clinical symptoms on the likelihood of infection transmission from person-to-person. When facemasks must be used by HCP entering a patient care area, source control (i.e. masking of symptomatic patients) and maintaining distance from the patient are particularly important to reduce the risk of transmission.

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This prioritization approach to conservation is intended to be used when N95 respirators are so limited that routinely practiced standards of care for all HCP wearing N95 respirators when caring for a COVID-19 patient are no longer possible. N95 respirators beyond their manufacture-designated shelf life, when available, are preferable to use of facemasks. The use of N95s or elastomeric respirators or PAPRs should be prioritized for HCP with the highest potential exposures including being present in the room during aerosol generating procedures performed on symptomatic persons.

Suggested facemask or respirator use, based upon distance from a patient with suspected or known COVID-19 and use of source control*

HCP planned proximity to the case patient during encounter	**Facemask or respirator determination**	
	Patient masked for entire encounter (i.e., with source control)	**Unmasked patient or mask needs to be removed for any period of time during the patient encounter**
HCP will remain at greater than 6 feet from symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: no facemask or respirator
HCP will be within 3 to 6 feet of symptomatic patient	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask	HCP remaining at this distance from the patient should not need to enter the patient care area; if entry required: facemask
HCP will be within 3 feet of symptomatic patient, including providing direct patient care	Facemask	N95 respirator/ elastomeric /PAPR, based on availability
HCP will be present in the room during aerosol generating procedures performed on symptomatic persons	N95 respirator/ elastomeric /PAPR, based on availability	N95 respirator/ elastomeric /PAPR, based on availability

*Based on availability, organizations may require and/or individuals may voluntarily choose to utilize higher levels of protection

When No Respirators are Left

Administrative Controls

Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients

During severe resource limitations, consider excluding HCP who may be at higher risk for severe illness from COVID-19, such as those of older age, those with chronic medical conditions, or those who may be pregnant, from caring for patients with confirmed or suspected COVID-19 infection.

Designate convalescent HCP for provision of care to known or suspected COVID-19 patients

It may be possible to designate HCP who have clinically recovered from COVID-19 to preferentially provide care for additional patients with COVID-19. Individuals who have recovered from COVID-19 infection may have developed some protective immunity, but this has not yet been confirmed.

Engineering Controls

Expedient patient isolation rooms for risk-reduction

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Portable fan devices with high-efficiency particulate air (HEPA) filtration that are carefully placed can increase the effective air changes per hour of clean air to the patient room, reducing risk to individuals entering the room without respiratory protection. NIOSH has developed guidance for using portable HEPA filtration systems to create expedient patient isolation rooms. The expedient patient isolation room approach involves establishing a high-ventilation-rate, negative pressure, inner isolation zone that sits within a “clean” larger ventilated zone. In the absence of any remaining supply of N95 respirators, it may be possible to use this technology in conjunction with HCP wearing facemasks.

Ventilated Headboards

NIOSH has developed the ventilated headboard that draws exhaled air from a patient in bed into a HEPA filter, decreasing risk of HCP exposure to patient-generated aerosol. This technology consists of lightweight, sturdy, and adjustable aluminum framing with a retractable plastic canopy. The ventilated headboard can be deployed in combination with HEPA fan/filter units to provide surge isolation capacity within a variety of environments, from traditional patient rooms to triage stations, and emergency medical shelters. In the absence of any remaining supply of N95 respirators, it may be possible to use this technology in conjunction with HCP and/or patients wearing facemasks.

Personal Protective Equipment and Respiratory Protection

HCP use of non-NIOSH approved masks or homemade masks

In settings where N95 respirators are so limited that routinely practiced standards of care for wearing N95 respirators and equivalent or higher level of protection respirators are no longer possible, and surgical masks are not available, as a last resort, it may be necessary for HCP to use masks that have never been evaluated or approved by NIOSH or homemade masks. It may be considered to use these masks for care of patients with COVID-19, tuberculosis, measles, and varicella. However, caution should be exercised when considering this option.[1,2]

References

1. Dato, VM, Hostler, D, and Hahn, ME. Simple Respiratory Mask , *Emerg Infect Dis*. 2006;12(6):1033–1034.
2. Rengasamy S, Eimer B, and Shaffer R. Simple respiratory protection-evaluation of the filtration performance of cloth masks and common fabric materials against 20-1000 nm size particles , *Ann Occup Hyg*. 2010;54(7):789-98.

Page last reviewed: March 17, 2020

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: President"s Coronavirus Guidelines For America: 15 Days to Slow the Spread
Date: Tuesday, March 17, 2020 12:18:54 PM
Attachments: image001.png

Dear Colleagues:

Yesterday, President Donald. J. Trump announced new guidelines to address COVID-19. Below, please find additional information on ***The President's Coronavirus Guidelines for America: 15 Days to Slow the Spread***. Please feel free to share broadly.

As a reminder, the CDC's official Coronavirus website – **www.coronavirus.gov** – is the best source for up-to-date information and guidance.

The President's Coronavirus Guidelines for America: 15 Days to Slow the Spread

1. Listen to and follow the directions of your state and local authorities.
2. If you feel sick, stay home. Do not go to work. Contact your medical provider.
3. If your children are sick, keep them at home. Do not send them to school. Contact your medical provider.
4. If someone in your household has tested positive for the coronavirus, keep the entire household at home. Do not go to work. Do not go to school. Contact your medical provider.
5. If you are an older person, stay home and away from other people.
6. If you are a person with a serious underlying health condition that can put you at increased risk (for example, a condition that impairs your lung or heart function or weakens your immune system), stay home and away from other people.
7. Even if you are young, or otherwise healthy, you are at risk and your activities can increase the risk for others. It is critical that you do your part to stop the spread of the coronavirus:
    a. Work or engage in schooling from home whenever possible.
    b. If you work in a critical infrastructure industry, as defined by the Department of Homeland Security, such as healthcare services and pharmaceutical and food supply, you have a special responsibility to maintain your normal work schedule. You and your employers should follow CDC guidance to protect your health at work.
    c. Avoid social gatherings in groups of more than 10 people.
    d. Avoid eating or drinking in bars, restaurants, and food courts – use drive-thru, pickup, or delivery options.
    e. Avoid discretionary travel, shopping trips, and social visits.
    f. Do not visit nursing homes or retirement or long-term care facilities unless to provide critical assistance.

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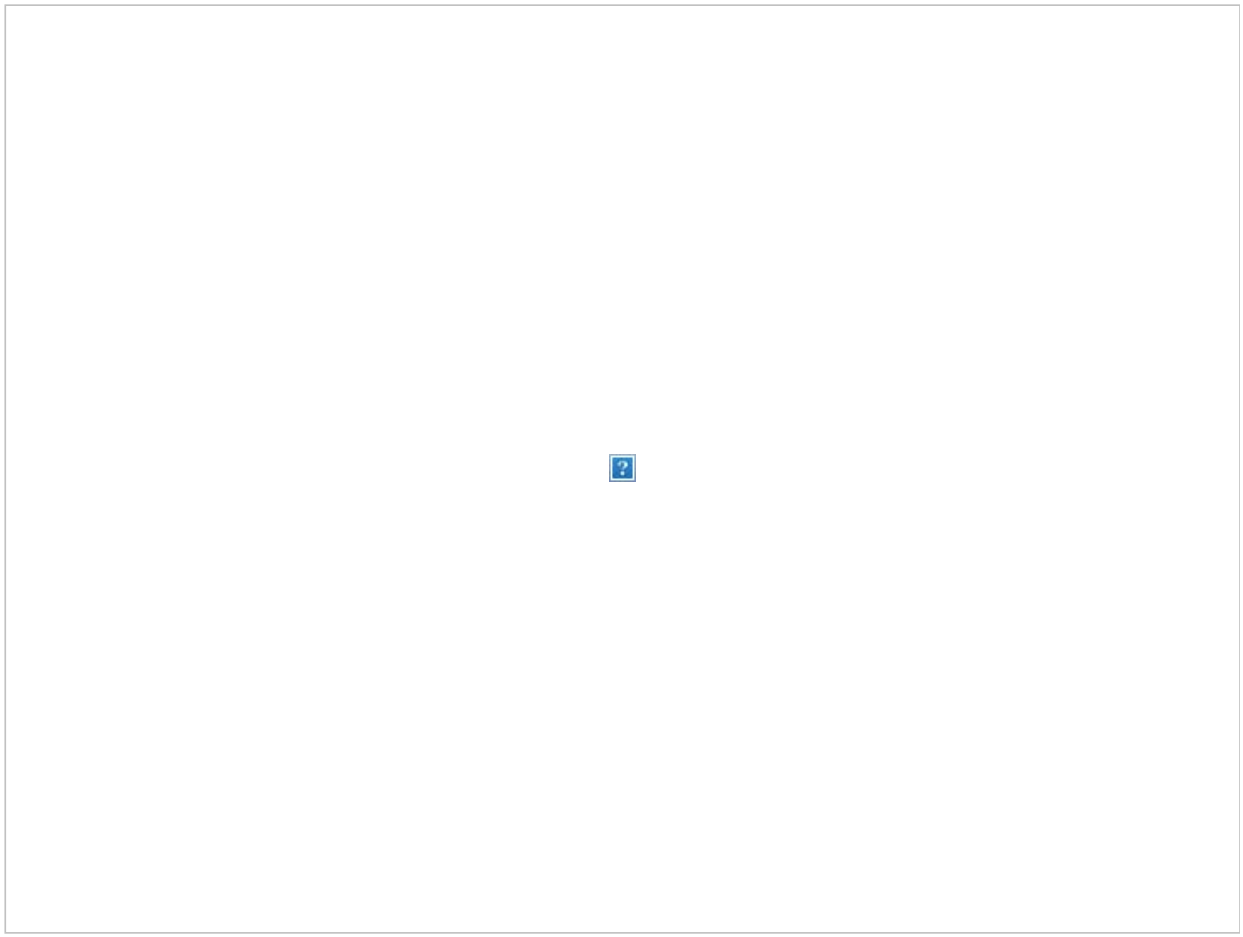
8. Practice good hygiene:
    a. Wash your hands, especially after touching any frequently used item or surface.
    b. Avoid touching your face.
    c. Sneeze or cough into a tissue, or the inside of your elbow.
    d. Disinfect frequently used items and surfaces as much as possible.

* School operations can accelerate the spread of the coronavirus. Governors of states with evidence of community transmission should close schools in affected and surrounding areas. Governors should close schools in communities that are near areas of community transmission, even if those areas are in neighboring states. In addition, state and local officials should close schools where coronavirus has been identified in the population associated with the school. States and localities that close schools need to address childcare needs of critical responders, as well as the nutritional needs of children.

** Older people are particularly at risk from the coronavirus. All states should follow Federal guidance and halt social visits to nursing homes and retirement and long-term care facilities.

*** In states with evidence of community transmission, bars, restaurants, food courts, gyms, and other indoor and outdoor venues where groups of people congregate should be closed.



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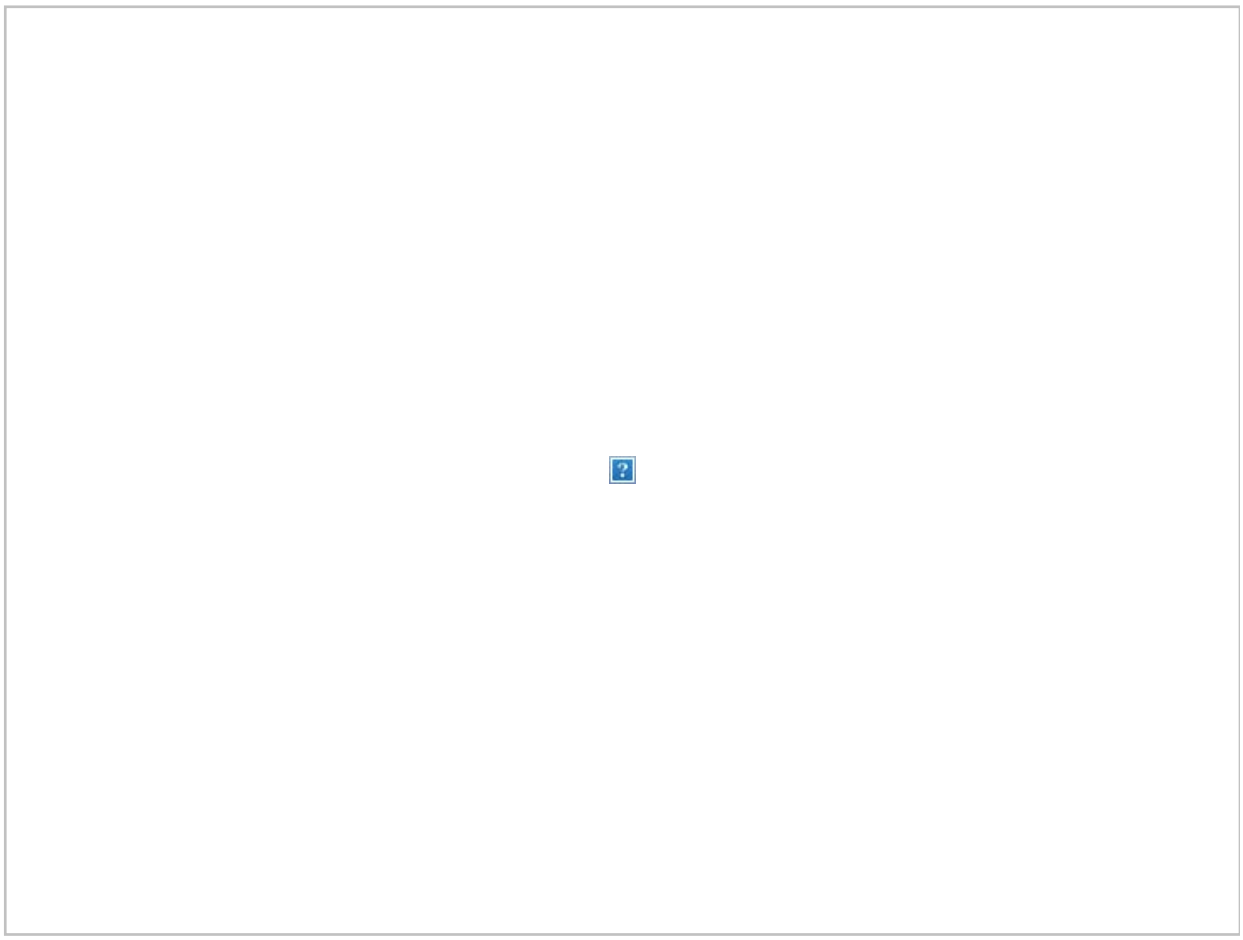

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

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THE WHITE HOUSE

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Eckes, Jeanne (OS/ASPR/EMMO)
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; D"Angelo, Joseph ; Dellamura, Joseph ; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; RRCC LOGS Supply Box
Subject:	public health lab reagent
Date:	Wednesday, March 25, 2020 7:56:25 PM

All

Many of our states are asking about the reagents and why are they not available to the public health lab **it is a supply and demand issue.**
Supply is low and demand is high - here is some info on an alternate reagent recipe for public health labs. Also including a FAQs sheet from FDA.

Here is the FDA FAQ site with alternative extraction reagents: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#whatif

If they want to use alternate reagents not already accepted by FDA, that would be considered a "Laboratory Developed Test", FDA guidance is at www.fda.gov/regulatory-information/search-fda-guidance-documents/policy-diagnostic-tests-coronavirus-disease-2019-during-public-health-emergency, and

FAQ's at https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#clinicallaboratories

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov

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HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From:	Schauer, Gillian (CDC/DDNID/NCCDPHP/OSH) (CTR)
To:	Ali Hamade; Amanda Borup; Michele.nakata@doh.hawaii.gov; Amanda Cue; Amanda Faulkner; Andre Ourso; Andrea Wojcik; Andrew Brisbo; Arian Gibson; Bagley, Bridget; Beth McLaughlin; Brian Lopez; Caitlin Barry-King; Cheryl Petersen-Kroeber; Chris Tholkes; Christina Dempsey; Christine Theriault; Cichowski, Cheryl; Courtney Coppola; Cristal Connelly; Tomiyasu, Danette W. (CDC doh.hawaii.gov); David Olsen; Doug Schultz; Eden Wells; Eliza Muse; Elyse Contreras; Erik Gundersen; Erin Reed; Errica Ferrelli; Ilana Kurtzig; Markiewicz, James (CDC maine.gov); Jamie Margetta; Jared Welehodsky; Jason Frame; Jason Wahl; Jennifer Epstein; Layden, Jennifer (CDC illinois.gov); Jessica Filley; Jessica Neuwirth; Jim Burak; McLaughlin, Joseph (CDC alaska.gov); Judy Barrett; Julia Dilley; Julia Hitchingham; Peek, Julia (CDC health.nv.gov); Julie Johnson; Karen Girard; Karyl Rattay; Katelyn Hall; Lofy, Kathy KL (CDC doh.wa.gov); Kay Doyle; Kristen Haley; Kyle Devine; Kyle Lambert; Kyril Plaskon; Linda Scarpetta; Lori Dodson; Lori Uerz; Lyla Hunt; Lyndall Fraker; Nascarella, Marc (CDC state.ma.us); Margaret Flerchinger; Margaret Machaiek; Marie Dotseth; Mark Hurst; Mark Krueger; Mark Pettinger; Mark Starr; Martha Stanbury; Megan Lockwood; Melissa Finnegan; Beardsley, Nancy (CDC maine.gov); Nancy McBrady; Ngozi Ezike; Nirav Shah; Paul Hyland; Rebecca Rodman; Rebecca Walsh; Rick Garza; Samantha Doonan; Sara Broschart; Shannon OFallon; Sharlet Kroll; Shelly Rowden; Stephanie Klapstein; Stephanie Woodard; Steve Marks; Steve Smothers; Steven Rekand; Susan Fanelli; Sydney King; Thomas Jeanne; TJ Sheehy; Todd Orlando; Travis Kirkpatrick; Trecia Ehrlich; Trevor Christensen; Tricia Blocher; gregory.mcilvaine@state.oh.us; Haegerich, Tamara M. (CDC/DDNID/NCIPC/DOP); Grant, Althea M. (CDC/DDNID/OD); norman.birenbaum@exec.ny.gov; tklimas@tax.state.nv.us
Cc:	Klein, Miren@CDPH; SIDELINGER DEAN E; Tapscott, Ryan (CDC/DDNID/NCIPC/DOP); heather.krug@state.co.us; Putnam, Michelle (CDC/DDNID/NCIPC/DOP); Thimjon, Lisa (MDH); Ferguson, Christopher K; farahaths.dave@maryland.gov; Scott, Megan; Pierre, Ermion; brandon.jeffery@state.co.us; Jesse.Wimberly@pharmacy.ohio.gov; Roehler, Douglas R. (CDC/DDNID/NCIPC/DOP)
Subject:	Quarterly Multi-State Collaborative All-State Discussion Call on Cannabis and Public Health

Please see the updated call in number and the proposed agenda (below).
Call in: 1-877-680-2010, Participant Code: 23065250. Call is at 11AM PST/2PM EST.

Thanks to all of you who are working on a covid19 response in your state, and to those of you who are keeping other important public health work going while your colleagues respond. We know not everyone will be able to attend this call, but are still planning to hold it, with a focus on the covid19/marijuana overlap. Marijuana operations (retail stores, processors, grows) have been deemed essential services in states so far, so we want to facilitate time for you all to talk about how you are approaching that, and to put forward any science-based questions that you need responses to for future work in this space.

Proposed agenda:

* Brief roll call
* Call purpose
* Covid19 response tracking
* Facilitated discussion about covid19 response and marijuana licensees
* Vaping updates and/or any other cannabis and public health topics (as time allows)

Let me know if you have any questions.

Respectfully,
Gillian

ORIGINAL MEETING REQUEST MESSAGE

Dear State Colleagues,

Thank you for completing the When2Meet poll. This looked like the best time for all states who responded. As a reminder, these quarterly calls will bring adult use and medical states together to provide updates related to cannabis vaping policy, prevention, and education, and to discuss other relevant cannabis and public health topics. CDC will provide updates about our cannabis related work as part of these calls, as well.

I will send a more detailed agenda closer to the call. In the meantime, please reach out to me if there are specific topics you would like to add to the agenda.

Respectfully,
Gillian

ORIGINAL MESSAGE

Dear State Colleagues,

It's hard to believe February is already upon us. I wanted to send out the notes from our cannabis vaping call earlier in January (see attached). Per our discussions on that call, we'll be moving to hold these multi-state, all state calls on a quarterly basis, and will continue to facilitate discussion on cannabis vaping issues, but will incorporate other cannabis and public health topics that are of interest to both medical and adult use states. If you are interested in continuing to participate in all-state cannabis and public health calls, please complete this When2Meet poll <https://www.when2meet.com/?8693306-VyueN> so we can try to schedule a March call. We'll talk on that call about getting a standing quarterly call on the calendar (e.g., X day of the last week of the second month of the quarter, or something like that). As a reminder, When2Meet automatically saves your entries. Please remember to select your timezone before completing the poll.

We will also pick back up with quarterly topic-based calls for adult use states only (the multi-state collaborative group), since some additional public

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health and policy issues exist in the adult use landscape. Adult use states - I will be sending a separate poll to try to schedule one of those calls in February, as I know some of you already have issues you'd like to discuss with each other, with legislative sessions underway.

For both the all-state and adult use state calls, I will continue to develop the agenda in the same manner - reaching out to a variety of states to solicit topics. Please feel free to reach out to me any time with policy questions, TA requests, or topics for these multi-state calls.

Thanks again for all you do in the field!

Respectfully,
Gillian

Gillian L. Schauer, PhD, MPH
Senior Consultant to:
Division of Overdose Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
gschauer@cdc.gov

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AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD)
Cc:	Torres, Yari
Subject:	RE: 100% of EIS officers and LLS fellows are needed for the COVID-19 response
Date:	Wednesday, March 18, 2020 3:21:42 PM

Hi Eric, our preference would be to plug Yari into our COVID response (She just returned from deployment and is self isolating). In fact, we have already started to bring her up to speed.
I hope that is ok.

From: Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD) <ecp9@cdc.gov>
Sent: Wednesday, March 18, 2020 2:46 PM
To: CDC EISO Supervisors 2018 <EISOSupervisors2018@cdc.gov>; CDC EISO Supervisors 2019 <EISOSupervisors2019@cdc.gov>; CDC LLS Supervisor 2018 <LLSSupervisor2018@cdc.gov>; CDC LLS Supervisors 2019 <DDPHSSCSELSDSEPDEWB2019LLSSupervisor@cdc.gov>
Cc: Glynn, Kate (CDC/DDPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Simone, Patricia (Pattie) (CDC/DDPHSS/CSELS/DSEPD) <pms6@cdc.gov>; Iademarco, Michael (CDC/DDPHSS/CSELS/OD) <mai9@cdc.gov>; CDC EISO Class 2018 <EISOClass2018@cdc.gov>; CDC EISO Class 2019 <EISOClass2019@cdc.gov>; CDC LLS Class 2018 <LLSClass2018@cdc.gov>; CDC LLS Class 2019 <LLSClass2019@cdc.gov>; CDC CSELS DSEPD EWB <OSELSSEPDPOEISStaff@cdc.gov>
Subject: 100% of EIS officers and LLS fellows are needed for the COVID-19 response

EIS and LLS supervisors,

I am writing again, asking for your support in having EIS officers and LLS fellows deploy or take on other roles for CDC's response to COVID-19. I want to emphasize that **completing CALs (graduation requirements) should NOT factor into whether an EIS officer or LLS fellow deploys**. Supervisors should not be asking to review deployment roles or objectives before approving a deployment. In the past we wanted to ensure deployments aligned with our training objectives. We no longer have that luxury, the primary responsibility of the EIS and LLS programs needs to be supporting the response until we are informed otherwise.

We will deal with CAL completion and how COVID-19 might impact graduation on a case-by-case basis. I want to assure you we will be very understanding in finding ways to compensate if involvement with the COVID-19 response prevented anyone from fulfilling the requirements to graduate.

We understand that some EISOs or LLS fellows may not be able to deploy to the field because of obligations to care for family members or themselves. There are response roles that can be completed while teleworking and do not require travel. We are available to assist in finding deployment roles – contact us at EpiAid@cdc.gov and we can discuss their particular circumstance. In addition, any fellows who are not currently deployed can volunteer by:

1. Emailing us at EpiAid@cdc.gov
2. Volunteer for a Go Team by submitting name in ReADI
3. Responding directly to any calls for volunteers they receive through other communication

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channels

Thank you for your support of the EIS and LLS programs and of your officers or fellows. We know a lot is being asked of you as well and CDC leadership appreciates all you are doing with respect to your individual contributions and your support of the EIS officers and LLS fellows.

Regards,
Eric

Eric Pevzner, PhD, MPH
CAPT, U.S. Public Health Service
Chief, Epidemiology Workforce Branch | Epidemic Intelligence Service (EIS)
U.S. Centers for Disease Control and Prevention (CDC)
Desk Phone: (404) 639-6094
Mobile: (404) 247-7974

For scheduling meetings please contact Ms. Daeshonna McNealy, at kyo9@cdc.gov.



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From:	Armstrong, Paige A (CDC/DDID/NCEZID/DVBD)
To:	Ashley Vineyard; Catherine Brown; Abelardo Moncayo; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID/DVBD); Blackmore, Carina (CDC flhealth.gov); elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc:	Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject:	RE: 2020 CSTE VBD Workshop Planning
Date:	Monday, March 9, 2020 10:31:28 PM

Hello Ashley,

As you know, I am deployed for coronavirus, but would be happy to speak on TG as needed.

Best,
Paige

Paige Armstrong MD MHS
Epidemiology Team Lead
LCDR, US Public Health Service
Rickettsial Zoonoses Branch
Centers for Disease Control and Prevention
YZU9@cdc.gov | (404) 639-8450 Office | (404) 639-2778 Fax | www.cdc.gov/ticks

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From: Ashley Vineyard <avineyard@cste.org>
Sent: Monday, March 9, 2020 2:32 PM
To: Catherine Brown <catherine.brown@state.ma.us>; Abelardo Moncayo <abelardo.moncayo@tn.gov>; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD) <bio1@cdc.gov>; Fischer, Marc (CDC/DDID/NCEZID/DVBD) <mxf2@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS) <Bonny.Mayes@dshs.texas.gov>; Broussard,Kelly (DSHS) <Kelly.Broussard@dshs.texas.gov>; Armstrong, Paige A (CDC/DDID/NCEZID/DVBD) <yzu9@cdc.gov>; Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD) <kzy2@cdc.gov>
Cc: Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD) <cue0@cdc.gov>
Subject: RE: 2020 CSTE VBD Workshop Planning

Good afternoon all,

Please review the attached draft skeleton agenda and notes below from our last call (action items bolded) in advance of our planning call on Wednesday.

- Panel on fleaborne diseases
    - Possible speakers
        - Paige Armstrong (DVBD) – **Paige, can you confirm?**
        - Laura Robinson and/or Bonny Mayes (TX) – **Bonny, can you confirm?**
        - Sarah Park (HI)
        - Plague – Carina recommended Danielle, Vicki Kramer (CA) – **Carina, any follow**

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up?

- Chagas and kissing bugs presentation/panel
    - Need speakers – **any ideas from AZ or TX?**
- TBRF – Bonny reached out to Job Lopez from TX
    - Hanna from WA – **Liz, can you follow up?**
- Vector control and risk reduction, focus on communication
    - Pros and cons of spraying, etc.
    - Risk communication during emergency response
    - Possible speakers:
        - Whitney Qualls (TX) – **Bonny can you confirm?**
        - Someone from WA – **Liz are our 3 WA speakers confirmed?**
        - Kiersten recommended CA
        - Roxanne (CDC)? – **Carina were you able to follow up?**
- EEE ecology (not in current draft agenda)
    - Possible speakers
        - Andrea Morrison (FL)
        - Katie Brown (MA)
        - Michigan
- Tick management (not in current draft agenda) – Abelardo can recommend speakers

Thanks and talk to you all on Wednesday!
Ashley

-----Original Appointment-----
From: Ashley Vineyard
Sent: Tuesday, February 4, 2020 9:28 AM
To: Ashley Vineyard; Brown, Catherine (DPH); Abelardo Moncayo; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID); Blackmore, Carina; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc: Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject: 2020 CSTE VBD Workshop Planning
When: Wednesday, March 11, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: RingCentral Meetings (see below)

Please save this date and time for our 2020 CSTE Annual Conference VBD Workshop planning calls.

To join and view screen: https://meetings.ringcentral.com/j/1493671493

Or Telephone:
Dial: US: +1 (773) 231 9226
Meeting ID: 149 367 1493

AMERICAN OVERSIGHT

From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow
Date:	Tuesday, March 17, 2020 3:25:03 PM

Hi Michelle –

Apologies for the delay. Here is the information on the 6 guests and 2 crew members who are experiencing mild flu-like symptoms and will be traveling via air ambulance to Miami:

Mrs Meredith Bess Amon (GUEST)
1700 Southwest Broadway Drive, Portland, Oregon, 97201 (wheelchair)

Mr. Harvey Norman Levitt (GUESTS)
Mrs. Mara Ellen Levitt
58 Sheridan Drive #22, Atlanta, Georgia 30305

Mr. Bruce Vincent Rodgers (GUESTS)
Mrs. Jeanne Alice Farley Rodgers
4356 2nd Street, Pleasanton, California, 904566

Mrs. Patricia Petrich (GUEST)
33 Shady Bend, Fort Myers, Florida

Ms. Amanda Charland (CREW):
1510 Pine Street, Apartment 3r, Philadelphia, Pennsylvania, USA 19102

Mr. Daniel Leflore (CREW):
1937 Hauser Boulevard, Los Angeles, California, 90016

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:59 AM
To: Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

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EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Dear Eleni,
2 questions and 2 points:

Among the 8 persons who will come on air ambulance,

1. Are any moderately or severe ill, or are they all with mild influenza-like illness?
2. What is their final destination/state of residence?

We are working on specific guidance for you – coming after we clear some items with Florida Health authorities, including Yesenia.

A couple of things for your awareness:

1. We strongly advise that the charter flights have clinicians (doctor/nurse) on board for safe travel and to assist with the arrival process in Miami in case anyone is ill.
2. We request that you distribute this infographic to the American passengers who will be traveling by charter (attached).

Best,
Michelle

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 9:22 AM
To: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>
Cc: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

Good morning, Rachel –

Is CDC able to provide the list of recommended quarantine locations in Miami?

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations

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Royal Caribbean Cruises Ltd.|1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799|Cell: 786.253.5305|ekalisch@rccl.com

From: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>
Sent: Tuesday, March 17, 2020 7:24 AM
To: Eleni Kalisch <ekalisch@rccl.com>; Koneff, Douglas A <KoneffD@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>
Cc: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

+ Andy Klevos from the Miami Quarantine station.
Thanks,
Rachel

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 7:22 AM
To: Koneff, Douglas A <KoneffD@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

Good Morning, Doug –

I will provide an update on Silver Shadow later this morning but, as of late last night, she was prepared to debark guests for charter flights home later today. I will provide an updated timeline after our internal calls this morning.

Thanks,

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Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Koneff, Douglas A <KoneffD@state.gov>
Sent: Tuesday, March 17, 2020 6:37 AM
To: Eleni Kalisch <ekalisch@rccl.com>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hamsik, Brett C <HamsikBC@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Brazil: Status of Royal Caribbean Silver Shadow

All - good morning. I have broken the Brazil and Chile ships into separate threads, for ease of tracking.

When able, if someone could provide a short status update on the Silver Shadow and any pending asks (for USG or Brazil) that would be very helpful, thanks. Doug

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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 8:17:33 PM
To: (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: [EXTERNAL] Re: Question for CBP

Hi Abdias –

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Thanks for the email. Below is the breakdown of guests by nationality:

NATIONALITY	COUNT
ARGENTINA	60
AUSTRALIA	55
AUSTRIA	2
BELGIUM	18
BOLIVIA	7
BRAZIL	45
BULGARIA	17
CANADA	456
CHILE	65
CHINA	1
COLOMBIA	25
CROATIA	2
DENMARK	6
ECUADOR	1
FINLAND	15
FRANCE	18
GERMANY	117
HONG KONG	1
ICELAND	1
INDIA	3
INDONESIA	1
IRELAND	18
ISRAEL	6
ITALY	1
MALAYSIA	2
MALTA	6
MEXICO	102
NETHERLANDS	11
NEW ZEALAND	13
NORWAY	6
PERU	2
POLAND	4
PORTUGAL	2
ROMANIA	5
RUSSIA	8
SERBIA	1
SINGAPORE	5
SOUTH AFRICA	4
SPAIN	43
SWEDEN	10
SWITZERLAND	8
UKRAINE	6
UNITED KINGDOM	253
UNITED STATES	1165

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URUGUAY	13
VENEZUELA	3
Grand Total	**2613**

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Tel: 305.539.6799|Cell: 786.253.5305|ekalisch@rccl.com

From: ORTIZ, ABDIAS <ABDIAS.ORTIZ@cbp.dhs.gov>
Sent: Monday, March 16, 2020 8:06 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Question for CBP

Hi, Eleni. I am seeking guidance from HQ to your question.

Thanks.

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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 6:22:44 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; ORTIZ, ABDIAS <ABDIAS.ORTIZ@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)

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<yqj1@cdc.gov>
Subject: Question for CBP

CAUTION: This email originated from outside of DHS. DO NOT click links or open attachments unless you recognize and/or trust the sender. Contact theCBP Security Operations Center with questions or concerns.

Hello Abdias –

I had reached out earlier today to your colleague, Chris Ashe. As mentioned in my earlier email, Azamara Pursuit has decided to abandon its efforts to dock and debark in South America and is instead en route to Miami.

Similarly, Celebrity Eclipse continues to have issues docking in Chile and is now considering a 10+ day trip to San Diego. If that is the course chosen, can you please provide guidance as to visa issues that will arise with the South American and Mexican guests onboard? I will send you a manifest by nationality shortly.

Thanks,

Eleni

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Tel: 305.539.6799 | Cell:786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make

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determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road

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Atlanta, GA 30329

470-487-4373

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 2:20 PM
To: Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC

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SparksTk@state.gov

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From:	Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM)
To:	Eleni Kalisch; Rosenfarb, Charles H; Yesenia.Villalta@flhealth.gov
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth (CDC state.gov); Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 12:22:31 PM

Hi Eleni,

Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.

Thank you,
Leah

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Monday, March 16, 2020 12:17 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

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I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

Thanks,

Eleni

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Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
Thanks for speaking just now. To reiterate CDC's recommendation:

- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
- Health screening of passengers would be done by the cruise line company prior to boarding in Recife, with no additional screening performed at the funneling airport (unless the individual

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has become obviously ill on the initial flight).

- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

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Regards,
Dr. Rosenfarb

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Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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AMERICAN OVERSIGHT

From: Barrett, John M (Recife)
To: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Rosenfarb, Charles H; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow
Date: Monday, March 16, 2020 12:45:26 PM

All -

To streamline this process with Royal Caribbean, Mission Brazil is initiating a conf call with a smaller group. We will report out shortly. Thank you.

Sent from Workspace ONE Boxer

On 16 March 2020 12:23:13 PM EDT, Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov> wrote:

> Hi Eleni,
>
> Dr. Rachel Eidex, copied here, is going to be the POC for CDC for the guidance needed. Please make sure she is included.
>
> Thank you,
> Leah
>
> ---
>
> **From:** Eleni Kalisch <ekalisch@rccl.com>
> **Sent:** Monday, March 16, 2020 12:17 PM
> **To:** Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
> **Cc:** Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted

AMERICAN OVERSIGHT

(OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

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Thanks,

Eleni

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Royal Caribbean Cruises Ltd.|1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799|Cell: 786.253.5305|ekalisch@rccl.com

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>;

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Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

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AMERICAN OVERSIGHT

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To:	Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Eleni Kalisch; Yesenia.Villalta@flhealth.gov; CBPCoronaVirusTaskForce@cbp.dhs.gov; Ashe, Christopher
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Walters, William; Charles, Julia (CDC/OD/OCS); WHA-FO; Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Kennedy, Ted (OS/ASPR/SPPR); Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal; Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 1:18:20 PM

Eleni, Yesenia,
Directly linking you with CBP on how the arrival of the repatriated passengers would be handled is certainly the best way to get you the answers you need. Christopher Ashe from CBP's Latin America and Caribbean Division has been our primary contact at CBP (CHRISTOPHER.ASHE@othergovagency.cbp.dhs.gov). A second contact is to the CBPCoronaVirusTaskForce@cbp.dhs.gov.

Regards,
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Sent: Monday, March 16, 2020 12:22 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Rosenfarb, Charles H <rosenfarbch@state.gov>; Yesenia.Villalta@flhealth.gov
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AMERICAN OVERSIGHT

- CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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To:	Rosenfarb, Charles H; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Yesenia.Villalta@flhealth.gov; CBPCoronaVirusTaskForce@cbp.dhs.gov; Ashe, Christopher
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Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 2:03:59 PM

Thank you Dr. Rosenfarb –

The smaller group just convened and addressed all pending issues.

Yesenia, I will be I touch to discuss.

Thanks everyone.

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
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Sent: Monday, March 16, 2020 1:18 PM
To: Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Yesenia.Villalta@flhealth.gov; CBPCoronaVirusTaskForce@cbp.dhs.gov; Ashe, Christopher <christopher.ashe@othergovagency.cbp.dhs.gov>
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Sent: Monday, March 16, 2020 12:17 PM
To: Rosenfarb, Charles H <rosenfarbch@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Yesenia.Villalta@flhealth.gov
Cc: Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ) <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD) <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR) <ted.kennedy@hhs.gov>; Hattingh, Elizabeth (CDC state.gov) <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: RE: [EXTERNAL] CDC guidance for Silver Shadow

Hi Dr. Rosenfarb –

In light of the guidance below and my earlier discussions with ConGen in Brazil, I understand that the US Government does not anticipate conducting any screening of our guests upon their arrival in the US and that we would need to comply with State of Florida screening requirements.

I am adding to this email Dr. Yesenia Villalta, Administrator of the Department of Health in Florida, who advises us that CBP is responsible for conducting the necessary screenings of our guests upon arrival at MIA. Rather than try to negotiate these details, I thought it would be helpful to link the Federal group up with Dr. Yesenia to resolve this matter.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

AMERICAN OVERSIGHT

From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD <dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

Leah,
Thanks for speaking just now. To reiterate CDC's recommendation:

- The cruise line charter flight should transport the AMCITs to one of the designated funneling airports in the US (Miami), where they would disembark away from the main passenger terminal and be transferred to onward charter flights (also arranged by the cruise line) to their home of record. (Our info is that the passengers reside in 22 different states)
- Health screening of passengers would be done by the cruise line company prior to boarding in Recife, with no additional screening performed at the funneling airport (unless the individual has become obviously ill on the initial flight).
- 14 day home monitoring at the passenger's final destination is the recommended guidance.
- Individual state public health authorities at the final destinations should be contacted by the cruise line in advance of arrival at each of the final destinations in the event monitored quarantine is necessary.

From our side, our ConGen in Recife has already explained to the company what they need to do to arrange the charter (including their responsibility to clear with FL authorities—company has already told us that they are working on it with FL). The CBP attache at post is already tracking the plan for charter (and has alerted Miami airport as heads up).

Please let me know if the final CDC guidance differs from anything stated above.

Regards,
Dr. Rosenfarb

AMERICAN OVERSIGHT

Charles Rosenfarb, M.D.
Senior Coordinator, Coronavirus Global Response Coordinating Unit (CGRCU)
U.S. Department of State
Room HST 5323
Office: 202-647-2908
Cell: 202-374-4128

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AMERICAN OVERSIGHT

From:	Eleni Kalisch
To:	Rosenfarb, Charles H; wvp4@cdc.gov; Yesenia.Villalta@flhealth.gov
Cc:	Negron, Ramon A (Chico) (Beijing); Okediji, Adedeji E (Beijing); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ; Regan, Joanna (CDC/DDID/NCEZID/DGMQ; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE; Walters, William; Charles, Julia (CDC/OD/OCS; WHA-FO; Marty Cetron (CDC); Costello, Kelly E; CDC IMS 2019 NCOV Response International Task Force; CDC IMS 2019 NCOV Response INT Cruise Ship Team; Mission Brazil Silver Seas Consular Task Force; CGRCU-CAReps; MED HART nCoV; Barrett, John M (Recife); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD; Kennedy, Ted (OS/ASPR/SPPR; Hattingh, Elizabeth F; Lampel, Michael D; Popp, William W; Daucher, Kevin G; Chung, Julie J; CGRCU-Internal
Subject:	RE: [EXTERNAL] CDC guidance for Silver Shadow
Date:	Monday, March 16, 2020 12:16:52 PM

Hi Dr. Rosenfarb –

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From: Rosenfarb, Charles H <rosenfarbch@state.gov>
Sent: Monday, March 16, 2020 10:50 AM
To: wvp4@cdc.gov
Cc: Eleni Kalisch <ekalisch@rccl.com>; Negron, Ramon A (Chico) (Beijing) <NegronRA@state.gov>; Okediji, Adedeji E (Beijing) <OkedijiAE@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED <ccf6@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI <hrt8@cdc.gov>; Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ <wjf3@cdc.gov>; Regan, Joanna (CDC/DDID/NCEZID/DGMQ <dlo8@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE <pew6@cdc.gov>; Walters, William <WaltersWA2@state.gov>; Charles, Julia (CDC/OD/OCS <yyb1@cdc.gov>; WHA-FO <WHAFO@state.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Costello, Kelly E <CostelloKE@state.gov>; CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>; CDC IMS 2019 NCOV Response INT Cruise Ship Team <eocevent349@cdc.gov>; Mission Brazil Silver Seas Consular Task Force <MissionBrazilSilverSeasConsularTaskForce@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>; MED HART nCoV <medhartncov@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD

AMERICAN OVERSIGHT

<dqc3@cdc.gov>; Kennedy, Ted (OS/ASPR/SPPR <ted.kennedy@hhs.gov>; Hattingh, Elizabeth F <HattinghEF@state.gov>; Lampel, Michael D <LampelMD@state.gov>; Popp, William W <PoppWW@state.gov>; Daucher, Kevin G <DaucherKG@state.gov>; Chung, Julie J <ChungJJ@state.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>
Subject: [EXTERNAL] CDC guidance for Silver Shadow

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Regards,
Dr. Rosenfarb

Charles Rosenfarb, M.D.
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AMERICAN OVERSIGHT

From:	Grow, Stefan
To:	Sayler, Erik; St Laurent, Louise R
Cc:	Larson, Bradford U (Brad) Col USAF NG FLANG (USA); Deleon, Melissa (FLNG)
Subject:	RE: [EXTERNAL] FW: MOA for CST testing lab (UNCLASSIFIED)
Date:	Wednesday, March 25, 2020 5:42:26 PM

I'll have someone look at it.

AHCA certified CLIA, so to the extent there are certification requirements, then we would need to be at least part of that process. Not sure if that warrants being part of the agreement though.

From: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Sent: Wednesday, March 25, 2020 5:19 PM
To: St Laurent, Louise R <Louise.StLaurent@flhealth.gov>; Grow, Stefan <Stefan.Grow@ahca.myflorida.com>
Cc: Larson, Bradford U (Brad) Col USAF NG FLANG (USA) <bradford.u.larson.mil@mail.mil>; Deleon, Melissa (FLNG) <Melissa.e.deleon.mil@mail.mil>
Subject: [External] FW: [EXTERNAL] FW: MOA for CST testing lab (UNCLASSIFIED)

Louise & Stefan,
Attached is the FLNG MOA for the testing machine between DOH and FLNG. Col. Bradford's team drafted it. Are these the right state parties to the MOA? The Colonel said the lab comes with some NG personnel, but they are not currently CLIA certified. Also, supplies and wrap-around services will need to be procured. Do you have any edits? If you have any questions, please let me know.

All,
Some logistics items to be addressed/questions to be answered about the lab, but don't necessarily need to be addressed in the MOA. These are logs/finc/management questions but worth noting and sharing internally.

1. Staffing the lab
    a. How many lab techs are needed to operate the lab at full capacity.
    b. The Colonel says the lab can test 500 samples per day, but is that in an 8, 12, or 24 hour period?
    c. Currently the NG personnel are not CLIA certified; so lab techs will need to be procured – who pays for the lab techs (DOH, AHCA, DEM)
2. Testing materials
    a. What materials are included with the lab (what not included)
    b. What materials are needed to operate the lab at full capacity
    c. Procuring those material that help the lab operate – who procures/pays for these material
3. Wrap-around services
    a. What services are needed (ie, 24-hr security, food for staff, maintenance of lab, etc.)
    b. Who pays for the wrap-around services (DOH, AHCA, DEM)?
4. Timing – It will take at least a week to get the lab.
5. Location – where to stage the lab – that's a logs/mgt decision

AMERICAN OVERSIGHT

6. Other items??

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

Florida has a very broad public records law. Written communications to or from state officials regarding state business constitute public records. Public records are available to the public and media upon request, unless the information is subject to a specific statutory exemption. Therefore, any information that you send to this address, including your contact information, may be subject to public disclosure.

-----Original Message-----
From: Larson, Bradford U (Brad) Col USAF NG FLANG (USA) <bradford.u.larson.mil@mail.mil>
Sent: Wednesday, March 25, 2020 4:25 PM
To: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Subject: [EXTERNAL] FW: MOA for CST and DOH (UNCLASSIFIED)

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

CLASSIFICATION: UNCLASSIFIED

Erik

Attached is the draft MOA we discussed. Please let me know if you have any suggestions. I contacted LTC Eastman and asked what we would need and what we may receive to run this machine. The National Guard Bureau is still working those details as far as what PPE, pipets, kits, etc. may come with the machine. He will get back with me. NGB is sending 2 to NY, so we will have a good idea of what to expect based on what they receive. He did say this would not get to us for about a week even if we do get one.

V/R
Brad

BRADFORD U. LARSON, Col, FLANG
Command Judge Advocate
Florida National Guard
Work: 904-823-0683

AMERICAN OVERSIGHT

Cell: 850-774-3000

CLASSIFICATION: UNCLASSIFIED

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

From:	Guthrie, Kevin
To:	Fitzgerald, John M CDR; Davis, Ashley
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:08:10 PM

10=4

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Subject: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

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Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald
D7 LNO to the FL EOC

AMERICAN OVERSIGHT

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Guthrie, Kevin; Fitzgerald, John M CDR; Davis, Ashley
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan
Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:28:20 PM

Good news here for the MS Marina

Here are the next two ship that I just got info in (good timing here)

Costa Magica and Costa Favolosa:

- The Costa Magica is currently close to the Martinique with 930 crew members, 50 of which may have symptoms of Covid-19 (one crew member have been brought inland by helicopter to get urgent care).

- The Costa Favolosa is currently close to Guadeloupe with 1030 crew members, among which 50 may also present symptoms of Covid-19

Perhaps USCG can track these vessels? I have no idea where home port is but in the thread of email sent me they are talking Miami as a landing place.
Sorry for the good news. ☺

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Saturday, March 21, 2020 2:08 PM
To: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Davis, Ashley <Ashley.Davis@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Subject: RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

10=4

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
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AMERICAN OVERSIGHT

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Hi Eli,
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Thank you and all the best,
Emily

Emily Davenport, MPH
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Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:29:09 PM

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61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

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Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Subject: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern

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Kevin and Ashley:

Please see below the cut line for CDC review and recommendation.

Additionally, Nicole Kimbrel in ESF-8, advised verbally that FDOH concurs with CDC's interpretation/recommendation.

Unless requested, I will advise USCG that there is no need to coordinate a teleconference concerning the MS MARINA. Should the port wish to discuss, I will let you know.

Please let me know if you need further.

v/r,

CDR Fitzgerald

AMERICAN OVERSIGHT

D7 LNO to the FL EOC

Hi Eli,
I have reached out to the ship physician to confirm all the information you sent me, discussed this case with our medical officer, and provided a situational update to Florida Department of Health (FDOH).

It looks like this ship has 3 passengers onboard who have tested positive for Influenza A and do not have known exposure to COVID-19 cases. There is no ILI outbreak onboard. I will follow up with the ship to instruct that these three passengers wear surgical masks while disembarking.

Given the information we have now, we do not have any additional concerns or public health recommendations regarding this vessel. Please let us know if you have any other questions or concerns.

Thank you and all the best,
Emily

Emily Davenport, MPH
Public Health Advisor
Miami Quarantine Station
Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
Office: 305-526-2910 | Cell: 305-407-5118
Fax: 305-869-1495 | Personal Fax: 404-471-8517
xkh2@cdc.gov

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AMERICAN OVERSIGHT

From:	Guthrie, Kevin
To:	Fitzgerald, John M CDR; Davis, Ashley
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian; Lock, Ryan; Jeanne Eckes
Subject:	RE: [EXTERNAL] MS MARINA - CDC/FDOH concurrence that this is not a COVID-19 concern
Date:	Saturday, March 21, 2020 2:07:59 PM

10=4

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Saturday, March 21, 2020 2:00 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Cc: Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>; Guidicelli, Ian <Ian.Guidicelli@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>
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Cc:	SWO_COMMAND; Lock, Ryan; Guthrie, Kevin; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:28:34 PM

I have no SA on this vessel.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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Sam/Ashley

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Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

AMERICAN OVERSIGHT

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

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To:	Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:36:30 AM

We discussed at the 1800 briefing last night. Ryan Lock has a little info Jared M and I will work this morning.

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

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Sam/Ashley

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AMERICAN OVERSIGHT

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Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
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Assistant Secretary for Preparedness and Response (ASPR)
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Cell: **202-230-9169**

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	Guthrie, Kevin
To:	Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:36:39 AM

We discussed at the 1800 briefing last night. Ryan Lock has a little info Jared M and I will work this morning.

Kevin Guthrie | Deputy Director

Office: (850) 815-4101
Cell: (850) 294-8250
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AMERICAN OVERSIGHT

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Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
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AMERICAN OVERSIGHT

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To:	"Guthrie, Kevin"; Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:40:56 AM

Kevin,

Tracking this one. It was off Panama yesterday with tentative arrival in Miami on March 23, 2020.

Advised Ashley and ESF-8 yesterday.

Let me know if you need further.

v/r,

John

CDR John Fitzgerald
D7 LNO to the FLEOC

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Friday, March 20, 2020 7:37 AM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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Subject: [Non-DoD Source] RE: [EXTERNAL] MS Marina (Oceania) - awareness???

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Office: (850) 815-4101
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AMERICAN OVERSIGHT

Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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To:	"Guthrie, Kevin"; Davis, Ashley; Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Toro, Manny J; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:41:06 AM

Kevin,

Tracking this one. It was off Panama yesterday with tentative arrival in Miami on March 23, 2020.

Advised Ashley and ESF-8 yesterday.

Let me know if you need further.

v/r,

John

CDR John Fitzgerald
D7 LNO to the FLEOC

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Friday, March 20, 2020 7:37 AM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Cc: SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Rosenstein, Jared <Jared.Rosenstein@em.myflorida.com>; fdot-emoncall@dot.state.fl.us
Subject: [Non-DoD Source] RE: [EXTERNAL] MS Marina (Oceania) - awareness???

We discussed at the 1800 briefing last night. Ryan Lock has a little info Jared M and I will work this morning.

Kevin Guthrie | Deputy Director
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com

From: Davis, Ashley <Ashley.Davis@em.myflorida.com>
Sent: Thursday, March 19, 2020 3:28 PM
To: Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees,

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Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Cc: SWO_COMMAND <SWO_COMMAND@em.myflorida.com>; Lock, Ryan <Ryan.Lock@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Rosenstein, Jared <Jared.Rosenstein@em.myflorida.com>; fdot-emoncall@dot.state.fl.us
Subject: RE: [EXTERNAL] MS Marina (Oceania) - awareness???

I have no SA on this vessel.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] MS Marina (Oceania) - awareness???

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Sam/Ashley

This is the string I got below and why I asked if you had this ship on the radar. Let me know if you find something out. HHS has no ask….we just want to make sure you are aware this may be headed to Miami.

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
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email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

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Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

18MAR: Indications that an Oceania cruise ship will be arriving at Port of Miami sometime next week with various COVID-19 positives on it. Consular Affairs from the Australian Embassy contacted to say they had been notified overnight that the MS Marina (Oceania) is returning to Miami from South America via the Panama Canal after it was denied docking by several countries. The latest advice the Embassy has is that it is passing through the Canal could take 5 or 6 days. Australian Embassy in Mexico and Honorary Consul in Panama are trying to assist at least 49 Australians on board - some of whom are starting to run short of medications etc. - but are having difficulty contacting the crew and Oceania's agents in Panama. CONS provided them with the contact for Norwegian cruise lines which is a parent company of Oceania. OFM indicates Port of Miami is not aware of the ship coming to Miami and questioned where it would even dock as all available ports are occupied. OFM in touch with Norwegian.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From:	Davis, Ashley
To:	Jeanne Eckes; Luce, Christie; Jeanne Eckes; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha
Cc:	SWO_COMMAND; Lock, Ryan; Guthrie, Kevin; Toro, Manny J; Fitzgerald, John M CDR; Rosenstein, Jared; fdot-emoncall@dot.state.fl.us
Subject:	RE: [EXTERNAL] MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 3:28:23 PM

I have no SA on this vessel.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Jeanne Eckes <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] MS Marina (Oceania) - awareness???

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From:	Abelardo Moncayo
To:	Ashley Vineyard; Catherine Brown; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID); Carina Blackmore; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc:	Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject:	Re: [EXTERNAL] RE: 2020 CSTE VBD Workshop Planning
Date:	Wednesday, February 12, 2020 2:44:01 PM
Attachments:	pntd.0007831.pdf

Hi All – I was made aware of this article by Tom Scott and others. It contains a nice history of vector control and a call for renewed political will and investment in VBDs and VBD control as a public health priority. Just wanted to throw this out there in case you think this topic may be of interest to the workshop participants.

Talk to you soon,
Abelardo

From: Ashley Vineyard <avineyard@cste.org>
Date: Wednesday, February 12, 2020 at 7:57 AM
To: Katie Brown <catherine.brown@state.ma.us>, Abelardo Moncayo <Abelardo.Moncayo@tn.gov>, "elizabeth.schiffman@state.mn.us" <elizabeth.schiffman@state.mn.us>, "Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD)" <bio1@cdc.gov>, "Marc (CDC/CCID/NCZVED) Fischer" <mxf2@cdc.gov>, Carina Blackmore <Carina.Blackmore@flhealth.gov>, "Elizabeth.Dykstra@DOH.WA.GOV" <elizabeth.dykstra@doh.wa.gov>, "Mayes,Bonny (DSHS)" <Bonny.Mayes@dshs.texas.gov>, "Broussard,Kelly (DSHS)" <Kelly.Broussard@dshs.texas.gov>, "Armstrong, Paige A (CDC/DDID/NCEZID/DVBD)" <yzu9@cdc.gov>, "Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)" <kzy2@cdc.gov>
Cc: "Alison F. Hinckley" <cue0@cdc.gov>
Subject: [EXTERNAL] RE: 2020 CSTE VBD Workshop Planning

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Good morning all,

Some materials that may be helpful for our workshop planning call this afternoon:

Workshop description:

Title: Improving Public Health Practice for Vector-Borne Diseases

This workshop will highlight a range of vectors and vector-borne diseases. There will be a series of presentations on vector ecology, surveillance, and emerging VBD issues. The final list of

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speakers/topics will be made when we have the draft agenda for the CSTE conference to ensure the workshop complements presentations and roundtables happening later in the week. The workshop will provide ample time for discussion and sharing of best practices.

Notes from last call:

- Discuss a breadth of VBD topics
- Texas suggested flea-borne and Chagas
- TBRF—Job Lopez from TX as potential speaker
- Vector ecology—similar to tick ecology last year
- Sociopolitical drivers of VBDs/Climate change etc. (article linked below)
- Mosquitoes!
- Note: include more interactive time based on comments from last year's evaluation
- Kiersten suggested a couple titles: "Improving Public Health Practice for Vector-Borne Diseases" and "Improving Knowledge of the Bugs We're Fighting"

This is the article Liz referenced about dengue and the various things impacting its resurgence in Honduras.
https://www.nytimes.com/2019/12/29/world/americas/honduras-dengue-epidemic.html

Thanks and looking forward to chatting soon!
Ashley

-----Original Appointment-----
From: Ashley Vineyard
Sent: Tuesday, February 4, 2020 9:28 AM
To: Ashley Vineyard; Brown, Catherine (DPH); Abelardo Moncayo; elizabeth.schiffman@state.mn.us; Kugeler, Kiersten (CDC/DDID/NCEZID/DVBD); Fischer, Marc (CDC/DDID/NCEZID); Blackmore, Carina; elizabeth.dykstra@doh.wa.gov; Mayes,Bonny (DSHS); Broussard,Kelly (DSHS); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Cherry-Brown, Dena (CDC/DDID/NCEZID/DVBD)
Cc: Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD)
Subject: 2020 CSTE VBD Workshop Planning
When: Wednesday, February 12, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: RingCentral Meetings (see below)

Please save this date and time for our 2020 CSTE Annual Conference VBD Workshop planning calls.

To join and view screen: https://meetings.ringcentral.com/j/1493671493

Or Telephone:
Dial: US: +1 (773) 231 9226
Meeting ID: 149 367 1493

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PLOS | NEGLECTED TROPICAL DISEASES

REVIEW

The importance of vector control for the control and elimination of vector-borne diseases

Anne L. Wilson[1]*, Orin Courtenay[2], Louise A. Kelly-Hope[3], Thomas W. Scott[4], Willem Takken[5], Steve J. Torr[1], Steve W. Lindsay[6]

1 Department of Vector Biology, Liverpool School of Tropical Medicine, Liverpool, United Kingdom, **2** Zeeman Institute and School of Life Sciences, University of Warwick, Coventry, United Kingdom, **3** Department of Tropical Disease Biology, Liverpool School of Tropical Medicine, Liverpool, United Kingdom, **4** Department of Entomology and Nematology, University of California Davis, Davis, California, United States of America, **5** Department of Plant Sciences, Wageningen University and Research, Wageningen, the Netherlands, **6** Department of Biosciences, Durham University, Durham, United Kingdom

* anne.wilson@lstmed.ac.uk

Check for updates

OPEN ACCESS

Citation: Wilson AL, Courtenay O, Kelly-Hope LA, Scott TW, Takken W, Torr SJ, et al. (2020) The importance of vector control for the control and elimination of vector-borne diseases. PLoS Negl Trop Dis 14(1): e0007831. https://doi.org/10.1371/journal.pntd.0007831

Editor: Roberto Barrera, Centers for Disease Control and Prevention, Puerto Rico, UNITED STATES

Published: January 16, 2020

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Funding: ALW and SWL received funding from the UK's Global Challenges Research Fund, supported by the Biotechnology and Biological Sciences Research Council, Medical Research Council and Natural Environment Research Council (BOVA Network, grant reference number: BB/R00532X/1)

Competing interests: The authors have declared that no competing interests exist.

Abstract

Vector-borne diseases (VBDs) such as malaria, dengue, and leishmaniasis exert a huge burden of morbidity and mortality worldwide, particularly affecting the poorest of the poor. The principal method by which these diseases are controlled is through vector control, which has a long and distinguished history. Vector control, to a greater extent than drugs or vaccines, has been responsible for shrinking the map of many VBDs. Here, we describe the history of vector control programmes worldwide from the late 1800s to date. Pre 1940, vector control relied on a thorough understanding of vector ecology and epidemiology, and implementation of environmental management tailored to the ecology and behaviour of local vector species. This complex understanding was replaced by a simplified dependency on a handful of insecticide-based tools, particularly for malaria control, without an adequate understanding of entomology and epidemiology and without proper monitoring and evaluation. With the rising threat from insecticide-resistant vectors, global environmental change, and the need to incorporate more vector control interventions to eliminate these diseases, we advocate for continued investment in evidence-based vector control. There is a need to return to vector control approaches based on a thorough knowledge of the determinants of pathogen transmission, which utilise a range of insecticide and non–insecticide-based approaches in a locally tailored manner for more effective and sustainable vector control.

Author summary

Vector-borne diseases (VBDs) such as dengue, Chagas disease, human African trypanosomiasis (HAT), leishmaniasis, and malaria exert a huge burden of morbidity and mortality worldwide. The principal method by which these diseases are controlled is through vector control. The authors chart the history of vector control through time from elucidation of the transmission route of VBDs to the present day. Pre-1940 vector control relied heavily

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on environmental management and larval control based on a thorough understanding of pathogen transmission but was replaced by insecticide-based vector control, often deployed as a monotherapy. The authors call for increased political will and investment in vector control and a return to locally tailored vector control that draws on the entire toolbox of interventions available.

Introduction

Vector-borne diseases (VBDs) are infections caused by pathogens that are transmitted by arthropods such as mosquitoes, triatomine bugs, blackflies, tsetse flies, sand flies, lice, and ticks. Dengue, Chagas disease, Japanese encephalitis, leishmaniasis, lymphatic filariasis (LF), malaria, and yellow fever threaten over 80% of the world's population and disproportionately affect the poorest populations living in the tropics and subtropics [1]. Many of these VBDs are co-endemic, and it is estimated that more than half the world's population live in areas where 2 or more VBDs are present [1]. VBDs contribute significantly to the global burden of disease, accounting for 17% of the global estimated burden of all infectious diseases [2]. Perhaps the best known VBD, malaria, is a major cause of morbidity and mortality, particularly in sub-Saharan Africa (SSA), with approximately half the world's population predicted to be at risk of malaria (Table 1) [3]. Many VBDs are classified as neglected tropical diseases (NTDs), e.g., arboviral diseases like dengue and chikungunya, Chagas disease, human African trypanosomiasis (HAT), leishmaniasis, LF, and onchocerciasis [4]. The burden of NTDs is poorly understood, and until the last 5 to 10 years, these diseases have suffered from a lack of prioritisation and investment. Important aspects of NTD biology, epidemiology, and prevention remain inadequately understood. While the global numbers of deaths from vector-borne NTDs is lower than for malaria, vector-borne NTDs continue to cause high levels of morbidity and represent a significant public health burden; e.g., from 1990 to 2013, dengue cases increased

Table 1. Global burden of VBDs.

	Data source	Estimated cases worldwide in 2017 (thousands [95% CI])	Estimated global all-age DALYs in 2017 (thousands [95% CI])	Estimated all-age deaths worldwide in 2017 (thousands [95% CI])
Malaria	World Malaria Report 2018 [8]	219,000 (203,000–262,000)	Not stated	435
	Global Burden of Disease 2017 [6, 7, 9]	208,768 (170,214–257,506)	45,000 (31,700–61,000)	619.8 (440.1–839.5)
Dengue	Global Burden of Disease 2017 [6, 7, 9]	104,771 (63 759–158,870)	2,920 (1,630–3,970)	40.5 (17.6–49.8)
CL and mucocutaneous leishmaniasis		4,166.6 (3,560.7–4,992.8)*	264 (172–389)	-
VL		10.6 (8.2–16.5)*	511 (1.02–2,440)	7.5 (0.0–34.5)
Yellow fever		97.4 (28.0–251.7)	314 (67.2–900)	4.8 (1.0–13.8)
Chagas disease		6,197.0 (5,248.5–7,243.9)*	232 (210–261)	7.9 (7.5–8.6)
HAT		4.9 (1.3–19.8)*	79.0 (15.4–287)	1.4 (0.3–4.9)
LF		64,623.4 (59,178.2–70,866.1)*	1,360 (752–2,160)	-
Onchocerciasis		20,938.1 (12,882.3–37,227.7)*	1,340 (639–2,370)	-
Trachoma		3,818.9 (2,842.6–5,135.2)*	303 (202–425)	-
Zika virus disease		2,232.2 (1,659.6–3,097.6)	2.24 (1.27–4.66)	0.0 (0.0–0.1)

*Prevalence.

Abbreviations: CL, cutaneous leishmaniasis; DALY, disability-adjusted life year; HAT, human African trypanosomiasis; LF, lymphatic filariasis; VBD, vector-borne disease; VL, visceral leishmaniasis

https://doi.org/10.1371/journal.pntd.0007831.t001

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nearly 450% globally [5]. Some zoonotic NTDs have an additional veterinary health burden [6, 7].

Vector control is the principal method available for controlling many VBDs—both historically and today. Moreover, for some diseases, such as dengue (a vaccine is licensed but is not widely used due to safety concerns [10]), chikungunya, Zika, and West Nile disease, vector control is currently the only method available to protect populations. Vector control aims to limit the transmission of pathogens by reducing or eliminating human contact with the vector. A wide range of vector control tools exist, which can be broadly classified into chemical- and non–chemical-based tools (Table 2). Tools targeting immature vectors can act by killing the immature stages (e.g., chemical or biological larvicides and predator species) or by removing suitable aquatic habitats (e.g., habitat modification or manipulation). Tools targeting the adult vectors function by killing the vector (e.g., indoor residual spraying [IRS], space spraying) and/or reducing vector contact (blood-feeding success) with human and/or animal reservoir hosts (e.g., topical repellents, house screening, insecticide-treated bed nets [ITNs], insecticide-treated dog collars). There are also several novel vector control tools under development, e.g., genetic manipulation of mosquitoes, bacterial infection of vectors (e.g., *Wolbachia*), and insecticide-treated eave tubes (Box 1).

Table 2. Categories and examples of vector control methods [11].

Chemical	Immature	Chemical larvicides	Contact pesticides affecting insect nervous system (e.g., temephos) or endocrine system (insect growth regulators, e.g., pyriproxyfen)
	Adult	ITNs	Pyrethroid-treated ITNs or combination ITNs (e.g., pyrethroid plus synergist piperonyl butoxide) for malaria, LF, and leishmaniasis control
		Insecticide-treated materials for personal protection	Insecticide-treated clothing for workers and mobile populations
		IRS	Spraying of residual insecticides (typically either pyrethroids, carbamates, or organophosphates) indoors for malaria and *Aedes*-borne disease control
		Space spraying	Aircraft, vehicle or hand-held space spraying for dengue epidemic and other *Aedes*-borne disease control
		Insecticidal treatment of habitat	Focal, perifocal, ground, or aerial insecticide spraying
		Insecticide-treated cattle	Pour-on or spot-on pyrethroids for control of tsetse
		Insecticide-treated traps and targets	Targets for control of HAT and insecticide-treated adulticidal oviposition traps for *Aedes*-borne diseases
		Topical repellent	Chemicals (e.g., N,N-diethyl-meta-toluamide [DEET], picaridin) applied to the skin to reduce vector biting
		Spatial repellent	Transfluthrin/metafluthrin passive emanators or coils
Nonchemical	Immature	Microbial larvicides	*Bacillus thuringiensis* var. *israelensis*, *B. sphaericus*
		Predator species	Predatory fish or invertebrates
		Habitat modification, i.e., a permanent change of land and/or water	Drainage of surface water, land reclamation and filling, and coverage of large water storage containers (or complete coverage of water surfaces) with a material that is impenetrable to mosquitoes, such as expanded polystyrene beads
		Habitat manipulation, i.e., a recurrent activity	Water-level manipulation, exposing habitats to the sun (depending on the ecology of the vector), flushing of streams, drain clearance, and source reduction, including rubbish disposal and regular emptying and cleaning of domestic containers (e.g., flowerpots, animal drinking water troughs)
		Regulatory measures	Removal of man-made aquatic habitats and appropriate waste disposal
	Adult	House improvement and screening	Closing eaves, door and window screening
		Removal trapping	Solar-powered mosquito trapping system for malaria control and sticky adulticidal oviposition traps for *Aedes*-borne diseases

Abbreviations: HAT, human African trypanosomiasis; IRS, indoor residual spraying; ITN, insecticide-treated bed net; LF, lymphatic filariasis

https://doi.org/10.1371/journal.pntd.0007831.t002

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Box 1. Examples of novel vector control interventions being developed

Gene drive

Gene drive is a method of genetic modification that can be used to spread favourable traits through interbreeding populations of malaria mosquitoes [12]. The gene drive allows genes to spread through populations in a self-sustaining manner, even if they confer a fitness cost. The technique can be used for population replacement (reducing the ability of mosquitoes to transmit a pathogen) or population suppression (reducing the size of the vector population by, e.g., reducing fertility of females or biasing the sex ratio towards males). The 'Target Malaria' group started initial work in Burkina Faso, in preparation for releases of gene drive mosquitoes.

Wolbachia

Wolbachia is a genus of bacteria that naturally infect some insect species but are not normally found in *Aedes* mosquitoes. Introduction of *Wolbachia* into *Aedes* mosquitoes reduces transmission of dengue and other arboviruses to people [13]. Mosquitoes carrying *Wolbachia* are released by field teams and mate with the wild mosquito population, and over time the percentage of mosquitoes carrying *Wolbachia* increases. The 'World Mosquito Program' is conducting a randomised controlled trial and programmatic evaluations in several countries worldwide (e.g., [14, 15]).

Spatial repellents

Spatial repellents are chemicals that prevent a vector from entering a space occupied by a potential human host to reduce encounters between the vector and the host [16]. They are typically used against malaria or *Aedes* mosquitoes and can be used indoors or outdoors, where they may serve as a useful tool in combating outdoor transmission of malaria. Spatial repellents exist in a number of formats, including coils, passive emanators, and impregnated fabric. Although several small trials of spatial repellent coils have been performed [17, 18], spatial repellents are not yet recommended for disease prevention. Results from randomised controlled trials for malaria and dengue are currently being analysed. A research programme was recently funded by UNITAID to carry out a second efficacy evaluation of spatial repellent passive emanators against malaria, and a second trial is being considered for dengue.

Eave tubes

Eave tubes are small plastic tubes with insecticide-laden electrostatic netting that are inserted into the house wall, below the roof [19]. Mosquitoes are lured to the house by host odours emanating through the eave tubes and are killed after contacting the insecticide-treated netting. Eave tubes are being tested in a large randomised-controlled trial in Côte d'Ivoire, which includes other house improvements, including eave closure and window screening [20].

Our goal was to review the history of vector control from the 1800s to the present day, highlighting what tools and approaches were adopted and the impacts they had on vectors and infection and disease. This Review focuses on the main VBDs: *Aedes*-borne viruses, Chagas

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disease, HAT, leishmaniasis, LF, malaria, and onchocerciasis. Malaria is the dominant focus of the Review given the high burden of morbidity and mortality and well-documented history of thinking on malaria vector control [21, 22]. The manuscript uses some terminology that is often misused in the public health literature and may require definition: 'control' refers to deliberate efforts to reduce disease incidence, prevalence, morbidity, or mortality to a locally acceptable level; 'elimination' refers to interruption of local transmission requiring continued efforts to prevent reestablishment of transmission; and 'eradication' refers to permanent reduction to zero of the worldwide incidence of infection as a result of deliberate efforts, so that intervention measures are no longer needed [23]. A summary of the programmes and campaigns discussed is given in Fig 1 and Table 3. The World Health Organization (WHO) calls for effective, locally adapted, and sustainable vector control in its recent Global Vector Control Response (GVCR) 2017–2030 strategy [2]. Increasing our understanding of the different types of vector control tools that were used in the past, what settings they were used in, and their impacts on vectors and disease can hopefully help us to select and promote new and existing vector control methods to sustainably reduce the burden and threat of VBDs. We conclude by drawing out key lessons from the history of vector control and identifying how these can be applied now and in the future.

A brief history of vector control

Elucidation of the transmission route of VBDs and early vector control

In the 1890s and early 1900s, the transmission route of Chagas disease, HAT, LF, malaria, and yellow fever were elucidated, primarily in response to the germ theory of Pasteur and Koch and advancements in microscopy [64–69]. The first VBD of humans to be identified was malaria when in 1897, ground-breaking work by Sir Ronald Ross showed that *Anopheles* mosquitoes transmitted malaria parasites [66]. However, vector control had been taking place prior to this, mainly due to an awareness of the connection between fevers and proximity of swamps and marshes. For example, historical reports from Greek (circa 550 B.C.) and Roman times describe large drainage schemes and reductions in 'plague' and fever [70, 71]. There are reports of the use of mechanical vector control methods, such as sleeping in high buildings, where mosquitoes were unable to fly due to wind; the use of bed nets in Egypt (as noted by Herodotus 484–425 B.C.) and by the Romans; and the use of bed curtains, as noted by Marco Polo during his travels to India in the 13th century [70]. Sanitary measures helped to control yellow fever in the US in the late 1700s, including cleaning sewers and pumping bilge water out of ships, which was practiced in Philadelphia during a large outbreak in 1793 when refugee ships from Saint Dominigue (now Haiti) inadvertently brought in the *Ae. aegypti* vector [72, 73].

Environmental management as the primary tool for control of VBDs

Prior to the use of insecticides, VBD control generally relied on understanding local vector behavioural ecology and tailored environmental control, although these were often labour intensive. Following Ross's discovery and pioneering work on quantitative epidemiology of VBDs, the focus of malaria control was on elimination of anopheline vectors, primarily by changing the aquatic habitats where the vectors developed. There was also a focus on housing improvements such as screening of doors and windows. The first trial of a malaria intervention was carried out by Angelo Celli among railway workers in Italy in 1899–1900 [74–76]. The combined intervention of housing screening, whitewashing internal walls, burning special powders (probably pyrethrum), and protective clothing was highly successful. Celli found that 92% of the families left unprotected contracted malaria compared to only 4% in the intervention group.

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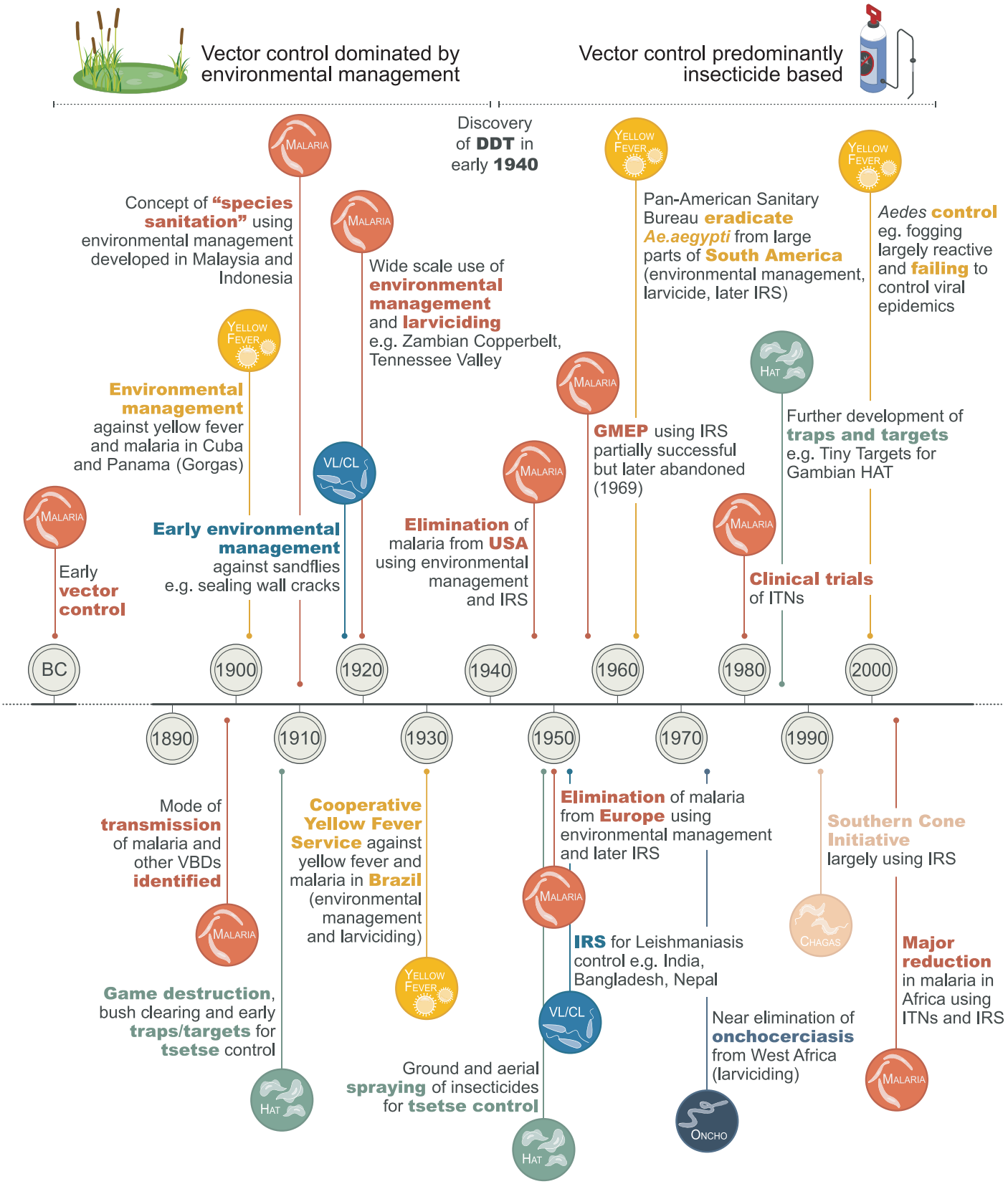

Fig 1. A short history of vector control. CL, cutaneous leishmaniasis; DDT, dichlorodiphenyltrichloroethane; GMEP, Global Malaria Eradication Programme; HAT, human African trypanosomiasis; IRS, indoor residual spraying; ITN, insecticide-treated bed net; VBD, vector-borne disease; VL, visceral leishmaniasis.

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Table 3. Historical overview of notable vector control programmes and their effects.

Date	Location	Programme	Disease	Vector species targeted	Vector control methods implemented	Effects observed	Reference
Late 1800s	East Africa	Efforts led by colonial powers	HAT	*Glossina*	Bush clearance, game destruction, trapping of tsetse	Decline in tsetse populations	[24–27]
1901–1920	Malaya (now Malaysia)	Efforts led by Sir Malcolm Watson	Malaria	*Anopheles umbrosus* *An. maculatus*	Draining marshes, subsoil drainage, filling water bodies, tree clearing, relocating housing	Reduction in malaria	[28]
1901–1912	Cuba	Efforts led by Gorgas and Le Prince, taken over by local authorities after 1904	Yellow fever and malaria	*Aedes aegypti* *An. albimanus*	Yellow fever: house inspection and destruction/oiling of containers, fines if cisterns not covered, and isolation of patients with screening and netting, and fumigation of their premises Malaria: drainage, filling or oiling of standing water, ditching, cutting vegetation at edges of ponds/streams, larvivorous fish and oiling of wells, restricting animal grazing during wet season, intermittent short-duration flooding of watercress beds (versus constant flooding)	Reduction in yellow fever and malaria	[29]
1904–1913	Panama Canal	Efforts led by Gorgas and Le Prince	Yellow fever and malaria	*An. albimanus* *An. tarsimaculata* *Ae. aegypti*	Yellow fever: house screening, premise and container inspections, destruction or treatment of containers with oil/larvicide Malaria: house screening, clearing water bodies, draining or filling standing water, installing drains, removing jungle, larviciding using oil or Paris Green	Reduction in malaria and yellow fever	[29] [30]
1920–1935	Indonesia	'Species sanitation' led by N. H. Swellengrebel	Malaria	*An. ludlowi* (now *An. sundaicus*) *An. aconitus* *An. maculatus*	Environmental management, e.g., filling and draining of ponds, maintaining and flushing drains, planting trees	Reduction in malaria	[31, 32]
1930–1962	Italy	Italian antimalarial campaign 'bonfica integrale' under Mussolini	Malaria	*An. labranchiae*	Draining of Pontine marshes, house screening, community education and mobilisation, larviciding using Paris Green, clearing canals and ditches, DDT aerial spraying (after 1946)	Malaria eradication	[33–35]

(*Continued*)

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Table 3. (Continued)

Date	Location	Programme	Disease	Vector species targeted	Vector control methods implemented	Effects observed	Reference
1930–1942	Brazil	Cooperative Yellow Fever Service directed by Fred Soper	Yellow fever and malaria	*Ae. aegypti* *An. gambiae*	Yellow fever: container inspections, oiling/ larviciding of aquatic habitats, sanitary legislation enforced by monetary fines Malaria: larviciding with Paris Green, house spraying with short-acting pyrethroids	Elimination of *Ae. aegypti* from many areas, reduction in yellow fever; elimination of *An. gambiae* from northeast Brazil	[36]
1929–1950	Copperbelt, Zambia	Roan Antelope Copper Mine and others, including Nchanga Consolidated Copper Mines, Rhokana Corporation, and Mufulira Cooper Mines	Malaria	*An. gambiae* *An. funestus*	Vegetation clearance along river and tributaries, modification of river boundaries and removal of man-made obstructions, draining flooded areas and swamps, oiling of larval habitats, and house screening	At Roan Antelope Mine, reduced malaria-related mortality and morbidity by 70%–95% within 3–5 years	[37] [38]
1933–1950	Tennessee Valley, US	TVA	Malaria	*An. quadrimaculatus*	Regulation of water levels in the lakes, shoreline improvements such as deepening or diking and draining, larviciding, and later (to a limited extent) house improvement, DDT aerial spraying, and IRS using DDT	Virtual malaria elimination	[39, 40]
1942–1943 (World War II)	Guadalcanal, Solomon Islands	US Navy, Malaria Control Unit 'Cactus'	Malaria	*An. farauti*	Oiling of swamps, fumigation of planes and huts, relocation of plantation workers, ITNs, topical repellents, atabrine prophylaxis	Reduction in malaria cases	[41, 42]
1942–1945	Upper Egypt	Species (*An. gambiae*) eradication	Malaria	*An. gambiae*	Larviciding with Paris Green (later Malariol due to supply issues); pyrethrum house spraying; residual spraying of boats, planes, trains, automobiles with pyrethrum (later DDT)	Massive reductions in malaria cases (10,193 cases in 1942, to 59 in 1946); eradication of *An. gambiae*	[43]
1947–1951	Southeast USA	US National Malaria Elimination Programme	Malaria	*An. quadrimaculatus* *An. freeborni*	IRS with DDT, larviciding using Paris Green, deepening or diking and draining of water bodies, lining canals with concrete	Free of malaria as a significant public health problem in 1949	[44]
1955–1969	Worldwide	Global Malaria Elimination Programme	Malaria	Varied depending on location	IRS with DDT and other residual insecticides	Elimination from some regions, but unsuccessful elsewhere	[45, 46]
1947–1962	South and Central America and Caribbean	Pan-American Sanitary Bureau	Yellow fever	*Ae. aegypti*	Container inspections, oiling of aquatic habitats, later perifocal spraying of DDT in water containers and nearby walls	Vector eradicated from large parts of South America	[47, 48]

(*Continued*)

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Table 3. (Continued)

Date	Location	Programme	Disease	Vector species targeted	Vector control methods implemented	Effects observed	Reference
1951–1980	China	National visceral leishmaniasis control programme	VL	*Phlebotomus chinensis* *P. longiductus* *P. wui* *P. alexandri*	IRS of houses and animal shelters using DDT, and elimination or topical deltamethrin treatment of dogs	Massive reduction in case incidence from 94/100,000 in 1950 to approximately 0.03/100,000 by 1980	[49]
1950s–1970s	Peruvian Andes	Gains as a result of Global Malaria Elimination Programme	CL	*Lutzomyia peruensis* *Lu. verrucarum* *Lu. ayacuchensis*	IRS with DDT	Decrease in cases but resurgence once IRS was stopped	[50]
1973–1991	Botswana	Tsetse control programme	HAT	*G. morsitans centralis*	Aerial spraying of insecticides; deltamethrin-treated targets to stop reinvasion of tsetse	Eliminated tsetse and HAT	[25, 51]
1970s–present	Solomon Islands and Papua New Guinea	Malaria Elimination Programme Pacific Programme for the Elimination of Lymphatic Filariasis (PacELF) post 1999	LF	*An. farauti* *An. koliensis* *An. punctulatus*	Solomon Islands: IRS using DDT Papua New Guinea: IRS with DDT, later mosquito nets (untreated), and since 2005 long-lasting ITNs	Elimination from Solomon Islands by late 1970s, and near elimination from PNG (ongoing)	[52–54]
1974–2002	West Africa	Onchocerciasis Control Programme (OCP) and to a lesser extent African Programme for Onchocerciasis Control (APOC)	Onchocerciasis	*Simulium* spp.	Larviciding	Near elimination of river blindness from West Africa	[55, 56]
1991–present	Argentina, Bolivia, Brazil, Chile, Paraguay, and Uruguay	Southern Cone Initiative (SCI)	Chagas disease	*Triatoma infestans* and other species	IRS, house improvements, and community education	Decline in indoor infestation and disease incidence	[57–59]
1953–present	India, Nepal, Bangladesh	Visceral Leishmaniasis Elimination Programme–Memorandum of Understanding between countries signed 2005 (previous gains as a result of Malaria Eradication Programme)	VL	*P. argentipes*	IRS using DDT in homes and animal shelters	Decline in cases in 3 countries from 77,000 in 1992 to 6,000 in 2016	[60]
1915 (California)–present	US	Mosquito abatement districts	*Aedes*-borne diseases	*Aedes* and nuisance mosquitoes	Predominantly larval control	Prevention of local *Aedes*-borne virus transmission, e.g., no locally transmitted Zika in US states	[61]
2000–present	SSA	Campaign to eliminate HAT (numerous donors, research institutions, and implementing partners)	HAT	*Glossina* spp.	Screening and treatment, traps and targets ('Tiny Targets'), insecticide-treated cattle	25,841 cases of *Trypanosoma brucei gambiense* HAT in 2000 to 2,110 in 2016 and from 709 *Trypanosoma brucei rhodesiense* HAT cases in 2000 to 54 in 2016	[62]
2000–present	SSA	Scale-up of ITNs and IRS	Malaria	*An. gambiae* and other species	ITNs and IRS	ITNs responsible for 68% of 663 million clinical cases averted from 2000 to 2015	[63]

Abbreviations: CL, cutaneous leishmaniasis; DDT, dichlorodiphenyltrichloroethane; HAT, human African trypanosomiasis; IRS, indoor residual spraying; ITN, insecticide-treated bed net; LF, lymphatic filariasis; SSA, sub-Saharan Africa; TVA, Tennessee Valley Authority; VL, visceral leishmaniasis

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Environmental management flourished in both Malaya (now Malaysia) and Netherlands East Indies (now Indonesia) in the early 1900s. British doctor Sir Malcolm Watson joined the Malayan Medical Service in 1900, where he led vector control efforts against malaria based on an understanding of the ecology of local vectors [28]. Drainage of aquatic habitats controlled malaria in 2 coastal towns in the state of Selangor and allowed resumption of port development. Later, Watson's work expanded to lowland areas—where he controlled *An. umbrosus* by clearing the forest within 0.8 km of plantation labourer houses so that water bodies were exposed to the sun—and in 1909 to hilly regions, where subsoil drainage was successful against *An. maculatus*. Watson also oversaw successful drainage schemes in Singapore in 1911, where local malaria transmission was practically eliminated [28]. The Dutch zoologist Nicolaas Swellengrebel was inspired by Watson and set out to replicate the work throughout the Indonesian archipelago between 1920 and 1935, terming his methods 'species sanitation' [31]. Swellengrebel aimed to control malaria primarily through environmental management, such as filling in or draining ponds and lagoons, maintaining and flushing drains, or planting shade trees depending on the vector species present and its ecology.

The Pontine marshes, near Rome, Italy, suffered from high malaria transmission for over 1,000 years. Large-scale drainage from 1930 onwards was highly successful in malaria control against the Italian malaria vector *An. labranchiae* [34]. This was done as part of the three-pronged 'bonifica integrale' campaign, or 'bonification', instigated by Mussolini. The campaign included agricultural improvements—e.g., draining swamps to increase agricultural land; hygienic measures, such as building sturdy, well-screened brick housing; and quinine distribution.

Another excellent example of environmental management for malaria control was in the Zambian Copperbelt during the 1920s and 1930s [37, 38, 77]. Control measures launched at the Roan Antelope Copper Mine in 1929—including vegetation clearance, modification of river boundaries, draining swamps, oil application to open water bodies, and house screening—were highly effective in targeting *An. gambiae* and *An. funestus* [37]. In 3 to 5 years, malaria-related mortality and morbidity declined by 70%–95%, and over a 20-year period, the programme averted an estimated 4,173 deaths and 161,205 malaria attacks.

Environmental management was also being implemented on a large scale in the southern US. The Tennessee Valley Authority (TVA) was set up in 1933 to exploit the Tennessee River's potential for hydroelectric power and improve the land and waterways for agricultural development of the region [39, 40]. At the time, the region was highly endemic for malaria, and the creation of artificial lakes would have exacerbated the problem. Vector control tools implemented included regulation of water levels in lakes, shoreline improvements such as deepening or diking and draining, larviciding, house screening, and later dichlorodiphenyltrichloroethane (DDT) spraying. Massive reductions in malaria were seen, and the disease was essentially eliminated from the area by the late 1940s.

Control of yellow fever in the Americas at the start of the 20th century was heavily reliant on environmental management. At this time, the US had taken control of Cuba following the end of the Spanish American war, but outbreaks of yellow fever and malaria were taking the lives of many US soldiers [78]. Following confirmation that *Ae. aegypti* was the yellow fever virus vector, in 1901 Major William Gorgas, Chief Sanitary Officer, was asked to initiate a programme for the elimination of *Ae. aegypti*, work he carried out with Joseph Le Prince [29]. The programme was highly successful and comprised house inspections, oiling or destruction of mosquito-producing containers, and isolation of yellow fever patients in screened quarters with fumigation of their premises with sulphur or pyrethrum. Havana residents not covering their cisterns were made to pay a US$10 fine. After introduction of the mosquito brigades, yellow fever deaths dropped from an average of 467 per year between 1890 and 1900 to 18 in

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1901 [29]. Later the *Aedes* programme was expanded to include *Anopheles* control by drainage, filling or oiling of standing water, ditching in a herringbone pattern, cutting vegetation at edges of ponds or streams, the addition of larvivorous fish or oil to wells, restricting animal grazing during the wet season to avoid creating habitats in flooded footprints, and intermittent short-duration flooding of watercress beds in Havana (versus constant flooding). This resulted in a fall in malaria deaths from 5,643 between 1890 and 1900 to 444 deaths between 1900 and 1910, despite a greatly increased human population [29].

In 1904, Gorgas became Chief Sanitary Officer during the building of the Panama Canal and with the aid of Le Prince eliminated yellow fever and kept malaria at low levels [29]. Control was achieved by screening living quarters, draining or filling standing water, installing drains, and larviciding using oil or Paris Green [30]. Paris Green is not used currently due to high human toxicity and ecological concerns, and we now have much less toxic chemicals that can be applied in a more targeted manner. After these successes, similar campaigns were launched by Joseph White in Havana, Oswaldo Cruz in Rio de Janeiro, and Emilio Ribas in Santos [79]. Successful control was followed by a period of apathy. Complacency was brought to a halt by an epidemic of yellow fever in Rio de Janeiro in 1928 in which population densities of *Ae. aegypti* were again at high levels. The Cooperative Yellow Fever Service, a collaboration between the Brazilian Government and the Rockefeller Foundation, was established under the direction of Fred Soper with the aim of eradicating *Ae. aegypti* from Brazil. From 1930 to 1934, Soper led a well-organised campaign, with control measures including oiling of water containers and house searches for larvae and adults. Campaigns initiated by the Cooperative Yellow Fever Service also succeeded in eliminating *An. gambiae* from the northeast of Brazil in 1942 largely using larviciding with Paris Green, complemented in some areas by house spraying with short-acting pyrethroids [36].

In the late 1800s, colonial expansion in SSA and massive outbreaks of HAT led to a number of scientific missions to study the disease. In 1903, David Bruce and colleagues found that the trypanosome that causes HAT was transmitted by *Glossina palpalis* (now *G. fuscipes*) [69]. In colonial times, game destruction and bush clearing were widely practised for tsetse control in many countries. The impetus for game destruction was a natural experiment—a rinderpest epizootic in the 1890s eliminated wild hosts and domestic stock across large parts of east and southern Africa [80]. This led to the disappearance of tsetse from large areas, but as the game populations recovered, so did the tsetse. Game destruction was first introduced in Southern Rhodesia (now Zimbabwe) in 1919, and by 1921, cases of trypanosomiasis were greatly reduced [81]. From 1922 until the early 1980s, game destruction was generally adopted as a tsetse control method [26]. In the 1950s, game destruction in Shinyanga, Tanzania, succeeded in eradicating an isolated tsetse population [25]. Full or partial habitat destruction was also practiced. For example, riverine tsetse species were eradicated from rivers and streams in Ghana and Nigeria by removing short bush and trees with low branches [24]. Despite these successes, the huge environmental impact of bush clearing and game destruction would be unacceptable today.

Traps and targets for tsetse control also started to be developed around this time, as scientists gained an understanding of tsetse behaviour in response to visual (e.g., colour, movement, size/shape) and olfactory cues [27, 82]. For example, in 1909 on the island of Príncipe, estate staff were made to wear squares of black cloth coated with bird lime on their backs, which succeeded in reducing local densities of *G. palpalis*. This approach was later incorporated into an island-wide programme (including, also, habitat and host destruction), which eliminated tsetse and lasted until at least 1932 [83, 84]. Early traps developed included the Harris Trap used in Zululand from 1931 onwards against *G. pallipides* [83] and the 'animal' trap used in West Africa to control *G. fuscipes* and *G. tachnoides* [85].

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From 1942 to 1945, *An. gambiae* was eradicated from Upper Egypt (Aswan, Qena, Girga, and Asyût Provinces) through a meticulous campaign of weekly larviciding using Paris Green and, to a lesser extent, house spraying using pyrethrum [43]. Residual treatment of trains, automobiles, and planes was also performed to prevent spread of *An. gambiae* to uninfested areas to the north. The number of malaria cases in the region fell from 10,193 cases in 1942 to 59 in 1946.

Prior to the use of residual insecticides, environmental management was also the standard control method against phlebotomine sand fly transmission of *Leishmania* species causing human cutaneous leishmaniasis (CL) and visceral leishmaniasis (VL). Early attempts towards the end of World War I to control sand flies was in response to epidemics of sand fly fever (rather than to leishmaniasis) that disrupted British troops in the Middle East and Mediterranean regions. Based on investigations of local sand fly ecologies and larval development locations, environmental management included the following: pitching camps away from refuse, debris, and loose friable rocks; pitching camps on levelled drained ground; sealing soil cracks with cresol, sand, or sawdust; and treatment with lime—all to render the ground impermeable to ovipositing and emerging sand flies. Additional chemical control included spraying cresol, crude oil, or paraffin or treating with tar around tents and the lower 3 feet (0.9 m) of buildings [86]. Similarly, in India, naphthalene in kerosene with petrol and carbon disulphide was applied 120 yards (110 m) around army barracks, resulting in a 50% reduction in sand flies [86]. Few chemical advances were made against adult sand flies during this period. Bed nets needed to be fine mesh sizes due to the small size of sand flies and were considered too uncomfortable in hot climates. Thus, sand fly control was in existence prior to its definitive incrimination as a vector of *Leishmania*, the result of cumulative experiments between 1904 and 1942 [86–88]. Plastering walls of houses, cattle sheds, and latrines with lime and mud to eliminate cracks used as diurnal resting sites by *Ph. argentipes*, a vector in the Indian subcontinent, continues to be part of an integrated approach to sand fly control [89].

Post–World War II era and the advent of DDT

The first residual insecticide DDT was added to the vector control toolbox in the early 1940s, consequently increasing the popularity of insecticide-based control. World War II had stemmed the supply of pyrethrum (derived from chrysanthemum flowers) from Japan, and alternatives were urgently needed [90]. The first major demonstration of DDT use was at the end of World War II when the allies used the insecticide to control an epidemic of typhus, transmitted by body lice, amongst the populations of war-torn Europe [91].

With the advent of DDT, malaria eradication became a more realistic proposition. In 1947, spurred on by malaria control successes—including the TVA and Malaria Control in War Areas programme to control malaria around military training bases in the southern US [92]—the US National Malaria Eradication Programme was established [44]. This was a joint undertaking by state and local health agencies in 13 southeastern states and the Communicable Disease Center of the US Public Health Service. Indoor DDT spraying, drainage, removal of mosquito larval development sites, and insecticide spraying eliminated malaria transmission, and in 1949 the US was declared free of malaria as a significant public health problem [44]. Support for an eradication approach and IRS using DDT was bolstered by insights from the Ross-Macdonald model, which illustrated that malaria transmission was highly sensitive to reductions in mosquito longevity [93, 94]. In 1955, WHO launched the Global Malaria Eradication Programme (GMEP)—excluding SSA, which they deemed too problematic—with the goal of interrupting transmission through IRS with DDT and other residual insecticides [45, 46]. Environmental management—such as drainage of marshes and housing improvements to

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prevent mosquito bites—was abandoned, and only later were antimalaria drugs included in the strategy. The GMEP succeeded in eliminating malaria from Europe, North America, the Caribbean, and parts of Asia and South-Central America, primarily where there were more temperate climates, seasonal transmission, and well-functioning control programmes. The northern part of Venezuela was the first to be WHO certified as malaria free in June 1961 through the use of IRS with DDT, sanitary engineering (water management and house improvement), and larviciding [95]. Parasite resistance to drugs, mosquito resistance to insecticides, lack of community participation, and reduced funding led to abandoning the GMEP in 1969 after it was realised that elimination was not possible everywhere with the approach adopted [45].

Also around this time, the Pare-Taveta Malaria Scheme, a pilot project to test the feasibility of malaria eradication in Africa, was initiated [96]. Between 1954 and 1966, the project evaluated the effect of IRS with dieldrin on malaria and mortality in the Taveta subdistrict of Kenya and the Pare district of Tanganyika (now Tanzania). The project succeeded in reducing malaria to low levels, but intensive IRS could not be sustained, and malaria bounced back after the intervention was stopped.

In 1947, Brazil called for elimination of *Ae*. *aegypti* across the whole South American continent, a task that was coordinated by the Pan-American Sanitary Bureau with the continued involvement of Fred Soper [47]. Brazil was encouraged by the success of the Cooperative Yellow Fever Service in northeast Brazil but also understood that *Ae*. *aegypti* could not be eradicated from Brazil unless frontiers and ports were protected from invasion from other countries in the region. Container inspections, oiling of larval development sites, and later perifocal spraying of DDT in water containers and nearby walls succeeded in eradicating *Ae*. *aegypti* from large parts of South America during the 1950s and 1960s. By October 1961, 16 countries in the Western Hemisphere were free of *Ae*. *aegypti* (Bolivia, Chile, Ecuador, Guatemala, Nicaragua, Paraguay, Uruguay, French Guiana, Brazil, Costa Rica, El Salvador, Honduras, Panama, Peru, Canal Zone, and British Honduras) [48]. During the 1940s and 1950s, yellow fever was virtually eliminated in the Americas, but unfortunately, this success became the downfall of the programme. As yellow fever subsided, political support for the eradication campaigns waned despite warnings from Soper about the risk that could result from pulling back the hemisphere-wide *Ae*. *aegypti* control programme [97]. Weak vector control and surveillance meant, as predicted, that *Ae*. *aegypti* gradually returned to many countries, most likely due to re-infestation from countries that had not achieved eradication, including Argentina, French Guyana, the US, Venezuela, and several Caribbean countries.

The advent of DDT and dieldrin also saw the use of residual insecticides for tsetse control. Ground spraying of insecticides onto tsetse resting sites was carried out from the 1950s until the mid-1970s by tsetse control programmes in large parts of East Africa, combined with screening, treatment, and follow-up of patients [98–100]. Aerial spraying was first used in Zululand, South Africa, in the 1950s but was expanded greatly in the 1970s and 1980s. The most successful example of aerial spraying was in the Okavango Delta of Botswana, where it was used from 1973 to 1991 and again in the early 2000s against *G*. *m*. *centralis* succeeding in eliminating tsetse and HAT [25, 51]. Reduced infrastructures for spraying, high costs, and concerns about the environmental impact of DDT and dieldrin, however, resulted in ground and aerial spraying being largely discontinued [69]. The idea of insecticide-treated cattle for tsetse fly control was also developed in the 1940s [101, 102]. Experiments in Tanganyika (now Tanzania) showed that DDT-treated cattle reduced the abundance of *G*. *morsitans* by 99% and *G*. *swynnerloni* by 93% [101]. Insecticides also started to be used in traps and targets. For example, reinvasion of Príncipe by tsetse in the 1950s led to the use of insecticidal 'animal' traps between 1956 and 1958, which were successful in eradicating tsetse in Príncipe [103].

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Much of the historical control of leishmaniasis has been attributed to IRS using DDT, both targeted specifically against *Leishmania* vectors, or as a beneficial consequence of the GMEP in the 1950s. In China, approximately 530,000 cases of co-circulating zoonotic and anthroponotic *Leishmania* species were reported north of the Yangtze River prior to the creation of the People's Republic in 1949. The national VL control programme, which started in 1951, included human VL case detection and treatment, IRS of houses and animal shelters using DDT, and elimination or topical deltamethrin treatment of dogs. This campaign reduced the case incidence from 94 per 100,000 population in 1950 to approximately 0.03 per 100,000 population by 1980, with clear effects associated with IRS interventions alone in some regions [49]. In Brazil, where zoonotic VL occurs, the government commission to investigate leishmaniasis and other diseases—created in 1936 and headed by Evandro Chagas—led to the first use of DDT in the 1950s in northeast Brazil. VL case incidence was reduced by 58% in 14 sprayed areas compared to a rise of 12% in 14 untreated areas [104]. Implementation of an integrated approach similar to that adopted in China (without the option of topical insecticide for dogs) led to considerable reductions in the number of cases, though with some reservations about the residuality of DDT on adobe houses [105, 106].

Reductions in *Leishmania* vectors—as well as human incidence, though this is less well reported—have been attributed to the GMEP operating in various countries [107]. In Rio de Janeiro, Brazil, DDT IRS circumstantially led to a reduction from 12.7% prevalence in 1947 to 0.3% in 1953 [108]. IRS spraying during the Indian National Malaria Eradication Programme of 1958 to 1970 apparently resulted in zero cases of VL being reported from the State of Bihar during that time period [109]. Perhaps the more compelling evidence is the rise in VL cases once the GMEP largely ceased in the late 1960s [107, 110]. For example, in the subsequent VL epidemic in Bihar, India, case numbers rose from a few to 40,000 cases by 1978 [109]. Similar rebounds were reported in several countries [107, 110, 111]. Retrospective analysis of household survey data from the Peruvian Andes showed that IRS with DDT from the 1950s until the 1970s resulted in a decrease in CL cases. Cases increased after IRS was discontinued [50].

GMEP abandoned—What next for malaria?

After the GMEP was abandoned, many countries switched from eradication to malaria control, even though WHO reaffirmed that eradication was still the ultimate goal [112]. During the 1970s and 1980s, malaria was poorly controlled. There were epidemics in the Indian subcontinent (1973–1976) and Turkey (1977) and focalisation of the malaria problem where there was sociopolitical instability or limited socioeconomic development, including countries in SSA, Brazil, and Sri Lanka [46, 113]. The economic crisis in the early 1970s and reorientation of collaborating agencies like the United Nations Children's Fund (UNICEF) towards general health (rather than malaria) meant less funding for malaria control, oil shortages led to increases in insecticide prices, drug and insecticide resistance were increasing, and operational capacity in programmes was reduced [45]. Also of note was a large WHO-funded research study conducted from 1969 to 1976 in Garki, northern Nigeria, known as the Garki Project [114]. Despite the GMEP not being implemented in Africa, WHO wanted to test whether IRS with propoxur and mass drug administration (MDA) with chloroquine and sulfadoxine-pyrimethamine would interrupt malaria transmission. The measures were successful in reducing parasite prevalence from 80% to 30%, but 1 year after stopping control, malaria rebounded back to pre-intervention levels.

After these setbacks, WHO called for a more tactical approach to malaria control based on the biological, social, ecological, and economic determinants of malaria rather than blanket distribution of insecticide-based vector control and MDA. This approach was endorsed by the

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World Health Assembly (WHA) in 1978 [115] and further developed at the Seventeenth WHO Expert Committee on Malaria in 1979 [116]. In the early 1990s, WHO devised with member states a new global malaria control strategy, which was endorsed by the WHA in 1993 [117]. The new strategy called for a selective approach in determining whether and where to attempt vector control (and if so, what method to use) and deemphasised IRS, stating that 'the proper use of insecticides is a complex matter, involving considerable expense and trained personnel and demanding sustained application, usually for many years.' A renewed focus on research led to new vector control tools becoming available.

In the early 1970s, ITNs emerged as a vector control idea because many communities were already sleeping under untreated bed nets. At this time, synthetic pyrethroids were developed (permethrin, cypermethrin, and deltamethrin), which were safe to use for impregnation of ITNs [118]. Following pioneering trials on ITNs, including those in The Gambia in the 1980s that showed huge impacts on malaria infection and mortality [119–121], WHO recommended the use of ITNs for children and pregnant women [122]. In the early 2000s, the late Chris Curtis and others were strong advocates for ITNs as a public good and for their provision via the public sector with financial assistance from donors [123]. Following several studies that showed a community-level effect of ITNs [124–126] through mass killing of mosquitoes, there was an increasing push for ITNs to be provided to entire communities, rather than just high-risk groups [127]. As a result, the WHO position statement was strengthened in 2007 to recommend the use of long-lasting ITNs (with long-lasting pyrethroid formulations that last for 3 years) distributed either free or highly subsidised and used by all community members [128]. A major stimulus for malaria control at this time was the recognition that malaria restrained economic development and that eliminating malaria in SSA would lead to rapid development [129]. Political will and resources for malaria increased, and in 2007, malaria eradication hit the agenda again following calls by the Bill and Melinda Gates Foundation to eradicate malaria with massive scale-up of existing and experimental interventions [130]. ITN coverage increased rapidly from 2000, predominantly financed through the Global Fund to fight AIDS, Tuberculosis and Malaria [131, 132], and an estimated 50% of the population at risk of malaria of SSA were sleeping under an ITN in 2017 [8]. IRS was used only in specific areas, and therefore only 7% of the population at risk in SSA was covered by IRS in 2017 [8]. Much of the IRS conducted in SSA was funded by the US Presidents Malaria Initiative [133].

Both ITNs and IRS have had considerable public health impact. Between 2000 and 2015, there was a decline in malaria infection by over 50% and an estimated 663 million clinical cases averted in SSA. ITNs were estimated to have been responsible for an estimated 68% of averted cases and IRS for 13% of cases averted [63]. This reliance on insecticide-based malaria vector control has, however, fuelled the development of insecticide resistance [134]. WHO noted that 68 of the 80 malaria-endemic countries that provided data for 2010–2017 reported resistance to at least 1 of the 4 insecticide classes in one malaria vector species, while 57 countries reported resistance to 2 or more insecticide classes [8]. Existing evidence is equivocal as to whether insecticide resistance is adversely impacting malaria control, but it remains a major concern [135–137]. In response to the growing threat of insecticide resistance, a public–private partnership—the Innovative Vector Control Consortium—was established in 2005 to bring new insecticide chemistries to the market, which led to several ongoing market-shaping initiatives on next-generation ITNs and IRS (www.ivcc.com). Despite these efforts, since 2017 WHO World Malaria Reports have highlighted stalling progress against malaria [8, 138, 139]. The reasons for this stagnation include inadequate coverage of ITNs, the need to replace old nets, high rainfall in some parts of SSA, and insecticide resistance. WHO called for increased investment, including filling gaps in coverage of core malaria tools like ITNs [8] and the need to develop additional tools for vector control.

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NTDs—Lagging behind in vector control

Vector control for vector-borne NTDs, including Chagas disease, Gambian HAT, leishmaniasis, LF, and onchocerciasis, took longer to gain traction compared to efforts against anopheline and *Aedes* vectors.

Despite the early discovery by Sir Patrick Manson of transmission of the main LF parasite—*Wuchereria bancrofti*—by mosquitoes in 1878 [67, 140], vector control against LF played a lesser role than for other VBDs. Uniquely among VBDs, LF can be transmitted by 5 genera of mosquito (*Anopheles*, *Aedes*, *Culex*, *Mansonia*, and *Ochlerotatus*), although it typically requires a large number of infective mosquito bites over many years to result in an infectious human host [141]. Although vector control for LF is advocated by WHO [142], much of the focus today is on use of MDA to eliminate microfilariae from the blood of infected humans in order to interrupt mosquito transmission. Despite this, there are several examples from the Pacific region of elimination of LF using vector control alone—including IRS using DDT against *Anopheles* vectors in the Solomon Islands and Papua New Guinea [52–54], as well as sanitation campaigns against culicine vectors in Australia [143]. It is likely that the recent massive rollout of ITNs in SSA has contributed to a decline in LF, although the evidence is equivocal [144–147]. In Papua New Guinea, however, an MDA campaign from 1994 to 1998 reduced transmission, but large declines in mosquito and human infection were not seen until ITNs were introduced in 2009 [148], which was consistent with the notion that combining drugs with vector control would be more effective than either approach alone. Polystyrene beads used in pit latrines against culicine vectors were also shown to augment MDA in India and Zanzibar in the 1980s and 1990s [149–151]. In 1997, WHO called for eradication of LF and 5 other infectious diseases. In 2000 the Global Programme to Eliminate Lymphatic Filariasis (GPELF) was launched, with vector control currently playing a minor role to MDA as a supplementary intervention [152, 153].

Vector control has been integral to the control of onchocerciasis [154], particularly in the Onchocerciasis Control Programme (OCP) in Africa from 1974 to 2002 [55]. Weekly aerial larviciding was conducted from 1976 to 1989 along the rivers of a wide area of west African savanna (700,000 km^2) where onchocerciasis was endemic [155]. The programme initially covered Benin, Burkina Faso, the northern parts of Côte d'Ivoire, Ghana, southeastern Mali, southwestern Niger, and Togo but was expanded to include additional river basins in Benin, Côte d'Ivoire, Ghana, Guinea, Sierra Leone, and Togo from where *Simulium* were invading [156]. The programme was hugely successful, and the level of onchocerciasis endemicity declined rapidly. Longitudinal entomological surveys at 4 catching points in Burkina Faso showed a decline in annual transmission potential of infective *Onchocerca volvulus* larvae from between 300 and 900 in 1975 to less than 100 by 1982 [155]. The same study reported a reduction in prevalence of human microfilariae infections from around 70% in 1976 to almost negligible levels through to 2000. The absence of—or at least very low levels of—transmission have been maintained since, despite the absence of vector control or ivermectin MDA. Several important lessons were learned from the OCP that can be applied to vector control more widely, including the need to rotate insecticides (implemented following development of resistance to temephos and chlorphoxim) and the value of using a targeted approach to eliminating residual foci based on entomological and epidemiological monitoring [156]. In 1991, the Onchocerciasis Elimination Program of the Americas (OEPA) was launched [157], and in 1995, the African Programme for Onchocerciasis Control (APOC) was established in 19 African countries not included in the OCP [56, 158]. Several of the APOC countries successfully used ground larviciding, although both APOC and the OEPA relied predominantly on community-directed treatment with ivermectin, the use of which was bolstered by the Merck Mectizan donation scheme that began in 1987 [159].

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Vector control has also been highly effective against Chagas disease as illustrated by successes of the Southern Cone Initiative (SCI) initiated during 1991 in Argentina, Bolivia, Brazil, Chile, Paraguay, and Uruguay [57–59] and similar initiatives launched in 1997 in Central America and Andean Pact countries. Interventions against the vector *T. infestans* focused mainly on IRS, house improvements (replacement of mud walls and floors with cement, and thatched roofs with corrugated metal), and community education. In the 1980s, there were thought to be between 16 and 18 million people infected with *Trypanosoma cruzi*, and the SCI achieved a decline in infestation rate and a sharp decline in the infection rates of children [160]. Uruguay became the first Latin American country to eliminate Chagas disease in 1997 [161], and domestic transmission was effectively eliminated in Chile (1999); Brazil (2006); substantial areas of Argentina, Bolivia, and Paraguay; and parts of Central America [162]. Despite these successes, there are estimated to be still over 6 million people infected with the parasite [6], and continued vigilance is necessary to combat peridomestic and sylvatic vector populations, which can re-invade houses or mediate transmission outside the home [162]. In some regions, successful vector control to maintain low house infestation rates is a prerequisite for human treatment [163].

Vector control continues to play an important role in the fight against leishmaniasis, particularly where sand flies are endophilic [50, 109, 111, 164, 165]. Control is complex, however, due to the numerous aetiologies and transmission cycles, many of which in the Americas are sylvatic, and most *Leishmania* species involve a zoonotic reservoir. To tackle anthroponotic VL, an elimination initiative was launched by India, Bangladesh, and Nepal in 2005 incorporating an IRS component alongside screening and treatment, which was associated with a reduction in VL cases from over 77,000 in 1992 to fewer than 6,000 cases in 2016 [60]. A large cluster randomised trial of ITNs in India and Nepal against anthroponotic VL, however, failed to show effectiveness against infection or disease [166], perhaps due to the vector being more exophagic than expected [167]. In contrast, successful deployment of bed nets reduced anthroponotic CL incidence in a variety of Old World foci [110]. Against zoonotic VL, an alternative insecticide application is deltamethrin-impregnated dog collars, which provide high levels of individual protection against canine infection [168]. Community-level dog collar implementation in Iran reduced human infection incidence by 43% [169] and infantile clinical VL by 50% [168].

Traps and targets for tsetse control also continued to be developed, now incorporating synthetic pyrethroids [82]. In West Africa, the Challier Laveissiére biconical trap was developed and found to catch many more tsetse than the 'animal' trap [170]. Deltamethrin-impregnated biconical traps deployed along River Léraba in Burkina Faso in the 1970s rapidly reduced *G. palpalis gambiensis* and *G. tachinoides* [171]. Different variants of the biconical trap were developed and deployed in different settings, including the pyramidal trap, monoconical and Vavoua trap, bipyramidal trap, and others [27]. Insecticidal targets, panels of insecticide-impregnated cloth, were developed including the R type, which was the first to be widely deployed, and the simplified S type target, which consisted of a rectangle of black cloth flanked by two pieces of black mosquito netting attached to a frame and inserted via a pole into the ground [172]. Pyrethroid treatment of cattle to combat ticks and tsetse was used widely in successful control programmes in Burkina Faso, Tanzania, Zanzibar, and Zimbabwe [173]. The sterile insect technique was used experimentally in Nigeria and Tanzania but only programmatically in Zanzibar, where between 1994 and 1997 tsetse was eliminated [174]. Unfortunately, scaling down of tsetse control campaigns and neglect of surveillance activities led to an increase in HAT cases by the turn of the century. Renewed efforts are underway to eliminate *T. b. gambiense* and *T. b. rhodesiense* HAT through reduction of the parasite reservoir using screening and treatment of humans, as well as vector control, including traps and targets for

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riverine tsetse and insecticide-treated cattle for savannah flies [175, 176]. WHO aims to eliminate HAT as a public health problem by 2020 (with elimination of transmission by 2030) and has developed a roadmap to achieve this goal [177]. Active screening and treatment of human cases provides the mainstay of efforts to achieve the elimination goal. Increased control efforts have coincided with plummeting case numbers from 25,841 cases of *T. b. gambiense* HAT in 2000 to 2,110 in 2016 and from 709 *T. b. rhodesiense* HAT cases in 2000 to 54 in 2016 [62]. While active screening and treatment have been responsible for the majority of this decline, in the last decade, new cost-effective methods of controlling riverine species of tsetse—the important vectors of *T. b. gambiense*—have begun to make an important contribution to the global effort. In particular, 'Tiny Targets' are—despite their small size—proving highly effective in reducing the density of riverine species where active screening and treatment alone is not predicted to achieve the elimination goals [178, 179]. Tiny Targets are currently deployed by control programmes in Chad, Côte d'Ivoire, the Democratic Republic of Congo, Guinea, and Uganda.

In Europe, the US, and Australia—where VBDs such as malaria were once endemic—effective disease control programs were replaced by the control of nuisance biting mosquitoes and the intermittent control of epidemics caused by viruses, such as West Nile virus, dengue, and Zika [180]. In Europe, large-scale mosquito control is confined largely to the Rhine Valley, where authorities are conducting larviciding and environmental management [181, 182]. In the US, mosquito abatement districts are present in many states, including large-scale programmes in California and Florida. The abatement district programme has been successful—e.g., in 2018, there were no locally transmitted Zika cases in US states despite importation of cases due to travellers returning from affected areas [61]. The distribution of *Ae. aegypti* in Australia is restricted to Queensland, where routine control measures include IRS (targeting the premises of contacts of dengue cases), lethal ovitraps, barrier/harbourage spraying, treatment of containers with residual chemicals, and source reduction [183].

The growing global threat of *Aedes*-borne diseases

While protozoa and nematodes were the dominant vector-borne pathogens of the 19th to 20th centuries, arboviruses are likely to be most important in the 21st century. *Aedes*-borne viral diseases, including chikungunya, dengue fever, yellow fever, and Zika disease, are a growing threat worldwide [184, 185] due to geographic expansion of vectors and viruses through globalisation and urbanisation [186]. Urbanisation, often unplanned, is typically associated with inadequate housing and lack of basic services, including water and waste management, which creates ideal habitats for expanding *Ae. aegypti* populations [187]. *Aedes albopictus*—once confined to tropical forests of Southeast Asia—has increased its geographic range since the mid-1960s and adapted to live in human-made habitats in urban and peri-urban areas [188]. This is exacerbated by a lack of investment in *Aedes* vector control, which in its current form is failing to prevent *Aedes*-borne epidemics. Indeed, as noted by Margaret Chan, Director General of WHO, during her opening address at the 69th WHA in 2016, '. . . Above all, the spread of Zika, the resurgence of dengue, and the emerging threat of Chikungunya are the price being paid for a massive policy failure that dropped the ball on mosquito control in the 1970s.' Successful *Aedes*-control campaigns of the past were replaced by reactive control during epidemics, which has been largely ineffective. In general, there is a lack of clarity on what vector control methods are effective for *Aedes*-borne diseases because the tools available have not been rigorously assessed against epidemiological outcomes [189]. This is of great concern because in the absence of effective vaccines, programmes that limit contact between humans and vectors and are expedient, comprehensive, and sustained are the most effective method of controlling arboviral diseases [189].

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Discussion

Vector control has been the principal method of preventing VBDs for over 100 years and remains highly effective, when comprehensively applied and sustained. It remains, for several diseases, the only control tool we currently have at our disposal. Key lessons that we can learn from the history of vector control are discussed further as follows and summarised in the 'Key learning points'.

History shows that complacency and lack of investment in vector control leads to VBD resurgence. A striking example comes from South America, where,—despite achieving eradication of *Ae*. *aegypti* in 16 countries—after control programmes were scaled back the vector reinvaded, flourished, and caused hemisphere-wide epidemics from multiple different viruses [48]. It is estimated that 91% (68/75) of malaria resurgence events from the 1930s to the 2000s were attributed, at least in part, to weakened vector control programmes [190]. Complacency in tsetse control and surveillance led to flareups of HAT in the early 2000s.

Political will and central coordination clearly have important roles to play. For example, the current successes in reducing VL incidence between 2012 and 2017 in the Indian subcontinent [191] are attributed to the advocacy and political support generated with substantial donations from pharmaceutical industry, governments, and nongovernmental agencies [192]. The VL initiative and other programmes—including the Pan American Sanitary Bureau efforts to eliminate *Ae*. *aegypti* from the South American continent, the OCP, and the SCI—all involved strong cross-border collaboration [48, 55, 59]. These large-scale collaborations enabled effective coordination and dialogue, sharing of best practices, and cross-border containment. Effectiveness of this approach is exemplified today by the Elimination8—a collaboration between 8 countries in southern Africa to eliminate malaria (https://malariaelimination8.org/).

It is imperative that political will and investment in vector control is maintained, particularly as we approach elimination targets when the cost per VBD case averted will inevitably increase. Despite this, vector control is chronically underfunded, for research and development (R&D) and at programme level. Investment in vector control R&D is dwarfed by that for drugs, diagnostics, and vaccines [193]. For example, for malaria, only 18 million US$ (3% of total R&D investment) supported vector control in 2014. Although we have seen an increase in investment in dengue vector control R&D from 5 million US$ in 2010 to 21 million US$ in 2014 (an increase from 8% to 25% of total R&D investment), there is negligible or no investment in vector control R&D for other VBDs such as LF. At the programme level, additional funding is needed to increase vector control capacity and build health systems. Programmes lack skilled personnel, in particular public health entomologists and vector control technicians [194]. Surveillance systems and monitoring and evaluation need significant strengthening to allow programmes to target interventions, track progress against programmatic indicators, and make adjustments as needed. Huge funding shortfalls are a roadblock to more effective intervention—even for malaria, which is better funded than other VBDs. Global financing for malaria control and elimination was 2.9 billion US$ in 2015, which represents only 46% of the Global Technical Strategy 2020 annual investment milestone of 6.4 billion US$ [195, 196]. NTDs received only 0.6% of Official Development Assistance in 2012, compared to 6.8% for malaria and 47.2% for HIV/AIDS [197]. At the international level, vector control is losing expertise fast with a massive reduction in the number of entomologists working at WHO's headquarters in Geneva. To sustain and further the gains already made, political will must be enhanced and investment in vector control dramatically increased.

Throughout the history of vector control, a range of different tools were successfully applied. It is striking, however, that environmental management such as drainage and filling and larviciding come up repeatedly—particularly pre 1940—but were less common thereafter

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(as noted by Keiser and colleagues for malaria control [22]). Work by Watson and Schwellengrebel, which took an ecological perspective [28, 31], shows that success can be achieved when we have a thorough understanding of the vector and context for transmission as a knowledge base on which to build vector control efforts. Similarly, the development of highly effective baits for tsetse would not have been possible without a rational and detailed understanding of vector behaviour. Unfortunately, the success of this approach is often forgotten in the search for seemingly more easily scalable solutions. Insecticides such as DDT gained favour because they gave a rapid result and were often less labour intensive to implement than environmental management. The availability of residual insecticides initiated a fundamental shift in vector control approaches from locally tailored approaches based on an understanding of the epidemiology and ecological, environmental, economic, and social determinants of VBDs to a focus on deployment of uniform insecticide-based commodities, particularly for malaria. In essence, entomologists stopped being thinkers and became monolithic deployment automatons.

Many of the historical vector control examples involved collaboration with the non-health sector. For example, public–private partnerships such as those in the Zambian Copper Belt and the pioneering work of Celli on improved housing against malaria [37, 38, 74, 77]. This has been largely taken over by health-sector–led vector control. There is huge potential for engagement of the non-health sector for greater resilience against VBDs and increased sustainability of vector control. For instance, farmers can be mandated to dry their fields regularly to reduce *Anopheles* habitats [198], the private sector (e.g., extractive industries) can implement vector control to maintain the health of their workforce and surrounding communities [199], and the housing sector can be engaged to implement housing improvements (e.g., screening) that can dramatically reduce house entry of anopheline and *Aedes* mosquitoes [200].

Development and testing of novel vector control tools is essential. While we are waiting for new tools to come to the market, however, the vector control community should draw upon the full toolbox of interventions that are currently available, including noninsecticidal tools like environmental management. This is particularly important given the changing landscape of VBDs, which mandates a transformation in how we do vector control. For example, insecticide resistance in *Anopheles* and *Aedes* vectors is on the rise and threatens to undermine control of these diseases [134, 201]. Social and environmental change such as urbanisation, climate change, agricultural expansion and intensification, water resource development, deforestation, natural resource exploitation, trade, and population movement are creating enabling conditions for VBD transmission, and current tools do not fully address these VBD determinants [202]. It is increasingly acknowledged that in order to control VBD more effectively and/or drive VBD transmission to zero, multiple interventions need to be applied based on local conditions and needs, and that this may not be achievable with the current tools being used [189, 203–205]. For example, in many settings—even in the presence of universal coverage with core malaria interventions—malaria vectors are able to maintain robust transmission through outdoor biting, feeding on nonhuman animal hosts, and resting outdoors [206]. Environmental management—e.g., house screening against malaria—can also play a role after VBD elimination has been achieved by reducing the risk of reestablishment of transmission.

A criticism of this rationale may be that some of the historic examples, particularly those against yellow fever in South America, involved a 'military-like' vector control response in less complex ecosystems that some say would not be feasible today. This is a reasonable point to consider. We argue, however, that a weakness of many of the historic examples was a lack of community engagement in vector control. This could be strengthened, particularly for control of *Aedes* mosquitoes. There are contemporary examples of successful community-based vector control against dengue, HAT, and malaria [207–209].

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There is an increasing recognition of the role that vector control can play in disease prevention. For example, the WHO GVCR strategy came about following calls from countries to strengthen vector control in the wake of the Zika epidemic [2]. The GVCR has 4 pillars of action, to (i) strengthen inter- and intra-sectoral action and collaboration; (ii) engage and mobilize communities; (iii) enhance vector surveillance and monitoring and evaluation of interventions; and (iv) scale up and integrate tools and approaches, within the health sector and—where relevant—outside the health sector. Rather than a one-size-fits-all approach, the GVCR advocates for locally appropriate solutions (insecticidal and noninsecticidal) based on solid epidemiological and entomological evidence, which harks back to the approach used by many successful historic vector control programmes. The GVCR will help to galvanise this transformative approach to vector control and should be supported by the entire vector control community.

Conclusion

Vector control has been shown to be highly effective, historically and presently. Lack of funding and weak programmatic capacity undermine programmes and mean that we are not well equipped to face the pressing new challenges to VBD control, such as environmental change, insecticide resistance, and population growth. There is an urgent need for increased investment in strengthening programmatic capacity for surveillance and control, as well as the development of new vector control tools. We cannot afford to wait until new tools and strategies, such as *Wolbachia* and genetically modified mosquitoes, are available. Instead, we should revisit successful programs from the past and adopt a problem-solving approach that implements tailored vector control solutions drawing upon our entire toolbox of available interventions, including insecticide and non–insecticide-based control methods.

Key learning points

- Political will and investment in capacity and capability must be maintained in order to keep VBDs and vector control as public health priorities. If this is not done, disease resurgence is inevitable.
- Train and retain entomologists at all programme levels—a better understanding of the vectors will enable more effective control.
- Encourage cross-border collaboration and regional efforts where possible.
- Expand the toolbox of vector control to include environmental management and larval control and develop the role of sectors outside health to deliver environmental interventions.
- Single vector control tools are unlikely to be sustainable; combined control (including additional vector control tools, vaccines, MDA, and diagnosis and treatment) are more effective and sustainable.

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Date: Friday, March 13, 2020 1:10:46 PM

yes

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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Subject: RE: [External] Re: communications test
Date: Friday, March 13, 2020 2:19:35 PM

Can everyone please STOP replying all? Please and thank you!

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Contact OSH's Compliance Hotline: 866-244-0486 to anonymously report possible illegal, unethical, or improper conduct.

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~ Passion to Service ~

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AMERICAN OVERSIGHT

Douglas
Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Subject: RE: [External] Re: communications test
Date: Friday, March 13, 2020 1:19:00 PM

Can everyone please STOP replying all? Please and thank you!

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Contact OSH's Compliance Hotline: 866-244-0486 to anonymously report possible illegal, unethical, or improper conduct.

From: Deborah Anderson <deanderson@signaturehomenow.com>
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~ Passion to Service ~

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AMERICAN OVERSIGHT

Douglas
Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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Subject: Re: [External] Re: communications test
Date: Friday, March 13, 2020 1:10:39 PM

yes

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Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Brooke, Keith; Larry McFarlan; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; ~Bell, Jeffrey FA; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Blakely, Danny; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ferland, Ross; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From:	Davis, Ashley
To:	Jeanne Eckes; Fitzgerald, John M CDR
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian
Subject:	RE: [EXTERNAL] Re: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 8:30:46 AM

I have copied in Ops (Ian) to assist us. Thank you, Ash

From: Jeanne Eckes <Jeanne.Eckes@hhs.gov>
Sent: Friday, March 20, 2020 8:28 AM
To: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Cc: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
Subject: [EXTERNAL] Re: MS Marina (Oceania) - awareness???

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Thanks

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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AMERICAN OVERSIGHT

On Mar 20, 2020, at 7:30 AM, Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil> wrote:

Jeanne,

Passed yesterday to Ashley and ESF-8 that vessel is off Panama and is tentative for arrival in Miami on March 23. Will keep tracking this one.

v/r,

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 6:31 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Subject: [Non-DoD Source] RE: MS Marina (Oceania) - awareness???

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
Jeanne

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From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Subject: MS Marina (Oceania) - awareness???

Sam/Ashley

This is the string I got below and why I asked if you had this ship on the radar. Let me know if you find something out. HHS has no ask….we just want to make sure you are aware this may be headed to Miami.

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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

18MAR: Indications that an Oceania cruise ship will be arriving at Port of Miami sometime next week with various COVID-19 positives on it. Consular Affairs from the Australian Embassy contacted to say they had been notified overnight that the MS Marina (Oceania) is returning to Miami from South America via the Panama Canal after it was denied docking by several countries. The latest advice the Embassy has is that it is passing through the Canal could take 5 or 6 days. Australian Embassy in Mexico and Honorary Consul in Panama are trying to assist at least 49 Australians on board - some of whom are starting to run short of medications etc. - but are having difficulty contacting the crew and Oceania's agents in Panama. CONS provided them with the contact for Norwegian cruise lines which is a parent company of Oceania. OFM indicates Port of Miami is not aware of the ship coming to Miami and questioned where it would even dock as all available ports are occupied. OFM in touch with Norwegian.

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From:	Davis, Ashley
To:	Jeanne Eckes; Fitzgerald, John M CDR
Cc:	Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Cooksey, Samantha; Guidicelli, Ian
Subject:	RE: [EXTERNAL] Re: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 8:30:36 AM

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Sent: Friday, March 20, 2020 8:28 AM
To: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Cc: Davis, Ashley <Ashley.Davis@em.myflorida.com>; Luce, Christie <christie.luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <samantha.cooksey@flhealth.gov>
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HHS/ASPR/OEMMO
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To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
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AMERICAN OVERSIGHT

From: Sayler, Erik
To: Deleon, Melissa (FLNG)
Cc: Grow, Stefan; St Laurent, Louise R
Subject: RE: [EXTERNAL] RE: National Guard Civil Support Team Mobile COVID-19 testing lab
Date: Wednesday, March 25, 2020 3:38:18 PM

Major DeLeon,
Do you have an ETA on the MOU for the CST mobile testing lab? Do you need anything from legal?

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

Florida has a very broad public records law. Written communications to or from state officials regarding state business constitute public records. Public records are available to the public and media upon request, unless the information is subject to a specific statutory exemption. Therefore, any information that you send to this address, including your contact information, may be subject to public disclosure.

From: Grow, Stefan <Stefan.Grow@ahca.myflorida.com>
Sent: Tuesday, March 24, 2020 6:29 PM
To: Sayler, Erik <Erik.Sayler@em.myflorida.com>; St Laurent, Louise R <Louise.StLaurent@flhealth.gov>
Cc: Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>; Ernst, Colleen <Colleen.Ernst@eog.myflorida.com>
Subject: [EXTERNAL] RE: National Guard Civil Support Team Mobile COVID-19 testing lab

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Erik,

Correct, AHCA certifies CLIA, so we would need to be part of the MOU. I sent the CMS 116 attachment to our field supervisor to begin approval and to make sure there are no hiccups with getting this expedited. They are working on it now.

Thanks,

From: Sayler, Erik <Erik.Sayler@em.myflorida.com>
Sent: Tuesday, March 24, 2020 6:05 PM
To: St Laurent, Louise R <Louise.StLaurent@flhealth.gov>; Grow, Stefan <Stefan.Grow@ahca.myflorida.com>
Cc: Primrose, Nicholas <nicholas.primrose@eog.myflorida.com>; Ernst, Colleen <Colleen.Ernst@eog.myflorida.com>
Subject: [External] National Guard Civil Support Team Mobile COVID-19 testing lab

Louise and Stefan,

AMERICAN OVERSIGHT

Our national guard liaison officer Maj. DeLeon is working to help secure a mobile testing lab resource from the National Guard Bureau (NGB) from the Civil Support Team (CST). The Major says there are 10 such mobile labs in the NGB. To secure it, we need an MOU for the equipment (the Guard is drafting that) and the DOH will need to authorize the CST members to work under their Clinical Laboratory Improvement Amendments (CLIA) certification.

Kevin Guthrie asked me to help facilitate this. I believe this touches on both DOH and AHCA jurisdiction. The attached emails include background information and the CLIA application. I'll let you know when I receive the NGB MOU for the equipment.

Sincerely,

Erik L. Sayler
Deputy General Counsel
Florida Division of Emergency Management
2555 Shumard Oak Boulevard
Tallahassee, Florida 32399-2100
Direct: (850) 815-4154 | Mobile: (850) 694-6620 | Erik.Sayler@em.myflorida.com

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AMERICAN OVERSIGHT

From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:16:49 PM
Attachments:	SOP for disembarking international cruise ships with passengers arriving in charter flights (ver 3_17_2020).docx

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.

AMERICAN OVERSIGHT

a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

    i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

    ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 1:57 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W

AMERICAN OVERSIGHT

<PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
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Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
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Tyler

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

AMERICAN OVERSIGHT

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
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> **Subject:** Royal Caribbean Ships off Brazil/Chile
>
> All -

AMERICAN OVERSIGHT

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
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- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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AMERICAN OVERSIGHT

Proposed SOP for Disembarking International Cruise Ships With Passengers Arriving In US On Charter Flights (Working Draft As Of 3/16/20)

1) Pre-departure
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6) After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7) If there is an air ambulance flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
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AMERICAN OVERSIGHT

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Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 8:16:27 PM

The flight will be arriving at Terminal J, Gate TBD at MIA tomorrow morning at 9:10am.

From: Eleni Kalisch
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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added Rachel , Michelle and Shannon

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329

470-487-4373

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 10:19:50 PM

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
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Tyler

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To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa

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Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

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Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

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> ***Currently detailed to the COVID-19 Response***
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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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To:	Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 10:36:03 PM

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to

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fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

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Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:20:41 PM

Also – forgot to add that the Florida Surgeon General, Dr Scott Rivkees, who is now included on the emails, has asked CDC to pass on his request that passengers wear surgical masks, if available, on the charter flight, arriving in Miami.

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.

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4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf
    b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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To: Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:22:37 PM

Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC

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c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.

d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.

2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
   a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking

   b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.

3. Passengers without any symptoms can board charter flights.

4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US

5. Upon arrival at airport in US
   a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.

   b. CDC Quarantine Station staff are available for illness response, as per protocol.

   c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.

   d. Passengers who are not ill will be allowed to continue their travel on commercial flights.

6. After arrival
   a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.

   b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.

7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
   a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

      i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

      ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

   b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***

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Cindy R. Friedman, MD

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329

470-487-4373

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:26:34 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png

Thanks Michelle.

Can I share this with ANVISA, for their awareness?

Is there anything else you need from ANVISA at this point? Is RC in contact with them for the ground logistics?

Just making sure all the loops are closed.

Amy

Amy DuBois MD MPH FACS
CAPT, US Public Health Service
Health Attaché | U.S. Department of Health and Human Services (HHS)
U.S. Embassy | Brasilia
☎ +55 61 3312-7569 | +55 61 982248700 | ✉ duboisae@state.gov

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3. Passengers without any symptoms can board charter flights.
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5. Upon arrival at airport in US
   a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
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   a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
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      i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329

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470-487-4373

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Sent: Monday, March 16, 2020 2:20 PM
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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
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SparksTk@state.gov

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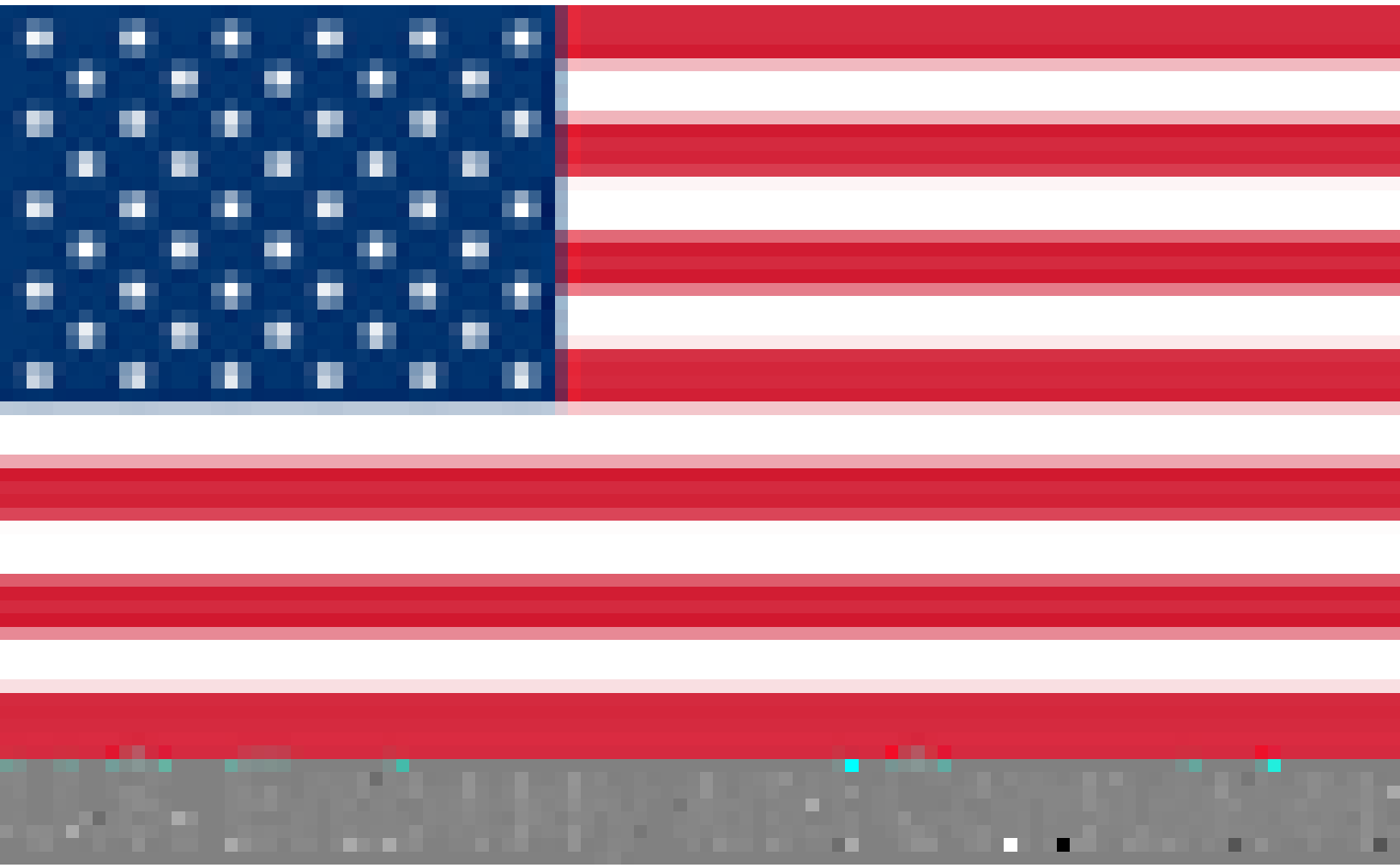

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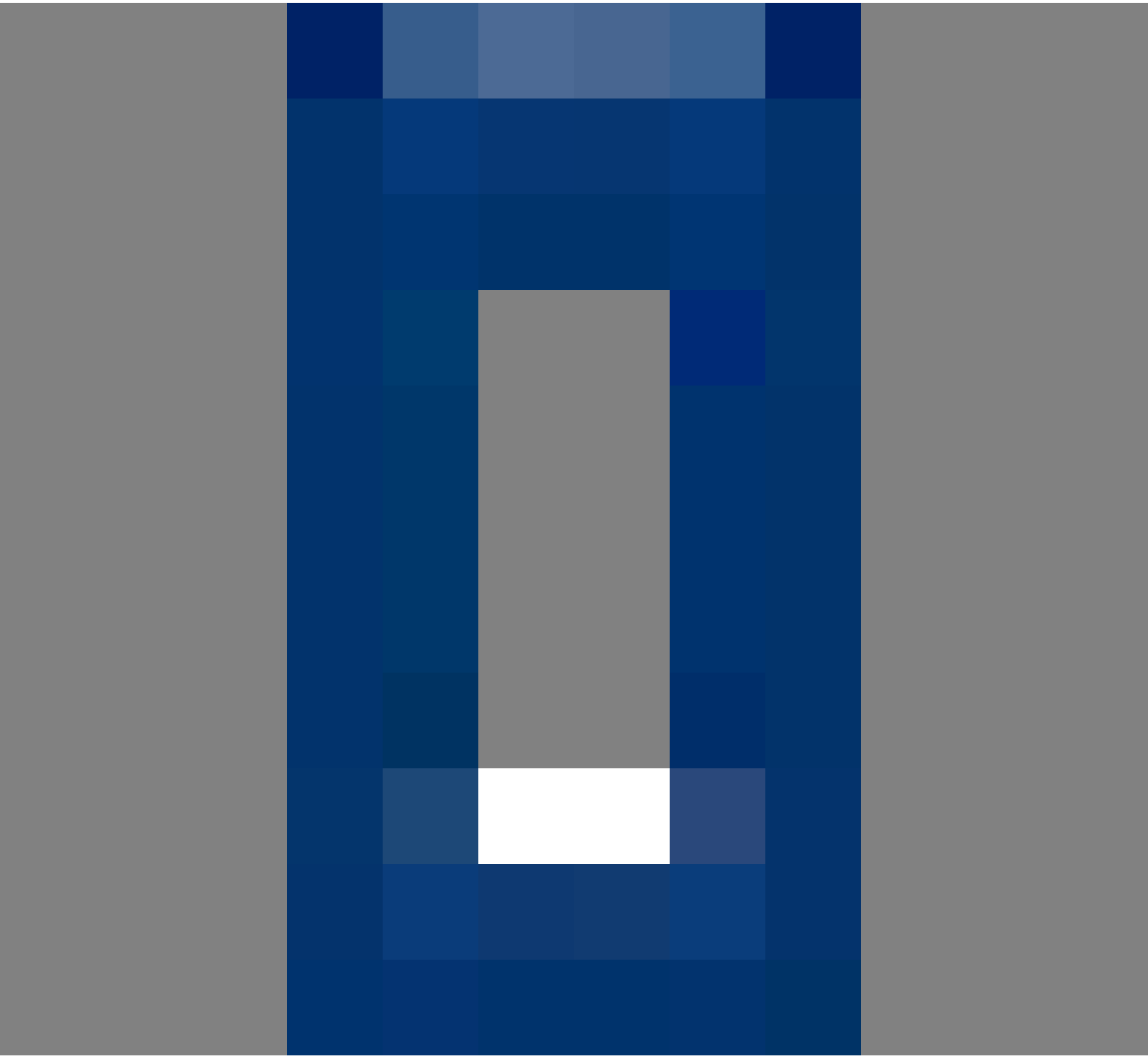

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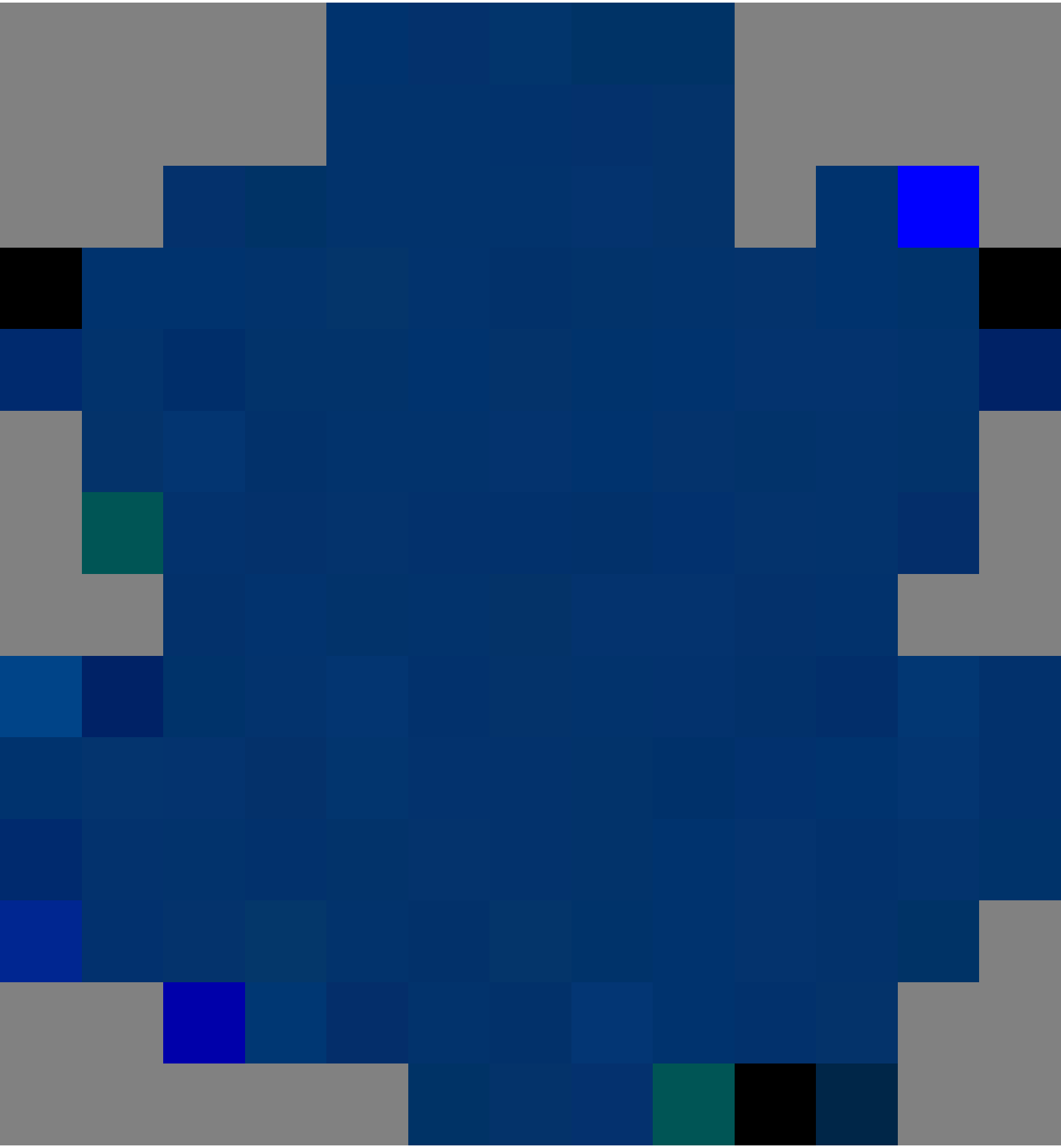

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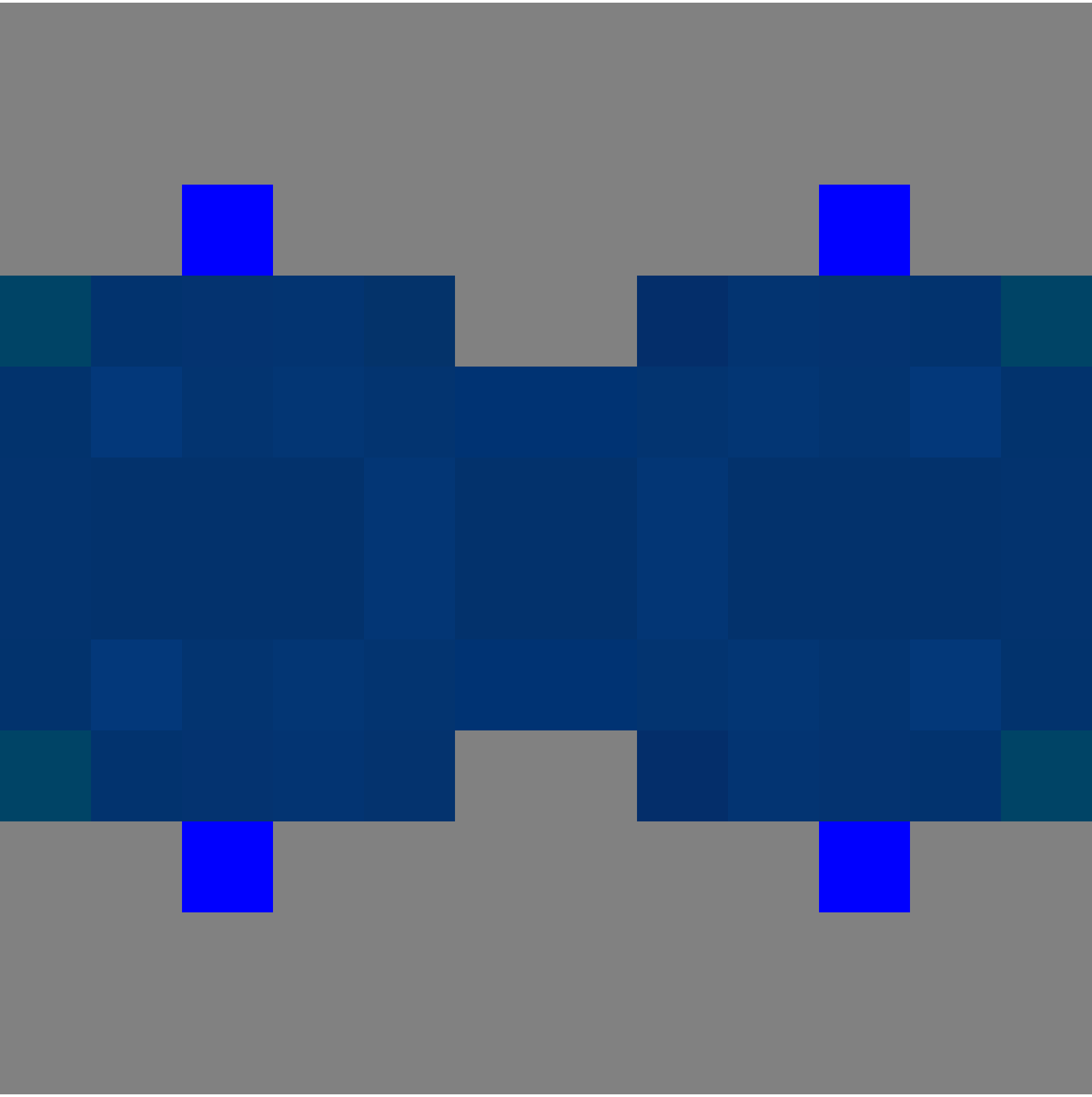

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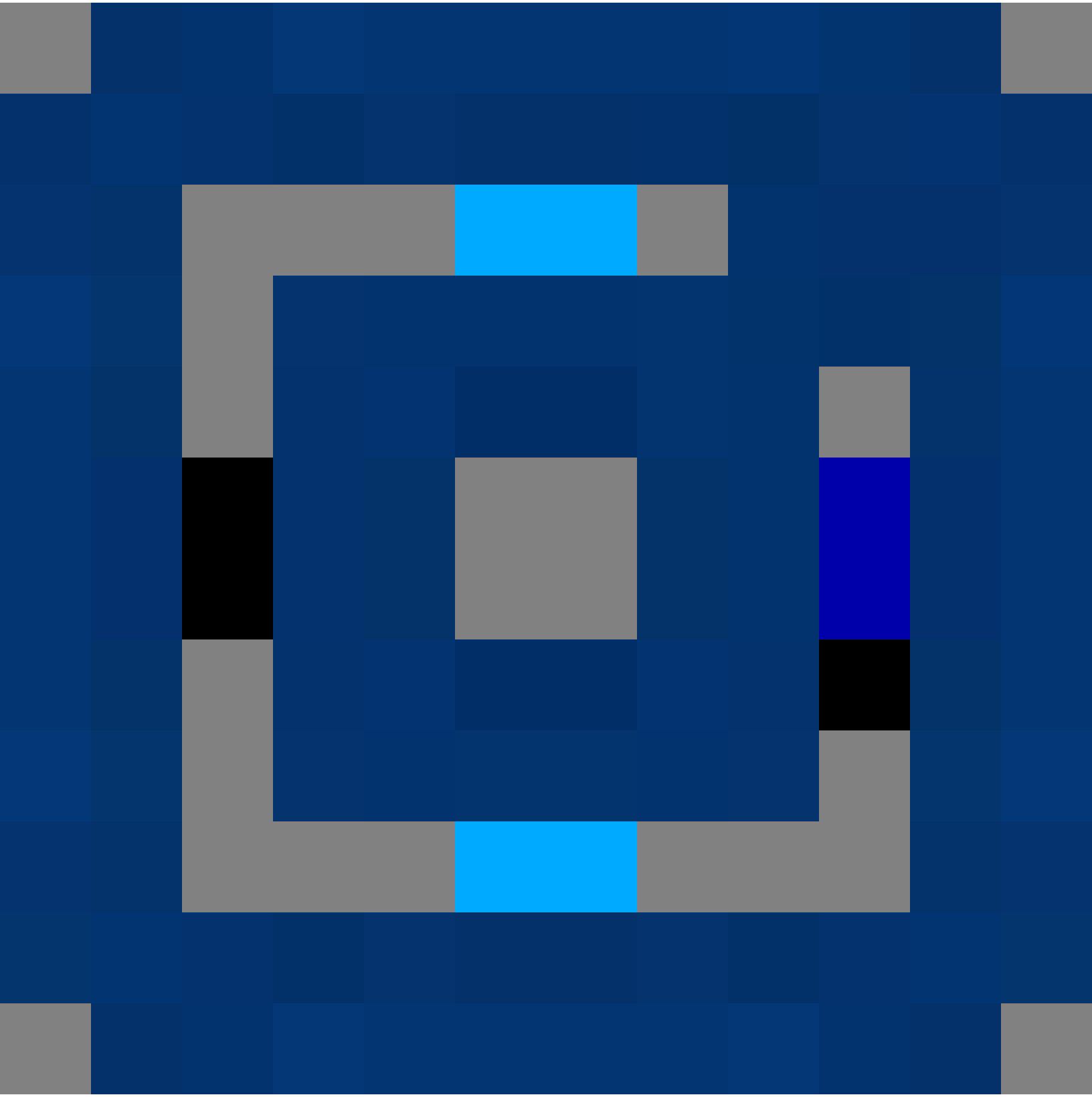

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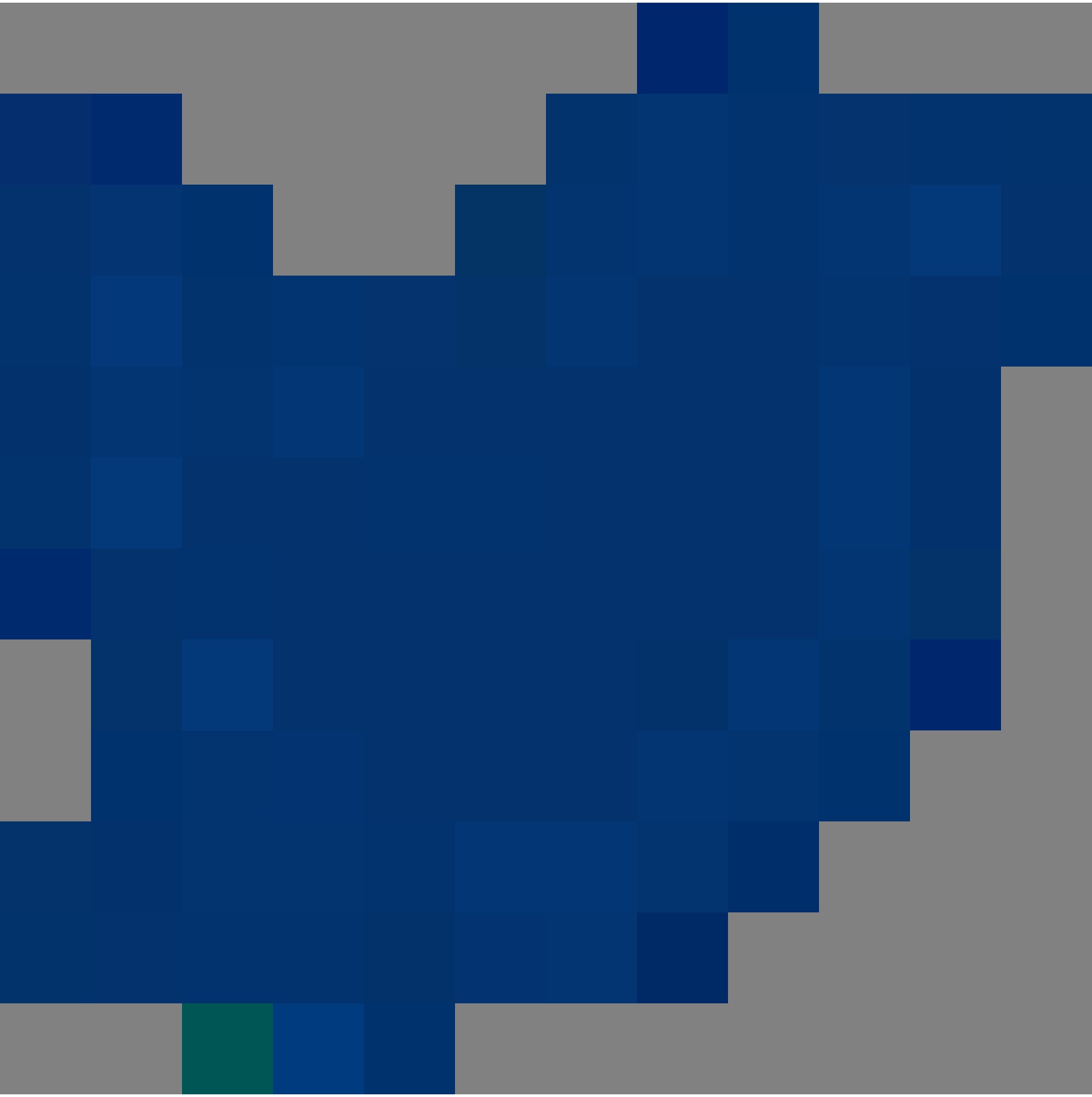

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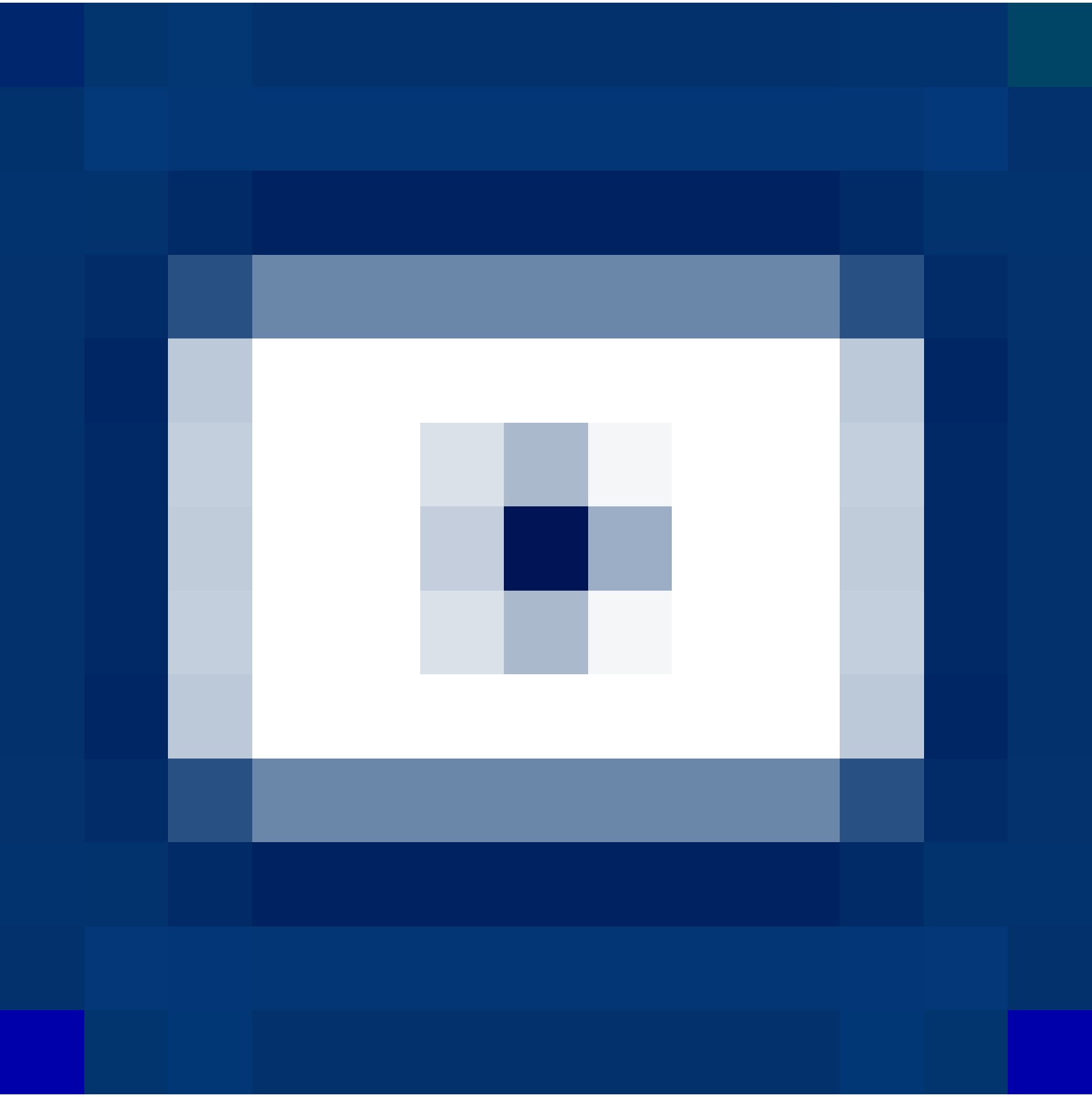

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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Dubois, Amy E; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:39:51 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png

Most definitely!

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 2:29 PM
To: Dubois, Amy E <DuboisAE@state.gov>; Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: Re: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

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Yes, feel free to share. I don't think anything else is needed in terms of our collaboration with Brazilian health colleagues.

Eleni - could you kindly confirm that RC is in touch with Brazilian authorities for on the ground issues?

From: Dubois, Amy E <DuboisAE@state.gov>
Sent: Tuesday, March 17, 2020 2:26:28 PM

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To: Eleni Kalisch <ekalisch@rccl.com>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Thanks Michelle.

Can I share this with ANVISA, for their awareness?

Is there anything else you need from ANVISA at this point? Is RC in contact with them for the ground logistics?

Just making sure all the loops are closed.

Amy

Amy DuBois MD MPH FACS
CAPT, US Public Health Service
Health Attaché | U.S. Department of Health and Human Services (HHS)
U.S. Embassy | Brasilia
☎ +55 61 3312-7569 | +55 61 982248700 | ✉ duboisae@state.gov

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Sent: Tuesday, March 17, 2020 3:23 PM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
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EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire

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completed

a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking

b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.

3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf
    b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>

Sent: Tuesday, March 17, 2020 1:57 PM

To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife)

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<BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
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Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

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- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

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Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

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> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*

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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

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Tyler Sparks
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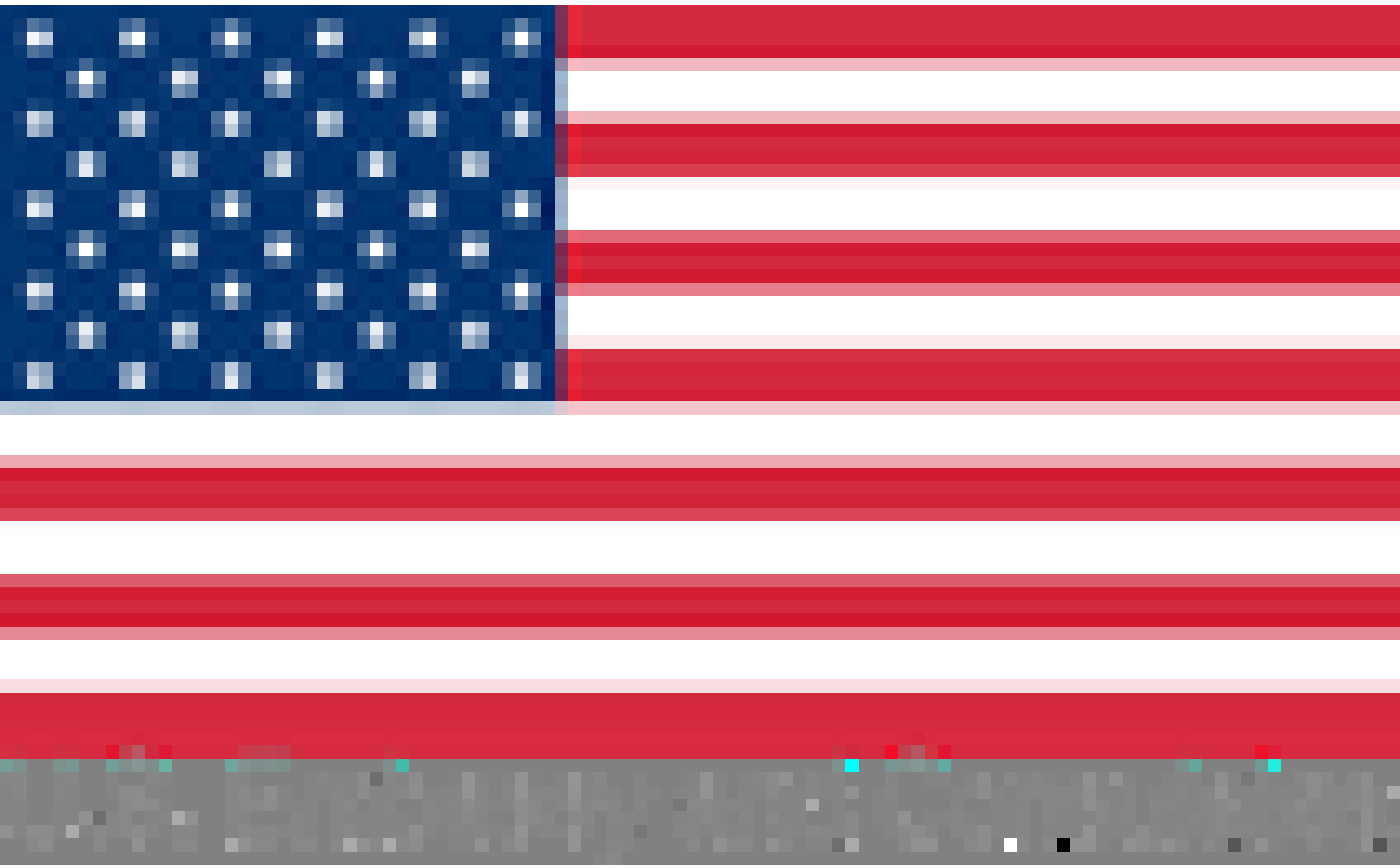

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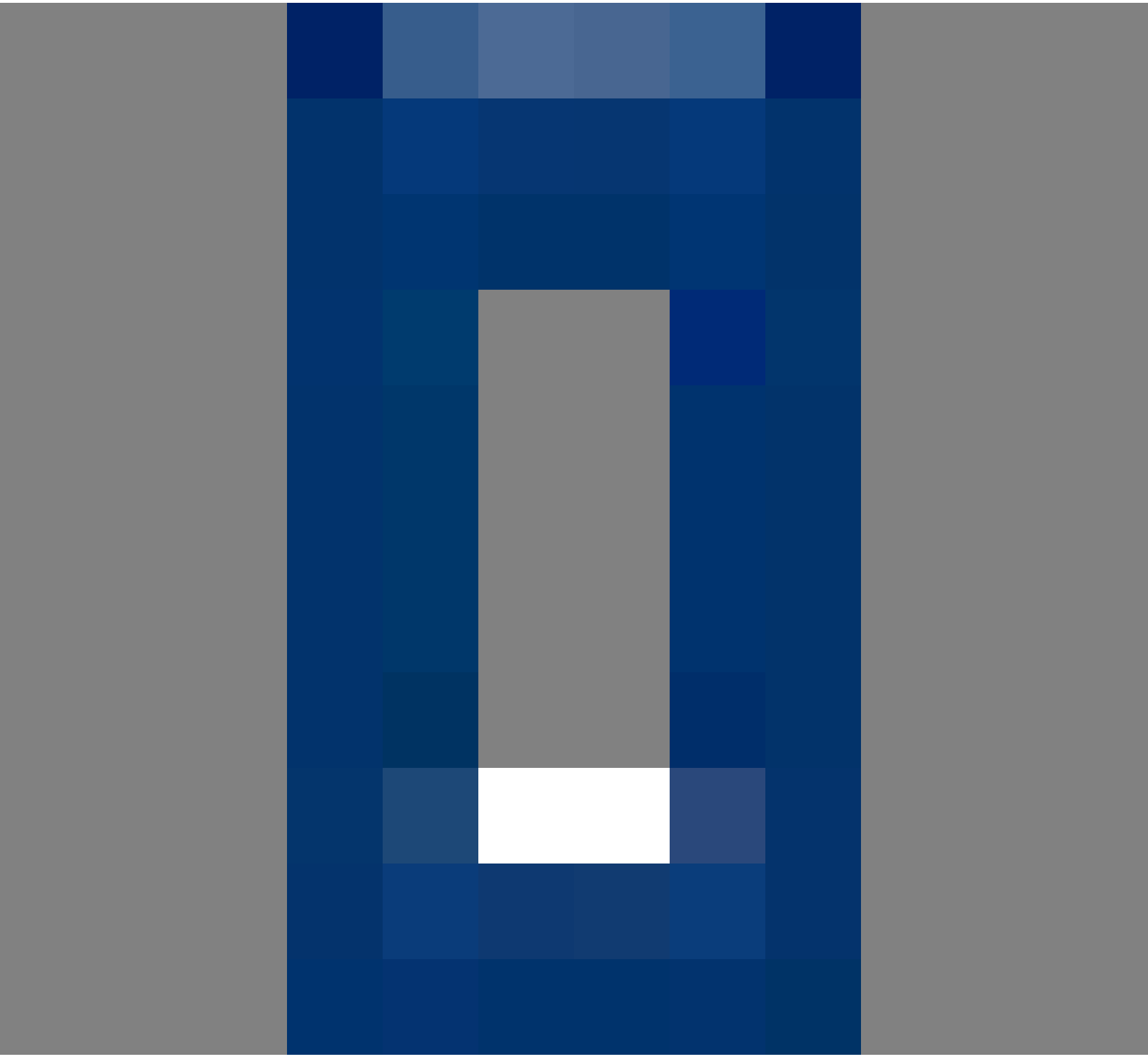

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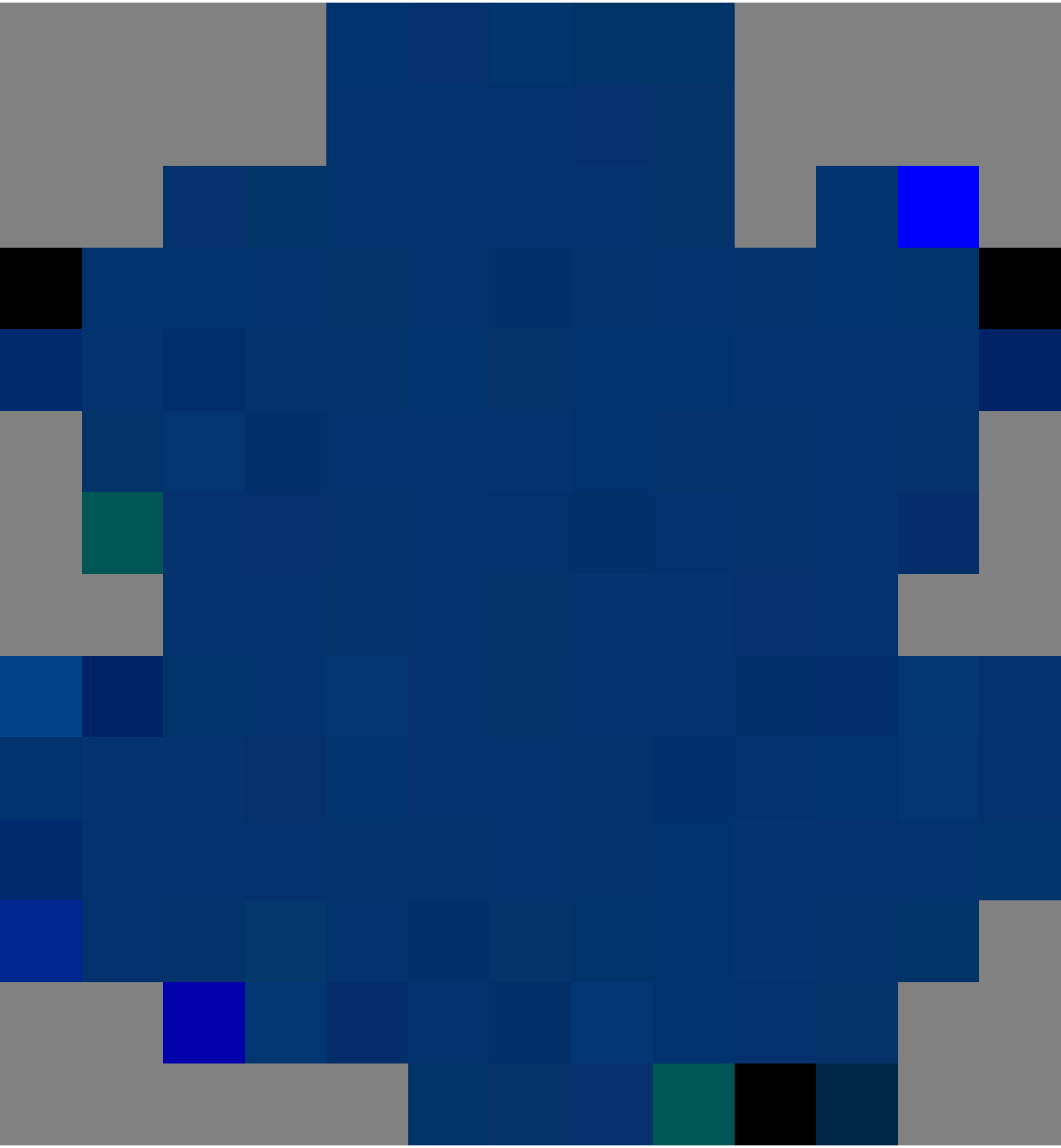

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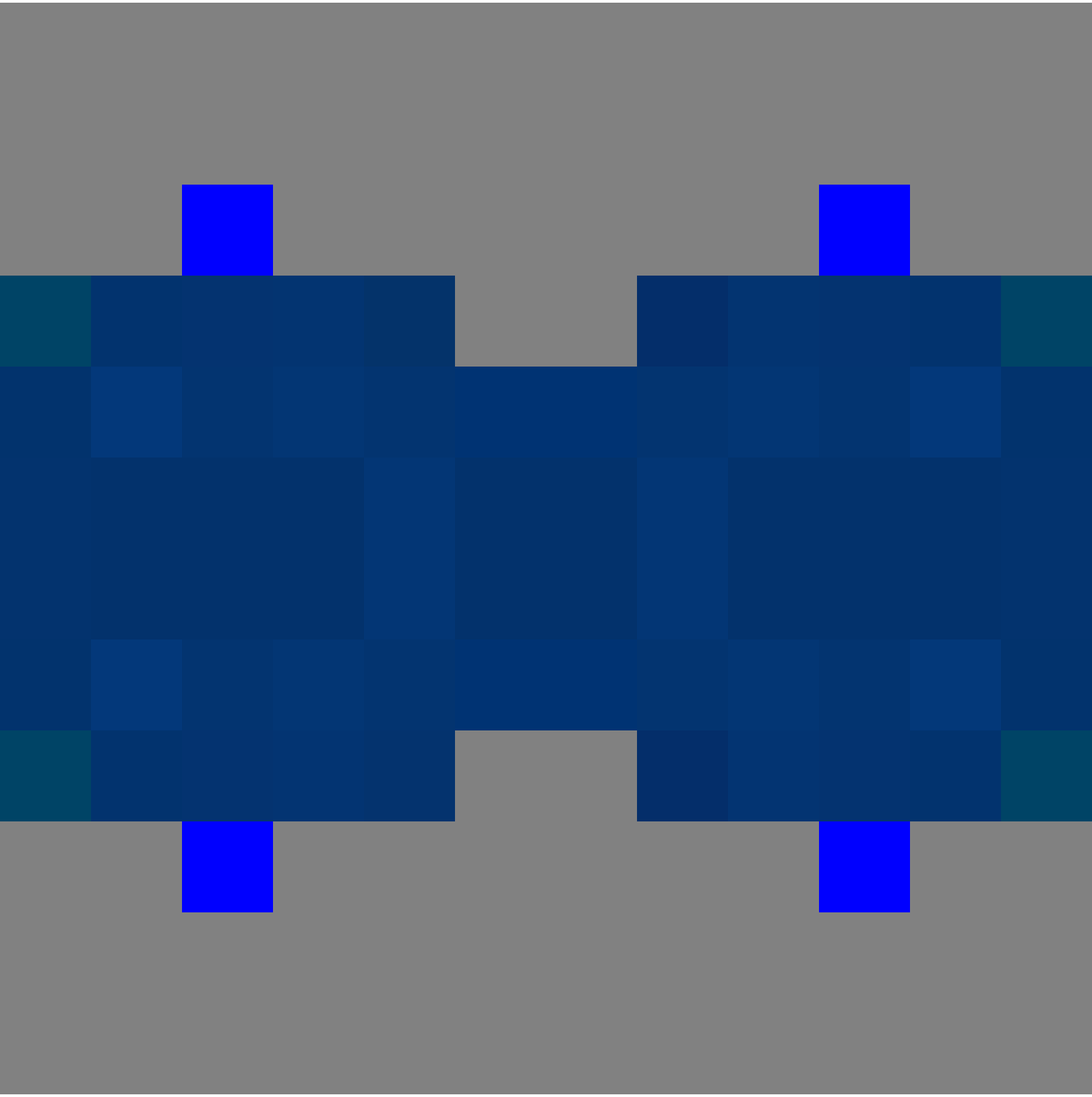

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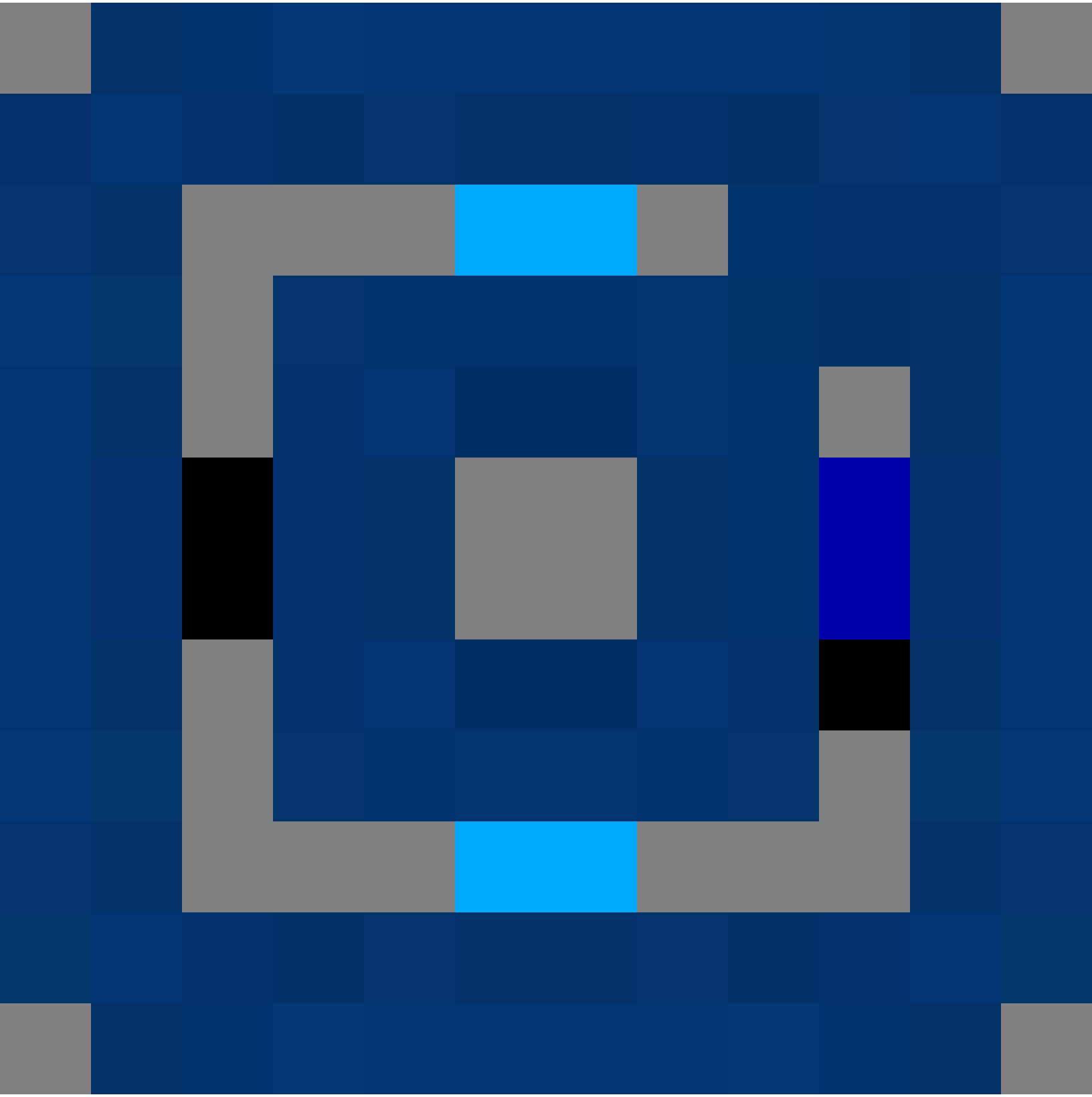

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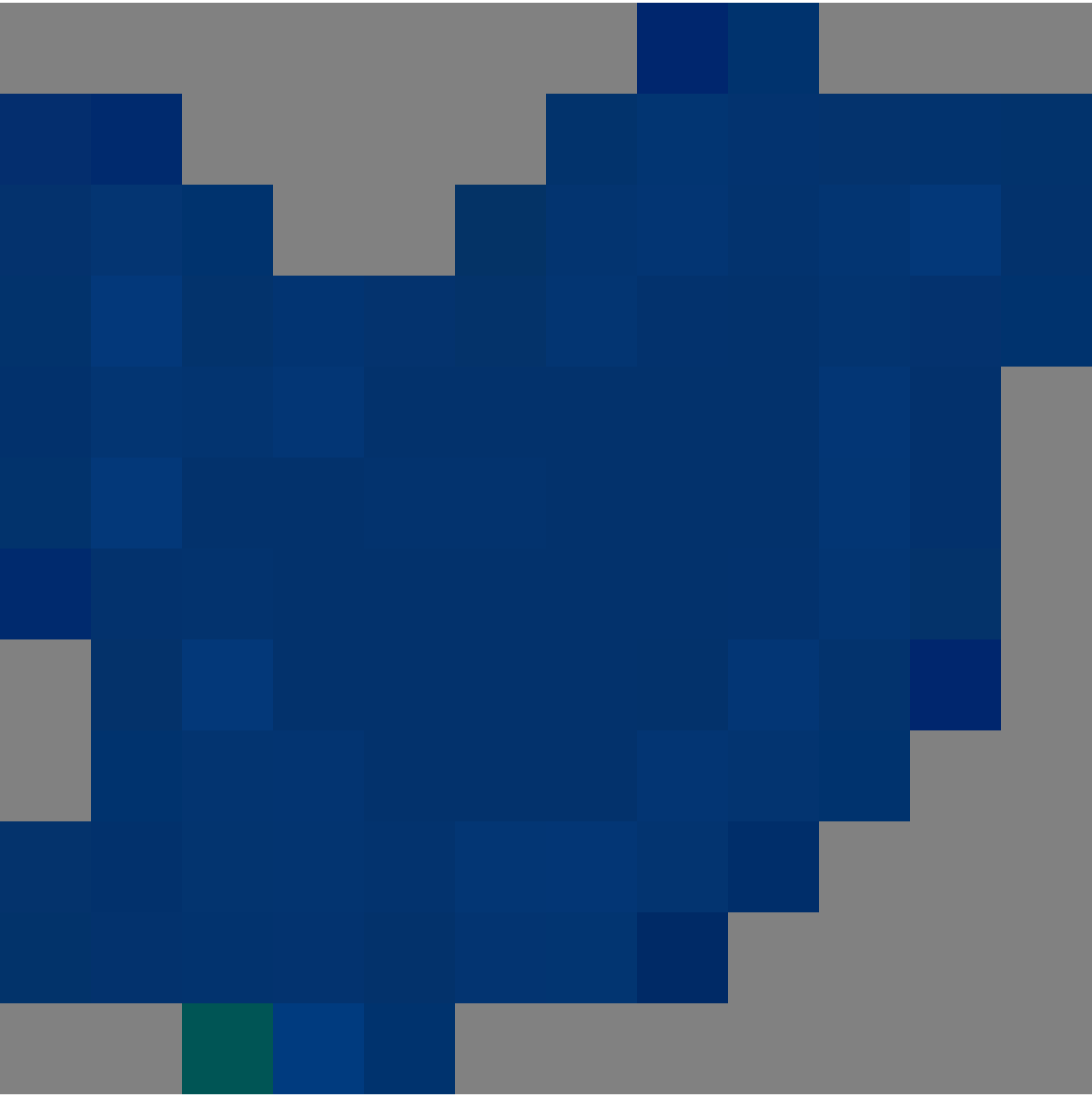

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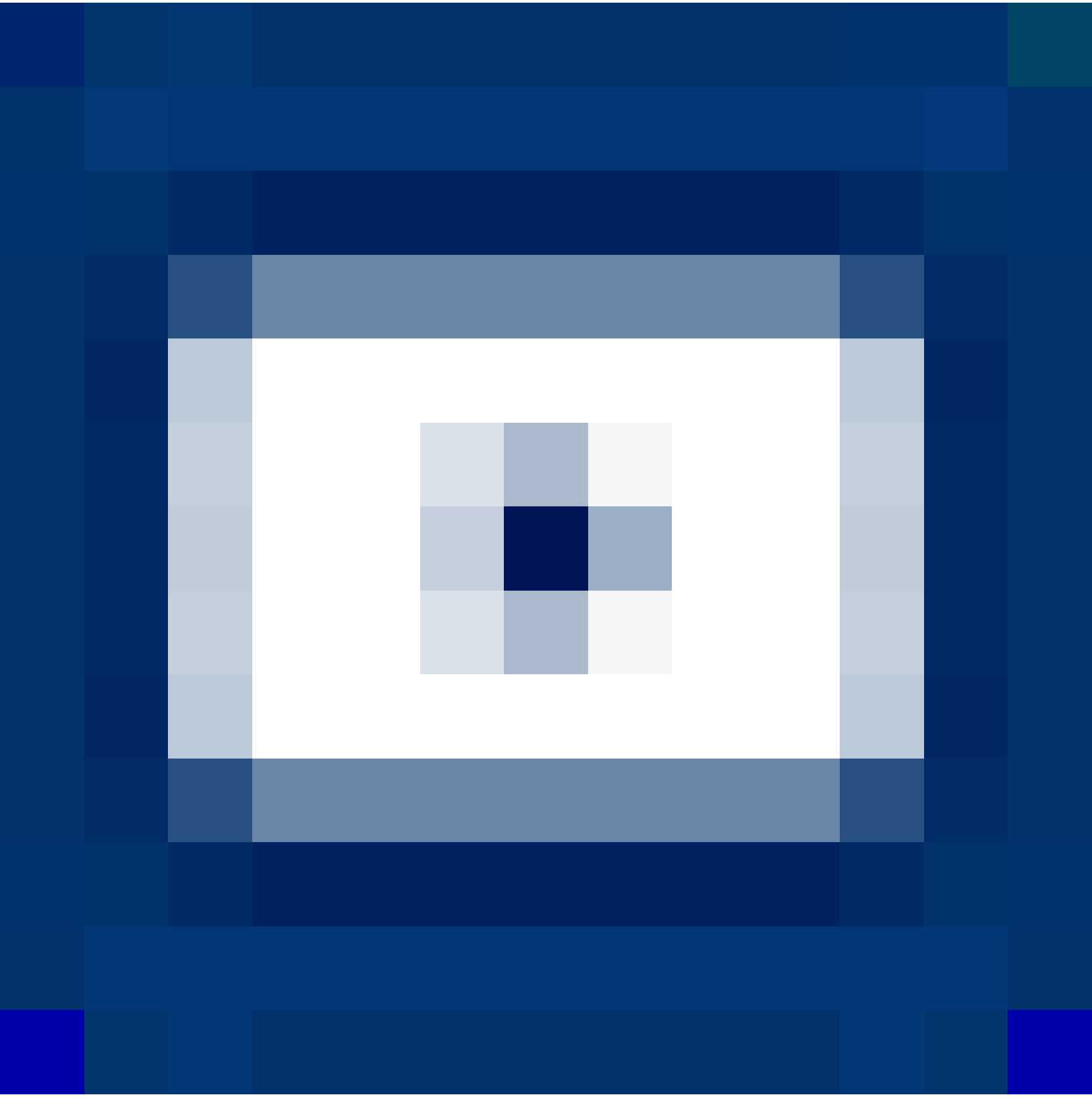

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From:	Eleni Kalisch
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Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:25:03 PM

Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

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Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

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Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at

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https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 1:57 PM
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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Subject: RE: Royal Caribbean Ships off Brazil/Chile

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Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

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added Rachel , Michelle and Shannon

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329

470-487-4373

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SparksTk@state.gov

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Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:32:27 PM

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
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Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM)
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:50:56 PM

Dear Eleni,
Could you kindly clarify Dr. Green at CDC? Is that CDC as in Centers for Disease Control and Prevention or is that a typo? If yes, we do not know him – could you kindly share his contact information?

Most importantly, you need to work with and have the approval of the Florida State and Local Health Departments – Dr. Rivkees, the Florida Surgeon General and Dr. Roberson, the Deputy Surgeon General are on this email.

Best,
Michelle

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From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 2:17 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate

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any passengers who become ill during travel and to assist at arrival in US

5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.
    a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.
        i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.
        ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf
    b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

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Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
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Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM

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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From:	Eleni Kalisch
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Roberson, Shamarial (CDC flhealth.gov); scott.rivkees@flhealth.gov
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM)
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 7:56:07 PM

Here is his background. The reference to CDC was provided by the Royal Caribbean doctor who shared his information with me.

https://doctors.umiamihealth.org/provider/Barth+Armand+Green/525094

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Sent: Tuesday, March 17, 2020 7:51 PM
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Dear Eleni,
Could you kindly clarify Dr. Green at CDC? Is that CDC as in Centers for Disease Control and Prevention or is that a typo? If yes, we do not know him – could you kindly share his contact information?

Most importantly, you need to work with and have the approval of the Florida State and Local Health Departments – Dr. Rivkees, the Florida Surgeon General and Dr. Roberson, the Deputy Surgeon General are on this email.

Best,
Michelle

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Hi Michelle –

Below please see an update on care for guests upon arrival at MIA.

Dr. Barth Green, the Global Coordinator for CDC, will accept all 45 US nationals from the Silver Explorer, providing that Bec Ware, R.N. can provide him details about these people. Minutes ago, I spoke with Bec, and she will provide Dr. Green with the information that he needs, including their marital status, their physical condition, where they are landing and what time they are to arrive at Miami International Airport. He will have a Medical team waiting to greet these folks, to screen them, and to triage them accordingly.

Until then, I will arrange for Dr. Green to receive 60 Quest Novel Coronavirus (2019-nCoV)/COVID-19 test kits from my office, so that he can make final determinations on those who are ill. Ms. Stephanie Buchler will follow Quest collection instructions and will ensure courier specimen pickup, if necessary.

Dr. Green will direct his Medical staff to triage the arrival of these patients to either Jackson Memorial Hospital or Hotel St. Michel in Coral Gables, depending on their physical condition.

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    a. Send ship and flight manifests to CDC.
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Senior Brazil Desk Officer
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Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD

Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30329

470-487-4373

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Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

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group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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From:	Eleni Kalisch
To:	Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 1:57:31 PM

+ Dr. Scott Rivkees, Florida Surgeon General, who requested to be added to the group.

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

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Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
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Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
> **To:** Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife)

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<BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
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From:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ)
To:	Dubois, Amy E; Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc:	Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov
Subject:	Re: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile
Date:	Tuesday, March 17, 2020 2:29:07 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png

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Yes, feel free to share. I don't think anything else is needed in terms of our collaboration with Brazilian health colleagues.

Eleni - could you kindly confirm that RC is in touch with Brazilian authorities for on the ground issues?

From: Dubois, Amy E <DuboisAE@state.gov>
Sent: Tuesday, March 17, 2020 2:26:28 PM
To: Eleni Kalisch <ekalisch@rccl.com>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Thanks Michelle.

Can I share this with ANVISA, for their awareness?

Is there anything else you need from ANVISA at this point? Is RC in contact with them for the ground logistics?

Just making sure all the loops are closed.

Amy

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Amy DuBois MD MPH FACS
CAPT, US Public Health Service
Health Attaché | U.S. Department of Health and Human Services (HHS)
U.S. Embassy | Brasilia
☎ +55 61 3312-7569 | +55 61 982248700 | ✉ duboisae@state.gov

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 3:23 PM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
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Hi Michelle –

Thank you for the guidance … very helpful! I think we are prepared to be in full compliance with perhaps a few items remaining to be addressed. I will forward to our operations team to make sure we are good to go.

Thanks for your help!

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
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Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

EXTERNAL EMAIL CAUTION: Use caution opening attachments or clicking links.

Here is interim guidance from CDC for these two ships/flights (also attached)

1. Pre-departure
    a. Send ship and flight manifests to CDC.
    b. Send information about possible COVID illness among any passengers (not just American Citizens and including reports of # of persons with confirmed or suspected COVID) to CDC
    c. Distribute general CDC COVID info-graphic and instructions for cruise ship passengers.
    d. In advance, cruise line should make arrangements for land-based management, including for persons with symptoms/illness (as described below) and communicate and clear those plans to appropriate local/state health authorities.
2. At disembarkation from boat and before boarding charter flight, screening questionnaire completed
    a. General screening questionnaire provided by CDC, or other questionnaire as per local/national authorities at port administered to passengers/crew disembarking
    b. Persons who are ill must be evaluated at local health facility – not allowed to board charter unless cleared by local clinician and deemed fit-to-fly.
3. Passengers without any symptoms can board charter flights.
4. During flight, have clinicians (physician and nurse) on board charter to assist/evaluate any passengers who become ill during travel and to assist at arrival in US
5. Upon arrival at airport in US
    a. CBP/CWMD will perform screening as if passengers were arriving from level 3 countries, as per their protocols.
    b. CDC Quarantine Station staff are available for illness response, as per protocol.
    c. Any ill persons are evaluated and referred for evaluation locally as per Quarantine Station protocol.
    d. Passengers who are not ill will be allowed to continue their travel on commercial flights.
6. After arrival
    a. CDC will provide EpiX notification to receiving states, if meet criteria from our protocol.
    b. Passengers should understand that all must self-quarantine and practice social distancing for 14 days.
7. For an air ambulance/medical evacuation flight, passengers should go to pre-determined clinical facility as arranged by cruise line/air ambulance company. This plan must be in place and cleared with local and state health authorities before departure of the charter flight.

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a. Persons who do not require hospitalization but are not fit-to-travel to home destination, should remain in hotel (as cleared with local/state health authorities) until fit-to travel.

    i. Alternative transportation arranges such as private vehicle or charter flights to home destination made be possible based on individual assessment.

    ii. Additional guidance is available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

b. These persons must follow all CDC guidance for persons who have been on cruise ships in the last 14 days. They must stay home for 14 days from the time they disembark, practice social distancing, and monitor their health. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible.

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>
> All -

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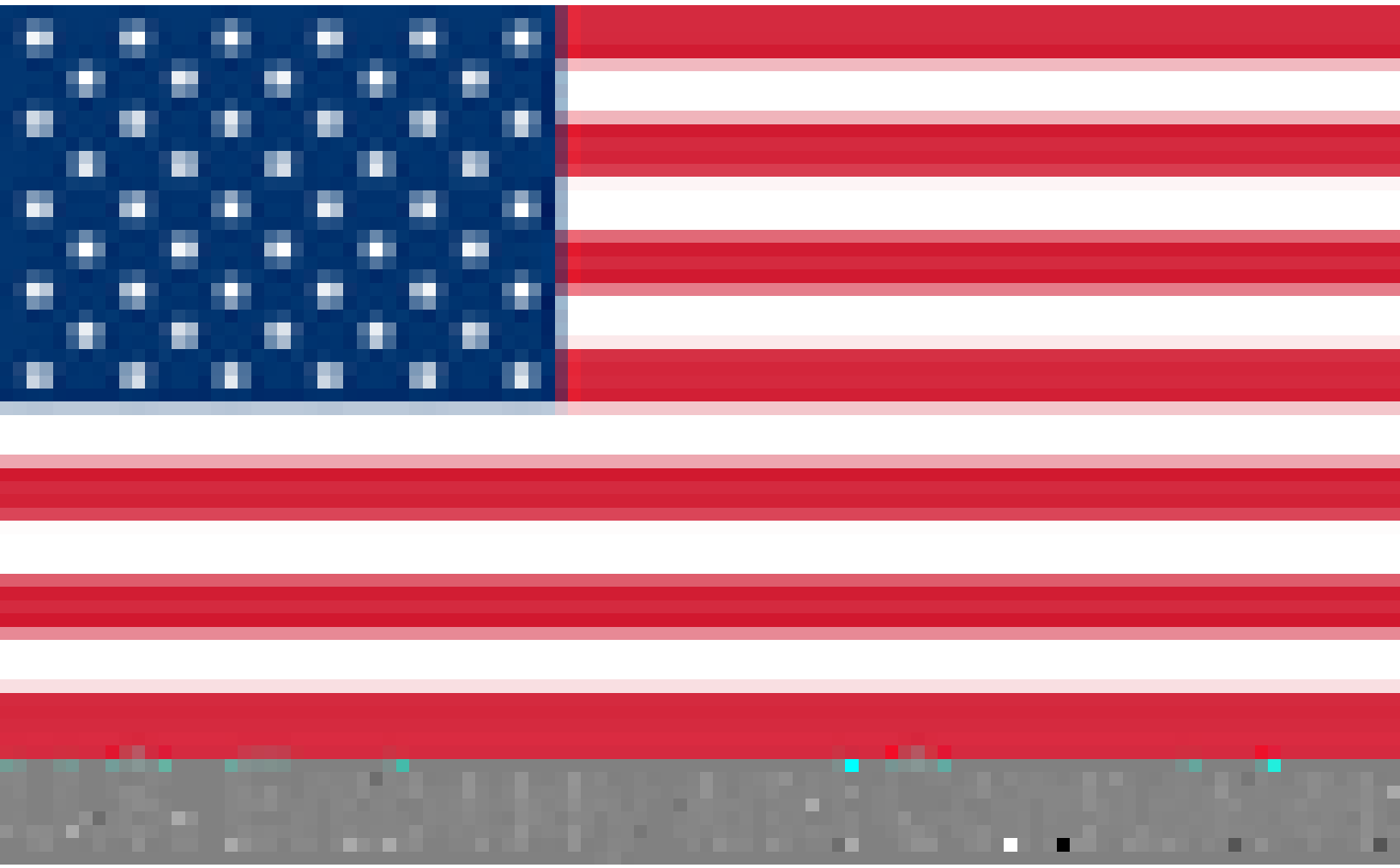

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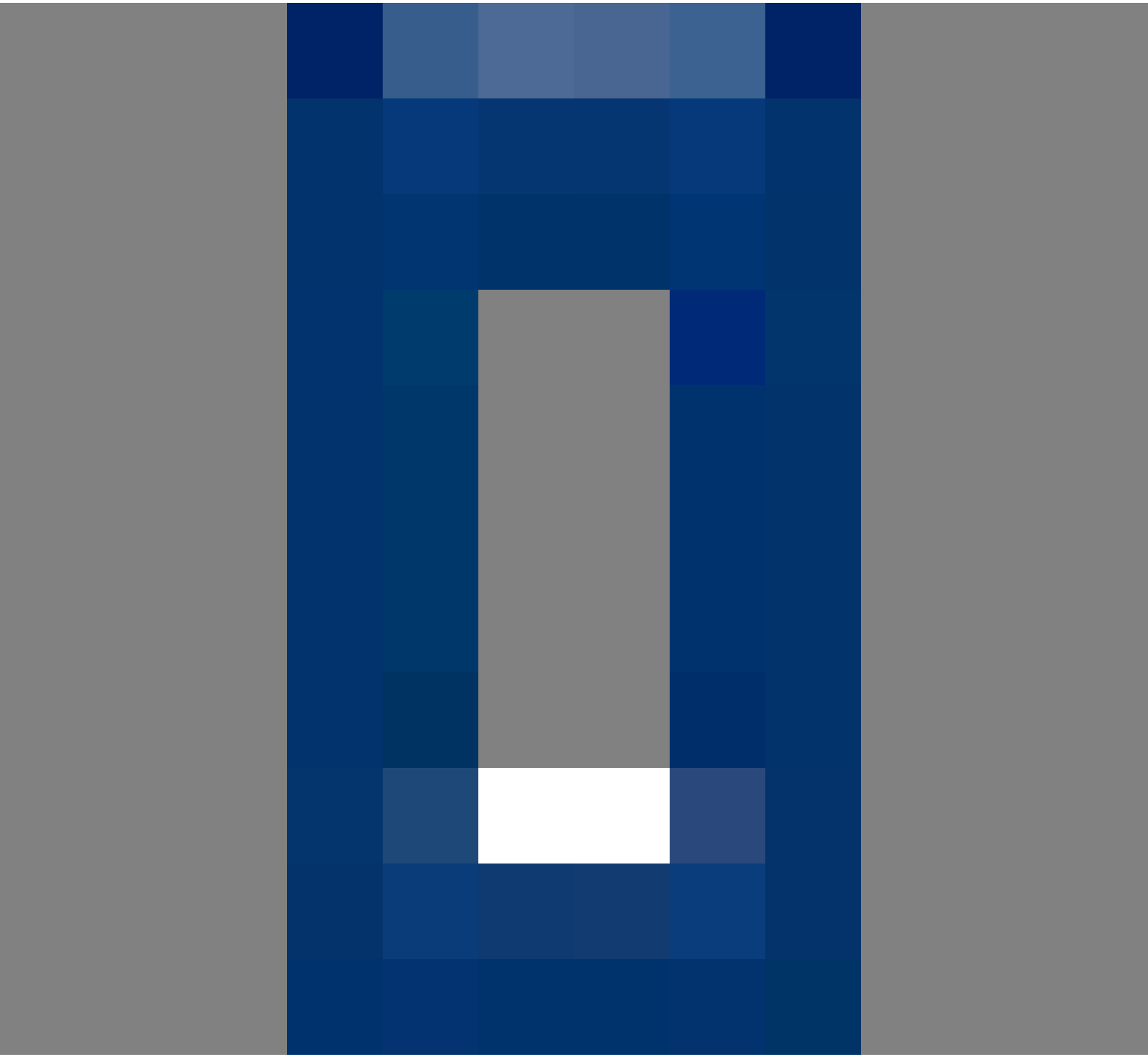

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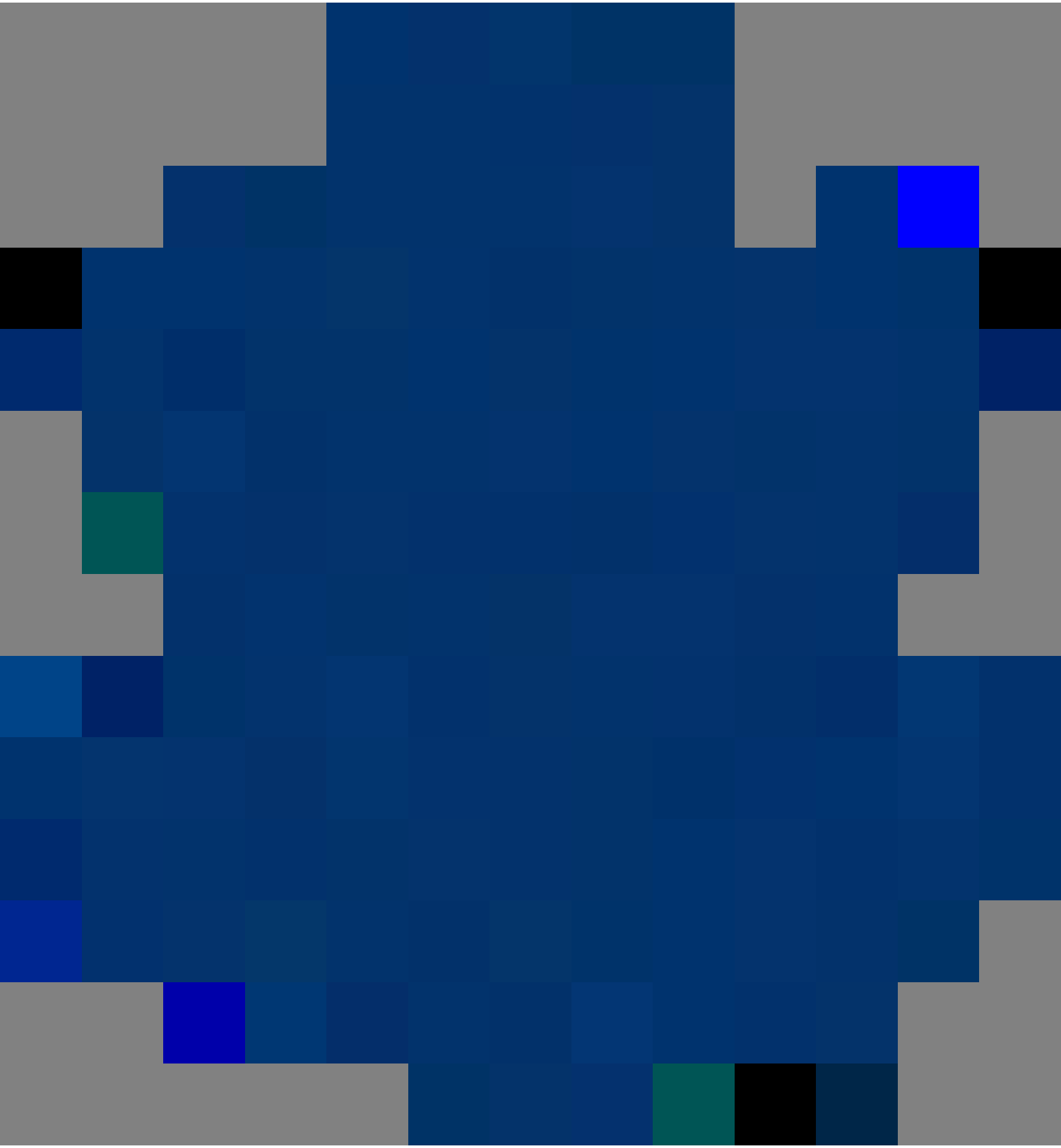

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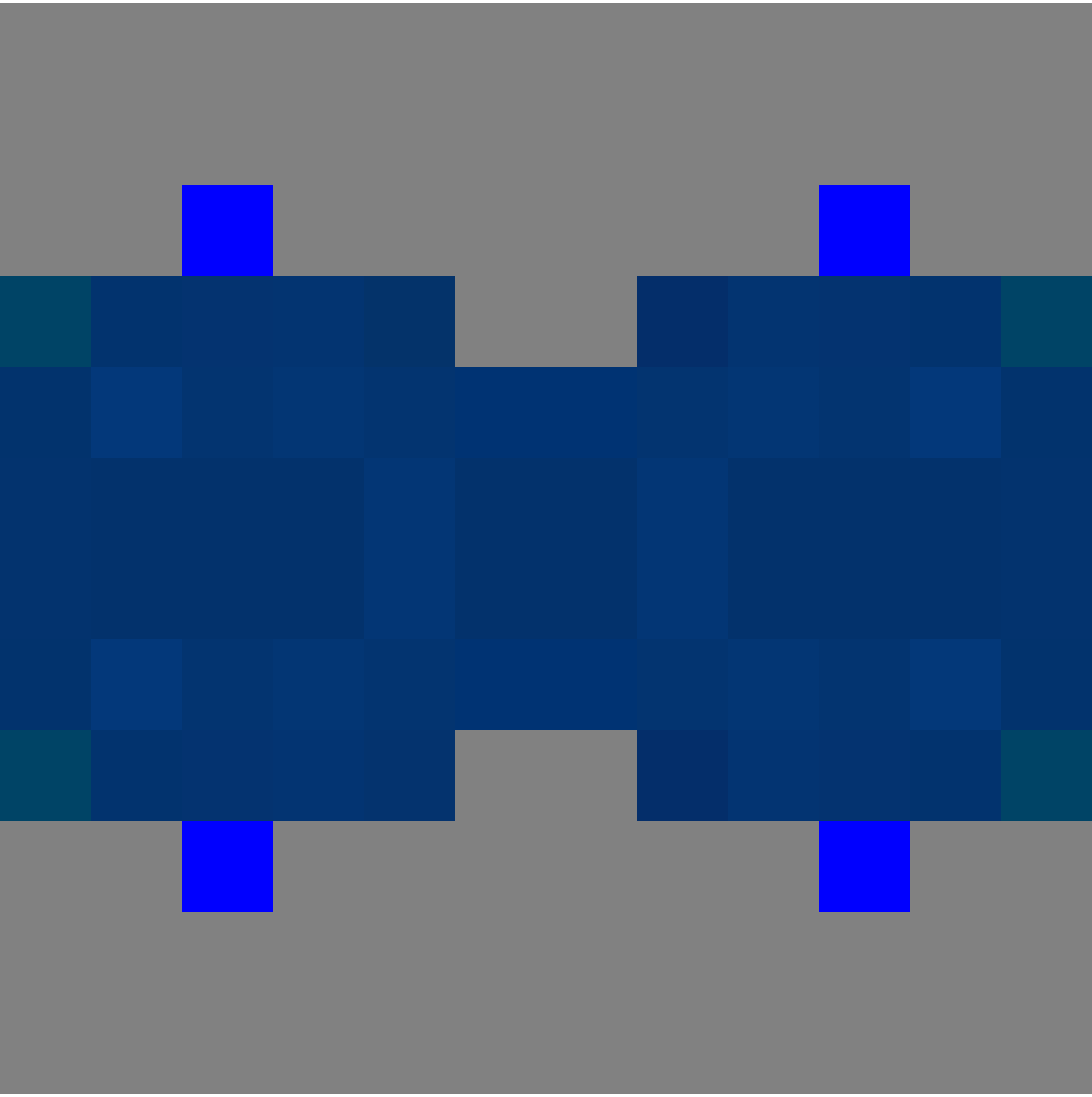

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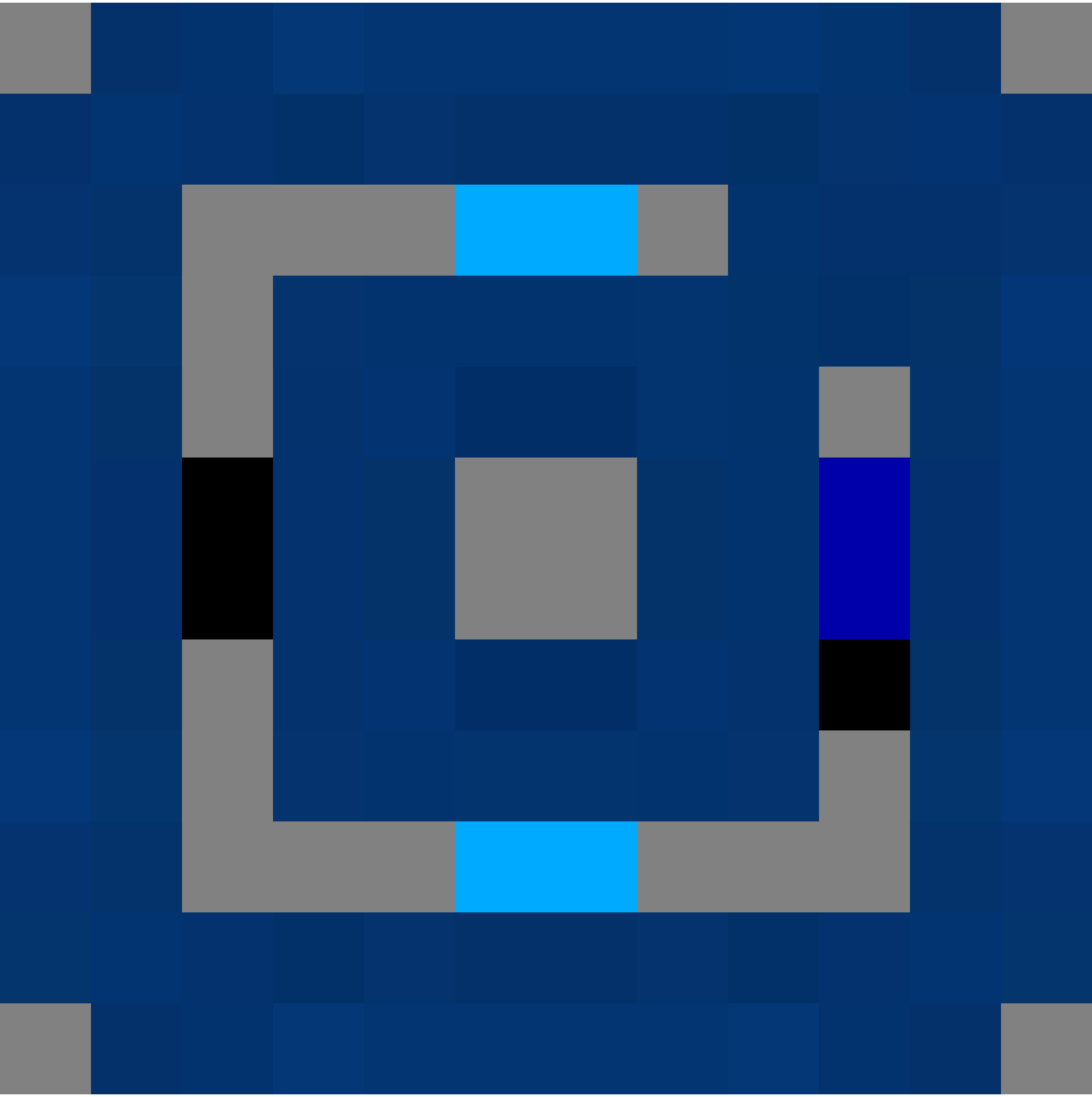

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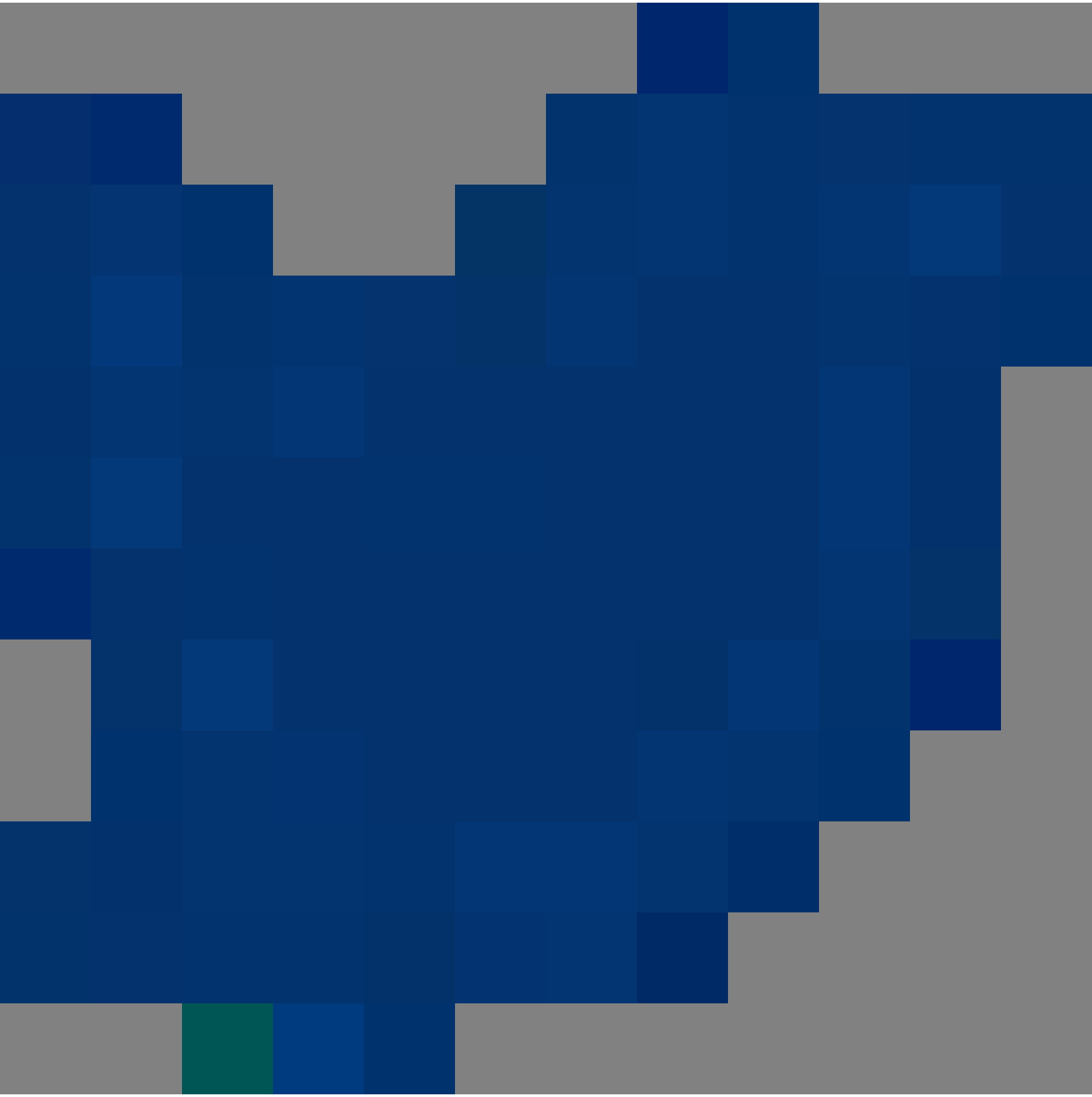

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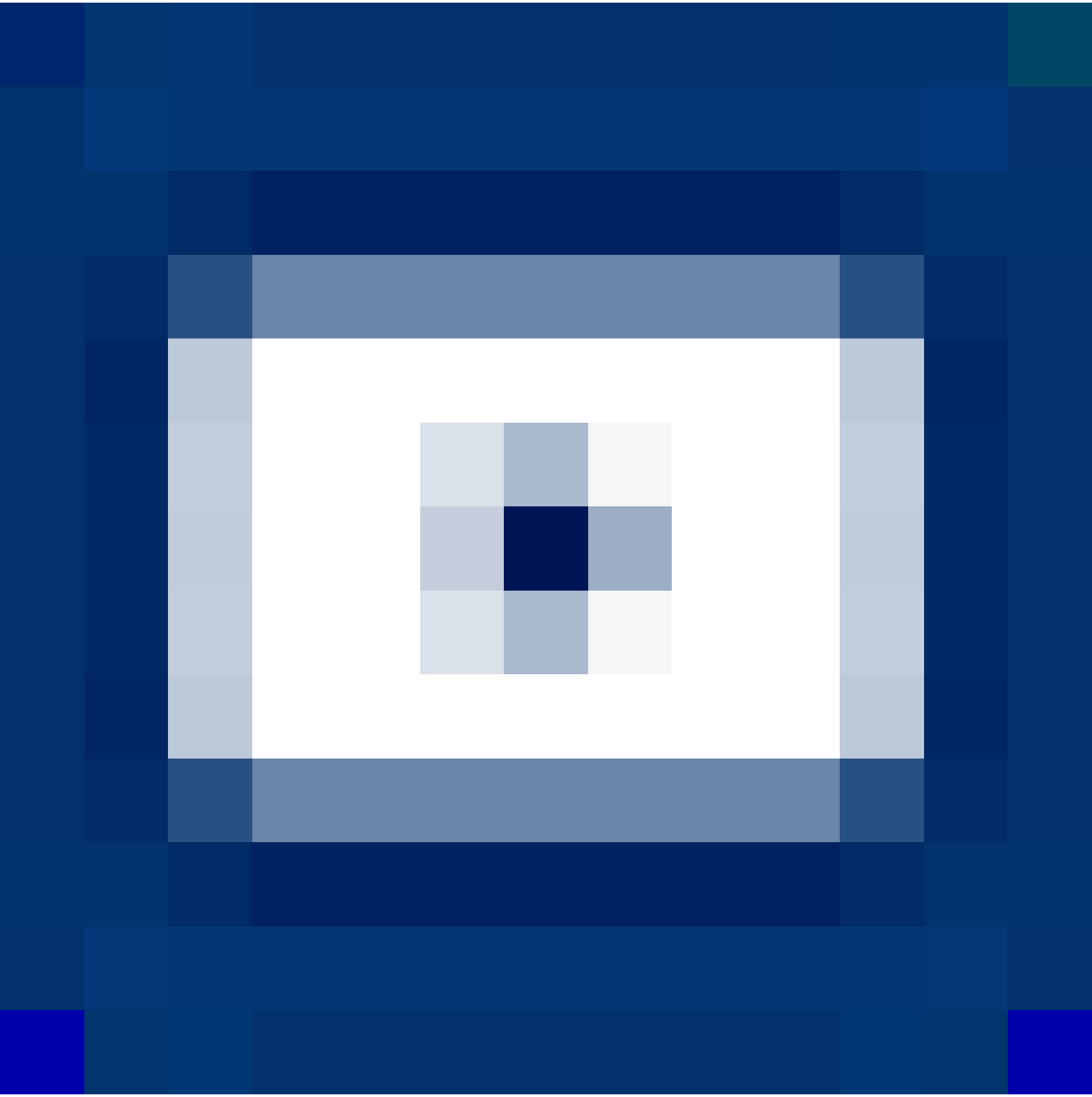

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From:	Kennedy, Ellen
To:	"Sudden, Terri M"; Anderton, David; "Burdian, JoAnn F CAPT"; Wiltshire, Glenn; Jones, Dan C CAPT; KRALICK, DEANNA M; Thaqi, Paula M; fdecenteceo@cdc.gov
Cc:	D07-SMB-SECMIAPreventionsArrivals; Lavan, Ken; Neiman, Jason A. LCDR; Silva, Anna; Henbest, Harris; Montfort, Alinda; Rossman, Richard; Lewis, David; Jenkins, Robert; D07-DG-SECMIAMI-IMT-SITL; Perez, Jose A CDR; Lavin, Kara M CDR; Papas, Christopher D LT; Briggs, Christopher M LCDR; White, Jeff; Pennypacker, William; "Cathcart, Christopher"
Subject:	RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20
Date:	Tuesday, March 24, 2020 12:06:37 PM

This is a developing situation. Here is what Holland America posted on their website yesteday.

ZAANDAM: This morning aboard Zaandam, 13 guests and 29 crew reported to the ship's medical center with influenza-like symptoms. Out of an abundance of caution, we have now asked all guests to remain in their staterooms until we have more information. There are 1,243 guests and 586 crew on board.

Zaandam is following the response protocols that have been developed in coordination with the U.S. Centers for Disease Control and Prevention (CDC). Since it is flu season, and COVID-19 testing is not available on board, it is difficult to determine the cause of these elevated cases at this time.

The safety and well-being of our guests and crew is one of our highest priorities. The ship has activated these precautionary measures out of an abundance of caution:

As is our standard practice, all ill persons have been isolated and their close contacts placed in quarantine.
Guests have been asked to remain in their staterooms and monitor their health. If they become symptomatic, they are asked to call the medical center for an evaluation and care from the ship's medical professionals (at no charge).
Effective today, meal service will be provided by room service until further notice. All public areas are closed.
The entire ship is operating at maximum sanitation levels, including rigorous cleaning and disinfecting of public and crew areas.
Crew who are not required for the safe operation of the ship are being quarantined. Those that are needed to maintain the ship's operation are being asked to self-isolate when not performing essential functions, practice social distancing, self-monitor and report any illness to the Medical Center.
Both internet and guest stateroom telephone services remain complimentary so that guests may stay in touch with their families.
Zaandam was sailing a South America voyage that departed Buenos Aires, Argentina, on March 7 and was originally scheduled to end in San Antonio, Chile, on March 21. However, due to global health concerns, Holland America Line made the decision to suspend its global cruise operations for 30 days and end its current cruises in progress as quickly as possible and return guests home. Despite previous confirmations that guests could disembark in Punta Arenas, Chile, for flights, we were not permitted to do so. No one has been off the ship since March 14 in Punta Arenas.

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Zaandam then sailed to Valparaiso, Chile, where it remained at anchor March 20-21 while taking on provisions and fuel, including regular medications for those that needed them. Zaandam departed Valparaiso on March 21 and is currently sailing north. Our intention is to proceed to Fort Lauderdale, Florida, for arrival on March 30, however we are still working on securing a reservation to transit the Panama Canal. Alternative options are also being developed.

From: Sudden, Terri M <Terri.Sudden@flhealth.gov>
Sent: Tuesday, March 24, 2020 11:13 AM
To: Anderton, David <DANDERTON@broward.org>; 'Burdian, JoAnn F CAPT' <JoAnn.F.Burdian@uscg.mil>; Wiltshire, Glenn <GWILTSHIRE@broward.org>; Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>; KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; fdecenteceo@cdc.gov
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>; Lavan, Ken <KLAVAN@broward.org>; Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>; Silva, Anna <ansilva@broward.org>; Henbest, Harris <Harris_Henbest@sheriff.org>; Montfort, Alinda <AMONTFORT@broward.org>; Rossman, Richard <Richard_Rossman@sheriff.org>; Lewis, David <David_Lewis@sheriff.org>; Jenkins, Robert <rojenkins@broward.org>; Kennedy, Ellen <EKENNEDY@broward.org>; D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>; Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>; Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>; Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>; White, Jeff <JEWHITE@broward.org>; Pennypacker, William <William_Pennypacker@sheriff.org>; 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>
Subject: RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

External Email

Well this is what we are seeing:

https://wgntv.com/news/a-cruise-ship-with-42-people-experiencing-flu-like-symptoms-is-headed-to-florida/

Terri Sudden, Director
Public Health Preparedness
Florida Department of Health in Broward County
780 SW 24th Street
Fort Lauderdale, Florida 33315
(954) 847-8136 Cell (954) 529-0953
Visit our website: http://broward.floridahealth.gov

Florida Health; the first accredited public health system in the U.S.

Mission: To protect, promote & improve the health of all people in Florida through integrated

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state, county, & community efforts.

Vision: To be the Healthiest State in the Nation

Values: (ICARE)

I nnovation: We search for creative solutions and manage resources wisely.

C ollaboration: We use teamwork to achieve common goals & solve problems.

A ccountability: We perform with integrity & respect.

R esponsiveness: We achieve our mission by serving our customers & engaging our partners.

E xcellence: We promote quality outcomes through learning & continuous performance improvement.

From: Anderton, David <DANDERTON@broward.org>
Sent: Tuesday, March 24, 2020 10:26 AM
To: 'Burdian, JoAnn F CAPT' <JoAnn.F.Burdian@uscg.mil>; Wiltshire, Glenn <GWILTSHIRE@broward.org>; Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>; KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; fdecenteceo@cdc.gov
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>; Sudden, Terri M <Terri.Sudden@flhealth.gov>; Lavan, Ken <KLAVAN@broward.org>; Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>; Silva, Anna <ansilva@broward.org>; Henbest, Harris <Harris_Henbest@sheriff.org>; Montfort, Alinda <AMONTFORT@broward.org>; Rossman, Richard <Richard_Rossman@sheriff.org>; Lewis, David <David_Lewis@sheriff.org>; Jenkins, Robert <rojenkins@broward.org>; Kennedy, Ellen <EKENNEDY@broward.org>; D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>; Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>; Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>; Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>; White, Jeff <JEWHITE@broward.org>; Pennypacker, William <William_Pennypacker@sheriff.org>; 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>
Subject: RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

Port Everglades concurs.

J. David Anderton II, AICP, PPM
Assistant Director of Port Everglades
Port Everglades Department
1850 Eller Drive, Suite 604
Fort Lauderdale, Florida 33316-4201
(954) 468-0144

From: Burdian, JoAnn F CAPT <JoAnn.F.Burdian@uscg.mil>
Sent: Tuesday, March 24, 2020 10:17 AM
To: Wiltshire, Glenn <GWILTSHIRE@broward.org>; Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>;

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KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>; paula.thaqi@flhealth.gov; fdecenteceo@cdc.gov
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>; terri.sudden@flhealth.gov; Lavan, Ken <KLAVAN@broward.org>; Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>; Anderton, David <DANDERTON@broward.org>; Silva, Anna <ansilva@broward.org>; Henbest, Harris <Harris_Henbest@sheriff.org>; Montfort, Alinda <AMONTFORT@broward.org>; Rossman, Richard <Richard_Rossman@sheriff.org>; Lewis, David <David_Lewis@sheriff.org>; Jenkins, Robert <rojenkins@broward.org>; Kennedy, Ellen <EKENNEDY@broward.org>; D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>; Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>; Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>; Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>; White, Jeff <JEWHITE@broward.org>; Pennypacker, William <William_Pennypacker@sheriff.org>; 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>
Subject: RE: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

External Email

All,
I propose we add PEV Pilots to the UC. Please provide concurrence; CG will execute.

Thank you,
JFB

From: Wiltshire, Glenn <GWILTSHIRE@broward.org>
Date: Thursday, Mar 19, 2020, 18:28
To: Jones, Dan C CAPT <Dan.C.Jones@uscg.mil>, KRALICK, DEANNA M <DEANNA.M.KRALICK@cbp.dhs.gov>, paula.thaqi@flhealth.gov <paula.thaqi@flhealth.gov>, fdecenteceo@cdc.gov <fdecenteceo@cdc.gov>
Cc: D07-SMB-SECMIAPreventionsArrivals <D07-SMB-SECMIAPreventionsArrivals@uscg.mil>, terri.sudden@flhealth.gov <terri.sudden@flhealth.gov>, Lavan, Ken <KLAVAN@broward.org>, Neiman, Jason A. LCDR <Jason.A.Neiman@uscg.mil>, Anderton, David <DANDERTON@broward.org>, Silva, Anna <ansilva@broward.org>, Henbest, Harris <Harris_Henbest@sheriff.org>, Montfort, Alinda <AMONTFORT@broward.org>, Rossman, Richard <Richard_Rossman@sheriff.org>, Lewis, David <David_Lewis@sheriff.org>, Jenkins, Robert <rojenkins@broward.org>, Kennedy, Ellen <EKENNEDY@broward.org>, D07-DG-SECMIAMI-IMT-SITL <D07-DG-SECMIAMI-IMT-SITL@uscg.mil>, Perez, Jose A CDR <Jose.A.Perez3@uscg.mil>, Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>, Papas, Christopher D LT <Christopher.D.Papas@uscg.mil>, Briggs, Christopher M LCDR <Christopher.M.Briggs@uscg.mil>, White, Jeff <JEWHITE@broward.org>, Pennypacker, William <William_Pennypacker@sheriff.org>, 'Cathcart, Christopher' <Christopher_Cathcart@sheriff.org>, Burdian, JoAnn F CAPT <JoAnn.F.Burdian@uscg.mil>
Subject: [Non-DoD Source] Port Everglades Vessel Arrivals for March 20

As discussed briefly during Wednesday morning's Unified Command meeting, attached is the Port Everglades Harbormaster report of vessels currently in Port Everglades and those that have

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submitted berth applications to enter the port on March 20th. Would appreciate a review against any USCG, CDC, CBP, and FDOH data to verify that all of the ships currently in port or scheduled to arrive tomorrow have no open health issues.

Regards,

Glenn

Glenn A Wiltshire

Acting Chief Executive & Port Director
Broward County Port Everglades Department
954-468-3504
954-895-5442 (cell)
954-523-8713 (fax)

Under Florida law, most e-mail messages to or from Broward County employees or officials are public records, available to any person upon request, absent an exemption. Therefore, any e-mail message to or from the County, inclusive of e-mail addresses contained therein, may be subject to public disclosure.

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

To: CDC IMS State Coordination Task Force (SCTF) Operations; Abinash.Achrekar@state.nm.us; adearinger@ky.gov; alexander.billioux@la.gov; Alexander-Scott, Nicole (CDC health.ri.gov); amy.acton@odh.ohio.gov; anne.zink@alaska.gov; Betsey.Tilson@dhhs.nc.gov; Bharel, Monica (CDC state.ma.us); bruce.s.anderson@doh.hawaii.gov; cathy.c.slemp@wv.gov; Christ, Cara (CDC azdhs.gov); Clabaugh, Gerd (CDC idph.iowa.gov); Coleman, Renee (CDC ct.gov); dannette.smith@nebraska.gov; elke.shaw-tulloch@dhw.idaho.gov; Jennifer Dillaha, MD; fran.phillips@maryland.gov; Gary.Anthone@nebraska.gov; GaryC@health.ok.gov; Gholzman@mt.gov; Harrist, Alexia (CDC wyo.gov); Hellerstedt, John (CDC dshs.texas.gov); jan.malcolm@state.mn.us; jeanne.ayers@dhs.wisconsin.gov; jill.hunsakerryan@state.co.us; Judith.Persichilli@doh.nj.gov; Kalani Kaneko, Honorable (CDC gmail.com); kathleen.toomey@dph.ga.gov; kathy.kunkel@state.nm.us; kbox@isdh.in.gov; KhaldunJ@michigan.gov; l.sherych@health.nv.gov; lee.norman@ks.gov; lisa.morris@dhhs.nh.gov; Lisa.Piercey@tn.gov; Malsam-Rysdon, Kim (CDC state.sd.us); mark.benton@dhhs.nc.gov; mark.levine@vermont.gov; Miner, Joseph (CDC utah.gov); mylynntufte@nd.gov; Nesbitt, LaQuandra (CDC dc.gov); Ngozi.Ezike@illinois.gov; nirav.shah@Maine.Gov; norm.oliver@vdh.virginia.gov; ralevine@pa.gov; Randall.williams@health.mo.gov; Rattay, Karyl (CDC state.de.us); rick.toomey@dhec.sc.gov; robert.neall@maryland.gov; Scott.Harris@adph.state.al.us; scott.rivkees@flhealth.gov; sheilahogan@mt.gov; Shirley, Lillian (CDC state.or.us); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; Thomas.Dobbs@msdh.ms.gov; Wiesman, John (CDC doh.wa.gov); Zucker, Howard (CDC health.ny.gov); Catherine.delacruz@salud.pr.gov; DrRafael.Rodriguez@salud.pr.gov; emais.roberts@palauhealth.org; justa.encarnacion@doh.vi.gov; linda.denorcey@dphss.guam.gov; msamo@fsmhealth.fm; Muña, Esther (CDC dph.gov.mp); Nua, Motusa Tuileama (CDC doh.as); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Dreyzehner, John (CDC/DDPHSIS/CPR/OD); Williams, Ian (CDC/DDID/NCEZID/DFWED); CDC IMS State Coordination Task Force (SCTF) Policy & Comm; CDC IMS State Coordination Task Force (SCTF) Lead; Fry, Alicia (CDC/DDID/NCIRD/ID); Weinbaum, Cindy (CDC/DDID/NCIRD/ISD); a.tufa@doh.as; Dunn, Angela (CDC utah.gov); ann.pobutsky@dphss.guam.gov; Bandy, Utpala (CDC health.ri.gov); Bell, Linda (CDC dhec.sc.gov); benjamin.chan@dhhs.nh.gov; Bennett, Siiri (CDC maine.gov); Blackmore, Carina (CDC flhealth.gov); Blog, Debra (CDC health.ny.gov); Blythe, David (CDC maryland.gov); Burnsed, Laurence (CDC health.ok.gov); caitlin.pedati@idph.iowa.gov; carmen.deseda@salud.pr.gov; Cartter, Matthew (CDC ct.gov); catherine.brown@state.ma.us; Chavez, Gilbert (CDC cdph.ca.gov); Clayton, Joshua (CDC state.sd.us); Cragin, Lori (CDC vermont.gov); Davidson, Sherri (CDC adph.state.al.us); Davies-Cole, John (CDC dc.gov); deFijter, Sietske (CDC odh.ohio.gov); Del Rosario, Maria (CDC wv.gov); Thoroughman, Douglas (CDC ky.gov); Drenzek, Cherie (CDC dph.ga.gov); Ellis, Esther (CDC doh.vi.gov); farah.ahmed@ks.gov; george.turabelidze@health.mo.gov; Herlihy, Rachel (CDC state.co.us); James.Rajotte@health.ri.gov; jonathan.meiman@dhs.wisconsin.gov; Jones, Tim F. (CDC tn.gov); Kelso, Patsy (CDC vermont.gov); Komatsu, Kenneth (CDC azdhs.gov); Landen, Michael (CDC state.nm.us); Larson, Sandra (CDC health.nv.gov); Layden, Jennifer (CDC cityofchicago.org); lilian.peake@vdh.virginia.gov; Lynfield, Ruth (CDC state.mn.us); lyoncallos@michigan.gov; McLaughlin, Joseph (CDC alaska.gov); Miller, Tracy (CDC nd.gov); Moore, Zackary (CDC dhhs.nc.gov); mpeekbullock@health.nv.gov; paul.byers@msdh.ms.gov; paul.white@dph.gov.mp; Pontones, Pamela (CDC isdh.in.gov); Ratard, Raoult (CDC la.gov); sarah.park@doh.hawaii.gov; Watkins, Sharon; Skilling, Vita A. (CDC fsmhealth.fm); tabatha.offutt-powell@state.de.us; Tan, Christina (CDC doh.state.nj.us); thomas.l.jeanne@state.or.us; Tolliver, Rickey (CDC state.co.us); Wasserman, Cathy (CDC doh.wa.gov); Shah, Dhara (CDC cste.org); Marcus Plescia; Blumenstock, Jim (CDC astho.org); Elizabeth.Daly@dhhs.nh.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; CDC IMS State Coordination Task Force (SCTF) EPI LNO; Engel, Jeff (CDC cste.org); Lichtenstein, Meredith (CDC cste.org); CDC IMS State Coordination Task Force (SCTF) GMTF LNO; Bowman, Thomas (OS/ASPR/EMMO); Gold, Rebecca (CDC/DDID/NCEZID/OD); "Daniel.huff@state.mn.us"; Daniel, Katherine Lyon (CDC/DDPHSIS/OD); CDC IMS 2019 NCOV Response Policy; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); "steven.stack@ky.gov"; Burns, Erin (CDC/DDID/NCIRD/ID); "MELISSA.E.POWELL@dhsoha.state.or.us"; CDC IMS State Coordination Task Force (SCTF) EOC Desk; "Stephen.Pont@dshs.texas.gov"; Weir, Charles (OS/ASPR/IO); Yeskey, Kevin (OS/ASPR/IO); Greene, Jonathan (OS/ASPR/EMMO); Baker, Michael (OS/IEA); Watson, John (CDC/DDID/NCIRD/DVD); "karyl.rattay@delaware.gov"; "bbilimon@hotmail.com"; Louie, Shirley (CDC arkansas.gov); "im.lno@hhs.gov"; Caceres, Victor (CDC/DDPHSIS/CPR/DSLR); McCarty, Colleen (CDC/OD/OADPS); Sloan, Katrina (CDC/OD/OCS)

Cc: Randolph, Jean (CDC/DDPHSIS/CPR/DSLR); Gallo, Bill (CDC/DDPHSIS/CSTLTS/OD); CDC IMS State Coordination Task Force (SCTF) Partner Share; Hawkins-Prather, Devi I. (CDC/DDPHSIS/CSTLTS/DPPS); CDC IMS State Coordination Task Force (SCTF) MCCM LNO; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD); Lindquist, Scott SL (CDC doh.wa.gov); Williamson, Laura (CDC mt.gov); Peart, Jordan (CDC cste.org); Hamilton, Janet (CDC cste.org); Roush, Sandra (CDC/DDID/NCIRD/OD); Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR); Friday, James (CDC/DDPHSIS/CPR/DSLR)

Subject: RE: **Extended** State Health Official & State Epi Touchbase

Date: Thursday, March 19, 2020 5:24:53 PM

Attachments: Scarce_Resource_Management_and_Crisis_Standards_of_Care_Overview_and_Materials 2020-3-16.pdf
COVID19_PPT_Healthsystems_preparedness_two weeks_3.19.2020_final.pdf

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Dear Colleagues:

As a follow-up to today's Crisis Standards of Care in Response to COVID-19 webinar, please see the attached slide deck and the Washington State Department of Health Crisis Standard of Care packet.

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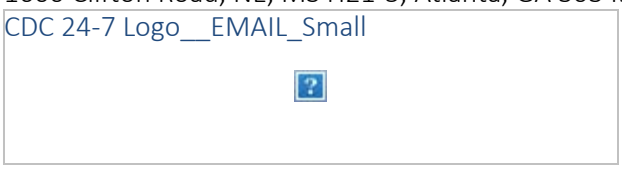
Please send any additional questions to preparedness@cdc.gov.

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



-----Original Appointment-----
From: CDC IMS State Coordination Task Force (SCTF) Operations <eocsctfops@cdc.gov>
Sent: Monday, February 3, 2020 6:15 PM
To: CDC IMS State Coordination Task Force (SCTF) Operations; Abinash.Achrekar@state.nm.us; adearinger@ky.gov; alexander.billioux@la.gov; Alexander-Scott, Nicole (CDC health.ri.gov); amy.acton@odh.ohio.gov; anne.zink@alaska.gov; Betsey.Tilson@dhhs.nc.gov; Bharel, Monica (CDC state.ma.us); bruce.s.anderson@doh.hawaii.gov; cathy.c.slemp@wv.gov; Christ, Cara (CDC azdhs.gov); Clabaugh, Gerd (CDC idph.iowa.gov); Coleman, Renee (CDC ct.gov); dannette.smith@nebraska.gov; elke.shaw-tulloch@dhw.idaho.gov; Jennifer Dillaha, MD; fran.phillips@maryland.gov; Gary.Anthone@nebraska.gov; GaryC@health.ok.gov; Gholzman@mt.gov; Harrist, Alexia (CDC wyo.gov); Hellerstedt, John (CDC dshs.texas.gov); jan.malcolm@state.mn.us; jeanne.ayers@dhs.wisconsin.gov; jill.hunsakerryan@state.co.us; Judith.Persichilli@doh.nj.gov; Kalani Kaneko, Honorable (CDC gmail.com); kathleen.toomey@dph.ga.gov; kathy.kunkel@state.nm.us; kbox@isdh.in.gov; KhaldunJ@michigan.gov; l.sherych@health.nv.gov; lee.norman@ks.gov; lisa.morris@dhhs.nh.gov; Lisa.Piercey@tn.gov; Malsam-Rysdon, Kim (CDC state.sd.us); mark.benton@dhhs.nc.gov; mark.levine@vermont.gov; Miner, Joseph (CDC utah.gov); mylynntufte@nd.gov; Nesbitt, LaQuandra (CDC dc.gov); Ngozi.Ezike@illinois.gov; nirav.shah@Maine.Gov; norm.oliver@vdh.virginia.gov; ralevine@pa.gov; Randall.williams@health.mo.gov; Rattay, Karyl (CDC state.de.us); rick.toomey@dhec.sc.gov; robert.neall@maryland.gov; Scott.Harris@adph.state.al.us; scott.rivkees@flhealth.gov; sheilahogan@mt.gov; Shirley, Lillian (CDC state.or.us); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; Thomas.Dobbs@msdh.ms.gov; Wiesman, John (CDC doh.wa.gov); Zucker, Howard (CDC health.ny.gov); Catherine.delacruz@salud.pr.gov; DrRafael.Rodriguez@salud.pr.gov; emais.roberts@palauhealth.org; justa.encarnacion@doh.vi.gov; linda.denorcey@dphss.guam.gov; msamo@fsmhealth.fm; Muña, Esther (CDC dph.gov.mp); Nua, Motusa Tuileama (CDC doh.as); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Dreyzehner, John (CDC/DDPHSIS/CPR/OD); Williams, Ian (CDC/DDID/NCEZID/DFWED); CDC IMS State Coordination Task Force (SCTF) Policy & Comm; CDC IMS State Coordination Task Force (SCTF) Lead; Fry, Alicia (CDC/DDID/NCIRD/ID); Weinbaum, Cindy (CDC/DDID/NCIRD/ISD); a.tufa@doh.as; Dunn, Angela (CDC utah.gov); ann.pobutsky@dphss.guam.gov; Bandy, Utpala (CDC health.ri.gov); Bell, Linda (CDC

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dhec.sc.gov); benjamin.chan@dhhs.nh.gov; Bennett, Siiri (CDC maine.gov); Blackmore, Carina (CDC flhealth.gov); Blog, Debra (CDC health.ny.gov); Blythe, David (CDC maryland.gov); Burnsed, Laurence (CDC health.ok.gov); caitlin.pedati@idph.iowa.gov; carmen.deseda@salud.pr.gov; Cartter, Matthew (CDC ct.gov); catherine.brown@state.ma.us; Chavez, Gilbert (CDC cdph.ca.gov); Clayton, Joshua (CDC state.sd.us); Cragin, Lori (CDC vermont.gov); Davidson, Sherri (CDC adph.state.al.us); Davies-Cole, John (CDC dc.gov); deFijter, Sietske (CDC odh.ohio.gov); Del Rosario, Maria (CDC wv.gov); Thoroughman, Douglas (CDC ky.gov); Drenzek, Cherie (CDC dph.ga.gov); Ellis, Esther (CDC doh.vi.gov); farah.ahmed@ks.gov; george.turabelidze@health.mo.gov; Herlihy, Rachel (CDC state.co.us); James.Rajotte@health.ri.gov; jonathan.meiman@dhs.wisconsin.gov; Jones, Tim F. (CDC tn.gov); Kelso, Patsy (CDC vermont.gov); Komatsu, Kenneth (CDC azdhs.gov); Landen, Michael (CDC state.nm.us); Larson, Sandra (CDC health.nv.gov); Layden, Jennifer (CDC cityofchicago.org); lilian.peake@vdh.virginia.gov; Lynfield, Ruth (CDC state.mn.us); lyoncallos@michigan.gov; McLaughlin, Joseph (CDC alaska.gov); Miller, Tracy (CDC nd.gov); Moore, Zackary (CDC dhhs.nc.gov); mpeekbullock@health.nv.gov; paul.byers@msdh.ms.gov; paul.white@dph.gov.mp; Pontones, Pamela (CDC isdh.in.gov); Ratard, Raoult (CDC la.gov); sarah.park@doh.hawaii.gov; Watkins, Sharon; Skilling, Vita A. (CDC fsmhealth.fm); tabatha.offutt-powell@state.de.us; Tan, Christina (CDC doh.state.nj.us); thomas.l.jeanne@state.or.us; Tolliver, Rickey (CDC state.co.us); Wasserman, Cathy (CDC doh.wa.gov); Shah, Dhara (CDC cste.org); Marcus Plescia; Blumenstock, Jim (CDC astho.org); Elizabeth.Daly@dhhs.nh.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; CDC IMS State Coordination Task Force (SCTF) EPI LNO; Engel, Jeff (CDC cste.org); Lichtenstein, Meredith (CDC cste.org); CDC IMS State Coordination Task Force (SCTF) GMTF LNO; Bowman, Thomas (OS/ASPR/EMMO); Gold, Rebecca (CDC/DDID/NCEZID/OD); 'Daniel.huff@state.mn.us'; Daniel, Katherine Lyon (CDC/DDPHSIS/OD); CDC IMS 2019 NCOV Response Policy; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); 'steven.stack@ky.gov'; Burns, Erin (CDC/DDID/NCIRD/ID); 'MELISSA.E.POWELL@dhsoha.state.or.us'; CDC IMS State Coordination Task Force (SCTF) EOC Desk; 'Stephen.Pont@dshs.texas.gov'; Weir, Charles (OS/ASPR/IO); Yeskey, Kevin (OS/ASPR/IO); Greene, Jonathan (OS/ASPR/EMMO); Baker, Michael (OS/IEA); Watson, John (CDC/DDID/NCIRD/DVD); 'karyl.rattay@delaware.gov'; 'bbilimon@hotmail.com'; Louie, Shirley (CDC arkansas.gov); 'im.lno@hhs.gov'; Caceres, Victor (CDC/DDPHSIS/CPR/DSLR); McCarty, Colleen (CDC/OD/OADPS); Sloan, Katrina (CDC/OD/OCS)
Cc: Randolph, Jean (CDC/DDPHSIS/CPR/DSLR); Gallo, Bill (CDC/DDPHSIS/CSTLTS/OD); CDC IMS State Coordination Task Force (SCTF) Partner Share; Hawkins-Prather, Devi I. (CDC/DDPHSIS/CSTLTS/DPPS); CDC IMS State Coordination Task Force (SCTF) MCCM LNO; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD); Lindquist, Scott SL (CDC doh.wa.gov); Williamson, Laura (CDC mt.gov); Peart, Jordan (CDC cste.org); Hamilton, Janet (CDC cste.org); Roush, Sandra (CDC/DDID/NCIRD/OD); Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR); Friday, James (CDC/DDPHSIS/CPR/DSLR)
Subject: **Extended**State Health Official & State Epi Touchbase
When: Thursday, March 19, 2020 4:30 PM-5:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Building 21, 5th Fl. 5116 OR Bridgeline: 1(888)455-7719 Participant Passcode: 1232930

****Please note – During today's touchbase we will cover the following, via webinar (link provided below):**

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Crisis Standards of Care in Response to COVID-19: Background and tools - Satish Pillai
- Legal Considerations for Crisis Standards of Care- Gregory Sunshine
- Washington State Experience with Crisis Standards of Care to COVID-19 - Kathy Lofy

CDC's 2019 Novel Coronavirus (2019-nCoV) IM leadership team will host a recurring weekly call series, twice a week (Tuesday's and Thursday's), from 4:30 p.m. to 5:00 p.m., to provide a platform to discuss relevant response matters with state health officials and state epidemiologists. Please extend this invite to other core members of your team.

Bridgeline: 1(888)455-7719
Participant Passcode: 1232930

For Participants:
URL: https://www.mymeetings.com/nc/join/
Conference number: PWXW1022793
Audience passcode: 1232930

Participants can join the event directly at:
https://www.mymeetings.com/nc/join.php?i=PWXW1022793&p=1232930&t=c

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

(Sent by BCC to state health officials and State epidemiologists)

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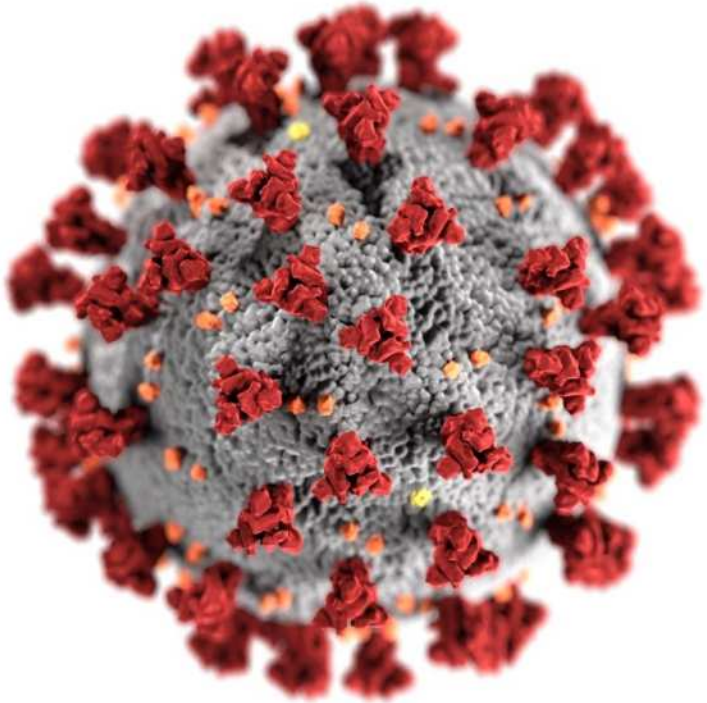
Altered Standards of Care in Response to COVID-19: Background, Tools and Experiences

March 19, 2020



For more information: www.cdc.gov/COVID19

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FL-DOH-20-0673-A-005426

Outline

- Example from Italy
- Fundamentals of a Response: Space, Staff, Stuff
- Crisis Standards of Care (CSCs)
- Examples of Elements of CSCs
- Applying CSCs to COVID-19
- Legal considerations

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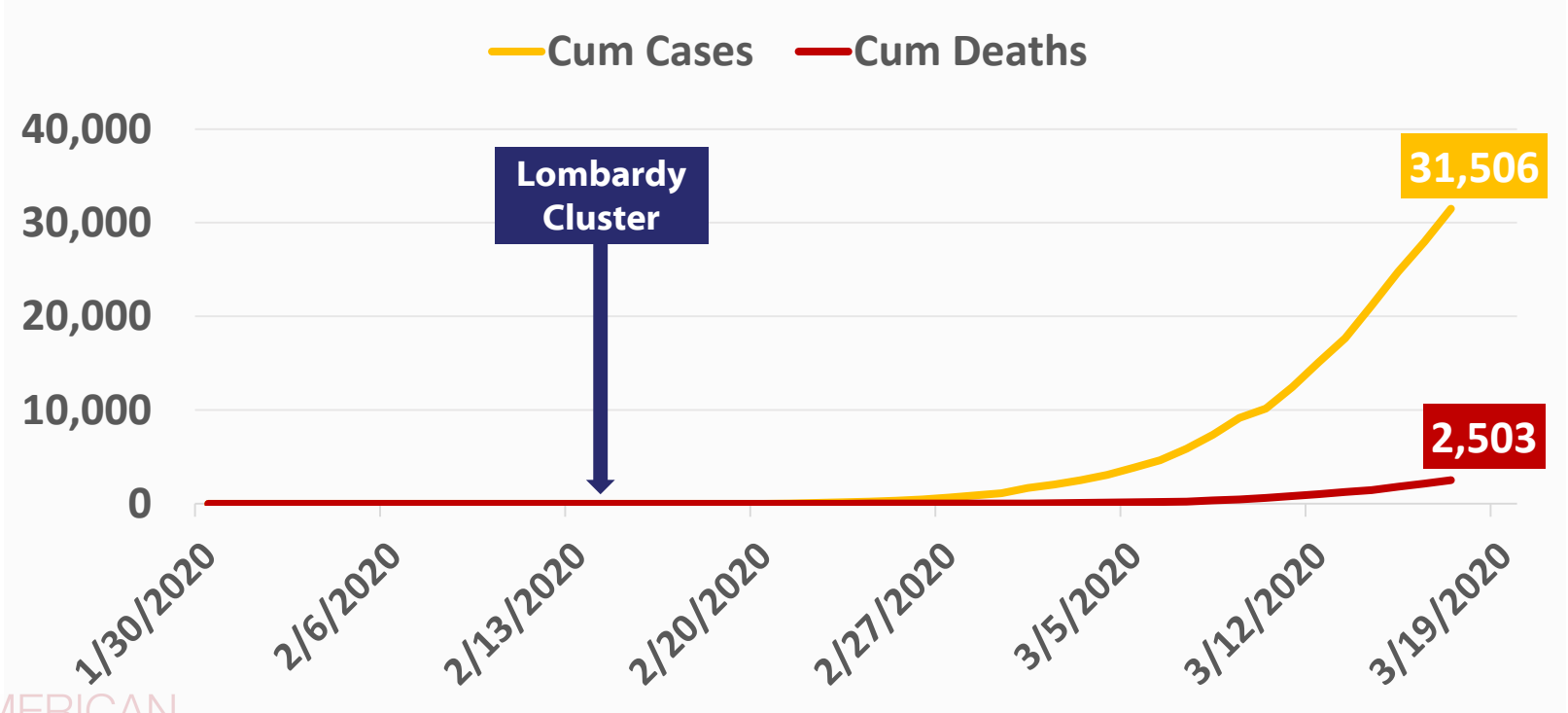
The outbreak in Italy started with a cluster of cases in the Lombardy region of Italy in mid-February



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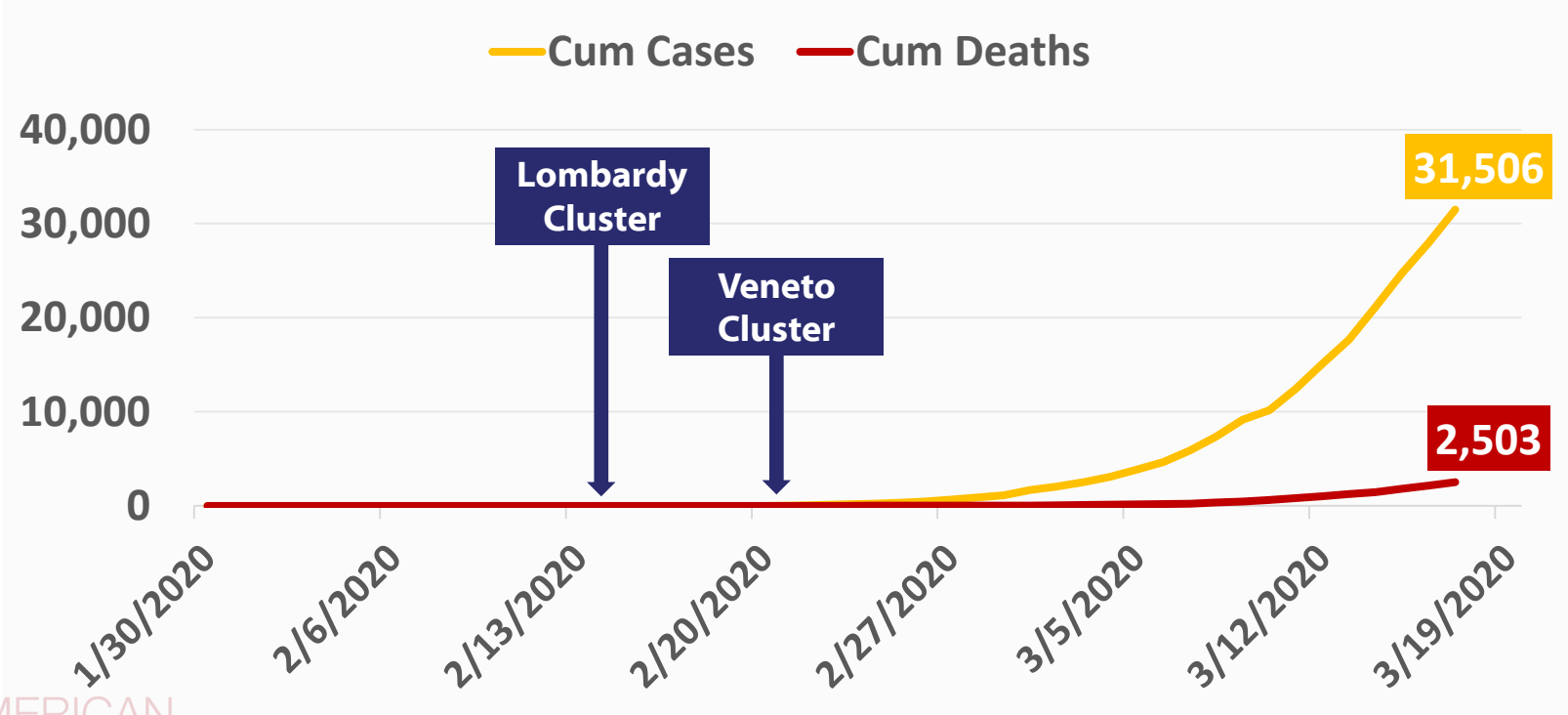
Data: Italy Protezione Civile

One week after the Lombardy Cluster, a smaller cluster of cases appeared in the Veneto region



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Data: Italy Protezione Civile

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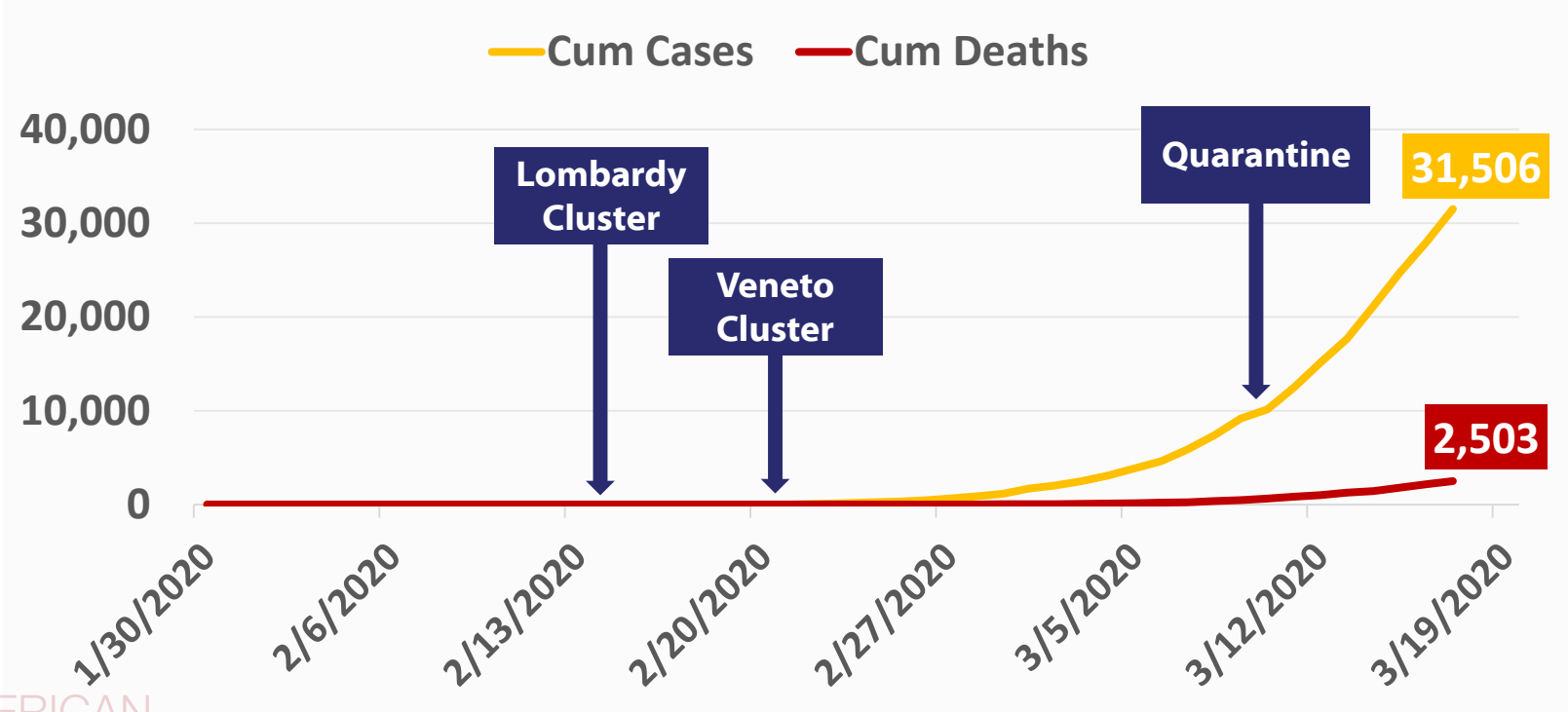
Cases in Italy continued to rise exponentially and exceed healthcare system capacity



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Data: Italy Protezione Civile

Lombardi region: Large influx of critically ill patients

- **Pre-Crisis ICU capacity**
  - 720 beds (representing 2.9% of total hospital beds at 74 hospitals)
  - Routinely operated at 85-90% capacity in the winter

- **Between 20 February and 7 March:**
  - 3,420 COVID-19 admissions of which 556 (16%) required ICU level care
  - Related to the older population with more medical co-morbidities

- **Adjusted to form cohorted COVID-19 ICU beds**
  - Increased capacity to 482 dedicated COVID-19 ICU beds for in 14 days

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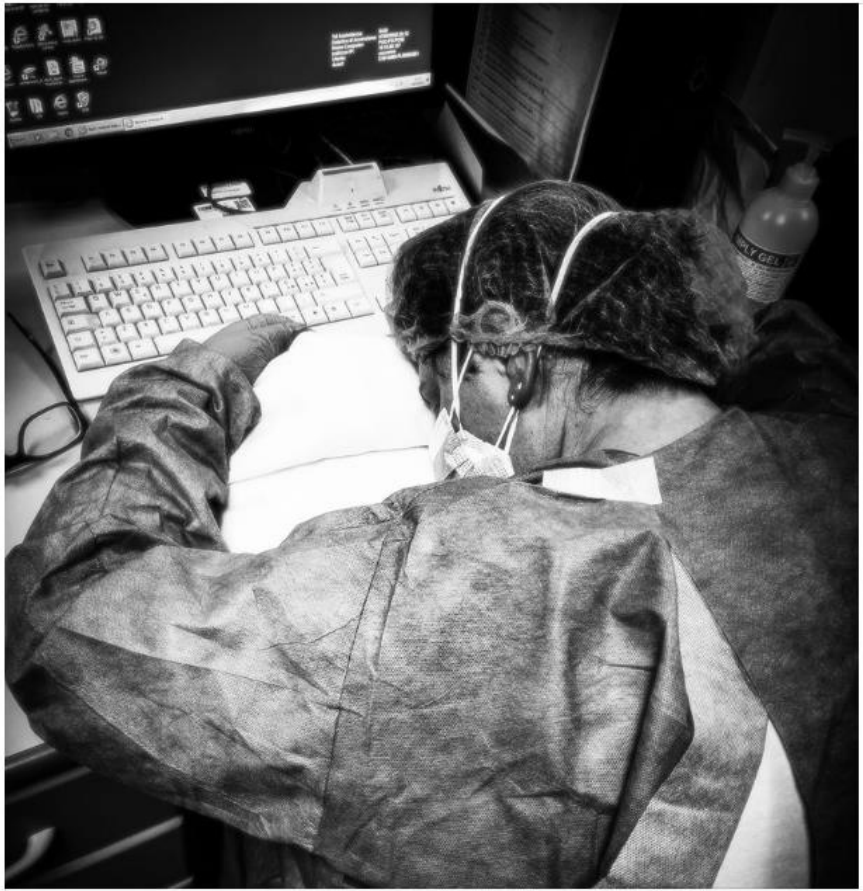
Grasselli et al. JAMA









Francesca Mangiatordi

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Images: https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html

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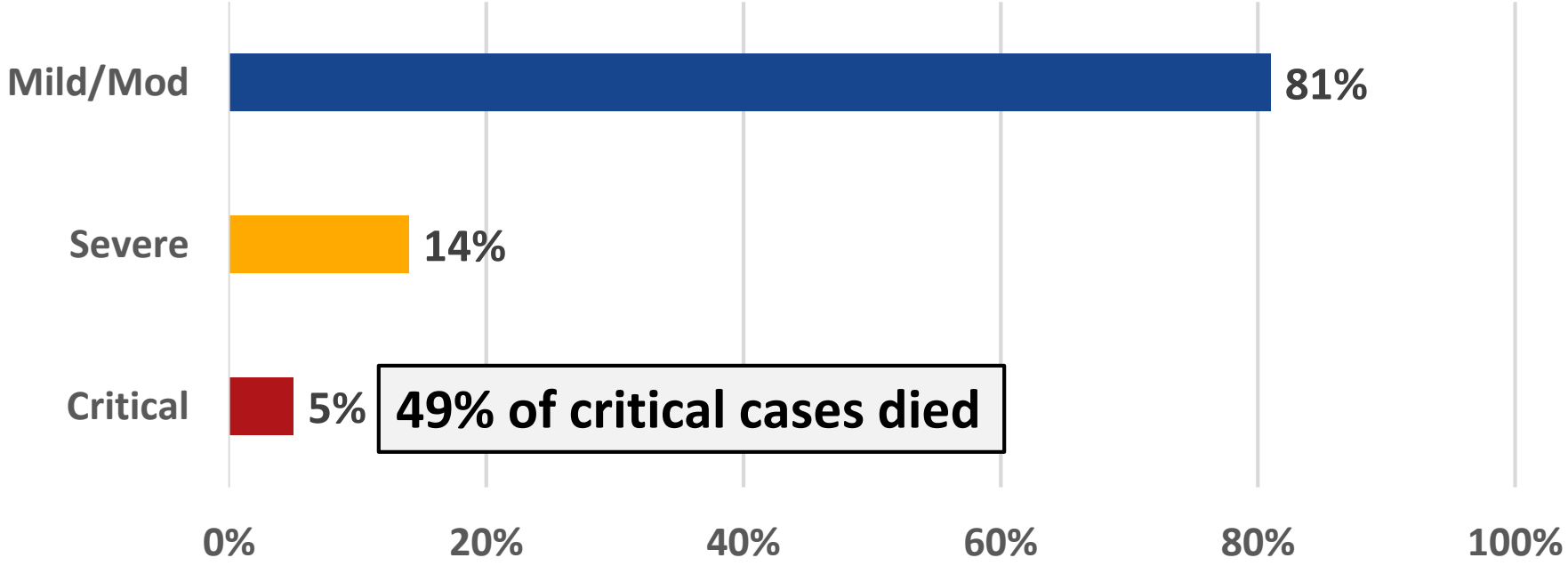
COVID-19 – China: most patients had mild illness, but a fifth had severe or critical disease (through 11-Feb-2020 (N=44,415)



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Wu et al. JAMA

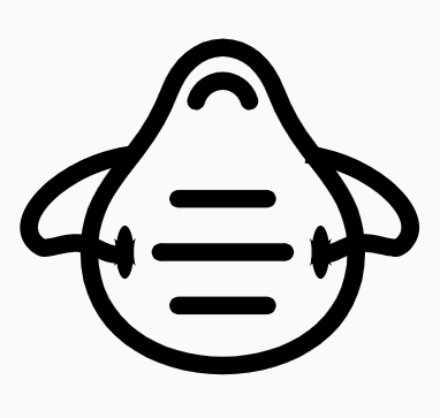
Three Foundational Elements of a Response



Space



Staff



Supply

Images: https://thenounproject.com/search/?q=doctor&i=1030175

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COVID-19 Concerns for the health system

- Current concerns as transmission accelerates:
  - **Space**: Maintaining capacity for inpatient, emergency, and critical care
  - **Staff**: Sufficient staff for patient triage and appropriate level of care
  - **Supply**: Increasing stress on PPE supply

- Clear communications to the public

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What are Crisis Standards of Care (CSC)?

- Crisis Standards of Care (CSC) guidelines help public health and healthcare personnel determine how to utilize resources during a public health emergency.
- Guides action by the state, county, and healthcare facilities
- Why is it necessary?
  - During catastrophic events, there may not be enough resources to give all patients the level of care they would normally receive.
  - A substantial change in usual healthcare operations and level of care it is possible to deliver due to a catastrophic disaster (e.g., pandemic influenza, earthquake, hurricane) (IOM 2012).

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COVID-19 health system elements to be accounted for as demand exceeds capacity

- **Process**
  - How are crisis care decisions integrated into hospital incident command?
  - What is the process for resource triage or allocation?
- **Criteria**
  - What is the basis for the allocation decisions (i.e. best practices/best evidence)?
- **Coordination**
  - How is this standard of care equalized across the region to assure consistency?
- **Policy**
  - How do regulatory and state actions support these non-traditional approaches to care?

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Continuum of Care

Conventional

	Conventional
Space	Usual patient care space fully utilized
Staff	Usual staff called in and utilized
Supplies	Cached and usual supplies used
Standard of care	Usual care

Normal operating conditions

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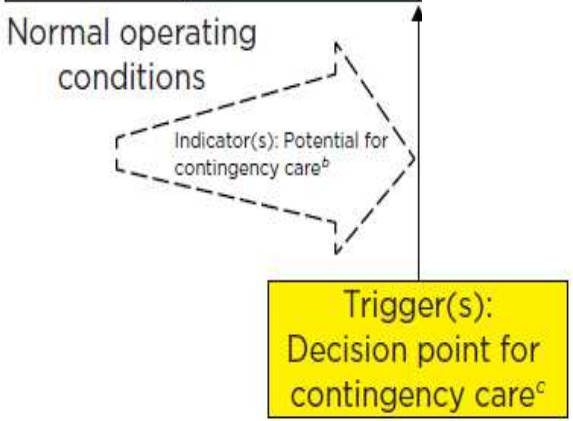
Continuum of Care

Conventional

	Conventional
Space	Usual patient care space fully utilized
Staff	Usual staff called in and utilized
Supplies	Cached and usual supplies used
Standard of care	Usual care



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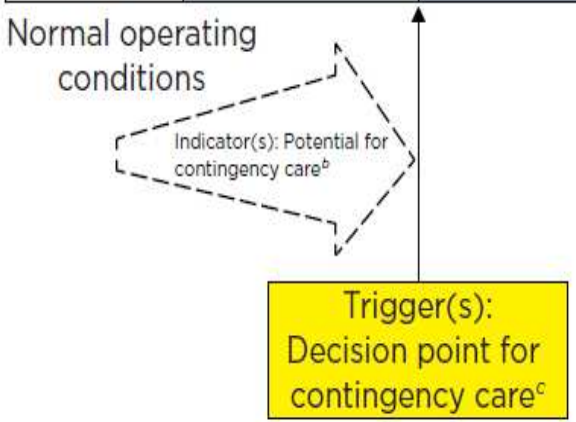
Continuum of Care

Conventional

Contingency

	Conventional	Contingency
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies
Standard of care	Usual care	Functionally equivalent care



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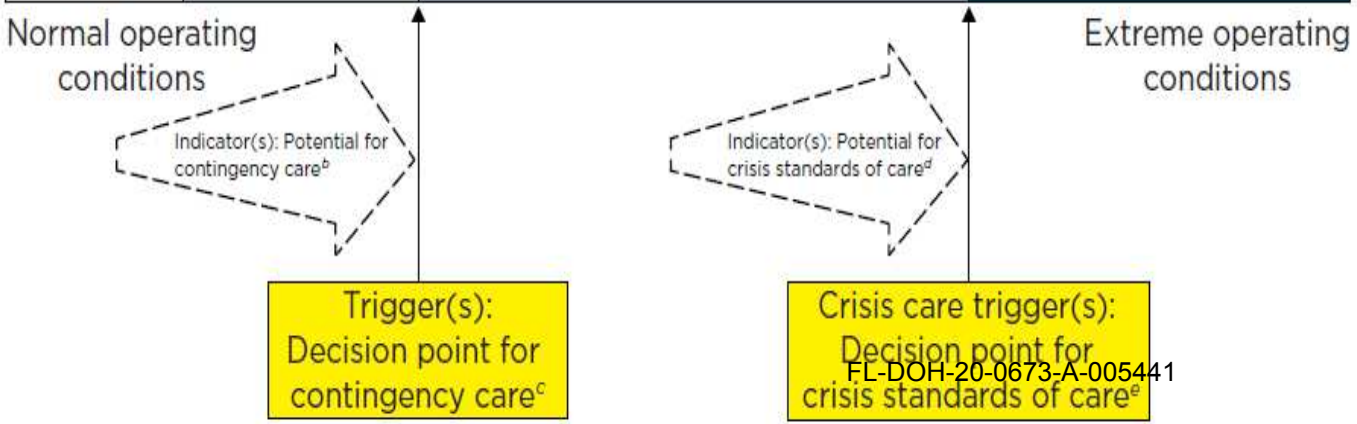
Continuum of Care

Conventional

Contingency

Crisis

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[a]



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Examples of triggers for shifting along this continuum of care standards

- Sustained community wide transmission
- Supply/medication shortage
- Unable to maintain normal staffing levels
- No available ICU beds
- Significant delays in access to care due to demand

- Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 (https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/)

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Crisis Standards of Care Considerations: Stuff

PPE	Current recommended actions	Planning for next 2 weeks
N95s	Reference CDC optimizing guidance OSHA fit testing waiver FDA EUA	Optimizing guidance incorporated for all products as part of larger IPC program • Extended use • Re-use • Alternative strategies • Disinfection
Face masks	CDC optimizing guidance posted 3/18/2020	
Face shields		
Gowns		
Gloves	Single use	Single use
Vents	• Understand stockpiled resources and how to request • Review CDC technical recommendations • Account for available ventilators and ancillary equipment	Identify alternative ventilator options Develop, socialize and coordinate triage and care protocols for life saving supplies across healthcare coalition

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Crisis Standards of Care Considerations: Space

Current Recommended Actions	Planning for next 2 weeks
Monitor daily bed use	Identify options for non-ED triage/evaluation and other locations for hospital-level care • Tents or off-site locations, understanding the minimum requirements for clinical care • Remote telehealth • Bots • Outpatient outreach and tools
Timely discharge of patients not requiring acute, inpatient management	Identify non-medical floor beds to accommodate overflow patients (e.g. surgical floors) Identify referral facilities within coalition if capacity exceeded
Timely transition of ICU patients to regular medical floor when appropriate	Identify non-ICU locations to provide advanced level care (e.g. post-anesthesia care units, telemetry floors) Identify referral facilities within coalition if capacity exceeded Review triage algorithms for ICU admission

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Crisis Standards of Care Considerations: Staff

Current recommended actions	Planning for next two weeks
Review hospital incident command system plans at the hospital and healthcare coalition level	Curtail non-essential staff
Plan for continuity of operations due to absenteeism	Reassignment of staff from other duties (shift elective surgery staff to other emergent/inpatient/critical care locations)
Review facility telemedicine services	Change staff hours, staffing patterns
Understand authorities around expanding scope of practice policies and establish t trigger decisions	Modify staff – to – patient ratios
Create crisis standards of care teams to assist with hospital specific triage and coordination	Obtain equivalent staff through hiring, expanded practice scope
Evaluate potential federal staffing option	Coordinate and allocate staffing resources between hospitals and facilities within and outside jurisdiction
	Track triggers to expand scope of practice for provider

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Actions for Hospital Incident Command

Prepare for patient surge while facing staff and supply shortages

- Be in regular communication with healthcare coalition or health department to understand regional resources
- Understand current hospital resources (vents, bed counts, etc.)
- Determine allocation strategies and triggers for when/how they need to be implemented
  - Decision process needs to be clear and made only when no other resources are available
  - Determine a triage process and team to include two clinicians that are not the caregivers for the patient(s) for clinical decision making
  - Ensure strategies/decision making processes are reviewed by health facility leadership

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Reference: Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 (https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/)

FL-DOH-20-0673-A-005446

Actions for Outpatient Services

- Review future appointments for the next three months
  - Strive to move visits to virtual appointments (telehealth, telemedicine, phone based appointments)
  - Cancel or postpone elective or non-urgent appointments and procedures
  - Provide good communication to patients about COVID-19
    - Encourage home care and over the counter medication unless they have severe symptoms
    - Offer to write “prescriptions” for home quarantine and self isolation as needed

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Reference: Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 (https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/)

Actions for Emergency Departments

Prevent transmission from suspect COVID patients, reduce burden in ED, and divert non-critical suspect COVID-19 patients

- Identify and establish outside triage point for non-critical COVID-19 patients (triage tents, parking lot triage)
- Coordinate with EMS (e.g. telephone triage) to avoid ED visits that can be treated as outpatient
- Identify potential changes in patient flow that can expedite non-emergency visits, when necessary
  - Specific times of day that individuals with respiratory illness to present
  - Specific entrance and triage route for those with respiratory illnesses

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Reference: Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 (https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/)

Actions for Inpatient Care

Optimize personal protective equipment, protect staff, and prevent hospital transmission of COVID-19

- Cohort patients and staff by unit or floor as numbers of cases increase
- Designate a specific room/floor for non-infectious hospitalized patients
- Cancel elective procedures
- Assess spaces such as pre-, post- anesthesia care, same day surgery, gastroenterology labs, intermediate care, and step-down units for critical care expansion
- Restrict visitors and promote electronic visiting instead of in-person visits

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Reference: Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 (https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/)

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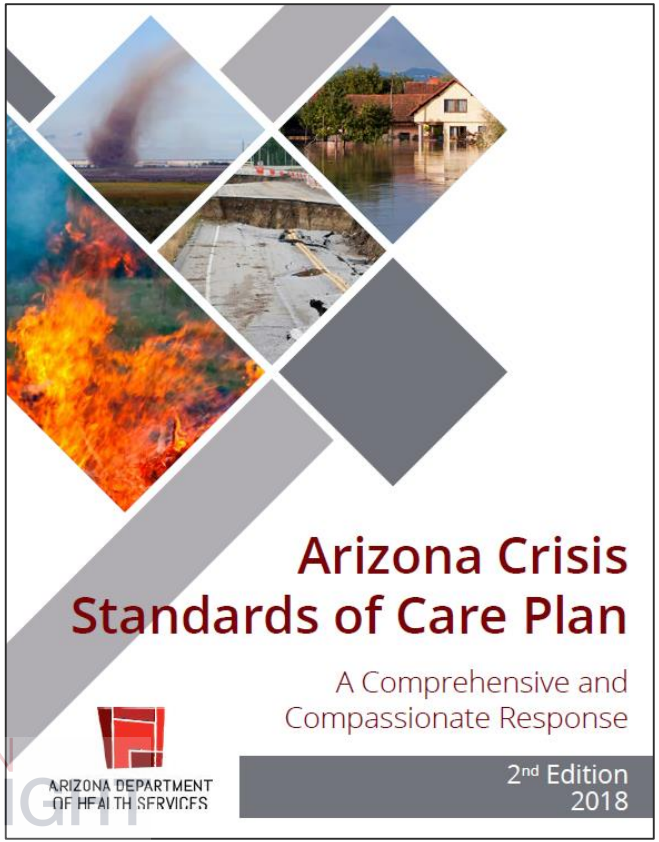
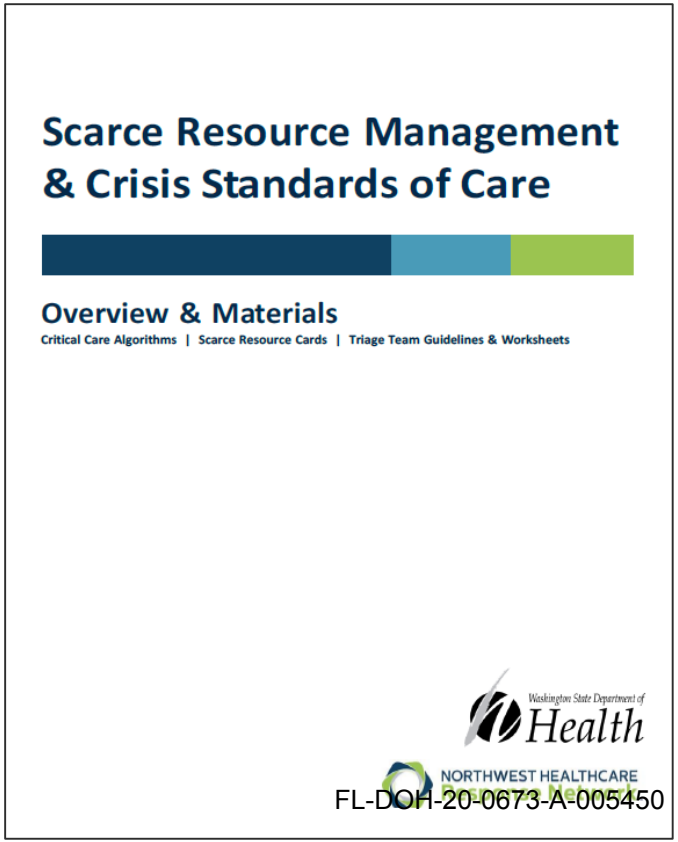
Examples and tools of CSC plans from two states





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CSCs can help decide whether escalation of care is appropriate

ADULT Critical Care Triage Worksheet
Critical Care Guidelines During Crisis Capacity[1]

Washington State Department of Health

NORTHWEST HEALTHCARE Response Network.

This Worksheet, along with the corresponding Adult Critical Care Algorithm, are to be used by "Triage Teams" during a declared emergency event whereby an appropriate healthcare official has implemented crisis standards of care. It is recommended that a "Triage Team" be comprised of senior medical personnel, preferably not those primarily taking care of the individual patient under consideration. Please see "Scarce Resource Triage Team Guidelines" for further information.

STEP 1: Screen adult patients for ICU care during scarce resources

Proceed to following after reviewing patient's end of life directives/POLST or similar living will documents. For the following conditions consider available staffing and resources. If resources are inadequate, ***consider*** transferring the following patients to out-patient or palliative care with appropriate resources and support as can be provided.

1. Pre-existing or Persistent coma or vegetative state
2. Severe acute trauma (e.g. non-survivable head injury)
3. Severe burns with Low Survival burn scores based on the Triage Decision for Burn Victims table (See Table A below). See Burn Scarce Resource Card for management of critical burn patient outside of a Burn Center.
4. Significant underlying disease process that predict poor short term survival*

   **Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*
   - *Severe congestive heart failure*
   - *Severe chronic lung disease*
   - *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
   - *Severe cirrhotic liver disease with multi-organ dysfunction*
5. Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

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Ref: WA CSC

Legal considerations

- Space
  - Waiving facility licensure rules to allow alternate triage, testing, and care sites
- Staff
  - Waiving or suspending healthcare provider licensing statutes and regulations to expanding scopes of practice, ease continuing education requirements, or allow retired practitioners to respond
  - Providing licensure reciprocity, liability protections, and workers compensation
- Equipment
  - Waiving procurement rules
  - Seizing private property for public use

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Legal considerations (cont.)

Tools for state law examples:

- Gubernatorial emergency suspension powers: http://lawatlas.org/datasets/emergency-powers
- Collection of state laws on liability protections and expanding scopes of practice: https://emergencylawinventory.pitt.edu/display-laws
- ASTHO Scope of Practice Toolkit: https://www.astho.org/ScopeofPracticeToolkit/
- Public Health Emergency Law Unit 3 (see slide “Commandeering or Utilizing Property Laws”): https://www.cdc.gov/phlp/phel-training/PHEL-Unit-03/

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CMS Waivers to support CSC: WA State experience

- Washington is implementing all of the blanket waivers announced by CMS on March 13 in Medicaid and CHIP, to the extent applicable

- Washington state is seeking additional blanket waivers under which “all CMS licensed providers will operate upon CMS approval”

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CMS Waivers to support CSC: WA State experience (cont.)

- Washington is implementing all of the blanket waivers announced by CMS on March 13 in Medicaid and CHIP, to the extent applicable

- Washington state is seeking additional blanket waivers under which “all CMS licensed providers will operate upon CMS approval”

  - Emergency Medical Treatment and Active Labor Act
  - Institutions of Mental Disease (IMD)
  - Medicaid and Medicare Hospital Conditions of Participation (CoPs) and similar requirements

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Additional Resources

- Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 (guidance on triggers, strategies for scarce resources, and actions for hospitals)
  - https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/
- How Should U.S. Hospitals Prepare for Coronavirus Disease 2019 (COVID-19)?
  - https://annals.org/article.aspx?articleId=2763037&guestAccessKey=8ba4f05e-efd2-4967-bd82-764ba23301f7
- CMS Emergency Waivers (includes state-specific waivers)
  - https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

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Background

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Guiding Ethical Principles of Crisis Standards of Care

Save the largest number of lives among those who have the longest to live

- Duty to Plan
- Distributive Justice
- Duty to Steward Resources
- Duty to Care
- Proportionality
- Consistency and Fairness
- Transparency and Public Accountability

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CMS Waivers to support CSC: WA State experience (cont.)

- **Discharge Planning** 42 C.F.R. §482.43(a)(8), 485.642(a)(8): Allowing for discharges in an efficient manner will free beds for acutely ill patients.

- **Facilities and Make-shift clinic and Physical Environment** 42 C.F.R. §482.41; A-0700 et seq: Non-hospital buildings/space can be used for patient care, provided sufficient safety and comfort is provided for patients and staff.

- **Medical Staff** 42 C.F.R. §482.22(a); A-0341: Physicians whose privileges will expire and new physicians can practice before full medical staff/governing body review and approval, keeping clinicians on the front lines during the emergency.

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CMS Waivers to support CSC: WA State experience (cont.)

- **Delivery of Services in Alternate Clinic Locations:** Waiver/flexibility to allow Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers to bill for their Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services from alternative physical settings, such as a mobile clinic or temporary location.

- **Flexibility for Teaching Hospitals.** Allow flexibility in how the teaching physician is present with the patient and resident.

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CMS Waivers to support CSC: WA State experience (cont.)

- **Skilled Nursing Facility/Nursing Facility (SNF/NF) Conditions of Participation (CoP):**
  - Waiver to allow receiving facilities or alternate settings to receive SNF/NF or ICF/IID payment if a client is moved to a specialty facility to receive care and recover from COVID-19 during the COVID-19 crisis.
  - Non-SNF/NF buildings/space can be certified for use as a temporary SNF/NF… allows state to open a temporary COVID 19 nursing facility to assist COVID 19 positive SNF/NF residents
  - Waiver of certain conditions of participation and certification requirements for opening a nursing facility if the state determines there is a need to quickly stand up a temporary COVID-19 facility

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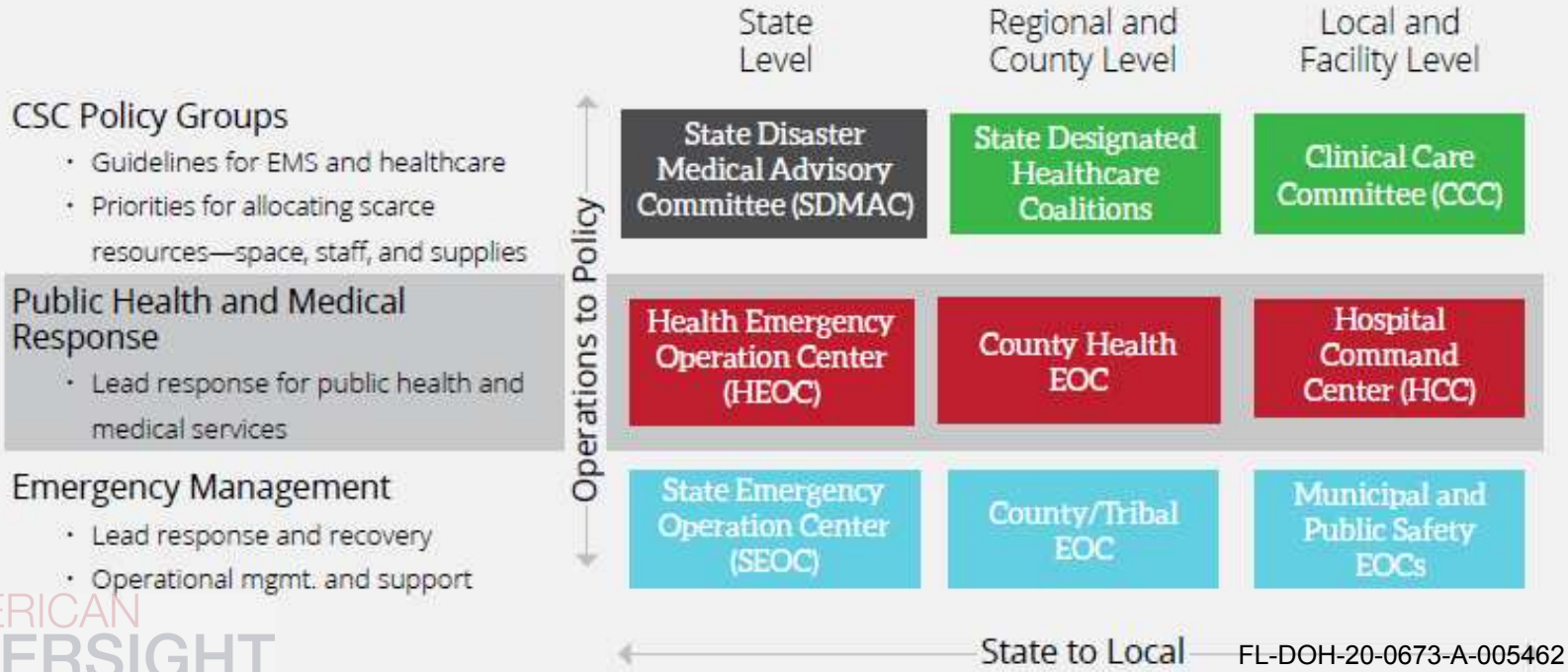
CSCs establish direction, control, and coordination across different levels of the response.

Ref: AZ CSC

Figure 4—Arizona CSC: Direction, Control, and Coordination



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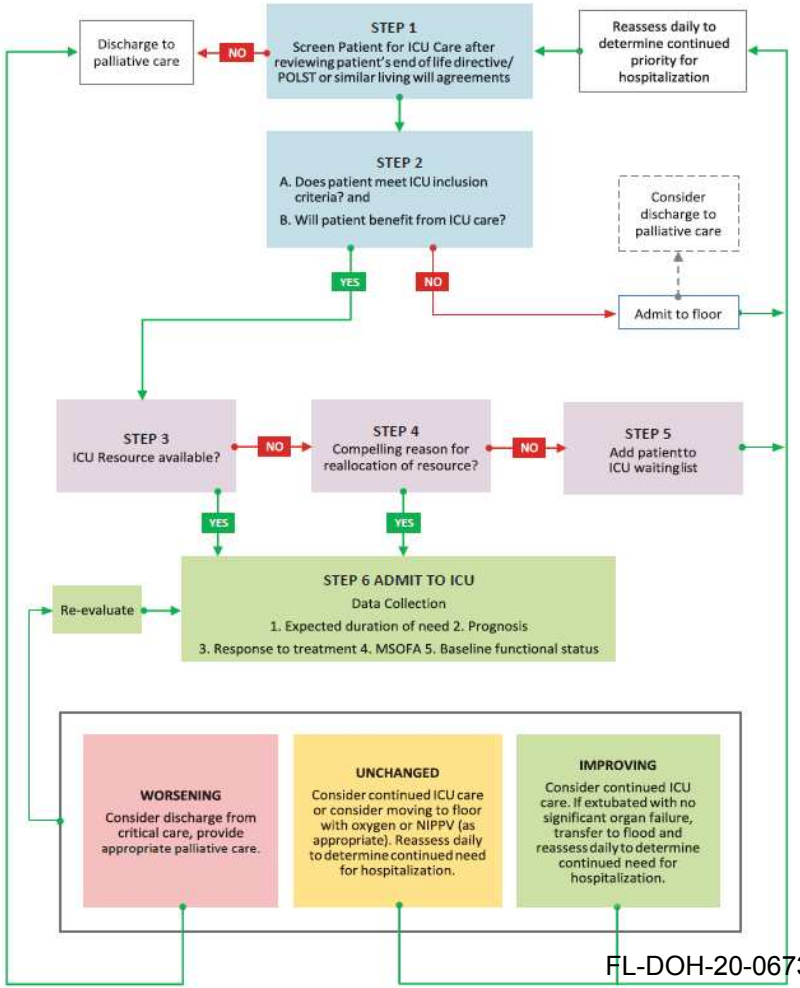
CSCs can suggest standard protocols to continually evaluate whether medical care should be continued.



ADULT Critical Care Triage Algorithm
Crisis Standards of Care
Updated Version: Mar 2020

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FL-DOH-20-0673-A-005463

Ref: WA CSC

Scarce Resource Management & Crisis Standards of Care

Overview & Materials

Critical Care Algorithms | Scarce Resource Cards | Triage Team Guidelines & Worksheets

Washington State Department of Health

NORTHWEST HEALTHCARE Response Network

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SCARCE RESOURCE MANAGEMENT and CRISIS STANDARDS OF CARE

I. INTRODUCTION

In the event of a large-scale disaster, either a no-notice event such as a natural disaster or a prolonged situation such as a pandemic, there is the potential for an overwhelming number of critically ill or injured patients. In these situations, certain medical resources may become scarce and prioritization of care may need to be considered.

Medical surge is a complex multifactorial event, the response to which is equally complex. In an effort to better understand, measure, discuss best practices and manage medical surge, it is essential to have an overall guiding framework.

In 2009, the Institute of Medicine (currently the National Academy of Medicine) published a landmark report, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situation: A Letter Report*. In this report the authors defined Crisis Standards of Care as follows:

> "A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g. pandemic influenza) or catastrophic (e.g. earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory power and protections for healthcare providers in the necessary task of allocating and using scarce medical resources and implementing alternate care facility operations."[1]

They outlined a framework for the discussion of surge capacity defining it as a continuum from conventional to contingency, and finally crisis. They defined this "Continuum of Care" as follows:

> **Conventional Capacity:** The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.
>
> **Contingency Capacity:** The spaces, staff, and supplies used are not consistent with daily practices but provide care that is functionally equivalent to usual patient care. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).
>
> **Crisis Capacity:** Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. [1]

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[1] IOM (Institute of Medicine). 2012 *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response.* Washington, DC: The National Academies Press.

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The National Academy of Medicine also stresses the importance of an ethically grounded system to guide decision making in crisis to ensure the most appropriate use of resources. They define these ethical principles as:

- **Fairness** – standards that are, to the highest degree possible, recognized as fair by all those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence-based and responsive to specific needs of individuals and the population.
- **Duty to care** – standards are focused on the duty of healthcare professionals to care for patients in need of medical care
- **Duty to steward resources** – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- **Transparency** – in design and decision making
- **Consistency** – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, pass use of resources)
- **Proportionality** – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources
- **Accountability** – if individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources[1]

This framework has been nationally accepted and adopted and has been used by King and PIerce Counties and adopted by the Washington State Department of Health Disaster Medical Advisory Committee.

I. Background:

In 2012, consistent with recommendations from the Institute of Medicine (IOM), the Northwest Healthcare Response Network developed a Disaster Clinical Advisory Committee (DCAC), a group of more than 45 clinicians from healthcare organizations across King and Pierce counties, representing more than 15 clinical subspecialties, working in coordination with Public Health – Seattle & King County and Tacoma-Pierce County Health Department. Since that time, a WA State Disaster Medical Advisory Committee (DMAC) has been developed and along with DCAC have focused on the development of clinically focused tools and planning for medical surge, including strategies for the implementation of Crisis Standards of Care.

The content of this document is based on a thorough review of the literature, guidelines published by leading national healthcare specialty colleges and societies, recommendations of the National Academy of Medicine and detailed discussion and deliberation by the WA State Disaster Medical Advisory Committee (DMAC), the Disaster Clinical Advisory Committee (DCAC) Central District and included input from both local and state Community Engagement Reports.[2,3]

II. Contents:

All individual Scarce Resource Cards and Triage Algorithms are continually under review and open for comments as outlined below in Section D.

[2] 5.Li-Vollmer, M. Health Care Decisions in Disasters: Engaging the Public On Medical Service Prioritization During a Severe Influenza Pandemic. Journal of Participatory Medicine. Vol 2. December 14, 2010.

[3] Washington State Crisis Standards of Care Community Engagement Report, June 2019, DOH

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A. Scarce Resource Cards

The Scarce Resource Cards (SRC) are based on work done by Minnesota Public Health[2]. They provide specific strategies which can be used in the conservation, adaptation, substitution, re-use, and re-allocation of a critical resource during an emergency. Additionally, the cards provide recommendations to be implemented in preparation as well as response thus covering the whole continuum of care (conventional, contingency, and crisis) as described above.

The content and composition between cards varies. Some cards are designed to provide specific clinical treatment strategies (e.g. Mass Casualty Burn Treatment Card). Others outline specific patient populations for which the recommendations are made (e.g. in-patient vs out-patient dialysis patients).

Scarce resource cards have been created for the following potentially limited resources:

- Behavioral Health
- Blood products
- Burn
- Hemodynamic support and IV fluids
- Mechanical ventilation
- Medication administration
- Nutritional support
- Oxygen
- Renal replacement therapy
- Respirator and General PPE
- Staffing

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B. Scarce Resource Triage Algorithms and Worksheets

Adult and Pediatric Critical Care Triage Algorithms which should be used when Critical Care resources are overwhelmed. The Algorithms are designed to be used side-by-side with the respective Worksheet which provides more in-depth clinical considerations and information needed to move through each step in the Algorithm. Decisions made using these algorithms need to be managed by a Triage Team.

Guidelines for the composition, roles and responsibilities of Triage Teams and their oversight are included in the Triage Team Guidelines mentioned below.

C. Crisis Standards of Care Clinical Triage Team Guidelines

Allocation of a scarce resource is a complex task and, in order to maintain the ethical framework outlined above, it is crucial that the decision-making process be consistent and that oversight and review mechanisms be established. The Triage Team Guidelines provide institutional and regional recommendations for this process.

D. Update and Input Procedures

1. All documents contained in this packet are maintained by NWHRN.
2. Each document is reviewed every 3 years during scheduled plan review. During a specific response, it is recognized that the clinical situation may change based on numerous incident-dependent factors. Therefore, in response, documents are reviewed as outlined in the Triage Team Guidelines.
3. At any time, input is welcomed and can be discussed at the institutional level with specific institutional DCAC members (if applicable). Input can also be made directly to the Chair or Vice-Chair of the WA State DMAC or to the Senior Medical Advisor of NWHRN. A full list of local DCAC and state DMAC members and the Senior Medical Advisor is available from NWHRN.

[2] http://www.health.state.mn.us/oep/healthcare/crisis/standards.pdf

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III. Institutional Distribution

The institutional distribution of the contents of this packet will be determined by each institution's Emergency Manager, DCAC member(s), if applicable, and appropriate administration.

IV. WA State Crisis Standards of Care Guidance Framework

In any medical surge, the primary goal is to prevent or limit the time in "Crisis" (as defined above by the NAM). It is understood that movement within the continuum of care is a fluid process and can vary depending on the resource in question or the situation at hand.

It is also paramount, when faced with potential scarce resources that the response is coordinated and communications among all of healthcare is maintained to provide accurate and up-to-date situational awareness. WA State in conjunction with State DMAC, DOH, and state healthcare coalitions have developed the WA State Crisis Standards of Care Guidance Framework and is available through DOH. This document outlines regional roles and responsibilities, provide an ethical framework and other tools which will assist in coordinated planning and response.

C. Contacts:

For any questions about this document or contents of this packet please contact:

Northwest Healthcare Response Network at info@nwhrn.org.

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BEHAVIORAL HEALTH – PATIENT PLANNING and RESPONSE 05-09-2019 FINAL

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity –** The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity –** Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
PLANNING **General** • 1. Encourage patients to assemble and maintain a disaster kit, to include an extra month worth of their medications, in addition to food, water, sanitation, and first aid supplies, should they need to shelter in place. • 2. Encourage patients to discuss planning for disruption in their care with their current healthcare providers, including primary care providers as well as behavioral health providers. • 3. Encourage Behavioral Health Providers to develop a disaster plan with the patient as part of treatment planning.	*Prepare*			

Gathering Resources
• 4. Encourage patients to identify tools and strategies they have found helpful in symptom relief and write down what works. Include a copy of the document in their disaster kit.
• 5. Encourage patients to explore other avenues for self-help, such as apps to assist with medication and symptom management, and to practice these prior to a disaster. Examples:
  ○ 5a) Headspace (meditation and mindfulness) https://www.headspace.com
  ○ 5b) Virtual Hopebox (distraction, coping exercises, relaxation) https://psyberguide.org/apps/virtual-hope-box/
• 6. Encourage patients to identify family members or friends who are helpful to them and include them as part of their resources. Family resources can be found at https://www.mentalhealth.gov/talk/friends-family-members
	Prepare			

Preparing a Team • 7. Encourage patients to reach out and identify a specific individual in their lives who can be a monitor and coach during disruptive/stressful events. • 8. Family and friends should be encouraged to take advantage of training through Red Cross, National Alliance on Mental Illness (NAMI), or local community mental health clinics, to assist the patient during times of disaster. https://www.namiwa.org/index.php/programs/education-training	*Prepare*			
Response • 9. Patients should be encouraged to locate their physical resources, such as food, water, and medications. • 10. Patients should reach out to their pre-identified support system (family, friends), and to their identified disaster monitor and coach. • 11. Patients should retrieve any written materials and plans to assist them in monitoring and managing symptoms. • 12. Patients may wish to reach out to community organizations (e.g. Red Cross, National Alliance on Mental Health and local community mental health clinics) for additional resources if available at the time of the disaster.				

Adapted From the Minnesota Department of Health, Office of Emergency Preparedness

FINAL: May 9 ,2019

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Washington State Department of Health
NORTHWEST HEALTHCARE Response Network.
FL-DOH-20-0673-A-005470

BEHAVIORAL HEALTH STAFF PLANNING and RESPONSE 05/09/2019 FINAL

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
GENERAL (For all clinical settings: inpatient, outpatient, group homes, specialty care facilities, ACF)				
• 1. Include Staff mental/behavioral health guidance/resources in all response plans and continue to maintain, test and update mental health surge plans.				
• 2. Include Mental Health surge issues in trainings and exercises including De-escalation Training, Management of the aggressive patient and Staff Safety.[1,2]	*Prepare*			
PLANNING for PATIENT Mental Health Surge				
• 3. Identify all staff with mental health/behavioral health training and appoint key individuals to lead and organize disaster mental health preparedness and response ○ 3a) Recommend specific disaster mental health training for Behavioral Health providers currently embedded in general medical settings. These individuals will be key in providing Just-in-Time (JIT) training to others in times of mental health patient surge. ○ 3b) Store resources and JIT disaster mental health training materials. (e.g. Health Support Team Curriculum, or Skills for Psychological Recovery National Child Traumatic Stress Network). See references below for specific material recommendations.[3,4,5]	*Prepare*			
PLANNING for STAFF Mental Health needs:				
• 4. Encourage psychological first aid training to all medical staff especially for key clinical leaders and administrators.[5,6]				
• 5. Identify and train willing behavioral health and non-behavioral health providers with more comprehensive curricula than PFA, to act as monitors and evaluators for their colleagues. Utilize evidence-based questionnaires as needed to determine current staff functioning. For example, ProQOL is one quick evaluation tool (https://proqol.org)				
• 6. Provide psycho-education for staff on caregiver fatigue, including symptoms, and coping/support tools[4,5,7,8]	*Prepare*			
• 7. Teach appropriate debrief strategies recognizing[9,10,11] ○ Group debriefing may not be appropriate for all. Prepare and plan to do 1 on 1 debriefing ○ The pace of the debrief session should be responder driven not agenda driven ○ Individuals process traumatic situations at their own pace. Forcing graphic or stressful debriefing can cause increased trauma.				
PLANNING FOR IN-PATIENT PSYCHIATRIC FACILITIES:				
• 8. Encourage inpatient psychiatric facilities to develop connections with other inpatient psychiatric facilities to develop planning for potential patient transfers, evacuations and staffing.	*Prepare*			
• 9. All inpatient psychiatric facilities should develop general disaster planning to include basic care for patients e.g. adequate food/water/shelter, staffing shortfalls, medications, transport of patients, methods of transport, and management of patients who may represent a danger to themselves or others.				

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RESPONSE **Patient Surge** • 10. Notify pre-trained providers to prepare for surge. Implement JIT training of other staff to help with patient surge. • 11. Ensure Alternate Care Facilities have written educational materials to assist with patients, and access to mental health consultation as needed. • 12. In preparation for possible loss of electronic medical records, have printed patient information to include diagnosis, allergies and current medications/dosages. • 13. Modify individual treatment to shorter, symptom focused appointments. • 14. Utilize psycho-educational, and brief evidence-based interventions. • 15. Use Telehealth mental health providers as off-site resource.	*Substitute/ Adapt*			
• 16. Shift treatment to emphasize coping strategies, interventions to manage symptoms, and identifying and accessing personal resources. • 17. Deploy multi-disciplinary response teams as needed to provide Just in Time training for healthcare providers/organizations, and to provide consultation on Behavioral Health interventions including medications and crisis management. • 18. Shift from individual therapy to group intervention.	*Substitute/ Adapt*			
Staff Self Care • 19. Consider "deliberate Coping and Calming" strategies or "Personal Reflective Debrief" techniques over mandated and prescribed CISD for staff during and after traumatic events.[9,10] • 20. Encourage and support staff self-care. When possible maintain schedules, routines and shifts. • 21. During an event encourage personal "pauses" for reflection and self-evaluation. • 22. Encourage utilization of organizational support systems, (e.g. employee assistance program, wellness programs, etc.). • 23. Maintain consistent scheduled communication between administrators and providers during and after acute event. (e.g. huddles, check-ins, sign-outs, etc)	*Substitute/ Adapt*			
MEDICATIONS RECOMMENDATIONS: • 24. Psychiatric medications may not be available due to supply chain disruptions during a major event. Encourage all facilities who care for mental health patients (outpatient, in-patient medical, long term care, group homes, or specialty care facilities) to develop psychiatric medication supply strategies. Consider increasing par levels, developing stockpiles, and/or planning with local retail pharmacies as potential psychiatric medication supply strategies.	*Prepare*			

Adapted From the Minnesota Department of Health, Office of Emergency Preparedness **FINAL:** *May 9, 2019*

[1]*https://handlewithcare.com/wp-content/uploads/2010/08/hwc-mentalhealth.pdf*

[2]*https://www.crisisprevention.com*

[3]*https://learn.nctsn.org/course/index.php?categoryid=11*

[4]*Contact Health Support Team directly at http://healthsupportteam.org for curriculum.*

[5]*https://www.nctsn.org/resources/skills-psychological-recovery-spr-online. Requires free registration for materials.*

[6]*https://learn.nctsn.org/course/index.php?categoryid=11*

[7]*Killian, K. Helping Till It Hurts? A Multimethod Study of Compassion Fatigue, Burnout, and Self-Care in Clinicians Working with Trauma Survivors. Traumatology. 2008, Vol 14(2) June 32-44*

[8]*Mendenhall, T., Trauma-Response Teams: Inherent Challenges and Practical Strategies in Interdisciplinary Fieldwork. Families Systems, & Health, 2006, 24(3):357-362.*

[9]*Cicognani, E., Pietrantoni, L., Palestini, L., & Prati, G. (2009). Emergency workers quality of life: The protective role of sense of community, efficacy beliefs and coping strategies. Social Indicators Research, 94(3):449*

[10]*http://www.massey.ac.nz/~trauma/issues/2003-1/orner.htm*

[11]*Joint Commission: https://www.jointcommissionjournal.com/article/S1553-7250(08)34066-5/fulltext*

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Blood Products – Last Updated 2/17/2020

STRATEGIES FOR SCARCE RESOURCE SITUATIONS Highest relevance: 1) P=pandemic 2) W=weather 3) MCI

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.

Contingency Capacity – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources

Crisis Capacity – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

Category	*RECOMMENDATIONS*	*Healthcare Facility*	*Blood Center*	*Strategy*	*Conventional*	*Contingency*	*Crisis*
All Blood Products	1. • Increase donations and consider local increase in frozen reserves P • Increase O positive levels P, W, MCI • Consider maintaining a frozen blood reserve if severe shortage P • Increase recruitment for specific product needs		√	*Prepare*			
	2. • Consider adjustment to donor HGB/HCT eligibility/ explore FDA variance*		√	*Adapt*			
	3. • Relax travel deferrals for possible malaria and BSE (bovine spongiform encephalitis)*P, MCI		√	*Prepare*			
Whole Blood	○ 3a. Consider using ABO-type specific whole blood if components cannot be produced MCI, P, W						
Packed Red Blood Cells	4. • Use cell-saver and auto transfusion to degree possible** P, W, +/- MCI	√		*Re-use*			
	5. • Limit O negative use to women of child-bearing age P,W, MCI	√		*Conserve*			
	6.• Use O positive in emergent transfusion in males or females who are no longer childbearing, to conserve O negative** (Seattle Children's and Mary Bridge Children's currently uses O neg in males < 18 yrs)	√		*Conserve*			
	7. • Change donations from whole blood to 2x RBC apheresis collection if specific shortage of PRBC's (Cascade has current capability)	√	√	*Adapt*			
	8. • Use aliquots from parent product for several children when possible P, W, MCI	√		*Conserve*			
	9. • Encourage use of blood sparing protocols for all patients P,W,MCI	√		*Adapt*			
	10. • Consider use of erythropoietin (EPO) for chronic anemia in appropriate patients	√		*Adapt*			
	11. • Prioritize freshest blood for infants and small children	√		*Conserve*			
	12. • More aggressive crystalloid resuscitation prior to transfusion in shortage situations (blood substitutes may play future role) Use RBC:Plasma in 1:1 ratio in Trauma cases. P, W, MCI	√		*Conserve*			
	13. • Long-term shortage, collect autologous blood pre-operatively and consider crossover transfusion P	√		*Conserve*			
	14. • Implement lower hemoglobin triggers for transfusion P, W, MCI	√	√**	*Conserve*			

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	15. • Consider limiting high-consumption elective surgeries (select cardiac, orthopedic, spinal, etc.)** (procedures likely to require blood transfusions) P, W, +/- MCI	√	√**	Conserve			
	16. • Consider use of EPO in patients with anticipated acute blood loss P, W, MCI						
	17. • Further limit PRBC use, if needed, to active bleeding states, consider subsequent restrictions including transfusion for treatable shock states only** (modification of transfusion thresholds) W, P, MCI	√	√**	Re-allocate			
	18. • Consider Minimum Qualifications for Survival (MQS) limits on use of PRBCs (for example, only initiate for patients that will require <6 units PRBCs and/or consider stopping transfusion when >6 units utilized), specific MQS limits should reflect available resources at facility. ** P, W, MCI	√	√**	Re-allocate			
	19. • Reduce or waive usual 56 days inter-donation period * based upon pre-donation hemoglobin/ explore FDA variance* P, MCI		√	Adapt			
	20. • Reduce weight restrictions for 2x RBC apheresis donations according to instruments used and medical director guidance * W, P, MCI		√	Adapt			
Plasma	21. • Consider increase in red cell: Plasma ratio (3:1) in massive transfusion protocols in consultation with blood bank medical staff** W, P	√		Conserve			
	22. • Encourage early use of plasma in trauma with anticipated massive hemorrhaging and/or brain injury. Thaw early and use blood warmer.	√		Conserve			
	23. • Switch community inventory to liquid plasma P, W, MCI		√**	Adapt			
	24. • Consider using Group A Plasma P, W, MCI		√**	Adapt			
	25. • Accept female donors without white cell antibody testing. P, W, MCI		√**	Adapt			
	26. • Though not true substitute, consider use of fibrinolysis inhibitors or other modalities to reverse coagulopathic states (tranexamic acid, aminocaproic acid, activated coagulation factor use, fibrinogen concentrate, prothrombin complex concentrate, or other appropriate therapies) MCI, P, W	√		Substitute			
	27. • Obtain FDA variance to exceed 24 collections per year for critical types* P =/-W (e.g. Group AB) P, W, MCI		√	Adapt			
Cryoprecipitate	28. • Encourage early use of cryo in trauma with anticipated massive hemorrhaging and/or brain injury. Thaw early and use blood warmer.	√		Conserve			
	29. • Though not true substitute, consider use of fibrinolysis inhibitors or other modalities to reverse coagulopathic states (tranexamic acid, aminocaproic acid, activated coagulation factor use, fibrinogen concentrate, prothrombin complex concentrate, or other appropriate therapies). MCI, P, W	√		Substitute			
	30. • Obtain FDA variance to exceed 24 collections per year for critical types* P =/-W (e.g. Group AB). P		√	Adapt			
Platelets	31. • Though not true substitute, consider use of desmopressin (DDAVP) to stimulate improved platelet performance in renal and hepatic failure patients MCI, P, W	√		Substitute			
	32. • Consider aliquoting from apheresis platelets. For children, consider splitting whole blood platelets for more than one recipient. P, W, MCI		√	Adapt Leukoreduced		Nonleukoreduced	

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	33. • Convert whole blood donors to apheresis donors. Standard Practice. W, P, MCI		√	*Adapt*			
	34. • Transfuse platelets only for active bleeding, further restrict to life-threatening bleeding if required by situation P, W, MCI	√		*Conserve*			
	35. • No prophylactic use of platelets. P, W, MCI	√		*Adapt*			
	36. • Accept female platelet donors regardless of HLA antibody, W, P, MCI		√	*Adapt*			
	37. • Consider changing bacterial detection strategy. MCI, P. Potentially W		√	*Adapt*			
	38. • Obtain FDA variance to allow new Pool and Store sites to ship across state lines* P, W, MCI		√	*Adapt*			
	39. • Apply for variance of 5 day outdate requirement *. W, P, MCI		√	*Adapt*			

Adapted from the Minnesota Department of Health, Office of Emergency Preparedness

**FDA approval/variance required via American Association of Blood Banks (AABB)*

***Education and/or experience is necessary in the setting of a community-wide critical shortage*

UPDATED: Feb 17, 2020

Next Revision Due: 2023

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MASS CASUALTY BURN TREATMENT – 2/24/2020 FINAL
REGIONAL RESOURCE CARD

Harborview Medical Center (HMC)
Transfer Center 1-888-731-4791

INITIAL ASSESSMENT

Call UW Transfer Center to talk with a Burn Fellow/Attending, who can assist with triage, care of burn injured patients and transfer

Mass Casualty Burn Consultation Guide:

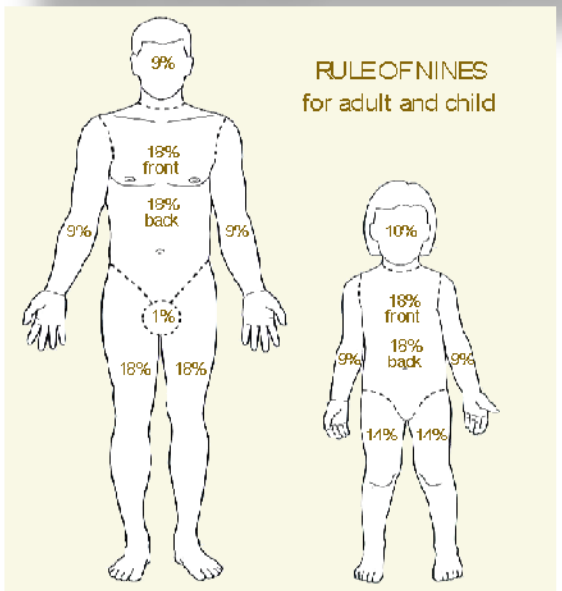
1. ≥ 20 % TBSA adults, ≥ 15% peds (2nd/3rd degree)
2. Circumferential 3rd degree burn
3. Respiratory injury/inhalation
4. Burn plus trauma or other comorbidities
5. High-voltage electrical (1000V) or chemical injury

YES

NO

OUTPATIENT MANAGEMENT
< 20% TBSA adults, < 15% TBSA pediatrics

- Oral fluid (sports drinks, electrolyte solution)
- PO pain management
- Refer to burn dressing guide and supply list
- Elevate extremity burns



DO NOT COUNT 1st DEGREE BURNS when calculating the Rule of Nines TBSA (Total Body Surface Area)

- 1st degree: red intact skin , no blisters
- 2nd degree: red/pink, moist, sensate, blisters, blanches
- 3rd degree: dry, leathery, insensate, non-blanching (see photos below for reference)

PRIMARY ASSESSMENT & INTERVENTIONS

6. Protect yourself using body substance isolation. Stop the burning process, cover with loose linen, keep warm
7. **Perform standard primary and secondary survey for any trauma patient.** Do not be distracted by burn tissue
8. **Airway/Breathing** - Assess for altered LOC, obstruction, respiratory compromise, burns to face or oropharynx
   - 8a. Administer 100% oxygen via non rebreather/ETT, if suspected inhalation injury (enclosed space, carbonaceous sputum, COHgb ≥ 10%)
   - 8b. Carbon monoxide (CO) exposure signs and symptoms:
     - HA and nausea (20%-30%)
     - Confusion (30%-40%)
     - Coma (40%-60%)
     - Death (>60%)
   - 8c. Consider intubation for GCS ≤ 8, ≥40% TBSA, direct upper airway injury, deep facial burns
9. **Circulation** - Assess vital signs. Hypovolemic shock signs including tachycardia are common >20% TBSA
   - 9a.2 large bore IV/IO's
   - 9b. **Initial fluids** LR/NS if estimated TBSA ≥ 20% adults and ≥15% pediatrics : (See secondary assessment for next steps in fluid resuscitation #12c)
     - ≤ 5 years: 125 mL/hr
     - 6-13 years: 250 mL/hr
     - ≥ 14 years : 500 mL/hr
   - 9c. Treat adult SBP <90 and pediatric SBP < [70 + (2x age in years)] with IV/IO fluid bolus. Avoid extra fluid when possible
10. **Disability** – Assess neurologic status: GCS/AVPU, check pupils, cervical spine protection, if trauma, high-voltage (>1000 V) injury
11. **Expose/Estimate** - Brush away loose material if concern for chemical exposure, remove clothing, jewelry, and contact lens. Protect from heat loss; hypothermia occurs quickly
    - 11a. Circumferential trunk or extremity burn: elevate extremities, check pulses. Full-thickness eschar may need surgical release

Additional Burn Center Consults

- **Cyanide Poisoning** – Consider if severe metabolic acidosis despite adequate fluid resuscitation as outlined in 12c.
- **Electrical**–If myoglobin in urine (red pigment) there is a risk of rhabdomyolysis
- **Chemical and radiologic** – consider need for antidote or specific therapies. Consult Poison Control

YES

SECONDARY ASSESSMENT & INTERVENTIONS

12. **Adjuncts-**
    - 12a. **Nasogastric or orogastric** – Intubated patients
    - 12b. **Estimate TBSA** using Rule of Nines chart
    - 12c. **Consensus formula LR/NS**: 3 mL x kg x % TBSA= fluids in 24 hrs. Give ½ in first 8 hrs and ½ in next 16 hrs. Increase/decrease fluids by 20% hourly to target UO
    - 12d. **Pediatrics**:<30kg, add maintenance fluid (below) using D5LR in addition to Consensus formula in #12c
      - 4 m x 1st 10 kg
      - 2 m x 2nd 10 kg
      - 1 mL x remaining kg = total mL/hr
    - 12e. **Foley** – Target urine output (uo) 30 mL/hr adults or 1mL/kg/hr in pediatrics < 30 kg.
    - 12f. **Pain control** – Use small doses of opioids
13. **History** – AMPLET or SAMPLE mnemonic
14. **Head to Toe Assessment**

YES

CRITICAL BURN FEATURES

15. TBSA >25% partial thickness or >10% full-thickness burns
16. Circumferential full thickness burns
17. Burn plus trauma or other comorbidities
18. Hemodynamic instability despite ongoing fluid resuscitation as outlined in 9b and 12c

CRITICAL: High priority for transfer to Burn Center.

YES

NO

SERIOUS BURN FEATURES

19. Secondary priority for transfer-may have to manage in place awaiting transfer (up to 72 hours)
    - 20. Refer to burn dressing guide and supply list
    - 21. Infection control – provider gown, glove, and mask when wounds exposed. No prophylactic antibiotics
    - 22. Intubated: Consider tube feeds
      - 22a. Non-intubated: encourage high calorie PO

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©2020 Northwest Healthcare Response Network. Burn Triage SRC.

	Resource and Recommendations	Strategy	Conventional	Contingency	Crisis
Command and Control, Communication, Coordination	**General Preparedness Information** • 23. HMC Burn Center is an ABA/ACS verified burn center in the WAMI region with 18 ICU and 23 acute care beds. • 24. Mass burn incidents are unusual but do occur. The ability of non-burn hospitals to triage and initially treat victims is critical to successful response and should be a planning goal of all hospitals with numbers of victims depending on the facility size and role in the community. • 25. In a major incident, victims may require care at the initial receiving hospital for up to 72 hours until transfer to definitive burn care. • 26. The role of the Disaster Medical Control Center (DMCC) in any major event is to distribute patients from the scene to area hospitals. There are different DMCC's in the region. HMC is the DMCC for King County. Patient distribution is often done by the DMCC with limited information from the field. In an event involving many burn patients it is highly probable that multiple ED's will receive patients and be responsible for their initial triage/stabilization. • 27. Notification: In a major burn incident, HMC, DMCC, NWHRN, Public health and area EOC's will be notified. • 28. If HMC is unable to accommodate casualties or require assistance with transportation/resource issues, multiple levels of coordination and communication will need to occur between area hospitals, DMCC, Healthcare coalitions, Public Health, area EOC's and potentially other regional burn centers depending on the magnitude of the event and extent of injuries. *(See Burn Surge Annex, pending 2021)*	*Prepare*			
Space	**Capacity** • 29. Each facility is encouraged to activate its own internal contingency/disaster plan if needed to manage multiple burn patients. • 30. In a major event, some burn ICU patients may need to be cared for in non-burn center acute care units. • 31. In coordination with HMC Burn Center, forward movement to other burn centers in adjoining states may be needed.	*Adapt*			
	• 32. National Disaster Medical System (NDMS) patient movement may need to be utilized.	*Adapt*			

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	Resource and Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Supplies (for 72 hours)	**Outpatient/ Supplies Planning** • 33. Institutions should prepare based on role in community. Outpatient clinics and urgent care centers may also cache appropriate supplies for their location and patient population. Suggested burn dressing supplies (per patient) (see below) **Inpatient Supplies Planning** • 34. Institutions should prepare based on role in community. In contingency or crisis situations non-burn centers may be asked to stabilize or potential provide extended care to burn patients. Suggested burn dressing supplies (per patient) (see below)	*Prepare* *Increase Supply*			
Staffing	**Staff** • 35. Strong consideration should be given to training physician and nursing staff on care of major burns pre-incident and having quick-reference cards/materials available for burn stabilization. • 36. Level II & III Trauma Centers should consider having a cohort of providers trained in the ABA Advanced Burn Life Support (ABLS) and ACS Disaster Management Emergency Preparedness (DMEP). • 37. Identify staff with prior burn treatment experience (i.e. military). • 38. See Staffing Scarce Resource Card for further staffing considerations. • 39. Staff should have access to just-in-time training provided to non-burn nursing and physician staff reinforcing key points of burn patient care (including importance of adequate fluid resuscitation, urine output parameters, principles of analgesia, dressing changes, wound care and monitoring) • 40. In a Mass casualty event, call the HMC Transfer Center 1-888-731-4791 for consultation in caring for burn patients. • 41. NDMS personnel and other supplemental staff may be required.	*Adapt* *Adapt* *Conserve* *Adapt* *Subst* *Prepare*			
Special	**Special Considerations** Consider availability of resources for: • 42. Pediatrics: age-and size appropriate equipment: intravenous, intraosseous access devices, medication dosing guides. Consider using color-coding pediatric guides.				

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	Resource and Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Triage	**Critical Burn Features : Survivability Grid** • 43. The following grid provides an example of triage decisions that may become necessary in the setting of overwhelmed resources or in austere conditions where crisis standards of care may be instituted. The survivability grid utilizes the same 4 color scheme used for EMS personal. Survivability will differ if the patient has sustained an inhalation injury. • 44. Use of the survivability table should be done in close collaboration with the Burn Center but should **NOT** substitute for a more global assessment of the patient. (See ABLS 2018 update) http://ameriburn.org/wp-content/uploads/2019/08/2018-abls-providermanual.pdf • 45. If Burn Center resources are limited, critical burn patients may need to be cared for in non-burn centers. Just in Time training and on-line resources are available to non-burn centers in these situations. Please refer to: https://crisisstandardsofcare.utah.edu/Pages/home.aspx; This website requires registration and login password. please consider planning ahead and gaining access before an event occurs.	*Re-Allocate*			

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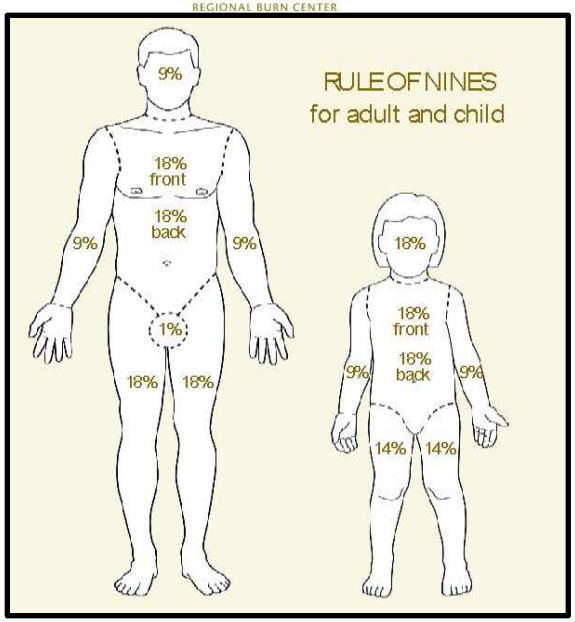
UW Medicine
HARBORVIEW MEDICAL CENTER
REGIONAL BURN CENTER



Burn Dressing Guide and Supply Estimates:

- Goal for partial thickness burn healing is to keep the wound moist and free from infection
- **1st degree burn:**
  - **1st degree burns do not count when calculating the TBSA using the Rule of Nines burn chart.** Apply lotion or ointment and leave open to air. No dressings needed
- **2nd degree burn:**
  - Apply a greasy gauze dressing with thin layer of antibiotic ointment. Change every 1-2 days
  - Or apply silver impregnated dressing to moist burns on flat surfaces. Dressing must lay flat against the burn. Secure in place with elastic, netting etc. Change every 7 days
- **3rd degree burn:**
  - Apply SSD and cover with thin layer of gauze Change every 1-2 days

- SSD 400 gm jar: 1 jar per 9% tbsa
- Antibiotic ointment: 1 tube per 9% tbsa
- Greasy gauze 4 in x 9 yard roll: 1 roll per 9% tbsa
- Gauze 6 inch x 3 yd roll: 1 roll per 9% tbsa
- 4x4 gauze: (1 box or boat) per 4% tbsa

Adult	SSD (Jar)	Greasy gauze (roll)	Antibiotic ointment (tubes)	Kerlix roll (6 in)	4x4 Gauze (Boat or package)	4x8 Gauze	18x18 Gauze	Elastic netting (inch)	Silver Impregnated drg
Head	1	1/4 face	8	-	1	3	-	10 inch	-
Arm	1	1	8	1	-	-	1-2	6 inch	Three 8x 8s OR One 8x 20
Hand/Fingers	1/4	1/4	1	1/2	1	1	-	Hand 4 in Fingers 1 in	-
Torso (ant/post)	2 each side	2	16	2	-	-	2	12 inch	Four 8 x 8s OR Two 8x 20s
Perineal (ant/post)	1/2 each side	1/4	1	-	1	1	2	12 inch	Two 8x 8s
Leg	2	2	8	2	-	-	3-4	10 inch	Six 8x 8s OR Four 8x 20
Foot/Toes	1/2 each	1/4	1	1/2	1	1-2	-	6 inch	-

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References:

- *i. American Burn Association. Advanced Burn Life Support Provider Manual 2018 Update. http://ameriburn.org/wp-content/uploads/2019/08/2018-abls-providermanual.pdf*
- *ii. American Burn Association. 2013 Burn Care Resources in North America US Burn Centers available from http://ameriburn.org/BCRDPublic.pdf*
- *iii. American College of Surgeons, ATLS: Advanced Trauma Life Support. 2018, Chapter 9, Pgs 169-185*
- *iv. DMEP: Disaster Management and Emergency Course, American College of Surgeons Committee on Trauma, Subcommittee on Disaster And Mass Causalities 2016 112-120*
- *v. Buidelines for Burn Care Under Austere Conditions: Introduction to Burn Disaster, Airway and Ventilator Management, and Fluid Resuscitation; ABA, J Burn Care&Res; Sep-Oct,2016; Kearns, Randy D.*
- *v1: Guidelines for Burn Care Under Austere Conditions: Special Etioloiges: Blast, Radiation, and Chemical Injuries; ABA, JBurn Care&Res 38(1) e482; Cancio, Leopoldo C; Jan-Feb, 2017*
- *viii. https://crisisstandardsofcare.hsc.utah.edu/ Requires login and password, recommend obtaining during planning not response.*

1st degree Superficial



2nd degree Partial Thickness



3rd degree Full Thickness



FINAL APPROVED: 2/24/2020

Next Revision due: 2023

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HEMODYNAMIC SUPPORT AND IV FLUIDS – March 19, 2019 FINAL

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Equipment and Supplies and Training • 1. Cache intravenous (IV) cannulas, tubing, fluids, medications, and administration supplies, oral rehydration packets (ORS) and intraosseous (IO) equipment, including drill and manual placement needles. • 2. Conduct training and education re: oral and enteral hydration, IO and hypodermoclysis fluid administration options. • 3. Develop system wide scarce resource communication plans with clear lines of responsibility and accountability to keep staff aware of shortages and conservation strategies. • 4. Consider centralized inventory control of critical medications and fluids (e.g. procedural areas, ORs, day surgery areas may have separate inventory control of critical resources).	*Prepare*			
IV Fluid Conservation Strategies[1] • 5. Monitor CDC, FDA and ASHP updates on supply and conservation strategies. • 6. Switch to oral therapy whenever possible (e.g. antibiotics, anticoagulants, electrolyte replacements).				
• 7. Discontinue KVO (Keep vein open) orders. • 8. Adopt NPO strategies as recommended by the ASA[2] (2 hours for liquids, 4 hours for breast milk, 6 hours for infant formula, light meal or nonhuman milk) to limit "maintenance IVF". • 9. Review electronic medical record order sets to ensure conservation strategies are being enforced. • 10. If oral therapy is not feasible or indicated consider IM or SQ injection.				
• 11. If IV medications must be used, consider alternative compounding strategies to minimize IVF use such as syringe infusion pumps; IV push administration, following the "ISMP Safe Practice Guidelines for Adult IV Push Medications".[3] • 12. Consider using alternative fluids (e.g. dextrose or LR), or other volume expanders (e.g. colloids) depending on clinical situation. • 13. Repackage small bags from larger source following the "Repackaging of certain Human Drug Products by Pharmacies and Outsourcing Facilities" 2017, authored by FDA.[4]				
Emphasize Enteral Hydration Instead of IV Hydration **Provide oral hydration (ORT), when possible** • 14. Provide guidelines for oral rehydration therapy, including indications for hospital referral, to outpatient providers. **Utilize Appropriate Oral Rehydration Solution** • 15. Oral rehydration solution: 1-liter water (5 cups) + 1 tsp salt + 8 tsp sugar, add flavor (e.g., ½ cup juice) as needed. • 16. Rehydration for moderate dehydration 50-100mL / kg over 2-4 hours. **Pediatric Hydration** Pediatric maintenance fluids: • 17. Four mL/kg/h for first 10kg of body weight (40 mL/h for 1st 10 kg). • 18. Two mL/kg/h for second 10kg of body weight (20 mL/h for 2nd 10kg = 60 mL/h for 20kg child). • 19. One mL/kg/h for each kg over 20kg (example - 40 kg child = 60 mL/h plus 20 mL/h = 80 mL/h). Supplement for each diarrhea or emesis.	*Substitute*			
Provide nasogastric or gastrostomy (NG, G-tube) hydration for both adults and pediatric patients when applicable. • 20. For fluid support, 8-12F (pediatric: infant 3.5F, < 2yrs 5F) tubes are better tolerated than standard size tubes. • 21. For additional equipment size guidelines, refer to a pediatric length-based resuscitation tape, e.g., the Broselow™ Tape. NOTE: Clinical (urine output, etc.) and laboratory (BUN, urine specific gravity) assessments and electrolyte correction are key components of fluid therapy and are not specifically addressed by these recommendations.	*Substitute*			

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IV and Syringe Pumps • 22. Ensure IV pumps are charged and battery life monitored. • 23. Consider stocking alternate emergency equipment for IV administration such as buretrols and drip counters, other devices such as the Drip Assist [T] designed for use in austere environments.	*Conserve*			
• 24. Reserve IV pumps, if limited, for use for critical medications such as sedatives, analgesics, certain antibiotics and hemodynamic support.	*Conserve*			
Substitute Epinephrine for Other Vasopressor Agents in Shortage • 25. For hemodynamically unstable patients > 18 yo who are adequately volume-resuscitated, consider adding 6mg epinephrine (6mL of 1mg/ml) to1000mL NS on mini-drip tubing and titrate to target blood pressure. • 26. For children < 18 yrs. add 0.6 X weight(kg) to equal total mg of Epinephrine to add to a 100 mL bag of NS. Run on mini-drip tubing start at 1 mL/hr (= 60 drips/hr or 1 drip/minute). This starting epinephrine rate = 0.1 mcg/kg/min, a standard starting epinephrine dose, assuming that 1 mL=60 drips for mini-drip tubing; increase drip rate to target blood pressure.	*Substitute*			
Re-use CVP, NG, and Other Supplies After Appropriate Sterilizations/Disinfection • 27. In crisis situations, when considering re-use of otherwise single use disposable equipment, alternate sterilization techniques should be discussed using available expert opinions such as CDC, WHO, local public health and infection control specialists. When possible, consensus recommendation should be made. Possible sterilization options during crisis include: ○ 27a) High-level disinfection for at least twenty minutes for devices in contact with body surfaces (including mucous membranes); glutaraldehyde, hydrogen peroxide 6%, or bleach (5.25%) diluted 1:20 (2500 ppm) may be acceptable solutions. NOTE: chlorine levels reduced if stored in polyethylene containers - double the bleach concentration to compensate).	*Re-use*			
Intraosseous and Subcutaneous (Hypodermoclysis) Replacement Fluids • 28. Consider "clysis" as an option when alternative routes of fluid administration are impossible/unavailable. • 29. Intraosseous administration should be considered before hypodermoclysis. Intraosseous • 30. Intraosseous infusion is not generally recommended for hydration purposes, but may be used until alternative routes are available. Intraosseous infusion requires pump or pressure bag. Rate of fluid delivery is often limited by pain of pressure within the marrow cavity. This may be reduced by pre-medication with lidocaine (preservative-free) 0.5mg/kg slow IV push. Hypodermoclysis [5,6] • 31. Cannot correct more than moderate dehydration via this technique. • 32. Many medications cannot be administered subcutaneously. • 33. Common infusion sites: pectoral chest, abdomen, thighs, upper arms. • 34. Common fluids: normal saline (NS), D5NS, D5 1/2 NS (Can add up to 20-40 mEq potassium if needed.). • 35. Insert 21/24 gauge needle into subcutaneous tissue at a 45 degree angle, adjust drip rate to 1-2 mL per minute (May use 2 sites simultaneously if needed.). • 36. Maximal volume about 3 liters / day; requires site rotation. • 37. Local swelling can be reduced with massage to area. • 38. Hyaluronidase 150 units / liter facilitates fluid absorption but is not required; may not decrease occurrence of local edema.	*Substitute*			
Consider Use of Veterinary and Other Alternative Sources for Intravenous Fluids and Administration Sets	*Adapt*			

Adapted From the Minnesota Department of Health, Office of Emergency Preparedness

FINAL version: *March 19, 2019*

Next review and update due: *2022*

[1] https://www.fda.gov/downloads/Drugs/DrugSafety/DrugShortages/UCM582461.pdf

[2] http://anesthesiology.pubs.asahq.org/article.aspx?articleid=2596245&_ga=2.204142672.159725813.1522250986-851673073.1522250986

[3] https://www.ismp.org/sites/default/files/attachments/2017-11/ISMP97-Guidelines-071415-3.%20FINAL.pdf

[4] https://www.fda.gov/downloads/Drugs/Guidances/UCM434174.

[5] *Caccialanza, R, et al, Subcutaneous Infusions of Fluids for Hydration or Nutrition: A Review, JPEN 2018;42:296-307*

[6] *Bruno, VG, Hypodermoclysis: a literature review to assist in clinical practice, Einstein (Sao Paulo) 2015;13(1):122-8*

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MECHANICAL VENTILATION/EXTERNAL OXYGENATION

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity –** The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity –** Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Increase Hospital Stocks of Ventilators and Ventilator Circuits, ECMO or bypass circuits	*Prepare*			
Access Alternative Sources for ventilators / specialized equipment • Obtain specialized equipment from vendors, healthcare partners, regional, state, or Federal stockpiles via usual emergency management processes and provide just-in-time training and quick reference materials for obtained equipment.	*Substitute*			
Decrease Demand for Ventilators • Increase threshold for intubation / ventilation. • Decrease elective procedures that require post-operative intubation. • Decrease elective procedures that utilize anesthesia machines. • Use non-invasive ventilatory support when possible.	*Conserve*			
Re-use Ventilator Circuits • Appropriate cleaning must precede sterilization. • If using gas (ethylene oxide) sterilization, allow full 12-hour aeration cycle to avoid accumulation of toxic byproducts on surface. • Use irradiation or other techniques as appropriate.	*Re-use*			
Use Alternative Respiratory Support Technologies • Use transport ventilators with appropriate alarms – especially for stable patients without complex ventilation requirements. • Use anesthesia machines for mechanical ventilation as appropriate / capable. • Use bi-level (BiPAP) equipment to provide mechanical ventilation. (Contingency and Crisis) • Consider bag-valve ventilation as temporary measure while awaiting definitive solution / equipment (as appropriate to situation extremely labor intensive and may consume large amounts of oxygen).	*Adapt*			
Assign Limited Ventilators to Patients Most Likely to Benefit if No Other Options are Available: **See Pediatric and/or Adult Critical Care Algorithm**	*Re-allocate*			

Adapted From the Minnesota Department of Health, Office of Emergency Preparedness

As of June 19, 2017

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FL-DOH-20-0673-A-005484

OXYGEN - 03/29/2019 DRAFT REVISION

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Inhaled Medications • 1. Use compressed or room air for administration of nebulized medications when clinically appropriate. • 2. Restrict the use of Small Volume Nebulizers when inhaler substitutes are available. • 3. Restrict continuous nebulization therapy. • 4. Minimize frequency through medication substitution that results in fewer treatments (6h-12h instead of 4h-6h applications). • 5. Change children from albuterol continuous nebulizers to Albuterol 8 puffs MDI Q2 hrs when they are ready to stop continuous treatments. Only use albuterol nebulizers in continuous form for truly acute status asthmaticus.	*Substitute & Conserve*			
High-Flow Applications • 6. Assure all resuscitation oxygen bags have shut off valves and are shut off when not in use.	*Conserve*			
• 7. Restrict the use of high-flow adult cannula systems as these can demand 12 to 40 LPM flows. • 8. Restrict the use of simple and partial rebreathing masks to 10 LPM maximum. • 9. Consider intubation or non-invasive ventilation with a well-sealed mask over the use of high flow oxygen delivery systems for both adult and pediatric patients during critical shortages.	*Conserve*			
Air-Oxygen Blenders • 10. Eliminate the low-flow reference bleed occurring with any low-flow metered oxygen blender use. This can amount to an additional 12 LPM. Reserve air-oxygen blender use for mechanical ventilators using high-flow non-metered outlets. (These do not utilize reference bleeds). • 11. Disconnect blenders when not in use.	*Conserve*			
Oxygen Conservation Devices • 12. Use reservoir cannulas if available at 1/2 the flow setting of standard cannulas. • 13. Replace simple and partial rebreather mask use with reservoir cannulas or venti-masks at flow rates of 6-10 LPM • 14. Use High Efficiency nebulizers and use air flow instead of oxygen when clinically possible.	*Substitute & Adapt*			
Augment Oxygen Supply • 15. Use hospital-based or independent home medical equipment supplier oxygen concentrators if available to provide low-flow cannula oxygen for patients and preserve the primary oxygen supply for more critical applications. • 16. Consider other source of oxygen such as dental or veterinary offices. • 17. Obtain oxygen supply from industrial sources, such as supplied by welding companies and underwater diving operations.	*Substitute & Conserve*			
• 18. Reduce hospital wide PSI from 50-40.	*Conserve*			
Monitor Use and Revise Clinical Targets • 19. Employ oxygen titration protocols to optimize flow or % to match targets for SPO2 or PaO2. • 20. Discontinue oxygen at earliest possible time.	*Conserve*			

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- 21. Consider variable parameters for initiating and continuing oxygen therapy:

Starting Example	Initiate O2	O2 Target	Note: These target ranges need to be continually re-evaluated depending on resources available, the patient's clinical presentation, or measured PaO2 determination. If no pulse oximetry is available initiate oxygen therapy based on clinical assessment (e.g. cyanosis, increased work of breathing, valid respiratory scores etc.)
Normal Lung Adults	SPO2 <88-90%	SPO2 90%	
Pediatrics	SPO2 <88-90%	SPO2 90%	
Severe COPD History	SPO2 <85%	SPO2 88-90%	

Expendable Oxygen Appliances

- 22. All non-standard disinfection and sterilization procedures should be tested and assessed prior to widespread use. Possible options during crisis include: Use terminal sterilization or high-level disinfection procedures for oxygen appliances, small & large-bore tubing, and ventilator circuits. Bleach concentrations of 1:10, high-level chemical disinfection, or irradiation may be suitable. Ethylene oxide gas sterilization (if available) is optimal, but requires a 12-hour aeration cycle to prevent ethylene chlorohydrin formation with polyvinyl chloride plastics.

Re-use

Oxygen Re-Allocation Implementation

- 23. For patient prioritization for oxygen administration or re-allocation during severe resource limitations please see Adult and Pediatric Critical Care Algorithms.

Re-Allocate

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Renal Replacement Therapy Card

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

Category	*RECOMMENDATIONS*	*Inpatient*	*Outpatient*	*Strategy*	*Conventional*	*Contingency*	*Crisis*
A. General	1. All organizations that provide dialysis need to maintain internal emergency plans to provide care for the special needs of dialysis patients during any external or internal emergency that may disrupt standard operations. These plans should address appropriate water and power supply, equipment and supply needs and staff/provider considerations. (See links to resources in #2 below)	√	√	*Prepare*			
	2. All dialysis providers must advise their patients in developing their own preparedness plans including emergency and contingency plans for food, medications, transportation and emergency contact resources. • Dialysis patients need to be self-sufficient for up to 96hrs. Note that shelters are unlikely to have foods appropriate for renal dietary needs (low sodium, etc.). Personal planning guidance is available at: https://www.kidney.org/sites/default/files/11-10-0807_IBD_disasterbrochure.pdf https://www.davita.com/kidney-disease/overview/living-with-ckd/emergency-preparedness-for-people-with-kidney-disease/e/4930		√				
	3. Medical needs of re-located renal failure patients from outside our region are substantial; the medical leadership of Northwest Kidney Center, DaVita and NW Renal Network need to be made aware of such incoming patients in order to be able to plan for their medical needs.[1]	√	√				
	Transportation Interruptions 4. Chronic dialysis patients should coordinate with their service providers/dialysis clinics first for transportation and other assistance during service/transportation interruptions.		√	*Prepare*			
	5. If individual providers/dialysis clinics are unable to meet emergent supplemental transportation needs, refer to the King County Winter Weather Medical Transport Plan and Pierce County Department of Emergency Management for their possible assistance [2].		√	*Adapt*			
B. Water	**Water Supply** 6. Identify and quantify water-purifying capabilities for dialysis 7. Identify alternative water source if city water is unavailable	√	√	*Prepare*			
	8. Identify limitations and special arrangements needed to use water tanker a) Availability of reverse osmosis (RO) machines with carbon tanks b) Available means to generate adequate water pressure to units providing dialysis	√	√				
	Water Contamination 9. Consider alternate sources of highly purified water (e.g. Northwest Kidney Center water reserve tank, individual facility wells, etc.) keeping in mind that potable water alone is NOT sufficiently purified for dialysis.	√	√	*Prepare*			
	10. Consider transferring stable inpatients to outpatient dialysis centers for dialysis treatments and vice versa depending on location of purified water source	√	√	*Substitute Adapt*			

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	11. Consider use of other regional assets for water reserves a) JBLM assets: well, tanker b) Navy assets: desalination and reverse osmosis capabilities (ship dependent) c) Commercial vessels	√	√	*Adapt*			
C. Power	12. Consider transferring stable inpatients to outpatient dialysis centers for dialysis treatments and vice versa	√	√	*Substitute* *Adapt*			
	13. Consider transferring inpatients or outpatients to other hospitals or facilities out of the affected region until issues have been resolved.	√	√				
D. Supplies	**Dialysis Catheters, Machines, Reverse Osmosis Machines, and/or Other Supply Shortages** 14. Maintain adequate stock of dialysis tubing sets and venous/peritoneal access catheters (Quinton, etc.) and medications (e.g. Kayexalate)	√	√	*Prepare*			
	15. Identify other sources of supplies and machines	√	√				
	16. Transfer machines/supplies between outpatient centers and hospitals, or between hospitals	√	√	*Substitute*			
E. Staff	17. Consider alternative staffing assignments with the following recommendations: **Alternative Staff Recommendations** *(listed in order of consideration)* **Dialysis Techs**: 1. Former Dialysis Techs who are now techs in other specialties; 2. General Nurse with prior dialysis experience. **Dialysis Nurses**: 1. General RN or Transplant RN with previous HD[1] or PD[2] experience; 2. Critical Care nurse with a dialysis training; 3. Critical Care Nurse with no dialysis experience and JIT[3]; 4. General nurse with JIT **MDs (Nephrologist)**: 1. Telemedicine nephrologist; 2. Retired nephrologist who has maintained medical license; 3. ARNPs/PAs trained in dialysis; 4. Critical Care MD with experienced dialysis nurse and JIT training.; 5. Dialysis nurse with extensive inpatient dialysis experience [1]Hemodialysis [2]Peritoneal Dialysis [3]Just-in-time Training (i.e. video, written instructions, handbook, etc.)			*Substitute*			
F. Treatment	**Crush Syndrome** 18. Initiate normal saline IV hydration and acidosis prevention protocols immediately either pre-hospital or as soon as possible upon arrival to a healthcare facility to prevent/treat rhabdomyolysis. Additional treatment recommendations: a) avoid nephrotoxic agents such as NSAIDS, aminoglycosides, ACE/ARB's along with other drugs which may cause hyperkalemia b) aggressive monitoring and treatment of potential hyperkalemia c) close monitoring of fluid status.	√		*Conserve*			

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	Mode of Dialysis 19. Optimize the mode of dialysis to provide care for the most patients possible given resources available a) if water is scarce, consider PD and CRRT as modes of dialysis b) if water is readily available restrict to HD or PD and discontinue CRRT for staff considerations.	√	√	*Substitute*			
	Increased Demand on Resources 20. Shorten duration of dialysis for patients that are more likely to tolerate it safely	√	√	*Conserve*			
	21. Patients to utilize their home "kits" of medication (Kayexalate) and follow dietary plans to help increase time between treatments.		√				
G. Triage	**Insufficient Resources Available For All Patients Requiring Dialysis** 22. Change dialysis from 'scheduled' to 'as needed' based on clinical and laboratory findings (particularly hyperkalemia and impaired pulmonary function) – parameters may change based on demand for resources	√	√	*Conserve*			
	23. Conceivable (but extraordinary) situations may occur where resources are insufficient to the point that some patients may not be able to receive dialysis (for example, pandemic when demand nationwide exceeds available resources). Prioritization should follow the Crisis RRT Triage Algorithm and Worksheet. In multi-organ system failure (MOSF) refer to the Adult/Pediatric Critical Care Triage Algorithm and Worksheet.	√	√	*Re-allocate*			

Adapted From the Minnesota Department of Health, Office of Emergency Preparedness ***Approved: 5/10/17***

1 Medical Leadership Contact Information: DaVita (253-733-4602); Northwest Kidney Centers (206-720-8505); NW Renal Network (206-923-0714).

[2] Contact Public Health Seattle King County Duty officer, Pierce County Emergency Management Duty Officer or the Northwest Healthcare Response Network Duty Officer for more information.

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PARTICULATE RESPIRATORS[1] AND GENERAL PPE
(N95, Elastomeric, PAPR, CAPR)
STRATEGIES FOR SCARCE RESOURCE SITUATIONS

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
General Infection Control Procedures • 1. Screen all patients for symptoms specific to current situation and keep updated to any changing screening recommendations • 2. At healthcare facilities where patients have scheduled appointments, consider screening prior to arrival to limit exposure and resources • 3. Establish procedures for managing visitors and ill healthcare personnel. • 4. Establish triage procedures and separate areas for ill and well patients. • 5. Assign dedicated staff to minimize exposure. • 6. Require, when possible, or strongly encourage vaccination of primary personnel and first responders, according to vaccine schedule as recommended for existing circumstances by the CDC and the Advisory Committee for Immunization Practices (ACIP). • 7. Seriously consider creation of a registry to reflect the vaccination status of primary personnel and first responders to aid in decisions regarding service assignments. • 8. Educate and routinely train all staff regarding appropriate use and proper donning and doffing procedures of PPE and particulate respirators. • 9. Maintain good hand hygiene procedures including gloves, hand washing with soap and water and/or alcohol based hand sanitizers depending on the current recommendations. • 10. Maintain plan for N95 Fit Testing **Engineering Controls** • 11. When applicable to specific institution consider designing and installing engineering controls to reduce or eliminate exposure by shielding healthcare providers and other patients from infection individuals. Examples of engineering controls include physical barriers or partitions to guide patients through triage areas, curtains between patients in shared areas, closed suctioning systems for airway suctioning for intubated patients, as well as appropriate air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained. **Cache/ Increase Supply Levels** • 12. Clarify current CDC and OSHA guidelines for respirator and other PPE use; monitor for updates and recommendations.[2] • 13. Cache additional supplies of PPE and respirators and their functional components (e.g. fit testing supplies, batteries, cartridges, filters, hoods etc.). • 14. Review vendor agreements, contingencies for delivery and production, including alternate vendors. • 15. Consider other NIOSH approved respirators in times of short supply (e.g. These include N99, N100, P95, P99, P100, R95, R99, and R100.)[5] • 16. Review current supply of PPE and determine baseline and surge burn rates to better plan supply needs. • 17. Maintain a reserve sufficient to meet estimated needs of PPE for all infectious diseases. • 18. Review cached PPE on a regular basis for expirations dates and consider replacing/updating caches by rotating PPE into daily use	*Prepare*			
• 19. Obtain masks, cartridges and other PPE from alternate sources such as industrial suppliers and companies – welding, manufacturing, etc. – as indicated.	*Substitute*			

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• 20. Request Strategic National Stockpile of respirators with the knowledge that they may be from different manufacturers. They may not be functional in all situations (i.e. surgical use) and they may require additional fit testing before deployment. • 21. Do not discard unused expired PPE; submit for extension through *** (?NIOSH? CDC?)				
Decrease Use of PPE • 22. Clarify current CDC, OSHA and NIOSH guidelines for PPE use; monitor for updates and recommendations.[2,3] • 23. Medical/surgical masks can be reused by infected patients until the masks are no longer useable due to moisture or damage.	*Substitute & Conserve*			
• 24. When PPE, especially Respirators are in short supply, aerosol-generating procedures should only be performed on patients when medically necessary and cannot be postponed. • 25. Limit the number of healthcare personnel with patient contact to only those essential for patient care and support, especially during aerosol generating procedures. • 26. Consider primary use of PAPRs, CAPRs Elastomeric or other Respirators to conserve on N95 masks • 27. Ensure staff are educated and understand specific PPE requirements during current situations so as not to *overuse* PPE • 28. Develop specific protocols for PPE distribution so as to ensure PPE is being used responsibly • 29. Cohort patients with known disease to limit donning and doffing of PPE • 30. Consider limiting visitors • 31. Consider changes in staffing (i.e. unimmunized staff given assignments that would not require significant PPE use)	*Conserve*			
Respirator Extended Use[6] • 32. Clarify current CDC and OSHA guidelines for respirator use; monitor for updates and recommendations.[6] • 33. Policies and recommendations around "extended use" or "re-use" of respirators should include input from occupational health, infection control, infectious disease specialists, state and local public health and any national recommendations around the situation at hand. • 34. For N95, consider wearing a loose-fitting barrier that does not interfere with fit or seal (e.g., surgical mask, face shield) over the respirator to extend its use. • 35. In general, wearing an N95 respirator over multiple serial patient encounters (while minimizing touching) is favored over removing and re-donning between encounters (i.e. extended use is favored over re-use of N95).[3] • 36. Cleaning and filter replacement procedures and extended use of filters and/or hoods/shields on all other mechanical respirators (i.e. elastomeric respirators, PAPRs , CAPRs etc.) should be done according to manufacturer's protocols and guidelines.	*Re-use*			
Re-use Respirator After Removal[6] • 37. Clarify current CDC and OSHA guidelines for respirator use; monitor for updates and recommendations.[6] • 38. Review manufacturer recommendations for cleaning and re-using PAPRs and CAPR face shields when appropriate. • 39. Policies and recommendations around "extended use" or "re-use" of respirators should include input from occupational health, infection control, infectious disease specialists, state and local public health and any national recommendations around the situation at hand.	*Re-use* *Re-allocate*			
• 40. Use and store used respirators (hood, mask, shield) individually in such a way that the physical integrity and efficacy of the respirator will not be compromised.[6] • 41. Label respirator with a user's name before use to prevent inadvertent use by another individual.[6] • 42. Practice appropriate hand hygiene before and after removal of the respirator and, if necessary and possible, appropriately disinfect the object used to store it.[6] • 43. Respirators should be discarded if visibly damaged or contaminated.[6] • 44. The specific number of safe reuses for N95's is very difficult to estimate. In general check the specific N95 manufacturer recommendations. In general Five (5) is the recommended number of donning of a re-used N95-type respirator.[6] • 45. Consider N95 decontamination with ultraviolet germicidal irradiation (UVGI), or other tested method of decontamination to extend the use of respirators.[4] **Re-allocate/ prioritize** • 46. Respirators use should be prioritized only to those healthcare providers identified as highest risk based on epidemiology of current situation. • 47. Identify medical personnel and caregivers with documented vaccination, immunity after an illness or lower risk of complicated infection to provide direct patient contact without a respirator.	*Re-use* *Re-allocate*			

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[1]*Refers to any device such as N95, elastomeric respirators, Powered Air Purifying respirators (PAPRs), Controlled Air Purifying Respirator (CAPRs) or equivalent. NIOSH approved particulate respirators can be found at: https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/RespSource.html; https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html*

[2]*CDC and NIOSH overview of respirators: https://www.cdc.gov/niosh/topics/respirators/default.html*

[3]*OSHA eTool: https://www.osha.gov/SLTC/etools/respiratory/index.html*

[4]*"Extended use" is defined as wearing the same respirator for repeated close contact encounters with multiple patients without removing the respirator between patients (e.g. triage area, dedicated waiting rooms or wards, etc). "Reuse" is defined as using the same respirator for multiple encounters but removing it after each encounter. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3respreuse.html*

[4]*Current research on the decontamination of N95 Respirators: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4699414/pdf/nihms747549.pdf, https://academic.oup.com/annweh/article/53/8/815/154763 https://academic.oup.com/annweh/article/56/1/92/166111*

[5] *https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html*

[6]*https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html*

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STAFFING

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

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RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Staff and Supply Planning • Assure facility has process and supporting policies for disaster credentialing and privileging - including degree of supervision required, clinical scope of practice, mentoring and orientation, and verification of credentials. • Encourage employee personal preparedness planning (ready.gov, redcross.org). • Cache adequate personal protective equipment (PPE) and support supplies. • Educate staff on facility disaster response and recommend regularly scheduled HICS training. • Educate staff on community, regional and state disaster plans and resources. • Develop facility plans addressing staff's family / pets or staff shelter needs (such as daycare and unaccompanied minor needs) as well as transportation plans for staff to get to and from the facility. • Include a process of staff identification and verification. Recommend photos and hard-copy files. • Create Job Cards for essential services and functions. • Pre-identify critical positions and ensure redundant staffing for these. • Recommend redundant staff communications and notification plans/procedures.	*Prepare*			
Focus Staff Time on Core Clinical Duties • Minimize meetings and relieve administrative responsibilities not related to event. • Cohort inpatients per OSHA/Public Health or CDC guidelines.	*Conserve*			
• Reduce documentation requirements.	*Adapt*			
Using Supplemental Staff • Utilize administrative positions (e.g. nurse managers) as patient care extenders. • Adjust personnel work schedules (longer but less frequent shifts, etc.) if this will not result in skill / PPE compliance deterioration. • Voluntary call-back of staff • Increase use of agency, per diem, travelers, float pools, locums staff • Retain staff for extended hours (in accordance with labor contract and existing contracts/agreements when applicable) • Use family members/lay volunteers to provide basic patient hygiene and feeding – releasing staff for other duties. • Postpone and reschedule out-patient non-acute and preventative care appointments to open more acute care out-patient appointments during surge.	*Substitute* *Adapt*			
Focus Staff Expertise on Core Clinical Needs • Personnel with specific critical skills (ventilator, burn management) should concentrate on those skills; specify job duties that can be safely performed by other medical professionals. • Reduce availability of non-time sensitive laboratory, radiographic, and other studies. • Postpone and reschedule elective procedures if it will improve staffing and space needs and does not result in undue patient inconvenience	*Conserve*			
• Have specialty staff oversee larger numbers of differently specialized staff and patients (for example, medical/surgery nurses working in critical care are overseen by a critical care nurse).	*Substitute* *Conserve*			
Use Alternative Personnel to Minimize Changes to Standards of Care • Bring in equally trained staff (burn or critical care nurses, Disaster Medical Assistance Team [DMAT], other health system or Federal sources). • Cancel all non-acute/preventative care appointments, surgeries and procedures (e.g. endoscopies, etc.) and divert staff to emergency duties including in-hospital or assisting public health at external clinics/screening/dispensing sites.	*Adapt*			

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• Use less trained personnel from outside institution with appropriate mentoring and just-in-time education (e.g., healthcare trainees or other health care workers, Medical Reserve Corps, retirees). • Implement alternate consultation and care techniques such as telemedicine. • Provide just-in-time training for specific skills.				

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ADULT Critical Care Triage Algorithm

Crisis Standards of Care

Updated Version: Mar 2020

This Algorithm is intended to be used alongside the attached Worksheet.
Answering each question requires the supplemental information in the Worksheet.
Please use them together

Assumptions for use:

1. Health Officer has declared a crisis situation requiring scarce resource management and crisis standards of care, where crisis standards of care is defined as *"a substantial change in usual healthcare operations and the level of care it is possible to deliver which is made necessary by a pervasive or catastrophic disaster"*.[1]
2. Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care.

Washington State has adopted and will use the ethical framework developed by the National Academy of Medicine, which stresses the importance of an ethically grounded system to guide decision-making in a crisis standards of care situation. All decisions and communications will be based on the ethical principles below. The National Academy of Medicine defines these ethical principles as:

- **Fairness** – Standards that are, to the highest degree possible, recognized as fair by those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.
- **Duty to care** – Standards are focused on the duty of healthcare professionals to care for patients in need of medical care.
- **Duty to steward resources** – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- **Transparency** – in design decision making, and information sharing.
- **Consistency** – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources).
- **Proportionality** – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.
- **Accountability** – of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.[2]

1. IOM (Institute of Medicine) 2009. Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report. Washington, DC: National Academies Press.

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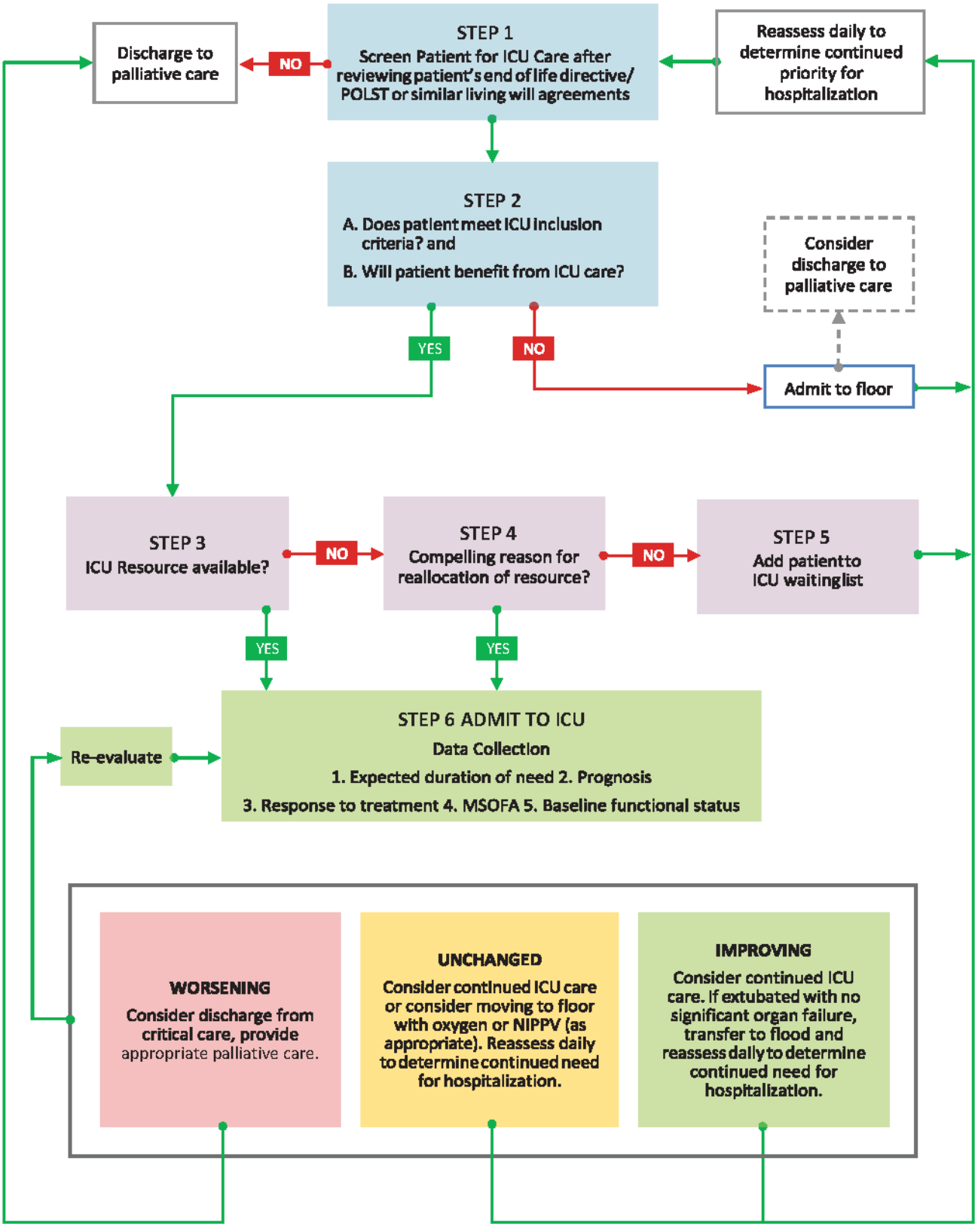
ADULT Critical Care Triage Algorithm

Crisis Standards of Care

Updated Version: Mar 2020



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ADULT Critical Care Triage Worksheet

Critical Care Guidelines During Crisis Capacity[1]

This Worksheet, along with the corresponding Adult Critical Care Algorithm, are to be used by "Triage Teams" during a declared emergency event whereby an appropriate healthcare official has implemented crisis standards of care. It is recommended that a "Triage Team" be comprised of senior medical personnel, preferably not those primarily taking care of the individual patient under consideration. Please see "Scarce Resource Triage Team Guidelines" for further information.

STEP 1: Screen adult patients for ICU care during scarce resources

Proceed to following after reviewing patient's end of life directives/POLST or similar living will documents. For the following conditions consider available staffing and resources. If resources are inadequate, ***consider*** transferring the following patients to out-patient or palliative care with appropriate resources and support as can be provided.

1. Pre-existing or Persistent coma or vegetative state
2. Severe acute trauma (e.g. non-survivable head injury)
3. Severe burns with Low Survival burn scores based on the Triage Decision for Burn Victims table (See Table A below). See Burn Scarce Resource Card for management of critical burn patient outside of a Burn Center.
4. Significant underlying disease process that predict poor short term survival*

   **Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*
   - *Severe congestive heart failure*
   - *Severe chronic lung disease*
   - *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
   - *Severe cirrhotic liver disease with multi-organ dysfunction*
5. Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

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STEP 2: Determine if patient meets ICU Inclusion Criteria

2A: Patients must have at least one of the following INCLUSION CRITERIA:

- ☐ **1.** Requires ventilatory support, either invasive or non-invasive
  - ☐ Clinical evidence of impending respiratory failure
    - *Refractory hypoxemia (SpO2<90% on FIO2>0.85)*
    - *Respiratory acidosis (pH<7.2)*
  - ☐ Inability to protect or maintain airway
- ☐ **2.** Hypotension (SBP <90) secondary to either an acute medical or trauma condition, with clinical evidence of shock (altered level off consciousness decreased urine output, or other evidence of end stage organ failure) refractory to volume resuscitation that cannot be managed in a non-ICU setting.

2B: To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) - *Please see Step 6 regarding use of scoring system*
- Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Severe congestive heart failure*
- *Severe chronic lung disease*
- *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
- *Severe cirrhotic liver disease with multi-organ dysfunction*

STEP 4: Assess for re-allocation of Critical Care Resource

To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) – *Please see Step 6 regarding use of scoring systems*
- Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Severe congestive heart failure*
- *Severe chronic lung disease*
- *Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery*
- *Severe cirrhotic liver disease with multi-organ dysfunction*

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STEP 5: Critical care waiting list

If a patient meets ICU inclusion criteria and resources are not available, patient will be placed on an ICU waiting list. As resources become available their clinical situation will be re-assessed and they will be re-triaged based on criteria outlined in Step 6. If a clear distinction cannot be made between patients of similar triage priority, the resource will be allocated to the patient who has been waiting the longest.

STEP 6: Admit to ICU

Patient data collection outlined on Step 6 of the Algorithm will be continuous and ongoing. It is recommended that every 24 hours of a patient's ICU stay, their clinical condition will be reviewed and they will be determined to be "Improving", "Unchanged" or "Worsening". This determination must not only take into account data points as outlined in Step 6 but must also include updated epidemiology, critical care resource availability and census demands.

Previously, recommendations had been made to use MSOFA score alone to determine triage categories. However, based on more recent data[2,3] it is current consensus that a specific SOFA or MSOFA score cannot accurately define clinical categories alone, and therefore all criteria outlined in Step 6 including current epidemiology must be taken into account when deciding if patients are "Improving," "Unchanged," or "Worsening".

Other Adult Considerations

All patients receiving critical care ***before the onset*** of crisis standards will be re-assessed based on the same criteria as all incoming critical care patients. The same Data as outlined in Step 6 should be obtained and resources re-allocated if needed dependent on the Triage Team assessment and decisions.

The use of ECMO should be decided on an individual basis by the ICU attending, nursing supervisor and ECMO representative based on prognosis, suspected duration of ECMO, availability of staff and other resources.

1. Crisis Capacity: Adaptive spaces, staff and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e. provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. (Hick et al, 2009, IOM)
2. Grissom, Colin K, Disaster Med Public Health Preparedness 4(4):277-284, 2011
3. Shahpori, R; Crit Care Med 39(4):827-832, 2011

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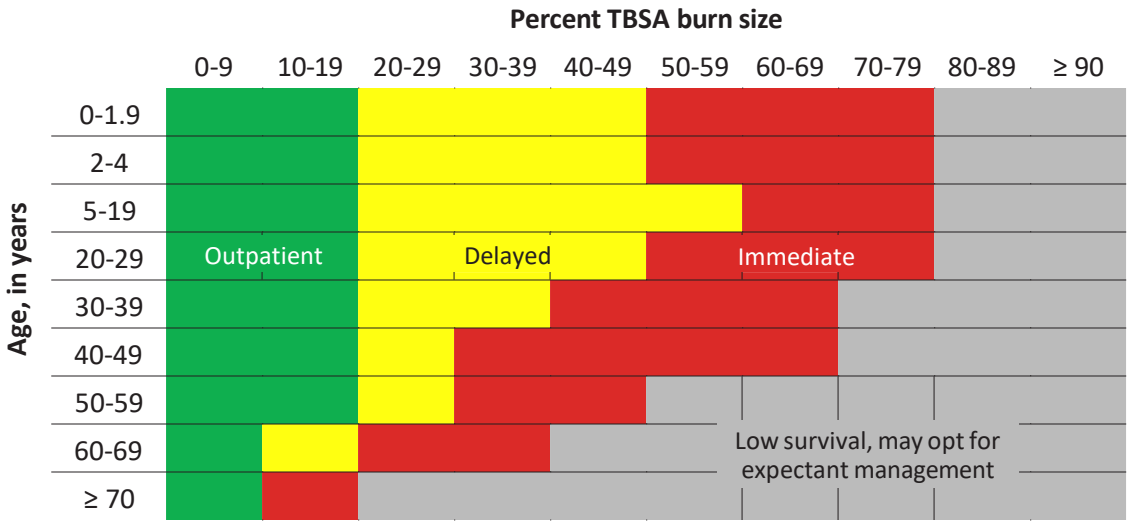

Table A

Saffle, JR, et al. Defining the ratio of outcomes to resources for triage of burn patients in mass casualties. J burn Care Rehabil 2005 26(6):478

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Pediatric Critical Care Triage Algorithm

Crisis Standards of Care

Updated Version: Mar 2020

This Algorithm is intended to be used alongside the attached Worksheet.
Answering each question requires the supplemental information in the Worksheet.
*****Please use them together.*****

Assumptions for use:

1. Health Officer has declared a crisis situation requiring scarce resource management and crisis standards of care, where crisis standards of care is defined as *"a substantial change in usual healthcare operations and the level of care it is possible to deliver which is made necessary by a pervasive or catastrophic disaster"*.[1]
2. Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care.

Washington State has adopted and will use the ethical framework developed by the National Academy of Medicine, which stresses the importance of an ethically grounded system to guide decision-making in a crisis standards of care situation. All decisions and communications will be based on the ethical principles below. The National Academy of Medicine defines these ethical principles as:

- **Fairness** – Standards that are, to the highest degree possible, recognized as fair by those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.
- **Duty to care** – Standards are focused on the duty of healthcare professionals to care for patients in need of medical care.
- **Duty to steward resources** – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- **Transparency** – in design decision making, and information sharing.
- **Consistency** – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources).
- **Proportionality** – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.
- **Accountability** – of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.[2]

1,2 IOM (Institute of Medicine) 2009. Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report. Washington, DC: National Academies Press.

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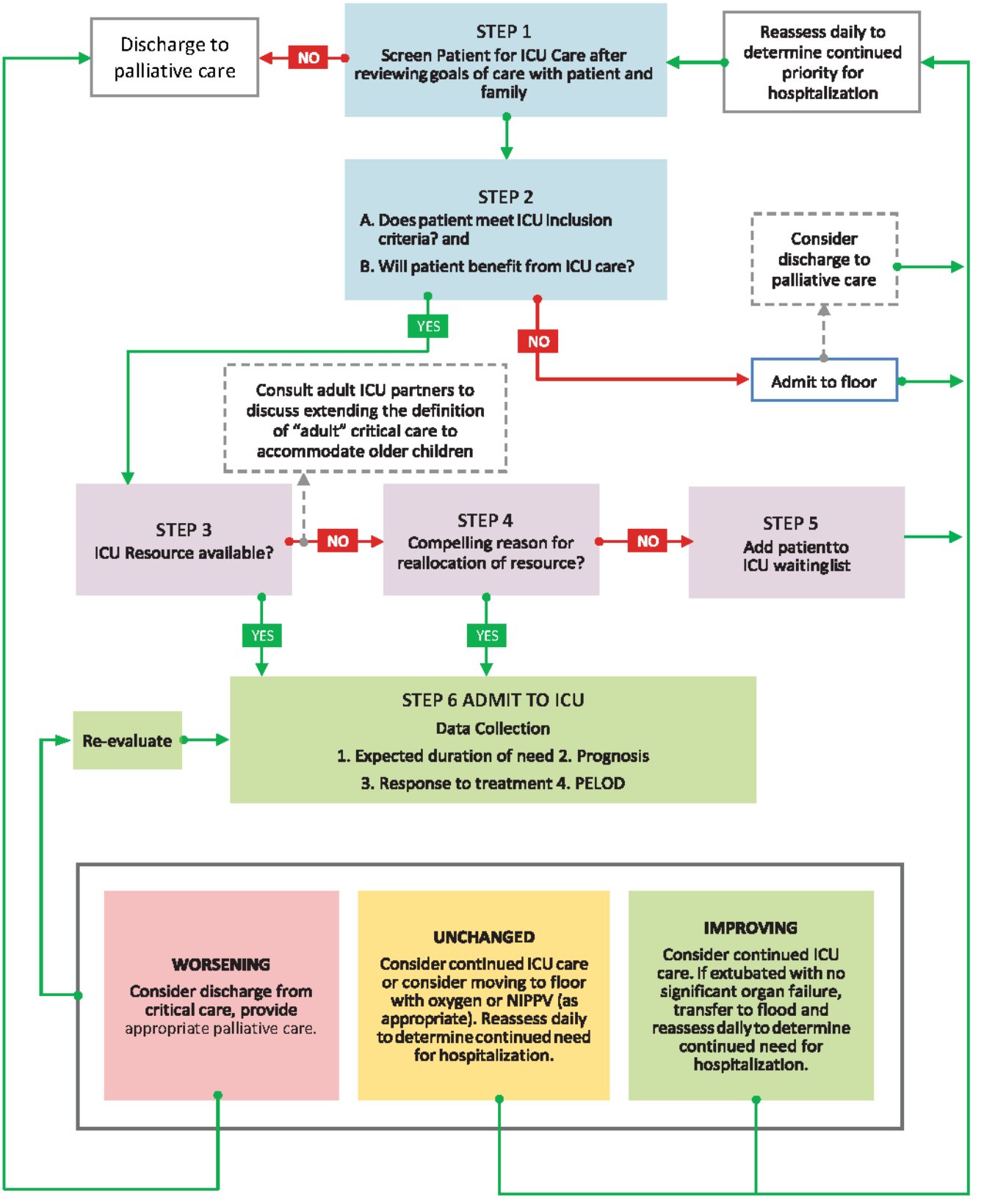
Pediatric Critical Care Triage Algorithm

Crisis Standards of Care

Updated Version: Mar 2020



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Pediatric Critical Care Triage Worksheet

Critical Care Guidelines During Crisis Capacity[1]

Updated Version: Mar 2020

This Worksheet, along with the corresponding Pediatric Critical Care Algorithm, are to be used by "Triage Teams" during a declared emergency event whereby an appropriate healthcare official has implemented crisis standards of care. It is recommended that a "Triage Team" be comprised of senior medical personnel, preferably not those primarily taking care of the individual patient under consideration. Please see "Scarce Resource Triage Team Guidelines" for further information.

STEP 1: Screen Pediatric Patients for ICU care During Scarce Resources

Proceed to the following after reviewing goals of care with patient and family (e.g. limited code status). The goals of care should reflect the best interest of the patient.

For the following conditions consider available staffing and resources. If resources are inadequate, consider transferring the following patients to out-patient or palliative care with appropriate resources and support as can be provided.

- ☐ **1.** Pre-existing or Persistent encephalopathy, coma or vegetative state
- ☐ **2.** Severe acute trauma (e.g. non-survivable head injury)
- ☐ **3.** Severe burns with Low Survival burn scores based on the Triage Decision for Burn Victims table (See Table A). See Burn Scarce Resource Card for management of critical burn patient outside of a Burn Center.
- ☐ **4.** Significant underlying disease process that predict poor short term survival*

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Known severe chromosomal abnormalities with poor prognosis*
- *Known severe metabolic, neuromuscular, cardiac, oncologic or pulmonary disease with poor prognosis*
- *Extreme prematurity at the limits of viability*

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STEP 2: Determine if patient meets ICU Inclusion Criteria

2A: Patients must have at least one of the following INCLUSION CRITERIA:

☐ **1.** Requires ventilatory support, either invasive or non-invasive

- ☐ Clinical evidence of impending respiratory failure
  - *Refractory hypoxemia (SpO2<90% on FIO2>0.85)*
  - *Respiratory acidosis (pH<7.2)*
- ☐ Inability to protect or maintain airway

☐ **2.** Hypotension (see table A) or clinical evidence of shock (defined as an altered level of consciousness, decreased urine output, or other evidence of end stage organ failure) refractory to volume resuscitation secondary to either an acute medical or trauma condition that cannot be managed in a non-ICU setting.

Age	SBP (mmHG)
0-28 days	<60
1 month – 1 year	<70
1 year – 10 years	(age in years x 2) + 70
>10 years	<90

Table A[2]

2B: To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the Pediatric Logistic Organ Dysfunction (PELOD 2) score. **(Table C) – *Please see Step 6 regarding use of scoring systems.***

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Known severe chromosomal abnormalities with poor prognosis*
- *Known severe metabolic, neuromuscular, cardiac, oncologic or pulmonary disease with poor prognosis*
- *Extreme prematurity at the limits of viability*

STEP 4: Assess for re-allocation of Critical Care Resource

To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the Pediatric Logistic Organ Dysfunction (PELOD 2) score. **(Table C) – *Please see Step 6 regarding use of scoring systems.***

**Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- *Known severe chromosomal abnormalities with poor prognosis*
- *Known severe metabolic, neuromuscular, cardiac, oncologic or pulmonary disease with poor prognosis*
- *Extreme prematurity at the limits of viability*

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STEP 5: Critical care waiting list

If a patient meets ICU inclusion criteria and resources are not available, patient will be placed on an ICU waiting list. As resources become available their clinical situation will be re-assessed and they will be re-triaged based on criteria outlined in Step 6. If a clear distinction cannot be made between patients of similar triage priority, the resource will be allocated to the patient who has been waiting the longest.

STEP 6: Admit to ICU

Patient data collection outlined on Step 6 of the Algorithm will be continuous and ongoing. It is recommended that every 24 hours of a patient's ICU stay, their clinical condition will be reviewed and they will be determined to be "Improving", "Unchanged" or "Worsening". This determination must not only take into account data points as outlined in Step 6 but must also include updated epidemiology, critical care resource availability and census demands.

Pediatric prognostic scoring systems currently available (e.g. PELOD2) are unable to accurately predict patient outcomes and thus should not be used as a sole indicator of prognosis especially in a disaster situation. When considering critical care resource allocation in a crisis, it is recommended that decisions be made by a Triage Team. Decisions should be made based on best clinical judgment with full knowledge of regional resource availability. (Ped Crit Care 2011)

Other Pediatric Considerations

All patients receiving critical care ***before the onset*** of crisis standards will be re-assessed based on the same criteria as all incoming critical care patients. The same Data as outlined in Step 2 should be obtained and resources re-allocated if needed dependent on the Triage Team assessment and decisions.

The use of ECMO should be decided on an individual basis by the PICU and/or NICU attending, nursing supervisor and ECMO representative based on prognosis, suspected duration of ECMO, availability of staff and other resources.

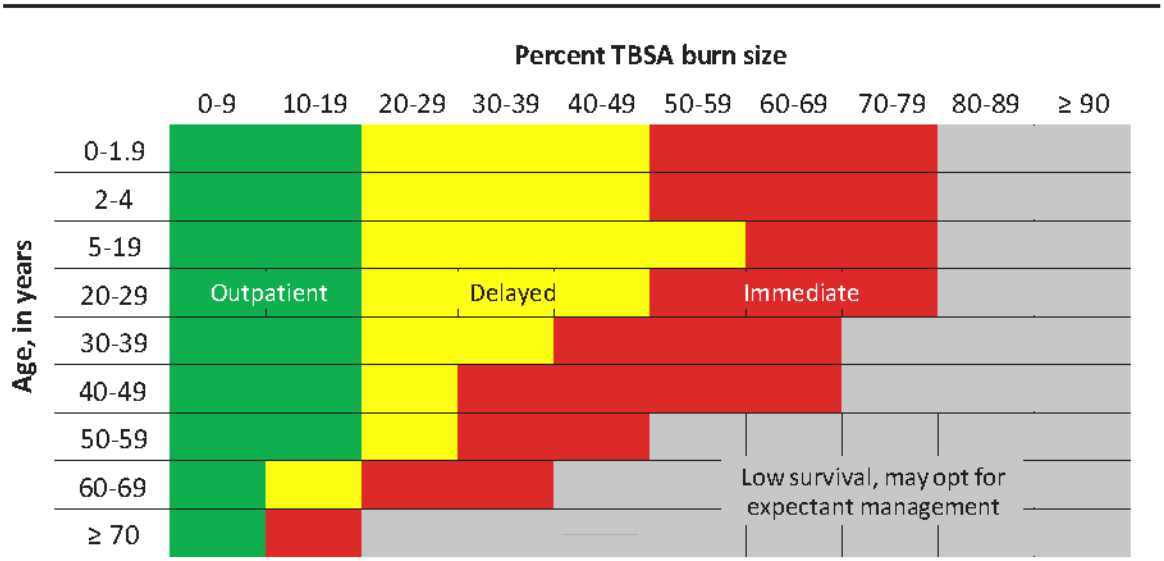

Table B

Saffle, JR, et al. Defining the ratio of outcomes to resources for triage of burn patients in mass casualties. J burn Care Rehabil 2005 26(6):478

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Table C. PELOD2 Scoring System[3]

Organ Dysfunctions and Variables[a]	Points by Severity Levels						
	0	1	2	3	4	5	6
Neurologic[b]							
Glasgow Coma Score	≥ 11	5–10			3–4		
Pupillary reaction	Both reactive					Both fixed	
Cardiovascular[c]							
Lactatemia (mmol/L)	< 5.0	5.0–10.9			≥ 11.0		
Mean arterial pressure (mm Hg)							
0 to < 1 mo	≥ 46		31–45	17–30			≤ 16
1–11 mo	≥ 55		39–54	25–38			≤ 24
12–23 mo	≥ 60		44–59	31–43			≤ 30
24–59 mo	≥ 62		46–61	32–44			≤ 31
60–143 mo	≥ 65		49–64	36–48			≤ 35
≥ 144 mo	≥ 67		52–66	38–51			≤ 37
Renal							
Creatinine (µmoL/L)							
0 to < 1 mo	≤ 69		≥ 70				
1–11 mo	≤ 22		≥ 23				
12–23 mo	≤ 34		≥ 35				
24–59 mo	≤ 50		≥ 51				
60–143 mo	≤ 58		≥ 59				
≥ 144 mo	≤ 92		≥ 93				
Respiratory[d]							
Pao_2 (mm Hg)/Fio_2	≥ 61		≤ 60				
$Paco_2$ (mm Hg)	≤ 58	59–94		≥ 95			
Invasive ventilation	No			Yes			
Hematologic							
WBC count (× 10^9/L)	> 2		≤ 2				
Platelets (× 10^9/L)	≥ 142	77–141	≤ 76				

[a]All variables must be collected, but measurements can be done only if justified by the patient's clinical status. If a variable is not measured, it should be considered normal. If a variable is measured more than once in 24 hr, the worst value is used in calculating the score. Fio_2: fraction of inspired oxygen.

[b]Neurologic dysfunction: Glasgow Coma Score: use the lowest value. If the patient is sedated, record the estimated Glasgow Coma Score before sedation. Assess only patients with known or suspected acute central nervous system disease. Pupillary reactions: nonreactive pupils must be > 3 mm. Do not assess after iatrogenic pupillary dilatation.

[c]Cardiovascular dysfunction: Heart rate and mean arterial pressure: do not assess during crying or iatrogenic agitation.

[d]Respiratory dysfunction: Pao_2: use arterial measurement only. Pao_2/Fio_2 ratio is considered normal in children with cyanotic heart disease. $Paco_2$ can be measured from arterial, capillary, or venous samples. Invasive ventilation: the use of mask ventilation is not considered invasive ventilation.

Logit (mortality) = −6.61 + 0.47 × PELOD-2 score.

Probability of death = 1/(1 + exp [−logit(mortality)]).

CRITICAL CARE MEDICINE

1. Crisis Capacity: Adaptive spaces, staff and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e. provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. (Hick et al, 2009)
2. ECC Guidelines 2010, Circulation 2010;122 Suppl3:S876-S908
3. Leteurtre, Stéphane; Duhamel, Alain; Salleron, Julia; Grandbastien, Bruno; Lacroix, Jacques; Leclerc, Francis; on behalf of the Groupe Francophone de Réanimation et d'Urgences Pédiatriques (GFRUP); Critical Care Medicine41(7):1761-1773, July 2013. doi: 10.1097/ CCM.0b013e31828a2bbd

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Scarce Resource Triage Team Guidelines

To be used in conjunction with Scarce Resource Algorithms during Crisis Standards of Care

Updated: Mar 2020

Introduction

In the event of a large scale disaster—either a no notice event such as a natural disaster or a prolonged situation such as a pandemic—there is the potential for an overwhelming number of critically ill or injured patients. In these situations, certain medical resources may become scarce and prioritization of care may need to be considered.

In 2009 the Institute of Medicine (currently the National Academy of Medicine) published a landmark report, Guidance for Establishing Crisis Standards of Care for use in Disaster Situation: A Letter Report. In this report the authors defined surge capacity as a continuum from conventional to contingency and finally crisis. This framework has been nationally accepted and adopted. The definition of "Crisis Capacity" as set by the NAM, is a situation where space, staff and supplies "are not consistent with usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available)."[1]

The content of this document is based on a thorough review of the literature, guidelines published by leading national healthcare specialty colleges and societies, recommendations of the National Academy of Medicine and detailed discussion and deliberation by the WA State Disaster Medical Advisory Committee (DMAC), the Disaster Clinical Advisory Committee (DCAC) Central District and included input from both local and state Community Engagement Reports.[2,3]

This document is to be used in conjunction with the DOH Scarce Resource Triage Algorithms which were developed by regional workgroups of Subject Matter Experts (SME), and approved by the Disaster Clinical Advisory Committee (DCAC) Central District. Implementation of these algorithms depends upon the development of individual Crisis Standards of Care Hospital, Hospital System, and Regional Triage Teams as outlined below.

Purpose

To provide a transparent, fair, equitable, and consistent approach to allocation of scarce resources during a declared emergency in which Crisis Standards of Care (CSC) has been implemented.

Scope

All healthcare organizations and providers within the affected region of the CSC declaration.

Assumptions

- A Health Officer has declared a crisis situation and crisis standards of care has been activated.
- Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care
- Federal assets have been requested but may be delayed.

1. IOM (Institute of Medicine) 2009. Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report. Washington, DC: National Academies Press.
2. 2 Washington State Crisis Standards of Care Community Engagement Report, June 2019, WA DOH.
3. 3 Li-Vollmer, M. Health Care Decisions in Disasters: Engaging the Public On Medical Service Prioritization During a Severe Influenza Pandemic. Journal of Participatory Medicine. Vol 2. December 14, 2010.

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Implementation Recommendations

A. General

All healthcare organizations within the affected region agree to implement a uniform triage process as outlined in this document to be used along with the DOH Scarce Resource Triage Algorithms to include: Adult Critical Care, Pediatric Critical Care and Renal Replacement Therapy (pending) Algorithms.

B. CSC Triage Teams: Identification and Composition

1. **CSC Hospital Clinical Triage Team**

   It is recommended that every in-patient healthcare institution have a CSC Hospital Clinical Triage Team which will report to the Medical Care Branch Director (or equivalent position within organization's command structure) during activation of HICS.

   a. It is recommended the CSC Hospital Clinical Triage Team

      - At least 2-3 senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer who oversees all Triage processes.
      - 1 medical ethicist
      - When possible clinicians on the Triage Team will not be primary providers of the patients under consideration
      - When patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc. then all attempts will be made to consult that specialty either in person or remotely during consideration

   b. All patients presented to the CSC Hospital Clinical Triage Team will be recorded in a CSC Hospital Clinical Triage Team Log, which will include:

      - Date and time of referral
      - Name of referring clinician and contact information
      - Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification but should not be made available to the Triage Team
      - All clinical information presented to the Triage Team at the time of decision
      - Triage Team decision, date and time of the decision, and all supporting documentation reviewed and produced for the decision
      - If patient is referred, date and time of referral and contact information of receiving Clinical Triage Team
      - Patient outcome (if known)

   c. If the patient requires referral outside an individual hospital and the hospital is part of a wider hospital system please see Section 2. If the hospital is not part of a larger hospital system then please refer to Section 3.

   d. It is recommended the CSC Hospital Clinical Triage Team follow the communication guidelines outlined in this document in order to maintain accurate and up to date situational awareness.

2. **Hospital systems during CSC**

   It is recommended every Hospital System maintain good communications between individual hospitals in their system to assist in situational awareness for the scarce resource in question. It is recommended that every hospital system have a mechanism by which a critical resource can be maximized and distributed throughout their system and that all appropriate channels have been exhausted to obtain additional resources. When a specific healthcare facility within a hospital system lacks a specific resource, identifying that resource within their system should be the first step in patient placement. This would be managed by the CSC Hospital System Triage Team.

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a. All patients presented to the CSC Hospital System Triage Team will be recorded in a CSC Hospital System Triage Team Log, which will include:
   - Date and time of referral
   - Name of referring clinician and contact information
   - Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification but should not be made available to Triage Team.
   - All clinical information presented to the Triage Team at the time of decision
   - Triage Team decision, date and time of the decision, and all supporting documentation reviewed and produced for the decision
   - If patient is referred to the Regional Triage Team, date and time of referral and contact information of receiving Regional Triage Team
   - Patient outcome (if known)

b. Those patients who cannot be managed within their system will need to be presented to the CSC Regional Clinical Triage Team for consideration and prioritization within a different hospital system.

3. CSC Regional Clinical Triage Team

It is recommended a CSC Regional Clinical Triage Team manage prioritization and placement of patients in need of a scarce resource in the affected geographic region who cannot be managed within a specific hospital system.

It is recommended the CSC Regional Clinical Triage Team fairly represent the healthcare facilities and systems within the region. If a region has developed a healthcare coalition DCAC then it is recommended that members of the CSC Regional Triage team be determined in coordination with local DCAC, State DMAC, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the local DCAC, healthcare executives or the clinical community at large.

If a region does not have a local DCAC then CSC Regional Clinical Triage Team members will be determined by the State DMAC in coordination with the SHO, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the DMAC, healthcare executives or the clinical community at large. Recommended members of the CSC Regional Clinical Triage Team are as follows:

- Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Lead Triage Officer who oversees all Triage processes.
- 1 medical ethicist
- When possible, clinicians on the CSC Regional Clinical Triage Team will not be primary providers of the patients under consideration, nor members of the referring CSC Hospital or Hospital System Clinical Triage Team(s).
- When patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc. then all attempts will be made to consult that specialty either in person or remotely during consideration.

a. All patients presented to the CSC Regional Clinical Triage Team will be recorded in a CSC Regional Clinical Triage Team Log which will include:
   - Date and time of referral
   - Name of referring clinician and contact information
   - Patient identifiers: These should include only date of birth and sex. Patient's name and other demographic data should not be considered by the Triage Team. Hospital specific MRN should be notated to confirm patient identification, but should not be made available to Triage Team.
   - All clinical information presented to the Triage Team at the time of decision Triage Team decision date and time and all supporting documentation
   - Patient outcome (if known)

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b. It is recommended the CSC Regional Clinical Triage Team follow the communication guidelines below in order to maintain accurate and up to date situational awareness.

c. The CSC Regional Clinical Triage Team is under the same Oversight and Re-evaluation processes as the CSC Hospital and Hospital System Triage Teams outlined below.

C. Oversight

In order to maintain transparency and ensure a fair, equitable and consistent approach to allocation of a scarce resources it is important that all triage teams have an oversight process for decisions made during an event.

1. **CSC Hospital and Hospital Systems Oversight Committee**

   When an event occurs which requires activation of the CSC Hospital or Hospital System Clinical Triage Team the following documentation will be required and should be maintained and reviewed by the CSC Oversight Committee designated by the Medical Operations Branch Director under HICS.

   a. It is recommended the CSC Triage Team Oversight Committee consist of the
      - Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Chair who oversees all Oversight processes
      - When possible clinicians on the CSC Triage Team Oversight Committee will not be primary providers of the patients under consideration
      - When patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc. then all attempts will be made to consult that specialty either in person or remotely during consideration
      - At least one medical ethicist

   b. All patients presented to the CSC Hospital or Hospital System Triage Team will be reviewed by an CSC Oversight Committee and will be recorded in an CSC Oversight Triage Team Log, which will
      - All patient demographics
      - Date and time of the case consideration
      - All patient information presented to the Clinical Triage Team at the time of consideration
      - Triage Team decision, date and time of the decision, and all supporting documentation reviewed and produced for the decision
      - If patient was referred, date and time of referral and contact information of receiving Clinical Triage Team
      - Patient outcome

   c. It is recommended that at agreed upon intervals the CSC Oversight Committee will review all cases presented to the CSC Hospital or Hospital System Triage Team to ensure the following:
      - All appropriate clinical information was considered
      - Accurate documentation was recorded
      - Significant variances be reviewed and addressed

   d. Depending on the nature of the incident oversight review may be in real time (e.g. in a prolonged event such as a pandemic). However in no notice, sudden or brief events, this review may be retrospective.

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2. **CSC Regional Oversight Committee**

When an event occurs which requires activation of the CSC Regional Clinical Triage Team the following documentation will be required and will be maintained and reviewed by the CSC Regional Oversight Committee. If a region has developed a healthcare coalition DCAC then it is recommended that members of the CSC Regional Oversight team be determined in coordination with local DCAC, State DMAC,LHO, other Public Health experts, outside SME's, etc. and can consist of members from the local DCAC, healthcare executives or the clinical community at large.

If a region does not have a local DCAC then the CSC Regional Oversight Team members will be determined by the State DMAC in coordination with the SHO, LHO, other Public Health experts, outside SME's, etc. and can consist of members from the DMAC (or their designees), healthcare executives or the clinical community at large. Recommended members of the CSC Regional Clinical Triage Team are as follows:

- Senior clinicians with experience in tertiary triage (e.g. Critical Care, Emergency Medicine, Trauma Surgery, etc.), with one designated as Chair who oversees all Oversight processes.
- When possible clinicians on the Regional Triage Team Oversight Committee will not be primary providers of the patients under consideration nor members of the Regional Triage Team.
- When patients requiring a scarce resource fall under a specific specialty such as burn, trauma, pediatrics, etc. then all attempts will be made to consult that specialty either in person or remotely during consideration.
- At least one medical ethicist

a. All patients presented to the CSC Regional Oversight Committee will be recorded in a CSC Regional Oversight Committee Log, which will include:
   - All patient demographics
   - Date and time of the case consideration
   - All patient information presented to the CSC Regional Clinical Triage Team at the time of consideration.
   - The CSC Regional Clinical Triage Team decision date, time and supporting documentation reviewed and produced for the decision
   - Patient outcome

b. It is recommended that at agreed upon intervals the CSC Regional Oversight Committee will review all cases presented to the Regional Triage Team to ensure the following:
   - All appropriate clinical information was considered
   - Accurate documentation was recorded
   - Extreme variances be reviewed and addressed

c. Depending on the nature of the incident oversight review may be in real time (i.e. in a prolonged event such as a pandemic). However in no notice, sudden or brief events, this review may be retrospective.

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D. Re-evaluation Process During Response

1. Request to change process

a. During an event individual clinicians may request a specific change to the Scarce Resource Cards, Triage Algorithms or protocols based on new clinical information such as changes in prognostic indicators or outcome measure. These requests should be made in writing to the Chair and Vice Chair of the WA State DMAC (or their designee).

b. WA State DMAC will keep a log and record of every CSC Reevaluation Process Request, date and time of request, and all the supporting documentation presented during the request and evaluation.

- Each request will be reviewed by the DMAC Chair and Vice Chair or their designee along with all relevant partners including additional input from SME's
- All request decisions will be made in a timely fashion and will be based on consensus of all relevant partners
- Final decisions for all CSC Reevaluation Process Requests will be in writing, dated and timed, and include all supporting documentation

2. Request to reevaluate specific case

a. Any clinician may bring a CSC Request for Patient Reevaluation of a specific case to the respective Medical Care Branch Director and designated ethicist. The Medical Care Branch Director has authority over the respective CSC Clinical Triage Team who made the initial decision under consideration (i.e. individual CSC hospital, hospital system, or regional Clinical Triage Team).

- At the individual hospital and hospital system, the Medical Branch Director will be determined by standards HICS designations within the organization
- At the Regional level, the Medical Branch Director will be the Chair or Vice Chair of the State DMAC (or their designee)
- At all levels, a CSC Request for Patient Reevaluation will be reviewed by the Medical Branch Director, a designated ethicist and any other relevant partners.

b. A log will be maintained of every Request for Reevaluation, date and time of request, and all supporting documentation presented during the request and reevaluation.

c. Every case brought to the Medical Care Branch Director and designated ethicist will be reviewed in a timely fashion to ensure the Triage Team documentation was complete and the decision process was consistent with Scarce Resource Cards, Triage algorithms, protocols or any other clinical documentation related to the case *that was available at the time the original decision was made.*

d. Depending on the event (i.e. no notice vs prolonged) it is understood that this process may be retrospective. However, if the event is more prolonged and the potential outcomes of the patient may be affected, then processes should be in place to allow a sufficiently rapid decision.

e. Final decisions for CSC Request for Patient Reevaluation of a specific case will be in writing, dated and timed, and include all supporting documentation.

f. Decision made by the respective Medical Care Branch Director and designated ethicist will be final.

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E. Resource Update Protocols

1 **During response**

It is understood that during an event, the clinical situation may change depending on resource availability, new epidemiologic information, new treatment protocols and guidelines, etc. *It will be the responsibility of the entire healthcare community* to maintain close communication with the Local and State Health Officer and all relevant partners to maintain accurate situational awareness and consensus regarding local triage recommendations.

2. **During preparedness**

All Scarce Resource Cards and algorithms and any supporting documentation will be reviewed and updated every 3 years.

3. **Communications**

a. During response, NWHRN in conjunction with DMAC will be responsible for identifying all pertinent partners during an activation of the Scarce Resource Triage Team Guidelines to include but not limited to: LHO, SME's, DOH and Federal partners.

b. Depending on the situation, clinical updates may be required at various frequencies, and will be determined by DMAC Chair and Vice Chair, SHO, LHO and all other pertinent partners. State Health officer (SHO) in conjunction with NWHRN will be responsible for disseminating this information in a timely fashion to all appropriate clinical entities.

c. Communications will be electronically, but if circumstances are such that electronic communication is not possible, secondary communication processes will include FAX, phone and courier.

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FL-DOH-20-0673-A-005513

From: Blackmore, Carina
To: Torres, Yari; Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Stanek, Danielle R
Subject: Re: Action Required: COVID-19 impact on your polio TDY
Date: Friday, March 13, 2020 5:28:25 AM

Looking forward to seeing yiu

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From: Torres, Yari <Yari.Torres@flhealth.gov>
Sent: Friday, March 13, 2020 3:13:35 AM
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Fwd: Action Required: COVID-19 impact on your polio TDY

FYI- At the moment my new return date is March 24th which is within that time frame, I will let you know if that changes.

Thank you and see you soon!

Yari
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From: Vertefeuille, John F. (CDC/DDPHSIS/CGH/GID) <dki4@cdc.gov>
Sent: Friday, March 13, 2020 3:23:29 AM
To: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP) <pja5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>
Cc: Frank, Daniel (CDC/DDPHSIS/CGH/GID) <fcd3@cdc.gov>; Rouse, Edward N. (CDC/DDPHSIS/CPR/DEO) <dmz0@cdc.gov>; Taylor, Bryan (CDC/DDPHSIS/CPR/DEO) <yzi8@cdc.gov>; Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>; Wiesen, Eric (CDC/DDPHSIS/CGH/GID) <ejw2@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>
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deployment telework and monitoring policies should be coming out by the end of the week and will be sent to you.

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John F. Vertefeuille, PhD, MHS
Incident Manager
CDC Polio Activation

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From: Torres, Yari
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Stanek, Danielle R; Blackmore, Carina
Subject: Re: Action Required: COVID-19 impact on your polio TDY
Date: Friday, March 13, 2020 3:19:45 AM

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John F. Vertefeuille, PhD, MHS
Incident Manager
CDC Polio Activation

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From:	Stanek, Danielle R
To:	"Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)"; Torres, Yari; Blackmore, Carina
Subject:	RE: Action Required: COVID-19 impact on your polio TDY
Date:	Friday, March 13, 2020 8:15:38 AM

We sure are!

From: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>
Sent: Friday, March 13, 2020 7:58 AM
To: Torres, Yari <Yari.Torres@flhealth.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Action Required: COVID-19 impact on your polio TDY

Hi Yari,
Thanks for letting us know. Please let me know the status of your arrangements and your flight info when available. I'm sorry you can't finish your polio deployment, but I think it makes sense for you to return. I'm sure Dr. Stanek and Dr. Blackmore will be glad to have you back!
Suzanne

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)
Epidemic Intelligence Service | Epidemiology Workforce Branch
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

From: Torres, Yari <Yari.Torres@flhealth.gov>
Sent: Friday, March 13, 2020 3:20 AM
To: Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD) <fgx5@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Action Required: COVID-19 impact on your polio TDY

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John F. Vertefeuille, PhD, MHS
Incident Manager
CDC Polio Activation

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From:	McWhorter, Linda
To:	Guthrie, Kevin
Cc:	Coppola, Courtney; Cabral, Irene; Deleon, Melissa (FLNG)
Subject:	RE: Airport Personnel
Date:	Wednesday, March 25, 2020 2:04:01 PM
Attachments:	image001.png Airport Site Point of Contact List.docx

---

Linda J. McWhorter
Preparedness Bureau Chief
2555 Shumard Oak Blvd
Tallahassee, FL 32399-21000
Office: (850) 815-4301
Mobile: (850) 528-7528
Linda.mcwhorter@em.myflorida.com

From: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Sent: Wednesday, March 25, 2020 1:41 PM
To: McWhorter, Linda <Linda.McWhorter@em.myflorida.com>
Cc: Coppola, Courtney <Courtney.Coppola@flhealth.gov>; Cabral, Irene <Irene.Cabral@dot.state.fl.us>; Deleon, Melissa (FLNG) <Melissa.e.deleon.mil@mail.mil>
Subject: Airport Personnel

Linda,

Can you please reply all with what contract staff augmentation will be at each airport?

Thanks,

Kevin Guthrie, MA MEP CEM FPEM | Deputy Director
Office of the Director
Florida Division of Emergency Management
2555 Shumard Oak Blvd
Tallahassee, FL 32399-2100
Office: (850) 815-4101
Cell: (850) 294-8250
Kevin.Guthrie@em.myflorida.com
www.floridadisaster.org

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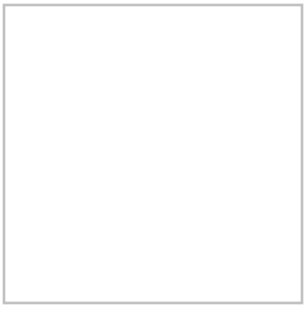

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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Airport Point of Contact (POC) List

Drive-Through Testing Location	Point of Contact
Jacksonville International Airport (JAX) 2400 Yankee Clipper Dr, Jacksonville, FL 32218	Jill McElwee (904) 962-3480 Cell jfrdjill@gmial.com
Orlando International Airport (MCO) 1 Jeff Fugua Blvd Orlando, FL 32827	Richard Knoff (904) 699-1072 Cell ccfrchief3@gmail.com
Tampa International Airport (TPA) 4100 George J Bean Parkway Tampa, FL 33607	Robert “Bob” Wesch (352) 422-7088 rwesch1@tampabay.rr.com

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
To: Blackmore, Carina (CDC flhealth.gov)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: RE: cdc consult
Date: Wednesday, March 11, 2020 9:17:47 PM

Dr. Blackmore:

Caroline is not working tonight, but I'm happy to work with you and discuss any questions. I think our cruise ship team is likely the best group to involve with this. I can see if they are able to discuss tonight, but it might be tomorrow AM before we are able to pull everyone together. Would that be OK? I'm also happy to have a call with you to clarify the questions as well before we set up the larger conference call. Let me know what would be best-

Thanks-

Sara Oliver, MD, MSPH
LCDR, U.S. Public Health Service
Medical Director, CDC COVID Clinical Call Unit
email: yxo4@cdc.gov

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:15 PM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi Caroline. We would be interested in a consult to discuss the port situation and your recommendations to minimize exposure to employees and passengers. Are u still willing to set this up? Thanks Carina

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

I communicated to our morning team that there was follow up needed with you all.

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Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: Re: cdc consult

Did you not hear from anyone today?

Get Outlook for iOS

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

Caroline Schrodt

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To:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Cc:	Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject:	Re: cdc consult
Date:	Wednesday, March 11, 2020 6:43:43 AM

Yes I believe we do need to circle back. What you describe didn't address the issues at the port itself. Let me check with the health officer first thing

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Subject: RE: cdc consult
Date: Wednesday, March 11, 2020 9:23:43 PM

Great- thanks will do!

Sara

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To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

Tomorrow sounds great!

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I communicated to our morning team that there was follow up needed with you all. Separately, FL health leadership (FL Surgeon General I think?) reached out to Jay Butler here at CDC separately to discuss issues, involving our cruise ship task force. Chris Jones, the lead for our call unit, followed up and was told that local leadership was connected with staff at the Miami Quarantine station and that there were no additional questions.

Are there remaining issues you would like to discuss? We can have a call tonight or set up additional calls in the AM. Apologize for the miscommunication: we were told all was taken care of. Happy to help in any way we can!

Sara

From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Tuesday, March 10, 2020 10:54 PM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: Re: cdc consult

Did you not hear from anyone today?

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 10, 2020 9:39:38 PM
To: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: Re: cdc consult

AMERICAN OVERSIGHT

Hi checking in about a follow up call. Thanks for your help. Carina

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From: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Sent: Monday, March 9, 2020 10:57:49 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: cdc consult

I am currently out of the office through March 13th assisting with the COVID19 response, and my e-mail responses may be delayed. Thank you for your understanding.

If you need immediate assistance please contact CDC Info at 800-232-4636 or by e-mail at https://wwwn.cdc.gov/dcs/ContactUs/Form .

Thank you.

Caroline Schrodt

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: Re: cdc consult
Date: Wednesday, March 11, 2020 8:14:55 PM

Hi Caroline. We would be interested in a consult to discuss the port situation and your recommendations to minimize exposure to employees and passengers. Are u still willing to set this up? Thanks Carina

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Tuesday, March 10, 2020 11:30:44 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

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Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: Re: cdc consult
Date: Wednesday, March 11, 2020 9:18:55 PM

Tomorrow sounds great!

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From: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Sent: Wednesday, March 11, 2020 9:17:45 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
Subject: RE: cdc consult

Dr. Blackmore:

Caroline is not working tonight, but I'm happy to work with you and discuss any questions. I think our cruise ship team is likely the best group to involve with this. I can see if they are able to discuss tonight, but it might be tomorrow AM before we are able to pull everyone together. Would that be OK? I'm also happy to have a call with you to clarify the questions as well before we set up the larger conference call. Let me know what would be best-

Thanks-

Sara Oliver, MD, MSPH
LCDR, U.S. Public Health Service
Medical Director, CDC COVID Clinical Call Unit
email: yxo4@cdc.gov

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:15 PM
To: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP) <pgx7@cdc.gov>
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To: Blackmore, Carina (CDC flhealth.gov)
Cc: Schrodt, Caroline (CDC/DDID/NCEZID/DHCPP)
Subject: RE: cdc consult
Date: Tuesday, March 10, 2020 11:30:48 PM

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AMERICAN OVERSIGHT

From:	Pesik, Nicki (CDC/DDID/NCEZID/OD)
To:	Pritchard, Scott
Cc:	Blackmore, Carina (CDC flhealth.gov); Pillai, Satish K. (CDC/DDID/NCEZID/DPEI); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD); Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Berger, Sherri (CDC/OCOO/OD); D"Angeli, Marisa (DOH)
Subject:	RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington
Date:	Tuesday, February 25, 2020 12:58:14 PM
Attachments:	image001.png

Scott
Thank you for taking time to speak with Sherri and myself. I will follow-up with you on the question regarding Fl residents.

Nicki

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Tuesday, February 25, 2020 11:54 AM
To: Pesik, Nicki (CDC/DDID/NCEZID/OD) <ndp9@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) <vig8@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <htv4@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Subject: RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Hi Nicki,
You can reach out to me 850-251-5558 (cell) or Dr. Blackmore (state epi) at 850-528-1595 (cell) to discuss the situation.
We understand the home care guidelines, but we have a lot of questions about this particular situation.

Additionally, we would like to request info on any other FL residents known to be infected with COVID-19.

Perhaps its best to schedule a conference call at your convenience. Let us know your preference.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Tuesday, February 25, 2020 11:38 AM

AMERICAN OVERSIGHT

To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: FW: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

Here you go.
Best,
Marisa

From: Pesik, Nicki (CDC/DDID/NCEZID/OD) [mailto:ndp9@cdc.gov]
Sent: Monday, February 24, 2020 3:34 PM
To: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) <vig8@cdc.gov>
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Could you please provide more specifics on your contact with Florida and GA? Who specifically has been contacted by regarding the requested transfers?

There are a number of items that the accepting states have to have and place and agree to for individuals requiring isolation. CDC can provide guidance if home isolation is being considered and happy to address questions.

Thanks Nicki

Nicki Pesik MD
Assoc. Director for Infectious Disease Preparedness
NCEZID/CDC
404-661-5516

From: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Sent: Monday, February 24, 2020 4:27 PM
To: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI)
Cc: Pesik, Nicki (CDC/DDID/NCEZID/OD); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD); Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR)
Subject: RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington

OK, thank you so much!

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From: Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) [mailto:vig8@cdc.gov]
Sent: Monday, February 24, 2020 1:23 PM
To: D'Angeli, Marisa (DOH) <Marisa.DAngeli@DOH.WA.GOV>
Cc: Pesik, Nicki (CDC/DDID/NCEZID/OD) <ndp9@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Patel, Anita (CDC/DDID/NCIRD/OD) <bop1@cdc.gov>; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR) <htv4@cdc.gov>
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Marisa D'Angeli, MD, MPH
Medical Epidemiologist
Healthcare Associated Infections and Antimicrobial Resistance Program
Washington State Department of Health
Marisa.dangeli@doh.wa.gov
206-418-5595 | www.doh.wa.gov



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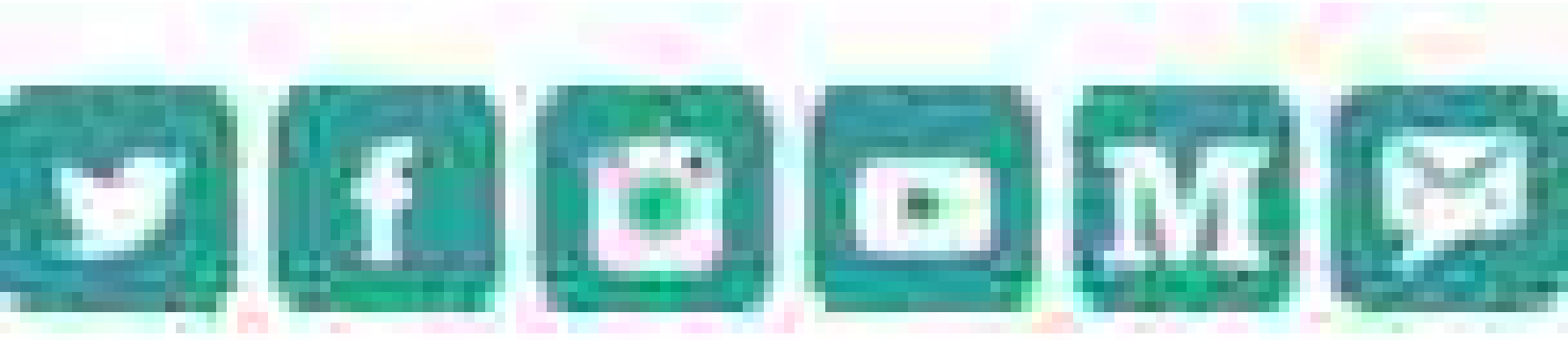

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Cc:	Blackmore, Carina; vig8@cdc.gov; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Patel, Anita (CDC/DDID/NCIRD/OD); Kosmos, Christine (CDC/DDPHSIS/CPR/DSLR); Berger, Sherri (CDC/OCOO/OD); D"Angeli, Marisa (DOH)
Subject:	RE: CDC contact for transfer of FL and GA residents COVID-19 + patients in Washington
Date:	Tuesday, February 25, 2020 11:54:27 AM
Attachments:	image003.png

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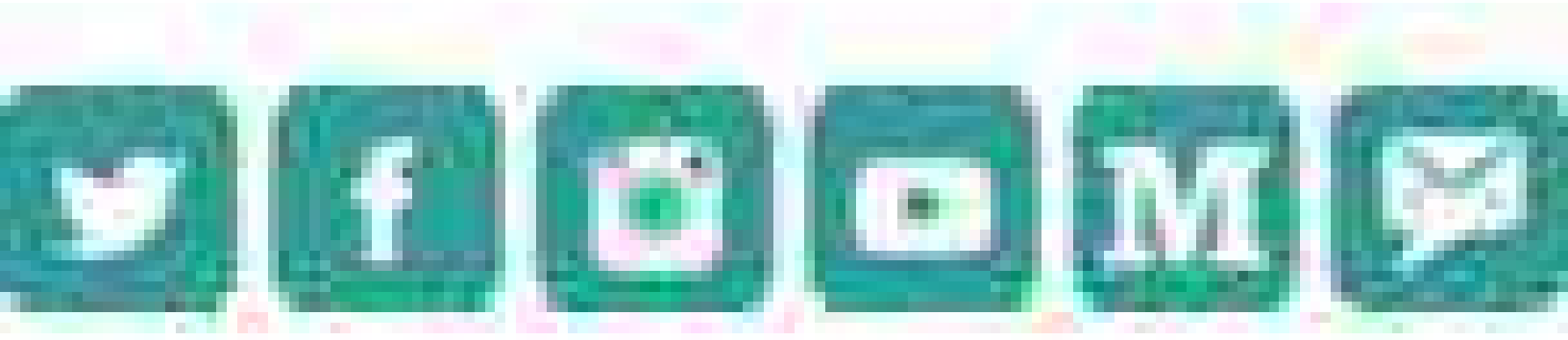

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov); CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: RE: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Friday, March 6, 2020 12:25:09 PM

Thank you for confirming your March 5th case count. We have updated our counts for FL based on your response.

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 6, 2020 10:26 AM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 03/05/2020

We have another presumptive. So 1 presumtive, two confirmed. 3 total.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Friday, March 6, 2020 10:16 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 03/05/2020

Good morning Carina,

We are following up on the email below. At your earliest, could you please confirm the COVID-19 case counts for March 5? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit

eocevent118@cdc.gov

CDC 2019-nCoV Response

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Thursday, March 5, 2020 7:22 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
    - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
    - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1

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Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

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* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab
**Values to be shared on the CDC website
***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: RE: CDC COVID-19 Case Count Confirmation 03/05/2020
Date: Friday, March 6, 2020 10:26:13 AM

We have another presumptive. So 1 presumtive, two confirmed. 3 total.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Friday, March 6, 2020 10:16 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 03/05/2020

Good morning Carina,

We are following up on the email below. At your earliest, could you please confirm the COVID-19 case counts for March 5? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit

eocevent118@cdc.gov

CDC 2019-nCoV Response

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Thursday, March 5, 2020 7:22 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/05/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these

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requests will likely decrease.

- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Thursday, March 5**.
- By **9 am ET Friday, March 6**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Thursday, March 5)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
    - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
    - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	28	17	45	1
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	3	2	5	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0

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Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	1	0	1	0
New Hampshire	NH	2	0	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	12	0	12	0
North Carolina	NC	1	0	1	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	1	1	2	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	1	2	3	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA			70	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	1	2	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov)
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit; CDC IMS 2019 NCOV Response Epi TF Data Team; Eisenstein, Leah; Kendrick, Katie; Rubino, Heather; Scott.Pritchard@flhealth.gov
Subject: RE: CDC COVID-19 Case Count Confirmation 03/09/2020
Date: Monday, March 9, 2020 9:18:46 PM

Dear Dr. Blackmore,

A generic email went out tonight (see below) asking states to confirm their COVID-19 case-counts for tomorrow's web update. We wanted to reach out to you personally, though, because we did not receive confirmation of Florida's case counts for Monday's web update, and we realize numbers may have changed over the weekend.

At your earliest, could you please confirm the COVID-19 case counts for Florida as of March 9, and make any corrections as needed to the table below? Please also let us know if you would like us to add any alternate contacts for future case confirmation emails. We greatly appreciate your response.

Jurisdiction	Code	Presumptive	Confirmed	Total**	Deaths reported to CDC***
Florida	FL	3	3	6	0

Regards,

State Coordination Unit
eocevent118@cdc.gov
CDC COVID-19 Epidemiology Task Force

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Monday, March 9, 2020 8:45 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/09/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Monday, March 9**.
- By **9 am ET Tuesday, March 10**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Monday, March 9)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):

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The total case count [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**

- Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	4	2	6	0
Arkansas	AR	0	0	0	0
California	CA			135	2
Colorado	CO	8	0	8	0
Connecticut	CT	1	0	1	0
Delaware	DE	0	0	0	0
Florida	FL	3	3	6	0
Georgia	GA	6	5	11	0
Hawaii	HI	2	0	2	0
Idaho	ID	0	0	0	0
Illinois	IL	6	4	10	0
Indiana	IN	3	0	3	0
Iowa	IA	0	0	0	0
Kansas	KS	1	0	1	0
Kentucky	KY	1	0	1	0
Louisiana	LA	1	0	1	0
Maine	ME	0	0	0	0
Maryland	MD	5	0	5	0
Massachusetts	MA	27	1	28	0
Michigan	MI	0	0	0	0
Minnesota	MN	2	0	2	0
Mississippi	MS	0	0	0	0
Missouri	MO	1	0	1	0
Montana	MT	0	0	0	0
Nebraska	NE	3	1	4	0
Nevada	NV	3	0	3	0
New Hampshire	NH	2	2	4	0
New Jersey	NJ	8	0	8	0

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New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	30	0	30	0
North Carolina	NC	2	0	2	0
North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	1	1	0
Oregon	OR	13	1	14	0
Pennsylvania	PA	7	0	7	0
Rhode Island	RI	1	2	3	0
South Carolina	SC	6	0	6	0
South Dakota	SD	0	0	0	0
Tennessee	TN	1	0	1	0
Texas	TX	9	4	13	0
Utah	UT	1	0	1	0
Vermont	VT	1	0	1	0
Virginia	VA	2	1	3	0
Washington	WA			162	21
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	2	0	2	0
Guam	GU	0	0	0	0
New York City	NYC	11	1	12	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

AMERICAN OVERSIGHT

From: Eisenstein, Leah
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Cc: Troelstrup, Thomas; Kendrick, Katie; Munroe, Julia; Blackmore, Carina; Pritchard, Scott
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020
Date: Monday, March 23, 2020 1:41:56 PM

I submitted the survey for Florida this morning, and I see that the count is updated to what I submitted on the website (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html), but the community transmission is not (I selected "Yes, distinct clusters of cases in a, or a few, defined geographical area(s)"). Did I do something wrong on the survey? I want to be sure our data are appropriately reflected…

Thanks!
Leah

Leah Eisenstein, MPH
Surveillance Epidemiologist
Bureau of Epidemiology, Division of Disease Control and Health Protection
Florida Department of Health

4052 Bald Cypress Way, Bin A12 (mail)
Tallahassee, FL 32399-1720
4025 Esplanade Way, Room 240.01 (physical)
Tallahassee, FL 32311
Phone: (850) 901-6892
Fax: (850) 922-9299
Confidential Fax: (850) 414-6894
Email: Leah.Eisenstein@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Monday, March 23, 2020 10:18 AM
To: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020

Hi Leah,

CDC is confirming case counts with states Sunday through Thursday evening. Please use the Epi Info link provided in the email and not bookmarked links, we routinely make updates to the epi info survey so bookmarked links are often outdated.

Thanks,

Colin Schwensohn

State Coordination Unit

eocevent118@cdc.gov

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CDC COVID-19 Epidemiology Task Force

From: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>
Sent: Monday, March 23, 2020 10:02 AM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

The email below says that we should be reporting this daily. Do we use the same survey link every day?

Thanks!
Leah

Leah Eisenstein, MPH
Surveillance Epidemiologist
Bureau of Epidemiology, Division of Disease Control and Health Protection
Florida Department of Health

4052 Bald Cypress Way, Bin A12 (mail)
Tallahassee, FL 32399-1720
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Email: Leah.Eisenstein@flhealth.gov

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Sunday, March 22, 2020 6:21 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>; Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Sunday, March 22, 2020 6:20 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 3/22/2020

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the

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frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
    - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 22**.
    - general community level transmission characterization
- By **9 am ET Monday, March 23**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
    - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 22)**
    - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
    - **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
    - Community level transmission characterization
    - Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	131	0	Undetermined
Alaska	AK	14	0	Undetermined
Arizona	AZ	104	1	Undetermined
Arkansas	AR	168	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	1534	27	Yes, distinct clusters or widespread
Colorado	CO	475	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	223	5	Undetermined
Delaware	DE	45	0	Undetermined
Florida	FL	706	12	Undetermined
				Yes, widespread community

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Georgia	GA	555	20	transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	42	0	Undetermined
Illinois	IL	753	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	126	4	Undetermined
Iowa	IA	68	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	55	2	Undetermined
Kentucky	KY	87	3	Undetermined
Louisiana	LA	763	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	94	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	190	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	4	Yes, widespread community transmission across several geographical areas
Michigan	MI	787	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	137	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Mississippi	MS	140	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	90	3	Undetermined
Montana	MT	27	0	Undetermined
Nebraska	NE	42	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	154	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	65	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	1831	19	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	75	0	Undetermined
New York (excluding New York City)	NY	6123	21	Yes, distinct clusters or widespread
North Carolina	NC	227	0	Undetermined
North Dakota	ND	28	1	Undetermined
Ohio	OH	247	3	Undetermined
Oklahoma	OK	53	1	Undetermined
Oregon	OR	137	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	482	2	Undetermined
Rhode Island	RI	66	0	Undetermined
South Carolina	SC	173	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	21	1	Undetermined
Tennessee	TN	371	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	5	Undetermined
Utah	UT	125	0	Undetermined
Vermont	VT	49	2	Undetermined

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Virginia	VA	152	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	1793	95	Undetermined
West Virginia	WV	12	0	Undetermined
Wisconsin	WI	281	4	Undetermined
Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	98	1	Undetermined
Guam	GU	14	0	Undetermined
New York City	NYC	6211	43	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	21	0	Undetermined
U.S. Virgin Islands	VI	6	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To:	Eisenstein, Leah; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Cc:	Troelstrup, Thomas; Kendrick, Katie; Munroe, Julia; Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject:	RE: CDC COVID-19 Case Count Confirmation 3/22/2020
Date:	Tuesday, March 24, 2020 9:12:16 AM

Hi Leah,

Thanks for bringing this to our attention. I don't see FL's response from yesterday in the Epi Info results but I do see your response from today at 6:45am confirming 1141 cases, 17 deaths, and (Yes, distinct clusters of cases in a, or a few, defined geographical area(s)). We will make sure the map is updated today and thank you for confirming case counts and contacting us if it doesn't look correct. We appreciate it.

Thanks,

Colin Schwensohn

State Coordination Unit

eocevent118@cdc.gov

CDC COVID-19 Epidemiology Task Force

From: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>
Sent: Monday, March 23, 2020 1:42 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>; Kendrick, Katie <Katie.Kendrick@flhealth.gov>; Munroe, Julia <Julia.Munroe@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020

I submitted the survey for Florida this morning, and I see that the count is updated to what I submitted on the website (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html), but the community transmission is not (I selected "Yes, distinct clusters of cases in a, or a few, defined geographical area(s)"). Did I do something wrong on the survey? I want to be sure our data are appropriately reflected…

Thanks!
Leah

Leah Eisenstein, MPH
Surveillance Epidemiologist
Bureau of Epidemiology, Division of Disease Control and Health Protection
Florida Department of Health

4052 Bald Cypress Way, Bin A12 (mail)
Tallahassee, FL 32399-1720
4025 Esplanade Way, Room 240.01 (physical)
Tallahassee, FL 32311

AMERICAN OVERSIGHT

Phone: (850) 901-6892
Fax: (850) 922-9299
Confidential Fax: (850) 414-6894
Email: Leah.Eisenstein@flhealth.gov

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DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Monday, March 23, 2020 10:18 AM
To: Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>; CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020

Hi Leah,

CDC is confirming case counts with states Sunday through Thursday evening. Please use the Epi Info link provided in the email and not bookmarked links, we routinely make updates to the epi info survey so bookmarked links are often outdated.

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Colin Schwensohn

State Coordination Unit

eocevent118@cdc.gov

CDC COVID-19 Epidemiology Task Force

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Cc: Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

The email below says that we should be reporting this daily. Do we use the same survey link every day?

Thanks!
Leah

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Sunday, March 22, 2020 6:21 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Eisenstein, Leah <Leah.Eisenstein@flhealth.gov>; Troelstrup, Thomas <Thomas.Troelstrup@flhealth.gov>
Subject: FW: CDC COVID-19 Case Count Confirmation 3/22/2020

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Sent: Sunday, March 22, 2020 6:20 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 3/22/2020

Dear Partners,

CDC continues to institute a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (for web posting Monday–Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the following:
    - current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Sunday, March 22**.
    - general community level transmission characterization
- By **9 am ET Monday, March 23**, **please use the CDC Case Confirmation Portal via the link below** (data are collected via Epi Info and stored on a secure CDC server) to:
    - confirm case counts for your jurisdiction (your numbers **as of 4 pm ET Sunday, March 22)**
    - if needed, modify your **"community level transmission characterization"**

Please use the link provided below and not a previously saved link in your web browser

https://go.usa.gov/xdtyJ

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):

AMERICAN OVERSIGHT

- **The total case count**, i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be depicted as a range: "1–5 cases"**
- Community level transmission characterization
- Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Jurisdiction	Code	Total cases reported*	Deaths reported**	Community Transmission Characterization
Alabama	AL	131	0	Undetermined
Alaska	AK	14	0	Undetermined
Arizona	AZ	104	1	Undetermined
Arkansas	AR	168	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
California	CA	1534	27	Yes, distinct clusters or widespread
Colorado	CO	475	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Connecticut	CT	223	5	Undetermined
Delaware	DE	45	0	Undetermined
Florida	FL	706	12	Undetermined
Georgia	GA	555	20	Yes, widespread community transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	42	0	Undetermined
Illinois	IL	753	6	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Indiana	IN	126	4	Undetermined
Iowa	IA	68	0	Yes, widespread community transmission across several geographical areas
Kansas	KS	55	2	Undetermined
Kentucky	KY	87	3	Undetermined
Louisiana	LA	763	20	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maine	ME	94	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Maryland	MD	190	3	Yes, widespread community transmission across several geographical areas
Massachusetts	MA	646	4	Yes, widespread community transmission across several geographical areas
Michigan	MI	787	5	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Minnesota	MN	137	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)

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Mississippi	MS	140	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Missouri	MO	90	3	Undetermined
Montana	MT	27	0	Undetermined
Nebraska	NE	42	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Nevada	NV	154	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Hampshire	NH	65	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Jersey	NJ	1831	19	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
New Mexico	NM	75	0	Undetermined
New York (excluding New York City)	NY	6123	21	Yes, distinct clusters or widespread
North Carolina	NC	227	0	Undetermined
North Dakota	ND	28	1	Undetermined
Ohio	OH	247	3	Undetermined
Oklahoma	OK	53	1	Undetermined
Oregon	OR	137	4	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Pennsylvania	PA	482	2	Undetermined
Rhode Island	RI	66	0	Undetermined
South Carolina	SC	173	3	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
South Dakota	SD	21	1	Undetermined
Tennessee	TN	371	1	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Texas	TX	507	5	Undetermined
Utah	UT	125	0	Undetermined
Vermont	VT	49	2	Undetermined
Virginia	VA	152	2	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
Washington	WA	1793	95	Undetermined
West Virginia	WV	12	0	Undetermined
Wisconsin	WI	281	4	Undetermined
Wyoming	WY	24	0	Yes, distinct clusters of cases in a, or a few, defined geographical area(s)
American Samoa	AS	0	0	N/A
District of Columbia	DC	98	1	Undetermined
Guam	GU	14	0	Undetermined
New York City	NYC	6211	43	Yes, widespread community transmission across several geographical areas
Northern Marianas Islands	MP	0	0	N/A
Palau	PW	0	0	N/A
Puerto Rico	PR	21	0	Undetermined
U.S. Virgin Islands	VI	6	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
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AMERICAN OVERSIGHT

From: Eisenstein, Leah
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Cc: Troelstrup, Thomas; Kendrick, Katie; Munroe, Julia; Blackmore, Carina; Pritchard, Scott
Subject: RE: CDC COVID-19 Case Count Confirmation 3/22/2020
Date: Monday, March 23, 2020 1:41:56 PM

I submitted the survey for Florida this morning, and I see that the count is updated to what I submitted on the website (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html), but the community transmission is not (I selected "Yes, distinct clusters of cases in a, or a few, defined geographical area(s)"). Did I do something wrong on the survey? I want to be sure our data are appropriately reflected…

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eocevent118@cdc.gov

AMERICAN OVERSIGHT

CDC COVID-19 Epidemiology Task Force

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Delaware	DE	45	0	Undetermined
Florida	FL	706	12	Undetermined
				Yes, widespread community

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Georgia	GA	555	20	transmission across several geographical areas
Hawaii	HI	48	0	Undetermined
Idaho	ID	42	0	Undetermined
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U.S. Virgin Islands	VI	6	0	Undetermined
Federated States of Micronesia	FSM	0	0	N/A
Republic of Marshall Islands	RMI	0	0	N/A

AMERICAN OVERSIGHT

From: Villalta, Yesenia D
To: State and Local Readiness (CDC)
Subject: RE: CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT
Date: Monday, March 9, 2020 12:12:33 PM
Attachments: image001.png

It states passcode is invalid.

Thank you,

Yesenia D. Villalta, APRN, DNP, MSN
Florida Department of Health in Miami-Dade County
Administrator/Health Officer
Email: Yesenia.Villalta@flhealth.gov
Phone:(786)336-1260
Address: 8323 NW 12th Street Floor:02 Room:212
Miami, FL 33126

How is my customer service? Please let me know by taking our survey at www.FDOHMDCares.com

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From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Monday, March 9, 2020 11:53 AM
To: State and Local Readiness (CDC) <preparedness@cdc.gov>
Subject: CDC COVID-19 Weekly Key Messages, Consular Notification Guidance, and CDC Media Telebriefing TODAY at 12:15 PM EDT

Dear Colleagues:

Please see the attached CDC COVID-19 weekly key messages, Consular Notification Guidance, and the bridgeline for today's **CDC Media Telebriefing at 12:15 PM EDT provided below**.

Please reference the "Consular Notification Guidance for State and Local Authorities." This document was developed by the U.S. State Department. It outlines existing requirements and treaty obligations for notifying foreign embassies and consulates in the United States when a foreign national is being medically detained (i.e., a case when a quarantine order is issued because of possible exposure to COVID-19 disease).

Media Advisory

AMERICAN OVERSIGHT

For Immediate Release
Monday, March 9, 2020

Contact: CDC Media Relations
(404) 639-3286

CDC Media Telebriefing: Update on COVID-19

What The Centers for Disease Control and Prevention (CDC) will provide an update to media on the COVID-19 response.

Who Nancy Messonnier, M.D., Director,
National Center for Immunization and Respiratory Diseases

When 12:15 p.m. ET Monday, March 9, 2020

Dial-In

Non-Media: 888-795-0855
International: 1-630-395-0498
PASSCODE: 3896719

Important Instructions
Due to anticipated high volume, please plan to dial in to the telebriefing 15 minutes before the start time.

Media: If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question. You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT
A transcript will be available following the briefing at CDC's web site:www.cdc.gov/media.

State Coordination Task Force (SCTF)
CDC COVID-19 Weekly Key Messages & Consular Notification Guidance for State and Local Authorities Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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[redacted]

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Guthrie, Kevin; Moskowitz, Jared; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Link, Paul (OS/ASPR/EMMO); Mann, Travis (OS/ASPR/EMMO); Sturrock, Lochlin (OS/ASPR/EMMO); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; Bowman, Thomas (OS/ASPR/EMMO); Dickinson, Jeanette (OS/ASPR/EMMO); Raspberry, Jenny (OS/ASPR/EMMO)
Subject:	RE: CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 11:11:08 PM

Danny Alonso from CBP is in charge of both ports I believe.
His contact info is email: DANIEL.ALONSO@CBP.DHS.GOV and phone is 305.395.2260.

Please let me know if you need anything else.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 10:52 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Moskowitz, Jared <Jared.Moskowitz@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis,

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Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Cc: Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; Manny J. Toro (manny.toro@fema.dhs.gov) <manny.toro@fema.dhs.gov>; Link, Paul (OS/ASPR/EMMO) <Paul.Link@hhs.gov>; Mann, Travis (OS/ASPR/EMMO) <Travis.Mann@hhs.gov>; Sturrock, Lochlin (OS/ASPR/EMMO) <Lochlin.Sturrock@hhs.gov>; FEMA-R4-RRCC-SITL <R04-rrcc-sitl@fema.dhs.gov>; FEMA-R4-WatchUnit (fema.dhs.gov) <FEMA-R4-WatchUnit@fema.dhs.gov>; Maiden, Shawn <shawn.maiden@fema.dhs.gov>; Strouse, Philip <Philip.Strouse@fema.dhs.gov>; Teague, Brian <Brian.Teague@fema.dhs.gov>; Bowman, Thomas (OS/ASPR/EMMO) <Thomas.Bowman@hhs.gov>; Dickinson, Jeanette (OS/ASPR/EMMO) <Jeanette.Dickinson@hhs.gov>; Raspberry, Jenny (OS/ASPR/EMMO) <Jenny.Raspberry@hhs.gov>
Subject: CDC Guidance for Cruise Ships

Dr. Rivkees

As always it is a pleasure to speak with you. I spoke with our HHS Liaison to the Department of State and he is willing to work to set up a call with the Department of State. Based on your desire we can include CDC. I included the CDC guidance on cruise ships.

I should have a name of a Customs and Border Protection (CBP) representative for you shortly.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Davis, Ashley (FDEM); Guthrie, Kevin; Moskowitz, Jared; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Link, Paul (OS/ASPR/EMMO); Mann, Travis (OS/ASPR/EMMO); Sturrock, Lochlin (OS/ASPR/EMMO); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Philip; Teague, Brian; Bowman, Thomas (OS/ASPR/EMMO); Dickinson, Jeanette (OS/ASPR/EMMO); Raspberry, Jenny (OS/ASPR/EMMO)
Subject:	RE: CDC Guidance for Cruise Ships
Date:	Wednesday, March 25, 2020 11:10:56 PM

Danny Alonso from CBP is in charge of both ports I believe.
His contact info is email: DANIEL.ALONSO@CBP.DHS.GOV and phone is 305.395.2260.

Please let me know if you need anything else.

Regards,
Jeanne

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HSDN: Jeanne.eckesroper@dhs.sgov.gov

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cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 10:52 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Moskowitz, Jared <Jared.Moskowitz@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis,

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From:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Blackmore, Carina (CDC flhealth.gov)
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 3:07:15 PM

Also, please let me know if it is better if I flew in to Fort-Lauderdale airport, given that this is Broward county.
Thanks,
Srinivas

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Sent: Friday, March 20, 2020 2:55 PM
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To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>

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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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We do ask that local or state PH support be present onsite with him as much as possible. And you will continue to have our support from CDC headquarters 24/7.

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Please reach out to Sri directly to arrange further logistics.

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Elizabeth Soda

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To:	Blackmore, Carina (CDC flhealth.gov); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response Field Investigations Team; CDC IMS 2019 NCOV Response At Risk; CDC IMS 2019 NCOV Response Clinical On-Call Unit; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP); Fagan, Ryan (CDC/DDID/NCEZID/DHQP); Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 2:45:43 PM

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From:	Pritchard, Scott
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Blackmore, Carina; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial; Schmitz, Ann; Dotson, Nychie; McCoy, Steve
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 3:56:18 PM

Small correction. Dr. Thaqi's cell is 954-295-9051.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Sent: Friday, March 20, 2020 3:55 PM
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Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks.

Dr. Thaqi - the number doesn't seem to work for me. Could you advise me the address and time where I need to get to tomorrow?
Thanks,
Srinivas

Get Outlook for iOS

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 2:45:50 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
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Subject: Re: CDC Infection Prevention and Control Assistance

It probably would be better to go to Ft Lauderdale airport
Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051

AMERICAN OVERSIGHT

Agency for Health Care Administration 561-573-5968.

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Sent: Friday, March 20, 2020 3:07:12 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV

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Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
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Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 3:55:07 PM

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Agency for Health Care Administration 561-573-5968.

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From:	McCoy, Steve
To:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Pritchard, Scott; Blackmore, Carina; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial; Schmitz, Ann; Dotson, Nychie
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 4:34:06 PM

Here are the contact numbers for the command staff we have on scene.

IMT

- Incident Commander - Nick Pachota - 407.340.5794
- Operations Section Chief - Chris Sorrentino - 954.448.0896
- Plans Section Chief - Joe Sorrentino, Jr. - 954.445.0229
- Logistics Section Chief - Paul Sumner - 954.536.3065

The IC should be on-scene between 4:30 and 5 PM.

The Section Chiefs should be on-scene by 4:00 PM.

Steve A. McCoy
Emergency Medical Services Administrator
Florida Department of Health
Office #: (850) 245-4927
Cell #: (850) 528-0012

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 4:00 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks!

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, March 20, 2020 2:56:18 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve

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<Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

Small correction. Dr. Thaqi's cell is 954-295-9051.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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To: Blackmore, Carina (CDC flhealth.gov)
Cc: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Subject: RE: CDC Infection Prevention and Control Assistance
Date: Monday, March 23, 2020 7:29:49 AM

Hi Dr. Blackmore,
Just wanted to check in with you about my deployment to Broward County so far. Dr. Thaqi likely looped you in already but I supported condensing of existing guidelines for SNFs and ALFs and training on them to public health staff and the IMT staff. Also helped with some site visits to these facilities supplementing existing Broward county infection control assessment protocols. Reaching out to you to let you know that my initial objectives for this mission could be considered complete. Let me know if you think there is anything else that I should be assisting the county or you with.
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Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response Field Investigations Team <eocevent359@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>; CDC IMS 2019 NCOV Response Clinical On-Call Unit <eocevent185@cdc.gov>; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP) <vii0@cdc.gov>; Fagan, Ryan (CDC/DDID/NCEZID/DHQP) <fev3@cdc.gov>; Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

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Best,
Elizabeth Soda

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From:	Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD)
To:	Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Thaqi, Paula M; Roberson, Shamarial (CDC flhealth.gov); Schmitz, Ann (CDC flhealth.gov); Dotson, Nychie; McCoy, Steve
Cc:	Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	Re: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 4:00:13 PM

Thanks!

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, March 20, 2020 2:56:18 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: RE: CDC Infection Prevention and Control Assistance

Small correction. Dr. Thaqi's cell is 954-295-9051.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:55 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Thanks.

Dr. Thaqi - the number doesn't seem to work for me. Could you advise me the address and time where I need to get to tomorrow?
Thanks,
Srinivas

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 2:45:50 PM
To: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Dotson, Nychie <Nychie.Dotson@flhealth.gov>; McCoy, Steve <Steve.McCoy@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

It probably would be better to go to Ft Lauderdale airport
Contact number: Fernanda (Facility) 786 409 1147
Dr Thaqi, Broward CHD 954-294-9051
Agency for Health Care Administration 561-573-5968.

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From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
Sent: Friday, March 20, 2020 3:07:12 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP) <jeq4@cdc.gov>
Subject: Re: CDC Infection Prevention and Control Assistance

Also, please let me know if it is better if I flew in to Fort-Lauderdale airport, given that this is Broward county.
Thanks,
Srinivas

From: Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD) <yxj2@cdc.gov>
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To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Blackmore, Carina (CDC flhealth.gov)
Cc: Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject: Re: CDC Infection Prevention and Control Assistance
Date: Friday, March 20, 2020 2:55:10 PM

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Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response Field Investigations Team; CDC IMS 2019 NCOV Response At Risk; CDC IMS 2019 NCOV Response Clinical On-Call Unit; Walters, Maroya S. (CDC/DDID/NCEZID/DHQP); Fagan, Ryan (CDC/DDID/NCEZID/DHQP); Chung, Koo-Whang (CDC/DDID/NCEZID/DHQP)
Subject:	RE: CDC Infection Prevention and Control Assistance
Date:	Friday, March 20, 2020 1:59:01 PM

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Best,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	CDC IMS 2019 NCOV Response PUI
Cc:	Roberson, Shamarial; Blackmore, Carina
Subject:	RE: CDC nCoV Clinician Inquiry Follow-up
Date:	Wednesday, February 5, 2020 2:15:52 PM

Thank you I have spoken with Dr. Abdul and rule out the need for nCoV testing.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Sent: Wednesday, February 05, 2020 1:55 PM
To: clinic@myffbenefits.com
Cc: Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: CDC nCoV Clinician Inquiry Follow-up

Caller: Dr. Lauren Abdul

Caller phone: 561-969-6663

Caller location/health facility: Florida

Day and Time of Call: 2/5/2020 13:54

Dear Dr. Abdul

Thank you for contacting the CDC with a novel coronavirus person under investigation (PUI) inquiry. If you suspect you have a patient with possible novel coronavirus infection, please contact your local health department immediately for further guidance. General information on novel coronavirus, including infection control measures can be found online here. CDC is working closely with local and state health authorities. CDC will only be facilitating novel coronavirus referral testing in coordination with public health departments.

Regards,

CDC Novel Coronavirus Response PUI Team

CDC IMS 2019 NCOV Response PUI Team

2019 Novel Coronavirus Response

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eocevent185@cdc.gov

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From:	Anderson, Jade (CDC/DDPHSIS/CPR/DSLR)
To:	State and Local Readiness (CDC)
Subject:	RE: CDC Releases Interim Movement & Monitoring Guidance
Date:	Monday, February 3, 2020 8:45:52 PM
Attachments:	314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-English.jpg 314423-D_Postcard_Coronavirus_T-HAN_Feb3_3pm-Mandarin.jpg

For your awareness, updated travel cards attached for your use.

From: State and Local Readiness (CDC) <preparedness@cdc.gov>
Sent: Monday, February 3, 2020 8:29 PM
To: CDC IMS State Coordination Task Force (SCTF) Lead <eocsctflead@cdc.gov>
Subject: CDC Releases Interim Movement & Monitoring Guidance

Dear Partners,

Today, the Centers for Disease Control and Prevention (CDC) released new movement and monitoring guidelines, "**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings"**. For your convenience, you can find it here. In addition, summary key points are attached.

Feel free to send any questions to preparedness@cdc.gov. For the latest information on the 2019 Novel Coronavirus (2019-nCoV), please visit the response webpage.

Thank you,

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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2019 nCoV CORONAVIRUS

HEALTH ALERT: *Travelers from China*

There is an outbreak of respiratory illness in China.



Travelers are required to be monitored for up to 14 days after leaving China.

Travelers should stay home and monitor their health within this 14-day period.

A health official will contact you to give additional instructions.

Take your temperature with a thermometer 2 times a day and watch your health.

If you develop a fever (100.4°F/38°C or higher), cough, or have difficulty breathing:

- Call your health department for advice before seeking care.
- If you can't reach your health department, call ahead before going to a doctor's office or emergency room.
- Tell them your symptoms and that you were in China.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC

For more information: **www.cdc.gov/nCoV**

CS 314423-D 02/03/2020

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2019 nCoV CORONAVIRUS

健康预警：来自中国的旅客请注意

近期，在中国爆发了由新型冠状病毒所引起的呼吸系统疾病。



我们要求各位旅客在离开中国后的14天内接受健康监察。

在这14天内，您需要在家隔离，并且监测您的健康情况。

卫生官员将与您联系，为您提供进一步的指导。

请每天用体温计测量您的体温两次，并且密切关注您的身体健康。

如果您出现发烧(100.4F/38C)，咳嗽，或呼吸困难的症状：

- 请在看医生之前，先打电话向您当地的卫生部门寻求建议。
- 如果您无法联系到当地的卫生部门，请在去医生办公室或急诊室之前先打电话咨询。
- 告知医生您的症状，并让医生知道您曾去过中国。

CS 314423-D 02/03/2020

详细信息请参见: **www.cdc.gov/nCoV**

AMERICAN OVERSIGHT

From:	Amy Chang
To:	Shea, Shari | APHL; apierce@wakegov.com; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD); Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Laura Wildey
Subject:	RE: CIFOR Promote DT - February Meeting Notes and Action Items
Date:	Friday, March 6, 2020 9:48:24 AM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Third Edition Guidelines_Twitter.png CIFOR Third Edition Guidelines_Facebook.png CIFOR Guidelines Third Edition Promotions.docx

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I would be happy to collect any of the suggested edits. And if there happens to be a communication specialist available---it would be great to have their input/help.

I don't think an official release date has been announced? Maybe India has updates?

Thanks,
Amy

From: Shea, Shari | APHL <shari.shea@aphl.org>
Sent: Friday, March 6, 2020 9:21 AM
To: Amy Chang <Achang@naccho.org>; apierce@wakegov.com; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>; Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Laura Wildey <lwildey@neha.org>
Subject: RE: CIFOR Promote DT - February Meeting Notes and Action Items

I believe we have now lost Michelle, Beth and Elizabeth, who were are go-to Promote members for fine tuning our promotional messages.
Do we need any other eyes on the draft messages from Michelle before we start using them? Also, do we have a release date for the 3rd Edition?
Thanks,
Shari

From: Michelle Shapiro <mshapiro@naccho.org>
Sent: Monday, February 24, 2020 1:15 PM
To: Amy Chang <Achang@naccho.org>; apierce@wakegov.com; Shea, Shari | APHL <shari.shea@aphl.org>; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>;

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Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Collaro, Thomas - FSIS <thomas.collaro@usda.gov>; Laura Wildey <lwildey@neha.org>
Subject: RE: CIFOR Promote DT - February Meeting Notes and Action Items

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi all,

I attached draft newsletter and social media promotions for the Guidelines, as well as social media graphics for Twitter and Facebook. Feel free to suggest edits!

Thanks,
Michelle

From: Amy Chang <Achang@naccho.org>
Sent: Wednesday, February 19, 2020 11:24 AM
To: apierce@wakegov.com; Shea, Shari | APHL <shari.shea@aphl.org>; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>; Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Michelle Shapiro <mshapiro@naccho.org>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
Cc: Collaro, Thomas - FSIS <thomas.collaro@usda.gov>; Laura Wildey <lwildey@neha.org>
Subject: CIFOR Promote DT - February Meeting Notes and Action Items

Good Morning,

Please see the attached notes from the meeting yesterday.

Immediate Action Items:

- 3rd Ed. Guidelines Promotion Plan
  - Promotion Plan
    - Newsletter blurb/couple social media - Michelle Shapiro will draft and send to group before she leaves at the end of February.
      - Postcard flyer (attached)
        - Action Item: If you have edits, send it to Michelle by 2/21.
      - Use Elizabeth's promotional plan 2020 - Amy posted updated copy post on Basecamp.

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- Action item: fill in and update the promotional plan where you can contribute.

Thank you,
Amy

Amy Chang
Senior Program Analyst
Environmental Health
National Association of County and City Health Officials (NACCHO) ¦1201 Eye Street NW 4th Floor ¦ Washington, DC 20005
Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
www.naccho.org



AMERICAN OVERSIGHT

Promotions for the Third Edition of the CIFOR Guidelines

Newsletter Blurb (Short)

Just Released: Third Edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response
The Council to Improve Foodborne Outbreak Response (CIFOR) released the streamlined and easy-to-read third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response. The CIFOR Guidelines are a comprehensive source of information on foodborne disease investigation and control for local, state and federal health agencies. Download the new Guidelines: https://cifor.us/products/guidelines.

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The Guidelines describe (a) the overall approach to addressing foodborne disease outbreaks, including preparation, detection, investigation, control and follow-up; and (b) the roles of key organizations in foodborne disease outbreaks.

These are a few of the updates in the new third edition:

- Provides information on the value and use of complaint systems
- Highlights Whole Genome Sequencing and Culture-Independent Diagnostic Testing
- Better illustrates how epidemiology, lab, and environmental health data come together
- Highlights importance of environmental assessments
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Social Media Posts

The highly anticipated third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response has arrived! Download your free copy today: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

The latest edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response is a streamlined and easy-to-read resource for local, state, and federal, agencies. Download your free copy today: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

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Download the third edition of the CIFOR Guidelines for Foodborne Disease Outbreak Response, with new information on the importance of Foodborne Illness Complaint Systems: https://cifor.us/products/guidelines. #CIFORFood #FoodSafety

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JUST
RELEASED

THIRD EDITION: CIFOR GUIDELINES FOR FOODBORNE DISEASE OUTBREAK RESPONSE

Free Download at cifor.us

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From:	Michelle Shapiro
To:	Amy Chang; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD); Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro (Thomas.Collaro@fsis.usda.gov); Sharp, Donald (CDC/DDID/NCEZID/DFWED); jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID); Scott E. Holmes; christina.ferguson@dph.ga.gov; India Bowman; Tiara Smith; Jesse C. Bliss
Cc:	Collaro, Thomas - FSIS; Laura Wildey
Subject:	RE: CIFOR Promote DT - February Meeting Notes and Action Items
Date:	Monday, February 24, 2020 1:14:39 PM
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png image007.png image008.png CIFOR Guidelines Third Edition Promotions.docx CIFOR Third Edition Guidelines_Twitter.png CIFOR Third Edition Guidelines_Facebook.png

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To: apierce@wakegov.com; Shea, Shari | APHL <shari.shea@aphl.org>; mcone@cste.org; Robert Casey <Robert.Casey@publix.com>; Moyer, Ben | APHL <Ben.Moyer@aphl.org>; Hainstock, Lisa (MDARD) <hainstockl@michigan.gov>; Carina.Blackmore@flhealth.gov; Katie Garman <Katie.Garman@tn.gov>; Tom Collaro (Thomas.Collaro@fsis.usda.gov) <Thomas.Collaro@fsis.usda.gov>; Sharp, Donald (CDC/DDID/NCEZID/DFWED) <das8@cdc.gov>; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID) <ypg0@cdc.gov>; Michelle Shapiro <mshapiro@naccho.org>; Scott E. Holmes <sholmes@lincoln.ne.gov>; christina.ferguson@dph.ga.gov; India Bowman <ibowman@cste.org>; Tiara Smith <tsmith@naccho.org>; Jesse C. Bliss <JBliss@neha.org>
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Amy

Amy Chang
Senior Program Analyst
Environmental Health
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Direct: 202.507.4221 | **Main:** 202.783.5550 x 4245 ¦**Fax:** 202.783.1583 ¦**Email:** achang@naccho.org
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From:	Amy Chang
To:	Tiara Smith; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro; Sharp, Donald (CDC/DDID/NCEZID/DFWED; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID; Scott E. Holmes; christina.ferguson@dph.ga.gov; Collaro, Thomas - FSIS; Laura Wildey; India Bowman; Jesse C. Bliss
Subject:	RE: CIFOR Promote DT Meeting
Date:	Thursday, March 12, 2020 9:38:10 AM

Good Morning, All,

Hope everyone is well. I know a lot of folks are involved with the COVID-19 response. Please let me know if you are able to attend this meeting at this time so we can plan accordingly.

Much thanks!
Amy

-----Original Appointment-----
From: Tiara Smith <tsmith@naccho.org>
Sent: Friday, February 21, 2020 3:51 PM
To: Tiara Smith; apierce@wakegov.com; Shea, Shari | APHL; mcone@cste.org; Robert Casey; Moyer, Ben | APHL; Hainstock, Lisa (MDARD; Carina.Blackmore@flhealth.gov; Katie Garman; Tom Collaro; Sharp, Donald (CDC/DDID/NCEZID/DFWED; jarieh@cste.org; McKenzie, Monica (CDC/OID/NCEZID; Scott E. Holmes; christina.ferguson@dph.ga.gov; Collaro, Thomas - FSIS; Laura Wildey; Amy Chang; India Bowman; Jesse C. Bliss
Subject: CIFOR Promote DT Meeting
When: Monday, March 16, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://naccho.zoom.us/j/871476261

Dear All,

Please save the date, the 3rd Monday of each month, for the CIFOR Promote DT Meeting.

Regards,
Tiara

tsmith@naccho.org is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://naccho.zoom.us/j/871476261

Meeting ID: 871 476 261

One tap mobile
+19292056099,,871476261# US (New York)

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+16699006833,,871476261# US (San Jose)

Dial by your location
+1 929 205 6099 US (New York)
+1 669 900 6833 US (San Jose)
Meeting ID: 871 476 261
Find your local number: https://naccho.zoom.us/u/acel60w87R

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From: Jenna McElyea

To: Johnson, Tommy; Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Barlow; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; Dahill, Gerard; David Morrison; Bell, Blake; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org; evelyn.ross@hcahealthcare.com; firemedic1931@yahoo.com; Florence Wegst; FONSECA, RAFAEL; Frank Daniel; Frankie Lumm; Thomas, Jim; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Greg Luka; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwendolyn Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Jamie Carmichael; Jamie Tutnjevic; Janet Kinney; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; jen.echcc@gmail.com; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Jennifer Arant; Jennifer Barrera; Jennifer Colley; Jennifer Landis; jessica.vangestel@hcahealthcare.com; Jim Richardson; Joby Smith; Joe Casal; John Ard; John Dosh; John Gainous; John Hatfield; John Otteson; John.Hatfield; JohnJ.Lanza@flhealth.gov; Johnson, Karen S (HolmesCHD); Jordan Cook; Jose Garcia; Joseph Milligan; Joseph Randolph; Judi Capello; Julie Bates; Jurenda McLamb; Justin Gillman; Justin Pullin; Kami Bailey; Karen Adams; Karen Cash; Karen Chestnut; Karen Hughes; Karen Peeples; karen.barron@hcahealthcare.com; Karen.Chapman@flhealth.gov; Karen.Urquhart@hcahealthcare.com; Kat Beedie; Kathlyn Campbell White; Kathrine Lee; Katie Scott; Kayla Henderson; Kays Brooks; Keels, Brandi; Kelley; Kelley Patrick; Kelley, Debbie A; Kellie Locher; Kelly Banks; Kelly C; Ken Skalitzky; Kevin Daniel; Kevin Sasser; Kim Adams; Kim Barron; Kim Goebert; Kim Lonas; Kimberly Fraley; kimberly.toone@med.navy.mil; Kimberlyn Bouler; Kirk Webb; Kristina Boone; Lacey Li; Lanie Osborn; Brooke, Keith; Official Group; Larry Petty; Laura Messer; Laura Pistey; Lautritia Moorehand; lbedley@mhrc.care; ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Linda Kent; Linda Langley; Linda Villanova; ~Bell, Jeffrey FA; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Louis Svehla; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Mary Winn; Matt Baltz; Matt Dobson; Matt Douglass; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Blakely, Danny; Melody Hines; Meo; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; Mooney, Dayle; Nancy Walls; Natalie Johnson; Nathan Monk; nhall@srso.net; Nicole; nicolette Bennett; Oscar Williams; Patricia Krimminga; Patricia Roberts; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Randi Nichole Sandoval; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Rick Talbert; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ferland, Ross; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Sandy K. Martin; Sarah Demotto; Scott Berube; Scott Vickers; Shandra Jenkins; Shannon Murray; Shannon.Richardson@bhcpns.org; Sharon Wise; Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Thomas knox; Thomas McDaniel; Thomas Smith; Thomas Verlaan; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Tracey Long; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kennison; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; Willowbrook Court at Azalea Trace; Woodlief, Douglas

AMERICAN OVERSIGHT

Subject: RE: communications test
Date: Friday, March 13, 2020 6:25:59 PM

yes



Healthy **O**ptions for **P**ersonal **E**mpowerment

Jenna McElyea, MBA, LPN
Behavioral Wellness Clinic Program Manager
Bridgeway Center, Inc
137 Hospital Dr.
Ft. Walton Beach FL 32548
850-833-7500 ext 211
850-419-6921 (C)

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From: Johnson, Tommy <bfmaint@SOUTHERNLTC.COM>
Sent: Friday, March 13, 2020 11:39 AM
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~ Passion to Service ~

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Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From: Jen Sulack

To: Ann Hill

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AMERICAN OVERSIGHT

	Douglas
Subject:	Re: communications test
Date:	Friday, March 13, 2020 12:51:51 PM

YES

On Fri, Mar 13, 2020 at 11:32 AM Ann Hill <ann.echcc@gmail.com> wrote:

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Jen Sulack
Emerald Coast Healthcare Coalition

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Jen Sulack
Emerald Coast Healthcare Coalition

AMERICAN OVERSIGHT

From: Johnson, Tommy

To: Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Re: communications test
Date: Friday, March 13, 2020 1:21:22 PM

yes

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~ Passion to Service ~

From: Ann Hill <ann.echcc@gmail.com>
Sent: Friday, March 13, 2020 12:31:22 PM
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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: Jenna McElyea

To: Johnson, Tommy; Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Barlow; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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AMERICAN OVERSIGHT

Subject: RE: communications test
Date: Friday, March 13, 2020 6:25:24 PM

yes



Healthy **O**ptions for **P**ersonal **E**mpowerment

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Sent: Friday, March 13, 2020 11:39 AM
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~ Passion to Service ~

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Subject: communications test

Emerald Coast Healthcare Coalition is conducting our quarterly communications test which seems very timely with everything going on due to coronavirus - this test ensures that we maintain communication with our partners
Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

--

Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

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From: Johnson, Tommy

To: Ann Hill; 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Re: communications test
Date: Friday, March 13, 2020 12:46:41 PM

yes

TOMMY JOHNSON, Maintenance Supervisor
Bonifay Nursing & Rehab Center
306 West Brock Ave
Bonifay, FL. 32425
PH: 850-547-9289 Fax: 850-547-2575
e-mail: bfmaint@southernltc.com
~ Passion to Service ~

From: Ann Hill <ann.echcc@gmail.com>
Sent: Friday, March 13, 2020 12:31:22 PM
To: 21st Century Oncology Inc.; A & J Transport; Aaron Otis; Abby Burdeshaw; Adam Principe; administrator@baycenterhealthandrehab.com; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Allison Blevins; Amanda Baker; Amanda Rae Bower; Amber; Amber Smith; Ami; Amy Johnson; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Aric Porter; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; Johnson, Tommy; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Brnadi Gill; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Charles Addison; Charlotte Merrill; Chasity Brady; Chat Long; Chautauqua; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. Nolan; Christopher Myers; cindy.tompkins@hcahealthcare.com; clare@mycoastalurgentcare.com; Clinic4707@fmc-na.com; Codie Paulie; Comfort Keepers; COMPTON, PATRICK D 1st Lt USAF ACC 325 CES/CEO; Connie Zuraff; Corey; Corky Young; Courtney Alford; Craig Ammons; Crisp, Derek J.; Cristin Carr Peterson; Crystal Dunaway; csims@myescambia.com; cwelch@washingtonfl.com; Cynthia Cort; D. Harr; Dale Dalbey; Dale Fleming; Daniel LaTour; Danielle Bourgeois; Danny; Darlene - No Okaloosa; Darrel Welborn; Darren Staggers; Dahill, Gerard; David Morrison; Bell, Blake; David Sigurnjak; David Whalen; Dawn Wilcox; Deanna.EdwardsWalton@kindredhospicecare.com; DeAnne Cutler; debbie.edwards@brooksrehab.org; Deborah Anderson RN, BSN; Debra Hutchinson; Debra Mobley; DeeDranae Cole; Dexter Harris; Diana VanHorn; Dianne James; Dianne Rimstom; Director; Doc Clinchy; Donna Deutsch; Donna Free; Donna Riddle Neely; Doug Mishler; Douglas.Hirsch@hcahealthcare.com; Dr; Drawdy, Lynne; Duane Bridges; duane@manoratbwb.com; Dustin Wooten; dwalker@weemsmemorial.com; dwelborn@co.okaloosa.fl.us; Eamonn Wheelock; Ebbin Spellman; Edy Rivard; Elizabeth Black; Elizabeth Grindstaff; Elizabeth Zaben; EMCVAY@gchc.com; Emily Allen; emily.mason@bhcpns.org; Eric Clayton; Eric Esmond; Eric Frank; Erika Elmore; Erin Brown; Esther Stoltzfus; Evan Scott; evelyn.mitchell@bhcpns.org;

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Subject: communications test

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Please respond to me only - do not copy all
Please send email answering YES that you received my communication for this test
Thank you

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Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

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From: McWhorter, Linda
To: Peterson, Amy; LogisticsDesk2; Deleon, Melissa (FLNG); Bequer, Samantha; Guidicelli, Ian; Dumas, Wendell; EOC-Plans; Mahon, Jason; Anspaugh-Naples, Stephanie; courtney.coppola@flhealth.gov; Kincaid, Brooke
Subject: Re: Community Based Testing Sites- SitRep from 3-23-20
Date: Tuesday, March 24, 2020 3:05:03 PM

Change Orlando report - they have one opening.
Add critical need statement: need test kits otherwise testing becomes nonexistent

Get Outlook for Android

On Tue, Mar 24, 2020 at 9:43 AM -0400, "Kincaid, Brooke" <Brooke.Kincaid@em.myflorida.com> wrote:

> All,
>
> Please see the attached SitRep, for personnel and potential burn rates for the Community Based Testing Sites. However, new numbers came in during the morning briefing on tests conducted. The most up to date numbers can be found in below:
>
> Jacksonville- TIAA Stadium
> Federal Tests- 254
> Not Meeting Criteria- 184
>
> Orlando- Convention Center
> First Responder Testing- 3/25
> General Public Testing- 3/26
>
> Broward- CB Smith Park
> Tested- 799
> Not Meeting Criteria- 272
>
> Miami- Hard Rock
> Federal Tests- 200
> State Testing- 575
> Not Meeting Criteria- 187
>
> **Brooke Kincaid, MPA | Recovery Regional Manager and Region 2**
> Bureau of Recovery
> Florida Division of Emergency Management
> *Rebuilding Together*
> (850)-567-6197 (c)
> (850) 815-4437 (o)
> Email: Brooke.Kincaid@em.myflorida.com
>
> *Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida.*
>
> Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made

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available upon request.

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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From:	Pritchard, Scott
To:	Doyle, Tim (CDC/DDPHSIS/CGH/DGHP); Blackmore, Carina; Rubino, Heather
Subject:	RE: Coronavirus Disease 2019 Information for Travel (New Travel Alerts)
Date:	Thursday, February 27, 2020 8:53:41 AM
Attachments:	image003.png image004.png

Great Time!
We are in Building 4025 Esplanade Way. I arrive at 8:15 each morning, and can meet you in the downstairs lobby and walk you to your office.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Sent: Thursday, February 27, 2020 8:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: FW: Coronavirus Disease 2019 Information for Travel (New Travel Alerts)

FYI, there is a CDC weekly update re COVID-19, which highlights most recent guidance, documents, etc.

From: Centers for Disease Control and Prevention <no-reply@emailupdates.cdc.gov>
Sent: Wednesday, February 26, 2020 2:04 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Subject: Coronavirus Disease 2019 Information for Travel (New Travel Alerts)

This message includes weekly updates on the COVID-19 response from CDC. This is a rapidly evolving situation and information will be updated on the COVID-19 Situation Summary as it becomes available.

Thank you for signing up for the weekly COVID-19. CDC sends this email every Monday at 2pm ET. Here is a copy of the email that was sent on Monday, February 24.

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CDC Weekly Updates on COVID-19

February 24, 2020

This message includes weekly updates on the COVID-19 response from CDC. This is a rapidly evolving situation and information will be updated on the COVID-19 Situation Summary as it becomes available.

What's New

Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings
MONDAY, FEBRUARY 24, 2020

Coronavirus Disease 2019 Information for Travel (New Travel Alerts)
MONDAY, FEBRUARY 24, 2020

CDC in Action: Preparing Communities for Potential Spread of COVID-19
SATURDAY, FEBRUARY 23, 2020

Frequently Asked Questions and Answers: Coronavirus Disease-2019 (COVID-19) and Children

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SATURDAY, FEBRUARY 22, 2020

Stigma Related to COVID-19
FRIDAY, FEBRUARY 21, 2020

More Updates

Resources and Guidance

State and Local Public Health Professionals

Healthcare Professionals

Laboratories

Travel

Businesses

Communication Resources

2019 Novel Coronavirus (2019-nCov)

Coronavirus Disease 2019 (COVID-19) in the U.S.

As of February 24, 2020

In the United States, there have been 14 confirmed cases of COVID-19 detected through U.S. public health surveillance systems. There have also been 39 cases of COVID-19 reported among people repatriated to the United States.

CDC provides updated U.S. case information online on Mondays, Wednesdays, and Fridays.

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Centers for Disease Control and Prevention

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

Questions or Problems | Unsubscribe

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More Updates

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U.S. Cases

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From:	Blackmore, Carina
To:	Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Green, Gary; Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Cc:	Pritchard, Scott
Subject:	Re: Coronavirus Guidance
Date:	Friday, February 28, 2020 6:16:42 PM

Happy to review. Carina

Get Outlook for iOS

From: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ) <fba8@cdc.gov>
Sent: Friday, February 28, 2020 5:07:42 PM
To: Green, Gary <Gary.Green@mlb.com>; Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: Coronavirus Guidance

Hi Jon, Gary— Great to hear from you both. Regarding contacts in FL, you may reachbout to Scott and Carina.

Scott.Pritchard@flhealth.gov
carina.blackmore@flhealth.gov

Checking on resource to assist with guidance. What topics were you addressing?
Francisco

From: Green, Gary <Gary.Green@mlb.com>
Sent: Friday, February 28, 2020 5:24 PM
To: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Subject: Re: Coronavirus Guidance

Hi and I'm sure you are inundated with calls. First, thanks for all of your help in the past and appreciate your help on the coronavirus. I have been in contact with the Maricopa and Pima County health departments regarding our teams that are training in Arizona. Florida is much more complicated as our teams are spread out throughout the state. I was wondering if you have a contact at the Florida Public Health for me to reach out to regarding our teams training in Florida? Thanks so much,
Gary Green, MD
Medical Director, MLB

From: Coyles, Jon <jon.coyles@mlb.com>
Sent: Wednesday, February 26, 2020 10:51 AM
To: fba8@cdc.gov <fba8@cdc.gov>; fba8@cdc.gov <fba8@cdc.gov>; shw2@cdc.gov <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>

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Cc: Green, Gary <Gary.Green@mlb.com>
Subject: Coronavirus Guidance

Hello Francisco and CDC colleagues – I hope all is well with you. As you can imagine, we have received a number of inquiries from MLB Clubs and Players with respect to the coronavirus and we are planning to disseminate guidance that is based on CDC recommendations. Prior to dissemination of this guidance, is there someone at CDC that you could recommend that we could briefly coordinate with to ensure that our guidance is 100% accurate and consistent with current CDC guidelines? CDC was incredibly helpful to us on the Zika situation a few years ago and it would be very much appreciated if CDC could provide similar guidance and support to our industry on this current public health topic as well.

Thank you in advance and I look forward to hearing back from you.

Sincerely,
Jon Coyles

Jonathan D. Coyles | MLB | Vice President • Drug, Health & Safety Programs
1271 Avenue of the Americas • New York, NY 10020
W: 212-931-7859 | C: 917-494-1256

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From:	Green, Gary
To:	Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Cc:	Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Subject:	Re: Coronavirus Guidance
Date:	Friday, February 28, 2020 6:20:20 PM
Attachments:	Memo re Coronavirus.pdf

Scott and Carina,
Francisco kindly forwarded me your contact information. I'm the medical director for Major League Baseball and just wanted to establish contact with the Florida public health in case the need arises for increased measure with our 15 teams currently doing spring training in Florida. I have distributed the enclosed memo to all of our teams and in close contact with them regarding any potential exposures. I have made similar contacts in Arizona with our teams training there and is much easier because they are all in one county. Florida is a bit more challenging with our team all spread out. Our teams are being very cautious with respect to screening people with potential travel risks. If you have any recommendations for MLB over the next month, please reach out to me and we will implement them. Also, I wanted to ensure that there are testing facilities throughout Florida that have the capability to test for coronavirus if needed and how to refer patients for testing.
Thank you in advance and let me know if there is anything we can do to assist Florida public health.
Gary Green, MD
Medical Director, MLB
cell: 310-740-7322

From: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ) <fba8@cdc.gov>
Sent: Friday, February 28, 2020 3:07 PM
To: Green, Gary <Gary.Green@mlb.com>; Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>
Cc: Scott.Pritchard@flhealth.gov <Scott.Pritchard@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Coronavirus Guidance

Hi Jon, Gary— Great to hear from you both. Regarding contacts in FL, you may reachbout to Scott and Carina.

Scott.Pritchard@flhealth.gov
carina.blackmore@flhealth.gov

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Francisco

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Sent: Friday, February 28, 2020 5:24 PM

AMERICAN OVERSIGHT

To: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Subject: Re: Coronavirus Guidance

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Gary Green, MD
Medical Director, MLB

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Sent: Wednesday, February 26, 2020 10:51 AM
To: fba8@cdc.gov <fba8@cdc.gov>; fba8@cdc.gov <fba8@cdc.gov>; shw2@cdc.gov <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>
Cc: Green, Gary <Gary.Green@mlb.com>
Subject: Coronavirus Guidance

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Thank you in advance and I look forward to hearing back from you.

Sincerely,
Jon Coyles

Jonathan D. Coyles | MLB | Vice President • Drug, Health & Safety Programs
1271 Avenue of the Americas • New York, NY 10020
W: 212-931-7859 | C: 917-494-1256

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MAJOR LEAGUE BASEBALL
1271 AVENUE OF THE AMERICAS, NEW YORK, NY 10020

M E M O R A N D U M

TO: All Major League Clubs and Players

FROM: Office of the Commissioner

DATE: February 27, 2020

RE: Coronavirus

Most of you are likely aware of the public health concerns regarding the outbreak of respiratory disease caused by a novel (new) coronavirus. The outbreak first stated in Wuhan, China but cases have been identified in a growing number of countries worldwide, including the United States.[1] The World Health Organization has declared the outbreak a "public health emergency" and has implemented travel restrictions to China and South Korea as a result. Although the greatest risk of infection is for individuals located in China and South Korea, or those who have recently traveled to or from these countries, it is important to inform all travelling employees (including players) about this serious and potentially fatal virus.

Major League Baseball is actively monitoring the spread of coronavirus, particularly in the United States, and is working closely with the Centers for Disease Control ("CDC"). As of this writing, there are 14 confirmed cases in the United States confined to 6 states, including, Arizona, California, Illinois, Massachusetts, Washington, and Wisconsin. Nearly all of these cases (12 of 14) are related to travel to China. This number is expected to rise, but CDC and other global public health entities are implementing aggressive measures to slow the spread of the virus and mitigate its impact.

While CDC has advised that the immediate risk of this new virus in the United States is believed to be low at this time, we can all do our part to help respond to this emerging public health threat. Since coronavirus is spread from person-to-person contact, the best way to prevent infection is to avoid being exposed to an infected person. Although there is currently no vaccine or specific treatment for coronavirus, CDC recommends a number of everyday preventive measures to prevent the spread of coronavirus, including:

- Avoid close contact with anyone who is sick
- Avoid touching your eyes, nose and mouth
- Stay home when you are sick
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash
- Wash hands frequently with soap and water for at least 20 seconds, especially after using the rest room, before eating, and after blowing your nose, coughing or sneezing
- Regularly use hand sanitizer that contains at least 60% alcohol
- Regularly clean and disinfect frequently touched objects and surfaces
- Avoid travelling to, or practice enhanced precautions when travelling to, high risk areas identified by the CDC (see www.cdc.gov/travel for current travel health notices)

[1] A complete listing of locations with confirmed coronavirus cases can be found on the CDC website at: www.cdc.gov/coronavirus/2019-ncov/locations-confirmed-cases.html

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If you feel sick, particularly if you have any early symptoms of a respiratory illness (*e.g.,* fever, cough or shortness of breath), you should:

- Stay home except to seek medical care
- Seek prompt medical attention if your symptoms worsen
- Continue to practice good hygiene:
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash
    - Wash hands frequently with soap and water for at least 20 seconds, especially after blowing your nose, coughing or sneezing
    - Regularly use hand sanitizer that contains at least 60% alcohol
- Clean and disinfect frequently touched objects and surfaces regularly
- Do not travel while sick

CDC has placed Level 3 travel warnings on China and South Korea, meaning that travelers should avoid all nonessential travel to these countries. CDC has also placed Level 2 travel warnings on Italy, Japan and Iran, meaning that enhanced precautions should be practiced. Prior to travel to any country with a Level 2 or Level 3 travel warning, Clubs are required to have their employees notify a team physician, and the team physician must notify MLB's Medical Director, Dr. Gary Green, prior to commencement of travel to ensure that CDC-recommended precautions are followed.

All travelers arriving from China, South Korea and other areas with a high exposure risk will be screened upon entry to the United States pursuant to CDC guidelines. Even if a traveler from China or South Korea is asymptomatic, the CDC considers them to be at medium risk and should stay home and monitored per CDC guidelines for 14 days to ensure that they do not develop symptoms. CDC also recommends that these individuals not travel again during this 14-day period.

If you recently traveled from China, South Korea or an area with a high exposure risk within the past 14 days and feel sick with fever, cough, or difficulty breathing, avoid contact with others and immediately seek medical care. You should call ahead before visiting your health care provider and tell him or her about your travel and symptoms. Your healthcare provider will provide specific recommendations (*e.g.,* wearing a facemask) to keep others from being infected or exposed. While sick, avoid contact with others (including those in your home), do not go out except to seek medical care, and delay any travel to reduce the possibility of spreading the illness to others.

Patients with confirmed coronavirus disease should remain under home isolation until the risk of secondary transmission to others is thought to be low. The decision to discontinue home isolation should be made in consultation with healthcare providers and state and local health departments.

The Office of the Commissioner will continue to closely monitor this rapidly evolving situation and provide additional guidance in the future. Additional information on coronavirus is available on the CDC website at www.cdc.gov/COVID19. Please contact Dr. Gary Green at 310-740-7322 or Jon Coyles at 212-931-7859 if you have any immediate questions or concerns.

cc: Major League Baseball Players Association
Gary Green, M.D.
Jon Coyles

AMERICAN OVERSIGHT

From:	Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ)
To:	Green, Gary; Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Cc:	Scott.Pritchard@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Subject:	Re: Coronavirus Guidance
Date:	Friday, February 28, 2020 6:07:44 PM

Hi Jon, Gary— Great to hear from you both. Regarding contacts in FL, you may reachbout to Scott and Carina.

Scott.Pritchard@flhealth.gov
carina.blackmore@flhealth.gov

Checking on resource to assist with guidance. What topics were you addressing?
Francisco

From: Green, Gary <Gary.Green@mlb.com>
Sent: Friday, February 28, 2020 5:24 PM
To: Alvarado-Ramy, Francisco (CDC/DDID/NCEZID/DGMQ); Waterman, Steve (CDC/DDID/NCEZID/DVBD); mev1@cdc.gov
Subject: Re: Coronavirus Guidance

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Gary Green, MD
Medical Director, MLB

From: Coyles, Jon <jon.coyles@mlb.com>
Sent: Wednesday, February 26, 2020 10:51 AM
To: fba8@cdc.gov <fba8@cdc.gov>; fba8@cdc.gov <fba8@cdc.gov>; shw2@cdc.gov <shw2@cdc.gov>; mev1@cdc.gov <mev1@cdc.gov>
Cc: Green, Gary <Gary.Green@mlb.com>
Subject: Coronavirus Guidance

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Thank you in advance and I look forward to hearing back from you.

Sincerely,
Jon Coyles

Jonathan D. Coyles | MLB | Vice President • Drug, Health & Safety Programs
1271 Avenue of the Americas • New York, NY 10020
W: 212-931-7859 | C: 917-494-1256

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From:	Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
To:	Roberson, Shamarial (CDC flhealth.gov)
Cc:	White, Stefanie B. (CDC/DDID/NCEZID/DGMQ); Brown, Clive (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT)
Subject:	RE: costa favalosa and magica
Date:	Wednesday, March 25, 2020 6:11:34 PM

Adding colleagues for awareness

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
Sent: Wednesday, March 25, 2020 5:57 PM
To: Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>
Subject: costa favalosa and magica

9 severely ill crew need medivac; 1 critically ill with RR 30 on O2 with increasing O2 demand and b/l pneumonia in yellow
These are the nine seriously ill crew. Plan being arranged with Cruise company (Carnival/ costa), Coast Guard and Miami regarding medivac of these severely ill 9 patients

Favolosa

Age	Gender
53	M
33	M
47	M
49	M
36	M

Magica

32	MALE
31	MALE
53	MALE
56	MALE

COSTA MAGICA Total crew - 932

- **ILI with flu-like symptoms**

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Total 35

- **Critically ill/unstable**

Total – 4

- March 14 - two positive Covid-19 (1 guest , 1 crew) tested in Martinique
- After positives and guests off ship spread out and isolated except for essential staff
- Isolated sick and positives
- Capacity – has PPE, 2 ICU beds, 2 vents, Oxygen concentrator, CPAP
- Medical staff: 3 MDs /3 RNs (1 was ill and has recovered but still isolated)

COSTA FAVALOSA Total crew - 1010

- **ILI with COVID-19-like symptoms**

Total 53

- **Critically ill/unstable**

Total – 5

- March 15 – 3 positive crew COVID-19 tested in Martinique
  March 18 -1 crew medivac to Guadelupe when out at sea for worsening illness
- After positives and guests off ship spread out and isolated except for essential staff
- Isolated sick and positives
- Capacity – has PPE, 2 ICU beds, 2 vents, Oxygen concentrator, CPAP
- Medical staff: 3 MDs and 4 RNS (1 MD was sick – COVID negative by SCREEN IgG/IgM and returned to work)

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

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From:	Laura Rothfeldt, DVM
To:	Pue, Howard; House - CDPHE, Jennifer; Heather Venkat; Abby Mathewson; patriciazinna@gmail.com; amber.singh@odh.ohio.gov; EBeeler; mchang@ph.lacounty.gov; Ehnert, Karen; BRIT O; JSinatra@PH.LACOUNTY.GOV; kelly.debaene@santacruzcounty.us; Woodall - CDPHE, Tracy; Kathy Kudish; nivedita.ravi-caldwell@dc.gov; Blackmore, Carina; barbara.progulske@flhealth.gov; Kerins, Jana (CDC cityofchicago.org); David.Day@ltdhd.org; KSigns; Beaudoin, Amanda (MDH); "Ghai, Ria (CDC/DDID/NCEZID/OD)"; Jenna Bjork; Holzbauer, Stacy (MDH); Malia Ireland; Smith, Kirk (MDH); jcalder@caa.columbia.edu; alison.kaufman@health.ny.gov; Maxted, Angie M (HEALTH); Erica Berl; Sally Slavinski; amanda.kieffer@dshs.texas.gov; Robinson,Laura (DSHS); Stonecipher,Shelley (DSHS); Ronald.Tyler@dshs.texas.gov; Dr. Patricia McKane; jen.sidge@gmail.com; gatto515@hotmail.com; brandy.darby@vdh.virginia.gov; Meagan Kay; Lipton, Beth; suzanne.gibbonsburgener@dhs.wi.gov; Sarah Koske; Mason, Jordan L - DHS; lynn.roberts@dhs.wisconsin.gov; Castrodale, Louisa J (HSS); Curtis Fritz; jocelyn.mullins@ct.gov; Stanek, Danielle R; Tengelsen, Leslie; Austin, Connie; Brown, Jennifer; Garvey, Ann [IDPH]; Ingrid Garrison; Kelly Giesbrecht; Gary Balsamo; Walsh, Michele; David Crum; Brown, Catherine (DPH); Stobierski, Mary Grace (DCH); Scheftel, Joni (MDH); kpride (kpride@mt.gov); Buss, Bryan; Newman, Alexandra P (HEALTH); Williams, Carl; LeMac Morris; Schroeder, Betsy; Stewart, Carol, DOH; Radcliffe, Rachel (CDC dhec.sc.gov); Daly, Russell (Russell.Daly@sdstate.edu); John Dunn; Kwit, Natalie; Julia Murphy (julia.murphy@vdh.virginia.gov); Rachel Klos; karl musgrave
Cc:	"Ghai, Ria (CDC/DDID/NCEZID/OD)"; Baker, Molly; Beddo, Monica
Subject:	RE: COVID Priority Services--Animal and Ag Industries
Date:	Friday, March 20, 2020 3:28:02 PM

Not that I know of yet.

Laura K. Rothfeldt, DVM, DACVPM
Arkansas Dept. of Health

From: Pue, Howard <Howard.Pue@health.mo.gov>
Sent: Friday, March 20, 2020 1:14 PM
To: Laura Rothfeldt, DVM <Laura.Rothfeldt@arkansas.gov>; House - CDPHE, Jennifer <jennifer.house@state.co.us>; Heather Venkat <heather.venkat@azdhs.gov>; Abby Mathewson <Abigail.Mathewson@dhhs.state.nh.us>; patriciazinna@gmail.com; amber.singh@odh.ohio.gov; EBeeler <ebeeler@ph.lacounty.gov>; mchang@ph.lacounty.gov; Ehnert, Karen <kehnert@ph.lacounty.gov>; BRIT O <boiulfstad@ph.lacounty.gov>; JSinatra@PH.LACOUNTY.GOV; kelly.debaene@santacruzcounty.us; Woodall - CDPHE, Tracy <tracy.woodall@state.co.us>; Kathy Kudish <Kathy.Kudish@ct.gov>; nivedita.ravi-caldwell@dc.gov; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; barbara.progulske@flhealth.gov; Kerins, Jana (CDC cityofchicago.org) <janna.kerins@cityofchicago.org>; David.Day@ltdhd.org; KSigns <signsk@michigan.gov>; Beaudoin, Amanda (MDH) <amanda.beaudoin@state.mn.us>; 'Ghai, Ria (CDC/DDID/NCEZID/OD)' <ofu9@cdc.gov>; Jenna Bjork <Jenna.Bjork@state.mn.us>; Holzbauer, Stacy (MDH) <stacy.holzbauer@state.mn.us>; Malia Ireland <malia.ireland@state.mn.us>; Smith, Kirk (MDH) <kirk.smith@state.mn.us>; jcalder@caa.columbia.edu; alison.kaufman@health.ny.gov; Maxted, Angie M (HEALTH) <angie.maxted@health.ny.gov>; Erica Berl <erica.berl@dhhs.nc.gov>; Sally Slavinski <sslavins@health.nyc.gov>; amanda.kieffer@dshs.texas.gov; Robinson,Laura (DSHS) <laura.robinson@dshs.texas.gov>; Stonecipher,Shelley (DSHS) <shelley.stonecipher@dshs.texas.gov>; Ronald.Tyler@dshs.texas.gov; Dr. Patricia McKane <mckanep@sbcglobal.net>; jen.sidge@gmail.com; gatto515@hotmail.com; brandy.darby@vdh.virginia.gov; Meagan Kay <Meagan.Kay@kingcounty.gov>; Lipton, Beth <beth.lipton@kingcounty.gov>; suzanne.gibbonsburgener@dhs.wi.gov; Sarah Koske <Sarah.Koske@dhs.wi.gov>; Mason, Jordan L - DHS <jordan.mason@dhs.wisconsin.gov>; lynn.roberts@dhs.wisconsin.gov; Castrodale, Louisa J (HSS) <louisa.castrodale@alaska.gov>; Curtis Fritz <cfritz@cdph.ca.gov>; jocelyn.mullins@ct.gov; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Tengelsen, Leslie <leslie.tengelsen@dhw.idaho.gov>; Austin,

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Subject: RE: COVID Priority Services--Animal and Ag Industries

Has CDC weighed in on this and if so, is it on their website?

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https://www.avma.org/resources-tools/animal-health-and-welfare/covid-19/veterinary-practices-are-essential-businesses

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Subject: COVID Priority Services--Animal and Ag Industries

NASPHV,

This morning during the active member call we discussed creating a list of priority services that should be excluded from mandatory shutdowns. The concern is a complete shutdown of these services (or quarantines on large numbers of employees) will lead to disruption of the food supply, increased risk to public health, significant welfare issues to animals, unnecessary euthanasia, and overall ethical dilemmas.

I generated this list based on today's call. Please add to this as needed.

Animal Food Supply Chain Services (specifically employees working in processing plants)
Veterinary Critical and Emergency Care
Initial Rabies Vaccines to animals in high risk areas
Rabies Booster Vaccines to rabies exposed pets and livestock
Other vaccinations in response to specific situations (example: parvo or distemper outbreaks)
Responding to reportable veterinary conditions (specifically foreign animal diseases and others requiring movement restrictions)
Animal Movement Regulations including required veterinary inspections

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Jennifer House, DVM, MPH, DACVPM

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State Public Health Veterinarian



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Cc:	"Ghai, Ria (CDC/DDID/NCEZID/OD)"; Baker, Molly; Beddo, Monica
Subject:	RE: COVID Priority Services--Animal and Ag Industries
Date:	Friday, March 20, 2020 2:15:11 PM

Has CDC weighed in on this and if so, is it on their website?

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Subject: COVID Priority Services--Animal and Ag Industries

NASPHV,

This morning during the active member call we discussed creating a list of priority services that should be excluded from mandatory shutdowns. The concern is a complete shutdown of these services (or quarantines on large numbers of employees) will lead to disruption of the food supply, increased risk to public health, significant welfare issues to animals, unnecessary euthanasia, and overall ethical dilemmas.

I generated this list based on today's call. Please add to this as needed.

Animal Food Supply Chain Services (specifically employees working in processing plants)
Veterinary Critical and Emergency Care
Initial Rabies Vaccines to animals in high risk areas
Rabies Booster Vaccines to rabies exposed pets and livestock
Other vaccinations in response to specific situations (example: parvo or distemper outbreaks)
Responding to reportable veterinary conditions (specifically foreign animal diseases and others requiring movement restrictions)
Animal Movement Regulations including required veterinary inspections

--

Jennifer House, DVM, MPH, DACVPM

State Public Health Veterinarian

AMERICAN OVERSIGHT



Communicable Disease Branch

P 303.692.2700 | F 303.782.0338
4300 Cherry Creek Drive South - A3, Denver, CO 80246
jennifer.house@state.co.us | www.colorado.gov/cdphe

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI)
To:	Munroe, Julia
Cc:	Kendrick, Katie; Rubino, Heather; Blackmore, Carina (CDC flhealth.gov); Mark.ONeill@flhealth.gov; Marla.Wallace@flhealth.gov; Scott.Pritchard@flhealth.gov; Patty.Lewandowski@flhealth.gov; Heather.Rubino@flhealth.gov; julie.farmington@flhealth.gov; Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI)
Subject:	RE: COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST
Date:	Thursday, February 20, 2020 3:23:03 PM

Hi Julia,
My sincere apologies for the delay in responding to you on this! I've added you to my internal list. These calls are not being coordinated through the ELC so I don't know if the call information will update with each call. It is my understanding that the invites are going to, at minimum, PHEP Directors and State Epidemiologists; we have been sending them to ELC Governance Team members.

From: Munroe, Julia <Julia.Munroe@flhealth.gov>
Sent: Tuesday, February 18, 2020 2:06 PM
To: O'Connor, Angelica (CDC/DDID/NCEZID/DPEI) <apw1@cdc.gov>
Cc: Kendrick, Katie <Katie.Kendrick@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: FW: COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST

Hi Angelica,

I have been asked to host these calls for the Florida Department of Health, but I am not receiving these emails directly. Could you add me to your email distribution list so I receive these emails moving forward? Also, could you clarify if the call-in number and passcode listed here is the one we should use moving forward?

Thank you so much for your help!

Best,
Julia

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

From: O'Connor, Angelica (CDC/DDID/NCEZID/DPEI) <apw1@cdc.gov> **On Behalf Of** Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Sent: Sunday, February 16, 2020 9:55 PM
Cc: Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI) <wsb2@cdc.gov>; Downing, Janice S. (CDC/DDID/NCEZID/DPEI) <jsb3@cdc.gov>; Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI) <hrt8@cdc.gov>; Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI) <wkv2@cdc.gov>; Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI) <pen3@cdc.gov>; Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI) <nkm8@cdc.gov>; Shultz, Alvin (CDC/DDID/NCEZID/DPEI) <fcu9@cdc.gov>; Simpson, De'Lisa D. (CDC/DDID/NCEZID/DPEI) <ion9@cdc.gov>; Snow, Jason N. (CDC/DDID/NCEZID/DPEI) <itk0@cdc.gov>; Byrd, Shirley K. (CDC/OCOO/OFR/OGS) <yuo6@cdc.gov>; Roush, Sandra (CDC/DDID/NCIRD/OD) <swr1@cdc.gov>; Brammer, Lynnette (CDC/DDID/NCIRD/ID) <lsb1@cdc.gov>; Gross, Melanie S. (CDC/DDID/NCIRD/ID) <ivk5@cdc.gov>; Lamont, Brock (CDC/DDID/NCIRD/ISD) <bal2@cdc.gov>; CDC IMS State Coordination Task Force (SCTF) ELC LNO <eocsctfvtflno@cdc.gov>
Subject: COVID-19 All State Call: Tuesday, 2/18/20; 2:00-2:45pm EST

The CDC will be hosting an all-state COVID-19 call on Tuesday, February 18 from 2:00pm-2:45pm EST. The ELC is not coordinating this call; however, we wanted to share this information in the event you had not received it through other channels.

CDC's Coronavirus Disease-2019 (COVID-19) response team will host a national call from 2 p.m. to 2:45 p.m. EST on Tuesday, February 18, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

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

Participant Information

Bridgeline: 1(888)790-1880
Participant Passcode: 8138992

Please note, this update call is being held on a Tuesday, in lieu of President's Day observance. Future calls will be held on Mondays.

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) Operations
To:	CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) Policy & Comm
Subject:	RE: COVID-19 Public Health Response Operations
Date:	Saturday, February 29, 2020 7:02:26 PM

Good Evening Colleagues,

As a follow-up to yesterday call, please find the "Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)" here.

Schools should continue to collaborate, share information, and review plans with local health officials to help protect the whole school community, including those with special health needs. School plans should be designed to minimize disruption to teaching and learning and protect students and staff from social stigma and discrimination. Plans can build on everyday practices (e.g., encouraging hand hygiene, monitoring absenteeism, communicating routinely) that include strategies for before, during, and after a possible outbreak.

Thank you!

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



-----Original Appointment-----
Subject: COVID-19 Public Health Response Operations
When: Friday, February 28, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Bridgeline: 1(888)455-7719 Passcode: 6905931

COVID-19 Public Health Response Operations
CDC's 2019 Novel Coronavirus (COVID-19) response team will host a recurring call series from 3 p.m. to 4 p.m. EST every Wednesday's and Friday's, to discuss plans for returning travelers, including movement & monitoring, quarantine, data reporting, and status reports or concerns. **Please note, this call is not open to the media**.

Invited participants include all 62 PHEP funded jurisdictions (state, local, and territorial preparedness directors, state epidemiologists, state health officials, public health laboratory directors, and emergency management officials), nongovernmental partner organization leadership (APHL, ASTHO, CSTE, and NACCHO), Big City

AMERICAN OVERSIGHT

Health Coalition (BCHC), and ASPR regional administrators. In order to ensure and maintain the appropriate target audience, please have **ONE** representative from each **CORE** function listed participate from your jurisdiction. Participant information can be found below.

Participant Information
Bridgeline: 1(888)455-7719
Passcode: 6905931

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



For your situational awareness, the forwarding option for this invite is DISABLED.

Please contact eocsctfops@cdc.gov if you have any questions.

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) Operations
To:	CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) Policy & Comm
Subject:	RE: COVID-19 Public Health Response Operations
Date:	Saturday, February 29, 2020 7:00:17 PM

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Schools should continue to collaborate, share information, and review plans with local health officials to help protect the whole school community, including those with special health needs. School plans should be designed to minimize disruption to teaching and learning and protect students and staff from social stigma and discrimination. Plans can build on everyday practices (e.g., encouraging hand hygiene, monitoring absenteeism, communicating routinely) that include strategies for before, during, and after a possible outbreak.

Thank you!

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



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Participant Information
Bridgeline: 1(888)455-7719
Passcode: 6905931

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

For your situational awareness, the forwarding option for this invite is DISABLED.

Please contact eocsctfops@cdc.gov if you have any questions.

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Fitzgerald, John M CDR; Christie Luce; Samantha Cooksey; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Scott.Rivkees@flhealth.gov; Ashley Davis; Kevin Guthrie; Aaron Otis (CDC flhealth.gov)
Cc:	ASPR Region 4 (HHS/ASPR/OEM); Toro, Manny J; Szczech, Gracia (DHS/FEMA); Samaan, Robert (DHS/FEMA); Lamana, Joseph (OS/ASPR/EMMO)
Subject:	RE: Cruise ships due into port next 48 hours
Date:	Tuesday, March 24, 2020 9:53:52 AM

Awesome. Thank you

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Sent: Tuesday, March 24, 2020 8:49 AM
To: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Christie Luce <Christie.Luce@flhealth.gov>; Samantha Cooksey <Samantha.Cooksey@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Scott.Rivkees@flhealth.gov; Ashley Davis <Ashley.Davis@em.myflorida.com>; Kevin Guthrie <Kevin.Guthrie@em.myflorida.com>; Aaron Otis <Aaron.Otis@flhealth.gov>
Cc: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: RE: Cruise ships due into port next 48 hours

AMERICAN OVERSIGHT

Jeanne

Grandeur of the Seas is in
MSC Lirca is not inbound to Miami

v/r,

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Monday, March 23, 2020 9:33 PM
To: Christie Luce <Christie.Luce@flhealth.gov>; Samantha Cooksey <Samantha.Cooksey@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Scott.Rivkees@flhealth.gov; Ashley Davis <Ashley.Davis@em.myflorida.com>; Kevin Guthrie <Kevin.Guthrie@em.myflorida.com>; Aaron Otis <Aaron.Otis@flhealth.gov>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Cc: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Toro, Manny J <Manny.Toro@fema.dhs.gov>; Szczech, Gracia <Gracia.Szczech@fema.dhs.gov>; Samaan, Robert <Robert.Samaan@fema.dhs.gov>; Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: [Non-DoD Source] Re: Cruise ships due into port next 48 hours

+ John Fitzgerald

Sorry John....

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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cell: 404.772.9701
fax: 404.562.7913
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HSDN: Jeanne.eckesroper@dhs.sgov.gov

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AMERICAN OVERSIGHT

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On Mar 23, 2020, at 9:31 PM, Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov> wrote:

All

FYI.... I know nothing of what is happening on these ships, just they are due to arrive in the next 48 hours.

From the State Department...

- Tracking **33 cruise ships** that have/are set to debark in the next 48hrs.
- 3 out of 33 are sked to arrive in US ports in next 48 hrs – GRANDEUR OF THE SEAS (Miami, FL), MSC LIRCA (Miami, FL), SEVEN SEAS EXPLORER (Miami, FL) –

Just wanting to know if the Port of Miami remains open. I understand that the cruise lines are to follow normal practices for debarkation of ships as they do every day.

Let me know if you have any questions.
Thanks

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Funk, Renee (CDC/DDNID/NCEH/OD)
Subject: Re: disinfection of PPE
Date: Sunday, March 22, 2020 3:13:17 PM

Super thanks

Get Outlook for iOS

From: Funk, Renee (CDC/DDNID/NCEH/OD) <rjf8@cdc.gov>
Sent: Sunday, March 22, 2020 3:06:13 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: disinfection of PPE

Hi Carina,

I know everyone is swamped these days! I don't know the answer but will send to NIOSH EOC desk. I am sure they get this question a lot.

Hope you are doing as well as you can.

Take care,

Renée

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Sunday, March 22, 2020 2:22:14 PM
To: Funk, Renee (CDC/DDNID/NCEH/OD) <rjf8@cdc.gov>
Subject: disinfection of PPE

Howdy,
I am assuming you, like me, are knee deep in the COVID response.
Do you by any chance know who I could talk to about using UV light to disinfect PPE? I am guessing that hard surfaces (plastic) might work but what about cloth ? (masks/ gowns)
Any intel on this would be helpful

Thanks a lot. Thankful to have wise friends
Carina

AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	Jeanne Eckes-Roper; Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	Re: DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:31:02 PM

We are on a call with them now. I'll provide briwf when the call ends.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 1:28 PM
To: Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>; Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>; Luce, Christie <Christie.Luce@flhealth.gov>; Jeanne Eckes-Roper <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>
Cc: Szczech, Gracia (DHS/FEMA) <Gracia.Szczech@fema.dhs.gov>; Manny J. Toro (manny.toro@fema.dhs.gov) <manny.toro@fema.dhs.gov>; Samaan, Robert (DHS/FEMA) <Robert.Samaan@fema.dhs.gov>; robert.p.ashe.mil@mail.mil <robert.p.ashe.mil@mail.mil>; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov) <Stacy.Gunnin@fema.dhs.gov>; IMT2 Administration and Finance (OS/ASPR) <IMT2.ANF@hhs.gov>; Barton, Jessie-Kate (OS/ASPR/EMMO) <Jessie-kate.Barton@hhs.gov>; Ramirez, Gabriela (OS/ASPR/EMMO) <Gabriela.Ramirez@hhs.gov>; R4 PHUL (FEMA.DHS.GOV) <r4-phul@fema.dhs.gov>; FEMA-R4-RRCC-SITL <R04-rrcc-sitl@fema.dhs.gov>; FEMA-R4-WatchUnit (fema.dhs.gov) <FEMA-R4-WatchUnit@fema.dhs.gov>; Maiden, Shawn <shawn.maiden@fema.dhs.gov>; Teague, Brian <Brian.Teague@fema.dhs.gov>
Subject: DoS update on cruise ships

Received the following from our LNO with DoS for your awareness
I am thinking they may be medivac'd to FL?

Costa Magica and Costa Favolosa are north of Cuba heading north toward the U.S. Costa Magica has a crew member in critical condition (male, 32, Philippines, bilateral pneumonia)and in is need of urgent medical evacuation. The Company is coordinating with USCG to perform a medivac (details being worked). Magica has an additional 3 crew members who need medical support ashore and Favolosa has 5 crew members who need medical support ashore. The Company is also working a plan to repatriate ~300 EU, ~600 Philippine and ~250 Indonesia asymptomatic crew members later this week.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov

AMERICAN OVERSIGHT

(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
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AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	Jeanne Eckes-Roper; Guthrie, Kevin; Davis, Ashley (FDEM); Fitzgerald, John M CDR; Luce, Christie; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A
Cc:	Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Teague, Brian
Subject:	Re: DoS update on cruise ships
Date:	Wednesday, March 25, 2020 1:30:50 PM

We are on a call with them now. I'll provide briwf when the call ends.

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Wednesday, March 25, 2020 1:28 PM
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Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov

AMERICAN OVERSIGHT

(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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From: Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD)

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Cc:	Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD); DeSalvo, Traci (CDC dhs.wisconsin.gov); Mbaeyi, Sarah (CDC/DDID/NCIRD/OD); Adams, Laura E. (CDC/DDID/NCEZID/DVBD); Hedges, Sarah (CDC/DDPHSIS/CGH/DGHP); Archer, Roodly (CDC/DDPHSIS/CGH/GID); Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Liang, Arthur P. (CDC/DDID/NCEZID/DFWED); Rinsky, Jessica Lynn (CDC/NIOSH/DFSE/HETAB); Yard, Ellen E. (CDC/DDNID/NCIPC/DIP); Dcruz, Jina J. (CDC/DDPHSS/CSELS/DSEPD); Adjemian, Jennifer (CDC/DDPHSS/CSELS/DHIS); Greenspan, Arlene (CDC/DDNID/NCIPC/OD); Grey, Jeremy A. (CDC/DDID/NCHHSTP/DSTDP); Marcus, Ruthanne (CDC/DDID/NCHHSTP/DHPSE); Neil, Karen P. (CDC/DDID/NCEZID/DFWED); Grigg, Cheri T. (CDC/DDID/NCEZID/DHQP); Basler, Colin A. (CDC/DDID/NCEZID/DFWED); Nichols, Megin C. (CDC/DDID/NCEZID/DFWED); Lozier, Matthew J. (CDC/DDID/NCEZID/DFWED); Collins, Jennifer (CDC/DDID/NCEZID/DFWED); Logan, Naeemah (CDC/DDID/NCEZID/DFWED); Nett, Randall J. (CDC/NIOSH/RHD/FSB); Harvey, Reid (CDC/NIOSH/RHD/FSB); Halldin, Cara N. (CDC/NIOSH/RHD/SB); Blackley, David (CDC/NIOSH/RHD/SB); Cherry, Cara C. (CDC/DDID/NCEZID/DVBD); Behel, Stephanie (CDC/DDPHSIS/CGH/DGHT); Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Razzaghi, Hilda (CDC/DDNID/NCBDDD/DHDD); Curran, Kathryn (CDC/DDPHSIS/CGH/DGHT); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Havers, Fiona (CDC/DDID/NCIRD/DBD)
Subject:	RE: EIS Supervisor Seminar: EIS Conference and Match Orientation
Date:	Wednesday, March 18, 2020 3:20:46 PM
Attachments:	EIS Supervisor Seminar_Virtual Match_2020.pdf

EIS Supervisors –

Slides from today's seminar on the virtual match are attached. The presentation recording will be shared with you when available.

Thanks,
Larry

Larry Cohen, MD, MPH
EIS CIO Support Coordinator / EIS Program Staff Epidemiologist
Epidemiology Workforce Branch
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Center for Surveillance, Epidemiology, and Laboratory Services

EIS Supervisor Seminar: 2020 EIS Virtual Match

Epidemiology Workforce Branch
Division of Scientific Education and Professional Development

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Priorities for EIS conference contingency planning

- **Match incoming EISOs to positions (essential for deployment preparedness)**
- **EISO training on scientific communication**
- **Facilitating job search for graduating EISOs**
- **Bringing EISOs together**

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Recruitment and matching

- **Open recruitment and virtual meetings between incoming EIS officers and positions ASAP**
- **Prepare for 3-week period of video-based interviewing – including the scheduled week of conference**



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Next steps following EIS cancellation

- **Plan for 2-day training in June at Clifton or Sheraton**
  - **Prioritize 2nd year EISOs needing EIS conference for CAL completion**
  - **Considering award sessions, graduation, satirical review**
- **Plan for 5-day scientific program in 2021**

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Post EIS Employment

- **EWB working with CDC leadership to compensate for the loss of interviewing and networking that would normally be at conference**
- **Asking that COVID-19 funds be used for positions for graduating EISOs**

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2020 EIS Virtual Recruitment and Match Timeline

3/20	PDs/CVs Distributed
3/23–4/17	Recruitment Period
4/13–4/17	Interview Scheduling
4/20–5/7	Interviews
5/8, 2pm ET	Submit Ranks/Ratings
5/11	Run Match
5/11–5/14	Scramble
5/15	Release Match Results

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Virtual Recruiting: March 23rd to April 17th



- Develop a system that is as flexible as possible to accommodate the schedules of those of you who are involved in response
- Provide tools for you to facilitate and encourage interaction but not be proscriptive about how you use those tools.
- Slack is a team collaboration tool (not unlike Microsoft Teams) that allows asynchronous or live communication via messaging, voice, or video calls.
- Is available to internal CDC and external users and can be accessed via web browser, desktop, or mobile phone. Note, it doesn't seem to like Internet Explorer, so you may want to go ahead and request Chrome via the SRT.

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Slack is organized into channels.



- Slack is organized into channels (similar to a folder). There will be (1) a general channel that houses information from the EIS Program, (2) An events channel where we will post group events, (3) and a Slack resources channel where we will will post user guides, tips & tricks, and other documentation.
- We will pre-populate Slack with channels for the CIOs, a general field channel, and channels for each individual position.
- Within each channel you can post messages, upcoming recruiting events, videos, etc. Incoming officers will also be able to join your channel and post questions that you can respond to when you have the available time.

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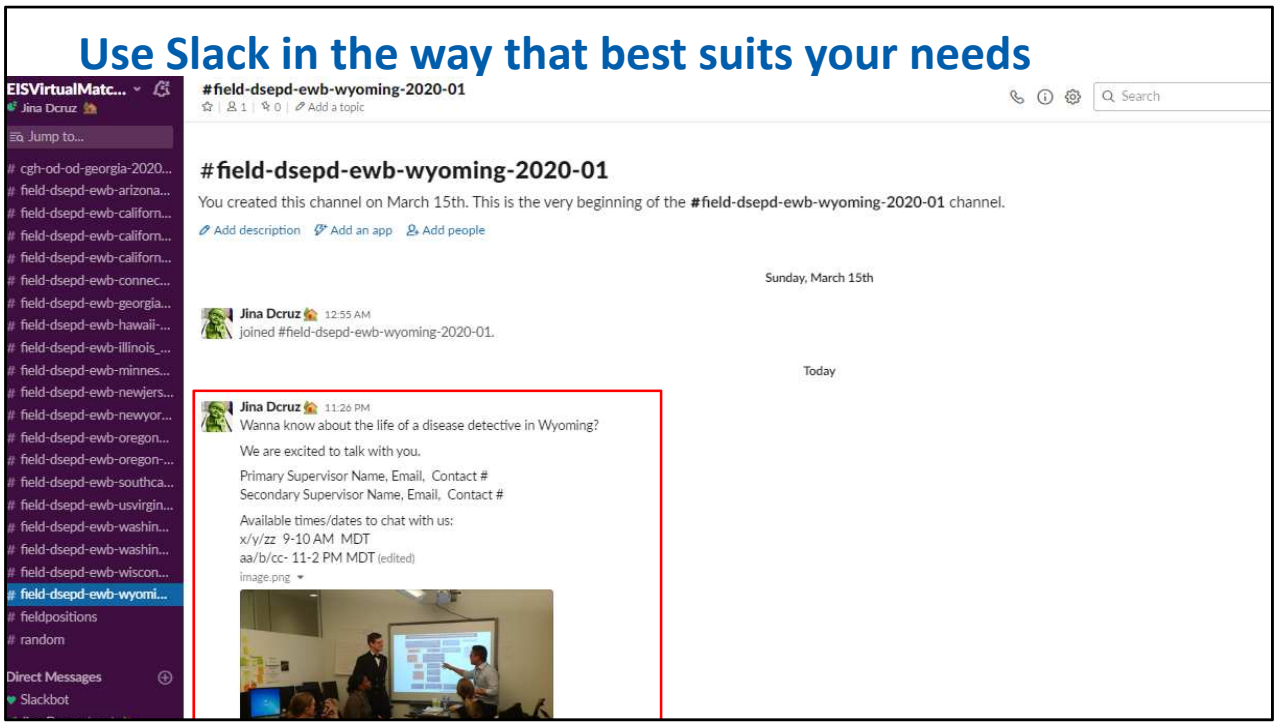
Use Slack in the way that best suits your needs



- Post messages and monitor the slack messages for questions from incoming officers

Use Slack in the way that best suits your needs

slack

powerpoint



- Post videos, PowerPoint slides, and other documentation

Use Slack to post on the main calendar



- We are investigating the best way to set up a shared calendar on slack in the events channel. You will be able to post your recruiting events such as webinars or AMA (Ask Me Anything) sessions.

We prefer you use Slack…



- We prefer you use Slack as we are concerned that incoming officers may be involved in the COVID-19 response or otherwise occupied during this period and Slack will provide them a way to check in on recruiting on their own schedules in one central location. We also understand, however, that you may not have the resources to monitor a slack channel or prefer to use your own method of interaction.

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At a minimum please post a "Preferred Method of Communication" message in Slack.

- **Who can be contacted directly (supervisor, 2ndary supervisor, EISO, etc.)**
  - **How to contact them (via Slack message, email, phone, etc.)**
  - **Best times/ways to contact**
- **Will you monitor your position's Slack channel?**
  - **If so, how often will you expect you will be checking in and responding to messages?**

- At a minimum, please post a pinned message on your preferred method of communication.
- We are going to ask incoming officers **not to initiate one-on-one contact until they have read the "preferred method of communication" post for a given position**

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- We are trying to develop this platform as rapidly as possible, so please bear with us. We will be sending out more detailed guidance.
- Each position will also be assigned an EWB staff POC who can assist you with slack and other issues with virtual recruitment and we will have Slack technical support backing them up.
- We invite your feedback on technical issues and we also ask that you share what seems to be working well for you.

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Questions on Slack or the Virtual Recruitment Period?

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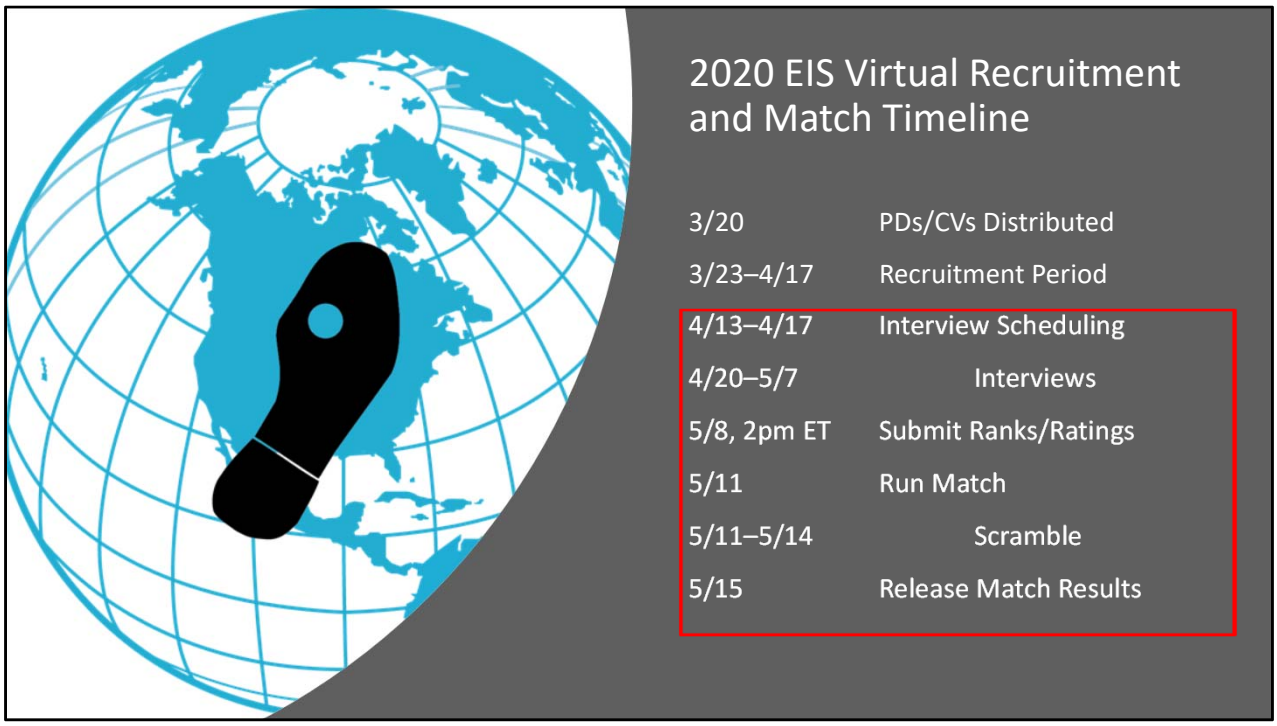

- Now I would like to go into a little more detail with respect to scheduling and conducting virtual interviews, running match, and the scramble process.
- Note that we will schedule another webinar in early to mid-April that will go into more technical detail on the eFMS platform that is used for the interview scheduling, rating submission, and match process.

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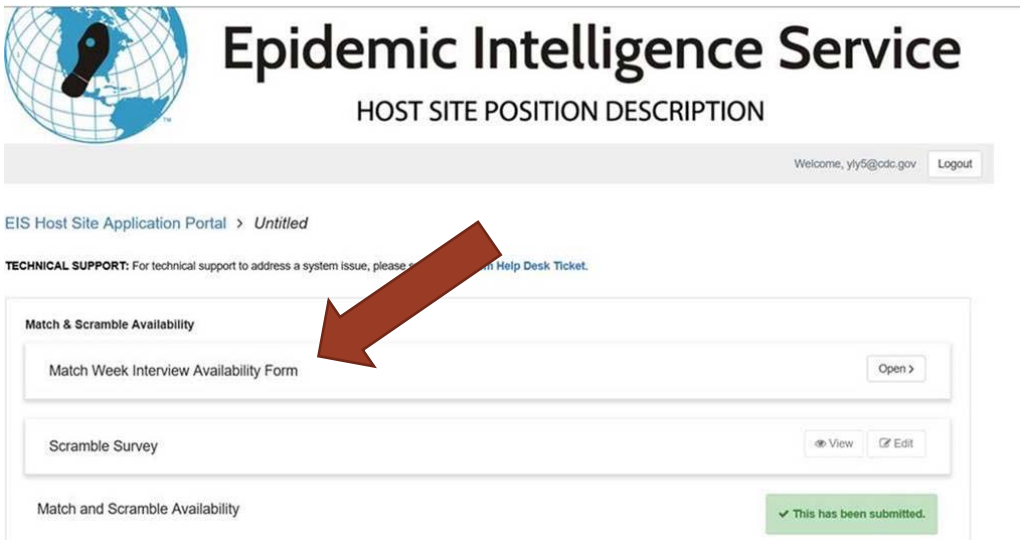
Set your interview availability by COB April 14th



- The first task related to virtual interviews will be for you to set up your availability for the 3 weeks during the interview time period. You can enter your availability in eFMS as was done last year.
- Please submit your schedule by COB on April 14th.
- Incoming officers will select interview slots over the next two days. On Friday April 17th, you will be able to see your schedule in eFMS. You should then send individual invites, including Skype or Zoom information, to the officers.

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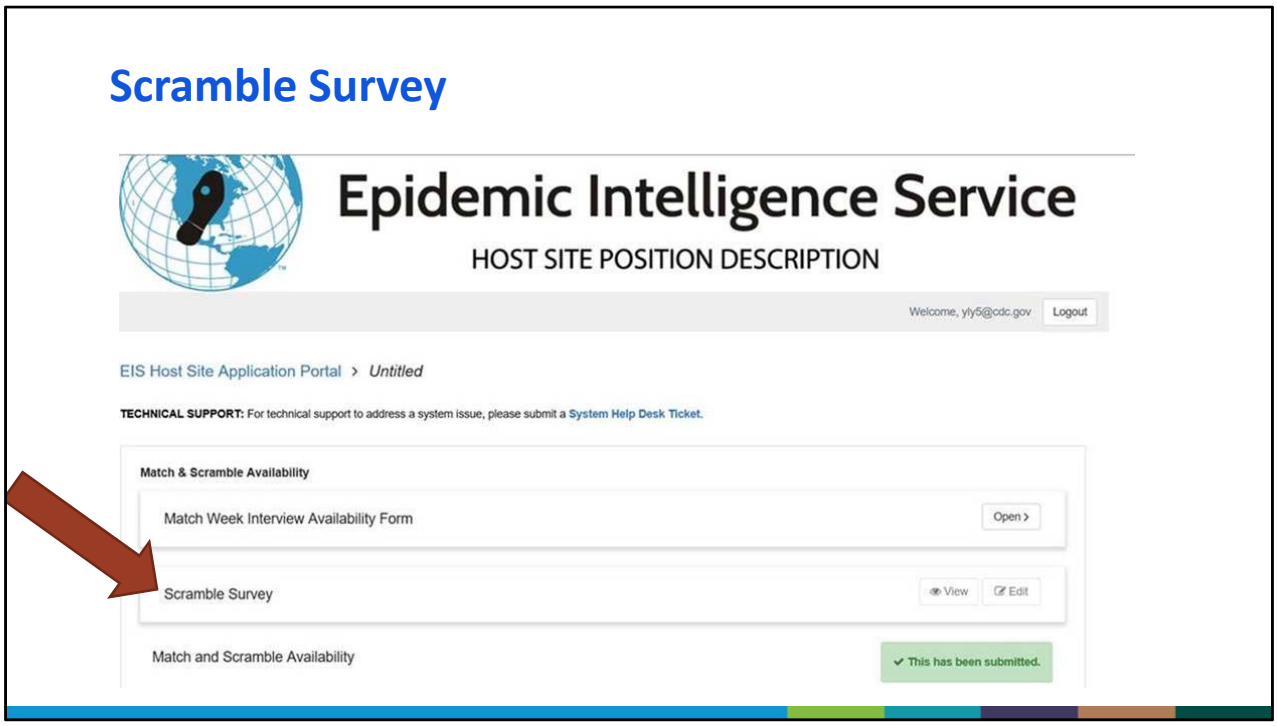
Scramble Survey



- When entering your interview availability, the system will also ask if you want your position to be entered into the scramble. In the event that an officer falls through the match, we will conduct a scramble in which the unmatched officers are given a list of unmatched positions that want to participate in the scramble rather than go unmatched. The officers and positions will then have a last opportunity to interview and match during this process.

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- From April 20th to May 7th you may conduct your interviews as scheduled using Skype or your preferred platform (e.g., Zoom).
- We want to ensure that interviews are as uniform as possible across positions and officers, so we ask that you conduct only the one 30 minute interview; please do not schedule additional interviews outside of the system with officers or conduct in-person interviews even if the officer is in Atlanta and available. You may, however, have as many people as you wish participate in the one interview.
- We also hope that you will be able to conduct video interviews rather than voice-only calls, but we understand that some who may be in the field may not be able to do this given speed of internet connections and other technical difficulties, so this will not be a requirement.

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- At any time after you complete all of your interviews, you may enter the ratings of the officers you interviewed in eFMS. Please have your ratings submitted by 2pm EST on May 7th. There will be a validation process where you will be asked to confirm your ratings and justify any zero scores. More information on this process will be forthcoming.

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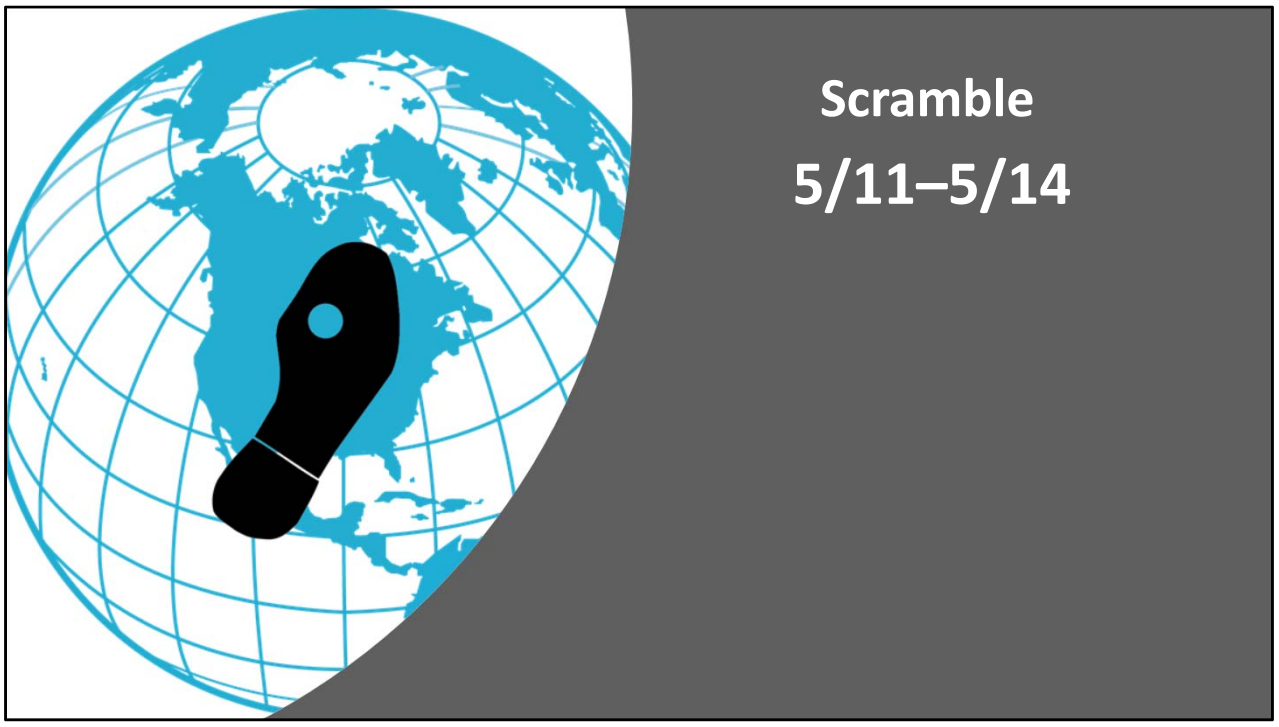

If you elected to have your position participate in the scramble and you do not match, scramble interviews will be conducted between May 11th and the 14th, with final match to be completed by COB on the 14th.

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Match Notification

5/15

- We will notify the EAC, supervisors, and officers of the match results no later than May 15th.

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To Do Checklist

- ❑ Accept the Slack Invitation when it is sent out next week
- ❑ Post a message in your position's channel indicating contact preferences
- ❑ Review incoming officer CVs
- ❑ Plan your recruitment events
- ❑ Contact your EWB POC if you need assistance

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Questions?

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

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



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From: Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH)

To: EIS (CDC); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC EIS EAC Roster 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Abara, Winston E. (CDC/DDID/NCHHSTP/DSTDP); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Annor, Francis (CDC/DDNID/NCIPC/DVP); Appiah, Grace D (CDC/DDID/NCEZID/DFWED); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Arvay, Melissa (CDC/DDID/NCIRD/DBD); awv4@cdc.gov; Bagchi, Suparna (CDC/DDID/NCEZID/DHQP); Balter, Sharon (CDC ph.lacounty.gov); barbara.montana@doh.nj.gov; Barfield, Wanda D. (CDC/DDNID/NCCDPHP/DRH); Basavaraju, Sridhar (CDC/DDID/NCEZID/DHQP); Beer, Karlyn D. 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Subject: RE: EIS Supervisor Seminar: EIS Conference and Match Orientation
Date: Tuesday, February 25, 2020 2:44:13 PM

Thanks, I didn't receive this!

-----Original Appointment-----
From: Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH) <ydg9@cdc.gov> **On Behalf Of** EIS (CDC)
Sent: Tuesday, February 25, 2020 2:20 PM
To: Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH)
Subject: FW: EIS Supervisor Seminar: EIS Conference and Match Orientation
When: Wednesday, March 18, 2020 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Adobe Connect Webinar
Importance: High

Not sure if you already received this but wanted to pass this along as I'll be deployed for COVID-19 on this day. If it's slow at the quarantine station I'll try to join remotely.

Regards,
Monique

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-----Original Appointment-----
From: EIS (CDC)
Sent: Tuesday, February 25, 2020 2:07 PM
To: EIS (CDC); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC EIS EAC Roster 2019; CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; McGowan, Eileen (CDC/DDPHSS/CSELS/DSEPD); Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Abara, Winston E. (CDC/DDID/NCHHSTP/DSTDP); Greiner, Ashley L. (CDC/DDPHSIS/CGH/DGHP); Lasry, Arielle (CDC/DDPHSIS/CGH/DGHT); Annor, Francis (CDC/DDNID/NCIPC/DVP); Appiah, Grace D (CDC/DDID/NCEZID/DFWED); Armstrong, Paige A (CDC/DDID/NCEZID/DVBD); Arvay, Melissa (CDC/DDID/NCIRD/DBD); awv4@cdc.gov; Bagchi, Suparna (CDC/DDID/NCEZID/DHQP); Balter, Sharon (CDC ph.lacounty.gov); barbara.montana@doh.nj.gov; Barfield, Wanda D. (CDC/DDNID/NCCDPHP/DRH); Basavaraju, Sridhar (CDC/DDID/NCEZID/DHQP); Beer, Karlyn D. (CDC/DDID/NCEZID/DFWED); Bell, Jeneita (CDC/DDID/NCEZID/DHQP); Bell, Linda (CDC dhec.sc.gov); Benowitz, Isaac (CDC/DDID/NCEZID/DHQP); Bish, Connie (CDC/DDNID/NCCDPHP/DRH); Bitsko, Rebecca (CDC/DDNID/NCBDDD/DHDD); Black, Stephanie SB (CDC cityofchicago.org); Blau, Dianna M. (CDC/DDPHSIS/CGH/OD); Bonwitt, Jesse (CDC/DDID/NCEZID/DHCPP); Bozio, Catherine H. (CDC/DDID/NCIRD/ID); Brown, Allison C. (CDC/DDID/NCEZID/DHQP); Bruce, Michael G. (CDC/DDID/NCEZID/DPEI); Busacker, Ashley (CDC wyo.gov); Cantey, Paul T. (CDC/DDPHSIS/CGH/DPDM); Carlson, Susan (CDC/DDNID/NCCDPHP/DNPAO); Carroll, Yulia (CDC/DDNID/NCEH/DEHSP); Cartter, Matthew (CDC ct.gov); Chaleunsy, Charlie (CMS/CMHPO); Chang, Arthur (Art) (CDC/DDNID/NCEH/DEHSP); Chatham-Stephens, Kevin (CDC/DDNID/NCBDDD/DHDD); Chen, Michael (CDC/DDID/NCIRD/ISD); Cherry, Cara C. (CDC/DDID/NCEZID/DVBD); Chew, Ginger L. (CDC/DDNID/NCEH/DEHSP); Chiu, Sophia (CDC/NIOSH/DFSE/HETAB); Christensen, Bryan E. (CDC/DDID/NCEZID/DHQP); Christensen, Deborah (Daisy) (CDC/DDNID/NCBDDD/DHDD); Cieslak, Paul (CDC dhsoha.state.or.us); Clayton, Heather B. (CDC/DDID/NCHHSTP/DASH); CMMainConfRoom (CDC); Cogdill, Keith (NIH/OD/ORS) [E]; Courtney-Long, Elizabeth A. (CDC/DDNID/NCCDPHP/OSH); Curran, Kathryn (CDC/DDPHSIS/CGH/DGHT); Cwynar, Kevin (NIH/CIT) [C]; Dale, Helen M. (CDC/DDPHSIS/CGH/DGHT); DAngelo, Denise V. (CDC/DDNID/NCCDPHP/DRH); Danielson, Melissa (CDC/DDNID/NCBDDD/DHDD); Dasgupta, Sharoda (CDC/DDID/NCHHSTP/DHPSE); Davies-Cole, John (CDC dc.gov); Dawood, Fatimah S. (CDC/DDID/NCIRD/ID); DBITSD (CDC); Dieffenbach, Carl (NIH/NIAID) [E]; Diekman, Shane T. (CDC/DDPHSIS/CGH/DGHT); Drenzek, Cherie (CDC dph.ga.gov); Eakin, Ann (NIH/NIAID) [E]; Edison, Laura (CDC dph.ga.gov); Elam-Evans, Laurie (CDC/DDID/NCIRD/ISD); Ellis, Esther (CDC doh.vi.gov); Epstein, Lauren H. (CDC/DDID/NCEZID/DHQP); Eyassu, Abinet (CDC/DDID/NCIRD/ISD) (CTR); Fairley, Temeika (CDC/DDNID/NCCDPHP/DCPC); Fechter-Leggett, Ethan (CDC/NIOSH/RHD/FSB); Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD); Foster, Monique Aaron (CDC/DDID/NCHHSTP/DVH); Galang, Romeo Regi (CDC/DDNID/NCCDPHP/DRH); Garcia-Williams, Amanda (CDC/DDID/NCEZID/DFWED); Gargano, Julia Marie W. (CDC/DDID/NCIRD/DVD); Gleason, Brigette (CDC/DDID/NCEZID/DFWED); Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Gould, Carolyn V. (CDC/DDID/NCEZID/DVBD); Gould, Hannah HG (CDC health.nyc.gov); Groenewold, Matthew (CDC/NIOSH/DFSE/HIB); Guerra, Marta (CDC/DDPHSIS/CGH/DGHP); Gupta, Neil (CDC/DDID/NCHHSTP/DVH); Gwynn, Charon R (CDC health.nyc.gov); Halik, Lindsay (FDA/CFSAN) (CTR); Hall, Aron (CDC/DDID/NCIRD/DVD); Hall, Noemi (CDC/NIOSH/RHD/SB); Hamner, Heather

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(CDC/DDNID/NCCDPHP/DNPAO); Harris, Aaron M. (CDC/DDID/NCHHSTP/DVH); Harrist, Alexia (CDC wyo.gov); Heath-Mason, Matthew (NIH/OD) [E]; Henao, Olga (CDC/DDPHSIS/CGH/DGHP); Herzig, Carolyn (CDC/DDID/NCEZID/DHQP); Hill, Holly A. (CDC/DDID/NCIRD/ISD); Hills, Susan (CDC/DDID/NCEZID/DVBD); Hinckley, Alison F. (CDC/DDID/NCEZID/DVBD); Hocevar Adkins, Susan N. (CDC/DDID/NCHHSTP/DASH); Holzbauer, Stacy (CDC state.mn.us); Hsu, Christopher (CDC/DDPHSIS/CGH/GID); Hughes, Christine (CDC/DDID/NCEZID/DHCPP); Hughes, Michelle (CDC/DDNID/NCBDDD/DHDD); Ly, Alpha (FDA/CBER) (CTR); Iyengar, Preetha (CDC dc.gov); Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Jackson, Sandra L. (CDC/DDNID/NCCDPHP/DHDSP); Jain, Seema (CDC cdph.ca.gov); Jannath, Syeda (CDC/OCOO/OFR/OFAS) (CTR); jcorbett@lgc.org (CDC lgc.org); Jennings, Andre'a (CDC/DDPHSS/CSELS/DSEPD) (CTR); Jones, Jefferson (CDC/DDID/NCEZID/DHQP); Jyothi Prakashan, Senthil Kumar (FDA/OC) (CTR); KathleenBuckheit (CDC email.unc.edu); Khetsuriani, Nino (CDC/DDPHSIS/CGH/GID); Kimura, Akiko (CDC cdph.ca.gov); Klabansky, Jennifer (NIH/NCI) [C]; Klos, Rachel (CDC wi.gov); Kmet, Matthew (FDA/CFSAN) (CTR); Kneipp, Teresa (CDC/NIOSH/HELD/CBMB); Ko, Jean Y. (CDC/DDNID/NCCDPHP/DRH); Komatsu, Kenneth (CDC azdhs.gov); Kracalik, Ian (CDC/DDID/NCEZID/DHQP); Lakkamraju, Suneetha (FDA/ORA) (CTR); Laney, Anthony S. (CDC/NIOSH/RHD/SB); Langer, Adam J. (CDC/DDID/NCHHSTP/DTE); Langley, Gayle E. (CDC/DDID/NCIRD/DVD); Laufer Halpin, Alison S. (CDC/DDID/NCEZID/DHQP); Lawson, Christina (Tina) (CDC/NIOSH/DFSE/FRB); Leadbetter, Laurie (NIH/NLM) [C]; Leman, Richard (CDC dhsoha.state.or.us); Lessa, Fernanda (CDC/DDID/NCEZID/DHQP); Li, Ruowei (Rosie) (CDC/DDNID/NCCDPHP/DNPAO); Loustalot, Fleetwood (CDC/DDNID/NCCDPHP/DHDSP); Luckhaupt, Sara E. (CDC/NIOSH/DFSE/HIB); Lundeen, Elizabeth Ann (CDC/DDNID/NCCDPHP/DDT); Lyman, Meghan Marie (CDC/DDID/NCEZID/DFWED); m.weston@ana.org (CDC ana.org); Maenner, Matthew J. (CDC/DDNID/NCBDDD/DHDD); Marano, Nina (CDC/DDID/NCEZID/DGMQ); Marietta, Cheryl (NIH/NIAAA) [E]; Markowitz, Lauri (CDC/DDID/NCIRD/DVD); Martin, Stacey (CDC/DDID/NCEZID/DVBD); Marx, Grace (CDC/DDID/NCEZID/DVBD); Materna, Barbara (CDC cdph.ca.gov); Meites, Elissa M. (CDC/DDID/NCIRD/DVD); Mhali, Tanesha (FDA/ORA); Midgley, Claire (CDC/DDID/NCIRD/DVD); Minta, Anna Akua (CDC/DDPHSIS/CGH/GID); Mirabelli, Maria (CDC/DDNID/NCEH/DEHSP); mstoops@nationalhomeless.org (CDC nationalhomeless.org); Mullins, Jocelyn (CDC ct.gov); Murrill, Christopher S. (CDC/DDPHSIS/CGH/GID); Nanduri, Srinivas Acharya (CDC/DDID/NCIRD/DBD); Nickel, Alexandra K (OIG/OMP) (CTR); Nolen, Leisha (CDC/DDID/NCEZID/DPEI); Omura, John Daniel (CDC/DDNID/NCCDPHP/DNPAO); Parashar, Umesh (CDC/DDID/NCIRD/DVD); Park, Benjamin (CDC/DDID/NCEZID/DHQP); Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD); Pazol, Karen (CDC/DDNID/NCBDDD/DHDD); Perrine, Cria G. (CDC/DDNID/NCCDPHP/DNPAO); Petersen, Brett W. (CDC/DDID/NCEZID/DHCPP); Pierce, Rebecca (CDC dhsoha.state.or.us); Pindyck, Talia (CDC/DDID/NCEZID/DFWED); Plumb, Ian (CDC/DDID/NCEZID/DFWED); Pollack, Loria A. (CDC/DDNID/NCCDPHP/DCPC); Psychas, Paul (CDC usaid.gov); Radcliffe, Rachel (CDC dhec.sc.gov); Rajasingham, Anangu (CDC/DDPHSIS/CGH/DGHP); Rao, Carol (CDC/DDPHSIS/CGH/DGHP); RDB Inquiries (CDC); Reichard, Audrey A. (CDC/NIOSH/DSR/SFIB); Reynolds, Laura (CDC/NIOSH/DFSE/HETAB); Ridpath, Alison D. (CDC/DDID/NCHHSTP/DSTDP); rmartinez@nas.edu (CDC nas.edu); Rolfes, Melissa (CDC/DDID/NCIRD/ID); Romero, Lisa (CDC/DDNID/NCCDPHP/DRH); Rose, Erica (CDC/DDID/NCEZID/DFWED); Roth, Joseph (CDC doh.vi.gov); Ryans, Eric (NIH/CIT) [C]; Saydah, Sharon (CDC/DDNID/NCCDPHP/DDT); Serbanescu, Florina (CDC/DDNID/NCCDPHP/DRH); Sferrazza, Giovanni (IHS/HQ) [C]; Shaw, Kelly (CDC/DDNID/NCBDDD/DHDD); Shetty, Sharmila (CDC/DDPHSIS/CGH/DGHP); Silk, Benjamin J. (CDC/DDID/NCHHSTP/DTE); Skrobarcek, Kimberly

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(CDC/DDID/NCEZID/DGMQ); Slayton, Rachel B. (CDC/DDID/NCEZID/DHQP); Smith, Kirk (CDC state.mn.us); Socias-Morales, Christina M. (CDC/NIOSH/DSR/AFEB); Soeters, Heidi (CDC/DDPHSIS/CGH/GID); Sosa, Lynn (CDC ct.gov); Sparkman, Jessica E. (CMS/OFM); Stinn, John (CDC/OCOO/OCIO) (CTR); Straily, Anne (CDC/DDPHSIS/CGH/DPDM); Sweeney, Marie (CDC/NIOSH/DFSE/HIB); Tan, Christina CT (CDC doh.nj.gov); Tate, Jacqueline E. (CDC/DDID/NCIRD/DVD); Terashita, Dawn (CDC ph.lacounty.gov); Terranella, Andrew J (IHS/POR); Thompson-Paul, Angela M. (CDC/DDNID/NCCDPHP/DHDSP); Tomasi, Suzanne (CDC/NIOSH/RHD/FSB); Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Trackemas, Jack D. (CDC/NIOSH/PMRD/GCB); Trout, Douglas (CDC/NIOSH/DFSE/HETAB); Twentyman, Evelyn Rebecca Ford (CDC/DDNID/NCCDPHP/OSH); Ussery, Emily Neusel (CDC/DDNID/NCCDPHP/DNPAO); VanFrank, Brenna (CDC/DDNID/NCCDPHP/OSH); Vanhouten, Clay (CDC wyo.gov); Wallace, Ryan (CDC/DDID/NCEZID/DHCPP); Warren-Mears, Victoria (CDC npaihb.org); Waterman, Steve (CDC/DDID/NCEZID/DVBD); Watson, John (CDC/DDID/NCIRD/DVD); Watt, James (CDC cdph.ca.gov); Weiser, Thomas (CDC npaihb.org); Whelan, Elizabeth A. (CDC/NIOSH/DFSE/FRB); Wiggins, Lisa (CDC/DDNID/NCBDDD/DHDD); Wilken, Jason (CDC cdph.ca.gov); Wilkinson, Amanda (CDC/DDPHSIS/CGH/GID); Wise, Matthew E. (CDC/DDID/NCEZID/DFWED); Woodworth, Kate (CDC/DDNID/NCBDDD/DBDID); Wortley, Pascale (CDC dph.ga.gov); Wu, Hsiu (CDC/DDID/NCEZID/DHQP); Zambrano, Laura (CDC/DDNID/NCBDDD/DBDID); Adams, Monica (CDC/DDID/NCHHSTP/DHPSE); Agnew Brune, Christine (CDC/DDID/NCHHSTP/DHPSE)
Subject: EIS Supervisor Seminar: EIS Conference and Match Orientation
When: Wednesday, March 18, 2020 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Adobe Connect Webinar
Importance: High

*****This seminar is primarily for supervisors who have been approved to match at the 2020 EIS Conference; however, all supervisors are welcome to participate. As a reminder, final dispositions on approvals to participate in the 2020 EIS match will be sent on March 9.*****

EIS Supervisors –

Do you have questions about the 2020 EIS Conference and match?
Would you like to become familiar with the recruitment venue?
Would you like to see an overview on how to schedule interviews, and assign and enter your match scores?

Then please join us for the next EIS Supervisor Seminar, where we will be discussing the EIS Conference and match!

During the seminar, we will review 2020 EIS match process, including the recruitment venue, how to enter your interview slots, and how to enter your scores.

If you already have questions about EIS Conference or match that you would like addressed during the seminar, please send them ahead of time to Larry Cohen at cbu1@cdc.gov. We will compile the submitted questions and answer them during the seminar.

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We look forward to your participation at the next EIS Supervisor Seminar!

Thank you,
EIS Program

Adobe Connect Webinar Information
https://adobeconnect.cdc.gov/ruqnt1n2uhla

If you have never attended an Adobe Connect meeting before:
Test your connection:
https://virtualsepd.adobeconnect.com/common/help/en/support/meeting_test.htm
Get a quick overview: http://www.adobe.com/products/adobeconnect.html

Phone Line Information
(770) 488-3600
Conference ID: 3183827

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From: Pritchard, Scott
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP)
Cc: Blackmore, Carina; Leapley, Andrea C
Subject: Re: EOC PUI team Questions
Date: Saturday, February 1, 2020 10:42:11 AM

Thanks. We still haven't heard any summaries of private provider calls directly to CDC. We really need to have the is information.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 10:26:59 AM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: RE: EOC PUI team Questions

Hi Scott,

We are staffed 24/7. I apologize for the delay, we are looking into why it occurred. I believe our on-call staff spoke with your department this morning. Please let me know if any questions or concerns remain.

Sincerely,
Runa

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 8:29 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: EOC PUI team Questions

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

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From: Blackmore, Carina
To: Pritchard, Scott; yet7@cdc.gov
Cc: Leapley, Andrea C
Subject: Re: EOC PUI team Questions
Date: Saturday, February 1, 2020 8:58:33 AM

Can you resend Broward info. I don't think I have it.

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From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 8:28:44 AM
To: yet7@cdc.gov <yet7@cdc.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: EOC PUI team Questions

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

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From:	Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD)
To:	bvanderslice; Gregory, Christopher (CDC/DDID/NCEZID/DVBD)
Cc:	Blackmore, Carina (CDC flhealth.gov); Christine Scott-Waldron; Varnado, Wendy (CDC msdh.ms.gov)
Subject:	RE: Examples of good state support for IR testing
Date:	Tuesday, March 3, 2020 10:22:18 AM

Good morning Bob,

The three states that I recommend are Florida, Mississippi, and Louisiana.

Florida contact is Dr. Carina Blackmore. Blackmore, Carina (CDC flhealth.gov) carina.blackmore@flhealth.gov
In this model, the State DOH received Zika and then Hurricane Funding that supported a contract with the University of Florida, Florida Medical Entomology Laboratory to conduct state-wide testing on Aedes aegypti, Aedes albopictus, and Culex spp.

Mississippi contact is Dr. Wendy Varnado. Varnado, Wendy Wendy.Varnado@msdh.ms.gov

Louisiana contact is Chrissie Waldron-Scott. Christine Scott-Waldron Christine.Scott-Waldron@la.gov
The State DOH has contracted with Louisiana State University to start testing this year.

Let me know if you need additional information.

Roxanne

Roxanne Connelly, PhD, BCE
Centers for Disease Control and Prevention
Division of Vector-Borne Diseases
Arboviral Diseases Branch
Entomology and Ecology Team Lead
3156 Rampart Road
Ft. Collins, CO 80521

970-266-3512 (office)

From: bvanderslice <bvanderslice@cox.net>
Sent: Thursday, February 27, 2020 2:01 PM
To: Gregory, Christopher (CDC/DDID/NCEZID/DVBD) <hgk4@cdc.gov>; Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD) <csz5@cdc.gov>
Subject: RE: Examples of good state support for IR testing

Hi Roxanne,

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ASTHO is working on a document to promote state health departments to support Insecticide Resistance testing. I think it would be valuable to include a few brief examples or mini-case studies of different state approaches to IR. Can you suggest 3 states that other states may want to model? Do you have information on who to contact?
Thanks,
Bob Vanderslice
401-864-7573

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: "Gregory, Christopher (CDC/DDID/NCEZID/DVBD)" <hgk4@cdc.gov>
Date: 2/26/20 4:06 PM (GMT-07:00)
To: bvanderslice@cox.net, "Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD)" <csz5@cdc.gov>
Subject: Examples of good state support for IR testing

Bob,

Wanted to connect you with Roxanne Connelly, our entomology and ecology team lead, to follow-up on our discussion from yesterday. Roxanne has some good examples of successful models for state support of IR testing.

Best,

Chris

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From:	Pritchard, Scott
To:	Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ)
Cc:	Quarantine Station - Miami (CDC); Smith, Christy (CDC/DDID/NCEZID/DGMQ); Jungerman, M. Robynne (CDC/DDID/NCEZID/DGMQ); Gulati, Reena (CDC/DDID/NCEZID/DGMQ); Blackmore, Carina; Drennon, Michael T
Subject:	Re: fee waiver
Date:	Sunday, March 1, 2020 7:43:15 PM

Thank you For the response Andrew. It is disappointing that CDC can leverage their partnership with airlines to contribute to the public health goal of limiting the spread of this growing outbreak. We will inform the family.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ) <ikb0@cdc.gov>
Sent: Sunday, March 1, 2020 7:36 PM
To: Pritchard, Scott
Cc: Quarantine Station - Miami (CDC); Smith, Christy (CDC/DDID/NCEZID/DGMQ); Jungerman, M. Robynne (CDC/DDID/NCEZID/DGMQ); Gulati, Reena (CDC/DDID/NCEZID/DGMQ)
Subject: RE: fee waiver

Good Evening Scott,

Thank you for reporting this CoVID-19 contact *and* for your patience with all the calls. After discussing the case with our medical officer and Travel Restriction officer, the "Fee Waiver" letter would not be applicable for this contact case.

Hope you have quiet evening.

Best,
Andrew

From: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ)
Sent: Sunday, March 1, 2020 5:55 PM
To: Scott Prichard - FL DOH Bureau of Epidemiology Laboratory Liaison (Tampa) (Scott.Pritchard@flhealth.gov) <Scott.Pritchard@flhealth.gov>
Cc: Quarantine Station - Miami (CDC) <QS-Miami@cdc.gov>; Smith, Christy (CDC/DDID/NCEZID/DGMQ) <ktp2@cdc.gov>; Jungerman, M. Robynne (CDC/DDID/NCEZID/DGMQ) <guk8@cdc.gov>; Gulati, Reena (CDC/DDID/NCEZID/DGMQ) <ffa0@cdc.gov>
Subject: RE: fee waiver

Hello Scott,

AMERICAN OVERSIGHT

Thank you for providing the update on the CoVID 19 case for the contacts who are currently in Reno, NV. We are in discussions regarding the return travel for the contacts.

Thank you for your patience.

Best,
Andrew

From: Quarantine Station - Miami (CDC) <QS-Miami@cdc.gov>
Sent: Sunday, March 1, 2020 4:47 PM
To: CDC DDID NCEZID DGMQ QBHSB Miami QS <DDIDNCEZIDDGMQQBHSBMiamiQS@cdc.gov>
Subject: FW: fee waiver

From: Pritchard, Scott
Sent: Sunday, March 1, 2020 4:46:16 PM (UTC-05:00) Eastern Time (US & Canada)
To: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ)
Cc: Quarantine Station - Miami (CDC)
Subject: RE: fee waiver

Andrew,
Call me back when you can receive all the requested information.
Thanks,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ) <ikb0@cdc.gov>
Sent: Sunday, March 01, 2020 12:21 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Quarantine Station - Miami (CDC) <QS-Miami@cdc.gov>
Subject: fee waiver

Hello Scott,

Please provide the case information for the airline fee waiver request. Thanks!

Best,

Andrew

Andrew Ganzon, MPH
Quarantine Public Health Officer

AMERICAN OVERSIGHT

CDC Miami Quarantine Station
Ph: 305-526-2910
Fax: 305-869-1495

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From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; Jacobs Slifka, Kara (CDC/DDID/NCEZID/DHQP); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Subject:	Re: FL Call Follow-up
Date:	Tuesday, March 17, 2020 11:55:35 AM

Thanks a lot. Very much appreciated.

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From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 17, 2020 11:35:21 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; Jacobs Slifka, Kara (CDC/DDID/NCEZID/DHQP) <ipf8@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Subject: FL Call Follow-up

Hello Everyone,

Thank you for chatting with us today.

As I mentioned the CDC Healthcare Infection Control can be reached for further TA via eocevent141@cdc.gov or via phone at 404-414-8385

I think your biggest challenge is going to be figuring out the contracted staff and how they have interacted with other facilities. It would be reasonable to apply many of the below listed concepts to other at risk facilities based upon how these staff moved to detect cases earlier among residents and staff. If helpful someone from our team developed a rapid facility phone assessment which could be deployed (attached).

Here are some good links:
LTC guidance which can apply to AL: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
General IPC guidance: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
Criteria for return to work for HCP (healthcare personnel): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Please remember many of the docs I have attached are not CDC cleared. Some were created as tools by our field team or by other jurisdictions so feel free to modify to your own needs.

A couple important points and lessons learned from other states:

1. Ensure a good active monitoring system for residents (at least once a day although more often if possible). They should be mindful (as you know) the elderly may present in other and

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potentially less dramatic fashion especially if they have baseline lung disease. I have attached a symptom/temp checking that we created for HCP but could be modified for use with residents.

2. Likewise a good monitoring system for all HCP is key. They should be self-monitoring with delegation (i.e., they know who to call with symptoms) when at home and then have a symptom/temp check before starting their shift. This pre-shift check could happen upon facility arrival or via something like facetime before leaving for work. Just make sure they take their temp and show while on facetime.
3. Implement universal masking for HCP while in the facility. Attached is a PPE strategy for LTC which accounts for shortages in gowns and extend use of masks and eye protection. In addition, I have attached some docs about general PPE for all HCF which we do expect to be posted to the web soon.
4. Ideally gowns, gloves, mask/respirator, eye should be used for all cases, PUIs, and anyone with unknown respiratory illness. Again may need to refer to the PPE strategy doc if not doable. NTEC has a good video that helps with donning and doffing: https://repository.netecweb.org/items/show/688
5. Restrict visitors. Any visitor that must enter should have symptom/temp check, masked, and controlled movement in and out of resident rooms. I have attached an example letter to families that can be modified.
6. Restrict resident movements, no congregate settings.
7. I have attached some cleaning consideration as well to include the use of nursing/CNAs to wipe high touch surfaces for cases or PUIs instead of EVS.
8. I have also attached a line list if you want it.
9. Contact tracing and risk assessment is not practical in this setting and ideally time should be spent in the above activities plus IPC. We understand that work restricting staff may shutter the entire facility and thus the emphasis of the good monitoring of HCP. We discuss this in the new risk assessment at the very bottom of the page: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
10. You and other PH staff should be wearing a facemask when you enter the facility and institute self-monitoring as well.

Please feel free to reach out with questions.

Best,
Elizabeth and Nicola

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From: Blackmore, Carina
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM)
Subject: Re: FL request for CDC assistance
Date: Wednesday, March 11, 2020 8:35:17 PM

Workplace exposure

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 8:31:02 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: FL request for CDC assistance

This info I got was confusing. It sounded like there were two different chains of communication and I wanted to make sure we hadn't left anything undone. What are your thoughts on the cases among the cruise port workers? Does it seem like a common workplace exposure or community transmission?
Thank you,
Stephanie

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:09:14 PM
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Subject: Re: FL request for CDC assistance

Ok. I am not familiar with that request. What we are interested in is a consult. We had a call the other night and had discussed a follow up call. I was working with someone else on that. Who made the request. Do you know.

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 7:17:35 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: FL request for CDC assistance

Dr. Blackmore,
I wanted to follow up on a call we had received through our EOC that Florida may have questions or possibly want assistance in investigating recent reports of cases of COVID-19 in Florida related to cruise port workers in Broward County. Please call me when it's convenient for you.
Thank you,
Stephanie
404-617-6374

Stephanie R. Bialek MD MPH

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Epidemiology Task Force Lead
CDC COVID-19 Response

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From: Blackmore, Carina
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM)
Subject: RE: FL request for CDC assistance
Date: Thursday, March 12, 2020 4:16:32 PM

Are you on the call with us now ? We have a group of your colleagues on the line.

From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Thursday, March 12, 2020 4:12 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: FL request for CDC assistance

Carina,
In response to your question about assessing risk level of contacts, below is the approach that we have been using. Please let me know if you have additional questions. When you have time, I'd be interested in following up on the questions about port workers.
Stephanie

How contacts are assessed: There is not a precise time-defined criteria for determining what is "prolonged" contact. Low risk is generally considered to be very brief interactions such as a brief greeting conversation, handshake, generally of less than 10 minutes. Medium risk exposures typically include those that include an interaction of 30 minutes or longer within 6 feet such as eating a meal together. Types of exposures that fall between are assessed on a case by case basis and take into consideration careful assessment of all aspects of the interaction including whether the case was symptomatic and how close the contact was to the case.

https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

Close contact in the guidance above is defined as 1) being within approximately 6 feet of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case or 2) having direct contact with infectious secretions of a COVId-19 case (e.g. being coughed on).
Medium risk exposures include "Being on an aircraft, being seated within 6 feet of a traveler with symptomatic lab-confirmed COVID-19 infection…".
Low risk exposures include "Being in the same indoor environment as a person with symptomatic lab-confirmed COVID-19 for a prolonged period of time but not meeting the definition of close contact

---

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:35 PM
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Subject: Re: FL request for CDC assistance

Workplace exposure

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From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 8:31:02 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Re: FL request for CDC assistance

This info I got was confusing. It sounded like there were two different chains of communication and I wanted to make sure we hadn't left anything undone. What are your thoughts on the cases among the cruise port workers? Does it seem like a common workplace exposure or community transmission?
Thank you,
Stephanie

Get Outlook for Android

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, March 11, 2020 8:09:14 PM
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Subject: Re: FL request for CDC assistance

Ok. I am not familiar with that request. What we are interested in is a consult. We had a call the other night and had discussed a follow up call. I was working with someone else on that. Who made the request. Do you know.

Get Outlook for iOS

From: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM) <zqg7@cdc.gov>
Sent: Wednesday, March 11, 2020 7:17:35 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: FL request for CDC assistance

Dr. Blackmore,
I wanted to follow up on a call we had received through our EOC that Florida may have questions or possibly want assistance in investigating recent reports of cases of COVID-19 in Florida related to cruise port workers in Broward County. Please call me when it's convenient for you.
Thank you,
Stephanie
404-617-6374

Stephanie R. Bialek MD MPH
Epidemiology Task Force Lead
CDC COVID-19 Response

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Bialek, Stephanie R. (CDC/DDPHSIS/CGH/DPDM)
Subject: Re: FL request for CDC assistance
Date: Wednesday, March 11, 2020 8:09:14 PM

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Stephanie
404-617-6374

Stephanie R. Bialek MD MPH
Epidemiology Task Force Lead
CDC COVID-19 Response

AMERICAN OVERSIGHT

From: Budd, Alicia (CDC/DDID/NCIRD/ID)
To: Scott.Pritchard@flhealth.gov
Cc: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Blackmore, Carina (CDC flhealth.gov); Andrea.Leapley@flhealth.gov; CDC IMS 2019 NCOV Response EPI Task Force
Subject: RE: FL: EOC PUI team Questions
Date: Saturday, February 1, 2020 12:46:47 PM

Scott –

Runa referred your email to me as we are trying to consolidate our state communication to the extent possible to help expedite responses.

When you say you haven't heard any summaries of private provider calls directly to CDC, I am not sure if you referring to getting testing results from PUIs or knowing that a provider has called to inquire about a patient potentially meeting criteria to be a PUI.

For the former, we have identified that there is an issue with the eLIMS automatic reporting feature. In the interim, until the issue is resolved, we are emailing negative nCoV PCR results to the public health lab submitter email that is included with the specimen. Official reports will follow when the eLIMS issue is resolved. The lab is testing throughout the weekend and we email the negative results out as soon as we get them.

If your question is about providers that might have called about a potential PUI, when that occurs, the provider is being instructed to contact the health department.

If I have not answered your question or if you have additional questions, don't hesitate to reach out.

Thanks,
Alicia Budd

EPI Task Force
2019 n-CoV Response
eocevent212@cdc.gov

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 11:40 AM
To: Budd, Alicia (CDC/DDID/NCIRD/ID) <acp4@cdc.gov>
Subject: FW: EOC PUI team Questions

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 10:42 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>

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Subject: Re: EOC PUI team Questions

Thanks. We still haven't heard any summaries of private provider calls directly to CDC. We really need to have the is information.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 10:26:59 AM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: RE: EOC PUI team Questions

Hi Scott,

We are staffed 24/7. I apologize for the delay, we are looking into why it occurred. I believe our on-call staff spoke with your department this morning. Please let me know if any questions or concerns remain.

Sincerely,
Runa

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 8:29 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: EOC PUI team Questions

Hi Runa,
What are the working hours of the EOC PUI team? FL has been waiting in a call on a PUI since around 8pm last night.

Also, when does CDC anticipate ending the request to call for every PUI?

Sincerely

Scott Pritchard, MPH
Interim Director

AMERICAN OVERSIGHT

Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Budd, Alicia (CDC/DDID/NCIRD/ID)
Cc:	Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP); Blackmore, Carina; Leapley, Andrea C; CDC IMS 2019 NCOV Response EPI Task Force
Subject:	Re: FL: EOC PUI team Questions
Date:	Saturday, February 1, 2020 1:00:43 PM

Would be easier to chat. Could you call my cell?
8502515558

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Budd, Alicia (CDC/DDID/NCIRD/ID) <acp4@cdc.gov>
Sent: Saturday, February 1, 2020 12:46:45 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; CDC IMS 2019 NCOV Response EPI Task Force <eocevent212@cdc.gov>
Subject: RE: FL: EOC PUI team Questions

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AMERICAN OVERSIGHT

EPI Task Force
2019 n-CoV Response
eocevent212@cdc.gov

From: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Sent: Saturday, February 1, 2020 11:40 AM
To: Budd, Alicia (CDC/DDID/NCIRD/ID) <acp4@cdc.gov>
Subject: FW: EOC PUI team Questions

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 1, 2020 10:42 AM
To: Gokhale, Runa Hatti (CDC/DDID/NCEZID/DHQP) <yet7@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: Re: EOC PUI team Questions

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Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
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To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>
Subject: RE: EOC PUI team Questions

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AMERICAN OVERSIGHT

Sent: Saturday, February 1, 2020 8:29 AM
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Sincerely

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

AMERICAN OVERSIGHT

From:	Koneff, Douglas A
To:	Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); McGough, John (HHS/IEA); Weir, Charles (OS/ASPR/IO); scott.rivkees@flhealth.gov; Roberson, Shamarial (CDC flhealth.gov)
Cc:	Butler, Jay C. (CDC/DDID/OD); Eidex, Rachel B (Dar es Salaam - CDC); Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); Marty Cetron (CDC); Knutson, Donna (CDC/DDNID/NCEH/OD)
Subject:	Re: Florida Cruise Ship Summary 3.17.20 4 pm
Date:	Wednesday, March 18, 2020 6:41:18 AM

I saw an email from Eleni this morning - the charter departed 0300 local fr Chile and ETA Miami is between 1200-1300 EDT. I asked whether coordinations had been completed with state of FL and DHS, but have not heard back yet.

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From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 11:45:40 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; Koneff, Douglas A <KoneffD@state.gov>; Roberson, Shamarial (CDC flhealth.gov) <shamarial.roberson@flhealth.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Marty Cetron (CDC) <mzc4@cdc.gov>; Knutson, Donna (CDC/DDNID/NCEH/OD) <dbk2@cdc.gov>
Subject: RE: Florida Cruise Ship Summary 3.17.20 4 pm

Hi Mr. McGough,
I wanted to update you about the situation with Royal Caribbean and the flights from Chile and Brazil

1. There has been no movement on any flights from Brazil
2. AT 6:30 PM EST, Ms. Kalisch from Royal Caribbean emailed us to tell us that the Government of Chile had put a hold on their flights
3. At around 6:44 PM, I received a call from Dr. Rivkees, the Florida Surgeon General who told me that the Governor was not going to allow any flights to land and disembark passengers in Miami until there was a solid plan articulated by the Cruise company.
4. Right after that call we notified the State Department and copied DHS. We also notified Eleni Kalisch and told her to contact the State of Florida to coordinate a plan(we gave her the relevant phone numbers)
5. At approximately 7:30 Eleni Kalisch emailed that the flight from Chile was going to proceed, but she never responded about contacting Florida state or local authorities despite multiple emails from CDC telling her to do so
6. At 10:07 she told us that the flight would be departing Chile at 12:10 AM local time and arriving in Miami at 9:10 AM EST

Attached is the last email chain starting at 10:20 when Eleni told us there is a slight change of plans which states that CDC will be screening her passengers. We have told her multiple times that CDC will not be screening passengers. We asked her to contact us by phone right away (11PM), but she has not done so. We believe that the flight may have already departed and we are concerned that

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no one has signed off on this from Florida and that a clear and reasonable plan has not been sent any of us.

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
Sent: Tuesday, March 17, 2020 4:23 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: RE: Florida Cruise Ship Summary 3.17.20 4 pm

Enormously helpful, thank you.

John G. McGough
Regional Director
U.S. Department of Health & Human Services
Region 1 - New England - (CT, ME, MA, NH, RI, & VT)
Region 4 - Southeast - (AL, FL, GA, KY, MS, NC, SC, & TN)
JFK Federal Building, Suite 2100
Boston, MA 02203

Tel (617) 565-1500
Fax (617) 565-1491
John.McGough@hhs.gov

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Tuesday, March 17, 2020 4:08 PM
To: McGough, John (HHS/IEA) <John.Mcgough@hhs.gov>
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AMERICAN OVERSIGHT

(OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
Subject: Florida Cruise Ship Summary 3.17.20 4 pm

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Kind regards,
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Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

AMERICAN OVERSIGHT

From:	Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
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Subject:	RE: Florida Cruise Ship Summary 3.17.20 4 pm
Date:	Tuesday, March 17, 2020 11:45:42 PM
Attachments:	Chile (37.2 KB).msg

Hi Mr. McGough,

I wanted to update you about the situation with Royal Caribbean and the flights from Chile and Brazil

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AMERICAN OVERSIGHT

(OS/ASPR/IO) <Charles.Weir@hhs.gov>; Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>
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U.S. Department of Health & Human Services
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Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

AMERICAN OVERSIGHT

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From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:36 PM EDT
To: Eleni Kalisch <ekalisch@rccl.com>; Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
CC: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 10:20 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch|Vice President|Federal Relations
Royal Caribbean Cruises Ltd.|1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799|Cell: 786.253.5305|ekalisch@rccl.com

From: Eleni Kalisch
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

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The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch|Vice President|Federal Relations
Royal Caribbean Cruises Ltd.|1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799|Cell: 786.253.5305|ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> ***Cindy R. Friedman, MD***
>
> *Centers for Disease Control and Prevention*
>
> *1600 Clifton Road*
>
> *Atlanta, GA 30329*

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470-487-4373

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 2:20 PM
To: Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
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SparksTk@state.gov

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From: Mooney, Dayle

To: Rivkees, Scott A; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org

Cc: Boswell, Patricia; James-Glasgow, Olivia N.; Moffses, Thomas P; Villalta, Yesenia D; Wegener-Vitani, Carol A; Myers, Paul D; Lander, Mark S; Vick, Stephanie; Waldron, Kerry S; Hawker, Miranda C; Durden, Tammy M; Danyluk, Gregory M; Harvey, James D; Snyder, Robert E; Conklin, Kelly H; Grabelle, Dorothy A; Singer, Keith A; Ming, Randy S; Jergens, Christy M; Duncan, Sherry L; Pepe, Joseph D; Speedling, Sandon S.; Johnson, Karen S (HolmesCHD); Smith, Angela M; Hess, Erin E; Cooksey, Adrian; Pino, Raul; Danielle Sorrentino-Brightman; Park-O"Hara, Sandra L; Johns, Amie G; Bill VanHelden; Amy Perez; CERULLO, TIMOTHY; HAWLEY, WILLIAM; WILLIAMS, RAYMOND; Martin, Sandy K; Henry, Charles H; Stahl, Maria A; Pierce, Bruce; Street, Karen K; Inman, Barry; Medlin, Helen K; Choe, Ulyee; Prosser, Kimberly; DL CHD46 ICSR; Chapman, Karen A; Allbritton, Kimberly; Napier, Mike J.; Baker, Lisa A; Nicholson, Garik A; Zelnick, Sanford D; Jena Glantz; Winn, Jason Esq ; Matt Jordan; "William Hightower"; Robinson, Lynn; Wadsworth, Lynn; Curt Sommerhoff; nmcdonald@uwf.edu; Courson, Sandi C; Foster, Kena K; Fleischman, Jennifer; Gray, Jennifer; Syfrett, Christine M; Bohaboy-Walby, Madalaine I; Byrge, Treasure L; Carmichael, Megan; Crumpton, Greg T; Etzel, Patricia L; Exline, Timothy; Hensley, Deborah S; Maguire, Ken G; Mullens, Donna J; Pavone, David; Pell, Jennie B; Snead, Jordan A; Watson, George F; Watts, Melissa E; alexandergolden@comcast.net; Sandoval, Randi C; Bailey, William H; Hodges, Zachary L; Cook, Helen M; Hogan, Lisa C; Hinds, Sarah JQ; Rolle, Pauline J; Sentman, Michael L; Sperber, Clint J.; Rubio, Tito G.; Central Florida Disaster Medical Coalition; Eric.Alberts@orlandohealth.com; Rogers, Jon; Rodrigues, Ruth; Phillipine, Kristin; Holt, Holly; Barley, Kathryn C; Portis, Alan L; Locke, Barbara L; Alonso, Alina M; Kissler, Aaron X; Medved, Daniel T; Matos, Nathaly; Cherry, Georgianne M; Juarez, Padraic R; Holtzclaw, Rhonda; Janet Kinney; jannamatautia@calhounlibertyhospital.com; BAKER, JOANN; jennifer.cloud@doctorsmemorialhospital.com; Sarah Catalanotto; Janet Smith; Long, Tracey; FREEBURG, RICHARD; David Abercombe; Debbie Stanger; Denise Grimsley; Rosalie Oliver; Cathy Jaco; matthew.l.smith@adventhealht.com; David Walker; Bill Storck; Rebecca Springer; Heath Huron; jbeltz@hhrmc.us; Temiela Blackman; Madeline Corbo; Pam Howard; Paula Webb; Jennifer Thomas; Jill Fulgham; Brett McClung; Martha Oakley; heidi.schaffer@hcahealthcare.com; Dan Hogan; Teresa Conerly; STONE, THOMAS; Doug Faircloth; david.ottati@fhms.org; Jermaine Bucknor; J.H. 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Abbott (mabbott@sheriff-okaloosa.org); BonicaLauren; SummersDan; ShawMichael; Kevin Gingras; Astrid Ramirez; Scuteri, Ana C; EmergencyManagementEmployees; Manuel Cela; Connor, Olga; Zach Annett; Eneida Roldan; Ashley Krutz; Smoak, Kimberly; Best, Jay; William Johnston - Northbay; Brian T. Cook; Ray Downs; Becky Washler; Louis Lamarche; Adrian Damms; Morell, Venita

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W; YOUNG, Brenna; Dominguez, Orlando J; Debra Boyce; Clark, Heath; Pokryfke, John; Glass Leighton, Kelli; Harold Jenkins; Amy Aiken

Subject: RE: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
Date: Wednesday, March 4, 2020 1:24:12 PM
Attachments: 030402020 Agenda COVID-19 All Public Health and Heathcare Stakeholders.pdf

Please see the attached Agenda for this afternoon's call.

Sincerely,

Dayle D. Mooney, Manager
Community Preparedness Section
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support

-----Original Appointment-----
From: Rivkees, Scott A
Sent: Wednesday, February 12, 2020 10:50 AM
To: Rivkees, Scott A; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; DL DOH CHD Administrators_Directors; Laura MacLafferty; Kinsley, Chris; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; steve winn; Molly.McKinstry@ahca.myflorida.com; mary.mayhew@ahca.myflorida.com; jeanetta.stalcup@uhsinc.com; michelle@foma.org; govaffairs@foma.org; MThomas@flmedical.org; CPrine@flmedical.org; andrew@foma.org
Cc: Boswell, Patricia; James-Glasgow, Olivia N.; Moffses, Thomas P; Villalta, Yesenia D; Wegener-Vitani, Carol A; Myers, Paul D; Lander, Mark S; Vick, Stephanie; Waldron, Kerry S; Hawker, Miranda C; Durden, Tammy M; Danyluk, Gregory M; Harvey, James D; Snyder, Robert E; Conklin, Kelly H; Grabelle, Dorothy A; Singer, Keith A; Ming, Randy S; Jergens, Christy M; Duncan, Sherry L; Pepe, Joseph D; Speedling, Sandon S.; Johnson, Karen S (HolmesCHD); Smith, Angela M; Hess, Erin E; Cooksey, Adrian; Pino, Raul; Danielle Sorrentino-Brightman; Park-O'Hara, Sandra L; Johns, Amie G; Bill VanHelden; Amy Perez; CERULLO, TIMOTHY; HAWLEY, WILLIAM; WILLIAMS, RAYMOND; Martin, Sandy K; Henry, Charles H; Stahl, Maria A; Pierce, Bruce; Street, Karen K; Inman, Barry; Medlin, Helen K; Choe, Ulyee; Prosser, Kimberly; DL CHD46 ICSR; Chapman, Karen A; Allbritton, Kimberly; Napier, Mike J.; Baker, Lisa A; Nicholson, Garik A; Zelnick, Sanford D; Jena Glantz; Winn, Jason Esq ; Matt Jordan; 'William Hightower'; Robinson, Lynn; Wadsworth, Lynn; Curt Sommerhoff; nmcdonald@uwf.edu; Courson, Sandi C; Foster, Kena K; Fleischman, Jennifer; Gray, Jennifer; Syfrett, Christine M; Bohaboy-Walby, Madalaine I; Byrge, Treasure L; Carmichael, Megan; Crumpton, Greg T; Etzel, Patricia L; Exline, Timothy; Hensley, Deborah S; Maguire, Ken G; Mullens, Donna J; Pavone, David; Pell, Jennie B; Snead, Jordan A; Watson, George F; Watts, Melissa E; alexandergolden@comcast.net; Sandoval, Randi C; Bailey, William H; Hodges, Zachary L; Cook, Helen M; Hogan, Lisa C; Hinds, Sarah JQ; Rolle, Pauline J; Sentman, Michael L; Sperber, Clint J.; Rubio, Tito G.; Central Florida Disaster Medical Coalition; Eric.Alberts@orlandohealth.com; Rogers, Jon;

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Rodrigues, Ruth; Phillipine, Kristin; Holt, Holly; Barley, Kathryn C; Portis, Alan L; Locke, Barbara L; Alonso, Alina M; Kissler, Aaron X; Medved, Daniel T; Matos, Nathaly; Cherry, Georgianne M; Juarez, Padraic R; Holtzclaw, Rhonda; janetkinney@calhounlibertyhospital.com; jannamatautia@calhounlibertyhospital.com; BAKER, JOANN; jennifer.cloud@doctorsmemorialhospital.com; Sarah Catalanotto; janet.smith@doctorsmemorial.org; Long, Tracey; FREEBURG, RICHARD; davidab@baptisthealth.net; dstanger@baptisthealth.net; denise.grimsley@ahss.org; rosalie.oliver@ahss.org; cathy.jaco@ahss.org; matthew.l.smith@adventhealht.com; dwalker@emmsmemorial.com; bstorck@weemsmemorial.com; rspringer@hrmc.us; hhuron@weemsmemorial.com; jbeltz@hhrmc.us; tblackman@hrmc.us; mcorbo@hrmc.us; Pam Howard; pwebb@lakebutlerhospital.com; jthomas@lakebutlerhospital.com; jfulgham@lakebutlerhospital.com; brett.mcclung@bmcjax.com; martha.oakley@bmcjax.com; heidi.schaffer@hcahealthcare.com; dhogan@dmh.org; tconerly@dmh.org; STONE, THOMAS; doug.faircloth@doctorsmemorial.com; david.ottati@fhms.org; jermaine.bucknor@ahss.org; jthompson@healthmarkregional.com; lmeese@jackhosp.org; Krovito@jackhosp.org; HUTCHINS, MICHAEL; keith.strickling@bhcpns.org; brandy.call@bhcpns.org; rroche@lmcpbc.org; briley@lmcpbc.org; dan.mcLean@lpnt.net; debra.noyes@lpnt.net; MELEAR, P; robin.arrieta@hcahealthcare.com; rhall@shhpens.org; christy.rizza@shhpens.org; robin.godwin@ascension.org; rhonda.sherrod@hma.com; cdavidjay@aol.com; jsmsith@aol.com; awiman@bigbendahec.org; aingram@bigbendahec.org; support@hrhn.org; jfeller@wellflorida.org; Abarca, Chris; Moderie, Julie; astephenson@lorhn.org; tparrish@hcsef.org; ecallwood@lorhn.org; lholmes@lorhn.org; mrangel@lorhn.org; vgauze@healthcareswfl.org; sconnell@holmescountyfl.org; hendricksa@ci.marathon.fl.us; mwalters@mywakulla.com; rblewis1107@gmail.com; pburkel@union-ems.net; Fireco@madisoncountyfl.com; flakeysambulance@gmail.com; randytruette@gmail.com; allen_parrish@bradfordcountyfl.gov; eddieh@suwgov.org; swilliams@panhandleareahealthnetwork.com; Susan Grich; melissa.thibodeau@hrhn.org; lynn.witt@hma.com; garyowens@nwfrhn.com; Rpearson@rhnmc.org; HALL, ROGER; Reich, Debbie A; Dunn, Nathan P; Beedie, Katherine A; psparks@uwf.edu; Kirsch, Holly S; Stewart, Gail; DAlessio, Rebecca; Smith, Kathy J; Oliver, Rosalie; Walsh, Donna; PLATT, CARROL; Moscoso, Alberto; SHERROD, RHONDA; Brown, Richard; Perez, Ellis E; Asim Jani; Struble,Wayne Gordon; Matt Meyers; peterpappas52@gmail.com; Crowe, David R; Jonathan Lord; Baker, Kevin M; Bencie, Jennifer L; Poniatowski, Michael; Klein, Jason L.; Rutledge, Laura X; Napier, Robin; Ziegler, Carolyn H; McDaniel, Allison L; Smith, Rita M; Ashley Beigle; Melyssa Callahan; DiFede, Matthew; MacDonell, Sam; Blevins, Allison M; Jenkins Kelley; Burns, Mary K; Lewis, Susan M.; Welter, Bonnie J; Stewart, Lewis Shayne; rhambrick@ncf.edu; Brafford, Melba G.; Loftin, Edwin; Schuffert, Michael; Andrews, Phil; Jo.Alverson@Steward.org; REED, PAMELA; Mann, William; Johns, Paul M.; Abbasi, Muhammad J; Harder, Terri A; Hollingsworth, Kristine M; Marr, Kathleen J; Mercado, Carlos A.; Pedigo, Ryan J.; Miller, Brian L.; Gordon, Leslene E.; Lanza, John J; Bolton, Beate H; Georgine Kruedelbach; Marcia Catania; Hendershot, Jeri; Albert, Michele M; Burns, David; Clincea, Radu; Moore, Valarie E; Roberson, Candice S; Smith, Bret A; Whitston, Shannon M; Combs, Sue S; Kimberly Sample; Jackson, Joy L; Joseph, Ashley; Claire Sutherland; Scott, Katie E; Beauchamp, Brittany J; Larkin, Emerald A; Simmons, Deanna T; Pippin, Jessie W; Richards, Shelby D; Fugate, Betty K; Fisher, Ashley; Stalnaker,Jeffrey C., MD; Reagan Husong; Langston, Taylor; Eadie, Bob; Senyshyn, William; Richards, Patricia; McMillan, Emily A; Reese, Suzette W; DL DEPCS00 BPR HCCTF; Wilsey, Leigh; Allicock, Dawn; Caldwell, Jamie S; Caitlyn Eck; Campbell, Sieglinde D; Dr. Corin DeChirico; Schenk, Terry; Mooney,

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Dayle; Rashena Clark; John James; Koncelik,Denise Lavern; Carhart, Ty; Collins, Tiffany L; Hardacre, Tod B; Shipley, Valerie D; Kelly Keys; Michele Jones; Cabrera, Mary Ann; Clifton, Nicholas L; Bradley, Edward; McKay, Leslie W; Tuero, Kim L; Bryant, Rachel W; Marilia VanKeeken; Eric Anderson; Ackerman, Craig; Crowley, Meaghan K; Bjelke, David; DL CHD13 SENIOR LEADERSHIP TEAM; Nickola-Williams, Noreen B; Dorans, Christopher; Bailey, Bobby; Rowe, Ann; Kelley, Debbie A; Stenberg, Christina; James, Susan; Alonso, Zuzel; Ngo-Seidel, Eugenia J; Zayas, Maribel A; Keyes, Becky (County Health Systems); Smith, Thomas M; Alison Doeing; Foerster, Lisa R.; Peggy Brown; Quigley, Jacob B; Harris, Nicole E.; Morris, Cindy K.; Hill, Ann; Weller, Karen; Yow, Annmarie; Bielling, Jeffery; acburke8@gmail.com; Luce, Christie; Nelson, Joanna; Robinson, Eriko M; Davis, Ashley; Vaughn, Freda G; Shedlock, Andrew (AndrewShedlock@fdle.state.fl.us); Woodlief, Douglas; Jackson, Iris F; Tracey Vause; Ciereck, Christina M.; HSU MD, Vincent; Taryn Kryzda; Steve Wolfberg; ddyess@ci.stuart.fl.us; commissioners@ci.stuart.fl.us; William Schobel; Gaylord, Laurie; comish@martin.fl.us; wdsnyder@sheriff.martin.fl.us; jtummine@ci.stuart.fl.us; Michelle Miller; Rouse, Renay C; Bowzer, Leah F; Powell, Sheryl L; Doug Smith; Watkins, Shirley; Kevin Herndon; Don Donaldson; Domenica Labbate; George Stokus; Meier, Mike; Katelyn White; Reinhold, Todd A; County Health Systems; Mich Mongel; Ronnie Daves; David Whalen; Darrel Welborn; Matthew D. Abbott (mabbott@sheriff-okaloosa.org); BonicaLauren; SummersDan; ShawMichael; Kevin Gingras; Astrid Ramirez; Scuteri, Ana C; EmergencyManagementEmployees; Manuel Cela; Connor, Olga; zannett@thearpc.com; Eneida Roldan; Ashley Krutz; Smoak, Kimberly; Best, Jay; William Johnston - Northbay; brian.cook@hcahealthcare.com; ray@healthmarkregional.com; becky.washler@ascension.org; llamarche@mywakulla.com; adamms@hendryfla.net; Morell, Venita W; YOUNG, Brenna; Dominguez, Orlando J; Debra Boyce; Clark, Heath; Pokryfke, John; Glass Leighton, Kelli; Harold Jenkins; Amy Aiken
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Wednesday, March 4, 2020 2:00 PM-3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

FYI

-----Original Appointment-----
From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Tuesday, February 11, 2020 2:36 PM
To: Rivkees, Scott A; DL DOH CHD Administrators_Directors; Molly.McKinstry@ahca.myflorida.com; Laura MacLafferty; Kinsley, Chris; mary.mayhew@ahca.myflorida.com; Knox, Thomas; Behrman, Andrew; Wilgis, John; Crystal Stickle; jeanetta.stalcup@uhsinc.com; steve winn; michelle@foma.org; andrew@foma.org; govaffairs@foma.org; Shepard, Lela; mcarter@flmedical.org; Blackmore, Carina; Pritchard, Scott; Roberson, Shamarial; Cooksey, Samantha; Otis, Aaron; Pasley, Cassandra; Coppola, Courtney; MThomas@flmedical.org; CPrine@flmedical.org
Subject: Florida Healthcare Provider Stakeholder Call for 2019 Novel Coronavirus
When: Occurs every Wednesday effective 2/12/2020 from 2:00 PM to 3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Call-In Information: 888-585-9008 Pin #: 208-305-233

The Florida Department of Health invites you to join us for a weekly public health stakeholder conference call regarding the 2019 novel corona virus outbreak. The target audience for this call is the healthcare community in Florida. During the call

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we will provide the most current situation both globally, as well as in Florida and share the Department's response actions.

Please share this invitation with your membership as appropriate.

When: Each Wednesday at 2:00 p.m. EST

Call in Information: 888-585-9008 Pin 208-305-233

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COVID-19
Healthcare Stakeholders

March 4, 2020

2:00 p.m. – 2:30 p.m. EDT

Call In # 1-888-585-9008
Participant Pin: 208-305-233#

Topic	Speaker
Introduction	**Dayle Mooney**
Briefing from State Surgeon General	**Dr. Scott Rivkees**
Briefing from State Epidemiologist	**Dr. Carina Blackmore**
Questions	

AMERICAN OVERSIGHT

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS); Wallace, Marla D.
Cc: Blackmore, Carina (CDC flhealth.gov); DSLRCrisisCoag (CDC)
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project
Date: Friday, February 14, 2020 1:13:28 PM

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing LA's vector project needs and are proposing some alternative use of funds.

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

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Please let me know if this makes sense. Thank you!

Kind regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the CDC's 2019 Novel Coronavirus response.

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Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share best practices and developed tools. The previous contract was using ELC Zika funding.

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager

AMERICAN OVERSIGHT

Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

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From:	Wallace, Marla D.
To:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS); Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Cc:	Blackmore, Carina; DSLRCrisisCoag (CDC); Clark, Marah; Stanek, Danielle R; Morrison, Andrea
Subject:	RE: Florida Hurricane Crisis CoAg Vector Control Project
Date:	Friday, February 14, 2020 1:49:13 PM

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

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Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
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Subject: Florida Hurricane Crisis CoAg Vector Control Project

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From:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
To:	Wallace, Marla D.; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Cc:	Blackmore, Carina (CDC flhealth.gov); DSLRCrisisCoag (CDC); Clark, Marah; Stanek, Danielle (CDC flhealth.gov); Morrison, Andrea
Subject:	RE: Florida Hurricane Crisis CoAg Vector Control Project
Date:	Friday, February 14, 2020 2:20:31 PM

Thank you, Marla. I appreciate the additional details. I believe both activities for **FL** are allowable, trailers and educational material, but because it is equipment, it will have to have prior approval in GMM. That is why I am I requesting the additional information/quotes now rather than later in the review process. Finally, as you are probably aware- FL's budget narrative and workplan will also have to reflect these new activities and should also be submitted accordingly. I hope that helps clarify. Please don't hesitate to reach out with any questions.

Thanks again and hope you have a great weekend.

Warm regards,

Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
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Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

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Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

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I'm passing this along to Kevin as he is helping me out for a few weeks as PO while I am on deployment with the CDC's 2019 Novel Coronavirus response.

Kevin, please keep me copied for awareness.

Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Thursday, February 13, 2020 3:06 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Florida Hurricane Crisis CoAg Vector Control Project

Sabrina,

Although the funding in the correct category of contractual we have a few question regarding approval of some projects within Vector Control.

A few of the mosquito control districts would like to purchase trailers to use for outreach and education of the public. I have read the guidance and did not see anything that prohibited this.

We would also like to contract again with the University of Florida Institute of Food and Agricultural Sciences Center for Public Issues and Education in Agriculture and Natural Resources (PIE Center) to create materials designed to educate the public about mosquito control in a simplified, understandable format that would increase public understanding of scientific information related to mosquito control. The PIE Center conducted focus groups on the public's and local officials' knowledge and perception of mosquito control, and the findings were used to create messages used in the Prevent & Protect project (https://preventmosquitoes.org/). PIE Center was able to create two toolkits (mosquito control and emergency response), infographics and information sheets, lesson plans, as well as social media plans, and conducted some preliminary evaluations of the materials. As the next step for this project, PIE Center plans to use this funding to conduct more in-depth evaluations of the materials, identify best methods of facilitating education about mosquito control topics, increase training for teachers and other groups, and develop an online mosquito control communication training program to share best practices and developed tools. The previous contract was using ELC Zika funding.

AMERICAN OVERSIGHT

We feel like it would fit under Domain 5: Strengthen Countermeasures and Mitigation. The funding being provided to the mosquito control programs under that domain specifically mentions: These funds would help local jurisdictions in preventing transmission of endemic and exotic arboviruses by using evidence based, best management practices which can also include source reduction, communication, and public education.

Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From:	Clark, Marah
To:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS); Wallace, Marla D.; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
Cc:	Carina Blackmore; DSLRCrisisCoag (CDC); Danielle Stanek; Andrea Morrison
Subject:	RE: Florida Hurricane Crisis CoAg Vector Control Project
Date:	Tuesday, February 18, 2020 1:11:10 PM

Good afternoon All,

The following is a breakdown and information from the two programs requesting to purchase a trailer. I was misinformed on the purpose for one of the trailers as they are not both for outreach/education. One plans to use the trailer to move equipment around the county, increasing their capacity in post storm treatment response. The other is interested in using the trailer to educate their constituents. Please see the information below for cost approximations, size, and use details.

Hernando:
The trailer would be used to transport ATV's equipped with larviciding/adulticiding equipment as the A1 was purchased last year is loaded on their 6 x 12 trailer now. Therefore, they need another transport trailer. They're looking at a 6 x 14 or so, estimated cost from $1300-$1900 without a side gate. If they go for a side gate it could go up to $2500. The cost is certainly within their 10k allotment from year two distribution.

Pasco:
The cost for the trailer alone was $9363. Designing the trailer and customizing it to meet their needs is something they will be working on in the upcoming months. Estimates could be another $4000 in order for them to design the interior (adding shelving, cabinets, flooring, etc.), customize the exterior paint/wrap, add a generator, and finally, purchasing the educational material (microscope, TV, artwork, banners, etc.). So, overall, the total cost of the education trailer is approximately $14000.

The education trailer will be used to showcase how Pasco County Mosquito Control District proactively uses integrated mosquito management strategies to reduce pestiferous mosquito populations and protect residents from mosquito-borne diseases. This educational tool will be fun and interactive, designed to educate children and adult audiences by providing outreach services to area school districts, libraries, civic organizations, and other community groups.

The specs on the trailer;

- 8.5' x 24' V-nose, enclosed trailer
- 2 – 7000lb axels
- 84" interior height
- Rear and side ramps (instead of full doors)
- 4" x 4" concession window

I hope this information helps in obtaining needed approval and amending the current workplan.

Marah

Marah Clark
Environmental Administrator
Entomology and Pest Control Section
Bureau of Scientific Evaluation and Technical Assistance
Division of Agricultural Environmental Services
Florida Department of Agriculture and Consumer Services

(850) 617-7918 – Office
Marah.Clark@FDACS.gov

AMERICAN OVERSIGHT

NOTE: New email address and website

The Conner Building, Lab 6
3125 Conner Boulevard
Tallahassee, FL 32399

www.FDACS.gov

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida

---

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Sent: Friday, February 14, 2020 2:20 PM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Carina Blackmore <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@fdacs.gov>; Danielle Stanek <Danielle.Stanek@flhealth.gov>; Andrea Morrison <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Thank you, Marla. I appreciate the additional details. I believe both activities for **FL** are allowable, trailers and educational material, but because it is equipment, it will have to have prior approval in GMM. That is why I am I requesting the additional information/quotes now rather than later in the review process. Finally, as you are probably aware- FL's budget narrative and workplan will also have to reflect these new activities and should also be submitted accordingly. I hope that helps clarify. Please don't hesitate to reach out with any questions.

Thanks again and hope you have a great weekend.

Warm regards,
Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor|404-623-4058|ydh1@cdc.gov
CDC/CSTLTS/National Partnership Branch (NPB)

From: Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Sent: Friday, February 14, 2020 1:49 PM
To: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>; Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>; Clark, Marah <Marah.Clark@freshfromflorida.com>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

The PIE Center Project is $90,000 and would come from the Mosquito Control Districts funding of $2,706,643. Which is a little more than 3% of 2.7 million and 1.6% of the total award for Vector Control.

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The funding for the trailers is also part of the Mosquito Control Districts funding. This funding has already been allocated to 2 of the districts. They reached out to us see if trailers would be allowable in the grant. We can reach back out to have them submit the quotes and specifications. The activity outreach and education is already an approved activity within the Mosquito Control Districts Project.

Have a nice weekend.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

From: Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) [mailto:ydh1@cdc.gov]
Sent: Friday, February 14, 2020 1:13 PM
To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; DSLRCrisisCoag (CDC) <DSLRCrisisCoag@cdc.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

Hi Marla,

Hope all is well. Thank you for your message. It's clear you have done your due diligence in reviewing **LA**'s vector project needs and are proposing some alternative use of funds. **Do you means FL?**

To be clear, are you clearing the idea of a redirection of funds towards the activities you mentioned below? I know you mentioned the funds are already in the correct budget category, but it is a matter of altering the activities.

In that's the case, it would be helpful to have specifics - a sheet outlining the previous activities and how much funds were involved, and then then where the money is going to (new activities). Please also provide vendor quotes and specific justification, as you laid out below, on official letter head, similar to what is typically done in an amendment/redirection.

In other words, we need to see clearly see what the money was originally approved for, and how much, and where the money is going toward now, how much, justifications, and associated quotes… Based on that, we will review and get the necessary prior approval, and if approved, have the appropriate changes documented in GMM.

AMERICAN OVERSIGHT

Please let me know if this makes sense. Thank you!

Kind regards,

Krunal Sevak (Kevin) MBA, MPH
Public Health Advisor, Crisis CoAg Coordination Team
National Partnership Branch (NPB)
Center for State, Tribal, Local and Territorial Support (CSTLTS)

Centers for Disease Control and Prevention (CDC)
1825 Century Center Blvd. | Atlanta, GA 30345
☎: (404) 623-4058
✉: ydh1@cdc.gov

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
Sent: Friday, February 14, 2020 7:11 AM
To: Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS) <ydh1@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project

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Thank you all,

Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

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1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
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AMERICAN OVERSIGHT

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Please feel to email or call me if you have any additional questions or concerns.

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS)
To: Wallace, Marla D.; Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS)
Cc: Blackmore, Carina (CDC flhealth.gov)
Subject: RE: Florida Hurricane Crisis CoAg Vector Control Project
Date: Friday, February 14, 2020 7:11:23 AM

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Sabrina Hansen, MPH
Public Health Advisor
Hurricane Crisis CoAg Coordination Team
Deputy Director for Public Health Service and Implementation Science

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1600 Clifton Road NE | Mailstop H21-5 | Atlanta, GA 30329
Cell: (404) 548-0044
YPJ8@cdc.gov

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To: Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS) <YPJ8@cdc.gov>
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AMERICAN OVERSIGHT

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Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

AMERICAN OVERSIGHT

From: Roberson, Shamarial
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED)
Subject: RE: Florida
Date: Wednesday, March 25, 2020 5:57:15 PM

Thank you!

From: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Sent: Wednesday, March 25, 2020 5:57 PM
To: Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>
Subject: RE: Florida

Just sent you an email

Currently detailed to the COVID-19 Response

Cindy R. Friedman, MD
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329
470-487-4373

From: Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>
Sent: Wednesday, March 25, 2020 5:55 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Subject: Florida

Good Afternoon,

Please send correspondence about the two cruises. Thanks for your assistance, it is greatly appreciated.

Best Regards,

Shamarial Roberson, DrPH, MPH
Deputy Secretary for Health
Florida Department of Health
4052 Bald Cypress Way, Bin A-13
Tallahassee, FL 32399-1721
Phone: 850-245-4391
Email: shamarial.roberson@flhealth.gov
****

pha

Mission: To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts. Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media on request. Your e-mail communications may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

AMERICAN OVERSIGHT

From: Jean, Reynald
To: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Cc: Villalta, Yesenia D; Rico, Edhelene
Subject: Re: Follow up to Illness in Passenger
Date: Wednesday, February 26, 2020 10:39:14 AM

Thank you so much, Michelle.

Get Outlook for iOS

From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Sent: Wednesday, February 26, 2020 10:36 AM
To: Jean, Reynald
Subject: Fwd: Follow up to Illness in Passenger

Good morning Dr. Jean,

See below regarding the report of ill passenger transported to Jackson. I also sent to Ann Schmitz.

Michelle

Get Outlook for iOS

From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Sent: Wednesday, February 26, 2020 10:35:47 AM
To: Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: Fwd: Follow up to Illness in Passenger

Ann, please see below regarding ill passenger who was taken to Jackson this morning.

Get Outlook for iOS

From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Sent: Wednesday, February 26, 2020 10:33:36 AM
To: Hatfield Jr., Mark O. (Aviation) <mhatfield@miami-airport.com>; Christopher Maston <christopher.d.maston@cbp.dhs.gov>; RODRIGUEZ, MICHELLE <michelle.rodriguez@cbp.dhs.gov>; John Gardner (gardnerj@miamidade.gov) <gardnerj@miamidade.gov>
Cc: Davenport, Emily Patricia (CDC/DDID/NCEZID/DGMQ) <xkh2@cdc.gov>; Ganzon, Andrew (CDC/DDID/NCEZID/DGMQ) <ikb0@cdc.gov>; Aboukheir, Mahmoud (CDC/DDID/NCEZID/DGMQ) <npa0@cdc.gov>
Subject: Follow up to Illness in Passenger

Good morning,

Based on the travel history and a lack of epidemiological risk for the passenger who was transported to the hospital this morning, and per a consultation with our Quarantine Medical Officer, this is NOT considered a patient under investigation for COVID-19.

AMERICAN OVERSIGHT

Our current guidelines require both symptoms AND either travel to China in the past 14 days OR close contact with a laboratory-confirmed COVID-19 patient. Additionally, the passenger has only been to Argentina, which currently does not have known community spread of COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html)

To ensure that this does not need additional public health intervention, and because there are other illnesses of public health concern, such as influenza, the passenger is being assessed at the hospital, and we will follow up in coordination with the Florida Department of Health.

If there are any changes to the above information, we will communicate this to you as soon as possible.

Thank you,

Michelle
Michelle Decenteceo
CDC Miami Quarantine Station

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Re: Follow-up Call
Date:	Friday, March 20, 2020 7:21:08 AM

And THANKS

Get Outlook for iOS

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 7:20:00 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
Subject: Follow-up Call

Hello Dr. Blackmore,

We were alerted that you would like to schedule a follow-up call regarding the LTC facility. The healthcare infection control team is happy to chat. Let us know what time works best.

Thanks,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	RE: Follow-up Call
Date:	Friday, March 20, 2020 7:22:43 AM

Absolutely. I will send out a call line. Feel free to forward as needed.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, March 20, 2020 7:21 AM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
Subject: Re: Follow-up Call

Would 930 am work?

Get Outlook for iOS

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 7:20:00 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
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From:	Blackmore, Carina
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Re: Follow-up Call
Date:	Friday, March 20, 2020 7:20:58 AM

Would 930 am work?

Get Outlook for iOS

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Friday, March 20, 2020 7:20:00 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; CDC IMS 2019 NCOV Response Healthcare IPC Field Unit <eocevent141@cdc.gov>; CDC IMS 2019 NCOV Response At Risk <eocevent269@cdc.gov>
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Thanks,
Elizabeth Soda

AMERICAN OVERSIGHT

From:	CDC IMS 2019 NCOV Response PUI
To:	EOC Report (CDC)
Cc:	CDC IMS 2019 NCOV Response PUI; Blackmore, Carina (CDC flhealth.gov); CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Follow-up email concerningJorge Trujillo-Concentra Urgent Care-2019 Novel Coronavirus–FL
Date:	Friday, February 7, 2020 3:25:05 PM

Closed, not PUI.

Summary of call:

Concentra clinician call (Tampa airport, Jorge Trujillo) about a flight attendant who had contact with an ill passenger on 2/2/20. The passenger had arrived from China on 12/21. Not ill. On 2/2 they shared a flight during which the traveler (with history of December travel from China) developed some dizziness and almost lost consciousness, and was attended to by the flight attendant. Upon arrival she was better. The flight attendant developed chills, cough, with mucous on 2/3 with hot feeling (no temp taken). On 2/5 he also developed dizziness, continued cough. On 2/6 had some nausea, with continued cough. On 2/7 no further cough; was recommended to see contractor health clinic in the Tampa airport (Concentra).

Dr Trujillo contacted the FL HD.

Discussed PUI definition and current unknowns of possible asymptomatic carriage., FL

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

From: EOC Report (CDC) <eocreport@cdc.gov>
Sent: Friday, February 7, 2020 2:54 PM
To: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Cc: EOC Report (CDC) <eocreport@cdc.gov>
Subject: Follow-up email concerningJorge Trujillo-Concentra Urgent Care-2019 Novel Coronavirus–FL

Call Information

Call/Journal ID:	322584
Date/Time:	02/07/2020 2:38PM
Shift:	A - 0700-1500
Officer:	Chandra Lewis

AMERICAN OVERSIGHT

Caller Contact Information

Agency: Clinician/RN
Title: N/A **Email Address:** N/A
Name: Jorge Trujillo
Phone #: 813-476-5484 **Alternate Phone #:** N/A
Contact Person Name: N/A
Facility Name: Concentra Urgent Care
Country: United States **State/Province:** Florida **City:** Tampa

Event Location Information

Street Address: N/A
Country: United States **State/Province:** N/A **City:** N/A

NNC Information

Disease being reported: N/A **NNC Category:** N/A
Unique NNC Id: N/A **Time SME Contacted:**
CDC Info Call: No

Category

Primary:
Event: 2019 Novel Coronavirus
Known As: 2019 Novel Coronavirus
Secondary:
Known As: N/A

Resolution & Notification

Resolution: Local 911/ PMD **Notification Method:**Clinician Line **SME Name:**Koumans Emilia **SME Contact:**770-488-6233

Call Information

Brief Summary: Division of Viral Diseases and Respiratory Virus Branch provided a consultation to a clinician in FL regarding 2019 Novel Coronavirus
Notes: PUI recent exposure to potential patient presenting with headache and running nose

Time Of Resolution: 02/07/2020 2:41PM
Time SME Contacted Agency:

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Pritchard, Scott; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Kuhar, David T. (CDC/DDID/NCEZID/DHQP); Perz, Joseph (CDC/DDID/NCEZID/DHQP); CDC IMS 2019 NCOV Healthcare Infection Control; mangordillo@gmail.com
Subject:	RE: Follow-up from call with facility
Date:	Tuesday, March 3, 2020 12:50:19 PM

We will put the hospital in contact with our emergency management team to discuss the facility capacity related issues.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:45 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

Thank you for reaching out and providing the summary.
Regarding lab testing, our current state lab turn around time is within 24 hours of receipt.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 03, 2020 12:40 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
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the community. They have some limited ability to create some negative pressure rooms in their ICU and ER but these rooms will have a shared air space among them which not allow them to mix PUIs with true cases. They also asked about the option of portable isolation units such as a tent. Our CDC NIOSH colleagues would know the most about this option. I have emailed them to request a call with the facility hopefully later today.

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Happy to chat.

Best,
Elizabeth

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP); Blackmore, Carina
Cc:	Cooksey, Samantha; Otis, Aaron
Subject:	RE: Follow-up from call with facility
Date:	Tuesday, March 3, 2020 1:36:37 PM

Yes, thank you!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 03, 2020 1:23 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>; Otis, Aaron <Aaron.Otis@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Follow-up from call with facility

Okay. NIOSH can meet at 3:30 today. I am happy to set up a call line. Scott would that be okay with you?

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 1:16 PM
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Cc: Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>; Aaron Otis (CDC flhealth.gov) <aaron.otis@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Follow-up from call with facility

Yes.
I am copying Sam and Aaron who will coordinate
Get Outlook for iOS

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 3, 2020 12:56:26 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Follow-up from call with facility

Thanks, Carina. To make I understand, would a call with NIOSH still be appropriate then from your perspective?

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 12:50 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)

AMERICAN OVERSIGHT

<lxn9@cdc.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com
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Interim Director
Infectious Disease Prevention and Investigations Section
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To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
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Best,
Elizabeth

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Magill, Shelley (CDC/DDID/NCEZID/DHQP); Kuhar, David T. (CDC/DDID/NCEZID/DHQP); Perz, Joseph (CDC/DDID/NCEZID/DHQP); CDC IMS 2019 NCOV Healthcare Infection Control; mangordillo@gmail.com; Blackmore, Carina
Subject:	RE: Follow-up from call with facility
Date:	Tuesday, March 3, 2020 12:44:42 PM

Thank you for reaching out and providing the summary.
Regarding lab testing, our current state lab turn around time is within 24 hours of receipt.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Sent: Tuesday, March 03, 2020 12:40 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Magill, Shelley (CDC/DDID/NCEZID/DHQP) <fxe9@cdc.gov>; Kuhar, David T. (CDC/DDID/NCEZID/DHQP) <jto7@cdc.gov>; Perz, Joseph (CDC/DDID/NCEZID/DHQP) <bzp4@cdc.gov>; CDC IMS 2019 NCOV Healthcare Infection Control <eocevent220@cdc.gov>; mangordillo@gmail.com; Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
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AMERICAN OVERSIGHT

Elizabeth

AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc: Cooksey, Samantha; Otis, Aaron; Pritchard, Scott
Subject: Re: Follow-up from call with facility
Date: Tuesday, March 3, 2020 1:15:43 PM

Yes.
I am copying Sam and Aaron who will coordinate
Get Outlook for iOS

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 3, 2020 12:56:26 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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Infectious Disease Prevention and Investigations Section
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Elizabeth

AMERICAN OVERSIGHT

From: Bresee, Joseph (CDC/DDID/NCIRD/ID)
To: Rivkees, Scott A
Cc: Meltzer, Martin I. (CDC/DDID/NCEZID/DPEI)
Subject: RE: Follow-up on modeling and social distancing
Date: Tuesday, March 24, 2020 11:03:16 PM

Sorry about that. Cc'here
joe

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Tuesday, March 24, 2020 10:57 PM
To: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>
Subject: Re: Follow-up on modeling and social distancing

Dear Joe

Many thanks for your note and your time.

Can you also pass along Martin's contact information?

All the best,

Scott

Scott Rivkees, M.D.
State Surgeon General

From: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>
Sent: Tuesday, March 24, 2020 10:51:20 PM
To: hwalke1@gmail.com <hfw3@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Cc: Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: RE: Follow-up on modeling and social distancing

Thanks, Henry and nice to talk with you Scott. As promised, I want to introduce you to Dr, Martin Meltzer.

Martin – Scott is the State Surgeon General of Florida and interested in planning for medical surge needs, I talked about your current plans to create tools for supporting this work. Wonder if you might have time to talk with him, as you are much more eloquent on your work than me!

Thanks

AMERICAN OVERSIGHT

Joe

Joseph Bresee, MD
Dep. Incident Manager
2020 CDC nCoV Response

From: Walke, Henry (CDC/DDID/NCEZID/DPEI) <hfw3@cdc.gov>
Sent: Tuesday, March 24, 2020 9:53 AM
To: scott.rivkees@flhealth.gov
Cc: Bresee, Joseph (CDC/DDID/NCIRD/ID) <jsb6@cdc.gov>; Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>
Subject: Follow-up on modeling and social distancing

Scott,

Jay said you have a couple of questions.

- I am connecting you to Joe Bresee, 404 421 5648, who has wide visibility on the modeling activities at CDC and can help answer your questions.

- The evidence base for social distancing is best found in the 2017 Community Mitigation Guidelines to Prevent Pandemic Influenza.
  https://www.cdc.gov/mmwr/volumes/66/rr/rr6601a1.htm

Best, Henry

Henry Walke, MD, MPH
Deupty Incident Manager
Jurisdiction Support
CDC COVID-19 Response
+1-404-639-3582 (office)
+1-404-452-9624 (mobile)
hwalke@cdc.gov

AMERICAN OVERSIGHT

From: Rivkees, Scott A
To: Bresee, Joseph (CDC/DDID/NCIRD/ID)
Subject: Re: Follow-up on modeling and social distancing
Date: Tuesday, March 24, 2020 10:57:18 PM

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State Surgeon General

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Date: Tuesday, March 24, 2020 10:51:22 PM

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+1-404-639-3582 (office)
+1-404-452-9624 (mobile)

AMERICAN OVERSIGHT

hwalke@cdc.gov

AMERICAN OVERSIGHT

From:	Cooksey, Samantha
To:	eocsctfmccmlno@cdc.gov
Cc:	Blackmore, Carina
Subject:	RE: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Tuesday, March 3, 2020 4:13:34 PM

Florida would request that supply chain issues be communicated to:

Primary
Florida Department of Health Incident Management Team
Email: StateESF8.Planning@flhealth.gov
Phone: 850-245-4012

Secondary
Samantha Cooksey, Deputy Incident Commander
Email: Samantha.Cooksey@flhealth.gov
Phone: 850-251-2553

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, March 3, 2020 3:23 PM
To: Cooksey, Samantha <Samantha.Cooksey@flhealth.gov>
Subject: Fwd: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Get Outlook for iOS

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Tuesday, March 3, 2020 3:08:57 PM
To: Mullins, Andy <Andy.Mullins@adph.state.al.us>; Christopher.Shields@cityofchicago.org <Christopher.Shields@cityofchicago.org>; Provenzano, Francesca <Francesca.Provenzano@ct.gov>; patrick.ashley@dc.gov <patrick.ashley@dc.gov>; Luce, Christie <Christie.Luce@flhealth.gov>; Scott.Minarcine@dph.ga.gov <Scott.Minarcine@dph.ga.gov>; Dudley, Matthew - EMS <Matthew.Dudley@dhw.idaho.gov>; Lytle, Megan <MLytle@isdh.IN.gov>; Denise L. Kelly [KDHE] <Denise.L.Kelly@ks.gov>; RickD.Johnson@ky.gov <RickD.Johnson@ky.gov>; Stella Fogleman <sfogleman@ph.lacounty.gov>; Doris Brown <Doris.Brown@LA.GOV>; Sherry.adams@maryland.gov <Sherry.adams@maryland.gov>; kerin.milesky@state.ma.us <kerin.milesky@state.ma.us>; Macqueen, Mary (DHHS) <MacqueenM@michigan.gov>; RPongliyab@fsmhealth.fm <RPongliyab@fsmhealth.fm>; cheryl.petersen-kroeber@state.mn.us <cheryl.petersen-kroeber@state.mn.us>; Nickelson, Paula <Paula.Nickelson@health.mo.gov>; O'Loughlin, Kevin

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<KOLoughlin@mt.gov>; warren.villagomez@dph.gov.mp <warren.villagomez@dph.gov.mp>; eric.sergeant@nebraska.gov <eric.sergeant@nebraska.gov>; Malinda Southard <msouthard@health.nv.gov>; Daly, Elizabeth <Elizabeth.Daly@dhhs.nh.gov>; Dana.johnson@doh.nj.gov <Dana.johnson@doh.nj.gov>; Christopher.emory@state.nm.us <Christopher.emory@state.nm.us>; Primeau, Michael J (HEALTH) <michael.primeau@health.ny.gov>; bmaldin@health.nyc.gov <bmaldin@health.nyc.gov>; jsickler@nd.gov <jsickler@nd.gov>; scotts@health.ok.gov <scotts@health.ok.gov>; ritter.udui@palauhealth.org <ritter.udui@palauhealth.org>; jcabrera@salud.gov.pr <jcabrera@salud.gov.pr>; Paul Petersen <paul.petersen@tn.gov>; jeff.hoogheem@dshs.state.tx.us <jeff.hoogheem@dshs.state.tx.us>; Kevin Mcculley <kmcculley@utah.gov>; Francine.lang@doh.vi.gov <Francine.lang@doh.vi.gov>; Halvorson, Clark (CDC doh.wa.gov) <Clark.Halvorson@DOH.WA.GOV>; donnie.w.haynes@wv.gov <donnie.w.haynes@wv.gov>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; Aifili Tufa <a.tufa@doh.as>; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Abdo, Mark (HHS/) <Mark.Abdo@hhs.gov>; Rachel-Philip, Disney (IHS/ABR/BCH) <Disney.Rachel-Philip@ihs.gov>; Davies-Cole, John (CDC dc.gov) <john.davies-cole@dc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; ann.pobutksy@dphss.guam.gov <ann.pobutksy@dphss.guam.gov>; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Hahn, Christine G. <ID> (CDC dhw.idaho.gov) <hahnc@dhw.idaho.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; farah.ahmed@ks.gov <farah.ahmed@ks.gov>; Ratard, Raoult (CDC la.gov) <raoult.ratard@la.gov>; Abdo, Mark (HHS/) <Mark.Abdo@hhs.gov>; Brown, Catherine (DPH) <catherine.brown@state.ma.us>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Eliaser Johnson <ejohnson@fsmhealth.fm>; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; Tan, Christina (CDC doh.state.nj.us) <Christina.Tan@doh.state.nj.us>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; Layton, Marci (CDC health.nyc.gov) <mlayton@health.nyc.gov>; Burnsed, Laurence (CDC health.ok.gov) <Laurence@health.ok.gov>; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; Dudley, Matthew - EMS <Matthew.Dudley@dhw.idaho.gov>; Francine.lang@doh.vi.gov <Francine.lang@doh.vi.gov>; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Eliaser Johnson <ejohnson@fsmhealth.fm>; Williamson, Laura (CDC mt.gov) <lwilliamson@mt.gov>

Cc: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>

Subject: Gentle Reminder-Time Sensitive Request Due Today, 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Good Afternoon, We are following up with you on the request below. This is a gentle reminder to provide the outlined information by COB today, March 3, 2020. You can send all responses to **eocsctfmccmlno@cdc.gov .**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at

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eocsctfmccmlno@cdc.gov .

We appreciate all you are doing to support COVID-19!

Thank you, Devi Hawkins-Prather
State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

404-232-0480

From: Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
Sent: Friday, February 28, 2020 1:31 PM
To: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

Greetings PHEP Directors & State Epidemiologists –

The outbreak of COVID-19 in China has led to a disruption in the global supply chain of personal protective equipment (PPE). CDC recognizes that healthcare facilities may experience temporary shortages even if they do not care for patients with COVID-19. CDC has released guidance for optimizing the use of N95 respirators, which includes some recommendations that may be applicable to other types of PPE, including surgical masks. CDC also has guidance regarding who needs and does not need PPE to help prevent excessive use of PPE.

As you are aware, this is a delicate system with many factors. When CDC receives notifications from healthcare systems about supply chain shortages, we encourage the Healthcare Coalition Partners to work together to problem solve within the coalition and/or wider state system. Further we encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

We have heard from the healthcare system partners that have contacted us that they are unsure whom to contact in the state health department about supply chain shortages in their facilities. As a way to help mitigate this, **we are asking you to reply to eocsctfmccmlno@cdc.gov no later than March 3, 2020, with an identified primary and secondary point of contact for any supply chain issues within your state.**

Please provide the following information:

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- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	CDC IMS State Coordination Task Force (SCTF) MCCM LNO
Cc:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	RE: Gentle Reminder-Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Monday, March 2, 2020 8:45:36 PM

Good evening,

Thanks so much to all of you who have submitted the requested information below!

For those of you who have no returned the requested information, this is a gentle reminder that we are asking for the information outlined below by COB tomorrow, March 3, 2020.

We appreciate all you are doing to support COVID-19!

Kimberly

Kimberly Cantrell
State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

From: Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
Sent: Friday, February 28, 2020 1:31 PM
To: CDC IMS State Coordination Task Force (SCTF) MCCM LNO <eocsctfmccmlno@cdc.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.

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Please provide the following information:

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

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From: Moulton, Diane
To: Eifert, James
Cc: Strum, Shane; Moskowitz, Jared; Rivkees, Scott
Subject: Re: Guardsmen in isolation
Date: Wednesday, March 18, 2020 9:03:39 PM

Sir,

Can you please send us the draft letter for Shane and the Governor's review?

Sent from my iPhone

> On Mar 18, 2020, at 9:00 PM, Eifert, James O Maj Gen USAF NG FLARNG (USA) <james.o.eifert.mil@mail.mil> wrote:
>
> Teammates,
> I was just notified that we currently have 4 FLNG Soldiers in isolation due to either exposure to COVID-positive patients prior to being activated to State Active Duty, or due to exhibiting COVID symptoms since they were activated.
>
> We're working through the details, but this is a scenario we have been preparing for, and is not unexpected. If we were able to activate them under 502(f) authority, they would be eligible for federal benefits instead of the state's Workman's Comp, which would be a better scenario for the Soldier and the State of Florida. If they get ill from the virus and require extensive treatment, the federal benefits afforded by a 502(f) activation could be substantial. The attached info paper discusses the issue in greater detail.
>
> Every TAG in the nation is pushing to get the Feds to authorize 502(f) since this situation is only going to get worse with time. I encourage Governor DeSantis to continue to support this initiative and will be presenting him with a letter tomorrow requesting his endorsement for this as well.
>
> As an aside, there are 30 Broward County 1st responders in quarantine due to exposure to COVID-positive patients. Our Drive-thru team will be testing them with collection and sampling kits tomorrow as part of their practice for opening the lanes on Friday.
>
> I'm available to answer any questions you may have...
>
> Thanks!
>
> V/R,
>
> Eif
>
> JAMES O. EIFERT
> Major General
> Florida National Guard
> The Adjutant General
>
> DSN: 822-0101, Comm: (904) 823-0101
> Work Cell: (904) 481-6387
> SIPR: james.o.eifert.mil@mail.smil.mil
>
>
> <Talking points regarding need for 502f authority IRT COVID emergency final.docx>

Please note that under Florida law correspondence sent to the Governor's Office, which is not confidential or exempt pursuant to chapter 119 of the Florida Statutes, is a public record made available upon request.

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From:	Schmitz, Ann
To:	Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Cc:	Thaqi, Paula M; Jenkins, Patrick H
Subject:	RE: High Priority: Norwegian Bliss
Date:	Thursday, March 19, 2020 4:07:17 PM

Thank you for the advance notification. I am cc'ing Broward CHD for their awareness.

From: Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Sent: Thursday, March 19, 2020 4:03 PM
To: Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: FW: High Priority: Norwegian Bliss

Hi Ann,

FYI—regarding a ship arriving tomorrow. Let me know if any additional questions.

Michelle

From: Aboukheir, Mahmoud (CDC/DDID/NCEZID/DGMQ) <npa0@cdc.gov>
Sent: Thursday, March 19, 2020 3:47 PM
To: Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Cc: Adams, Regina E CDR <Regina.E.Adams@uscg.mil>
Subject: RE: High Priority: Norwegian Bliss

Greetings Kara

Correct, the Bliss had a case on the voyage of 03/01 to 03/08. Regarding the current voyage, we do not have any reported illness, death or influenza like illness for the ship.

Gracias
Mahmoud K.
404-435-9624

From: Lavin, Kara M CDR <Kara.M.Lavin@uscg.mil>
Sent: Thursday, March 19, 2020 2:21 PM
To: Aboukheir, Mahmoud (CDC/DDID/NCEZID/DGMQ) <npa0@cdc.gov>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Cc: Adams, Regina E CDR <Regina.E.Adams@uscg.mil>
Subject: High Priority: Norwegian Bliss

Good Afternoon Mahmoud,

Pls take a look at Norwegian Bliss; they were denied entry to Norfolk, VA so are requesting to enter Miami tomorrow, March 20. Supposedly they have a COVID case onboard, a 2 YOM. Can you

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confirm? Also, what other reporting do you have on this ship?

I'm aware per the EpiX dtd 13 March that the Bliss had a case from 1 March following debarkation.

Thank you for your time.

V/R,
Kara

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From: Torres, Yari
To: Sikka, Neha (CDC/DDPHSIS/CGH/GID); Abebe, Fikru (CDC taskforce.org)
Cc: Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR); Greene, Sharon (CDC/DDPHSIS/CGH/GID); Polio Surge (CDC); Durry, Elias (CDC/DDPHSIS/CGH/GID); Datta, Deblina (CDC/DDPHSIS/CGH/GID)
Subject: Re: ITF NCOV Daily Update - 02-12-2020
Date: Thursday, February 13, 2020 9:58:37 AM

Good morning team,

Thank you for this information. This is a good opportunity to let everyone know that while deployed my primary email will be my CDC account HVB0@cdc.gov, please send all further correspondence to that account.

Thank you for your support.

Yari

Please

Yaritbel Torres-Mendoza, DVM, MPH
CDC Epidemic Intelligence Service Officer
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Phone: 850 -901-6933
Mobile: 850 -815-0059
E-mail: Yari.Torres@flhealth.gov | hvb0@cdc.gov
DOH Mission: To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.
Please Note: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

Sent from Outlook for iOS

From: Sikka, Neha (CDC/DDPHSIS/CGH/GID) <ptr1@cdc.gov>
Sent: Thursday, February 13, 2020 8:21:28 AM
To: Abebe, Fikru (CDC taskforce.org) <fabebe-c@taskforce.org>; axmadgedi2@hotmail.com <axmadgedi2@hotmail.com>; hamudismail99@gmail.com <hamudismail99@gmail.com>; tilahuntafeseafele@yahoo.com <tilahuntafeseafele@yahoo.com>; mesitase2003@gmail.com <mesitase2003@gmail.com>; Blau, Erin (CDC/DDPHSS/CSELS/DSEPD) <okl2@cdc.gov>; dagnachewalemu7@gmail.com <dagnachewalemu7@gmail.com>; Jones, Sydney (CDC/DDPHSS/CSELS/DSEPD) <okn7@cdc.gov>; McMichael, Temet (CDC/DDPHSS/CSELS/DSEPD) <pgv4@cdc.gov>; Oakley, Lisa P. (CDC/DDPHSS/CSELS/DSEPD) <vru2@cdc.gov>; Owusu, Daniel (CDC/DDID/NCIRD/ID) <pgv7@cdc.gov>; Rispens, Jared (CDC/DDNID/NCEH/DEHSP) <okq6@cdc.gov>; Tompkins, Lindsay (CDC/DDNID/NCEH/DEHSP) <pgx9@cdc.gov>; Varela, Kate (CDC/NIOSH/RHD/FSB) <nwn2@cdc.gov>; Wansaula, Zimy (CDC/DDPHSIS/CGH/GID) <lxq5@cdc.gov>; Kanu, Florence (CDC/DDNID/NCCDPHP/DNPAO) <VKW7@cdc.gov>; Wu, Alexander (CDC/DDPHSS/CSELS/DSEPD) <ohh5@cdc.gov>; Mooring, Eric (CDC/DDPHSS/CSELS/DSEPD)

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<pgv5@cdc.gov>; Myers, Tanya R. (CDC/DDID/NCEZID/DHQP) <vje9@cdc.gov>; Bugli, Dante (CDC/DDPHSIS/CGH/DGHP) <kpt7@cdc.gov>; Feder, Kenneth (CDC/DDPHSS/CSELS/DSEPD) <phv3@cdc.gov>; Ortiz, Nancy (CDC/DDPHSS/CSELS/DSEPD) <hqo5@cdc.gov>; Nielsen, Carrie F. (CDC/DDPHSIS/CGH/GID) <hgo6@cdc.gov>; Patel, Jaymin (CDC/DDPHSIS/CGH/GID) <isr0@cdc.gov>; Talwar, Amish (CDC/DDID/NCHHSTP/DTE) <nvr0@cdc.gov>; Rubenstein, Beth (CDC/DDPHSIS/CGH/DPDM) <pgx2@cdc.gov>; Rao, Carol (CDC/DDPHSIS/CGH/DGHP) <cnr3@cdc.gov>; Araujo, Aufra (CDC/DDPHSS/CSELS/DLS) <aka8@cdc.gov>; Bustamante, Nirma (CDC/DDPHSS/CSELS/DSEPD) <okl6@cdc.gov>; Espinosa, Catherine Couper (CDC/DDPHSIS/CPR/DEO) <xwn7@cdc.gov>; Sreevatsava, Meghana (CDC taskforce.org) <msreevatsava-c@taskforce.org>; Pao, Leah (CDC/DDPHSIS/CGH/DGHP) <UZY8@cdc.gov>; Ghiselli, Margherita (CDC/DDPHSIS/CGH/GID) <wkz8@cdc.gov>; Gourmanon, Djebo (CDC/DDPHSIS/CGH/GID) <lrk6@cdc.gov>; Regan, Kelly Ann (CDC/DDPHSIS/CSTLTS/OD) <ngi6@cdc.gov>; Karmarkar, Ellora (CDC cdph.ca.gov) <Ellora.Karmarkar@cdph.ca.gov>; Tesfa, Merhawit (Mary) (CDC/DDPHSIS/CGH/OD) <kpp5@cdc.gov>; Torres, Yari <Yari.Torres@flhealth.gov>; Whitehouse, Erin (CDC/DDID/NCEZID/DHCPP) <okp7@cdc.gov>
Cc: Meyer, Erika (CDC/DDPHSIS/CGH/GID) (CTR) <wyt1@cdc.gov>; Greene, Sharon (CDC/DDPHSIS/CGH/GID) <fny9@cdc.gov>; Polio Surge (CDC) <poliosurge@cdc.gov>; Durry, Elias (CDC/DDPHSIS/CGH/GID) <exd4@cdc.gov>; Datta, Deblina (CDC/DDPHSIS/CGH/GID) <skd2@cdc.gov>
Subject: FW: ITF NCOV Daily Update - 02-12-2020

Dear Polio deployers,

We have heard from many of you that nCOV/COVID-19 has become a concern in many of the countries where you are deployed. I wanted to forward the below email to you so that you may stay informed. Please note the final section of the email below, containing information that is public and may be shared with partners.

Kind regards
Neha Sikka

From: CDC IMS 2019 NCOV Response International Task Force <eocevent223@cdc.gov>
Sent: Wednesday, February 12, 2020 6:47 PM
To: CDC CGH Non-Atlanta Based *Non-Emp <NTBDLORGCGHNonAtlanta-BasedNonEmp@cdc.gov>
Cc: CDC IMS 2019 nCoV Response International TF DL <IMS2019nCoVResponseInternationalTFDL@cdc.gov>
Subject: ITF NCOV Daily Update - 02-12-2020

Greetings colleagues: This is the nCoV ITF Daily Update for February 12, 2020.

If you have questions that you would like to have answered in these Daily Updates, please send them to the International Task Force at eocevent223@cdc.gov.

> ***PLEASE NOTE:*** *The nCoV outbreak is a rapidly evolving situation. We are sharing information with you as we receive it, but remain mindful that known information may*

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change quickly.

Information shared on these updates will come from a variety of sources. We will endeavor to ensure that the source and 'sharability' of each document is noted. Any document that is located on a public website (i.e. it is a link in this email) can be shared freely as long as properly attributed. Any document cleared for distribution by the CDC JIC will be so labeled and can be shared as official CDC guidance. There will, however, be some documents that are for internal CDC use only. Please be mindful not to disseminate uncleared and internal-use materials. ***Please do not forward this entire email to non-CDC recipients.***

We are maintaining a repository of all materials disseminated through the Daily Update on a **ITF SharePoint site**, found **here**. The **COVID-19 Communications SharePoint Site** with CDC Response Key Messages/Key Points is available **here**.

Talking Points

- No updates today

News & Updates

- The WHO has issued an official name of the 2019 novel coronavirus, COVID-19, which CDC has adopted and will implement on all guidance and websites.
- The Lancet has published a retrospective review of nine pregnant women with COVID-19 pneumonia; in his small group, there was no evidence of vertical transmission of COVID-19 , attached (PDF document, **Public**)
- The following social media links have gone live, and will be maintained in real-time with the most up-to-date information
    - Facebook: https://www.facebook.com/CDC/videos/794433791055151/
    - Twitter handle: @CDCgov: https://twitter.com/CDCgov/status/1227615594163449856
    - Instagram: https://www.instagram.com/p/B8eMt2uHZod/
- WHO's SitRep for February 12, 2020 is attached (PDF document, **Public**)
- Today's communication surveillance report is attached (PDF document, **CDC-Internal**)

Guidance Documents

Response Planning

- State Department guidance on foreign engagement for COVID-19 was sent out earlier today for your situational awareness.

Surveillance and Case/Contact Investigation

- No updates today

Traveler Screening & Travel Notices

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- WHO published today "Key considerations for repatriation and quarantine of travelers in relation to the outbreak of novel coronavirus 2019-nCoV" at: https://www.who.int/ith/Repatriation_Quarantine_nCoV-key-considerations_HQ-final11Feb.pdf?ua=1

PPE & Infection Control

- The CDC has released a **DRAFT** version of the "Interim guidance for public health personnel evaluating persons under investigation (PUIs) and asymptomatic close contacts of confirmed cases at their home". This document lays out the precautions that public health professionals must take when evaluating PUIs in their own homes (PDF document, **CDC-Internal**)
- The CDC has centralized all information pertaining to the PPE recommended for healthcare workers, including "Strategies for Optimizing Supply of N95 Respirators", at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html

Laboratory Support

- Update on the status of the CDC 2019-nCoV Real-Time RT-PCR test kit:
    - We have learned that one of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel reagents, N3, is not performing as expected.
    - All CDC reagent kit orders are now on a quality hold until the new N3 reagent can be manufactured, validated, and distributed to the IRR. We appreciate your patience during this time.
    - If you have urgent need, we encourage you to consider other diagnostic options until this issue is resolved and your order is received. Please contact us if you have further questions or concerns.

Risk Communications

- No updates today

Communication to your Country Office Staff

- No updates today

Management & Operations

- No updates today

Standing list of Important links to share with partners – all public:

- CDC's 2019-nCoV page: https://www.cdc.gov/coronavirus/2019-ncov/index.html
- CDC Risk Assessment Summary page: https://www.cdc.gov/coronavirus/2019-nCoV/summary.html#risk-assessment
- CDC Health Advisory Network (HAN): https://emergency.cdc.gov/han/index.asp
- WHO's Novel Coronavirus (2019-nCoV) technical guidance: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

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- WHO SitReps: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports
- WHO's Training portal pertinent to nCoV: https://openwho.org
- Several major journals have created nCoV portals:
    - The Lancet https://www.thelancet.com/coronavirus
    - NEJM https://www.nejm.org/coronavirus?query=main_nav_lg
    - JAMA https://jamanetwork.com/journals/jama/pages/coronavirus-alert
    - Elsevier https://www.elsevier.com/connect/coronavirus-information-center

International Task Force

2019 Novel Coronavirus Response

eocevent223@cdc.gov

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From:	Coppola, Courtney
To:	Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE)
Subject:	RE: Letters from Princess Cruise Line to passengers and crew of Sky Princess
Date:	Saturday, March 14, 2020 7:30:46 PM

Received, thank you!

Courtney F. Coppola
Chief of Staff
& Marijuana Coordinator
Florida Department of Health

Florida Department of Health|4052 Bald Cypress Way|Tallahassee, FL 32399




Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>
Sent: Saturday, March 14, 2020 6:58 PM
To: Coppola, Courtney <Courtney.Coppola@flhealth.gov>
Cc: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>
Subject: Letters from Princess Cruise Line to passengers and crew of Sky Princess

Good evening Ms. Coppola,

Dr. Rivkees gave me your name and email to forward these letters sent by Princess Cruise Line to passengers and crew of the Sky Princess voyages on 2/22 and 2/29. Alberto Moscoso (cc'd here) was involved with the crafting of the letters.

Thank you and please acknowledge receipt.

On Detail to COVID-19 Response

Paul J. Weidle, PharmD, MPH, CAPT USPHS
Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30329
404-639-6155
pweidle@cdc.gov

From: Peyton, Dennis (PCL) <dpeyton@hagroup.com>
Sent: Saturday, March 14, 2020 6:14 PM
To: Weidle, Paul (CDC/DDID/NCHHSTP/DHPSE) <pew6@cdc.gov>; alberto.moscoso@flhealth.gov

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Cc: Tardivel, Kara M. (CDC/DDID/NCEZID/DGMQ) <wjf3@cdc.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; White, Stefanie B. (CDC/DDID/NCEZID/DGMQ) <ixy3@cdc.gov>; Poser, Sarah (CDC/DDID/NCEZID/OD) <wzk8@cdc.gov>; Rinker, Robin (CDC/OD/OADPS) <vqb2@cdc.gov>; Brooks, Ashley (CDC/DDID/NCIRD/OD) <ylo5@cdc.gov>; Tarling, Grant (PCL) <gtarling@hagroup.com>; Howard, Daniel (PCL) <dhoward@hagroup.com>; Drumalds, Aleks (PCL) <adrumalds@hagroup.com>
Subject: RE: Connection - Princess with State of Florida Comms

Good Day Paul and Kara,

Thank you kindly for reaching out today.

As per telephonic guidance received the evening of 12 March 2020 from Alberto Moscoso and team at Florida Department of Health, as well as Cindy Friedman and Paul Weidle from US CDC, it was recommended that an email notification to be sent to individuals with travel history aboard Sky Princess voyage A [22-29 February 2020] and voyage B [29 February – 7 March]. Attached are the email notifications sent on 13 March 2020.

Thanks,

Dennis Peyton Jr., MPH, CIC
Epidemiologist | Health Services
Holland America Group | Princess Cruises, Holland America Line, Seabourn, P&O Australia, & HAP Alaska
+1 (661) 753-2353 office | +1 (661) 645-4013 mobile | dpeyton@hagroup.com
24/7 Emergency Line: +1-661-753-2355

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From:	Catherine de la Cruz Duran
To:	Karl Ensign; Esther Muna; Livinson Taulung (LTaulung2@fsmhealth.fm); Laurent Duenas, MPH, BSN, RN; Emais Roberts; Bruce Bilimon; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com); Nate Smith; Angell, Sonia Y@CDPH; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; Howard Zucker; John Wiesman; Motusa Nua
Cc:	Reva Ferguson; Rachelle Ashe; Peggy Ullom; linda.fullem@flhealth.gov; Tangonan, Sharon S.; Jacqueline Silvia; Terry Bergener; Eti Uiagalelei; Janet Guerrero; Fancy Soloman; Suzanne Kaneshiro; Lalie Ikluk; Marline Loeak; Louise Baa; Aniah John; Carolyn Mullen; Michael Fraser; Joe Davis; Taveras, Sam (CDC/OSTLTS/DPHCD); Jose T. Montero, MD, MPH; Subroto Banerji; lauri.ogumoro@dph.gov.mp; Danny Staley; Carolyn McCoy; Cendra Clarke; Christi Mackie; Mark Mioduski; Emi Chutaro (emic@pihoa.org); Gallo, Bill (CDC/OSTLTS/DPHCD); Ottley, Basil C
Subject:	Re: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date:	Monday, February 24, 2020 1:10:37 PM
Attachments:	image001.png

Thank you Karl for keeping us updated. Yes, change is the only constant.
Catherine

From: Karl Ensign <kensign@astho.org>
Sent: Monday, February 24, 2020 1:06 PM
To: Esther Muna <esther.muna@dph.gov.mp>; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <Laurent.Duenas@dphss.guam.gov>; Emais Roberts <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon <rmiminister.mohhs@gmail.com>; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com) <justa.elisa@gmail.com>; Nate Smith <nathaniel.smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; bruce.s.anderson@doh.hawaii.gov <bruce.s.anderson@doh.hawaii.gov>; Howard Zucker <howard.zucker@health.ny.gov>; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Reva Ferguson <Reva.Ferguson@arkansas.gov>; Rachelle Ashe <rachelle.ashe@arkansas.gov>; Peggy Ullom <peggy.ullom@cdph.ca.gov>; linda.fullem@flhealth.gov <linda.fullem@flhealth.gov>; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak <marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Joe Davis <jdavis@astho.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Jose T. Montero, MD, MPH <znn3@cdc.gov>; Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp <lauri.ogumoro@dph.gov.mp>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Canceled: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
When: Tuesday, February 25, 2020 5:00 PM-6:30 PM.
Where: Madison Hotel – Adams B, 1177 15th Street, NW, Washington, DC 20005

Dear Subcommittee on Insular Affairs Members & Meeting Participants –

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

Apologies for multiple emails.

Thanks,
Karl

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Sent: Sunday, February 23, 2020 3:35 PM
To: esther.muna@dph.gov.mp; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov>; Emais Roberts MD (emais.roberts@palauhealth.org) <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon <rmiminister.mohhs@gmail.com>; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com) <justa.elisa@gmail.com>; Nate Smith, MD <Nathaniel.Smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; howard.zucker@health.ny.gov; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp; Reva Ferguson <Reva.Ferguson@arkansas.gov>; 'Rachelle Ashe' <rachelle.ashe@arkansas.gov>; Peggy Ullom <Peggy.Ullom@cdph.ca.gov>; linda.fullem@flhealth.gov; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak <marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov) <znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

On behalf of Subcommittee Chair Esther Muna, CNMI and ASTHO CEO Mike Fraser, we welcome you

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Tuesday, February 25th, 2020
4:00 – 5:30 pm ET
Madison Hotel – Adams B
1177 15th Street, NW
Washington, DC 20005

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https://naturalresources.house.gov/imo/media/doc/Insular%20Fact%20Sheet_ks.pdf
https://scholarlycommons.pacific.edu/pjh/vol2/iss1/1/

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See you soon!
Karl

Karl Ensign, Chief
Territorial Support
Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450,
Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000,
Atlanta, GA 30308

Tel: (571) 527-3143 | astho.org
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From:	Justa Encarnacion
To:	Karl Ensign
Cc:	Angell, Sonia Y@CDPH; Aniah John; Bruce Bilimon; Carolyn McCoy; Carolyn Mullen; Catherine de la Cruz Duran; Cendra Clarke; Christi Mackie; Danny Staley; Emais Roberts; Emi Chutaro (emic@pihoa.org); Esther Muna; Eti Uiagalelei; Fancy Soloman; Gallo, Bill (CDC/OSTLTS/DPHCD); Howard Zucker; Jacqueline Silvia; Janet Guerrero; Joe Davis; John Wiesman; Jose T. Montero, MD, MPH; Lalie Ikluk; Laurent Duenas, MPH, BSN, RN; Livinson Taulung (LTaulung2@fsmhealth.fm); Louise Baa; Mark Mioduski; Marline Loeak; Michael Fraser; Motusa Nua; Nate Smith; Ottley, Basil C; Peggy Ullom; Rachelle Ashe; Reva Ferguson; Subroto Banerji; Suzanne Kaneshiro; Tangonan, Sharon S.; Taveras, Sam (CDC/OSTLTS/DPHCD); Terry Bergener; bruce.s.anderson@doh.hawaii.gov; lauri.ogumoro@dph.gov.mp; linda.fullem@flhealth.gov; scott.rivkees@flhealth.gov
Subject:	Re: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date:	Monday, February 24, 2020 12:01:03 PM
Attachments:	image001.png

Thank you for the update. I'll be available to meet.

Kind regards.

On Mon, Feb 24, 2020 at 11:59 AM Karl Ensign <kensign@astho.org> wrote:

> *Dear Subcommittee on Insular Affairs Members & Meeting Participants –*
>
> Well, change is a constant!! Given that we have a last minute request from the White House for our members to brief officials on COVID-19 while they are in town, the meeting of the Subcommittee on Insular Affairs held during Washington Week will be cancelled this year. However, in the absence of the full committee meeting, Cendra and I would still appreciate having a working session with our partners and staff not traveling to the White House tomorrow to further our priorities and action steps for the coming year. It is critical that we keep this work moving. I have emailed these individuals separately.
>
> Apologies for multiple emails.
>
> Thanks,
>
> Karl
>
> ---
>
> **From:** Karl Ensign
> **Sent:** Sunday, February 23, 2020 3:35 PM
> **To:** esther.muna@dph.gov.mp; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov>; Emais Roberts MD (emais.roberts@palauhealth.org) <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon <rmiminister.mohhs@gmail.com>; RN

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BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com) <justa.elisa@gmail.com>; Nate Smith, MD <Nathaniel.Smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; howard.zucker@health.ny.gov; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp; Reva Ferguson <Reva.Ferguson@arkansas.gov>; 'Rachelle Ashe' <rachelle.ashe@arkansas.gov>; Peggy Ullom <Peggy.Ullom@cdph.ca.gov>; linda.fullem@flhealth.gov; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak <marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov) <znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

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4:00 – 5:30 pm ET

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1177 15th Street, NW

Washington, DC 20005

A calendar invite will follow.

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

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

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See you soon!

Karl

Karl Ensign, Chief
Territorial Support

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials

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

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

Tel: (571) 527-3143| astho.org
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--

Warm regards,

Justa "Tita" Encarnacion, RN, BSN, MBA/HCM

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From:	Karl Ensign
To:	Esther Muna; Livinson Taulung (LTaulung2@fsmhealth.fm); Laurent Duenas, MPH, BSN, RN; Emais Roberts; Catherine de la Cruz Duran; Bruce Bilimon; RN BSN MBA/HCM Justa (Tita) Encarnacion (justa.elisa@gmail.com); Nate Smith; Angell, Sonia Y@CDPH; scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; Howard Zucker; John Wiesman; Motusa Nua
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Subject:	RE: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date:	Monday, February 24, 2020 11:59:34 AM
Attachments:	image001.png

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Cc: Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp; Reva Ferguson <Reva.Ferguson@arkansas.gov>; 'Rachelle Ashe' <rachelle.ashe@arkansas.gov>; Peggy Ullom <Peggy.Ullom@cdph.ca.gov>; linda.fullem@flhealth.gov; Tangonan, Sharon S. <Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euiagalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak

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<marlineloeak@gmail.com>; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov) <znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
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Attached and below please find materials for our meeting. During our time together, we will re-visit the priorities established during last year's meeting, hear about progress made on these, and define action steps and priorities for the coming year. Also, please note that during or after the Tuesday dinner, those of us visiting on the Hill Wednesday and engaging in meetings with the Administration on Thursday will huddle to hone talking points.

https://naturalresources.house.gov/imo/media/doc/Insular%20Fact%20Sheet_ks.pdf
https://scholarlycommons.pacific.edu/pjh/vol2/iss1/1/

The Insular Affairs Subcommittee to the ASTHO Government Affairs Policy Committee was formed in 2018 to identify the unique policy needs and priorities of the Pacific and Atlantic jurisdictions. The subcommittee provides a forum for ASTHO's members to exchange information on policy challenges and solutions within the insular areas. Additionally, the subcommittee provides recommendations to the full committee on policy priorities.

See you soon!
Karl

Karl Ensign, Chief
Territorial Support

AMERICAN OVERSIGHT

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308

Tel: (571) 527-3143 | astho.org
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AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

From:	Mejia-Echeverry, Alvaro
To:	Dobson, Jolie T; Burger, Ron; Cicerrella, Richard; Connor, Olga; Cyrille, Charles; Davis, Joanna; Disbrow, Scott; Jeanne Eckes-Roper; Elmir, Samir; Erase, Romualde X; Franco, Benjamin; Frost, Matthew; Garcia, Maikel; Gomez, Tatiana ; Hernandez, Richard; Horner, Alicia; Jean, Reynald; Kelly Keys; Lara, William; Lewandowski, Patty A; Loo, Georgina; Lopez, Jose M; Milian, Victor ; Nunez, R. Jaime; Presmanes, Cristina; Quaye, Elesi A; Rafky, Brian; Schmitz, Ann; Senyshyn, William; Serrano, Maria; Steele, Michelle; Sudden, Terri M; Toñanez, Alvaro Lt.; Trim, Anthony Capt.; Vaughn, Freda G; Villalta, Yesenia D; White, Stephen L; Chao Morales, Christina A; Castillo, Klelia S; Celorio, Oscar; Villamil, Vanessa
Cc:	Suarez, Ana; Pognon, Monica; Jaime Hernandez; jzambella@icerif.com; John Antapasis; Chambliss, James; James Russo; Franco, Benhamin; Davis, Joanna S - APHIS; Lara, William (RER); Bello, Joel; vmmilian@gmail.com; Zambella, Joseph; Serrano, Maria (ASD); Oliphant, Mark C; Yereb, Daniel
Subject:	Re: Miami-area BAC Quarterly Meeting
Date:	Thursday, March 12, 2020 9:58:15 PM

Thanks to all who attended the BAC meeting/ conference call today. It was important to maintain continuity even in these difficult times! Glad we were able to debrief about the Super Bowl LIV and learn or review basics about COVID-19. Also, it's great to know that BioWatch has offered its assets to assist with COVID-19 testing. We are very thankful about that offer!

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From: Dobson, Jolie T <Jolie.Dobson@flhealth.gov>
Sent: Thursday, March 12, 2020 11:40:33 AM
To: Burger, Ron <Ron.Burger@flhealth.gov>; Cicerrella, Richard <rwcicerrella@fbi.gov>; Connor, Olga <Olga.Connor@flhealth.gov>; Cyrille, Charles <charles.cyrille@miamidade.gov>; Davis, Joanna <joanna.s.davis@aphis.usda.gov>; Disbrow, Scott <sdisbrow@hialeahfl.gov>; Jeanne Eckes-Roper <Jeanne.Eckes@hhs.gov>; Elmir, Samir <Samir.Elmir@flhealth.gov>; Erase, Romualde X <Romualde.Erase@flhealth.gov>; Franco, Benjamin <Franco.Benjamin@epamail.epa.gov>; Frost, Matthew <matthew.frost@hq.dhs.gov>; Garcia, Maikel <hazmat@miamigov.com>; Gomez, Tatiana <tgomez@hialeahfl.gov>; Hernandez, Richard <rfhernandez@mdpd.com>; Horner, Alicia <ahorner@miamidade.gov>; Jean, Reynald <Reynald.Jean@flhealth.gov>; Kelly Keys <Kkeys@browardhealth.org>; Lara, William <laraw@miamidade.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Loo, Georgina <Georgina.Loo@miamidade.gov>; Lopez, Jose M <Jose.Lopez@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>; Milian, Victor <vmmilian@mdpd.com>; Nunez, R. Jaime <rjnunez@mdpd.com>; Presmanes, Cristina <cristina.presmanes@miamidade.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rafky, Brian <blrafky@mdpd.com>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>; Senyshyn, William <William.Senyshyn@flhealth.gov>; Serrano, Maria <serranm@miamidade.gov>; Steele, Michelle <Michelle.Steele@miamidade.gov>; Sudden, Terri M <Terri.Sudden@flhealth.gov>; Toñanez, Alvaro Lt. <Tonanez@miamidade.gov>; Trim, Anthony Capt. <ttrim@miamidade.gov>; Vaughn, Freda G <Freda.Vaughn@flhealth.gov>; Villalta, Yesenia D <Yesenia.Villalta@flhealth.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Chao Morales, Christina A <Christina.ChaoMorales@flhealth.gov>; Castillo, Klelia S <Klelia.Castillo@flhealth.gov>; Celorio, Oscar <Oscar.Celorio@flhealth.gov>; Villamil, Vanessa <Vanessa.Villamil@flhealth.gov>
Cc: Suarez, Ana <ASUAREZ@broward.org>; Pognon, Monica <mpognon@Broward.org>; Jaime Hernandez <jahernandez@hollywoodfl.org>; jzambella@icerif.com <jzambella@icerif.com>; John Antapasis <John_Antapasis@davie-fl.gov>; Chambliss, James <Jim_Chambliss@bsosid.org>; James Russo <JRusso@hollywoodfl.org>; Franco, Benhamin <franco.benjamin@epa.gov>; Davis, Joanna S - APHIS <joanna.s.davis@usda.gov>; Lara, William (RER) <William.Lara@miamidade.gov>; Bello, Joel

AMERICAN OVERSIGHT

<jbello@mdpd.com>; vmmilian@gmail.com <vmmilian@gmail.com>; Zambella, Joseph <jzambella@gmail.com>; Serrano, Maria (ASD) <Maria.Serrano@miamidade.gov>
Subject: Miami-area BAC Quarterly Meeting
When: Thursday, March 12, 2020 10:00 AM-12:00 PM.
Where: 8175 NW 12 Street (Suite 300); Doral, FL 33126. Dial-in# 888-585-9008; Conference Room# 219-046-121

Please find the updated COVID-19 ppt.

Thank you.

Jolie Dobson
Biological Scientist IV
Florida Department of Health in Miami-Dade County
Email: Jolie.Dobson@flhealth.gov
Phone: (305) 470-5558



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AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Doyle, Tim (CDC/DDPHSIS/CPR/DSLR); Balda, Michael
Cc:	Pritchard, Scott; Rubino, Heather
Subject:	Re: Monday
Date:	Monday, March 2, 2020 7:57:52 AM

Michael should get you shortly

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From: Doyle, Tim (CDC/DDPHSIS/CPR/DSLR) <tcd2@cdc.gov>
Sent: Monday, March 2, 2020 7:56:17 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Monday

Ok, I am in lobby

Get Outlook for iOS

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Monday, March 2, 2020 6:17:03 AM
To: Doyle, Tim (CDC/DDPHSIS/CPR/DSLR) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Monday

Change of plans. We can meet first thing this morning.

Get Outlook for iOS

From: Blackmore, Carina
Sent: Sunday, March 1, 2020 10:26:23 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Monday

Hi Tim, The good news is you are coming right at the best time. Expect to be plugged into the Coronavirus response from day one. The bad news is that tomorrow morning will likely be a tad chaotic. We may have our two first cases confirmed tomorrow and we have just declared an emergency. I have a meeting between 830-9 am. It may drag out a little. I will try to meet you at 8 and we will get your badge and computer etc set up started. Then we will all get together as soon as we have a chance. Hopefully shortly after 9. Just wanted to give you a heads up and wish you a warm welcome :). Carina

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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Fitzgerald, John M CDR
Cc:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Re: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 8:28:54 AM

Thanks

Respectfully,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

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cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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> On Mar 20, 2020, at 7:30 AM, Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil> wrote:
>
> Jeanne,
>
> Passed yesterday to Ashley and ESF-8 that vessel is off Panama and is tentative for arrival in Miami on March 23. Will keep tracking this one.
>
> v/r,

AMERICAN OVERSIGHT

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 6:31 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Subject: [Non-DoD Source] RE: MS Marina (Oceania) - awareness???

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
Jeanne

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From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM

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To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Subject: MS Marina (Oceania) - awareness???

Sam/Ashley

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Jeanne,

AMERICAN OVERSIGHT

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

Hi Joe – are you tracking the MS Marina (Oceania)? I'm tracking 653 Amcits on board, COVID(+) cases on ship, headed to Miami but no ports there open. This is going to be a problem soon. We're getting inquiries from the Australians and Andorrans. This is the latest I have:

18MAR: Indications that an Oceania cruise ship will be arriving at Port of Miami sometime next week with various COVID-19 positives on it. Consular Affairs from the Australian Embassy contacted to say they had been notified overnight that the MS Marina (Oceania) is returning to Miami from South America via the Panama Canal after it was denied docking by several countries. The latest advice the Embassy has is that it is passing through the Canal could take 5 or 6 days. Australian Embassy in Mexico and Honorary Consul in Panama are trying to assist at least 49 Australians on board - some of whom are starting to run short of medications etc. - but are having difficulty contacting the crew and Oceania's agents in Panama. CONS provided them with the contact for Norwegian cruise lines which is a parent company of Oceania. OFM indicates Port of Miami is not aware of the ship coming to Miami and questioned where it would even dock as all available ports are occupied. OFM in touch with Norwegian.

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To:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR
Subject:	RE: MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 6:30:50 PM

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
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AMERICAN OVERSIGHT

From:	Fitzgerald, John M CDR
To:	"Eckes, Jeanne (OS/ASPR/EMMO)"; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	RE: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 7:30:27 AM

Jeanne,

Passed yesterday to Ashley and ESF-8 that vessel is off Panama and is tentative for arrival in Miami on March 23. Will keep tracking this one.

v/r,

John

From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 6:31 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov; Fitzgerald, John M CDR <John.M.Fitzgerald2@uscg.mil>
Subject: [Non-DoD Source] RE: MS Marina (Oceania) - awareness???

+ Fitzgerald from USCG

This is all I know. Thanks John for any info you can find out

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
Nurse Consultant/Regional Emergency Coordinator – Region IV
United States Department of Health & Human Services (HHS)
Assistant Secretary for Preparedness and Response (ASPR)
Emergency Management & Medical Operations (EMMO)
Field Operations and Response

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers

AMERICAN OVERSIGHT

cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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From: Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Sent: Thursday, March 19, 2020 3:18 PM
To: Davis, Ashley (FDEM) <Ashley.Davis@em.myflorida.com>; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov) <Christie.Luce@flhealth.gov>; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>; Otis, Aaron (CDC/DDPHSIS/CPR/DSLR) <fio6@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Samantha.Cooksey@flhealth.gov
Subject: MS Marina (Oceania) - awareness???

Sam/Ashley

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Jeanne,

See below. Is FL DOH tracking this?

Joe

Joe Lamana
HHS/ASPR/OEMMO
Cell: **202-230-9169**

From: Jao, Richard C (Beijing) <JaoRC@state.gov>
Sent: Thursday, March 19, 2020 2:27 PM
To: Lamana, Joseph (OS/ASPR/EMMO) <Joseph.Lamana@hhs.gov>
Subject: MS Marina (Oceania)

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AMERICAN OVERSIGHT

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Cc:	Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Subject:	Re: MS Marina (Oceania) - awareness???
Date:	Friday, March 20, 2020 8:28:06 AM

Thanks

Respectfully,
Jeanne

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>
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AMERICAN OVERSIGHT

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Subject:	RE: MS Marina (Oceania) - awareness???
Date:	Thursday, March 19, 2020 6:30:40 PM

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AMERICAN OVERSIGHT

From:	Traci, Meg
To:	Lushbaugh, Justin (CDC/DDNID/NCBDDD/DHDD); Claudia.Johnson@ky.gov; Pier, Kristi (CDC maryland.gov); Cramer, Steve (CDC health.mo.gov); Paras, Kathy (CDC utah.gov); Kamp, Susan (CDC vermont.gov); Laurie.Eldridge-Auffant@adph.state.al.us; Roberson, Shamarial (CDC flhealth.gov); bryan.russell@flhealth.gov; maggie.ferguson@idph.iowa.gov; jhall@ku.edu; Kbruns@ku.edu; hoffmana5@michigan.gov; Manning, Mary (CDC state.mn.us); Bluhm, Jim JB (CDC state.mn.us); Susan.havercamp@osumc.edu; vanessas@uark.edu; Rodrigo.Monterrey@MassMail.State.MA.US; Barbara.wallace@health.ny.gov; weaverro@ohsu.edu; SMCDERMO@mailbox.sc.edu; devlinj@mailbox.sc.edu; Barb.Locker@ky.gov; Allison.perline@vermont.gov; Wimberley, Richard (CDC michigan.gov); HWelch@mt.gov; erin.ashinghurst@maryland.gov; bdkilpat@uark.edu; ann.robinson@osumc.edu; Kimberly.Phillips@unh.edu; holly.teal@health.ny.gov; Brenda.Maley@health.mo.gov; Kimberley.Warsett@state.ma.us; hornerjo@ohsu.edu; nettie.romanzo-smith@health.ny.gov; Evan.England@unh.edu; nassira.d.nicola@state.ma.us; aBraner@utah.gov; ctamayo@phhp.ufl.edu; Rachael.Austin@health.ny.gov; Patrick.Hodge@flhealth.gov; Casey, Margaret MC (CDC health.ny.gov); maureen.spence@health.ny.gov; rodrigo.monterrey@state.ma.us; LeeC@michigan.gov; anna.fuller@uky.edu; lindsey.c.mullis@uky.edu; chithra.adams@uky.edu; David.Ellsworth@odh.ohio.gov; Edward.Clark@flhealth.gov; FrameA@michigan.gov; Bishop, Susan (CDC state.mn.us); emily.smoak@state.mn.us; Mackenzie.Jones@mt.gov; Schulte, Ann (MDH); Crotty, Anne E
Cc:	Tilahun, Selam (MDH); Erin Taylor; Vincent-Mark, Arlene (CDC/DDNID/NCBDDD/DHDD)
Subject:	Re: NCHPAD Home workout toolkit
Date:	Friday, March 20, 2020 12:27:20 PM

Thanks, Justin.

We have added the NCHPAD toolkit to the MTDH website with other information and resources that partners have been sharing related to COVID-19 and People with Disabilities at: https://mtdh.ruralinstitute.umt.edu/?p=7763

Justin and others-- please let us know of additional information and resources to add and share with partners and people with Montana.

Thank you,
Meg

Meg Ann Traci, PhD
Pronouns: she, her, hers
Research Associate Professor
Montana Disability and Health Program
The Rural Institute for Inclusive Communities
University of Montana
Office: 245 Corbin Hall
Phone: 406-243-4956
Email: meg.traci@mso.umt.edu
Websites:
UM RIIC http://ruralinstitute.umt.edu/
MTDH https://mtdh.ruralinstitute.umt.edu/

The University of Montana acknowledges that we are in the aboriginal territories of the Salish and Kalispel people. We honor the path they have always shown us in caring for this place for the generations to come.

AMERICAN OVERSIGHT

Subject: NCHPAD Home workout toolkit

Good morning, all:

Please find attached NCHPAD's Inclusive Home Workout Toolkit, and please feel free to share the content with your networks.

Thanks, and please let me know if you have any questions.

Stay happy and healthy!

-Justin

Justin Lushbaugh
Public Health Analyst
Disability Science and Program Team ¦ Disability & Health Promotion Branch
Division of Human Development and Disability
National Center on Birth Defects and Developmental Disabilities
Centers for Disease Control and Prevention
4770 Buford Hwy MS-S101-3
Chamblee, GA 30341-3717
Xko0@cdc.gov
(404) 498-3036 Office
(470) 421-0183 Mobile
(770) 488-0270 Fax

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Blackmore, Carina; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Cc:	Rubino, Heather
Subject:	Re: Next week
Date:	Wednesday, February 26, 2020 6:49:45 PM

Can't wait to have you Tim!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 26, 2020 6:23:53 PM
To: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Next week

We are excited to have you on site next week. Coronavirus is the first item on the menu as you can imagine. But we are also engaged in hep A and legionella response. Not to forget flu. What time do you think you will be in the office? We would like to sit down sometimes early in the day to discuss scientific on boarding. Carina

Get Outlook for iOS

AMERICAN OVERSIGHT

From:	Rubino, Heather
To:	Pritchard, Scott; Blackmore, Carina; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP)
Subject:	RE: Next week
Date:	Thursday, February 27, 2020 8:36:02 AM

Completely agree!

From: Pritchard, Scott
Sent: Wednesday, February 26, 2020 6:50 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Cc: Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Next week

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Get Outlook for iOS

AMERICAN OVERSIGHT

From:	Reich, Andrew
To:	Roberts, Virginia (CDC/OID/NCEZID); Veytsel, Gabriella (CDC/DDID/NCEZID/DFWED)
Cc:	Clark, Rick; Goff, Kendra F; Mitchell, Michael S; Ursin, Elke; Wade, Tracy L
Subject:	RE: OHHABS Data Transfer
Date:	Friday, February 7, 2020 9:10:57 AM
Attachments:	OHHABS Environmental Form Data Dictionary 2-7-2020.xlsx

Virginia, Gabriella

We made some great progress on the OHHABS data dictionary descriptions and identifying ways to facilitate uploads to OHHABS. Please see attachment for the latest revisions. Elke has done a great job updating the spreadsheet since the last discussion including adding a couple of columns: CDC Follow-up questions and remaining DOH Action Items.

We would like to have another conference call to finish the review. I will send out a Doodle poll soon for us to pick a day and time that work.

Thanks.

Andy
Andrew Reich MS, MSPH, RRT
Scientific Advisor
Bureau of Environmental Health
Florida Department of Health
813.559.4370
andy.reich@flhealth.gov
floridahealth.gov/environmental-health/

AMERICAN OVERSIGHT

	A	B	C
1	**Required/Preferred**	**Tab/Table Name**	**OHHABS Interface:** *Section, Tab*
2		EnviroMain	n/a
3		EnviroMain	n/a
4	Required to upload	EnviroMain	n/a
5		EnviroMain	n/a
6		EnviroMain	Author and Agency
7	EnBloomDate OR EnNotificationDate OR EnNoBloomDate is required to upload and finalize	EnviroMain	General, Dates
8		EnviroMain	General, Dates
9		EnviroMain	General, Dates
10	Required to finalize	EnviroMain	General, Event Summary
11	Required to upload and finalize	EnviroMain	General, Geographic Description
12	Preferred/Requested	EnviroMain	General, Geographic Description

AMERICAN OVERSIGHT

	D	E	F
1	Variable Name	Variable Description	Data Format
2	CDCReportID	The CDCReportID is automatically assigned by the system and links forms across all tables in the relational database to a single OHHABS report. Multiple instances of the same CDCReportID within a table refer to multiple entries for one record (e.g., may include symptom data reported for multiple human cases).	Number
3	CDCFormID	The CDCFormID is automatically assigned by the system and links information from a single form across all tables in the relational database. Multiple instances of the same CDCFormID within a table refer to multiple entries for one record (e.g., one form with two laboratory results).	Number
4	StateReportID	The StateReportID is assigned by the reporting site (e.g., state). The StateReportID must be unique within each reporting site. However, the StateReportID is not unique across all reporting sites (i.e., OHHABS reports with the same StateReportID may exist in all reporting sites, but OHHABS reports in the same reporting site cannot have the same StateReportID).	Text
5	EnDateCreated	The date that the environmental form was created.	Date
6	EnFormAuthor	The author of the environmental form.	Text
7	EnBloomDate	The date that an algal bloom was observed.	Date
8	EnNotificationDate	The date that a local, territorial, tribal, or state health department was notified of the algal bloom.	Date
9	EnNoBloomDate	If no bloom was observed, this field indicates why a bloom date was not observed.	Text
10	EnEventClassification	Suspect or confirmed.	
11	EnState	The state or jurisdiction a bloom or event occurred.	Text
12	EnWaterQualOtherState	Indicates if a bloom or event affected the water quality of other states.	Number

AMERICAN OVERSIGHT

	G	H	I
1	**Data Format Details:** *(detailed description)/character maximum*	**Elke's questions/comments**	**Andy Comments**
2	(################)/15		
3	(################)/15		
4	(Text)/50	Do we know what we have used in the past? Is this alpha-numeric? Does the module to upload into the OHHABS auto populate this, or is this just for our internal tracking purposes? If so, should we create a standardized format? [YY]-[DEP OBJECT ID]. Also, what is considered a "report" or a "reporting site"?	Need clarification from CDC; We can have multiple samples from one water body (like Lake Okeechobee). Also blooms move around so it might be the same bloom at different distinct locations.
5	(MM/DD/YYYY)/10		
6	(Text)/80	FirstName LastName? Any specific format preferences (Initials, all caps)	Need clarification from CDC; would think firstname and last name should be separate entry fields.
7	(MM/DD/YYYY)/10	We can pull this from our Excel tracking sheet. Need clarification from CDC whether they want only bloom observation date here. What about if a bloom was not seen, a sample was taken, and toxins were detected? Since this is a required field, our recommendation would be to include the site visit date regardless of whether a bloom was seen. Not sure if the "EnNoBloomDate" field influences what we put here. See the notes for that data field.	Need clarification from CDC.
8	(MM/DD/YYYY)/10	We can pull this from our Excel tracking sheet. Clarify with CDC that the date we will use here is when state level notifies the county level that a caution or alert sign needs to be placed.	Need clarification from CDC.
9	(Text)/50	Check with CDC about intent of this field. Would this be where we would put those where a bloom was not observed but toxins were detected? I see on the form the suggested choices include "Other evidence of harmful algal/algae toxicity" which would fit the scenario mentioned above. Need to know CDC's preference. Also, mention to CDC that the form says "algal" but the pull-down list populates the word as "algae".	Why a bloom was not observed? Not sure about what to say as we don't evaluate that.
10		How do we want to make this decision? Bloom vs. toxins found?	I believe that CDC has criteria for suspect or confirmed blooms; will need to check with CDC.
11	(Text)/50	"Florida"	
12	(0="No", 1="Yes",7="Unknown", 9="Not applicable", Null/blank ="No Response")/1	Most will be null	

AMERICAN OVERSIGHT

	J	K
1	Internal	CDC
2		
3		
4	Do we know what we have used in the past? We can have multiple samples from one water body (like Lake Okeechobee). Also blooms move around so it might be the same bloom at different distinct locations.	Is this alpha-numeric? Does the module to upload into the OHHABS auto populate this, or is this just for our internal tracking purposes? If so, should we create a standardized format? [YY]-[DEP OBJECT ID]. Also, what is considered a "report" or a "reporting site"?
5		
6		FirstName LastName? Any specific format preferences (Initials, all caps) May need separate entry fields for first and last name.
7	We can pull this from our Excel tracking sheet.	Need clarification from CDC whether they want only bloom observation date here. What about if a bloom was not seen, a sample was taken, and toxins were detected? Since this is a required field, our recommendation would be to include the site visit date regardless of whether a bloom was seen. Not sure if the "EnNoBloomDate" field influences what we put here. See the notes for that data field.
8	We can pull this from our Excel tracking sheet.	Clarify with CDC that the date we will use here is when state level notifies the county level that a caution or alert sign needs to be placed.
9	Why a bloom was not observed? Not sure about what to say as we don't evaluate that.	Check with CDC about intent of this field. Would this be where we would put those where a bloom was not observed but toxins were detected? I see on the form the suggested choices include "Other evidence of harmful algal/algae toxicity" which would fit the scenario mentioned above. Need to know CDC's preference. Also, mention to CDC that the form says "algal" but the pull-down list populates the word as "algae".
10		Need to check with CDC for possible criteria for suspect or confirmed blooms. One potential might be to differentiate between those where only a bloom was seen visually (suspect) and sites where toxins were detected (confirmed).
11	Value = "Florida"	
12	Most will be null	

AMERICAN OVERSIGHT

	A	B	C
13	Preferred/Requested	EnviroMain	General, Geographic Description
14	Preferred/Requested	EnviroMain	General, Geographic Description
15	Preferred/Requested	EnviroMain	General, Geographic Description
16	Preferred/Requested	EnviroMain	General, Geographic Description
17		EnviroMain	General, Geographic Description
18		EnviroMain	General, Geographic Description
19		EnviroMain	General, Geographic Description
20		EnviroMain	General, Geographic Description
21		EnviroMain	General, Geographic Description
22	Preferred/Requested	EnviroMain	General, Water Body Characteristics
23	Preferred/Requested	EnviroMain	General, Water Body Characteristics
24		EnviroCounty	General & Geographic Description
25		EnviroCounty	General & Geographic Description
26		EnviroOtherState	General & Geographic Description
27		EnviroHUC	General & Geographic Description
28	Preferred/Requested	EnviroWaterUse	
29	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
30	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings

AMERICAN OVERSIGHT

	D	E	F
13	EnOfficialWaterName	The official name of the water body (e.g. Lake Erie).	Text
14	EnCommonWaterName	The common name of the water body.	Text
15	EnLocationName	The specific location name (e.g. Ruggles Beach).	Text
16	EnNearestCity	The city or town nearest to the water body.	Text
17	EnCoordinateFormat	The format of the location coordinates in latitude and longitude (i.e., "DMS" for Degrees Minutes Seconds, "DD" for Decimal Degrees).	Text
18	EnLatitudeDMS	The latitude of the event collected in Degrees Minutes Seconds format	Text
19	EnLongitudeDMS	The longitude of the event collected in Degrees Minutes Seconds format.	Text
20	EnLatitudeDD	The latitude of the bloom or event. Can be in Degrees Minutes Seconds or Decimal Degrees format.	Number
21	EnLongitudeDD	The longitude of the bloom or event. Can be in Degrees Minutes Seconds or Decimal Degrees format.	Number
22	EnWaterType	Indicates the water body type the event occurred in.	Text
23	EnWaterSalinity	Indicates the salinity of the water body the event occurred in.	Text
24	EnCounty	The county or counties where a bloom or event occurred.	Text
25	EnAssociatedState	The corresponding state of the county.	Text
26	EnOtherState	Other states affected by a HAB or HAB event.	Text
27	EnHUC	Indicates the hydrologic unit code (HUC).	Text
28	EnWaterUse	Indicates what the water body or if applicable the portion of the water body is used (e.g., agriculture, industrial/occupational).	
29	EnAdvisoryType	If an advisory or warning was issued, this field indicates the type of advisory or warning.	Text
30	EnAdvisoryResponse	Indicates whether an advisory type was issued.	Number

AMERICAN OVERSIGHT

	G	H	I
13	(Text)/50	Is there a list of these? What about small lakes? Would we use the Water Body ID (WBID) number and associated name as assigned by DEP?	I agree that WBID would be good; there are multiple lakes with same name in Florida.
14	(Text)/50	Similar to question above.	
15	(Text)/50	Similar to question above.	
16	(Text)/50	This would need some automation using GIS or some other method. That is not a field we currently capture.	This might be a problem with larger lakes such as Lake O. In what direction from the lake? There are a lot of small towns near lakes but definitely not cities.
17	(DMS or DD)/ 10	DD	
18	(Text)/50	NA	
19	(Text)/50	NA	
20	(+/-##.######)/10	We can pull this from our Excel tracking sheet	
21	(+/- ###.######)/11	We can pull this from our Excel tracking sheet	
22	(Text)/50	Options like: Canal, Lake/Reservoir/Impoundment, Ocean, Pond, River/Stream, Spring, Other, Unknown. We could look into whether this could be automated when linking to the WBID information. That is a data field stored in the WBID dataset.	
23	(Text)/50	Options are: Fresh, Brackish, Salt. We can make educated guesses, but am wondering if this is a dataset that DEP may have that might tie to WBID.	Will need to check with FDEP about salinity measurements. They are not on the map data from their website.
24	(Text)/100	We can pull this from our Excel tracking sheet	
25	(Text)/50	Florida	
26	(Text)/100		
27	(Text)/50	Looks like there are limited choices. Verify with CDC that our correct choice is "Region 03 - South Atlantic -Gulf". If we link by WBID, we could bet more detailed HUC numbers (03080102 for example).	Confirm with CDC on choice for Florida.
28	(Text)/50	Options that seem relevent are: Public drinking water system, Recreation, None, Unknown, Other-describe in remarks. Not sure how we will automate this criteria.	Can this be made to be a drop down? This might take a lot of work. Could it be done via GIS land use maps?
29	(Text)/50	Choices are: Health advisory, No contact warning, water body closure (recreational activity), Water body closure (fish/shellfish), other. Since we do not issue "advisories" would we choose "No contact warning" or "other"?	Discuss with CDC that our system does not match drop downs; can use have qualifiers to selections for Florida?
30	(0="No", 1="Yes",7="Unknown", Null/Blank="No Response")/1	Depends on what we choose in EnAdvisoryType.	

AMERICAN OVERSIGHT

	J	K
13	I agree that WBID would be good; there are multiple lakes with same name in Florida.	Is there a list of these? What about small lakes? Would we use the Water Body ID (WBID) number and associated name as assigned by DEP?
14		Similar to question above.
15		Similar to question above.
16	This would need some automation using GIS or some other method. This is not a field we currently capture.	This might be a problem with larger lakes such as Lake O. Could one approach be to geographically identify the nearest city/town as the crow flies?
17	Value = DD	
18	NA	
19	NA	
20	We can pull this from our Excel tracking sheet	
21	We can pull this from our Excel tracking sheet	
22	Options like: Canal, Lake/Reservoir/Impoundment, Ocean, Pond, River/Stream, Spring, Other, Unknown. We could look into whether this could be automated when linking to the WBID information. That is a data field stored in the WBID dataset.	Is CDC OK with us using the WBID dataset to gather this information? That is a data field stored in the WBID dataset.
23	Options are: Fresh, Brackish, Salt. We can make educated guesses, but am wondering if this is a dataset that DEP may have that might tie to WBID. Will need to check with FDEP about salinity measurements. They are not on the map data from their website.	
24	We can pull this from our Excel tracking sheet	
25	Value = Florida	
26		
27		Verify with CDC that our correct choice is "Region 03 - South Atlantic -Gulf". If we link by WBID, we could get more detailed HUC numbers (03080102 for example).
28	Options that seem relevent are: Public drinking water system, Recreation, None, Unknown, Other-describe in remarks. Not sure how we will automate this criteria. Can this be made to be a drop down? This might take a lot of work. Could it be done via GIS land use maps?	How critical is this field for CDC reporting? We will look into how we could get that information, but it may be difficult.
29	Choices are: Health advisory, No contact warning, water body closure (recreational activity), Water body closure (fish/shellfish), other. Since we do not issue "advisories" would we choose "No contact warning" or "other"?	Discuss with CDC that our process does not match drop down choices. We do not issue "advisories" but "caution" and "alert". Can we change the options for this pull-down list to make them specific for Florida?
30		This ties to the question from the previous field. What is CDC's preference?

AMERICAN OVERSIGHT

	A	B	C
31	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
32	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
33	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
34	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
35	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
36	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
37	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
38	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
39	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
40	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
41	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
42	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
43	Preferred/Requested	EnviroLabTesting	Laboratory Testing, Algae, Algal Toxins, or Components Testing
44	Preferred/Requested	EnviroTestReason	Laboratory Testing, Algae, Algal Toxins, or Components Testing
45	Preferred/Requested	EnviroWaterTesting	Laboratory Testing, Algae, Algal Toxins, or Components Testing
46	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
47	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results

AMERICAN OVERSIGHT

	D	E	F
31	EnAdvisoryAgency	Indicates the agency that issured the advisory or warning.	Text
32	EnAdvisoryReason	Indicates the criteria or reason the advsory or warning was issued.	Text
33	EnAdvisoryStartDate	Indicates the date the advisory or warning began.	Date
34	EnAdvisoryEndDate	Indicates the date the advisory or warning ended.	Date
35	EnDateDocumented	If an event was observed, this field indicates the date an observation was documented.	Date
36	EnDocumentedBy	Indicates who made and documented the observation.	Text
37	EnScumObserved	Indicates whether any scum or algal matter was observed.	Number
38	EnWaterColor	Indicates the color of the water.	Text
39	EnWaterClarity	Indicates the clarity of the water.	Text
40	EnWaterOdor	Indicates if the water had an odor.	Number
41	EnWaterFlow	Indicates if there was any water flow.	Text
42	EnTidalCondition	Indicates the type of tidal conditions in the water.	Text
43	EnSampleTested	Indicates the type(s) of environmental sample tested (e.g., air, algae, finished drinking water).	Text
44	EnSampleTestReason	Indicates the reason for testing samples (e.g., fish kill, citizen complaint)	Text
45	EnSampleWaterTesting	If water sample testing was performed, this field indicates the type of testing performed (e.g., algae, algal toxins, chlorophyll)	Text
46	EnLabResultID	Automatically assigned numeric value for identifying lab results.	Numeric
47	EnClassification	Indicates the broad category or classification of the pathogen/toxin.	Text

AMERICAN OVERSIGHT

	G	H	I
31	(Text)/50	"Health Department"	
32	(Text)/50	We can pull this from our Excel tracking sheet. "Bloom observed", "Toxin detected". Check with CDC if it is OK for us to use "Bloom observed and toxin detected" and other similar variations and if there is any standardization to this field they would like.	Need clarification from CDC.
33	(MM/DD/YYYY)/10	We can pull this from our Excel tracking sheet. We would use the date we notified the CHD.	
34	(MM/DD/YYYY)/10	We should decide how to report this, when we notify CHD of an AlertLift or when CHD removes the signage?	
35	(MM/DD/YYYY)/10	We can pull this from our Excel tracking sheet	
36	(Text)/50	We can pull this from our Excel tracking sheet	
37	(0="No", 1="Yes",7="Unknown", Null/Blank="No Response")/1	We can pull this from our Excel tracking sheet. If "bloom observed" then "Yes"	
38	(Text)/50	No data	
39	(Text)/50	No data	
40	(0="No", 1="Yes",7="Unknown", Null/Blank="No Response")/1	No data	
41	(Text)/50	No data	
42	(Text)/50	No data	
43	(Text)/50	This would be "Raw/Ambient water"	
44	(Text)/50	Wonder if we can get this level of detail from DEP? I seem to remember the Caspio data having info on sample reason that was pulled from a DEP data source. Or we can use "Monitoring" for all.	
45	(Text)/50	Would we select "Algae" and "Algal toxins"? Or just "Algal toxins"?	Algal ID, Toxin analyses; types of toxins tested??
46	(###############)/15		
47	(Text)/50	Options include "Cyanobacteria" and "Toxin". Would we split them all out (Microcystin; Anatoxin-a; Cylindrospermopsin; Saxitoxin/Paralytic Shellfish Toxins) and list the results for all in individual columns? Seems like the best way to show all the toxins and associated results. Need clarification on whether "Toxin" is the best option for Anatoxin-a; Cylindrospermopsin; and Saxitoxin/Paralytic Shellfish Toxins. Or are some of those Cyanobacteria?	Clarification from CDC needed.

AMERICAN OVERSIGHT

	J	K
31	Value = "Health Department"	
32	We can pull this from our Excel tracking sheet if CDC approves our suggestion.	Check with CDC if it is OK for us to use "Bloom observed and toxin detected" and other similar variations and if there is any standardization to this field they would like. Here are the values we could use: "Bloom Present, No Toxin Data" "Toxins Found, No Bloom Present" "Both Bloom and Toxins Found" "Toxins Found but Subsequent Sampling Data Show No Toxins" [this last option leads to one of the overall questions about modifying existing records and if that is something CDC wants]
33	We can pull this from our Excel tracking sheet. We would use the date we notified the CHD.	
34	We should decide how to report this, when we notify CHD of an AlertLift or when CHD removes the signage?	CDC have any preference on how to report this? When we notify CHD of an AlertLift or when CHD removes the signage?
35	We can pull this from our Excel tracking sheet	
36	We can pull this from our Excel tracking sheet	
37	We can pull this from our Excel tracking sheet. If "bloom observed" then "Yes"	
38	No data	
39	No data	
40	No data	
41	No data	
42	No data	
43	This would be "Raw/Ambient water"	
44	Wonder if we can get this level of detail from DEP? I seem to remember the Caspio data having info on sample reason that was pulled from a DEP data source. Or we can use "Monitoring" for all.	
45		Any preference from CDC on what we put here? Would we select "Algae" and "Algal toxins"? Or just "Algal toxins"?
46		
47		Options include "Cyanobacteria" and "Toxin". Would we split them all out (Microcystin; Anatoxin-a; Cylindrospermopsin; Saxitoxin/Paralytic Shellfish Toxins) and list the results for all in individual columns? Seems like the best way to show all the toxins and associated results. Need clarification on whether "Toxin" is the best option for Anatoxin-a; Cylindrospermopsin; and Saxitoxin/Paralytic Shellfish Toxins. Or are some of those Cyanobacteria?

AMERICAN OVERSIGHT

	A	B	C
48	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
49	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
50	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
51	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
52	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
53	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
54	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
55	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
56	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
57	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
58		EnviroDetectedIn	Laboratory Testing, Laboratory Results
59		EnviroDetectedIn	Laboratory Testing, Laboratory Results
60		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
61		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
62		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
63		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
64		EnviroRemarks	General, Dates
65		EnviroRemarks	General & Water Body Characteristics
66	For additional consideration	EnviroRemarks	Laboratory Testing, Laboratory Results
67		EnviroRemarks	Supplemental Info, Remarks
68			
69			

AMERICAN OVERSIGHT

	D	E	F
48	EnGenusorToxin	Indicates the genus name of the pathogen or toxin.	Text
49	EnSpecies	Indicates the species name of the pathogen.	Text
50	EnSubspecies	Indicates the subspecies name of the pathogen.	Text
51	EnSampleDescrip	Description of the environmental sample that tested positive.	Text
52	EnSampleConc	Indicates the concentration of the pathogen/toxin detected.	Number (up to 3 decimal places)
53	EnSampleConcUnit	Indicates the sample concentration unit of the pathogen/toxin.	Text
54	EnTestType	Indicates the test type performed to detect the pathogen/toxin.	Text
55	EnCollectionDate	The date of sample collection.	Date
56	EnCollectionTime	The time of sample collection.	Time
57	EnCollectionAMPM	Indicates AM or PM for sample collection time.	Text
58	EnLabResultID	Automatically assigned numeric value for identifying lab results.	Numeric
59	EnDetectedIn	Type of sample in which the algae or algal toxin was detected (e.g., food, air, water).	Text
60	EnSystemType	If other systems contain information about this report, this field indicates the system type. (e.g. federal, state)	Text
61	EnSystemName	Indicates the system name.	Text
62	EnSystemReportID	Indicates the system report ID number.	Text
63	EnSystemDescrip	Descripton of linked information.	Text
64	EnDateRemarks	Additional information regarding dates.	Text
65	EnGeoDescripRemarks	Additional information regarding geographic description.	Text
66	EnLabTestRemarks	Additional remarks regarding laboratory testing.	Text
67	EnGeneralRemarks	Additional remarks regarding the environmental event.	Text
68			
69			

AMERICAN OVERSIGHT

	G	H	I
48	(Text)/50	We can automate this once we determine how we will do the EnClassification.	
49	(Text)/50	We can automate this once we determine how we will do the EnClassification.	
50	(Text)/50	No data	
51	(Text)/100	Check with CDC that "Surface water sample" would suffice, or should we concatenate the EnWaterType result into this field. Not sure what level of detail is good here.	Clarification from CDC needed.
52	(############.###)/16	Can pull this from the Excel tracking sheet	
53	(Text)/50	Can pull this from the Excel tracking sheet	
54	(Text)/100	Need clarification from DEP on what test types they do for these results. ELISA?	Clarification from DEP needed; might be an issue if private or university based lab result is utilized; there may be differences in testing methodologies.
55	(MM/DD/YYYY)/10	Can pull this from the Excel tracking sheet	
56	(HH:MM)/5	Can pull this from the Excel tracking sheet. See comment below on AM/PM.	
57	(AM or PM)/2	Time is reported in military time format. Is that OK or do we need to modify the format?	
58	(################)/15		
59	(Text)/50	Water for the majority	
60	(Text)/50	Only would use this if it was put into NORS, we would likely leave this null.	
61	(Text)/50	Only would use this if it was put into NORS, we would likely leave this null.	
62	(Text)/50	Only would use this if it was put into NORS, we would likely leave this null.	
63	(Text)/50	Only would use this if it was put into NORS, we would likely leave this null.	
64	(Text)/5000		
65	(Text)/5000		
66	(Text)/5000		
67	(Text)/5000		
68	GENERAL QUESTIONS	We would submit only sites that had observed blooms or toxins detected, correct?	Need clarification from CDC.
69			

AMERICAN OVERSIGHT

	J	K
48	We can automate this once we determine how we will do the EnClassification.	
49	We can automate this once we determine how we will do the EnClassification.	
50	No data	
51		Check with CDC that "Surface water sample" would suffice, or should we concatenate the EnWaterType result into this field. Not sure what level of detail is good here.
52	Can pull this from the Excel tracking sheet	
53	Can pull this from the Excel tracking sheet	
54	Need clarification from DEP on what test types they do for these results. ELISA? Might be an issue if private or university based lab result is utilized; there may be differences in testing methodologies.	
55	Can pull this from the Excel tracking sheet	
56	Can pull this from the Excel tracking sheet	
57		Data that comes to us has time reported in military time format. Is that OK or do we need to modify the format?
58		
59	Water for the majority	
60	Only would use this if it was put into NORS, we would likely leave this null.	
61	Only would use this if it was put into NORS, we would likely leave this null.	
62	Only would use this if it was put into NORS, we would likely leave this null.	
63	Only would use this if it was put into NORS, we would likely leave this null.	
64		
65		
66		
67		
68		We would submit only sites that had observed blooms or toxins detected, correct?
69		Do we have the ability to update a record once submitted? If we want to capture whether a site with toxins found has subsequently been found not to have toxins?

AMERICAN OVERSIGHT

	A	B	C
1	**Required/Preferred**	**Tab/Table Name**	**OHHABS Interface:** *Section, Tab*
2		EnviroMain	n/a
3		EnviroMain	n/a
4	Required to upload	EnviroMain	n/a
5		EnviroMain	n/a
6		EnviroMain	Author and Agency
7	EnBloomDate OR EnNotificationDate OR EnNoBloomDate is required to upload and finalize	EnviroMain	General, Dates
8		EnviroMain	General, Dates
9		EnviroMain	General, Dates
10	Required to finalize	EnviroMain	General, Event Summary
11	Required to upload and finalize	EnviroMain	General, Geographic Description
12	Preferred/Requested	EnviroMain	General, Geographic Description

AMERICAN OVERSIGHT

	D	E	F	G
1	Variable Name	Variable Description	Data Format	Data Format Details: *(detailed description)/character maximum*
2	CDCReportID	The CDCReportID is automatically assigned by the system and links forms across all tables in the relational database to a single OHHABS report. Multiple instances of the same CDCReportID within a table refer to multiple entries for one record (e.g., may include symptom data reported for multiple human cases).	Number	(###############)/15
3	CDCFormID	The CDCFormID is automatically assigned by the system and links information from a single form across all tables in the relational database. Multiple instances of the same CDCFormID within a table refer to multiple entries for one record (e.g., one form with two laboratory results).	Number	(###############)/15
4	StateReportID	The StateReportID is assigned by the reporting site (e.g., state). The StateReportID must be unique within each reporting site. However, the StateReportID is not unique across all reporting sites (i.e., OHHABS reports with the same StateReportID may exist in all reporting sites, but OHHABS reports in the same reporting site cannot have the same StateReportID).	Text	(Text)/50
5	EnDateCreated	The date that the environmental form was created.	Date	(MM/DD/YYYY)/10
6	EnFormAuthor	The author of the environmental form.	Text	(Text)/80
7	EnBloomDate	The date that an algal bloom was observed.	Date	(MM/DD/YYYY)/10
8	EnNotificationDate	The date that a local, territorial, tribal, or state health department was notified of the algal bloom.	Date	(MM/DD/YYYY)/10
9	EnNoBloomDate	If no bloom was observed, this field indicates why a bloom date was not observed.	Text	(Text)/50
10	EnEventClassification	Suspect or confirmed.		
11	EnState	The state or jurisdiction a bloom or event occurred.	Text	(Text)/50
12	EnWaterQualOtherState	Indicates if a bloom or event affected the water quality of other states.	Number	(0="No", 1="Yes",7="Unknown", 9="Not applicable", Null/blank ="No Response")/1

AMERICAN OVERSIGHT

	H	I	J
1	Internal	CDC	Comments from January 7, 2020 Call
2			
3			
4	Do we know what we have used in the past? We can have multiple samples from one water body (like Lake Okeechobee). Also blooms move around so it might be the same bloom at different distinct locations.	Is this alpha-numeric? Does the module to upload into the OHHABS auto populate this, or is this just for our internal tracking purposes? If so, should we create a standardized format? [YY]-[DEP OBJECT ID]. Also, what is considered a "report" or a "reporting site"?	Can use what state prefers; don't need state ID; If bloom moves around, would say it's the same event; uncertain how to document with blooms that move around in large lakes; Event based; If sampled multiple times, would be single state ID and event with multiple samples. If get observation of bloom but not confirmed, don't need to enter. Lab confirmation is best.
5			
6		FirstName LastName? Any specific format preferences (Initials, all caps) May need separate entry fields for first and last name.	Its based on the permission structure; auto populated.
7	We can pull this from our Excel tracking sheet.	Need to find out whether CDC wants only bloom observation date here. What if a bloom was not seen, a sample was taken, and toxins were detected? Since this is a required field, FDOH recommends to include the site visit date regardless of whether a bloom was seen. Not sure if the "EnNoBloomDate" field influences what we put here. See the notes for that data field.	Visual and lab confirmation preferred; If toxins detected, would be entered as sampling date
8	We can pull this from our Excel tracking sheet.	Clarify with CDC that the date we will use here is when state level notifies the DOH county entity that a caution or alert sign needs to be placed.	When agency gets notified that might be a bloom; could be citizen, could be from agency staff.
9	Why a bloom was not observed? Not sure about what to say as we don't evaluate that.	Check with CDC about intent of this field. Would this be where we would put events where a bloom was not observed but toxins were detected? Suggested choices include "Other evidence of harmful algal/algae toxicity" which would fit the scenario mentioned above. Need to know CDC's preference. Also, the form says "algal" but the pull-down list populates the word as "algae".	Might be used for non-cyano blooms; such as ciguatera;not date field but drop down; other evidence available adds flexibilty for response.
10		Need to check with CDC for possible criteria for suspect or confirmed blooms. One potential might be to differentiate between those where only a bloom was seen visually (suspect) and sites where toxins were detected (confirmed).	To confirm bloom: can have lab confirmation such as toxins, microscopic evaluation; suspect could also be from reported health impacts; state report id will link animal, human illnesses to environmental report.
11	Value = "Florida"		
12	Most will be null		

AMERICAN OVERSIGHT

	K	L
1	CDC Follow-up Questions	Remaining DOH Action Items
2		
3		
4	None	Determine format. Suggestion: FL-[YY]-[WBID] Use WBID to classify "event" so we can look at the area throughout the bloom from environmental, human, and animal cases. What do we do with December samples that span two years? Suggest to go with initial year of sample.
5		
6	None	
7	None	Use the sample/field visit date here
8	None	Need to verify with DEP if the Field "REQUEST ID" in the spreadsheet from Dave Whiting includes the request date. Example: RQ-2018-10-01-81, we could extract the date 10/1/2018.
9	None	We would generally leave this blank unless the other two date fields above are unknown.
10	None	Conditions for both choices: **Confirm**: lab confirmation of toxins, toxins detected in microscopic evaluation, visual bloom noted **Suspect**: reported health impacts, satellite data
11		
12		

AMERICAN OVERSIGHT

	A	B	C
13	Preferred/Requested	EnviroMain	General, Geographic Description
14	Preferred/Requested	EnviroMain	General, Geographic Description
15	Preferred/Requested	EnviroMain	General, Geographic Description
16	Preferred/Requested	EnviroMain	General, Geographic Description
17		EnviroMain	General, Geographic Description
18		EnviroMain	General, Geographic Description
19		EnviroMain	General, Geographic Description
20		EnviroMain	General, Geographic Description
21		EnviroMain	General, Geographic Description
22	Preferred/Requested	EnviroMain	General, Water Body Characteristics
23	Preferred/Requested	EnviroMain	General, Water Body Characteristics
24		EnviroCounty	General & Geographic Description
25		EnviroCounty	General & Geographic Description
26		EnviroOtherState	General & Geographic Description
27		EnviroHUC	General & Geographic Description
28	Preferred/Requested	EnviroWaterUse	

AMERICAN OVERSIGHT

	D	E	F	G
13	EnOfficialWaterName	The official name of the water body (e.g. Lake Erie).	Text	(Text)/50
14	EnCommonWaterName	The common name of the water body.	Text	(Text)/50
15	EnLocationName	The specific location name (e.g. Ruggles Beach).	Text	(Text)/50
16	EnNearestCity	The city or town nearest to the water body.	Text	(Text)/50
17	EnCoordinateFormat	The format of the location coordinates in latitude and longitude (i.e., "DMS" for Degrees Minutes Seconds, "DD" for Decimal Degrees).	Text	(DMS or DD)/ 10
18	EnLatitudeDMS	The latitude of the event collected in Degrees Minutes Seconds format	Text	(Text)/50
19	EnLongitudeDMS	The longitude of the event collected in Degrees Minutes Seconds format.	Text	(Text)/50
20	EnLatitudeDD	The latitude of the bloom or event. Can be in Degrees Minutes Seconds or Decimal Degrees format.	Number	(+/-##.######)/10
21	EnLongitudeDD	The longitude of the bloom or event. Can be in Degrees Minutes Seconds or Decimal Degrees format.	Number	(+/- ###.######)/11
22	EnWaterType	Indicates the water body type the event occurred in.	Text	(Text)/50
23	EnWaterSalinity	Indicates the salinity of the water body the event occurred in.	Text	(Text)/50
24	EnCounty	The county or counties where a bloom or event occurred.	Text	(Text)/100
25	EnAssociatedState	The corresponding state of the county.	Text	(Text)/50
26	EnOtherState	Other states affected by a HAB or HAB event.	Text	(Text)/100
27	EnHUC	Indicates the hydrologic unit code (HUC).	Text	(Text)/50
28	EnWaterUse	Indicates what the water body or if applicable the portion of the water body is used (e.g., agriculture, industrial/occupational).		(Text)/50

AMERICAN OVERSIGHT

	H	I	J
13	I agree that WBID (Water body ID number) would be good; there are multiple lakes with same name in Florida.	Is there a list of these? What about small lakes? Could we use the WBID number and associated name as assigned by DEP?	Can use state ID and water body names.
14		Similar to question above.	
15		Similar to question above.	
16	This would need some automation using GIS or some other method. That is not a field we currently capture.	This might be a problem with larger lakes such as Lake O. Could one approach be to geographically identify the nearest city/town as the crow flies?	Can use GIS but with big lakes; but might not need to do; not required field; would use if can be automated.
17	Value = DD		
18	NA		
19	NA		
20	We can pull this from our Excel tracking sheet		
21	We can pull this from our Excel tracking sheet		
22	Options like: Canal, Lake/Reservoir/Impoundment, Ocean, Pond, River/Stream, Spring, Other, Unknown. We could look into whether this could be automated when linking to the WBID information. That is a data field stored in the WBID dataset.	Is CDC OK with us using the WBID dataset to gather this information? That is a data field stored in the WBID dataset.	
23	Options are: Fresh, Brackish, Salt. We can make educated guesses, but am wondering if this is a dataset that DEP may have that might tie to WBID. Will need to check with FDEP about salinity measurements. They are not on the map data from their website.		
24	We can pull this from our Excel tracking sheet		
25	Value = Florida		
26			
27		Verify with CDC that our correct choice is "Region 03 - South Atlantic -Gulf". If we link by WBID, we could get more detailed HUC numbers (03080102 for example).	Yes. Used for looking at national landscape; large scale view.
28	Options that seem relevent are: Public drinking water system, Recreation, None, Unknown, Other-describe in remarks. Not sure how we will automate this criteria. Can this be made to be a drop down? This might take a lot of work. Could it be done via GIS land use maps?	How critical is this field for CDC reporting? We will look into how we could get that information, but it may be difficult.	Longer term goal

AMERICAN OVERSIGHT

	K	L
13	None	Use field from WBID dataset: [PLANNING_UNIT]
14	None	Use hybrid of two fields from WBID dataset: [WATERBODY_NAME]-[WBID]
15	None	Use field from DEP Cyano Sampling dataset: Sample Location
16	None	Use field from WBID dataset: [GROUP_NAME]
17		
18		
19		
20		
21		
22	None	Use field from WBID dataset: [WATER_TYPE]
23		Use field from WBID dataset: [CLASS] and crosswalk the appropriate choices on OHHABS sheet with the following definitions: Class 1 - Potable Water; Class 2 - Shellfish Propagation or Harvesting; Class 3F/3M - Freshwater/Predominantly Marine for Fish Consumption, Recreation, Propagation and Maintenance of a Healthy, Well-Balanced Population of Fish and Wildlife
24		
25		
26		
27	None	Use "Region 03 - South Atlantic -Gulf"
28	None	Project to find data source that classifies this and crosswalk data fields into the OHHABS choices

AMERICAN OVERSIGHT

	A	B	C
29	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
30	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
31	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
32	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
33	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
34	For additional consideration	EnviroHealthAdvisory	Bloom Description, Health Advisories/Warnings
35	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
36	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
37	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
38	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
39	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
40	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
41	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
42	Preferred/Requested	EnviroObservationalData	Bloom Description, Observational Data
43	Preferred/Requested	EnviroLabTesting	Laboratory Testing, Algae, Algal Toxins, or Components Testing
44	Preferred/Requested	EnviroTestReason	Laboratory Testing, Algae, Algal Toxins, or Components Testing
45	Preferred/Requested	EnviroWaterTesting	Laboratory Testing, Algae, Algal Toxins, or Components Testing
46	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results

AMERICAN OVERSIGHT

	D	E	F	G
29	EnAdvisoryType	If an advisory or warning was issured, this field indicates the type of advisory or warning.	Text	(Text)/50
30	EnAdvisoryResponse	Indicates whether an advisory type was issued.	Number	(0="No", 1="Yes",7="Unknown", Null/Blank="No Response")/1
31	EnAdvisoryAgency	Indicates the agency that issured the advisory or warning.	Text	(Text)/50
32	EnAdvisoryReason	Indicates the criteria or reason the advsory or warning was issued.	Text	(Text)/50
33	EnAdvisoryStartDate	Indicates the date the advisory or warning began.	Date	(MM/DD/YYYY)/10
34	EnAdvisoryEndDate	Indicates the date the advisory or warning ended.	Date	(MM/DD/YYYY)/10
35	EnDateDocumented	If an event was observed, this field indicates the date an observation was documented.	Date	(MM/DD/YYYY)/10
36	EnDocumentedBy	Indicates who made and documented the observation.	Text	(Text)/50
37	EnScumObserved	Indicates whether any scum or algal matter was observed.	Number	(0="No", 1="Yes",7="Unknown", Null/Blank="No Response")/1
38	EnWaterColor	Indicates the color of the water.	Text	(Text)/50
39	EnWaterClarity	Indicates the clarity of the water.	Text	(Text)/50
40	EnWaterOdor	Indicates if the water had an odor.	Number	(0="No", 1="Yes",7="Unknown", Null/Blank="No Response")/1
41	EnWaterFlow	Indicates if there was any water flow.	Text	(Text)/50
42	EnTidalCondition	Indicates the type of tidal conditions in the water.	Text	(Text)/50
43	EnSampleTested	Indicates the type(s) of environmental sample tested (e.g., air, algae, finished drinking water).	Text	(Text)/50
44	EnSampleTestReason	Indicates the reason for testing samples (e.g., fish kill, citizen complaint)	Text	(Text)/50
45	EnSampleWaterTesting	If water sample testing was performed, this field indicates the type of testing performed (e.g., algae, algal toxins, chlorophyll)	Text	(Text)/50
46	EnLabResultID	Automatically assigned numeric value for identifying lab results.	Numeric	(###############)/15

AMERICAN OVERSIGHT

	H	I	J
29	Choices are: Health advisory, No contact warning, water body closure (recreational activity), Water body closure (fish/shellfish), other. Since we do not issue "advisories" would we choose "No contact warning" or "other"?	Discuss with CDC that the FDOH process does not match drop down choices. FDOH does not issue "advisories" but "caution" and "alert". Can we change the options for this pull-down list to make them specific for Florida?	What is the rationale for putting up the caution? Alert? Based on what is known; alert is for toxin presence; CDC will discuss internally; might compare with past interpretations.
30		This ties to the question from the previous field. What is CDC's preference?	
31	Value = "Health Department"		
32	We can pull this from our Excel tracking sheet if CDC approves our suggestion.	Check with CDC if it is OK for FDOH to use "Bloom observed and toxin detected" and other similar variations and if there is any standardization to this field they would like. Here are the values we could use: "Bloom Present, No Toxin Data" "Toxins Found, No Bloom Present" "Both Bloom and Toxins Found" "Toxins Found but Subsequent Sampling Data Show No Toxins" [this last option leads to one of the overall questions about modifying existing records and if that is something CDC wants]	
33	We can pull this from our Excel tracking sheet. We would use the date we notified the CHD.		
34	We should decide how to report this, when we notify CHD of an AlertLift or when CHD removes the signage?	Does CDC have any preference on how to report this; when FDOH notifies (FDOH County Health Department (CHD)) of an AlertLift or when a CHD removes the signage?	
35	We can pull this from our Excel tracking sheet		
36	We can pull this from our Excel tracking sheet		
37	We can pull this from our Excel tracking sheet. If "bloom observed" then "Yes"		
38	No data		
39	No data		
40	No data		
41	No data		
42	No data		
43	This would be "Raw/Ambient water"		
44	Wonder if we can get this level of detail from DEP? I seem to remember the Caspio data having info on sample reason that was pulled from a DEP data source. Or we can use "Monitoring" for all.		
45		Any preference on what FDOH puts here? Would we select "Algae" and "Algal toxins"? Or just "Algal toxins"?	
46			

AMERICAN OVERSIGHT

	K	L
29	Discuss further with CDC	
30	Discuss further with CDC	
31		
32	Resume review starting here at a follow-up meeting	
33		
34		
35		
36		
37		
38		
39		
40		
41		
42		
43		
44		
45		
46		

AMERICAN OVERSIGHT

	A	B	C
47	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
48	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
49	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
50	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
51	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
52	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
53	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
54	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
55	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
56	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
57	For additional consideration	EnviroLabResult	Laboratory Testing, Laboratory Results
58		EnviroDetectedIn	Laboratory Testing, Laboratory Results
59		EnviroDetectedIn	Laboratory Testing, Laboratory Results
60		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
61		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
62		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
63		EnviroOtherSystems	Other Systems, Links to Other Data Systems Containing Information About This Bloom
64		EnviroRemarks	General, Dates
65		EnviroRemarks	General & Water Body Characteristics
66	For additional consideration	EnviroRemarks	Laboratory Testing, Laboratory Results
67		EnviroRemarks	Supplemental Info, Remarks
68			

AMERICAN OVERSIGHT

	D	E	F	G
47	EnClassification	Indicates the broad category or classification of the pathogen/toxin.	Text	(Text)/50
48	EnGenusorToxin	Indicates the genus name of the pathogen or toxin.	Text	(Text)/50
49	EnSpecies	Indicates the species name of the pathogen.	Text	(Text)/50
50	EnSubspecies	Indicates the subspecies name of the pathogen.	Text	(Text)/50
51	EnSampleDescrip	Description of the environmental sample that tested positive.	Text	(Text)/100
52	EnSampleConc	Indicates the concentration of the pathogen/toxin detected.	Number (up to 3 decimal places)	(############.###)/16
53	EnSampleConcUnit	Indicates the sample concentration unit of the pathogen/toxin.	Text	(Text)/50
54	EnTestType	Indicates the test type performed to detect the pathogen/toxin.	Text	(Text)/100
55	EnCollectionDate	The date of sample collection.	Date	(MM/DD/YYYY)/10
56	EnCollectionTime	The time of sample collection.	Time	(HH:MM)/5
57	EnCollectionAMPM	Indicates AM or PM for sample collection time.	Text	(AM or PM)/2
58	EnLabResultID	Automatically assigned numeric value for identifying lab results.	Numeric	(###############)/15
59	EnDetectedIn	Type of sample in which the algae or algal toxin was detected (e.g., food, air, water).	Text	(Text)/50
60	EnSystemType	If other systems contain information about this report, this field indicates the system type. (e.g. federal, state)	Text	(Text)/50
61	EnSystemName	Indicates the system name.	Text	(Text)/50
62	EnSystemReportID	Indicates the system report ID number.	Text	(Text)/50
63	EnSystemDescrip	Descripton of linked information.	Text	(Text)/50
64	EnDateRemarks	Additional information regarding dates.	Text	(Text)/5000
65	EnGeoDescripRemarks	Additional information regarding geographic description.	Text	(Text)/5000
66	EnLabTestRemarks	Additional remarks regarding laboratory testing.	Text	(Text)/5000
67	EnGeneralRemarks	Additional remarks regarding the environmental event.	Text	(Text)/5000
68				GENERAL QUESTIONS

AMERICAN OVERSIGHT

	H	I	J
47		Options include "Cyanobacteria" and "Toxin". Would FDOH split them all out (Microcystin; Anatoxin-a; Cylindrospermopsin; Saxitoxin/Paralytic Shellfish Toxins) and list the results for all in individual columns? Seems like the best way to show all the toxins and associated results. Need clarification on whether "Toxin" is the best option for Anatoxin-a; Cylindrospermopsin; and Saxitoxin/Paralytic Shellfish Toxins. Or are some of those Cyanobacteria?	
48	We can automate this once we determine how we will do the EnClassification.		
49	We can automate this once we determine how we will do the EnClassification.		
50	No data		
51		Would "Surface water sample" suffice, or should we concatenate the EnWaterType result into this field. Not sure what level of detail is good here.	
52	Can pull this from the Excel tracking sheet		
53	Can pull this from the Excel tracking sheet		
54	Need clarification from DEP on what test types they do for these results. ELISA? Might be an issue if private or university based lab result is utilized; there may be differences in testing methodologies.		
55	Can pull this from the Excel tracking sheet		
56	Can pull this from the Excel tracking sheet		
57		Data that comes to FDOH has time reported in military time format. Is that OK or do we need to modify the format?	
58			
59	Water for the majority		
60	Only would use this if it was put into NORS, we would likely leave this null.		
61	Only would use this if it was put into NORS, we would likely leave this null.		
62	Only would use this if it was put into NORS, we would likely leave this null.		
63	Only would use this if it was put into NORS, we would likely leave this null.		
64			
65			
66			
67			
68		FDOH would submit only sites that had observed blooms or toxins detected, correct?	

AMERICAN OVERSIGHT

	H	I	J
69		Does FDOH have the ability to update a record once submitted? How would OHHABS capture when a site with toxins was found not to have toxins, from additional sampling ?	

AMERICAN OVERSIGHT

From:	Yoon, Paula (CDC/DDPHSS/CSELS/DHIS)
To:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Rivkees, Scott A
Cc:	Blackmore, Carina (CDC flhealth.gov)
Subject:	RE: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Tuesday, March 10, 2020 11:07:33 AM

Our team has already reached out to colleagues in FL with instructions for turning on data access but if you have questions, I would be happy to take them.

Paula

Paula W. Yoon, ScD, MPH
Director
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS E-97, Atlanta, GA 30333
404-498-6298 Office | pyoon@cdc.gov
Assistant: Bessie Holland | 404-498-6346 | vbb3@cdc.gov

From: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Sent: Tuesday, March 10, 2020 11:06 AM
To: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS) <pay3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: RE: Outreach: COVID-19 Collaborative Syndromic Surveillance

Hi Scott

Dr Paula Yoon will follow up directly with Dr Balckmore.

Thanks

JT

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Monday, March 9, 2020 7:59 PM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

AMERICAN OVERSIGHT

Thank you,
Scott

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Yoon, Paula (CDC/DDPHSS/CSELS/DHIS); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Rivkees, Scott A
Subject:	Re: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Tuesday, March 10, 2020 11:10:57 AM

we appreciate the partnership.

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From: Yoon, Paula (CDC/DDPHSS/CSELS/DHIS) <pay3@cdc.gov>
Sent: Tuesday, March 10, 2020 11:07:31 AM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>; Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: RE: Outreach: COVID-19 Collaborative Syndromic Surveillance

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Paula

Paula W. Yoon, ScD, MPH
Director
Division of Health Informatics and Surveillance
Center for Surveillance, Epidemiology, and Laboratory Services
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1600 Clifton Road, NE, MS E-97, Atlanta, GA 30333
404-498-6298 Office | pyoon@cdc.gov
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Sent: Tuesday, March 10, 2020 11:06 AM
To: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS) <pay3@cdc.gov>
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JT

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>

AMERICAN OVERSIGHT

Sent: Monday, March 9, 2020 7:59 PM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance

Dear Jose

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Thank you,
Scott

AMERICAN OVERSIGHT

From: Rivkees, Scott A
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD)
Cc: Blackmore, Carina
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date: Monday, March 9, 2020 7:58:40 PM

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

Thank you,
Scott

From: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Sent: Monday, March 9, 2020 3:34:41 PM
To: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Subject: FW: Outreach: COVID-19 Collaborative Syndromic Surveillance

Scott

I know you are buried under a lot of COVID 19 related work, but I wanted to bring back to your attention our request for your participation on syndromic surveillance.
We raised this topic at SHP call a few weeks back and I highlighted again when I had the chance to address the SHO in DC.
I know ASTHO sent you a couple of weeks an email with a specific request on this topic. Hopefully you will be able to join the other 30 that already agreed

I would be happy to connect you to NSSP team doing the work if you need more detail

Here are a few bullets describing the work to date:

1. **Community Outreach**: Twenty-nine jurisdictions are currently sharing syndromic data with CDC for COVID-19 surveillance. NSSP staff are actively engaged with staff from other states who are interested but have questions, concerns, or need a new DUA.

2. **Developing queries** to identify potentially relevant visits from the emergency department data: NSSP staff are developing two COVID-19 queries, one focused on chief complaint narratives and one focused on discharge diagnosis codes. Queries are shared with the community of practice via Slack and discussed on calls among community partners. The discharge-diagnosis based query has been developed and incorporated into ESSENCE. The chief-complaint query is being refined using site specific data shared with NSSP and the team is exploring the utility of including triage notes as part of this effort.

3. **Methods for tracking trends** of persons exhibiting symptoms consistent with COVID-19:

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Development effort is focused on reducing the effect of influenza and other non-coronavirus etiologies. The influenza query using discharge diagnosis has been developed to help negate confirmed influenza in the COVID-19 query using site-specific data that has been shared with NSSP.

4. **Developing approaches for querying emergency department data** to analyze records for persons under isolation and with infectious disease. A query was shared with the Community of Practice via Slack and was revised. The community is using the query. Some noted a large increase in patients under isolation, and others noted a small increase. The community said this is helpful for identifying severe illness.

5. **Developing reports and dashboards** that can be shared in ESSENCE to aid state and local users in tracking trends and active case finding. The dashboard will update in real-time with the level of data accessible to each user. Development is dependent on completion of queries/syndromes identified above. The addition of newly shared data will accelerate development of this ESSENCE dashboard by enabling NSSP staff to test functionality that will be accessible to state and local jurisdictions.

6. **Developing reports for the CDC EOC** on national and HHS-region-level syndromic summaries. Also working on state-level summaries for sites sharing data. The report will be shared with participating states for approval before sharing with the CDC EOC.

Thanks

JT
José T. Montero, MD, MHCDS
Director, Center for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention
Century Center, Atlanta GA
Tel: 404-498-0300
E-mail:znn3@cdc.gov
MS: E70

AMERICAN OVERSIGHT

From:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD)
To:	Rivkees, Scott A; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS)
Cc:	Blackmore, Carina (CDC flhealth.gov)
Subject:	RE: Outreach: COVID-19 Collaborative Syndromic Surveillance
Date:	Tuesday, March 10, 2020 11:05:57 AM

Hi Scott

Dr Paula Yoon will follow up directly with Dr Balckmore.

Thanks

JT

From: Rivkees, Scott A <Scott.Rivkees@flhealth.gov>
Sent: Monday, March 9, 2020 7:59 PM
To: Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Outreach: COVID-19 Collaborative Syndromic Surveillance

Dear Jose

I am told that we are participating in this important activity.

Copied in this note is our state epidemiologist Dr. Blackmore who can discuss this with you.

Thank you,
Scott

AMERICAN OVERSIGHT

From:	Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
To:	Chapman, Jennifer Rose; Stanek, Danielle (CDC flhealth.gov); Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); Cohen, Jonathan
Cc:	Blackmore, Carina (CDC flhealth.gov); Jones, Patricia Denise; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); CGH DPDM DPDx Web Inquiries (CDC); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); White, Stephen L; Holland, Aubrey; Quaye, Elesi A; Rico, Edhelene; Noya-Chaveco, Pedro A; Mejia-Echeverry, Alvaro
Subject:	RE: Possible Leishmaniasis Patient: FL 29 yo F Miami
Date:	Monday, February 10, 2020 3:40:51 PM
Attachments:	image001.png image002.png
Sensitivity:	Confidential

Dr. Chapman,

We will need the entire FFPE block. The block will be returned to the submitter after the case is finalized but please note, the block may be depleted during testing. For evaluation of Leishmania, the infectious diseases pathology branch (IDPB) performs immunohistochemistry. The DNA is extracted here (at IDPB) and then sent to the Div. of Parasitic Diseases (DPD) for PCR analysis.

Thank you for your understanding.

Regards,
Eddy

Eduard Matkovic, M.D.
Associate fellow | National Center for Emerging and Zoonotic Infectious Diseases | Division of High-Consequence Pathogens and Pathology | Infectious Disease Pathology Branch | Centers for Disease Control and Prevention | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 | Tel: (404) 626-8119 | lua6@cdc.gov

From: Chapman, Jennifer Rose <JChapman@med.miami.edu>
Sent: Monday, February 10, 2020 3:24 PM
To: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
Subject: Re: Possible Leishmaniasis Patient: FL 29 yo F Miami
Sensitivity: Confidential

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Dear all,

We plan to cut tissue scrolls from a FFPE block of bone marrow aspirate that has not been decaled.

I will send the scrolls to the Florida Department of Public Health with the CDC requisition.

I assume that the Florida Dept of Health will then send them to the infectious disease pathology branch within the CDC.

Please confirm that this is appropriate.

Thank you.

Jennifer Chapman, MD
Associate Professor
Acting Director, Hematopathology Division
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowships
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

University of Miami Hospital
Department of Pathology
4th floor, room 4076
1400 NW 12th Ave.
Miami, Florida 33138
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From: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>
Sent: Monday, February 10, 2020 12:40 PM
To: 'Benoit, Tina (CDC/DDID/NCEZID/DHCPP)' <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>;

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Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>

Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami

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You've received an encrypted message from Danielle.Stanek@flhealth.gov
To view your message
Save and open the attachment (message.html), and follow the instructions.
Sign in using the following email address: JChapman@med.miami.edu

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Message encryption by Microsoft Office 365



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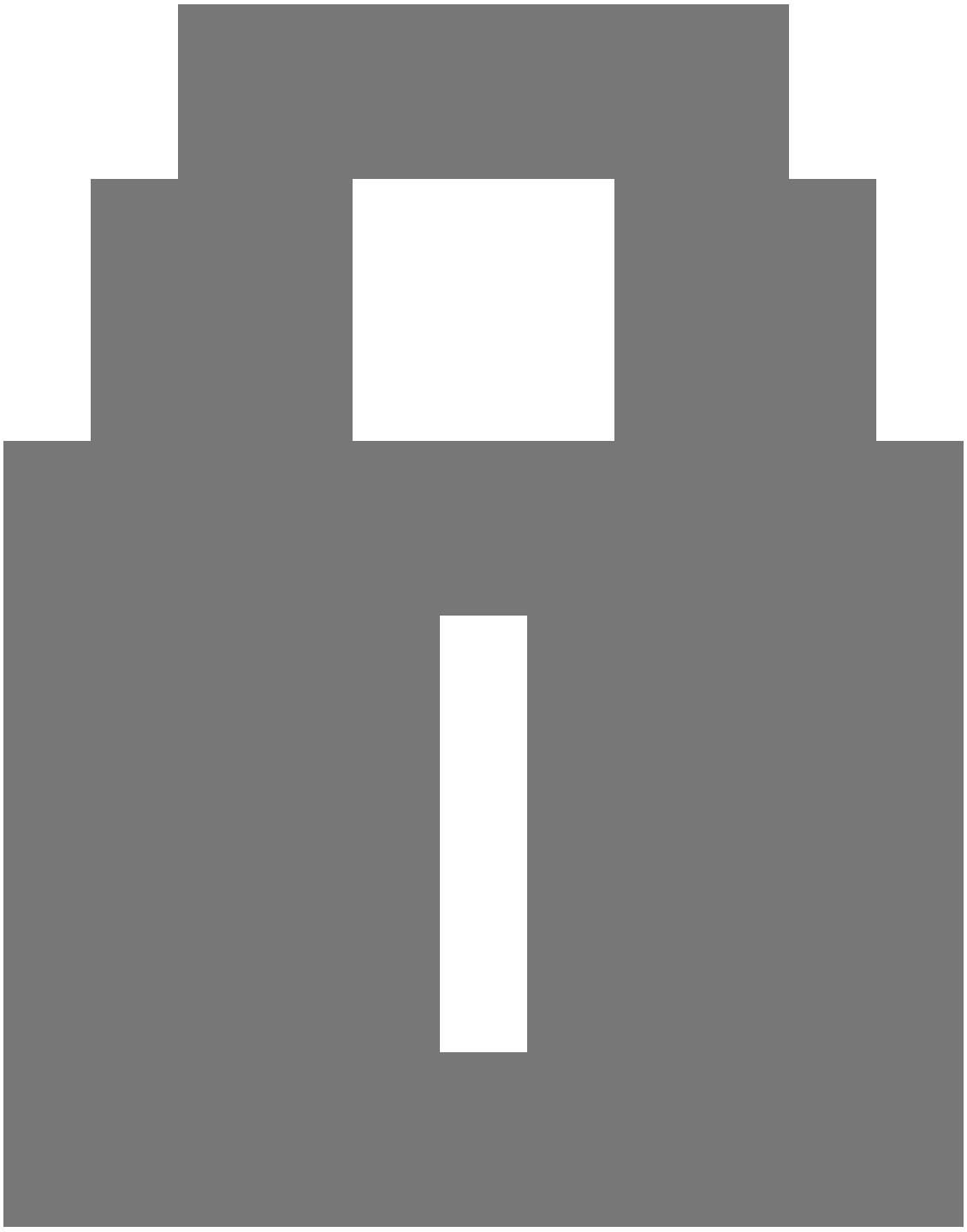

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From:	Chapman, Jennifer Rose
To:	Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP); Stanek, Danielle (CDC flhealth.gov); Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); Cohen, Jonathan
Cc:	Blackmore, Carina (CDC flhealth.gov); Jones, Patricia Denise; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); CGH DPDM DPDx Web Inquiries (CDC); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); White, Stephen L; Holland, Aubrey; Quaye, Elesi A; Rico, Edhelene; Noya-Chaveco, Pedro A; Mejia-Echeverry, Alvaro
Subject:	Re: Possible Leishmaniasis Patient: FL 29 yo F Miami
Date:	Monday, February 10, 2020 4:57:14 PM
Attachments:	image001.png image002.png
Sensitivity:	Confidential

Okay. We will send the FFPE clot section, which has not been decalcified.

Jennifer Chapman, MD
Associate Professor
Acting Director, Hematopathology Division
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowships
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

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From: Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
Sent: Monday, February 10, 2020 3:40 PM
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Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; White, Stephen L <Stephen.White@flhealth.gov>; Holland, Aubrey <Aubrey.Holland@flhealth.gov>; Quaye, Elesi A <Elesi.Quaye@flhealth.gov>; Rico, Edhelene <Edhelene.Rico@flhealth.gov>; Noya-Chaveco, Pedro A <Pedro.Noya-Chaveco@flhealth.gov>; Mejia-Echeverry, Alvaro <Alvaro.Mejia-Echeverry@flhealth.gov>
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Thank you for your understanding.

Regards,
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Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami

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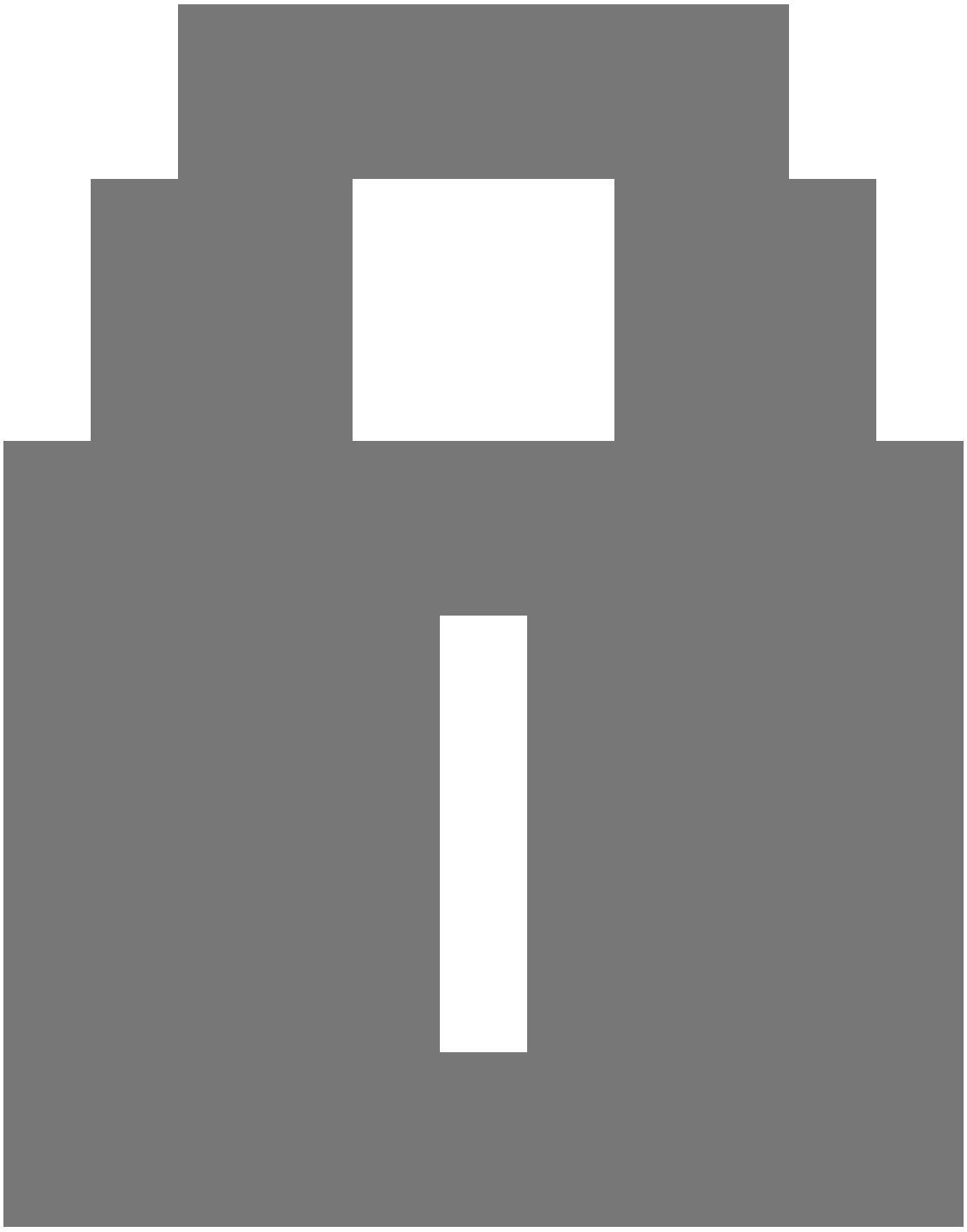

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From:	Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
To:	Pathology (CDC); Cohen, Jonathan
Cc:	Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Chapman, Jennifer Rose; Jones, Patricia Denise; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); CGH DPDM DPDx Web Inquiries (CDC); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP)
Subject:	RE: Possible Leishmaniasis Patient: FL 29 yo F Miami
Date:	Monday, February 10, 2020 11:58:32 AM
Attachments:	image001.png
Sensitivity:	Confidential

Good morning Dr. Cohen

The FL Department of Public Health prefers that specimens for leishmaniasis are routed through their state Public Health Laboratory for shipment to CDC. I'm connecting you with Drs. Danielle Stanek (Danielle.Stanek@flhealth.gov) and Carina Blackmore (carina.blackmore@flhealth.gov) from the FL Department of Health who will provide additional guidance on how to submit the specimen to their state public health lab.

This email serves as approval to submit fixed tissue to IDPB (***through your state health department***) for testing. Please enclose with your submission:

- A copy of the path report
- Recent ID consult note or other similar clinical note on the patient that might include information on presentation, course, testing performed, treatment provided and any medical history
- Information on travel history and/or country of birth
- History of insect bites

Regards,

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
Centers for Disease Control and Prevention
1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027
MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc.gov

From: Pathology (CDC) <Pathology@cdc.gov>
Sent: Monday, February 10, 2020 7:30 AM
To: Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>
Subject: RE: Possible Leishmaniasis Patient: FL 29 yo F Miami
Sensitivity: Confidential

Hi Dr. Cohen,

The pathologist on service this week (Dr. Eduard Matkovic) and epidemiologist (Tina Benoit) have been cc'd on your query and should be responding to you.

Note: this email and it's attachments are specific only to paraffin block(s) or wet formalin-fixed tissues intended for testing by our branch (IDPB) and do not apply to any unfixed tissues or other specimens being submitted to Dr. Yvonne Qvarnstrom's Leishmania lab.

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WARNING (per CDC's Mail Services): After September 30th, 2019, mail received with an incorrect or outdated mailstop will be returned to the sender with no exceptions. For our branch (IDPB), the new mailstop is "**MS: H18-SB**" as shown in section D of the attached guidelines.
If approved, please see the attached IDPB General Guidelines for Specimen Submission PDF and submit one hardcopy (per case) of the attached required electronically completed pre-populated CDC 50.34 form with the formalin-fixed wet tissues and/or formalin-fixed paraffin-embedded tissue blocks at ambient temperature. Paraffin-embedded tissue blocks are preferred if formalin-fixation of the wet tissues has exceeded 2 weeks; and, tissue scrolls or unstained slides are not accepted for PCR testing per IDPB's protocols. Select Test Order Code CDC-10365. Enter any test specifics in the Comments section on page 2.
Note, for human cases from the USA, the attached CDC 50.34 form has been pre-populated for your convenience with the correct Test Order Code and Public Health Lab contact information. Do not change or delete this information. Receipt of incorrect information in these sections can lead to a delay in testing.

Testing subject to CLIA regulations requires two primary patient identifiers (i.e., patient first and last name, date of birth, unique patient identifier from time of collection, such as medical record number) on the specimen container and on the test requisition

The course of testing will be determined by the clinical history, the histopathology observed, and the availability of specimens. Scant tissue is subject to depletion during the course of testing.
Please first inform/consult your City/State Health Department about this case, as specimens are normally required to be routed through them http://www.cdc.gov/laboratory/specimen-submission/who-may-submit-specimens.html. Dr. Danielle Stanek has been cc'd.
Thank you,
Pathology Team

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Sunday, February 9, 2020 9:04 AM
To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Pathology (CDC) <Pathology@cdc.gov>
Subject: Re: Possible Leishmaniasis Patient

Excellent
I will speak with our pathologists
Patient will see Dr Jones from the Hepatology service on Monday; consideration of liver biospy
Thanks
Jonathan Cohen

From: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Sent: Friday, February 7, 2020 5:09 PM
To: Cohen, Jonathan <j.cohen11@miami.edu>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>; Pathology (CDC) <Pathology@cdc.gov>
Subject: RE: Possible Leishmaniasis Patient

Ok, if we are going to proceed with fixed tissue, that will actually have to be submitted through our Infectious Diseases Pathology Branch, because they have the protocol for extracting DNA from tissue blocks. I've cc'ed our colleagues over there, they can provide guidance for their submission process, which differs from ours.

If you are able to get fresh tissue, that specimen can be sent to us. If so, let me know and I'll ship you some vials of our transport/culture medium prior to the procedure.

Sorry for the complexity, this is one of our most complicated diseases to test, particularly because it can arise in so many tissue types.

Best,
DPDx

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Friday, February 07, 2020 5:05 PM

AMERICAN OVERSIGHT

To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>
Subject: RE: Possible Leishmaniasis Patient

Will ask Dr Chapman to send fixed tissue
Dr. Jones will evaluate for possible liver biopsy, to send fresh tissue
Thanks
Jonathan Cohen

From: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Sent: Friday, February 7, 2020 5:02 PM
To: Cohen, Jonathan <j.cohen11@miami.edu>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>
Subject: RE: Possible Leishmaniasis Patient

Ok thanks! We can do PCR from fixed tissue, though that's not optimal because the time in formalin reduces our chance of success. If we can get fresh tissue, that lets us attempt culture, PCR and microscopy as described below.

- DPDx

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Friday, February 07, 2020 4:58 PM
To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Jones, Patricia Denise <pdjones@med.miami.edu>
Subject: RE: Possible Leishmaniasis Patient

I will talk with my pathologist on Monday, but the bone marrow specimen is fixed in blocks with stained slides
If a liver biopsy is done I assume tissue can also be sent
I will give you more information Monday or Tuesday
Thanks

From: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Sent: Friday, February 7, 2020 4:46 PM
To: Cohen, Jonathan <j.cohen11@miami.edu>; CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Cc: Leishmania (CDC) <leishmania@cdc.gov>
Subject: RE: Possible Leishmaniasis Patient

Hello Dr. Cohen,

If possible, please send an aliquot of the bone marrow (0.5mL or more would be ideal). We can prepare a stained smear for microscopic analysis, perform PCR for Leishmania detection and species identification, and attempt to culture the parasites if they are present. The bone marrow should be sent chilled but not frozen, for weekday delivery, to the address below. Please also complete and print the attached specimen submission form, and send it with the patient sample.

CDC STAT Lab
Attn Unit 52
1600 Clifton Rd NE
Atlanta GA 30329

Best regards,
The DPDx Team

From: Cohen, Jonathan <j.cohen11@miami.edu>

AMERICAN OVERSIGHT

Sent: Friday, February 07, 2020 4:38 PM
To: CGH DPDM DPDx Web Inquiries (CDC) <nciddpddpdx@cdc.gov>
Subject: Possible Leishmaniasis Patient

I am seeing a 29 yo female at the University of Miami with massive splenomegaly documented since 2017, hepatomegaly, cutaneous lesions, neutropenia and thrombocytopenia
Her leishmania antibody IgG was positive 1.79 (greater than 1.00 is considered positive at Quest)
Bone marrow biopsy appears normal, but will be reexamined Monday for parasites now that I have this serology.
The patient will also be seen by our hepatology service on Monday.
What other test should I do confirm or rule out this diagnosis?
Thanks
Jonathan Cohen

AMERICAN OVERSIGHT

Testing subject to CLIA regulations requires **two primary patient identifiers** (i.e., patient first and last name, date of birth, unique patient identifier from time of collection, such as medical record number) **on the specimen container and on the test requisition**

AMERICAN OVERSIGHT

From:	Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED)
To:	Pritchard, Scott; Oh, David (CDC/DDID/NCEZID/DFWED); Blackmore, Carina (CDC flhealth.gov)
Cc:	Stanek, Danielle (CDC flhealth.gov); Tomson, Kelly F; Rowlinson, Marie-Claire; Lockhart, Shawn (CDC/DDID/NCEZID/DFWED); Natarajan, Pavithra (CDC/DDID/NCEZID/DFWED)
Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Wednesday, February 12, 2020 4:54:24 PM

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I'd be happy to set up a conference call on C. gattii… would tomorrow, Friday, or the week of the 24th work for you? I'm sure you're busy with COVID work these days. Please let us know if any particular dates/times work well for you.

Danielle, to answer your question, our information on these cases is so anecdotal at this point, but Pete Pappas at UAB says he sees quite a bit of pulmonary disease from the southern part of the state. Hard to know at this point.

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AMERICAN OVERSIGHT

Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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brjackson1@cdc.gov | Phone: 404-639-0536

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Please do not hesitate to let me know if you have any questions.

Thank you.

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Mycotic Diseases Branch
qbr7@cdc.gov

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Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Wednesday, February 12, 2020 4:58:31 PM

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Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Thursday, February 13, 2020 1:06:44 PM

Thank you Scott for your response. When I ask the L kidney recipient's cultured isolate sample to be sent to the CDC, I'll make sure to forward them the directions you've provided here.

Thank you.

David

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To: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
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Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle (CDC

AMERICAN OVERSIGHT

flhealth.gov) <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

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Our Jacksonville location has experience receiving *C. gattii* isolates to CDCs mycotics lab.
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The submitter can reach out to Kelly Tomson or Marie-Claire Rowlinson at 904-791-1500 for more information.

Sincerely,

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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David Oh

AMERICAN OVERSIGHT

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Cc: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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Thank you.

David Hyung Won Oh
Epidemiology Elective Student
Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases
Division of Foodborne, Waterborne, and Environmental Diseases
Mycotic Diseases Branch
qbr7@cdc.gov

AMERICAN OVERSIGHT

From:	Oh, David (CDC/DDID/NCEZID/DFWED)
To:	Rowlinson, Marie-Claire; Stanek, Danielle (CDC flhealth.gov); Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov)
Cc:	Tomson, Kelly F
Subject:	RE: Potential Donor Derived Infection Investigation
Date:	Friday, February 14, 2020 7:53:26 AM
Attachments:	form-50-34.pdf

Hi Marie-Claire,

Thanks again for all your help with this potential DDI investigation! As we discussed, here are the instructions for sending the sample to CDC once you receive the sample from the hospital.

--Please complete one 50.34 form (attached), as completely as possible, and include in the shipment. We use this form's barcode to accession isolates into our LIMS system.

--Under Lab examination Requested, please fill in:
Test order code: CDC-10179
Suspected agent: Cryptococcus Gattii
At CDC, bring to the attention of: Elizabeth Berkow

--Please mention MLST and WGS in the comments

--As for the actual isolate, we require 2 identifiers on the isolate. These can be things like patient information (DOB, patient last name), medical record number, or a unique number that you've created to distinguish between isolates. These 2 identifiers must also be present on the 50.34 form. Failure to meet our 2 identifier requirement may result in testing delays or rejection of submission.

--Shipments should be addressed to the following:
Centers for Disease Control and Prevention
1600 Clifton Road
DASH Unit 37
Attn: ELIZABETH BERKOW -- MDB Fungal Diseases Laboratory
Atlanta, GA 30329

Again, thanks so much for your help and please feel free to reach out to me with any questions (650 669 7292).

David

From: Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
Sent: Wednesday, February 12, 2020 4:45 PM
To: Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Tomson, Kelly F <Kelly.Tomson@flhealth.gov>
Subject: RE: Potential Donor Derived Infection Investigation

Please let me know how I may assist in coordination from the laboratory.

Kind regards,

Marie-Claire

Marie-Claire Rowlinson, PhD, D(ABMM)
Assistant Laboratory Director/CLIA Laboratory Director

AMERICAN OVERSIGHT

Bureau of Public Health Laboratories - Jacksonville
Tel: 904-791-1562 | Cell: 904-271-1823 | Fax: 904-791-1567
Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
****
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From: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>
Sent: Wednesday, February 12, 2020 4:42 PM
To: Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED) <iyn0@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
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Subject: Re: Potential Donor Derived Infection Investigation

Do you have information about clinical presentation from the IDs? Pulmonary primarily?

Danielle Stanek, DVM, DACVPM
State Public Health Veterinarian
Florida Department of Health
850-245-4117 work
850-294-1087 cell

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To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Oh, David (CDC/DDID/NCEZID/DFWED) <qbr7@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Tomson, Kelly F <Kelly.Tomson@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>
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Please don't hesitate to reach out if we can provide further info.

Best,
Brendan

AMERICAN OVERSIGHT

Brendan Jackson, MD, MPH
Epidemiology Team Lead
CDC Mycotic Diseases Branch
CDR, U.S. Public Health Service
brjackson1@cdc.gov | Phone: 404-639-0536

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qbr7@cdc.gov

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The document you are trying to load requires Adobe Reader 8 or higher. You may not have the Adobe Reader installed or your viewing environment may not be properly configured to use Adobe Reader.

For information on how to install Adobe Reader and configure your viewing environment please see http://www.adobe.com/go/pdf_forms_configure.

AMERICAN OVERSIGHT

From: Rowlinson, Marie-Claire
To: Stanek, Danielle R; Jackson, Brendan R. (CDC/DDID/NCEZID/DFWED); Pritchard, Scott; Oh, David (CDC/DDID/NCEZID/DFWED); Blackmore, Carina
Cc: Tomson, Kelly F
Subject: RE: Potential Donor Derived Infection Investigation
Date: Wednesday, February 12, 2020 4:45:16 PM

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Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases
Division of Foodborne, Waterborne, and Environmental Diseases
Mycotic Diseases Branch
qbr7@cdc.gov

AMERICAN OVERSIGHT

From: Moscoso, Alberto
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Cc: Burns, Erin (CDC/DDID/NCIRD/ID); Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Pritchard, Scott
Subject: Re: Press release planning for Florida
Date: Sunday, March 1, 2020 1:20:20 PM

Thanks, Scott.

Kristen,

I really appreciate your reaching out. We have updated our website to reflect Florida test results and PUIs: www.FloridaHealth.gov/COVID-19

I would certainly be grateful for whatever information you are able to share. Situational awareness is always a priority.

Is there anything else I can provide on my end to support your mission?

Thanks,

Alberto Moscoso
Communications Director
Florida Department of Health
(850) 408-7687 (cell)

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:35:19 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

Hi Alberto,

Happy to chat anytime. Illinois announced a community case today and as I mentioned, we expect at least one other than you guys this week.

Thanks,
Kristen
404-956-0336 (cell)

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 29, 2020 9:16 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Moscoso,

AMERICAN OVERSIGHT

Alberto <Alberto.Moscoso@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:11:11 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>
Subject: RE: Press release planning for Florida

Hi Scott,

Sorry if others have reached out, but wanted to make sure we followed up. CDC and other states have put out a lot of communication in the last few days about both travel and unknown exposure related COVID-19 cases that I'm happy to share.

I can also let you know that other states will be putting out communication this weekend about cases they've identified through testing.

Thanks,
Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

AMERICAN OVERSIGHT

Hi Kristen, Conne, and Erin,

Scott Pritchard at the DOH in Florida will be coordinating the press for their two presumptive positive COVID-19 cases. Can you please coordinate with Scott regarding press? They will likely wait until CDC confirmation, but want to plan ahead in case they need to go public earlier as contacts and HCWs will be notified before CDC confirmation. Can you connect with Scott about this?

Quick summaries are:
NCoVID: FL 2785091
63 year old male with unknown exposure who is in the ICU.

NCoVID: FL 2785125
29 year old female with travel to Europe who is at home in isolation.

Best,
Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

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Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject: RE: Press release planning for Florida
Date: Sunday, March 1, 2020 2:14:49 PM

I am not actually seeing an announcement about your presumptive-positive. Are you waiting for CDC confirmation? We won't report until you do.
All our press releases are online: https://www.cdc.gov/media/dpk/diseases-and-conditions/coronavirus/coronavirus-2020.html#tabz
Thanks,
Erin

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Sent: Sunday, March 1, 2020 1:20 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
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AMERICAN OVERSIGHT

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Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject:	RE: Press release planning for Florida
Date:	Sunday, March 1, 2020 3:15:38 PM

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Cc:	Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Pritchard, Scott
Subject:	Re: Press release planning for Florida
Date:	Sunday, March 1, 2020 2:16:45 PM

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Sent: Sunday, March 1, 2020 3:15:36 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; CDC IMS JIC Lead -2 <eocjiclead2@cdc.gov>; LaRocque, Marcie (CDC/DDID/NCIRD/OD) (CTR) <lox3@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

We absolutely will NOT light up FL on the map until you announce.

Thanks,

Erin

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 3:04 PM
To: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

Would it be possible for you to hold on lighting up Florida on your map until we announce?

We will be moving very expeditiously.

Thank you,

Alberto

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>

AMERICAN OVERSIGHT

Sent: Sunday, March 1, 2020 2:16 PM
To: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

That's exactly right. Thanks!

From: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>
Sent: Sunday, March 1, 2020 2:14 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>; Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

I am not actually seeing an announcement about your presumptive-positive. Are you waiting for CDC confirmation? We won't report until you do.
All our press releases are online: https://www.cdc.gov/media/dpk/diseases-and-conditions/coronavirus/coronavirus-2020.html#tabz
Thanks,
Erin

From: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Sent: Sunday, March 1, 2020 1:20 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks, Scott.

Kristen,

I really appreciate your reaching out. We have updated our website to reflect Florida test results and PUIs: www.FloridaHealth.gov/COVID-19

I would certainly be grateful for whatever information you are able to share. Situational awareness is always a priority.

Is there anything else I can provide on my end to support your mission?

AMERICAN OVERSIGHT

Thanks,

Alberto Moscoso
Communications Director
Florida Department of Health
(850) 408-7687 (cell)

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:35:19 PM
To: Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Subject: RE: Press release planning for Florida

Hi Alberto,

Happy to chat anytime. Illinois announced a community case today and as I mentioned, we expect at least one other than you guys this week.

Thanks,
Kristen
404-956-0336 (cell)

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 29, 2020 9:16 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Subject: Re: Press release planning for Florida

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:11:11 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>

AMERICAN OVERSIGHT

Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>
Subject: RE: Press release planning for Florida

Hi Scott,

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I can also let you know that other states will be putting out communication this weekend about cases they've identified through testing.

Thanks,
Kristen

Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

From: Fleming-Dutra, Katherine E. (CDC/DDID/NCIRD/DBD) <ftu2@cdc.gov>
Sent: Saturday, February 29, 2020 8:13 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>; Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Gerber, Susan I. (CDC/DDID/NCIRD/DVD) <bhx1@cdc.gov>
Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
Subject: Press release planning for Florida

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Quick summaries are:
NCoVID: FL 2785091
63 year old male with unknown exposure who is in the ICU.

NCoVID: FL 2785125
29 year old female with travel to Europe who is at home in isolation.

Best,
Katherine

AMERICAN OVERSIGHT

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Cc:	Burns, Erin (CDC/DDID/NCIRD/ID); Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina; Moscoso, Alberto
Subject:	Re: Press release planning for Florida
Date:	Saturday, February 29, 2020 9:15:44 PM

Thanks! Our communications director is Alberto Moscoso, his cell (850) 408-7687, he is copied on this email.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Sent: Saturday, February 29, 2020 9:11:11 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>
Subject: RE: Press release planning for Florida

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Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

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Cc: CDC IMS 2019 NCOV Response Epi TF Lead <eocevent332@cdc.gov>; CDC IMS 2019 NCOV Response EPI Clearance <eocevent210@cdc.gov>
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AMERICAN OVERSIGHT

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Katherine

Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From:	Nordlund, Kristen (CDC/DDID/NCIRD/OD)
To:	Moscoso, Alberto
Cc:	Burns, Erin (CDC/DDID/NCIRD/ID); Ward-Cameron, Conne (CDC/OCOO/OCIO); Blackmore, Carina (CDC flhealth.gov); Pritchard, Scott
Subject:	RE: Press release planning for Florida
Date:	Saturday, February 29, 2020 9:35:22 PM

Hi Alberto,

Happy to chat anytime. Illinois announced a community case today and as I mentioned, we expect at least one other than you guys this week.

Thanks,
Kristen
404-956-0336 (cell)

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Saturday, February 29, 2020 9:16 PM
To: Nordlund, Kristen (CDC/DDID/NCIRD/OD) <hok4@cdc.gov>
Cc: Burns, Erin (CDC/DDID/NCIRD/ID) <eub5@cdc.gov>; Ward-Cameron, Conne (CDC/OCOO/OCIO) <goa4@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Moscoso, Alberto <Alberto.Moscoso@flhealth.gov>
Subject: Re: Press release planning for Florida

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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

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Kristen Nordlund
CDC Public Affairs
p. 404.639.7387 | c. 404.956.0336 | e.hok4@cdc.gov

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Katherine E. Fleming-Dutra, MD
Case Tracking Team
COVID-19 Epi Task Force
Centers for Disease Control and Prevention
ftu2@cdc.gov

AMERICAN OVERSIGHT

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To: Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov)
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M; Schmitz, Ann (CDC flhealth.gov)
Subject: RE: remote TA call from CDC - COVID-19
Date: Thursday, March 12, 2020 12:09:45 PM

Thanks Scott. Lets hold 4-5 pm EST for now. Will follow up with a confirmation once I lock down CDC SMEs.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Anytime between 2-5 could work for me.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Thursday, March 12, 2020 11:29 AM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: Re: remote TA call from CDC - COVID-19

The most important people who need to be on is not me although will try my hardest but it is Dr Thaqi and her team from Broward CHD and Scott Pritchard and his team. I will defer to them about an ideal time. Thanks so much.
Get Outlook for iOS

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 8:24:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: remote TA call from CDC - COVID-19

Hi Dr. Blackmore,

I am working to set up a follow up TA call to assist with your questions related to the cruise ship port.

AMERICAN OVERSIGHT

Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From:	Thaqi, Paula M
To:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Blackmore, Carina; Jenkins, Patrick H; Pritchard, Scott
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Schmitz, Ann
Subject:	Re: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 12:13:16 PM

We will becon the call. Thx.

Sent from my Verizon, Samsung Galaxy smartphone
Get Outlook for Android

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 12:10:42 PM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Jenkins, Patrick H <Patrick.Jenkins@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Dr. Thaqi and Patrick, does this time work for you?

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 12:10 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
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AMERICAN OVERSIGHT

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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

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To:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD); Blackmore, Carina; Thaqi, Paula M; Jenkins, Patrick H
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Schmitz, Ann
Subject:	RE: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 12:10:42 PM

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Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Sent: Thursday, March 12, 2020 12:10 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann <Ann.Schmitz@flhealth.gov>
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Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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Subject: Re: remote TA call from CDC - COVID-19

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Senior Advisor
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National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From:	Schmitz, Ann
To:	Pritchard, Scott; Blackmore, Carina; Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M
Subject:	RE: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 12:12:46 PM

That window works for me as well.

Ann Schmitz, DVM, AM
CDR, USPHS
Career Epidemiology Field Officer
Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Epidemiology
1325 NW 14th Avenue
Miami, FL 33125
Tel: (305) 325-2547
Fax: (305) 325-2560
Cell: (850) 251-4502
24/7 EPI Hotline: (850) 245-4401
Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
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Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Thursday, March 12, 2020 11:29 AM
To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott

AMERICAN OVERSIGHT

<Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: Re: remote TA call from CDC - COVID-19

The most important people who need to be on is not me although will try my hardest but it is Dr Thaqi and her team from Broward CHD and Scott Pritchard and his team. I will defer to them about an ideal time. Thanks so much.
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From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Sent: Thursday, March 12, 2020 8:24:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: remote TA call from CDC - COVID-19

Hi Dr. Blackmore,

I am working to set up a follow up TA call to assist with your questions related to the cruise ship port. Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To: Pritchard, Scott; Blackmore, Carina (CDC flhealth.gov)
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M; Schmitz, Ann (CDC flhealth.gov)
Subject: RE: remote TA call from CDC - COVID-19
Date: Thursday, March 12, 2020 1:26:49 PM

We are locked in for 4pm EST. Will send out an invite.

Chris

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Thursday, March 12, 2020 11:30 AM
To: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>
Subject: RE: remote TA call from CDC - COVID-19

Anytime between 2-5 could work for me.

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AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Pritchard, Scott; Thaqi, Paula M
Subject:	Re: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 11:28:59 AM

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O: 404-498-0756 | C: 404-747-5988
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AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Blackmore, Carina; Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
Cc:	Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD); Thaqi, Paula M; Schmitz, Ann
Subject:	RE: remote TA call from CDC - COVID-19
Date:	Thursday, March 12, 2020 11:30:22 AM

Anytime between 2-5 could work for me.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

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To: Jones, Christopher M. (CDC/DDNID/NCIPC/OD) <FJR0@cdc.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Thaqi, Paula M <Paula.Thaqi@flhealth.gov>
Subject: Re: remote TA call from CDC - COVID-19

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Sent: Thursday, March 12, 2020 8:24:47 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD) <yxo4@cdc.gov>
Subject: remote TA call from CDC - COVID-19

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Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

AMERICAN OVERSIGHT

O: 404-498-0756 | C: 404-747-5988
E: fjr0@cdc.gov

AMERICAN OVERSIGHT

From: Amores, Norma A.
To: Gilliard, Deric (HHS/IEA)
Cc: Villalta, Yesenia D
Subject: RE: request for Dr. Yesinia"s cell #
Date: Thursday, March 12, 2020 3:03:38 PM
Attachments: image001.png

Good afternoon Mr. Gilliard,
Thank you for providing the attached and contact information, I shall save this to her Outlook directory. Dr. Villalta's mobile contact as you request is (305) 423-5247

Norma Amores
Florida Department of Health in Miami-Dade County
Administrative Assistant II
Email: Norma.Amores@flhealth.gov
Phone: (786) 336-1259
Mailing Address: 8323 NW 12 STREET Floor: 02 Room: 212 Bin : 212
MIAMI, FL 33126

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From: Gilliard, Deric (HHS/IEA) <deric.gilliard@hhs.gov>
Sent: Thursday, March 12, 2020 2:38 PM
To: Amores, Norma A. <Norma.Amores@flhealth.gov>
Cc: yesinia.villalta@flhealth.gov
Subject: request for Dr. Yesinia's cell #
Importance: High

Hello Norma.

You may recall, your office and I held a call with Dr. Yesinia and her staff late last year to discuss secretarial priorities.
Please accept this cell # for regional director John McGough, (202) 774-7692, in the event she may need to reach him on a pressing matter regarding the coronavirus. Also, I am requesting her cell, in the event we need to do the same, for the spreadsheet we are developing. We will not bother her, otherwise.

AMERICAN OVERSIGHT

Thanks,

Deric

DERIC GILLIARD, MA
Public Affairs Specialist
U.S. Department of Health and Human Services
Atlanta Federal Center
61 Forsyth St, SW Suite 5B95
Atlanta, GA 30303-8909
Deric.Gilliard@hhs.gov
Twitter: @HHSRegion4
404-562-7910 Office
202-868-9202 Cell

AMERICAN OVERSIGHT





AMERICAN OVERSIGHT

From: Blackmore, Carina
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane
Date: Wednesday, February 5, 2020 10:08:18 AM

I am

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>
Sent: Wednesday, February 5, 2020 10:03 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane

Morning, team –
I'm back and relatively alive after a bout of the flu. I wanted to check in with the team – who all from FL DOH will be attending Vector Week? I think that'll be a good way for us to get together and chat in person about funding strategy for ELC BP2. We can call in folks that will not be in attendance in person.

Nga

From: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>
Sent: Tuesday, January 28, 2020 8:08 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD) <csz5@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: Request for reschedule : FL DOH - ELC/Hurricane

Good morning,

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(Winter colds...not corona!)

Thank you,

Chris

AMERICAN OVERSIGHT

DVBD - Arboviral Disease Branch
(970) 219-8034

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
Sent: Friday, January 17, 2020 7:54:45 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Connelly, C. Roxanne (CDC/DDID/NCEZID/DVBD) <csz5@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Subject: Spenddown discussion: FL DOH - ELC/Hurricane
When: Tuesday, January 28, 2020 11:00 AM-12:00 PM.
Where: Skype line 855-348-8390 / 2855050

FL DOH has funding in the following buckets:

1. ELC BP1 (19-20) PMS: $40,233.07
    a. ELC Yellow Fever PMS: _____
2. ELC Zika NCE PMS: $105,790.75
3. Hurricane PMS: $921,483.93 REDCap: $1,750,512

Let's focus the conversation on…

- Progress of spenddown
- Key challenges in spenddown
- At-risk activities or projects
- Priorities for any redirection

Blocked off an hour in case we need the full time.

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From: Blackmore, Carina
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD); Stanek, Danielle R; Wallace, Marla D.; Morrison, Andrea
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane
Date: Friday, February 7, 2020 4:45:23 PM

I am sorry but I am not sure any of these times will work great for me. I am traveling and have several extra CoV calls. The best time is probably Friday at 2. I could reschedule the meeting I have then. Marah is the lead for the hurricane vector funds so if we are to talk about that funding she should be on the line.
Carina

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>
Sent: Thursday, February 6, 2020 9:47 AM
To: Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane

Good morning,
Looks like the CDC team would like to have a brief call prior to vector week, and then follow it up with a brief 30 min 1:1 meeting during vector week later. Would you all be available during one of the following dates/times? I'll block it off for a full hour, but we may not use all of it.

- Monday, Feb 10 2 pm – 3 pm ET
- Tuesday, Feb 11 11 am – 1 pm ET*
- Tuesday, Feb 11 2 pm – 3 pm ET*
- Wednesday, Feb 12 4 pm – 5 pm ET
- Thursday, Feb 13 2 pm – 3 pm ET
- Friday, Feb 14 2 pm – 3 pm ET

*There is a standing monthly FL hurricane call on Feb 11th between 1 pm – 2 pm. We just want to go over the funding streams in depth with the FL DOH team without FDACS on the line and to give us adequate room to talk about funding strategy for FL DOH within the ELC for BP2.

Let us know what will work best for you all. Thanks!
Nga

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>
Sent: Wednesday, February 05, 2020 10:03 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Stanek, Danielle R <Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD) <cnd8@cdc.gov>
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane

Morning, team –

AMERICAN OVERSIGHT

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Thank you,

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AMERICAN OVERSIGHT

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To: Blackmore, Carina (CDC flhealth.gov); Stanek, Danielle (CDC flhealth.gov); Morrison, Andrea; Wallace, Marla D.
Cc: Duggar, Christopher (CDC/DDID/NCEZID/DVBD)
Subject: RE: Request for reschedule : FL DOH - ELC/Hurricane
Date: Wednesday, February 5, 2020 10:02:50 AM

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AMERICAN OVERSIGHT

<Danielle.Stanek@flhealth.gov>; Morrison, Andrea <Andrea.Morrison@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
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AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Vinson, Alonna; ASPR Region 4 (HHS/ASPR/OEM); Bowman, Thomas (OS/ASPR/EMMO); gwen.keenan@fema.dhs.gov; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Manny.Toro@fema.dhs.gov; Logs Command; Davis, Ashley; Guthrie, Kevin
Subject:	RE: Request for USS Hope & USS Mercy
Date:	Tuesday, March 17, 2020 2:25:29 PM
Attachments:	CDC HAN 430_Info and Guidance about Global Travel on Cruise Ships due to COVID-19_Updated 03 17 2020.pdf

FDOH ESF 8

I am passing this back to you as well for further information. I will call again.
I am also attaching the CDC guidance about global travel and cruise ships for your reference.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Vinson, Alonna <Alonna.Vinson@em.myflorida.com>
Sent: Tuesday, March 17, 2020 7:10 AM
To: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Bowman, Thomas (OS/ASPR/EMMO) <Thomas.Bowman@hhs.gov>; gwen.keenan@fema.dhs.gov; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Cc: Manny.Toro@fema.dhs.gov; Logs Command <Logs_Command@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Subject: Request for USS Hope & USS Mercy

Good morning all,

Attached is an RRF for the USS Hope & USS Mercy. This request has been approved by Kevin Guthrie, SERT Chief.

AMERICAN OVERSIGHT

Please acknowledge receipt of this request.

Respectfully,

Alonna E. Vinson
Mutual Aid Branch Director & EMAC Coordinator
Florida Division of Emergency Management
Bureau of Response | Logistics Section
Alonna.Vinson@em.myflorida.com
Office: 850-815-4280 | Mobile: 850-901-8456

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

This is an official

CDC HEALTH UPDATE

Distributed via the CDC Health Alert Network
March 15, 2020, 5:45 PM ET
Updated: March 17, 2020, 12:10 PM ET
CDCHAN-00430

Information and Guidance about Global Travel on Cruise Ships, Including River Cruises, due to Coronavirus Disease 2019 (COVID-19)

Summary
The Centers for Disease Control and Prevention (CDC) recommends all persons defer any travel on cruise ships, including river cruises, worldwide because of the increased risk of SARS-CoV-2 transmission onboard ships. Deferring travel is especially important for older adults and all people with serious chronic medical conditions (such as heart disease, diabetes or lung disease), because of their increased risk for severe disease. This health update provides information to clinicians and state and local health departments about the current coronavirus disease 2019 (COVID-19) situation and the risks associated with travel on cruise ships, including river cruises.

Background
Cruise ship passengers, including those who take river cruises, are at increased risk of exposure to SARS-CoV-2, the virus that causes COVID-19. In the past month, there have been reports of outbreaks of COVID-19 among passengers and crew on cruises. Recent examples include 696 cases and 8 deaths on the *Diamond Princess* cruise ship in Japan, 28 cases on the *Grand Princess* cruise ship in the United States, and at least 60 cases in 15 states associated with multiple Nile River voyages in Egypt as of March 14, 2020. Illness onset occurred both onboard ships and after passengers returned to the United States. The proximity of passengers and crew on small ships and boats traveling on rivers may result in an even higher number of COVID-19 infections.

Recommendations for Clinicians
Ask all patients about their planned or recent cruise ship travel, including river cruises.

1. Pre-travel advice
   a. Advise patients to defer all cruise ship travel, including river cruises, worldwide.
   b. Explain that their return travel to the United States may be impacted, and formal quarantine procedures may be implemented if confirmed cases are identified on board.
   c. Explain that appropriate medical care or medical evacuation may not be available internationally.
   d. Explain that some countries may refuse docking or disembarkation if there are known or suspected cases on board.
   e. For patients who still intend to cruise, advise them to
      i. Stay in their cabin and notify the onboard medical center immediately if they get sick with fever, new or worsening cough, or trouble breathing during their cruise.
      ii. Stay home for 14 days after returning from travel, practice social distancing, and monitor their health both during travel and after they return. Social distancing means staying out of crowded places, avoiding group gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others, when possible.
2. Post-travel management
   a. Tell patients to follow CDC's guidance on steps to prevent the spread of COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/about/steps-when-sick.html) if they develop acute febrile or respiratory illness after travel.

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b. Implement recommended infection prevention and control practices (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html) if you suspect a patient has COVID-19.
c. Immediately notify the local health department (https://www.naccho.org/membership/lhd-directory) if a patient meets clinical and epidemiologic criteria for a person under investigation (PUI) (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html) for COVID-19 and test as appropriate.

Recommendations for State and Local Health Departments

Check *The Epidemic Information Exchange* (*Epi-X*) notification system for information on COVID-19 cases on cruise ships and river cruises. In accordance with the Level 3 travel warning (https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-cruise-ship) for cruise ships, cruise travelers should stay home for 14 days after returning from travel, monitor their health, and practice social distancing.

For More Information

State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours, weekends, or holidays.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention; highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

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

AMERICAN OVERSIGHT

From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Vinson, Alonna; ASPR Region 4 (HHS/ASPR/OEM); Bowman, Thomas (OS/ASPR/EMMO); gwen.keenan@fema.dhs.gov; Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc:	Manny.Toro@fema.dhs.gov; Logs Command; Davis, Ashley; Guthrie, Kevin
Subject:	RE: Request for USS Hope & USS Mercy
Date:	Tuesday, March 17, 2020 2:25:15 PM
Attachments:	CDC HAN 430_Info and Guidance about Global Travel on Cruise Ships due to COVID-19_Updated 03 17 2020.pdf

FDOH ESF 8

I am passing this back to you as well for further information. I will call again.
I am also attaching the CDC guidance about global travel and cruise ships for your reference.

Regards,
Jeanne

Jeanne Eckes-Roper, RN, MBA
DFHCO-ME Oakland – Grand Princess

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
fax: 404.562.7913
email: Jeanne.eckes@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

From: Vinson, Alonna <Alonna.Vinson@em.myflorida.com>
Sent: Tuesday, March 17, 2020 7:10 AM
To: ASPR Region 4 (HHS/ASPR/OEM) <ASPR.R4@hhs.gov>; Bowman, Thomas (OS/ASPR/EMMO) <Thomas.Bowman@hhs.gov>; gwen.keenan@fema.dhs.gov; Eckes, Jeanne (OS/ASPR/EMMO) <Jeanne.Eckes@hhs.gov>
Cc: Manny.Toro@fema.dhs.gov; Logs Command <Logs_Command@em.myflorida.com>; Davis, Ashley <Ashley.Davis@em.myflorida.com>; Guthrie, Kevin <Kevin.Guthrie@em.myflorida.com>
Subject: Request for USS Hope & USS Mercy

Good morning all,

Attached is an RRF for the USS Hope & USS Mercy. This request has been approved by Kevin Guthrie, SERT Chief.

AMERICAN OVERSIGHT

Please acknowledge receipt of this request.

Respectfully,

Alonna E. Vinson
Mutual Aid Branch Director & EMAC Coordinator
Florida Division of Emergency Management
Bureau of Response | Logistics Section
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AMERICAN OVERSIGHT

From: Wallace, Marla D.
To: Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Blackmore, Carina; ONeill, Mark; Framingham, Julie L
Subject: RE: Second Quarter PMS Report
Date: Tuesday, February 25, 2020 4:00:36 PM

De'Lisa

Thanks we will review. We do have a few vacancies at this time in the Lab, Surveillance Systems, Epi Food & Water and Vector Borne. On added note I am preparing out budget request from Project E to help assist with our COVID-19 response. Ad indicated we are applying for the 874K that was approved but unfunded.

To clarify we just need a cover letter signed by Dr. Blackmore and the detailed budget. These documents will be emailed to the ELC Mailbox and a courtesy copy to you. Should the letter be addressed to you, Angelica or the Grants Management (OGS) Official.

Thanks

Marla

Marla D. Wallace
Grants & Budget Manager
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way Bin A-12
Tallahassee, FL 32399-1720
Telephone: (850) 901-6945

From: Simpson, De'Lisa D. (CDC/DDID/NCEZID/DPEI) [mailto:ion9@cdc.gov]
Sent: Tuesday, February 25, 2020 3:28 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; ONeill, Mark <Mark.ONeill@flhealth.gov>; Framingham, Julie L <Julie.Framingham@flhealth.gov>; Wallace, Marla D. <Marla.Wallace@flhealth.gov>
Subject: Second Quarter PMS Report
Importance: High

Good afternoon,

AMERICAN OVERSIGHT

I am sending you the attached PDF file, which is your jurisdiction's Payment Management System (PMS) Quarter 2 (Q2) Report. This Q2 report covers transactions reported from August 1 through October 31 (Q1), and expenditures from November 1 through January 31, 2020 (Q2). The intent of sharing these quarterly reports is to increase your awareness and provide you with resources to have informed conversations with your financial office.

A few things to point out when reviewing the attached PMS report:

1. PMS does track charges and spending but is only as accurate as the data being entered, as well as the frequency.

2. The attached report shows base funding as well as special funding (Ebola & Hurricane). If you received special funding, you will see suffixes in the document number.
    a. '-19EBLA' is the designation for Ebola funds.
    b. '-19HURR' is the designation for Hurricane funds.

3. Columns to focus on when reviewing:
    a. 'Percentage of Total Charged Against Account' column shows the percentage of funds charged against what was awarded.
    b. 'Percentage of Total Paid Out' column shows the percentage of funds paid out against what was awarded.
    c. Given that we are 50% into Budget Period 1, the charged &/or disbursement should be showing relative spending progress.
        i. On average, ELC awards are comprised of over 70% personnel costs so, if all positions are filled, then a good portion of Q2 funding should be charged &/or disbursed.
        ii. Things like contracts may not be invoiced until work is completed which could result in an artificially lower amount being expended.

Again, the intent of sharing this information is to help with the monitoring and managing of ELC funds.

Feel free to contact me with any questions or concerns.

De'Lisa

De'Lisa D. Simpson, MBA
Program Advisor/Project Officer
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)
Division of Preparedness and Emerging Infections
National Center for Emerging & Zoonotic Infectious Diseases (NCEZID)
Centers for Disease Control and Prevention
1600 Clifton Rd, Mailstop C-12
Atlanta, GA 30333
Office: 404-639-3629
Blackberry: 404-372-5928
Fax: 404-718-1874
ion9@cdc.gov

AMERICAN OVERSIGHT

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From: Clark, Marah

To: Castaneda, Maribel; agentes@clarke.com; alopez@clarke.com; sschneider@clarke.com; jamesclauson@comcast.net; leeduke1@live.com; cindymulla@comcast.net; michael.riles@comcast.net; summerseddie@comcast.net; Joe.Faella@brevardcounty.us; Inman, Barry; lacy.kittles@brevardfl.gov; Beth.Carey-Kovach@charlottecountyfl.gov; Rebecca.owers@charlottecountyfl.gov; Turner, Edna L; Scott.Schermerhorn@charlottecountyfl.gov; Bagley, Rebecca L; gdeskins@citrusmosquito.org; Dunn, Freta K; bkellner@citrusmosquito.org; Poirier, Thomas P; Rashley, Merton J; BenjaminA@coj.net; Rwishard@coj.net; lrosie1965@gmail.com; matthew_mello@co.escambia.fl.us; bill@flaglermosquito.com; markefmcd@outlook.com; fmbmctd@gmail.com; mcothran@gulfcounty-fl.gov; Legg, Keith O; Prowant, Brian K; sfisher@co.hernando.fl.us; JWhitehurst@co.hernando.fl.us; BurnsL@HillsboroughCounty.org; McFaulN@hillsboroughcounty.org; MontgomeryR@hillsboroughcounty.org; shafers@HillsboroughCounty.org; s.artman@irmosquito2.org; s.burroughs@irmosquito2.org; d.pelley@irmosquito2.org; h.whitehead@irmosquito2.org; m.kartzinel@irmosquito2.org; sterling@lcmcd.org; Lloyd@lcmcd.org; Roth, Jennifer; kbaker@lcmcd.org; Armstrong, Angela N; colvinh@leoncountyfl.gov; forda@leoncountyfl.gov; PourciauG@leoncountyfl.gov; CDBaum@manateemosquito.com; Barbara.Bayer@manateemosquito.com; max.dersch@manateemosquito.com; gduesterbeck@martin.fl.us; amcgowan@martin.fl.us; Reinhold, Todd A; snoe@martin.fl.us; Kylie Zirbel; Cason, Emily; connerla@msn.com; Geib, Kim N; Godwin, Michael D; Beedie, Katherine A; eevers@co.okaloosa.fl.us; carin.harrison@us.af.mil; srhenson@myokaloosa.com; Steve.Harrison@ocfl.net; susan.durand@ocfl.net; Jeremy.Brown@ocfl.net; Rafael.Melendez@ocfl.net; dpenson@rcid.org; kpeters@rcid.org; asolis@rcid.org; Rick.Baird@osceola.org; Fricano, Pat; ajanus@pascomosquito.org; Arogers@pascomosquito.org; Dennis Moore; Bohinc, Becky; GEdson@co.pinellas.fl.us; blawton@pinellascounty.org; dnovich@pinellascounty.org; LSmith@pinellascounty.org; Lamb, JoAnne; jstuck@co.pinellas.fl.us; Carlboohene@polk-county.net; hugoortiz@polk-county.net; wynonah.little@putnam-fl.com; sanitation@putnam-fl.com; aprilm@santarosa.fl.gov; nosborn@scgov.net; geby@seminolecountyfl.gov; tjones03@seminolecountyfl.gov; snieves@seminolecountyfl.gov; lreaves@seminolecountyfl.gov; quallsamcd@bellsouth.net; gainesamcd@bellsouth.net; mfarooqamcd@gmail.com; ssmoleroffamcd@gmail.com; xueamcd@gmail.com; jacksons@stlucieco.org; JacobsenR@stlucieco.org; Harts@stlucieco.org; hendersong@stlucieco.org; Koerner, David J; Kossler, Kimberly; minceyt@stlucieco.org; Jared.Stokes@sumtercountyfl.gov; SBartlett@volusia.org; jdillon@volusia.org; DFalcon@volusia.org; mlauth@volusia.org; lraymaley@volusia.org; rlucas@volusia.org; tmachardy@volusia.org; CEfstathion@volusia.org; TVasconcellosByrd@volusia.org; Mosquito Control-North; nwmosquito4@gmail.com; lab@swcmcd.org; director@swcmcd.org; reception@swcmcd.org; mcteche@swcmcd.org; operations@swcmcd.org; mctechb@swcmcd.org; supervisor@swcmcd.org; supervisor@swcmcd.org; Bryant, Glenn W; Andrew Cannons; Choe, Ulyee; Dennis, Anthony D; Dunn, Freta K; Godwin, Michael D; Gregos, Eliot M.; Guidash, Gayle; Hensley, Deborah S; Koerner, David J; Legg, Keith O; Matthias, James M; Miller, Brian L.; Mock, Valerie; Lewandowski, Patty A; Morris, Cindy K.; Myers, Paul D; Pierce, Bruce; Prowant, Brian K; Rashley, Merton J; Reinhold, Todd A; Roth, Jennifer; Rowlinson, Marie-Claire; Scuteri, Ana C; Seaton, Lylah J; Smith, Bret A; Steele, Crystal C; Turner, Scott M; Ulery, Sheryl P; Walsh, Donna; Williams, Diana J; Young, Zelda J; Zipperer, Angela; dwayne.carbonneau@fwc.state.fl.us; seth.britch@ars.usda.gov; JFDay@mail.ifas.ufl.edu; jrey@ufl.edu; crr@mail.ifas.ufl.edu; docmx8@gmail.com; dbowers@unf.edu; hhassan@health.usf.edu; tunnasch@health.usf.edu; pvanderkelen@gmail.com; lstarkm@aol.com; taytaylor518@gmail.com; ciadams@fsu.edu; stacey.k.booker.mil@mail.mil; Rachel.Beck@adph.state.al.us; Joshua.Coleman@adph.state.al.us; PEfird@mchd.org; dlee@mchd.org; antrimm@chathamcounty.org; lfpeaty@chathamcounty.org; keith@mosquitocs.com; Jayna@mosquitocs.net; william.schommer@rentokil.com; cwaldron@la.gov

Cc: Heberlein-Larson, Lea A.; Andrew Cannons; Lewandowski, Patty A; LaCrue, Alexis N; Kopp, Edgar W; Danielle Stanek; Lamberg, Frieda; Pierre-Saint, Ashley; Andrea Morrison; Carina Blackmore; Gill, Caitlin; Welch, Johanna; Nicely, Bruce; Ber, Jessica

Subject: RE: Sentinel Chicken Program Important Update

Date: Thursday, March 12, 2020 1:05:07 PM

Good afternoon Mosquito Control Arboviral Surveillance Coordinators and Directors,

After speaking with Dr. Stanek, the following is suggested for mosquito control programs currently and planning to start their sentinel chicken surveillance programs for the year based on the email from the FDOH Tampa Laboratory:

1. If you have already started your program, do not continue bleeding chickens, but maintain your flocks. Once the FDOH lab is able to start testing samples, they will contact you to start back up again. At that point, the chickens will be considered NEW birds and tested as such.
2. If you are only in the planning stages and preparing to launch the program in the upcoming months, hold off until you receive the go ahead from the lab or FDOH arbovirus coordinators to implement your program for the year.

Having been responsible for arboviral surveillance previously, I truly understand the significance of the data this testing provides and the impacts this can have on your program's proactive response.

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The FDOH laboratories understands the importance of sentinel sera testing for endemic mosquito borne viruses and this was not an easy decision for them to make. ***Please trust that they are doing everything possible to increase lab capacity and will be providing more guidance as they move forward. Your support of this decision is appreciated.***

As always,

Marah Clark
Environmental Administrator
Entomology and Pest Control Section
Bureau of Scientific Evaluation and Technical Assistance
Division of Agricultural Environmental Services
Florida Department of Agriculture and Consumer Services

(850) 617-7918 – Office
Marah.Clark@FDACS.gov

NOTE: New email address and website

The Conner Building, Lab 6
3125 Conner Boulevard
Tallahassee, FL 32399

www.FDACS.gov

Please note that Florida has a broad public records law (Chapter 119, Florida Statutes). Most written communications to or from state employees are public records obtainable by the public upon request. Emails sent to me at this email address may be considered public and will only be withheld from disclosure if deemed confidential pursuant to the laws of the State of Florida

---

From: Castaneda, Maribel <Maribel.Castaneda@flhealth.gov>
Sent: Thursday, March 12, 2020 12:06 PM
To: agentes@clarke.com; alopez@clarke.com; sschneider@clarke.com; jamesclauson@comcast.net; leeduke1@live.com; cindymulla@comcast.net; michael.riles@comcast.net; summerseddie@comcast.net; Joe.Faella@brevardcounty.us; Inman, Barry <Barry.Inman@flhealth.gov>; lacy.kittles@brevardfl.gov; Beth.Carey-Kovach@charlottecountyfl.gov; Rebecca.owers@charlottecountyfl.gov; Turner, Edna L <Edna.Turner@flhealth.gov>; Scott.Schermerhorn@charlottecountyfl.gov; Bagley, Rebecca L <Rebecca.Bagley@flhealth.gov>; gdeskins@citrusmosquito.org; Dunn, Freta K <Freta.Dunn@flhealth.gov>; bkellner@citrusmosquito.org; Poirier, Thomas P <Thomas.Poirier@flhealth.gov>; Rashley, Merton J <Merton.Rashley@flhealth.gov>; BenjaminA@coj.net; Rwishard@coj.net; lrosie1965@gmail.com <RWSMITH@coj.net>; matthew_mello@co.escambia.fl.us; bill@flaglermosquito.com; markefmcd@outlook.com; fmbmctd@gmail.com; mcothran@gulfcounty-fl.gov; Legg, Keith O <Keith.Legg@flhealth.gov>; Prowant, Brian K <Brian.Prowant@flhealth.gov>; sfisher@co.hernando.fl.us; JWhitehurst@co.hernando.fl.us; BurnsL@HillsboroughCounty.org; McFaulN@hillsboroughcounty.org; MontgomeryR@hillsboroughcounty.org; shafers@HillsboroughCounty.org; s.artman@irmosquito2.org; s.burroughs@irmosquito2.org;

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d.pelley@irmosquito2.org; h.whitehead@irmosquito2.org; m.kartzinel@irmosquito2.org; sterling@lcmcd.org; Lloyd@lcmcd.org; Roth, Jennifer <Jennifer.Roth@flhealth.gov>; kbaker@lcmcd.org; Armstrong, Angela N <Angela.Armstrong@flhealth.gov>; colvinh@leoncountyfl.gov; forda@leoncountyfl.gov; PourciauG@leoncountyfl.gov; CDBaum@manateemosquito.com; Barbara.Bayer@manateemosquito.com; max.dersch@manateemosquito.com; gduesterbeck@martin.fl.us; amcgowan@martin.fl.us; Reinhold, Todd A <Todd.Reinhold@flhealth.gov>; snoe@martin.fl.us; Kylie Zirbel <kzirbel@martin.fl.us>; Cason, Emily <Emily.Cason@flhealth.gov>; connerla@msn.com; Geib, Kim N <Kim.Geib@flhealth.gov>; Godwin, Michael D <Michael.Godwin@flhealth.gov>; Beedie, Katherine A <Katherine.Beedie@flhealth.gov>; eevers@co.okaloosa.fl.us; carin.harrison@us.af.mil; srhenson@myokaloosa.com; Steve.Harrison@ocfl.net; susan.durand@ocfl.net; Jeremy.Brown@ocfl.net; Rafael.Melendez@ocfl.net; dpenson@rcid.org; kpeters@rcid.org; asolis@rcid.org; Rick.Baird@osceola.org; Fricano, Pat <Pasquale.Fricano@flhealth.gov>; ajanus@pascomosquito.org; Arogers@pascomosquito.org; Dennis Moore <dmoore@pascomosquito.org>; Bohinc, Becky <Rebecca.Bohinc@flhealth.gov>; GEdson@co.pinellas.fl.us; blawton@pinellascounty.org; dnovich@pinellascounty.org; LSmith@pinellascounty.org; Lamb, JoAnne <JoAnne.Lamb@flhealth.gov>; jstuck@co.pinellas.fl.us; Carlboohene@polk-county.net; hugoortiz@polk-county.net; wynonah.little@putnam-fl.com; sanitation@putnam-fl.com; aprilm@santarosa.fl.gov; nosborn@scgov.net; geby@seminolecountyfl.gov; tjones03@seminolecountyfl.gov; snieves@seminolecountyfl.gov; lreaves@seminolecountyfl.gov; quallsamcd@bellsouth.net; gainesamcd@bellsouth.net; mfarooqamcd@gmail.com; ssmoleroffamcd@gmail.com; xueamcd@gmail.com; jacksons@stlucieco.org; JacobsenR@stlucieco.org; Harts@stlucieco.org; hendersong@stlucieco.org; Koerner, David J <David.Koerner@flhealth.gov>; Kossler, Kimberly <Kimberly.Kossler@flhealth.gov>; minceyt@stlucieco.org; Jared.Stokes@sumtercountyfl.gov; SBartlett@volusia.org; jdillon@volusia.org; DFalcon@volusia.org; mlauth@volusia.org; lraymaley@volusia.org; rlucas@volusia.org; tmachardy@volusia.org; CEfstathion@volusia.org; TVasconcellosByrd@volusia.org; Mosquito Control-North <hunbrenda@co.walton.fl.us>; nwmosquito4@gmail.com; lab@swcmcd.org; director@swcmcd.org; reception@swcmcd.org; mcteche@swcmcd.org; operations@swcmcd.org; mctechb@swcmcd.org; supervisor@swcmcd.org; supervisor@swcmcd.org; Andrea Morrison <Andrea.Morrison@flhealth.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>; Bryant, Glenn W <Glenn.Bryant@flhealth.gov>; Andrew Cannons <Andrew.Cannons@flhealth.gov>; Choe, Ulyee <Ulyee.Choe@flhealth.gov>; Dennis, Anthony D <Anthony.Dennis@flhealth.gov>; Dunn, Freta K <Freta.Dunn@flhealth.gov>; Godwin, Michael D <Michael.Godwin@flhealth.gov>; Gregos, Eliot M. <Eliot.Gregos@flhealth.gov>; Guidash, Gayle <Gayle.Guidash@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>; Hensley, Deborah S <Deborah.Hensley@flhealth.gov>; Koerner, David J <David.Koerner@flhealth.gov>; Legg, Keith O <Keith.Legg@flhealth.gov>; Matthias, James M <James.Matthias@flhealth.gov>; Miller, Brian L. <Brian.Miller@flhealth.gov>; Mock, Valerie <Valerie.Mock@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Morris, Cindy K. <Cindy.Morris@flhealth.gov>; Myers, Paul D <Paul.Myers@flhealth.gov>; Pierce, Bruce <Bruce.Pierce@flhealth.gov>; Prowant, Brian K <Brian.Prowant@flhealth.gov>; Rashley, Merton J <Merton.Rashley@flhealth.gov>; Reinhold, Todd A <Todd.Reinhold@flhealth.gov>; Roth, Jennifer <Jennifer.Roth@flhealth.gov>; Rowlinson, Marie-Claire <Marie-Claire.Rowlinson@flhealth.gov>; Scuteri, Ana C <Ana.Scuteri@flhealth.gov>; Seaton, Lylah J <Lylah.Seaton@flhealth.gov>; Smith, Bret

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A <Bret.Smith@flhealth.gov>; Danielle Stanek <Danielle.Stanek@flhealth.gov>; Steele, Crystal C <Crystal.Steele@flhealth.gov>; Turner, Scott M <Scott.Turner@flhealth.gov>; Ulery, Sheryl P <Sheryl.Ulery@flhealth.gov>; Walsh, Donna <Donna.Walsh@flhealth.gov>; Williams, Diana J <Diana.Williams2@flhealth.gov>; Young, Zelda J <Zelda.Young@flhealth.gov>; Zipperer, Angela <Angela.Zipperer@flhealth.gov>; Clark, Marah <Marah.Clark@fdacs.gov>; dwayne.carbonneau@fwc.state.fl.us; seth.britch@ars.usda.gov; JFDay@mail.ifas.ufl.edu; jrey@ufl.edu; crr@mail.ifas.ufl.edu; docmx8@gmail.com; dbowers@unf.edu; hhassan@health.usf.edu; tunnasch@health.usf.edu; pvanderkelen@gmail.com; lstarkm@aol.com; taytaylor518@gmail.com; ciadams@fsu.edu; Pierre-Saint, Ashley <Ashley.Pierre-Saint@fdacs.gov>; Lamberg, Frieda <Frieda.Lamberg@fdacs.gov>; stacey.k.booker.mil@mail.mil; Rachel.Beck@adph.state.al.us; Joshua.Coleman@adph.state.al.us; PEfird@mchd.org; dlee@mchd.org; antrimm@chathamcounty.org; lfpeaty@chathamcounty.org; keith@mosquitocs.com; Jayna@mosquitocs.net; william.schommer@rentokil.com; cwaldron@la.gov
Cc: Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>; Andrew Cannons <Andrew.Cannons@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; LaCrue, Alexis N <Alexis.LaCrue@flhealth.gov>; Kopp, Edgar W <Edgar.Kopp@flhealth.gov>; Castaneda, Maribel <Maribel.Castaneda@flhealth.gov>
Subject: Sentinel Chicken Program Important Update

Good Morning Sentinel Chicken Program Participants,

Our laboratory and epidemiology leadership have decided to suspend Sentinel Chicken Testing effective immediately. At this time, all personnel are need to help perform COVID-19 testing. For the next seven weeks or until further notice, we will not be performing HAI, ELISA, PRNT, and mosquito pool testing. Specimens received today or tomorrow will not be processed. Please send me an e-mail so that I know what you would like us to do with those specimens. We will notify you when we are able to resume testing.

Reports:

1. This Friday, March 13, 2020 the regular HAI report will be e-mailed.
2. Tuesday, March 17, 2020 the IgM ELISA report will be e-mailed.
3. Wednesday, March 18, 2020 the PRNT report (for February specimens) will be e-mailed.

Please understand that we are doing what is best to promote, protect, and improve the health of all people in the state. Please contact me, if you have any questions or concerns.

Thank you,

Maribel

Maribel Castaneda
Lead Scientist

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Sentinel Chicken Program Coordinator
Bureau of Public Health Laboratories – Tampa
Division of Disease Control and Health Protection
Florida Department of Health
3602 Spectrum Blvd.
Tampa, FL 33612
Phone: 813-233-2342

Division of Disease Control and Health Protection
Florida Department of Health

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From: Cohen, Jonathan
To: Chapman, Jennifer Rose; Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); BPHL13FL@flhealth.gov
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Date: Thursday, February 13, 2020 9:40:09 AM
Sensitivity: Confidential

All,
The patient was born in [redacted]
She has traveled to the Caribbean and Central America but not South America.
All of us in South Florida have history of insect bites.
January 29, 2020 positive leishmaniasis IgG
Testing negative for hepatitis B, hepatitis C, HIV

Jonathan Cohen

From: Chapman, Jennifer Rose <JChapman@med miami edu>
Sent: Wednesday, February 12, 2020 3:18 PM
To: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc gov>; Pathology (CDC) <Pathology@cdc gov>; BPHL13FL@flhealth gov; Cohen, Jonathan <j cohen11@miami edu>
Cc: Elesi Quaye@flhealth gov; Stanek, Danielle (CDC flhealth gov) <Danielle Stanek@flhealth gov>; Blackmore, Carina (CDC flhealth gov) <carina blackmore@flhealth gov>; Edhelene Rico@flhealth gov; Alvaro Mejia-Echeverry@flhealth gov; pedro noya-chaveco@flhealth gov; Schmitz, Ann (CDC flhealth gov) <ann schmitz@flhealth gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc gov>; Leishmania (CDC) <leishmania@cdc gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc gov>
Subject: Re: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

Adding Dr Cohen, treating physician, to answer the questions below

Jennifer Chapman, MD
Associate Professor
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowship Program
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc gov>
Sent: Wednesday, February 12, 2020 3:03:35 PM
To: Pathology (CDC) <Pathology@cdc gov>; BPHL13FL@flhealth gov <BPHL13FL@flhealth gov>
Cc: Chapman, Jennifer Rose <JChapman@med miami edu>; Elesi Quaye@flhealth gov <Elesi Quaye@flhealth gov>; Stanek, Danielle (CDC flhealth gov) <Danielle Stanek@flhealth gov>; Blackmore, Carina (CDC flhealth gov) <carina blackmore@flhealth gov>; Edhelene Rico@flhealth gov <Edhelene Rico@flhealth gov>; Alvaro Mejia-Echeverry@flhealth gov <Alvaro Mejia-Echeverry@flhealth gov>; pedro noya-chaveco@flhealth gov <pedro noya-chaveco@flhealth gov>; Schmitz, Ann (CDC flhealth gov) <ann schmitz@flhealth gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc gov>; Leishmania (CDC) <leishmania@cdc gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc gov>
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171

Good afternoon

We are requesting additional information regarding this case:

- Travel history and/or country of birth
- History of insect bites
- Leish testing date
- Results of any other microbiologic evaluation

Tina Benoit MPH
Clinical Epidemiology Coordinator Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
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Centers for Disease Control and Prevention
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MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc gov

From: Pathology (CDC) <Pathology@cdc gov>
Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth gov
Cc: jchapman@med miami edu; Elesi Quaye@flhealth gov; Stanek, Danielle (CDC flhealth gov) <Danielle Stanek@flhealth gov>; Blackmore, Carina (CDC flhealth gov) <carina blackmore@flhealth gov>; Edhelene Rico@flhealth gov; Alvaro Mejia-Echeverry@flhealth gov; pedro noya-chaveco@flhealth gov; Schmitz, Ann (CDC flhealth gov) <ann schmitz@flhealth gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc gov>; Leishmania (CDC) <leishmania@cdc gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc gov>
Subject: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence.
Dr. Stephen White,
This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.
If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

Eduard Matkovic, M.D. | Pathology Fellow | Tel 404-639-0549 | Fax 404-639-3043 | Eduard Matkovic@cdc hhs gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS H18-SB | Atlanta, GA 30329-4027 |

Report Password: the password to open the password protected Pathology Report PDF (Preliminary/Final/Addendum) for this case will be provided in a separate email after you receive the Final Pathology Report Email and will be a unique 12 digit number. If additional specimens are subsequently received on the same case by IDPB, the password will remain unchanged. Animal case reports will not have password protection.

Specimen Receipt Notice: the official contact(s) at the Health Departments (if known) will be cc'd on IDPB's Specimen Receipt Notice emails, in addition to cc'ing other case specific relevant parties. The same official contact(s) at the Health Departments (if known) will continue to receive IDPB's Final Pathology Reports once finalized.

ePathology Service: IDPB now offers telepathology consu tation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http //www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
To: Cohen, Jonathan; Chapman, Jennifer Rose; Pathology (CDC); BPHL13FL@flhealth.gov
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Date: Thursday, February 13, 2020 9:41:45 AM
Sensitivity: Confidential

Noted
Thanks for the update Dr. Cohen

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
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Tel: 404-718-7263
Fax: 404-639-3043
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954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc.gov

From: Cohen, Jonathan <j.cohen11@miami.edu>
Sent: Thursday, February 13, 2020 9:40 AM
To: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
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All,
The patient was born in [redacted]
She has traveled to the Caribbean and Central America but not South America.
All of us in South Florida have history of insect bites.
January 29, 2020 positive leishmaniasis IgG
Testing negative for hepatitis B, hepatitis C, HIV

Jonathan Cohen

From: Chapman, Jennifer Rose <JChapman@med.miami.edu>
Sent: Wednesday, February 12, 2020 3:18 PM
To: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>; Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov; Cohen, Jonathan <j.cohen11@miami.edu>
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
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Adding Dr Cohen, treating physician, to answer the questions below.

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- Travel history and/or country of birth
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- Results of any other microbiologic evaluation

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Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>; Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Subject: Specimen Receipt Notice: IDPB 2020-0171
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence
Dr. Stephen White,
This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.
If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

****

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AMERICAN OVERSIGHT

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
To: Pathology (CDC); BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: RE: Specimen Receipt Notice: IDPB 2020-0171
Date: Wednesday, February 12, 2020 3:03:37 PM
Sensitivity: Confidential

Good afternoon

We are requesting additional information regarding this case:

- Travel history and/or country of birth
- History of insect bites
- Leish testing date
- Results of any other microbiologic evaluation

Tina Benoit, MPH
Clinical Epidemiology Coordinator, Infectious Diseases Pathology Branch (IDPB)
Abacus Corporation
Division of High-Consequence Pathogens and Pathology
Centers for Disease Control and Prevention
1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027
MailStop H18-SB
Tel: 404-718-7263
Fax: 404-639-3043
Telework on Tuesdays
954-673-0731 (**Tuesdays ONLY**)
TBenoit@cdc.gov

From: Pathology (CDC) <Pathology@cdc.gov>
Sent: Wednesday, February 12, 2020 2:07 PM
To: BPHL13FL@flhealth.gov
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****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
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AMERICAN OVERSIGHT

From: Chapman, Jennifer Rose
To: Benoit, Tina (CDC/DDID/NCEZID/DHCPP); Pathology (CDC); BPHL13FL@flhealth.gov; Cohen, Jonathan
Cc: Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP)
Subject: Re: Specimen Receipt Notice: IDPB 2020-0171
Date: Wednesday, February 12, 2020 3:18:03 PM
Sensitivity: Confidential

Adding Dr Cohen, treating physician, to answer the questions below.

Jennifer Chapman, MD
Associate Professor
Director of Anatomic Pathology Operations @UHealth
Director, Immunohistochemistry Laboratory
Director, Hematopathology Fellowship Program
Department of Pathology and Laboratory Medicine
University of Miami / Jackson Memorial Hospital

From: Benoit, Tina (CDC/DDID/NCEZID/DHCPP) <uzo7@cdc.gov>
Sent: Wednesday, February 12, 2020 3:03:35 PM
To: Pathology (CDC) <Pathology@cdc.gov>; BPHL13FL@flhealth.gov <BPHL13FL@flhealth.gov>
Cc: Chapman, Jennifer Rose <JChapman@med.miami.edu>; Elesi.Quaye@flhealth.gov <Elesi.Quaye@flhealth.gov>; Stanek, Danielle (CDC flhealth.gov) <Danielle.Stanek@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; Edhelene.Rico@flhealth.gov <Edhelene.Rico@flhealth.gov>; Alvaro.Mejia-Echeverry@flhealth.gov <Alvaro.Mejia-Echeverry@flhealth.gov>; pedro.noya-chaveco@flhealth.gov <pedro.noya-chaveco@flhealth.gov>; Schmitz, Ann (CDC flhealth.gov) <ann.schmitz@flhealth.gov>; Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM) <bvp2@cdc.gov>; Leishmania (CDC) <leishmania@cdc.gov>; Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP) <wbs9@cdc.gov>; Zaki, Sherif (CDC/DDID/NCEZID/DHCPP) <sxz1@cdc.gov>; Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP) <sor1@cdc.gov>; Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP) <lua6@cdc.gov>
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Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

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AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Kopp, Edgar W; sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Cannons, Andrew C; Heberlein-Larson, Lea A.
Subject:	Re: Specimen Submission for COVID-19 PUI ID# 0001287
Date:	Thursday, February 20, 2020 8:08:33 PM

Thanks

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Kopp, Edgar W <Edgar.Kopp@flhealth.gov>
Sent: Thursday, February 20, 2020 7:43:16 PM
To: sgk5@cdc.gov <sgk5@cdc.gov>; eocevent177@cdc.gov <eocevent177@cdc.gov>; eocevent185@cdc.gov <eocevent185@cdc.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Cannons, Andrew C <Andrew.Cannons@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>
Subject: Specimen Submission for COVID-19 PUI ID# 0001287

FedEx tracking number 777820256263
Sender's name: Edgar Kopp

From: Pritchard, Scott
Sent: Wednesday, February 19, 2020 3:41 PM
To: Cannons, Andrew C <Andrew.Cannons@flhealth.gov>; Kopp, Edgar W <Edgar.Kopp@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Specimen Submission COVID-19 PUI ID# 0001287

Here are the details for an incoming PUI from Hillsborough county.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Sent: Wednesday, February 19, 2020 3:37 PM
To: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; CDC IMS Logistics Transportation <eocevent306@cdc.gov>; Hyde, Allen W. (CDC/DDPHSIS/CPR/DEO) <fnb4@cdc.gov>; Schneider, Eileen (CDC/DDID/NCIRD/DVD) <ees2@cdc.gov>; CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Subject: PUI ID# 0001287

Hello Scott:

Thank you for contacting CDC about the patient under investigation (PUI) for novel coronavirus (COVID-19). Please find summary information below to help assist in the PUI evaluation and specimen referral.

Summary

38 yo male who resides in China (Guangzhou City) came to US on 2/3. on 2/15 he developed cough, congestion, rash and subjective fever. Patient presented to ED for evaluation. Decision made to admit patient but patient signed himself out AMA. Specimen x 3 were collected prior to his signing himself out. Denied other risk factors (travel to Wuhan or Hubei province; contacts to a known case).

CDC COVID-19 ID #0001287

POC Details

Name: Scott Pritchard

Location: Florida

Phone: 850-251-5558

Email: scott.pritchard@flhealth.gov

Additional information

Guidance for health departments to submit PUI information to CDC can be found here.

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Include the CDC COVID-19 ID issued to you by CDC in the top right box and on all specimen forms. The PUI form should be submitted as soon as able and need not wait for specimen shipping. Instructions on how to submit the PUI form are located at the top of the form.

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

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

Please see the attached *2019 Novel Coronavirus (nCoV) Specimen Submission Guidelines* for detailed guidance on specimen shipment, packaging, and documentation. Please ensure that the patient information on the specimen tube exactly matches the 50.34 DASH Form, or the CDC may have to reject the specimen or testing may be delayed.

For questions about specimen collection or completing the 50.34 Form, please see https://www.cdc.gov/laboratory/specimen-submission/help-faqs.html.

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

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

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

Thank you,

CDC IMS 2019 NCOV Response PUI Team

2019 Novel Coronavirus Response

eocevent185@cdc.gov

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From:	CDC IMS State Coordination Task Force (SCTF) Operations
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	RE: State Health Official & State Epi Touchbase
Date:	Thursday, February 27, 2020 7:29:40 PM
Attachments:	DRAFT - Home Q or Iso Considerations v5.4_2.27.20.pdf

Good Evening Colleagues,

As a follow-up to today's state health official and state epidemiologist touchbase, please find the **DRAFT** "Home Containment for Persons Exposed to (Quarantine) or Infected with (Isolation) COVID-19 Coronavirus" guidance attached to this email. In addition, please be mindful this is a working document. As we learn more through science and the duration of the COVID-19 response, we anticipate adjusting the guidance accordingly.

Lastly, please take a moment to review the guidance and provide feedback to preparedness@cdc.gov. We are aware many jurisdictions are currently doing home containment planning. Subject matter experts at CDC wanted to provide draft guidance to assist you with your planning efforts. At this time, we are only sharing this guidance with the participants of state health official and state epidemiologist touchbase. Please let us know if you have any questions. Thank you.

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

(Sent by BCC to state health officials and State epidemiologists)

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Home Containment for Persons Exposed to (Quarantine) or Infected with (Isolation) COVID-19 Coronavirus

"Home containment" is a strategy to separate asymptomatic individuals who may have been exposed to COVID-19 or those who are mildly ill with symptoms of COVID-19 and do not require hospitalization, from the rest of the community. Home containment for persons exposed to, or infected with, COVID-19 can safely be used to reduce transmission, may be required based on practical logistical issues, and should be considered if the person can be safely transported home and state and local authorities are able to accept monitoring responsibility for the person. Logistical challenges exist for implementation of home containment, including the need for persons practicing social distancing to access basic provisions such as food, the loss of income for hourly wage workers expected to stay home from work, and the need for routine healthcare for individuals with underlying medical conditions.

Home containment (quarantine or isolation) for persons exposed to (**Q**uarantine) or infected with (**I**solation) COVID-19 should be considered if the person can be safely transported home for monitoring by state and local authorities.

Home Quarantine

For persons exposed to the COVID-19 coronavirus, quarantine (i.e., separation from unexposed persons) at home for a period of 14 days after the most recent exposure can be considered when the following criteria are met:

Transport

- Must be asymptomatic (i.e. afebrile with no respiratory symptoms)
- Must use State, local or Federally approved transportation mode from initial holding location to home location for quarantine. This may include:
    - Direct commercial air carrier may be considered from US arrival port of entry to home airport
    - Non-commercial ground transportation (for persons living locally or within driving distance). Ground transportation recommended via a privately owned or state-owned vehicle. Do not recommend use of privately-owned commercial transport services like Uber, Lyft, or taxis
    - Other Federal or State/local approved transportation
- Must be able to travel directly home without requiring multiple stops or any overnight stays
- Follow recommended infection control practices while enroute*:
    - Should practice social distancing and avoid congregate settings as much as possible
    - Follow recommended infection control practices:
        - Practice good respiratory hygiene including maintaining good hand hygiene using soap/water or alcohol-based hand gel, covering cough etc.

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- Surgical facemasks should be provided by the transferring authorities for the traveler to put on should they develop fever or respiratory symptoms during transport
- If traveling in a ground conveyance, surgical facemasks should be provided by the transferring authorities for the driver (or other passengers of the vehicle such as family members) to put on should a traveler develop fever or respiratory symptoms
- If symptoms develop enroute, the traveler or operator of the conveyance should notify relevant Federal (e.g. arrival POE Q station) and State/local authorities as soon as possible

**Note, the recommended approach for transportation and PPE requirements may be different for special groups who have been exposed to the COVID-19 virus (e.g. cohorts with exposures that are known to result in high attack rates would not be allowed to use commercial transportation*)

- CDC must be consulted and approve of any transportation that involves crossing state lines as Federal conditional release bridging orders may be required

Housing

- State and local health jurisdictions and state/local political leadership where housing is located implement quarantine and monitoring responsibilities. For persons under Federal quarantine orders, those orders will be rescinded upon arrival to housing location and assumed by the local or state jurisdiction's authority
- Home/location for home containment quarantine has been assessed by state or local authorities and deemed appropriate. Requirements include:
  - ability to maintain social distancing from any non-exposed members in household,
  - use of an unshared bedroom/bathroom from non-exposed household members,
  - no non-exposed persons present in household who would be at high risk for severe disease if exposed to Covid-19
- The person in quarantine should remain at home during the period of quarantine. Delivery of food and other essentials should be assured
- State or local authorities monitoring individual should assure there is a medical facility available that can provide the appropriate isolation and care of the individual should they become ill and require hospitalization for care
- State/Local and Federal authorities must be notified by the traveler or the conveyance operator when they arrive at housing location
- State/local authorities should refer to CDC guidance on movement and monitoring as published at: https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

Home Isolation

For persons infected with COVID-19 coronavirus who have no or only mild symptoms, or during recovery after release from hospital, isolation (i.e., separation from uninfected persons) at home until after 2

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negative tests collected at least 24 hour apart on both oropharyngeal (OP) *and* nasopharyngeal swabs, can be considered when the following criteria are met:

Transport

- Must use State/Local or Federally approved transportation to arrive at destination. This may include:
    - Non-commercial ground transportation for persons living locally or within a reasonable driving distance. Ground transportation may be via a privately owned or state-owned vehicle, or ambulance, but not via privately-owned commercial transport services like Uber, Lyft or taxis
    - Federally approved, non-commercial air transportation or medical evacuation flight
- Must wear a surgical facemask during transport. Additional facemasks should be available should one become wet/dirty and must be changed
- Other person(s) in transport (e.g. driver) should wear a surgical facemask and try to maintain a 6 ft distance from transported individual. CDC has issued guidelines for patients transported by ambulance Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs) for COVID-19 in the United States. This guidance includes recommendations for cleaning EMS transport vehicles following use.
- Practice good respiratory hygiene including maintaining good hand hygiene using soap/water or alcohol-based hand gel, covering cough, etc.
- Must be transported directly home without multiple stops or any overnight stays
- While in transit, should avoid public locations. If the individual(s) must enter a public location (e.g. to use the restroom), duration of visit should be kept to a minimum, and the individual(s) must wear a surgical mask. Waste can be disposed of in regular trash receptacles.
- CDC must be consulted and approve of any transportation that crosses state lines as Federal conditional release bridging orders may be required

Housing

- State and local health jurisdictions and state/local political leadership where housing is located implement isolation and monitoring responsibilities. Federal isolation orders will be rescinded upon arrival to location and care assumed by local or state jurisdiction
- The person in isolation should remain at home until released by state/local health authorities. Delivery of food and other essentials should be assured
- Location for isolation has been assessed by state or local authorities and deemed appropriate for use per the existing guidance for home isolation of COVID-19 patients. Guidance on assessment of the home for isolation can be found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fguidance-home-care.html
- State or local authorities should assure there is a medical facility available that can provide the appropriate isolation and care of the individual should their clinical condition worsen, and they require hospitalization for care
- State/Local and Federal authorities must be notified by the traveler or the conveyance operator when they arrive at housing location

DRAFT: pre-decisional, deliberative

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- State or local authorities must have appropriate plans in place for specimen collection and shipping and notification of results
- State/local authorities should refer to CDC guidance on movement and monitoring as published at: https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

DRAFT

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From:	Koneff, Douglas A
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Eleni Kalisch; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); CGRCU-Internal; O"Reilly, Kevin M; WHA-BSC-only; CGRCU-CAReps
Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject:	Re: Status of Chile charter (Silver Express pax)
Date:	Wednesday, March 18, 2020 9:13:17 AM

From Eleni:

The Latam charter from Chile is scheduled to arrive MIA at 11:30AM. We are arranging charters for this afternoon for non-Floridians to return them to airports closer to their homes. I have reached out to DOT to see if we can continue the Latam charter aircraft on to another airport and am awaiting guidance.

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From: Koneff, Douglas A <KoneffD@state.gov>
Sent: Wednesday, March 18, 2020 8:59:09 AM
To: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Eleni Kalisch <ekalisch@rccl.com>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; CGRCU-Internal <CGRCU-Internal@state.gov>; O'Reilly, Kevin M <OReillyKM@state.gov>; WHA-BSC-only <WHA-BSC-only@state.gov>; CGRCU-CAReps <CGRCU-CAReps@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ) <hvc4@cdc.gov>; Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ) <vqi8@cdc.gov>
Subject: Status of Chile charter (Silver Express pax)

I am slimming the chain to take our overseas colleagues off for right now. Please add DHS and others in the US as needed. Adding the State Department COVID coordination unit and consular reps.

Eleni - we understand the charter from Chile is scheduled to land in MIA between 1200-1300 EDT, and that FL state authorities have said non FL residents will not be allowed to continue onward to home unless moved to another charter.

Can you give us the latest? We are concerned both about Amcits on this flight as well as future charters by RC or other charters seeking to land in FL.

Thanks - Doug

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From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:37 PM

AMERICAN OVERSIGHT

To: Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc: Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 10:20 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

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Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Eleni Kalisch
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM

AMERICAN OVERSIGHT

To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

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Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329
>
> *470-487-4373*
>
> ---
>
> **From:** Sparks, Tyler K <SparksTK@state.gov>
> **Sent:** Monday, March 16, 2020 2:20 PM
> **To:** Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
> **Subject:** Royal Caribbean Ships off Brazil/Chile
>
> All -

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Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
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From:	India Bowman
To:	John Dunn; Carina Blackmore
Cc:	Craig Hedberg; Donald Sharp
Subject:	RE: Third Edition CIFOR Guidelines for Foodborne Outbreak Response Final Draft for Association Approval
Date:	Wednesday, February 12, 2020 4:55:19 PM
Attachments:	image001.png 3rd edition CIFOR Guidelines Final Draft.docx.pdf

Dear NASPHV Colleagues,

I would like to follow up on the status of your leadership review and approval of the 3rd edition *CIFOR Guidelines*. If your leadership has not yet completed their review, Craig and I welcome any comments or edits that you may have compiled up to this point. As CDC is very keen on obtaining our printing goal below, we ask that you provide these comments or edits as soon as possible and to keep us informed of your internal approval status.

Once more, I have provided you with a copy for review. Please let me know if you have any questions or need any assistance!

Sincerely,

India

From: India Bowman
Sent: Tuesday, December 31, 2019 1:13 PM
Cc: Craig Hedberg <hedbe005@umn.edu>; India Bowman <ibowman@cste.org>
Subject: Third Edition CIFOR Guidelines for Foodborne Outbreak Response Final Draft for Association Approval
Importance: High

Sent to Members of the CIFOR Council

Dear CIFOR Colleagues,

We are happy to announce the final draft of *The CIFOR Guidelines for Foodborne Outbreak Response* (3rd. Edition) is now available for CIFOR member association approvals!

As an update, the Guidelines were available on the CIFOR website for public commenting from November 6th through December 1st, 2019. In total, we received comments from five individuals. These comments primarily consisted of format changes, graphics requests and minor technical edits. Currently, we are working with a graphic design firm to produce a cover and modify the visual aspects of the Guidelines. The firm estimates that the design work will take 3-4 weeks to complete and our publishing timeline is as follows:

- We expect to have cover designs produced by **mid to late January** and will ask CIFOR Council members to vote. If you have any suggestions for design ideas, we welcome your input.
    - In **early January**, we will be reaching out to obtain high-resolution versions of your agency's graphics placed throughout the Guidelines.
- This design firm also has printing capabilities and estimates that printing will take approximately 3 weeks to complete. Depending on how quickly approvals are obtained, this has our final printing taking place in **late February.**

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- Our overall goal is to have books in hand at InFORM in **Early March** or shortly thereafter.

In the interim, we are asking that members provide their organizations with a copy of the draft (attached) to obtain appropriate leadership approvals prior to publication. Once obtained, please provide CSTE with a confirmation of approval. We are asking that approvals be obtained no later than **Friday, February 7th, 2020**. *Please note: This draft does not contain the foreword nor any appendices*.

To better assist with organizational approvals, we have listed below the most significant, high-level changes to the Guidelines:

- Content:
  - WGS and CIDT issues are discussed.
  - Integration of consumer complaint systems with pathogen-specific surveillance are discussed.
  - Importance of sub-cluster investigations and epidemiologic tracebacks are emphasized.
  - Importance of environmental assessments are emphasized.
  - Importance of after-action reviews are emphasized.
  - More coordinated inclusion of communications sections.
  - Elimination of CIFOR metrics, better referencing of existing program metrics.
- Format:
  - More functional, easier-to-use format.
  - Reorganization of chapters into foundational (1-3) and operational (4-8).
  - Streamlined organization of chapters and less redundancy between chapters.
  - Chapter summary points to highlight content of each chapter.

As always, please let us know if you have any questions. Thank you all for your hard work! Please have a safe and happy New Year!

Sincerely,
India

India Bowman, MPH
Program Analyst

Council of State and Territorial Epidemiologists
"Using the power of epidemiology to improve the public's health"
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Documents with personal data and/or confidential information must be sent to CSTE's national office only through a secure ShareFile request and not through regular email.

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Guidelines for Foodborne Disease Outbreak Response

Third Edition

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Acknowledgements PARTICIPANTS IN DEVELOPMENT OF THE THIRD EDITION OF THE CIFOR GUIDELINES

Association of Food and Drug Officials (AFDO)

Association of Public Health Laboratories (APHL)

Association of State and Territorial Health Officials (ASTHO)

Centers for Disease Control and Prevention (CDC)

Council of State and Territorial Epidemiologists (CSTE)

Food and Drug Administration (FDA)

National Association of County and City Health Officials (NACCHO)

National Association of State Departments of Agriculture (NASDA)

National Association of State Public Health Veterinarians (NASPHV)

National Environmental Health Association (NEHA)

U.S. Department of Agriculture/Food Safety and Inspection Service (USDA/FSIS)

The first edition of the Guidelines was supported by Cooperative Agreement Number 1U38HM000414-01 from CDC. The second edition was supported by Cooperative Agreement Numbers 1U38HM000414-05 and 1U38OT000143-01 from CDC. The third edition was supported by Cooperative Agreement Numbers 5U38OT000143-05 and 1 NU38OT000297-01-00. The findings and conclusions in this document are solely those of the authors and do not necessarily represent the official views of CDC.

CIFOR MEMBERS

Co-Chair: Kirk Smith, DVM, MS, PhD; Manager, Foodborne, Waterborne, Vectorborne, and Zoonotic Diseases Section, Minnesota Department of Health

Co-Chair: Scott Holmes, MS, REHS; Manager, Environmental Health Division, Lincoln Lancaster County Health Department

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Kirsten Larson; Manager, Food Safety Program, Association of Public Health Laboratories

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Elizabeth Landeen; Associate Director, Program & Partnership Development, National Environmental Health Association

Abraham Kulungara, MPH; Senior Director, Environmental Health, Association of State and Territorial Health Officials

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CIFOR GUIDELINES FOR FOODBORNE ILLNESS OUTBREAK RESPONSE, THIRD EDITION

Lead Author: Craig Hedberg, PhD; Professor, University of Minnesota

CIFOR GUIDELINES OVERVIEW:

Author: Tim Jones, MD; State Epidemiologist, Tennessee Department of Health

Workgroup Members:

Andre Pierce, MPA, REHS; Director, Division of Environmental Health & Safety, Wake County Government

Danny Ripley; Food and Public Facilities Protection Services, Metro Public Health Department

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Kirsten Larson; Manager, Food Safety Program, Association of Public Health Laboratories

Michele DiMaggio, REHS; Supervising Environmental Health Specialist, Contra Costa County

Paul Cieslak, MD; Medical Director, Communicable Disease & Immunizations, Oregon Health Authority

CHAPTER 1: THE EVOLVING CHALLENGE OF FOODBORNE OUTBREAK RESPONSE

Authors:

Paul Cieslak, MD; Medical Director, Communicable Disease & Immunizations, Oregon Health Authority

Joseph Russell, MPH, RS; CSTE Consultant

Workgroup Members:

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Sherri McGarry; CDC Liaison to FDA; Centers for Disease Control and Prevention

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Veronica Burell, REHS; Environmental Health Specialist II, Contra Costa County Environmental Health

Jessica Healy, PhD; Epidemiologist, Enteric Diseases Epidemiology Branch, Centers for Disease Control and Prevention

CHAPTER 2: LEGAL PREPAREDNESS FOR THE SURVEILLANCE, INVESTIGATION AND CONTROL OF FOODBORNE ILLNESS OUTBREAKS

Authors:

Patricia Elliott, JD, MPH; President, Health | Environment Concepts

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Shannon O'Fallon, JD; Oregon Department of Justice

Carlynne Cockrum, JD; U.S. Department of Agriculture Food Safety and Inspection Service

Sherri McGarry; CDC Liaison to FDA; Centers for Disease Control and Prevention

CHAPTER 3: PLANNING AND PREPARATION: BUILDING TEAMS

Authors:

Maha Hajmeer, PhD; Research Scientist IV, California Department of Public Health

D’Ann Williams, DrPH, MS, LEHS; Chief, Center for Food Emergency Response and Defense; Maryland Department of Health

Tim Jones, MD; State Epidemiologist, Tennessee Department of Health

Workgroup Members:

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Chapter 1: The Evolving Challenge of Foodborne Illness Outbreak Response

Chapter summary points

- Foodborne illness strikes tens of millions, hospitalizes more than 100,000, and kills an estimated 3,000 people in the United States each year.
- The U.S. diet has changed in response to numerous factors creating new food-safety challenges.
- Important advances in clinical laboratory techniques and public health approaches to detect and investigate clusters of illness are being used to better define the scope and nature of foodborne illness.
- Information systems and food-supply investigation techniques are developing to enhance our ability to trace contaminated foods, identify and control contamination sources, and remove contaminated food from circulation.
- Industry-driven and regulatory food-safety standards are being changed to better address risks identified by foodborne illness outbreak investigations to prevent similar outbreaks.

URLs in this chapter are valid as of July 11, 2019.

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1.0 Introduction

Outbreaks of foodborne illness and their detection, investigation, and control are functions of several constantly changing factors. The U.S. diet has changed in response to public health recommendations; economics of food production and distribution; and the growing demands for convenience in food service, as well as diversity and freshness of foods in the marketplace. Important advances have been made in clinical laboratory techniques to diagnose foodborne illnesses and in public health approaches to detect and investigate clusters of illness. Information systems are developing to enhance our ability to trace contaminated food and eliminate it from circulation and to glean lessons learned from these investigations to prevent similar outbreaks. In addition, industry-driven and regulatory food-safety standards are being changed to better address risks identified by foodborne illness outbreak investigations to prevent similar outbreaks.

This chapter provides an overview of these ever-changing factors. Subsequent chapters detail specific approaches used by investigators.

1.1 The Burden of Foodborne Illness in the United States

1.1.1 In 2011, the Centers for Disease Control and Prevention (CDC) estimated that each year in the United States 47.8 million illnesses, resulting in 128,000 hospitalizations and 3,000 deaths, were attributable to contaminated food (*1, 2*). Of these illnesses, 9.4 million are caused by 31 known agents of foodborne illness, and the remaining 38.4 million by unspecified agents. Tracking overall changes in the burden of foodborne illness from year to year is not currently possible, but trends are evident in known foodborne illnesses tracked by FoodNet (https://wwwn.cdc.gov/foodnetfast). Most notably, the incidence of *Escherichia coli* O157:H7 infections dropped from approximately 2.5 cases per 100,000 population during the mid-1990s to fewer than 1 case per 100,000 by the mid-2000s, accomplishing a goal of Healthy People 2010. Following early declines in the incidence of *Listeria* and *Campylobacter* infections, rates remained stable throughout the 2000s, whereas the incidence of *Vibrio* infections increased. Overall rates of *Salmonella* infections remained stable; the incidence of infection by serotypes Typhimurium and Heidelberg decreased; and infection by serotypes Enteritidis, Javiana, and the monophasic variant of Typhimurium, serotype I 4,[5],12:i:-, increased (*3*).

Because not all illnesses caused by foodborne pathogens are individually reportable, recognition of other pathogen-specific trends relies on surveillance of foodborne illness outbreaks. CDC's National Outbreaks Reporting System (NORS) logged 20,854 outbreaks comprising 403,110 illnesses, 16,517 hospitalizations, and 392 deaths during 1998–2017 (https://wwwn.cdc.gov/norsdashboard/). Reporting of foodborne illness outbreaks caused by norovirus increased during 1998–2004, but since 2010, annual totals have varied little, hovering around 300 per year. A comparison of etiologies causing single-agent outbreaks during 2012–2017 with those during 2002–2011 showed that outbreaks caused by agents associated with poor food-holding practices in commercial food-service establishments decreased: *Bacillus cereus*, down from an average of 17 outbreaks per year to 10 per year; *Clostridium perfringens*, from 40 to 32 per year; scombroid or histamine, from 23 to 17 per year; and *Staphylococcus aureus*, from 27 to 12 per year. These changes most likely represent actual reductions in outbreak occurrence

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because the percentage of reported outbreaks for which no etiologic agent was identified dropped from 59% in 1998 to 23% in 2017 (*4*).

1.1.2 In 2014, the U.S. Department of Agriculture's Economic Research Service (USDA–ERS) estimated the average annual economic burden of foodborne illness at $15.5 billion (*5*). USDA–ERS based this burden on cost estimates of foodborne illness caused by 15 major pathogens in the United States (Table 1.1). These 15 pathogens account for 95% of illnesses and deaths from foodborne illness acquired in the United States for which a pathogen was identified. These estimates include costs associated with medical treatment of acute and chronic illness, lost wages of persons who recovered, and costs associated with premature deaths.

Table 1.1. Estimated Annual Cost of Foodborne Illness, Total Number of Cases Identified, and Average Cost per Case Identified, United States, 2013

Pathogen	Total Cost	Total Cases Identified	Cost per Case
Vibrio vulnificus	$319,900,000	96	$3,332,000
Listeria monocytogenes	$2,834,400,000	1,591	$1,782,000
Toxoplasma gondii	$3,304,000,000	86,686	$38,100
Vibrio spp. (other noncholera)	$72,800,000	17,564	$8,100
Shiga toxin–producing *Escherichia coli* O157	$271,400,000	63,153	$4,300
Salmonella spp. (nontyphoidal)	$3,666,600,000	1,027,561	$3,600
Yersinia enterocolitica	$278,000,000	97,656	$2,900
Campylobacter spp.	$1,928,800,000	845,024	$2,300
Vibrio parahaemolyticus	$40,700,000	34,664	$1,200
Shigella (all species)	$138,000,000	131,254	$1,100
Cryptosporidium parvum	$51,800,000	57,616	$900
Norovirus	$2,255,800,000	5,461,731	$410
Clostridium perfringens	$342,700,000	965,958	$360
Non-O157 Shiga toxin–producing *E. coli*	$27,400,000	112,752	$240
Cyclospora cayetanensis	$2,300,000	11,407	$200

Source: US Department of Agriculture. Cost estimates of foodborne illnesses. https://www.ers.usda.gov/data-products/cost-estimates-of-foodborne-illnesses

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1.1.3 The impact of foodborne illness on the food industry varies greatly, and the costs seldom are limited to one company. This impact is evident when the distribution network of the food supply is considered. The impacts of recalls on the food industry are far-reaching, in some cases topping $10 million in direct costs.

Direct costs of recalls include notification of regulators, supply chain, and consumers; product retrieval, storage, and destruction; unsalable product; and the additional labor associated with these activities. These direct costs do not include litigation, increased regulatory compliance, and the impact to the company's market value and brand reputation.

The outbreak of *E. coli* O157:H7 associated with romaine lettuce grown in the Yuma, Arizona, growing region in April 2018 provides a good example of the indirect costs to the industry associated with lost sales and brand damage. This outbreak sickened 210 people in 36 states. During the week that followed the initial news of the outbreak, sales of romaine lettuce fell 20% (*6*). In addition, data from Nielsen also showed marked drops in sales of iceberg lettuce, red leaf lettuce, and endive. The impact of a second, although unrelated, outbreak of *E. coli* O157:H7 associated with romaine lettuce in November 2018 (*7*) was even more dramatic because CDC advised consumers to avoid eating romaine lettuce from any source in an effort to remove potentially contaminated romaine from commercial distribution channels.

With a more comprehensive accounting of potential costs, researchers at the Johns Hopkins Bloomberg School of Public Health suggested that the cost to a restaurant for a single foodborne illness outbreak can range from $4,000 to $2.6 million, depending on the pathogen, type of restaurant involved, and size of the outbreak. For example, a foodborne illness outbreak in which five people became sick in a fast food restaurant would result in costs of approximately $4,000 if there was no loss in revenue and no lawsuits, legal fees, or fines. In contrast, a single outbreak of listeriosis involving 250 persons in a fine dining restaurant could cost upwards of $2.6 million in lost sales, lawsuits, legal fees, fines, and higher insurance premiums (*8*).

1.2 Growing Complexity of the Food Supply

U.S. food-consumption patterns change continuously. Changes in diets and food preferences have resulted in a greater demand for a broader variety of fruits, vegetables, and other foods. Moreover, Americans expect to consume these foods year-round, driving importation from areas of the world with the growing seasons necessary to meet U.S. demand. Meeting global supply-chain demands also has increased the complexity and logistics of how food is transported from farm to fork.

1.2.1 A major indicator of changing diets is the consumption of fresh fruits and vegetables. Since 1996, loss-adjusted per capita availability of fresh fruit increased 7% from 55 to 59 pounds (*9*). Consumption of fresh vegetables increased only marginally from 68 to 70 pounds per person. During the same time, per capita consumption of chicken increased 30% from 40 to 52 pounds, whereas that of beef declined 17% from 49 to 41 pounds (*9*). Within the arena of fresh produce, consumption of head lettuce declined 34% from 12 to 8 pounds per capita, whereas consumption of romaine and leaf lettuce doubled from 3 to 6 pounds per capita, and consumption of fresh spinach nearly tripled from 0.3 to 0.9

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pounds per capita. Consumption of fresh berries also increased substantially. The general pattern of these dietary changes reflects public health recommendations toward healthier eating (*9*).

The food industry has met this demand through routine importation of items once considered out of season or exotic. According to reports by USDA–ERS (*10*), the proportion of imported fresh fruits increased from 39% in 1996 to 53% in 2016. Excluding bananas, for which there is no domestic production, the share of imported fruits increased from 16% to 38%. Similarly, the percentage of imported fresh vegetables increased from 14% to 31%. Although a high proportion of some fresh produce items, such as mango and papaya, always have been imported, an increasingly more conventional produce items are also imported. For example, the percentage of imported avocadoes increased from approximately 14% in 1996 to 89% in 2016, and that of blueberries increased from 24% to 57% during that same period (*10*).

The safety of imported food products depends largely on the public health and food-safety systems of other countries. Recent analyses of foodborne illness outbreaks reported to CDC support the existence of food-safety problems in other countries. During 1996–2014, the number of confirmed foodborne illness outbreaks associated with imported foods increased from 3 per year to 18 per year. *Salmonella* and *Cyclospora* accounted for about one third of the outbreaks and 75% of cases, most due to contaminated produce from Latin America (*10*).

1.2.2 Culinary preferences for undercooked or raw foods also contribute to more frequent infections and outbreaks caused by the microorganisms associated with these foods. These include classical outbreaks of Shiga toxin–producing *E. coli* (STEC), *Salmonella*, *Campylobacter*, and *Listeria* infections associated with raw milk and raw milk cheeses; *Salmonella* associated with raw tuna in sushi; and *Campylobacter* and *Salmonella* in minimally processed liver pates. A corresponding trend for raw pet foods made from meat and poultry products also has led to outbreaks among people from handling the raw pet food, exposure to ill animals, or environmental contamination in the household.

Foodborne illnesses also can be associated with ingestion of products not typically thought of as food. During 2017–2018, kratom, a tree leaf with stimulant and opioid properties, caused illness by a variety of *Salmonella* serotypes. Smoking marijuana caused an outbreak of salmonellosis in 1981 (*11*); and a cannabis-associated toxidrome among four persons who attended the August 2014 Denver County Fair was associated with consumption of chocolate bars obtained at the “LoveAll” booth at the fair’s “Pot Pavilion” (*12*). The full legalization of cannabis products in at least nine other states and the District of Columbia since 2014 and associated sales of cannabis-infused edibles could lead to more foodborne illness outbreaks.

1.2.3 Changes in how food is cultivated or raised, processed, and distributed and where, how, and by whom food is prepared also contribute to changing patterns of foodborne illness. The demand for processed and ready-to-eat foods has led to the industrialization of food production with increasingly intense agricultural practices and broadening distribution of food products. Changes in agricultural, processing, or packaging methods might facilitate bacterial contamination or growth. Large multistate STEC outbreaks associated with leafy green vegetables reflect the challenges of intensive animal and

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fresh produce production in a shared environment. The scale of these operations magnifies the impact of food-safety system failures, resulting in thousands of exposures and potential illnesses across multiple states, and even multiple countries.

Increasingly complex food-distribution systems span the globe. Products move from farm to fork through a network of farms, processors, manufacturers, packers, importers, brokers, storage facilities, distribution centers, and retail outlets. In some instances, food from a farm can change hands more than 10 times before it reaches a consumer. These complex supply chains are maintained by a wide variety of record-keeping systems; outbreak investigators charged with tracing foods back through the supply chain are left to decode these systems and piece together, step by step, how a food reached its final destination.

At the same time, a counter-trend promoting local food sources and small-scale farm-to table distribution networks (sometimes termed the "locavore movement" or "community-supported agriculture") has emerged. The number of small food producers and direct-to-consumer marketing avenues (e.g., farmer's markets, farm stands, farm-to-school programs, and "pick-your-own" operations) also has risen. According to national agriculture census data, from 1997 to 2017, direct sales of agricultural products to the public increased by 374%, compared with an increase of 93% for all agricultural sales. During the same period, the number of farms selling directly to consumers increased by 18%, compared with an 8% decrease in the total number of farms (*13*). In addition, most states have "cottage food" laws, allowing small producers to cook, can, or pickle outside of licensed kitchens certain foods that are typically considered low-risk.

The effect of increased consumption of locally produced foods is yet to be determined, but the consequences of eating unsafe food apply to both small and large producers. For an individual, it is equally as bad to get STEC infection from farm-fresh strawberries harvested from a local field frequented by wild deer as it is to get STEC infection from romaine lettuce shipped hundreds of miles after contamination with runoff from a cattle feed lot. Although a small producer's limited distribution system might affect fewer people, implementing improved food-safety measures might be more challenging for the small producer. In addition, farm direct sales (i.e., farmers selling produce, eggs, and other foods they produced directly to retail customers, such as through farmers' markets and farm stands) are not included among food facilities in the 2011 Food Modernization and Safety Act (FMSA) (*14*). In some states and local jurisdictions, these sales have been exempted from food-safety regulations that pertain to other food facilities.

By whom and where our food is prepared also plays a role in foodborne illness occurrence and outbreaks. Americans increasingly eat away from home, spending more than 50% of food dollars away from home, since 2010 (*15*). During this period, there was considerable growth in limited service "fast casual" restaurants that featured more complex food handling than traditional fast-food restaurants. The increased number of meals eaten away from home most likely influenced the increase in foodborne illness. In an analysis of foodborne illness outbreaks reported to CDC during 2009–2017, 62% were associated with restaurants (4, 16). In addition, studies of sporadic and outbreak-associated foodborne illness, including infection with STEC O157, *Salmonella enterica* serotypes Enteritidis and Typhimurium,

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and *Campylobacter jejuni* suggest that commercial food-service establishments, such as restaurants, play an important role in foodborne illness in the United States (*17*).

Finally, the growing e-commerce in delivery of groceries and restaurant food directly to consumers' homes provides foodborne illness investigators with opportunities for verifying food purchases and dates. Whether an increased risk for illness accompanies these means of food distribution remains to be determined.

1.3 Enhanced U.S. Foodborne Illness Surveillance Systems

A variety of surveillance systems have been developed to identify foodborne illness and detect outbreaks. Some systems focus on specific pathogens likely to be transmitted through food and have been used extensively for decades. More recently, new surveillance methods have emerged that provide data on food vehicles, settings, pathogens, contributing factors, and environmental antecedents. Effective surveillance to track cases of foodborne illness and outbreaks is critical to developing effective control strategies.

1.3.1 Changes in surveillance for human illness have affected how outbreaks are detected (Chapter 4) and investigated (Chapter 5). All states and territories have legal requirements for the reporting of certain illnesses and conditions, including illnesses likely to be foodborne (e.g., salmonellosis, campylobacteriosis, and STEC infection), by healthcare providers and laboratories to the local, state, or territorial public health agency (Chapter 2). Local and state agencies also receive and respond to complaints of illness directly from the public. The adoption of new testing methods in clinical and public health laboratories, as well as improved information management systems and social media, are transforming surveillance activities.

- Molecular subtyping by public health laboratories has been the basis for national pathogen-specific surveillance since the initiation of PulseNet in 1996. The use of pulsed-field gel electrophoresis (PFGE) increased the ability to link isolates from distant locations and thereby to infer epidemiologic relatedness; PFGE revolutionized the detection and investigation of foodborne illness outbreaks and led to prevention of illnesses. However, PFGE provided limited information about the organism itself. Rapid bacterial sequencing technology and the informatics tools needed to accommodate whole-genome sequencing (WGS) have been developed and in 2019 rapidly deployed to public health laboratories across the United States. On July 15, 2019, WGS replaced PFGE as the primary molecular subtyping tool for pathogen-specific surveillance.
- Concurrent with the development of WGS to improve molecular subtyping, clinical laboratories have moved away from traditional fecal culture in favor of culture-independent diagnostic tests (CIDTs). These methods can rapidly identify pathogens and expedite treatment decisions, but they do not yield the bacterial isolates required by public health officials. Many public health jurisdictions require submission of CIDT-positive specimens for subsequent culture and subtyping—but this shifts the burden of isolation from the clinical laboratory to the public health laboratory and delays cluster recognition. Conversely, CIDTs may be more sensitive and offer the prospect of detecting pathogens (e.g., enterotoxigenic *E. coli*) that may elude detection by culture.

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- Although newer technologies sometimes lead to delayed recognition of clusters and reduced cluster sizes, improved epidemiologic investigation practices have been developed. These include the standardization of common data elements for interviewing case-patients, use of standardized hypothesis-generating questionnaires, increased use of consumer product purchase (e.g., "shopper card") data, aggregation of case-patient exposures and comparison with population reference standards, and improved subcluster investigation and informational traceback methods to improve the specificity of exposure assessments.
- The principles of foodborne illness complaint surveillance are being standardized (Chapter 4). The value of using electronic databases to review and analyze complaints and to link complaints with pathogen-specific surveillance systems has been demonstrated. Numerous social media platforms have been evaluated to assess their potential utility to enhance conventional complaint surveillance. To the extent these can facilitate linking illnesses with exposure, rather than just reinforcing the "last meal eaten" bias, they may warrant attention from public health agencies.
- Standards and procedures for outbreak reporting have been developed for NORS. NORS supports outbreak reporting from state, local, and territorial health departments in the United States. NORS Dashboard is a public-facing, web-based tool containing limited and cleaned NORS data that can be filtered using an interactive interface that produces summary data, statistics, and a variety of graphs based on user preferences (https://wwwn.cdc.gov/norsdashboard/www.cdc.gov/fdoss/nors-dashboard.html). CDC, USDA's Food Safety and Inspection Service (FSIS), Food and Drug Administration (FDA), and other investigating agencies analyze these data to improve understanding of the impact of foodborne illness outbreaks on human health and of the pathogens, foods, and settings involved in these outbreaks.
- Specialized surveillance networks have been developed for specific pathogens. For example, CaliciNet is a norovirus outbreak surveillance network of local, state, and federal public health laboratories. Network partners perform viral sequencing and upload sequences into CaliciNet to monitor circulating strains, and identify newly emerging norovirus strains. CryptoNet, the first U.S. national molecular tracking system for a parasitic infection, was formally launched in 2015 to collect specimens and to characterize the molecular epidemiology of infection by *Cryptosporidium* spp., only some of which are pathogenic for humans but which are typically indistinguishable morphologically.

1.3.2 Surveillance for food-preparation hazards and environmental assessments of outbreaks have been developed to identify root causes (Chapter 5) and improve preventive controls (Chapter 6). Routine food-safety inspections are conducted for all licensed food-service establishments by approximately 3,000 local and 75 state and territorial agencies. Although traditionally conducted to ensure that food-service establishments were operating within the provisions of state food codes, many of which are adopted from the FDA Model Food Code (*18*), inspection results are being increasingly displayed at the point of service or online to provide information to consumers about potential food-safety risks. A growing body of evidence suggests that such public disclosure of inspection results might improve restaurant inspection results and reduce the risk for illness transmission to patrons.

- To standardize assessment of retail food risk factors**,** FDA initiated the Retail Food Risk Factor Study to measure practices and behaviors commonly identified as contributing factors in foodborne illness outbreaks (*19*). Data from the initial study, collected during 1998, 2003, and

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2008, documented progress toward the goal of reducing contributing factors (https://www.cdc.gov/nceh/ehs/nears/cf-definitions.htm) at retail establishments: five of the nine facility types showed a statistically significant improvement in compliance for all 42 contributing factors during the study period. A second round of the Retail Food Study was initiated in 2013 to assess food-protection manager certification and food-safety management systems. In restaurants, having a well-developed and documented food-safety management systems was associated with fewer food-safety items out of compliance (*20*).

- The Environmental Health Specialists Network (EHS-Net) of environmental health specialists and epidemiologists from local and state health departments, FDA, FSIS, USDA's Food and Nutrition Service, and CDC developed the National Environmental Assessment Reporting System (NEARS) to systematically monitor and evaluate root causes of foodborne illness outbreaks, including contributing risk factors and environmental antecedents. This system is cross-referenced with NORS and collects information from detailed environmental assessments on factors contributing to the outbreak and the underlying conditions that led to it. The information collected through NEARS can inform hypothesis generation about antecedents to foodborne illness outbreaks and strengthen the ability of food-control authorities to formulate and evaluate the effectiveness of food-safety actions.

1.3.3 The food supply and associated environments are tested by local, state, and federal regulatory officials and the food industry. Food testing is a tool used to assess whether an establishment's food-safety system is functioning adequately to address hazards in food production and manufacturing and prevent foodborne illnesses. Food and environmental testing data, including molecular subtyping data, can be used to inform hypothesis generation during outbreaks. Food testing data also can be used to estimate the fraction of selected foodborne illnesses caused by specific food sources, to assess changes in food contamination over time, and to assess the success of regulatory measures. Foodborne pathogens of interest that are isolated from food or from animal or environmental sources during various government testing programs are being characterized by WGS and the sequence data added to FDA's GenomeTrakr BioProjects housed at NIH NCBI, where they can be compared with data from human isolates directly on NCBI Pathogen Browser and/or in the CDC-PulseNet National Database.No formal framework exists to link industrywide testing to public health surveillance data. Mechanisms have been discussed that would provide access to aggregated, or blinded industry data to avoid regulatory penalties to individual companies.

To ensure technical competence and the ability to generate reliable data, food testing laboratories within FDA and FSIS maintain accreditation in the International Organization for Standardization/International Electrotechnical Commission 17025 standard—the main international standard used by testing and calibration laboratories. Additionally, FDA is leading an effort to bring state human and animal food testing laboratories into International Organization for Standardization/International Electrotechnical Commission 17025 accreditation to enhance efforts to protect the food supply. Data generated by accredited laboratories will be made available for consideration during FDA enforcement actions, as well as for surveillance purposes and during local, state, or federal response to foodborne illness outbreaks. Laboratory accreditation also will assist state manufactured food-regulatory programs in achieving conformance with the Manufactured Food Regulatory Program Standards.

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1.4 Foodborne Illness Outbreak Response and System Change

1.4.1 Although foodborne illness surveillance and response are rooted in individual states' laws, the growing trend in multistate outbreaks associated with widely distributed foods requires increasing standardization of methods, integration of activities, and federal support and oversight. In response to the emergence of *E. coli* O157:H7 and other foodborne pathogens during the 1990s, CDC developed the active surveillance network FoodNet, with funding assistance from FSIS, to conduct comprehensive surveillance of diagnosed illnesses within defined populations to assess and monitor trends in the burden of illness associated with specific agents. Simultaneously, CDC established the national molecular subtyping network PulseNet to improve laboratory-based surveillance for bacterial pathogens routinely detected by clinical laboratories. PulseNet increased detection of multistate outbreaks, and FoodNet provided a framework to interpret the impact of food system changes in response to improved outbreak detection and regulatory activity.

In 2005, CIFOR was established to identify barriers to effective surveillance and investigation of foodborne illnesses and outbreaks. One of the first CIFOR projects was to develop guidelines for outbreak detection and response. The First Edition of the CIFOR Guidelines, published in 2009, established model practices for foodborne disease surveillance at local and state levels, with specific reference to coordination of multijurisdictional outbreaks investigations and development of performance indicators to measure the effectiveness of surveillance activities. The Second Edition of the Guidelines was published in 2014.

During this time, CDC began providing dedicated funding to state-level support foodborne illness outbreak response through Epidemiology and Laboratory Capacity grants. This led to development of several CDC programs: OutbreakNet, CDC's Foodborne Diseases Centers for Outbreak Response Enhancement (FoodCORE), and the Integrated Food Safety Centers of Excellence and OutbreakNet Enhanced (OBNE). The CDC Integrated Food Safety Centers of Excellence were created by FSMA. These programs are intended to work together to enhance the development and evaluation of foodborne illness surveillance and outbreak response activities across the United States.

In conjunction with CDC's investments in the performance of public health agencies, FDA has used additional resources provided by FSMA to develop a network of Rapid Response Teams to enhance coordination between public health and food-regulatory agencies at the state level and formed a Coordinated Outbreak Response and Evaluation (CORE) Network to centralize coordination of outbreak response activities within FDA. FSIS has developed parallel outbreak response capacity (Chapter 3).

With a stated goal of building an Integrated Food Safety System, FDA established the Partnership for Food Protection in 2008, bringing together local, state, territorial, tribal, and federal representatives with expertise in food; feed; epidemiology; laboratory; and animal, environmental, and public health. The Partnership for Food Protection brings the collective expertise of the above stakeholders to work on projects that enhance human and animal food safety in the United States.

Coordination of activities on the federal level is accomplished through mutual liaisons between agencies, and joint participation in the Intergovernment Food Safety Analytics Collaboration which seeks to improve the use of outbreak surveillance in foodborne illness attribution models and thus better guide food-safety regulation. Chapter 3 details the agencies currently involved in foodborne illness

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outbreak response, along with their respective roles and responsibilities. Issues posed in the response to multijurisdictional outbreaks are discussed in Chapter 7.

1.4.2 Food-safety standards are changing to better control food-safety risks identified by foodborne illness outbreak investigations. Both industry-driven standards (e.g., from the Global Food Safety Initiative, https://www.mygfsi.com/about-us/about-gfsi/what-is-gfsi.html) and government-driven regulatory requirements are being updated to identify and manage food-safety hazards more rapidly. Examples of noteworthy regulatory changes in the United States include

- The 2011 FSMA—the first major reform of the FDA's food-safety authority since the 1938 enactment of the Food, Drug, and Cosmetic Act. Since the Second Edition of the CIFOR Guidelines, some key provisions of FSMA have been rolled out in seven federal regulations (Chapter 2), which provide FDA with additional legal authorities and resources to strengthen food-safety systems. They enable FDA and its food-safety partners, to focus on preventing food-safety problems and to address food-safety risks more rapidly when they are identified. FSMA and its associated regulations grant FDA substantial new authority to protect food all along the farm-to-fork line, covering preventive controls, inspections, laboratory testing, product tracing, mandatory recall authority, importer accountability, authority to deny entry to the U.S. market, state and local capacity building, and other areas.
- Since enactment of its Pathogen Reduction, Hazard Analysis and Critical Control Point Systems rule to reduce risks associated with meat and poultry in 1996, FSIS has continued to address food-safety hazards. In 2011, FSIS established raw poultry performance standards for *Campylobacter* and updated existing ones for *Salmonella*. In 2012, FSIS added six non-O157 STEC serogroups as "adulterants" in raw beef. In 2015, after agency investigators noted they often were impeded in efforts to trace ground beef to its source during outbreak investigations and in response to STEC-positive sample results, FSIS required its regulated establishments and retail stores to maintain detailed records to identify all ground-beef source materials.

In summary, the foods we eat and the processes by which they are produced, distributed, and prepared; the means for diagnosing illness and detecting outbreaks; the methods whereby outbreaks are investigated; and the response of government and private partners are always changing. The following chapters provide updated guidance to responders with these changes in mind. The final chapter (Chapter 8) provides and references metrics for evaluating an agency's progress toward optimizing its response to foodborne illness outbreaks.

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Chapter 2: Legal Preparedness for the Surveillance, Investigation, and Control of Foodborne Illness Outbreaks

Chapter Summary Points

- The authority to identify, investigate, and control foodborne illness outbreaks is shared across local, state, and federal, governments and requires ongoing cooperation. Legal preparedness is the assurance that agencies and jurisdictions are equipped with sufficient legal authorities to conduct effective disease surveillance and control and have staff trained to use these authorities.
- Local and state statutes and regulations authorize the reporting and investigation of foodborne illnesses. The communicable disease control regulatory process is often used to specify diseases and conditions to be reported, the information to be reported, and the process for making a report. State laws and regulations also address the confidentiality of disease reports and enforcement of reporting requirements.
- Local and state agencies need to regularly access confidential records when investigating reports of foodborne illness. They must navigate differing local, state, and federal legal authorities and requirements as they seek to access and share information with other government agencies and respond to media inquiries.
- Shared goals of the public and private sectors are to prevent as many outbreaks as possible and to mitigate those that occur. In the public sector, local, state, and federal agencies accomplish those goals by working independently and together to exercise their legal authorities to, among other things, inspect, seize or destroy foods, and close establishments.
- Although reporting, surveillance, and mitigation of foodborne illness outbreaks are well established in local, state, and federal law, issues continue to arise that demonstrate differences among state and federal laws and the need for ongoing communication and collaboration among state, local, and federal officials who are united in the common goal of protecting the public's health.
- During foodborne illness investigations, public officials may find issues that require the initiation of administrative actions or even civil or criminal proceedings. Data collected during a foodborne illness investigation can become the basis for further action by local, state, and federal agencies.

URLs and email addresses in this chapter are valid as of July 3, 2019.

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2.0 Introduction

2.0.1 Understanding and appropriately using law is a fundamental part of protecting the public's health from foodborne illness. Local, state, and federal government agencies share the authority to identify, investigate, and control foodborne illness outbreaks, but each level of government and each agency within it has specific roles, responsibilities, and legal authorities. The success of a public agency's efforts to combat foodborne illness also greatly depends on its cooperation and communication with multiple parties in the food, agriculture, healthcare, and laboratory sectors. Ultimately, the goal is to become more effective at protecting public health and preventing disease by leveraging legal authorities across local, state, and federal jurisdictions.

2.0.2 This chapter addresses legal preparedness in the various aspects of foodborne illness outbreak surveillance and control—reporting, surveillance, investigation, mitigation, and prevention—through the perspective of local, state, and federal agencies. It also discusses critical issues that arise during outbreak investigations, such as confidentiality of data and use of public health investigations as the basis for regulatory actions or criminal prosecutions.

2.1 Public Health Legal Preparedness

Legal preparedness is an indispensable part of a comprehensive preparedness plan for public health threats. The Centers for Disease Control and Prevention (CDC) defines public health legal preparedness as the attainment by a public health agency or system of specified legal benchmarks or standards of preparedness for specified public health concerns (*1*). Public health legal preparedness has four core elements:

- Laws and legal authorities;
- Competency in understanding and using law;
- Coordination across sectors and jurisdictions in the implementation of law; and
- Information about best practices in using law for public health purposes.

These core elements apply to all areas of public health, especially in the areas of food safety and foodborne illness outbreaks. Because the U.S. food system is highly complex, public health, food, and agriculture officials responding to foodborne illness outbreaks face the challenge of rapidly gathering and processing information to identify and mitigate the source of an outbreak while protecting confidentiality and preserving rights.

2.1.1 Legal preparedness within the context of surveillance, investigation, and control of foodborne illness outbreaks requires state and local officials to ensure their agencies and jurisdictions have the following:

- Laws and legal authorities needed to conduct all functions essential to effective surveillance, investigation, and control (e.g., reporting, enforcement, prevention, mitigation, investigation, and regulation).
- Trained professional staff with demonstrated competency in applying relevant laws.

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- Mutual aid agreements or memoranda of understanding in place to facilitate investigation and response across jurisdictions and agencies.
- Access to information about model practices in using relevant legal authorities and applying them.

The adequacy of local and state legal preparedness for foodborne illness outbreaks also should be evaluated regularly through exercises and after-action reviews from actual outbreaks.

As part of ensuring their jurisdictions' legal preparedness, local and state officials should consult with their legal counsel (Box 2.1) and with counterparts in other government agencies that have authority relevant to ensuring successful surveillance and control of foodborne illness outbreaks. These include food and agriculture regulatory and law enforcement agencies, legal counsel to local and state governments, and local and state courts and court administrators.

Box 2.1. Partnering with Your Agency's Attorney (2)

To prepare for an outbreak:

Meet with your agency's attorney to discuss specific legal authority and responsibilities contained in local, state, and federal law relative to disease reporting, investigations, and food-regulatory actions (e.g., permit suspension and closure, employee restrictions).

Identify outbreak settings or conditions for which legal assistance might be needed.

Outbreak settings or conditions for which legal assistance might be needed (2):

There is a reasonable chance the public's health is or might be threatened without specific public health intervention.

Your ability and authority to address the situation is unclear.

The event or circumstance could expose your agency or organization to potential liability, or political pressure.

In an outbreak situation in which you might need legal assistance:

Contact your agency's attorney as soon as possible for legal input.

Be candid and open; give all the facts—don't allow for surprises.

Proactively include your agency's attorney in discussions rather than seeking ratification of decisions later.

If you do not understand or you disagree with the advice provided by your agency's attorney, ask for clarification or discuss other options with him or her rather than requesting different advice from another attorney.

Private organizations also must be aware of their legal duties regarding food safety and disease reporting). These duties vary by state. Relevant private entities include private laboratories, food firms, hospitals, and other health institution food services. Food-industry entities should be prepared to address both regulatory requirements and the way these requirements might affect their internal policies on sharing information (*3*). Where possible, both public and private entities should be included in foodborne illness exercises to test their understanding of their legal authority and duties related to outbreaks.

2.1.2 As government entities, public health, food, and agriculture agencies operate within the context of the U.S. Constitution, state constitutions, federal and state statutes and regulations, local charters

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and ordinances, court decisions, and more. Thus, these agencies are empowered and limited within this context and must navigate the country's foundational legal principles, i.e.,

- **A system of checks and balances.** Public health, food, and agriculture agencies belong to the Executive Branch and are broadly charged with implementing laws enacted by the legislature and interpreted by the courts.
- **Federalism.** The U.S. Constitution enumerates specified powers for the federal government and reserves other powers to the states (tribes are autonomous or sovereign bodies). In addition, state and local governments possess inherent police powers to protect the health and safety of the public.
- **Protection for civil liberties and property rights.** The Fourth, Fifth, and Fourteenth Amendments protect citizens from unreasonable searches and from deprivation of life, liberty, and private property without due process of law. State constitutions, statutory law, and court rulings provide additional protections relevant to the conduct of foodborne illness surveillance and operations by public agencies.

2.1.3 The legal authority supporting local and state public health agencies' role in the protection and promotion of the public's health stems from constitutional, statutory, regulatory, and judicial case law, as well as from the general police powers. However, these powers are not unlimited. Important legal parameters for public health authority and practice were articulated in the foundational 1905 U.S. Supreme Court ruling in *Jacobson v. Massachusetts* (*4*):

- With compelling reason, individual liberties can be subordinated to the well-being of the community.
- The police power of the state authorizes issuance and enforcement of reasonable regulations to protect the health of the community.
- Courts defer to the authority that legislative bodies give to public health agencies if that authority is exercised on the basis of persuasive public health and medical evidence.
- Public health agencies cannot act in an arbitrary manner or pose unreasonable risks for harm.

In general, these parameters apply to state and local public health agencies' surveillance and control of foodborne illness outbreaks. Those activities, however, are further authorized and conditioned by the statutes, regulations, ordinances, and case law of the individual jurisdictions. Some of these laws relate specifically to foodborne illnesses, but in many jurisdictions, public health agencies rely on laws (state statutes and local ordinances) that authorize surveillance for infectious diseases generally.

2.1.4 CDC operates under congressionally enacted statutory law and, especially in the case of foodborne illness surveillance, under provisions of the Public Health Service Act (*5*). CDC is not authorized to mandate reporting of diseases and conditions by state and local governments or by private entities. However, states do mandate reporting pursuant to state laws.

Among many other provisions, the Public Health Service Act authorizes CDC to gather data on nationally notifiable diseases pursuant to guidelines CDC develops in partnership with state and local public health agencies and professional societies. Many of these data come from state and local public health agencies. CDC partners with the Council of State and Territorial Epidemiologists to establish (and modify as needed) case definitions for diseases. These guidelines and case definitions, however, are not legally binding. States have the autonomy to adopt these Council of State and Territorial Epidemiologists–

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developed case definitions or develop their own definitions for use in their states. CDC does not collect personal identifiers on routine surveillance data that it receives from public health departments.

The Public Health Service Act also authorizes CDC to perform laboratory tests on specimens received from state and local governments (and from other sources) to identify pathogens, confirm serotypes or molecular subtypes, perform diagnostic assays, and report findings to appropriate state and local health departments. Virtually all enteric illness specimens tested in CDC laboratories are initially tested in state or local public health laboratories.

Additionally, CDC may participate in an outbreak investigation within a state if invited by the state. Multistate investigations are typically led by CDC or the state health department where most of the cases occurred.

2.2 Legal Framework for Surveillance and Disease Reporting

Investigation of enteric illnesses to determine the source of exposure, risk factors for infection, and contacts of a person with a contagious disease is usually considered part of surveillance and disease control activities authorized by local and state statutes. Likewise, state and local authority to mandate disease reports arises from state law. The regulatory process is used to specify diseases and conditions to be reported, the information to be reported about a case, and the process for making a report. State laws and regulations also address the confidentiality of disease reports and enforcement of reporting requirements (Box 2.2).

Box 2.2. Communication with Laboratories and Hospitals

Ongoing communication arrangements should be established with national or regional commercial and clinical laboratories to ensure that the investigating agencies receive results for relevant cases, even when those tests are conducted out of state. Similar communication channels also should be established with in-state and out-of-state hospitals that serve a population within the community affected by the outbreak.

2.2.1 Local and state health agencies learn about foodborne illnesses through a variety of sources that vary in reliability and traceability. As discussed further in Chapter 4, these include

- Reports through the state's mandatory disease and conditions reporting system;
- Surveillance reports for enteric pathogens;
- Requests for antitoxin for botulism;
- Reports of food poisoning or gastrointestinal illness in individuals or defined groups, such as diarrhea and vomiting among residents of a nursing home or hospital, attendees at schools or childcare centers, or attendees at a work-related meeting;
- Reports to poison control centers;
- Reports of enteric illness suspected of being caused intentionally;

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- Complaints of suspected foodborne illness or alleged exposure to contaminated, adulterated, or improperly cooked food purchased from stores or in restaurants and reported voluntarily by the public;
- Syndromic surveillance using de-identified emergency department or pharmacy data; and
- Reports directly from the food industry of consumer complaints of illness.

2.2.2 The state legislature generally gives broad statutory authority to the state health department to collect information and to require reports of diseases, conditions, and outbreaks of public health importance. Generally, the state legislature also gives the state health department the authority to adopt rules or regulations that specify which diseases or conditions must be reported, who must report them, and how to report (Table 2.1). The list of reportable diseases and conditions and laboratory findings is maintained and updated by epidemiologists and health officers in state and local agencies, with review and approval by the body overseeing the health department.

In addition to broad authority, states typically have several disease-specific statutes, such as those for human immunodeficiency virus/acquired immunodeficiency syndrome, tuberculosis, and vaccine-preventable diseases, which authorize surveillance and control activities. All states also have statutes addressing reporting and response to bioterrorism incidents.

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Table 2.1. Reporting Processes Typically Specified by Statutes and Regulations

Process	Requirement	Comment

Sources of reports	The usual sources of mandatory reports are
	● Laboratories
	  ○ Hospital-based laboratories;
	  ○ Clinical laboratories;
	  ○ National or regional commercial referral laboratories;
	  ○ Local or state health department laboratories; and
	  ○ CDC laboratories;
	● Health care institutions
	  ○ Hospitals (e.g., hospitalized patients reported by infection control practitioners);
	  ○ Emergency departments; and
	  ○ Long-term–care facilities or nursing homes;
	● Physicians;
	● Schools and childcare centers;
	● Food establishments (e.g., restaurants); and
	Other state health departments.
		The source of a report does not affect the legal status of the information; if it is required information, it is protected by statutes and regulations.
		
		Conversely, reports to the agency of an illness not listed as a reportable condition might not be subject to disease surveillance regulations and confidentiality protections.

Time frame and content of reports	Statutes and regulations usually specify the following aspects of disease reports: ● Time frame for reporting (e.g., within 7 days after diagnosis, within 24 hours after diagnosis, immediately); and ● Information to be reported (e.g., diagnosis; personal identifying and locating information; date of onset or diagnosis regardless of whether the case is suspected or confirmed).	
Reporting methods	A state or municipality can use a variety of methods for reporting. Specifics vary from one locale to another. These methods include ● Internet-based, highly secure disease reporting to websites maintained by state or local public health agencies; ● Reports sent by email; ● Automatic electronic submission through health information exchange; ● Telephone; and/or ● Hard copy (fax or mail).	
Required submission of laboratory specimens	Many public health agencies have adopted regulations that require laboratories to submit isolates of specific pathogens to a state or local health department laboratory for further confirmatory and/or genomic testing, such as pulsed-field gel electrophoresis and/or whole-genome sequencing, to improve surveillance for foodborne disease (see also 6).When the clinical laboratory does not obtain	In some locales, voluntary submission of specimens achieves the same goal.

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	isolates, some states require or request submission of primary clinical material or enrichment broths. The regulations often include a time frame for submission of such materials. With the increasing development and use in clinical settings of culture-independent diagnostic tests (CIDT), which do not produce an isolate, there is growing concern that the supply of isolates to health departments will be depleted, hindering public health surveillance activities. To address these concerns, states have begun to amend their laws. A few states have added language that gives specific submission instructions to a clinical laboratory that has used CIDT methods to make a diagnosis. Other states have expanded their list of acceptable materials for submission beyond only an "isolate" to include "specimen," "primary clinical material," "enrichment broths," and other alternative materials to submit if the preferred isolate is not available. States may continue to amend their disease reporting laws, in various ways to fit the needs of the jurisdiction, as CIDT continues to develop for a broader number of pathogens."	

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2.2.3 Reliable reporting by persons and institutions mandated to submit disease reports is the foundation of the reporting system. When enteric illnesses are not reported, a foodborne illness outbreak may be missed. Because of the problem of nonreporting, redundant reporting systems have been established to ensure a case will be reported (e.g., a *Salmonella* infection might be separately reported by physicians, laboratories, and healthcare institutions). Because health agencies want to encourage compliance, ongoing education and communication with persons and institutions mandated to report is imperative to reinforce the importance of reporting requirements.

Education is the preferred method to obtain reporting compliance, but when violations arise, statutes and regulations mandating disease reporting also contain enforcement and penalty provisions. Depending on the jurisdiction and the frequency and severity of nonreporting, sanctions can range from notification to a state licensure board to civil fines and/or criminal penalties.

Reporting may be difficult to enforce with a laboratory or healthcare provider outside an agency's jurisdiction, such as when a state seeks reports from a reference laboratory located in another state. In that situation, lack of reporting usually results from misunderstanding of how to report. Occasionally a laboratory will assert that it complies with requirements of the public health agency in the state in which it is physically located—which might or might not require reporting of the specific disease, infection, or laboratory result. Again, ongoing communication with the parties required to report and coordination with the state health agency in the parties' home state can improve reporting.

2.3 Protection of Confidentiality and Authority to Access Records

State and local health agencies need to regularly access confidential records when investigating reports of foodborne illness. However, when doing so, federal and state laws mandate the protection of confidential personal information during these public health investigations.

Typically, the broad authority to conduct surveillance includes authority to investigate and control diseases of public health significance, including review of relevant and pertinent medical and laboratory records and reports (i.e., information that is not necessarily included in the basic case report). Although medical and laboratory staff might be concerned about potential violations of federal Health Insurance Portability and Accountability Act (HIPAA) (*7*) and state privacy laws in releasing records, exceptions for public health and other government agencies allow access to records. Consulting with an agency attorney is advisable whenever questions or concerns arise about accessing or disclosing confidential information (Box 2.3).

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Box 2.3. Prepare for Questions about Authority to Access Information

Staff in an organization that might be required to provide information to local, state, and federal officials about foodborne illnesses and outbreaks might not be familiar with the authority of government officials to access individually identifying and other privacy-restricted information under certain provisions of state and/or federal law.

These organizations might include those (e.g., childcare, elder care) that, depending on state law, might not have routine interaction with disease reporting and outbreak investigation systems.

Consult with your agency's attorney to prepare memorandum or information sheets tailored to different types of organizations that specify state and federal authority to access information.

2.3.1 HIPAA and its associated regulations limit access to a person's protected health information (PHI) (*7, 8*). PHI is information that can be used to individually identify a person through demographic data, diagnosis, treatment, or payment for treatment (*9*).

Important exceptions to HIPAA allow public health and other government agencies to access PHI, including

- **Required by Law.** Entities covered by HIPAA (e.g., doctors, healthcare plans) may use and disclose PHI without individual authorization if required by law (e.g., statute, regulation, or court order).
- **Public Health Activities.** Covered entities may disclose PHI under several circumstances related to public health activities, including
  - Public health authorities authorized by law to collect or receive information for preventing or controlling disease, injury, or disability;
  - Persons who might have been exposed to or contracted a communicable disease when notification is authorized by law; or
  - Entities subject to Food and Drug Administration (FDA) regulation for purposes such as tracking products or product recalls.

These exceptions in effect authorize a covered entity (e.g., doctor) to disclose otherwise confidential PHI. Explaining these exceptions to physicians or their staff often results in better compliance with reporting requirements. HIPAA does not restrict the use of de-identified information, which does not identify a person or provide a basis for identification (*10*).

2.3.2 Local and state health agency staff must know the requirements of their freedom of information laws and the exemptions from them. Personal identifying information (PII) (e.g., name, age, sex, race, ethnicity, residence, or date of diagnosis) in disease reports and investigation records is generally confidential and exempt from disclosure in response to freedom of information requests. Each state can define what it considers to be PII. The goal is to avoid releasing data that make it possible to directly or indirectly identify the affected person if the released data are combined with other information. When there are a large number of cases, it might be possible to release data *other than names and residences* in response to freedom of information requests. When there are too few cases

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among the population of a given area, an agency might have a policy of not releasing data to guard against potential identification of an individual person. This determination should be made in each instance in conjunction with agency epidemiologists, statisticians, and attorneys.

In addition to potential restrictions on sharing PII, state laws might restrict sharing of other types of information, such as confidential commercial information and predecisional/deliberative information. Furthermore, the federal Privacy Act can restrict the sharing of certain personal privacy information (PPI) by federal agencies (*11*).

Occasionally a public health agency must respond to a media inquiry in which the media have learned the identity of a particular case from another source. The agency's response to the media inquiry must be carefully structured to avoid unintentional confirmation of the patient's identity. Preparing final outbreak investigation summary reports without any PII can hasten and simplify release of those reports to attorneys or media.

2.3.3 A public health agency may be restricted from sharing PPI with other government agencies without the consent of the reported person. However, these restrictions are subject to several exceptions:

- Local and state health agencies are generally permitted to share information with other state, local, and federal agencies to confirm and track cases.
- Many state statutes contain an exception for sharing information when, in the agency's judgment, sharing is necessary to protect public health.
- Virtually every state has an exception for sharing information with law enforcement agencies for investigation of intentional contamination or a bioterrorism incident.

2.3.4 The U.S. Department of Health and Human Services (DHHS), FDA, has formalized arrangements for information sharing with local and state regulatory agencies. FDA provides nonpublic information to state and local agencies under 20.88 agreements (*12*) and to certain state and local officials who have been commissioned by FDA (Box 2.4).

- 20.88 agreements are authorized under 21 CFR 20.88. 20.88 agreements allow FDA to share certain nonpublic information with state and local government officials. These agreements allow for the sharing of confidential commercial information, PPI, and predecisional information (PDI), and predeliberative information but not trade secret information. The receiving agency must commit to keep this information confidential (*12,13*). FDA offers several types of 20.88 agreements:
    - Single-Signature Long-Term Information Sharing Agreements (Food and Feed, Pharmacy Compounding, Drug Security) (Long-Term 20.88) allows for the sharing of nonpublic information proactively or on request related to food, animal food, cosmetics, pharmacy compounding, drug security with all employees who report to the signatory.
    - Case-Specific 20.88 allows for the sharing of nonpublic information related to a particular incident involving an FDA-related industry (e.g., food, drugs, devises, biologics). A Case-Specific 20.88 can be expedited if FDA is made aware of the need for urgent processing. Each employee who will need access to the information must sign.
    - 20.88 with Associations allows for proactive or upon request sharing of nonpublic deliberative processes and predecisional information only. Examples may include draft rules and/or draft guidance.

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- **Commissioning.** FDA's commissioning process enables a state or local health, food, or drug official to be commissioned as an officer of DHHS (*14*). Commissioned officials may receive nonpublic information solely for the purpose of their work on behalf of FDA as a commissioned official. They may generally disclose that information to other FDA-commissioned officials (in their capacity as FDA commissioned officials) and FDA employees (*15*). Such information remains FDA information. Commissioning also authorizes state or local officials to conduct inspections under the Federal Food, Drug, and Cosmetic Act (FFDCA) (*16*).

2.3.5 The U.S. Department of Agriculture (USDA) Food Safety and Inspection Service (FSIS) has a process for sharing information with government partners. FSIS Directive 2620.5 addresses "procedures needed to share information concerning FSIS regulated products with State or local agencies, foreign government officials, and international organizations responsible for food inspection programs and laboratories" (*17*). To request outbreak-related information from FSIS, send an email to FoodborneDiseaseReports@usda.gov.

Box 2.4. Cross-Jurisdiction and Cross-Sector Coordination
Effective reporting of foodborne illness cases hinges on coordinated reporting across jurisdictions (e.g., local, state, tribal, and federal governments) and across sectors (e.g., healthcare and public health). Local and state health officials should periodically assess the need for memoranda of agreement (or other legal agreements) with partners in other jurisdictions and sectors to ensure timely and effective reporting. CDC has created several resources for assessing and improving cross-jurisdictional and cross-sector coordination (*18,19*).

2.4 Legal Framework to Prevent or Mitigate Foodborne Illness Outbreaks

Shared goals of the public and private sectors are to prevent as many outbreaks as possible and to mitigate those that do occur. Changes in technology and food production have brought opportunities and challenges. Improvements in laboratory and communication technologies have enabled agencies to link cases that previously were thought to be sporadic and to identify and address implicated foods and sources. However, with continued globalization of food-production industries, more multistate and international foodborne illness outbreaks are being discovered, thus expanding the focus of outbreak investigations and control measures. This section reviews the roles of local, state, and federal, agencies and the legal authorities empowering them to act.

2.4.1 U.S. law authorizes several federal agencies to undertake regulatory and nonregulatory actions over food safety at various stages on the continuum of food production, importation, processing, transportation, storage, and sale. Agencies regulating food have the authority to inspect, recall, and seize unsafe foods. All agencies coordinate and collaborate with states and localities in the prevention of foodborne illness and in multistate investigations. This section focuses on CDC, FDA, USDA, and the Environmental Protection Agency (EPA) and their legal authority related to food safety (see Chapter 3 for each federal agency's roles and resources).

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- **DHHS, CDC**
  The Public Health Service Act (*5*) authorizes CDC to identify and monitor foodborne diseases and to investigate foodborne illness outbreaks in coordination with local and state health agencies. CDC can lead investigations into multistate foodborne illness outbreaks and, when invited, work in partnership with the state where the most cases have occurred.

- **DHHS, FDA**
  The FFDCA (*16*) authorizes FDA to regulate domestic and imported food, except meat, poultry, and processed egg products (i.e., frozen, dried, and liquid eggs), which are regulated by USDA.

  - **FFDCA**
    The primary legislation by which FDA exercises authority over food is the FFDCA. A goal of FDA is to prevent contamination of food products before distribution. FFDCA also empowers FDA to pursue

    - Voluntary compliance through the issuance of inspectional observations, untitled letters and warning letters;
    - Civil action, such as an injunction to prevent future violations of the FFDCA (e.g., continued distribution of adulterated food);
    - Seizure action to remove specific lots of adulterated food;
    - Mandatory recall of food that presents a certain risk to public health;
    - Criminal action against an individual or company that violates the FFDCA such as by causing food to become adulterated by inadequate processing and handling;
    - Administrative detention of certain food for up to 30 days; and
    - Suspension of the registration of a facility so that food from the facility cannot be introduced into commerce.

    In some circumstances, FDA's authority under the FFDCA is limited by the requirement that food be in interstate commerce. However, under both the FFDCA and the Public Health Service Act, FDA can regulate intrastate commerce in certain instances. Even when authority exists for FDA action, relying on state agency action might be faster when state authorities are more expansive or flexible than FDA's authorities.

    Amendments to the FFDCA in 2007 require registered food facilities that manufacture, process, pack, or hold food for human or animal consumption in the United States to report to FDA's Reportable Food Registry when a reasonable probability exists that the use of, or exposure to, an item of food will cause serious adverse health consequences or death to humans or animals (*20*). FFDCA was further amended in 2011 by the Food Safety Modernization Act (*21*).

  - **FDA Food Safety Modernization Act**
    The FDA Food Safety Modernization Act (FSMA), signed into law in January 2011, amended the FFDCA to enhance the federal government's ability to prevent and respond to contamination in the food supply (*21*). The law addresses prevention, inspection, compliance, and response activities.

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FDA, the agency primarily responsible for implementing FSMA, has developed a series of rules and guidance documents to address the law's requirements. As of April 2018, FDA has finalized the following rules:

- Current Good Manufacturing Practice, Hazard Analysis, and Risk-Based Preventive Controls for Human Food (*22,23*).
- Current Good Manufacturing Practice, Hazard Analysis, and Risk-Based Preventive Controls for Food for Animals (*24,25*).
- Foreign Supplier Verification Programs (*26,27*).
- Mitigation Strategies to Protect Food Against Intentional Adulteration (*28,29*).
- Sanitary Transportation of Human and Animal Food (*30,31*).
- Standards for the Growing, Harvesting, Packing, and Holding of Produce for Human Consumption (*32,33*).
- Accredited Third-Party Certification (*34,35*).

FDA has also implemented a Voluntary Qualified Importer Program (*36*). It is a fee-based, voluntary program that provides importers meeting specified criteria with expedited review and import entry of human and animal foods. In addition to rules, FDA has issued multiple guidance documents regarding implementation of FSMA and its rules. The FDA website (https://www.fda.gov/Food/GuidanceRegulation/FSMA/default.htm) provides details about the law, rules and updates on the status of FSMA implementation.

- **FDA Food Code**
  Although the FDA Food Code is not a federal law or regulation, this model code may be adopted or adapted by states, tribes, and localities as the basis for their jurisdictions' food-safety rules for retail and food-service establishments (e.g., restaurants, grocery stores, institutions) (*37*). The Food Code assists jurisdictions in updating their rules to be consistent with federal food-safety policy, although each jurisdiction undergoes its own rulemaking process to adapt the code to fit the jurisdiction's legal framework. Currently, FDA revises the Food Code every 4 years.

- **USDA, FSIS**
  FSIS has the legal authority to regulate meat, poultry, and egg products on the basis of the following statutes:
  - Federal Meat Inspection Act (*38*).
  - Poultry Products Inspection Act (*39*).
  - Egg Products Inspection Act (*40*).

  Each of these Acts is intended to protect the health and welfare of the consuming public by preventing the introduction of adulterated or misbranded meat, poultry, or egg products in interstate commerce. In addition, in states that do not have meat or poultry inspection programs "at least equal to" the federal programs, Federal Meat Inspection Act and Poultry Products Inspection Act provide for federal regulation and inspection of wholly intrastate operations and transactions to

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the same extent as if such operations and transactions were conducted in interstate or foreign commerce.

In carrying out its duties under these Acts, FSIS may pursue the following actions:

- Regulatory action for federally inspected facilities, such as retention of product, withholding actions, and notices of intended enforcement, suspension, or withdrawal;
- Civil action, such as an injunction to prevent future violations of the Acts (e.g., continued distribution of adulterated or misbranded products);
- Detention and seizure action to remove specific products from commerce;
- Criminal action against an individual or company that violates the Acts; or
- Voluntary compliance through notices of warning.

Specifically, in response to a foodborne illness outbreak, if a basis exists to conclude that a FSIS-regulated product contains a pathogen or is otherwise harmful to human health, and an outbreak investigation has identified a specific product, FSIS may recommend a product recall (*41*). A recall is a firm's action to remove a product from commerce to protect the public from consuming misbranded or adulterated products. Although it is a firm's decision to recall a product, FSIS coordinates with the firm to ensure it has properly identified and removed the recalled product from commerce by verifying the effectiveness of the firm's recall activities. FSIS also notifies the public about product recalls.

Alternatively, if after review of investigative findings, a basis exists for FSIS to conclude that a FSIS-regulated product contains a pathogen or is otherwise harmful to human health, but the investigation has not identified a product that can be recalled (e.g., no specific brand name of product identified), then FSIS may issue a public health alert (*41*).

Further, depending on the evidence collected, and how strongly human illness is linked to a FSIS-regulated product, FSIS may take actions other than recommending a product recall or issuing public health alert. These actions may include increasing or enhancing inspection activities; increasing the frequency of microbial testing; conducting a Public Health Risk Evaluation; performing an in-plant Food Safety Assessment; or taking any of the actions listed above, such as effecting a regulatory control action or detaining and/or seizing product (*41*).

- **USDA, Animal and Plant Inspection Service (APHIS)**
  APHIS is charged with protecting animal and plant resources from agriculture pests and diseases, including those that impact public health. APHIS operates under multiple statues, including
  - **Animal Health Protection Act.** This Act authorizes the prevention, detection, control, and elimination of diseases and pests in animals to protect animal health, public health and welfare, and economic and environmental concerns (*42*).
  - **Plant Protection Act.** This Act permits regulation to prevent the introduction or dissemination of plant pests in the United States, including certain biological control organisms (*43*).

- **EPA**
  EPA establishes the limits for pesticide residues in foods under the Food Quality Protection Act (*44*). EPA is also authorized to set standards for drinking water in the Safe Drinking Water Act (*45*).

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2.4.2 State public health, agriculture, and food and drug agencies each play a role in mitigating and preventing outbreaks of foodborne illness. Each agency operates under one or more specific statutory and regulatory authorities. How these roles and authorities are structured and the assignment of responsibilities between the state and its localities vary by state. Local health departments in general operate under two frameworks: independent home rule and delegated authority.

State and/or local agencies are authorized to undertake a range of actions to mitigate and prevent outbreaks, including

- Requiring changes in food preparation;
- Temporarily removing persons with infectious illnesses from the workplace;
- Embargoing, seizing, or destroying contaminated food or requiring removal of contaminated lots from retail stores;
- Closing food establishments representing an imminent public health threat; and
- Issuing press releases

These actions are taken through agency authority granted by statute and implemented through rules or through administrative orders. In issuing an administrative order closing a restaurant, for example, such an order should contain time limits for the closure and specify the conditions that would permit the restaurant to reopen. If necessary, agencies can seek enforcement of their administrative orders through the court.

2.5 Evolving Legal Issues

Even though reporting, surveillance, and mitigation of foodborne disease outbreaks is well established in state and federal law, issues continue to arise that demonstrate differences in state and federal law. Such issues further demonstrate the ongoing need for communication and collaboration among local, state, and federal officials who are united in the common goal of protecting the public's health.

2.5.1 Food sovereignty initiatives are based on the idea that people should have the ability to democratically control their own food and agriculture policies. For some groups, the concept is tied to reducing poverty and providing healthy food through ecologically sound and sustainable metrics. These groups also focus on strategies to resist and dismantle corporate food production and increase local food production and control. For other groups, deregulation is the primary focus of food sovereignty laws.

For example, Maine enacted a law in October 2017 authorizing municipalities to "adopt ordinances regarding local food systems and community self-governance that set forth provisions that apply exclusively to direct producer-to-consumer food exchanges and other traditional foodways" (*46*). The provisions essentially remove state oversight from certain food-production areas. The state, however, retains authority to implement and enforce rules related to the inspection of meat and poultry producers. This version of the statute took effect after USDA questioned whether the original version of the law would have enabled Maine to maintain its "at least equal to" status and continue to operate its

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meat and poultry inspection programs. The law also requires that anyone who "grows, produces, processes or prepares food or food products intended for any wholesale distribution or retail distribution outside of" a municipality to comply with state and federal food-safety laws, rules, and regulations (*46*).

2.5.2 While acknowledging the differing positions of the federal government and many states on the legality of marijuana use for medical and nonmedical purposes, food-safety concerns exist that are related to the incorporation of marijuana, hemp derivatives, and cannabidiol in food (edibles). States are continuing to work on the application of food-safety laws to the producers of such edibles. Some states subject those who produce edibles to state food worker restrictions and/or to local and state kitchen-related health and safety standards used for retail food establishments.

2.5.3 Cottage food laws collectively refer to state laws and regulations that allow for the sale, with restrictions, of certain foods produced in private homes. The foods eligible for sale typically are considered safe from bacterial contamination and do not require time or temperature safety measures for production and/or storage (*47*). Examples include baked goods, candies, condiments, preserves, and dry mixes. Cottage food laws are viewed as promoting economic opportunities for home- and farm-based food businesses, while providing some regulatory safeguards of these businesses. As of June 2018, 49 states and the District of Columbia have some type of cottage food law; New Jersey does not have such a law (*48,49*).

Although cottage food laws vary among states, these laws generally address the types of foods permitted to be sold, who can sell, limits on sales, and labeling licensing, permitting and/or inspection requirements (*50*). In many states efforts are ongoing to expand the permitted foods or alter restrictions on sales. Any move to change existing cottage food laws, either by expanding them or adding limitations, should be done so with food safety and the public's health in mind.

2.6 Public Health Investigations as the Basis for Further Action

The goal of a foodborne illness outbreak investigation is to identify and control the source of the outbreak. In the course of the investigation, officials may find issues that require the initiation of regulatory or administrative actions or even civil or criminal proceedings.

2.6.1 Data collected during a public health investigation can become the basis for further action by the health agency or other state and federal agencies. For example, if epidemiologic and laboratory data provide evidence linking illness to consumption of a particular food, an informational traceback investigation can result to identify the source of that food. Given the national and international scope of food production, the informational and regulatory traceback investigations might involve multiple state and federal regulatory agencies. Violations of federal or state law that are identified during a regulatory traceback investigation may lead to further action, such as seizure of the implicated foods or injunctive remedies.

Local and state agencies also can initiate administrative actions over persons or businesses that violate state or local regulations. For example, if a restaurant has repeated food handling or food storage violations, it may be subject to administrative hearings leading to suspension or revocation of its food-service license.

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2.6.2 If during an investigation it is suspected or confirmed that a foodborne illness outbreak was caused because of criminally negligent behavior, intentional contamination or bioterrorism, additional state criminal, antiterrorism, and emergency response laws will enhance or dictate the course of the outbreak investigation and response. If the outbreak is multistate, then federal response resources and laws apply, and local and state public health agencies must work closely with other state and federal agencies.

Joint investigations by public health, food, agriculture, and law enforcement agencies can be hindered by the different legal powers and investigatory practices each agency brings to such an event. For example, officials from public health agencies are authorized to collect and test samples to determine their public health threat, whereas law enforcement officials can consider samples subject to seizure as evidence. Public health, food, agriculture, and law enforcement officials all must conform to constitutional standards (e.g., Fourth and Fifth Amendments) about collection of evidence, especially in situations requiring a joint investigation. Laboratory specimens collected for regulatory purposes must be collected and submitted using procedures that ensure the chain-of-custody of the specimen is admissible in court (*51*). Chain-of-custody is a process that may be followed for evidence to be legally defensible and includes the following main elements: properly identifying the evidence, a neutral evidence collector, tamper-proofing and securing evidence at the collection site, and keeping physical control of the evidence.

Local and state officials, in collaboration with law enforcement agencies, should periodically assess the need for memoranda of understanding to clarify the roles of public health, food, agriculture, and law enforcement agencies in conducting joint investigations. Local and state officials who have roles in investigating foodborne illness outbreaks should understand and demonstrate competence in applying their legal authorities in conducting joint investigations. Resources for improving competency in joint investigations include CDC training curricula (*52*) and sample memoranda of understanding (*53*).

2.7 CIFOR Legal Preparedness Resources

CIFOR has created several resource documents to further assist local and state public health agencies in improving their legal preparedness to conduct surveillance for foodborne illness and respond to outbreaks within their jurisdictions and across multiple states and other jurisdictional boundaries. The CIFOR Law Project created the following three documents, each designed to address a discrete, but related, research need and audience.

- **Analysis of State Legal Authorities for Foodborne Disease Detection and Outbreak Response**. This document describes and analyzes the types of state legal authorities available to conduct foodborne illness surveillance and outbreak response activities. It highlights the patchwork of state laws and regulations across several topic areas—public health, communicable disease, food safety, food regulation, agriculture, environmental health, and general government authority—on which public health professionals and their legal counsel must rely to accomplish foodborne illness surveillance and outbreak response activities.
- **Practitioners' Handbook on Legal Authorities for Foodborne Disease Detection and Outbreak Response**. This document is a practical guide for public health professionals who perform key roles in foodborne illness surveillance and outbreak response. The handbook presents information and resources for practitioners charged with implementing their jurisdiction's legal authorities related to foodborne disease events. The handbook is a primer on the array of possible legal authorities (e.g.,

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communicable disease laws, food-safety laws) that might be available and provides practitioners with checklists for identifying relevant agency actors and laws within their jurisdictions.

- **Menu of Legal Options for Foodborne Disease Detection and Outbreak Response**. This document provides a menu of legal options for state public health officials and policy makers to consider when reviewing their jurisdiction's legal authorities to conduct foodborne illness surveillance and outbreak response actions. The menu includes legal provisions relevant to activities conducted during foodborne illness surveillance and outbreak response—outbreak detection, outbreak investigation, outbreak control, and outbreak documentation. It is intended to be a resource for states to use in filling gaps and clarifying or enhancing their legal authorities.

All the documents are available through the CIFOR website: https://cifor.us/products/law-project

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Chapter 3: Planning and Preparation: Building Teams

Chapter Summary Points

- This chapter describes the roles of the core outbreak investigation and control team members and major agencies and partners involved in foodborne illness outbreak response and highlights the resources, processes, and relationships that should be in place before an outbreak.
- Agency plans, training programs, and response partner working relationships must anticipate the need to rapidly expand and contract the scope and structure of investigation and control teams to address changing conditions.
- Key roles in outbreak detection and response include epidemiology, environmental health and public health, food testing, and regulatory laboratory practice.
- A core team should be involved in all outbreak investigation and control efforts, giving consistency to investigations, serving as the focal point for coordinating multidisciplinary and/or multiagency tasks, and enabling development of effective working relationships with external partners and advanced expertise among staff.

URLs in this chapter are valid as of August 7, 2019.

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3.0 Introduction

3.0.1 This chapter describes the roles of the core outbreak investigation and control team members, major agencies, and partners involved in foodborne illness outbreak response and highlights the resources, processes, and relationships that should be in place before an outbreak. Agencies must be prepared to mount and participate in effective single-agency and multiagency responses to incidents ranging from local to potentially national in scope. The authority to identify, investigate, and control foodborne illness outbreaks is shared across local, state, territorial, tribal, and federal government agencies. Each agency at every level of government has specific roles and responsibilities.

3.0.2 Agency plans, training programs, and response partner working relationships must anticipate the need to rapidly expand and contract the scope and structure of investigation and control teams to address changing conditions. All agencies should maintain standard procedures and all-hazards emergency operations plans identifying the mechanisms for conducting routine and nonroutine investigations and responses. This chapter promotes practices that have been helpful in developing effective multidisciplinary foodborne illness investigation and control teams and provides links to related topics. These Guidelines contain detailed information about outbreak investigation and response. All responsible agencies should regularly work with their attorneys to anticipate legal issues that can arise during foodborne illness outbreak investigation and control. (See Chapter 2 for details about legal preparedness and the CIFOR law project that provides additional tools to help agencies and jurisdictions improve legal preparedness.)

3.1 Roles

3.1.1 Key roles in outbreak detection and response include epidemiology, environmental health, and laboratory. These roles are distributed across the multiple entities—more than 3,000 local health departments, more than 50 state and territorial health departments, other state agencies, tribal organizations, and several federal agencies—that interact in a complex system to detect and respond to enteric and other human and animal foodborne illnesses. These roles include conducting surveillance to detect outbreaks through complaint-based, pathogen-specific, or other forms of surveillance (Chapter 4) and rapidly conducting outbreak investigation activities to identify the mode of transmission and vehicle (Chapter 5) and determine the potential for ongoing transmission and need for control procedures (Table 5.1 in Chapter 5; Chapter 6).

3.1.2 Agencies' roles, responsibilities, and resources influence outbreak responses. The nature of the outbreak, including the type of pathogen or contaminant, severity of illness, suspected or implicated vehicle, number and location of affected persons, geographic jurisdictions involved, and local and state food safety rules and laws (Chapter 2) determine the individuals, disciplines (further discussed in section 3.2), and types of agencies that need to be involved. (Table 7.3 in Chapter 7 provides detailed information about multijurisdictional outbreak identification methods and required notification steps, by agency level).

Each agency's response plan should include its likely role in a foodborne illness outbreak investigation,

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staff (or positions) that may be involved, contact information for relevant external agencies, and communication and escalation procedures for working with those agencies.

3.1.3 Local and state (Table 3.1) and federal (Table 3.2) levels, other important cross-agency programs (Table 3.3), and nongovernment, industry and academic partners (Table 3.4) contribute to foodborne illness investigation and outbreak response.

For local and state agencies, responsibilities vary depending on a state's organizational, legal, and regulatory structure; the distribution of responsibilities across different types of local and state agencies; and the size and capacity of the local agencies. Responsibilities for federal agencies follow regulatory jurisdictions for Food and Drug Administration (FDA) and the U.S. Department of Agriculture's (USDA's) Food Safety Inspection Service (FSIS), and public health surveillance and disease control mandates for the Centers for Disease Control and Prevention (CDC).

In addition to these primary federal agencies, several other federal jurisdictions may be relevant to outbreak investigations. The National Park Service may have exclusive or shared jurisdiction with state and local agencies depending on legislation designating the specific park. Local and state agencies whose jurisdiction contains or adjoins a national park should establish relationships with the National Park Service Office of Public Health. On many other types of federal lands, state laws apply, but federal agencies may have overlapping responsibilities. The Department of Defense has autonomous authority over U.S. military bases, facilities (including food production, food service, and healthcare facilities), and vehicles.

Indigenous tribes have complete sovereignty and are completely autonomous. Investigations on tribal land may be conducted by tribal health staff, Indian Health Service staff, or state or local health agencies, but nontribal entities can become involved in an investigation only at the tribe's request. Memoranda of understanding may establish lines of communication and reciprocal support during public health emergencies.

Law enforcement agencies at multiple levels will become involved in an investigation if intentional contamination of food or other criminal activity is suspected. Agencies responsible for controlling foodborne illness outbreaks should establish relationships and communication pathways with law enforcement agencies before any outbreak.

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Table 3.1. Examples of Typical Foodborne Outbreak Investigation Roles, Responsibilities, and Contributions of Local and State Agencies*

Agency	Roles, Responsibilities, and Contributions
Local health agencies and laboratories	Responsible for local policies to protect public health: ● Maintain communication and working networks with local populations and community businesses, healthcare providers and community organizations, and other local resources. ● Regulate and inspect food service establishments and educate food workers about food safety. ● Conduct complaint-based, pathogen-specific, and other forms of surveillance to identify local outbreaks. ● Investigate and control potential foodborne illnesses using local authorities, policies, and resources. ● Manage local public risk communication during foodborne outbreaks. ● Coordinate investigation and communication activities with other agencies and response partners during multijurisdictional outbreaks. ● Conduct after-action reviews to improve investigation effectiveness and prevent future outbreaks from the same causes.
State health department and laboratories	Responsible for statewide public health protection: • Conduct statewide pathogen-specific surveillance; some states may also coordinate statewide complaint-based surveillance. • Provide technical assistance and surge capacity for local and state response partner agencies as needed; conduct investigations in local areas without local health agency jurisdiction. • Conduct and coordinate statewide or multijurisdictional investigations of outbreaks of human illness, including foodborne illness outbreaks. • Manage statewide public risk communication during foodborne illness outbreaks. • Serve as liaison with nongovernment response partners and stakeholders, including healthcare providers and food industry representatives. • Provide legal support for outbreak investigation and control activities. • Conduct after-action reviews to improve investigation effectiveness and prevent future outbreaks from the same causes.
State food safety regulatory authorities and laboratories†	Responsible for statewide policies to protect food safety: ● Conduct routine regulatory inspections and activities for food establishments under their jurisdiction. ● Maintain 1) knowledge of food industry practices in their jurisdiction and 2) working relationships with food industry managers, associations, and technical experts. ● Conduct investigations of food producers, food establishments, and food supply chains within their jurisdiction, including product tracing investigations (traceback, traceforward), environmental health assessments, sampling, and implementation of regulatory control measures. ● Provide technical assistance and surge capacity for local and state response partner agencies as needed. ● Coordinate response actions with local, state, and national food supply stakeholders and response partners, including law enforcement for instances of suspected intentional contamination. ● Conduct after-action reviews to improve investigation effectiveness and prevent future outbreaks from the same causes.

*The three core disciplines involved in foodborne outbreaks—epidemiology, environmental health/food regulatory program, and laboratory—may be housed in the same agency at the state or local level.
†Agencies with different names (e.g., Department of Agriculture, Health, or Environmental Health) may carry out these roles.

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Table 3.2. Examples of Typical Foodborne Illness Outbreak Investigation Roles, Responsibilities, and Contributions of Primary Federal Agencies

Agency	Roles, Responsibilities, and Contributions
U.S. Food and Drug Administration (FDA, DHHS)	Responsible for investigation and regulation of most foods moving in interstate commerce (except products regulated by the U.S. Department of Agriculture [USDA] Food Safety and Inspection Service [FSIS]) (Appendix __.__): ● Perform regulatory activities, including facility registration, routine risk-based inspections, limited food supply surveillance testing, and compliance and enforcement. ● Publish voluntary regulatory food safety standards for food service and retail food establishments (the model FDA Food Code) (*1*). ● Coordinate and collaborate with international food regulatory agencies, and support capacity building and training in product-related aspects of investigation and laboratory methods pertaining to foods that FDA regulates. ● Conduct outbreak investigations: The Coordinated Outbreak Response and Evaluation network (CORE) (*2*) for investigations of human illness potentially linked to human food, the Center for Veterinary Medicine for human illness potentially linked to animal food or feed, and the Office of Emergency Operations. ● Coordinate with states on informational product tracing for use as part of exposure assessments in epidemiologic studies potentially linked to FDA-regulated products. ● Conduct investigations and environmental health assessments of food establishments under their jurisdiction in coordination with other government partner agencies. ● Conduct laboratory testing of product(s) obtained from commerce, consumer homes, or production. ● Coordinate communication with states and with other federal agencies, particularly CDC, during foodborne outbreak investigations. ● Implement short- and long-term control measures and follow-up activities as needed to protect public health consistent with regulatory authorities. ● Conduct after-action reviews
FSIS, USDA	Responsible for ensuring that meat, poultry, and processed egg products are safe, wholesome, and accurately labeled: ● Perform inspection and regulatory activities to ensure industry compliance with applicable laws, pathogen reduction and hazard analysis and critical control point system regulations and other regulations, robust food supply surveillance testing, and compliance and enforcement. ● Perform scientific and technical assessments of known and emergent hazards, including quantitative microbial risk assessments. ● Conduct outbreak investigations: In-establishment inspectors at FSIS-regulated establishments with operational knowledge of industry food safety systems (Office of Field Operations); In-commerce field investigators with expertise in sample collection and informational traceback (Office of Investigation, Enforcement, and Audit); and public health science personnel with expertise in performing epidemiologic and environmental assessments (Office of Public Health Science). ● Perform informational traceback for use as part of exposure assessments in epidemiologic studies potentially linked to FSIS-regulated products, coordinating with states, where possible. ● Conduct investigations and environmental assessments of FSIS-regulated establishments and in-commerce facilities in coordination with other government partner agencies. ● Conduct laboratory testing of product(s) collected from commerce, consumer

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	homes, or production. ● Assess testing results from non-FSIS laboratories to determine whether they can be used to support FSIS outbreak response. ● Coordinate communication and exchange information with states and other federal agencies, particularly CDC, during foodborne outbreak investigations. ● Implement short- and long-term control measures and follow up activities as needed to protect public health consistent with regulatory authorities. ● Conduct after-action reviews.
CDC, DHHS	Responsible for conducting or coordinating surveillance for human illnesses caused by pathogens commonly transmitted through food and for outbreaks of foodborne illnesses of any cause: ● Lead and support national surveillance, communication and disease investigation networks, including National Notifiable Disease Surveillance System (NNDSS), Foodborne Diseases Active Surveillance Network (FoodNet), The National Molecular Subtyping Network for Foodborne Disease Surveillance (PulseNet), NEARS National Environmental Assessment Reporting System, Foodborne Disease Outbreak Surveillance System (FDOSS), National Outbreak Reporting System (NORS), Foodborne Disease Centers for Outbreak Response Enhancement (FoodCORE), the Integrated Food Safety Centers of Excellence (COE), Norovirus Laboratory Surveillance Network (CaliciNet), and Norovirus Sentinel Testing and Tracking (NoroSTAT). ● Develop and implement better tools for collecting and analyzing public health surveillance and outbreak-associated information. ● Improve and standardize laboratory testing methods of clinical specimens for foodborne illness pathogens, including resources to develop new testing methods. ● Provide training in epidemiologic and environmental health investigation and laboratory methods related to human enteric disease surveillance as mandated by the Food Safety Modernization Act (*3*) through the Centers of Excellence and under other longstanding CDC roles. ● Conduct outbreak investigations: o Provide clinical, epidemiologic, and laboratory expertise in pathogens of public health importance; epidemiologic and environmental health expertise to assist with cluster evaluation and outbreak investigations; expertise in water systems and large-volume water sample collection. o Provide leadership, coordination, logistical support, surge capacity, and centralized data collection and analysis for multistate outbreaks. o Coordinate communication with collaborating state and local agencies, other federal agencies, and international partners. o Provide advanced laboratory testing of clinical specimens (and occasionally consumer-held food products), including identification of new or rare disease agents. ● Lead after-action review of human health investigation component of multistate outbreak investigations.

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Table 3.3. Examples of Typical Foodborne Outbreak Investigation Roles, Responsibilities, and Contributions of Cross-Agency Programs

Program	Roles, Responsibilities, Resources, and Contribution
Rapid Response Teams (RRT)	Responsible for implementing partnership between the Food and Drug Administration (FDA) and state programs to build food safety infrastructure and integrated rapid response for all-hazards human and animal food emergencies: ● Maintain and promote RRT Best Practices Manual (*4*) ○ Food outbreak and all-hazard human and animal food emergency response procedures, specific disease agents, epidemiologic and environmental outbreak investigation, informational traceback and implicated product traceforward. ○ Collection of environmental and food samples for chemical, radiologic, physical, and microbial contaminant analysis. ● Provide training in outbreak response methods for local health agencies. ● Conduct outbreak investigations. The RRT serves as the Outbreak Investigation and Control Team for multijurisdictional and state-level outbreaks: ○ Lead, assist, and support investigations conducting facility inspections; informational traceback investigations; and food recalls that involve food products (manufactured, commercially produced, and retail) through consultation with health department investigators, federal food safety agency partners, and food industry firms. ○ Initiate chain-of-custody, quality assurance, and safety procedures when collecting and submitting food samples to support regulatory response.
Food Emergency Response Network	Responsible for prevention, preparedness, response, and recovery activities (*5*): ● Maintain an integrated network of local, state, and federal laboratories across the United States that are capable of rapid response to food-related emergencies and attacks on the U.S. food supply. ● Detect and identify biological, chemical, and radiologic agents in food, and provide food testing surge capacity during national emergencies.

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Table 3.4. Examples of Typical Foodborne Outbreak Investigation Roles, Responsibilities, and Contributions of Nongovernment, Industry, and Academic Partners

Partner	Roles, Responsibilities, and Contributions

Healthcare Providers	Responsible for appropriate testing, provision of patient care, and reporting of required illnesses and conditions:
	● Maintain supplies (specimen collection kits) and trained staff to support outbreak investigations.
	● Speed detection, investigation, and control of foodborne illness outbreaks by
	  ○ Gathering of preliminary exposure and clinical history.
	  ○ Early recognition and reporting of possible outbreaks.
	  ○ Timely collection and submission of appropriate specimens for testing.
	  ○ Application of infection control measures.
	● Provide appropriate patient education and information to prevent further spread of disease.

Industry*	Responsible for maintaining the safety of food offered to the public:
	● Firm Level: A specific point of sale, distributor, manufacturer, processor, or farm that is directly impacted by an ongoing outbreak investigation.
	  ○ Have detailed knowledge about the firm's processes and organizational culture that are key to understanding possible
	  ▪ Point(s) of contamination.
	  ▪ Contributing factors.
	  ▪ Underlying environmental root cause(s) (i.e., antecedent[s], underlying reason[s]) that lead to outbreaks.
	  ○ Communicate with employees, suppliers, government agencies, and customers during outbreaks.
	  ○ Implement control measures that can stop the current outbreak and prevent reoccurrence.
	  ▪ Firm level controls, e.g., employee restrictions/exclusion, food process changes.
	  ▪ In-distribution controls: cease distribution and initiate recalls
	  See CIFOR Industry Guidelines for further details relevant to the food service and retail food sectors (https://cifor.us/products/industry).
	● Commodity-Specific and Regional Levels: Groups and associations focused on a specific commodity or product
	  ○ Can provide expertise on how the commodities or products are grown, processed, manufactured, packed, distributed, and served.
	  ○ Discussions with this level of industry can help investigators better understand how to investigate contamination issues.
	  ○ Have preexisting networks that can be used to
	  ▪ Gather and provide information needed during the investigation.
	  ▪ Communicate the findings of outbreak investigations to relevant individuals and entities.
	  ▪ Build consensus regarding changes needed to protect public health and consumer confidence in their products.
	● National Level**:** Groups and associations that represent many food-related entities at the national level:
	  ○ Can provide expertise on how a range of food products are grown, processed, manufactured, packed, distributed, and served.
	  ○ Ongoing collaboration and partnership with these groups is important for changes to laws, regulations, policies, and initiatives that impact industries nationally.

Academic centers	Responsible for providing technical assistance, training, and specialized laboratory support:

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- Publish research results to help inform future outbreak investigations and implement control measures (e.g., NoroCORE) (*6*).
- Conduct special laboratory analyses or provide additional resources.
- Conduct applied food safety research to expand results of investigations.

*Partnerships with individuals and entities at each level should be well-established, and discussions should be ongoing, not occur just during an outbreak crisis.

3.2 Outbreak Investigation and Control Team

The responsibility for investigating foodborne illness outbreaks and implementing control measures rests on a team of people who each contribute different knowledge and skills. Depending on the size and scope of the investigation, the size of the team varies from a few people to hundreds. In smaller investigations, individuals may fulfill multiple roles concurrently. Regardless of the size or complexity of an individual investigation, investigation and control teams must be able to synthesize information from a variety of sources as they investigate individual cases, clusters, and outbreaks.

Job titles alone might not accurately indicate who does what. Team members' assigned tasks and their knowledge and skills define their roles. Members may come from different programs within an agency or from different agencies. Composition of the outbreak investigation and control team varies depending on the specifics of the outbreak. In many investigations, roles are defined relatively informally and may change as the investigation unfolds. In other investigations, roles are mapped to the formal structure of the National Incident Management System, which government agencies and Rapid Response Teams use (see Section 7.2.3 for specifics about the National Incident Management System and Incident Command System [ICS]) (*7*). The composition of core outbreak investigation and control team should be determined before any outbreaks.

3.2.1 A core team should be involved in all outbreak investigation and control efforts, giving consistency to investigations, serving as the focal point for coordinating multidisciplinary and/or multiagency tasks, and enabling development of effective working relationships with external partners and advanced expertise among staff. The approach for structuring an investigation and control team will not look the same for all agencies. In small agencies with limited outbreaks, this might be accomplished by designating a few people who receive outbreak response training. In large agencies responding to more frequent and/or complex outbreaks, this might be a dedicated outbreak response team of epidemiologists, environmental health specialist, environmental scientists, and laboratorians who train and work together.

- *Team leader*: Sets and enforces priorities; coordinates all activities associated with the investigation; serves as the point of contact about the investigation; coordinates content of messages to the public through the public information officer; communicates with other organizations involved in the investigation; communicates recommended course of action determined by team to agency decision-makers.
- *Epidemiologist*: Identifies and interviews case-patients; develops hypotheses and strategies to test them; plans epidemiologic studies; re-interviews case-patients and healthy controls; provides insights and guidance to environmental health specialists (and federal regulatory

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partners) on cases and clusters for informational traceback, collects and analyzes investigation data using statistical analyses or collaborating with a statistician; reports results; collects clinical specimens; coordinates testing of clinical specimens and environmental samples; consults and coordinates with environmental and laboratory investigators.

- *Environmental health specialist*: Investigates food preparation sites across the food chain; reviews food inventory and food distribution records for informational traceback investigations in epidemiologic studies; collects environmental and food samples, maintaining chain-of-custody and coordinates testing with laboratorian; interviews food workers and managers; reviews food preparation and food handling records; observes and maps food flow, reviews firm's inspectional and enforcement records for prior food safety history; conducts environmental health assessments to determine contributing factors and environmental root causes (i.e., antecedent[s], underlying reason[s]).
- *Laboratorian*: Analyzes clinical specimens, food and environmental samples (depending on the state, the food and environmental samples may be tested in different laboratories than the clinical specimens); interprets test results and suggests follow-up testing; reports results; coordinates testing among laboratories; advises other team members about sampling requirements and testing, including collection, handling, storage, and transport of specimens; communicates laboratory testing methods and results and the maintenance of chain-of-custody to FSIS and FDA investigators or other food regulatory agency gathering evidence of food product adulteration.
- *Public information officer*: Develops general and specific messages for the public through the media; responds to media inquiries or identifies the appropriate spokesperson; coordinates communication with multiple agencies; disseminates information about outbreak status and overall policies, goals, and objectives to widespread and diverse audiences that include the executive and legislative branches of the government; local governments; the general public; and the local, state, and national news media.

Additional team members with other expertise may be needed, depending on the unique characteristics of the illness or outbreak.

3.2.2 Team members should have the expertise and training needed to competently fulfill assigned responsibilities and tasks for the types of outbreaks they will be expected to investigate and control. They should understand the roles of the other team members, be able to recognize when an outbreak response exceeds agency resources, and know how to expand the investigation team and request additional resources when needed. Training and procedures should anticipate and address how response team members will manage increased coordination and communication workloads when outbreak investigations rapidly escalate. Ongoing training is critical for all members of the outbreak investigation and control team to ensure they are proficient at performing their assigned duties.

At a minimum, the outbreak investigation and control team should have training in specific protocols for routinely assigned tasks. The training should include continuing education to maintain and improve skills within their specialty and specific training in the agency's outbreak response protocols and the member's role on the team.

For a smaller agency with a limited number of outbreak investigations, special training opportunities

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should be arranged. Consider the use of webinar technology where little or no opportunity exists for travel. The CDC-supported Integrated Food Safety Centers of Excellence have approximately 150 tools and training courses available online at no charge.

- Ensure all team members have a common understanding of the primary goal for outbreak response, which is to implement control measures as quickly as possible to prevent additional illness.
- Provide team members with continuing education and training opportunities, including cross-training/joint training.
- Conduct regional training with multiple agencies, including tabletop exercises. Such training can help identify problems that might arise during a multijurisdictional outbreak.
- Offer just-in-time training to refresh the knowledge and skills of staff who do not routinely perform assigned tasks.
- Identify opportunities to collaborate with representatives of the food industry in training exercises, to foster understanding and develop communication strategies that can help streamline actual outbreak investigations.
- Use outbreak investigations as training opportunities to develop individual and organizational skills.

3.3 Planning to Rapidly Expand and Contract Investigation and Control Team Structure

Agency plans must anticipate the need to rapidly expand and contract the size and structure of investigation and control teams to address changing conditions, including to participate in multiagency investigation and control teams (Chapter 7).

3.3.1 The following practices can be used to scale up (escalate) and down (de-escalate) investigation and control teams to meet the often rapidly changing needs of an outbreak response.

- Ensure foodborne outbreak investigation team plans and procedures are updated regularly.
- Determine jurisdiction; investigations may require management in multiple jurisdictions.
- Identify criteria (triggers) used to indicate when the needs of investigation and control teams exceed agency resources, such as
    - Size of the outbreak.
    - Likelihood that resources will be exceeded.
    - New or rapidly emerging incident.
    - Long duration of incident.
- Identify resources that can be tapped for surge, and develop relationships and plans to facilitate quick access to these resources should the need arise. For example:
    - Cross-train persons from within the agency or from other organizations—such as other branches of government, university students, volunteers (e.g., Medical Reserve Corps)—who have adequate skills or knowledge and would be willing to help conduct interviews or provide other support during a large-scale outbreak.
    - Establish Memorandums of Understanding, Mutual Aid, or other agreements along with plans, procedures, communication strategies, and protocols before a foodborne illness outbreak.

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- Consider using ICS principles and organizational structures, as appropriate, to manage outbreak responses—especially those that cannot effectively be managed using the agency's standard operating procedures and chain of command.

3.3.2 Agencies involved in foodborne illness outbreak investigation and response should decide in advance whether and how to apply an ICS and, if applicable, incorporate the ICS into their response planning. Such planning should be coordinated with all other agencies that may be drawn into the investigation and response over time. Many foodborne illness outbreak investigations do not require formal activation of ICS, but outbreak investigation and control teams will benefit from training in ICS principles and methods (Chapter 7).

3.4 Response Resources

A critical aspect of preparing to investigate a foodborne illness outbreak is assembling the necessary resources; supplies, equipment, people, and outbreak investigation–related documents (some accessible via reference materials or pertinent databases) to ensure that everything needed in the investigation and response is quickly available. This enables the outbreak investigation and control team to move rapidly into the field.

3.4.1 Identify staff to support the Outbreak Investigation Team.

- *Administrative staff*: Support personnel to make phone calls, answer incoming calls from concerned members of the public, assist in travel arrangements and other logistics, enter data into a database, copy paperwork, and other administrative work.
- *Executive and financial staff*: Executive staff to guide response priorities and objectives, facilitate communication and role changes, and financial staff to release funds, track expenditures, and assist in procurement of supplies and equipment.
- *Legal counsel*

3.4.2 Develop field investigation or "go" kits for environmental health investigators, including sampling utensils, thermometers, fecal collection kits, and appropriate forms (Box 3.1.). Ensure that relevant field investigators have access to these kits and are aware of where they are located and that the kits are available at all times. Foodborne illness outbreak investigation kits should be maintained in ready-to-use condition, with sterile sampling supplies, containers and implements. Establish, maintain, and review or verify inventory regularly. (Detailed information about kits and sample lists are included at the CIFOR Clearinghouse, https://www.cifor.us/clearinghouse and in the International Association for Food Protection *Procedures to Investigate Foodborne Illness* (http://www.foodprotection.org/publications/other-publications/). Procedures for routinely reviewing and replacing missing or outdated supplies and equipment should be part of an agency's outbreak response protocol.

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Box 3.1. Example Supplies for Outbreak Investigation Go-Kits

Personal protective equipment to ensure safety and aseptic sampling techniques.

Sterile and wrapped sample-collection supplies (e.g., gloves, spoons, scoops, tongue-depressor blades, spatulas, spongesticks, swabs, knives).

Sterile sample containers (e.g., plastic bags, wide-mouth plastic and glass jars with screw caps, bottles, sterile sampling bags) and mailing instructions.

Sterile fecal sample kits for food workers or case-patients.

Sterilizing and sanitizing agents (e.g., 95% ethyl alcohol, sodium or calcium hypochlorite, alcohol swabs), hand sanitizers, and sanitizer test strips.

Equipment to determine food characteristics (e.g., pH, water activity, sugar content).

Temperature-checking probes and backups.

Refrigerants (e.g., ice packs), insulated containers.

Labeling and sealing equipment (e.g., fine-point or felt-tip permanent marking pen, roll of adhesive or masking tape, waterproof labels or tags, custody tape).

Shipping boxes/coolers, prepaid shipping labels, and forms.

Forms, including sample collection and blank laboratory submission forms, chain-of-custody and other forms for documenting activities.

Camera or other method to visually document the investigation.

Trash bags for the waste generated during the investigation (always take your trash with you).

In addition to the sampling supplies, ensure that staff have access to radios and other team communication devices appropriate to the response situation, including

- Capabilities and equipment for conference calls.
- Multiple phone lines.
- Computers, laptops, software (e.g., data entry, statistical), extension cords, multioutlet power strip surge protector, portable printers, paper, graph paper, pens, clipboards, camera.

3.4.3 Make sure investigation and control team members have access to necessary documents and forms and be trained to use them appropriately in a response situation. These include

- Chain-of-custody forms.
- Foodborne illness complaint worksheets.
- Blank disease-specific case report forms.
- Laboratory test requisition forms.
- Standardized outbreak questionnaires (available at https://www.cdc.gov/foodsafety/outbreaks/surveillance-reporting/investigation-toolkit.html).
- Environmental health assessment forms, such as hand hygiene assessment (examples available at https://www.cdc.gov/nceh/ehs/EHSNet).

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- Shipping protocols, forms and required prepaid labels

These and other sample documents are available from the CIFOR Clearinghouse at https://cifor.us/clearinghouse.

3.4.4 Team members must have access and are trained (if applicable) to use key databases, communication platforms, and other resources before an outbreak. Although not exhaustive, the following databases, listservs, and other systems are recommended:

- CDC Foodborne Outbreak listserv.
- PulseNet SharePoint website.
- SEDRIC.
- NCBI Pipeline.

3.4.5 Assemble a reference library (including online resources) with information about foodborne illnesses, enteric illnesses, and control measures. Where possible, include electronic resources that can be accessed by laptop computers or mobile devices during field investigations. Regularly review and update the contents of this reference library.

- Books, Web resources for support during outbreak (e.g., CDC's Diseases and Conditions A–Z index, FDA's Bad Bug Book).
- Latest version of the American Public Health Association's *Control of Communicable Diseases Manual* (*8*).
- *Procedures to Investigate Foodborne Illness* by the International Association for Food Protection (*9*).
- *Investigating Foodborne Disease Outbreaks* by the World Health Organization (*10*).
- FDA's *Investigations Operations Manual* (*11*).
- FSIS online resources
  - Template for Including FSIS in Foodborne Illness Outbreak Response Procedures: www.fsis.usda.gov/OutbreakProcedures.
  - Information Helpful to FSIS During Foodborne Illness Investigations: www.fsis.usda.gov/InvestigationInfo.
  - Resources for Public Health Partners: Foodborne Illness Investigation: www.fsis.usda.gov/PHPartners.
- Integrated Food Safety Centers of Excellence all products website: https://coefoodsafetytools.org/AllCoEProducts.aspx.
- CIFOR Guidelines: https://cifor.us/products/guidelines.

3.5 Communication Plans

Good communication is one of the most important factors in successful outbreak investigation and control. At all points in the outbreak continuum—from detection through investigation and response to debriefing—communication is critical. Without it, investigations and responses can be delayed, uncoordinated, and ineffective. Furthermore, good communication can help allay agency management and public concerns and improve industry support for actions to control outbreaks. To promote better outcomes, use the time before and between outbreaks to lay the groundwork for communication, such as developing and updating contact lists, defining communication processes, establishing relationships

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with key persons internal and external to the agency, and determining how confidential information will be stored, and whether and how it can be shared.

Although the following practices for communication are all recommended, full implementation may not be possible in some jurisdictions because of resource limitation. Implementing as many as possible as completely as possible will improve communication.

3.5.1 Prepare a list of people in the agency who should be contacted in the event of an outbreak, including backups, and contact people in external agencies (adjacent local, territorial, state, tribal, and federal agencies). Ensure the list includes after-hours and weekend contact information, and update it regularly.

Assemble a contact list of resource persons who have expertise in specific disease agents and investigation methods with primary phone numbers and alternates, cell phone numbers, 24-hour numbers, home phone numbers, email, fax numbers, and addresses) of

- Core members of the outbreak investigation and control team.
- Other officials inside the agency, such as the chief of the epidemiology unit, director of the public health laboratory, director of environmental health, public health information officer, and the agency director.
- Critical contacts in other government agencies.
- Important food industry contacts, including trade associations (e.g., National Restaurant Association).
- Key healthcare provider contacts.
- Laboratory contacts.
- Primary media contacts.

3.5.2 Define a formal communication process for the outbreak investigation and control team to use during outbreaks. Anticipate what information and data response partners and agency leadership need, and at what frequency, to maintain situational awareness and guide decision-making about investigation and control measures. Options include daily meetings, daily phone calls, and email updates. Developing a consistent approach to internal communications during an outbreak helps everyone on the team know what to expect.

- Identify the persons responsible for communication on behalf of their organizational unit (epidemiology, environmental health, laboratory) and for the outbreak investigation and control team. Communicators must be brought in early as the outbreak develops for a more efficient response.
- Determine how nonpublic information will be saved and whether and how it can be shared. Local and state agencies can receive certain types of confidential information from FDA under a 20.88 information sharing agreement (*12,13*) (Chapter 7.3).
- Distribute a list of the agency's contacts to other agencies, and obtain their contacts.
- Establish processes for participating in multiagency, multijurisdictional conference calls, and train staff in appropriate conference call etiquette.
- Establish procedures for coordinating communication with the following entities to provide consistent messaging and accurate information flow:
    - Local, state, and federal authorities.
    - Local organizations, food industry, and other professional groups (including healthcare

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providers).
    - The public.
    - The media.
- Create templates for communications with the public (e.g., press releases, fact sheets), focusing on the most common foodborne illnesses. Sample materials are available at the CIFOR Clearinghouse (https://www.cifor.us/clearinghouse).
- Create and test online tools to communicate with the public (e.g., blast emails, surveys, social media).
- Guide staff on how to respond to and communicate during conflict situations, such as with upset food service workers, food protection managers, and members of the public.
- Identify people with clinical training, such as public health nurses or medical epidemiologists, to communicate with case-patients about the outbreak and actions they should take to protect their health and their family's health.
- Identify a person from an agency to talk to the media, ideally someone trained in media relations or a public information officer. Establish procedures for coordinating communication with the media to provide consistent messaging and accurate information flow.

3.6 Planning for Recovery and Follow-Up

Part of preparing for outbreak response is planning for the recovery and follow-up stages. This planning helps ensure appropriate actions are taken after each outbreak and helps identify and correct problems to prevent future outbreaks from the same causes. Establish a process to conduct hot-washes so participants can provide feedback. Create after-action reports that identify lessons learned and action items for follow-up, including ways to improve. Report the root cause(s) of the outbreak and other key investigation findings to national foodborne outbreak and response databases, such as the National Outbreak Reporting System and the National Environmental Assessment. Reporting System (Chapter 6).

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10. World Health Organization. Foodborne disease outbreaks: guidelines for investigation and control. https://apps.who.int/iris/handle/10665/43771
11. Food and Drug Administration. Investigations Operations Manual. https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/inspection-references/investigations-operations-manual
12. 21 C.F.R. 20.88.
13. Food and Drug Administration. Information sharing. https://www.fda.gov/ForFederalStateandLocalOfficials/CommunicationsOutreach/ucm472936.htm

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Appendix 3.1

Resources (current as of August 8, 2019)

Academia

- Colorado Integrated Food Safety Center of Excellence: https://www.cdc.gov/foodsafety/centers/sites/colorado.html
- Minnesota Integrated Food Safety Center of Excellence: https://www.cdc.gov/foodsafety/centers/sites/minnesota.html
- New York Integrated Food Safety Center of Excellence: https://www.cdc.gov/foodsafety/centers/sites/newyork.html
- Tennessee Integrated Food Safety Center of Excellence: https://www.cdc.gov/foodsafety/centers/sites/tennessee.html
- Cornell Department of Food Science: https://foodscience.cals.cornell.edu
- American Public Health Laboratories

Federal Government

U.S. Department of Agriculture, Food Safety and Inspection Service: https://www.fsis.usda.gov/wps/portal/fsis/home

FoodSafety.gov: http://www.foodsafety.gov

Centers for Disease Control and Prevention

- List of Selected Multistate Foodborne Outbreak Investigations: http://www.cdc.gov/foodsafety/outbreaks/multistate-outbreaks/outbreaks-list.html
- Foodborne Diseases Active Surveillance Network (FoodNet): http://www.cdc.gov/foodnet/index.html
- The National Molecular Subtyping Network for Foodborne Disease Surveillance (PulseNet): https://www.cdc.gov/pulsenet/index.html
- CDC Division of Food, Waterborne and Environmental Diseases: http://www.cdc.gov/ncezid/dfwed/
- Foodborne Disease Outbreak Surveillance System (FDOSS): https://www.cdc.gov/fdoss/index.html
- National Outbreak Reporting System (NORS): https://www.cdc.gov/nors/index.html
- System for Enteric Disease Response, Investigation, and Coordination (SEDRIC): https://www.cdc.gov/foodsafety/outbreaks/investigating-outbreaks/sedric.html
- CDC Vital Signs: https://www.cdc.gov/vitalsigns/
- CDC Zoonotic Diseases: http://www.cdc.gov/zoonotic/gi/index.html
- CDC Foodborne Outbreak Team: http://www.cdc.gov/ncezid/dfwed/orpb/ort.html
- Salmonella Reporting Timeline: http://www.cdc.gov/salmonella/reportingtimeline.html
- National Antibiotic Resistance Monitoring System for Enteric Bacteria (NARMS): https://www.cdc.gov/narms/index.html
- Norovirus information: http://www.cdc.gov/norovirus/index.html
- Burden of Foodborne Illness: Findings: http://www.cdc.gov/foodborneburden/2011-foodborne-estimates.html
- National Environmental Assessment Reporting System (NEARS) (https://www.cdc.gov/nceh/ehs/nears/index.htm)Integrated Food Safety Centers of Excellence: https://www.cdc.gov/foodsafety/centers/index.html

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Food and Drug Administration

- FDA Investigations Operation Manual: https://www.fda.gov/iceci/inspections/iom/default.htm
- FDA Rapid Response Team Links: RRT Best Practices Manual (Edition 2017): http://www.afdo.org/RRT-Manual
- Best Practices for Improving FDA State Communications Recalls (Summer 2015): https://www.fda.gov/downloads/ForFederalStateandLocalOfficials/ProgramsInitiatives/PartnershipforFoodProtectionPFP/UCM460013.pdf
- Best Practices for Use of FoodSHIELD During Food and Feed Incidents (Summer 2015): https://www.fda.gov/downloads/ForFederalStateandLocalOfficials/ProgramsInitiatives/PartnershipforFoodProtectionPFP/UCM524721.pdf
- National Program Standards Crosswalk Resource Paper (September 2013): https://www.fda.gov/downloads/ForFederalStateandLocalOfficials/ProgramsInitiatives/PartnershipforFoodProtectionPFP/UCM404725.pdf
- Model for Local Federal/State Planning and Coordination of Field Operations and Training (October 2013): https://www.fda.gov/downloads/ForFederalStateandLocalOfficials/ProgramsInitiatives/PartnershipforFoodProtectionPFP/UCM404722.pdf
- Food/Feed Testing Laboratories Best Practices Manual—Draft (December 2013): https://www.fda.gov/downloads/ForFederalStateandLocalOfficials/ProgramsInitiatives/PartnershipforFoodProtectionPFP/UCM404716.pdf
- Quick Start Food Emergency Response Job Aids (Winter 2017): https://www.fda.gov/downloads/ForFederalStateandLocalOfficials/ProgramsInitiatives/PartnershipforFoodProtectionPFP/UCM535097.pdf

Other Organizations

- Association of Public Health Laboratories
  - APHL and Food Safety: https://www.aphl.org/programs/food_safety/Pages/APHL-Food-Safety.aspx
  - Food Safety Tools and Resources: https://www.aphl.org/programs/food_safety/Pages/Food-Safety-Tools-and-Resources.aspx
  - Food Safety: https://www.aphl.org/programs/food_safety/Pages/default.aspx
- Association of Food and Drug Officials: http://www.afdo.org
- Association of State and Territorial Health Officials: https://www.astho.org
- Council of State and Territorial Epidemiologists: http://www.cste.or
- International Association for Food Protection: https://www.foodprotection.org
- International Food Protection Training Institute: https://ifpti.org
- National Association of County and City Health Officials: https://www.naccho.org
- National Association of State Departments of Agriculture: https://www.nasda.org
- National Association of State Public Health Veterinarians: http://www.nasphv.org
- National Environmental Health Association: https://www.neha.org

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Chapter 4: Foodborne Illness Surveillance and Outbreak Detection

Chapter Summary Points

- Two general methods are used to detect most outbreaks: pathogen-specific surveillance and complaint systems.
- Recent technology changes have altered foodborne illness surveillance, including culture-independent diagnostic testing (CIDT) and whole-genome sequencing (WGS).
  - Molecular multitarget CIDTs that can detect up to 22 pathogens in an hour are replacing enteric pathogen culture in many clinical laboratories, shifting the burden of isolating bacteria for subtype and other characterization to public health laboratories.
  - WGS offers major improvements over traditional subtyping methods but currently takes longer than pulsed-field gel electrophoresis to complete, leading to potential delays in identification of clusters.
- The usefulness of consumer complaint systems to identify outbreaks is based either on 1) the ability of groups with a common exposure to self-identify illness and link it to the exposure or 2) the ability of the complaint system to independently link multiple independent complaints to a common source.
  - To complement the review of individual complaints and patterns of complaints detected through the foodborne illness complaint system, communicable disease surveillance staff should conduct standard interviews for foodborne illness detected through pathogen-specific surveillance (e.g., *Salmonella* and Shiga toxin–producing *Escherichia coli*).
  - Regardless of who receives the complaint or how the complaint is received (phone, online), the complaint should be evaluated for the likelihood of a foodborne illness or outbreak associated with the establishment that is the subject of the complainant or other establishments identified in the food history.

URLs in this chapter are valid as of August 13, 2019.

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4.0 Introduction

4.0.1 Foodborne illness surveillance identifies clusters of illness that may be caused by a common food source. This chapter reviews major features, strengths, and limitations of surveillance methods and provides recommendations for increasing the effectiveness of each. In practice, detecting individual foodborne illness outbreaks involves multiple approaches. However, in general, two methods are used to detect most outbreaks: pathogen-specific surveillance and complaint systems (Table 4.1). A third method, syndromic surveillance, is used in some jurisdictions, but its role in detecting foodborne illness outbreaks is limited.

- **Pathogen-specific surveillance:** Healthcare providers and laboratorians report individual cases of illness when selected pathogens, such as *Salmonella enterica* and *Escherichia coli* O157:H7, or specific clinical syndromes, such as hemolytic uremic syndrome and botulism, are identified. Public health professionals gather exposure information through interviews with case-patients.
- **Complaint systems:** Healthcare providers or the public identify and report suspected illness clusters (group notifications) or individual complaints. Exposure information is acquired by interviews with ill people.
- **Syndromic surveillance:** This surveillance method generally involves systematic (usually automated) gathering of data on nonspecific health indicators that might reflect increases in illness, such as purchase of loperamide (an antidiarrheal agent), visits to emergency departments for diarrheal complaints, or calls to poison control hotlines. Exposure information is not routinely collected.

Although these methods are presented separately for descriptive purposes, they are most effective when used together and integrated with food, veterinary, and environmental monitoring programs (Chapters 4 and 5). The range of possible food vehicles detectable through foodborne illness surveillance includes all food or other substances contaminated at any link in the chain from production to ingestion. Foodborne illness surveillance complements regulatory and commercial monitoring programs by providing primary feedback on the effectiveness of prevention programs.

4.0.2 This chapter highlights how recent technology changes have altered foodborne illness surveillance; including the use of culture-independent diagnostic testing (CIDT) and whole-genome sequencing (WGS). Molecular multitarget CIDTs can detect up to 22 pathogens in an hour, which makes them very attractive for clinical laboratories (*1*). Molecular multitarget CIDTs are replacing enteric pathogen culture in many clinical laboratories. The use of CIDTs in clinical laboratories shifts the burden of isolating bacteria for subtype and other characterization to public health laboratories (PHLs). Another major change is the advancement of WGS at PHLs. WGS has replaced traditional methods used at PHLs, such as serotyping and subtyping by pulsed-field gel electrophoresis (PFGE), for the primary foodborne pathogens under routine surveillance.

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Table 4.1. Comparison of Foodborne Illness Surveillance Systems

Functional Characteristic of Method	Surveillance Method			
		Complaint		
	Pathogen-Specific	Group Notification	Individual Complaint	Syndromic
Inherent speed of outbreak detection	Relatively slow	Fast	Fast	Variable*
Sensitivity to widespread, low-level contamination events (best practices used)	High	Intermediate	Intermediate	Low†
Types of outbreaks (etiology) that method can potentially detect	Limited to clinically suspected or laboratory-confirmed diseases under surveillance	Any‡	Any, although effectiveness limited to agents with short incubation periods‡	Limited to syndromes (or indicators) under surveillance
Initial outbreak signal (at public health level)	Cluster of cases in space or time with common agent	Report of group illnesses recognized by healthcare provider, laboratory, or the public	Multiple independent reports with common exposures in space or time or unique clinical presentation recognized by the agency receiving the reports	Trend in health indicator different from expected, space/time clusters of diagnosed cases
No. cases needed to create initial signal	Low to moderate	Low	Low to moderate	High§
Signal-to-noise ratio	High¶ (after interview of case-patients and collection of appropriate food history). Even higher when combined with subtyping	High¶ (after interview of case-patients and collection of appropriate food history)	Low to moderate (after interview of case-patients and collection of appropriate food history)	Low**

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*An advantage in speed is limited mainly to nonspecific health indicators (preclinical and clinical prediagnostic data). Data must be analyzed, and a follow-up investigation is required, including comparison with standard surveillance, before public health action can be taken.
†Sensitivity is higher for rare, specific syndromes, such as botulism-like syndrome.
‡Although outbreaks can be detected without an identified etiology, linking multiple outbreaks to a common source may require agent information.
§The number of cases needed to create a meaningful signal is related to the specificity of the indicator. Indicators that offer an advantage in speed also tend to have low specificity.
¶A high signal-to-noise ratio means that even a small number of cases stand out against a quiet background. A low ratio means a cluster of cases or events is difficult to perceive because it is lost in the many other similar cases or events happening simultaneously—similar to a weak radio signal lost in static noise. The signal-to-noise ratio for syndromic surveillance is lowest for nonspecific health indicators, such as loperamide use or visits to the emergency department with diarrheal disease complaints. The ratio increases with increasing specificity of agent or syndrome information. For highly specific, rare syndromes, such as botulism-like syndrome, the signal-to-noise ratio would approach that of pathogen-specific surveillance.
**Exposure histories are not typically obtained.

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4.1 Pathogen-Specific Surveillance

4.1.1 The purpose of pathogen-specific surveillance is to systematically collect, analyze, and disseminate information about laboratory-confirmed illnesses or well-defined syndromes as part of prevention and control activities. Surveillance for typhoid fever began in 1912 and was extended to all *Salmonella* spp. in 1942. National serotype-based surveillance of *Salmonella* began in 1963, making it one of the oldest pathogen-specific surveillance programs and the oldest PHL subtype-based surveillance system. The usefulness of pathogen-specific surveillance is related to the specificity with which agents are classified (i.e., use of subtyping and method), enabling grouping of individual cases of illness with other cases most likely to share a common food source or other exposure (Box 4.1). The utility of bacterial surveillance increased during the 1990s with the development of PulseNet and molecular subtyping of selected foodborne pathogens, including *Salmonella*, Shiga toxin–producing *E. coli* (STEC) O157:H7, *Shigella*, and *Listeria*. Additional gains in usefulness are anticipated with the adoption of WGS in 2019.

Box 4.1. Selected Nationally Notifiable Diseases that Can be Foodborne

- Anthrax (gastrointestinal)
- Botulism, foodborne
- Campyobacteriosis
- Cholera
- Cryptosporidiosis
- Cyclosporiasis
- Giardiasis
- Hemolytic uremic syndrome, postdiarrheal
- Hepatitis A virus infection, acute
- Listeriosis
- Salmonellosis
- Shiga toxin–producing *Escherichia coli* infection
- Shigellosis
- Trichinellosis (trichinosis)
- Typhoid fever
- *Vibrio* infection

In addition, the following are nationally notifiable:

- Foodborne illness outbreaks
- Waterborne illness outbreaks

Source: Centers for Disease Control and Prevention. Nationally Notifiable Infectious Diseases. United States 2018. Historical.
https://wwwn.cdc.gov/nndss/conditions/notifiable/2018

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4.1.2 Most illnesses included under pathogen-specific surveillance are reportable (i.e., notifiable) diseases. State or local health agencies establish criteria for voluntary or mandatory reporting of infectious illnesses, including those that might be foodborne (Box 4.1). These criteria describe the illnesses to report, to whom, how, and in what timeframe. For this type of surveillance, illnesses are defined by specific laboratory findings or by well-defined syndromes, such as hemolytic uremic syndrome.

- **Illnesses are reported primarily by laboratories, medical staff (e.g., physicians, infection-control practitioners, medical records clerks), or both.** Reports can be automatically generated from an electronic medical record or laboratory information system or reported through a secure website. Legacy systems, such as telephone, mail, or fax reporting, also are used but are slower and more labor intensive and error prone.
- **Isolates or other clinical materials are forwarded from clinical laboratories serving primary healthcare facilities to PHLs** for confirmation and further characterization, as required by state laws or regulations or as requested by the local jurisdiction.

  Molecular multitarget CIDTs are replacing enteric pathogen culture in many clinical laboratories. Many clinical laboratories that perform enteric pathogen detection using CIDTs do not culture the pathogens identified by the CIDT. Instead, the clinical laboratory sends the specimen to the PHL to perform culture to obtain an isolate for further testing, which is important for foodborne disease surveillance.

  It is imperative that clinical laboratories send the specimens in a transport media (i.e., Cary Blair) to PHLs immediately to improve the chances of isolating the pathogen. Immediate transport of specimens also helps identify potential clusters as soon as possible. The Association of Public Health Laboratories has produced guidelines for specimen submission for optimal isolate recovery from specimens that test positive for pathogens by CIDTs (*2*).

4.1.3 Laboratory staff record receipt of samples at the PHL and enter sample information into the laboratory information management system, or LIMS. This process facilitates downstream information sharing with investigation partners. Patient information submitted with the sample may be provided to the epidemiology department for comparison with information from cases already reported and to enable reconciliation of case reports and laboratory samples and identification of previously unreported cases.

- If CIDTs have been used to detect the pathogen in the clinical laboratory, and a specimen is submitted, the PHL attempts to isolate that pathogen.
- Once the isolated pathogen is identified, it is further characterized (e.g., by serotyping, virulence assays, molecular subtyping, or antimicrobial susceptibility tests).
- WGS and PFGE (if conducted at the state level) data, along with accompanying metadata, are uploaded to local and national PulseNet databases. Consolidated daily reports, such as subtype frequency reports, often are used to facilitate cluster recognition. These reports may be automatically generated by laboratory or epidemiology information systems, extracted from the PulseNet database, or extracted from the System for Enteric Disease Response, Investigation and Coordination.

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- Specimen data (including detailed subtyping results) are uploaded to national surveillance systems, such as Laboratory-based Enteric-Diseases Surveillance).
- PHLs issue reports either singly or in groups to the epidemiology department either through electronic systems such as laboratory information management system submission to the epidemiology database or manual entry. Reports also may be issued to submitters as permitted by local policies.
- Rapid identification of clusters in the laboratory and communication of the cluster to foodborne illness epidemiologists is vital to outbreak detection. Case cluster data are enhanced by inclusion of information about matching isolates or outbreaks through PulseNet from other jurisdictions and by matching isolates from food, animal, or environmental monitoring tests that provide information for hypothesis generation.

4.1.4 WGS has replaced traditional methods used at PHLs, such as serotyping using antiserum and subtyping PFGE. PFGE has been the predominant subtyping method for PulseNet since its inception but was replaced by WGS in 2019 (*3*).

- Subtypes, serotypes, virulence factors, and antibiotic resistance genes can be predicted from WGS data.
- WGS data generated from isolates are analyzed to compare isolate relatedness (Figure 4.1). Generally, this comparison is done using the complementary approaches of high-quality single-nucleotide polymorphism (hqSNP) analysis and core or whole-genome multilocus sequence typing (cg/wgMLST). hqSNP analysis identifies differences in single base pairs between closely related isolates, whereas cg/wgMLST analysis relies on a database of all potential genes, or loci, for a particular enteric pathogen. cgMLST looks at those genes in common between all isolates being compared and primarily is used for surveillance and outbreak detection, whereas wgMLST looks at both the genes in common and those that represent the diversity of the strains and is used to further characterize isolates that are related and part of a cluster. Both of these approaches identify differences between compared isolates and can be used to assign a threshold of genetic relatedness between isolates. For hqSNP isolates, the threshold of relatedness is a number of SNP, or base pair, differences; for cg/wgMLST it is the number of allele, or gene, differences. Both methods can produce a phylogenetic tree, which aids in interpretation of results.
- There are no clearly established rules for what constitutes a cluster by WGS. Currently, PulseNet uses a definition of at least 3 cases within a 60-day window with 0–10 allele differences, where at least 2 of the cases differ by 5 or fewer alleles. PHLs may consider a narrower definition (such as 0–5 alleles) to reduce the number of clusters that need to be investigated and to focus investigation resources. Similar to PFGE, there can be common sequence types or rare sequence types, which should be considered during cluster investigations. In addition, if the outbreak occurs over a long period or is zoonotic, more allele differences are detected than in an outbreak representing a point source contamination event. When an outbreak source is contaminated with multiple diverse sequence types, known as a polyclonal outbreak, sequence data may be used to identify multiple independent clusters, which can then be used to identify the polyclonal outbreak. One strategy is to use a narrow cluster definition to identify clusters. That strategy will reduce the number of

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misclassified cases and will increase the measure of association. Once an outbreak is identified, the cluster definition can be expanded to identify addition cases that were missed because of the initial stringent cluster definition.

- cgMLST analyses are built from a stable database of genes so a pattern name, or allele code, can be assigned to the sequence data (Figure 4.2). Allele codes are built from a single linkage tree of all isolates for an organism, and cutoffs are set along certain points, which represent percentage similarity cutoffs, along the tree that produce a stable nomenclature and provide enough resolution to identify potential outbreak clusters. Using the allele code, which is a string of 5–7 numbers, similar to a ZIP code, closely related isolates can be identified and historic frequencies can be tracked. Each shared number along the allele code indicates the genetic relatedness of the isolates. For example, isolates A and B that have the same allele code, 1.1.1.1.1, are closely genetically related; a new isolate, isolate C, that has allele code 1.1.1.1.2 is more closely related than isolate D, with allele code 1.1.1.2.2. Additionally, the allele code can be used to identify clusters and combined with other information predicted from the WGS data, including virulence, serotype, and predicted antibiotic resistance, can be used to prioritize cluster follow-up as part of the triage process.
- WGS data can be used to identify an organism, predict serotype and antibiotic resistance, and identify virulence genes. There are several tools for conducting these analyses, including tools available through the PulseNet database system.
- Although WGS offers major improvements over traditional subtyping methods and enables PHLs to have more efficient workflows, some challenges exist to using this technology in public health practice.. WGS takes longer than PFGE to complete (a minimum of 4 days for WGS vs. 1 day for PFGE). In addition, if WGS replaces traditional serotyping methods, identification of clusters is delayed. PHLs need to perform WGS in a timely manner to ensure clusters are identified as soon as possible, which can be difficult to do in a cost-efficient manner if the testing level of a jurisdiction is low.

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Figure 4.1. Depiction of Whole-Genome Sequencing (WGS) and Sequencing Analysis. WGS starts with extracted DNA from isolated bacteria. Library preparation is then performed by sequencing, which creates millions of short reads. The reads are combined to create long strands of DNA. DNA from one bacterium can be compared with others using the complementary approaches of high-quality single-nucleotide polymorphism (hqSNP) analysis and core genome multilocus sequence typing (cgMLST). hqSNP analysis identifies differences in single base pairs among closely related isolates, and the cgMLST analysis relies on a database of all potential genes, or loci, for a particular enteric pathogen. Both approaches identify differences between compared isolates and can be used to assign a threshold of genetic relatedness between isolates: for hqSNP isolates, it is a number of SNP, or base pair, differences; and for cgMLST, it is the number of allele, or gene, differences. A phylogenetic tree can be used to visualize the genetic differences using either SNP-based testing or cgMLST.

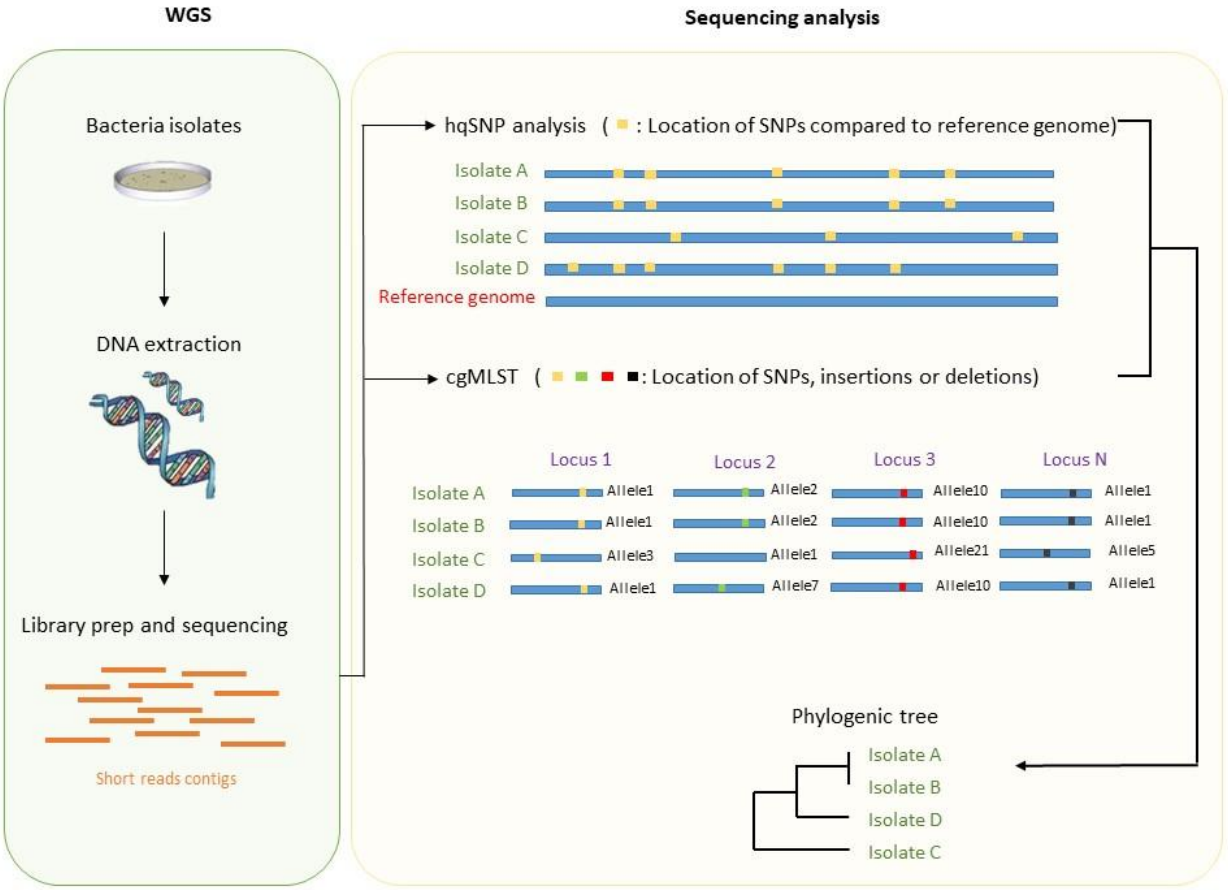

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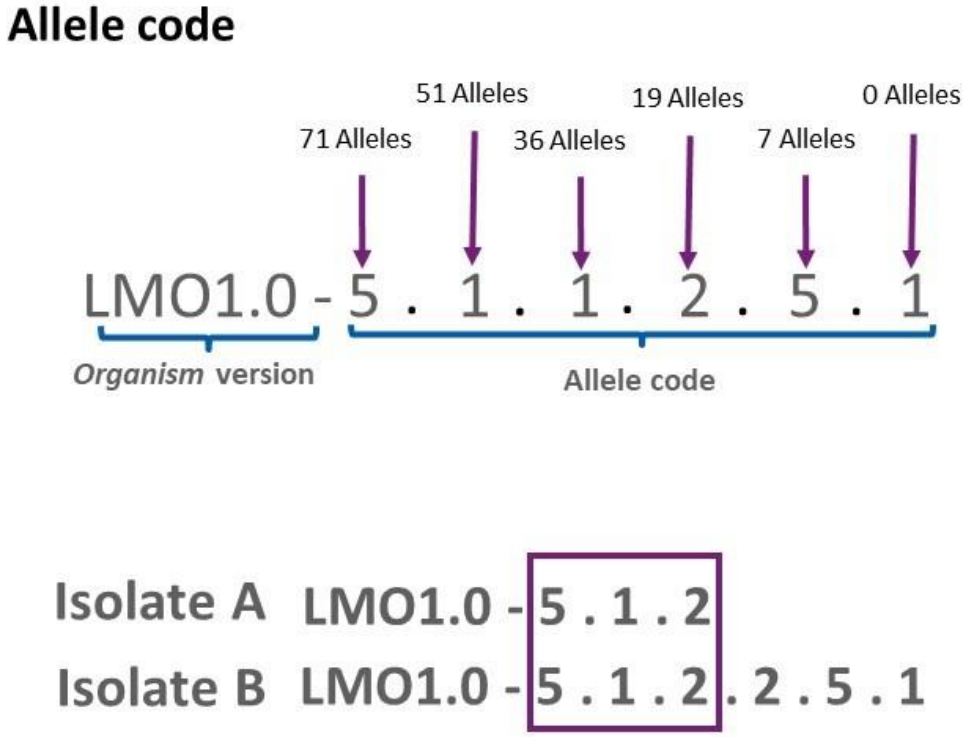
Figure 4.2. Depiction of Allele Code Assembly. Nomenclature is organism-specific with different thresholds for the digits. Organism-specific allele codes are built from a string of 5–7 numbers, similar to a ZIP code. Each shared number along the allele code indicates the genetic relatedness of the isolates. When sequences have partial names, they are singletons in clusters below their last digit. For example, isolates A and B are *Listeria monocytogenes* isolates that are approximately within 36 and 19 alleles of each other.



4.1.5 Case-patients are usually interviewed one or more times about potential exposures and additional clinical and demographic information. Routine collection of detailed exposure information as soon as possible after reporting (either CIDT- or culture-positive result) maximizes exposure recall, provides a basis for rapid cluster investigation, is critical to the environmental investigation, and is strongly recommended for high-consequence enteric pathogens, such as STEC O157:H7, *Salmonella*, and *Listeria monocytogenes*.

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- The scope of routine interviews varies by jurisdiction, agent, and type of test result. Initial interviews typically cover basic descriptive information and exposures of local importance, such as attendance at a childcare facility, occupation as a food worker, and medical follow-up information. Whereas many local agencies collect information about a limited set of high-risk exposures, where resources are limited, detailed exposure interviews might be collected only when clusters are investigated or outbreaks are recognized (Chapter 5).

Information the public health agency receives through multiple avenues, including basic clinical and demographic data from individual case-patients of specific laboratory-confirmed illness or well-defined syndromes, is reconciled and linked with case isolates or other clinical materials received in the PHL. Reconciled case reports are forwarded to higher jurisdictional levels (local health agency to state agency, state agency to federal agency) by a variety of mechanisms. In general, records are redacted (stripped of individual identifiers) when they are sent outside the reporting states.

4.1.6 Initial cluster identification and cluster assessment might occur as two processes conducted, respectively, by the laboratory and epidemiology departments or might occur as a single process within epidemiology. Agent, time, and place are examined individually and in combination to identify possibly significant clusters or trends. This is the critical first step in hypothesis generation. Clusters of unusual exposures, exposure frequencies, demographic distributions (e.g., predominance of cases in a particular age group), or connection to food, animal, or environmental monitoring studies might be identified. Clusters of cases are examined as a group and, if a common exposure seems likely, are investigated further (Chapter 5). In some jurisdictions, cluster detection and triage are a laboratory function (see section 4.2.5).

- A cluster is defined as two or more cases of disease linked by place, time, pathogen subtype, or other characteristic. Isolates closely related by genetic subtyping are more likely than isolates that are not closely related by genetic subtyping to share a common source.
- Clusters may be more or less recognizable and more or less actionable. This chapter focuses on case clusters and outbreaks, but for some high-consequence agents or syndromes (e.g., botulism or paralytic shellfish poisoning), even a single case might merit a prompt and aggressive public health response.
- Clusters are common, and pursuing them all with equal vigor is not practical or productive. Laboratory staff often identify clusters when they detect an increase of a specific subtype or serotype. Incoming surveillance data are evaluated for unusual case counts based on historical frequencies (accounting for seasonality), the severity of disease, and molecular matches between human cases and food or animal monitoring samples In general, cases clustered over a relatively short period are more likely to indicate an outbreak. The time window used to delimit clusters varies by agent. For example, a wider window is used to evaluate clustering of listeriosis cases than to evaluate salmonellosis cases because of differences in the natural history of each disease.
- Although cluster recognition software, such as SaTScan™, cumulative summary (cusum) outbreak detection algorithms, and query algorithms in the System for Enteric Disease Response, Investigation and Coordination, have been developed, none have yet been validated for broad-based enteric disease data. The decision to report or pursue a cluster is an important part of the outbreak detection process but not one that is easily distilled into simple best practices. For many

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organisms, clusters identified by WGS are more indicative of a close genetic relationship and epidemiologic relatedness than are clusters identified by PFGE. An increase in frequency of a strain is only one indication of a potentially significant cluster. Furthermore, absence of an increase in case numbers from expected values does not rule out significance.

4.1.7 The timeline for pathogen-specific surveillance covers a series of events from the time a person is infected through the time public health officials determine that person is part of a disease cluster. The time from infection to cluster detection is one of the limiting factors of pathogen-specific surveillance. Minimizing delays by streamlining the individual processes improves the likelihood of overall success. A sample timeline for *Salmonella* case reporting is presented in Figure 4.3.

- **Incubation time:** the time from ingestion of a contaminated food to beginning of symptoms. For *Salmonella*, this typically is 1–4 days, sometimes longer. For more information about incubation times of foodborne pathogens see the Outbreaks of Undetermined Etiology (OUE) Agent list from the CIFOR website (https://cifor.us).
- **Time to contact with healthcare provider or doctor:** the time from the first symptom to medical care (when a fecal sample will ideally be collected for laboratory testing). This time may be an additional 1–3 days, sometimes longer.
- **Time to diagnosis:** the time from provision of a sample to laboratory identification of the agent in the sample as *Salmonella*. CIDT tests often produces same-day results, whereas culture-based diagnostic methods take 2–3 days.
- **Sample/isolate shipping time:** the time required to ship the *Salmonella* isolate or positive specimen from the initial testing laboratory to the public health authorities who will perform serotyping and subtyping. This usually takes 1–3 days or longer, depending on transportation arrangements within a state and distance between the clinical laboratory and the public health department. Diagnostic laboratories are not required by law in many jurisdictions to forward *Salmonella* isolates to PHLs, and not all diagnostic laboratories forward any isolates unless specifically requested to do so. When a laboratory does submit an isolate or specimen to public health, the timeframe for submission is often based on convenience and cost effectiveness rather than public health considerations.
- **Confirming isolated pathogen**: The time after a sample has tested positive for *Salmonella* to isolation and confirmation of *Salmonella*. Specimens identified as *Salmonella* by CIDTs require culture to Isolate the organism from clinical samples that were used to perform CIDT, which takes 2–3 days. If culture-based methods are used at the clinical laboratory, the isolated bacteria is confirmed at the PHL, which takes 1 day.
- **Time to pathogen characterization:** The time required for the state public health authorities to serotype and to perform subtyping on the *Salmonella* isolate and compare it with the outbreak pattern. Serotyping typically takes 3 working days but can take longer. PFGE can be accomplished in 1 working day (24 hours), whereas WGS can take as little as 4 working days. However, many PHLs have limited staff and space and experience multiple emergencies simultaneously. In practice, serotyping and PFGE or WGS subtyping may take several days to several weeks in extreme cases. Data derived from WGS can be used to determine the serotype and subtype and predict the antibiotic resistance profile of an isolate, thereby streamlining laboratory processes into a single workflow. However, completion of WGS will be longer than traditional workflows. Additionally, most or all PHLs will have to perform some batching to reduce the cost of the sequencing. Batching

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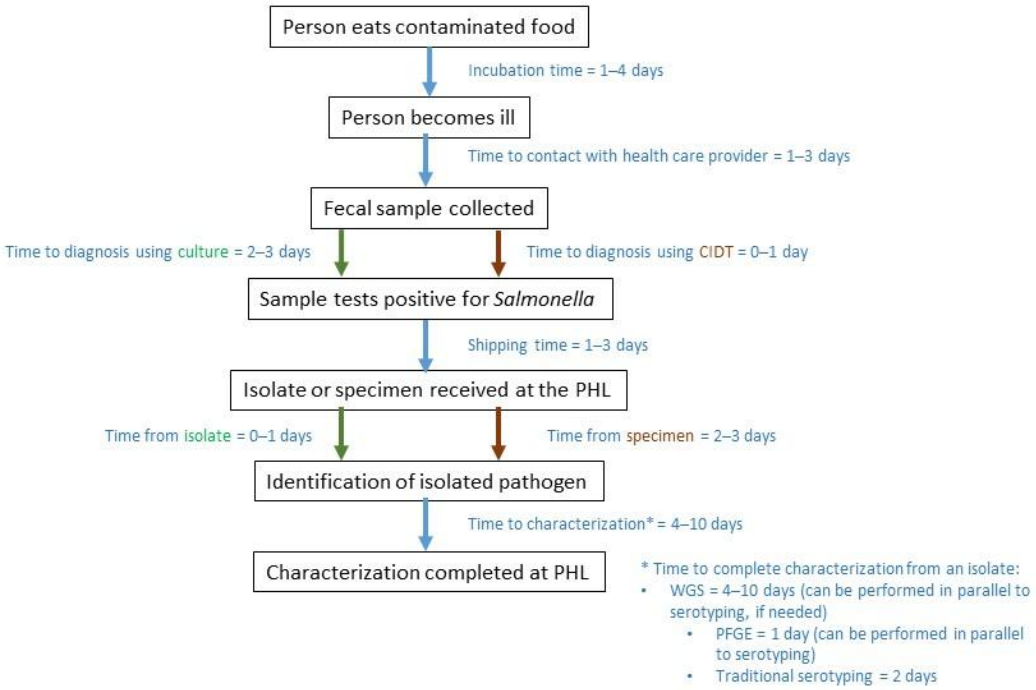
should be minimized as much as possible, however, because faster turnaround for pathogen characterization is highly desirable.

- The total time from onset of illness to confirmation of the case as part of an outbreak is typically 2–3 weeks.

Figure 4.3. Sample Timeline for *Salmonella* Case Reporting*



*Abbreviations: CIDT, culture-independent diagnostic testing; PFGE, pulsed-field gel electrophoresis; PHL, public health laboratory; WGS, whole-genome sequencing.

4.1.8 Routine testing for specific pathogens of food in production is conducted as part of larger food-safety verification programs operated by the Food and Drug Administration (FDA), U.S. Department of Agriculture (USDA), and state agriculture agencies.

- WGS is routinely performed on food isolates from FDA- and USDA-regulated products as part of the GenomeTrakr program, and the sequence data and limited metadata are uploaded to a genomic database housed at the National Institutes of Health, National Center for Biotechnology Information (NCBI). On NCBI, GenomeTrakr sequences are compared with sequences from the Centers for

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Disease Control and Prevention and other federal, academic, and international public health agencies; closely related isolates identified on the NCBI Pathogen Detection Portal (*4*) can be potential leads for cluster sources.

- Incorporating this routine food or animal monitoring or regulatory surveillance test data into the disease surveillance information stream enhances hypothesis generation and improves the sensitivity and timeliness of outbreak detection. In the United States, data streams from human disease surveillance, food-testing programs, environmental sources, and selected live-animal testing are co-mingled in the PulseNet database; however, important product details might not be readily available.

4.1.9 A key strength of pathogen-specific surveillance is its ability to detect widespread disease clusters initially linked only by a common agent. Most national and international foodborne disease outbreaks are detected in this manner.

Combining specific exposure information with case information from clusters recognized though complaints makes pathogen-specific surveillance the most sensitive method for detecting unforeseen problems in food- and water-supply systems caused by the agents under surveillance. The specificity of agent or syndrome information combined with specific exposure information obtained by interviews enables the positive association of small numbers of cases with exposures.

4.1.10 A key limitation of pathogen-specific surveillance is that it works only for diseases detected by routine testing and reported to a public health agency.

- Pathogen-specific surveillance is relatively slow because of the many steps required (Figure 4.1).
- Subtype-specific surveillance requires an isolate, which is challenging because of the use of CIDTs in clinical laboratories.

4.2 Complaint Systems

Consumer complaint systems are an effective surveillance tool for detecting a variety of food-related incidents, including reportable pathogens. Notification or complaint systems are intended to provide agencies with a tool for documenting, evaluating, and responding to reports from the community about possible foodborne disease events. The information maintained in these systems also helps to conduct prevention and control activities.

4.2.1 The usefulness of consumer complaint systems to identify outbreaks is based on 1) the ability of groups with a common exposure to self-identify illness and link it to the exposure or 2) the ability of the complaint system to independently link multiple independent complaints to a common source. Complaints involving multiple households, instances of multiple independent complaints about the same food establishment, reports of clusters of illness, and complaints involving multiple people in the same household that suggest an exposure outside the home often indicate an outbreak and should be evaluated to determine whether an investigation is warranted. In the absence of common, suspicious exposures shared by two or more case-patients, complaints of individual illness with nonspecific

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symptoms—such as diarrhea or vomiting—generally are not worth pursuing. Thus, sufficient exposure information about every independent complaint should be collected because reported exposures might become more significant when also reported by subsequent complainants. Complaint reporting involves passive collection of reports of possible foodborne illness from individuals or groups, such as the following:

- Reports from any individual or group who observes a pattern of illness affecting a group of people, usually after a common exposure: Examples include reports of illness among multiple persons eating at the same restaurant or attending the same event and reports from healthcare providers of unusual patterns of illness, such as multiple patients with bloody diarrhea in a short time span.
- Multiple independent complaints about illness in single persons or households. Group illness and independent complaints can be used together and linked with data obtained through pathogen-specific surveillance. In contrast to pathogen-specific surveillance, complaint reporting does not require identification of a specific agent or syndrome or contact with the healthcare system.

4.2.2 Detection of outbreaks based on multiple individual complaints requires a system for recording complaints and comparing food histories and other exposures reported by individuals.

All complaints require some level of follow-up. A telephone caller should be given some expectation for what follow-up is likely. A person sending a complaint by text, email, or online reporting system should be notified the complaint was received.

- Document complaints received by telephone with a standard intake form to record complainant information. Complaints received through other formats may warrant additional follow-up to fully document the complaint.
- Questions should cover name and contact information of the caller, detailed illness information (including exact time of symptom onset and recovery), suspected food product and product packaging information (if applicable), name and location of retail or restaurant establishment, names and contact information of other members of the dining party (if applicable), and all potentially relevant nonfood exposures.
- When illness is limited to a single person or members of a single household, obtain food history for the 3 days before onset that focuses on meals eaten outside of the home. People often identify an incorrect exposure as the cause of their illness, often attributing it to the last thing they ate. However, only one in five complaints with a known etiology is caused by an agent with an incubation period shorter than 24 hours.
    - A food history of at least 3 days before illness onset should be collected for individual complaints because common exposures are the sole mechanism to link cases. A standardized form that includes both food and nonfood exposures is preferred.
    - Complaint systems that rely on Web-based reporting or other means of self-reporting should also ask for a 3-day food history, with emphasis on meals eaten outside the home; and should request contact information in case additional information is needed.
    - Efforts to capture complaints using social media should incorporate a link to online reporting, an online survey, or a phone number to the health department.

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    - Given the ubiquity of norovirus infections, pay particular attention to exposures in the 24–48 hours before onset whenever norovirus is suspected. As more information about the likely etiologic agent is collected, this approach can be modified.
    - The complaint and subsequent interviews can lead to a hypothesis about the pathogen that leads to a different time frame for the exposure history (e.g., vomiting leads to a different hypothesis and exposure history time frame than does bloody diarrhea).
- When illness is reported among members of multiple households, collect information only for meals in common to members of the different households. Attempt to contact and interview ill meal companions reported by the original caller about symptoms and food consumption.
    - Focus interviews on the event shared by members of the group. However, be aware they might have more than one event in common, and explore that possibility.
    - Ask about other possible exposures for the interviewee or for others he or she might have contacted, such as childcare attendance, employment as a food worker, or ill family members.
- Enter all information collected into the complaint database. Review interview data regularly to look for trends or commonalities. As part of the review of the data, consider running reports showing frequencies of specific restaurants or other exposures (such as recreational water venues).
- Set up the reporting process so all reports go through one person or one person routinely reviews reports. Centralization of the reporting or review process increases the likelihood that patterns among individual complaints and seemingly unrelated outbreaks will be detected.

4.2.3 To complement the review of individual complaints and patterns of complaints detected through the foodborne illness complaint system, conduct standard interviews for foodborne illness cases detected through pathogen-specific surveillance (e.g., *Salmonella* and STEC). Enter all food establishments at which affected persons reported eating within the 7 days before illness onset into the complaint database. Routinely examine a list of restaurants reported by complainants and case-patients in pathogen-specific surveillance to search for common establishments.

Complaint data and results of pathogen-specific surveillance are much easier to link if complaint systems are centralized at the same jurisdictional level as pathogen-specific disease surveillance. The link of data from pathogen-specific and complaint surveillance systems can occur at the level of the local health agency or between individual city-based environmental health staff and county-based communicable disease program or at the state level. Such a shared/centralized system should enhance the ability of agencies to detect and respond to possible foodborne outbreaks but should not prevent any participating jurisdiction from fulfilling whatever role is required by law or is determined to be necessary to protect health in the jurisdiction's area.

4.2.4 Environmental health assessment and follow-up is generally managed by environmental health staff at local health departments that also license and inspect restaurants and other food-service establishments.

In jurisdictions where visits are not required to every restaurant named in illness complaints, the investigation and control team must decide whether investigation of a commercial food establishment is likely to be beneficial. To make this decision, consider details of the complainant's illness and the foods eaten at the establishment (Box 4.2).

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- If communicable disease surveillance staff receive the complaint, they should immediately share the complaint information with the responsible environmental health staff.
- Regardless of who receives the complaint or how the complaint is received (e.g., phone, online), the complaint should be evaluated for the likelihood of a foodborne illness or outbreak associated with the establishment that is the subject of the complaint or with other establishments listed in the food history. In addition, environmental health staff should review the establishment's inspection history, contact the establishment's manager, and determine the value of conducting an environmental assessment. Additional steps, such as an inspection, may be unnecessary if the complaint involves only one person (or persons in one household) and the illness reported is inconsistent with an exposure at the restaurant that is the subject of the complaint.
- All jurisdictions should have a process to ensure that complaints outside that jurisdiction are forwarded to the proper authority. This process includes forwarding complaints between local health agencies, between local health agencies and state departments of agriculture or health, and between local health agencies and state agencies and federal agencies: USDA's Food Safety and Inspection Service (FSIS) for meat, poultry, and egg product–related complaints and FDA for complaints related to other food items.
- Nongovernment complaint systems that do not share all information with the appropriate jurisdiction(s) and that do not have the authority to investigate the complaint (inspect the establishment or conduct an epidemiologic investigation) are not useful if the goal is to protect the public's health. Such systems should clearly state that the complaint is not being filed with an agency that can act on the complaint and should refer the complainant to the appropriate jurisdiction.

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Box 4.2. Considerations for Investigating a Commercial Food Establishment

In the following situations, investigation of a named commercial food establishment might be warranted:

The confirmed diagnosis and/or clinical symptoms are consistent with the foods eaten and the timing of illness onset (e.g., a person in whom salmonellosis is diagnosed reports eating incompletely cooked eggs 2 days before becoming ill).

The complainant observed specific food-preparation or serving procedures likely to lead to a food safety problem at the establishment.

Two or more persons with a similar illness or diagnosis implicate a food, meal, or establishment and have no other shared food history or evident source of exposure.

Regular review of individual complaints is critical to recognizing that multiple persons have a similar illness or diagnosis and share a common exposure.

Clues that a follow-up investigation of a food establishment is unlikely to be productive include

Confirmed diagnoses and/or clinical symptoms that are not consistent with the foods eaten at the establishment and/or the onset of illness (e.g., bloody diarrhea associated with a well-cooked hamburger eaten the night before illness onset).

Signs and symptoms (or confirmed diagnoses) among affected persons that suggest they might not have the same illness.

4.2.5 Collection and testing of clinical specimens and food samples related to group illness. PHL activities are essential for determining etiology, linking separate events during the investigation, and monitoring the efficacy of control measures (Chapters 5 and 6).

- Because of public health laboratory testing, links may be seen across jurisdictional boundaries and beyond; even national outbreaks may then be detected.
    - For instance, an outbreak associated with a particular restaurant may come to the attention of authorities solely on the basis of a report by a customer who observed illnesses among multiple fellow patrons. Laboratory testing and identification of *Salmonella* Typhimurium can result in refinement of the case definition used in this investigation, in additional testing and restrictions for workers found to be carriers, or in connecting this outbreak with other outbreaks (concurrent or historic) from a contaminated commodity.
- Obtain clinical specimens from at least five members of the ill group. Collect specimens as soon as possible after illness onset. For certain etiologies, clinical specimens need to be collected while the

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patient is still ill (bacterial intoxications); for many etiologies (norovirus, bacterial pathogens), specimens can be collected days after illness recovery. Clinical specimens should be tested as soon as possible- some test types such as syndromic panels (commercially available tests that simultaneously tests for common bacterial, viral, and parasitic pathogens) require testing within 4 days or specimen collection for the results to be valid.
    - Because complaint systems are the primary tool for detecting outbreaks caused by pathogen not under surveillance, the clinical presentation and epidemiologic data should direct the testing priorities.
    - A number of references are available to help ascertain the etiology of an outbreak, e.g., CIFOR's Outbreak of Undetermined Etiology agent tables and interactive tool (*5*), Diagnosis and Management of Foodborne Illnesses, A Primer for Physicians and Other Health Care Professionals (*6*), and 2017 Infectious Diseases Society of America Clinical Practice Guidelines for the Diagnosis and Management of Infectious Diarrhea (*7*).
- If the presumed exposure involves food at a catered event, collect and store food from the implicated event, if feasible.
- Conduct all sampling using legally defensible procedures (e.g., chain-of-custody) and using protocols as guided by the laboratory that will conduct the analysis. Samples should be analyzed within 48 hours after receipt; however, generally test the food only after epidemiologic implication or identification of specific food-safety problems through an environmental health assessment. If the epidemiologic investigation is ongoing and a specific food item has not been implicated or is not suspected yet, food should be stored. Consideration include the following:
- Storage under refrigeration can be longer than 48 hours, if necessary, but the length of the storage period is food-dependent. Because certain bacteria (e.g., *Campylobacter jejuni*) die when frozen, affecting laboratory results, immediate examination of samples without freezing is encouraged.
    - Perishable foods should be frozen (–40°C to –80°C).
    - Food samples that are frozen when collected should remain frozen until examined.
    - Food samples can be collected as part of the process of removing suspected food from service.

If food testing is determined to be necessary—for example, if a food has been epidemiologically implicated—official reference testing methods must be used at a minimum for regulated products (e.g., pasteurized eggs or commercially distributed beef).

Note: Food testing has inherent limitations because most testing is agent-specific, and demonstration of an agent in food is not always possible or necessary before implementation of public health action. Detection of microbes or toxins in food is most important for outbreaks involving preformed toxins, such as enterotoxins of *Staphylococcus aureus* or *Bacillus cereus*, where detection of toxin or toxin-producing organisms in human specimens frequently is problematic. In addition, organisms such as *S. aureus* and *Clostridium perfringens*, which are commonly found in the human intestinal tract, can confound interpretation of culture results.

Furthermore, food-testing results are often difficult to interpret. Samples collected during an investigation might not represent food ingested when the outbreak occurred. Subsequent handling or processing of food might result in the death of microorganisms, multiplication of microorganisms

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originally present in low levels, or introduction of new contaminants. If the food is not uniformly contaminated, the sample collected might miss the contaminated portion. Finally, because food usually is not sterile, microorganisms can be isolated from samples but not be responsible for the illness under investigation. Thus, food testing should not be routinely undertaken but should instead be based on meaningful associations identified through data analysis of interviews with suspected case-patients or during environmental health assessments at the implicated food-service establishment.

4.2.6 A key strength of complaint systems is their ability to detect outbreaks from any cause, known or unknown. Thus, the complaint system is one of the best methods for detecting nonreportable pathogens and new or reemerging agents. Recent examples include recognition of sapovirus as a significant agent in norovirus-like outbreaks [*8*] identification of *Arcobacter butzleri* as the likely agent in an outbreak of gastroenteritis at an event [*9*], and atypical enteropathogenic *E. coli* at a restaurant (*10*). In one study, consumer complaint surveillance alone led to detection of 79% of confirmed foodborne outbreaks, including most norovirus outbreaks (*11*).

- For event-related complaints, food items eaten and other exposures are easily determined because items consumed at the event can be identified by menus or other means and specifically included in the interview.
- Complaint surveillance systems are inherently faster than pathogen-specific surveillance because the chain of events related to laboratory testing and reporting is not required. Exposure information gained through patient interviews has the potential for being high quality because patient recall is highest close to the exposure event.
- Because of the relatively limited number of exposures to consider, investigations of event-related notifications can be pivotal to solving widespread outbreaks detected through pathogen-specific surveillance. For example, a norovirus outbreak associated with contaminated imported raspberries used in commercially distributed ice cream was initially identified from complaints as multiple independent outbreaks (*12*). Complaint systems are key in identifying intentional contamination events that would not be detected in pathogen-specific surveillance, for example, an outbreak of methomyl poisoning caused by intentionally contaminated salsa at a restaurant (*13*).

4.2.7 The value of single complaints of possible cases of foodborne disease in detecting outbreaks is limited by a lack of exposure information to link to any other cases and by the lack of specific agent or disease information to exclude unrelated cases. The illness reported by individuals might or might not be foodborne, and illness presentation might or might not be typical.

- Without a detailed food history (either from the initial report or follow-up interview), surveillance of independent complaints is sensitive only for short incubation (generally chemical- or toxin-mediated) illness or illness with unique symptoms because most people associate illness with the last meal eaten before onset of symptoms, they are likely to be correct only for exposures with short incubation times. This is not a limitation if full interviews are conducted.
- Notification of illness in groups generally is less sensitive to widespread low-level contamination events than is pathogen-specific surveillance because recognition of a person–place–time connection among case-patients by a healthcare provider or member of the community is required.

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- These limitations can be minimized by
  - Collecting a food history for the 3 days before illness onset to detect outbreaks caused by etiologic agents with longer incubations than bacterial toxins.
  - Looking for commonalities between the complete food histories for all complaints with case-patient interviews from pathogen-specific surveillance.
  - Promptly forwarding all complaint to the jurisdictions of establishments mentioned in the food histories for prompt follow-up and/or gathering of additional pertinent information.

4.2.8 Improve communication and cooperation among agencies that receive illness complaints. Consumers may submit complaints to multiple organizations and agencies, such as poison control centers, agricultural agencies, facility-licensing agencies, grocery stores, and online platforms and social media sites.

- Identify the agencies/organizations in the community that are likely to receive complaints. Establish regular communication between agencies that receive illness complaints, epidemiology staff, and laboratory staff. Always keep contact information current. Because complaints might be made to multiple agencies, having a robust method of sharing information is important. If possible, set up a database that public health agencies can access and review. Information-sharing is particularly important in adjacent jurisdictions.
- Check complaint information against national databases, such as the USDA FSIS Consumer Complaint Monitoring System (CCMS). Consumers can report complaints to CCMS by contacting the FSIS Meat and Poultry Hotline (1-888-MPHotline [1-888-674-6854]) or using the FSIS online complaint reporting system, the Electronic Consumer Complaint Form (https://foodcomplaint.fsis.usda.gov/eccf).

4.2.9 To increase surveillance sensitivity, remove barriers to reporting by making the reporting process as simple as possible for the public. For example, provide one 24/7 toll-free telephone number or an online reporting form. Such systems enable callers to leave information that public health staff can check later.

Promote reporting by routine press releases that educate the public about food safety, and advertise the contact phone number or website for reports of illness. Use a telephone number that easily can be remembered or found online. Train food managers and workers about the importance of reporting unusual patterns of illness among workers or customers and Food Code requirements for disease reporting (*14*). Communicate the value of such reporting, not just to protect public health, but also to protect food establishments from unfounded allegations of foodborne illness.

4.3 Syndromic Surveillance

The concept of syndromic surveillance was developed in the 1990s and expanded after the 2001 postal system anthrax attacks in an attempt to improve readiness for bioterrorism.

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The utility of syndromic surveillance for nonspecific health indicators for foodborne illness surveillance and outbreak investigation is very limited. In theory, the electronic collection of such indicators could permit rapid detection of major trends, including outbreaks. In practice, the right mix of sensitivity and specificity has proven difficult to find, and the utility of such systems might be marginal. Surveillance for highly specific syndromes, such as hemolytic uremic syndrome or botulism, is a critical public health function.

- Some groups (e.g., public health agencies, academic researchers, nongovernment organizations) monitor social media to identify potential outbreaks. The effectiveness of the use of social media tools to identify outbreaks is still being evaluated but may be useful to enhance traditional complaint systems.
- In theory, syndromic surveillance can be used as a tool to identify cases during an outbreak of an emerging or rare pathogen before laboratory testing protocols have been put into place or results have been received.
- Syndromic surveillance can help identify general enteric disease trends in a community (e.g., norovirus activity levels) to craft targeted prevention messaging (e.g., remind food-service establishments to exclude ill food-service employees).

Syndromic surveillance typically relies on automated extraction of health information, such as school and work absenteeism, posts or complaints on social media sites, emergency department chief complaint, lab test orders, or hospital discharge codes (ICD-10). Epidemiology or emergency preparedness groups evaluate alerts triggered by the syndromic surveillance system, and interview case-patients to determine whether the alert represents a true outbreak.

4.3.1 Potential strengths of syndromic surveillance include the use of nonspecific health indicators to identify clusters of disease before definitive diagnosis and reporting.

- Syndromic surveillance may be able to detect large undiagnosed events, such as an increase in gastrointestinal illness among persons of all ages consistent with norovirus or an increase in diarrheal illness among young children consistent with rotavirus, and It may be helpful for monitoring health status after a natural disaster, if other surveillance systems are temporarily unavailable.

4.3.2 The lack of specificity for most syndromic surveillance indicators in the area of foodborne disease is a limitation that makes for an unfavorable signal-to-noise ratio, meaning that only the largest events would be detected, and many false-positive signals would be expected.

- Responding to false-positive signals substantially drains an agency's resources.
- Syndromic surveillance cannot replace routine surveillance.

The ultimate measure of success for any surveillance system is outbreaks detected. Because the usefulness of syndromic surveillance for detecting foodborne disease events is limited, additional investment would compete for resources with under-resourced standard surveillance systems;

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therefore, it should be used only under very special circumstances when routine surveillance is not possible.

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Resource

Cornell College of Agriculture and Life Sciences. New York Integrated Food Safety Center of Excellence. Molecular epidemiology and sequencing approaches in public health. Webinars. https://nyfoodsafety.cals.cornell.edu/molecular-epidemiology/webinars/

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Chapter 5: Cluster and Outbreak Investigation

Chapter Summary Points

- Outbreak investigations are conducted to rapidly identify the source of contamination and take action to prevent additional illnesses. These investigations require effective and timely integration of three types of data:
    - Epidemiologic data that describe illness distributions and reveal common exposures;
    - Informational traceback and environmental assessment data that identify common contamination points and factors in the distribution chain; and
    - Testing data that identify outbreak-associated strains in implicated foods or in environmental samples linked to the foods.
- How a potential outbreak of foodborne illness is initially recognized determines approaches taken to investigate.
    - Complaints identifying multiple illnesses associated with a common event or establishment will lead to an investigation to identify the agent and the mode(s) of transmission. Although most of these investigations will be local, some will be subclusters of larger, multijurisdictional outbreaks.
    - Clusters of cases identified through laboratory-based surveillance at the local or state level will lead to investigations to determine the mode of transmission or source of contamination. Multistate clusters of these cases suggest a commercially distributed food source.
    - Identification of a foodborne pathogen in a commercially distributed food product will lead to a search for illnesses caused by the same organism and an investigation to determine whether the food item was the source of the illness.
- A priority for all investigations is to establish the basis for implementing control measures to stop transmission and prevent additional illnesses.

URLs in this chapter are valid as of July 26, 2019.

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5.0 Introduction

5.0.1 Outbreak investigations can help prevent illnesses. This chapter helps investigators quickly and accurately conduct the various steps of an investigation.

These steps are

- Detecting a possible outbreak (Chapter 4).
- Defining and finding cases.
- Generating hypotheses about likely sources.
- Testing hypotheses and evaluating evidence.
- Finding contamination sources.
- Controlling the outbreak (Chapter 6).

Because outbreak investigations are dynamic, multiple steps can occur simultaneously. In addition, as the outbreak investigation progresses, steps might need to be repeated.

When a potential foodborne illness outbreak is first detected or reported, investigators will not know whether the illness is foodborne, waterborne, or attributable to other causes. Investigators must keep an open mind in the early stages of the investigation to ensure that potential causes are not prematurely ruled out. Even though these Guidelines focus on foodborne illness, many of the investigation methods described in this chapter apply to a variety of enteric and other illnesses, regardless of source of contamination.

5.0.2 Recent developments in laboratory and epidemiologic methods impact cluster and outbreak investigation methods.

- Whole-genome sequencing (WGS) used by public health laboratories increases the specificity of pathogen-specific surveillance because case-patients with isolates that have the same DNA fingerprint are more likely to share a common source (Chapter 4). In addition, WGS increases confidence in the relationships between pathogens isolated from food/environments and historical samples, which provides better opportunities to identify outbreaks through food and environmental surveillance sampling. However, WGS may increase the timeline for public health laboratories to characterize foodborne pathogens and thus delay the identification of clusters of cases that warrant investigation.
- Culture-independent diagnostic tests (CIDTs) used by clinical laboratories provide rapid test results but require follow-up culture to produce an isolate for WGS. CIDTs might increase the number of cases reported and decrease the timeline from onset of illness to report but also reduce the proportion of isolates available for WGS and increase the timeline for conducting WGS. CIDTs used by public health agencies may enhance additional case finding in an outbreak investigation by rapidly identifying the agent in fecal samples from suspected case-patients.
- Enhanced use of new exposure assessment methods streamlines epidemiologic investigations to identify common sources for clusters and determine whether they constitute foodborne illness outbreaks.

For purposes of outbreak reporting, the National Outbreak Reporting System (https://www.cdc.gov/nors/downloads/guidance.pdf) distinguishes the definitions of a foodborne illness outbreak and a cluster as follows:

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- An *outbreak* is two or more cases of similar illness associated with a common exposure.
- A *cluster* is two or more cases of similar illness that are suspected to be associated with a common exposure, but investigators are unable to identify a shared food, animal, venue, or experience among ill persons.

Outbreak and cluster definitions vary by jurisdiction.

Regardless of how clusters are defined for surveillance purposes, the investigations needed to identify a common exposure include multiple, interrelated epidemiologic, environmental, and laboratory activities (Table 5.1, Figure 5.1).

5.1 Outbreak Investigation Initiation

5.1.1 Alert outbreak investigation and control team leaders as soon as a possible outbreak is identified. Outbreaks are detected in several principle ways (Chapter 4). However, a common initial approach is to review descriptive features of the outbreak setting and relevant background information about the etiologic agent, establishment, or event:

- Most local investigations require coordination between epidemiologists, environmental health specialists, and public health laboratorians within the jurisdiction of the cases, event, or establishment.
- Multistate clusters also require communication and coordination of activities between local, state, and federal agencies to rapidly investigate a suspected vehicle (Chapter 7).

5.1.2 Assess the priority of the outbreak investigation. Although any outbreak might warrant investigation, give highest priority for investigation to outbreaks that

- Have a high public health impact:
  - Cause severe or life-threatening illness, such as infection with *Escherichia coli* O157:H7, *Listeria monocytogenes*, or botulism;
  - Affect populations at high risk for complications of the illness (e.g., infants, elderly persons, immunocompromised persons); or
  - Affect a large number of persons.
- Appear to be ongoing:
  - May be associated with food-service establishment in which ill food workers provide a continuing source of infection.
  - May be associated with a commercially distributed food product that is still being consumed.

If the scale or complexity of an outbreak investigation is likely to overwhelm agency resources, the agency should request assistance as soon as possible for the additional resources and expertise required to respond to it (Chapter 3).

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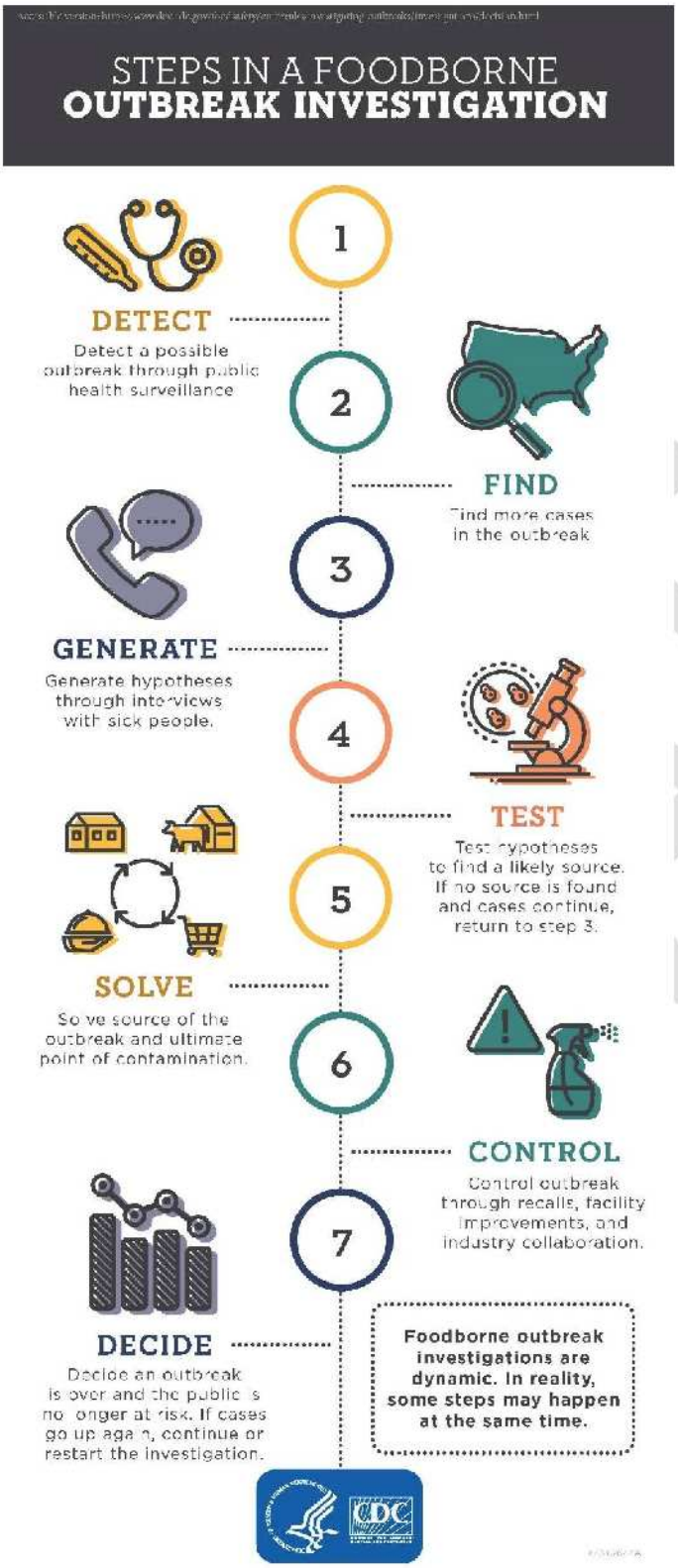
Figure 5.1. Steps in a Foodborne Illness Outbreak Investigation



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5.1.3 Assemble and brief the outbreak investigation and control team. Open communication between investigation members to plan, conduct, and evaluate outbreak investigation activities is critical to the success of the investigation.

- Investigation and control team leaders should assess the availability of staff to conduct the investigation. In particular, the team leader should ensure the presence of adequate staffing to interview case-patients within 24–48 hours. If sufficient staff are not available, request external assistance to conduct interviews.
- Outbreak investigation and control staff should be briefed on the outbreak, and their individual roles in the investigation. Ensure that all members of the investigation team—epidemiologists, laboratorians, and environmental health specialists—are familiar with and follow relevant state and federal laws and data handling practices.
- For outbreaks involving multiple jurisdictions, the outbreak investigation and control team should include members from all agencies participating in the investigation (Chapter 7).

5.1.4 Ensure that leadership of the investigation reflects the focus of investigation activities, which may change over time. During an investigation, the focus of activities may shift among the following:

- Laboratory studies to identify an agent, including microbiologic studies and applied food-safety research.
- Epidemiologic studies to identify transmission routes, exposure sources, or food vehicles and risk factors for illness.
- Regulatory investigations of food-production sources and distribution chains to identify where, during production or distribution of the food, contamination occurred and facilitate recall of food items.
- Environmental assessments of food production, processing, and service facilities to identify routes of contamination, contributing factors, and environmental antecedents;
- Communication of investigation findings to the public and the food industry to support control and prevention measures.

5.1.5 Coordinate activities and set up good lines of communication between individuals and agencies involved in the investigation (Chapter 3, Chapter 7).

Investigations are rarely linear (Figure 5.1). Although the steps for investigating outbreaks follow a logical process—from determining whether an outbreak is occurring to identifying and controlling the source—most investigations feature multiple concurrent steps. Maintaining close communication and coordination among members of the outbreak investigation team is the best way to ensure that concurrent activities do not interfere with each other and important investigation steps are not forgotten.

5.1.6 Establish goals and objectives for the investigation. The primary goal for most investigations is to obtain enough information to implement specific interventions to stop the outbreak. The results of the investigation also should provide information to prevent a similar outbreak from occurring in the future. Secondary goals are to increase knowledge of the epidemiology and control of foodborne illnesses. Unanswered questions about the etiologic agent, the mode of transmission, or contributing factors should be identified and included in the investigation to add to the public health knowledge base.

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Objectives for meeting these goals vary by type of outbreak.

- **Complaints identifying multiple illnesses associated with a common event or establishment** will lead to an investigation to identify the agent and the mode(s) of transmission. Most of these investigations will be local and require coordination between epidemiologists, environmental health specialists, and public health laboratorians within the jurisdiction of the event or establishment. Case-patients need to be rapidly interviewed to confirm illness and exposure details that may suggest a likely etiology and potential source of exposure. Environmental health specialists, guided by descriptive epidemiology, need to assess food-handling practices and food worker health and hygiene habits at the establishment. Public health laboratories need to test clinical specimens to confirm the etiology of the outbreak based on the description of signs, symptoms, and incubation periods (CIFOR Outbreaks of Undetermined Etiology Guidelines [*1*]). If the source of contamination was determined to be upstream from the establishment, the outbreak could involve multiple locations and require a multijurisdictional investigation (Chapter 7).
- **Clusters of cases identified through laboratory-based surveillance** at the local or state level will lead to investigations to determine the mode of transmission or source of contamination. Case-patients need to be rapidly interviewed with a thorough exposure assessment questionnaire to identify potentially common exposures or likely routes of transmission. Environmental health specialists and food regulators need to be prepared to help investigate subclusters associated with food establishments and to initiate product tracing for suspected food exposures. Public health laboratories need to rapidly confirm additional cases, and food-regulatory laboratories need to prepare to rapidly test suspected food products.
- **Multistate clusters of cases** suggest a commercially distributed food source (Chapter 7). Product tracing may be needed for successful exposure assessment. Communication and coordination of activities between local, state, and federal agencies must be established at the onset of the investigation.
- **Identification of a foodborne pathogen in a commercially distributed food product** will lead to a search for illnesses caused by the same organism and an investigation to determine whether the food item was the source of the illness. This type of outbreak presentation will most likely increase with the use of WGS to link isolates from food or environmental samples with cases identified through pathogen-specific surveillance. In all instances, investigating the possible link between contaminated food product and illnesses requires multijurisdictional investigation to assess the likelihood the cases are attributable to the suspected food exposure.

5.2 Define and Find Cases

5.2.1 Developing case definitions. Initially, case definitions reflect the cluster recognition methods.

- A cluster of illnesses linked to foodborne illness complaints most likely will be defined by similar features of the illness and by common suspected source of exposure, such as time, place, or person. As case-patients are interviewed, a distinctive clinical profile may emerge that suggests an etiology. If testing of clinical specimens confirms an agent, the features of that agent can be used to establish a clinical case definition.
- Clusters of cases identified by pathogen-specific surveillance are usually defined by common phenotypic or molecular characteristics (serotype, pulsed-field gel electrophoresis [PFGE] pattern, WGS), time

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frame when the cases occurred, and geographic distribution of the cases. CIDTs are a challenge to this approach. Although the initial CIDT-positive result may be available within a few days after onset of illness, the need to perform culture and then subtype the isolate means that some cases will not be subtyped, and the timeline will be longer for those that are cultured and subtyped.

- **During the early stages of the investigation, case definitions should be made specific to increase the likelihood that the detected cases share a common exposure.** Including unrelated cases in an outbreak investigation makes recognizing a common exposure more difficult and dilutes observed measures of association in analytic studies. For example, in an outbreak of salmonellosis, case-patients may share common symptoms of diarrhea and fever and all their illnesses might be caused by isolates with the same serotype that have a distinctive PFGE pattern and are closely related by WGS. Each of these additional points of identity increases the likelihood that the cases are related and the source may be identified.
- **After a common source has been identified, changing the case definition might be necessary or desirable to better assess the magnitude of the outbreak.** A change might be needed when additional pathogens, or strains of a pathogen, are linked to the same source. Although outbreaks are detected through monoclonal surveillance for highly defined clusters, many food-contamination events are polyclonal, i.e., involve multiple strains of pathogenic bacteria. The true nature of these events is usually not discovered until late in the investigation. In addition, after a common source has been identified, accounting for illnesses that occurred after exposure to the source that were not confirmed but had similar clinical characteristics to the confirmed cases can help provide a better estimate of the size, scope, and public health impact of the outbreak.

5.2.2 Reviewing current surveillance systems for illnesses that meet the case definition. Once a case definition has been established, investigators should search for more illnesses related to the outbreak.

- **For clusters of illnesses reported through complaints, review complaint logs or databases to find other complaints that identify exposure to the suspected event or establishment.** Although many complainants focus on their most recent exposure, reviewing all exposures in a 3-day food history could link unrecognized cases to the outbreak. A 3-day history may not cover the exposure window for all cases, but it covers the most common foodborne illness incubation periods and saves resources.

  In addition, if the confirmed etiology of the complaint-based outbreak is *Salmonella*, Shiga toxin–producing *E. coli*, or other foodborne pathogen for which case-patients are routinely interviewed, reviewing all exposures for case-patients interviewed during the likely outbreak period could link unrecognized cases to the outbreak.

- **For clusters identified through laboratory-based surveillance, review regular surveillance reports and laboratory reports**. In addition, for restaurants and retailers identified in the relevant exposure window, review the complaint database to identify potential subclusters of cases.

5.2.3 Supplement case-finding activities. Ask local clinical and laboratory professionals to report cases as soon as they suspect the diagnosis, alert health officials in surrounding areas to watch for illnesses that might be related, and survey groups that may have been exposed.

5.2.4 Plot Cases on an Epidemic Curve to Track Illnesses Over Time

The epidemic curve (epi curve) shows progression of an active outbreak over time. The horizontal axis (x-axis) is the date a person became ill (date of onset). The vertical axis (y-axis) is the number of persons

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who became ill on each date. These numbers are updated as new data come in and thus are subject to change. The epi curve is complex and incomplete. Several issues are important in understanding it:

- An inherent delay exists between the date of illness onset and the date the case is reported to public health authorities. For example, for *Salmonella* infections, this delay is typically is 2–3 weeks. Therefore, a person who became ill last week is unlikely to have been reported yet, and a person who became ill 3 weeks ago might just now be reported. (See Salmonella Outbreak Investigations: Timeline for Reporting Cases [Chapter 4, Figure 4.1].)
- Some cases are background cases of illness that most likely would have occurred even without an outbreak; therefore, determining exactly which case is the first in an outbreak is difficult. Epidemiologists typically focus on the first recognized cluster or group of cases rather than on the first case. Because of the inherent reporting delay, a cluster sometimes is not detected until several weeks after people became ill.
- For some cases, date of illness onset is not known because of the delay between reporting and case-patient interview. Sometimes an interview never occurs. If the date an ill person brought his or her specimen to the laboratory for testing is known, date of illness onset can be estimated as 3 days before that.
- Determining when cases start to decline can be difficult because of the reporting delay but becomes clearer as time passes.
- Because of the reporting delay, determining the end of an outbreak can be difficult. The curve for the most recent 3 weeks always makes the outbreak appear to be ending, even it is ongoing. The full shape of the curve is clear only after the outbreak ends.

5.3 Generate Hypotheses about Likely Sources

To narrow the focus of an investigation and most effectively use time and resources, investigators should begin to generate hypotheses about potential sources of the outbreak during the earliest stages of the investigation and refine them as they receive information. Hypotheses may emerge from common case characteristics, shared exposures, or historical information about the agent. The process comprises several key steps.

5.3.1 Review demographic information, including age, sex, and geographic and temporal distributions of case-patients. The Centers for Disease Control and Prevention (CDC) developed the System for Enteric Disease Response, Investigation, and Coordination to help organize and visualize cluster-associated data (*2*). Patterns in the distributions of these characteristics may suggest possible sources. On a local level, case surveillance data should be reviewed with data from foodborne illness complaints.

5.3.2 Review previous exposure sources linked to the agent. Identify previous vehicles associated with outbreaks and isolation of the agent from food items or food-production environments. However, avoid focusing only on historic sources because they could miss a new or previously unknown source.

5.3.3 Use standardized data collection forms, and compile data from case-patient interviews. CDC, in collaboration with states, developed a National Hypothesis Generating Questionnaire (NHGQ) to collect information on a broad range of food and nonfood exposures (http://cifor.us/downloads/clearinghouse/NHGQ_v2_OMB0920_0997.pdf).

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The NHGQ contains a mix of closed- and open-ended questions designed to elicit likely exposure sources. However, the NHGQ cannot capture detailed source information about all possible exposures, and supplemental approaches may be needed. A key to identifying the source of an outbreak is to collect detailed information on both the food item and its source for as many cases as possible as early in the process as possible.

When conducting hypothesis-generating interviews, use the following interview techniques to improve food recall:

- Question case-patients as soon as possible after their illnesses are reported.
- Encourage them to remember information by asking them to elaborate on where they ate, with whom they ate, and events associated with the meals. Ask them to look at a calendar from the appropriate time periods to jog their memory.
- Interview persons who prepared meals during the period of interest.
- Ask case-patients whether they keep cash register or credit card receipts, or review online banking or bank statements to indicate where or what they ate. Purchase receipts can often be reproduced if the case-patient paid with a credit card.
- If the case-patient uses a grocery store shopper card, ask permission to obtain purchase records for a specified time period. Some grocery chains readily cooperate with these requests; others require additional documentation, which delays investigation.
- Use a structured list of the places where people might get food to encourage case-patients to think about possible exposures other than restaurants and grocery stores. The list could include food pantries, farmers markets, conferences and meetings, caterers, and meal delivery services.

5.3.4 Use a dynamic cluster investigation process to generate and develop hypotheses. In the dynamic cluster investigation model, initial case-patients within a recognized cluster are interviewed with a detailed exposure history questionnaire. As suspicious exposures are identified during interviews, the initial case-patients are systematically reinterviewed to uniformly assess these suspicious exposures. Newly reported case-patients also will be asked specifically about these exposures (Figure 5.2).

On the basis of this information, investigators can identify possible exposures for further evaluation by epidemiologic, laboratory, or environmental studies. These should include the review of specific information about establishments/products of interest:

- Guest lists for common events reported by case-patients.
- Historical information on firms or food items of interest.
- Recipe and ingredient lists for common menu items.
- Shopper card data or reproduced receipts from credit card purchases to compare grocery store or online meal purchases

In practice, the generation and testing of hypotheses is an iterative process, and the hypothesis is modified as more information is obtained.

Figure 5.2. Dynamic Cluster Investigation

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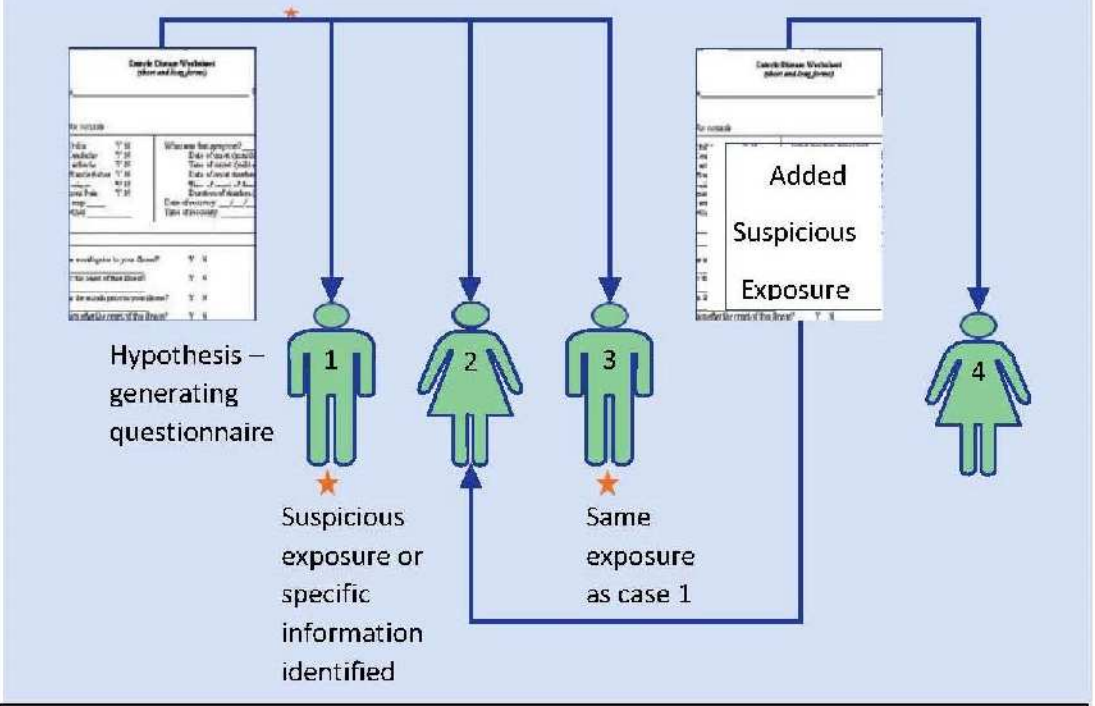
Figure 5.2. Dynamic cluster investigation



In this model, case-patients are interviewed with a detailed hypothesis-generating questionnaire. Specific exposures shared by multiple cases might surface that are suspicious because the involve commodities not commonly eaten, or involve specific brands of a commonly eaten food item. Because the original questionnaire might not have captured these exposures, specific questions should be added to the questionnaire for future use, and to systematically re-interview cases to assess the suspicious sources discovered during the investigation process.

5.3.5 Investigate subclusters. When a group of case-patients within a cluster identifies exposure to the same individual point of service, such as a restaurant, cafeteria, grocery store, or institution, this group of cases is termed a subcluster and represents an invaluable opportunity to solve the outbreak because the outbreak vehicle was most likely served or sold by the common establishment. Thus, subcluster investigations represent a hybrid of hypothesis-generating and hypothesis-testing approaches and are a useful model of the general approach to outbreak investigations.

- **Commit all available resources to rapidly and comprehensively investigate such a subcluster to increase the investigation's likelihood of success.** If resources are not available to conduct an investigation fully and rapidly, seek assistance from other agencies.
- **Ascertain additional cases associated with subcluster locations.** In their initial interview, ask all newly identified case-patients within a cluster to identify all dining locations at which they ate during the exposure period. Case-patients often do not recall eating at some locations outside the home when asked open ended questions on initial interview (e.g., "What restaurants did you eat at?"). Ask all newly identified case-patients in a cluster specifically about the list of dining locations

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named by previously interviewed persons. Ascertain additional subcluster cases by contacting additional patrons of the subcluster establishment (e.g., through credit card receipts, online orders, or reservations).

- **Once a subcluster is identified, reinterview previously interviewed case-patients and ask specifically about the subcluster establishment.** Ask all newly identified cluster case-patients specifically about the subcluster establishment during their first interview. Ask them to check credit/debit card statements to improve recall. Obtain and analyze shopper card records for cases linked to common grocery store chains; grocery store receipts also can often be reproduced if the purchase was made with a credit card, even for a store without a shopper card program. Pinpointing the purchase date and meal date to the extent feasible is important. (If a receipt or credit card statement is not available, record the case-patient's level of confidence about the purchase or meal date.)
- **Gather detailed food-consumption data for subcluster cases.** Interview case-patients using the subcluster establishment's menu or, if an event cohort with a limited discrete menu is identified, a more defined menu.
    - Ask case-patients about additions or subtractions to the menu item(s) they ordered.
    - Interview the establishment manager and/or chef to obtain ingredient lists for menu items.
    - Compile a frequency distribution of ingredients consumed by case-patients. Include every ingredient consumed by at least one case-patient.
- **Conduct an analytical study at the subcluster establishment.** Conduct an ingredient-specific case–control study. There is no rule as to a minimum number of cases necessary to initiate such a study, but it is reasonable to do so with as few as three cases.
    - Identify additional cases and enroll controls by
        - Asking case-patients for meal companions;
- Obtaining credit card receipts, reservation lists, takeout orders, and/or lists of workers or students (if a school cafeteria) for patrons who dined at the establishment on the implicated meal dates.
    - Ascertain additional cases (and increase the number of controls) to increase the likelihood of meaningful results and your confidence in those results.
    - Make the clinical case definition specific for the pathogen of interest (e.g., for *Salmonella* use "fever and diarrhea" or "diarrhea duration ≥3 days") to minimize the likelihood that unrelated illness will dilute associations.
    - **Include every plausible ingredient** in the study. Be systematic—do not focus solely on one or two ingredients case-patients commonly reported. Some ingredients (e.g., spices, garnishes) may be used in multiple menu items and thus could be overlooked.
    - **Trace back suspected vehicle(s).** If there are multiple subclusters (i.e., multiple points of service), trace back ingredients implicated in analytic studies or, if analytic studies cannot be done, ingredients that case-patients most frequently consumed. Do not exclude food ingredients from an analytic study based on apparent differences in distributors for ingredients used by the subcluster establishments because commonalities in the source of food items might not occur until farther back in the distribution chain.
- **Link subclusters in multistate outbreak to look for common distribution links between establishments** (possible even if there are too few cases for a case–control study). Traceback of individual cases also can provide important information to corroborate subcluster data.

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5.3.6 Maintain open, regular communication between public health and regulatory partners to discuss new or updated information about the epidemiologic investigation and food/establishment findings.

5.4 Test Hypotheses

Much of the work of outbreak investigations involves developing sound hypotheses that explain the patterns of illnesses observed. Testing these hypotheses requires epidemiologic analysis of common exposures, typically combined with informational traceback and environmental assessment data that identify common contamination points in the distribution chain and testing data that identify outbreak-associated strains in implicated foods or in environmental samples linked to the foods.

5.4.1 Analytic studies: characteristics, use, and limitations. Epidemiologic studies to analyze the association between illness and exposures take different forms depending on the setting of the outbreak, number of cases reported, and public health resources available. In recent years, approaches to using these study methods have evolved that have resulted in fewer large community case–control studies. Instead, investigators now often use case-aggregation methods with comparisons to reference data or, for very specific product identification (e.g., brand names and lot numbers), direct intervention with no analytic study whatsoever.

- **Cohort study.** Cohort studies are limited to outbreaks with defined exposure settings in which exposed persons can be identified without respect to illness status, e.g,, a banquet with a defined guest list. Interviewing persons without respect to their illness status enables determination of attack rates to assess the magnitude of the outbreak and calculation of relative risks for individual exposures. Because many of these settings involve a defined menu and guest list, developing an online survey to rapidly collect illness and exposure information might be possible.
- **Establishment-specific case–control study**. In defined setting outbreaks where it is more feasible to identify individual cases than groups of exposed persons, conduct an establishment-specific case–control study (similar to a subcluster study).
- **Community case–control study.** Community case–control studies are a staple of outbreak investigations. Comparing food exposures among case-patients in an outbreak with food exposures among healthy controls has great power to identify foods associated with the illnesses. For example, in a nationwide outbreak of *Salmonella* associated with commercially distributed ice cream, the source was identified based on interviews of 15 case-patients and 15 community controls (*3*). Although results of the case–control study implicated an exposure source within 3 days after initiating the case–control study, regulatory testing to confirm the source of contamination required an additional 10 days.
    - Having a stringent case definition is important to reduce the likelihood of including unrelated cases in the study. Because unrelated cases would not share the same exposure source, they would reduce the apparent odds ratio, and make it difficult to implicate the exposure source. WGS subtyping enables stringent case definitions. Along with specific case definitions, having detailed exposure source information is critical.

      Despite their empirical usefulness, large community-based case–control studies are no longer routinely conducted in outbreak investigations. Recruiting suitable controls because of the changing demographics of telephone use is increasingly difficult. Thus, they have become too expensive to conduct and can be too slow to produce actionable results.

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- **Case–case comparison studies.** Case–case comparison studies provide many of the same benefits as community case–control studies but are logistically easier to conduct. Molecular subtype–specific surveillance based on PFGE or WGS makes it possible to compare cases caused by an outbreak-associated strain with cases caused by unrelated strains. Because cases caused by unrelated strains have many different sources of exposure, they make an efficient control group. When persons with sporadic cases are routinely interviewed with detailed food-exposure questionnaires, case–case comparison studies can be conducted. For example, in the 2011 outbreak of listeriosis identified by the Colorado Department of Public Health and Environment, cantaloupe was implicated by comparing exposures from reported outbreak-associated case-patients to aggregated exposures of nationally reported cases collected by CDC's *Listeria* Initiative (*4*).

  Case–case comparisons produce the same measures of association as case–control studies and are interpreted the same way. The increased stringency of WGS to discriminate outbreak-associated from unrelated cases makes case–case comparisons a desirable alternative to case–control studies when aggregate case exposure data are available.

- **Case series with binomial exposure assessments.** The use of case series with binomial exposure assessments was pioneered by the late Bill Keene at the Oregon Health Authority, who also developed a simple binomial calculator to test the significance of differences between case and population exposure proportions. Like the other analytic study methods, it requires that outbreak-associated case-patients to be systematically interviewed using a detailed exposure questionnaire. However, instead of comparing case exposure histories with community controls or unrelated cases, the case exposures are compared with an expected value based on population survey data. FoodNet's Atlas of Exposures (*5*) has been the most commonly used source of population exposure data. However, changing food consumption patterns limit the usefulness of 2006 Atlas data for some exposures. A survey to collect updated population exposure data was conducted in December 2017 through July 2019. Identifying current, local population exposure data is preferred. The Oregon Health Authority is compiling multistate sporadic *Salmonella* case exposure data known as Project Hg, for case–case binomial comparisons (6).

  The binomial comparison functions as advanced hypothesis generation. It identifies associations that must be confirmed by product source tracing and corroborated by other investigation findings. Statistically, binomial comparisons emulate very large case–control studies. Results must be cautiously interpreted to avoid spuriously significant results that could lead to errors in identifying the source of an outbreak.

For all analytical studies the significance of results depends on the strength of the association and the size of the study. Thus, studies with large numbers of cases are more likely than studies with few cases to yield statistically significant results. However, the goal of outbreak investigations is to rapidly identify the source to prevent additional cases. In this regard, WGS will improve the efficiency of these studies by providing precise case definitions. Increasing the specificity of food exposures will similarly increase the efficiency of the study. However, with WGS, the expected increase in small cluster investigations limits the usefulness of any of these study designs to produce "significant" results. For clusters involving fewer than five cases, product source tracing and corroborating evidence are needed to confirm the source.

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5.4.2 Product tracing. Tracing the source of food items or ingredients through distribution to source of production can be critical to identifying epidemiologic links among cases or ruling them out. For nonbranded commodities, such as produce items, the identification of a common point in multiple distribution pathways that provided a suspected product to case-patients may identify the point where the food(s) became contaminated (Figure 5.3). An onsite environmental assessment of this point (farm, ingredient supplier, processor, restaurant) can then be conducted to identify the contributing factors and environmental antecedents that caused the outbreak. Once the source is identified, tracing products forward through distribution can help identify additional cases or help remove contaminated product from the marketplace. Product tracing is an important tool to inform the epidemiologic investigation, test the hypothesis, and control the outbreak.

Two types of product tracing tools can be used to investigate outbreaks. **Traceback** investigations are used to trace a product suspected to cause the outbreak through the supply chain to determine whether it converges on a common source or supplier. Once a common source or supplier of the contaminated product is identified, **traceforward** investigations are used to determine other locations that received the contaminated product. Both traceback and traceforward activities can be conducted as informational or regulatory endeavors. Informational product tracing needs to be conducted quickly to be incorporated into the epidemiologic studies. Formal regulatory product tracing may be subsequently needed to confirm the distribution of implicated products.

Traceback Investigations. Traceback investigations begin at the point of service where a case-patient was exposed to the product. Informational, traceback investigations are conducted to help inform the epidemiologic investigation and can be the final step in confirming the outbreak vehicle (http://mnfoodsafetycoe.umn.edu/wp-content/uploads/2015/10/Product-Tracing-in-Epidemiologic-Investigations.pdf).

- If two or more case-patients report the same point of service, specific information must be collected from this subcluster so a traceback investigation can be initiated.
  - Ideal subclusters contain case-patients who can provide the following information: precise illness onset dates, exposure dates to the product of interest, and relative certainty about what foods they ate before illness onset.
  - Traceback of individual cases can provide important information to corroborate subcluster data.
- As informational tracebacks progress and a single product of interest is identified, regulatory traceback can be performed if necessary to assist in confirming the vehicle. These regulatory tracebacks enable detailed record collection and documentation of the product of interest through the supply chain.
- Once an informational traceback is initiated, specific information is necessary from the case-patients within the subcluster and from the point of sale. As the traceback continues, establishment types will change and questions about the handling of the product of interest, time frames, and available record need to be amended accordingly.

Figure 5.3. Exposure Distribution Pathways Documented During Informational Traceback of Romaine Lettuce during an *Escherichia coli* O157:H7 Outbreak. Romaine lettuce from multiple growers in the Yuma, Arizona, growing region were implicated as the source of the outbreak. The lack of association with a single grower ultimately reflected the use of contaminated surface water by multiple growers (*7*).

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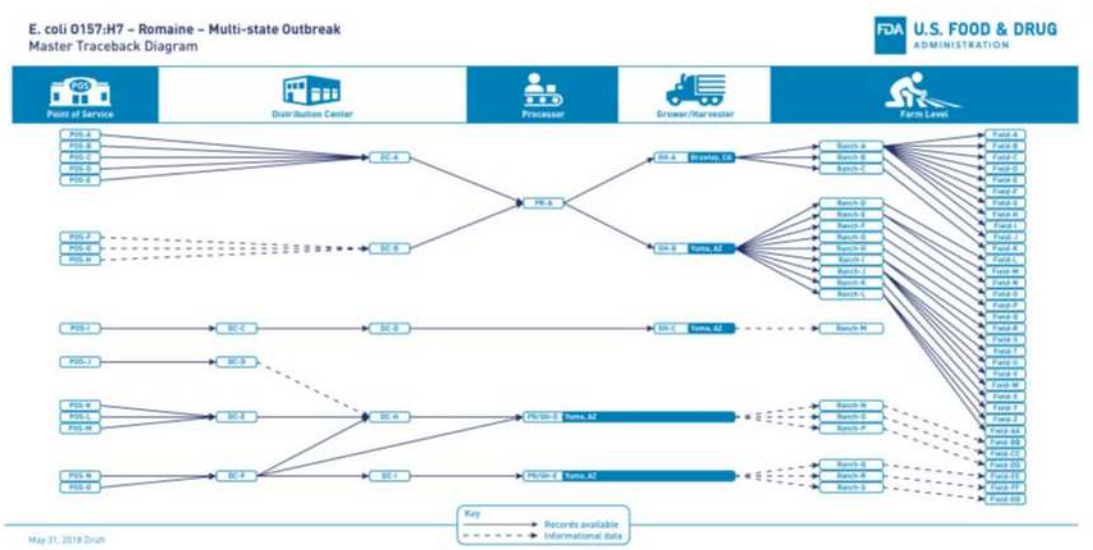

Information collected from each subcluster serves as one leg of the overall traceback investigation. Distribution chains from multiple traceback legs are documented and compared to identify commonalities. Convergence of multiple legs of a traceback on a specific facility assists in targeting resources for environmental assessments, inspections, and/or sampling. In addition, information from the traceback is continuously evaluated as part of the evidence for the overall outbreak investigation; convergence reinforces the hypothesis generated by the epidemiologic investigation.

Informational traceback investigations continue until the product of interest is followed as far back through the supply chain as possible. Interpretation of the traceback can be challenging and should not be done without consideration of the epidemiologic, laboratory, and environmental information collected during the investigation. If no convergence on a single supplier is identified, reevaluate the hypothesis. Informational tracebacks are challenging and can be limited by a case-patient's ability to accurately remember his or her food history, poor record-keeping, lack of common product identifiers through the supply chain, co-mingling, and many other factors. Therefore, lack of convergence of a traceback does not necessarily rule out a vehicle as the source of the outbreak.

Important information for initiation of informational tracebacks:

- **Subcluster information**
  - Exposure dates to product at point of sale (including location name and address).
  - Identification of specific menu items or purchases.
  - Documentation of purchase of product (e.g., credit card, shopper card).
- **Point-of-sale information**
  - List of ingredients in menu items or purchases of interest.
  - Time frame of interest for distribution record collection (determined by considering case-patient exposure dates, product shelf life, shipment frequency, and other pertinent factors).
  - Identity of all suppliers of the product of interest to the point of sale.
  - Frequency the product of interest is ordered by the point of sale.
  - Product handling and inventory management in the facility (example: First in First Out).
  - Point of sale handling of shipments and documentation of receipt of the product of interest.

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- Storage and transportation practices, potential cross contamination; products with common source materials.
- Distribution records (e.g., invoices, order forms, bills-of-lading) for the time frame of interest that are available at the point of service/sale. Note gaps in or concerns about record keeping.

Traceforward investigations. Tracing products forward in the supply chain can determine where contaminated products were distributed and enable their removal from the supply chain (Chapter 6). Traceforward investigations also are an important tool to identify additional case-patients who were exposed to contaminated products. In the hypothesis-testing phase of an outbreak investigation, tracing a suspected product forward can identify additional points of sale that received the suspected product. Enhanced surveillance efforts in areas where suspected products were distributed can be an effective way of identifying new clinical cases. Linking points of sale of suspected products with additional clinical cases provides additional evidence about the outbreak source.

Communication of product tracing information. Product tracing is always multijurisdictional and requires strong collaboration between public health and regulatory agencies. Predetermined lines of communication should be in place to effectively move information between the necessary parties. Updates on the epidemiologic investigation being conducted by the public health agency may greatly impact the traceback being conducted by the regulatory agency and vice versa.

Special considerations need to be given to distribution information collected by regulatory agencies because it may be protected from disclosure by confidentiality agreements. Investigational partners should have agreements in place to allow for the lawful exchange of the information (Chapters 3 and 7).

5.4.2 **Environmental assessments.** When a food-production, food-processing, or food-service establishment is identified as being associated with a foodborne illness outbreak, environmental health and/or regulatory officials should conduct an environmental assessment. To stop the current outbreak and prevent future ones, investigators must identify both how (contributing factors) and why (environmental antecedents/root causes) the food became contaminated so effective controls can be put in place (Table 5.2).

Table 5.2. Differences between Routine Inspections and Environmental Assessments

Routine Inspection	Environmental Assessment
• Nontargeted • Regularly scheduled • Snapshot of current day • Code/regulation-based • Assessment of current conditions • Identification of violations	• Targeted • Response to an outbreak • Focus on the past • Outbreak information-based • Examination of processes and problems during outbreak • Identification of system failures • Identification of underlying factors that enable the system failure

An environmental assessment is a systematic, detailed, science-based evaluation of environmental factors that contributed to the introduction and/or transmission of agents that cause an illness in an outbreak. Environmental assessments are conducted in response to an outbreak and address specific food and process(es) to identify the outbreak's cause. The environmental assessment is guided by

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epidemiologic and laboratory information and examines how the causative agent, host factors, and environmental conditions interacted to result in the system failure and people becoming ill.

Goals of an environmental assessment:

- **Identify contributing factors**
  - Factors that introduce or otherwise permit contamination and relate to how the agent got onto or into the food vehicle.
  - Factors that enable proliferation or growth of the agent and relate to how the bacterial agent could increase in numbers and/or produce toxins before the vehicle was ingested.
  - Factors that enable survival or fail to inactivate the contaminants and refer to processes or steps that should have eliminated or reduced the microbial agent.
- **Identify environmental antecedents (root causes) that enabled the system failure**
  - Assessing the internal system components (e.g., people, equipment, processes, foods, and economics) and their effect on allowing the system failure to occur
  - Identifying and address root causes of outbreaks that appear to be part of a pattern.

Five main steps in conducting an environmental assessment:

- **Plan and prepare:** Members of the outbreak investigation team review epidemiologic information, product tracing information, laboratory results, and food facility information. Roles and responsibilities, intended outcomes, sampling plans, and ways the team will communicate during the site visit should be determined at this step.
- **Visit the site:** Observe the facility, and evaluate its practices. Collect records and samples pertinent to the investigation. Information that can be collected as part of the visit includes
  - How food moves through the establishment (physical flow diagram).
  - How food is processed and handled within the establishment (process flow diagram).
  - Policy and procedures in place at the establishments and interviews with responsible parties about the execution of policies and procedures.
  - Ill employee records.
  - Sales records for the suspected food item.
  - Employee interviews.
  - Product coding and distribution information if food is suspected to have arrived at the facility contaminated.
- **Assess information:** Review information to identify the outbreak's contributing factors and environmental antecedents.
- **Recommend prevention and control strategies:** Control strategies reflect steps that should be taken immediately to stop the outbreak and prevent further spread of the agent. Longer term strategies reduce the likelihood of future outbreaks at this type of establishment (Chapter 6).
- **Complete the report:** Prepare a summary of the findings that includes detailed diagrams, descriptions, and results. Incorporate this report into the outbreak investigation report.

The timing of an environmental assessment depends largely on the specifics of the outbreak and available information but should be initiated as soon as possible (ideally an initial site visit within 24–48 hours after identification of the establishment). Early investigation and collection of food and environmental specimens will best reflect the conditions at the time of the outbreak. In addition, possible food vehicles can be discarded or grow old, and persons involved in the production,

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processing, storage, transportation, or preparation of the item can change their practices and procedures. If investigators have identified a common location and a profile of symptoms among ill persons that indicates whether the illness agent is likely to be viral, bacterial, toxic, or chemical, they often can begin an environmental assessment based on possible factors more likely to be associated with that illness-causing agent. As more information becomes available, investigators may need to make additional trips to the establishment to investigate the additional lines of inquiry.

Communication of environmental assessment findings is vital. Share results of the environmental assessments with the outbreak investigation team as soon as possible. This information may change the course of the investigation or confirm the suspected food item causing the outbreak. Sharing findings with industry partners on the contributing factors and environmental antecedents that led to contamination is key to improving hazard identification and implementing control measures (*8*).

5.4.4 Laboratory testing of food products and environments. Targeted sampling of food items and environments of interest in the outbreak investigation can help confirm the food causing illness. Targeted sampling occurs when partners working on the epidemiologic and traceback investigations share information about products and establishments of interest. Coordinate with the testing laboratory, and consider sampling products and storing appropriately for potential future testing to reduce the chance the product of interest will be unavailable for sampling later.

- Sampling products of interest early in the epidemiologic investigation can help quickly bring an investigation together, especially if the products of interest are shelf stable. In 2017, state and local authorities sampled soy nut butter reported by case-patients associated with an outbreak of *E. coli* O157:H7 (*9*). The positive samples generated by that early sampling was used as evidence to suspend the registration of the facility manufacturing the product. Not all product sampling occurs at the outset of an investigation. Traceback investigations can identify locations along the supply chain to collect samples.
- Food and environmental sampling enables investigators to directly test hypotheses generated during an investigation, often picking up where analytic studies leave off. By gathering information about items of interest (such as food items or ingredients commonly consumed at a restaurant in question; animals to which case-patients were exposed before illness; or other less common environmental exposures, such as contaminated milk crates), investigators can target very specific items or areas to sample for microbiologic testing. When combined with the case series with binomial exposure assessments, such testing can quickly hone a list of suspected products to a single source.
- Sampling also can be used to illuminate the root cause of product contamination, especially when done in partnership with the grower or product manufacturer. Pathogens such as *Salmonella* and *L. monocytogenes* are known to persist in manufacturing and processing environments. Identification of a pathogen in a processing environment that was linked by epidemiologic and traceback information to clinical cases supports confirmation of the outbreak vehicle.
- WGS is being used to perform molecular subtyping on pathogens recovered from foods and environments impacting foods. The high resolution of WGS increases confidence in the relatedness of pathogens from products and environments to clinical samples. Food or environmental samples that are closely related by WGS can launch retrospective outbreak investigations, in which laboratory evidence from the products or environments drives the epidemiologic investigation. Retrospective outbreak investigations often lead to the swift identification of the outbreak source.

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5.4.5 Coordination of epidemiologic, traceback, and sampling activities. Whether the outbreak is restricted to one jurisdiction or involves multiple jurisdictions, notification and updates should be provided to other interested agencies following the Special Considerations for Multijurisdictional Investigations (Chapter 7).

- Arrange for the outbreak investigation and control team to meet daily and to regularly update the entire outbreak control team. In particular, if the outbreak has gained public attention, the public information officer needs to prepare a daily update for the media.
- During investigation of outbreaks involving events or establishments, maintaining close collaboration between epidemiology and environmental health is particularly important. Interview results from persons who attended the event or patronized the establishment will help environmental health specialists focus their environmental assessments by identifying likely agents and food vehicles. Similarly, results of interviews of food workers and reviews of food preparation can identify important differences in exposure potential that should be distinguished in interviews of persons attending the event or patronizing the establishment. For example, environmental health investigators might determine that food items prepared only on certain days or by certain food workers are likely to be risky. These refinements also can help establish the need for or advisability of collecting fecal samples from food workers or food and environmental samples from the establishment.
- During the earliest stages of the investigation, patrons need to be interviewed rapidly. However, the focus of outbreak activities is likely to shift to interviews of food workers, environmental assessments of the establishment, and review of food-preparation procedures as the investigation progresses.
- During investigation of outbreaks detected by pathogen-specific surveillance, the public health laboratory needs to immediately forward case information to epidemiologists for every new potentially outbreak-associated case they receive. Doing so ensures rapid enrollment of new cases in the outbreak investigation studies. Similarly, as investigators acquire information from case-patients about exposures in restaurants and other licensed facilities, they should rapidly forward that information to environmental health specialists to ensure rapid identification of commodity ingredients and their distribution sources.
- During the early stages of an investigation, efforts to identify mode of transmission and food vehicle require close coordination of the outbreak team under the leadership of epidemiology. After identification of a likely food vehicle, efforts to identify the source of contamination and contributing factors require engagement of local, state, or federal food-regulatory programs. As the investigation proceeds, the outbreak investigation and control team should always consider whether any information indicates the outbreak might be multijurisdictional (Chapter 7).

5.5 Evaluate Evidence to Solve Point of Contamination and Source of the Food

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5.5.1 Evaluate evidence. Identifying the source of contamination and taking action to prevent additional illnesses requires effective and timely integration of three types of data:

- Epidemiologic data that describe illness distributions and enable analysis of common exposures.
- Traceback and environmental assessment data that identify common contamination points in the distribution chain.
- Testing data that identify outbreak-associated strains in implicated foods or in environmental samples linked to the foods.

Evidence from each of these pillars of the outbreak investigation is evaluated in concert to determine whether the data support the conclusion that a suspected food or other exposure caused the outbreak. Investigators typically determine that they have identified the likely source of the outbreak when they have clear and convincing evidence from two pillars. In rare instances, data from one pillar alone might be sufficient to determine the likely source of an outbreak (e.g., complaints or point source clusters linked to a meal or single event). In investigations of products with a short shelf life (e.g., unpasteurized milk or leafy greens), conducting testing on products during the likely period of contamination might be impossible and investigators must rely on evidence from the other pillars to determine the likely source of the outbreak.

5.5.2 Solve point of contamination and source of the food. The outbreak investigator's job is to use all available information to construct a coherent narrative of what happened and why. This begins with the initial detection of the outbreak and formation of hypotheses based on the agent's ecology, microbiology, and mechanisms of transmission in addition to the descriptive epidemiology of reported cases. Results of subsequent analytic studies (e.g., cohort or case–control study results) must be integrated with results of product tracing, food worker interviews, environmental assessments, and food-product and environmental testing. When all of these data elements support and explain the primary hypothesis, investigations can draw very strong conclusions (Box 5.1).

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Box 5.1. Questions to Consider When Associating an Exposure with an Outbreak

Strength of association

- How strong was the association between illness and the implicated item? (The strength of the association increases with the size of the odds ratio or relative risk: 1 = no association; <5 = relatively weak association; 5–10 = relatively strong association; >10 = very strong association.)
- Was the finding statistically significant? (<0.05 is a traditional cutoff p value, but in small studies, even relatively strong associations might not reach this level of significance. Conversely, in large studies examining many exposures, relatively weak associations might reach this level of significance by chance or as an effect of confounding.)
- Were most ill persons exposed to the implicated item? "Yes" is desirable but might not always be apparent if the implicated item is an ingredient in multiple food items.)

Timing

- Did the exposure to the implicated item precede illness by enough time for a reasonable incubation period?
- Do the time windows obtained during traceback and traceforward investigations correlate with reported dates of production, distribution, and purchase of the implicated item?

Dose–response effects

- If assessed, were persons with greater exposure to the implicated item more likely to become ill or have more severe clinical manifestations?

Plausibility

- Is the association consistent with historical experience with this or similar pathogens? Can investigators develop a rational explanation for opportunities for contamination, survival, and proliferation of the pathogen in the implicated item? (If otherwise strong and consistent results cannot be readily explained, the outbreak might herald emergence of a new hazard, which will require additional studies to confirm.)
- Is the geographic location of ill persons consistent with the distribution of the implicated item? (Discrepancies might be explained by gaps in surveillance, product distribution data, or involvement of additional food products.)

Consistency with other studies

- Studies associated with current investigation
    - Do the results of traceback and traceforward investigations suggest a common source?
    - Have environmental health assessments identified problems in the production, transport, storage, or preparation of the implicated item that would enable contamination, survival, and proliferation of the pathogen in that item?
    - If the pathogen was isolated from ill persons and from the implicated item, do subtyping results (e.g., WGS analysis) confirm the association?
- Studies not associated with current investigation
    - Is the association between the pathogen and the implicated item consistent with other investigations of this pathogen?

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Outbreak investigators should be open to new developments and new twists to old problems. New hazards are frequently identified through outbreak investigations. However, they should be wary of explanations that depend on implausible scenarios.

5.6 Implement Control Measures, Investigation Closeout, and Reporting

5.6.1 Deciding an outbreak is over (Chapter 6). Outbreaks end when cases are no longer detected or reported. Outbreak investigations can continue after the outbreak ends, given product tracing and observations on practices at suspected firms may take longer to obtain. In addition, control measures need to be evaluated if the source of the outbreak was identified. For outbreaks where the source has not been identified, consideration to the prioritization of resources and expected outcome of the investigation should be considered before continuing investigational activities. Experience reminds us—again and again, unfortunately—that even seemingly well-executed investigations can be inconclusive. Small sample sizes, multivehicle situations, "stealth" food items that may not be recognized, and foods with high background rates of consumption are only some of the factors that can reduce the effectiveness of standard epidemiologic methods and make investigations extremely difficult.

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Table 5.1. Objectives and Investigation Activities that Can Be Conducted During Epidemiologic, Environmental Health, and Public Health Laboratory Investigations of Foodborne Illness Outbreaks*

Objective	Epidemiology	Environmental Health	Public Health and/or Food Testing Regulatory Laboratory
Identify etiologic agent.	If outbreak is associated with event or establishment:		
	• Contact healthcare providers of case-patients who have sought medical attention. • Interview case-patients to characterize symptoms, incubation period, and duration of illness. • Obtain fecal specimens from case-patients. • Determine whether symptoms, incubation period, or duration of illness suggest a likely pathogen. • Establish case definition based on confirmed diagnosis or clinical profile of cases.	• Interview management to determine whether it has noticed any ill employees or any circumstances that could cause a foodborne illness. • Interview food workers to determine illness. This activity also could be conducted by nursing/healthcare staff. • Obtain fecal specimens from ill or all food workers. This activity could also be conducted by nursing/healthcare staff. • Obtain and store samples of implicated and suspected food items and ingredients. • Determine whether setting or food item suggests a likely pathogen.	• Contact clinical laboratories that might have performed primary testing on case-patients, and obtain specimens or isolates. • Test fecal samples to identify agent. • Test samples of implicated food items to identify agent. • Subtype all isolates as soon as possible after receipt.
	If outbreak is identified by pathogen-specific surveillance: Agent is known.		
Identify persons at risk, and determine size and scope of outbreak.	If outbreak is associated with event or establishment:		
	• Obtain from event organizer a list of persons attending event or, if possible, list of persons patronizing the establishment during the outbreak period. • Interview persons who attended event or patronized establishment to determine attack rates by time. • Contact healthcare providers to identify additional persons seeking medical care	• Obtain list of reservations for establishment, credit card receipts, receipts for takeout orders, inventory of foods ordered at establishment, or guest lists for events. Where possible, obtain information electronically.	• Contact clinical laboratories to identify additional fecal specimens being tested.

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	whose illnesses meet the case definition. • If identified agent is reportable, review recently reported cases to identify possible exposures to event or establishment.		
	If outbreak identified by pathogen-specific surveillance:		
	• Alert healthcare providers of possible outbreak to identify additional persons seeking medical care, and review laboratory reports and medical charts at hospitals or physicians' offices to identify possible cases. • Ask case-patients if they know of others who are similarly ill. • Depending on nature of outbreak, take additional steps as warranted.For example, review employee or school absences, review death certificates, survey population affected, or directly ask members of the public to contact the health department if they have the illness under investigation.	• Review foodborne illness complaints to identify undiagnosed cases that could be linked to outbreak. • Contact restaurants, grocery stores, or other points of final service visited by multiple case-patients to identify employee illnesses or foodborne illness complaints from patrons.	• Contact clinical laboratories to identify additional fecal specimens being tested. • Prioritize referral and subtyping of outbreak pathogen.
Identify mode of transmission and vehicle.	If outbreak is associated with event or establishment:		
	• Determine appropriate analytical study approach. • Interview identified case-patients and controls or well meal companions about all common exposure sources. • Calculate measures of association for specific exposures, appropriate to study design (i.e., odds ratios for case–control study or attack rates and relative risks for cohort study).	• Obtain menu from establishment or event. • Interview food workers to determine food-preparation responsibilities. • Reconstruct food flow for implicated meal or food item. • Identify contributing factors and environmental antecedents. • Obtain samples of implicated food. • Obtain environmental samples from food contact surfaces or possible environmental reservoirs.	• Test implicated food and environmental samples to confirm presence of agent. • Subtype all isolates as soon as possible after receipt. • Conduct applied food-safety research to determine ability of agent to survive or multiply in implicated vehicle and how vehicle might have become contaminated.
	If outbreak identified by pathogen-specific surveillance:		

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	• Interview case-patients as soon as possible with standardized detailed exposure history questionnaire to identify possible common exposures. • Establish case definition on the basis of characteristics of agent that led to detection of outbreak. • Characterize cases by person, place, and time, and evaluate this descriptive epidemiology to identify patterns possibly associated with particular food items or diets. • Compare detailed exposure history questionnaire frequencies against known or estimated background exposure rates, to identify suspected food item. • Interview nonill community controls or nonoutbreak-associated ill persons to obtain detailed exposure information to be used in a case-comparison analysis of exposures. • Obtain shopper card information to identify and verify grocery purchases and possibly determine background rates of purchase of item. • Document brand names and product code information for prepackaged food items. • Analyze exposure information comparing cases to relevant comparison groups (e.g., nonill controls or cases not associated with outbreak) to implicate food item or nonfood exposure source.	• Contact restaurants, grocery stores, or other locations identified by multiple case-patients to verify menu choices, identify ingredients, and identify distributors and/or source(s) for ingredients and/or food items of interest. • Obtain samples of suspected food items. Work with appropriate regulatory authority to ensure that food samples are collected and maintained with appropriate chain of custody. This will help the regulatory authority to take appropriate regulatory action. • Conduct an informational traceback to determine whether a suspected food vehicle from multiple case-patientss has a distribution or other point in common. • If specific food item or ingredient is implicated, conduct formal regulatory traceback.	• Store collected food samples, pending results of epidemiologic analyses. • Culture implicated food samples to confirm presence of agent. • Conduct whole-genome sequencing to further characterize pathogen as necessary for investigation. • Conduct applied food-safety research to determine ability of agent to survive or multiply in implicated vehicle and how vehicle might have become contaminated.
Identify source of contamination.	If outbreak is associated with event or establishment:		
	• Combine descriptive and analytical	• Interview food workers to	• Evaluate results of all

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	epidemiology results to develop a model for the outbreak.	determine food-preparation responsibilities. ● Reconstruct food flow for implicated meal or food item. ● Evaluate food flow for implicated meal or food item to identify contamination event at point of preparation or service. ● If no contamination event identified, trace source of ingredients of implicated food item back through distribution to point where a contamination event can be identified or, if no contamination events can be identified during distribution, to source of production.	outbreak-associated culture subtyping to highlight possible relations among isolates from clinical, food, and environmental samples. ● Conduct applied food-safety research to determine how vehicle might have become contaminated.
If outbreak is identified by pathogen-specific surveillance:			
	● Combine descriptive and analytical epidemiology results to develop a model for outbreak.	● Trace source of implicated food item or ingredients through distribution to point where a contamination event can be identified or to source of production if no contamination events can be identified during distribution. ● Conduct environmental assessment of likely source of contamination, including ○ Reconstruct food flow for implicated food item. ○ Interview food workers to determine food-preparation responsibilities and practices before exposure. ○ Obtain samples of implicated food or ingredients. ○ Obtain environmental samples from food contact surfaces or potential	● Evaluate results to highlight possible relations among isolates from clinical, food, and environmental samples. ● Conduct applied food-safety research to examine likely sources of contamination. ● Work with appropriate regulatory authority to ensure that food samples are collected and maintained with appropriate chain of custody. This will help the regulatory authority to take appropriate regulatory action.

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	environmental reservoirs.		
Identify contributing factors and antecedents (root causes)	If outbreak is associated with event or establishment:		
	• Summarize information to identify confirmed or suspected agent. • Summarize information to identify confirmed or suspected food vehicle.	• Evaluate results of environmental assessment, given identification of agent and results of epidemiologic investigation, to identify factors most likely to have contributed to outbreak and their environmental antecedents.	• Summarize information about testing results from clinical, food, and environmental samples.
	If outbreak is identified by pathogen-specific surveillance:		
	• Summarize information to identify confirmed or suspected food vehicle.	• Evaluate results of environmental assessment, given identification of agent and results of epidemiologic investigation, to identify contributing factors and antecedents.	• Summarize information about testing results from clinical, food, and environmental samples. • Provide background statistics on pathogen prevalence.
Determine potential for ongoing transmission and need for abatement procedures.	If outbreak is associated with event or establishment:		
	• On the basis of agent, incubation period, and likelihood of secondary spread, create epidemic curve, and evaluate the course of the outbreak to determine whether additional cases may still be occurring. • If outbreak appears to be ongoing, review possible control measures in collaboration with environmental health specialists.	• Implement control measures to prevent further exposures: ○ Verify that all food workers who pose a risk for transmission have been excluded or restricted, as appropriate. ○ Verify that potentially contaminated foods have been properly disposed of. ○ Verify that food contact surfaces and potential environmental reservoirs have been adequately cleaned and sanitized. ○ Train staff in safe food-preparation practices. ○ Modify food-production and food-	• Assess status of completed and pending testing to identify gaps that suggest a potential for ongoing transmission.

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	preparation processes with appropriate preventive controls. ○ Modify menu. ● If any of these measures cannot be verified, review additional control measures, or if further exposure appears likely, alert public or close premises.	
If outbreak is identified by pathogen-specific surveillance:		
● Create and evaluate epidemic curve to determine whether additional cases might still be occurring. ● If outbreak appears to be ongoing, continue surveillance, and review potential abatement procedures.	● Verify that food workers who might have been infected during outbreak and who pose a risk for transmission have been excluded or restricted, as appropriate. ● Verify that potentially contaminated foods have been removed from distribution. ● Train staff on safe food-preparation practices. ● Modify food-production and food-preparation processes by implementing appropriate preventive controls. ● Modify menu.	● Assess status of completed and pending testing to identify gaps that may suggest a potential for ongoing transmission.

*The table format highlights the major objectives of the investigation to help ensure coordination among epidemiologists, environmental health specialists, and laboratorians in meeting each objective. The assignment of investigation responsibilities to a particular discipline within each table is not intended to be prescriptive. The actual responsibilities for an individual vary by the practices of the jurisdiction responsible for the investigation, roles defined in the outbreak investigation and control team, and resources.

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Chapter 6: Control Measures and Prevention

Chapter Summary Points

- Effective control measures include a combination of immediate controls to stop the current outbreak and longer term controls to prevent future outbreaks.
- Effective and timely information sharing among investigation and response partner agencies, impacted food industries, and the public is essential to control foodborne illness outbreaks.
- Appropriate control measures vary depending on whether the implicated food was contaminated
  - At a single local food-service or retail food establishment, or
  - Before being commercially distributed.
- Three strategies used to stop foodborne illness outbreaks are
  - Controlling contaminated foods at their source.
  - Controlling contaminated food products that have left the source (e.g., recalls).
  - Preventing secondary spread of infection.
- To identify appropriate control measures, information from different sources, such as epidemiology, laboratory, and environmental health should be integrated into the outbreak response.
- General control measures are often followed up with more specific controls as investigators learn more about the source(s), contributing factor(s) and root cause(s) (i.e., antecedents, underlying reasons) of the outbreak.
- Investigation and control teams should use the after-action review processes to:
  - Assess the strengths and limitations of past responses.
  - Identify action steps to improve future responses.
  - Track corrective actions using the organization's continuous process improvement programs.
  - Prevent outbreak recurrence by applying lessons learned regarding root cause and contributing factors.
- Foodborne illness investigation reports are used to accurately document actions and conclusions to improve future investigation practices and make changes to prevent future outbreaks.

URLs in this chapter are valid as of July 29, 2019.

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6.0 Introduction

6.0.1 The purposes of outbreak investigations are to stop the current outbreak, determine how contamination occurred, and implement measures to prevent future outbreaks by addressing the root cause(s) in the implicated, and potentially other, facilities. Whereas the investigation is critical for understanding the cause, effective and timely control measures are critical for stopping the outbreak and preventing reoccurrence of illness. Identifying the root cause(s) of foodborne illness improves the effectiveness of prevention efforts.

The rapid and accurate response to foodborne illness is critical.

Investigators from all three primary disciplines (epidemiology, environmental health, and laboratory) must quickly assess information and identify suspected foods or facilities to prevent additional illnesses.

There are generally two types of foodborne disease outbreaks, and each requires different control measures.

- **Local outbreaks** may be associated with food-preparation errors or contamination of food by food workers at the site of preparation or distribution, e.g., foods prepared at home, food-service, and retail food establishments. Local outbreaks typically are controlled through local actions.
- Outbreaks associated with contaminated **commercially distributed foods** may originate from a commercial food manufacturer or agricultural commodity distributed to multiple sites. The resulting foodborne illness may be linked to a variety of food establishments or to foods prepared in the home. These outbreaks are usually multijurisdictional and require coordinated intervention by local, state, territorial, tribal, and federal agencies and the industry.

6.0.2 Effective communication between team members and with other response partners is essential during all phases of the investigation to ensure opportunities to quickly implement or improve control measures are not missed. The exchange of specific actionable information is paramount to success. Communication within the response team and with other stakeholders during an outbreak response is of primary importance. For all foodborne illness outbreaks, early sharing of information between epidemiologists, laboratory staff, and environmental health specialists is critical to determine what control measures to implement to prevent foodborne illness. Timely food-supply investigations, such as product tracing and environmental assessments, can better define the food vehicle(s) that need to be controlled and identify the contributing factors and environmental root causes that led to foodborne illness (Chapter 5).

6.1 Information-Based Decision Making

6.1.1 Investigation and control teams should be prepared to act at any point in the investigation when credible information identifies opportunities to control or mitigate disease transmission. Controls can be implemented concurrently with product tracing (i.e., traceback, traceforward) investigations, environmental assessments, or other investigative processes. Waiting for laboratory results, medical diagnosis confirmation, or implication of a specific food may not be necessary before implementation of initial control measures to prevent additional exposures.

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Control measures typically progress from general to specific as investigations gather more information and should be implemented immediately whenever their need becomes apparent. General precautionary control measures that have high potential for public health benefit and low impact on business operations are usually not controversial and can be implemented relatively quickly in the field by the regulatory authority. Examples include holding a suspected nonperishable food from sale or screening for and excluding an ill employee. Decisions to implement more costly controls, such as recalling a food from distribution or closing a facility, should be based on clear and convincing evidence that food from the facility caused illness or that an imminent hazard to health exists. These decisions should involve input from the entire response team, including risk communication specialists and legal advisors (Chapter 2). Depending on the complexity of the outbreak, input from federal agencies, trade associations, or other industry and academic experts may be necessary.

6.1.2 Investigation and control teams should use a systematic process to evaluate information and regularly reassess control measure decisions. Sometimes the type of control measures needed to stop an outbreak is readily apparent early in the investigation (e.g., significant food temperature or risk factor violations). More commonly, however, key information is initially unavailable about the source, contributing factors, and root causes of foodborne illness outbreaks.

Typical steps in the evaluation include the following:

- Send a team to the likely source as soon as possible.
- Inform and involve the owner or manager of the implicated establishment.
- Assess potential risks on the basis of information provided by each discipline.
- Assess availability of resources needed to implement controls (e.g., legal authorities, equipment, and staff).
- Identify priority control measures, and clarify expectations among team members about the timeliness and completeness of control efforts.
- Implement control measures.
- Reassess and adjust control measures as additional information is gathered.

The quality of information is related to multiple factors (Chapter 5). Evaluate epidemiologic, laboratory, environmental health, and other evidence together to determine the degree to which the integrated data are consistent with each other, biologically plausible, and sufficiently strong to support implementation of control measures.

6.1.3 Investigation and control teams must balance the likelihood that control measures will prevent further illness against other consequences (Box 6.1). Inaction or delayed action in the face of ongoing exposure can result in additional illnesses. Conversely, aggressive control interventions, such as recalling food or closing a food establishment, can have legal or economic consequences for food workers, employers, communities, and entire food industries. Investigation and control team members should not delayinitiating steps to protect public health if available information indicates the need to act.

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Box 6.1. Questions to Address when Considering Control Options

Is the contaminant causing the disease highly pathogenic, virulent, or toxic? Are susceptible populations exposed?

Is the causative microorganism highly infectious and likely to be a source of secondary infections in the community?

How effective, and how costly, is the proposed control measure likely to be?

Who would play a role in implementing the control (government agency, food industry, or others)? What information will they need to act?

Is a narrow, focused action possible—such as recalling a specific group of products or notifying only the persons most likely to have been exposed—rather than a more general recommendation to avoid consuming a general category of food or notifying the public?

Will the actions affect only one business or an entire industry? How much economic or operational burden will be placed on the public who will need to respond on the basis of the proposed action?

As they ponder these questions, investigation and control team members must recognize that a rapid response is critical if the threat of serious illness and death is ongoing.

6.2 Communications With the Public

Agencies should anticipate, prepare for, and allocate resources to respond to and manage public concerns related to any public health messaging about the investigation. All members of the outbreak investigation and control team (epidemiology, environmental health, and laboratory) and health department leadership should provide input into the decision to make a public notification (Box 6.2)

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Box 6.2. Questions to Address when Considering Whether Public Notification is Necessary

What is the potential severity of disease and risk for additional illnesses (e.g., secondary infections in the community?

Is medical treatment necessary for persons who might have been exposed to the etiologic agent? If so, urgent public notification is critical.

Is public reporting of suspected illness necessary to determine the scope of the outbreak? If so, public notification might be appropriate.

Does risk for exposure still exist? People take food home from restaurants, so public notification still might be appropriate.

Are large numbers of unknown persons likely to be ill with highly infectious agents, such as norovirus or *Shigella*? If so, an advisory that ill persons should stay out of work or restrict activities may help prevent secondary transmission at other food establishments, day care, and healthcare facilities.

Is the source of the outbreak past its shelf life so no further risk exists to the public? If so, public notification may not be needed.

6.2.1 Messages to the public about foodborne disease outbreaks should follow best practices for risk communication and provide objective, fact-based information about the outbreak.

- Ideally, before an outbreak occurs, prepare templates for public messages and have them reviewed by appropriate staff, including legal counsel. Use the templates consistently during the investigation. For examples of communication templates, see the CIFOR Clearinghouse (https://cifor.us/clearinghouse/cifor-toolkit-focus-area-3-communications).
- Follow agency communication protocols. Prepare communication following the agency's risk communication protocols. Seek assistance from the agency public information officer or the public information officer at another agency if the agency with jurisdictional responsibility does not have this resource.
- Provide information about the disease, including symptoms, mode of transmission, prevention, and actions to take if illness occurs.
- Include information about what is known, what is not known, and what officials are doing to learn more.
- Do not speculate about the outbreak. Sharing preliminary or unconfirmed information with the public may result in undue worry if there is no definite action to be taken (i.e., avoidance of a certain food). Such announcements often result in inquiries from concerned citizens and the media, and the resulting expanded workload can rapidly divert resources from the investigation and control team and increase pressure to quickly name the source of the outbreak.

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- Ensure that officials prepare talking points to respond to media inquiries and social media questions, if needed. The Colorado Integrated Food Safety Center of Excellence developed the Communications Toolkit: Media Relations to help agencies work constructively with the media during foodborne illness outbreaks (*1*).
- Work closely with public information officers to ensure that consistent messaging is used to answer inquiries. This collaboration can reduce the potential for confusion or panic among consumers and industry.
- Maintain effective, accurate, and consistent communication with other agencies (i.e., local, state, territorial, tribal, and federal) involved in, or impacted by, the investigation.

6.2.2 Notify the public when actionable information is available that the public can act on to prevent additional illness (Box 6.3)**.** Attempt to reach all members of the population at risk, including non–English-speaking and low-literacy populations.

- Means of notification depend on the public health risk and the target population and might include press releases, radio, television, fax, telephone, text messaging, email, Web posting, social media, or letters.
- Provide clear and actionable information about how to handle a suspected product (discard, special preparation instructions, or return to place of purchase) or whether the local jurisdiction is interested in obtaining the product from households that still have it.
- Consider notifying area clinicians and healthcare facilities if an increase is expected in the number of people seeking healthcare after public notification.

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Box 6.3. Notifying the Public About Actionable Information

Early public announcements should reinforce basic food safety messages and inform the public about how to contact appropriate authorities to report suspected foodborne illnesses.

Educational materials on food safety targeted at the public are available from the Partnership for Food Safety Education (http://www.fightbac.org) and the Centers for Disease Control and Prevention's Food Safety website (https://www.cdc.gov/foodsafety). The following specific food safety messages are important to communicate to the public.

Personal protection from disease outbreak:

- Thoroughly wash hands with soap and warm water after using the bathroom and before preparing or eating food. Also wash hands after changing diapers, assisting a child at the toilet, and handling animals or animal waste. Hand washing is the single most important measure to protect the public's health.
- At home or at a social gathering (e.g., potluck dinner), avoid eating food that has not been handled properly (e.g., hot food that has not been kept hot, cold food that has not been kept cold).

Proper food preparation:

- Thoroughly cook food; keep hot food hot and cold food cold; thoroughly clean all food-preparation surfaces and utensils with soap and water; avoid contaminating food that will not be cooked, such as salads, with food that must be cooked, such as raw meat or chicken products; and wash hands frequently with soap and water.
- If you are ill with diarrhea or vomiting, do not prepare food for others until at least 72 hours after you are free of diarrhea or vomiting.
- Wash hands before and during food preparation.

Actions if someone in the household or childcare, or institutional setting has diarrhea or vomiting:

- If norovirus is involved, emphasize the importance of thorough cleaning and sanitation of high-risk transmission surfaces, such as toilet seats and flush handles, washbasin taps, and washroom door handles.

Appropriate community guidance, references, and educational materials are available at https://www.cdc.gov/norovirus/preventing-infection.html.

6.2.3 If public notification is expected to generate considerable public concern and/or media inquiries, consider setting up an emergency hotline for the public and media. Train people answering the phones to give consistent responses. Give them talking points or frequently asked questions and answers. Consider staffing the hotline after hours to answer phones after the early evening news or to respond to questions posed on social media.

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6.3 Communications With Response Partners and Stakeholders

Early communication with healthcare providers, the food industry involved, and others impacted by the outbreak can increase case detection, reduce the risk for secondary transmission, and help identify the source of contamination. If the pathogen causing enteric illnesses is known, use of general communicable disease control measures may limit further spread, even before the mode of transmission is clear or a food or facility has been implicated. Control measures at this point typically focus on preventing secondary spread by known cases and communicating with healthcare providers and the public about precautionary measures they can take to prevent illness transmission of the identified pathogen.

6.3.1. Effective communication with other agencies involved in the investigation or potentially impacted by the response helps staff from multiple agencies take timely actions to prevent further illnesses. During multistate outbreaks, others involved might include agencies and organizations at the local, state, territorial, tribal, and federal public health and regulatory levels (Chapter 7). A consistent public message alleviates confusion and reduces the potential for panic among consumers.

6.3.2 Communications with healthcare providers should include reminders and instructions to be shared with ill persons about personal hygiene, ways to avoid spreading infection, and infection control precautions for hospitalized patients and residents of long-term–care facilities. Instruct healthcare providers to report suspected illness to local health departments for follow-up and interviews, especially when ill persons work in settings where the risk for disease transmission is most likely, such as in food establishments and childcare and healthcare facilities. Advise healthcare providers about whether to collect clinical samples for analysis, if indicated.

6.3.3 Early communication with impacted food establishments, commodity groups, or food industries likely impacted by the public notification can assist them to

- Prepare for media enquiries.
- Consider how they can cooperate with the investigation to identify the cause(s).

Implement control measures to prevent further cases.

Food-industry representatives often have detailed knowledge about typical food-handling, storage, and distribution practices that can guide investigation and control efforts. Early sharing of clear, credible, and objective information often motivates firms to voluntarily bolster efforts to comply with standard food safety and communicable disease control measures, such as

- Excluding or restricting ill persons from food handling.
- Eliminating bare-hand contact with ready-to-eat foods.
- Proper handwashing.
- Thorough cooking.
- Effective cleaning and sanitizing procedures.

It is often helpful to provide a written summary identifying key information, including the type of agent (viral, bacterial, chemical, toxic), the exposure time period (particularly if exposure is potentially ongoing), and whether a single point source or multiple different exposures most likely caused the illnesses.

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The Communications Toolkit: Industry Relations developed by the Colorado Integrated Food Safety Center of Excellence is an example of resources available to help agencies communicate effectively with the food industry during foodborne illness outbreaks (*1*).

6.4 Control Measures

Although most reported foodborne illness outbreaks are investigated and controlled at the local level, site-specific food-safety controls may be needed at multiple points along the distribution network and in the impacted communities (Figure 6.1).

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Figure 6.1. Controlling the Source and Communicating with the Public



At the source:

Stop further production of contaminated food at the implicated food establishment.

Control any contaminated food remaining at the establishment.

In distribution:

Remove contaminated food from commercial distribution.

In the community:

Notify the public not to consume contaminated products that may be in their homes.

Appropriate control measures vary depending on whether the implicated food is associated with a food-service/retail food establishment or is a manufactured food that has been commercially distributed. The outbreak response team must determine as soon as possible whether one facility or multiple facilities are involved.

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6.4.1 Implement initial control measures at an implicated facility on the basis of investigation findings and review of what is known about other outbreaks caused by the agent and the food establishment's food-safety history. Credible epidemiologic, laboratory, and environmental health evidence can support early implementation of nonspecific control measures at an implicated facility, even though a specific food has not yet been identified.

- Adjust control measures on the basis of knowledge of the agent and whether a food item is suspected. An outbreak caused by *Clostridium perfringens* has very different contributing factors and control measures than one caused by norovirus. Controls for a *C. perfringens* outbreak focus on time and temperature for food safety, including rapid cooling, proper hot holding, and reheating. Controls for a norovirus outbreak focus on identifying and excluding ill employees. Also ensure proper hand-washing, no bare-hand contact of ready-to-eat foods, disposal or embargo of ready-to-eat foods when bare-hand contact occurs and thorough cooking is not possible, enhanced cleaning and sanitizing procedures, and (possibly) changes in the source of suspected high-risk foods used in the facility. Focusing on pathways commonly linked to the agent are most likely to identify and address the root causes of the outbreak.
- Review the establishment's history for recurring foodborne illness risk factors, previous outbreaks, illness complaints, recall, positive food samples, and correction of serious food-safety hazards. This information can indicate management's capability and willingness to consistently maintain food-safety controls. Understanding the facility's existing level of active managerial or process control can guide how the investigation and control team works with management to implement changes needed to address contributing factors and the environmental root causes that led to the outbreak.

6.4.2 Coordinate onsite investigation, environmental assessment, and control measures at the implicated facility. Most foodborne illness outbreaks are local events investigated and controlled by staff from local public health agencies. For large-scale or multijurisdictional outbreaks, staff from multiple disciplines or agencies may be involved. Staff should identify investigation and control objectives and clarify agency roles and responsibilities before arriving at the implicated food establishment. Initial clarification of both types of objectives helps ensure that appropriate staff visit the facility.

- A team approach is often needed to effectively conduct the onsite investigation and implement control measures. When conducting any environmental assessment, at least two environmental health specialists should be deployed in the field to ensure both investigative and control measure objectives are achieved. Environmental assessment teams visiting facilities for the first time must often simultaneously seek to complete multiple objectives. A few examples include communicating with firm management to enlist its cooperation, ensuring the safety of foods being served/sold, placing seizures/embargoes/holds on implicated or suspected foods or leftovers, interviewing food workers, assessing foods served and processes during the period of interest, and collecting documents and samples as needed.
- Rapid initial assessments to identify conditions requiring immediate control measures should be coordinated with ongoing investigation activities. Effective control measures address both the contributing factors that resulted in foodborne illness (what went wrong) and the root cause(s) of the outbreak (why it went wrong at this location).

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6.4.3 Gather samples while they are still available. Early collection of samples while they are still available can greatly aid in determining the root causes of foodborne illness (Chapter 5). Discarding suspected food can help stop the outbreak, but isolating the etiologic agent from the food provides the most convincing evidence a food was the source of the outbreak. Use both epidemiologic data and guidance from the laboratory to inform decisions about what samples to collect and how to handle them.

6.4.4 Control measures for localized events associated with a single food-service or retail food establishment will usually be established by local public health agencies or state and local food-regulatory agencies.

Although all of the following control measures are recommended, some may be more appropriate than others in specific outbreaks, and full implementation might not be possible in some jurisdictions. Implementing the most appropriate control measures as completely and promptly as possible improves the effectiveness of those measures. Before using any control measure, the environmental health/regulatory specialist must understand applicable laws and procedures for implementing them (Chapter 2).

- **Inform and engage facility management in implementing controls.** Environmental health specialists should work with the food establishment's person-in- charge (PIC) to implement active managerial controls and create a risk-control plan or consent agreement. Active involvement of the PIC uses his or her expertise and often increases commitment to implement controls to stop the current outbreak and prevent additional outbreaks. The CIFOR Industry Guidelines outlines, clarifies, and explains the recommended role of owners, operators, and managers of food establishments in a foodborne illness outbreak investigation (*2*).
- **Remove food from sale or prevent consumption.** If evidence from the epidemiologic, laboratory, and environmental assessment/root cause analysis supports the action, implicated or potentially unsafe foods should be embargoed, seized, placed under regulatory hold, or otherwise removed from service or sale. Fully document the information that led to the decision and the process used to make the decision. Issuing a written hold or embargo order establishes clear expectation and regulatory requirements and prevents the establishment owner from serving or destroying the food before the investigation is complete.
- **Clean and sanitize.** If evidence from the outbreak investigation identifies the potential for onsite contamination during the outbreak, the environmental health specialist must ensure involved equipment and areas of the facility are thoroughly cleaned and sanitized. This process includes disassembling all equipment and retraining staff on proper cleaning and maintenance procedures for the equipment. The cleaning and sanitizing process is particularly important if *Salmonella*, *Listeria monocytogenes*, or norovirus contamination of food is suspected. Industry guidance documents are identified under references.
- **Train food managers and workers.** Assess to what degree the presence of food-safety risks is due to inadequate food worker knowledge, inadequate supervision, or lack of active managerial control. Ensure the firm's food-safety management system is adequate to ensure that managers and food workers receive consistent food-safety training appropriate for their job duties. Ensure remedial training is provided, as needed so that food managers and workers have a functional understanding of the disease (e.g., symptoms, modes of transmission) and the food-safety practices (e.g., use of

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procedures for rapid cooling and thorough cooking and reheating of foods) needed to stop the outbreak and prevent recurrence.

- **Modify a food process.** Assess food-production or food-preparation processes at the establishment using both investigation findings and the best available scientific information. Examples of critical steps and controls include process times, temperatures, parameters (pH, water activity level), and label instructions. Implement changes needed to consistently prevent contamination of food or the survival and proliferation of disease-causing microorganisms.
- **Modify the menu**. Eliminate implicated foods from the menu until adequate control measures are in place to ensure food safety. For example, if shell eggs are implicated, remove all foods that contain shell eggs, and substitute pasteurized egg product until the investigation is complete and proper controls are in place.
- **Remove infected food workers.** Ensure that ill or infected food workers are excluded from the workplace or restricted in accordance with the Food Code (*3*) or other regulatory requirements unless evidence gathered by the investigation team indicates that a longer exclusion period is needed (e.g., evidence exists of ongoing norovirus transmission within the food establishment). Because many food workers are employed by more than one food establishment, ensure ill workers are excluded or restricted from all food establishments where they work.
    - Food establishment management should conduct daily monitoring of worker health to prevent further contamination of food by ill or infected workers. For example,
        - A person ill with vomiting or diarrhea should be excluded from the facility.
        - Pathogen-specific guidance and other information about restricting and excluding food workers is available in the latest version of the Food and Drug Administration (FDA) Food Code (*3*).
    - In *Salmonella* and *Shigella* outbreaks, fecal samples should be analyzed for the pathogen because of the likelihood of asymptomatic but infectious food workers. Restricting activities of food workers who do not comply with the request might be necessary.
    - Excluding ill food workers is not as simple as it might seem. Food workers may be reluctant to inform managers of illness because of fear of lost wages, reprisal, or leaving their co-workers short-handed. Conversely, managers underappreciating the risk to public health and their firm's economic viability may be reluctant to relieve food workers of their duties or may themselves work while ill.
    - Facilities with a strong food-safety culture ensure that both managers and food workers are well informed about alternatives to coming to work while sick, including alternate jobs that ill food workers can perform and allowing ill employees to trade for shifts when their exclusion has been lifted.
- **Use risk-control plans.** Written risk-control plans or other agreements are used to identify and focus control measures that establishments need for safe operation. Important aspects of these plans include
    - Process changes, such as recipe adjustments or development of a Hazard Analysis and Critical Control Point plan.
    - Worker training.
    - Adequate oversight measures to ensure workers follow proper procedures.

  Plans may require

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- Increased focus on regulatory requirements (e.g., additional measures to ensure appropriate handwashing by all employees).
- Additional measures above and beyond regulatory minimum requirements (e.g., extra temperature checks and logging of temperature).

- **Close food establishments.** Facilities that cannot safely remain in operation must be closed in accordance with applicable local and/or state regulations. A facility linked to an ongoing foodborne illness outbreak, in which significant noncompliance with regulatory food-safety standards is documented, is an imminent or substantial health hazard.
- **Communicate findings**. Effective communication of the evidence gathered by the investigation and control team can be a powerful motivator for establishment management to close or significantly modify operations. Voluntary actions are often the most efficient and timely way to reduce risks to the public. If the owner cannot or will not take immediate corrective action to eliminate ongoing food-safety hazards, mandatory closing of the premises may be necessary.
- **Notify the public.** As control measures are implemented at the source, public notification can be an effective way to prevent additional illnesses and further disease transmission, but it must be used judiciously. If the outbreak involves only one facility, carefully consider whether public notification is truly necessary. See 6.2 for details.
- **Monitor control measures.** The strategy for monitoring short- and long-term correction of the factors within the food establishment that caused the outbreak should be identified in writing. Food establishments should integrate monitoring steps into their food-safety management systems (e.g., Active Managerial Control), and regulatory officials should provide the facility with timely follow up inspections so the effectiveness of control measures can be assessed, modified, or removed when appropriate. Public health officials should maintain enhanced surveillance of potentially exposed populations to ensure controls are effective, secondary spread of infections is not occurring, and systems are in place to prevent reoccurrence.

6.5 Outbreaks Involving Commercially Distributed Foods

6.5.1. Control measures associated with commercially distributed foods typically require coordination of multiple agencies across jurisdictional levels, especially when an implicated food item is subject to recall (Chapter 7)**.** Careful coordination of control measures at the food-manufacturing facility, in distribution channels, and in consumer homes often is needed to stop outbreaks linked to commercially distributed foods. Food manufacturers can range from small facilities with limited local distribution to large, complex facilities capable of producing huge quantities of diverse products daily. Although contaminated products may still be stored onsite at the manufacturing facility, the probability is much higher that they have moved through various points of often complex distribution networks that can span the globe and include a wide range of locations, including; warehouses, distributors, retail establishments, consumer homes, and food banks. Timely product tracing investigations often identify the point in the production and distribution process where the implicated food became contaminated and where contaminated products may have been distributed after that (Chapter 5). The type of food products involved and the extent of their distribution often determine which regulatory agency leads the implementation and coordination of control measures.

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- **Implement onsite controls at the food-manufacturing facility.** Depending on the scope of the outbreak and probable point of contamination, most of the specific onsite control measures for food-service and retail food establishments also will be appropriate to control contaminated foods and food-safety risks at other points in food-supply chains where contamination was introduced. Given the size and complexity of many of these establishments, timely sharing of the most specific and accurate information available (e.g., product descriptions, lot codes, and periods of interest) is vital to focusing control measures where they are most needed.
- **Determine whether a food recall is needed.** Public health and food-regulatory agencies need to determine whether the contaminated product is still in distribution or consumer homes and, if so, decide how contaminated products can most effectively be removed from the market and consumers notified when appropriate (Box 6.4).

Food firms have the primary legal responsibility to initiate and conduct effective food recalls. If the food-regulatory agency has adequate information to implicate and accurately identify a contaminated food item, that agency will take the lead on working with the manufacturer to initiate recall activities. Consider the capabilities of the firm and involved agencies to: notify the public when appropriate, conduct recalls, and verify their effectiveness. Past recall experience and prior recall planning are often good indicators of likely future performance by the manufacturer.

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Box 6.4. Considerations for Whether to Remove Food from Distribution

Questions to Ask

Is risk to consumers ongoing?

Is the product still in distribution based on product tracing information (Chapter 5)?

Is the product likely to still be in the homes of consumers?

Do the combined epidemiologic, laboratory, and environmental health data support removing food from the market?

Remove the food if

Specific exposure information links the illness with consumption of that food (e.g., through a quality analytic study or other epidemiologic method), even if the pathogen has not been isolated from the food. OR

Definitive lab results show the outbreak pathogen is present in the product. The results must be based on a food sample that is representative of the food eaten by case-patients and has been handled properly to avoid cross-contamination. OR

An investigation at the source reveals adulterated products or other conditions that pose an imminent hazard to health. OR

Epidemiologic association is not significant, but the pathogen, chemical, or other contaminant is so hazardous that the risk to the public is very high (e.g., botulism). Under these circumstances, there may be no analytic controlled studies, but if the descriptive epidemiology (e.g., demographic characteristics of case-patients, geographic distribution, or illness onset) suggests an association between the disease and the suspected food, then removing food from the market might be warranted, even in the absence of confirmed laboratory findings.

- **Contact the federal or state regulatory agency that has jurisdiction over the product.** FDA regulates the safety of most foods moving in interstate commerce, except meat, poultry, farm raised catfish, and most out-of-shell egg products (which are regulated by the U.S. Department of Agriculture's Food Safety and Inspection Service [FSIS]) (Chapter 3).

Both FDA and FSIS have developed informational websites to assist their investigation and response partners. FDA developed a general website (*4*) with Resources for Regulatory Partners, and FSIS developed a website with resources for its investigation partner agencies to improve communication and sharing of information during foodborne illness outbreak investigations (*5*).

- **Initiating a recall.** State agencies, FDA, FSIS, and the Centers for Disease Control and Prevention (CDC), often contact the manufacturer seeking to obtain its cooperation in initiating a food recall. In addition,

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the regulatory authority and/or the manufacturer may ask retail facilities to remove the product from their shelves and ask distributors to withhold the product from distribution.

Quickly determining the extent of a recall needed in a large manufacturing plant with multiple processing lines can be difficult. Although industry often wants to limit the recall to the production lots implicated in illnesses, the conditions or extent of contamination observed within the facility may warrant a more comprehensive recall. Was an ingredient identified as a possible source of illness used in multiple food processes? Often, implicated lots will be recalled while a hold is placed on other products until their safety can be determined through an environmental assessment and product sampling. Because recalls often expand as more contaminated products are identified, some processors will voluntarily recall or be compelled to recall all suspected product to avoid the negative publicity and the economic impact associated with multiple recalls of their products.

Recall of food at the processor level generally requires federal and/or state action. In some jurisdictions, the local health jurisdiction will embargo (impound) the food (tagging the food to make sure it is not moved or sold, or ordering it destroyed). Under the Food Safety Modernization Act (*6*), FDA can order the embargo of food for up to 30 days without a court order.

- **Remove product from distribution.** Once a decision is made to remove food from the distribution, the food must be removed as quickly and efficiently as possible (Box 6.5). Foods with short shelf lives (e.g., fresh produce, dairy products) generally are consumed within the shelf life or discarded. Foods with longer shelf lives, especially frozen foods and foods that may be frozen, will be available for extended periods of time. Prevent additional exposure by ensuring effective recall practices and public notification.

  Conduct product tracing (traceback, traceforward) investigations to better learn where contaminated products were distributed and how contaminated products were used. For example, a contaminated food may have been used as an ingredient in food(s) that were not subsequently treated to destroy the contaminant, and additional recalls may be necessary. An ingredient also may be indicated if a large number of illnesses are not linked to the foods from one implicated facility.

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Box 6.5. Steps to Improve the Effectiveness of Recall Measures and Industry Response

Conduct recall effectiveness checks to assess whether efforts to remove products from distribution channels work.

Share distribution lists of recalled foods among government agencies and with the public

Develop a list of verification or control measures to implement immediately when an outbreak- related or illness-related recall has been identified.

Identify industry needs and develop guidance for

Interacting with public health or agriculture officials investigating an outbreak. Provide retailers and manufacturers with 24/7 contact numbers and emails for regulators at the local, state, and federal levels, including FDA and USDA's Food Safety and Inspection Service.

Providing timely notification of customers, appropriate government agencies, and the public of recalls involving particularly hazardous contaminants.

Mitigating the impact of an outbreak- related or illness-related recalls. Examples: clean out the display cases, follow destruction for recalled product, recommended practices for disposing of returned product.

Develop guidance for communicating with the news media, including the preparation of talking points to answer inquiries. Have a plan for coordinating a news media telebriefing or video briefing, if needed. Identify a spokesperson.

Develop standard templates for press releases and social media messages for use during an outbreak that follow best practices for crisis and emergency risk communication (https://emergency.cdc.gov/cerc).

Detailed information and sample forms for use by food establishments are included in the "CIFOR Foodborne Illness Response Guidelines for Owners, Operators and Managers of Food Establishments" (*7*).

- **Food regulators should consider ways to immediately notify food facilities in their jurisdiction through text messaging, email, blast fax, or phone calls of recalls associated with high severity hazards (e.g., botulism associated with under processed canned foods) that have a reasonable probability of still being in commercial distribution.** Identifying subcategories of facilities is highly recommended so notices can be targeted to specific facilities (e.g., notices of a seafood recall sent specifically to seafood retail establishments). This process should include food bank donation centers and other sites that might have received food donations.
- **If any distributors or retailers refuse to remove the food, issuance of a public health warning and order to require action might be necessary.** The appropriate agency for this action depends on the type of food and etiologic agent. Passage of the Food Safety Modernization Act gave the FDA the authority to order a responsible firm to recall a human or animal food when FDA determines that 1) there is a

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reasonable probability that the food is adulterated or misbranded and 2) consumption would cause serious adverse health consequences or death to humans or animals.

- **The agency/jurisdiction should monitor to ensure the recall is effective in stopping illnesses and food is completely removed.** Are illnesses continuing after the recall? If so, why? Is there another contaminated product or lot number that has not been recalled? Was the product purchased after the recall? If so, from where? Was the consumer aware of the recall notice?
- **Assessing recall effectiveness requires close cooperation among local, state, territorial, tribal, and federal agencies to accomplish risk-based recall effectiveness checks across the distribution system.** For example: many large-volume retailers routinely sell product to smaller retailers that may use cash for purchases. Participating in recall effectiveness checks can help local and state agency staff maintain proficiency in tracing contaminated products from the source(s) throughout distribution chains. If the product is not immediately removed, determine why.
    - Did the manufacturer notify the distributor of the recall?
    - Did the distributor notify retailers of the recall?
    - Was the recall information clear and complete, including all lot numbers, use-by dates, bar codes?
    - Did notifications occur but no action was taken?
    - Was returned recalled product diverted and sold elsewhere?
    - If the recall is not effective, notify appropriate state, federal, and neighboring health and food-regulatory agencies.
    - Issue a public advisory if needed.
- **Post-recall reporting by the food business or manufacturer.** If a food business or manufacturer recalls a product, it should prepare interim and final reports about the recall. The contents of these reports are used to determine the need for further recall actions. The reports should include copies of all notices distributed to the public and through the distribution chain, as well as the following information:
    - Circumstances leading to the recall and actions taken.
    - Extent of distribution of the suspected food (documentation that can support traceforward investigations).
    - Result of recall (percentage of suspected food recovered).
    - Method of disposal or reprocessing of suspected food.
    - Difficulties experienced in recall and actions taken to prevent recurrence of food-safety problems and any recall difficulties.

6.6 Outbreak Wrap-up Activities

6.6.1 Most outbreaks are considered over when two or more incubation periods of the etiologic agent have passed with no new cases. However, outbreak investigation and control activities should not cease when new cases of human illnesses cease to be identified. Clusters with low attack rates and cases from some sources might appear intermittently for years. This is especially common with agricultural products, such as romaine lettuce, where outbreaks have occurred each year, around the same time of year, when products are harvested from the same contaminated farms. PulseNet data should be

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reviewed and monitored to make certain control measures have been effective in preventing additional illnesses.

The outbreak is truly over when the source has been identified and controlled so it cannot cause additional illnesses. To prevent additional illnesses and future outbreaks, it is vital that investigation and control teams learn why the outbreak occurred so effective controls can be applied to address the contributing factors and root cause(s). Sharing lessons learned from each outbreak with the food industry in that sector or commodity group can prevent future outbreaks in other locations.

6.6.2 Restrictions put in place to prevent additional illnesses may be removed when no further risk to the public exists, such as when

- Risk factors in the facility have been eliminated and an effective system has been put in place to prevent their reoccurrence.
- Ill food workers have recovered and are no longer shedding pathogens (refer to the FDA Food Code for specific recommendations on restricted/excluded employees).
- Tests indicate no further contamination within the facility.
- Employees have been trained on proper methods to avoid the contributing factor(s) of foodborne illness.
- Managerial controls are implemented and integrated within day-to-day operations and the facility's operational culture (culture of food safety).

6.6.3 Monitoring plans should be developed to ensure the effective control of the outbreak.

- **Monitor the population at risk** for signs and symptoms of the foodborne illness to ensure the outbreak has ended and the source of illness has been eliminated. Epidemiologists and communicable disease control staff should consider conducting active surveillance, working with healthcare providers to increase their identification of associated cases, and collecting fecal samples from the population at risk. Monitor the Whole Genome Sequence (WGS)– PulseNet database to assess whether closely related cases have occurred in the region or nationally. An outbreak at a food establishment may be caused by a contaminated food ingredient or product that they received. Also monitor WGS-PulseNet over the next year for matching cases. *Listeria*, *Salmonella*, and Shiga toxin–producing *Escherichia coli* outbreaks often reoccur from the same source. Another outbreak could recur the following year around the same time if contaminated produce from certain farms with unsafe water is the source.
- **Monitor the implicated foods or food establishments** to ensure agreed-to changes in food-safety management systems are maintained and that no additional contamination is occurring.
    - Identify needed changes in writing, such as with a Risk Control Plan or Standard Operating Procedure.
    - Maintain communication with managers of the implicated food establishment and give them additional information if it becomes available.
    - Increase the number of risk-based inspections at the implicated food establishment and sampling of implicated foods, as needed, to monitor the firm's development and implementation of preventive controls.

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Outdated, unsafe practices often are difficult to change, and new practices might need to be reinforced multiple times before they become routine. Consider customized training to support the desired behavioral change. Determine whether behavioral change has occurred long term. Consider requiring that the establishment or firm hire a consultant to assist in developing safe systems and in monitoring if the facility has a history of unsafe practices.

6.6.4 Outbreak investigation and control teams should routinely meet and review all aspects of the investigation. Processes that systematically review investigation and control efforts after the response is over have two primary goals (Box 6.6):

1. Improve the effectiveness of future investigations and responses.
2. Prevent recurrence at the facility or in similar types of food operations.

Assessments of the effectiveness of the investigation and control efforts should maintain a balanced approach that identifies strengths to be built upon and areas of improvement to be addressed. The complexity of the review depends on the size and complexity of the outbreak. For a small outbreak associated with a single facility or event, a quick meeting and short written summary may be sufficient.

Box 6.6. Goals of Formal After-Action Meeting

Improve the effectiveness of future investigations and responses:

Clarify resource needs, structural changes, or training needs to improve future outbreak response.

Identify factors that compromised the investigations, and seek solutions.

Identify necessary changes to current investigation and control guidelines and development of new guidelines or protocols as required.

Discuss any legal issues that might have arisen and the need for new laws to strengthen response (Chapter 2).

Prevent recurrence at this facility or in similar types of food operations:

Identify the contributing factors and environmental root causes of the outbreak and measures (preventive controls) to prevent additional outbreaks at this and other food establishments.

Determine whether others need to be notified of lessons learned from the investigation to prevent outbreaks elsewhere.

Identify the long-term and structural control measures, develop a plan for their implementation, and determine surveillance and follow-up needed to ensure an outbreak does not reoccur.

Assess the effectiveness of outbreak control measures and difficulties in implementing them.

Assess whether further scientific studies should be conducted.

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For a large outbreak involving multiple agencies, a series of meetings resulting in a formal after-action report is appropriate.

Two types of meetings can be used as part of effective after-action review processes:

- **Hot wash/debriefings** involve investigation and control team members to gather input within 1–2 weeks after the investigation's completion while it is fresh in responders' minds. These are often less formal and single-agency in nature. Examples of typical agenda items include
    - What went well?
    - What did not go well?
    - What resources were needed that were unavailable?
    - What will be done differently next time?
    - What follow-up is needed from root-cause analysis to ensure this does not happen again (Action Plan: who will do what by when)?

- **After-action review meetings** often involve response team members, response partners, and sometimes stakeholders. These meetings are more formal, systematic, and comprehensive and, because of the need to coordinate schedules and information sharing, might occur 1–2 months after the response.

Effective after-action review processes result from planning and the intentional dedication of resources to support these meetings. Share written summaries of each meeting with attendees and interested response partners. Lessons learned from outbreaks should be communicated appropriately so they can promote improvement; even the best lessons learned have minimal impact if they are not shared with relevant partners and stakeholders. Link formal action items identified by the process to the agency's continuous process improvement program(s) to ensure appropriate accountability for tracking and correction.

If additional information becomes available in the weeks or months after the outbreak and the official after-action meeting, disseminate that information to the outbreak investigation and control team and appropriate external partners.

6.6.5 Prepare reports for all outbreaks. The report complexity depends on the size of the outbreak. For small outbreaks, a simple summary (following a template established by the agency) should suffice. Use the report to educate staff and share important investigation findings with others. When combined with other reports, this information can help identify trends across outbreaks that can be useful in future investigations.

Use outbreak reports as an opportunity for continuous quality improvement. If all the after-action reports cite the same areas for improvement, then nothing is being corrected. Outbreak investigation reports provide an opportunity to document both lessons learned during the investigation and the investigation's results.

Well-conducted and documented outbreak investigations guide prevention efforts by identifying foods at risk for contamination, locations within food-supply chains where contamination is introduced, factors directly contributing to contamination, and the root causes)

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The final report for a large outbreak should be comprehensive, provide information by all team participants, and be disseminated to all participating organizations. Sample outbreak and after-action reports are available at the CIFOR Clearinghouse (*7*).

1. Given that reports, especially those for large outbreaks, are likely to be subject to Freedom of Information Act (*8*) requests, they should be written with public disclosure in mind. The reports should not identify individuals or other protected information unless necessary and legally defensible. Proper care in writing the report will save time redacting information when the report is released to the public. Some jurisdictions allow or mandate the inclusion of identifying information, so review state and local laws and policies.
2. Submit a final report of the outbreak to CDC's National Outbreak Reporting System and National Environmental Assessment Reporting System databases (*9,10*). FDA-funded Rapid Response Teams have uploaded after-action reports into FoodSHIELD (*11*).

Control of contributing factors without addressing the root cause for their presence in the facility can result in a repetitive cycle of short-term correction followed by gradual loss of food-safety controls and outbreak recurrence. Sharing the root causes of outbreaks enables a broad range of food-safety stakeholders (e.g., agencies, food industries, academic institutions, and consumers) to coordinate work within their respective spheres of influence to strengthen food-safety systems worldwide.

6.6.6 The outbreak investigation findings may indicate the need for future research. For example, investigators may determine that for certain pathogens in certain foods, standard control measures do not seem effective or routine handling practices and their role in outbreaks are not completely understood. The food-safety or public health agency or research centers should consider such observations for in-depth study. Regular review of reports of foodborne illness outbreak investigations can identify important trends and areas of undercontrolled risks. Questions raised by stakeholders and researchers include

- How common is this pathogen as identified to the subtyping level by WGS?
- Is there a recurring pattern every year around the same time?
- Is there a high baseline in this region of the country that may indicate an ongoing source that needs to be identified and eliminated?

6.6.7 If unusual findings characterized the outbreak (e.g., unusual exposure, presence of a pathogen in a food where it had not previously been reported or by the magnitude of the outbreak) or new methods were used in its investigation, disseminate the report more widely (e.g., through Epi-X, *MMWR*, or other national forum; peer-reviewed journals)**.** Publish important lessons learned (such as new investigation methods that proved particularly helpful, control measures that seemed particularly effective, actions taken that seemed to shorten the outbreak) in an appropriate national forum.

6.6.8 An outbreak can identify the need for broad education of the public; the food-service, retail, food processing, and agricultural industries; food-safety regulators; or healthcare providers. Public outreach, including public service announcements, can remind the public about food-preparation precautions. National training programs for food workers and managers are regularly revised to reflect current understanding of the root causes of foodborne illness. Food-safety management systems

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increasingly hold managers accountable for ensuring that training of food workers is appropriate for assigned job responsibilities. Healthcare providers might need continuing education focused on diagnosing, treating, or reporting foodborne diseases. Such actions can help prevent future outbreaks or reduce the number of cases or severity of illness during an outbreak.

Trade associations, food-industry organizations, and national conferences often request presentations on outbreak investigations. These events provide an opportunity to educate representatives of the food industry, colleagues, and others about investigation procedures, outbreak management, preventive controls, and CIFOR.

6.6.9 Information gained during an outbreak is used to identify the need for new public health or regulatory policy at the local, state, territorial, tribal, or federal level. Different inspection practices, source controls, surveillance procedures, or recall process controls have been established on the basis of well documented investigation reports.

Ongoing and regular review of outbreak investigation reports, research, and industry practices identifies the need for new policy. FDA regularly updates the Food Code (*3*) to better address the leading foodborne illness risk factors identified by epidemiologic outbreak data. For example, an analysis of outbreaks by the Environmental Health Specialist Network identified an association between not having a manager certified in food safety and outbreaks (*12*). Similarly, FDA found an association between the presence of certain foodborne illness risk factors and the lack of a certified manager (*13*). These findings led to changing the FDA Food Code to require the person in charge of most retail and food-service establishments, those posing more than a minimal foodborne illness risk, be a Certified Food Protection Manager.

Consult other public health and environmental health agencies to determine whether concurrence exists on the need for new policy. If so, present the issue to the appropriate jurisdictional authority by using the appropriate policy development processes.

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Chapter 7: Special Considerations for Multijurisdictional Outbreaks

Chapter Summary Points

- A multijurisdictional outbreak of foodborne illness requires the resources of more than one local, state, territorial, tribal, or federal public health or food regulatory agency to detect, investigate, or control.
- Recognition of outbreaks with multistate exposures will continue to increase with implementation of whole-genome sequencing in foodborne illness surveillance.
- Special efforts may be needed to
  - Help agencies recognize when a multijurisdictional outbreak is occurring and then identify and engage key partners in the investigation.
  - Improve communication and coordination among agencies at all levels of government that are investigating multijurisdictional outbreaks.
  - Increase the speed and effectiveness of investigating and controlling multijurisdictional outbreaks.

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7.0 Introduction

Multijurisdictional investigations range from different agencies and departments at a local level collaborating on a simple investigation to a large multistate outbreak with the potential identification of imported foods. As the number of agencies and levels of organizations across jurisdictions increases, the need for special efforts to maintain effective communication and coordination increases as well. (See Chapter 5 for general approaches to investigating clusters and outbreaks of foodborne illnesses.)

7.1 Categories and Frequency of Multijurisdictional Outbreaks

A multijurisdictional outbreak of foodborne illness requires the resources of more than one local, state, territorial, tribal, or federal public health or food regulatory agency to detect, investigate, or control the pathogen in question (Box 7.1). For some, such as multistate outbreaks identified through PulseNet surveillance, the multijurisdictional nature of the outbreak may be readily apparent. For others, it may emerge during the investigation. Special efforts may be needed to help agencies recognize a multijurisdictional outbreak and then to identify and engage key partners in the investigation.

The passage of the Food Safety Modernization Act (*1*) in 2011 gave new authorities to the Food and Drug Administration (FDA) and provided a mandate to enhance surveillance and response capacity at local, state, territorial, tribal, and federal levels. Combined with the development and implementation of whole-genome sequencing (WGS), these investments in foodborne disease surveillance have increased the number of outbreaks recognized as multijurisdictional (Table 7.1). For example, during 2006–2010, 1.7% of all foodborne illness outbreaks reported to the Centers for Disease Control and Prevention (CDC) National Outbreak Reporting System [NORS] involved multistate exposures and many more affected residents of multiple states or counties (*2*). During 2011–2016 the percentage of outbreaks with multistate exposures doubled to 3.4% (*3*). In particular, 22.0% of *Escherichia coli* O157:H7 outbreaks and 11.5% of *Salmonella* outbreaks involved multistate exposures, discovered largely through PulseNet (*3*). Thus, for these most important foodborne pathogens, the need for multijurisdictional coordination should be anticipated during the earliest stages of an investigation.

Box 7.1. Categories of Multijurisdictional Outbreaks

- Outbreaks affecting multiple local health jurisdictions (e.g., city, county, town) within the same state.
- Outbreaks involving multiple states.
- Outbreaks involving multiple countries.
- Outbreaks affecting multiple distinct agencies (e.g., public health, food regulatory, emergency management).
- Outbreaks, regardless of jurisdiction, caused by highly pathogenic or unusual agents (e.g., *Clostridium botulinum*) that require specialized laboratory testing, investigation procedures, or treatment.
- Outbreaks in which the suspected or implicated vehicle is a commercially distributed, processed, or ready-to-eat food contaminated before the point of service.

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- Outbreaks involving large numbers of cases that may require additional resources to investigate.
- Outbreaks in which intentional contamination is suspected.

Specifically related to multijurisdictional outbreaks, recent investments have been made to

- Improve coordination and data-sharing between public health partners and the public.
- Increase state and local participation in national surveillance networks.
- Expand and integrate national surveillance systems.
- Enhance laboratory and epidemiologic methods for agent identification and outbreak detection and investigation.

Coordinating offices for foodborne illness investigations in the three primary federal agencies include

- CDC: Outbreak Response and Prevention Branch (Division of Foodborne, Waterborne, and Environmental Diseases, National Center for Emerging and Zoonotic Infectious Diseases).
- FDA: Coordinated Outbreak Response and Evaluation Network (CORE).
- U.S. Department of Agriculture (USDA) Food Safety and Inspection Service (FSIS): Applied Epidemiology Staff.

Table 7.1. Number of outbreaks with multistate exposure, multistate residents, multicounty exposure, and multicounty residents, by etiology, United States, 2011–2016 (*3*)

Etiology and Agent	No. Total Outbreaks	Multistate Exposure	Multistate Residents	Multicounty Exposure	Multicounty Residents
Confirmed etiology	2,454	154	324	150	646
Escherichia coli O157:H7	100	22	14	23	26
Salmonella	748	86	107	74	207
Clostridium perfringens	89	0	8	0	26
Staphylococcus aureus	30	0	3	1	6
Hepatitis A virus	12	2	2	2	3
Norovirus	894	2	127	14	274
Other	581	42	63	36	104
Suspected etiology	1,153	5	120	8	153
Unknown etiology	1,292	1	118	14	165
Multiple etiologies	430	23	81	10	76
Total	**5,329**	**183**	**643**	**182**	**1,040**

7.2 Multijurisdictional Outbreak Detection

7.2.1 Multijurisdictional outbreaks may be detected at local, state, territorial, tribal, or federal levels. Outbreaks detected at the local level through investigations of consumer complaints, individual cases, or case clusters of reportable foodborne illnesses (Chapter 4) may identify common-source outbreaks or multiple subclusters of illnesses that implicate or suggest likely contamination of food before the point of service.

Detection of multijurisdictional outbreaks at a state level may result from an increase of sporadic infections with common subtype characteristics identified, investigation of subclusters of illnesses that

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identify a possible association with multiple food service establishments, or the linking of multiple, discrete common-source outbreaks by common agent, food, or water.

Similarly, national increases of infections with common subtype characteristics identified; identification of subclusters of illnesses associated with multiple restaurants or food service establishments in multiple states; and linkage of multiple, discrete common-source outbreaks in multiple states would lead to a multijurisdictional outbreak investigation.

Detection of a pathogen, such as *Listeria monocytogenes*, Shiga toxin–producing *E. coli*, or *Salmonella*, from a food item that resulted from testing by a federal or state food regulatory agency would lead to a search for human illnesses caused by the same organism with common subtype characteristics. Multijurisdictional investigation of infections with common subtype characteristics would be conducted to determine whether they were part of an outbreak.

7.2.2 When findings indicate that multiple jurisdictions might be involved in an investigation, additional communication and coordination are needed (Table 7.2). With initiation of an investigation of a potential multijurisdictional outbreak, a local agency should ensure notification of the state health department and other local agencies, as appropriate, and provide subsequent updates in accordance with state procedures to ensure coordination between epidemiology, environmental health, and the public health laboratory.

Detection of multijurisdictional outbreaks at a state level requires notification of affected county and city health departments. CDC and state and federal food regulatory agencies need to be notified of subclusters or linked common-source outbreaks. For example, FDA has established its CORE Network to respond to outbreaks. FSIS has developed a template for including FSIS in foodborne illness outbreak response procedures (*4*). Notify FSIS of outbreaks potentially associated with FSIS-regulated products by sending an email to FoodborneDiseaseReports@usda.gov and to the appropriate regional contact in the FSIS Office of Enforcement, Investigation, and Audit (https://www.fsis.usda.gov/wps/portal/informational/districtoffices#oiea).

Detection of multijurisdictional outbreaks at a national level requires notification of appropriate state and federal food regulatory agencies and state health departments of an increase in apparently sporadic infections, subclusters, or linked common-source outbreaks. In these events, states typically notify local agencies of the outbreak and the need for their assistance in conducting the investigation. Of particular importance are requests to interview case-patients as soon as possible using a detailed exposure questionnaire to obtain detailed food and environmental exposure histories, including product brand and retail source.

7.2.3 Assemble and brief the outbreak and investigation control team. Open communication between investigation team members to plan, conduct, and evaluate outbreak investigation activities is critical to the success of the investigation (Chapter 5). For multijurisdictional investigations, the outbreak investigation and control team should include members from all agencies participating in the investigation (Chapter 3, Tables 3.1 and 3.2). Agency preparedness plans should be in place to facilitate rapid identification and notification of these key partners. In addition, many health departments have an incident command system (ICS) that guide outbreak response (Box 7.2). Historically, investigations of multijurisdictional foodborne illness outbreaks have not required formal activation of ICS. However, federal regulatory agencies use ICS for their response to outbreak incidents.

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Box 7.2. Use of Incident Command Systems

An incident command system (ICS) is the nationally recognized way that diverse individuals, agencies, and the private sector plan to work together to command, coordinate, and communicate during emergencies. Agencies responding to a public health emergency or foodborne outbreak can use ICS principles to help manage responses. ICS principles provide the flexibility needed to manage a wide range of foodborne illness outbreak responses, including single agency and multiagency outbreak investigation and control teams.

ICS provides for internal communications among primary event responders, public information officers, and security/safety officers and for external liaison with various organizations. Key features for foodborne outbreak investigation and control teams include the following:

- Standardized but flexible organizational structure.
- Clearly defined and standardized roles and responsibilities.
- Formal and systematic planning approach.
- Coordinated response team, stakeholder, and public communications.
- Formal mechanisms for managing transitions from routine to nonroutine responses by expanding and contracting response team structure and resources as needed.

These features provide a predictable framework that can bring order to potentially chaotic situations when standard agency operating procedures and routine chain of command are inadequate to address the needs of an incident.

Because outbreak investigation staff may be physically located in different agencies in several different cities or states, briefings may need to be conducted by teleconference or webinar. All members of the of the investigation team—epidemiologists, environmental health specialists, laboratorians, and food regulators—need to be familiar with and follow relevant state and federal laws, terms of any memorandum of understanding between agencies, and data-handling practices.

7.3 Identifying and Investigating Subclusters

Subclusters are groups of cases within a larger defined cluster for which exposure to the same individual points of service, such as a restaurant, cafeteria, grocery store, or institution, is identified. Subcluster investigations provide an invaluable opportunity to solve an outbreak because the outbreak vehicle was most likely served by the common establishment (Chapter 5). Although subclusters have traditionally been identified within clusters of cases defined by a common serotype, pulsed-field gel electrophoresis pattern, or closely related genomic sequence, successful subcluster investigations also have been conducted during *Cyclospora* outbreaks, where no subtyping of the outbreak strain characteristics was possible.

In multijurisdictional investigations, make special efforts to identify potential subclusters across the geographic distribution of outbreak cases and to prioritize the coordination of subcluster investigations and tracing of common food exposures associated with the subclusters. If not previously established, a coordinating office (or individual) for subcluster investigations should be empowered to prioritize collection, organization, and dissemination of subcluster data.

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7.4 Coordinating Multijurisdictional Investigations

Coordinating a multijurisdictional investigation might require establishment of a coordinating office to collect, organize, and disseminate data from the investigation. Depending on the scope and nature of the multijurisdictional event, the coordinating office might be located at a local or state public health or food regulatory agency or at CDC, FDA, or FSIS.

Several principles guide decision about where to locate the coordinating office for a given multijurisdictional investigation. The primary goal is to avoid interagency conflict about coordination that might distract from prompt conduct of the investigation and to present unified, consistent messages to the public.

- Outbreaks are most efficiently investigated as close to the source as possible. In general, investigations should be coordinated at the level at which the outbreak originally was detected and investigated. This is likely to be where most relevant investigation materials will reside, which can facilitate organization and analysis of data. An outbreak involving several local health agencies might best be coordinated by a lead local agency. Similarly, investigation of a multistate outbreak with most cases in one or a few adjacent states might best be coordinated by a lead state agency. Investigations of outbreaks of more widely dispersed cases identified through pathogen-specific surveillance might best be coordinated by CDC.
- The coordinating office must have sufficient resources, expertise, and legal authority to collect, organize, and disseminate data from the investigation. Local agencies might not have sufficient resources to effectively coordinate a multijurisdictional investigation, or state rules might assign jurisdiction over multicounty investigations to the state health department. In these situations, the coordinating office should be located at the state level. In multistate investigations, the coordinating office should be located at CDC if no individual state is prepared to do so. In multistate investigations led by an individual state, CDC should support the investigation in coordination with the lead agency.
- Investigations of the food contamination phase should be coordinated within food regulatory agencies. In addition to food regulatory agencies' greater expertise and experience with these investigations, rules governing the collection of product manufacturing and distribution information might dictate that authorized food regulatory agencies not share that information with outbreak investigators in other agencies.

7.4.1 Outbreak investigations progress through phases of activity, and leadership of the investigation should reflect the focus of the investigation at the time. Investigations initiated at a local level are handled in accordance with routine policies and procedures under local agency leadership unless otherwise specified by state procedures. The level of state involvement depends on local or state protocols.

During investigations that require active participation from multiple local agencies and state agencies, a state agency needs to coordinate among the epidemiology, environmental health, and laboratory components of the investigation at the state level and ensure that state epidemiology, environmental health, and laboratory programs communicate and coordinate activities with counterparts at the local and federal levels. Typically, epidemiologic efforts to characterize the outbreak by person, place, and

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time dominate the early stages of an investigation. Efforts to identify the mode of transmission and food vehicle begin to incorporate environmental health specialists and food regulators. Determining contributing factors and environmental antecedents, conducting regulatory tracebacks, and implementing control measures move the investigation into the food regulatory realm. Transition of leadership within the outbreak control team should be planned in advance by consensus and communicated to the entire team.

During investigations of national significance, federal agencies need to coordinate the epidemiology, environmental health, and laboratory components of the investigation at the federal level and ensure that federal epidemiology, environmental health, and laboratory programs are communicating and coordinating activities with their counterparts at the state and local levels.

7.4.2 Communication and coordination plans should reflect the focus of the investigation at the time. Investigations initiated at a local level require information sharing and coordination among multiple local agencies under local agency leadership unless otherwise specified by state procedures. The state receives information and provides consultation.

When the resources of one or more local jurisdictions cannot adequately respond to events by following routine procedures, the state should provide response coordination, consultation, and information sharing. On the basis of established procedures, emergency management systems, possibly including ICS, might be activated at the local—or possibly state—level. Federal agencies are notified and involved depending on product type and distribution.

Multistate outbreaks and outbreaks associated with regionally or nationally distributed food products involve a transition from state to national significance. These outbreaks might require regional or national resources. Although they require active participation from multiple local agencies and state response coordination, consultation, and information sharing, they also might require federal agency leadership, depending on the capabilities and willingness of the states involved.

Sharing of information between public health and food regulatory agencies is critical to the effectiveness of multijurisdictional investigations. Ensuring the facilitation of rapid and open information sharing can greatly enhance the efficiency and effectiveness of multijurisdictional investigations. Because these activities build on each other, establishing information-sharing protocols during the earliest stages of the investigation is critical. State, local, and federal public health officials should ensure that their agencies have the legal authorities needed to share information and that their professional staff understand those authorities (Chapter 2). Unless state and local public health officials have been commissioned to receive confidential information from FDA, they might need to work directly with the establishment implicated in the outbreak to obtain those data (Chapters 2 and 3). FDA's Office of Partnerships has a commissioning and credentialing program that enables the sharing of commercial confidential information to Commissioned Officials and/or signatories of Confidentiality Agreements (Chapter 2.3.4).

Identifying the source of a multijurisdictional outbreak is a collaborative process among local, state, and federal agencies and industry. Individual food companies and trade associations should be engaged early on to help with the investigation. Industry collaborators might be able to provide important information about food product identities, formulations, and distribution patterns that can improve hypothesis generation and assist in informational tracebacks to aid hypothesis testing. Early

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engagement of industry also can facilitate control measures by enabling affected industries to implement orderly product withdrawal or recall procedures.

Release of public information about the outbreak should be coordinated with the lead investigating agency when feasible. Although the public and news media are not aware of most outbreak investigations, the results of investigations are public information. In addition, responding to media attention is important to address public concerns about the outbreak. Although individual agencies participating in the investigation might be obligated to provide the perspective of their own leadership when responding to media inquiries, a coordinated communications plan can help provide a consistent, unified message about the progress of the investigation, the source of the outbreak, or any prevention activities that the public can do to protect itself. Coordinating communications with the media is particularly important when media attention is needed for public action to avoid exposure to a specific contamination source, such as a recalled food product.

7.4.3 Use standardized data-collection forms and centralize compilation of data from case-patient interviews. The National Hypothesis Generating Questionnaire (NHGQ) can be used to collect information on a broad range of food and nonfood exposures (http://cifor.us/downloads/clearinghouse/NHGQ_v2_OMB0920_0997.pdf) during the early stages of an outbreak investigation (Chapter 5). As hypotheses develop and are refined, an outbreak-specific questionnaire can be developed to systematically collect data from the various states or local jurisdictions contributing to the investigation. Collecting detailed information on both the food item and its source as early in the process as possible is key to identifying the source of an outbreak. Thus, ensuring that all agencies participating in the investigation use the same outbreak-specific questionnaire is important. In addition, if sufficient staff are not available to rapidly conduct interviews, agencies should request external assistance to conduct interviews. Compiling data from case-patient interviews in a central location where they can be reviewed in aggregate will facilitate recognition of suspected food items, particularly when an unusual or new food item may be involved.

7.4.4 Coordinate informational tracebacks to identify suspected vehicles and guide sampling activities. Tracing the source of food items or ingredients through distribution to source of production can be critical to identifying epidemiologic links among cases or ruling them out (Chapter 5).

Multijurisdictional investigations increase the importance of product tracing because they can triangulate among multiple distribution pathways that may link geographically dispersed cases. Thus, coordinating traceback investigation across the outbreak should be prioritized. The coordinating office (or individual) for traceback investigations should be empowered to prioritize collection, organization, and dissemination of traceback data to determine whether it converges on a common source or supplier. Because this information can be critical to identifying epidemiologic links, results should be shared, as they develop, with epidemiologists, which will enable epidemiologists to have meaningful input in exposure selection and interpretation to help guide future directions for the investigation (*5*).

Identification of a common source or supplier can facilitate sampling activities to confirm contamination of the product and the potential source of the contamination.

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7.5 Multijurisdictional Outbreak Investigation After-Action Reports and Reporting to NORS

The lead agency(ies) coordinating the investigation should hold a conference call 1–3 months after the initial investigation ends to review lessons learned and to update participants about findings, conclusions, and actions taken (Chapter 6). After the conference call, they should prepare an after-action report to summarize the effectiveness of communication and coordination among jurisdictions, identify specific gaps or problems that arose during the investigation, and communicate lessons learned regarding root cause and contributing factors.

All participating agencies should have the opportunity to review and comment on the report before it is more widely distributed. The lead agency(ies) should review after-action reports periodically to determine whether common problems regarding investigation, response, or root cause are recurring over time; this review can help with an agency's quality improvement and prevention efforts.

Individual states should report all multijurisdictional investigations to NORS. They should indicate the multijurisdictional nature of the investigation by completing appropriate data fields in the NORS report form. CDC will consolidate Individual state reports as part of a multistate outbreak report. In addition, FDA and FSIS write a summary report of each investigation in which they participated.

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Table 7.2. Multijurisdictional Outbreak Identification Methods and Required Notification steps, by Agency Level

Outbreak Identification Method	Required Notification Steps
Local level	
● Common-source outbreak identified with cases among persons who reside in other local jurisdictions.	● Notify affected jurisdictions to request assistance to contact and interview case-patients in other jurisdictions.
● Common-source outbreak identified with exposures in another jurisdiction.	● Notify the affected jurisdiction immediately.
● Common-source outbreak identified in one jurisdiction, investigation implicates food item contaminated before the point of service. ● Subcluster of illnesses associated with restaurants or food service establishments.	● Notify appropriate state and federal food regulatory agencies about probable contaminated food vehicle, or subcluster. ● Notify affected county and city health departments, state health department, and Centers for Disease Control and Prevention (CDC).
State level	
● Statewide increase identified in infections with common subtype characteristics. ● Subclusters of illnesses associated with multiple restaurants or food service establishments. ● Common-source outbreaks in multiple local jurisdictions linked by common agent, food, or water.	● Notify affected county and city health departments and CDC. ● Notify appropriate state and federal food regulatory agencies of subclusters or linked common-source outbreaks.
Federal level	
● National increase identified in infections with common subtype characteristics. ● Subclusters of illnesses associated with multiple restaurants or food service establishments in multiple states. ● Common-source outbreaks in multiple states linked by common agent, food, or water.	● Notify appropriate state and federal food regulatory agencies, and state health departments of increase in infections, subclusters, or linked common-source outbreaks.
● Food item tested positive by federal or state food regulatory agency linked to apparently sporadic infections with common subtype characteristics.	● Notify CDC, affected state health departments, and other state and federal food regulatory agencies.

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Chapter 8: Performance Metrics for Foodborne Illness Programs

Chapter Summary Points

- Evaluating the timeliness and effectiveness of surveillance, investigation, and control of foodborne illnesses and outbreaks is critical to improving these activities at the local, state, territorial, tribal, and national levels.
- Numerous programs involved in foodborne illness outbreak detection, investigation, and response have developed and routinely use metrics to assess their work and measure performance.
- The aggregation of data at state, regional, or national levels could provide a comprehensive overview of foodborne illness surveillance and control programs, rather than a system for ranking them.

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8.0 Introduction

Surveillance and investigation of foodborne illnesses and outbreaks are essential for controlling and preventing foodborne illnesses. Multiple entities—more than 3,000 local health departments; 50 state and numerous territorial and tribal health departments; and several federal agencies—interact in a complex system covering surveillance for, detection of, and response to enteric and other foodborne illnesses and outbreaks.

Evaluating the timeliness and effectiveness of surveillance, investigation, and control of foodborne illnesses and outbreaks is critical to improving these activities at all levels. Since the publication of the Second Edition of the CIFOR Guidelines, the use of performance metrics by various food-safety programs and agencies has increased. Performance metrics enable a program to assess processes and identify opportunities to improve processes. This Third Edition of the CIFOR Guidelines draws heavily on the experiences of other programs in developing and using performance metrics.

Performance metrics are commonly associated with quality improvement initiatives, including accreditation and capacity building. The types of performance metrics, and how they are developed and implemented, are often determined by the type of program or initiative in which a jurisdiction is participating. Quality improvement literature and programmatic experience has shown that

- The most meaningful performance metrics are tied directly to a program's activities;
- Metrics promote a common understanding of the key elements of foodborne illness surveillance and control activities across local, state, territorial, tribal, and federal public health agencies;
- Using a framework (like the one presented in this chapter) can save time and resources by describing what types of activities could be measured, but programs or jurisdictions will need to determine how to measure components in a way that is meaningful for their purposes;
- Process-based metrics are often easier to design and implement, whereas multifactorial outcome metrics can be more challenging;
- Evaluating performance metric data over time can enable programs or jurisdictions to evaluate the impact of changes in practice and target additional activities for ongoing improvement efforts; and
- Metrics can elucidate successes and identify gaps in the detection, investigation, prevention, and control of sporadic foodborne illnesses and outbreaks.

8.1 Purpose and Intended Use

Numerous programs involved in foodborne illness outbreak detection, investigation, and response have developed and use metrics for routine program evaluation (Table 8.1). The combined experience of these programs was used to develop the performance metrics in Table 8.2. URLs for each program's complete list of metrics are available on the CIFOR website. In addition, an updated version of the longer tables from the Second Edition of the Guidelines is included in the Appendix of the Guidelines().

The metrics are a curated list of the most important metrics that programs can use to assess their work and measure performance in activities related to surveillance, investigation, and control of foodborne illnesses and outbreaks.

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FL-DOH-20-0673-A-006218

Foodborne illness and outbreak investigations are multidisciplinary, but different agencies use staff in varying disciplines or areas of expertise to perform surveillance, investigation, and control activities. Thus, categories of environmental health, laboratory, and epidemiology are used solely for the organization of the metrics, not to suggest which staff should perform the specific duties within an agency. In other words, not every metric applies to every agency; for example, some laboratory metrics may not be relevant to local public health agencies.

Users can evaluate their performance metric data over multiple time points, when those data are available. Additionally, users can compare their data to the summary data from other programs or agencies to determine where improvements might be realistic. Neither target ranges nor participant data are intended to be used as scorecards or performance standards. Defining the level of performance expected from foodborne illness and outbreak surveillance, investigation, and control programs exceeds the scope of these Guidelines. The aggregation of data at state, regional, or national levels could provide a comprehensive overview of foodborne illness surveillance and control programs, rather than a system for ranking them.

Table 8.1. Programs with Performance Metrics

Host Agency	Program	About the Program
Centers for Disease Control and Prevention (CDC)	Foodborne Diseases Centers for Outbreak Response Enhancement (FoodCORE)	FoodCORE centers collaborate to develop new and better methods to detect, investigate, respond to, and control multistate outbreaks of foodborne illness. They focus primarily on outbreaks caused by bacteria, including *Salmonella*, Shiga toxin–producing *Escherichia coli* (STEC), and *Listeria*.
CDC	OutbreakNet Enhanced	OutbreakNet Enhanced supports local and state health departments to improve their capacity to detect, investigate, control, and respond to enteric illness outbreaks. OutbreakNet Enhanced sites collaborate with each other and CDC to share experiences and insights that help improve enteric illness outbreak response. OutbreakNet Enhanced activities focus on improving detection and rapid interviewing *Salmonella*, STEC, and *Listeria* case-patients and of persons with enteric illness caused by pathogens that demonstrate antimicrobial resistance.
CDC	National Environmental Assessment Reporting System (NEARS)	NEARS is a Web-based surveillance system that local and state health departments use to report environmental assessment data from foodborne illness outbreak investigations. NEARS helps the national food-safety system by providing critical data from environmental assessments to prevent and reduce future outbreaks.
CDC	National Outbreak Reporting System (NORS)	NORS is a Web-based platform launched in 2009. It is used by local, state, and territorial health departments to report to CDC all waterborne and foodborne illness outbreaks and enteric disease outbreaks transmitted by contact with

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		environmental sources, infected persons or animals, or unknown modes.
Food and Drug Administration (FDA)	Rapid Response Teams (RRTs)	RRTs are multiagency, multidisciplinary teams that operate using Incident Command System/National Incident Management System principles and a Unified Command structure to respond to human and animal food emergencies. RRTs are housed in food-regulatory agencies.
FDA	Voluntary National Retail Food Regulatory Program Standards (Retail Program Standards)	The Retail Program Standards define what constitutes a highly effective and responsive program for regulating food-service and retail food establishments. The Retail Program Standards are intended to reinforce proper sanitation (good retail practices) and operational and environmental prerequisite programs while encouraging regulatory agencies and industry to focus on the factors that cause and contribute to foodborne illness, with the ultimate goal of reducing the occurrence of those factors.
FDA	Manufactured Foods Regulatory Program Standards (MFRPS)	The MFRPS are a critical component in establishing the national Integrated Food Safety System. The goal of the MFRPS is to implement a nationally integrated, risk-based, food-safety system focused on protecting public health. The MFRPS establish a uniform basis for measuring and improving the performance of prevention, intervention, and response activities of manufactured food-regulatory programs. Development and implementation of the standards help state and federal programs better direct their regulatory activities toward reducing foodborne illness.
U.D. Department of Agriculture–Food Safety and Inspection Service (FSIS)	Public Health Indicators (from FSIS 2017–2021 Strategic Plan)	The mission of FSIS is to protect the public's health by ensuring the safety of meat, poultry, and processed egg products. FSIS has developed plans and resources to strengthen collaborative relationships with outbreak investigation partners.

8.2 Performance Metrics

The remainder of this chapter focuses on Table 8.2, which includes 21 metrics organized by discipline: environmental health, epidemiology, and laboratory. As noted above, the disciplines listed are for organizational purposes, not to suggest which staff should conduct certain portions of outbreak investigations. Within the epidemiology section, metrics are grouped by investigations typically initiated from laboratory surveillance data and investigations typically initiated from complaint data (see Chapter 4).

Details on calculating a particular metric are available on the websites of the programs that produced the metrics, as are other metrics from these groups that might be relevant to their programs. The original source metrics also may provide additional instructions, summary data from implementation of

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the metrics, and examples of how the metrics have been used to guide planning and evaluation activities.

Agencies that frequently use metrics (Table 8.1) have extensive metrics but do not capture every component of foodborne illness surveillance and control programs. Table 8.3 presents additional metrics that are not currently available from the referenced programs but may be valuable for agencies to examine. Because these metrics are not routinely collected by programs, users may need to create standardized definitions to calculate the metrics.

Table 8.2. Foodborne Illness Performance Metrics from Existing Programs

Category	Performance Metric	Source of Metric
Environmental health	The program maintains logs or databases for all complaint or referral reports from other sources alleging food-related illness, food-related injury, or unintentional food contamination. The final disposition for each complaint is recorded in the database or log and is filed in, or linked to, the establishment record for retrieval purposes.	Voluntary National Retail Food Regulatory Program Standards, https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/ProgramStandards/ucm245409.htm
	Percentage of outbreak investigations that included an environmental assessment.	National Environmental Assessment Reporting System (NEARS), https://www.cdc.gov/nceh/ehs/nears/resources.htm
	Percentage of outbreak investigations that identified a contributing factor.	NEARS, https://www.cdc.gov/nceh/ehs/nears/resources.htm
	Average number of days between date the outbreak establishment was identified for an environmental assessment and date of the establishment observation.	NEARS, https://www.cdc.gov/nceh/ehs/nears/resources.htm
	Percentage of traceback investigations that successfully result in identification of an implicated food.	Rapid Response Teams (RRTs), https://www.fda.gov/ForFederalStateandLocalOfficials/ProgramsInitiatives/ucm475021.htm#Manual
	Percentage of outbreaks reported to NEARS.	NEARS, https://www.cdc.gov/nceh/ehs/nears/resources.htm
Epidemiology	Percentage of confirmed cases with exposure history obtained for *Salmonella*, Shiga toxin–producing *Escherichia coli* (STEC), and *Listeria*.	Foodborne Diseases Centers for Outbreak Response Enhancement (FoodCORE), https://www.cdc.gov/foodcore/metrics/ssl-metrics.html OutbreakNet Enhanced (OBNE), https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html

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	Time from case report to first interview attempt for *Salmonella*, STEC, and *Listeria* cases.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html
	Number and percentage of *Salmonella*, STEC, and *Listeria* investigations with supplemental or targeted interviewing of case-patients.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html
	Number and percentage of *Salmonella*, STEC, and *Listeria* investigations for which an analytic epidemiologic study was conducted.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html
	Number and percentage of *Salmonella*, STEC, and *Listeria* investigations with *suspected* vehicle/source identified.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html
	Number and percentage of *Salmonella*, STEC, and *Listeria* investigations with *confirmed* vehicle/source identified.	OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html
	Number and percentage of all investigations with clinical specimens collected and submitted to any laboratory (public health or clinical).	FoodCORE https://www.cdc.gov/foodcore/metrics/nou-metrics.html
	Number and percentage of foodborne or point-source investigations with *suspected* vehicle/source identified.	FoodCORE, https://www.cdc.gov/foodcore/metrics/nou-metrics.html
	Number and percentage of foodborne or point-source investigations with *confirmed* vehicle/source identified.	
	Number and percentage of outbreaks for which National Outbreak Reporting System form was completed.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html
Laboratory	Time from isolation/isolate-yielding *Salmonella*, STEC, or *Listeria* specimen collection to receipt at public health laboratory.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html
	Time from *Salmonella* or STEC isolate receipt (or	FoodCORE,

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recovery) at public health laboratory to serotype result (not applicable for *Listeria*).	https://www.cdc.gov/foodcore/metrics/ssl-metrics.html
Percentage of primary *Salmonella*, STEC, and *Listeria* isolates with pulsed-field gel electrophoresis (PFGE) results.	FoodCORE https://www.cdc.gov/foodcore/metrics/ssl-metrics.html
Percentage of primary *Salmonella*, STEC, and *Listeria* isolates with whole-genome sequencing results.	OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html
Time from *Salmonella*, STEC, and *Listeria* isolate receipt (or recovery) at public health laboratory to PFGE upload to PulseNet.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html
Time from *Salmonella*, STEC, and *Listeria* isolate receipt (or recovery) at public health laboratory to sharing of whole-genome sequences with national database.	FoodCORE, https://www.cdc.gov/foodcore/metrics/ssl-metrics.html OBNE, https://www.cdc.gov/foodsafety/outbreaknetenhanced/metrics.html

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Table 8.3. Additional Performance Metrics to Assess Response Effectiveness

Category	Performance Metric
Environmental health	Program maintenance of complaint data in an electronic manner that can be queried. Number of complaints received and rate of complaints per 100,000 population in the jurisdiction. Number of outbreaks detected from complaints and rate of outbreaks per 1,000 complaints. Percentage of investigations reported to federal regulatory agencies within 72 hours after the suspected vehicle is identified. Median number of days from initiation of investigations to implementation of control measures
Epidemiology	Median number of days from initiation of *Salmonella*, Shiga toxin–producing *Escherichia coli* (STEC), and *Listeria* investigations to identification of source Foodborne illness outbreak rate: number of foodborne outbreaks reported (all agents) per 1,000,000 population. Number of foodborne outbreaks reported (*Salmonella*, STEC, and *Listeria*) per 1,000 cases Percentage of outbreaks for which etiology is identified.
Laboratory	Number and percentage of *Salmonella*, STEC, and *Listeria* isolates/clinical specimens submitted to the public health laboratory from cases diagnosed by culture-independent diagnostic testing at the clinical laboratory. Percentage recovery of *Salmonella* and STEC isolates from culture-independent diagnostic test positive specimens received at the public hHealth Laboratory.

**Add accompanying table on CIFOR website with direct links to each metric source, including available data from program.

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From: Blackmore, Carina
To: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR)
Subject: Re: Tim Doyle will be on Board with CPR/DSLR effective Sunday and should be reporting to FL next week
Date: Thursday, February 27, 2020 3:26:37 PM

Hi Hugh. Delighted to see the news about Dr Philip. Have great respect for her. Drs B and D also seem to be skilled, thoughtful, practical and personable people.
Yes We are very excited to have Tim on boa d next week and expect to immediately plug him in to our Corona response effort. Not a day too soon! Carina

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From: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR) <hmm2@cdc.gov>
Sent: Thursday, February 27, 2020 1:20:54 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Tim Doyle will be on Board with CPR/DSLR effective Sunday and should be reporting to FL next week

Hi Carina-
Tim is on his way to you.
On the information exchange side and not related to COVID 19- we just received the following note from Dr Redfield….
With the addition of Dr Philip, there are an increasing number of former senior state health officials joining CDC at executive ranks. This now includes Dr Butler from Alaska, Dr Dreyzhner from Tennessee, Dr Montero from New Hampshire. This may mark a new trend toward increased responsiveness to the public health issues and priorities of SLTT jurisdictions.
Cheers

Hugh

I am pleased to announce that **Celeste Philip, MD, MPH**, has been selected as CDC's Deputy Director for Non-Infectious Diseases.

Dr. Philip brings a wealth of public health management, knowledge, and experience as a physician to the agency. She most recently served as Health Officer for the Sonoma County Department of Health Services in Santa Rosa, California, where she oversaw the public health division during a period of unprecedented response efforts, including the Kincade Fire, numerous public safety power shut-offs, and health service provisions for a large number of people experiencing homelessness. Previously, she was appointed by the Governor of Florida to serve as Florida's Surgeon General and Secretary of Health from 2016-2018. In this role, she managed a $3 billion budget and more than 13,000 full-time employees. She led the state-wide response to the Zika virus; directed the state's Emergency Support Function—Public Health and Medical Services (ESF8)—during five hurricanes, including Irma (2017) and Michael (2018); and guided the redesign of the state's HIV program to provide pre-exposure prophylaxis (PrEP) in all 67 counties. From 2013-2016, Dr. Philip served as Florida's Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services. During her tenure, she brokered the negotiation of settlement terms to end 10 years of litigation

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against the State of Florida over Title XIX; the settlement helped to build bridges and led to statewide collaborations on immunizations, mental health, adverse childhood experiences, and opioid policy with clinician groups.

Her professional training includes serving as an EIS Officer from 2006-2008, with the Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion; and completing CDC's Preventive Medicine Residency as a Lieutenant Commander in the US Public Health Service with the Florida Department of Health in Polk County (Bartow, Florida).

Dr. Philip received a bachelor's degree from Howard University (magna cum laude), and both a Master of Public Health degree in maternal and child health and a Doctor of Medicine degree from Loma Linda University in California. She is certified by the American Board of Preventive Medicine and the American Board of Family Medicine and holds medical licenses in both Florida and California.

Dr. Philip has been recognized as the Loma Linda University School of Public Health Alumnus of the Year, the Florida Outstanding Woman in Public Health by the University of South Florida, and as a Trustee Scholar by Howard University. She has also received the American Cancer Society's Southeast Region Impact Award, an Outstanding Unit Citation for CDC's H1N1 response, the MacKenzie Foundation Award, the Selma Andrews Award in Public Health, and both the Special Act or Service Award and the On the Spot Award from the National Library of Medicine.

She has also given numerous public health presentations, published medical journal articles, and served on many boards, advisory councils, and volunteer positions over the course of her career.

Please join me in welcoming Dr. Philip as she returns to CDC in her new role, starting March 30, 2020, as Deputy Director for Non-Infectious Diseases.

I would also like to express my gratitude to both Anne Schuchat, MD (RADM, USPHS, RET) and Ileana Arias, PhD for serving as Acting Deputy Director for Non-Infectious Diseases. Thank you both for supporting our mission to see the possible in public health.

Sincerely,

Robert R. Redfield, MD
Director, CDC, and
Administrator, ATSDR

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From: Blackmore, Carina
To: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR)
Cc: Pritchard, Scott; Rubino, Heather
Subject: RE: Tim"s email
Date: Monday, February 17, 2020 6:20:40 PM

Thanks Hugh. Hope you had a good trip.

Carina

From: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR) <hmm2@cdc.gov>
Sent: Monday, February 17, 2020 6:17 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Re: Tim's email

Hi Carina
Just coming back from leave. My understanding is that Tim is starting a few transition weeks with our FSB team getting oriented to the CEFO program and also supporting the corona virus state coordination task force. When I departed on Feb 10, He was still slated to start with you on March 1- but will hopefully have a good understanding of State issues and priorities related to recent corona virus events.
Hugh

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Monday, February 17, 2020 8:40:43 AM
To: Mainzer, Hugh (CDC/DDPHSIS/CPR/DSLR) <hmm2@cdc.gov>
Cc: Pritchard, Scott <Scott.Pritchard@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: FW: Tim's email

Hi Hugh, is Tim deployed? Will that affect his start date with us?

From: Doyle, Tim (CDC/DDPHSIS/CGH/DGHP) <tcd2@cdc.gov>
Sent: Monday, February 17, 2020 8:38 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Subject: Automatic reply: Tim's email

I will be out of the office indefinitely, on response related issues.
For DGHP ADS clearance related issues, please contact Curtis Blanton (cgb9@cdc.gov) or David Scharf (zuc1@cdc.gov).

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From: Cooksey, Samantha
To: eocsctftfcoord@cdc.gov
Cc: Coulter, Jennifer; Luce, Christie; Blackmore, Carina; Rubino, Heather
Subject: RE: Time Sensitive Request – Verification for DCIPHER User Access for 2019-nCoV (Florida)
Date: Friday, February 7, 2020 3:54:33 PM

No Florida DCIPHER users need access to the 2019-nCov reporting database.

Please refer any additional questions regarding reporting of Movement & Monitoring data to Heather Rubino in our Bureau of Epidemiology. She is copied on this email. Her phone number is (850) 901-6940.

Thank you.

Samantha Cooksey Strickland
State ESF8 Planning & Operations Section Manager
Bureau of Preparedness & Response
Florida Department of Health
Office | 850.617.1506
Mobile | 850.251.2553
Email| Samantha.Cooksey@flhealth.gov

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Thursday, February 6, 2020 1:14 PM
To: Luce, Christie <Christie.Luce@flhealth.gov>
Cc: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>; Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>
Subject: Time Sensitive Request – Verification for DCIPHER User Access for 2019-nCoV (Florida)

Good Morning,

In preparation for data entry regarding 2019-nCoV Movement and Monitoring for EpiX notification of travelers, we are providing you a list of people currently credentialed for DCIPHER in your jurisdiction.

Please review the names below and indicate in the column labeled **Grant access to 2019-nCoV** those people you want to access the 2019 nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

Current DCIPHER Users

OrgState	First Name	Last Name	Email Address	OrgName	Grant access to 2019-nCoV
Florida	Ruth	Adams	Ruth.Adams@flhealth.gov	Florida Department of Health	
Florida	Stephanie	Anspaugh-Naples	stephanie.anspaugh-naples@flhealth.gov	Florida Department of Health	
Florida	Sebastian	Arenas	Sebastian.Arenas@flhealth.gov	Florida Department of Health	
Florida	Elizabeth	Beshearse	elizabeth.beshearse@flhealth.gov	Florida Department of Health	
Florida	Dean	Bodager	Dean.Bodager@flhealth.gov	Florida Department of Health	
Florida	Laura	Castro	laura.castro@flhealth.gov	Florida Department of Health	
Florida	Oscar	Celorio	Oscar.Celorio@flhealth.gov	Florida Department of Health	
Florida	Georgianne	Cherry	Georgianne.Cherry@flhealth.gov	Florida Department of Health	
Florida	Peter	Chirinos	peter.chirinos@flhealth.gov	Florida Department of Health in Palm Beach County	
Florida	Deborah	Collinge	deborah.collinge@FLHealth.gov	Orange County Health Department	
Florida	Kevan	Cook	Kevan.Cook@flhealth.gov	Florida Department of Health	
Florida	Jennifer	Coulter	jennifer.coulter@flhealth.gov	Florida Department of Health, Bureau of Preparedness and	

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				Resposne	
Florida	Jenny	Crain	jenny.crain@flhealth.gov	Florida State Department of Health	
Florida	Jason	Crowe	jason.crowe@fdacs.gov	Florida Department of Agriculture and Consumer Services	
Florida	Jamie	DeMent	Jamie.DeMent@flhealth.gov	Florida Department of Health	
Florida	Nychie	Dotson	nychie.dotson@flhealth.gov	Florida Department of Health	
Florida	Philip	Dulmage	philip.dulmage@flhealth.gov	Florida Department of Health	
Florida	Timothy	Exline	timothy.exline@flhealth.gov	Florida Department of Health	
Florida	Paul	Fiorella	paul.fiorella@flhealth.gov	Florida Dept of Health	
Florida	Scott	Fryberger	scott.fryberger@flhealth.gov	Florida Department of Health-Seminole County	
Florida	Teresa	Gorden	Teresa.Gorden@flhealth.gov	Florida Department of Health	
Florida	Gayle	Guidash	Gayle.Guidash@flhealth.gov	Department of Health in Pinellas	
Florida	Ashley	Hoskins	Ashley.Hoskins@flhealth.gov	Florida Department of Health	
Florida	Brandi	Keels	brandi.keels@flhealth.gov	Florida Department of Health	
Florida	Nicole	Kikuchi	Nicole.Kikuchi@flhealth.gov	Florida Department of Health	
Florida	Kamal	King	Kamal.King@flhealth.gov	Broward Department of Health	
Florida	Lea	Knezevich	Lea.knezevich@flhealth.gov	Florida Department of Health In Hernando County	
Florida	Shamilla	Lutchman	shamilla.lutchman@flhealth.gov	Florida Department of Health	
Florida	Christie	Mathison	Christie.Mathison@flhealth.gov	Florida Department of Health	
Florida	Nina	Mattei	nina.mattei@flhealth.gov	Florida Department of Health in Hernando County	
Florida	Katherine	McCombs	katherine.mccombs@vdh.virginia.gov	FL Department of Health	
Florida	Rafael	Mendoza	Rafael.Mendoza@flhealth.gov	Florida Department of Health - Broward County	
Florida	Megan	Milanese	Megan.Milanese@flhealth.gov	Florida Department of Health in Lake County	
Florida	Denita	Mitchell	denita.mitchell@flhealth.gov	Florida Department of Health	
Florida	Sasha	Nelson	Sasha.Nelson@flhealth.gov	Florida Department of Health	
Florida	Ihab	Osman	Ihab.Osman@FLHealth.gov	Florida Department of Health	
Florida	Aaron	Otis	aaron.otis@flhealth.gov	Centers for Disease Control and Prevention	
Florida	Noemi	Padro	Noemi.Padro@flhealth.gov	Florida Department of Health - Hillsborough	
Florida	Ryan	Pedigo	Ryan.Pedigo@flhealth.gov	FL DOH - Hillsborough	
Florida	William	Ritten	William.Ritten@flhealth.gov	Department of Health in Lake County	
Florida	Jordan	Snead	Jordan.Snead@flhealth.gov	Florida Department of Health Pasco County	
Florida	Kimberly	Stockdale	Kimberly.Stockdale@flhealth.gov	FL Department of Health	
Florida	Natasha	Strokin	Natasha.Strokin@flhealth.gov	Florida Department of Health in Miami-Dade	
Florida	Terri	Sudden	Terri.Sudden@flhealth.gov	Florida Department of Health in Broward	
Florida	Gastrude	Tassy Toussaint	Gastrude.Tassy-Toussaint@flhealth.gov	Florida Department of Health in Miami-Dade	
				Florida Department of Health	

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Florida	Samantha	Taylor	samantha.taylor@flhealth.gov	- Seminole County	
Florida	Mackenzie	Tewell	Mackenzie.Tewell@azdhs.gov	Florida Department of Health in Hillsborough County	
Florida	James	Turchetta	James.Turchetta@flhealth.gov	Florida Department of Health in Broward County	
Florida	Ana	Urueta	Ana.Urueta@flhealth.gov	Florida Department of Health in Pinellas County	
Florida	Kaila	Yeager	Kaila.Yeager@flhealth.gov	Florida Department of Health in Pinellas County	

If you would like to add additional designees to access 2019-nCoV data, we need to know **ASAP.** At present, staff who are not currently credentialed would have to go through the verification process, in order to be granted access to the system. **Provide the names and emails (in the table below) that you would like to add, and we will initiate the process with our IT team**. Correspondence will follow providing a timeline for the verification process for all new designees.

Staff that need to be added to DCIPHER		
First Name	**Last Name**	**Email Address**

More information will be shared on today's 1:00 p.m. EST call, to discuss "Data Reporting to CDC & Supply Conservation Strategies for PHEP Directors & State Epidemiologists".

For additional questions, please email the State Coordination Task Force (SCTF) regional desk at eocsctftfcoord@cdc.gov.

Thank you for expeditiously fulfilling this time-sensitive request.

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

404-232-0480

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Blackmore, Carina (CDC flhealth.gov); Luce, Christie
Cc:	Coulter, Jennifer; Rubino, Heather; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Tuesday, February 18, 2020 5:37:02 PM

Thanks. We are still gathering information from each state, and will reach out to you soon to discuss how you could send the data in an aggregate form.

Thanks again!

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

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Tuesday, February 18, 2020 4:25 PM
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>; Luce, Christie <Christie.Luce@flhealth.gov>
Cc: Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: RE: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Per previous conversations, we will not be using DCIPHER. Case data will be sent through NNDSS. We can discuss how to send monitoring data in an aggregate form.

Carina

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Saturday, February 15, 2020 11:24 AM
To: Luce, Christie <Christie.Luce@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

We are following up with the request below. Once we have received your submission access will be granted for 2019-nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

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As a reminder, please consult with your state Epi and state Lab counterparts to ensure we provide access to all staff in your jurisdiction that might need to enter data for various aspects of the response.

If you have any questions please contact eocsctftfcoord@cdc.gov.

Thank you,

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

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Sent: Wednesday, February 12, 2020 4:41 PM
To: Christie.Luce@flhealth.gov <Christie.Luce@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: jennifer.coulter@flhealth.gov <jennifer.coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

As we prepare to use DCIPHER for the 2019-nCoV response (e.g., data collection, transmission, and data sharing), we are seeking additional information about the type of access for the users you previously identified for the nCoV 2019 DCIPHER platform.

The "access group" options are described here:

1. **Access to DCIPHER to VIEW (only) data**. Role allows individual to see a view of different reports and analyses for their jurisdiction's information and any aggregate national report that may be created.
2. **Access to DCIPHER for DATA ENTRY and EDITING**. Role allows individual to directly enter information into DCIPHER, edit data, see all data associated with the jurisdiction, in addition to viewing/creating different reports and analyses.

In the attachment, please complete information in the last two columns (epi and monitoring), select either **view** or **data entry/editing** for each user.

Please return your response to eocsctftfcoord@cdc.gov as soon as possible so we can configure the platform to support your jurisdictions' access requests.

Warm Regards,
State Coordination Task Force (SCTF)
Regional Coordination Team - eocsctftfcoord@cdc.gov

AMERICAN OVERSIGHT

Center for Preparedness and Response (CPR)
404-232-0480

AMERICAN OVERSIGHT

From:	Blackmore, Carina
To:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; Luce, Christie
Cc:	Coulter, Jennifer; Rubino, Heather
Subject:	RE: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Tuesday, February 18, 2020 4:25:48 PM

Per previous conversations, we will not be using DCIPHER. Case data will be sent through NNDSS. We can discuss how to send monitoring data in an aggregate form.

Carina

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Saturday, February 15, 2020 11:24 AM
To: Luce, Christie <Christie.Luce@flhealth.gov>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Coulter, Jennifer <Jennifer.Coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

Greetings PHEP Directors and State Epidemiologists,

We are following up with the request below. Once we have received your submission access will be granted for 2019-nCoV database. Please respond as soon as possible, your information is necessary to grant access. We will use your response to **turn on access** for the designated staff.

As a reminder, please consult with your state Epi and state Lab counterparts to ensure we provide access to all staff in your jurisdiction that might need to enter data for various aspects of the response.

If you have any questions please contact eocsctftfcoord@cdc.gov.

Thank you,

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

AMERICAN OVERSIGHT

404-232-0480

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Sent: Wednesday, February 12, 2020 4:41 PM
To: Christie.Luce@flhealth.gov <Christie.Luce@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: jennifer.coulter@flhealth.gov <jennifer.coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Subject: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)

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State Coordination Task Force (SCTF)

AMERICAN OVERSIGHT

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

404-232-0480

AMERICAN OVERSIGHT

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To: Christie.Luce@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Cc: jennifer.coulter@flhealth.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject: Re: Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date: Saturday, February 15, 2020 11:24:11 AM
Attachments: Florida.xlsx

Greetings PHEP Directors and State Epidemiologists,

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If you have any questions please contact eocsctftfcoord@cdc.gov.

Thank you,

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

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Sent: Wednesday, February 12, 2020 4:41 PM
To: Christie.Luce@flhealth.gov <Christie.Luce@flhealth.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: jennifer.coulter@flhealth.gov <jennifer.coulter@flhealth.gov>; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
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State Coordination Task Force (SCTF)
Regional Coordination Team - eocsctftfcoord@cdc.gov
Center for Preparedness and Response (CPR)
404-232-0480

AMERICAN OVERSIGHT

	A	B	C	D	E	F
1	OrgState	First Name	Last Name	Email Address	OrgName	Access Granted to 2019-nCoV
2	Florida	Ruth	Adams	Ruth.Adams@flhealth.gov	Florida Department of Health	No
3	Florida	Stephanie	Anspaugh-Naples	stephanie.anspaugh-naples@flhealth.gov	Florida Department of Health	No
4	Florida	Sebastian	Arenas	Sebastian.Arenas@flhealth.gov	Florida Department of Health	No
5	Florida	Elizabeth	Beshearse	elizabeth.beshearse@flhealth.gov	Florida Department of Health	No
6	Florida	Dean	Bodager	Dean.Bodager@flhealth.gov	Florida Department of Health	No
7	Florida	Laura	Castro	laura.castro@flhealth.gov	Florida Department of Health	No
8	Florida	Oscar	Celorio	Oscar.Celorio@flhealth.gov	Florida Department of Health	No
9	Florida	Georgianne	Cherry	Georgianne.Cherry@flhealth.gov	Florida Department of Health	No
10	Florida	Peter	Chirinos	peter.chirinos@flhealth.gov	Florida Department of Health in Palm Beach County	No
11	Florida	Deborah	Collinge	deborah.collinge@FLHealth.gov	Orange County Health Department	No
12	Florida	Kevan	Cook	Kevan.Cook@flhealth.gov	Florida Department of Health	No
13	Florida	Jennifer	Coulter	jennifer.coulter@flhealth.gov	Florida Department of Health, Bureau of Preparedness and Resposne	No
14	Florida	Jenny	Crain	jenny.crain@flhealth.gov	Florida State Department of Health	No
15	Florida	Jason	Crowe	jason.crowe@fdacs.gov	Florida Department of Agriculture and Consumer Services	No
16	Florida	Jamie	DeMent	Jamie.DeMent@flhealth.gov	Florida Department of Health	No
17	Florida	Nychie	Dotson	nychie.dotson@flhealth.gov	Florida Department of Health	No
18	Florida	Philip	Dulmage	philip.dulmage@flhealth.gov	Florida Department of Health	No
19	Florida	Timothy	Exline	timothy.exline@flhealth.gov	Florida Department of Health	No
20	Florida	Paul	Fiorella	paul.fiorella@flhealth.gov	Florida Dept of Health	No
21	Florida	Scott	Fryberger	scott.fryberger@flhealth.gov	Florida Department of Health-Seminole County	No
22	Florida	Teresa	Gorden	Teresa.Gorden@flhealth.gov	Florida Department of Health	No
23	Florida	Gayle	Guidash	Gayle.Guidash@flhealth.gov	Department of Health in Pinellas	No
24	Florida	Ashley	Hoskins	Ashley.Hoskins@flhealth.gov	Florida Department of Health	No
25	Florida	Brandi	Keels	brandi.keels@flhealth.gov	Florida Department of Health	No
26	Florida	Nicole	Kikuchi	Nicole.Kikuchi@flhealth.gov	Florida Department of Health	No
27	Florida	Kamal	King	Kamal.King@flhealth.gov	Broward Department of Health	No
28	Florida	Lea	Knezevich	Lea.knezevich@flhealth.gov	Florida Department of Health In Hernando County	No
29	Florida	Shamilla	Lutchman	shamilla.lutchman@flhealth.gov	Florida Department of Health	No
30	Florida	Christie	Mathison	Christie.Mathison@flhealth.gov	Florida Department of Health	No
31	Florida	Nina	Mattei	nina.mattei@flhealth.gov	Florida Department of Health in Hernando County	No
32	Florida	Katherine	McCombs	katherine.mccombs@vdh.virginia.gov	FL Department of Health	No
33	Florida	Rafael	Mendoza	Rafael.Mendoza@flhealth.gov	Florida Department of Health - Broward County	No
34	Florida	Megan	Milanese	Megan.Milanese@flhealth.gov	Florida Department of Health in Lake County	No
35	Florida	Denita	Mitchell	denita.mitchell@flhealth.gov	Florida Department of Health	No
36	Florida	Sasha	Nelson	Sasha.Nelson@flhealth.gov	Florida Department of Health	No
37	Florida	Ihab	Osman	Ihab.Osman@FLHealth.gov	Florida Department of Health	No
38	Florida	Aaron	Otis	aaron.otis@flhealth.gov	Centers for Disease Control and Prevention	No
39	Florida	Noemi	Padro	Noemi.Padro@flhealth.gov	Florida Department of Health - Hillsborough	No
40	Florida	Ryan	Pedigo	Ryan.Pedigo@flhealth.gov	FL DOH - Hillsborough	No
41	Florida	William	Ritten	William.Ritten@flhealth.gov	Department of Health in Lake County	No
42	Florida	Jordan	Snead	Jordan.Snead@flhealth.gov	Florida Department of Health Pasco County	No
43	Florida	Kimberly	Stockdale	Kimberly.Stockdale@flhealth.gov	FL Department of Health	No

AMERICAN OVERSIGHT

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1	Epi Forms	Movement and Monitoring Form
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AMERICAN OVERSIGHT

	A	B	C	D	E	F
44	Florida	Natasha	Strokin	Natasha.Strokin@flhealth.gov	Florida Department of Health in Miami-Dade	No
45	Florida	Terri	Sudden	Terri.Sudden@flhealth.gov	Florida Department of Health in Broward	No
46	Florida	Gastrude	Tassy Toussaint	Gastrude.Tassy-Toussaint@flhealth.gov	Florida Department of Health in Miami-Dade	No
47	Florida	Samantha	Taylor	samantha.taylor@flhealth.gov	Florida Department of Health - Seminole County	No
48	Florida	Mackenzie	Tewell	Mackenzie.Tewell@azdhs.gov	Florida Department of Health in Hillsborough County	No
49	Florida	James	Turchetta	James.Turchetta@flhealth.gov	Florida Department of Health in Broward County	No
50	Florida	Ana	Urueta	Ana.Urueta@flhealth.gov	Florida Department of Health in Pinellas County	No
51	Florida	Kaila	Yeager	Kaila.Yeager@flhealth.gov	Florida Department of Health in Pinellas County	No

AMERICAN OVERSIGHT

From:	Pritchard, Scott
To:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
Cc:	Kabbani, Sarah (CDC/DDID/NCEZID/DHQP); Vallabhaneni, Snigdha (CDC/DDID/NCEZID/DHQP); Blackmore, Carina; Dotson, Nychie
Subject:	RE: Updated IPC Guidance
Date:	Tuesday, March 10, 2020 5:03:54 PM

Thanks for the update!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: Soda, Elizabeth (CDC/DDID/NCEZID/DHQP) <lxn9@cdc.gov>
Sent: Tuesday, March 10, 2020 4:42 PM
To: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Cc: Kabbani, Sarah (CDC/DDID/NCEZID/DHQP) <nfq8@cdc.gov>; Vallabhaneni, Snigdha (CDC/DDID/NCEZID/DHQP) <fco6@cdc.gov>
Subject: Updated IPC Guidance

Hi Scott,

The new **Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings** has been released and can be found at this link: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Biggest changes to highlight:

1. **PPE recommendations:**
    a. Based upon local and regional supplies, facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to healthcare personnel (HCP). When the supply chain has been restored, facilities should return to the use of respirators.
    b. Eye protection, gloves, and gowns continue to be recommended. If gown shortages are experienced, they should be for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Additional guidance is given regarding how to extend the use of respirators, facemasks, and eye protection as well on PPE shortages.
    c. Increased emphasis on the implementation of early source control measures such as putting a facemask on patients presenting with symptoms of respiratory infection.
2. **Rooming:**

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a. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.
b. Patients with known or suspected COVID-19 can be cared for in a single-person room with the door closed.
c. Facilities could consider designating entire units with dedicated HCP to care for those with known or suspected HCP which will also help facilitate the extended use of respirators, facemasks, and eye protection.

3. **Additional consideration during times of wide spread community transmission:** Additional language regarding this has been added under the minimizing exposure and visitor sections.

Always happy to chat.

Best,
Elizabeth

AMERICAN OVERSIGHT

From: Barnett - CDPHE, Aislinn
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Cc: Patricia Vinson (CDC/pdph.state.al.us); heidi.hedberg@alaska.gov; Ulagalelei, Eli (CDC/doh.as); Snyder, Wendy (CDC/azdhs.gov); Ferguson, Reva (CDC/arkansas.gov); rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC/cdph.ca.gov); Jensen, Dana (CDC/ct.gov); richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@ihealth.gov; angelica.mcgrier@dph.ga.gov; fanny.vasquez@dph.ga.gov; Solomon, Fancy (CDC/fsmhealth.fm); Kaneshiro, Suzanne (CDC/dphss.guam.gov); Sharon.Tangonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Oluwaseun.Oyeniran@illinois.gov; Musgrave, Shirely (CDC/illinois.gov); Barrett, Tami (CDC/isdh.in.gov); Caskey, Jennifer (CDC/idph.iowa.gov); Denise.Schimmel@ks.gov; ccanfieldsmither@ky.gov; Jane.Killen2@la.gov; Lawrence, Peggie (CDC/maine.gov); lacey.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benyenga@maryland.gov; rebecca.white@state.ma.us; Egelski@michigan.gov; Rizzuti, Sandy (CDC/state.mn.us); Griffin, Jenny (CDC/msdh.ms.gov); Mebruer, Debbie (CDC/health.mo.gov); kacech@mt.gov; Kellie.Richetti@mt.gov; Engel, Bonnie (CDC/nebraska.gov); Magen.Schachtal@nebraska.gov; jpfilippi@health.nv.gov; Bogert, Kelly (CDC/dhhs.nh.gov); White, Barbara (CDC/dhhs.nh.gov); deanna.morris@doh.nj.gov; Soliz, Angela (CDC/state.nm.us); jacki.silvia@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guerrero, Janet (CDC/doh.gov.mp); Ashley.Wilson@odh.ohio.gov; mdaneh@health.ok.gov; Nist, Patricia (CDC/state.or.us); tbarnettno@pa.gov; pbeene@pa.gov; Byrnes, Carolyn (CDC/pa.gov); lalie.ikluk@palauhealth.org; marlinelopeak@gmail.com; Menard, Rita (CDC/health.ri.gov); Higgins, Teresa (CDC/dhec.sc.gov); Harding, Monica (CDC/state.sd.us); Stanton, Tammy (CDC/in.gov); carolyn.geter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idhelsh@doh.vi.gov; McFarlane, Lesa (CDC/doh.vi.gov); tesha.plunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC/vermont.gov); Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC/doh.wa.gov); Fisher, Andrea (CDC/wv.gov); tara.vasby@dhs.wisconsin.gov; Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Moluaa Tulleama (CDC/doh.as); Christ, Cara (CDC/azdhs.gov); Smith, Nathaniel (CDC/arkansas.gov); Sonia.angell@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC/ct.gov); karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC/dc.gov); scott.rivkees@ihealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; Linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Clabaugh, Gerd (CDC/idph.iowa.gov); lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; niray.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC/state.ma.us); Khaldun,Jl@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; shellahogan@mt.gov; Gholzman@mt.gov; dennette.smith@nebraska.gov; gary.anthone@nebraska.gov; Lahanych@health.ny.gov; jazzam@health.ny.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC/health.ny.gov); mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; malynntufte@nd.gov; Mufa, Esther (CDC/doh.gov.mp); amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC/state.or.us); ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; emais.roberts@palauhealth.org; bbillmon@hotmail.com; Alexander-Scott, Nicole (CDC/health.ri.gov); rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC/state.sd.us); Lisa.Piercey@tn.gov; Hellerstedt, John (CDC/dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC/utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC/doh.wa.gov); cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexis (CDC/wyo.gov); Montero, Jose (CDC/DOPHS/CSTLTS/OD); marcus.plescia@ASTHO.com
Subject: Re: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)
Date: Monday, March 2, 2020 4:33:30 PM

Hello,
Our top health official remains the same.

We do have our Chief Medical Officer on board now.
CO, Eric France, MD, Chief Medical Officer, 720-651-1137, eric.france@state.co.us, Amber Beren, 303-692-2614, amber.beren@state.co.us.

Aislinn Barnett, MS
Executive Assistant, Jill Hunsaker Ryan - Executive Director
Executive Assistant, Karin McGowan - Deputy Executive Director/Director of Community Relations

4300 Cherry Creek Drive South, Denver, CO 80246 | Ph: 303-880-0764
aislinn.barnett@state.co.us | www.colorado.gov/cdphe
Your feedback is important to us! Please let us know how I am doing.

On Mon, Mar 2, 2020 at 9:39 AM CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov> wrote:

> Good Morning,
>
> CDC Incident Management has asked the State Coordination Task Force for contact information of the **top health official** in each jurisdiction to expedite outreach in the event of an emergencies and to provide COVID-19 updates as expeditiously as possible. To accomplish this task, I am reaching out to the SHO/THO Assistant with a cc to the SHO/THO. This information will be used in tandem with the information we have for the SHO/THO maintained by ASTHO. You all are in a great position to assist us!
>
> We know that in many cases the top health official is the SHO/THO. If that case is , just **reply** to this email that they are the **same**.
>
> For those where there is a person who is more senior to the SHO/THO (as a reminder, we are looking for the most senior health official), please complete the following information:

State/Territory	Highest Health Official (i.e. Commissioner/ Minister/Secretary) Name (including degrees as appropriate)	Title	Phone Number (Please provide a **number or** numbers where we can reach out ***after hour*** should the need arise for COVID-19)	Email	Executive Assistant Name	Phone Number	Email

> Due to the nature of this **urgent request**, respond by **COB today**.
>
> Thank you so much for your assistance.
>
> If you have questions or concerns, please contact me.
>
> *Kimberly*
>
> Kimberly Cantrell
>
> State Coordination Task Force
>
> c: 404-232-0480
>
> SCTF: comssctftfcoord@cdc.gov

AMERICAN OVERSIGHT

From: Lalie Ikluk
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; Patricia Vinson (CDC adph.state.al.us); heidi.hedberg@alaska.gov; Uiagalelei, Eti (CDC doh.as); Snyder, Wendy (CDC azdhs.gov); Ferguson, Reva (CDC arkansas.gov); rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC cdph.ca.gov); aislinn.barnett@state.co.us; Jensen, Dana (CDC ct.gov); richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@flhealth.gov; angelica.mcgrier@dph.ga.gov; Solomon, Fancy (CDC fsmhealth.fm); Kaneshiro, Suzanne (CDC dphss.guam.gov); Sharon.Tangonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Oluwaseun.Oyeniran@illinois.gov; Musgrave, Shirely (CDC illinois.gov); Barrett, Tami (CDC isdh.in.gov); Caskey, Jennifer (CDC idph.iowa.gov); Denise.Schimmel@ks.gov; ccanfieldsmither@ky.gov; Jane.Killen2@La.gov; Lawrence, Peggie (CDC maine.gov); lacey.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benvenga@maryland.gov; rebecca.white@state.ma.us; Egelskil@michigan.gov; Pizzuti, Sandy (CDC state.mn.us); Griffin, Jenny (CDC msdh.ms.gov); Mebruer, Debbie (CDC health.mo.gov); kacech@mt.gov; Kellie.Richetti@mt.gov; Engel, Bonnie (CDC nebraska.gov); Magen.Schachta@nebraska.gov; jpfilippi@health.nv.gov; Bogert, Kelly (CDC dhhs.nh.gov); Ashley.Wilson@odh.ohio.gov; mdianeh@health.ok.gov; Nest, Patricia (CDC state.or.us); Guerrero, Janet (CDC dph.gov.mp); Ashley.Wilson@odh.ohio.gov; Boggert, Kelly (CDC dhhs.nh.gov); White, Barbara (CDC dhhs.nh.gov); deanna.morris@doh.nj.gov; Soliz, Angela (CDC state.nm.us); jacki.silvia@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guerrero, Janet (CDC dph.gov.mp); Ashley.Wilson@odh.ohio.gov; Lalie Ikluk; marlineloeak@gmail.com; Menard, Rita (CDC health.ri.gov); Higgins, Teresa (CDC dhec.sc.gov); Harding, Monica (CDC state.sd.us); Stanton, Tammy (CDC tn.gov); carolyn.geter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idheileh@doh.vi.gov; McFarlane, Lesa (CDC doh.vi.gov); tesha.plunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC vermont.gov); Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC doh.wa.gov); Fisher, Andrea (CDC wv.gov); tara.vasby@dhs.wisconsin.gov
Cc: Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Motusa Tuileama (CDC doh.as); Christ, Cara (CDC azdhs.gov); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC ct.gov); karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC dc.gov); scott.rivkees@flhealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; Linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Clabaugh, Gerd (CDC idph.iowa.gov); lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; nirav.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC state.ma.us); Khaldun1@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; sheilahogan@mt.gov; Gholzman@mt.gov; dannette.smith@nebraska.gov; gary.anthone@nebraska.gov; l.sherych@health.nv.gov; iazzam@health.nv.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC health.ny.gov); mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; mylynntufte@nd.gov; Muña, Esther (CDC dph.gov.mp); amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC state.or.us); ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; Emais Roberts; bbiilimon@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov); rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC state.sd.us); Lisa.Piercey@tn.gov; Hellerstedt, John (CDC dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC doh.wa.gov); cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); marcus.plesia@ASTHO.com.
Subject: RE: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)
Date: Monday, March 2, 2020 11:42:32 PM

Attention: CDC IMS State Coordination Task Force (SCTF):

Submitting information of the top health official for Replublic of Palau. Please see high-lighted information.

Thank you.

Lalie Ikluk
Administrative Manager
BHASS-Ministry of Health
Republic of Palau
Ph: (680) 488-2552/3
Alt. Email: lalsikluk@gmail.com

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocscttftfcoord@cdc.gov>
Sent: Tuesday, March 3, 2020 1:40 AM
To: Patricia Vinson (CDC adph.state.al.us) <Patricia.Vinson@adph.state.al.us>; heidi.hedberg@alaska.gov; Uiagalelei, Eti (CDC doh.as) <euiagalelei@doh.as>; Snyder, Wendy (CDC azdhs.gov) <Wendy.Snyder@azdhs.gov>; Ferguson, Reva (CDC arkansas.gov) <Reva.Ferguson@arkansas.gov>; rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC cdph.ca.gov) <peggy.ullom@cdph.ca.gov>; aislinn.barnett@state.co.us; Jensen, Dana (CDC ct.gov) <dana.Jensen@ct.gov>; richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@flhealth.gov; angelica.mcgrier@dph.ga.gov; fanny.vazquez@dph.ga.gov; Solomon, Fancy (CDC fsmhealth.fm) <fsolomon@fsmhealth.fm>; Kaneshiro, Suzanne (CDC dphss.guam.gov) <suzanne.kaneshiro@dphss.guam.gov>; Sharon.Tangonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Oluwaseun.Oyeniran@illinois.gov; Musgrave, Shirely (CDC illinois.gov) <shirley.musgrave@illinois.gov>; Barrett, Tami (CDC isdh.in.gov) <tbarrett@isdh.in.gov>; Caskey, Jennifer (CDC idph.iowa.gov) <jennifer.caskey@idph.iowa.gov>; Denise.Schimmel@ks.gov; ccanfieldsmither@ky.gov; Jane.Killen2@La.gov; Lawrence, Peggie (CDC maine.gov) <peggie.d.lawrence@maine.gov>; lacey.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benvenga@maryland.gov; rebecca.white@state.ma.us; Egelskil@michigan.gov; Pizzuti, Sandy (CDC state.mn.us) <sandy.pizzuti@state.mn.us>; Griffin, Jenny (CDC msdh.ms.gov) <jenny.griffin@msdh.ms.gov>; Mebruer, Debbie (CDC health.mo.gov) <debbie.mebruer@health.mo.gov>; kacech@mt.gov; Kellie.Richetti@mt.gov; Engel, Bonnie (CDC nebraska.gov) <bonnie.engel@nebraska.gov>; Magen.Schachta@nebraska.gov; jpfilippi@health.nv.gov; Bogert, Kelly (CDC dhhs.nh.gov) <kelly.bogert@dhhs.nh.gov>; White, Barbara (CDC dhhs.nh.gov) <barbara.white@dhhs.nh.gov>; deanna.morris@doh.nj.gov; Soliz, Angela (CDC state.nm.us) <angela.soliz@state.nm.us>; jacki.silvia@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guerrero, Janet (CDC dph.gov.mp) <janet.guerrero@dph.gov.mp>; Ashley.Wilson@odh.ohio.gov; mdianeh@health.ok.gov; Nest, Patricia (CDC state.or.us) <patricia.nest@state.or.us>; tbarnettno@pa.gov; pbeene@pa.gov; Byrnes, Carolyn (CDC pa.gov) <cabyrnes@pa.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; marlineloeak@gmail.com; Menard, Rita (CDC health.ri.gov) <rita.menard@health.ri.gov>; Higgins, Teresa (CDC dhec.sc.gov) <higgint@dhec.sc.gov>; Harding, Monica (CDC state.sd.us) <monica.harding@state.sd.us>; Stanton, Tammy (CDC tn.gov) <tammy.stanton2@tn.gov>; carolyn.geter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idheileh@doh.vi.gov; McFarlane, Lesa (CDC doh.vi.gov) <lesa.mcfarlane@doh.vi.gov>; tesha.plunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC vermont.gov) <sarah.gregorek@vermont.gov>; Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC doh.wa.gov) <terry.bergener@doh.wa.gov>; Fisher, Andrea (CDC wv.gov) <Andrea.L.Fisher@wv.gov>; tara.vasby@dhs.wisconsin.gov
Cc: Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Motusa Tuileama (CDC doh.as) <tuinua@doh.as>; Christ, Cara (CDC azdhs.gov) <cara.christ@azdhs.gov>; Smith, Nathaniel (CDC arkansas.gov) <nathaniel.smith@arkansas.gov>; Sonia.angell@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC ct.gov) <renee.coleman-mitchell@ct.gov>; karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC dc.gov) <laquandra.nesbitt@dc.gov>; scott.rivkees@flhealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; Linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Clabaugh, Gerd (CDC idph.iowa.gov) <gerd.clabaugh@idph.iowa.gov>; lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; nirav.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC state.ma.us) <monica.bharel@state.ma.us>; Khaldun1@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; sheilahogan@mt.gov; Gholzman@mt.gov; dannette.smith@nebraska.gov; gary.anthone@nebraska.gov; l.sherych@health.nv.gov; iazzam@health.nv.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC health.ny.gov) <howard.zucker@health.ny.gov>; mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; mylynntufte@nd.gov; Muña, Esther (CDC dph.gov.mp) <esther.muna@dph.gov.mp>; amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC state.or.us) <lillian.shirley@state.or.us>; ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; Emais Roberts <emais.roberts@palauhealth.org>; bbiilimon@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov) <Nicole.alexanderscott@health.ri.gov>; rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC state.sd.us) <kim.malsam-rysdon@state.sd.us>; Lisa.Piercey@tn.gov; Hellerstedt, John (CDC dshs.texas.gov) <John.Hellerstedt@dshs.texas.gov>; justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC utah.gov) <joeminer@utah.gov>; mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC doh.wa.gov) <jmwiesman@doh.wa.gov>; cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>; Montero, Jose (CDC/DDPHSIS/CSTLTS/OD) <znn3@cdc.gov>; marcus.plesia@ASTHO.com.
Subject: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)

Good Morning,

CDC Incident Management has asked the State Coordination Task Force for contact information of the **top health official** in each jurisdiction to expedite outreach in the event of an emergencies and to provide COVID-19 updates as expeditiously as possible. To accomplish this task, I am reaching out to the SHO/THO Assistant with a cc to the SHO/THO. This information will be used in tandem with the information we have for the SHO/THO maintained by ASTHO. You all are in a great position to assist us!

We know that in many cases the top health official is the SHO/THO. If that case is , just **reply** to this email that they are the **same**.

For those where there is a person who is more senior to the SHO/THO (as a reminder, we are looking for the most senior health official), please complete the following information:

State/Territory	Highest Health Official (i.e. Commissioner/ Minister/Secretary) Name (including degrees as appropriate)	Title	Phone Number (Please provide a **number or** numbers where we can reach out ***after hour*** should the need arise for COVID-19)	Email	Executive Assistant Name	Phone Number	Email
Republic of Palau	Emais Roberts, MD, FACS Ministry of Health Degrees: BS-Visual Science MD-Medicine Medical Training: General Surgery Residency Integrated Surgical Residency Trauma-Burns Resident Surgeon	Minister of Health	680 488-2552/3 680 775-4321	emais.roberts@palauhealth.org	Lalie Ikluk Omengkar D. Wally	680 775-5257 680 775-0000	lalie.ikluk@palauhealth.org omengkar.wally@palauhealth.org

Due to the nature of this **urgent request**, respond by **COB today**.

Thank you so much for your assistance.

If you have questions or concerns, please contact me.

Kimberly
Kimberly Cantrell
State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

Read about the Palau Health disclaimer

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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Pritchard, Scott
Cc:	Blackmore, Carina (CDC flhealth.gov); Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD); CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Re: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers
Date:	Saturday, February 15, 2020 8:27:10 AM

Thank you for your response. SCTF confirm receipt.

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

From: Pritchard, Scott <Scott.Pritchard@flhealth.gov>
Sent: Friday, February 14, 2020 10:21 PM
To: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Cc: Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Subject: Re: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Florida: 850-245-4401

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 14, 2020 5:05 PM
To: Pritchard, Scott
Subject: FW: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Did you respond

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Friday, February 14, 2020 11:57 AM
To: Stevens, Kelly (CDC adph.state.al.us) <kelly.stevens@adph.state.al.us>; McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; eugene.livar@azdhs.gov; Smith, Nathaniel (CDC arkansas.gov) <nathaniel.smith@arkansas.gov>; catherine.waters@arkansas.gov;

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sonia.angell@cdph.ca.gov; Black, Stephanie SB (CDC cityofchicago.org) <stephanie.black@cityofchicago.org>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Coleman, Renee (CDC ct.gov) <renee.coleman-mitchell@ct.gov>; Heather.Aaron@ct.gov; doh.epi@dc.gov; karyl.rattay@delaware.gov; Paula.Eggers@delaware.gov; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Elke.Shaw-Tulloch@dhw.idaho.gov; Katherine.Turner@dhw.idaho.gov; molly.lamb@illinois.gov; kbox@isdh.in.gov; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; farah.ahmed@ks.gov; White, Connie (CDC ky.gov) <connie.white@ky.gov>; Nirav.shah@maine.gov; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; fran.phillips@maryland.gov; catherine.brown@state.ma.us; lyoncallos@michigan.gov; jsarofalpiy@fsmhealth.fm; jan.malcolm@state.mn.us; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; Thomas.Dobbs@msdh.ms.gov; Randall.Williams@health.mo.gov; Anderson, Stacey (CDC mt.gov) <sanderson2@mt.gov>; eric.sergeant@nebraska.gov; mpeekbullock@health.nv.gov; iazzam@health.nv.gov; benjamin.chan@dhhs.nh.gov; christopher.neuwirth@doh.nj.gov; chelsea.mcmullen@state.nm.us; ddaskalakis@health.nyc.gov; Zucker, Howard (CDC health.ny.gov) <howard.zucker@health.ny.gov>; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; Moore, Zackary (CDC dhhs.nc.gov) <zack.moore@dhhs.nc.gov>; mylynntufte@nd.gov; Muña, Esther (CDC dph.gov.mp) <esther.muna@dph.gov.mp>; Amy.Acton@odh.ohio.gov; GaryC@health.ok.gov; MELISSA.E.POWELL@dhsoha.state.or.us; desedamd@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov) <Nicole.alexanderscott@health.ri.gov>; Jamie Blair <BlairJD@dhec.sc.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; josh.clayton@state.sd.us; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Dunn, Angela (CDC utah.gov) <angeladunn@utah.gov>; Kelso, Patsy (CDC vermont.gov) <patsy.kelso@vermont.gov>; lilian.peake@vdh.virginia.gov; cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>; jennifer.shuford@dshs.texas.gov; joy.zimmermanbodi@dshs.texas.gov; Linda.denorcey@dphss.guam.gov; alexander.billioux@la.gov; ralevine@pa.gov; bbilimon@hotmail.com; emais.roberts@palauhealth.org; Nua, Motusa Tuileama (CDC doh.as) <tuinua@doh.as>; Arwady, Allison AA (CDC cityofchicago.org) <allison.arwady@cityofchicago.org>; BFerrer@ph.lacounty.gov

Cc: McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; a.tufa@doh.as; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Tolliver, Rickey (CDC state.co.us) <rickey.tolliver@state.co.us>; Cartter, Matthew (CDC ct.gov) <matt.cartter@ct.gov>; Davies-Cole, John (CDC dc.gov) <john.davies-cole@dc.gov>; Tabatha.Offutt-Powell@state.de.us; Skilling, Vita A. (CDC fsmhealth.fm) <Vskilling@fsmhealth.fm>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Ann.Pobutsky@dphss.guam.gov; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; Hahn, Christine G. <ID> (CDC dhw.idaho.gov) <hahnc@dhw.idaho.gov>; Layden, Jennifer (CDC illinois.gov) <jennifer.layden@illinois.gov>; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; farah.ahmed@ks.gov; Thoroughman,

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Subject: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Good Morning,

We need your help, please.

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

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

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

Thank you
State Coordination Task Force
Regional Desk

State Coordination Task Force (SCTF)

AMERICAN OVERSIGHT

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

AMERICAN OVERSIGHT

From: Pritchard, Scott
To: eocsctftfcoord@cdc.gov
Cc: Blackmore, Carina
Subject: Re: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers
Date: Friday, February 14, 2020 10:21:00 PM

Florida: 850-245-4401

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigation Section
Bureau of Epidemiology
Office: 850-245-4406
Cell: 850-251-5558

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 14, 2020 5:05 PM
To: Pritchard, Scott
Subject: FW: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Did you respond

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM <eocsctftfcoord@cdc.gov>
Sent: Friday, February 14, 2020 11:57 AM
To: Stevens, Kelly (CDC adph.state.al.us) <kelly.stevens@adph.state.al.us>; McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; eugene.livar@azdhs.gov; Smith, Nathaniel (CDC arkansas.gov) <nathaniel.smith@arkansas.gov>; catherine.waters@arkansas.gov; sonia.angell@cdph.ca.gov; Black, Stephanie SB (CDC cityofchicago.org) <stephanie.black@cityofchicago.org>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Coleman, Renee (CDC ct.gov) <renee.coleman-mitchell@ct.gov>; Heather.Aaron@ct.gov; doh.epi@dc.gov; karyl.rattay@delaware.gov; Paula.Eggers@delaware.gov; Roberson, Shamarial <Shamarial.Roberson@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Elke.Shaw-Tulloch@dhw.idaho.gov; Katherine.Turner@dhw.idaho.gov; molly.lamb@illinois.gov; kbox@isdh.in.gov; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; farah.ahmed@ks.gov; White, Connie (CDC ky.gov) <connie.white@ky.gov>; Nirav.shah@maine.gov; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; fran.phillips@maryland.gov; catherine.brown@state.ma.us; lyoncallos@michigan.gov; jsarofalpiy@fsmhealth.fm; jan.malcolm@state.mn.us; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; Thomas.Dobbs@msdh.ms.gov; Randall.Williams@health.mo.gov; Anderson, Stacey (CDC mt.gov) <sanderson2@mt.gov>; eric.sergeant@nebraska.gov; mpeekbullock@health.nv.gov; iazzam@health.nv.gov; benjamin.chan@dhhs.nh.gov; christopher.neuwirth@doh.nj.gov; chelsea.mcmullen@state.nm.us;

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ddaskalakis@health.nyc.gov; Zucker, Howard (CDC health.ny.gov) <howard.zucker@health.ny.gov>; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; Moore, Zackary (CDC dhhs.nc.gov) <zack.moore@dhhs.nc.gov>; mylynntufte@nd.gov; Muña, Esther (CDC dph.gov.mp) <esther.muna@dph.gov.mp>; Amy.Acton@odh.ohio.gov; GaryC@health.ok.gov; MELISSA.E.POWELL@dhsoha.state.or.us; desedamd@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov) <Nicole.alexanderscott@health.ri.gov>; Jamie Blair <BlairJD@dhec.sc.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; josh.clayton@state.sd.us; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Dunn, Angela (CDC utah.gov) <angeladunn@utah.gov>; Kelso, Patsy (CDC vermont.gov) <patsy.kelso@vermont.gov>; lilian.peake@vdh.virginia.gov; cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>; jennifer.shuford@dshs.texas.gov; joy.zimmermanbodi@dshs.texas.gov; Linda.denorcey@dphss.guam.gov; alexander.billioux@la.gov; ralevine@pa.gov; bbilimon@hotmail.com; emais.roberts@palauhealth.org; Nua, Motusa Tuileama (CDC doh.as) <tuinua@doh.as>; Arwady, Allison AA (CDC cityofchicago.org) <allison.arwady@cityofchicago.org>; BFerrer@ph.lacounty.gov

Cc: McLaughlin, Joseph (CDC alaska.gov) <joseph.mclaughlin@alaska.gov>; Davidson, Sherri (CDC adph.state.al.us) <sherri.davidson@adph.state.al.us>; a.tufa@doh.as; Louie, Shirley (CDC arkansas.gov) <shirley.louie@arkansas.gov>; Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Herlihy, Rachel (CDC state.co.us) <rachel.herlihy@state.co.us>; Tolliver, Rickey (CDC state.co.us) <rickey.tolliver@state.co.us>; Cartter, Matthew (CDC ct.gov) <matt.cartter@ct.gov>; Davies-Cole, John (CDC dc.gov) <john.davies-cole@dc.gov>; Tabatha.Offutt-Powell@state.de.us; Skilling, Vita A. (CDC fsmhealth.fm) <Vskilling@fsmhealth.fm>; Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Ann.Pobutsky@dphss.guam.gov; Park, Sarah Y., MD <sarah.park@doh.hawaii.gov>; Pedati, Caitlin <caitlin.pedati@idph.iowa.gov>; Hahn, Christine G. <ID> (CDC dhw.idaho.gov) <hahnc@dhw.idaho.gov>; Layden, Jennifer (CDC illinois.gov) <jennifer.layden@illinois.gov>; Pontones, Pamela (CDC isdh.in.gov) <ppontones@isdh.in.gov>; farah.ahmed@ks.gov; Thoroughman, Douglas (CDC ky.gov) <douglas.thoroughman@ky.gov>; Ratard, Raoult (CDC la.gov) <raoult.ratard@la.gov>; catherine.brown@state.ma.us; Blythe, David (CDC maryland.gov) <david.blythe@maryland.gov>; Bennett, Siiri (CDC maine.gov) <Siiri.Bennett@maine.gov>; lyoncallos@michigan.gov; Lynfield, Ruth (CDC state.mn.us) <Ruth.Lynfield@state.mn.us>; george.turabelidze@health.mo.gov; paul.byers@msdh.ms.gov; Williamson, Laura (CDC mt.gov) <lwilliamson@mt.gov>; Moore, Zackary (CDC dhhs.nc.gov) <zack.moore@dhhs.nc.gov>; Miller, Tracy (CDC nd.gov) <tkmiller@nd.gov>; Safranek, Thomas <NE> (CDC nebraska.gov) <tom.safranek@nebraska.gov>; benjamin.chan@dhhs.nh.gov; Tan, Christina (CDC doh.state.nj.us) <Christina.Tan@doh.state.nj.us>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; paul.white@dph.gov.mp; mpeekbullock@health.nv.gov; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; deFijter, Sietske (CDC odh.ohio.gov) <Sietske.deFijter@odh.ohio.gov>; Burnsed, Laurence (CDC health.ok.gov) <Laurence@health.ok.gov>; dean.e.sidelinger@dhsoha.state.or.us; shawatkins@pa.gov; carmen.deseda@salud.pr.gov; Bandy, Utpala (CDC health.ri.gov) <utpala.bandy@health.ri.gov>; Bell, Linda (CDC dhec.sc.gov) <belllw@dhec.sc.gov>; Clayton, Joshua (CDC state.sd.us) <joshua.clayton@state.sd.us>; Dunn, John (CDC tn.gov) <john.dunn@tn.gov>; Gaul, Linda (CDC

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dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Ellis, Esther (CDC doh.vi.gov) <esther.ellis@doh.vi.gov>; Dunn, Angela (CDC utah.gov) <angeladunn@utah.gov>; lilian.peake@vdh.virginia.gov; Kelso, Patsy (CDC vermont.gov) <patsy.kelso@vermont.gov>; Cragin, Lori (CDC vermont.gov) <lori.cragin@vermont.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; Wasserman, Cathy (CDC doh.wa.gov) <cathy.wasserman@doh.wa.gov>; jonathan.meiman@dhs.wisconsin.gov; Ryan.Westergaard@dhs.wisconsin.gov; Del Rosario, Maria (CDC wv.gov) <Maria.C.delRosario@wv.gov>; Harrist, Alexia (CDC wyo.gov) <alexia.harrist1@wyo.gov>
Subject: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers

Good Morning,

We need your help, please.

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

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

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

Thank you

State Coordination Task Force

Regional Desk

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

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404-232-0480

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From:	Chris Johnstone
To:	Blackmore, Carina
Cc:	Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 1:14:03 AM
Attachments:	image002.png Carina Blackmore - Emergency Mosquito Control in FL.pdf Carina Blackmore - FDACS Mosquito Control Incident Response Teams.pptx

Hi Carina – This is the 3rd slide deck I have for you. Is this presentation intended to replace one of the attached? Also this slide deck has a DRAFT watermark.

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692

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Alaka`ina Foundation Family of Companies Email Privacy Policy.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 19, 2020 3:33 PM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

CAUTION: This email originated from outside of the Alakaina FOC organization. DO NOT click links or open attachments unless you recognize the sender.

Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She

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received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Sent: Wednesday, February 19, 2020 2:03 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Landry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: FW: Vector Week Presentation slides

Hi Carina
I hope you're doing well.

Just a friendly reminder if you could at your earliest convenience send the slides for your presentation for Vector Week's Tuesday afternoon's session on dengue to cjohnstone@alakaina.com (so she can load them ahead of time) with a copy to me along with a short bio, we'd much appreciate it.

See you next week.

Best regards,
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Thursday, February 13, 2020 12:09 PM
To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: RE: Vector Week Speaker Guidance

AMERICAN OVERSIGHT

Hello Speakers for the Dengue Prevention and Control Session on Tuesday afternoon, February 25, 2020–

I want to thank you all again for agreeing to participate in this session. I think the audience will be excited about and learn a lot from what you all have to say!

Below is what we currently have you planning to talk about --- if your content is significantly different, please let us know as soon as possible!

1. *World Mosquito Program, Wolbachia replacement intervention trials (Steven Kern) ~20 min*

2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela Paz-Bailey) ~20 min*

3. *Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min*

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name
b. Job title
c. Credentials
d. Name of organization

As noted below, if you can send your slides ahead of time to cjohnstone@alakaina.com, it would facilitate the logistics of loading of the presentations.

Looking forward to seeing you all in a couple of weeks.

Thanks again ~
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

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From: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Sent: Friday, January 31, 2020 12:26 PM
To: Ciota, Alexander T (HEALTH) <alexander.ciota@health.ny.gov>; Rebecca.Osborn@dhs.wisconsin.gov; bcreiner@uw.edu
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; Powers, Ann (CDC/DDID/NCEZID/DVBD) <akp7@cdc.gov>; CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #8, Emerging Issues in Mosquito Borne Diseases**. The session is scheduled for Wednesday February 26, 2020, 10:00-11:15am in Salon II & III at the University Hilton in Fort Collins, CO.

Presentation time: 20 minutes
Speakers in session: 3
Moderator(s) (cc'd here): Ann Powers, Steve Waterman

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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Emergency Mosquito Control in Florida

Carina Blackmore, DVM, PhD

Florida Department of Health

On behalf of

Marah Clark

Florida Department of Agriculture and Consumer Services

FL-DOH-20-0673-A-006259

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Mosquito control in Florida

- Independent taxing districts
- County government
- County health departments
- Nothing

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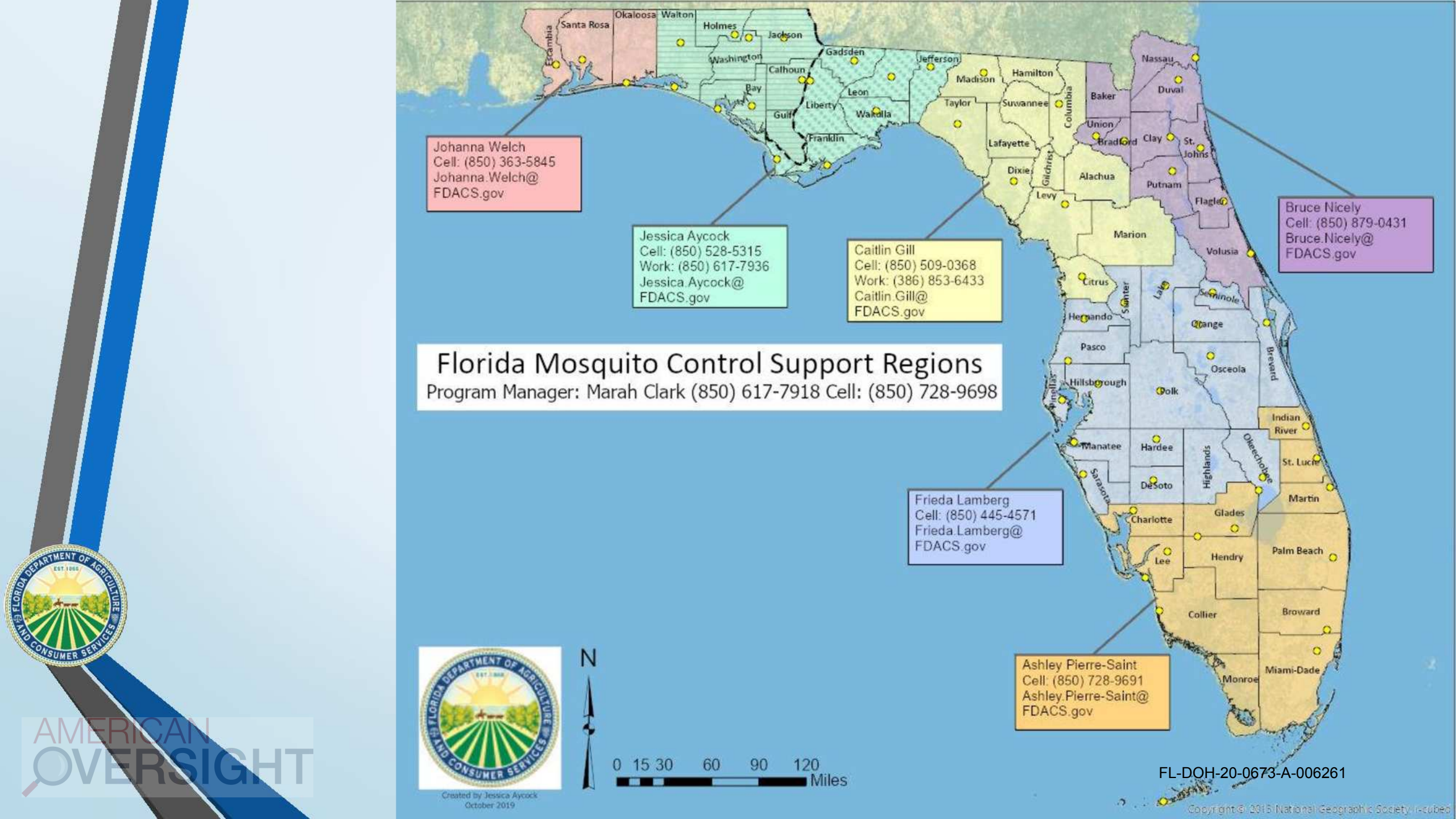

FL-DOH-20-0673-A-006261

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Emergency Response

All disasters are local

State Department of Emergency Management

- Emergency Support Function (ESF) 8- Health
- ESF-17- Animal Protection
  - Funding
  - Technical support

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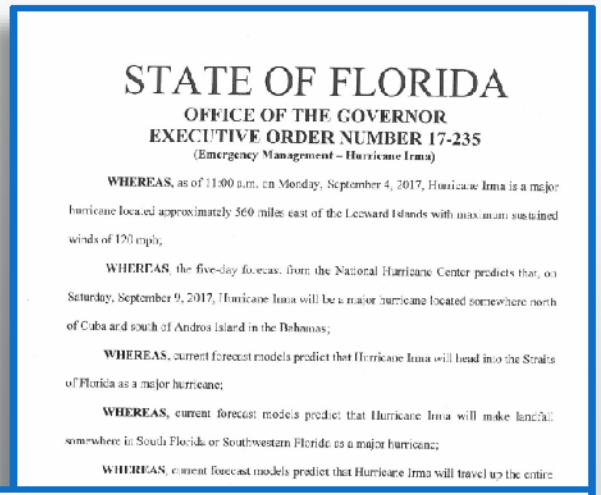
Declarations and Public Assistance

- **State of FL-Governor's executive order**
  - Declaration of a State of Emergency
    - Provides availability of funding for relief & recovery efforts
- **Presidential Declaration**
  - Initiates availability of Federal Emergency Management Agency (FEMA) Public Assistance Program providing for reimbursement for recovery and response expenses



STATE OF FLORIDA

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER NUMBER 17-235

(Emergency Management – Hurricane Irma)

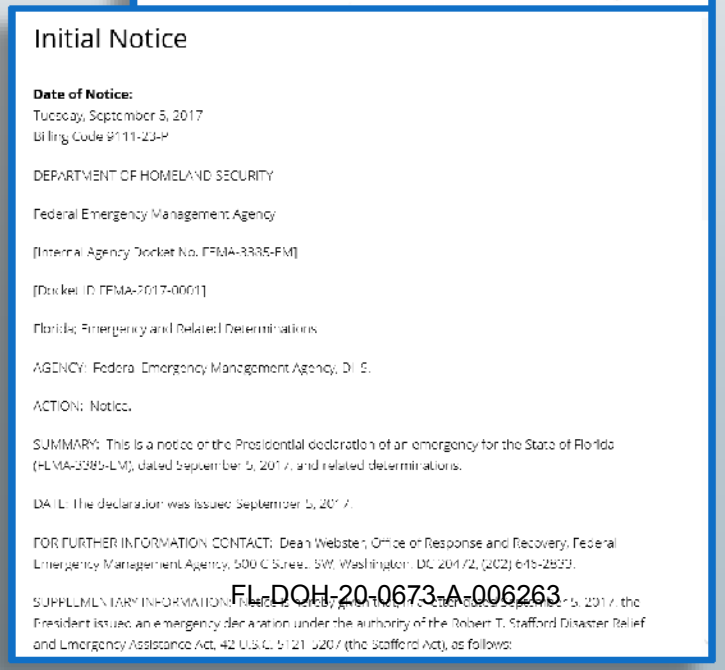
WHEREAS, as of 11:00 a.m. on Monday, September 4, 2017, Hurricane Irma is a major hurricane located approximately 560 miles east of the Leeward Islands with maximum sustained winds of 120 mph;

WHEREAS, the five-day forecast from the National Hurricane Center predicts that, on Saturday, September 9, 2017, Hurricane Irma will be a major hurricane located somewhere north of Cuba and south of Andros Island in the Bahamas;

WHEREAS, current forecast models predict that Hurricane Irma will head into the Straits of Florida as a major hurricane;

WHEREAS, current forecast models predict that Hurricane Irma will make landfall somewhere in South Florida or Southwestern Florida as a major hurricane;

WHEREAS, current forecast models predict that Hurricane Irma will travel up the entire



Initial Notice

Date of Notice:
Tuesday, September 5, 2017
Billing Code 9111-23-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA-3385-EM]

[Docket ID FEMA-2017-0001]

Florida; Emergency and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of an emergency for the State of Florida (FEMA-3385-EM), dated September 5, 2017, and related determinations.

DATE: The declaration was issued September 5, 2017.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street, SW, Washington, DC 20472, (202) 646-2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that on September 5, 2017, the President issued an emergency declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the Stafford Act), as follows:

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State Role

- Department of Emergency Management
  - Coordinates local assistance requests through WebEOC
  - Coordinates with federal partners
  - Activates Memoranda of Understanding
- Florida Department of Agriculture and Consumer Services (FDACS)
  - Contacts local mosquito control or county officials
  - Collects surveillance data and provides technical assistance
  - Coordinates with Florida Department of Environmental Protection if spraying on state lands
  - Works with pesticide application contractors
- Florida Department of Health (FDOH)
  - Local health department letter, technical assistance if needed

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Local Role

- Documentation required for Public Assistance Request
  - A letter from the County Health Department indicating a serious health threat or mosquito nuisance exists that hampers recovery efforts
  - Trap data that verifies the increase in mosquito populations
  - Three years of baseline data from non-event years
  - Maps showing the areas affected and in need of treatment

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Surveillance and Treatment

Florida Administrative Code 5E-13.036: surveillance activities must detect an increase in the mosquito population above a predetermined baseline prior to conducting adulticide activities

- > 50% above baseline is an indication of the potential for transmission of mosquito-borne disease
- A quantifiable and sustained increase can hamper recover efforts in post-storm cleanup efforts
  - Increase in species distribution and relative abundance to justify treatment
    - > 25 adult mosquitoes/trap/trap night
  - Increase in constituent complaints and service requests



FL-DOH-20-0673-A-006266

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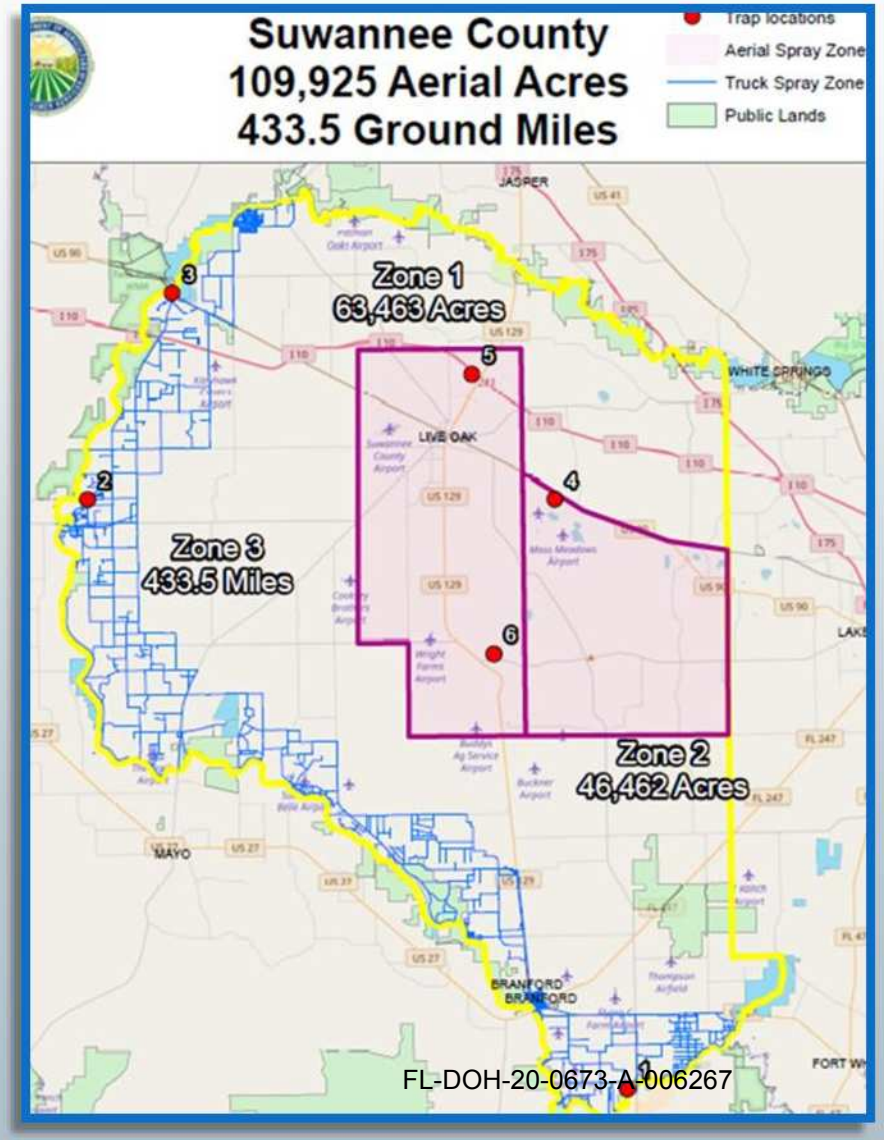
Identifying Trap Locations

- All traps are deployed within treatment zones
- FEMA requires minimum of 5 traps per county
- Each aerial spray zone should have at least 1 CDC Light Trap
  - If less than 3 zones, traps should be distributed as evenly as possible within zones; not on the edge of zones



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CDC Light Trap





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Post-treatment Surveillance

- **Conducted again to assess effectiveness of the treatment**
  - Traps are deployed again the day after treatment is completed
  - Traps are placed in exact geographical location as pre-treatment surveillance
  - Methods are the same as pre-treatment surveillance
    - Trap deployment form
    - Trap set-up
    - Timing of deployment and retrieval



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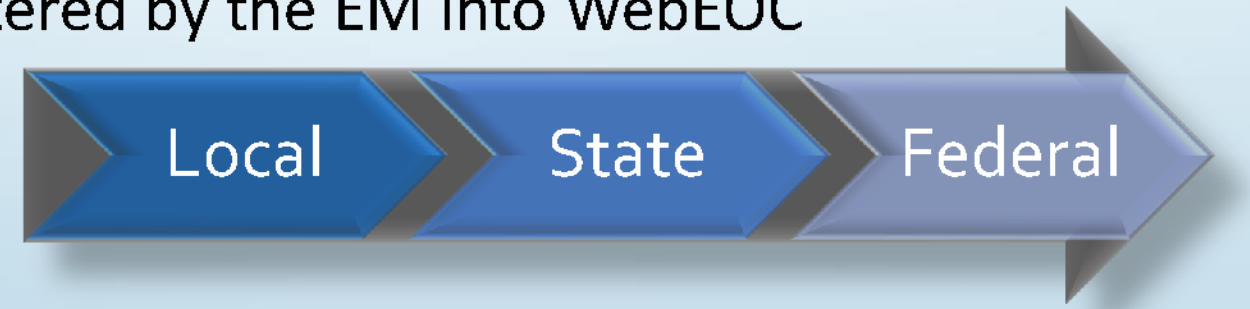
Ground Zero for Mosquito Abatement

- Everything begins at the local level!
  - Emergency Management (EM) communicates with local mosquito control to determine capabilities for post-storm abatement.
    - If a county does not require assistance, then expenses associated with post-storm treatment can be submitted through FEMA directly
    - If a county requires assistance, then requests must be entered by the EM into WebEOC



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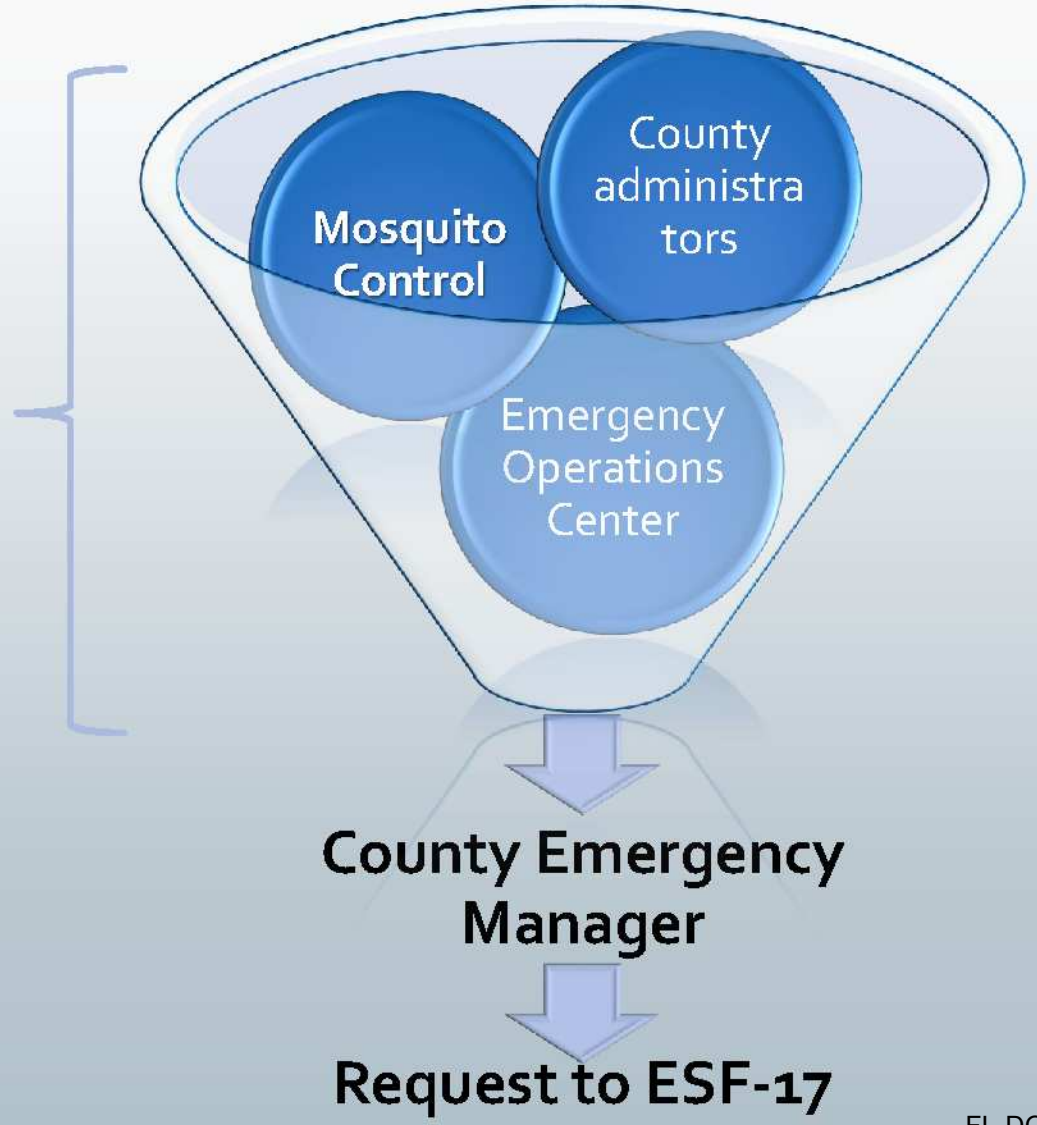
Hierarchy

Open communication between local agencies to ensure a unified message is sent to the County Emergency Manager



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County Notifications

- FDACS requires written verification that the county has made adequate efforts in notifying its constituents prior to initiation of treatment:
  - Local law enforcement, emergency operations, fire departments, department of health, agriculture extension agents, newspaper, radio, television, and social media
  - Local apiaries, aquaculture, and those who may be chemically sensitive
  - Notifications are "weather pending" and may need to be updated based on schedule of treatment

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Notifications

Subject: Florida State Beekeepers note of thanks

On behalf of the Florida beekeepers, I wish to express our a
about mosquito spraying after hurricane Irma. Your timely
to beekeepers in the counties designated for aerial sprayin
beekeepers can use to take precautionary action when and
10 FSBA sent 4370 mosquito spray information emails to Fl
makes Fl agriculture work.

Thanks for your support

Tony Hobb

Florida State Beekeepers Assn



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FDACS Mosquito Control Incident Response Teams

- **Roles During Incident Response:**
  - Assembly and analyses of baseline data
  - Conduct pre-treatment surveillance
  - Perform trap evaluation
  - Mapping of treatment zones
  - Public notifications
  - Contract applications
  - Conduct post-treatment surveillance
  - Data analysis



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Mosquito Control Incidence Response Team

- Activated 10 times since 2001
  - Organized treatment of over 11 million acres
  - Aerial and truck
- West Nile virus, Zika and Dengue virus response
- Flooding from hurricanes
  - Wide area spraying to combat pestiferous species







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Response– Hurricane Michael

- 7 counties requested assistance
- 25 Division personnel participated
- 781,210 acres treated aerially with Dibrom
- $1,566,860.81 expended





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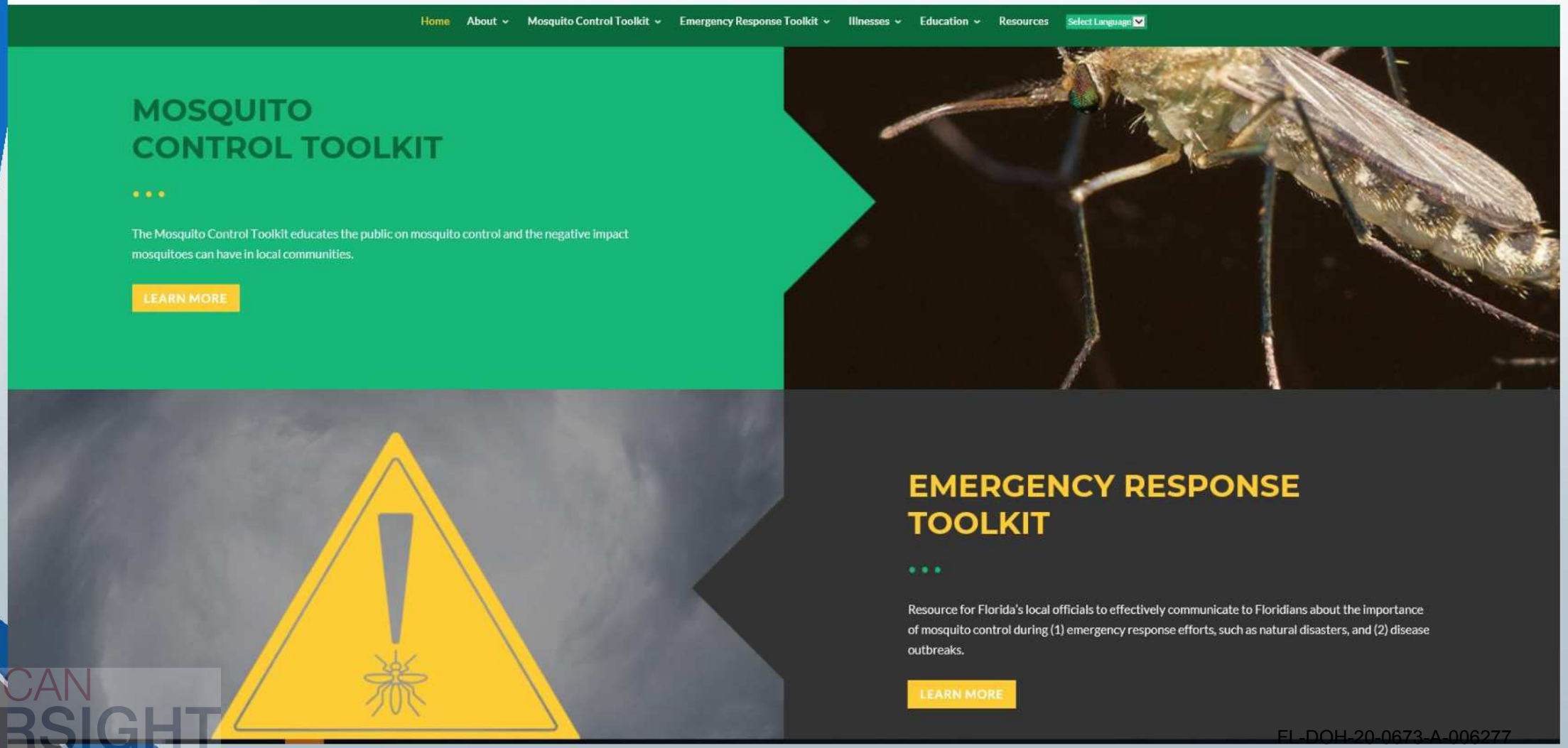
Center for Public Issues Education

University of Florida PIE Center



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Questions?

Carina.Blackmore@FLHealth.gov

Director, Division of Disease Control and Health Protection
State Epidemiologist
Florida Department of Health

Marah.Clark@FDACS.gov

Entomology and Pest Control Section
Bureau of Scientific Evaluation and Technical Assistance
Division of Agricultural Environmental Services

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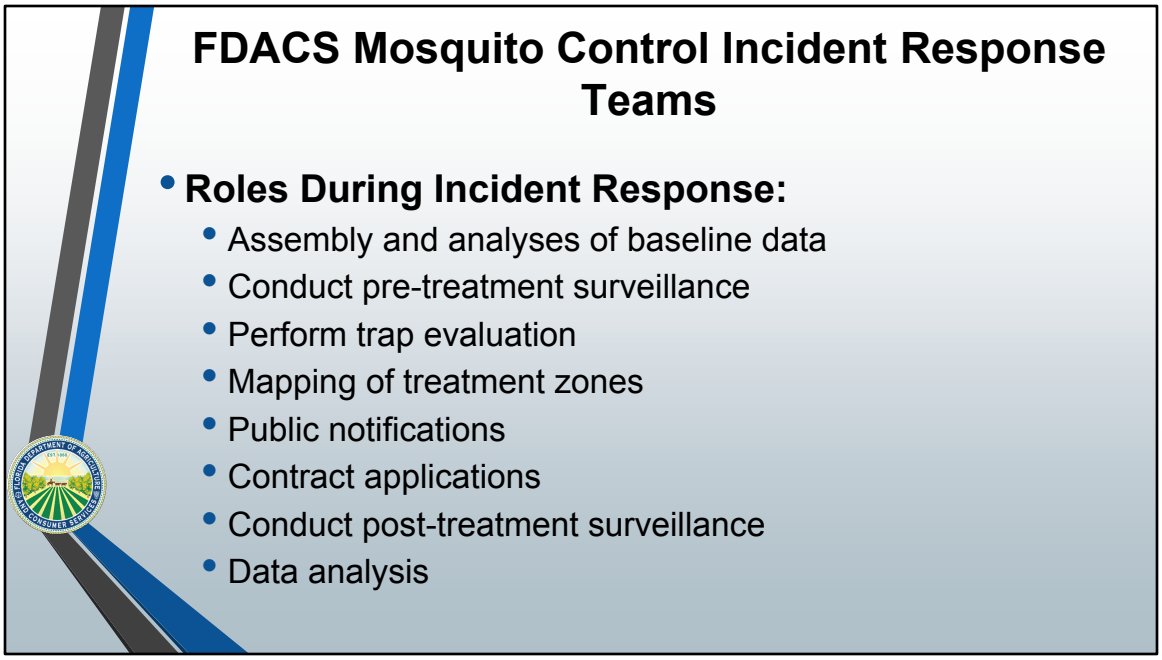

Since our experience when WVN first arrived in FL in 2001, we created the Mosquito Control Incident Response Team. We also worked with FEMA to create their national policy on this.

We've worked to assist FL counties with Assembling baseline population data
Pre-treatment surveillance
Trap evaluation
Mapping of treatment zones
Public notification
Contracted applications
Post-treatment surveillance
Data analysis

Please note: **FDACS DOES NOT** conduct the actual treatments. The work is contracted out to applicable vendors. Also, **FDACS DOES NOT** provide direct reimbursement for work completed by the MCP. We are not set up as a mechanism to complete mosquito control.

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Mosquito Control Incidence Response Team

- Activated 10 times since 2001
  - Organized treatment of over 11 million acres
  - Aerial and truck
- West Nile virus, Zika and Dengue virus response
- Flooding from hurricanes
  - Wide area spraying to combat pestiferous species







FDACS has a history of emergency response for mosquito control. When WNV first came to FL in 2001, the Department was involved in wide area ground and aerial adulticide campaigns, combating Culex vector species in North FL.

In response to flooding from tropical storms or hurricanes, the department has also provided emergency wide area adulticide applications to fight pestiferous mosquito species that hamper cleanup and recovery efforts. FDACS has developed the MCIRT, which follows the incident command structure and has been activated 7 times since 2001, organizing the treatment of over 11 million acres collectively!

In 2016, we used a modified version of our previous emergency response to form a Zika vector control task force that was deployed in Taylor county, twice in Okee, and in Broward county we provided surveillance assistance. In highlands county earlier in 2017, we provided assistance to respond to a DENV case.

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Response– Hurricane Michael

- 7 counties requested assistance
- 25 Division personnel participated
- 781,210 acres treated aerially with Dibrom
- $1,566,860.81 expended





All treatments were conducted by air. Ground treatments were not conducted. The outcome of the MCIRT response for Hurricane Michael

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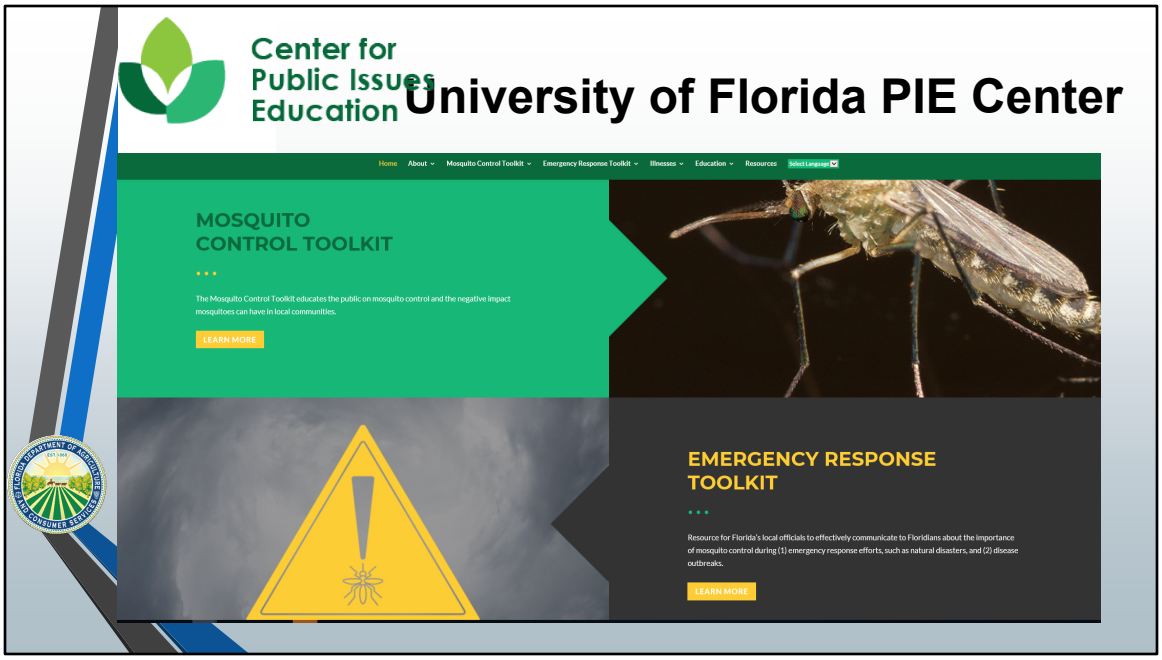

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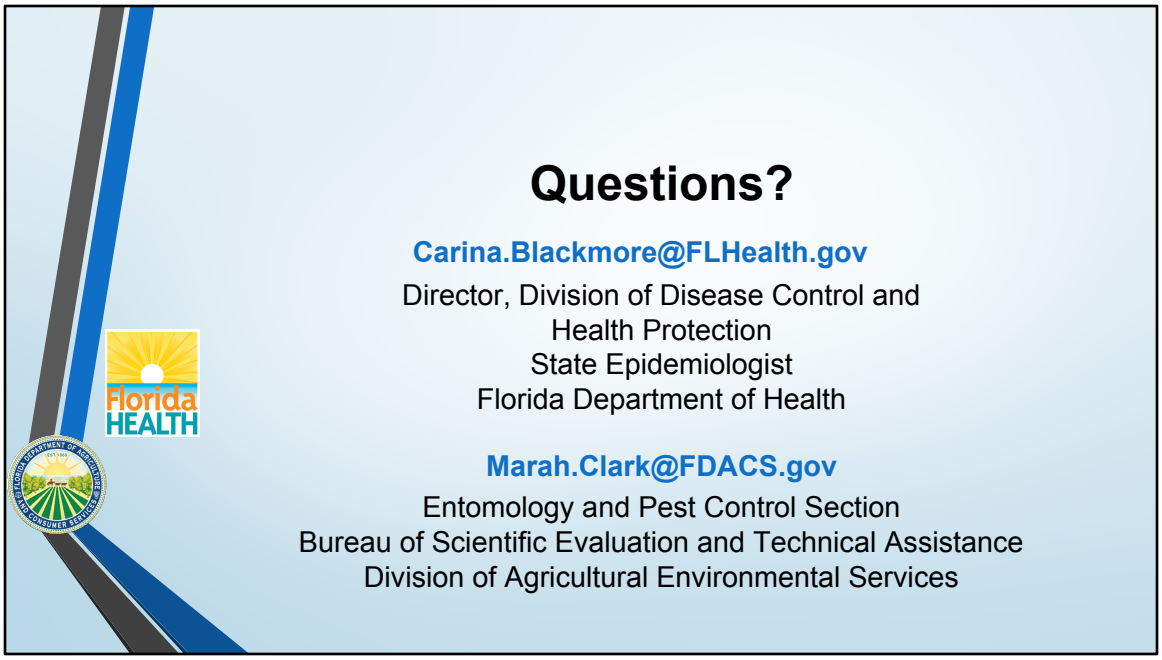

Note: the information will need to be changed if a rep from BIIR conducts the presentation.

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From:	Blackmore, Carina
To:	Chris Johnstone
Cc:	Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 10:08:52 AM
Attachments:	image001.png dengue slides for blackmore VV20final.pptx

The dengue file. Let me know if you need anything else

From: Chris Johnstone <cjohnstone@alakaina.com>
Sent: Friday, February 21, 2020 9:39 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Carina – To avoid surprises and misunderstandings. I would like to request that you make final edits to your presentations as needed and send me both slide decks once completed. What you send me is what will be on the computer at the podium.

Thank You,

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692



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Alaka`ina Foundation Family of Companies Email Privacy Policy.

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 21, 2020 9:11 AM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

CAUTION: This email originated from outside of the Alakaina FOC organization. DO NOT click links or open attachments unless you recognize the sender.

I am giving two different presentations. I didn't mean to send the emergency preparedness slides to

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you… I sent the dengue presentation to Steve. I sent a different presentation (the emergency preparedness presentation) to Nga. Didn't understand you needed to upload these so first sent a pdf, then sent the ppt to her but had to divide into a and b. Together they should be the same file as the emergency preparedness pdf. Does that make more sense. You can remove the draft watermark.

From: Chris Johnstone <cjohnstone@alakaina.com>
Sent: Friday, February 21, 2020 1:13 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Hi Carina – This is the 3rd slide deck I have for you. Is this presentation intended to replace one of the attached? Also this slide deck has a DRAFT watermark.

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692



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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 19, 2020 3:33 PM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

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Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

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Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Sent: Wednesday, February 19, 2020 2:03 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Landry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: FW: Vector Week Presentation slides

Hi Carina
I hope you're doing well.

Just a friendly reminder if you could at your earliest convenience send the slides for your presentation for Vector Week's Tuesday afternoon's session on dengue to cjohnstone@alakaina.com (so she can load them ahead of time) with a copy to me along with a short bio, we'd much appreciate it.

See you next week.

Best regards,
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Thursday, February 13, 2020 12:09 PM
To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>

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Cc: Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: RE: Vector Week Speaker Guidance

Hello Speakers for the Dengue Prevention and Control Session on Tuesday afternoon, February 25, 2020–

I want to thank you all again for agreeing to participate in this session. I think the audience will be excited about and learn a lot from what you all have to say!

Below is what we currently have you planning to talk about --- if your content is significantly different, please let us know as soon as possible!

1. *World Mosquito Program, Wolbachia replacement intervention trials (Steven Kern) ~20 min*

2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela Paz-Bailey) ~20 min*

3. Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name
b. Job title
c. Credentials
d. Name of organization

As noted below, if you can send your slides ahead of time to cjohnstone@alakaina.com, it would facilitate the logistics of loading of the presentations.

Looking forward to seeing you all in a couple of weeks.

Thanks again ~
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch

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Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Sent: Friday, January 31, 2020 12:26 PM
To: Ciota, Alexander T (HEALTH) <alexander.ciota@health.ny.gov>; Rebecca.Osborn@dhs.wisconsin.gov; bcreiner@uw.edu
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; Powers, Ann (CDC/DDID/NCEZID/DVBD) <akp7@cdc.gov>; CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #8, Emerging Issues in Mosquito Borne Diseases**. The session is scheduled for Wednesday February 26, 2020, 10:00-11:15am in Salon II & III at the University Hilton in Fort Collins, CO.

Presentation time: 20 minutes
Speakers in session: 3
Moderator(s) (cc'd here): Ann Powers, Steve Waterman

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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Department of Health

DENGUE, 2019 RESPONSE



Carina Blackmore, DVM, PhD

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Objectives

- Historical context
- Brief overview of dengue surveillance systems in Florida
- Protocols and protocols
- 2019 data and response



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FL-DOH-20-0673-A-006291

Acknowledgments

- Dr. Andrea Morrison

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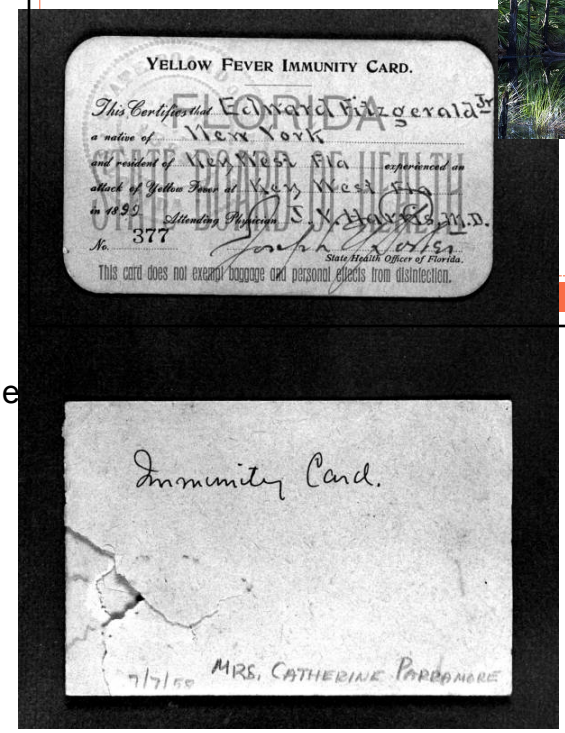
Vectorborne disease-of historic importance in Florida





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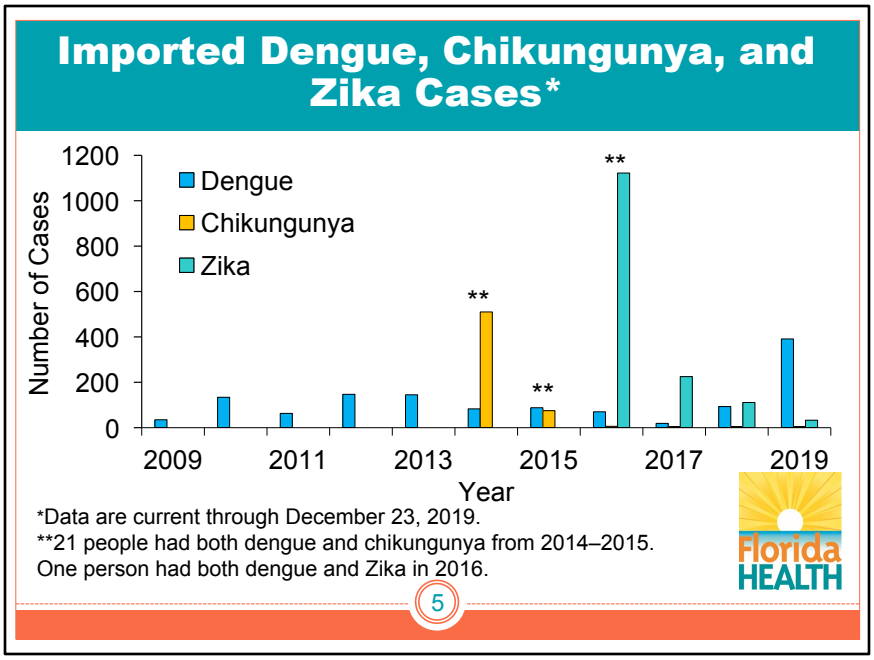

Previously approved
Increased font size and took out the word cases. “had both dengue and chikungunya cases” ----AM: thanks!

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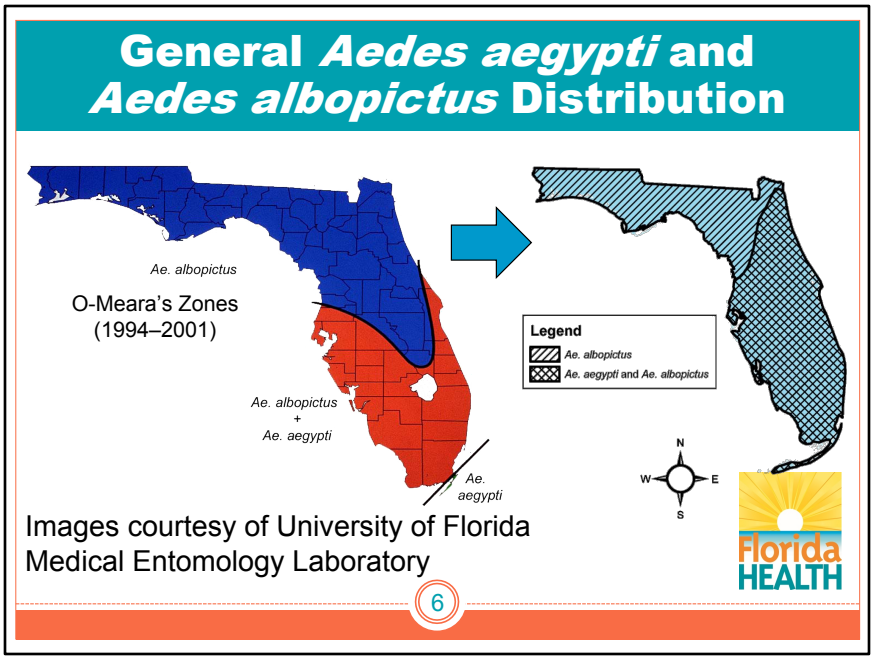

Previously approved

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Dengue background, Florida

- Periodic outbreaks reported until 1934
- Dengue outbreak in Key West 2009-2010
- Dengue outbreak in Martin County 2013
- Sporadic locally acquired cases since 2010

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Key West Dengue Outbreak, 2009–2010

- 2009
  - 22 cases + 5 from the serosurvey
- 2010
  - 66 cases
- Vector: *Aedes aegypti*



Image courtesy of www.florida-keys.fl.us/

Florida HEALTH

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Previously approved
Source graphics-----AM: added

Dengue 1 infections. 1st case was a NY resident. 34 yo female visited Key West 8/2-8/9. Recalled mosquito bites. Back home (NY state): Malaise 8/10, Fever 8/11, Severe headache, eye pain, body joint pain, rash 8/13. Assayed in NY, Dengue IgM positive. Reported by NY to Florida ~ 9/1. 9/11 CDC confirmed Den 1. 2nd and 3rd end of August, confirmed by end of September. 4th onset 7/27, reported by

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physician after publicity about local transmission. Case 5, 6, 7 all live within 0.2 miles from each other: Case 5: 73 yo male, onset 8/10, Case 6: 46 yo female, onset 9/15, Case 7: 69 yo male, onset 9/27.

Epidemiological survey of area

- Serosurvey
- Questionnaire: risk factors, travel history
- 170 participating households
- 240 total samples
- 1.4 individuals per participating house

Mosquito Control survey

Need public participation-drain and cover

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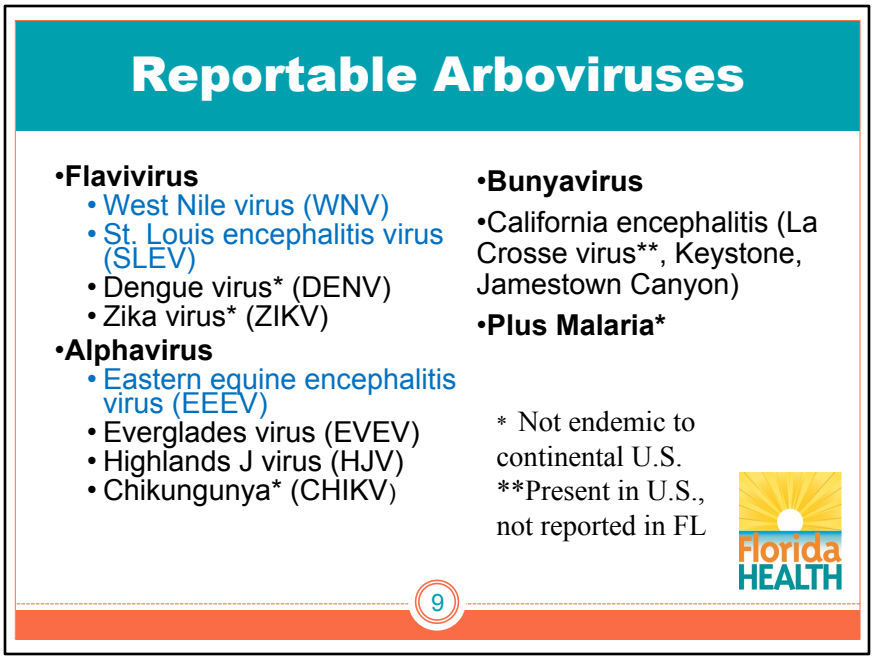

Arboviruses are RNA viruses, and the main ones that we do surveillance for here in Florida fall into 2 genera: flavivirus and alphavirus. The flaviviruses include St. Louis Encephalitis (SLE), West Nile (WN) virus, and Dengue virus. The alphaviruses include Eastern Equine Encephalitis (EEE) virus, and Highlands J (HJ).

Red= FL endemic

Reportable

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Dengue investigation guidance

Dengue Fever/Severe Dengue Fever/Chikungunya Fever!

Report on suspicion of infection during business hours

PROTOCOL CHECKLIST

- ☐ Enter available information into Merlin upon receipt of initial report
- ☐ Review background information on the disease (see Section 2), case definitions (see Section 3 for dengue and for chikungunya), and laboratory testing (see Section 4)
- ☐ Forward specimens to the Florida Department of Health (DOH) Bureau of Public Health Laboratories (BPHL) for confirmatory laboratory testing (as needed)
- ☐ Inform local mosquito control personnel of suspected chikungunya or dengue case as soon as possible (if applicable)
- ☐ Inform state Arbovirus Surveillance Coordinator on suspicion of locally acquired arbovirus

Florida HEALTH

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Dengue investigation guidance

- Detailed case investigation protocol-17 pages!
- Arrange for confirmatory testing at the public health laboratory
- Notify mosquito control district upon suspicion
- Notify statewide arbovirus coordinator upon suspicion of local case

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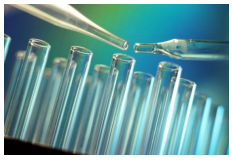
Testing at Bureau of Public Health Laboratories (BPHL)



- Antibody detection
  - **IgM**
  - IgG: recent or past exposure
- **PCR**
- **Culture**
- Plaque Reduction Neutralization Test (PRNT)

Florida HEALTH

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Advisories and Alerts

- Mosquito-borne illness risk level (1-5)
  - Awareness
  - Advisory
  - Alert
  - Threat
- County health department issues advisories and alerts in consultation with mosquito control district.



Florida HEALTH

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Talk about Level 2-4

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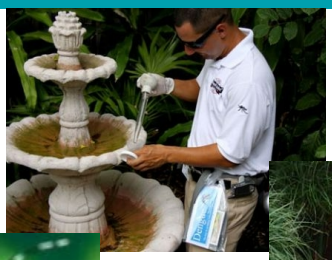
Aedes aegypti, the house mosquito







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Prevention



- Drenar y Cubrir
- Drennen epi Kouvri
- Draineret de Couvrir
- Drenar e Cobrir

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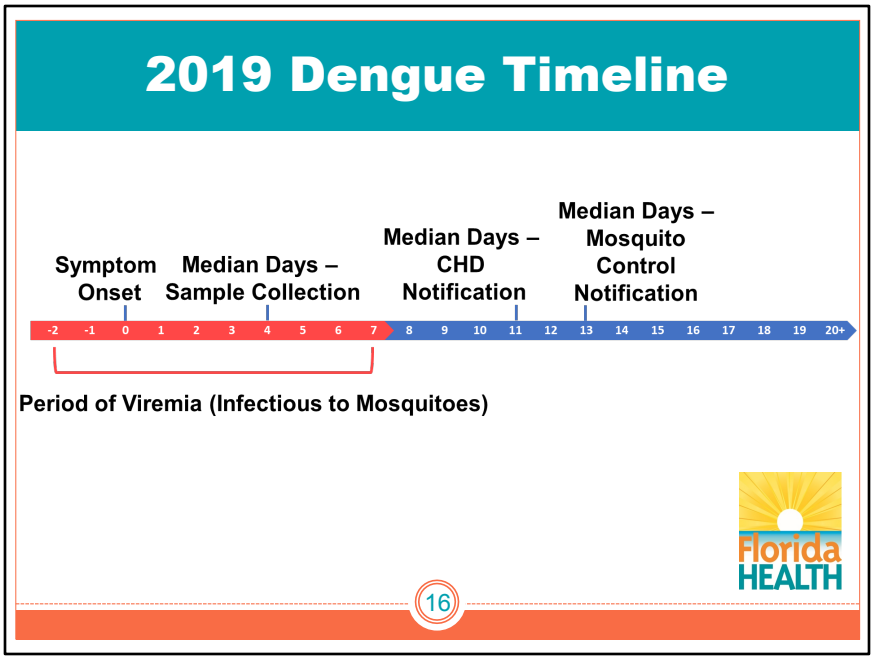

New slide
Font siize is questionable, CHD needs to be defined - ----AM: updated font size, added CHD definition to previous slide

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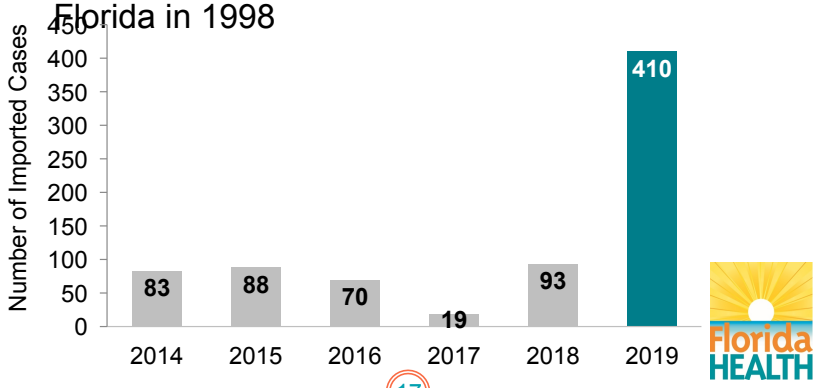
Florida Dengue Virus Activity, 2019

- Most imported cases reported in a single year since dengue became regularly reported in Florida in 1998



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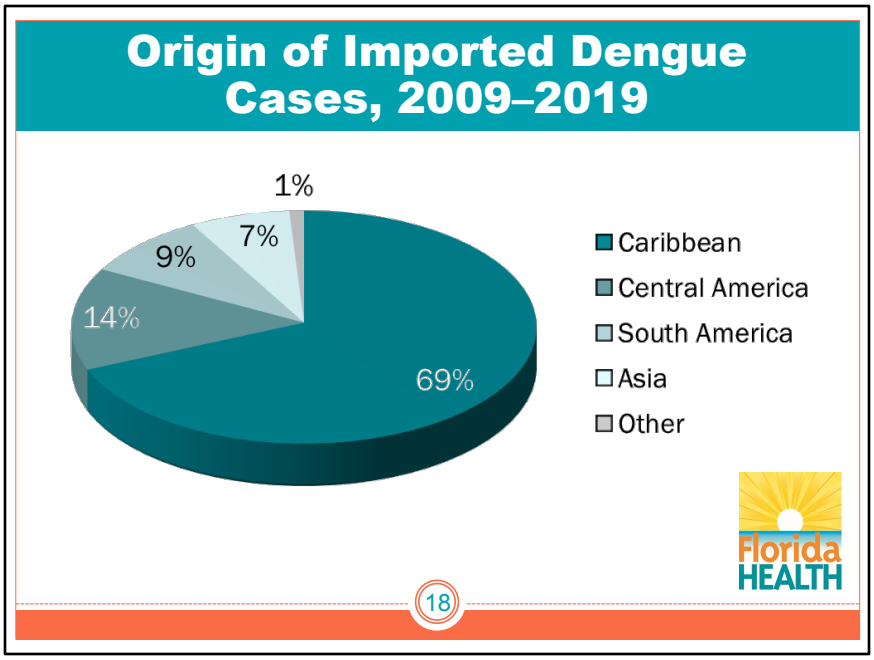

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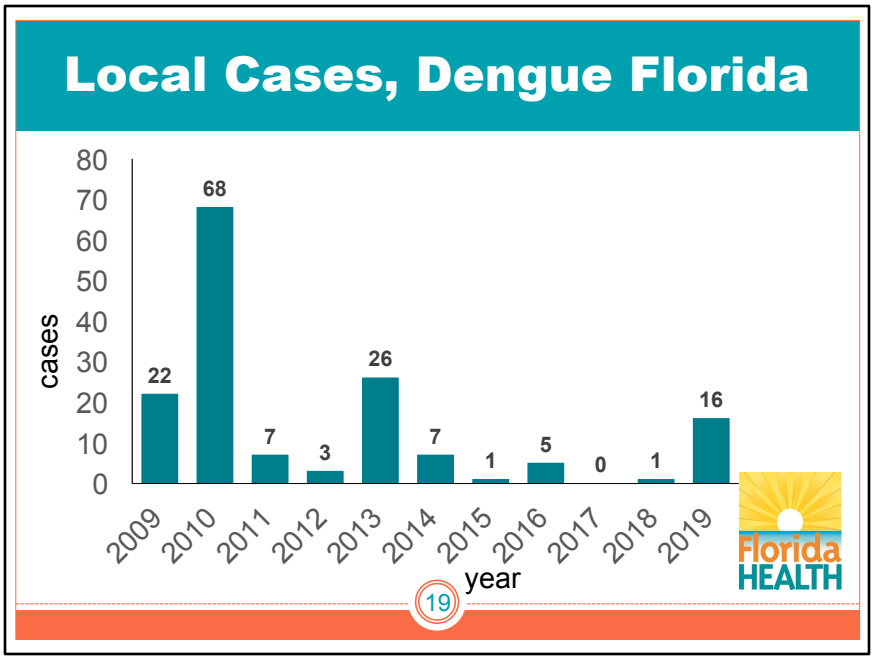

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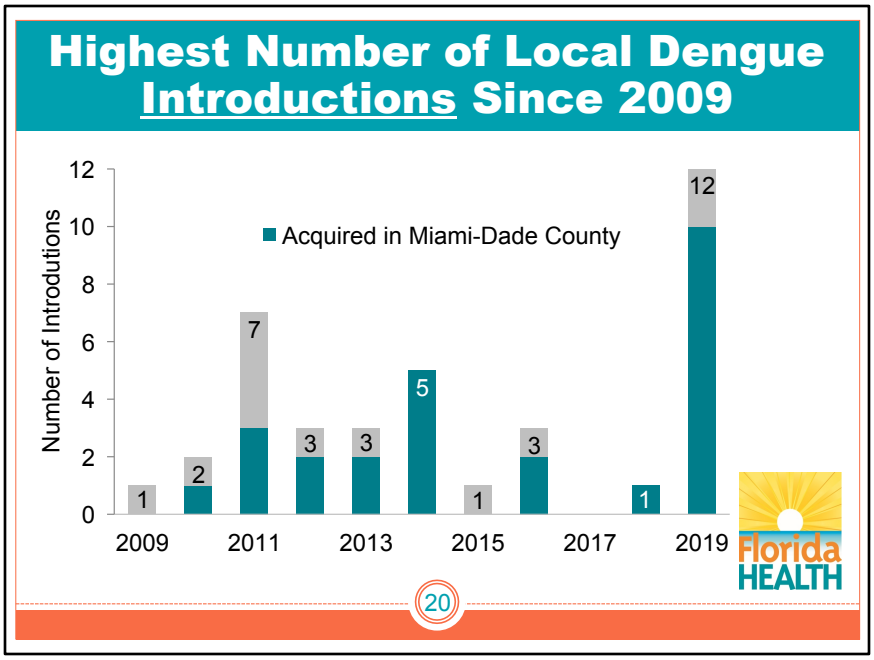

Most number of dengue virus introductions since 2009. Miami-Dade County has had the most introductions (26)

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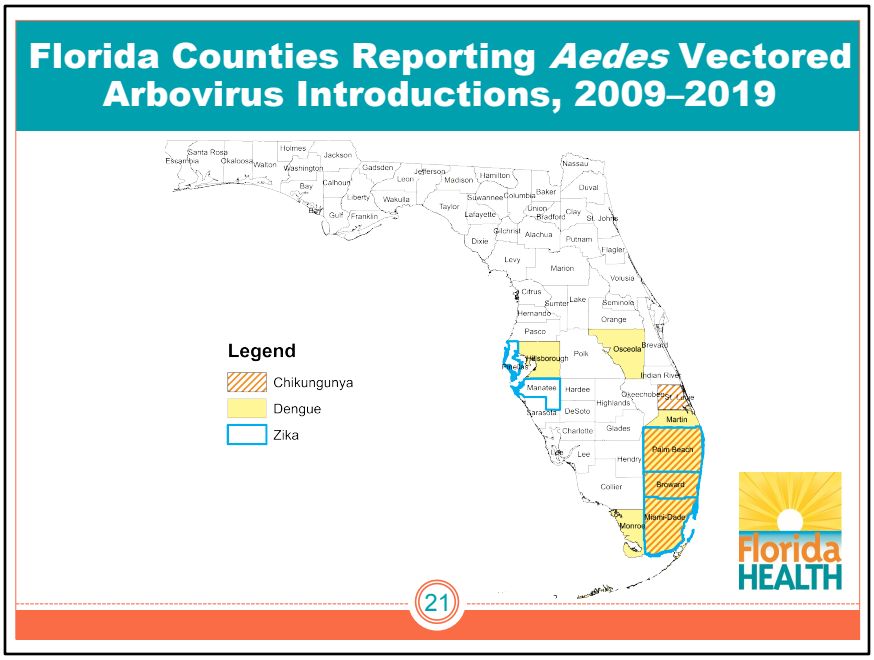

New slide

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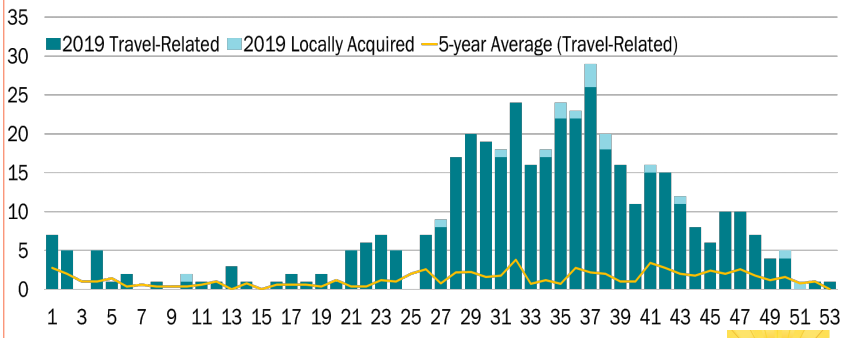
Dengue Timeline, 2019



Florida HEALTH

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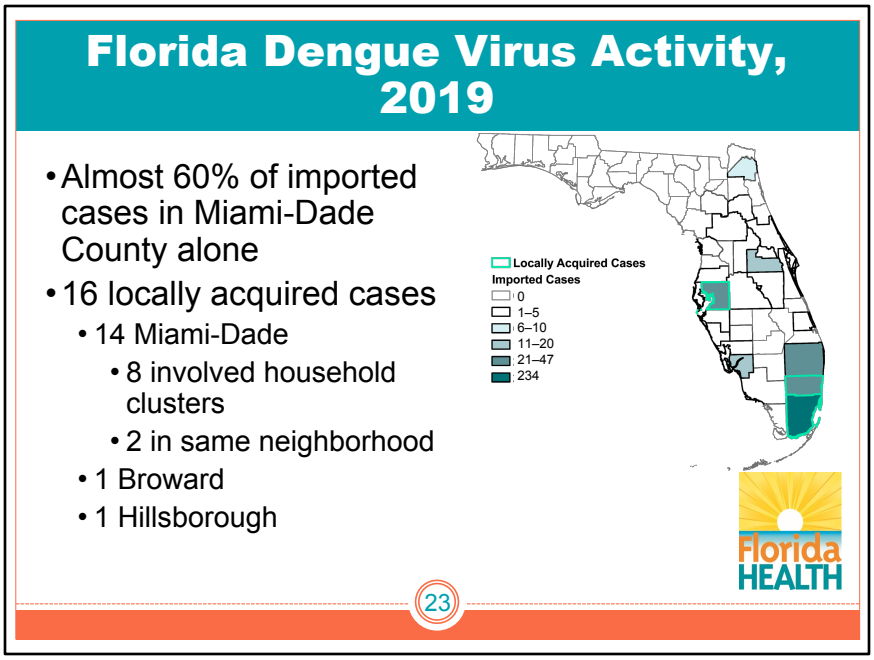

Total of 12 introductions
13 severe cases

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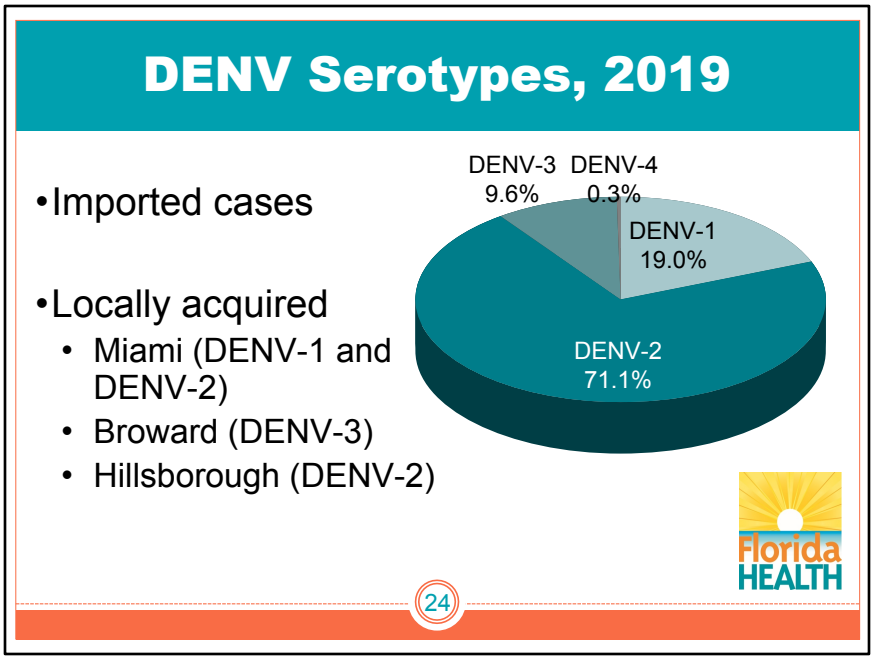

Figure shows imported cases

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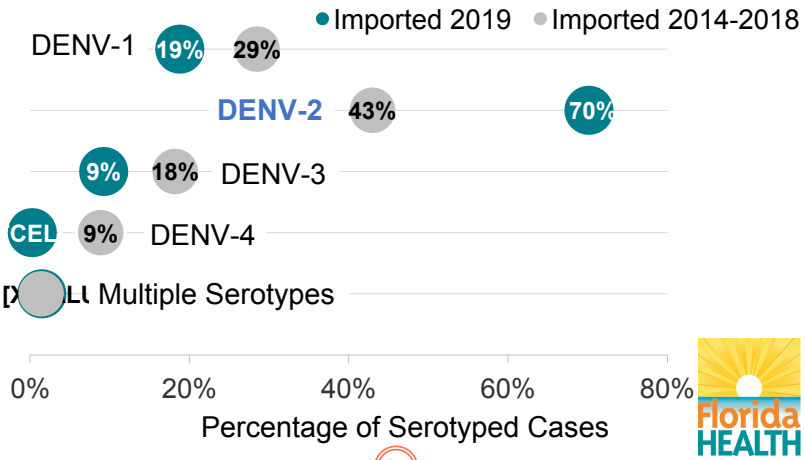
Large Increase in Imported Cases Exposed to DENV-2 in 2019



Florida HEALTH

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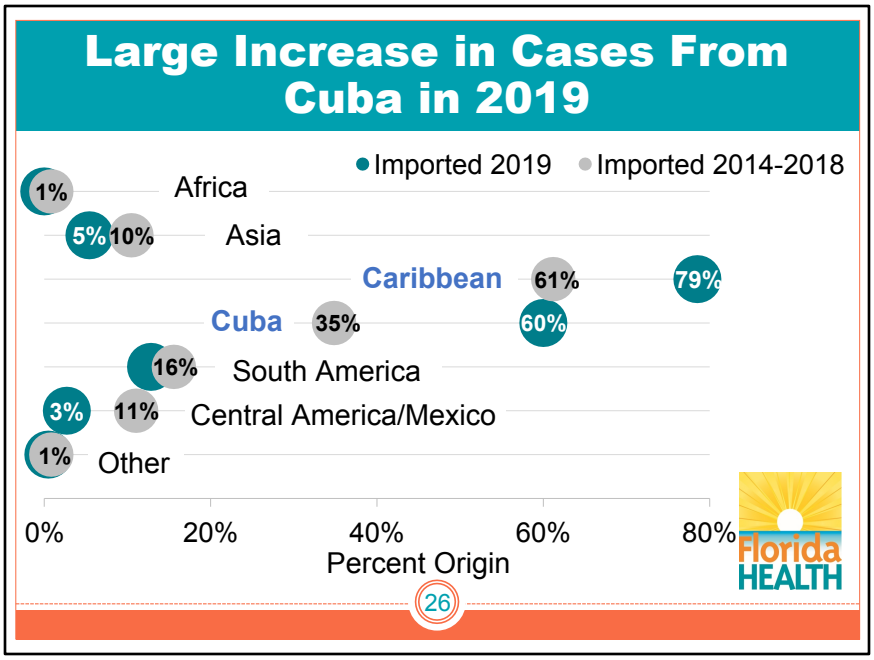

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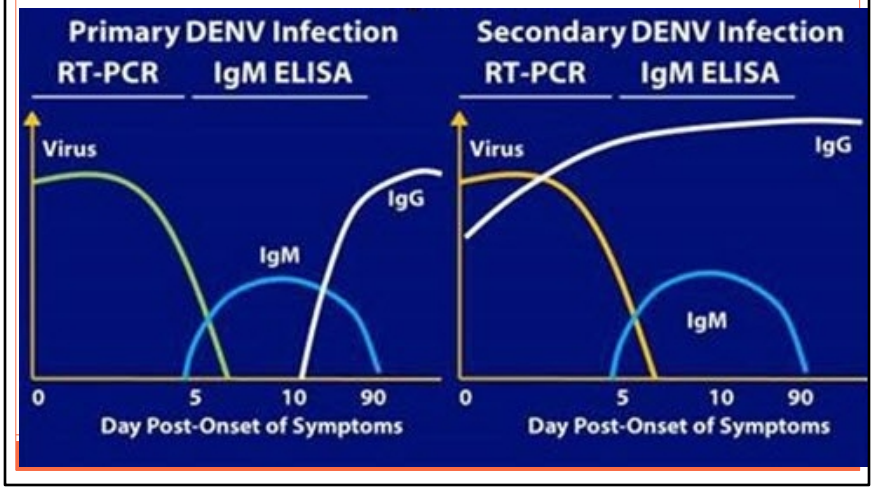
Dengue Diagnostic Testing



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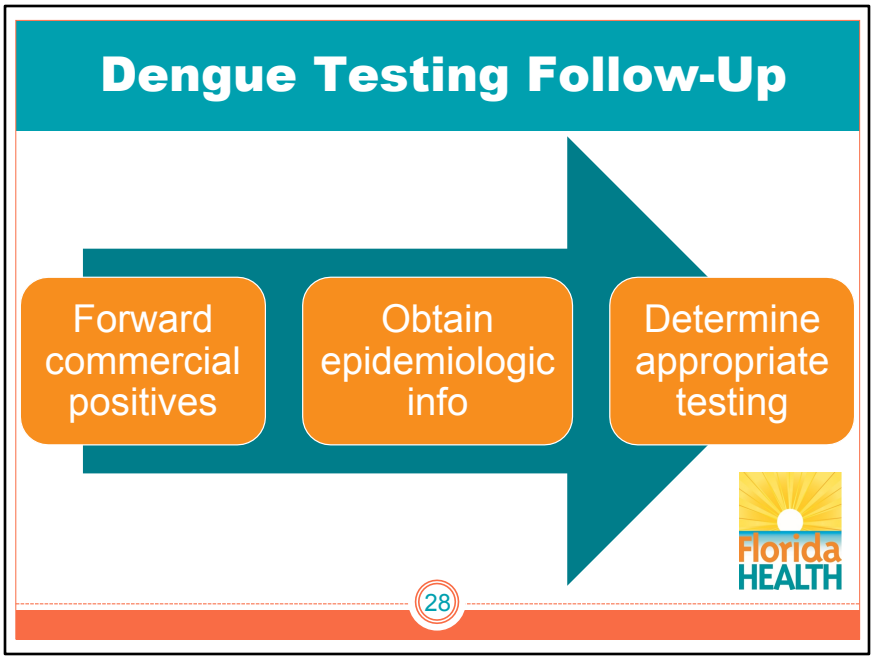

Sample forwarding to BPHL

Confirm commercial positives for samples meeting laboratory case criteria

Also

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review samples that are only IgG positive Epidemiologists determine appropriate testing (based on timing of symptoms, sample collection, and travel [if applicable])

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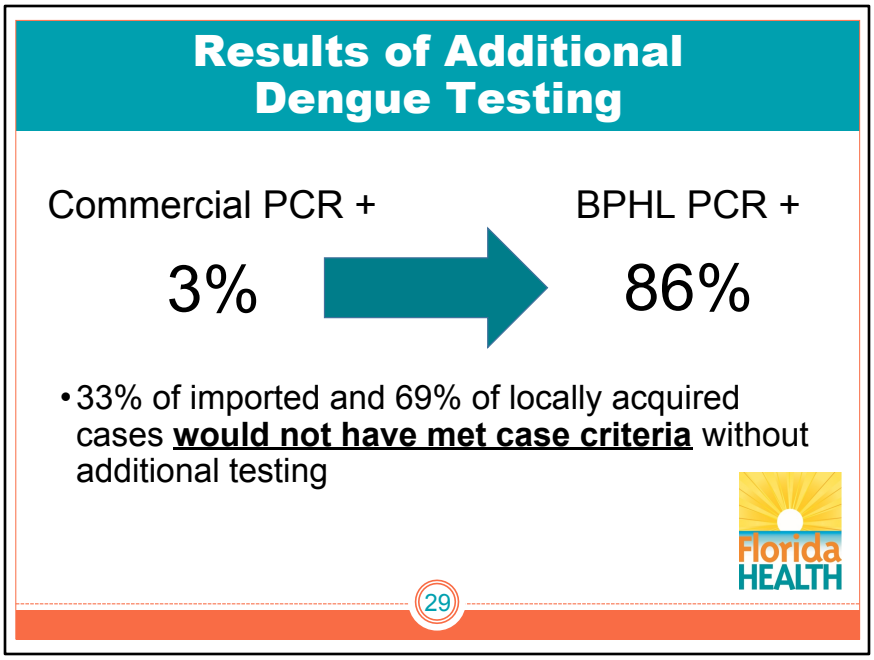

3% of cases were PCR positive at a commercial lab
Overall, 86% of dengue cases were PCR positive at bphl

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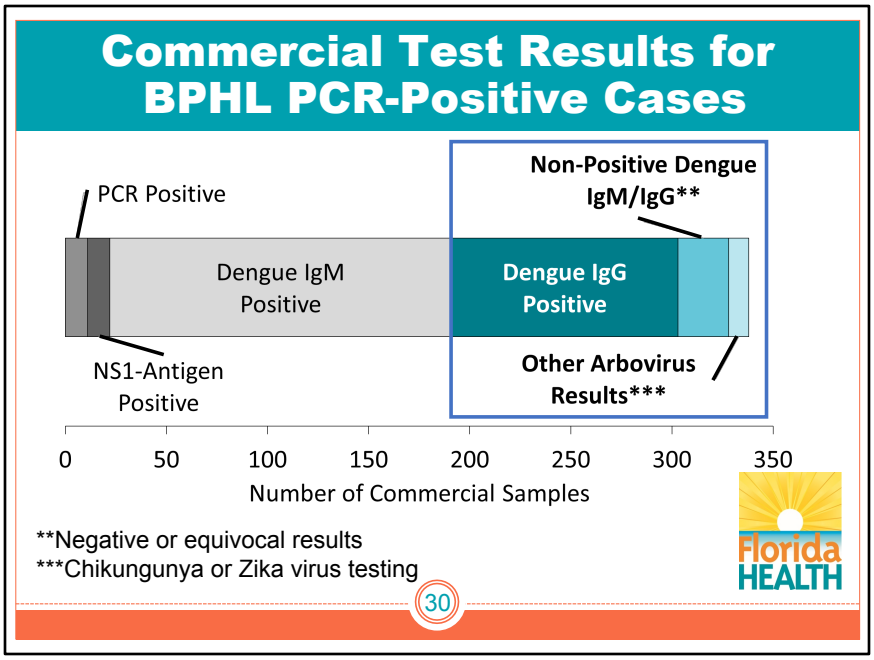

This slide shows the commercial test results for the samples that ended up being BPHL PCR+
Gray = met dengue laboratory case criteria
Non-positive = negative or equivocal serologic results, collected early after onset

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Questions?

Carina Blackmore, DVM, PhD
Florida Department of Health
Carina.Blackmore@FLHealth.gov
850-245-4732

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From:	Waterman, Steve (CDC/DDID/NCEZID/DVBD)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD)
Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 10:31:45 AM
Attachments:	image001.png Adam J Clinician Survey Texas Am J Trop Med Hyg 2014.pdf DengueCliniciansurveyAZ2015VectorborneZoonoticDis.pdf

Hi Carina
I'm sure you and others have done work on dengue clinical education for physicians in Florida. Do you have anything written up such as was done in Texas and Arizona regarding knowledge gaps?

Thanks.
Steve

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 21, 2020 11:09 AM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

The dengue file. Let me know if you need anything else

From: Chris Johnstone <cjohnstone@alakaina.com>
Sent: Friday, February 21, 2020 9:39 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Carina – To avoid surprises and misunderstandings. I would like to request that you make final edits to your presentations as needed and send me both slide decks once completed. What you send me is what will be on the computer at the podium.

Thank You,

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692

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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 21, 2020 9:11 AM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

CAUTION: This email originated from outside of the Alakaina FOC organization. DO NOT click links or open attachments unless you recognize the sender.

I am giving two different presentations. I didn't mean to send the emergency preparedness slides to you… I sent the dengue presentation to Steve. I sent a different presentation (the emergency preparedness presentation) to Nga. Didn't understand you needed to upload these so first sent a pdf, then sent the ppt to her but had to divide into a and b. Together they should be the same file as the emergency preparedness pdf. Does that make more sense. You can remove the draft watermark.

From: Chris Johnstone <cjohnstone@alakaina.com>
Sent: Friday, February 21, 2020 1:13 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Hi Carina – This is the 3rd slide deck I have for you. Is this presentation intended to replace one of the attached? Also this slide deck has a DRAFT watermark.

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692



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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 19, 2020 3:33 PM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week

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Presentation slides

CAUTION: This email originated from outside of the Alakaina FOC organization. DO NOT click links or open attachments unless you recognize the sender.

Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Sent: Wednesday, February 19, 2020 2:03 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Landry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: FW: Vector Week Presentation slides

Hi Carina
I hope you're doing well.

Just a friendly reminder if you could at your earliest convenience send the slides for your presentation for Vector Week's Tuesday afternoon's session on dengue to cjohnstone@alakaina.com (so she can load them ahead of time) with a copy to me along with a short bio, we'd much appreciate it.

See you next week.

Best regards,
Steve

Stephen Waterman, MD, MPH

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CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Thursday, February 13, 2020 12:09 PM
To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: RE: Vector Week Speaker Guidance

Hello Speakers for the Dengue Prevention and Control Session on Tuesday afternoon, February 25, 2020–

I want to thank you all again for agreeing to participate in this session. I think the audience will be excited about and learn a lot from what you all have to say!

Below is what we currently have you planning to talk about --- if your content is significantly different, please let us know as soon as possible!

1. *World Mosquito Program, Wolbachia replacement intervention trials (Steven Kern) ~20 min*

2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela Paz-Bailey) ~20 min*

3. *Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min*

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name

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b. Job title
c. Credentials
d. Name of organization

As noted below, if you can send your slides ahead of time to cjohnstone@alakaina.com, it would facilitate the logistics of loading of the presentations.

Looking forward to seeing you all in a couple of weeks.

Thanks again ~
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Sent: Friday, January 31, 2020 12:26 PM
To: Ciota, Alexander T (HEALTH) <alexander.ciota@health.ny.gov>; Rebecca.Osborn@dhs.wisconsin.gov; bcreiner@uw.edu
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; Powers, Ann (CDC/DDID/NCEZID/DVBD) <akp7@cdc.gov>; CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #8, Emerging Issues in Mosquito Borne Diseases**. The session is scheduled for Wednesday February 26, 2020, 10:00-11:15am in Salon II & III at the University Hilton in Fort Collins, CO.

Presentation time: 20 minutes
Speakers in session: 3
Moderator(s) (cc'd here): Ann Powers, Steve Waterman

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Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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Clinician Survey to Determine Knowledge of Dengue and Clinical Management Practices, Texas, 2014

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[1]*Epidemic Intelligence Service, Division of Scientific Education and Professional Development, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia;* [2]*Texas Department of State Health Services, Harlingen, Texas;* [3]*Texas Department of State Health Services, Harlingen, Texas;* [4]*Texas Department of State Health Services, Austin, Texas;* [5]*Division of Vector-Borne Diseases, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia;* [6]*Division of Global Migration and Quarantine, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia*

Abstract. Dengue, a mosquito-borne viral disease, is increasingly being identified as a cause of outbreaks in the United States. During July–December 2013, a total of three south Texas counties reported 53 laboratory-confirmed dengue cases; 26 were locally acquired, constituting the largest outbreak in Texas since 2005. Because dengue outbreaks are expected to continue in south Texas and early case identification and timely treatment can reduce mortality, we sought to determine clinicians' knowledge of dengue and its clinical management. A survey was sent to 2,375 south Texas clinicians; 217 (9%) completed the survey. Approximately half of participants demonstrated knowledge needed to identify dengue cases, including symptoms (56%), early indicators of shock (54%), or timing of thrombocytopenia (48%). Fewer than 20% correctly identified all prevention messages, severe dengue warning signs, or circumstances in which a dengue patient should return for care. Knowledge of clinical management was limited; few participants correctly identified scenarios when plasma leakage occurred (10%) or a crystalloid solution was indicated (7%); however, 45% correctly identified when a blood transfusion was indicated. Because of the ongoing threat of dengue, we recommend clinicians in south Texas receive dengue clinical management training.

INTRODUCTION

Dengue is a mosquito-borne acute febrile illness that is caused by one of four dengue viruses (DENV-1, 2, 3, and 4).[1] Dengue is endemic throughout the tropics and subtropics worldwide, including the Americas where the incidence of dengue has increased greater than 4-fold during the last three decades.[2] During the same period, the region has experienced an increase in both frequency of dengue outbreaks and disease severity.

In the United States, dengue is endemic in the territories of Puerto Rico and the U.S. Virgin Islands.[3] The majority of dengue cases identified in the 50 states are travel associated, and dengue is the leading cause of febrile illness among U.S. travelers returning from southeast Asia, Latin America, and the Caribbean.[4] Travel-associated dengue cases have led to outbreaks with local DENV transmission in Hawaii,[5] Florida,[6] and Texas.[7,8] Since 1980, Texas border communities have experienced multiple dengue outbreaks concurrent with epidemics in Mexico.[8–10] The possibility of dengue outbreaks in Texas is a continual threat because of its proximity to Mexico, substantial cross-border traffic, presence of *Aedes aegypti* mosquitoes,[11] and a predominantly nonimmune U.S. population.

Although the majority of DENV infections result in asymptomatic infection or mild acute febrile illness, a limited number (~5%) of symptomatic infected persons will develop severe dengue, a potentially life-threatening illness with a vascular leakage syndrome resulting in hypovolemic shock and hemorrhage.[12–14] Fatality rates for hospitalized patients with severe dengue can be as high as 10%; however, studies have reported that mortality rates can be reduced to < 0.5% with early case identification and timely initiation of correct clinical management.[1,15,16]

During May–October 2013, the Mexican state of Tamaulipas, which borders Texas, experienced a dengue epidemic and ~5,500 suspected dengue cases were reported.[17] During the same period in Texas, 53 laboratory-confirmed dengue cases (median patient age = 28 years, range = 1–85 years) were detected in south Texas border counties; 26 (49%) were locally acquired.[18] Although sporadic cases of dengue have been detected in south Texas during past decades, this outbreak was the largest since the 2005 outbreak in Brownsville, TX.[9,19] Because of the substantial increase in dengue cases reported along the United States–Mexico border, the Texas state and local public health officials partnered with Centers for Disease Control and Prevention (CDC) to develop strategies to reduce morbidity and mortality associated with dengue. One objective was to survey local Texas clinicians' knowledge of dengue and its clinical management to guide intervention strategies.

MATERIALS AND METHODS

Physicians, physician extenders (nurse practitioners [NPs], and physician assistants [PAs]) practicing medicine in the Texas counties of Cameron, Hidalgo, Starr, Willacy, and Zapata (collectively known as south Texas) were invited by e-mail to participate in the dengue clinical survey. We also invited clinicians from the Houston metropolitan area (HMA) to participate because of identification of both locally acquired and travel-associated dengue cases in the HMA.[20] We specifically sought participation from clinicians in general practice, family medicine, internal medicine, pediatrics, emergency medicine, infectious disease, hematology, obstetrics, and intensive care, because these medical specialties might be more likely to encounter a patient with dengue.

We developed our survey instrument by using multiple data sources to formulate the survey questions. We conducted key informant interviews with treating clinicians and

*Address correspondence to Tyler M. Sharp, Centers for Disease Control and Prevention, Dengue Branch, 1324 Calle Cañada, San Juan, Puerto Rico 00920. E-mail: iyp4@cdc.gov

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FL-DOH-20-0673-A-006330

a medical record review of confirmed and suspected dengue patients at south Texas hospitals to identify clinical management practices and whether these practices varied from the World Health Organization 2009 dengue guidelines[21]. Findings of deficiencies in recommended clinical management practices (e.g., failure to recognize dengue and warning signs for developing severe dengue, inaccurate understanding of dengue diagnostics, and use of nonsteroidal anti-inflammatory drugs [NSAIDs]) were used to develop survey questions.

The 28-question survey included 10 optional demographic questions and 18 technical questions. The technical questions were divided into three knowledge areas, including dengue prevention messages and anticipatory guidance, clinical presentation and course, and dengue clinical management. We also asked questions to assess clinical practice habits. We piloted the survey to assess for clarity and level of difficulty by using a convenience sample of nine physicians and incorporated feedback. The survey was administered online through SurveyMonkey® (SurveyMonkey, Palo Alto, CA).[22] Answering all technical questions was required to advance and complete the survey. After survey completion, participants were redirected to a webpage that provided the correct answers with explanations. Participants had the option to redirect to the CDC dengue website (http://www.cdc.gov/dengue) for additional information. Data were analyzed using IBM SPSS Statistics for Windows (Version 20.0; IBM Corporation, Armonk, NY) and difference in responses among groups was analyzed using Pearson's χ^2 test. Time in practice was analyzed using clinicians in practice > 30 years as the comparator. Some of the 18 technical questions had multiple correct answers, so each answer was treated like a true or false question. We decided a priori to exclude surveys from clinicians who were no longer practicing clinical medicine, practicing outside the catchment area, and did not return complete survey instruments. We chose to exclude the first and second categories of clinicians since our goal was to evaluate clinical decision-making in dengue-prone areas.

Potential participants included all members of local medical societies in south Texas and HMA. In addition, we partnered with the two major health systems in HMA to distribute our survey via e-mail to their clinician employees. All participants were invited via e-mail either through their membership with a local medical society or in the case of the HMA clinicians; many received an invitation from their employer. We were unable to access a list of all licensed clinicians in the catchment area. A letter of endorsement from the Regional Medical Director of south Texas was included with the e-mail containing the survey website link. As an incentive, participants completing the survey were entered in a drawing to win a tablet device provided by the CDC U.S. Mexico Unit. Participants were asked to complete the survey within 2 weeks; a reminder e-mail was sent after the first week had passed, if the survey had not been completed.

This survey was reviewed by CDC for human subjects protection, and was deemed to be nonresearch.

RESULTS

The survey was sent to 2,375 clinicians, including 1,410 (59%) physicians, 400 (17%) NPs, and 565 (24%) PAs (Figure 1). A total of 339 (14%) clinicians responded, although 71 (21%) did not complete all the technical questions and were excluded from analysis. Of 268 completed surveys, 51 (15%) were excluded because the participant was either not active in direct patient care or practiced outside of the defined catchment area. Data from the remaining 217 (9%) surveys were included in our analysis.

Response rates differed by the following geography and clinician type: HMA physicians had the highest response rate (16%), followed by HMA physician extenders (15%), south Texas physician extenders (8%), and south Texas physicians (4%). Participants from all regions were approximately equally split between physicians (54%) and physician extenders (46%) (Table 1). The majority (73%) of participants had been in practice for ≤ 20 years and reported working in an outpatient setting (86%). The majority (90%) of participants practiced in a primary care specialty, and a substantial number (42%) were pediatricians. The majority (81%) of participants had never diagnosed a case of dengue; 25 (12%) participants had diagnosed 1–4 cases. Seven (3%) participants (all south Texas physicians) reported having diagnosed > 20 dengue cases during their career; the majority of these participants were trained in infectious disease. Deficiencies in knowledge of dengue

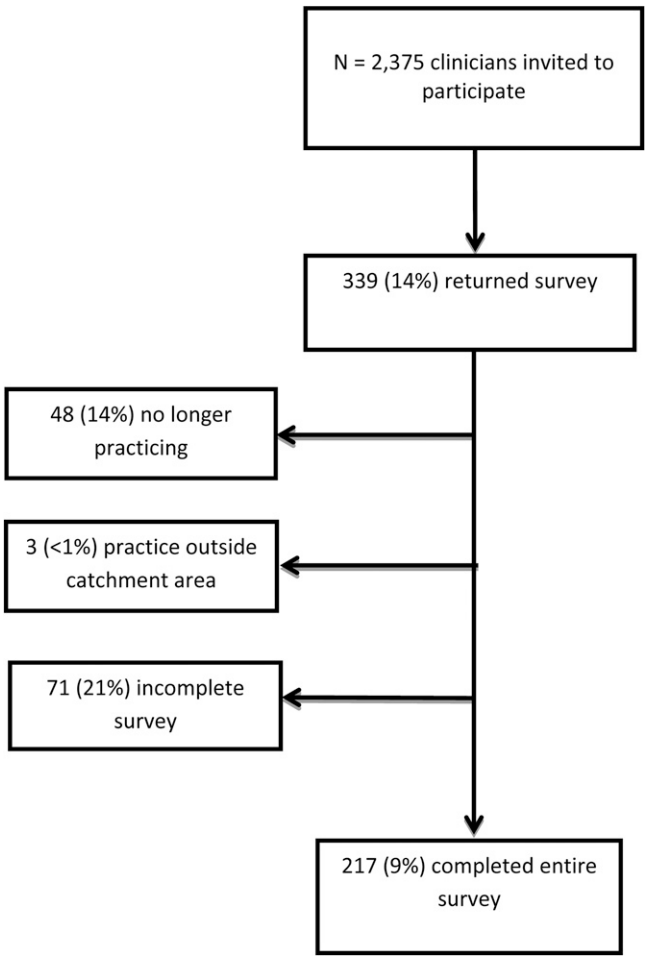

FIGURE 1. Clinician enrollment for dengue clinical survey in Texas during 2014.

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FL-DOH-20-0673-A-006331

TABLE 1
Dengue survey respondent characteristics by practice site and clinician type, Texas, 2014

Characteristic	All	South Texas		Houston metropolitan area	
		MD	NP or PA	MD	NP or PA
Response rate (%)		33/854 (4)	40/537 (7)	85/556 (15)	59/456 (13)
Total respondents, *n* (%)	217 (100)	33 (15)	40 (18)	85 (39)	59 (27)
Practice duration, years (*N* = 217)					
< 5	47 (22)	5 (15)	15 (38)	11 (13)	16 (27)
5–10	45 (21)	8 (24)	15 (38)	9 (11)	13 (22)
11–20	64 (30)	7 (21)	9 (23)	28 (33)	20 (34)
21–30	29 (13)	4 (12)	0 (0)	19 (22)	6 (10)
> 30	32 (15)	9 (27)	1 (3)	18 (21)	4 (7)
Practice site (*N* = 217)*					
Outpatient clinic	187 (86)	22 (67)	39 (98)	81 (95)	45 (76)
Community health center	11 (5)	3 (9)	1 (3)	1 (1)	6 (10)
ED or urgent care	28 (13)	11 (33)	4 (10)	4 (5)	9 (15)
Inpatient ward	48 (22)	12 (36)	1 (3)	21 (25)	14 (24)
ICU	19 (9)	6 (18)	2 (5)	8 (9)	3 (5)
Specialty (*N* = 217)*					
General practice	14 (7)	3 (9)	5 (13)	0 (0)	6 (10)
Family practice	57 (26)	7 (21)	17 (43)	10 (12)	23 (39)
Internal medicine	23 (11)	5 (15)	1 (3)	12 (14)	5 (9)
Pediatrics	90 (42)	9 (27)	18 (45)	54 (64)	9 (15)
Emergency medicine	11 (5)	8 (24)	1 (3)	0 (0)	2 (3)
Infectious disease	6 (3)	0 (0)	0 (0)	3 (4)	3 (5)
Hematology	6 (3)	1 (3)	1 (3)	0 (0)	4 (7)
Obstetrics or gynecology	9 (4)	1 (3)	2 (5)	3 (4)	3 (5)
Intensivist	3 (1)	0 (0)	1 (3)	1 (1)	1 (2)
Other	23 (11)	2 (6)	3 (8)	5 (6)	13 (22)
Dengue cases diagnosed (*N* = 204)					
None	166 (81)	13 (41)	33 (85)	66 (84)	54 (100)
1–4	25 (12)	9 (28)	6 (15)	10 (13)	0 (0)
5–10	6 (3)	3 (10)	0 (0)	3 (4)	0 (0)
11–20	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
> 20	7 (3)	7 (22)	0 (0)	0 (0)	0 (0)

ED = emergency department; ICU = intensive care unit; MD = medical doctor; NP = nurse practitioner; PA = physician assistant.
*Categories are not mutually exclusive.

were present among all groups, and no differences were noted among specialties.

Knowledge of anticipatory guidance and prevention messages. Participant knowledge of anticipatory guidance (education about expected dengue clinical course) and prevention messages did not vary by duration of practice (Table 2), but did vary by level of clinical experience with dengue patients (Table 3). Only a limited number of participants (6%) correctly identified two of two prevention messages (Table 4). Although nearly all (99%) participants knew that avoidance of mosquito bites is necessary to avoid dengue, only 38% correctly identified that febrile dengue patients should take precautions to avoid mosquito bites to prevent transmitting DENV to household members or neighbors. Participants who reported having diagnosed ≥ 1 case of dengue (i.e., dengue-experienced clinicians) were more likely than those who had never diagnosed a case (i.e., dengue-inexperienced clinicians) to identify both of these prevention messages (21% versus 2%, $P = 0.001$; Table 3).

Fewer than 1% of participants correctly identified all warning signs for severe dengue (Table 4), and the majority (59%) did not recognize severe abdominal pain as a warning sign for severe dengue. Dengue-experienced clinicians did not perform better than dengue-inexperienced clinicians in identifying warning signs (Table 3). Approximately one-fifth (19%) of participants were able to correctly identify all three situations that should prompt a patient with suspected dengue to return for care (e.g., persistent vomiting, drowsiness or lethargy, or hematemesis) (Table 4); dengue-experienced clinicians were more likely than dengue-inexperienced clinicians to correctly identify all three situations (34% versus 15%, $P = 0.006$; Table 3). The majority (70%) of participants correctly reported avoidance of administering NSAIDs (Table 4), although dengue-experienced clinicians were more likely to report doing so than dengue-inexperienced clinicians (84% versus 68%, $P = 0.041$; Table 3).

Knowledge of clinical presentation and course. Participant knowledge concerning clinical presentation and course of dengue did not vary by duration of medical practice or level of clinical experience with dengue patients (Tables 2 and 3). Approximately half (56%) of participants were able to identify all clinical signs and symptoms of dengue presentation (Table 4). A greater number (65%) of participants were able to correctly identify when plasma leakage might occur than were able to correctly identify when thrombocytopenia might be expected (46%). Approximately half (54%) of participants correctly identified tachycardia in the absence of fever or delayed capillary refill as the best early indicator of shock.

Knowledge of dengue clinical management. Participant knowledge of dengue clinical management varied somewhat by duration of practice (Table 2), but not by level of clinical experience with dengue patients (Table 3). A limited number (10%) of participants correctly identified two ways to detect clinically significant plasma leakage (i.e., a 20%

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TABLE 2
Dengue knowledge and reported practices by clinical practice duration, Texas, 2014

	Practice duration, years				
	≤ 10	*P* value	11–30	*P* value	> 30
Total respondents, *n* (%)	92 (42)		93 (43)		32 (15)
Knowledge of anticipatory guidance and prevention messaging					
Correctly identified all prevention messages	7 (8)	0.001	5 (5)	0.001	13 (6)
Correctly identified all warning signs for severe dengue	0 (0)	0.867	1 (1)	0.635	1 (3)
Correctly identifies circumstances when patients should return for care	16 (17)	0.634	20 (22)	0.473	5 (16)
Correctly tells patient to avoid NSAIDs	61 (66)	0.697	71 (76)	0.129	20 (63)
Knowledge of clinical presentation and course					
Understood timing of thrombocytopenia	48 (52)	0.606	41 (44)	0.784	15 (47)
Understood timing of plasma leakage	60 (65)	0.128	66 (71)	0.999	16 (50)
Correctly identified dengue signs and symptoms	52 (57)	0.739	53 (57)	0.704	17 (53)
Correctly identifies early indicators of shock	45 (49)	0.308	54 (58)	0.897	19 (59)
Knowledge of dengue clinical management					
Correctly identified scenarios of plasma leakage	6 (7)	0.139	15 (16)	0.015	0 (0)
Correctly identified indications for crystalloids	4 (4)	0.289	7 (8)	0.740	3 (9)
Identified crystalloids as initial fluid in setting of elevated hematocrit	41 (45)	0.078	55 (59)	0.200	23 (72)
Correctly identified indications for blood transfusion	32 (35)	0.033	47 (51)	0.577	18 (56)
Identified blood transfusion as initial fluid in the setting of clinical bleeding	64 (70)	0.268	73 (79)	0.861	24 (75)
Correctly identified when discharge criteria met	11 (12)	0.691	12 (13)	0.596	3 (9)
Considered comorbidities before discharge	33 (36)	0.003	39 (42)	0.021	21 (66)
Identified hemoconcentration as indication for further monitoring	56 (61)	0.633	53 (57)	0.391	21 (66)
Correctly identified appropriate dengue diagnostic testing	60 (65)	0.255	55 (59)	0.553	17 (53)
Clinical practice					
Prescribes corticosteroids for dengue patients	1 (1)	0.005	2 (2)	0.018	4 (13)
Understands Texas dengue reporting requirements	69 (75)	0.472	74 (80)	0.838	26 (81)
Orders dengue diagnostic testing*					
On all suspected dengue patients	47 (51)	0.083	40 (43)	0.012	22 (69)
Only patients with low platelet counts	10 (11)	0.802	11 (12)	0.920	4 (13)
Patients in ED	11 (12)	0.935	10 (11)	0.787	4 (13)
Patients admitted to hospital	11 (12)	0.336	20 (22)	0.740	6 (19)
When diagnosis is uncertain	23 (25)	0.491	26 (28)	0.650	10 (31)
Do not test for dengue	11 (12)	0.236	6 (7)	0.147	2 (6)
Never treated a patient	57 (62)	0.236	60 (65)	0.147	16 (50)

ED = emergency department; NSAIDS = nonsteroidal anti-inflammatory drugs.
*Not mutually exclusive categories.

increase of hematocrit above baseline level and chest radiograph with lateral decubitus view to identify pleural effusion) (Table 4). Only 7% correctly identified all three indications for intravenous crystalloids in dengue patients (i.e., initial fluid resuscitation for suspected dengue patient with hypotension, high hematocrit or tachycardia, and low urine output) (Table 4). Approximately half (55%) of participants recognized that intravenous crystalloids should be used as the initial fluid replacement in dengue patients with elevated hematocrit. Dengue-experienced clinicians were more likely than dengue-inexperienced clinicians to correctly identify this indication (76% versus 51%, $P = 0.005$; Table 3). Approximately one-fourth (26%) of all participants failed to recognize the need for blood transfusion instead of intravenous crystalloids in dengue patients with clinically significant bleeding (Table 4). The majority (61%) of participants knew that anti-DENV IgM antibodies are first detectable on days 3–5 after illness onset.

Dengue patients can present for medical care at any point during or after illness, and clinicians should anticipate the need for hospital admission and safe discharge. When presented with four possible scenarios for safe hospital discharge, dengue-experienced clinicians were more likely to take into consideration comorbidities (e.g., diabetes) than dengue-inexperienced clinicians (61% versus 39%, $P = 0.016$; Table 3). Numerous participants (40%) did not know that hemoconcentration is an indication for further monitoring (Table 4).

Clinical practice. Corticosteroid use in the management of dengue patients was correctly low (3%) among all participants (Table 2); a higher proportion of clinicians practicing ≥ 30 years reported prescribing corticosteroid use than those practicing < 30 years (13% versus 1% for < 10 years, $P = 0.005$; 13% versus 2% for 11–30 years of practice, $P = 0.018$; Table 3). A higher proportion of dengue-experienced clinicians reportedly ordered diagnostic tests for all suspected dengue patients than clinicians without dengue experience (74% versus 45%, $P = 0.001$; Table 4). In a similar way, a higher proportion of physicians reportedly ordered diagnostic tests for all suspected dengue patients compared with physician extenders (73% and 50% for south Texas and HMA physicians, respectively, versus 48% and 41% for south Texas and HMA physician extenders, respectively; $P = 0.030$ (Table 4). The majority (78%) of participants correctly identified that dengue is a reportable disease in Texas, and that suspected and confirmed cases should be reported to the health department within 1 week (Table 2).

DISCUSSION

This survey among HMA and south Texas clinicians revealed critical knowledge gaps of dengue and its clinical management. Overall knowledge of anticipatory guidance and prevention messages for dengue and its clinical management was low among all participants regardless of clinician type, years of practice, and experience managing

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TABLE 3
Dengue knowledge and reported practices by dengue clinical experience, Texas, 2014

	Ever diagnosed dengue		
	No	Yes	*P* value
Total respondents, *n* (%)	166 (81)	38 (19)	
Knowledge of anticipatory guidance and prevention messaging			
Correctly identified all prevention messages	4 (2)	8 (21)	0.001
Correctly identified all warning signs for severe dengue	1 (< 1)	1 (3)	0.176
Correctly identified circumstances patients should return to care	25 (15)	13 (34)	0.006
Correctly tells patients avoids NSAIDs	112 (68)	32 (84)	0.041
Knowledge of clinical presentation and course			
Understood timing of thrombocytopenia	77 (46)	20 (53)	0.487
Understood timing of plasma leakage	106 (64)	26 (68)	0.595
Correctly identified dengue signs and symptoms	93 (56)	22 (58)	0.834
Correctly identifies early indicators of shock	91 (55)	20 (53)	0.807
Knowledge of dengue clinical management			
Correctly identifies scenarios of leakage	14 (8)	7 (18)	0.176
Correctly identifies indications for crystalloids	9 (5)	3 (8)	0.559
Identified crystalloids as initial fluid in setting of elevated hematocrit	85 (51)	29 (76)	0.005
Correctly identifies indications for blood transfusion	70 (42)	19 (50)	0.380
Identified blood transfusion as initial fluid in the setting of clinical bleeding	124 (75)	28 (74)	0.897
Correctly identify when discharge criteria met	149 (90)	30 (79)	0.067
Considered comorbidities before discharge	65 (39)	23 (61)	0.016
Identified hemoconcentration as indication for further monitoring	99 (60)	23 (61)	0.920
Clinical practice			
Prescribes corticosteroids for dengue patients	3 (2)	3 (8)	0.
Understands Texas dengue reporting requirements	130 (78)	28 (74)	0.538
Orders dengue diagnostic testing*			
On all suspected dengue patients	74 (45)	28 (74)	0.001
Only on patients with low platelet counts	14 (8)	9 (24)	0.007
Patients in emergency department	17 (10)	8 (21)	0.067
Patients admitted to hospital	21 (13)	15 (40)	0.001
When diagnosis is uncertain	39 (24)	17 (48)	0.008
Do not test for dengue	15 (9)	3 (8)	0.823
Never treated a patient	123 (74)	0 (0)	0.001

NSAIDS = nonsteroidal anti-inflammatory drugs.
*Not mutually exclusive categories.

dengue patients. However, numerous clinicians did report correctly avoiding NSAIDS and ordering dengue diagnostic testing for patients suspected of having dengue. Participants understood dengue clinical presentation and course. Specific differences were noted between physicians and physician extenders in the identification of early indicators of shock and indications for blood transfusion. Physician extenders performed better concerning questions related to dengue identification than questions concerning inpatient clinical management, which might be related to training and practice sites (physician extenders may be more commonly involved in primary care versus specialty training). In addition, those in clinical practice > 10 years were more likely to identify the indications for blood transfusion in dengue patients than those practicing ≤ 10 years. Participants in clinical practice > 30 years were less likely to recognize scenarios of plasma leakage and more likely to prescribe corticosteroids to dengue patients than those practicing ≤ 30 years.

This survey was subject to multiple limitations, including participants' response and survey completion rates were low and varied with regard to specialty and geographic region. Specifically, HMA clinicians were more likely to participate, which might be attributable to differing recruitment methods in HMA and south Texas (i.e., the former received survey invitations from their employer and the latter from local medical societies). Second, the number of participating physicians from south Texas was low and prevented direct comparisons between groups. Third, less knowledge of inpatient clinical management might be attributable to an overrepresentation of outpatient clinicians. Fourth, the survey did not allow participants to leave any question blank, forcing a response to maximize the number of completed surveys for analysis but may have skewed the sample toward those with more knowledge on dengue. Fifth, the sampling method may have selected for clinicians with more interest in dengue and potentially biasing toward those with more dengue knowledge. Finally, we were unable to describe clinicians who did not complete the survey, which limited our ability to fully account for bias.

Response rates in clinician surveys have traditionally been poor with the best response rates being roughly 40–50%.[23] Despite the low response rate, clear deficiencies in knowledge about dengue were evident among all participants. Given the abovementioned limitations and biases, it is possible that knowledge was skewed toward those with greater dengue interest and knowledge, magnifying knowledge deficiencies. Clinicians who reported experience in diagnosing and managing dengue, albeit with a limited number of patients, still scored poorly. We identified knowledge gaps reported from similar clinical surveys administered in dengue-endemic areas; clinicians lacked knowledge about dengue clinical characteristics,[24] severe disease warning signs, discharge criteria,[25] and prevention methods.[26] Limited recognition of the critical phase of disease by clinicians was also demonstrated in

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TABLE 4
Dengue knowledge and reported practices by practice site and clinician type, Texas, 2014

	All	South Texas		Houston metropolitan area		P value
		MD	NP or PA	MD	NP or PA	
Total respondents, *n* (%)	217 (100)	33 (15)	40 (18)	85 (39)	59 (27)	
Knowledge of anticipatory guidance and prevention messages						
Correctly identified two of two prevention messages	13 (6)	4 (12)	3 (8)	5 (6)	1 (2)	0.231
Correctly identified all warning signs for severe dengue	2 (1)	1 (3)	0 (0)	1 (1)	0 (0)	0.460
Correctly identifies circumstances patients should return for care	41 (19)	10 (30)	4 (10)	24 (28)	3 (5)	0.153
Correctly tells patient to avoid NSAIDs	152 (70)	26 (79)	24 (60)	64 (75)	38 (64)	0.162
Knowledge of clinical presentation and course						
Understood timing of thrombocytopenia	104 (48)	18 (55)	24 (60)	33 (39)	29 (49)	0.123
Understood timing of plasma leakage	142 (65)	21 (64)	31 (78)	52 (61)	38 (64)	0.343
Correctly identified dengue signs and symptoms	122 (56)	18 (55)	25 (63)	51 (60)	28 (48)	0.390
Correctly identified early indicators of shock	118 (54)	21 (64)	9 (23)	60 (71)	28 (48)	0.001
Knowledge of dengue clinical management						
Correctly identified scenarios of plasma leakage	21 (10)	2 (6)	0 (0)	14 (17)	5 (9)	0.000
Correctly identified all indications for crystalloids	14 (7)	1 (3)	0 (0)	11 (13)	2 (3)	0.058
Identified crystalloids as initial fluid in setting of elevated hematocrit	119 (55)	23 (70)	12 (30)	58 (68)	26 (44)	0.01
Correctly identified all indications for blood transfusion	97 (45)	17 (52)	12 (30)	49 (58)	19 (32)	0.003
Identified blood transfusion as initial fluid in the setting of clinical bleeding	161 (74)	28 (85)	28 (70)	65 (77)	40 (68)	0.282
Correctly identified when discharge criteria met	26 (12)	7 (21)	2 (5)	10 (12)	7 (12)	0.211
Considered comorbidities before discharge	93 (43)	21 (64)	15 (38)	38 (45)	19 (32)	0.027
Identified hemoconcentration as indication for further monitoring	130 (60)	18 (55)	19 (48)	52 961)	41 (70)	0.153
Correctly identified appropriate dengue diagnostic testing	132 (61)	21 (64)	28 (70)	56 (66)	27 (46)	0.045
Clinical practice						
Prescribes corticosteroids for dengue patients	7 (3)	1 (3)	2 (5)	4 (5)	0 (0)	0.000
Understands Texas dengue reporting requirements	169 (78)	22 (67)	30 (75)	71 (84)	46 (78)	0.243
Orders dengue diagnostic testing*						
On all suspected dengue patients	109 (50)	24 (73)	19 (48)	42 (50)	24 (41)	0.030
Only patients with low platelet counts	25 (12)	4 (12)	6 (15)	10 (12)	5 (9)	0.794
Patients in ED	25 (12)	4 (12)	8 (20)	9 (11)	4 (7)	0.240
Patients admitted to hospital	37 (17)	11 (33)	6 (15)	17 (20)	3 (5)	0.005
When diagnosis is uncertain	59 (27)	13 (39)	13 (33)	21 (25)	12 (20)	0.194
Do not test for dengue	19 (9)	4 (12)	6 (15)	5 (6)	4 (7)	0.310
Never treated a patient	133 (61)	5 (15)	25 (63)	56 (66)	47 (80)	0.001

ED = emergency department; MD = medical doctor; NP = nurse practitioner; NSAIDS = nonsteroidal anti-inflammatory drugs; PA = physician assistant.
*Not mutually exclusive categories.

a survey conducted in Puerto Rico.[16] These surveys were conducted in endemic areas and reported higher response rates than our survey. However, it is likely that physicians working in areas which see only sporadic dengue (such as south Texas) have less knowledge about dengue, especially since U.S. medical education often lacks tropical medicine training.

These findings highlight a need for clinical management training for U.S. clinicians across all points of care in regions likely to treat dengue patients. Training is especially important in south Texas, because studies have demonstrated a continued risk for dengue outbreaks attributable to a highly mobile and susceptible population, regular DENV introduction, and presence of competent mosquito vectors in south Texas.[11] Further, all four DENV have been reported in the region, thereby increasing risk for secondary infections among the susceptible resident U.S. population.[9] Because dengue patients experiencing secondary DENV infection are associated with increased risk for developing severe dengue, compared with patients with primary infection,[1] future outbreaks in south Texas might be associated with increased incidence of severe dengue.[8]

Focus on clinician training and education in areas at risk for DENV transmission or among clinicians who serve at-risk travelers is an important public health strategy to decrease morbidity and mortality associated with dengue. Previous physician trainings on dengue clinical management in Puerto Rico demonstrated improved management of hospitalized dengue patients after the implementation of a classroom-style physician training course.[27] Medical curriculum should emphasize identified knowledge gaps, including warning signs for severe dengue and the clinical management of severe dengue. Online curriculum such as the CDC's Dengue Clinical Management Course (http://www.cdc.gov/dengue/training/cme.html) is an attractive option for education with free continuing medical education. Clinicians in Texas might also benefit from cross-border collaboration with clinicians in Mexico who have extensive dengue experience; possible projects might include clinical exchange programs or clinical research collaboration.

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Dengue Knowledge, Attitudes, and Practices Among Arizona Health Care Providers, 2014–2015

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Abstract

Background: Detection of local dengue transmission requires an aware and engaged medical community, as health care providers are the front line of public health surveillance. To assess the knowledge, attitude, and practice about dengue, an online survey was distributed among Arizona health care providers during 2014 and 2015.

Materials and Methods: The survey consisted of a total of 10 knowledge, attitude, and practice questions divided as follows: 5 knowledge questions, 2 attitude questions, and 3 practice questions. The link to the Qualtrics survey was distributed through the Arizona Health Alert Network to a total of 4582 e-mail addresses, of which 335 participants opened the survey, and 196 completed and submitted their responses.

Results: Less than half the respondents reported choosing the right dengue diagnostic test (40.4%) or understanding the epidemiology of dengue in Arizona (40.9%). Slightly more than half the respondents reported frequently asking for travel history (59%), and three-fourth of them would notify the local health department on suspicion of a dengue patient (76.1%). Survey score was associated with providers specialized in infectious diseases (1.88, 95% CI: 0.42–3.33, $p = 0.01$), medical doctors or doctors of osteopathic medicine (1.82, 95% CI: 0.98–2.65, $p < 0.0001$), and respondents who reported to have heard about the increase in dengue cases in Sonora (Mexico) in fall 2014 (1.51, 95% CI: 0.67–2.34, $p = 0.0005$), indicating better survey performance.

Conclusions: These results indicate that education for health care providers on dengue should be improved particularly among general practice noninfectious disease providers who might be the first point of care for dengue patients. Findings suggest that additional training on clinical management, asking travel history, and notifying the local health department on suspicion of a dengue patient are needed.

Keywords: dengue, Arizona, Mexico, knowledge, arboviral diseases

Introduction

Dengue viruses can cause serious and potentially fatal acute febrile illness. An estimated 390 million cases of dengue infection occur annually worldwide (Bhatt et al. 2013), with infections increasing nearly 30-fold in the past 50 years (WHO 2009). An estimated 500,000 of these infections are cases of severe dengue, and 22,000 result in fatalities annually (Brady et al. 2012, Bhatt et al. 2013). Dengue is caused by infection with any one of four viral serotypes: DENV-I, DENV-II, DENV-III, or DENV-IV, which are transmitted by *Aedes* (*Ae.*) species mosquitoes, primarily *Aedes aegypti* and *Aedes albopictus*.

In the United States, dengue outbreaks have occurred in the last 15 years in Florida (CDC 2010), Texas (Abell et al. 2007, Thomas et al. 2016), and Hawaii (Johnston et al. 2016). The disease is endemic in Mexico, with the annual number of dengue cases increasing from 1714 cases in 2000 to 15,424 in 2011 (Dantes et al. 2014). The Mexican state of Sonora, which borders Arizona, has also seen an increase in the number of dengue cases in 2010 and in 2014, when it reached an incidence of 100 cases per 100,000 population (DGE 2014).

Beginning in September 2014, an increase in locally acquired dengue cases in Sonora, Mexico, was reported in the border region with Arizona. Between December 2014 and

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January 2015, a binational dengue outbreak was identified, with 52 cases detected in San Luis Rio Colorado, Sonora, and 70 cases reported in the neighboring Arizona border county of Yuma (Jones et al. 2016). This outbreak represented a ninefold increase in reported cases among Arizona residents compared with 10 dengue cases reported in 2010 and 2012 (1994–2009 median of 2 cases annually). Despite the increase in cases, no locally acquired cases in Arizona were identified as all cases reported travel to Mexico within 14 days before symptom onset (Jones et al. 2016).

Arizona is home to a dengue-competent mosquito vector, *Ae. aegypti*, which is known to be well-established across parts of the state (ADHS 2016). Although the complete range of *Ae. aegypti* in Arizona is unknown, current and historical data suggest substantial establishment in central and southern Arizona, including the Arizona-Sonora border region. The mosquito's presence in Arizona, along with the northward expansion of dengue virus infections toward the border, enhances the likelihood of both locally acquired and travel-associated dengue cases in Arizona. Early detection of locally acquired cases is particularly important, to promptly initiate a public and environmental health response to avoid the spread of the disease in Arizona. Identification of locally acquired dengue cases requires an aware and engaged medical community; as the front line of public health surveillance, health care providers start the process of outbreak investigation and control by reporting suspected cases to local public health officials. To detect locally acquired cases, health care providers should have detailed knowledge of dengue epidemiology, symptoms, appropriate diagnostic tests, and reporting procedures.

To better understand the knowledge and behaviors of health care providers in Arizona with respect to dengue, we administered a knowledge, attitudes, and practices (KAP) survey to Arizona providers between December 2014 and March 2015, starting soon after the identification of the binational dengue outbreak in Yuma County. The goals of this survey were to assess providers' knowledge of dengue epidemiology, symptoms and transmission, confidence in diagnosing and treating the disease, and practices when treating a patient with suspected dengue virus infection. A few studies have been published on the knowledge, attitudes, or practices of providers with respect to dengue in the United States, specifically in Puerto Rico (Tomashek et al. 2014), in Florida (Doblecki-Lewis et al. 2016), and in Texas (Adam et al. 2017). However, our study is unique as it surveyed physicians in Arizona, a state that has not yet reported local dengue transmission, but that is at high risk of dengue emergence.

Materials and Methods

The survey consisted of a total of 10 multiple choice KAP questions divided as follows: 5 knowledge questions (clinical symptoms, transmission, diagnosis, treatment, and epidemiology), 2 attitude questions (confidence in diagnosis and treatment), and 3 practice questions (reporting, asking for travel history, and ordering of laboratory testing). In addition, an eight-question demographics section gathered information about the participants' county of practice, number of years practicing in Arizona, patient demographics, medical specialty, and type of health care practice.

Qualtrics software (Qualtrics, Provo, UT) was used to collect responses. A link to the survey was distributed thrice through the Arizona Health Alert Network, a tool used by the Arizona Department of Health Services (ADHS) to distribute important alerts to public health officials and health care professionals and to ADHS Division of Licensing e-mail lists, in December 2014, January 2015, and March 2015. These lists had a total of 4582 e-mail addresses, which included: $\sim$3000 points of contacts for licensed medical facilities, 1128 independent health care providers, 12 medical organizations, 250 hospital infection preventionists, and 192 emergency department directors. However, it is difficult to accurately determine the number of unique providers reached as some e-mails might have reached nonclinical or nonpracticing health care workers and some organizations might have further disseminated the link to their individual members.

This project was evaluated by the Arizona Human Subjects Review Board and found to be a nonresearch activity (HSRB 16-0042).

By the end of the survey period, 335 participants had opened the survey, and 196 completed and submitted their responses, corresponding to a 4.3% response rate (196/4582). Only respondents involved in direct patient care were included in the analysis ($n=188$), excluding, for example, medical students and pharmacists. Differences in clinical degree type were analyzed by grouping doctors of medicine (MDs) or doctors of osteopathic medicine (DOs) ($n=106$) and nurse practitioners (NPs) or physician assistants (PAs) ($n=39$); registered nurses or nurses holding a bachelor of science in nursing ($n=15$) and respondents with other or missing degrees ($n=6$ and 22, respectively) were excluded from this component of the analysis due to the small numbers of these respondents.

To analyze a respondent's overall performance, each answer to the 10 KAP questions was given a point value of 1 (inadequate knowledge), 2 (adequate knowledge), or 3 (high knowledge) (see Supplementary Table S1 for details); an overall KAP score, ranging from 10 to 30, was calculated for each respondent as the sum of points from the 10 questions. For categorical variables, chi-squared test or Fisher's exact tests (for $n<21$) were used to identify differences. *t*-Tests were used for comparisons of mean KAP scores between degrees or other characteristics. Associations with $p<0.05$ were considered significant. Stepwise multivariate linear regression was used to identify independent predictors of KAP score, and predictors with $p<0.05$ were retained in the final model. Data were analyzed using SAS 9.3 software (Institute, Inc., Cary, NC).

Results

Of the 188 respondents included in the final analysis, the majority ($n=106$, 64%) were MDs or DOs; 22 had missing degrees. The most commonly reported specialties were family medicine (24%), pediatric medicine (18%), or emergency medicine (15%); practice locations were mainly private offices or clinics (48%) or hospitals (32%) (Table 1). The majority of the participants had practiced in Arizona for more than 10 years (57%), practiced in an urban county (73%), and practiced in a county not bordering Sonora, Mexico (65%). Participants were located throughout Arizona (11 of 15

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Table 1. Characteristics of the Health Care Professionals Included in the Analysis ($N = 188$)

Respondent characteristics (n = *188*)	n *(%)*
Degree (missing = 22)	
DO/MD	106 (63.8)
NP/PA	39 (23.5)
RN/BSN	15 (9.0)
Other	6 (3.6)
Specialty (missing = 12)	
Family medicine	43 (24.0)
Pediatric medicine	31 (17.6)
Emergency medicine	26 (14.7)
Internal medicine	14 (7.9)
Infectious diseases	13 (7.4)
Other[a]	49 (27.8)
Practice location (missing = 13)	
Private office/clinic	84 (48.0)
Hospital	56 (32.0)
Urgent care	10 (5.7)
School/College Health Center	5 (2.9)
Community Health Clinic	4 (2.3)
Health Department	2 (1.1)
Clinical social programs	2 (1.1)
Indian Health Services	2 (1.1)
Other	7 (4.0)
Years of practice in Arizona (missing = 12)	
>10 years	101 (57.4)
6–10 years	35 (19.9)
1–5 years	31 (17.6)
1 year or less	9 (5.1)
County of practice type (missing = 14)	
Urban	128 (73.5)
Rural–rural	35 (20.1)
Rural–urban	11 (6.3)
County of practice bordering Mexico (missing = 14)	
Yes	64 (36.8)
No	110 (63.2)
Percent of patients that are primarily Spanish speaking (missing = 14)	
0%	16 (9.2)
1–24%	87 (50.0)
25–49%	50 (28.7)
>50%	18 (10.3)
Don't know	3 (1.7)
Serving predominantly Native American population (missing = 16)	
Yes	19 (11.1)
No	153 (88.9)
Having seen patients meeting the clinical dengue case definition[b] since October 2014 (missing = 2)	
Yes	17 (9.1)
No	150 (80.7)
Don't know	19 (10.2)
Having heard of the increase in dengue cases in Sonora (Mexico) in fall 2014 (missing = 3)	
Yes	101 (54.6)
No	84 (45.4)

Percentages exclude missing values.

[a]"Other" specialty includes: optometry, geriatrics, obesity medicine, hospitalist, dermatology, pain management, international practice/travel medicine.

[b]CDC/NNDSS Clinical dengue case definition: fever as reported by the patient or health care provider and the presence of one or more of the following signs and symptoms: nausea/vomiting, rash, aches and pains, tourniquet test positive, leukopenia (a total white blood cell count of $<5000/mm^3$), or any warning sign for severe dengue (abdominal pain or tenderness, persistent vomiting, extravascular fluid accumulation, mucosal bleeding at any site, liver enlargement >2 cm, increasing hematocrit concurrent with rapid decrease in platelet count) (WHO, 2009).

DO, doctor of osteopathic medicine; MD, doctor of medicine; NP, nurse practitioner; PA, physician assistant; RN, registered nurse; BSN, bachelor of science in nursing.

counties), although the majority were from Maricopa (42%) and Pima (31%) counties (Fig. 1). Maricopa and Pima counties are the most populated counties in Arizona, making up ~60% and 15% of the state's population, respectively, and are home to the top 2 most populated cities in the state (Phoenix and Tucson). Both cities are only a few hours away from the United States–Mexico border (181 miles for Phoenix and 68 miles for Tucson), so the population at risk of acquiring dengue from across the border and importing the disease in the state is potentially very high.

Half of respondents reported a low proportion (1–24%) of primarily Spanish speaking patients; only 10% reported that >50% of their patients were primarily Spanish speaking. Approximately 11% of respondents reported serving a predominantly Native American population. Few (9%) reported seeing a patient in the past year that met the CDC/NNDSS clinical dengue case definition ["acute onset of fever plus two or more of the following signs or symptoms: headache, retro-orbital pain, myalgia, arthralgia, rash, hemorrhagic manifestation, leukopenia, and not fitting another diagnosis" (NNDSS 2010); Table 1].

In questions about knowledge of dengue symptoms and transmission, the majority of respondents correctly identified common symptoms of dengue (88% identified fever and 56% hemorrhagic manifestations), the correct route of transmission (89% reporting mosquito bite as possible transmission route), and appropriate treatment (64% reporting intravenous [IV] fluids) (Table 2). Respondents were less knowledgeable about geographic areas with active dengue transmission and clinical and laboratory diagnostic techniques (Fig. 2 and Table 2). Specifically, 41% of the respondents incorrectly reported that the Arizona border region (*e.g.*, Yuma, AZ; Nogales, AZ; Douglas, AZ) was endemic for dengue virus; this region has reported only travel-associated cases to date. There was also a notable lack of knowledge about the appropriate diagnostic methods for dengue virus infection, with ~60% of respondents unable to identify that ELISA (IgM/IgG) should be used ≥5 days after symptom onset and PCR should be used <5 days from symptom onset (Table 2). Participants also reported low confidence in diagnosis and treatment of patients with dengue virus infection, regardless of whether it was a mild case (35% confidence in diagnosis and 44% confidence in treatment) or a severe case (44% and 26% confidence for diagnosis and treatment, respectively). More than half of respondents reported that they regularly asked patients about travel history (60%) and would notify public health partners about suspected dengue cases (76%) (Fig. 2 and Table 2).

When results were compared by respondents' degree, DO/MDs had higher scores than NP/PAs in the knowledge and attitude questions. Specifically, NP/PAs less frequently identified hemorrhagic manifestations as a sign or symptom of dengue (33% vs. 68%, $p < 0.001$) (Table 3). They also less frequently reported that dengue can be transmitted through blood transfusions (36% vs. 61%, $p = 0.006$) or *in utero* (20% vs. 42%, $p = 0.011$). The correct diagnostic tests were less frequently reported by NP/PAs than by DO/MDs (13% vs. 55%, $p < 0.001$) and IV fluids less frequently recognized as a common dengue treatment (56% vs. 74%, $p = 0.03$). The KAP score was significantly different between DO/MDs and NP/PAs, with DO/MDs performing better (mean of 20.19, 95% CI 19.5–20.8 for DO/MDs vs. 17.70, 95% CI 16.8–18.5 for NP/PAs, *t*-test $p < 0.001$).

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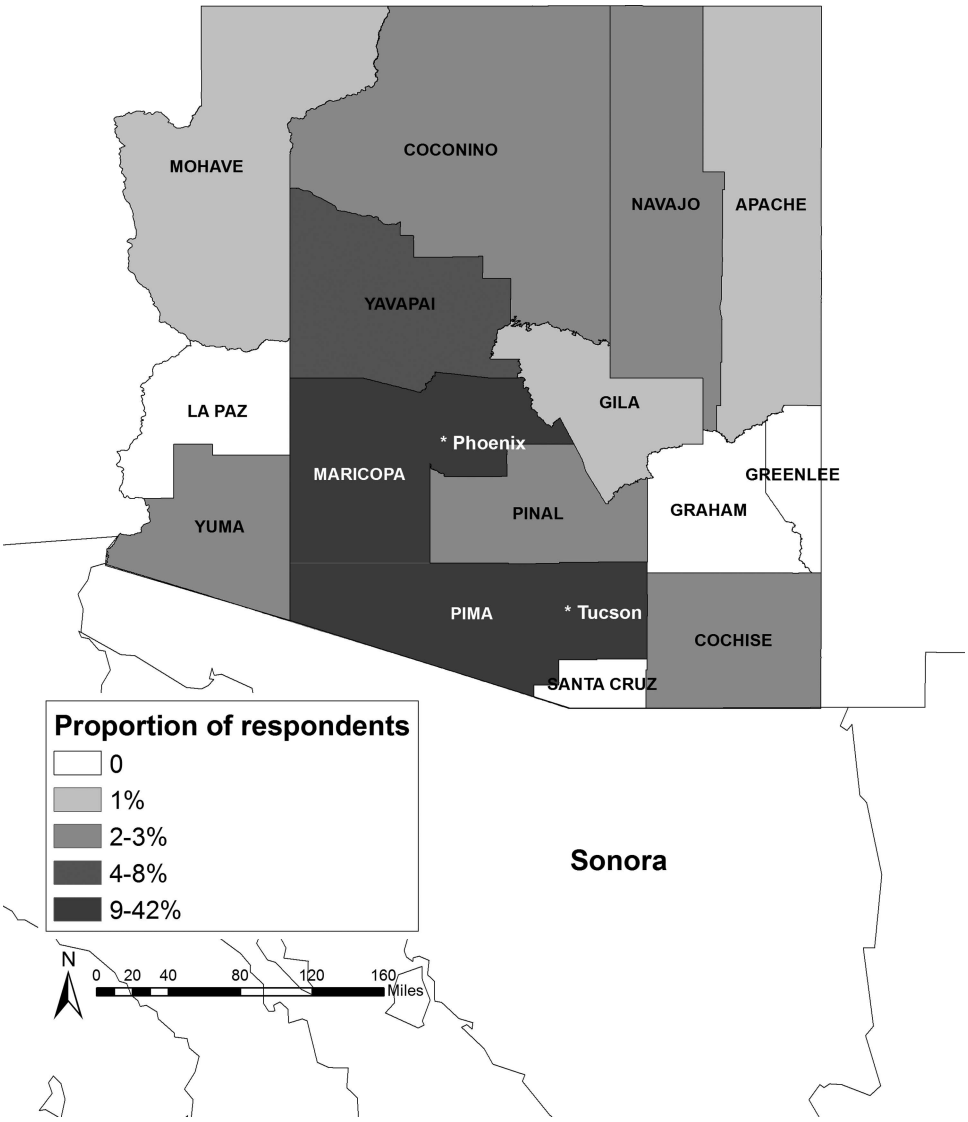

FIG. 1. Map of Arizona showing the percentage of survey respondents by county of practice.

Providers who reported hearing about the increase in dengue cases in Sonora, Mexico, in fall 2014 performed overall better than those who had not ($n = 101$, mean KAP score 17.3, 95% CI 16.8–17.8 vs. mean 15.4, 95% CI 14.6–16.1, *t*-test $p = 0.01$). Specifically, this group of providers more frequently identified the correct diagnostic tests (50% vs. 30%, $p < 0.001$), correctly reported IV fluids as common treatment for dengue (75% vs. 52%, $p = 0.001$), more frequently asked patients for travel history (70.2% vs. 46.4%, $p = 0.001$), and would notify the local health department about a patient with suspected dengue virus infection (84% vs. 68%, $p = 0.009$) (Table 4). However, this group also more frequently believed, incorrectly, that dengue virus can be locally acquired on the Arizona side of the United States–Mexico border region (56% vs. 23%, $p < 0.0001$). When asked about sources of the information regarding the increase in dengue cases in Sonora, the Arizona Health Alert Network (37/101) was most frequently mentioned, followed by the local health department (36/101), the mass media (34/101), and the local hospital (21/101).

Respondents serving predominantly Native American populations more commonly reported the belief that dengue virus can be transmitted through close personal contact (21.0% vs. 5.3%, $p = 0.03$).

When analyzing the overall performance of the 188 respondents, three factors were identified as independent predictors of KAP score. These were: specializing in infectious diseases (parameter estimate = 1.88, 95% CI 0.42–3.33, $p = 0.01$), being a DO/MD (parameter estimate = 1.82, 95% CI 0.98–2.65, $p < 0.0001$), and having heard of the increase in dengue cases in Sonora (Mexico) in fall 2014 (parameter estimate = 1.51, 95% CI 0.67–2.34, $p = 0.0005$).

Among DO/MDs, predictors of KAP score were: specializing in infectious diseases (parameter estimate = 1.90, 95% CI 0.25–3.55, $p = 0.024$) and having seen patients meeting the dengue clinical case definition in the previous year (parameter estimate = 2.20, 95% CI 0.52–3.89, $p = 0.01$). Among NP/PAs, practicing in border counties was the only predictor of KAP score (parameter estimate = 2.98, 95% CI 0.61–5.36, $p = 0.015$). NP/PAs practicing in border counties had

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Table 2. Dengue Knowledge, Attitude, and Practice Among All Respondents (Selected Questions) ($N = 188$)

Survey response (n = *188*)	n *(%)*
Symptom knowledge[a]	
Identifying fever as a sign or symptom	165 (87.7)
Identifying hemorrhagic manifestations as a sign or symptom	105 (55.8)
Transmission knowledge[a]	
Knowing that dengue can be transmitted from the bite of a mosquito	168 (89.4)
Knowing that dengue can be transmitted through blood transfusions	98 (52.1)
Knowing that dengue can be transmitted *in utero*	70 (37.2)
Believing that dengue can be transmitted through close personal contact	12 (6.3)
Diagnosis knowledge	
Knowing that ELISA (IgM/IgG) should be used ≥5 days after onset and PCR should be used <5 days from onset	76 (40.4)
Treatment knowledge[a]	
Reported IV fluids as common dengue treatment	121 (64.4)
Epidemiology Knowledge[a]	
Selecting only the correct geographical areas endemic for dengue (Central and South America, Northern and Southern Mexico, Africa, Asia, and Pacific Islands)	57 (30.3)
Believing that dengue can be locally acquired in Arizona border region (*e.g.*, Yuma, AZ; Nogales, AZ; and Douglas, AZ)	77 (40.9)
Diagnosis attitude	
Confident to diagnose mild dengue	65 (34.6)
Confident to diagnose severe dengue	83 (44.1)
Treatment attitude	
Confident to treat mild dengue	82 (43.6)
Confident to treat severe dengue	49 (26.1)
Practice	
Frequently ask patients for travel history	111 (59.0)
Would notify the local health department on suspicion of a dengue patient	143 (76.1)
Would order confirmatory laboratory tests on 100% of suspect dengue patients	5 (2.7)

[a]Multiple answers allowed.
IV, intravenous.

a significantly higher mean KAP score than their counterparts practicing in nonborder counties (mean KAP score 17.6, 95% CI 16.9–18.2, vs. 14.6, 95% CI 13.7–15.6, $p = 0.02$). Interestingly, this group of providers did not report seeing any patients meeting the clinical case definition for dengue since October 2014, nor did they have more years of practice, or report hearing more often about the increase of dengue in Sonora than NP/PAs from nonborder counties.

Discussion

The results of our survey suggest that responding Arizona practitioners tend to be aware of and have some basic knowledge about dengue. However, incorrect responses were sometimes reported, suggesting that education on these topics is still important. In addition, most respondents did not feel confident in diagnosing or treating dengue and had poor knowledge of the appropriate diagnostic tests to perform. The analysis also revealed that practices important from a public health perspective, such as reporting suspect cases to public health officials or asking for travel history, are not performed widely enough.

One surprising finding was the misconception that the Arizona border region is endemic for dengue virus, whereas only travel-associated cases have been reported to date. Providers possessing this misconception might not recognize the urgency of reporting potentially locally acquired cases to public health officials.

Some results of this study were expected, such as findings that respondents who specialized in infectious diseases or who were aware of the increase in the dengue cases in Sonora would have higher overall scores, as providers more trained or informed will likely know more about the disease. Similarly, the observation that participating DO/MDs performed better than NP/PAs may be related to the more extensive and comprehensive nature of the curriculum. Some observations from this analysis suggest that factors in addition to educational background could influence dengue knowledge in these two groups, as predictors of KAP score were having seen a patient with dengue-compatible symptoms since October 2014 for DO/MDs and practicing in border counties for NP/PAs. These findings may be helpful in tailoring education and training on dengue to different subgroups of health professionals.

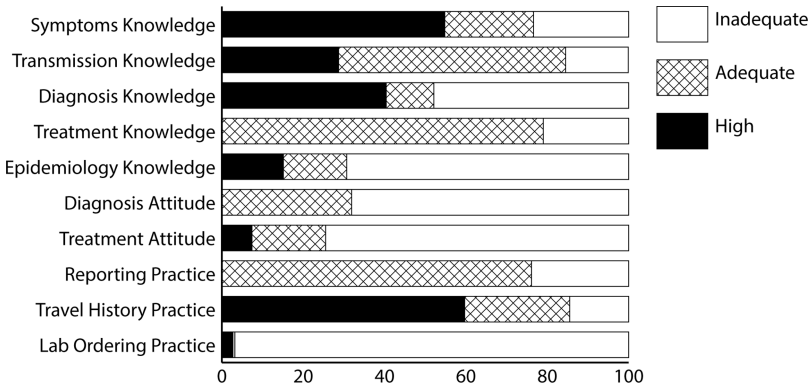

FIG. 2. Overview of respondents' knowledge and gaps ($n = 188$). Proportion of respondents reporting high, adequate, and inadequate knowledge for the 10 KAP questions. KAP, knowledge, attitudes, and practices.

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Table 3. Differences in Dengue Knowledge, Attitude, and Practice by Respondent's Degree

Survey responses	*DO/MD* (n = *106*), n *(%)*	*NP/PA* (n = *39*), n *(%)*	p[a]
Symptom knowledge			
Identifying hemorrhagic manifestations as a sign or symptom	72 (67.9)	13 (33.3)	<0.001
Transmission knowledge			
Knowing that dengue can be transmitted through blood transfusions	65 (61.3)	14 (35.9)	0.006
Knowing that dengue can be transmitted *in utero*	45 (42.4)	8 (20.5)	0.015
Diagnosis knowledge			
Knowing that ELISA (IgM/IgG) should be used >5 days after onset and PCR should be used <5 days from onset	58 (54.7)	5 (12.8)	<0.001
Treatment knowledge			
Reported IV fluids as common dengue treatment	79 (74.5)	22 (56.4)	0.03

Comparison of MD and DO to NP and PA.
[a]Chi-square or Fisher's Exact tests (for $n < 21$).

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Conclusions

Overall, the results from this survey indicate that education for health care providers on dengue should be improved particularly among noninfectious disease providers in general practice who might be the first point of care for dengue patients. Among all topics, findings suggest that additional training on dengue clinical management is needed. The epidemiology of dengue in Arizona (including the difference between locally acquired and travel-associated cases) should also be highlighted, stressing the importance of asking for travel history, as well as notifying the local health department on suspicion of a dengue patient, as required by rule (A.A.C. R9-6-202).

This KAP survey had several limitations. The main limitation is likely the low response rate and the difficulty in calculating it accurately. As a result, the presence of some selection bias is possible as survey respondents often represent those more interested or more knowledgeable about a topic. This decreases the representativeness and the generalizability of our results to all Arizona providers. In addition, survey questions could also have been misinterpreted, with possible impact on the validity and reliability of the information collected; however, we tried to minimize misinterpretation by carefully drafting the questions and piloting the survey with providers before dissemination. Despite these limitations, this work represents one of the first surveys of health care providers in the United States in a region at high risk of dengue emergence and elicited responses from providers with diverse backgrounds and geographic range.

As clinicians tend to be unfamiliar with newly emerging infectious diseases, that this and similar studies found mostly low levels of confidence in treating or diagnosing dengue is not surprising (Tomashek et al. 2014, Adam et al. 2017). However, the potential for fatal outcomes without proper fluid management, the importance of timely reporting of dengue cases to public health officials, and the potential for locally acquired cases in Arizona requiring response underscore the importance of, at a minimum, health care providers being aware of the symptoms of dengue virus infection, knowing which diagnostic tests to select, and alerting public health partners about suspected cases.

Since the administration of this dengue KAP survey, chikungunya and Zika viruses have also rapidly emerged throughout the Americas, raising the additional threat of the spread of these viruses into Arizona *Aedes* mosquito populations. While this survey was specific for dengue, some of these results are relevant to chikungunya and possibly Zika, although with heightened media and medical attention to Zika, providers may now be more familiar with Zika than dengue. Knowledge of both diseases is critical, as dengue and

Table 4. Differences in Dengue Knowledge, Attitude, and Practice Between Respondents Who Heard About the Increase in Dengue Cases in Sonora (Mexico) in Fall 2014 Versus Those Who Had Not ($N = 185$)

Having heard about the increase in dengue cases in Sonora (Mexico) in fall 2014	*Yes* (n = *101*), n *(%)*	*No* (n = *84*), n *(%)*	p[a]
Symptom knowledge			
Believing that dengue can be locally acquired in Arizona border region	57 (56.4)	19 (22.6)	<0.0001
Diagnosis knowledge			
Knowing that ELISA (IgM/IgG) should be used >5 days after onset and PCR should be used <5 days from onset	51 (50.4)	25 (29.7)	0.004
Treatment knowledge			
Reported IV fluids as common dengue treatment	76 (75.2)	44 (52.4)	0.001
Practice			
Frequently asking patients for travel history	71 (70.2)	39 (46.4)	0.001
Would notify the local health department on suspicion of a dengue patient	85 (84.1)	57 (67.8)	0.009

[a]Chi-square or Fisher's Exact test (for $n < 21$).

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Zika present as similar acute febrile or rash illnesses, have different clinical management, and can be difficult to diagnostically distinguish by serologic tests. These disease features further highlight the importance of effective strategies for training providers about emerging infectious diseases, such as the use of CDC online continuing education (CDC TRAIN 2017) or similar methods.

Acknowledgments

This work was supported by the CDC Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases cooperative agreement and the Public Health Emergency Preparedness (PHEP) cooperative agreement. Other individuals who contributed to this work are Jefferson Jones, MD, MPH and Lisa Villarroel, MD, MPH.

Author Disclosure Statement

No conflicting financial interests exist.

Supplementary Material

Supplementary Table S1

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To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD)
Subject:	RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides
Date:	Friday, February 21, 2020 10:38:57 AM
Attachments:	image001.png Floridaphysiciandengue2016.pdf

I found that indeed there is.

Steve

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Friday, February 21, 2020 11:32 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Hi Carina
I'm sure you and others have done work on dengue clinical education for physicians in Florida. Do you have anything written up such as was done in Texas and Arizona regarding knowledge gaps?

Thanks.
Steve

From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Friday, February 21, 2020 11:09 AM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

The dengue file. Let me know if you need anything else

From: Chris Johnstone <cjohnstone@alakaina.com>
Sent: Friday, February 21, 2020 9:39 AM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

Carina – To avoid surprises and misunderstandings. I would like to request that you make final edits to your presentations as needed and send me both slide decks once completed. What you send me is what will be on the computer at the podium.

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Thank You,

Chris Johnstone
Sr. Program Manager
12565 Research Parkway, Suite 300, Orlando, FL 32826
O: 407.308.3748 | F: 407.308.3749 | M: 470.503.7692

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To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

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Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
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From: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Sent: Wednesday, February 19, 2020 3:33 PM
To: Chris Johnstone <cjohnstone@alakaina.com>
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Subject: RE: VecLandry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>tor Week Presentation slides

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Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>
Sent: Wednesday, February 19, 2020 2:03 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Landry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: FW: Vector Week Presentation slides

Hi Carina
I hope you're doing well.

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Just a friendly reminder if you could at your earliest convenience send the slides for your presentation for Vector Week's Tuesday afternoon's session on dengue to cjohnstone@alakaina.com (so she can load them ahead of time) with a copy to me along with a short bio, we'd much appreciate it.

See you next week.

Best regards,
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Thursday, February 13, 2020 12:09 PM
To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: RE: Vector Week Speaker Guidance

Hello Speakers for the Dengue Prevention and Control Session on Tuesday afternoon, February 25, 2020–

I want to thank you all again for agreeing to participate in this session. I think the audience will be excited about and learn a lot from what you all have to say!

Below is what we currently have you planning to talk about --- if your content is significantly different, please let us know as soon as possible!

1. *World Mosquito Program, Wolbachia replacement intervention trials (Steven Kern) ~20 min*

2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela*

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Paz-Bailey) ~20 min

3. Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name
b. Job title
c. Credentials
d. Name of organization

As noted below, if you can send your slides ahead of time to cjohnstone@alakaina.com, it would facilitate the logistics of loading of the presentations.

Looking forward to seeing you all in a couple of weeks.

Thanks again ~
Steve

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Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

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Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #8, Emerging Issues in Mosquito Borne Diseases**. The session is scheduled for Wednesday February 26, 2020, 10:00-11:15am in Salon II & III at the University Hilton in Fort Collins, CO.

Presentation time: 20 minutes
Speakers in session: 3
Moderator(s) (cc'd here): Ann Powers, Steve Waterman

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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BMC Medical Education

RESEARCH ARTICLE Open Access

Knowledge, attitudes, and practices of Florida physicians regarding dengue before and after an educational intervention

Susanne Doblecki-Lewis[1*], Aileen Chang[2], Renee Jiddou-Yaldoo[3], Kay M. Tomashek[4], Danielle Stanek[5], Leena Anil[6] and Paola Lichtenberger[7]

Abstract

Background: Failure to recognize and appropriately manage dengue early in the clinical course may result in late initiation of supportive treatment for severe disease. In Florida, travel-related and autochthonous dengue occur and are likely under-recognized. The objective of this study was to evaluate physician knowledge of dengue and its management before and after an educational intervention in Florida.

Methods: From 2012–13 we conducted 14 grand-rounds style lectures on dengue clinical management attended by 413 physicians, and analyzed data from the pre- and post-tests.

Results: Of those attending, 231 and 220 completed the pre-and post-tests, respectively. Overall, the mean pre-test score for knowledge-based questions was 74.3 and average post-test score was 94.2 %, indicating a mean increase of 19.9 % ($P < 0.0001$, 95 % CI 17.7–22.4). Reported confidence in dengue recognition and management also increased. Non-US trained physicians and those who had treated more than ten dengue cases performed significantly better in the pre-test. Post-test scores did not differ by subgroup.

Conclusions: The train-the-trainer approach with grand-rounds style presentations appear to be an effective intervention to improve knowledge of dengue among physicians.

Keywords: Dengue, Clinical practice, Physician training, Evaluation, Survey

Background

Dengue is a mosquito-transmitted viral disease that is endemic throughout the subtropics and tropics worldwide. Clinical manifestations range from a mild acute febrile illness to a severe life-threatening disease with a plasma leakage syndrome resulting in hypovolemic shock and hemorrhage [1]. Prior to 1940, dengue outbreaks occurred regularly in Florida including approximately 15,000 cases from 1934–1935. Locally-acquired dengue was not reported again in Florida until 2009–2010 when 88 cases were detected in Monroe County, Florida [2–4]. Since that time, a few sporadic locally-acquired dengue cases have been reported from other Florida counties including an outbreak in Martin County in 2013 [5].

Florida is at risk for dengue outbreaks with locally acquired dengue cases because of its largely non-immune population, an abundance of the mosquito vectors, *Aedes aegypti* and *Aedes albopictus*, and importation of dengue virus via viremic tourists and residents returning from neighboring dengue-endemic areas including Mexico, Central and South American, and the Caribbean. In fact, the majority of dengue cases reported in Florida are travel-associated cases [3]. Florida is a leading reporter of travel-associated dengue cases among the U.S. states and in 2015, Florida was second only to California [6]. Travel-associated cases may result in subsequent autochthonous transmission [2, 5, 7].

While physicians in endemic areas are likely to consider dengue in the differential diagnosis of a patient presenting with an acute febrile illness [8], dengue may

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not be considered in non-endemic areas, leading to under-diagnosis [9]. In the Key West 2009–2010 outbreak, initial cases were attributed by local physicians to non-specific viral illness and the diagnosis of dengue was not considered [4]. Similarly, in a 1999 dengue outbreak in Laredo, Texas, most patients identified as having a recent dengue infection by serologic diagnostic tests were initially given a clinical diagnosis of non-specific viral syndrome and not dengue [9].

Early recognition of dengue cases and timely initiation of appropriate supportive care is critical because it has been shown to reduce medical complications and mortality among patients with severe dengue [10–14]. As there is no licensed vaccine in the United States to prevent dengue or antiviral medication to prevent the development of severe disease manifestations, educating clinicians on the recognition and clinical management of dengue is an important public health strategy [7]. Educating physicians regarding standard clinical management protocols including how to identify e severe dengue have been demonstrated to reduce the case fatality rate associated with dengue hemorrhagic syndrome [14].

Train-the-trainer interventions, in which a small group of individuals receive in-depth training with the intent to further disseminate information to a broader audience, have been used to train emergency room providers in management of sickle cell disease, improve recognition and treatment of chronic fatigue syndrome, and educate physicians in Puerto Rico in response to a dengue outbreak in 2010 [8, 15, 16]. These interventions allow rapid scale-up of training initiatives and offer promise for rapid dissemination of expert-level content delivered in a local context by physicians within the area.

In response to an increase in travel-associated dengue cases and two outbreaks with several locally acquired dengue cases, the Florida Department of Health (FDOH) in collaboration with University of Miami and the Centers for Disease Control and Prevention (CDC) Dengue Branch developed a train-the-trainer initiative to offer grand rounds-style presentations with continuing medical education (CME) credit for Florida physicians with the goal of increasing early recognition and standardizing treatment of dengue cases. This paper describes the initiative and results from the pre- and post-training evaluation of attendees' knowledge of dengue.

Methods

Study design

This study involved an evaluation of physician knowledge, attitudes, and practices regarding dengue before and after the educational intervention.

Train-the-trainer symposium

CDC training materials that were used to train physician master trainers in Puerto Rico in 2010 were adapted [8, 17], and used to conduct a one-day, intensive training symposium hosted at the University of Miami. Symposium attendees included a select group of ten physicians from four counties in southern Florida who had prior clinical experience and interest in dengue. The symposium included presentations on the epidemiology, clinical presentation, laboratory diagnosis, reporting requirements, and clinical management of dengue.

Educational intervention

Following the symposium, a one-hour grand-rounds style presentation was developed using the CDC training materials. The presentation offered an overview of dengue clinical characteristics, diagnosis, monitoring, reporting, and treatment. The physicians attending the training symposium delivered the presentations as part of weekly grand rounds activities at venues within major hospital networks and practices throughout Florida. Participants in the grand rounds sessions were self-selected. One CME credit was offered to attendees of the grand-rounds presentations.

Evaluation of physician knowledge, attitudes, and practices

To assess physician knowledge and attitudes and practices regarding dengue, a two page, 20-item questionnaire was administered before each presentation and identical questions were repeated after the presentation. The questionnaire assessed participant's knowledge of dengue virus and its transmission and the epidemiology, diagnosis, reporting, and clinical management of dengue. Questions regarding knowledge and practice were multiple choice questions. The instrument also asked participants for their opinion on the relevance of dengue in their medical practice and confidence in their ability to diagnose and treat dengue patients. These were assessed on a zero to ten scale with zero indicating "no confidence or relevance at all" and ten "very confident/very relevant." Demographic information including age, years in practice, medical specialty, and location of medical school training was obtained in the pre-test. To preserve confidentiality, pre- and post-tests were not linked. Only those completing the pre-test were asked to complete the post-test.

Ethics and informed consent

The study protocol was reviewed and approved by the University of Miami Institutional Review Board (study #20120015). A waiver of written informed consent was granted by the Institutional Review Board. A verbal consent script was presented at the beginning of the

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presentation and attendees were informed that completion of the survey was construed as consent to participate. All attendees were offered the option of not participating.

Analysis

We conducted a descriptive analysis of participant demographics characteristics, and compared pre- and post-tests findings overall and by demographic groups. The mean percentage of questions correctly answered in the pre- and post-tests were compared using the unpaired student's *t*-test. For individual items of interest, pre- and post-test responses were compared using the z-test for comparison of proportion of respondents correctly answering the question and the student's *t*-test with Satterthwaite method for unequal variances for continuous scale responses. Statistical differences in baseline (pre-test) scores were tested using analysis of variance and Tukey's post-hoc test. The relationship between continuous variables was calculated using Pearson correlation coefficient. Paper questionnaires were completed in-person. Data analysis was conducted using SAS (v. 9.3; SAS Institute Inc., Cary, North Carolina) and graphs were produced in Microsoft Excel (Microsoft Corp., Redmond, WA).

Results

A total of 413 physicians attended 14 dengue grand-rounds presentations offered in Florida between January 2012 and October 2013. Of these, 231 (55.9 %) completed the pre-test and 220 (53.3 %) also completed the post-test assessment. More than half of all pre-test respondents were reportedly Internal Medicine physicians (42.9 %) or Pediatricians (13.4 %) (Table 1). The majority (68.4 %) of respondents were in practice for 0–5 years while 21.2 % were in practice for more than 10 years. Slightly more than half (54.5 %) of respondents reportedly attended medical school in the United States (U.S.) while 43 % attended medical school in Central America, South America, or the Caribbean. Most (62.3 %) respondents indicated they had never diagnosed a case of dengue; however, nearly one-third of respondents had diagnosed at least one dengue case. Non-U.S. educated physicians were significantly more likely to report having diagnosed at least one dengue case in their career ($p < 0.0001$).

Table 1 Demographic characteristics of physicians completing pre-test dengue surveys ($n = 231$)

Medical specialty	*N*	(%)
Internal Medicine	99	42.9
Pediatrics	31	13.4
Dermatology	21	9.1
Infectious Diseases	13	5.6
Emergency Medicine	8	3.5
Internal Medicine/Pediatrics	6	2.6
Family Practice	3	1.3
Other/No Answer	50	21.6
Years in Practice	*N*	(%)
0–5	158	68.4
6–10	16	6.9
> 10	49	21.2
No Answer	8	3.5
Dengue Cases Treated	*N*	(%)
0	144	62.3
1–5	46	19.9
6–10	5	2.2
> 10	18	7.8
No Answer	18	7.8
Medical School	*N*	(%)
In United States	126	54.5
Oustide U.S.	99	42.9
Other/No Answer	6	2.6

Overall, the mean pre-test score for the knowledge-based questions was 74.3 % and the average post-test score was 94.2 %, indicating a mean increase of 19.9 % ($P < 0.0001$, 95 % CI 17.7–22.4) (Table 2). The lowest scoring questions in the pre-test involved identification of clinically significant plasma leakage as the cardinal feature distinguishing severe dengue from dengue (27.3 % correct) and identification of the 1–2 day period after defervescence as the critical phase for development of severe manifestations (40.8 %). High scoring questions included identification of mosquitoes as the vector (98.7 %) and correct management of a patient with warning signs for severe dengue during the critical phase (91.5 %). Scores for all knowledge questions increased from pre-test to post-test assessment.

Reported self-confidence in ability to recognize dengue cases increased significantly from pre- to post-test assessment from a mean of score of 4.1 to 7.0, respectively (Table 2). Similarly, confidence in ability to treat dengue cases increased from a mean of 3.9 in the pre-test to 7.2 in the post-test. The assessment of the course relevance to the respondent's practice increased from 6.9 to 8.3 from pre- to post-test. Greater confidence in recognition and treatment of dengue prior to the presentation were significantly associated with better performance on the pre-test ($r = 0.34$, $p < 0.001$ for recognition; $r = 0.35$, $p < 0.001$ for treatment). Perceived relevance to their own medical practice also demonstrated a weak but significant correlation with pre-test scores ($r = 0.18$, $p < 0.007$).

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Table 2 Physician survey test results before and after attending training

Test responses mean (SD)	Pre-test	Post-test	*p*-value[a]
	n = 231	*n* = 220	
Overall mean number of questions correct	74.3 (14.1)	94.2 (8.7)	<0.001
Knowledge Responses (% who correctly identified)			
Background			
Type of organism that causes dengue is a virus	192/230 (83.5 %)	219/221 (99.1 %)	<0.001
Vector of the disease is a mosquito	227/229 (99.1 %)	221/221 (100 %)	0.16
Infection with one serotype gives lifelong immunity to that serotype	197/224 (83.2 %)	201/215 (93.5 %)	0.05
Intrinsic incubation period within the human	188/226 (83.2 %)	201/218 (92.2 %)	<0.001
Diagnosis			
Cardinal feature distinguishing severe dengue from non-severe cases	60/220 (27.3 %)	198/218 (90.8 %)	<0.001
Timing of the critical phase in dengue	89/218 (40.8 %)	197/215 (91.6 %)	<0.001
Optimal timing to send sample for PCR laboratory diagnosis	132/213 (62.0 %)	178/209 (85.2 %)	<0.001
Management			
Medication used for fever control in a suspected dengue patient	150/223 (67.3 %)	200/215 (93.0 %)	<0.001
Most appropriate treatment for a dengue patient	203/224 (90.6 %)	221/221 (100 %)	<0.001
Management of a suspected dengue patient with warning signs	205/224 (91.5 %)	210/219 (95.9 %)	0.06
Fatality rate with proper recognition and early treatment	133/222 (59.9 %)	194/215 (90.2 %)	<0.001
Timing requirements for reporting to local health department	24/222 (10.8 %)	60/215 (27.9 %)	<0.001
Attitudinal Responses (scale 0–10) Mean (SD)			
Level of confidence recognizing dengue cases (*n* = 216)	4.1 (2.9)	7.0 (2.1)	<0.001
Level of confidence treating dengue cases (*n* = 215)	3.9 (3.2)	7.2 (2.2)	<0.001
Relevance of dengue in their clinical practice (*n* = 215)	6.9 (2.8)	8.3 (1.9)	<0.001

[a]Comparison using paired, Students *t*-test with an alpha set to 0.05

Average test scores varied by respondent demographic characteristics. Respondents trained at a non-U.S. medical school had higher pre-test scores compared with those educated in the U.S. (76.7 % vs. 72.7 %; $p = 0.036$). Similarly, those who reported diagnosing more than 10 cases of dengue had higher pre-test scores than those who reported having never diagnosed a dengue case (83.8 % vs. 72.0 %; $p = 0.0003$). Respondents who reportedly had never diagnosed a patient with dengue had a significantly greater increase in test score from pre-to post-test compared with those who had diagnosed the most cases (+23.0 % vs. +6.8 %; $p < 0.0001$); post-test scores were not significantly different by number of dengue cases diagnosed. Pre-test and post-test scores did not significantly differ by years in practice.

Discussion

In our assessment of Florida physicians attending a grand-rounds style presentation on dengue, we found wide variability in baseline knowledge and confidence regarding dengue diagnosis and management. For example, physicians trained at non-U.S. medical schools, in areas where dengue is endemic, reportedly had more experience diagnosing dengue and scored significantly higher on the pre-test than U.S. medical school graduates and those who had never diagnosed a case of dengue. Physician pre-test confidence regarding dengue diagnosis and treatment was also low at baseline, however those with higher pre- test scores tended to report higher levels of confidence.

Knowledge presented in this format appeared to be at a level accessible to practicing physicians with or without prior experience with the disease, and was successful in increasing knowledge and confidence regarding the essential features of diagnosis and treatment of dengue. For example, despite lower baseline knowledge, physicians with no clinical experience with dengue patients and those educated in U.S. medical schools made significantly greater gains from pre-test to post-test than more experienced physicians trained in non U.S. medical schools. In fact, post-test scores did not differ by demographic characteristics and overall test scores were high. In addition, perceived relevance to practice and confidence regarding dengue diagnosis and treatment demonstrated significant gains following the presentation indicating an improved

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recognition of the importance of dengue among Florida physician attendees.

The finding of differences in dengue knowledge by location of medical school is not unexpected given the small number of dengue cases likely to be encountered by a U.S. medical student during their clinical rotations and the lack of consistent inclusion of tropical medicine education in U.S. medical school curricula [18]. However, physician surveys in areas where dengue is endemic and commonly diagnosed have also demonstrated lack of concordance of practice with available guidelines, lack of recognition of the critical phase of illness, and suboptimal compliance with Department of Health case reporting requirements [8, 19, 20]. Of concern, the recognition of the critical phase of infection in which symptoms may dramatically worsen and correct identification of warning signs were content areas frequently missed in our baseline survey as well as in a recent physician survey conducted in Puerto Rico [8]. Early identification of the warning signs for development of severe dengue can result in more appropriate monitoring and intensive supportive care for more severe symptoms, interventions that have been demonstrated to decrease morbidity and mortality [10–14].

Limitations of this study include non-completion of surveys from some attendees and lack of long-term follow-up to determine retention of knowledge gained. Additionally, while only those participating in the pre-intervention survey were asked to complete the post-intervention survey, the pre- and post-intervention surveys were not individually linked and demographic information was collected only in the pre-intervention survey. Thus, there is the possibility that the individuals completing the post-intervention survey may have differed from those completing the pre-intervention survey. In addition, our study did not investigate if the increase in knowledge and change in attitude demonstrated by respondents led to a change in clinical practice, improved case recognition, or increased testing of suspected cases among attendees. Nevertheless, this assessment and educational program was successful in assessing baseline knowledge of Florida physicians and in disseminating information regarding a locally important disease to many physicians over a short period of time.

Conclusions

Within the continental United States, Florida is one of the states with both a significant number of imported cases of dengue as well as autochthonous transmission [2]. Early recognition and timely, appropriate treatment of dengue is the cornerstone of public health efforts to mitigate local transmission and optimize patients' clinical outcomes [7]. Ensuring that Florida physicians know how to recognize potential dengue cases, order appropriate diagnostic tests, and notify public health officials is therefore a priority for any dengue response plan. Further, clinician awareness of the clinical course of dengue including the timing of the critical phase is necessary to offer correct anticipatory guidance for dengue patients and make timely referrals for patients demonstrating warning signs of severe dengue. With increasing international travel and resultant globalization of communicable diseases, there is a need for expanded training for U.S. physicians in the management of tropical diseases [21]. Expanding the traditional medical school curricula to address common emerging tropical diseases affecting travelers and new immigrants may be warranted [22–24]. The train-the-trainer approach and grand-rounds style presentations appear to be an effective intervention to improve knowledge, confidence, and awareness of the importance of tropical diseases that affect Floridians.

Ethics approval and consent to participate

The study protocol was reviewed and approved by the University of Miami Institutional Review Board (study #20120015). Verbal consent was obtained from each participant prior to survey completion. A waiver of written informed consent was granted by the Institutional Review Board.

Consent for publication

Not Applicable.

Availability of data

De-identified data available upon request.

Abbreviations

CDC: Centers for Disease Control and Prevention; CME: Continuing Medical Education; FDOH: Florida department of health; U.S.: United States.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

SD-L and PL conceived of the study, participated in the design of the survey instruments, analyzed the data, and wrote the manuscript. AC participated in study design, survey implementation, and data analysis. RJ-Y participated in study design including instrument development, survey implementation, and analysis. KT participated in the design of the training sessions, data analysis and manuscript revisions. DS participated in the design of the training sessions and development of survey instruments. LA participated in the study design and design of training sessions. All authors read and approved the final manuscript.

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Date:	Wednesday, February 19, 2020 3:32:39 PM
Attachments:	dengue slides for blackmore VV20.pptx

Dengue presentation and brief Bio.

Please let me know if you need anything else.

Carina

Bio:
Dr. Blackmore is the State Epidemiologist and Director for Division of Disease Control and Health Protection at the Florida Department of Health. She has served the Department in a variety of roles since 1998. She also serves as the Co-Chair of the CSTE Vector-borne Disease Subcommittee. She received her DVM from the Swedish University of Agricultural Sciences, Uppsala, Sweden in 1989 and her PhD in arbovirus epidemiology from University of Notre Dame, IN, in 1996.

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Sent: Wednesday, February 19, 2020 2:03 PM
To: Blackmore, Carina <Carina.Blackmore@flhealth.gov>
Cc: Landry, Kimberly (CDC/DDID/NCEZID/DVBD) (CTR) <nrn8@cdc.gov>; Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>; Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: FW: Vector Week Presentation slides

Hi Carina
I hope you're doing well.

Just a friendly reminder if you could at your earliest convenience send the slides for your presentation for Vector Week's Tuesday afternoon's session on dengue to cjohnstone@alakaina.com (so she can load them ahead of time) with a copy to me along with a short bio, we'd much appreciate it.

See you next week.

Best regards,
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service

AMERICAN OVERSIGHT

Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: Waterman, Steve (CDC/DDID/NCEZID/DVBD)
Sent: Thursday, February 13, 2020 12:09 PM
To: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>; Paz-Bailey, Gabriela (CDC/DDID/NCEZID/DVBD) <gmb5@cdc.gov>; Steven Kern <Steven.Kern@gatesfoundation.org>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>
Cc: Soltero, Vera E. (CDC/DDID/NCEZID/DVBD) <eeu4@cdc.gov>
Subject: RE: Vector Week Speaker Guidance

Hello Speakers for the Dengue Prevention and Control Session on Tuesday afternoon, February 25, 2020–

I want to thank you all again for agreeing to participate in this session. I think the audience will be excited about and learn a lot from what you all have to say!

Below is what we currently have you planning to talk about --- if your content is significantly different, please let us know as soon as possible!

1. *World Mosquito Program, Wolbachia replacement intervention trials (Steven Kern) ~20 min*

2. *Communities Organized to Prevent Arboviruses, Wolbachia Suppression Randomized Clinical Trial in Puerto Rico (Gabriela Paz-Bailey) ~20 min*

3. Florida 2019 Dengue Outbreak Epidemiology and Response (Carina Blackmore) ~20 min

Finally, if you all could send this information as well, it would be very helpful as we introduce each of you. A very short bio would also be helpful but not required – please don't make anything for this – if you have something already prepared, that is great!

a. Full name
b. Job title

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c. Credentials
d. Name of organization

As noted below, if you can send your slides ahead of time to cjohnstone@alakaina.com, it would facilitate the logistics of loading of the presentations.

Looking forward to seeing you all in a couple of weeks.

Thanks again ~
Steve

Stephen Waterman, MD, MPH
CAPT, US Public Health Service
Chief, Dengue Branch
Division of Vector-Borne Diseases, CDC
San Juan, Puerto Rico
787 706 2465

From: CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Sent: Friday, January 31, 2020 12:26 PM
To: Ciota, Alexander T (HEALTH) <alexander.ciota@health.ny.gov>; Rebecca.Osborn@dhs.wisconsin.gov; bcreiner@uw.edu
Cc: Waterman, Steve (CDC/DDID/NCEZID/DVBD) <shw2@cdc.gov>; Powers, Ann (CDC/DDID/NCEZID/DVBD) <akp7@cdc.gov>; CDC Vector Week (CDC) <cdcvectorweek@cdc.gov>
Subject: Vector Week Speaker Guidance

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #8, Emerging Issues in Mosquito Borne Diseases**. The session is scheduled for Wednesday February 26, 2020, 10:00-11:15am in Salon II & III at the University Hilton in Fort Collins, CO.

Presentation time: 20 minutes
Speakers in session: 3
Moderator(s) (cc'd here): Ann Powers, Steve Waterman

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Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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Department of Health

DENGUE, 2019 RESPONSE

Florida HEALTH

Carina Blackmore, DVM, PhD

DRAFT

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Objectives

- Historical context
- Brief overview of dengue surveillance systems in Florida
- Protocols and protocols
- 2019 data and response

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Acknowledgments

- Dr. Andrea Morrison

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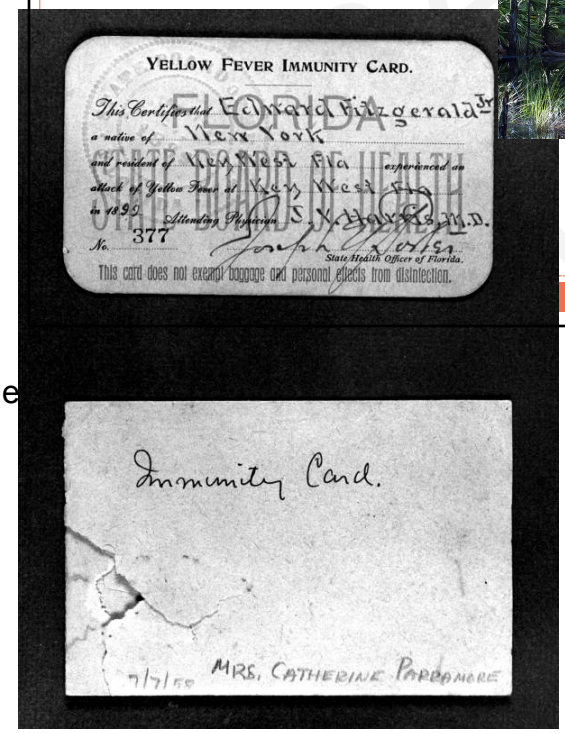
Vectorborne disease-of historic importance in Florida





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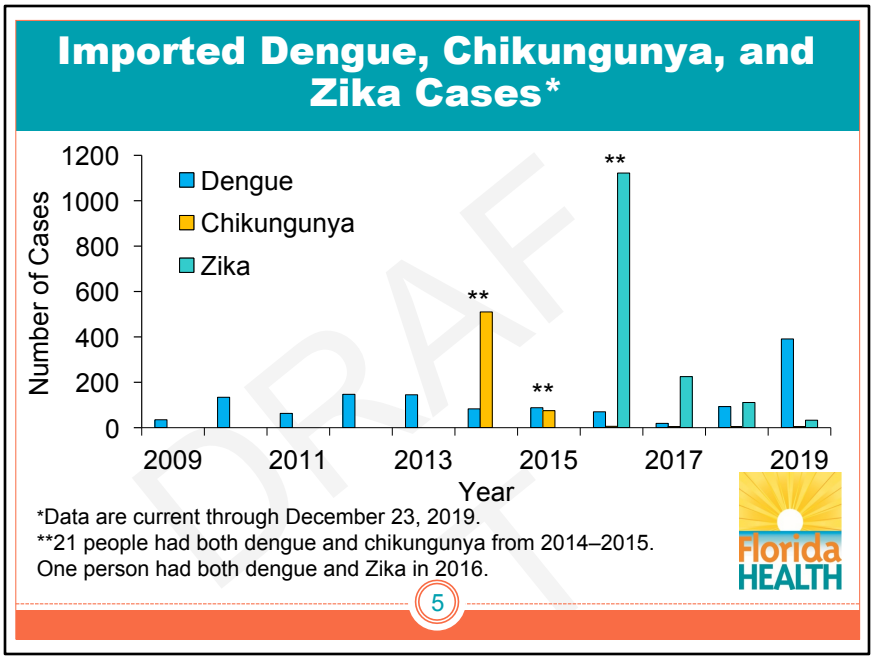

Previously approved
Increased font size and took out the word cases. “had both dengue and chikungunya cases” ----AM: thanks!

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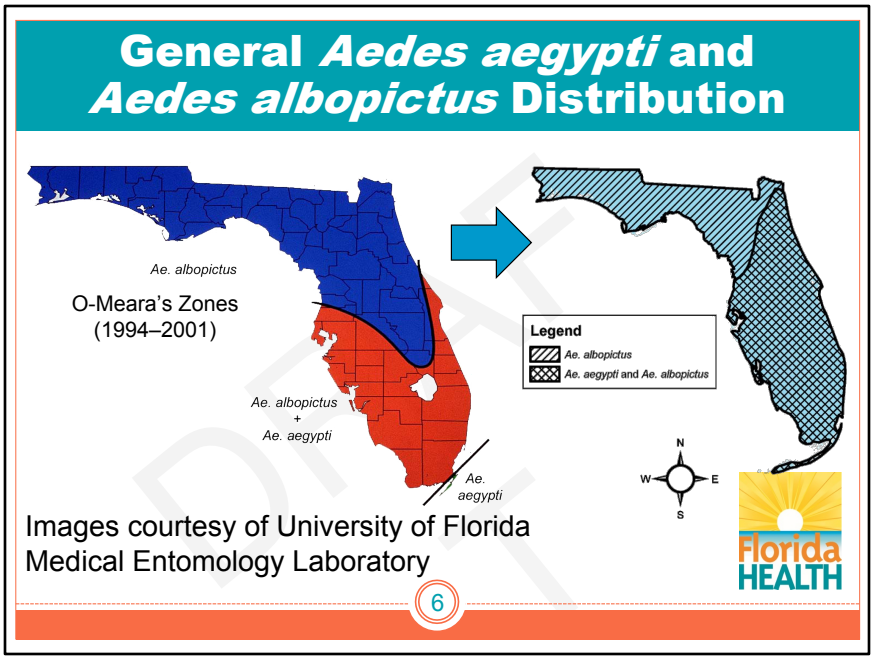

Previously approved

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Dengue background, Florida

- Periodic outbreaks reported until 1934
- Dengue outbreak in Key West 2009-2010
- Dengue outbreak in Martin County 2013
- Sporadic locally acquired cases since 2010

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Key West Dengue Outbreak, 2009–2010

- 2009
  - 22 cases + 5 from the serosurvey
- 2010
  - 66 cases
- Vector: *Aedes aegypti*



Image courtesy of www.florida-keys.fl.us/

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Previously approved
Source graphics-----AM: added

Dengue 1 infections. 1st case was a NY resident. 34 yo female visited Key West 8/2-8/9. Recalled mosquito bites. Back home (NY state): Malaise 8/10, Fever 8/11, Severe headache, eye pain, body joint pain, rash 8/13. Assayed in NY, Dengue IgM positive. Reported by NY to Florida ~ 9/1. 9/11 CDC confirmed Den 1. 2nd and 3rd end of August, confirmed by end of September. 4th onset 7/27, reported by

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physician after publicity about local transmission. Case 5, 6, 7 all live within 0.2 miles from each other: Case 5: 73 yo male, onset 8/10, Case 6: 46 yo female, onset 9/15, Case 7: 69 yo male, onset 9/27.

Epidemiological survey of area

- Serosurvey
- Questionnaire: risk factors, travel history
- 170 participating households
- 240 total samples
- 1.4 individuals per participating house

Mosquito Control survey

Need public participation-drain and cover

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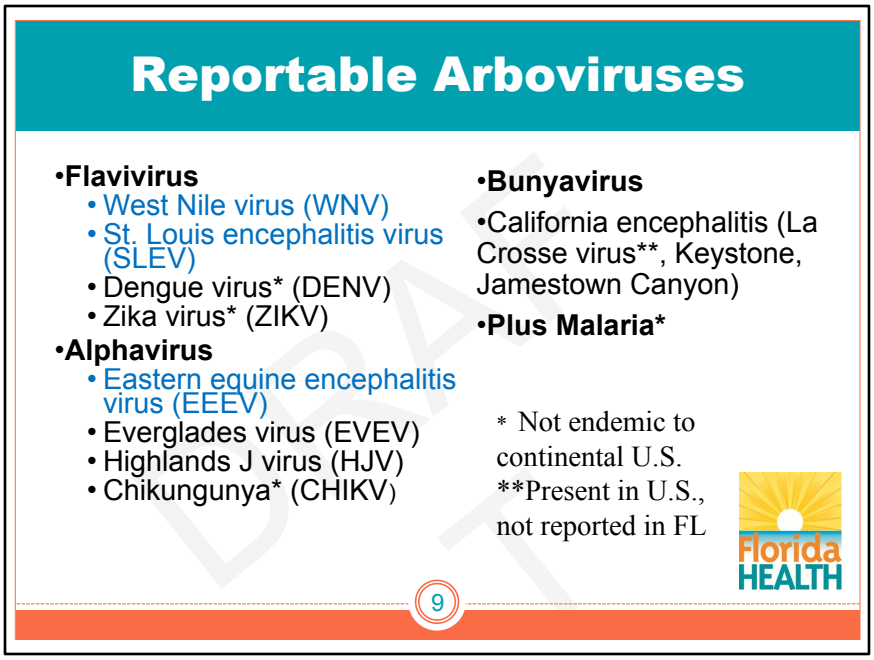

Arboviruses are RNA viruses, and the main ones that we do surveillance for here in Florida fall into 2 genera: flavivirus and alphavirus. The flaviviruses include St. Louis Encephalitis (SLE), West Nile (WN) virus, and Dengue virus. The alphaviruses include Eastern Equine Encephalitis (EEE) virus, and Highlands J (HJ).

Red= FL endemic

Reportable

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Dengue investigation guidance

Dengue Fever/Severe Dengue Fever/Chikungunya Fever!

Report on suspicion of infection during business hours

PROTOCOL CHECKLIST

- ☐ Enter available information into Merlin upon receipt of initial report
- ☐ Review background information on the disease (see Section 2), case definitions (see Section 3 for dengue and for chikungunya), and laboratory testing (see Section 4)
- ☐ Forward specimens to the Florida Department of Health (DOH) Bureau of Public Health Laboratories (BPHL) for confirmatory laboratory testing (as needed)
- ☐ Inform local mosquito control personnel of suspected chikungunya or dengue case as soon as possible (if applicable)
- ☐ Inform state Arbovirus Surveillance Coordinator on suspicion of locally acquired arbovirus

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Dengue investigation guidance

- Detailed case investigation protocol-17 pages!
- Arrange for confirmatory testing at the public health laboratory
- Notify mosquito control district upon suspicion
- Notify statewide arbovirus coordinator upon suspicion of local case

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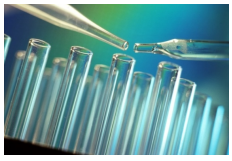
Testing at Bureau of Public Health Laboratories (BPHL)



- Antibody detection
  - **IgM**
  - IgG: recent or past exposure
- **PCR**
- **Culture**
- Plaque Reduction Neutralization Test (PRNT)

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Advisories and Alerts

- Mosquito-borne illness risk level (1-5)
  - Awareness
  - Advisory
  - Alert
  - Threat
- County health department issues advisories and alerts in consultation with mosquito control district.



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Talk about Level 2-4

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Aedes aegypti, the house mosquito







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Prevention



- Drenar y Cubrir
- Drennen epi Kouvri
- Draineret de Couvrir
- Drenar e Cobrir

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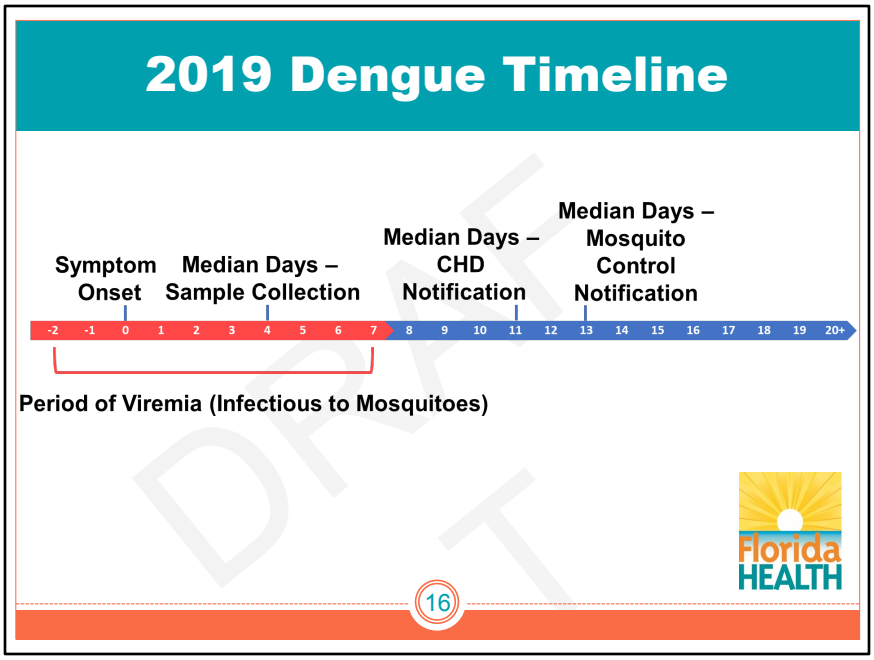

New slide
Font siize is questionable, CHD needs to be defined - ----AM: updated font size, added CHD definition to previous slide

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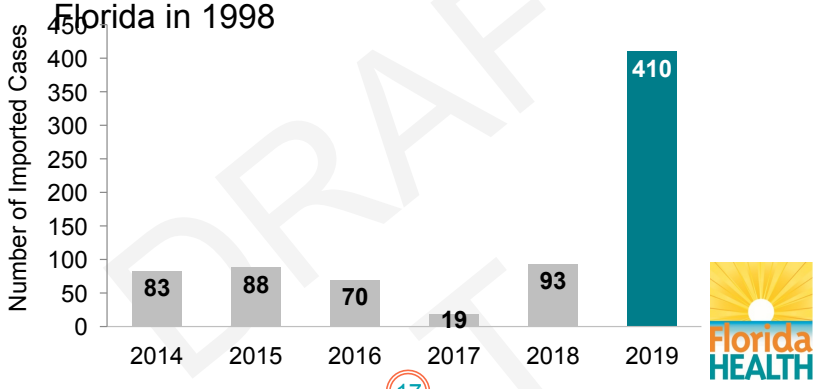
Florida Dengue Virus Activity, 2019

- Most imported cases reported in a single year since dengue became regularly reported in Florida in 1998



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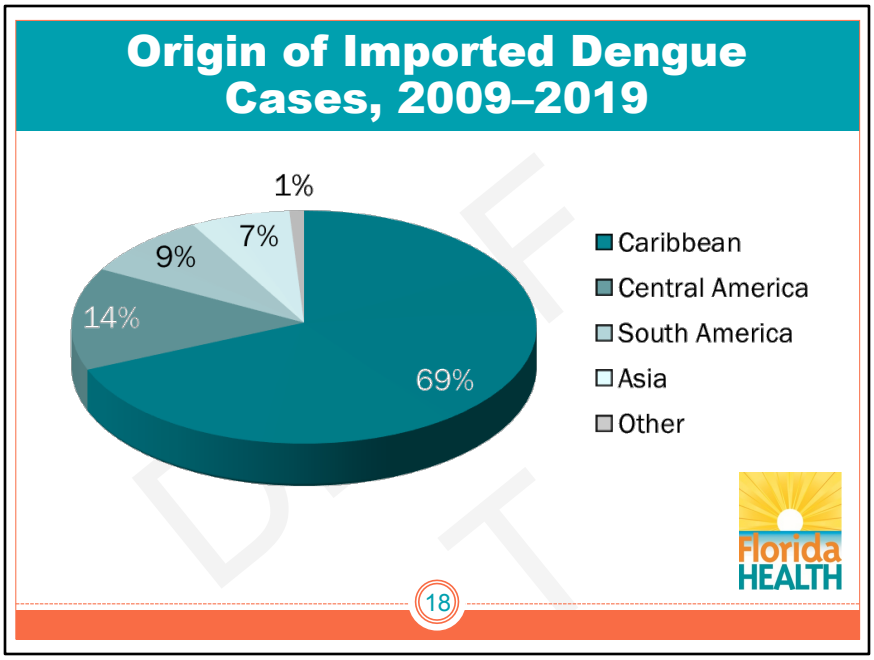

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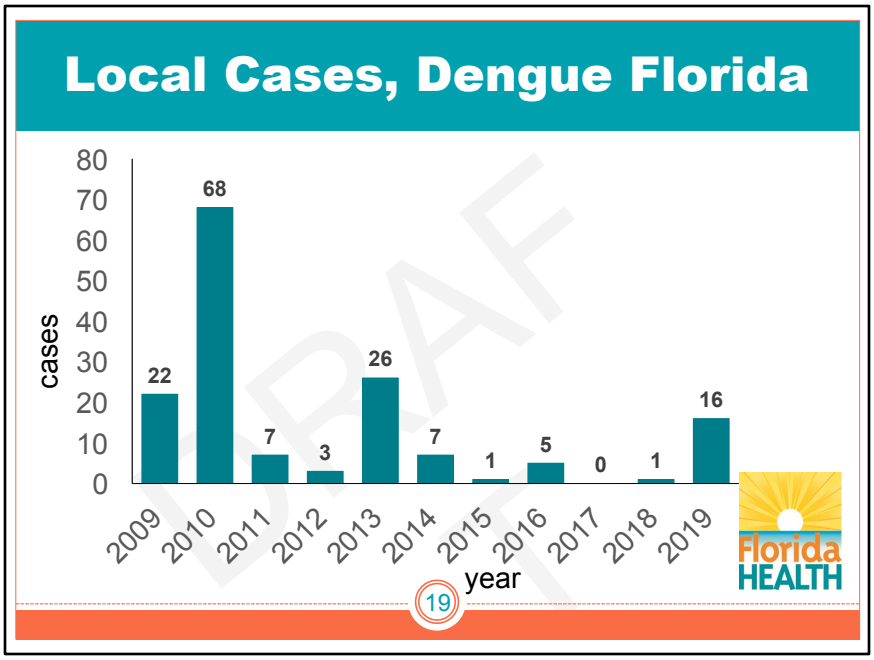

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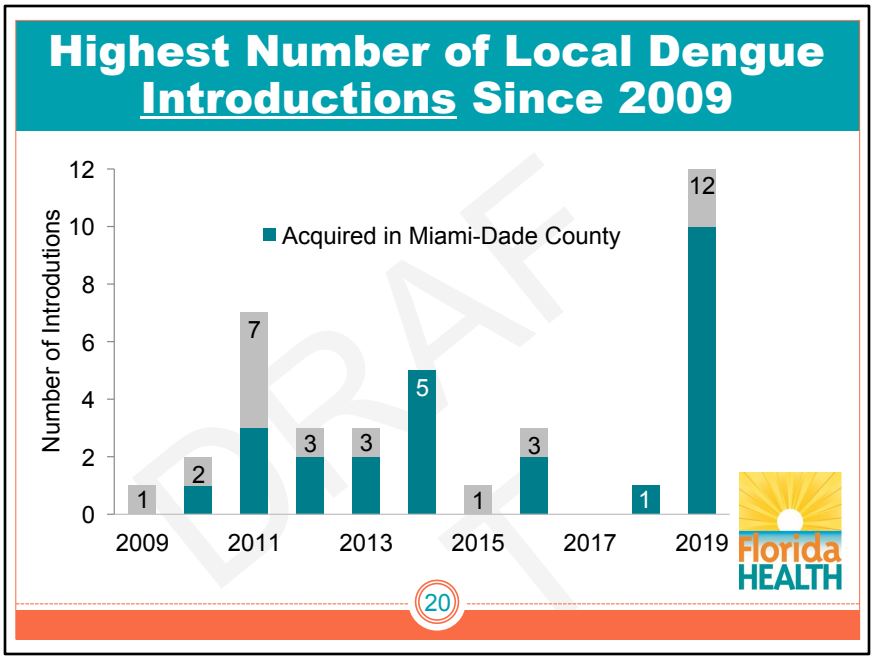

Most number of dengue virus introductions since 2009. Miami-Dade County has had the most introductions (26)

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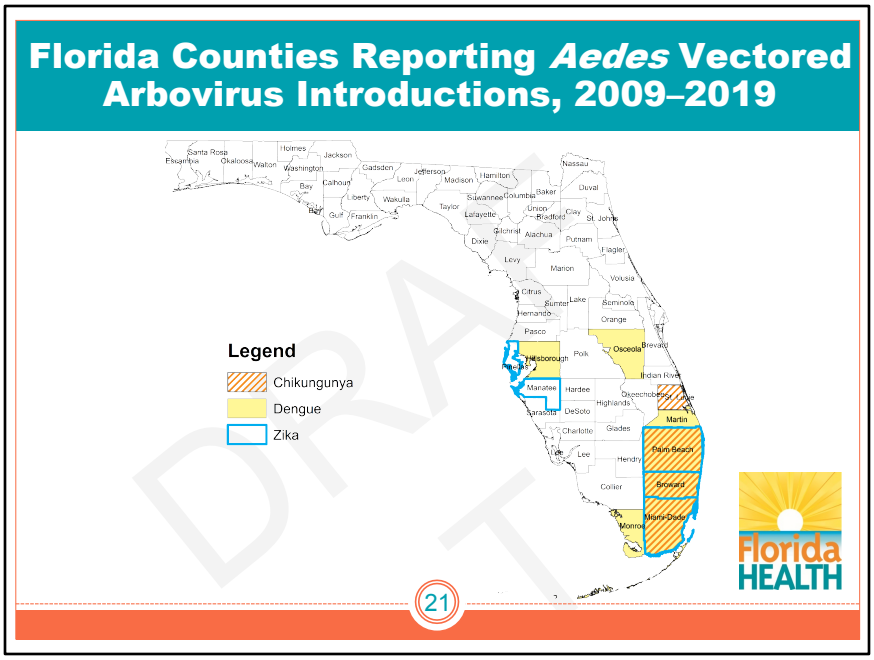
Florida Counties Reporting *Aedes* Vectored Arbovirus Introductions, 2009–2019
Legend
Chikungunya
Dengue
Zika
Florida HEALTH
21
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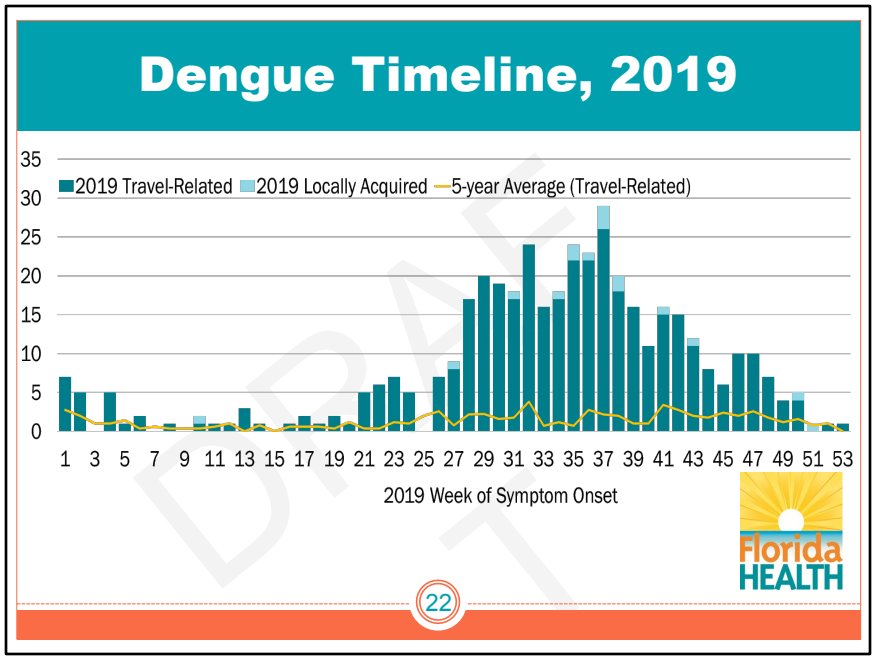
New slide



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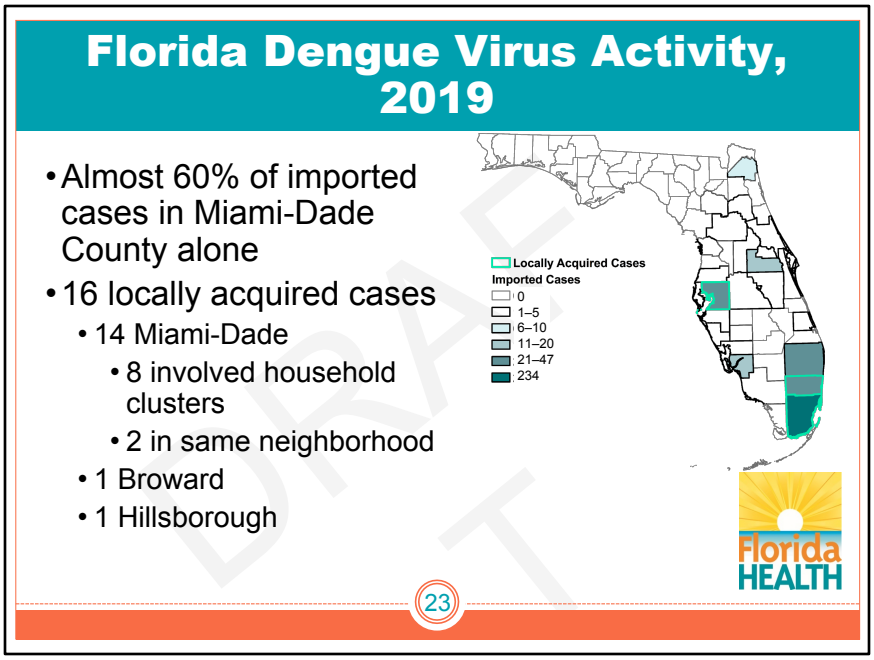

Total of 12 introductions
13 severe cases

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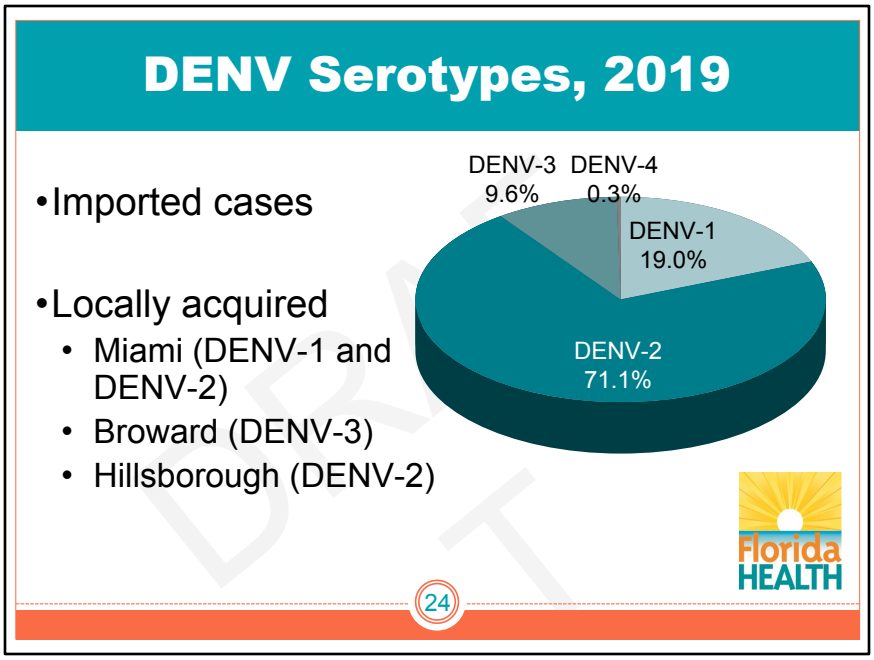

Figure shows imported cases

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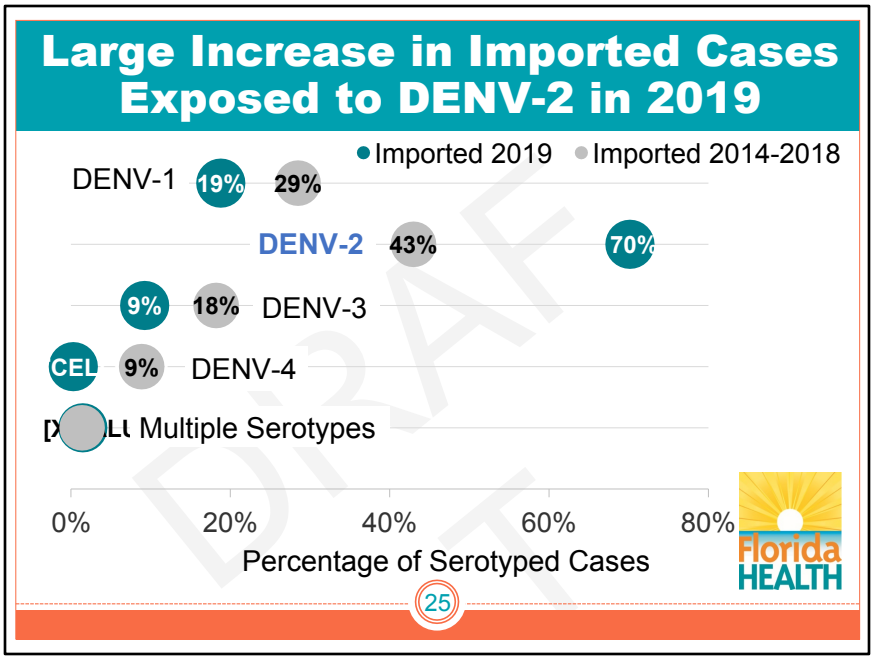

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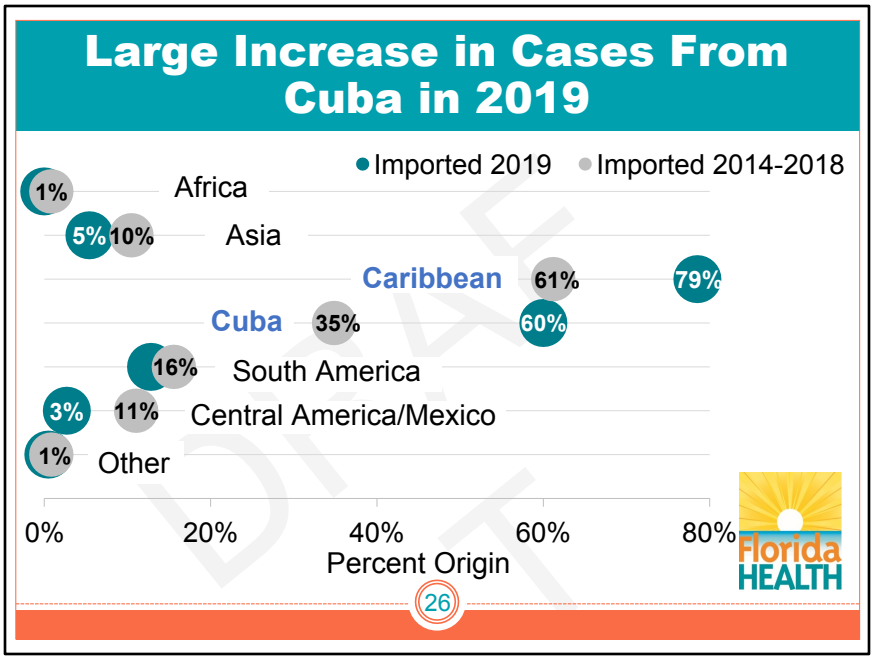

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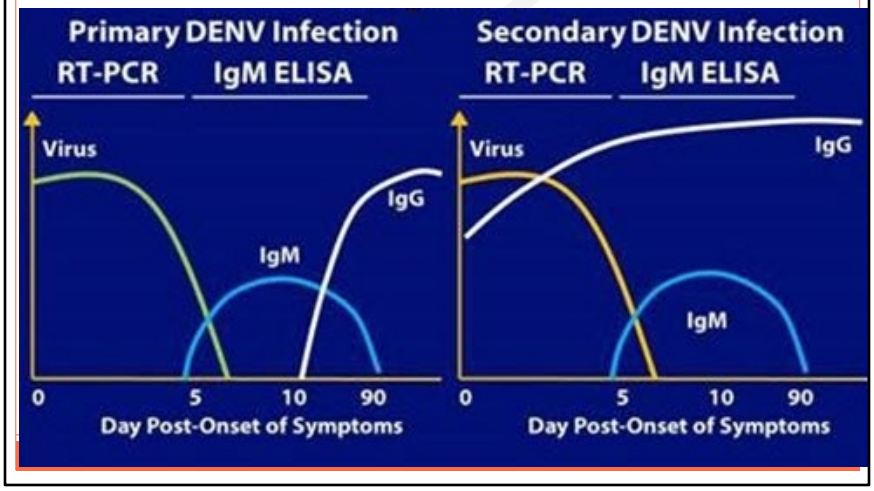
Dengue Diagnostic Testing



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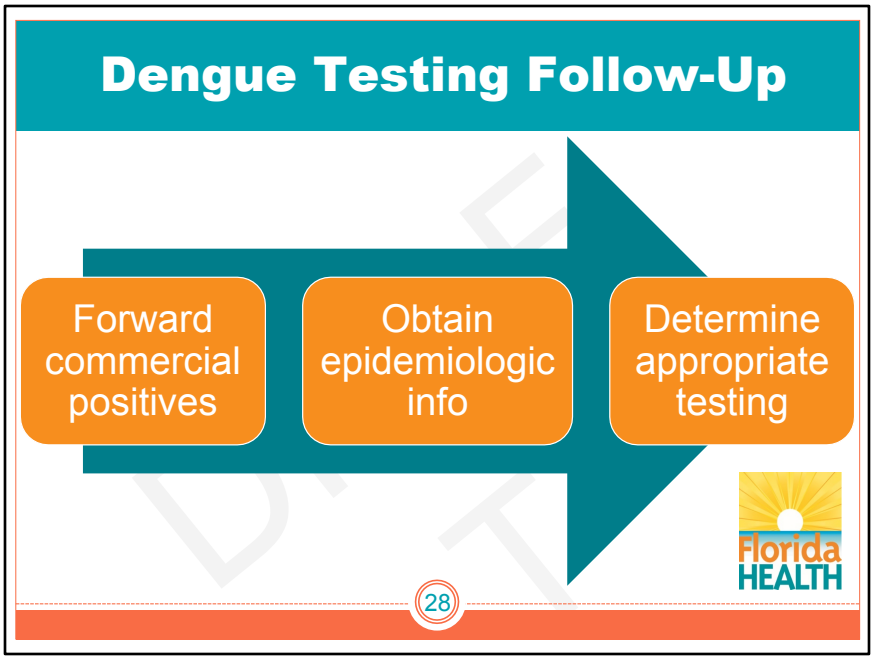

Sample forwarding to BPHL

Confirm commercial positives for samples meeting laboratory case criteria

Also

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review samples that are only IgG positive Epidemiologists determine appropriate testing (based on timing of symptoms, sample collection, and travel [if applicable])

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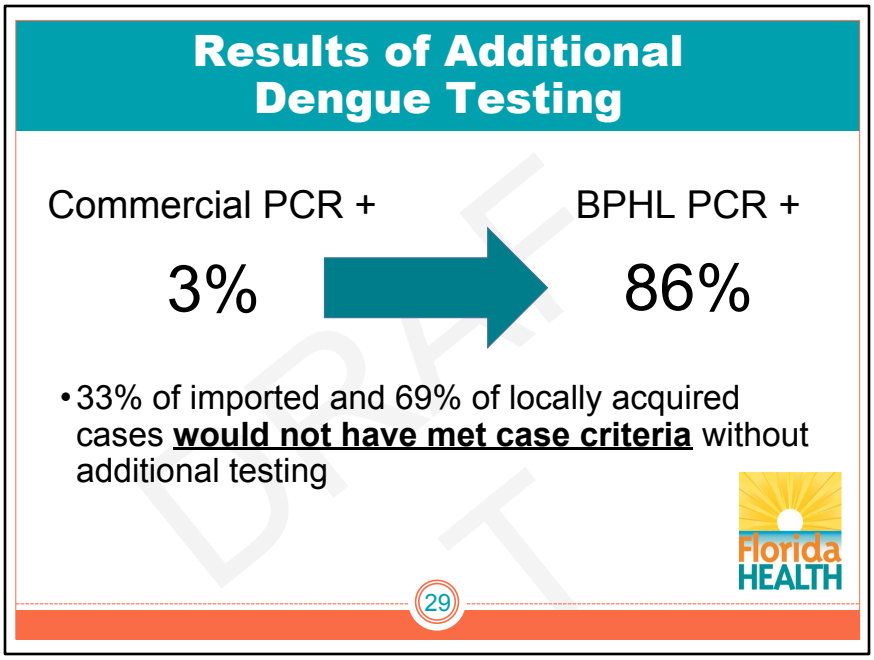

3% of cases were PCR positive at a commercial lab
Overall, 86% of dengue cases were PCR positive at bphl

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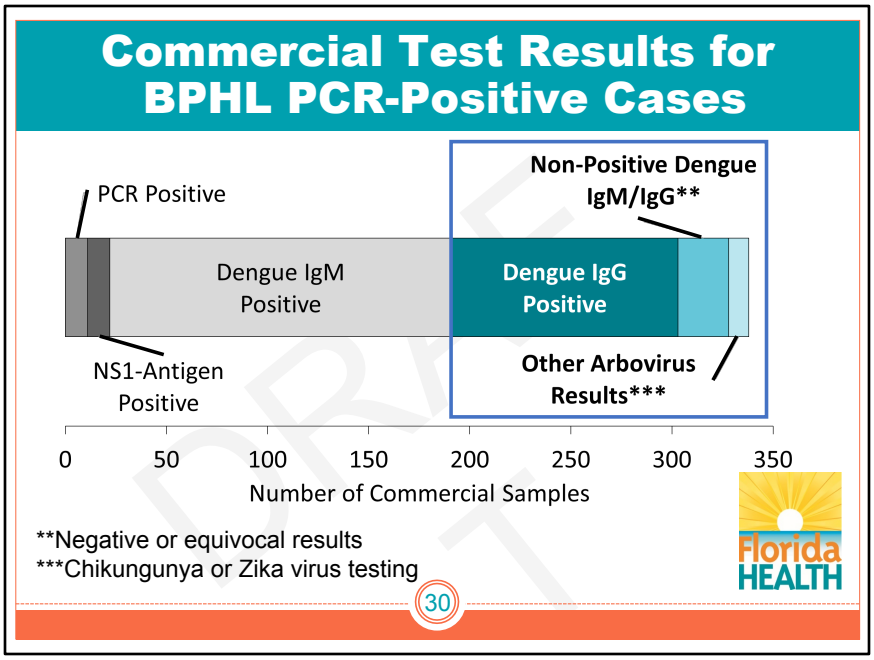

This slide shows the commercial test results for the samples that ended up being BPHL PCR+
Gray = met dengue laboratory case criteria
Non-positive = negative or equivocal serologic results, collected early after onset

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Questions?

Carina Blackmore, DVM, PhD
Florida Department of Health
Carina.Blackmore@FLHealth.gov
850-245-4732

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From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
To: Robinson,Laura (DSHS); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD)
Cc: Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject: RE: Vector Week Speaker Guidance
Date: Tuesday, February 11, 2020 10:56:52 AM

Morning, team –
Thanks again for joining Angi and I on the speakers call yesterday. Here's the outline/flow of presentations for Session 16:

Name	Presentation
Erin Staples	Title: CDC-developed Arboviral Response Plans Focus: Overview of the CDC response plans – possible review of future plans in development too.
Carina Blackmore	Title: Emergency Mosquito Control in FL Focus: Structure of FL for emergency response to mosq disaster and outbreak.
Laura Robinson	Title: Hurricane and Flooding Mosquito Response in Texas Focus: Structure of TX for emergency response focused on hurricane and flooding events.
Kathy Dolan	Title: Resources and Tools to Enhance State Capacity for Vector-Borne Disease Response Focus: Overview of tools and resources for SHDs – Highlight of ASTHO developed tools incl. PH Confronts the Mosquito.
Jennifer Li	Title: Vector-Borne Diseases Preparedness for Locals Focus: Resources and tools to vector programs – being more prepared to detect VBD threats/respond to outbreaks. Recommendations to integrate overall prep structure. NACCHO toolbox.

Notes:

- Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.**
- Send your name, occupation title, organization to Molly, Angi, and I as soon as possible. We'll use this to assist Molly in introducing the speakers.
- Arrive 10 minutes before the presentation. Sit at the front of the room.

Please reach out to Molly, Angi, and I if you have any further questions. See you all in Fort Collins in 2 weeks!

Thanks,
Nga

From: Robinson,Laura (DSHS) <Laura.Robinson@dshs.texas.gov>
Sent: Monday, February 10, 2020 11:23 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Harris, Angela (CDC/DDID/NCEZID/DVBD) <lwl3@cdc.gov>; Baker, Molly <Molly.Baker@health.mo.gov>;

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Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; jli@naccho.org (CDC naccho.org) <jli@naccho.org>; Chelsea Gridley-Smith <cgridley-smith@naccho.org>; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD) <auv1@cdc.gov>
Cc: Garcia,Imelda M (DSHS) <ImeldaM.Garcia@dshs.texas.gov>; Aldridge,Tiffany (DSHS) <Tiffany.Aldridge@dshs.texas.gov>
Subject: RE: Vector Week Speaker Guidance

Hello, everyone -
I wanted to send you my name, contact information, and credentials. Due to novel coronavirus activities, Associate Commissioner Imelda Garcia will not be attending the CDC Vector Week conference. She asked that I present "Hurricane and Flooding Mosquito Response in Texas."

Thank you,
LER
Laura E. Robinson, DVM, MS
Acting State Public Health Veterinarian
Zoonosis Control Branch
Department of State Health Services
Phone: 512-776-3306 Fax: 512-776-7454
Laura.Robinson@dshs.texas.gov

Mailing Address:
P.O. Box 149347, MC1956
Austin, Texas 78714-9347

https://www.dshs.texas.gov/idcu/health/zoonosis/

-----Original Appointment-----
From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) [mailto:ypg2@cdc.gov]
Sent: Friday, February 7, 2020 3:57 PM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD); Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject: Vector Week Speaker Guidance
When: Monday, February 10, 2020 11:00 AM-11:30 AM (UTC-07:00) Mountain Time (US & Canada).
Where: Skype line / 855-348-8390 / 2855050

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

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Your presentation is included in **Session #16, Emergency Response Plans**. The session is scheduled for Thursday February 27, 2020, 8:30-9:45am in Breakout Room A (Salon III, IV & VI) at the University Hilton in Fort Collins, CO.

Presentation time: 10-12 minutes
Speakers in session: 5
Moderator(s) (cc'd here): Angela Harris, Nga Vuong, Molly Baker

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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(404) 553-8912,,2855050# (Ft. Collins Dial-in Conference Region)	English (United States)
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From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
To: Robinson,Laura (DSHS); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD)
Cc: Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject: RE: Vector Week Speaker Guidance
Date: Friday, February 14, 2020 9:12:13 AM
Importance: High

Good morning, everyone –
Please send your slides to cjohnstone@alakaina.com as soon as possible. Reach out to Kimi Landry at nrn8@cdc.gov for any questions or concerns.

Thank you,
Nga

From: Vuong, Nga (CDC/DDID/NCEZID/DVBD)
Sent: Tuesday, February 11, 2020 8:57 AM
To: Robinson,Laura (DSHS) <Laura.Robinson@dshs.texas.gov>; Harris, Angela (CDC/DDID/NCEZID/DVBD) <lwl3@cdc.gov>; Baker, Molly <Molly.Baker@health.mo.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; jli@naccho.org (CDC naccho.org) <jli@naccho.org>; Chelsea Gridley-Smith <cgridley-smith@naccho.org>; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD) <auv1@cdc.gov>
Cc: Garcia,Imelda M (DSHS) <ImeldaM.Garcia@dshs.texas.gov>; Aldridge,Tiffany (DSHS) <Tiffany.Aldridge@dshs.texas.gov>
Subject: RE: Vector Week Speaker Guidance

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Name	Presentation
Erin Staples	Title: CDC-developed Arboviral Response Plans Focus: Overview of the CDC response plans – possible review of future plans in development too.
Carina Blackmore	Title: Emergency Mosquito Control in FL Focus: Structure of FL for emergency response to mosq disaster and outbreak.
Laura Robinson	Title: Hurricane and Flooding Mosquito Response in Texas Focus: Structure of TX for emergency response focused on hurricane and flooding events.
Kathy Dolan	Title: Resources and Tools to Enhance State Capacity for Vector-Borne Disease Response Focus: Overview of tools and resources for SHDs – Highlight of ASTHO developed tools incl. PH Confronts the Mosquito.
Jennifer Li	Title: Vector-Borne Diseases Preparedness for Locals Focus: Resources and tools to vector programs – being more prepared to detect VBD threats/respond to outbreaks. Recommendations

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	to integrate overall prep structure. NACCHO toolbox.

Notes:

- Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.**
- Send your name, occupation title, organization to Molly, Angi, and I as soon as possible. We'll use this to assist Molly in introducing the speakers.
- Arrive 10 minutes before the presentation. Sit at the front of the room.

Please reach out to Molly, Angi, and I if you have any further questions. See you all in Fort Collins in 2 weeks!

Thanks,
Nga

From: Robinson,Laura (DSHS) <Laura.Robinson@dshs.texas.gov>
Sent: Monday, February 10, 2020 11:23 AM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD) <ypg2@cdc.gov>; Harris, Angela (CDC/DDID/NCEZID/DVBD) <lwl3@cdc.gov>; Baker, Molly <Molly.Baker@health.mo.gov>; Blackmore, Carina (CDC flhealth.gov) <carina.blackmore@flhealth.gov>; jli@naccho.org (CDC naccho.org) <jli@naccho.org>; Chelsea Gridley-Smith <cgridley-smith@naccho.org>; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD) <auv1@cdc.gov>
Cc: Garcia,Imelda M (DSHS) <ImeldaM.Garcia@dshs.texas.gov>; Aldridge,Tiffany (DSHS) <Tiffany.Aldridge@dshs.texas.gov>
Subject: RE: Vector Week Speaker Guidance

Hello, everyone -
I wanted to send you my name, contact information, and credentials. Due to novel coronavirus activities, Associate Commissioner Imelda Garcia will not be attending the CDC Vector Week conference. She asked that I present "Hurricane and Flooding Mosquito Response in Texas."

Thank you,
LER

Laura E. Robinson, DVM, MS
Acting State Public Health Veterinarian
Zoonosis Control Branch
Department of State Health Services
Phone: 512-776-3306 Fax: 512-776-7454
Laura.Robinson@dshs.texas.gov

Mailing Address:
P.O. Box 149347, MC1956
Austin, Texas 78714-9347

https://www.dshs.texas.gov/idcu/health/zoonosis/

-----Original Appointment-----

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From: Vuong, Nga (CDC/DDID/NCEZID/DVBD) [mailto:ypg2@cdc.gov]
Sent: Friday, February 7, 2020 3:57 PM
To: Vuong, Nga (CDC/DDID/NCEZID/DVBD); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD); Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject: Vector Week Speaker Guidance
When: Monday, February 10, 2020 11:00 AM-11:30 AM (UTC-07:00) Mountain Time (US & Canada).
Where: Skype line / 855-348-8390 / 2855050

VECTOR WEEK 2020: SPEAKER GUIDANCE

-
-

Thank you for participating in Vector Week 2020 as a conference speaker!

Your presentation is included in **Session #16, Emergency Response Plans**. The session is scheduled for Thursday February 27, 2020, 8:30-9:45am in Breakout Room A (Salon III, IV & VI) at the University Hilton in Fort Collins, CO.

Presentation time: 10-12 minutes
Speakers in session: 5
Moderator(s) (cc'd here): Angela Harris, Nga Vuong, Molly Baker

Please send your presentation slides to cjohnstone@alakaina.com by **February 14, 2020.** This will enable the conference staff to pre-load your presentation onto the computer in your session room. Additionally, your session moderator(s) will likely be contacting you with additional information. Please contact them for questions relating to this session.

If you haven't yet registered for Vector Week, please email cdcvectorweek@cdc.gov.

Thanks again for participating in Vector Week 2020 and we look forward to seeing you at the conference!

Sincerely,
The Vector Week Steering Committee

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To:	Vuong, Nga (CDC/DDID/NCEZID/DVBD); Harris, Angela (CDC/DDID/NCEZID/DVBD); Baker, Molly; Blackmore, Carina (CDC flhealth.gov); jli@naccho.org (CDC naccho.org); Chelsea Gridley-Smith; kdolan@astho.org; Staples, J. Erin (CDC/DDID/NCEZID/DVBD)
Cc:	Garcia,Imelda M (DSHS); Aldridge,Tiffany (DSHS)
Subject:	RE: Vector Week Speaker Guidance
Date:	Monday, February 10, 2020 1:22:32 PM

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Thank you,
LER

Laura E. Robinson, DVM, MS
Acting State Public Health Veterinarian
Zoonosis Control Branch
Department of State Health Services
Phone: 512-776-3306 Fax: 512-776-7454
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https://www.dshs.texas.gov/idcu/health/zoonosis/

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Sent: Friday, February 7, 2020 3:57 PM
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VECTOR WEEK 2020: SPEAKER GUIDANCE

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AMERICAN OVERSIGHT

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From: MAXWELL, LAUREN

To: ZIKApregnancy (CDC); lauren.maxwell@emory.edu; lauren.maxwell@uni-heidelberg.de; Davidson, Sherri (CDC adph.state.al.us); McIntyre, Mary (CDC adph.state.al.us); Rachael.Montgomery@adph.state.al.us; tobytha.powell@adph.state.al.us; Brenda.Ryals@adph.state.al.us; janice.smiley@adph.state.al.us; Stevens, Kelly (CDC adph.state.al.us); amy.stratton@adph.state.al.us; grace.thomas@adph.state.al.us; tammie.yeldell@adph.state.al.us; mirwais.zhuben@adph.state.al.us; evelyn.geeter@adph.state.al.us; Castrodale, Louisa (CDC alaska.gov); Fearey, Donna (CDC alaska.gov); r.ropeti@doh.as; lugafono, Sunia (CDC doh.as); a.tufa@doh.as; Dianna.contreras@azdhs.gov; Timothy.Flood@azdhs.gov; Lora.Andrikopoulos@azdhs.gov; Rigler, Jessica (CDC azdhs.gov); irene.ruberto@azdhs.gov; Joseph.Spadafino@azdhs.gov; Tarter, Kara (CDC azdhs.gov); Venkat, Heather (CDC azdhs.gov); Villarroel, Lisa (CDC azdhs.gov); Joli.Weiss@azdhs.gov; RangelCF@archildrens.org; Rupa.Sharma@arkansas.gov; Lori.Simmons@arkansas.gov; SmithHL@archildrens.org; brandi.stricklin@arkansas.gov; catherine.waters@arkansas.gov; harit.agroia@cdph.ca.gov; Olga.Barer@cdph.ca.gov; Valorie.Eckert@cdph.ca.gov; Similoluwa.Sowunmi@cdph.ca.gov; Richard.Olney@cdph.ca.gov; Charsey.Porse@cdph.ca.gov; Barbara.Warmerdam@cdph.ca.gov; Watt, James (CDC cdph.ca.gov); Eileen.Yamada@cdph.ca.gov; ccroker@ph.lacounty.gov; MIbrahim@ph.lacounty.gov; along@ph.lacounty.gov; clyu@ph.lacounty.gov; Mascola, Laurene (CDC ph.lacounty.gov); vngo@ph.lacounty.gov; SReynaldo@ph.lacounty.gov; cvincent-jones@ph.lacounty.gov; Cchang@ph.lacounty.gov; House, Jennifer (CDC state.co.us); Natalie.Marzec@state.co.us; Cartter, Matthew (CDC ct.gov); karin.davis@ct.gov; abdi.elmi@ct.gov; brenda.esponda-morrison@ct.gov; tabitha.fox@ct.gov; zack.Fraser@ct.gov; Claudia.gutierrez@ct.gov; paula.eggers@state.de.us; Davies-Cole, John (CDC dc.gov); Iyengar, Preetha (CDC dc.gov); PRAMS District of Columbia (CDC dc.gov); shreya.khuntia@dc.gov; McGee, Sasha (CDC dc.gov); lbarrow@fsmhealth.fm; EEdward@fsmhealth.fm; Masao, Carolee (CDC fsmhealth.fm); anena@fsmhealth.fm; jsarofalpiy@fsmhealth.fm; BTaoTao-Wini@fsmhealth.fm; ltaulung@fsmhealth.fm; PVelasco@fsmhealth.fm; rewaguk@fsmhealth.fm; health; andrea.morrison@flhealth.gov; Blackmore, Carina (CDC flhealth.gov); fdoh.grantsoffice@flhealth.gov; Melissa.Jordan@flhealth.gov; heather.lake-burger@flhealth.gov; Mary.Hilton@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Catherine.McDermott@flhealth.gov; Amanda.elmore@flhealth.gov; jerusha.barton@dph.ga.gov; Michael.Bryan@dph.ga.gov; Cragan, Janet D. (CDC/DDNID/NCBDDD/DBDID); teri.willabus@dph.ga.gov; Drenzek, Cherie (CDC dph.ga.gov); julie.gabel@dph.ga.gov; michele.mindlin@dph.ga.gov; ashton.thompson@dph.ga.gov; ada, Estelle (CDC dphss.guam.gov); Margaret.Bell@dphss.guam.gov; margarita.gay@dphss.guam.gov; AnneMarie.Santos@dphss.guam.gov; tommy.taitague@dphss.guam.gov; William.Aakhus@doh.hawaii.gov; nianest.alersbarreto@doh.hawaii.gov; Jonathan.kimura@doh.hawaii.gov; sylvia@hawaiigenetics.org; sarah.park@doh.hawaii.gov; Carter, Kris (CDC dhw.idaho.gov); Hahn, Christine G. <ID> (CDC dhw.idaho.gov); tengelse@dhw.idaho.gov; Turner, Kathryn (CDC dhw.idaho.gov); Marcia.Witte@dhw.idaho.gov; jane.fornoff@illinois.gov; Debbie.Freeman@illinois.gov; Kauerauf, Judy (CDC illinois.gov); Jonathan.popovitch@illinois.gov; theresa.sandidge@illinois.gov; tiefu.shen@illinois.gov; Arwady, Allison AA (CDC cityofchicago.org); Black, Stephanie SB (CDC cityofchicago.org); jennifer.levy@cityofchicago.org; Toews, Karrie-Ann (CDC cityofchicago.org); Jessica.Wilkerson@cityofchicago.org; abianco@isdh.in.gov; Brown, Jen (CDC isdh.in.gov); rchauhan1@isdh.in.gov; aforkner@isdh.in.gov; Pontones, Pamela (CDC isdh.in.gov); tastevens@isdh.in.gov; julie.coughlin@idph.iowa.gov; carrie-fall@uiowa.edu; florence-foo@uiowa.edu; Garvey, Ann (CDC idph.iowa.gov); nih@uiowa.edu; oluwakemi.oni@idph.iowa.gov; paul-romitti@uiowa.edu; Kenneth.Sharp@idph.iowa.gov; Farah.Ahmed@ks.gov; Jamie.Kim@ks.gov; hsmith@kdheks.gov; stubach@kdheks.gov; Emily.Ferrell@ky.gov; paul.bellamy@ky.gov; martie.kupchinsky@ky.gov; Carrell.Rush@ky.gov; Teresa.Fields@ky.gov; Matthew.Johnson@ky.gov; Rachel.Zinner@ky.gov; dimple.patel@ky.gov; Nancy.Hamilton@ky.gov; brittany.followell@ky.gov; Edward.Holmberg@la.gov; jenna.ibergjohnson@la.gov; julie.johnston@la.gov; Ratard, Raoult (CDC la.gov); christine.scott-waldron@la.gov; sean.simonson@la.gov; Sokol, Theresa (CDC la.gov); julius.tonzel@la.gov; tri.tran@la.gov; Farmer, Ann (CDC maine.gov); catie.peranzi@maine.gov; Robinson, Sara (CDC maine.gov); Blythe, David (CDC maryland.gov); Duwell, Monique MD (CDC maryland.gov); judie.hyun@maryland.gov; McLean, Sandra (CDC maryland.gov); kristin.silcox@maryland.gov; monika.piccardi@maryland.gov; Catherine.Brown@state.ma.us; alfred.demaria@state.ma.us; cathleen.higgins@state.ma.us; rebecca.liberman@state.ma.us; matthew.a.osborne@state.ma.us; kayleigh.sandhu@state.ma.us; Sarah.Scotland@MassMail.State.MA.US; susan.soliva@massMail.state.ma.us; eileen.m.sullivan@state.ma.us; mahsa.yazdy@MassMail.state.ma.us; alversonG@michigan.gov; ehrhardtj@michigan.gov; Fussman, Chris (CDC michigan.gov); reikr@michigan.gov; Signsk@michigan.gov; simmonsl@michigan.gov; Stobierski, Mary Grace (CDC michigan.gov); BohnerA2@michigan.gov; sook.ja.cho@state.mn.us; Danila, Richard (CDC state.mn.us); barbara.frohnert@state.mn.us; carolyn.hoel@state.mn.us; michele.hort@state.mn.us; erin.kough@state.mn.us; david.neitzel@state.mn.us; elizabeth.schiffman@state.mn.us; paul.byers@healthyms.com; gerri.cannon-smith@msdh.ms.gov; Katherine.farrington@msdh.ms.gov; Beryl.polk@msdh.ms.gov; Alyce.Stewart@msdh.state.ms.us; kathryn.taylor@msdh.ms.gov; jennifer.hanson@msdh.ms.gov; LaShunda.Williams@msdh.ms.gov; Chana.Winder@msdh.ms.gov; Molly.baker@health.mo.gov; grants@health.mo.gov; Alexandra.Berkley@health.mo.gov; john.bos@health.mo.gov; rose.kowieski@health.mo.gov; qian.liu@health.mo.gov; Loise.Wambuguh@health.mo.gov; Erika.baldry@mt.gov; debgibson@mt.gov; Jeff.hamik@nebraska.gov; Koirala, Samir (CDC nebraska.gov); Qu, Ming (CDC nebraska.gov); barker@snhdmail.org; henri@snhdmail.org; johnsonmi@snhdmail.org; mehretu@SNHDMAIL.ORG; mpeekbullock@health.nv.gov; ramand@SNHD.ORG; Zhang, Lei (CDC snhdmail.org); hertin@SNHD.ORG; vllegarde@health.nv.gov; jdumonte@health.nv.gov; heather.barton@dhhs.nh.gov; christine.bean@dhhs.nh.gov; Suzann.Beauregard@dhhs.nh.gov; carolyn.fredette@dhhs.state.nh.us; Mathewson, Abigail (CDC dhhs.state.nh.us); paulette.valliere@dhhs.nh.gov; Andria.Scacheri@dhhs.nh.gov; eric.carlsson@doh.nj.gov; Kim.Cervantes@doh.nj.gov; Kristin.Garafalo@doh.nj.gov; Sandra.Howell@doh.nj.gov; Loletha.Johnson@doh.nj.gov; Mary.Knapp@doh.nj.gov; Joy.Rende@doh.nj.gov; nancy.scotto-rosato@doh.nj.gov; Tan, Christina CT (CDC doh.nj.gov); Mojisola.Ojo@doh.nj.gov; Janis.gonzales@state.nm.us; Krapfl, Heidi (CDC state.nm.us); Martina.Garcia@state.nm.us; Aimee.Roth@state.nm.us; Blog, Debra (CDC health.ny.gov); laura.brady@health.ny.gov; marilyn.browne@health.ny.gov; Donna.DeLuca@healthresearch.org; deb.fox@health.ny.gov; Lisa.Jackson@health.ny.gov; nicole.longcore@health.ny.gov;

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	jennifer.white@health.ny.gov; ccanary@health.nyc.gov; Fine, Annie (CDC health.nyc.gov); mlash@health.nyc.gov; elee4@health.nyc.gov; tmcveigh@health.nyc.gov; Paladini, Marc (CDC health.nyc.gov); fpoteat@health.nyc.gov; sslavins@health.nyc.gov; ttseyang@health.nyc.gov; mvachon@health.nyc.gov; swillis@health.nyc.gov; awinters@health.nyc.gov; mandy.cohen@dhhs.nc.gov; nina.forestieri@dhhs.nc.gov; kristin.bergman@dhhs.nc.gov; Maillard, Jean-Marie (CDC dhhs.nc.gov); mdethloff@nd.gov; lcronquist@nd.gov; Miller, Tracy (CDC nd.gov); Luu, Ngoc Phuong NPL (CDC dph.gov.mp); Muña, Esther (CDC dph.gov.mp); margarita.aldan@dph.gov.mp; warren.villagomez@gmail.com; rosita.waldron@dph.gov.mp; educator.dph@gmail.com; deFijter, Sietske (CDC odh.ohio.gov); Kirstan.Duckett@odh.ohio.gov; richard.gary@odh.ohio.gov; Shelby.hale@odh.ohio.gov; Kimberly.Machesky@odh.ohio.gov; Mohr, Marika (CDC odh.ohio.gov); Norma.Ryan@odh.ohio.gov; Anna.Starr@odh.ohio.gov; BRANDI.TAYLOR@odh.ohio.gov; lisarc@health.ok.gov; MikeT@health.ok.gov; LISA.C.IGUCHI@dhsoha.state.or.us; kliu.basilius@palauhealth.org; Elechuus, Brenice (CDC palauhealth.org); losii.samsel@palauhealth.org; mindy.sugiyama@palauhealth.org; tmong.udui@palauhealth.org; jane.baker@phila.gov; Johnson, Caroline (PHILA) (CDC phila.gov); carol.larach@phila.gov; Dana.Perella@phila.gov; Sharon.Starr@phila.gov; Trevor.Kanaskie@Phila.gov; kerri.simone@phila.gov; c-kihauser@pa.gov; c-chowells@pa.gov; Long, Jonah (CDC pa.gov); Mariott, Chandra (CDC pa.gov); bmiller@pa.gov; lstubbs@pa.gov; shawatkins@pa.gov; Longenberger, Allison (CDC pa.gov); camilledelgado@salud.pr.gov; stephany.perez@salud.pr.gov; mvalencia@salud.gov.pr; mayabing@gmail.com; Anzures, Edlen (CDC gmail.com); k.briand123@yahoo.com; Aina.Garstang@gmail.com; ransenjr@gmail.com; wasejacklick@gmail.com; jillmccready@yahoo.com; Alexander-Scott, Nicole (CDC health.ri.gov); Bandy, Utpala (CDC health.ri.gov); Gosciminski, Michael (RI) (CDC health.ri.gov); daniela.quilliam@health.ri.gov; St John, Kristen (CDC health.ri.gov); bridget.teevan@health.ri.gov; samara.vinerbrown@health.ri.gov; Bell, Linda (CDC dhec.sc.gov); Daguise, Virginie VD (CDC dhec.sc.gov); Drociuk, Dan (CDC dhec.sc.gov); henderdl@dhec.sc.gov; LeedomVO@dhec.sc.gov; Radcliffe, Rachel (CDC dhec.sc.gov); chris.carlson@state.sd.us; cassandra.deffenbaugh@state.sd.us; Meghan.Marx@state.sd.us; Carolina.Clark@tn.gov; Cristina.alford@tn.gov; Jacqueline.Johnson@tn.gov; Katherine.Lolley@tn.gov; morgan.mcdonald@tn.gov; Laura.price@tn.gov; tiffany.aldridge@dshs.texas.gov; monica.gamez@dshs.texas.gov; Linda.Gaul@dshs.texas.gov; Tom.Sidwa@dshs.texas.gov; Kelly.Broussard@dshs.texas.gov; Canfield, Mark (CDC dshs.texas.gov); ImeldaM.Garcia@dshs.texas.gov; peter.langlois@dshs.texas.gov; idaresit.umoh@dallascounty.org; Kyoo.Shim@dallascounty.org; wendy.chung@dallascounty.org; Folasuyi.Richardson@dallascounty.org; ilianna.mata@hchd.org; steven.hinojosa@hchd.org; connie.sanchez@hchd.org; patricia.garcia@hchd.org; Tahani.Hamdan@houstontx.gov; Salma.Khuwaja@houstontx.gov; McNeely, Wesley (CDC houstontx.gov); Tolulope.Olumuyiwa@houstontx.gov; ifrah.chaudhary@houstontx.gov; Paul.Afnan@Houstontx.gov; Kirstin.Short@houstontx.gov; Yang, Biru (CDC houstontx.gov); leah.dewilde@doh.vi.gov; Ellis, Esther (CDC doh.vi.gov); eleanor.johannes@doh.vi.gov; cosme.harrison@doh.vi.gov; cburnett@utah.gov; janejohnson@utah.gov; aenance@utah.gov; ddpeterson@utah.gov; asteele@utah.gov; Watkins, Shari A. (CDC utah.gov); peggy.brozicevic@vermont.gov; Cook, Sally (CDC vermont.gov); paul.daley@vermont.gov; brennan.martin@vermont.gov; Nicolai, Laura Ann (CDC vermont.gov); lucia.orantes@vermont.gov; katherine.crawford@vdh.virginia.gov; Kurkjian, Katie (CDC vdh.virginia.gov); Jennifer.Macdonald@vdh.virginia.gov; elena.mircoff@vdh.virginia.gov; mary.chan@doh.wa.gov; Hanna.Oltean@doh.wa.gov; melissa.a.baker@wv.gov; Tara.L.Buckner@wv.gov; kathy.g.cummons@wv.gov; amy.bittrich@dhs.wisconsin.gov; DeSalvo, Traci (CDC dhs.wisconsin.gov); DHSGrantReview@wisconsin.gov; Kimberly.Meinholz@dhs.wisconsin.gov; christine.muganda@dhs.wisconsin.gov; rebecca.osborn@dhs.wisconsin.gov; Rohan, Angela (CDC dhs.wisconsin.gov); Wozniak, Ryan (CDC dhs.wisconsin.gov); Vanhouten, Clay (CDC wyo.gov); Akosa, Amanda (CDC/DDNID/NCBDDD/DBDID) (CTR); Lewis, Elizabeth L. (CDC/DDNID/NCBDDD/DBDID) (CTR); Castillo, Keila (CDC/DDNID/NCBDDD/DBDID) (CTR); King, Kellianne M. (CDC/DDNID/NCBDDD/DBDID) (CTR)
Cc:	BROUTET, Nathalie Jeanne Nicole; KIM, Caron Rahn; Kara, Edna; SAYERS, Janet; THWIN, Soe Soe; Tong, Van T. (CDC/DDNID/NCBDDD/DBDID); Gilboa, Suzanne (CDC/DDNID/NCBDDD/DBDID); Roth, Nicki (CDC/DDNID/NCBDDD/DBDID) (CTR); Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID)
Subject:	RE: WHO/CDC ZIKV IPD Consortium Presentation
Date:	Friday, February 28, 2020 6:14:30 AM
Attachments:	ZIKV IPD-MA Protocol_BMJ Open.pdf LOA_ZIKV IPD Consortium IPD-MA_UPDATED March 2019_CDC SPECIFIC.docx

Dear USZPIR partners,

Many thanks to everyone who was able to attend the presentation on the ZIKV IPD Consortium-led individual participant data meta-analysis (IPD-MA) of cohorts of pregnant women and their infants and children.

Please find the protocol for the ZIKV IPD-MA and the Letter of Agreement (LoA) for data sharing and authorship, which includes the amendments that were requested by US-CDC and DHHS.

Please let us know if there are any follow-up questions. We would also be happy to host a presentation with your specific team if that would be useful.

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Because the ZIKV IPD-MA will use de-identified data for the same objectives for which that data was collected, the IPD-MA was deemed exempt from ethical review by the WHO Ethics Review Committee. As mentioned on the call, USZPIR sites that wish to participate in the IPD-MA would need to review and sign the LoA for data sharing and authorship, but the de-identified data for that specific site would be uploaded to the WHO e-Archive system from the existing USZPIR dataset rather than the participating site.

Thank you again!

Lauren Maxwell

Lauren Maxwell, PhD, MPH
Project Manager
ZIKV IPD Consortium
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Human Reproduction Programme

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-----Original Appointment-----
From: ZIKApregnancy (CDC) <ZIKApregnancy@cdc.gov>
Sent: Thursday, February 13, 2020 3:10 PM
To: ZIKApregnancy (CDC); lauren.maxwell@emory.edu; lauren.maxwell@uni-heidelberg.de; MAXWELL, LAUREN; Davidson, Sherri (CDC adph.state.al.us); McIntyre, Mary (CDC adph.state.al.us); Rachael.Montgomery@adph.state.al.us; tobytha.powell@adph.state.al.us; Brenda.Ryals@adph.state.al.us; janice.smiley@adph.state.al.us; Stevens, Kelly (CDC adph.state.al.us); amy.stratton@adph.state.al.us; grace.thomas@adph.state.al.us; tammie.yeldell@adph.state.al.us; mirwais.zhuben@adph.state.al.us; evelyn.geeter@adph.state.al.us; Castrodale, Louisa (CDC alaska.gov); Fearey, Donna (CDC alaska.gov); r.ropeti@doh.as; Iugafono, Sunia (CDC doh.as); a.tufa@doh.as; Dianna.contreras@azdhs.gov; Timothy.Flood@azdhs.gov; Lora.Andrikopoulos@azdhs.gov; Rigler, Jessica (CDC azdhs.gov); irene.ruberto@azdhs.gov; Joseph.Spadafino@azdhs.gov; Tarter, Kara (CDC azdhs.gov); Venkat, Heather (CDC azdhs.gov); Villarroel, Lisa (CDC azdhs.gov); Joli.Weiss@azdhs.gov; RangelCF@archildrens.org; Rupa.Sharma@arkansas.gov; Lori.Simmons@arkansas.gov; SmithHL@archildrens.org; brandi.stricklin@arkansas.gov; catherine.waters@arkansas.gov; harit.agroia@cdph.ca.gov; Olga.Barer@cdph.ca.gov; Valorie.Eckert@cdph.ca.gov; Similoluwa.Sowunmi@cdph.ca.gov; Richard.Olney@cdph.ca.gov; Charsey.Porse@cdph.ca.gov; Barbara.Warmerdam@cdph.ca.gov; Watt, James (CDC cdph.ca.gov); Eileen.Yamada@cdph.ca.gov; ccroker@ph.lacounty.gov; MIbrahim@ph.lacounty.gov; along@ph.lacounty.gov; clyu@ph.lacounty.gov; Mascola, Laurene (CDC ph.lacounty.gov); vngo@ph.lacounty.gov; SReynaldo@ph.lacounty.gov; cvincent-jones@ph.lacounty.gov; Cchang@ph.lacounty.gov; House, Jennifer (CDC state.co.us); Natalie.Marzec@state.co.us; Cartter, Matthew (CDC ct.gov); karin.davis@ct.gov; abdi.elmi@ct.gov; brenda.esponda-morrison@ct.gov; tabitha.fox@ct.gov; zack.Fraser@ct.gov; Claudia.gutierrez@ct.gov; paula.eggers@state.de.us; Davies-Cole, John (CDC dc.gov); Iyengar, Preetha (CDC dc.gov); PRAMS District of Columbia (CDC dc.gov);

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Cc: Reynolds, Megan (CDC/DDNID/NCBDDD/DBDID); BROUTET, Nathalie Jeanne Nicole; KIM, Caron Rahn; Kara, Edna; SAYERS, Janet; THWIN, Soe Soe
Subject: WHO/CDC ZIKV IPD Consortium Presentation
When: Wednesday, February 26, 2020 2:00 PM-2:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Skype Meeting

***Updated to include presentation slides (attached**).

Dear USZPIR partners,

We invite you to attend a presentation by Lauren Maxwell, Project Manager for the ZIKV IPD Consortium with WHO. Dr. Maxwell will be discussing the current and future efforts of the Individual Participant Data Meta-Analysis (IPD-MA) lead by WHO. This project involves plans to pool data on various cohorts to do a series of analyses related to Zika and pregnancy and could be of interest to jurisdictions who participated in the USZPIR at any time.

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Letter of Agreement
Regarding
Data Sharing, Use and Publication of Results
Relating to:

"Understanding the relation between Zika virus infection during pregnancy and adverse fetal, infant, and child outcomes: a protocol for a systematic review and individual participant data meta-analysis of longitudinal studies of pregnant women and their infants and children*" (the "**Protocol**")*

This Letter of Agreement is between the World Health Organization ("**WHO**") and [INSERT NAME OF INVESTIGATOR] on behalf of [INSERT NAME OF INSTITUTION] (the "**Institution**"). WHO and the Institution are hereinafter referred to each as a "**Party**" and together as the "**Parties**".

1. Background and purpose

1.1 The Parties enter into this Letter of Agreement to collaborate regarding the activities and study described in the Protocol (the "**Research Activities**"), and pursuant to the terms of this Letter of Agreement, the Institution will provide one or more de-identified, participant-level data set(s), data dictionary(ies), and variable code list(s) (the "**Data**") to WHO for the performance of the Research Activities. This Letter of Agreement also addresses, among other things, the ownership, transfer, use and publication of results relating to the Data and the Research Activities.

1.2 The ZIKV IPD Consortium is a global collaboration of Zika Virus (ZIKV) researchers whose purpose is to use individual participant data meta-analysis (IPD-MA) to address extant questions related to the relation between ZIKV infection and adverse maternal and child health outcomes. WHO and the Institution are members of the ZIKV IPD Consortium.

1.3 All parties participating with WHO in the Research Activities by contributing data sets to WHO for analysis are also members of the ZIKV IPD Consortium, and each such party is required to enter into a Letter of Agreement with WHO materially similar to this Letter of Agreement to participate in the Research Activities.

1.4 Emory and Heidelberg Universities have been contracted by WHO to create the meta-analysis dataset of all submitted data by ZIKV IPD Consortium members to WHO in connection with the Research Activities (the "**Meta-Analysis Dataset**"). The Meta-Analysis Dataset will only include de-identified an anonymized information and will not contain any personally identifiable information or personal data.

2. Cooperation regarding the Research Activities

2.1 WHO and the Institution agree to collaborate on the Research Activities according to the terms of this Letter of Agreement and those set out in the Protocol, attached as **Annex 1**.

2.2 The date by which the Research Activities are expected be completed and any manuscripts prepared and submitted (the "**Completion Date**") will be agreed by the ZIKV IPD Consortium. Unless otherwise agreed (see section 3.4.2, below), WHO will complete the Research Activities and destroy the Data received from the Institution and

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remove the Institution's data from the Meta-Analysis Dataset by the Completion Date and will provide certification of the destruction. The tentative Completion Date is 1 January 2026.

3. Data and dataset ownership and use

3.1 The Institution represents that it owns all rights in the Data and/or has the legal authority to share the Data.

3.2 Except as expressly provided in this Letter of Agreement, WHO does not hold, and is not granted under this Letter of Agreement, any rights in the Data, whether in implementing the Research Activities or otherwise.

3.3 Parties agree that the Data provided by Institution is public domain material. Institution shall maintain full rights to re-use the content and material it provides for any and all Institution purposes, and/or to share with other collaborators or requestors. Subject to the Institution's ownership or other rights in the Data and ability to re-use and share set out above, and the similar ownership or other rights of other members of the ZIKV IPD Consortium providing other data sets to WHO for the Research Activities, WHO will own all rights in the meta-analysis dataset and the analysis resulting from the Research Activities.

3.4 In addition to use in support of the Research Activities, and notwithstanding anything to the contrary in this Letter of Agreement, the Institution agrees and acknowledges that WHO is entitled to:

3.4.1 use, and allow third parties to use, the results of the Research Activities (including the Meta-Analysis Dataset) for normative guidance to countries until the agreed-upon Completion Date; and

3.4.2 if the Instution so agrees by signing below, allow the third parties (including, without limitation, Institutional members of the ZIKV IPD Consortium and institutions which have not committed data to the ZIKV IPD Consortium effort) to access the Meta-Analysis Dataset, subject to the following conditions:

3.4.2.1 The proposed recipient of the Meta-Analysis Dataset has provided to WHO a research protocol for which the proposed recipient is the sponsor, and the ZIKV IPD Consortium Data Access Committee (a group of cohort PIs and/or MoH officials who agree to oversee requests for access to the Meta-Analysis Dataset and associated codebooks) has decided that the research protocol is not duplicative of existing research protocols and is clinically relevant;

3.4.2.2 The proposed recipient of the Meta-Analysis Dataset has provided to WHO documentation of ethics committee review and approval of the aforementioned research protocol; and

3.4.2.3 The entry into a Data Access and Authorship Agreement between WHO and the proposed recipient of the Meta-Analysis Dataset which includes, without limitations terms for secure data transfer and storage, use of the Meta-Analysis Dataset by the recipient (only for conducting prespecified,

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approved-upon analyses), and authorship citation for the ZIKV IPD Consortium members who created the Meta-Analysis Dataset or whose data is included in the proposed analysis.

4. Undertakings of WHO

4.1 The WHO Research Ethics Review Committee has deemed this analysis exempt from Ethical Review.

4.2 In implementing the Research Activities, WHO will:

4.2.1 Not attempt to identify or contact research participants included in the Data;

4.2.2 Respect the confidentiality of the Data, including that WHO will take all reasonable measures to ensure that the Data will only be used for the Research Activities and will only be disclosed to those persons who need to receive the Data for the Research Activities;

4.2.3 WHO will transmit Data to the data synthesis groups at Emory and Heidelberg Universities securely, using secure file transfer protocol;

4.2.4 WHO will maintain the Data in a secure location on a password-protected, WHO-internal network protected by standard encoding and the WHO firewall for the duration of the project; and

4.2.5 WHO will require Emory and Heidelberg Universities to enter into a contractual commitment to maintain the Data in a secure location on a password-protected, internal network protected by standard encoding and by the Emory and Heidelberg University firewalls during the creation of the synthesized dataset (two years from the date that the data is received by WHO); and

4.2.6 Only perform analysis of the Data that addresses the objectives specified in the Protocol (with the exception of using the Data to provide normative guidance to countries, as cited in 3.4). Any additional analyses of the Data deemed necessary to meet the objectives of the Protocol will be performed by WHO only after it has received approval from the Institution and all other members of the ZIKV IPD Consortium whose data would be involved in such additional analyses, if any. Approval of any such additional analyses will be assumed if the Institution does not reply to WHO's request within 10 working days. Notwithstanding the foregoing, additional analyses of the Data which would address completely novel objectives not included in the Protocol must be affirmatively approved by the Institution.

4.3 With respect to preparation of the dataset for the Research Activities, WHO will assess the Data for irregularities and review the distribution of the Data with the Institution. Once the WHO has resolved any irregularities in the data with the Institution (i.e. discrepancies between the Data received and any published reports of the Data), WHO will return a copy of the Data to the Institution in the "cleaned" format. WHO will retain its copy of such "cleaned" Data for the purposes provided herein.

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4.4 As part of its implementation of the Research Activities, WHO will:

4.4.1 Keep a detailed record of the formation of the Meta-Analysis Dataset;

4.4.2 Seek feedback on data synthesis questions (i.e., combining results from different diagnostic tests) from an expert panel of scientists and researchers decided upon by the ZIKV IPD Consortium;

4.4.3 Inform the Institution and other ZIKV IPD Consortium members of decisions made during the data synthesis process through monthly telephone or email updates; and

4.4.4 Share results of analyses with the Institution and all members of the ZIKV IPD-MA Consortium through monthly telephone or email updates.

4.5 With respect to the Meta-Analysis Dataset, WHO will:

4.5.1 Publish the requirements that need to be met to apply for and, pending approval, access the Meta-Analysis Dataset;

4.5.2 Keep a record of approved access to the Meta-Analysis Dataset;

4.5.3 Facilitate the ZIKV IPD Consortium Data Access Committee's remotely hosted, quarterly meetings to review eligible requests to access the Meta-Analysis Dataset; and

4.5.4 Transmit the Meta-Analysis Dataset to approved users pursuant to the terms of this Agreement through a secure file transfer protocol.

5. Undertakings of the Institution

5.1 The Institution represents that:

5.1.1 It has obtained all rights and permissions necessary to transfer the Data to WHO and for WHO to implement the Research Activities and all other activities relating to the Data as described herein, including, without limitation, in Article 3.4;

5.1.2 The Data have been collected from clinical trials, observational studies, or surveillance systems that have been conducted in accordance with all applicable laws;

5.1.3 The individual(s) to whom the Data relate have provided their 'informed consent' to participate in the study wherein their data was collected if required by, and in accordance with, applicable laws.

5.2 Prior to transmitting the Data to WHO, the Institution will:

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5.2.1 Verify whether approval from their local/relevant Ethics Review Committee is required for the use of the Data in the Research Activities, and if that approval is required, obtain it; and

5.2.2 Anonymize all participant-level data in the Data, pursuant to agreed standards, to remove all information in the Data that could be used to identify research participants.

5.3 The Institution will transmit the Data to WHO securely, using secure file transfer protocol.

5.4 The Institution will avoid providing to WHO or any other ZIKV IPD Consortium member any information relating to the Data or the Research Activities that relates to a natural person, which, either directly or indirectly, in combination with other information available or likely to be available to WHO, can identify such natural person.

5.5 The Institution will participate in the ZIKV IPD Consortium and the Research Activities pursuant to the Protocol, the terms of this Letter of Agreement, and any other participation modalities agreed by the ZIKV IPD Consortium members.

6. Authorship and publications

6.1 WHO will prepare manuscript(s) of the results of the Research Activities for publication, pursuant to the terms of the Protocol, and publish such manuscripts pursuant to WHO's rules and regulations, including its policy on open access, as contained at: http://www.who.int/about/policy/en/. WHO may further use the results of the Research Activities to update relevant WHO recommendations and develop any guidelines, including publication thereof, and may further publish those results.

6.2 WHO will provide all publications relating to the Research Activities, including all preliminary and final results of analyses performed by WHO in coordination with ZIKV IPD Consortium membership and all public reports of results or manuscripts, to all members ZIKV IPD Consortium (including the Institution) for review. WHO will provide such review publications at least fifteen (15) working days (seven (7) days for abstracts) before a proposed publication is submitted to any editor, publisher, referee or meeting organizer. In the absence of an objection by any member of the ZIKV IPD Consortium within that 15 day period (or 7 days as the case may be) concerning prejudice to its proprietary rights, the publication may proceed.

6.3 If a manuscript of the Research Activities is submitted for publication, WHO will in all events retain the Data until the peer review process is completed, and then for one year after publication to ensure sufficient time to address any required responses to the findings (e.g., letters to the editor).

6.4 WHO will ensure that all publications relating to the Research Activities will appropriately acknowledge WHO, the Institution, and all other participating institutions. The "ZIKV IPD Consortium" will be listed as the author of the manuscripts associated with Objectives 1-4 in the Protocol. Individual authors will be listed in alphabetical order at the end of the publication. The manuscripts associated with Objectives 3 and 4 will have separate groups for the writing committee and for institutions that contribute data to the analyses. The corresponding author will be a representative of WHO. The

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number of authors listed from each site will be decided by a majority vote that includes all sites or studies that contribute data to the proposed analyses.

7. Confidentiality and disclosure

7.1 As noted in Section 3.2, Data provided by Institution is public domain and may be re-used and shared by Institution, consistent with applicable law. However, Parties agree that either party may disclose or receive confidential information under this Letter of Agreement. All confidential information exchanged between the Parties must conspicuously bear the words “Confidential Information” or “Confidential.” Confidential Information exchanged orally or through observation must be reduced to writing and marked “Confidential Information” or “Confidential” within 30 days after disclosure to be considered confidential information.

7.2 The results of the Research Activities will be disclosed pursuant to the agreed publication and dissemination means as set forth in the Protocol and this Letter of Agreement. The Parties shall maintain the confidentiality of all results relating from the Research Activities, including all preliminary results and draft manuscripts, to the extent allowed by law. Without limiting the foregoing, the Institution agrees, prior to publishing (including posting on the Internet), presenting in any public forum, or otherwise disseminating through any medium any results of the Research Activities, to ensure the ZIKV IPD Consortium membership has the opportunity to review the proposed publication, presentation or dissemination to assure that confidential information is used consistent with this Letter of Agreement and applicable law.

7.3 The obligations of confidentiality and restrictions on use contained in this Letter of Agreement will continue without termination, commencing on the date of disclosure.

7.4 The obligations of confidentiality and restrictions on use contained in this Letter of Agreement shall not apply to any confidential information (including the Data) which the disclosing Party is clearly able to demonstrate:

7.4.1 was lawfully in its possession and known to it prior to disclosure hereunder, as evidenced by documents antedating the date of disclosure;

7.4.2 was in the public domain or the subject of public knowledge at the time of disclosure by the disclosing Party;

7.4.3 becomes part of the public domain or the subject of public knowledge through no fault of the disclosing Party;

7.4.4 becomes available to the disclosing Party from a third party not in breach of a legal obligation of confidentiality in respect thereof;

7.4.5 was subsequently and independently developed by or on behalf of the disclosing Party, as shown by written records, by persons who had no knowledge of such confidential information; or

7.4.6 is required to be disclosed by law, provided that the disclosing Party will immediately notify the non-disclosing Party in writing of such obligation and shall

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provide adequate opportunity to the non-disclosing Party to object to such disclosure or request confidential treatment thereof.

8. Other matters

8.1 This Letter of Agreement will enter into force on the date of last signature and shall continue until completion of the Research Activities and all ancillary activities (which is anticipated to be on or near the Completion Date), unless earlier terminated pursuant to its terms.

8.2 Either Party may withdraw its agreement to participate in the Research Activities and thereby terminate this Letter of Agreement at any time by written notice to the other Party stating the basis for such termination, provided, however, that the Institution may not terminate its participation in the Research Activities or this Agreement, or withhold any consent required under this Agreement (including any consent to publication), on the basis of disapproval or disagreement with the results of the Research Activities, subject to the orderly conclusion of any activities then ongoing.

8.3 Neither Party shall use the other Party's name (or any abbreviation thereof) and/or emblem in any statement or material of an advertising or promotional nature, without the prior written approval of the other Party. The Parties acknowledge that, as Institution is an agency of the United States Government, Institution is subject to the United States Freedom of Information Act, 5 U.S.C. Section 552, as amended.

8.4 Any dispute relating to the interpretation or application of this Letter of Agreement shall, unless amicably settled, be subject to conciliation, to the extent consistent with applicable law.

8.5 Nothing contained herein shall be construed as a waiver of any of the privileges and immunities enjoyed by WHO under national or international law, and/or as submitting WHO to any national court jurisdiction.

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IN WITNESS WHEREOF, the Parties have caused this Letter of Agreement to be executed by their duly authorized representatives on the date written below.

Agreed by **the World Health Organization:**

_____ _____

Dr. Ian Askew Date
Director, Reproductive Health and Research
(includes the UNDP/UNFPA/UNICEF/WHO/ World Bank Special Programme – HRP)

Regarding data sharing between the WHO and the Institution for the analyses specified in the Protocol:

Agreed by **the Institution:**

_____ _____

[INSERT NAME OF SIGNATORY HERE] Date
[INSERT TITLE OF SIGNATORY HERE]

Regarding data sharing between the WHO and eligible third parties as outlined in Section 3.4.2 of this Letter of Agreement:

*Inclusion of the Data in the Meta-Analysis Dataset that can be accessed by eligible third parties (including, without limitation, Institutional members of the ZIKV IPD Consortium and institutions which have not committed data to the ZIKV IPD Consortium effort) for analyses other than those described in the Protocol, subject to the conditions outlined in **Section 3.4.2** of this Letter of Agreement*

Agreed by **the Institution**:

_____ _____

[INSERT NAME OF SIGNATORY HERE] Date
[INSERT TITLE OF SIGNATORY HERE]

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Annex 1:

*"*Understanding the relation between Zika virus infection during pregnancy and adverse fetal, infant, and child outcomes: a protocol for a systematic review and individual participant data meta-analysis of longitudinal studies of pregnant women and their infants and children*" (the "**Protocol**")*

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Understanding the relation between Zika virus infection during pregnancy and adverse fetal, infant and child outcomes: a protocol for a systematic review and individual participant data meta-analysis of longitudinal studies of pregnant women and their infants and children

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ABSTRACT

Introduction Zika virus (ZIKV) infection during pregnancy is a known cause of microcephaly and other congenital and developmental anomalies. In the absence of a ZIKV vaccine or prophylactics, principal investigators (PIs) and international leaders in ZIKV research have formed the ZIKV Individual Participant Data (IPD) Consortium to identify, collect and synthesise IPD from longitudinal studies of pregnant women that measure ZIKV infection during pregnancy and fetal, infant or child outcomes.

Methods and analysis We will identify eligible studies through the ZIKV IPD Consortium membership and a systematic review and invite study PIs to participate in the IPD meta-analysis (IPD-MA). We will use the combined dataset to estimate the relative and absolute risk of congenital Zika syndrome (CZS), including microcephaly and late symptomatic congenital infections; identify and explore sources of heterogeneity in those estimates and develop and validate a risk prediction model to identify the pregnancies at the highest risk of CZS or adverse developmental outcomes. The variable accuracy of diagnostic assays and differences in exposure and outcome definitions means that included studies will have a higher level of systematic variability, a component of measurement error, than an IPD-MA of studies of an established pathogen. We will use expert testimony, existing internal and external diagnostic accuracy validation studies and laboratory external quality assessments to inform the distribution of measurement error in our models. We will apply both Bayesian and frequentist methods to directly account for these and other sources of uncertainty.

Ethics and dissemination The IPD-MA was deemed exempt from ethical review. We will convene a group of patient advocates to evaluate the ethical implications and utility of the risk stratification tool. Findings from these

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analyses will be shared via national and international conferences and through publication in open access, peer-reviewed journals.
Trial registration number PROSPERO International prospective register of systematic reviews (CRD42017068915).

Strengths and limitations of this study

- This is one of the first applications of an individual participant data meta-analysis (IPD-MA) to address public health concerns in the context of an emerging pathogen. Lessons learnt from this IPD-MA may facilitate the formation of research collaborations to inform the public health response to future epidemics.
- By using a diversity of populations to develop and validate the risk prediction tool that identifies pregnancies at the highest risk of congenital Zika syndrome, the IPD-MA provides a real opportunity to help inform how clinicians and laboratory scientists communicate Zika virus (ZIKV) results to pregnant women and their families.
- There is a high degree of variability in the accuracy of diagnostic assays for ZIKV, coinfection and outcome ascertainment. Addressing this variability will be a challenge and ultimately a limitation of the accuracy of IPD-MA results.
- There is no gold standard diagnostic assay to detect ZIKV infection during pregnancy and few studies have been able to measure fetal infection. The statistical methods traditionally used to account for measurement error in IPD-MA need to be adapted to account for the myriad, correlated sources of uncertainty that arise in the synthesis of participant-level data from studies that arise in the context of an emerging pathogen.

INTRODUCTION

Zika virus (ZIKV) infection during pregnancy is an acknowledged cause of microcephaly and other forms of fetal brain defects and disability.[1 2] ZIKV is an arbovirus in the genus Flavivirus that is usually transmitted through the female *Aedes aegypti* mosquito. *Aedes aegypti* is also the main vector for dengue (DENV), urban yellow fever (YF) and chikungunya viruses. The Asian strain of ZIKV has been shown to replicate in the placenta and fetal brain;[3] ZIKV transmitted from mother to fetus during pregnancy may have a detrimental effect on fetal brain development.[4–6] Microcephaly, generally defined as a 2–3 SD reduction from the mean head circumference,[7 8] is caused by infections during pregnancy, maternal diet, drug abuse, genetic factors or environmental exposures.[9 10] Microcephaly (congenital or acquired) may be associated with developmental delays: intellectual, hearing and visual impairment and epilepsy.[11] The causal relation between ZIKV and a spectrum of fetal anomalies that includes microcephaly, now known as congenital Zika syndrome (CZS),[12] has been supported through several case-control;[13 14] cohort[15 16] and surveillance studies;[17] animal and cell studies[18] and through two systematic reviews of the evidence for causality that considered all study designs.[1 2] The relation between ZIKV infection during pregnancy and miscarriage (pregnancy loss <20 weeks gestation) and fetal loss (pregnancy loss ≥20 weeks gestation) is still under investigation.

Prior to the 2013–2016 epidemic waves, ZIKV infection was known clinically as a mild illness characterised by symptoms shared with other arboviruses, including maculopapular rash, headache, fever, non-purulent conjunctivitis and/or joint and muscle pain.[19] During the 2015–2016 ZIKV outbreak in Brazil, which extended to a number of other Latin American countries, there was a sharp increase in reports of microcephaly and other neonatal neurological conditions and in Guillain-Barré syndrome (GBS),[20–22] an autoimmune neurological disorder. Subsequent analysis of medical records collected during and after the 2013–2014 ZIKV outbreak in French Polynesia identified several ZIKV-linked pregnancies that had not been recorded earlier because they ended in elective abortion or stillbirth. The reanalysis of medical records indicated that the prevalence of both microcephaly and GBS had increased in the wake of the outbreak in French Polynesia.[23 24] The Pan American Health Organization (PAHO) issued a ZIKV Epidemiological Alert for Member States on 7 May 2015,[25] the Brazilian Ministry of Health (MOH) declared a national public health emergency due to the time and cluster of microcephaly cases identified in Northeastern Brazil on 12 November 2015[26] and the WHO declared that the clusters of microcephaly and related neurological complications represented a Public Health Emergency of International Concern on 1 February 2016.[27]

ZIKV presents myriad challenges from an epidemiological, virological, diagnostic and outbreak control perspective. Diagnosing ZIKV infection is complicated by the absence of symptoms in most cases or the presence of non-specific symptoms; cross-reactivity with DENV;[28 29] the short window for diagnosing acute infection and the lack of point-of-care diagnostics.[30] Recent research suggests that the relation between ZIKV infection during pregnancy and fetopathology may vary by virus genotype or lineage; primary versus secondary infection[31] and DENV-immune status and genotype in the presence of coinfection.[29 32 33] The unequal spatial distribution of microcephaly cases has been discussed extensively.[34–36] These differences may be related to population-level differences in baseline risk of adverse fetal outcomes (clinically important heterogeneity), differences in study design (eg, inclusion criteria; measurement of important cofactors) or to measurement error, defined as the difference between the observed and actual level of a given variable. Laboratory confirmation of ZIKV infection and coinfection differs by diagnostic algorithms (eg, definition of positive and negative ZIKV diagnostic assay results); factors that affect the regularity of testing (eg, provision of incentives, distance from testing centre, differences across protocols); population-specific distribution of related coinfections; differing levels of training of laboratory staff and the accessibility of materials and technology (eg, ultrasound, immunoassays, reliability panels), among other factors. In addition to documented difficulties in accurately measuring infant head circumference, measurement standards for identifying microcephaly differ across populations

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and standards themselves may not appropriately classify reduced or enlarged head circumference.[37 38]

Our limited understanding of the absolute risk of adverse fetal, infant and child outcomes in ZIKV-infected mothers led to calls from several governments suggesting that women avoid becoming pregnant for as long as 2 years.[39 40] ZIKV disproportionately affects low-income populations residing in areas with poor living conditions.[41] The impetus placed on women to delay pregnancy as a ZIKV control measure is complicated by the limited access to contraception and safe abortion in many of the countries and regions with the highest burden of ZIKV-related microcephaly.[42 43] Identifying the risk factors for CZS is a global health priority and central for prioritising resource allocation for vector control and effective and targeted family planning interventions and for improving risk counselling for ZIKV-infected pregnant women or women planning a pregnancy in endemic areas.

Rationale for the individual participant data meta-analysis of longitudinal studies of pregnant women

Individual participant data meta-analysis (IPD-MA) is the quantitative synthesis of participant-level data from included studies, while appropriately accounting for the clustering of information at the study level. The proposed IPD-MA will combine deidentified, participant-level cohort data from different populations of pregnant women to identify and quantify the relative importance of different predictors of CZS. Individual participant data (IPD) have a number of analytic benefits over aggregate data meta-analysis (AD-MA), a form of knowledge synthesis that combines study-level measures of effect.[44 45] IPD facilitate the assessment of effect measure modification, the development and validation of risk prediction models, and the application of a unified analytic approach. In addition to using the same statistical model across studies, with IPD we can apply the same or similar exclusion criteria, diagnostic algorithms, methods for addressing missing data and confounding and conduct the same types of sensitivity analyses needed to explore unexplained within- and between-study heterogeneity.

Increased precision of estimates

Timely, accurate and reliable predictions are predicated on well-designed studies that minimise the risk of bias, adequate sample size and the inclusion of a diversity of populations. Adequate sample size is crucial for precise estimation of the risk of CZS within important subgroups (eg, women infected during the first trimester; pregnant women with previous or concurrent DENV, CHIKV and STORCH (syphilis, toxoplasmosis, rubella, cytomegalovirus and herpes) pathogen exposure). Vector control measures, including pesticides, public education campaigns, the use of drones to detect standing water and the introduction of sterilised male vectors to reduce *Aedes aegypti* populations, have been implemented in the wake of the 2015/2016 ZIKV epidemics.[46–48] Fortunately, these measures, in combination with other factors that are currently being investigated, seem to have reduced the numbers of ZIKV infections during the 2017/2018 epidemic cycle. While many studies have followed infants to the end of their first year, certain developmental milestones can only be assessed after age 2[49] or when a child reaches school age. Leveraging limited data from studies with extended follow-up of ZIKV-infected and non-infected women will be essential for estimating the risk of more subtle, long-term effects of ZIKV infection during pregnancy. By combining data from individual studies, the proposed IPD-MA will improve the precision of risk estimates.

Identify and quantify the relative importance of effect measure modifiers

The benefits of using IPD rather than AD to assess effect measure modification and interaction are myriad.[50] In a one-stage analysis with IPD, subject level data are meta-analysed using the exact binomial distribution; in a two-stage analysis of IPD or AD, study-level outcome measures are combined assuming asymptomatic normality.[51] In a one-stage analysis of IPD, study-level and individual-level sources of heterogeneity can be assessed concurrently and IPD are better able to identify heterogeneity in the context of rare events or small studies.[50 52] Individual studies are often powered to detect the overall effect of the exposure rather than subgroup effects. Due to variations in the characteristics of the affected populations and in the potential confounders and effect modifiers measured by different studies, it is unlikely that individual studies will be powered to definitively quantify the importance of different sources of heterogeneity in the relation between ZIKV infection during pregnancy and adverse fetal, infant or child outcomes.

Clinical risk prediction to inform decision-making and resource allocation

While there are a number of vaccine trials underway,[53] the development of a ZIKV vaccine is complicated by the necessity of testing the vaccine in pregnant women; assessing whether the vaccine is associated with development of GBS; the difficulties inherent in developing an arbovirus vaccine;[46 54–56] findings from in vivo studies that indicate cross-reactivity between ZIKV and DENV or West Nile virus is related to antibody-dependent enhancement of ZIKV infection;[55 57 58] and by the potential use of prevention of infection as a vaccine efficacy endpoint.[59] In this context, identifying the pregnancies at the highest risk of adverse neonatal and later developmental outcomes is critical for effective resource allocation and prevention strategies. We will use participant-level data to develop and externally validate clinical risk prediction models to facilitate the identification of pregnancies that are most likely to result in ZIKV-related adverse fetal or infant outcomes and longer-term developmental delays.

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Standardisation and cross-national partnerships to inform the public health response to emerging pathogens

Formation of the ZIKV IPD Consortium

The ZIKV IPD Consortium is a global collaboration designed to streamline the international response to ZIKV. To facilitate cross-country analyses and a coordinated response to ZIKV, representatives from WHO, PAHO, the US Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the National Institute of Allergy and Infectious Diseases (NIAID), Institut national de la santé et de la recherche médicale (INSERM), Institut Pasteur, and the networks of Fundação Oswaldo Cruz (Fiocruz), Grupo de Pesquisa da Epidemia da Microcefalia (MERG)/ZikaPlan, ZIKAlliance, ZIKAction, the Consortium for the Standardization of Influenza Seroepidemiology (CONSISE) and International Severe Acute Respiratory and Emerging Infection Consortium (ISARIC) have developed a standardised protocol for cohorts of pregnant women and their infants exposed to ZIKV to facilitate the proposed IPD-MA; identified existing or planned cohorts and prospectively introduced cohort principal investigators (PI)s and MOH officials to the methodological and public health benefits related to IPD-MA in the context of Zika. Many of the longitudinal studies and surveillance systems identified to date through the review of country-level registries, existing literature reviews and ZIKV IPD Consortium membership have agreed to contribute deidentified, participant level data to the analysis. A complete list of the studies and surveillance systems who have agreed to contribute data to the ZIKV IPD Consortium led IPD-MA is included in online supplementary table 1.

Standardised protocols for cohorts of pregnant women and their infants

A multiplicity of mechanisms for exposure and outcome ascertainment as well as differences in the measurement of important cofactors are known challenges for the meta-analysis of data from individual research studies. To minimise the potential for heterogeneity caused by differences in study inclusion criteria and the measurement of ZIKV, infant outcomes and important cofactors, WHO/PAHO, Institut Pasteur, Fiocruz, CONSISE and ISARIC convened an international meeting of ZIKV researchers and MOH officials in June 2016 to develop standardised protocols and data collection instruments for cohort studies of pregnant women and newborns and other ZIKV-related studies.[60] Standardisation of protocols and data collection instruments was intended to minimise differences in case ascertainment and data collection methods to facilitate data synthesis and the identification of sources of heterogeneity in the relation between congenital Zika infection and adverse fetal, infant and child outcomes. The protocols were made available on WHO website in October 2016 (http://www.who.int/reproductivehealth/zika/en). The standardised protocols do not include detailed guidance on laboratory methods, but testing algorithms were developed by an expert panel and made available on the WHO website in March 2016 (http://www.who.int/csr/resources/publications/zika/laboratory-testing/en/). The IPD-MA will need to account for the between-study and within-study differences in diagnostic assays and testing algorithms.

OBJECTIVES OF THE IPD-MA

1. Estimate the absolute and relative risks of fetal infection; miscarriage (<20 weeks gestation), fetal loss (≥20 weeks gestation), microcephaly and other manifestations of CZS and later developmental delays for women who do and do not experience ZIKV infection during pregnancy.
2. Identify factors that modify women's risk of adverse ZIKV-related fetal, infant and child outcomes and infants' risk of infection (eg, gestational age at time of infection, clinical or subclinical illness, concurrent or prior arbovirus exposure, other congenital infections and other posited effect measure modifiers).
3. Use information on the relative importance of different effect measure modifiers identified in Objective 2 to decompose the total effect of ZIKV infection during pregnancy on adverse fetal, infant and child outcomes into (1) the direct effect of ZIKV; (2) the indirect effect of ZIKV as mediated by the effect measure modifier of interest (eg, DENV, CHIKV or STORCH pathogens) and (3) the effect of the interaction between ZIKV and the mediator of interest.
4. Develop and validate a risk prediction tool to identify pregnant women at a high risk of an adverse ZIKV-related outcome and to inform couples planning a pregnancy, healthcare providers and/or resource mobilisation (eg, vector control strategies; antenatal care; open access to contraception).

METHODS AND ANALYSIS

This protocol has been drafted in accordance with the PRISMA-P Statement (online supplementary table 2).[61] The proposed systematic review and meta-analysis will follow the PRISMA-IPD guidelines for the systematic review of non-randomised studies.[62]

Step 1. Study identification

Eligibility criteria

Eligible studies will use a longitudinal design where ZIKV infection is measured in pregnant women prior to outcome ascertainment. Eligible studies may include cohort studies, case-cohort studies, randomised control trials or active surveillance systems, regardless of publication status. Studies may enrol symptomatic and/or asymptomatic women prior to or following a confirmed pregnancy. Included studies and active surveillance systems will test women for ZIKV infection during pregnancy, follow women until the end of pregnancy and assess for CZS or related fetal, infant or child outcomes (see table 1). We will exclude studies with fewer than 10

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Wilder-Smith A, *et al*. *BMJ Open* 2019;**9**:e026092. doi:10.1136/bmjopen-2018-026092

Table 1 Participant-level variables of interest

Exposure	Maternal ZIKV infection (diagnosis: confirmed, probable, unlikely; primary, secondary, naïve; viral load)
	Fetal or placental ZIKV infection (diagnosis: confirmed, probable, unlikely; primary, secondary, naïve; viral load)*
Primary outcomes	Miscarriage (<20 weeks gestation)
	Fetal loss (≥20 weeks gestation)
	Microcephaly (diagnosis: severe microcephaly, microcephaly, normocephaly, macrocephaly; Z-score)
	CZS (diagnosis: confirmed, probable, unlikely)
Secondary fetal outcomes†	Induced abortion with microcephaly (diagnosis: confirmed, probable, unlikely)
	Early fetal death (20–27 weeks gestation)
	Late fetal death (≥28 weeks gestation)
	Late fetal death (≥28 weeks gestation) with microcephaly
	Placental insufficiency (diagnosis: confirmed, probable, unlikely)‡
	Intrauterine growth restriction
Secondary infant outcomes†	Postnatal microcephaly (diagnosis: severe microcephaly, microcephaly, normocephaly, macrocephaly; Z-score)
	Gestational age at birth
	Birth weight (diagnosis: normal birth weight; low birth weight; very low birth weight; extremely low birth weight; Z-score)
	Craniofacial disproportion
	Neuroimaging abnormalities (intracranial calcification, lissencephaly, hydranencephaly, porencephaly, ventriculomegaly, posterior fossa abnormalities, cerebellar hypoplasia, corpus callosal and vermian dysgenesis; focal cortical dysplasia)
	Postnatal intraventricular haemorrhage
	Motor abnormalities (hypotonia, hypertonia, hyperreflexia, spasticity, clonus, extrapyramidal symptoms)§
	Seizures, epilepsy§
	Ocular abnormalities (blindness, other)§
	Congenital deafness or hearing loss§
	Congenital contractures (arthrogryposis, unilateral or bilateral clubfoot)
	Other non-neurological congenital abnormalities
Secondary outcomes detected after the infant period¶	Cortical auditory processing
	Neurodevelopment (expressive and receptive language, fine and gross motor skills, attention and executive function, memory and learning, socioemotional development, overall neurodevelopmental score)
	Vision (Cardiff test)
Posited confounders	Demographic factors (age, education, marital status, racial/ethnic group; BMI)
	Socioeconomic factors
	Maternal smoking, illicit drug and alcohol use
	Maternal prescription drug use, vaccination
	Maternal experience of violence during pregnancy; infant or child exposure to intimate partner violence[127]
	Workplace or environmental exposures to teratogenic substances (eg, maternal exposure to lead, mercury)

Continued

Table 1 Continued

Potential effect measure modifiers	Genetic anomalies, metabolic disorders, perinatal brain injury
	Gestational age, term at birth
	Timing of infection during pregnancy
	Clinical/subclinical illness
	Viral genotype and load
	Concurrent or prior flavivirus or alphavirus infection
	Maternal history of YF or JE vaccination
	Maternal immunosuppressive conditions, disorders, comorbidities (eg, chronic hypertension, diabetes) or pregnancy-related conditions (eg, pre-eclampsia, gestational diabetes)
	Intrauterine exposure to STORCH pathogens
	Maternal malnutrition
	Presence and severity of maternal and infant clinical symptoms

*Fetal ZIKV infection will be considered as both an exposure and an outcome; definition of fetal infection will be based on clinical and radiological criteria defined by an expert panel.
†Both with and without microcephaly.
‡As estimated by antenatal consequences of placental insufficiency, including fetal growth restriction, oligohydramnios, non-reassuring fetal heart rate tracing or small for gestational age at birth as markers of placental insufficiency.
§May also be detected after the infant period.
¶As measured by the Bayley Scale;[128] Ages and Stages;[129] INTERGROWTH-21st Neurodevelopmental Assessment.[49]
BMI, body mass index; CZS, congenital Zika syndrome; JE, Japanese encephalitis; STORCH, syphilis, toxoplasmosis, rubella, cytomegalovirus and herpes; YF, yellow fever virus; ZIKV, Zika virus

participants and limit included surveillance systems to those that capture country or territory-level active surveillance data (ie, individual hospital active surveillance data will not be included). Before sharing participant-level data, research studies will be asked to provide documentation of ethics review.

Information sources

ZIKV IPD Consortium

We anticipate that most eligible studies will have been identified through the efforts of the ZIKV IPD Consortium. The Consortium is an international initiative that is meant to include the PIs from all planned, ongoing or completed ZIKV longitudinal studies at the time of this review. We have searched clinical trials and ZIKV-related databases[63] (online supplementary table 3) to identify existing or planned longitudinal studies. We have circulated the list of ongoing or planned ZIKV-related longitudinal studies of pregnant women to MOH Officials in countries with autochthone ZIKV transmission and to PIs of ZIKV cohorts and asked them to update the list as necessary.

Systematic review

We will perform a systematic search of biomedical databases for published longitudinal studies and protocols. The search strategy is based on Medical Subject Headings (MeSH) and text-based search terms for ZIKV, pregnant women, infants and children. The search strategy was developed in collaboration with an information scientist and adapted for the following electronic databases: Embase (Medline), Embase (Ovid) and SCOPUS (see online supplementary text 1 for the search strategy for Embase (Medline and Ovid). We also will search the additional databases listed in online supplementary table 3 and review the reference lists of published systematic reviews and the list of studies produced by a living systematic review of ZIKV studies conducted by the University of Bern[64] to identify additional studies. After removing duplicates from the list of identified studies, two reviewers will independently screen the title and abstracts of included studies to identify longitudinal studies or active surveillance systems that measure ZIKV infection during pregnancy and subsequent fetal, infant or child outcomes. Disagreements about study inclusion will be resolved by consensus.

Collection of study-level data

We will contact the PIs of eligible studies identified through either the ZIKV IPD Consortium or the electronic searches to invite them to take part in the IPD-MA and ask them to provide a copy of their study protocol. We will develop and pilot an electronic data extraction form to record study-level characteristics for all eligible studies, regardless of whether study PIs agree to participate in the IPD-MA. Two reviewers will independently review protocols and study-related publications to extract data on study design; study population; enrolment, follow-up and laboratory procedures; assay and specimen type; criteria used to define ZIKV infection and timing of infection and exposure, cofactor and outcome ascertainment for all eligible studies. We will ask study PIs for clarification if there are outstanding questions or disagreements regarding study-level data.

Step 2. Collection, review and synthesis of deidentified, participant-level data

We will contact the PIs and authors of studies that meet our inclusion criteria to request deidentified, participant-level data on select variables and the associated surveys and data dictionaries or codebooks. If study data have been imputed, we will request both the original and imputed data so that we can apply consistent imputation methods across studies and review the imputed dataset for validation purposes. To reduce the burden on individual studies and ensure clear documentation of all steps in the creation of the synthesised dataset, we will use the study codebooks or data dictionaries to develop study-specific code in the statistical language used by the study data manager that selects only the study variables required for the proposed analyses and removes information that could be used to identify individual participants. The study's data manager will apply the code to the original dataset. The deidentified, participant-level data will be transferred from the study site to Emory University, which will serve as the WHO data synthesis partner centre, using secure file transfer protocol and will be protected on a secure server with standard encryption and by the Emory University firewall. Data synthesis-related decisions will be reviewed by a ZIKV IPD Consortium membership and will be recorded using Jupyter Notebook.[65] Researchers who are unable or unwilling to provide their participant data after at least four attempts at contact by the project team over a period of 6 months will be excluded from the IPD-MA and we will report the reason for their exclusion. When IPD are not available for a given study, we will extract study-level effect estimates from any publications to compare study-level estimates from all eligible studies, whether or not they provide data for the IPD-MA.

Variables of interest

Despite efforts to develop protocols that can be applied across studies, there will be significant cross-study heterogeneity in how congenital Zika infection, cofactors and outcomes are measured and reported. Exposure, outcome variables and posited confounders and effect measure modifiers are listed in table 1. Where possible, ZIKV and other infections (eg, DENV, CHIKV, STORCH pathogens) will be modelled as time-varying, rather than time-fixed covariates. Given that the case definitions for microcephaly have changed over time (and may change during the course of included studies), we will allow for the coding of variables with different definitions (ie, WHO fetal growth chart,[66] Fenton scale,[67] INTERGROWTH 21st Project[49]). We will ask studies for data on the continuous measures used to make diagnoses (eg, viral load;

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head circumference) rather than just the diagnoses themselves (eg, maternal ZIKV infection, microcephaly). Using continuous variables will allow us to test the sensitivity of results to the application of different cutoffs and the reference standards used to generate Z-scores. Definitions for miscarriage, fetal loss and other pregnancy outcomes vary across countries. We will explore the sensitivity of project findings to different outcome definitions.

Assessing the integrity of deidentified, participant-level data

We will review the distribution of variables to identify potential outliers and to assess the proportion missing within each study. We will discuss the distribution of key variables with the study data manager to identify and address any inconsistencies. If there has been a publication related to a given longitudinal study, we will attempt to replicate table 1 presented in the publication and will resolve any inconsistencies with the data manager.

Synthesis of participant-level data

Given that these longitudinal studies and active surveillance systems are part of the global research response to an emerging pathogen, there is a high degree of variability in the data that have been collected across studies and the algorithms that have been applied to define ZIKV exposure, symptoms, components of CZS and so on. Where possible, we will ask studies for the individual factors (ie, fever, rash) that were used to define certain parameters (ie, clinical infection) to ensure cross-study consistency in composite markers. Similarly, we will combine the data inputs for exposure, cofactor and outcome classification algorithms to reduce cross-study differences in the classification of important factors.

Critical review of study quality

We will use the Cochrane Methodological Quality Assessment of Observational Studies[68] and the Q-Coh tool[69] to help describe the risk of bias within non-randomised studies and will apply the Cochrane Risk of Bias 2.0 tool to assess the risk of bias in randomised controlled trails.[70] Rather than using a score-based bias assessment, a panel that includes experts on the evaluation of laboratory assays and external quality assessment (EQA); obstetrics and perinatal epidemiology will provide a detailed description of the role of selection, confounding and measurement-related biases within studies.

Step 3. Statistical analyses

Objectives 1 and 2

Estimate the absolute and relative risks of adverse ZIKV-related fetal, infant and child outcomes; identify and quantify relative importance of sources of heterogeneity

Estimating the absolute risk of CZS by the gestational age of the fetus at the time of infection is as important as it is difficult. Early in the outbreak, cohort studies limited enrolment to symptomatic pregnant women. While an estimated 50%–70% of infections are subclinical, when symptoms are detected they generally appear 3–14 days after infection.[71] For asymptomatic infections, the gestational age of infection is interval censored because it is defined by the last negative and first positive tests for ZIKV. Rather than using the midpoint between the last negative and first positive ZIKV test, which is known to be biased, we will impute the trimester or week that asymptomatic infections occurred using methods that are routinely applied in studies with interval censored covariates in the field of perinatal research.[72 73] In table 2, we present sample definitions for the absolute risk of fetal and infant outcomes. These definitions will be reviewed prior to analysis and publication and we will assess the sensitivity of our results to the definition applied. Later developmental outcomes (eg, neurodevelopment, cortical auditory processing), listed in table 1 as secondary outcomes, will follow a fetus-es-at-risk approach.[74] We will apply censoring to account for competing risks where necessary.

We will apply mixed binomial models for binary outcomes, and multinomial models for categorical outcomes, with a logit link to provide estimates for each measure of absolute risk by week or trimester of congenital infection. Because of the differences in baseline risks across populations, pooling measures of absolute risk

Table 2 Definitions applied to estimation of absolute risk of primary fetal and infant outcomes

Outcome	Numerator	Denominator
Miscarriage	Number of miscarriages (pregnancy loss prior to 20 weeks gestation)	Total number of pregnancies
Early fetal death	Number of pregnancies lost between 20 and 27 weeks gestation	Total number of pregnancies carried to 20 weeks gestation
Late fetal death	Number or pregnancies lost at or following 28 weeks gestation	Total number of pregnancies carried to 28 weeks gestation
Microcephaly	Number of microcephaly cases	Total number of pregnancies carried to ≥24 weeks gestation, when microcephaly can be assessed by ultrasound in ZIKV-infected mothers,[38] we will consider all pregnancies regardless of whether the pregnancy results in a live birth

ZIKV, Zika virus.

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across studies may not be clinically relevant and can even be misleading.[75] We will combine study-level estimates of absolute risk through: (1) a one-stage meta-analysis (mixed binomial or multinomial model with a log link) that includes study-level sources of heterogeneity and a separate intercept for each study to account for additional cross-study differences in baseline risk and (2) a forest plot of study-level estimates of absolute risk that does not include a summary meta-analytic estimate.

Absolute measures of effect are considered more important for informing clinical practice than relative measures.[76] We will conduct both (1) a one-stage meta-analysis where we estimate the relative risk of the aforementioned outcomes of interest by congenital Zika infection across studies and (2) a two-stage meta-analysis where we estimate the relative risk in each study and combine study-level measures using random effects meta-analysis to allow the underlying true effect to vary across studies.[77] In the one-stage models, we will include study-specific intercepts to quantify and account for between-study variation in baseline risk. We will use random slopes to allow the relation between certain cofactors and the risk of CZS to vary across populations.

Combining absolute measures of effect, like the risk difference, across studies may mask important differences in the baseline risk.[78] We will present estimates of the risk difference in a forest plot of study-level estimates without presenting a summary meta-analytic estimate. In both the one-stage and two-stage analyses, we will use log binomial regression models to estimate the relative risk of each binary outcome and will use log Poisson regression to estimate the relative risk if log binomial models fail to converge.[79 80] In the two-stage models, we will assess the potential for non-linear relationships between continuous exposures (viral load) and covariates (eg, gestational age, maternal age) by using the Akaike information criteria to compare restricted cubic splines with three knots to exponential, quadratic and linear terms. In the one-stage models, we will use generalised additive mixed models (GAMMs) to assess potential non-linearities as the GAMM random smoothing parameter addresses the bias/variance trade-off by penalising the added complexity from non-linear terms while accounting for between-study variation in non-linear effects.[81]

Joint estimation of multiple nested or otherwise related outcomes (multivariate meta-analysis)

Not all studies will have measured all primary or secondary outcomes of interest. For example, most studies will have measured ventriculomegaly, but may not include values for intracranial calcification or ocular abnormalities.[9] This analysis is intended to increase the precision of estimates of the spectrum of CZS abnormalities. Studies that do not include the measurement of a given outcome will necessarily be excluded from univariate estimates of that outcome, but will be included in multivariate models that estimate the joint probability of related outcomes. In the multivariate models, we will assume that the outcomes that are excluded from certain studies are missing at random and will incorporate studies by setting the missing observations and within-study correlations between outcomes to zero and will set the within-study variance to a very high number such that the artificial value that acts as a substitute for the missing outcome will have a negligible effect on the meta-analytic estimate from the multivariate model.[82] Alternatively, under a Bayesian framework, we will model a joint distribution for studies providing multiple outcomes and a univariate distribution for studies providing a single outcome without needing to address the missing within-study correlations and variance for studies with only one outcome.[83] The secondary outcomes that will be included in the multivariate analysis are listed in table 1.

We will compare generalised linear mixed models (GLMMs) where we use one model to analyse nested or otherwise related outcomes to the standard univariate approach where we apply a separate model to analyse each outcome. Multivariate meta-analysis allows for the estimation of joint probabilities across multiple outcomes and accounts for cross-study and within-study correlation between related outcomes.[82 84] Modelling several outcomes simultaneously improves the precision over univariate models by sharing information about heterogeneity and the average effect of the treatment which may facilitate inference about the relation between different CZS-related outcomes[82 85 86] (ie, vermian dysgenesis and ocular abnormalities).

Multivariate model to combine estimates from fully and partially adjusted studies

A number of longitudinal studies will not include the minimal sufficient set of confounders. Estimates from partially adjusted studies (that are missing values for important confounders) will be combined with fully adjusted estimates in a one-stage multivariate meta-analysis. The one-stage multivariate model allows us to borrow information from partially adjusted studies with different sets of confounders while ensuring that we control for important confounders.[82 85]

Special considerations for the meta-analysis of cohort studies with rare events

Two-stage meta-analytic methods are based on large sample approximations and may be unsuitable in the context of CZS, which can be considered a rare event.[87 88] Two-stage meta-analysis may be biased when small studies are included, the effect of an exposure is very large or the outcome is rare, all of which may affect this analysis.[89] We will highlight any instances when the two-stage meta-analytic estimates may be biased by the aforementioned issues and will limit our inference to one-stage analyses in those cases. If we have a number of longitudinal studies with zero events, we will focus our inference on a one-stage approach to avoid reliance on large sample approximations.

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Assessment of study-level and participant-level heterogeneity

Separating within-study and between-study heterogeneity is central to assessing participant-level heterogeneity and to understanding the relative importance of different potential effect measure modifiers.[50] We are only able to separate within-study and between-study heterogeneity across studies that include both levels of the effect measure modifier of interest. The presence of clinical illness may be related to disease course through viral load or be a marker for the strength of the immune system's response to infection. We will conduct a one-stage analysis of longitudinal studies that include both symptomatic and asymptomatic women to assess whether the risk of CZS or of the most severe effects of congenital infection (miscarriage, fetal loss) differs for clinical and subclinical infections. Between-study heterogeneity is reflective of study-level differences, while within-study heterogeneity may be indicative of clinically important differences. We will mean centre covariates included in the interaction terms at the study level to separate between-study and within-study heterogeneity in our one-stage meta-analytic estimates of how prior or co-infection with alpha or flaviviruses or STORCH pathogens modifies the effect of ZIKV infection.[90]

Heterogeneity in effect estimates will arise from clinically important differences between congenital infections or women (effect measure modification) and from study-level differences in exposure and outcome ascertainment (measurement error). With IPD, we are able to jointly assess study-level and participant-level heterogeneity.[52] We will incorporate participant-level interaction terms in a one-stage analysis that includes random intercepts to account for unmeasured study-level factors. We will consider random slopes for certain covariates to allow for between-study variation in covariate effects across studies. Given the difficulty in assessing the total df in mixed models, we will apply bootstrapping to assess the approximate confidence intervals of the pooled interaction terms. We will present the analysis of effect measure modifiers in accordance with the revised STROBE guidelines.[91]

Based on our review of research protocols for planned or ongoing cohort studies, we expect to include data from longitudinal studies with different enrolment criteria, exposure and outcome ascertainment, diagnostic assays for prior-infections or coinfections and measurement of important cofactors. We will include measures of study-level sources of heterogeneity (eg, diagnostic assay, outcome definitions) as covariates in the one-stage regression to assess the variance explained by these factors. We will perform a sensitivity analysis where we limit our inference to studies with similar inclusion criteria and exposure, cofactor and outcome ascertainment to reduce spurious cross-study heterogeneity. While two-stage analyses of interaction effects that fail to separate between-study and within-study heterogeneity are subject to ecological bias[90] and our inference about the importance of interaction terms will primarily be derived from one-stage analyses, we will use a two-stage analysis to compare the magnitude of the interaction effects across studies. The interaction between certain cofactors and ZIKV exposure may not be consistent across studies. In the first stage of the two-stage analysis, we will use the likelihood ratio test ($p<0.05$) to assess the importance of including interaction terms within each study. Individual cohort studies may not have the sample size needed to detect clinically important interactions between ZIKV and important cofactors. We will also assess whether a certain interaction is consistent across studies, while not necessarily statistically significant within individual studies.

Meta-regression and subgroup analyses have limited power to detect interactions and can only be used to make inference about the relation between the exposure and study-level, average values of participant characteristics.[89 92] Studies that are not willing or able to provide participant-level data may differ importantly from longitudinal studies whose data is included in the IPD-MA. We will apply subgroup analysis to a two-stage analysis of effect estimates from studies included in the IPD-MA and published estimates from studies that did not participate in the IPD-MA to assess whether study-level variation in recruitment and enrolment criteria, exposure and outcome ascertainment and measurement of coinfections and other cofactors are important sources of heterogeneity in the pooled estimates. Some sources of heterogeneity (eg, vector density and feeding patterns; DENV serotype) may not be measured and should be considered in sensitivity analyses.

Objective 3

Use information on the relative importance of different effect measure modifiers identified in Objective 2 to decompose the total effect of ZIKV infection during pregnancy on adverse fetal, infant and child outcomes

Some studies suggest that antibody-dependent enhancement related to concurrent or prior DENV infection or Japanese encephalitis vaccination may modify the effect of ZIKV infection on fetal development. Both the timing of exposure to DENV and DENV serotype may contribute to regional differences in the strength of the relation between ZIKV infection and CZS.[28 32] If we find evidence in the literature that the effect measure modifier identified in Objective 2 (eg, DENV) may affect the outcome (eg, CZS), we will apply inverse probability of treatment weighted-marginal structural models to decompose the total effect of ZIKV on the outcome of interest into the direct effects of ZIKV infection, the effect of ZIKV infection mediated by the posited effect measure modifier and the effect of the interaction between ZIKV and the effect measure modifier.[93 94]

Objective 4

Develop and validate a risk prediction tool to inform decision making by pregnant women, couples planning a pregnancy and healthcare providers and/or resource mobilisation

We will fit one-stage logistic regression models with random intercepts to account for differences in the

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baseline risk within each study. We will apply group Lasso regression[95] to identify the prognostic variables that predict progression to miscarriage, fetal loss and microcephaly. Lasso regression is implemented using L1-penalised estimation. The application of group Lasso ensures that the algorithm selects all levels of categorical variables by treating corresponding dummy variables as a group instead of allowing the model to only select certain levels of categorical variables.[96 97] The L-1 penalty term allows for concurrent consideration of predictors and shrinkage, which facilitates variable selection in the context of high dimensional data.[98] We will standardise included variables so that all variables use the same scale. We will adopt cross-validation on the study level to select the optimal tuning parameter (λ) and will adopt restricted maximum likelihood (REML) to estimate the variance-covariance matrix of the study-level random effects.

Not all studies will have the resources to implement the most accurate and reliable ZIKV-related diagnostic tools. As part of the data synthesis, we will identify the exposure and cofactor diagnostic methods that are most commonly applied. As a sensitivity analysis, we will use these diagnostic methods to develop a risk prediction model so that the model can be applied in regular clinical practice.

Development and external validation of the prediction model

We will apply internal-external cross-validation where we rotate the cohort that is used for external validation to improve the model's predictive ability.[99] For example, given k cohort studies, we will use k-1 cohort studies to develop the prediction model and will validate model performance by applying the prediction model to a cohort that was not used to develop the prediction model. Internal-external cross-validation allows for the use of all available data for model development and validation which improves model performance and generalisability.[100]

Evaluation of model performance

We will generate receiver operating characteristic (ROC) curves[101 102] in the cohort that was not used to develop the prediction model to estimate the model's true-positive (sensitivity) versus false-positive (1-specificity) rate for each binary outcome. These curves will then be summarised using the area under the ROC curve (AUC). In some instances, the pregnant woman or couple planning a pregnancy may prefer a more sensitive rather than a more specific model. We will present a range of cut-off values that maximise sensitivity, specificity or both sensitivity and specificity to facilitate decision making by pregnant women or couples planning a pregnancy. We will assess the extent to which these thresholds yield consistent sensitivity and specificity across different regions and populations. We will use calibration plots to compare the observed and predicted probability of the outcome of interest within risk quintiles and summarise these plots by calculating the total ratio of observed versus expected events (O:E ratio) and the calibration slope. Internal-external cross-validation of k studies will result in kAUCs, O:E ratios and calibration slopes. We will apply random effects meta-analysis to combine estimates of the discrimination and calibration of the kpredictive models. We will assess model calibration and discrimination and choose the model with the best properties.[99 103] We will use bootstrap validation to evaluate model optimism and will follow the TRIPOD statement guidelines for reporting the final prediction models.[104]

Step 4. Quantitative bias analysis

Given the complexity and level of measurement error, we will conduct a quantitative bias analysis under a Bayesian framework where we use a combination of expert opinion, laboratory EQA and external and internal assessment of the relative accuracy of diagnostic assays and other methods for cofactor and outcome ascertainment to inform the prior distributions of bias parameters. Where possible, we will apply frequentist methods for quantitative bias analysis[105] as a sensitivity analysis and will use the GRADE criteria[106] to compare the quality of the evidence from Bayesian and frequentist models, with a focus on how imprecision, inconsistency, indirectness, magnitude of effect differ in the Bayesian and frequentist approaches to addressing the myriad sources of bias expected to affect these analyses.

Selection bias

Studies or surveillance systems that only recruit or test symptomatic pregnant women or studies that only enrolled pregnant women who tested positive for ZIKV infection are affected by selection bias because selection into the study is associated with the exposure.[63] This situation is similar to the inclusion of a single treatment arm in a randomised controlled trial. Although data from studies that only enrol pregnant women who test positive for ZIKV cannot directly inform estimates of the causal effect of ZIKV, these data can inform the development of prediction models because they contain information on the prognosis of ZIKV positive women. Longitudinal studies that restrict enrolment to ZIKV positive pregnant women may also increase the precision of relative treatment effects by providing more events within ZIKV-exposed pregnant women. Longitudinal studies have reported that women who perceive their infants as unaffected by CZS are less likely to participate in follow-up. We will consider matching on the propensity score or the use of inverse probability of censoring weights[107] and prognostic score analysis[108] to account for measured determinants of differential loss to follow-up in the aetiological and prognostic models, respectively. Selection bias can be induced when we inappropriately adjust for a time-varying confounder affected by prior exposure (a confounder that also acts to mediate the relation between ZIKV infection and adverse fetal, infant or child outcomes). We will use G-computation methods to appropriately adjust for time-dependent confounders affected by prior exposure.[109]

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Confounding bias

We will adjust for confounders that are unlikely to mediate the causal relation between infection during pregnancy and adverse infant outcomes (table 1). We will estimate each participant's likelihood of being infected during pregnancy, conditional on the study group and important confounders, to identify possible violations of the positivity assumption. In sensitivity analyses, we will apply propensity score matching within studies to ensure that important confounders are adequately balanced across exposure groups. Despite the prospective, collaborative development of a standardised research protocol for ZIKV cohort studies of pregnant women, confounders and effect measure modifiers may be defined differently across studies or not measured in certain studies. We will develop a detailed codebook that reflects the heterogeneity in confounder definitions and report on this heterogeneity in our analyses.

Measurement (ie, detection, misclassification) bias

Despite efforts to harmonise case definitions across studies with the prospective development of a standardised protocol for cohorts of pregnant women and their infants,[60] the case definitions, diagnostic tools and algorithms used to ascertain ZIKV infection, cofactors and CZS-associated outcomes vary across studies.[110] The literature on the accuracy of ZIKV-related and DENV-related assays is evolving rapidly.[30 111] Prior to initiating our analyses, we will synthesise the current evidence on the sensitivity and specificity of different assays for ZIKV diagnosis, for the assessment of concurrent or prior DENV infections and for estimating the time of infection, among other relevant factors. The WHO standardised protocol for ZIKV-related cohorts of pregnant women includes WHO recommendations on the screening and assessment of neonates and infants with intrauterine ZIKV exposure;[112] we will compare study-level outcome definitions with the standardised WHO definitions. The role of heterogeneity related to case definitions and diagnostic tools will be explored through both frequentist and Bayesian methods. In the frequentist approach, we will: (1) include categorical or continuous markers of sensitivity and specificity of diagnostic tools as study-level covariates in the one-stage analyses and (2) apply diagnostic tool specific-subgroup analysis to both the one-stage and two-stage meta-analysis of effect measures from different studies. In the Bayesian approach, we will use a combination of expert opinion and data from external and internal validation studies to inform the probability distributions of bias parameters.[113]

Missing data

Missing data at the study level, as when confounders are not measured in certain studies, is a well-known challenge of IPD-MA[114 115] and a likely source of residual confounding. In keeping with current recommendations for addressing missingness in IPD-MA, we will apply new methods for multilevel multiple imputation to account for missing values.[116] As a sensitivity analysis, we will impute missing participant-level data in each study separately and use multivariate meta-analysis to combine data across studies that have and have not measured important host-level and environmental-level cofactors.

Publication bias

IPD-MA may have a lower risk of publication bias than AD-MA because they include data from unpublished studies.[114] We have tried to ensure that the ZIKV IPD Consortium includes representatives from all of the academic and government institutions responsible for planned or ongoing ZIKV-related longitudinal studies of pregnant women and their infants. We expect that Consortium members will identify most ZIKV longitudinal studies and active surveillance systems of pregnant women and their infants, regardless of publication status, and we will conduct a systematic review to identify additional longitudinal studies and active surveillance systems. The degree of publication bias will be assessed visually by reviewing the asymmetry of study-level estimates from published and unpublished studies using funnel plots that compare log RR to the corresponding studies' sample size.[117]

We will convene a group of patient advocates to evaluate the ethical implications and utility of the risk stratification tool.

DISCUSSION

The application of IPD-MA to an emerging pathogen presents an important opportunity to harness global collaboration to inform the development of recommendations for pregnant women, couples planning a pregnancy and public health practitioners. While IPD-MA offers real benefits compared with AD-MA or to the inference possible with individual cohort studies, the ability of IPD-MA to inform public health practice is directly related to the quality of the exposure, cofactor and outcome ascertainment in the original cohort studies. Statistical methods for IPD-MA were developed in the context of clinical research and randomised control trials. These methods needs to be adapted to account for the myriad sources of uncertainty and bias that affect observational research, especially for field epidemiology studies conducted as part of the research response to unknown or emerging pathogens.

Historically, arboviruses and other neglected tropical diseases have been understudied because the burden of disease falls on under resourced populations in the Global South.[118] In the context of ZIKV, the unequal distribution of risk is coupled with inequities in access to preventative measures like modern contraception and to critical clinical and therapeutic care for infants affected by microcephaly and ZIKV-related neurological disorders. Each case of microcephaly is associated with a loss of 29.95 disability adjusted life years (DALYs) and treatment costs ranging from US$91K to US$1 million.[119] To put these figures into perspective, the yearly per capita

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income in Pernambuco, the Brazilian state with one of the highest burdens of CZS, is US$3471.[120]

There is no vaccine for ZIKV and the only treatment is supportive.[58] There have been numerous calls for data sharing[121 122] and cooperation between governments and academic institutions,[54 123] and public and private charities have pledged significant financial support to improve our understanding of ZIKV epidemiology and to develop a vaccine or small molecule prophylaxis to decrease the risk of infection. In the wake of the Ebola epidemic, the global response to ZIKV has been characterised by unprecedented levels of international cooperation. In the absence of a ZIKV vaccine or prophylaxis, international leaders in ZIKV research have formed the ZIKV IPD Consortium to identify, collect and synthesise IPD from longitudinal studies of pregnant women that measure ZIKV infection during pregnancy and fetal, infant and child outcomes. These data will be used to quantify the absolute risk of ZIKV-related pregnancy complications with the goal of aiding women and their families in making difficult reproductive decisions and with helping public health systems prevent and quantify the burden of congenital Zika infection.

Challenges of developing and conducting an individual participant data-meta-analysis in the context of an emerging pathogen

Ideally, researchers prespecify confounders, effect measure modifiers and plans for subgroup or sensitivity analyses in their research protocol. In the context of Zika, our understanding of the virus is changing so rapidly that analysis plans may change significantly despite our best efforts to review the latest evidence on transmission, immunological response, diagnostic assays, vector biology and basic ZIKV epidemiology. Our ability to appropriately account for measurement error will play a critical role in the accuracy of estimates for the risk of CZS and other adverse fetal, infant and child outcomes. This is one of the first instances where an IPD-MA has been used to address public health concerns in the context of an emerging pathogen. We expect that best practices and lessons learnt from this IPD-MA can be used to facilitate the formation of research collaborations to streamline the public health response to future epidemics.

Patient and public involvement

In keeping with guidelines for public involvement in research,[124] knowledge users (ie, women of reproductive age and their families, clinicians) will be consulted at each stage of this research. The research question and protocol were designed with feedback from clinicians who treat pregnant women in ZIKV-endemic areas and infants and children affected by CZS. Focus groups that include women of reproductive age in ZIKV-endemic areas will be used to evaluate the ethical implications and utility of the risk stratification tool in three countries.

ETHICS AND DISSEMINATION

This IPD-MA protocol has been deemed exempt from ethical review by the WHO Ethics Review Committee and the Emory University Institutional Review Board. Individual longitudinal studies will provide documentation of ethics review prior to sharing their deidentified, participant-level data. The WHO has developed guidance for data sharing in public health emergencies or in the context of emerging pathogens.[125] Sharing deidentified data for IPD-MA is generally considered exempt from ethical review if the objectives of the IPD-MA are in keeping with the objectives of the original studies.[126] Individual research studies and consortia will secure additional ethics review and/or legal guidance on the sharing of deidentified, subject-level data as needed. The results of this analysis will be published under the ZIKV IPD Consortium name and will include a list of the names of key investigators from each study that contributed data for that analysis and researchers who contributed to the analysis or writing at the end of the publication. Findings from the proposed analysis will be shared via national and international conferences; existing platforms for dissemination of ZIKV-related research (eg, The Global Health Network) and through publication in open access, peer-reviewed journals.

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From: Clark, Marah
To: Schramm, Danielle; Carina Blackmore
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD)
Subject: RE: Y2Q2 Submission Reminder, Request
Date: Friday, February 7, 2020 8:04:25 AM
Attachments: image001.png

Vector Week Update:

SIT: Florida has two programs implementing Sterile Insect Technique targeting the *Aedes aegypti* mosquito with assistance from the CDC grant funding. Despite the delay in receiving funding, both programs have made progress to start releasing sterile males in cities in both the northeast and southwest regions of the state.

Insecticide Resistance: In the past few years, insecticide resistance testing for disease vectoring mosquitoes has become an important part of Florida's mosquito control programs. Funding has allowed the Florida Medical Entomology Laboratory to not only continue testing Aedes aegypti and Aedes albopictus mosquitoes, but to expand testing to a Culex species mosquito. Since July 2019, mosquito control programs have been submitted eggs and testing for both pyrethroid and organophosphate mosquito adulticides.

I am working on the spreadsheet and hope to have it in by COB. I have been in training this week and several programs have been slow in providing requested info.

Thanks!

Marah

From: Schramm, Danielle <Danielle.Schramm@icf.com>
Sent: Thursday, February 6, 2020 12:21 PM
To: Clark, Marah <Marah.Clark@fdacs.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: RE: Y2Q2 Submission Reminder, Request

Hi Marah,

Just a note to check on your Y2Q2 submission and success story highlight. Do you anticipate sending to us by tomorrow?

I am going to be out of the office Feb. 10-19, so I just wanted to see where things are and finalize what I can before being out.

Thanks!
Danielle

From: Schramm, Danielle
Sent: Tuesday, January 28, 2020 3:38 PM
To: 'Clark, Marah' <Marah.Clark@fdacs.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>

AMERICAN OVERSIGHT

Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: RE: Y2Q2 Submission Reminder, Request

Hey Marah,

Great to hear that! Feel free to send separate ones and we'll try to fit them both in.

Thank you! Let me know if you need anything from me!
Danielle

From: Clark, Marah <Marah.Clark@fdacs.gov>
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To: Schramm, Danielle <Danielle.Schramm@icf.com>; Carina Blackmore <Carina.Blackmore@flhealth.gov>
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
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From: Schramm, Danielle <Danielle.Schramm@icf.com>
Sent: Tuesday, January 28, 2020 3:29 PM
To: Clark, Marah <Marah.Clark@fdacs.gov>; Carina Blackmore <Carina.Blackmore@flhealth.gov>
Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD) <gqx1@cdc.gov>
Subject: Y2Q2 Submission Reminder, Request

Hi Marah & Carina!

This is a friendly reminder to submit your completed Y2Q2 quarterly performance measure data collection tool by Friday January 31, 2020. If you need additional time, please submit no later than Friday February 7, 2020. Please email your completed Excel template as well as any relevant attachments to me and cc KCZ2@cdc.gov and Jeff Borchert gqx1@cdc.gov when submitting.

In addition, ICF will be developing a poster for Vector Week highlighting the accomplishments of the Hurricane Supplemental Funding thus far. We will be presenting data at the aggregate level with the exception of success stories that we would like to highlight from each state/territory. If there is a specific accomplishment you would like to highlight, we are asking that you develop a 3-4 sentence blurb summarizing the accomplishment along with the specific activity in your workplan to which it aligns. If you are unable to develop a blurb, we can pull from your progress submissions and develop a summary

AMERICAN OVERSIGHT

and share with you for approval. Feel free to provide this information when sending in your Y2Q2 data submission. If you would like us to develop a summary for you, please let us know by COB this Friday January 31, 2020.

If you have any questions or need any assistance completing your data collection tool, please don't hesitate to contact me.

Thank you,
Danielle

Danielle Schramm, MSPH | Senior Research Scientist | 404-592-2299 direct or 404-321-3211 main | danielle.schramm@icf.com | icf.com
ICF | 3 Corporate Blvd. NE, Suite 370, Atlanta, GA 30329 USA |

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Get Outlook for Android

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Cc: Borchert, Jeff N. (CDC/DDID/NCEZID/DVBD)
Subject: RE: Y2Q2 Submission Reminder, Request
Date: Thursday, February 6, 2020 12:20:41 PM
Attachments: image001.png

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Thank you,
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ICF | 3 Corporate Blvd. NE, Suite 370, Atlanta, GA 30329 USA |

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AMERICAN OVERSIGHT

From:	DNPAO Comm TA (CDC)
To:	DNPAO Comm TA (CDC)
Subject:	Reminder -- Register for Feb 13 Comm Networking Call: Using Audience Research to Inform Communication Activities
Date:	Tuesday, February 11, 2020 2:49:01 PM

Dear State and Community Health Media/Communication Contacts,

This is a reminder of our next communication networking call on **Thursday, February 13 at 2:00pm ET**. We will share new audience research and discuss how you can use in your communication activities.

You must register using the link provided below to get the webinar log-on details. Details on how to join will come in a separate email.

Warm regards,
DNPAO Strategic Communication Team
DNPAOCommTA@cdc.gov

Please join CDC's Division of Nutrition, Physical Activity, and Obesity for the following Networking Call:

"Using Audience Research to Inform Communication Activities"

Thursday, February 13, 2020
2:00-3:30 pm EDT

Who should participate?

Principal Investigators, Program Managers, communication staff, and other interested staff
**Principal Investigators – please forward this invitation to other staff working on communication activities.*

How do I connect?

Participants must register for this event.

Let us know if you have any accessibility accommodations (e.g., captioning) by February 11.

What will the networking call cover?

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The networking call will cover:

- Audience research findings conducted by CDC's Division of Nutrition, Physical Activity, and Obesity
- Ways state and local public health programs can apply the audience research to their work

Who are the presenters and panelists?

Presenters and panelists will include recipients along with staff and contractors from CDC/DNPAO's Strategic Communication Team.

- Suzi Gates, DNPAO Strategic Communication Team
- Shea Van Horn, FHI 360 Contractor, DNPAO Strategic Communication Team
- Rebecca Ledsky, FHI 360 Contractor, DNPAO Strategic Communication Team
- Thomas Lehman, FHI 360 Contractor, DNPAO Strategic Communication Team
- Maureen Spence, New York State Department of Health
- Jasmine Deskins, Marion County Public Health Department
- Emily DeWitt, University of Kentucky

Hints and reminders for the event

1. Register to get event login details.
2. Check your connection and Adobe Connect access the day before the session.
3. Contact your organization's IT staff if you have trouble accessing Adobe Connect.
4. Visit Adobe Connect Support if you need help.
5. Log onto **Adobe Connect (website)** and **phone** line 10 minutes before the start time.

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Reminder: COVID-19 Call Today, 1:45 PM EST
Date: Friday, February 14, 2020 12:37:47 PM

Just a reminder if you haven't registered for today's COVID-19 federal update call:

Please join us for a national briefing call **TODAY, Friday, February 14 at 1:45 p.m. Eastern Time** on the President's Coronavirus Task Force **(Please register, see link below).** The national briefing call will include updates from the U.S. Department of Health & Human Services and Centers for Disease Control & Prevention (CDC) along with our Federal partners at U.S. Department of Homeland Security, U.S. Department of Transportation, and the State Department. This national briefing call will provide an update from the Federal government and our ongoing partnership with State and local jurisdictions.

Additional Information

- You can find more information and resources at the CDC website here: https://www.cdc.gov/coronavirus/.
- **NEW: Excerpts from Secretary Azar's interviews with CNN and CNBC**

Briefing Call Details
Date: Friday, February 14
Time: 1:45 p.m. Eastern Time
Call-In Information: LINK *(Participants will receive instructions on accessing the conference after RSVPing to the link)*

What The Admin Is Saying | HHS Secretary Alex Azar Discusses the Coronavirus on CNN and CNBC

Secretary Azar provided an update on the coronavirus and the administration's aggressive efforts to protect the health and safety of Americans.

PROTECTING THE HEALTH AND SAFETY OF THE AMERICAN PEOPLE

AZAR: "We're working aggressively across the whole of government to protect the health and safety of the American people and using the time that we have bought through our very aggressive, multilayered approaches of public health to prepare."

AZAR: "This is about protecting America's borders and allowing us the time to continue our proactive preparations."

AZAR: "People who are not U.S. citizens or permanent residents of the United States may not enter the United States if they have been in China in the previous 14 days.

AMERICAN OVERSIGHT

Once they've been out of China for that 14-day incubation period, they are welcome as always into the United States."

AZAR: "Americans coming back who have been in China in the previous 14 days, we ask them to both funnel to 11 airport ports of entry where they can be inspected, surveilled, and we ask them voluntarily to isolate themselves at home for 14 days. If they've been in the hot zone, which is an increasingly diminishing number of people who've been in Hubei province in the previous 14 days, we will actually quarantine them for that 14-day period."

IDENTIFYING AND MONITORING CASES

AZAR: "We are proactively planning now to prevent further spread in the U.S., but also to conduct aggressive surveillance, to have an early warning system. Our public health system's the best in the world, and it's working. That system is what identified the 15 cases that we have."

AZAR: "The 15 cases that we have were identified by our public health system. We immediately alerted our hospitals, our doctors, our public health departments, of the symptoms and of the connection to China. And so we have been scanning and surveilling from day one on this."

AZAR: "One of the things that we did – the CDC – within a week of getting the genetic sequencing, developed a test, we had a diagnostic there at CDC. We've now deployed that around the country in over 170 public health labs."

AZAR: "We're taking an important measure that we announced yesterday, which is we are using our flu surveillance network in Seattle, San Francisco, L.A., Chicago and New York, where individuals who present with flu-like, or China coronavirus-like symptoms will be tested not just for flu, but also tested for China coronavirus. That way we have an early warning system."

IMPACT WITHIN THE UNITED STATES

AZAR: "The risk to the average American is very low right now. Let's remember, we have 15 confirmed cases here in the United States – all of whom were either traveling in Hubei province, where Wuhan is, or had a direct intimate personal contact with an individual who was there."

AZAR: "They should be more worried about flu and regular cold season, in terms of taking precautions like washing their hands, coughing into their arms, and not touching their face."

AZAR: "So far, we're seeing very limited impact here in the United States, but that could change at any time. We're working to prevent that from happening, to keep that risk low, and we're working to proactively prepare with states, local governments, and the private sector."

AMERICAN OVERSIGHT

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AZAR: "The World Health Organization must insist that China be transparent and fully cooperative, as they would insist on the United States or any other country."

AZAR: "It is very important that the World Health Organization hold China to account for transparency and cooperation, as they would any other country, including the United States."

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AZAR: "We need to get this team that I have offered now for 39 days of CDC experts. We've got to get them into China and they've got to be given access to data, genetic sequences, run the studies to get answers to the key questions."

AZAR: "They have got to be able to work shoulder to shoulder with their Chinese scientific colleagues – looking at raw data, running the studies, looking at genetic sequences, doing the virology and epidemiology that is their mission – or it won't be a useful mission."

###

Thanks,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

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Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: Reminder: EPIC Webinar @ 1 PM TODAY (3-18-20)
Date: Wednesday, March 18, 2020 12:22:09 PM

Dear Colleagues:

We wanted to provide a quick reminder that there is an EPIC Webinar @ 1 PM TODAY. Please pass this information along to your partners if you feel like they might be interested. The topic is **"Answering 20 Questions About COVID-19" and is geared towards the general public**. It will be broadcast on Facebook live and will have closed captioning.

https://emergency.cdc.gov/epic/learn/2020/webinar_20200318.asp

Kind Regards,

State Coordination Task Force

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, BCHC, and national and federal partners)

AMERICAN OVERSIGHT

From:	ASTHO Executive Office
To:	ASTHO Executive Office
Cc:	Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD); Research and Evaluation
Subject:	Reminder: Help CDC Improve its Project Officer Support
Date:	Wednesday, February 5, 2020 10:26:35 AM
Attachments:	Survey Distribution Instructions.pdf

Dear Senior Deputies,

This email is another request for action and a follow-up to the survey launched on Tuesday, January 14th (announcement email is attached). For those of you who have already distributed this evaluation to the appropriate points of contact within your agency, we appreciate your support. At this time we ask that you remind your staff about this survey by simply forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department.

As a reminder, ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements and grants. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

This survey should be completed by health agency staff who work on and serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements or grants (full list of selected cooperative agreements/grants is attached).

Our ask of you: Please remind your staff about this survey by forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department for their response. The invitation content to request participation is provided below the signature on this email. Feel free to directly forward this email to the intended recipients or create a new outreach message using the content below.

Thank you for your assistance.

Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308
www.astho.org | Twitter | Facebook | Blog

EMAIL FOR SURVEY RESPONDENT:

Instructions for survey respondent: The Association of State and Territorial Health Officials

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(ASTHO), in partnership with the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support is administering an assessment to health departments in all 50 states and the District of Columbia related to satisfaction with the services and support provided by CDC project officers.

Results from the assessment will be used by CDC to improve project officer support to state health agencies. Participation is voluntary, and your feedback will inform continued project officer development and training.

In order to participate in this voluntary assessment, please click the hyperlink provided in this email to be redirected to the web-based assessment. The assessment should take no longer than 25 minutes to complete. All responses are immediately saved and can be changed at any time. However, once the assessment is submitted, you will be unable to modify any responses. Also, you are not required to complete the assessment in one sitting. When finished responding to all relevant questions, click the **SUBMIT** button at the end of the assessment to submit your responses.

Information collected will be kept on secure, password protected servers accessible only to ASTHO project team members. All information you provided will be analyzed and reported in the aggregate with no identifying information attached.

Follow this link to the Assessment: Take the Assessment

Please submit responses to this assessment no later than February 27, 2020.

Note: The survey is designed for respondents to consider only one project officer within each selected cooperative agreement and grant. If your agency has more than one project officer for the Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations (DP17-1701), we invite your agency's appropriate point of contact to complete separate survey entries for each project officer.

Additionally, a few of the HIV, Viral Hepatitis, TB, and STD cooperative agreements have been updated with the current cooperative agreement numbers. The updated names and numbers are in the attached survey distribution instructions. If you already submitted responses under a prior cooperative agreement number you do not need to re-submit.

If you experience problems with the web-based assessment or have any questions, please contact Allen Rakotoniaina at researchandevaluation@astho.org for technical assistance.

Thank you in advance for your participation.

Disclaimer

The information contained in this communication from the sender is confidential. It is intended solely for use by the recipient and others authorized to receive it. If you are not the recipient, you are hereby notified that

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any disclosure, copying, distribution or taking action in relation of the contents of this information is strictly prohibited and may be unlawful.

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ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements. This survey should be completed by health agency staff who serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements.

Instructions for survey distribution: We ask that you please forward the invitation email to the primary staff working on the following cooperative agreements for their response:

COOPERATIVE AGREEMENT NUMBER	PROGRAM/PROJECT TITLE
CE14-1401	Rape Prevention and Education Program
CK14-1401	Epidemiology and Lab Capacity for Infectious Diseases
DP18-1815	Diabetes and Heart Disease & Stroke Prevent Programs-Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke
DP15-1509	National State Based Tobacco Control Programs
DP15-1513	Behavioral Risk Factor Surveillance System (BRFSS)
DP16-001	Pregnancy Risk Assessment Monitoring System (PRAMS)
DP17-1701	Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations
IP19-1901 (NOFO NUMBER FOR PRIOR CYCLE WAS IP13-1301)	Immunizations and Vaccines for Children Program
OT18-1805	Preventive Health and Health Services Block Grant
PS17-1702	Improving Hepatitis B and C Care Cascades: Focus on Increased Testing and Diagnosis, and Application
PS17-1703	Strengthening Surveillance in Jurisdictions with High Incidence of Hepatitis C Virus (HCV) and Hepatitis B Virus (HBV) Infections
PS18-1802	Integrated HIV Surveillance and Prevention Programs for Health Departments
PS19-1901	Strengthening STD Prevention and Control for Health Departments
PS20-2001 (NOFO NUMBER FOR PRIOR CYCLE WAS PS15-1501)	Tuberculosis Elimination and Laboratory Cooperative Agreement
TP19-1901 (NOFO NUMBER FOR PRIOR CYCLE WAS TP12-1201)	Public Health Emergency Preparedness (PHEP)
EH17-1701	Childhood Lead Poisoning Prevention Program
EH17-1702	Enhancing Innovation and Capabilities of the Environmental Public Health Tracking Network
DD17-1701	Early Hearing Detection and Intervention Program
DD16-1605	Surveillance, Intervention, and Referral to Services and Activities for Infants with Microcephaly or Other Adverse Outcomes Linked with the Zika Virus

AMERICAN OVERSIGHT

Survey announcement shared with ASTHO's Senior Deputy Peer Network on Thursday, January 19th

Dear Senior Deputies,

ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

To capture this information, ASTHO will be fielding a survey on Tuesday, January 14 inviting the primary program staff who work on ***and*** *serve as the primary point of contact with the CDC project officer for the select CDC-funded cooperative agreements or grants listed below to share their feedback.*

As your agency's senior deputy, you will receive an invitation to complete the survey and we ask that you ***please forward the invitation to the primary staff working on the various cooperative agreements*** *for their response. The respondents to the survey should be the primary staff working on each of the listed cooperative agreements.*

Responses will remain confidential, and data will be analyzed and aggregated by ASTHO. Results will be used by CDC to inform future training and identification of best practices and opportunities for improvement in the support provided by CDC to state health departments.

Questions about the project?

For questions about the project or survey, contact Emily Peterman, Director of Research & Evaluation (epeterman@astho.org).

Thank you,
Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: *2231 Crystal Drive, Suite 450, Arlington, VA 22202*
Regional Office: *600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308*
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AMERICAN OVERSIGHT

From: Jones, Christopher M. (CDC/DDNID/NCIPC/OD)
To: Blackmore, Carina (CDC flhealth.gov)
Cc: Oliver, Sara Elizabeth (CDC/DDID/NCIRD/DBD)
Subject: remote TA call from CDC - COVID-19
Date: Thursday, March 12, 2020 8:24:49 AM

Hi Dr. Blackmore,

I am working to set up a follow up TA call to assist with your questions related to the cruise ship port. Can you let me know some times that work for you today?

Thanks,

Chris

Christopher M. Jones, PharmD, DrPH, MPH
CAPT, US Public Health Service
Senior Advisor
Associate Director, Office of Strategy and Innovation
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
O: 404-498-0756 | C: 404-747-5988
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From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	scott.rivkees@flhealth.gov
Cc:	Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); Cantrell, Russell (CDC/DDPHSIS/CSTLTS/DPIFS)
Subject:	Response to: Request on Cleaning Guidance at hotels sent to Dr. Montero
Date:	Wednesday, February 19, 2020 12:56:14 PM
Attachments:	20200208 Enviro Cleaning Recs_Final.docx SCTF Talking Points from GMTF 02142020.docx public-health-management-decision-making.pdf

Good Afternoon Dr. Rivkees,

I am following up on a message you recently sent Dr. Montero.

Attached are two documents to address your request. The Global Migration Task Force provided the cleaning guidance. They also provided quarantine-related talking points. Please feel free to use the talking points in conjunction with the hotel cleaning guidance as appropriate.

I have also included a document that was recently added to the CDC guidance documents that helps in the assessment of a travelers risk for developing infection. The newest guidance documents are highlighted in the "What's New" section at the following CDC website https://www.cdc.gov/coronavirus/2019-ncov/index.html .

Please let me know if we can be of further assistance.

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

AMERICAN OVERSIGHT

Interim Cleaning Recommendations Related to People with Exposures to 2019 Novel Coronavirus Under Observation while Quarantined in Non-Home Residential Settings

Background

Current knowledge about how 2019-nCoV spreads is based on what is known about early cases of 2019-nCoV infection and what is known about similar coronaviruses such as SARS and MERS. Most often, spread from person-to-person happens among close contacts (within about 6 feet). People with certain types of exposure to 2019-nCoV may be housed and quarantined for observation until 14 days after their exposure. The purpose of the observation period is to ensure they don't develop symptoms and potentially infect others during this time. Quarantine means people exposed to an infectious disease are separated from others during the observation period to prevent possible spread of infection. Some people stay at home for the observation period, but others may be housed either separately or in groups in other residential settings. This guidance addresses those individuals housed in designated, non-home residential settings.

Purpose

This guidance is intended to address recommended cleaning and disinfection practices for non-home residential quarantine locations, as well as associated worker protection practices according to expected job tasks.

General Recommendations for Non-home Residential Settings Housing People Exposed to 2019-nCoV

- Employers should educate workers performing cleaning, laundry, and trash pick-up activities to recognize the signs and symptoms of 2019-nCoV and provide instructions on what to do if they develop signs and symptoms.
- Workers should observe their health (fever or symptoms of respiratory illness) for 14 days beginning after the last time they had possible exposure to 2019-nCoV. Workers should be instructed that if they develop a fever (100.4°F or higher), cough, or have difficulty breathing, symptoms should be reported to their supervisor and the local health department. The health department will provide guidance on what actions need to be taken.
- Employers should develop policies for worker protection and provide training to all workers on site prior to providing cleaning tasks. Training should include an understanding of when to use personal protective equipment (PPE), what PPE is necessary, how to properly don (put on), use, and doff (take off) PPE, and how to properly dispose of PPE.
- Hand hygiene should be performed often including upon removal of disposable gloves by washing hands with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol.
- Workers should report breaches in PPE (e.g., tear in gloves) or any potential exposures to their supervisor.

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- Employers must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), PPE (29 CFR 1910.132), and other requirements, including those established by state plans, whenever such requirements apply
- For cleaning and disinfection chemicals, always follow the manufacturer's instructions (e.g., concentration, application method and contact time, PPE use) being used.

Activities During the 14-Day Observation Period

Cleaning staff should be aware that people under observation during the 14-day observation period after exposure to 2019-nCoV may be infectious. For example, after they have been medically evaluated, symptomatic people who are not sick enough to stay in the hospital might go back to their quarantine location (e.g., hotel) to wait for laboratory results.

Because cleaning staff will not by themselves know which of the people under observation may be infectious and which are not, cleaning of rooms in non-home residential settings, once rooms are vacated, should proceed only after consultation with public health officials. Before the rooms are cleaned, local public health departments should determine if rooms were occupied by potentially infectious people and advise if enhanced cleaning is therefore recommended.

- Individuals being observed under quarantine should remain in their rooms.
- Access to rooms where quarantined individuals are housed should be restricted to authorized public health officials.
- Cleaning staff should not enter the rooms of individuals who are quarantined.
- Consider placing two carts, or something similar, outside the occupant's room; one to set "clean" materials on and one to set "used" materials on. Carts should be labeled. Used materials for disposal and laundry should be set on the cart labeled as "dirty" materials. Meals, clean sheets/towels and toiletries should be set on the cart labeled as "clean."
- Occupants of the rooms should place used towels and bedding that need to be laundered in a sturdy, leak-proof (e.g., plastic) bag that is tied shut and not re-opened while being transported to the laundry facility.
- Bagged laundry should be transported to the laundry facility on a cart or something similar and contents carefully unloaded into machine with minimal agitation. The used bag carrying the laundry should be discarded as regular solid waste (e.g., municipal trash) as it is not considered biohazardous or regulated medical waste.
- Disposable meal containers, cups, and utensils should be used, and discarded as trash.
- If a room occupant wishes to clean their room, regular cleaning products should be supplied for them.

Cleaning After the Room is Vacated if Person Remained Asymptomatic

Cleaning staff should follow normal preventive actions while at work and at home to help prevent the spread of respiratory viruses (such as seasonal flu), including recommended hand hygiene and avoiding touching eyes, nose, or mouth with unwashed hands. These recommendations will be updated if additional information becomes available.

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- Clean all “high-touch” surfaces (e.g., counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables) according to routine cleaning practices using regular cleaning products.
- No additional PPE (beyond what is normally worn by housekeeping staff) is necessary for handling luggage and cargo.
- No additional PPE is required beyond what is normally worn for regular housekeeping activities.
- Management of laundry and waste should be handled in accordance with routine procedures.

Cleaning After the Room Is Vacated if a Symptomatic Person Was Present in the Room (Enhanced Cleaning)

Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected (e.g., no respiratory protection) individuals from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). We do not yet know how long 2019-nCoV remains infectious in the air. In the interim, it is reasonable to apply a similar time period before entering the sick person’s room without respiratory protection as that used for other pathogens spread by the airborne route (e.g., measles).

Cleaning recommendations are based on existing CDC infection control guidance for preventing 2019-nCoV from spreading to others in homes and residential communities. This guidance contains information on how to clean surfaces in the community setting where a person confirmed to have, or being evaluated for, 2019-nCoV infection has been present.

Disinfectant products with EPA-approved emerging viral pathogens claims are recommended for use against 2019-nCoV. This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, “1-800” consumer information services, social media sites and company websites (non-label related). These products can be identified by the following claim:

- [Product name] has demonstrated effectiveness against viruses similar to 2019-nCoV on hard non-porous surfaces. Therefore, this product can be used against 2019-nCoV when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces.”
    - Specific claims for “2019-nCoV” will not appear on the product or master label.
    - Additional information about EPA-approved emerging viral pathogens claims can be found here: https://www.epa.gov/pesticide-registration/emerging-viral-pathogen-guidance-antimicrobial-pesticides
    - If there are no available EPA-registered products that have an approved emerging viral pathogen claim for 2019-nCoV, products with label claims against human coronaviruses should be used according to label instructions.

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- In addition to disposable gloves used during routine cleaning, disposable gowns should be worn when cleaning quarantine locations after identification of someone as symptomatic during the 14-day observation period. PPE should be compatible with the disinfectant products being used; additional PPE might be required based on the cleaning/disinfection products being used and whether or not there is a risk for splash. Gloves and gowns should be removed carefully to avoid cross-contamination of themselves and the surrounding area.
- Hand hygiene should be performed upon removal and disposal of gloves by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol.

Clean and disinfect all “high-touch” surfaces in quarantine locations (e.g., counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables)
according to instructions described for the EPA-registered product above.

If visible contamination (e.g., a body substance such as blood or body fluids) is present, the basic principles for blood or body substance spill management are outlined in the United States Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard. CDC guidelines recommend removal of bulk spill matter, cleaning the site, and then disinfecting the site with the above EPA-registered disinfectant. For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present, and launder in accordance with the manufacturer’s instructions. Clean and disinfect unremovable materials with products mentioned above and allow to air dry.

When cleaning is completed, collect soiled material and PPE in a sturdy, leak-proof (e.g., plastic) bag that is tied shut and not reopened. This waste can go to the regular solid waste stream (e.g., municipal trash) as it is not biohazardous or regulated medical waste. Porous materials that will be laundered can be transported to the laundry facility in the same manner. Immediately clean hands with soap and water or an alcohol-based hand sanitizer and avoid touching the face with gloved or unwashed hands.

No additional cleaning is needed for supply and return ventilation registers or filtration systems for the building.

No additional treatment of wastewater is needed before discharge to sanitary sewer.

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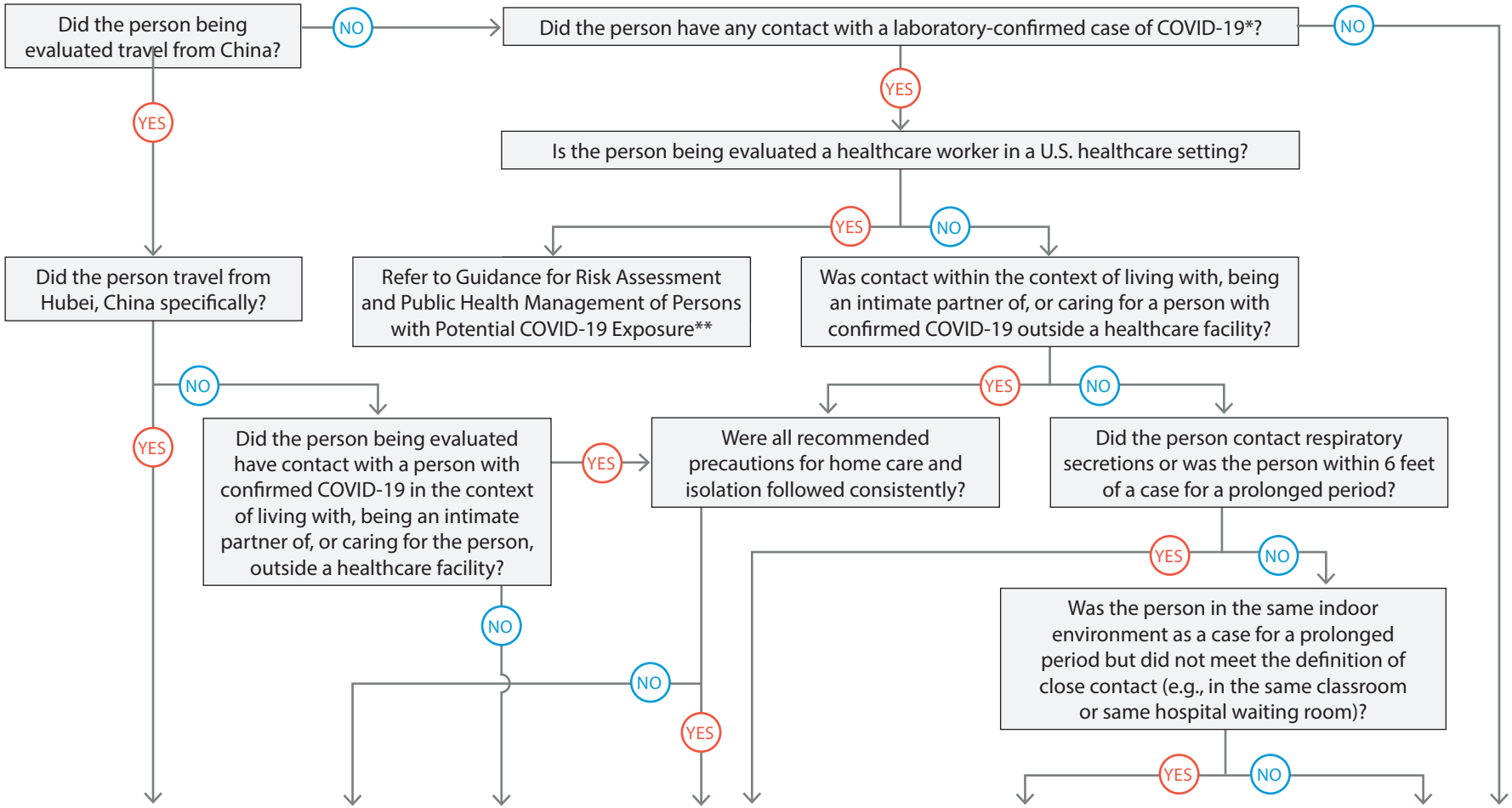
Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making *Each question refers to within the past 14 days*

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



	High Risk	Medium Risk	Low Risk	No identifiable risk
Actions for people without symptoms consistent with COVID-19	Remain under quarantine authority; no public activities; daily active monitoring; controlled travel	Stay home; active monitoring or self-monitoring with public health supervision; recommend to not travel	Self observation	None
Actions for people with symptoms consistent with COVID-19	Immediate isolation; medical evaluation guided by PUI definition; pre-notify healthcare services; controlled travel	Immediate isolation; medical evaluation guided by PUI definition; pre-notify healthcare services; controlled travel	Stay home from work or school, avoid contact with others, don't travel. Seek health advice	None; routine medical care

These examples may not cover all potential exposures to laboratory confirmed case of COVID-19. If you are concerned about an exposure that does not align with these categories, please contact the CDC Emergency Operations Center at 1-800-232-4636

*Or a case diagnosed clinically with COVID-19 infection outside of the United States who did not have laboratory testing
**Healthcare provider (HCP) guidance outlines risk categories to determine work exclusion and monitoring procedures. After identifying risk category in the HCP guidance, use the categories outlined here to determine quarantine requirements.

AMERICAN OVERNIGHT

02/14/20

FL-DOH-20-0673-A-006464

February 14, 2020

Talking Points for SCTF to State and Local Public Health Officials

Quarantine

Which agency will be responsible for issuing public health orders if a traveler with high-risk exposure (e.g., been in Hubei Province) to COVID-19 is identified at a US port of entry?

State and local authorities have primary jurisdiction for isolation and other public health orders within their respective jurisdictions. Federal public health authority primarily extends to international arrivals at ports of entry and to preventing interstate communicable disease threats. In general, CDC prefers that state or local authorities issue public health orders if the state or local authority is willing and issuance of the order can be accomplished expediently because in most cases housing and monitoring of these individuals will be the responsibility of state or local authorities. Also, if necessary, CDC's order can be issued as an interim measure and rescinded when the state or local authority is ready to issue their order. Decisions regarding the issuance of public health orders will be made on a case-by-case basis in coordination between CDC and the state and local health departments of jurisdiction.

CDC can also issue orders that "bridge" public health orders by two different states if an individual under quarantine is relocated from one state to another.

Where will travelers needing quarantine for high-risk exposures to COVID-19 be housed?

CDC is working with state and local health departments with jurisdiction at the 11 airports receiving passengers from China, to identify locations for housing travelers with high-risk exposures who need to be quarantined. In all cases, housing of quarantined travelers will be discussed with state and local authorities before a quarantine order is issued.

In some situations, conditional release orders that allow individuals subject to quarantine to travel to other parts of a state or to other states by private vehicle may be acceptable in coordination with public health authorities at travelers' final destinations. **Conditional release** defines a set of legally enforceable conditions under which a person may be released from more stringent public health movement restrictions, such as quarantine in a secure facility. These conditions may include public health supervision through in-person visits by a health official or designee, telephone, or any electronic or internet-based means of communication as determined by the CDC Director or state or local health authority. A conditional release order may also place limits on travel or require restriction of a person's movement outside their home.

If a state is unable to get a quarantine order for a non-symptomatic traveler from China outside Hubei Province who arrives at one 11 funneling airports to his or her final destination, would/could CDC use Federal Public health travel restrictions (Do Not Board listing)?

CDC is not recommending quarantine or travel restrictions for travelers from China outside Hubei Province as these travelers are considered medium risk for exposure. CDC acknowledges that state and local jurisdictions may choose to make decisions about isolation,

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other public health orders, and monitoring that exceed those recommended in federal guidance; however, federal authority will not be used to enforce these additional restrictions.

What is the expected level of enforcement for travelers returning from Hubei Province who are asymptomatic, but are considered high risk and thus are asked to "self-quarantine" and not engage in any public activities? The concern is health departments don't necessarily know the individual was exposed to the disease just because the individual was in Hubei Province.

CDC has assessed all of Hubei Province as having high risk of exposure based on the high degree of sustained human-to-human transmission in the region. If such individuals are identified at a post of entry, CDC will coordinate with the state or local health department of jurisdiction to issue a quarantine order. If they are identified in a community setting, the state or local health authority may choose to issue a quarantine order based on the individual's willingness to comply with voluntary quarantine.

What documentation will be provided to individuals who are in quarantine to provide to their employers or schools? Who provides this documentation?

Each person quarantined or conditionally released under a federal order receives a copy of the order that specifies the conditions of the order. At the end of the quarantine or conditional release period, the individual received a document rescinding the order.

Will CDC provide a copy of the federal quarantine order to states?
CDC can provide a copy of its template orders upon request. We request that distribution be limited.

Are there recommendations for carrying out mass quarantine of an exposed group (e.g., could they be quarantined in a gym/school setting)?
CDC does not recommend quarantining people in congregate settings such as school gymnasiums. Such settings risk amplifying exposure if someone in the group becomes symptomatic with COVID-19 infection. If state or local jurisdictions are planning for mass quarantine facilities, these facilities should have capacity to quarantine individuals or families in separate rooms.

Flight Crews

What is CDC doing to address risk associated with airline or cargo flight crews who have been in China in the past 14 days?

CDC and the Federal Aviation Administration have issued joint guidance that advises all crew members who have been in China in the past 14 days to self-monitor with supervision by their employer's occupational health program. US-based air crews and those based in other countries (not China) to practice social distancing while on layovers in China and limit their exposure to local populations; crews who follow these recommendations are considered low risk for exposure to COVID-19 and have no restrictions on work or travel as long as they remain asymptomatic. Crews based in China are considered to have medium risk for exposure and recommended to remain in their hotel rooms to the extent possible and practice social

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distancing while on layovers in the United States; as long as they are asymptomatic, these crews are not restricted to work on flights into and within the United States.

As an added precaution, China-based crews on passenger flights will have expedited screening upon arrival at a funneling airport. This recommendation is made because these crew have interactions with passengers onboard the airplane and may work on connecting domestic flights within the United States.

How should health departments manage airline or cargo flight crew members who have been in China if they become symptomatic while in the United States, and other crew members who may have been exposed to the ill crew member?

Air carriers have been asked to notify CDC if crew members become symptomatic with acute respiratory illness (a cough, shortness of breath, or a fever) within 14 days of having been in China. The ill crew member or the air carrier should also notify the local health department of jurisdiction. Symptomatic crew members should be excluded from work on flights until cleared by the employer's occupational health program in coordination with public health authorities. If a crew member is diagnosed with laboratory-confirmed COVID-19 and is known to have worked or otherwise traveled by commercial aircraft while symptomatic, CDC will coordinate an aircraft contact investigation with the air carrier, other federal agencies. and state and territorial health departments following usual procedures.

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From: Scott, Katie E

To: Hill, Ann; 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Subject: Revised Agenda: ECHCC General Coalition Meeting

AMERICAN OVERSIGHT

Date:	Wednesday, February 12, 2020 9:47:26 AM
Attachments:	AGENDA 2 13 2020.docx
Importance:	High

On behalf of Ann Hill, please see the revised agenda for the ECHCC General Coalition Meeting.

From: Ann Hill <ann.echcc@gmail.com>
Sent: Wednesday, February 12, 2020 8:28 AM
Subject: ECHCC General Coalition Meeting

Good morning
this will serve as a reminder that there is NO general coalition meeting today in Washington County
The meeting is scheduled for tomorrow THURSDAY FEBRUARY 13 at the coalition offices located at 755 Lovejoy Road, Ft Walton Beach, FL atm 10:00 am CST

We will have items on display to view, a board to suggest requested trainings, an inventory list that the coalition has on hand for distribution during disasters or affiliated events, speakers on Cyber Security, Lean on Me Project, Training and Exercises, report on Influenza and coronavirus, and more

Please make every attempt to appear in person or send someone from your agency if you are busy. Come see the new training room improvements and learn how to use this facility for your meetings.

Agenda is attached for the meeting - at the top, there is the call-in information
Also, remember that this Friday is the deadline for submitting your project ideas to the coalition

Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

AGENDA

GENERAL COALITION MEETING

February 13, 2020 at 10:00 am CST – ECHCC office, 755 Lovejoy Road, Ft Walton Beach, FL 32548

Teleconference Information: 1-310-372-7549 Participant Code: 875091

Welcome and Introductions	Ann Hill
Updates on Coalition	Ann Hill Several upcoming Trainings Scheduled
Digital Boardwalk	James Todd, Sales Engineering Manager Cyber Security, Spam emails and more updates
Cyber Liability Insurance	Dawn Grace Underwood Anderson & Associates
Lightsticks for your Security	Phillip Smallcorn Cyalume Technologies (appearing via phone)
Lean on Me Project	Katie Scott DOH – Okaloosa
Emerald Coast Emergency Care Symposium March 11, 12 and 13, 2020	Ann Hill
Upcoming ECHCC Meetings	May 12th Walton EOC (9 am CST) Escambia EOC (130 pm CST)

AMERICAN OVERSIGHT

From: Scott, Katie E

To: Hill, Ann; 21st Century Oncology Inc.; A & J Transport; Otis, Aaron; Abby Burdeshaw; PRINCIPE, ADAM; JEFFREY C LIND; agnes.dubose@hcahealthcare.com; Aimee Gray; ajolly@brookdaleliving.com; Alberta Granger; Alexandra.collins@kindredhospicecare.com; Blevins, Allison M; Washington County Health Dept.; Amanda Rae Bower; Amber; Amber Smith; Ami; Johnson, Amy; Angel Barber; Angie Bowen; Anita T; Ann Brown; Anna Pope; Anthony Booth; Anthony Brown; Porter, Aric J; ASBERRY, MICHELE A MSgt USAF ACC 325 MDOS/SGO; Aubrey; Avery, Emily; Batts, Howell T; Beasley, Karla; Belie Williams; Bernard Restrepo; Berryhill Manor; Bethany.Sanders@angmarcompanies.com; Betsy Schatti; Betty Scott; bfmaint@southernltc.com; Bill Storck; Blitch, Brenda J; Blood, Joshua; Bonnie Rushton; brace@bereadyalliance.org; Brad Baker; Brad Dennis; BRAD HATTAWAY; Brett Fisher; Brian Davis; Brian Hardin; Brieanne Raines; Brittney.Newby@hcahealthcare.com; Gill, Brandi N; Brooke Powell; Bruce Grabbe ARA/GCS; bwr1972@cox.net; Calhoun Emergency Manager; Candice Mayeur; Casey Haire; cbrunner@jacksoncountyfl.com; Chandra Smiley; Addison, Charles B; Charlotte Merrill; Chasity Brady; Chat Long; DEXTER BARBER; Chelsea Ranew; Cheryl Edmonson; Cheryl Pence; Cheryl Sheffield; Cheryl.Hamilton@covenanthospice.org; Chris; Chris Carlson; Chris Eladis; Chris J Holloman; Chris Jones; Chris Meyers; Christin Chavez-Inocencio; Christopher J. 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Frank Daniel; Frankie Lumm; fwmaint@southernltc.com; gary.wright3@hcahealthcare.com; George E Legge; George Stapleton; George.meeker@medxcelfm.com; Gerry Pierce; gmeade@shhpens.org; godwin.adm@gmail.com; Good Time Tours; Luka, Greg; Greg Massengill; Greg Strader; Gulf Imaging; Gwen Kady; Gwen Williams; Gwen Rhodes; Hanna; Hanson, Brett; heather slane; Hilary Joseph; Holly; Holt, Holly; Hope Medical Center Destin; Hope Medical Center Destin; Houston Whitfield; info@swfd.org; Interim Healthcare of Northwest Florida Inc.; Issac Jackson; Jacquie Arnott; James Rawus; james.edwards@brooksrehab.org; james.nutt@bhcpns.org; Carmichael, Jamie B; Jamie Tutnjevic; KINNEY, JANET; JANKOWSKI, ROBERT J GS-11 USAF AFSOC 1 SOMDSS/SGSX; Jason Cotton; Jason Redding; Jay Snodgrass; jcampagna@mesotheliomaguide.com; Jean Allred; Jeanine Melvin; Jeff Anderson; Jeff Goldberg; Jeffery Scott; Jeffery Scott; Jenni.Brunson@hcahealthcare.com; Jennifer Adams; Arant, Jennifer S; Jennifer Barrera; Jennifer Colley; Jennifer Landis; 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ldorch@washingtonfl.com; Lee Ann Blackwell; Linda Clarke; Kent, Linda H; Linda Langley; Linda Villanova; RENEE HAMILTON; Lisa Morrison; Lisa Racic; Liz Kuehn; Lori Stitt; Svehla, Louis; Loyd Shaffer; Luciano-Green, Candy; Luis Real; Lynne Johnson; MacDonell, Sam; maint@srhrc.com; Mandi Manzie; Maralee Sartain; Margie Hobbs; MARIANNE MARTIN; Mark Bowen; Mark Bowen; Mark Hutchinson; Marsha Buchanan; Martin Yeomans; Winn, Mary; MATT H BALTZ; Dobson, Roger M; Douglass, Matt; Mauricia Stanton; Megan Braunschweig; Megan Rawlinson; Melanie Henning; Melanie Motiska; Melissa Fijalkowski; Melody Hines; Dang, Meo T; Michael Jenkins; Michael Jenkins; Michael Johnson; Michelle Beale; Mike Matroni; Miriam Gordon; Mivhael Madewell; Monica Zeis; Mooney, Dayle; StateESF8.Planning; Nancy Walls; Johnson, Natalie N; Nathan Monk; nhall@srso.net; Kimbrel, Nicole H; nicolette Bennett; Oscar Williams; Patricia Krimminga; Roberts, Patricia J; Patrick Maddox; Paul Hubert; Peggy McCullough; Perez, Martha; Priscilla Bode; Priscilla Brewer; RaJackson@gchc.com; Randall McClellan; Sandoval, Randi C; Rebecca Carmichael; Reese, Juliet; Reese, Juliet; Renee Hamilton; rgonzalez@visitingangels.com; Rhonda Harden; Rhonda Sullivan; Rich Harrington; Rich Huffnagle; Richard Pittman; Richard Stanton; Talbert, Rick; Robert Kiskaddon; Robert Maxwell; Robert Sims; Robin Wood-Gay; Romeo@afev.us; Ron Mosley; Ron Samuelian; Rosa; Ross Ferland; Roxanne.Pierce@kindredhospicecare.com; Rudy Mendiola; Salley Beck; Sandra Nunes; Sandra Watson; Martin, Sandy K; Sarah Demotto; DONALD H RIPLEY; Scott Vickers; Shandra Jenkins; Shannon Murray; Sharon Wise; Stewart, Lewis Shayne; Shepard, Lela; Sheri Baerresen; smcguffin@myokaloosa.com; Smith, Angie (Calhoun Co EM); Sodora Phillips; Stephen Hinnant; Sumner, Samuel M; Susan Priddy; Suzette Gramm; swilcoxen@white-wilson.com; Tami Miles; Tanya Holloway; Tara Freibert; Terri Swift-Schumann; Knox, Thomas; Thomas McDaniel; Smith, Thomas M; Verlaan, Thomas D; Tim Orenic; Timothy A. Gooden, MD, FASAM, DABAM; Timothy Anderson; Tina Barker; Tina Hill; Tina Maloy; Tina Odom; Todd Arno; Tommy Mayhair; Tony Holland; Tracey Blackmon; Long, Tracey; Tracey Personal; Tracey Vause; Trent Page; Troy Taylor; Turner McMurphy; Vickie Dollhausen; Victorian Manor Retirement Center; Violet Kianison, RN, RM; Vivian Callaghan; Walter Turner; Water Mark of Gulf Breeze; Webb, Dawn; Wendy Halina; Wendy Morris; Wes Johnston; Wesley Scott Place; William Lord; Williams, Grant; BRENDA J BASFORD; Woodlief, Douglas; Wyatt Barton

Subject: Revised Agenda: ECHCC General Coalition Meeting

AMERICAN OVERSIGHT

Date:	Wednesday, February 12, 2020 9:47:21 AM
Attachments:	AGENDA 2 13 2020.docx
Importance:	High

On behalf of Ann Hill, please see the revised agenda for the ECHCC General Coalition Meeting.

From: Ann Hill <ann.echcc@gmail.com>
Sent: Wednesday, February 12, 2020 8:28 AM
Subject: ECHCC General Coalition Meeting

Good morning
this will serve as a reminder that there is NO general coalition meeting today in Washington County
The meeting is scheduled for tomorrow THURSDAY FEBRUARY 13 at the coalition offices located at 755 Lovejoy Road, Ft Walton Beach, FL atm 10:00 am CST

We will have items on display to view, a board to suggest requested trainings, an inventory list that the coalition has on hand for distribution during disasters or affiliated events, speakers on Cyber Security, Lean on Me Project, Training and Exercises, report on Influenza and coronavirus, and more

Please make every attempt to appear in person or send someone from your agency if you are busy. Come see the new training room improvements and learn how to use this facility for your meetings.

Agenda is attached for the meeting - at the top, there is the call-in information
Also, remember that this Friday is the deadline for submitting your project ideas to the coalition

Thank you

--



Ann Hill, Executive Director
Emerald Coast Healthcare Coalition
850-585-1679

AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

From:	Perry, Kaylynn
To:	Miller, Carly; chris@waltoncountyem.org; Courtney.Coppola@flhealth.gov; EduardoBustillo@semtribe.com; EOC-Plans; Bussey, Jon; Guthrie, Kevin; Waterman, Laura; Cintron, Morgan; espe0001@shands.ufl.edu; edward.f.toombs2.mil@mail.mil; twillrick@daytonainternationalspeedway.com; County Emergency Management Directors
Subject:	Revised Situation Report # 22
Date:	Tuesday, March 24, 2020 2:53:27 PM
Attachments:	COVID-19 Sit Rep 22.pdf

Please see attached for a revised Situation Report.

Kaylynn Perry
All-Hazard Preparedness Unit / SERT ESF 5
Florida Division of Emergency Mangement
Kaylynn.perry@em.myflorida.com
Office: (850) 815-4337
Mobile: (850) 254-5657

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

AMERICAN OVERSIGHT

Florida SEOC Situation Report COVID-19

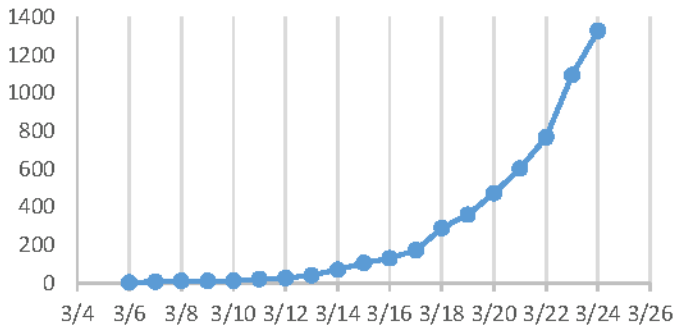
Published: 3-24-2020 @ 14:00 EDT | **Changes in Red** | **Situation Report #22**

Cases in Florida

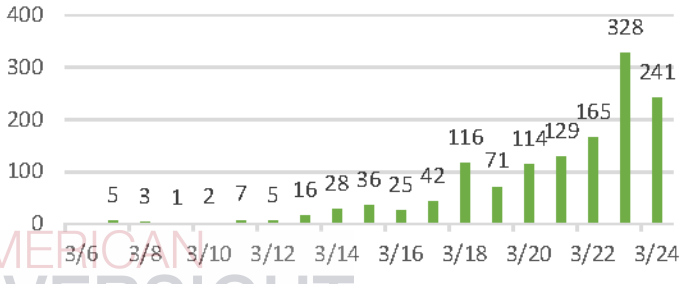
	Current	Change
Total Cases in Florida	1,412	+241
Florida Resident Cases	1,330	+234
Florida Fatalities	18	+4
Cases Hospitalized	259	+50
# of Counties with Cases	47	+4

Note: information in the below charts reflects the numbers reported on this and previous situation reports using only the morning DOH reports for consistency.

Resident Cases

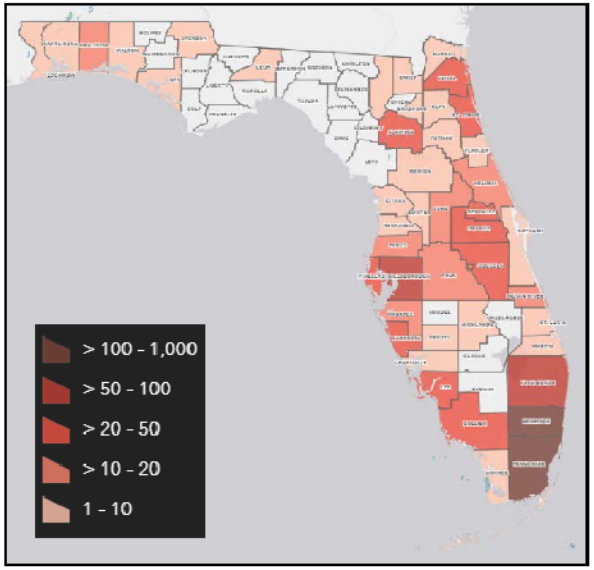


New Cases per Day



County Summary

- Local State of Emergencies have been declared in 64 counties.
- Level 1 EOC in 1 county.
  - Alachua County
- Level 2 EOC in 47 counties.
- There are 53 county staging areas.
- 78 community-based testing sites activated across the state.
- All School districts are extending spring break.

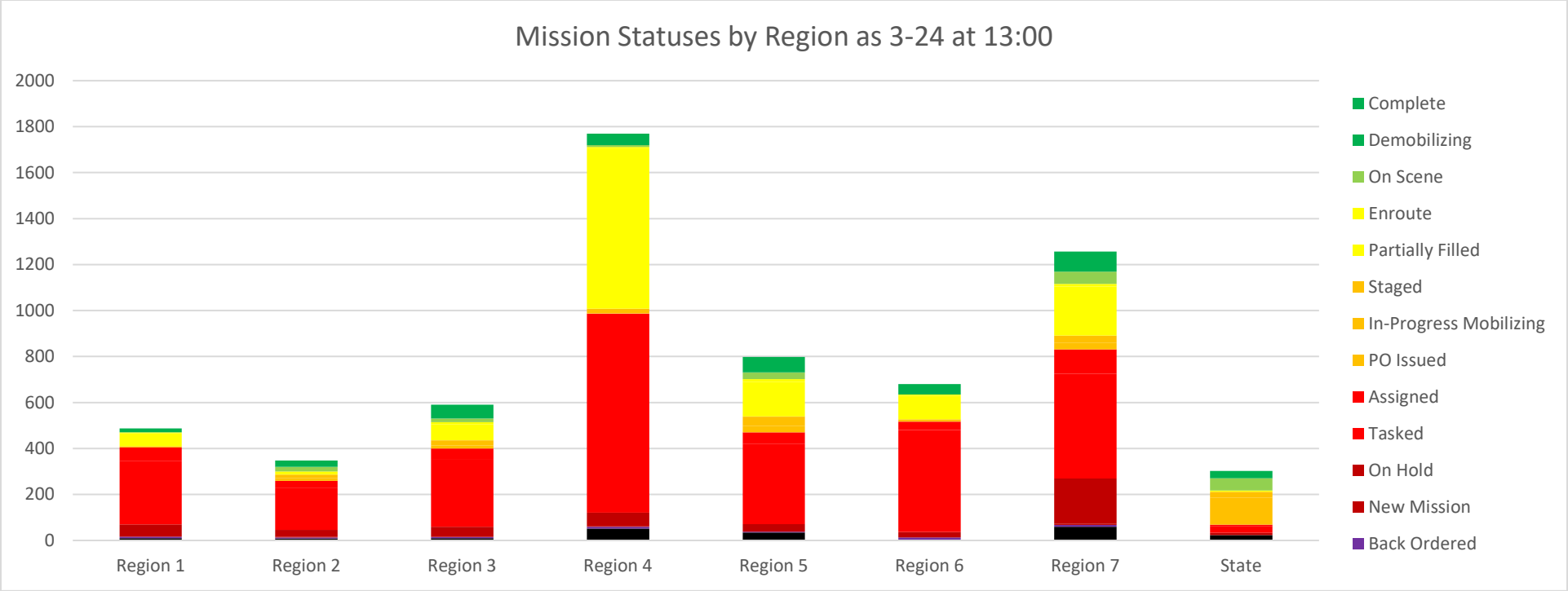


State Actions

- State EOC has been activated to a Level 1 with Emergency Services and Human Services emergency support functions at full staffing.
- All Executive Orders are being uploaded to Information Message 433.
- All FDEM Emergency Orders uploaded to Information Message 454.
- Governor of Florida has signed EO-68 with guidance on restaurants and bars. (Info Message 264).
- The SEOC is receiving and distributing resource mission orders.
- FDOH, ESF-16, and ESF-13 are coordinating screening at select Florida airports. Visitors from New York, New Jersey, and Connecticut must self-isolate for 14 days pursuant to EO 20-80.

Send any curfew notifications to eoc-plans@em.myflorida.com

AMERICAN OVERSIGHT



County	Cases	Fatalities	County	Cases	Fatalities	County	Cases	Fatalities	County	Cases	Fatalities
Alachua	37		**Franklin**	0		**Lee**	32	2	**Pinellas**	45	
Baker	4		**Gadsden**	0		**Leon**	8		**Polk**	13	
Bay	1		**Gilchrist**	0		**Levy**	0		**Putnam**	2	
Bradford	1		**Glades**	0		**Liberty**	0		**St. Johns**	22	1
Brevard	9		**Gulf**	0		**Madison**	0		**St. Lucie**	6	
Broward	311	3	**Hamilton**	0		**Manatee**	16	1	**Santa Rosa**	4	1
Calhoun	0		**Hardee**	0		**Marion**	4		**Sarasota**	26	
Charlotte	3		**Hendry**	0		**Martin**	4		**Seminole**	23	
Citrus	9		**Hernando**	5		**Miami-Dade**	338		**Sumter**	10	
Clay	10	2	**Highlands**	4		**Monroe**	3		**Suwannee**	0	
Collier	34		**Hillsborough**	91		**Nassau**	1		**Taylor**	0	
Columbia	3		**Holmes**	0		**Okaloosa**	14		**Union**	0	
DeSoto	1		**Indian River**	11		**Okeechobee**	0		**Volusia**	18	
Dixie	0		**Jackson**	1		**Orange**	50	2	**Wakulla**	0	
Duval	50	3	**Jefferson**	0		**Osceola**	26		**Walton**	10	
Escambia	10		**Lafayette**	0		**Palm Beach**	101	3	**Washington**	0	
Flagler	4		**Lake**	14		**Pasco**	15		**Out of State**	6	1

AMERICAN OVERSIGHT

From: Flakes, Krystal

To: arturo.lopez@coffo.org; birypa@cs.com; brodriguez@med.miami.edu; Britney.Moore@dep.state.fl.us; Charla@frpa.org; Mitchem, Emily; jgordon1@health.usf.edu; kpagan@ufl.edu; kwilliams@flimpact.org; lynn.b.brannon.ctr@mail.mil; Robert.Hill@heart.org; tami@fdha.org; Tonya.Ehrhardt@heart.org; adamsw@hhcs.com; Cambridge, Amber K; Odeh, Asma; Russell, Bryan M; Hanson, Elvira J; Zayas, Fatima A.; Davis, Janiece N; Johnson, Jennifer S; Weller, Karen; Jackson, Rhonda G; Collins, Sade X; Isaac, Sean; Harp, Shannon; Chapman, Shay; Bane, Summer; Lee, Valerie

Subject: Save-The-Date: PHHSBG Advisory Committee Meeting / Webinar

---

Greetings Preventive Health and Health Services Block Grant Advisory Committee Members,

Please Save-The-Date on your calendars for the next Advisory Committee Meeting to be held Friday, April 24, 2020 from 10:00 A.M – 11:30 A.M. Agenda forthcoming.

The purpose of this meeting is to:

- Discuss the FY 2019-2020 workplan (Public Health Dental Program, Violence and Injury Prevention Program and Chronic Disease Prevention).
- Share updates from the Centers for Disease Control and Prevention

The Florida Department of Health is required to keep record of external membership annually.

For external partners, if you have not done so, please complete the application for membership at this link:
https://apps.floridahealth.gov/bcquestionnaire/

Please do not hesitate to contact our office if you have any questions.

Please be advised, meeting date and time are subject to change based on Covid-19 response efforts. We will keep you updated should any changes occur.

Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/508577157

You can also dial in using your phone.
United States (Toll Free): 1 866 899 4679 <tel:+18668994679,,508577157>
United States: +1 (786) 535-3119 <tel:+17865353119,,508577157>

Access Code: 508-577-157

Join from a video-conferencing room or system.
Dial in or type: 67.217.95.2 or inroomlink.goto.com
Meeting ID: 508 577 157
Or dial directly: 508577157@67.217.95.2 <mailto:508577157@67.217.95.2> or 67.217.95.2##508577157

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https://global.gotomeeting.com/install/508577157

Krystal Flakes, MPH

Preventive Health and Health Services Block Grant Coordinator

Bureau of Chronic Disease Prevention

Florida Department of Health

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AMERICAN OVERSIGHT

Sadé Collins, MPH, CHES ®

Environmental Approaches Section Administrator

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AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc: ASPR Region 4 (HHS/ASPR/OEM); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov)
Subject: second shipment
Date: Sunday, March 22, 2020 9:24:31 AM

All

It appears in the second shipment that will be off loaded today this is what is in the trucks. See the second line "high intensity" for the shipment from last night

Florida

	Date Directed	Status	N95 Respirators	Surgical Masks	Face Shield	Surgical Gowns	Coveralls	Gloves	First Shipment Est. Delivery Date	Last Shipment Est. Delivery Date
Pro Rata			180,868	430,860	82,043	66,892	342	238,179		3/14/2020
High Intensity	3/20/2020		180,868	430,860	82,043	66,892	342	238,179		

Regards,
Jeanne

COVID-19 Response-HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

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cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Guthrie, Kevin; Davis, Ashley (FDEM); Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov
Cc: ASPR Region 4 (HHS/ASPR/OEM); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); Szczech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov)
Subject: second shipment
Date: Sunday, March 22, 2020 9:24:15 AM

All

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Regards,
Jeanne

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AMERICAN OVERSIGHT

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

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Subject:	Senior Administration Officials Briefing Call on COVID-19 // Regarding President Trump issuing proclamation under section 212(f) of the Immigration and Nationality Act (INA), restricting travel
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png

State and Local Leaders,

On Thursday, March 12, at 2:00 p.m. Eastern Time, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

* Date: Today, Thursday, March 12
* Time: 2:00 PM ET (please note time zone)
* Call-In Registration: CLICK HERE <https://ems9.intellor.com/?do=register&t=1&p=901287>
* Note: You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,

Zach

The White House Office of Intergovernmental Affairs

Zach Swint

Office of Intergovernmental Affairs

The White House

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President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

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“Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!” – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: “Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures.”

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

* President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.

* Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.

* The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
* Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
* There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

* The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.
* President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.

* These loans will help overcome disruptions caused by the coronavirus.
* The President is calling on Congress to increase funding for this program by an additional $50 billion.

* The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.

* This action will provide more than $200 billion of additional liquidity to the economy.

* President Trump is calling on Congress to immediately pass payroll tax relief.
* The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.

* The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

* The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
* The Trump Administration declared a public health emergency in January to bolster response efforts.
* President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.

* In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
* In February, the President restricted travel for individuals recently traveling from Iran.
* The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
* Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.

* Today, the President directed his Administration to make general-use face masks available to our healthcare workers.

* The Administration’s actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.

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* President Trump signed into law more than $8 billion to fund response efforts.
* The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
* Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.

* More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
* Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.

* The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.

* From the start, President Trump has made keeping the public informed a top priority.

* The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

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Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

WATCH HERE. <https://grabien.com/getmedia.php?id=856365&key=8a068e0e7ba2ceda6bd6ed7452ddb3de>

From very early on, President Trump took decisive action to put the health of the American people first.

"We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

"The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE <https://grabien.com/getmedia.php?id=856357&key=57d8648a9738379794d8d7cc05271db7> .

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no higher priority than the health, safety and well-being of the American people.

"The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country.

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You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS

WATCH HERE <https://grabien.com/getmedia.php?id=856379&key=cb1ba3743718e73a552d06d4ad66a617> AND HERE <https://grabien.com/getmedia.php?id=856383&key=9e8d30fd728e132040b652f01534deb4> .

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

"The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

"Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

WATCH HERE <https://grabien.com/getmedia.php?id=856387&key=11a16cd41a35ed71b5740a5915232784> AND HERE <https://grabien.com/getmedia.php?id=856391&key=8c259b68ce8df48e55ad39eaae2c0b4a> .

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

"We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

"Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

"But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

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ON CBS This Morning

WATCH HERE <https://grabien.com/getmedia.php?id=856403&key=076e051c5bee0accd97969ffc61e1e8a> .

We are going to continue to put in every effort in place to protect the health and safety of the American people.

“The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people.”

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

“Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand.”

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

“Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days.”

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(CDC/DDPHSIS/CPR/DSLR); Sakyi, Stephanie (CDC/DDPHSIS/CPR/DSLR); McHugh, Katherine (CDC/DDPHSIS/CPR/DSLR); Schultz, Lindsay (CDC/DDPHSIS/CPR/DSLR); Polk, Jennifer (CDC/DDPHSIS/CPR/DSLR); Bemisdarfer, Sara (CDC/DDPHSIS/CPR/DSLR); McCardle, Candice (CDC/DDPHSIS/CPR/DSLR); Kroessler, Elizabeth (CDC/DDPHSIS/CPR/DSLR); Cabato, Erika (CDC/DDPHSIS/CPR/DSLR); Trapp, Haley (CDC/DDPHSIS/CPR/DSLR); Kopania, Kathryn (CDC/DDPHSIS/CPR/DSLR); Daniels, Marissa (CDC/DDPHSIS/CPR/DSLR); Johnson, Jennifer (CDC/DDPHSIS/CPR/DSLR); Herreros, Celia (CDC/DDPHSIS/CPR/DSLR); Skewes, Andrea (CDC/DDPHSIS/CPR/DSLR); Ho, Lauren (CDC/DDPHSIS/CPR/DSLR); Stark, Kristina (CDC/DDPHSIS/CPR/DSLR); Gorgen, Lindsay (CDC/DDPHSIS/CPR/DSLR); Lira, Rosa (CDC azdhs.gov); stephanie.sakyi@arkansas.gov; kate.mchugh@cdph.ca.gov; jennifer.polk@dph.ga.gov; sara.bemisdarfer@dhw.idaho.gov; Candice.McCardle@state.mn.us; danielm@dhec.sc.gov; Jennifer.N.Johnson@tn.gov; lauren.ho@partner.vermont.gov; lindsay.gorgen@wa.gov; askewes@utah.gov; CDC IMS State Coordination Task Force (SCTF) Lead; CDC IMS State Coordination Task Force (SCTF) Science Advisor; CDC IMS State Coordination Task Force (SCTF) Chief of Staff; CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) EOC Desk; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM; CDC IMS State Coordination Task Force (SCTF) Policy & Comm; CDC IMS State Coordination Task Force (SCTF) Partner Share; CDC IMS State Coordination Task Force (SCTF) Eval & Analysis; CDC IMS State Coordination Task Force (SCTF) Prog Services Unit; CDC IMS State Coordination Task Force (SCTF) Field Services Unit; eocsctftfcoord2@cdc.gov; CDC IMS State Coordination Task Force (SCTF) MCCM LNO; CDC IMS State Coordination Task Force (SCTF) Lab LNO; CDC IMS State Coordination Task Force (SCTF) EPI LNO; CDC IMS State Coordination Task Force (SCTF) GMTF LNO; CDC IMS State Coordination Task Force (SCTF) Funding Programs LNO; mplescia@astho.org; barbara.blake@alaska.gov; donna.steward@alaska.gov; lynn.trujillo@state.nm.us; morgan.ferris@state.co.us; CommOffice@michigan.gov; dawn.vick@wisconsin.gov; tribalnations@mt.gov; Jim.Suennen@chhs.ca.gov; nahc@nahc.ca.gov; jill.avery@iowa.gov; linda.scott@iowa.gov; Kathy.Aplan@state.sd.us; scott.w.shafer@nebraska.gov; sjdavis@nd.gov; aiac@att.net; benjamin.hermerding@governor.virginia.gov; burne.stanley-peters@mass.gov; daphne.pinto@doa.nc.gov; eddietullis@yahoo.com; Feedback@sos.nj.gov; GOCI.info@Maryland.gov; soo.koo@maryland.gov; info@cfma.sc.gov; info@fgcia.org; info@georgiaindiancouncil.org; info@ocfs.ny.gov; john.peters@mass.gov; MelWilliams@icrc.in.gov; mitsced@roadrunner.com; nhcnativeamericanaffairs@gmail.com; pat.arnould@la.gov; Brian.Hendrix@sos.ok.gov; KNAA@ks.gov; gotrinfo@az.gov; ssilversmith@utah.gov; craig.bill@goia.wa.gov; inquiry@ihrc.idaho.gov; jguthrie@senate.idaho.gov; LCIS@oregonlegislature.gov; mystique.hurtado@goia.wa.gov; tamara.fulwyler@doh.wa.gov; afninfo@NativeFederation.org; Vboerner@anhb.org; anthcwebsite@anthc.org; apiai@apiai.org; Cindy@ancsaceos.org; info@beringstraits.com; rclark@bbahc.org; Chitina_village@outlook.com; scott.davis@chugachgov.com; info@CITCI.org; info@crnative.org; charleen.fisher@catg.org; communications@doyon.com; kejaw@eatribes.net; info@fairbanksnative.org; tvanderhoop@kictribe.org; info@kodiakhealthcare.org; info@mstc.org; news@nana.com; nve@eklutna-nsn.gov; Kerin@eyak-nsn.gov; ntc@ninilchiktribe-nsn.gov; cpiscoya@nshcorp.org; corpcomm@sealaska.com; KGottlieb@SouthcentralFoundation.com; TACdirectors@aleutcorp.com; info@ykhc.org; nmalonzo@aaihb.org; russel.pederson@ihs.gov; Debra.Grabowski@ihs.gov; info@aihschgo.org; ATuomi@aihfs.org; LaPlaunt, Tyler (CDC glitc.org); info@ihb-mpls.org; kellumm@juelfairbanks.org; m.a.s.t@frontiernet.net; vsandoval@helenaindianalliance.com; Snell, Bill (CDC rmtlc.org); admin@aihscorp.org; dadtatum@aol.com; info@friendshiphousesf.org; awscott@ihcscv.org; intertribal.ca@itccinc.org; rvaladez@nativedirections.org; info@snahc.org; info@sdaihc.com; info@tasin.org; info@uaii.org; mark.lebeau@crihb.net; jerilyn.church@gptchb.org; ColonialEraTribes@gmail.com; info@nativelifelines.org; sking@newyorkindiancouncil.org; kcarroll@usetinc.org; jill.jim@nndoh.org; information@kcindiancenter.org; angie.c@okcic.com; nwahpepah@spthb.org; info@itcaonline.com; info@itcn.org; outreach@nacainc.org; jreeves@nvui.org; Maria.dadgar@itcaonline.com; info@naranorthwest.org; NPInfo@nativeproject.org; info@sihb.org; atni@atnitribes.org; jfinkbonner@npaihb.org; Bernal, Jacob (CDC ticenter.org); Provost, Ellen (CDC anthc.org); English, Kevin (CDC aaihb.org); Cresci, Vanesscia (CDC crihb.org); Gonzalez, German (CDC glitc.org); Beaudry, PJ (CDC gptchb.org); Ritchey, Jamie (CDC itcaonline.com); ramona.nez@nndoh.org; Warren-Mears, Victoria (CDC npaihb.org); Prather, Tracy (CDC spthb.org); Andreini,

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Subject:	Senior Administration Officials Briefing Call on COVID-19 // Regarding President Trump issuing proclamation under section 212(f) of the Immigration and Nationality Act (INA), restricting travel
Attachments:	image001.png image002.png image003.png image004.png image005.png image006.png

State and Local Leaders,

On Thursday, March 12, at 2:00 p.m. Eastern Time, please join Senior Administration Officials for a briefing call on COVID-19 (coronavirus) regarding President Trump issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries. Additional details can be found below. We will also provide an update on implementing mitigation strategies for communities with local COVID-transmission (A Framework for Mitigation: Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf>).

Briefing Call Registration on 212(f) & Community Mitigation Strategies

* Date: Today, Thursday, March 12
* Time: 2:00 PM ET (please note time zone)
* Call-In Registration: CLICK HERE <https://ems9.intellor.com/?do=register&t=1&p=901287>
* Note: You must RSVP to join the call. Upon successful registration, you will receive dial-in details to the email address you use to register. Note that multiple people cannot dial-in using the same registration information.

Below, please find additional information. The White House Office of Intergovernmental Affairs (WH IGA) will continue to share pertinent information as it becomes available. Please do not hesitate to reach out to our office directly if we can be of assistance.

Sincerely,

Zach

The White House Office of Intergovernmental Affairs

Zach Swint

Office of Intergovernmental Affairs

The White House

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President Donald J. Trump Has Taken Unprecedented Steps to Respond to The Coronavirus and Protect the Health and Safety Of Americans

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“Together we are putting into policy a plan to prevent, detect, treat and create a vaccine against coronavirus to save lives in America and the world. America will get it done!” – President Donald J. Trump

President Donald J. Trump signed a Presidential Proclamation, which suspends the entry of most foreign nationals who have been in certain European countries at any point during the 14 days prior to their scheduled arrival to the United States. These countries, known as the Schengen Area, include: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. This does not apply to legal permanent residents, (generally) immediate family members of U.S. citizens, and other individuals who are identified in the proclamation.

Statement from DHS Acting Secretary Chad F. Wolf: “Protecting the American people from threats to their safety is the most important job of the President of the United States. The actions President Trump is taking to deny entry to foreign nationals who have been in affected areas will keep Americans safe and save American lives. I applaud the president for making this tough but necessary decision. While these new travel restrictions will be disruptive to some travelers, this decisive action is needed to protect the American public from further exposure to the potentially deadly coronavirus. In January and February, the Administration issued similar travel restrictions on individuals who had been in China and Iran. That action proved to be effective in slowing the spread of the virus to the U.S., while public health officials prepared. In the next 48 hours, in the interest of public health, I intend to issue a supplemental Notice of Arrivals Restriction requiring U.S. passengers that have been in the Schengen Area to travel through select airports where the U.S. Government has implemented enhanced screening procedures.”

RESTRICTING TRAVEL FROM IMPACTED AREAS: President Donald J. Trump is taking further action to curb the spread of the coronavirus to the United States from other countries.

* President Trump is issuing a proclamation under section 212(f) of the Immigration and Nationality Act (INA) to restrict travel to the United States from foreign nationals who have recently been in certain European countries.

* Section 212(f) of the INA only applies to the movement of human beings, not goods or cargo.

* The restriction applies to foreign nationals who have been in the Schengen Area, 26 countries in Europe with open borders agreements, in the last 14 days.
* Those who are exempt from these restrictions, such as American citizens, will be directed to a limited number of airports where screening can take place.
* There is extensive travel back and forth between Europe that heightens the risk here in the United States.

LOOKING OUT FOR AMERICAN BUSINESSES AND WORKERS: President Donald J. Trump is committed to protecting American businesses and workers from the impacts of coronavirus.

* The President is announcing an economic assistance package to help support businesses and workers who have been harmed by this outbreak.
* President Trump has instructed the Small Business Administration (SBA) to exercise available authority to provide loans to businesses affected by the coronavirus.

* These loans will help overcome disruptions caused by the coronavirus.
* The President is calling on Congress to increase funding for this program by an additional $50 billion.

* The President will be instructing the Department of the Treasury to defer tax payments for certain individuals and businesses negatively impacted by the coronavirus.

* This action will provide more than $200 billion of additional liquidity to the economy.

* President Trump is calling on Congress to immediately pass payroll tax relief.
* The President announced that he will soon be taking emergency action to provide financial relief for workers who are ill, quarantined, or caring for others due to the coronavirus.

* The President also called on Congress to take action to extend this relief for workers.

LEADING AN AGGRESSIVE, WHOLE-OF-GOVERNMENT APPROACH: President Trump has taken unprecedented steps to protect the health of Americans in response to the coronavirus.

* The President is leveraging all of our resources to respond to the coronavirus, bringing together government and private industry in a collaborative response.
* The Trump Administration declared a public health emergency in January to bolster response efforts.
* President Trump took early action to help curb the spread of the virus from other countries to the United States, providing important time for response and preparations.

* In January, President Trump acted quickly to restrict travel from foreign nationals traveling from China.
* In February, the President restricted travel for individuals recently traveling from Iran.
* The Administration put into place mandatory screening for all travelers coming into the country from Italy and South Korea.
* Travel advisories for severely impacted areas like Italy and South Korea have been raised to their highest level.

* Today, the President directed his Administration to make general-use face masks available to our healthcare workers.

* The Administration’s actions will help make millions of general-use respirators available to keep healthcare workers safe and mitigate transmission of the virus.

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* President Trump signed into law more than $8 billion to fund response efforts.
* The Administration has taken bold steps to incentivize the development of therapeutics and vaccines to treat and prevent the spread of the coronavirus.
* Working across the public and private sectors, the Trump Administration continues to drastically expand testing capacity.

* More than 1 million tests have been distributed nationwide, with another 4 million tests being shipped out by the end of the week.
* Testing is now available in every State lab in the country and commercial labs are now deploying tests, which will help generate a dramatic increase in availability.

* The Trump Administration has released guidance on how to keep businesses, schools, community gathering places, and families safe.

* From the start, President Trump has made keeping the public informed a top priority.

* The Administration has announced that health plans with health savings accounts will be able to cover coronavirus testing and treatment without co-payments.

ICYMI | Vice President Pence Discusses the Coronavirus Response on the Morning Shows

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Earlier this morning, Vice President Pence joined Good Morning America, The Today Show, Fox & Friends, New Day, and CBS This Morning to discuss the steps that this administration is taking to combat the coronavirus.

ON ABC's GOOD MORNING AMERICA

WATCH HERE. <https://grabien.com/getmedia.php?id=856365&key=8a068e0e7ba2ceda6bd6ed7452ddb3de>

From very early on, President Trump took decisive action to put the health of the American people first.

"We all have known from the beginning that the coronavirus would continue to spread across this country, and it's one of the reasons why, from very early on, President Trump took decisive action to put the health of the American people first, not only declaring a public health emergency in January, but in that same month he suspended all travel from China -- an unprecedented move -- and quarantined Americans that were returning from the region. Since that time, George, we've -- we've issued travel advisories for areas of South Korea, Italy; screened all persons coming on direct flights. But, frankly, as we watched the epicenter of the coronavirus shift from China and South Korea to Europe, the President thought it was proper for us to impose a 30-day suspension on all travel from continental Europe."

The President, again, made another unprecedented decision in suspending all travel from Europe, because we want to stop the flow of people bringing the coronavirus here.

"The reality is that, really, just two weeks ago, in Italy, there were less than 500 cases and now there's 12,000 cases in Italy, George. We have tens of thousands of people that travel to the United States from Europe every day. Seventy percent of new cases in the world were in Europe. And when we looked yesterday at the -- what was then the 35 states where we had cases, about 30 of them could be traced to contacts with Europe. And so the President, again, made another unprecedented decision in suspending all travel from Europe, because we essentially want -- we essentially want to stop the flow of people bringing the coronavirus here, but then continuing to surge resources, particularly into California, Washington State, New York, and other communities where we've seen community spread. It's a combination of efforts that's being driven by the top health experts in the world on our task force. But the President -- the President showed again yesterday a willingness to take decisive action on multiple levels to protect the American people."

We want to send a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus, you should not be worried about the cost of testing or treatment.

"We're making steady progress. We're going to continue to make a very clear message to Americans that if for any reason you believe you've been exposed to the coronavirus or you have symptoms, we don't want people to be worried about the cost of testing, to be worried about the cost of treatment… As the President made clear last night, we're working with Congress and exploring actions the President can take to make sure that hourly wage earners know that you can stay home without risking losing a paycheck or losing your job if you feel if you feel that you've been exposed to the coronavirus."

ON NBC's TODAY SHOW

WATCH HERE <https://grabien.com/getmedia.php?id=856357&key=57d8648a9738379794d8d7cc05271db7> .

From early on in this effort, we have addressed the testing issue. We made changes through the FDA that allowed for state labs and hospitals to engage in testing.

"From early on in this effort we've been addressing the testing issue. We made changes through the FDA that allowed for state labs and university hospitals and hospitals to engage in testing. And I'm pleased to report every state lab in America can do testing now. Many university laboratories are doing it. Washington State – the University of Washington is doing extraordinary work. but we are literally working hour by hour to expand the testing and we think the key Savannah is going to be what we call commercial laboratories like LabCorp and Quest who are already spinning up production at the president's direction last week on tests that can be available on a broad basis in the days ahead for the American people. we're making real progress but rest assured we're going to continue to drive forward."

The American people should know that President Trump has no higher priority than the health, safety and well-being of the American people.

"The American people should know that President Trump has no higher priority than the health and safety and wellbeing of the people in this country.

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You can go to coronavirus.gov right now to find out what every American can do to keep yourself, your family, your workplace and your school safe. But you can rest assured we're going to focus on communities where we've had community spread, and the President's action yesterday suspending travel from Europe is one more example of how he's putting the health of America first."

ON FOX NEWS' FOX & FRIENDS

WATCH HERE <https://grabien.com/getmedia.php?id=856379&key=cb1ba3743718e73a552d06d4ad66a617> AND HERE <https://grabien.com/getmedia.php?id=856383&key=9e8d30fd728e132040b652f01534deb4> .

The President has called this a whole-of-government approach, but he has also called this is a whole-of-America approach.

"The President, you know, he said this was a whole-of-government approach but he also said this is a whole-of-America approach. So he's brought in business leaders from nursing homes; yesterday, banking; hospitals, and the rest. But one of the things we did that's most important on testing was the President brought in the leaders of the top commercial laboratories in the country who, as we speak, have already approved a test that is being spun up. It's being sent out to market. Quest, LabCorp, the largest commercial laboratories in the country, are working very closely with our administration. We're clearing the red tape out of the way. That's going to be the way that, in the days ahead, we're going to -- we're going to have broad-based testing available all across the country."

We are working together to contain the spread of the coronavirus. And we will get through this.

"Our goal, as the coronavirus spreads in this country -- and the vast majority who would contract it will have flu-like symptoms and recover. Our goal nonetheless is to hold down that overall number as much as possible. And we will do that with the continuing cooperation of American families, schools, businesses, and states. And that's the vision President Trump has. All of us working together will get through this."

We are focusing on supporting efforts at the state and local level in Washington State, and in California. CDC issued strong guidelines for those communities about public activities, large gatherings and at schools. We will continue simply to follow the data on this.

"Make no mistake about it: We are also focusing on supporting efforts at the state and local level in California, in Washington State, and in California. CDC issued very strong guidelines for those communities about public activities, large gatherings, schools. And we'll continue simply to follow the data on this and make strong recommendations where we have what's known as "community spread. But for every American, right now, as the President said last night, it's a good time to use common sense. Wash your hands often. Clean, you know, often-used surfaces. All that information is available at Coronavirus.gov. So we're going to try and mitigate the spread in this country but also prevent, through the President's decisive action last night, people from bringing the coronavirus into the United States any further from Europe."

We are encouraging best practices for every American. We are focusing on communities where we have community spread.

"I want to say to your viewers, just as the President said last night, the risk to the average American of contracting the coronavirus remains low, but we do know that seniors with serious underlying chronic health conditions are particularly vulnerable to very serious outcomes. And so we're encouraging best practices for every American. We're focusing on communities where we have community spread."

Those with a family member who is a senior citizen should support them in engaging in good hygiene and good health practices.

"For any American that's watching today that has a family member or a loved one who's a senior citizen with a serious underlying health condition, this is a very good time to help and to support them to be able to avoid public places, and everyone around them to engage in good hygiene and good practices to protect those that are most vulnerable."

ON CNN's NEW DAY

WATCH HERE <https://grabien.com/getmedia.php?id=856387&key=11a16cd41a35ed71b5740a5915232784> AND HERE <https://grabien.com/getmedia.php?id=856391&key=8c259b68ce8df48e55ad39eaae2c0b4a> .

We have been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear.

"We're not doing a travel ban as our strategy. The suspending all travel for 30 days from Europe is a part of the strategy. The other part is an aggressive mitigation strategy. I spoke to the governors of New York, Washington State, and California tomorrow -- or yesterday. CDC issued strong guidance to those areas where we have community spread. We've flowed resources. We've flowed support to those areas. And so it's a combination of strategies that the President has employed here. As he says, it's "all hands on deck," "a whole-of-government approach," but it's also a whole-of-America approach. We've literally been meeting with industry leaders in one relevant industry after another to ensure that the full resources of America are being brought to bear."

Any American who is concerned about being exposed to the coronavirus, should call their doctor and get tested.

"Anyone who's looking on today who might be concerned that they were exposed to coronavirus or have symptoms should call their doctor. Their doctor, with any question, can call their state laboratory and be able to find out how they can have a test processed."

We are making steady progress. We don't want anybody to avoid having a test because they are concerned financially.

"But make no mistake about it: We're making steady progress. We've made changes at the FDA in January, at the President's direction. And the American people can be confident we're going to continue to roll out the test. And maybe most significant on that score is that the President brought health insurance companies in last week and they all agreed to waive the co-pays on testing. We expanded testing to Medicare and Medicaid patients. And we also expanded coverage for treatment, and health insurance companies expanded coverage for treatment. We don't want anybody to avoid having a test because they're concerned financially."

The risk to the average American remains low.

"I want people to know that the risk to contracting the coronavirus, according to all of our experts, for the average American remains low. Most people that contract it, will have flu-like symptoms and recover."

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ON CBS This Morning

WATCH HERE <https://grabien.com/getmedia.php?id=856403&key=076e051c5bee0accd97969ffc61e1e8a> .

We are going to continue to put in every effort in place to protect the health and safety of the American people.

“The President took the unprecedented step of suspending all travel from China which was the originating country of this virus. We also established travel advisories, and we've been screening passengers on all direct flights from South Korea and Italy. But with the epicenter of this epidemic now moving from China and South Korea to Europe, yesterday the President again took the unprecedented step of suspending all travel from Europe for the next 30 days, and that in combination with our strong mitigation efforts in communities that are experiencing what our experts call community spread, areas of California, Washington State, and New York, we're going to continue to put every effort at home and with regard to these travel restrictions in place to protect the health and safety of the American people.”

In the days ahead, we are going to continue to see the availability of tests at your local doctor and your local pharmacy expand.

“Testing is happening in every state lab in the country. Many university hospitals have taken the FDA test, like the University of Washington, is doing a great job expanding testing capabilities. But the biggest piece on the testing is that our commercial labs that the President brought in last week, companies like Quest and LabCorp, have already had approved a new test that they several days ago had begun to take to market which they can do in a vast and expansive way across the country. And literally in the days ahead, we're going to continue to see the availability of tests at your local doctor, ultimately at your local pharmacy, continue to expand.”

When President Trump learned that 70% of the new cases this week, around the world, were in Europe, he took decisive action to protect the American people.

“Make no mistake about it: All the new cases in the world, this week, 70% of the new cases were in Europe. And the increase has been dramatic. When the President imposed the travel advisory and we began screening all flights, all passengers coming into the United States from Italy two weeks ago, there were roughly 500 coronavirus cases. Now there's 12,000, about 1,000 in Germany, about 1,000 in France. That's the reason why the President essentially said full stop, we're going to suspend all travel, and that American citizens coming home and legal residents will be funneled through 13 different airports. They'll get an initial health screening coming in. But we're going to ask everyone returning to our country to self-quarantine for 14 days.”

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From: Castaneda, Maribel

To: agentes@clarke.com; alopez@clarke.com; sschneider@clarke.com; jamesclauson@comcast.net; leeduke1@live.com; cindymulla@comcast.net; michael.riles@comcast.net; summerseddie@comcast.net; Joe.Faella@brevardcounty.us; Inman, Barry; lacy.kittles@brevardfl.gov; Beth.Carey-Kovach@charlottecountyfl.gov; Rebecca.owers@charlottecountyfl.gov; Turner, Edna L; Scott.Schermerhorn@charlottecountyfl.gov; Bagley, Rebecca L; gdeskins@citrusmosquito.org; Dunn, Freta K; bkellner@citrusmosquito.org; Poirier, Thomas P; Rashley, Merton J; BenjaminA@coj.net; Rwishard@coj.net; lrosie1965@gmail.com; matthew_mello@co.escambia.fl.us; bill@flaglermosquito.com; markefmcd@outlook.com; fmbmctd@gmail.com; mcothran@gulfcounty-fl.gov; Legg, Keith O; Prowant, Brian K; sfisher@co.hernando.fl.us; JWhitehurst@co.hernando.fl.us; BurnsL@HillsboroughCounty.org; McFaulN@hillsboroughcounty.org; MontgomeryR@hillsboroughcounty.org; shafers@HillsboroughCounty.org; s.artman@irmosquito2.org; s.burroughs@irmosquito2.org; d.pelley@irmosquito2.org; h.whitehead@irmosquito2.org; m.kartzinel@irmosquito2.org; sterling@lcmcd.org; Lloyd@lcmcd.org; Roth, Jennifer; kbaker@lcmcd.org; Armstrong, Angela N; colvinh@leoncountyfl.gov; forda@leoncountyfl.gov; PourciauG@leoncountyfl.gov; CDBaum@manateemosquito.com; Barbara.Bayer@manateemosquito.com; max.dersch@manateemosquito.com; gduesterbeck@martin.fl.us; amcgowan@martin.fl.us; Reinhold, Todd A; snoe@martin.fl.us; Kylie Zirbel; Cason, Emily; connerla@msn.com; Geib, Kim N; Godwin, Michael D; Beedie, Katherine A; eevers@co.okaloosa.fl.us; carin.harrison@us.af.mil; srhenson@myokaloosa.com; Steve.Harrison@ocfl.net; susan.durand@ocfl.net; Jeremy.Brown@ocfl.net; Rafael.Melendez@ocfl.net; dpenson@rcid.org; kpeters@rcid.org; asolis@rcid.org; Rick.Baird@osceola.org; Fricano, Pat; ajanus@pascomosquito.org; Arogers@pascomosquito.org; Dennis Moore; Bohinc, Becky; GEdson@co.pinellas.fl.us; blawton@pinellascounty.org; dnovich@pinellascounty.org; LSmith@pinellascounty.org; Lamb, JoAnne; jstuck@co.pinellas.fl.us; Carlboohene@polk-county.net; hugoortiz@polk-county.net; wynonah.little@putnam-fl.com; sanitation@putnam-fl.com; aprilm@santarosa.fl.gov; nosborn@scgov.net; geby@seminolecountyfl.gov; tjones03@seminolecountyfl.gov; snieves@seminolecountyfl.gov; lreaves@seminolecountyfl.gov; quallsamcd@bellsouth.net; gainesamcd@bellsouth.net; mfarooqamcd@gmail.com; ssmoleroffamcd@gmail.com; xueamcd@gmail.com; jacksons@stlucieco.org; JacobsenR@stlucieco.org; Harts@stlucieco.org; hendersong@stlucieco.org; Koerner, David J; Kossler, Kimberly; minceyt@stlucieco.org; Jared.Stokes@sumtercountyfl.gov; SBartlett@volusia.org; jdillon@volusia.org; DFalcon@volusia.org; mlauth@volusia.org; lraymaley@volusia.org; rlucas@volusia.org; tmachardy@volusia.org; CEfstathion@volusia.org; TVasconcellosByrd@volusia.org; Mosquito Control-North; nwmosquito4@gmail.com; lab@swcmcd.org; director@swcmcd.org; reception@swcmcd.org; mcteche@swcmcd.org; operations@swcmcd.org; mctechb@swcmcd.org; supervisor@swcmcd.org; supervisor@swcmcd.org; Morrison, Andrea; Blackmore, Carina; Bryant, Glenn W; Cannons, Andrew C; Choe, Ulyee; Dennis, Anthony D; Dunn, Freta K; Godwin, Michael D; Gregos, Eliot M.; Guidash, Gayle; Heberlein-Larson, Lea A.; Hensley, Deborah S; Koerner, David J; Legg, Keith O; Matthias, James M; Miller, Brian L.; Mock, Valerie; Lewandowski, Patty A; Morris, Cindy K.; Myers, Paul D; Pierce, Bruce; Prowant, Brian K; Rashley, Merton J; Reinhold, Todd A; Roth, Jennifer; Rowlinson, Marie-Claire; Scuteri, Ana C; Seaton, Lylah J; Smith, Bret A; Stanek, Danielle R; Steele, Crystal C; Turner, Scott M; Ulery, Sheryl P; Walsh, Donna; Williams, Diana J; Young, Zelda J; Zipperer, Angela; Marah.Clark@freshfromflorida.com; dwayne.carbonneau@fwc.state.fl.us; seth.britch@ars.usda.gov; JFDay@mail.ifas.ufl.edu; jrey@ufl.edu; crr@mail.ifas.ufl.edu; docmx8@gmail.com; dbowers@unf.edu; hhassan@health.usf.edu; tunnasch@health.usf.edu; pvanderkelen@gmail.com; lstarkm@aol.com; taytaylor518@gmail.com; ciadams@fsu.edu; Ashley.pierre-saint@freshfromflorida.com; Frieda.Lamberg@FreshFromFlorida.com; stacey.k.booker.mil@mail.mil; Rachel.Beck@adph.state.al.us; Joshua.Coleman@adph.state.al.us; PEfird@mchd.org; dlee@mchd.org; antrimm@chathamcounty.org; lfpeaty@chathamcounty.org; keith@mosquitocs.com; Jayna@mosquitocs.net; william.schommer@rentokil.com; cwaldron@la.gov

Cc: Heberlein-Larson, Lea A.; Cannons, Andrew C; Lewandowski, Patty A; LaCrue, Alexis N; Kopp, Edgar W; Castaneda, Maribel

Subject: Sentinel Chicken Program Important Update

Date: Thursday, March 12, 2020 12:05:45 PM

Good Morning Sentinel Chicken Program Participants,

Our laboratory and epidemiology leadership have decided to suspend Sentinel Chicken Testing effective immediately. At this time, all personnel are need to help perform COVID-19 testing. For the next seven weeks or until further notice, we will not be performing HAI, ELISA, PRNT, and mosquito pool testing. Specimens received today or tomorrow will not be processed. Please send me an e-mail so that I know what you would like us to do with those specimens. We will notify you when we are able to resume testing.

Reports:

1. This Friday, March 13, 2020 the regular HAI report will be e-mailed.
2. Tuesday, March 17, 2020 the IgM ELISA report will be e-mailed.
3. Wednesday, March 18, 2020 the PRNT report (for February specimens) will be e-mailed.

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Please understand that we are doing what is best to promote, protect, and improve the health of all people in the state. Please contact me, if you have any questions or concerns.

Thank you,

Maribel

Maribel Castaneda
Lead Scientist
Sentinel Chicken Program Coordinator
Bureau of Public Health Laboratories – Tampa
Division of Disease Control and Health Protection
Florida Department of Health
3602 Spectrum Blvd.
Tampa, FL 33612
Phone: 813-233-2342

Division of Disease Control and Health Protection
Florida Department of Health

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From:	EOC-Plans
To:	Rosenstein, Jared; Andrew.Love@flhealth.gov; Mooney, Dayle; Kimbrel, Nicole H; Madeleine Nobles; McKinstry, Molly; Hagan, Karen (ARC-TLH); Melanie Motiska; Bob Asztalos; Emmett Reed; Nick Van Der Linden; Steve Bahmer; Gail Matillo; COVID-19@flhealth.gov; Rivkees, Scott A; Blackmore, Carina; Roberson, Shamarial; Coppola, Courtney; Mary.Mayhew@ahca.myflorida.com; Prudom, Richard
Cc:	Perry, Kaylynn; lgriffin@floridaseniorliving.org; Tiffani Hart; Delgado, Austin; Sokoloski, Kristin; Catherine McGrath; Dori Landsberg; Jeanne Curtin; Derinda Kirkland; Anne Chansler; Godfrey, Diane; Givens, Michelle; ungrug@elderaffairs.org; Alberta Granger; Ginnifer Barber; McClendon, Alexander; MacLafferty, Laura; Kimberly Stewart (Agency for Health Care Administration); Register, Joshua (Elder Affairs); Carr,Carol (Elder Affairs); Dobbs, David; Michael Phillips; Carhart, Ty; Yow, Annmarie; Peggy Brown; Eck, Caitlyn; Zach Annett; Tracey Vause; Anderson, Eric; Jeanne Eckes; Wilgis, John (FL Hospital Assoc); Kelley, Debbie A; Denise Imbler; Keys, Kelly R; hunter.zager@tampabayhmpc.org; Moscoso, Alberto; LGTeam@eog.myflorida.com; Tommy Cleversy; Clarence Lewis; Melanie Etters; Lynne Daw; Jeannette Estes; Leslie Richards; Erin Romeiser; Barbara Palmer; Kevin Bailey; Francis Carbone; Amanda Smith; Robin Keller; Wagner, Maureen; Leigh Wilsey; Otis, Aaron; Marilia Van Keeken; Jaime Caldwell; Lorena Fulcher; Stacie Cleveland; Nicole Miller; Kristin Korinko; CFDMC; Matt Meyers; Salinas, Rose; Lisa Robertson; Hillary Jackson; Linda Donar; Marguerite Morgan; Michael Mayfield; Rebecca Roberts; Barbara Matthews; Martha Mason; Kim Barnes; Heather Battista; Lynelle Smith; Sharon Taber; Rita Castor; Jeff Ivey; Musgrave, Lisa; Thomas Holcomb; Nathan Koch; Harris, Shevaun; Henley, Victoria; Kirk Hall; Rivas, Erin; McCleary, Denise; Janice Phillips (jphillips@hmsfl.com); Smith, Cary (ACC); Jenny Rojas; Smith, Brandi; annmarie.winter@aaapp.org; Kristen Griffis; Lisa Bretz; karla.radka@sraflorida.org; Linda Levin; Barbara Suarez; Lt.John.Longacre@districtgov.org; mathertaylorc@adrcbroward.org; Josh Jensen; Marsha Lorenz; Elizabeth Lombardo; Nancy Tufts; Kim Streit; Cheryl Love
Subject:	SEOC Aging and Vulnerable Populations Call

UPDATE: This Call is now only on Tuesday and Thursday. Please distribute to your applicable partners.

Aging and Vulnerable Populations Call

Tuesday and Thursday

4:15 PM to 4:45 PM

Call-In Information

Call-In Number: 888-585-9008

Conference Room ID: 208-305-233

Join the State Emergency Operations Center for a call concerning updates on the State's response to COVID-19.

Standing Agenda

* Situation Updates from the Florida Department of Health
* Briefing from the Agency for Healthcare Administration
* Updates from other State Agencies
* Questions from Partners

Under Florida law, correspondence with the Florida Division of Emergency Management, which is neither confidential nor exempt pursuant to Florida Statutes Chapter 119, is a public record made available upon request.

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To:	Rosenstein, Jared; Andrew.Love@flhealth.gov; Mooney, Dayle; Kimbrel, Nicole H; Madeleine Nobles; McKinstry, Molly; Hagan, Karen (ARC-TLH); Melanie Motiska; Bob Asztalos; Emmett Reed; Nick Van Der Linden; Steve Bahmer; Gail Matillo; COVID-19@flhealth.gov; Rivkees, Scott A; Blackmore, Carina; Roberson, Shamarial; Coppola, Courtney; Mary.Mayhew@ahca.myflorida.com
Cc:	Perry, Kaylynn; lgriffin@floridaseniorliving.org; Tiffani Hart; Delgado, Austin; Sokoloski, Kristin; Catherine McGrath; Dori Landsberg; Jeanne Curtin; Derinda Kirkland; Anne Chansler; Godfrey, Diane; Givens, Michelle; ungrug@elderaffairs.org; Alberta Granger; Ginnifer Barber; McClendon, Alexander; MacLafferty, Laura; Kimberly Stewart (Agency for Health Care Administration); Register, Joshua (Elder Affairs); Carr,Carol (Elder Affairs); Dobbs, David; Michael Phillips; Carhart, Ty; Yow, Annmarie; Peggy Brown; Eck, Caitlyn; Zach Annett; Tracey Vause; Anderson, Eric; Jeanne Eckes; Wilgis, John (FL Hospital Assoc); Kelley, Debbie A; Denise Imbler; Keys, Kelly R; hunter.zager@tampabayhmpc.org; Moscoso, Alberto; LGTeam@eog.myflorida.com; Tommy Cleversy; Clarence Lewis; Melanie Etters; Lynne Daw; Jeannette Estes; Leslie Richards; Erin Romeiser; Barbara Palmer; Kevin Bailey; Francis Carbone; Amanda Smith
Subject:	SEOC Aging and Vulnerable Populations Call

UPDATE: This call is now daily at 4:15 PM. Call-In Information has changed.

Aging and Vulnerable Populations Call

Daily

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To:	Rosenstein, Jared; Andrew.Love@flhealth.gov; Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; Stalcup, Jeanetta; TKnox@fachc.org; abehrman@fachc.org; winnsr@earthlink.net; michelle@foma.org; andrew@foma.org; govaffairs@foma.org; mcarter@flmedical.org; MThomas@flmedical.org; CPrine@flmedical.org; COVID-19@flhealth.gov; StateESF8.Planning@flhealth.gov; Molly.McKinstry@ahca.myflorida.com; AHCAEOC@ahca.myflorida.com; Mary.Mayhew@ahca.myflorida.com
Cc:	Faustin, Marilyne; Kriebel, Devon; Kerry.waldron@flhealth.gov; Morgan, Cindy D; Aliene Harris; Buhrow, Rena; St Laurent, Louise R; Wenhold, Jennifer; Yow, Annmarie; Peggy Brown; Eck, Caitlyn; Zach Annett; Anderson, Eric; Tracey Vause; Denise Imbler; Jeanne Eckes; Carhart, Ty; Marilia Van Keeken; Jaime Caldwell; Wilgis, John (FL Hospital Assoc); Matt Meyers; Hale, Rebecca; AnnMarie.Kleczkowski@ocfl.net; Klein, Jason L.; Perez, Ellis E; Lauren Possinger; Litton, Bill (Osceola Co EM); Manuel Soto; Kelley, Debbie A; hunter.zager@tampabayhmpc.org; Maldonado, Carmelo; Johns, Paul M.; Judge II, James (Volusia Co EM); Doyle, Philip; Royer, Melissa; John Maze; Crowe, David R
Subject:	SEOC Healthcare Provider Call

UPDATE: The Call time and number has been updated. Please see updates below.

SEOC Healthcare Provider Call

Hosted by the Florida Department of Health

Every Tuesday

6:30 PM to 7:30 PM

Call-In Information

Call-In Number: 888-585-9008

Conference Room ID: 208-305-233

Join the State Emergency Operations Center for a call concerning updates on the State's response to COVID-19.

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AMERICAN OVERSIGHT

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To:	Rosenstein, Jared; Love, Andrew; Rivkees, Scott A; Blackmore, Carina; Mooney, Dayle; Roberson, Shamarial; Coppola, Courtney; Pasley, Cassandra; Stalcup, Jeanetta; Knox, Thomas; Behrman, Andrew; steve winn; michelle@foma.org; andrew@foma.org; govaffairs@foma.org; mcarter@flmedical.org; MThomas@flmedical.org; CPrine@flmedical.org; COVID-19; StateESF8.Planning; Molly.McKinstry@ahca.myflorida.com; AHCAEOC@ahca.myflorida.com; Mary.Mayhew@ahca.myflorida.com
Cc:	Faustin, Marilyne; Kriebel, Devon; Waldron, Kerry S; Morgan, Cindy D; Aliene Harris; Buhrow, Rena; St Laurent, Louise R; Wenhold, Jennifer; Yow, Annmarie; Peggy Brown; Caitlyn Eck; Zach Annett; Eric Anderson; Tracey Vause; Denise Imbler; Jeanne Eckes-Roper; Carhart, Ty; Marilia VanKeeken; Caldwell, Jamie S; Wilgis, John; Matt Meyers; Hale, Rebecca; AnnMarie.Kleczkowski@ocfl.net; Klein, Jason L.; Perez, Ellis E; Lauren Possinger; Litton, Bill (Osceola Co EM); Manuel Soto; Kelley, Debbie A; hunter.zager@tampabayhmpc.org; Maldonado, Carmelo; Johns, Paul M.; Judge, Jim; Philip Doyle; Royer, Melissa; John Maze; Crowe, David R
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From:	Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD)
To:	Blackmore, Carina (CDC flhealth.gov); Stanek, Danielle (CDC flhealth.gov)
Cc:	Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD)
Subject:	site visit report
Date:	Thursday, February 27, 2020 1:59:34 PM
Attachments:	Site Visit External 2020 Florida_Torres.docx

Dear Dr. Blackmore and Dr. Stanek,

Thank you very much for hosting me for my site visit to FDOH last month to discuss Yari's EIS experience and how the Epidemiology Workforce Branch and FDOH can continue to work together to provide an excellent experience for future EISOs. I really appreciate you spending the day with me and enjoyed meeting you and FDOH staff in person.

Attached is an site visit report summarizing my meetings and the visit. The report is essentially the same as the internal report (I removed the logistics section pertaining to lodging and transportation and revised the wording in several spaces to improve clarity). One item we didn't discuss during the meeting but that has come up internally afterwards was the potential involvement of local health departments to improve field investigation opportunities. Would staff in Miami or Orlando, for example, have interest in setting up an arrangement to host an EISO to assist with field investigations?

Thank you again for meeting me, and please don't hesitate to contact me with questions or comments about the site visit report or any other concerns you have.

Regards,

Suzanne Beavers

Suzanne Beavers, MD
CDR, United States Public Health Service
Medical Officer, Fellowship and Response Support Team (FRST)

Epidemic Intelligence Service | Epidemiology Workforce Branch
Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology, and Laboratory Services
Office of Public Health Scientific Services

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS V24-5, Atlanta 30329-4027
(770) 488-3960 (office)
(404) 345-2751 (cell)
Fgx5@cdc.gov

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Site Visit Report Template

Date: February 10, 2020
To: The Record
From: Suzanne Beavers
Subject: Site Visit to Florida Department of Health

On January 30th, I visited the Florida Department of Health (FDOH) to assess the progress of the current Epidemic Intelligence Service (EIS) Officer, Yari Torres, and to assess the health department's suitability to host another EISO in 2020.

During the site visit, I met with the following people:

Scott Pritchard, MPH (interim director for Acute Disease Investigations)
Megan Gumke, MPH
Prakash Mulay, MBBS MPH
Jim Matthias, MPH (CDC assignee to the Division of STD Prevention)
Samuel Prahlow, MPH
Dr. Carina Blackmore, DVM PhD DACVPM CPM **Primary supervisor**
Dr. Danielle Stanek, DVM DACVPM **Secondary supervisor**
Scott Rivkees, MD **State Surgeon General**

Assignment Overview

The Florida Department of Health is located in Tallahassee, Florida, the state capital. Florida contains 67 counties and has a population of approximately 21 million people. Yari lives about a 5-minute drive from the health department; her location is convenient to shopping and work. She doesn't have trouble with traffic and likes her living location.

Currently, there's nobody at the health department who is an EIS alumnus. She had a former supervisor who was an alumnus who has returned to clinical practice. There are currently no career epidemiology field officers in Tallahassee, though a CEFO (Tim Doyle, who has previously worked at FDOH) will join them soon. Her supervisors are Dr. Danielle Stanek and Dr. Carina Blackmore, both veterinarians. She meets with them regularly. Due to the nature of their positions (Dr. Blackmore is the Director of Medical and Health Services), she often works with Dr. Stanek more closely. However, both supervisors are accessible to her.

FDOH has a CSTE fellow and a Florida EISO (typically an MPH) from the state program (http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/florida-epidemic-intelligence-service/index.html).

No type of degree is more preferable for this position, although Yari's supervisors feel that someone who is only interested in analysis won't be happy at FL. They said that someone who had broad interests would be best suited for the position. Spanish fluency is helpful but not necessary. Someone who can take direction is helpful. They noted that in Florida the local health departments are sophisticated and the EISO wasn't expected to do as much shoe leather epidemiology as in the past. Yari said that the site has a lot of data to analyze but that she hasn't done a lot of analysis because of her skill set. She said that characteristics that make you

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more likely to succeed in this position include communication skills, broad interests, and willingness to ask questions. She said that people who think they're too advanced to do certain tasks won't do well.

Yari has access to SAS and ArcGIS. She can download R if needed. She receives excellent technical support at FDOH. She has an office on the second floor of the building.

EIS Officer, Yari Torres:

Yari has enjoyed her time at FDOH. She has always been given the freedom to participate in investigations that interest her. She has taken call for the health department and always has excellent backup when on call. She has been involved in a variety of types of investigations, which she has appreciated. She has also participated in several trainings while at FDOH, including a media training that compared favorably with that offered at CDC. The state also had a Stephanie Evergreen training she attended.

Yari stated that her assignment started off slowly. She has found it difficult at times to become involved in field investigations. She said involving Scott Pritchard would help her learn more quickly about new outbreaks so she could become involved more quickly. She felt that the fact that the state functioned as a home rule state and that many of the larger investigations occurred a several-hour drive away from her (e.g., in Orlando or Miami) also made it more difficult for her to become involved. She feels that the next EISO will have an easier time because Yari was able to work with a number of people and convince them of the value added of having an EISO to work on projects.

Progress on CALs:

1) Field investigation – CASPER in Florida Keys after Hurricane Irma, *C. auris* investigation, Brucella investigation (complete)
2) Epidemiologic analysis – syphilis retesting (complete)
3) Surveillance evaluation – CO poisoning syndromic surveillance evaluation
4) 30-min oral presentation – cluster of *C. auris* cases, rabies guidelines testing, Florida Environmental Health Association training, Hurricane Michael CASPER (complete)
5) 5-15 min oral presentation – CO syndromic surveillance at CSTE (complete)
6) First-authored scientific manuscript for peer-reviewed journal – case report on rabies virus in cat (not started), CASPER done after Hurricane Irma for MMWR (preclearance)
7) First-authored concise public health update – Rabies virus in Florida (complete)
8) First-author on abstract – CO poisoning syndromic surveillance; Brucella investigation; CASPER in Florida Keys (complete)
9) Communicate complex scientific concepts to a lay audience – on call for general and zoonotic inquiries from the public; gave rabies training; co-led public health merit badge activity for Boy Scouts (complete)
10) Service to the agency – Hurricane Michael ESF-8 volunteer; Salmonella interviews; multiple rabies trainings; *C auris* workgroup (complete)

After EIS, Yari Torres has been accepted to the CDC Preventive Medicine Fellowship program.

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Meetings with ....

Scott Pritchard, MPH
Megan Gumke, MPH
Prakash Mulay, MBBS MPH
Jim Matthias, MPH
Samuel Prahlow, MPH
Nikki Sebastian

Jim Matthias (CDC assignee to the Division of STD Prevention) has supervised Yari on her syphilis analysis. The analysis has been challenging, because reportable disease datasets can be difficult. They have continued to hit roadblocks and have found that some of the retests in the dataset might not actually be a retest for syphilis reinfection but a confirmation of the initial positive test. Yari has been doing all the work on this analysis, and Jim has been happy with her analysis. They hope to submit an abstract based on the work, but if not, that would be ok.

Samuel Prahlow has worked on ESSENCE with Yari. He has helped Yari learn syndromic surveillance and has taught her about MERLIN, PRISM, EMS data, Health Information Exchange, and ASPR data on DMATs. Yari understood the systems quickly and asked good questions. She is good at seeing the broader picture. He also worked with Yari on the CASPER and helped with cluster selection. He found her to be thorough and good at understanding the process. He enjoyed seeing her work with Monroe County Health Department and University of Miami in the field during the CASPER.

Prakash Mulay worked with Yari on the CO surveillance project. She came on board right as they were wrapping up Irma surveillance and asking how they could improve surveillance in the future. Yari was asked to quickly complete the surveillance project so had to learn ESSENCE quickly. She did a wonderful job. She worked with several partners (EPHT, CSTE fellow, county health departments) and reviewed her presentations with Prakash and others. She transitioned quickly from infectious (her primary area of expertise prior to EIS) to noninfectious diseases. She also has done interviews in Spanish, which is helpful.

Nikki Sebastian worked with Yari on the *Candida auris* investigation. They needed help with contact screening. Yari was able to help contact facilities and create relationships, scheduling visits, point prevalence surveys, and observations. She helped convince facilities of the importance of the outbreak given that a CDC EISO was participating. She went to the facilities during the day shift and night shift to provide education. At one point a facility staff member arrived late to the presentation on cleaning/disinfection practices. Rather than asking the other staff members attending to explain the presentation to the late staff member, Yari spent extra time to educate the staff member. She helped the Healthcare Associated Infections team increase their capacity. She built relationships with the staff at healthcare facilities, who liked her a lot. She has been open to continuing to answer questions the staff might have about recommendations. The HAI team in Florida is unique in that many staff are in the field. They were looking for subject matter expertise and assistance with their regional response plan. Yari gave them additional resources, ideas, education, creative ways to engage healthcare providers. She also helped them by procuring preexisting *C. auris* Spanish resources.

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Scott Pritchard has worked with Yari on measles and Hepatitis A investigations. She has demonstrated the ability to work complex cases. She studies and works up cases better that most people. There are few people he would trust to work up outbreaks, but he would trust Yari. She is thorough and talks to the right people, a “tremendous asset”.

Megan Gumke is a regional epidemiologist responsible for the 18 panhandle counties. She helped Yari understand the county realm vs. the state realm. Yari always wants to understand and learn more so that she would be more effective while taking calls.

Dr. Danielle Stanek and Dr. Carina Blackmore

Yari is an independent, curious thinker. She goes out of her way to obtain professional development opportunities and tries to speak with people who are interested in public health to promote careers in public health. She was very beneficial in securing another EISO for the 2020 class. People in the HD have appreciated her help, as she is a good team worker and empathetic. She listens to feedback and thinks about ways to improve as well as telling her supervisors if she has an added perspective. She has progressed a lot on her presentations.

Her supervisors have found it helpful to have an EISO who will write up their epidemiologic investigations for publication to increase awareness. She has written a document on rabies clinical guidance, which has been helpful.

To finish Yari’s CALs, they think writing up the rabies vaccine failure for cats will be easiest and fastest. We discussed the need for Yari to be done with her CALs at the end of her program or one month afterwards, which is particularly important for Yari given that CAL completion is a PMR requirement.

For the next EISO, they have a bank of projects ready to go. They want to learn the new EISO’s interests and skill set. They will match the EISO with people working on projects of interest. They are interested in a surveillance project on people who are not getting vaccinated.

When talking about ways EWB could better support FDOH, Dr. Blackmore mentioned making sure that the EWB supervisor contacts them about any problems they note with the EIS program. They also noted that epidemiology work at a state HD has changed in that it is much more laptop-based. EWB should continue to educate EISOs so they understand that they will get a field experience but need to be skilled on other areas because they won’t be doing field work often once they are done with EIS. (We discussed the work that EWB does in summer course to manage expectations of incoming EISOs, but I noted that expectation management was more challenging in a year when so many EISOs had participated in EVALI, Ebola, polio, and now coronavirus deployments.) They stated that CDC’s support on the CASPER investigation (Amy Schnall) and Byron’s support with statistics have been helpful.

Scott Rivkies, State Surgeon General

Dr. Stanek, Dr. Blackmore, Yari, and I met briefly with Dr. Rivkies and one of his staff members. We talked about the EIS program, an investigation on Campylobacter in pet food that Yari was working on, and Yari’s experience in Florida. One staff member asked

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a question about obtaining an EISO in FL to work on chronic disease. We talked briefly about the past history of chronic disease EISOs in FL.

EISO submitted and supervisor(s) reviewed CAL Reports in eFMS on time (by due date): Yes

Supervisor completed Progress Assessments on time: Yes

EISO completed confidential Host Site Assessment: Yes

Qualifications and Experience of Supervisors
Supervisors have the experience and credentials necessary to supervise EISOs. Yari said she is able to get support from both supervisors. She often works more with Dr. Stanek, as Dr. Blackmore is particularly busy.

Quality of EIS projects/outbreak/field investigation opportunities

At times Yari's opportunities for field investigations have been more limited than she would have liked. No EISO was in the health department in the year prior to her assignment there, so she had to familiarize people with her capabilities and what she could offer to an investigation. In addition, local health departments in Florida have high capacity and perform many investigations without requesting state involvement. Ultimately, Yari has been able to participate in several field investigations. The next EISO should have opportunities as well, her supervisors note, particularly if she is interested in healthcare-associated infections (where they stated they are likely to need help).

Availability of EISO support

She suggested having Scott Pritchard as a formal secondary supervisor or an informal supervisor who has a role in getting the EISO more quickly involved in field investigations. Both her supervisors thought this was a good idea. Having a CEFO come to the state will likely provide the EISO additional opportunities for interaction.

Assignment Strengths

- Broad EIS experience
- Experienced supervisors
- Positive experience with current EISO will likely increase next EISOs ability to get involved in projects

Assignment Potential Weaknesses

- Slow start for field investigations (I suspect geography and high-capacity local health departments play a role here). Involving Scott Pritchard or someone else who can get Yari more quickly looped into opportunities will likely help, as will greater awareness of what an EISO is and does when the 2020 EISO arrives.

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Recommendations

- FDOH has prematched with a 2020 EISO. This position offers a lot of opportunity for the EISO, and I'd anticipate the next EISO will have a wide variety of good experiences.
- Involve Scott Pritchard in supervision of the next EISO to promote early involvement in field investigations.

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From:	Pritchard, Scott
To:	Rico, Edhelene; Mejia-Echeverry, Alvaro; Jean, Reynald
Cc:	Schmitz, Ann; Villalta, Yesenia D; Blackmore, Carina; Moran, Susan O Col USAF SOUTHCOM SC-CC (USA)
Subject:	SouthCom COVID Exposures
Date:	Thursday, March 12, 2020 5:46:24 PM

Good Afternoon,
Dr. Susan Moran (305-437-1327 and copied) from Southcom reached out to me. She is leading a contact investigation of a reportedly positive COVID-19 case that visited the facility on Sunday. She is currently stratifying risk for around 97 persons. Est 10-20 may be medium risk. During our discussion we developed a plan that I think meets all of our needs.

- Southcom will plan to monitor all medium risk enlisted persons and only reach out if they have persons that need testing.
- They will also, develop a list of medium risk civilians with contact information, and provide to Miami-Dade CHD and you can notify other counties as needed by residence to monitor those folks.
- They will educate all low risk and ask that they call them if they develop illness they will triage and report as needed.

Her colleague Dr. Alexis Bowers(sp?) is also involved and can be reached at 305-437-3916.

Thank you!

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
Division of Disease Control and Health Protection

Phone: 850-245-4406
Cell: 850-251-5558
Fax: 850-414-6894
24/7 EPI Hotline: (850) 245-4401
Email: scott.pritchard@flhealth.gov

Physical Address:
4025 Esplanade Way, Room 240-H
Tallahassee, FL 32399-1720

Mailing Address:
4052 Bald Cypress Way, Bin A-12
Tallahassee, FL 32399-1720

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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From: SNRegistry

To: Carly.Swartz@em.myflorida.com; Colby.Maxwell@em.myflorida.com; DEM_Regional_Coordinators@em.myflorida.com; mjones@martin.fl.us; ELoPresti@ircgov.com; aharris@seminolecountyfl.gov; wpecci@martin.fl.us; wmayo@holmescountyem.org; richard.halquist@osceola.org; Lauren Possinger; Rhonda Lewis; tashondawhaley@tds.net; scott.garner@dixie.fl.gov; shawnw@tds.net; shayne_morgan@columbiacountyfla.com; donna@waltoncountyem.org; kwolfe@myokaloosa.com; danielh@santarosa.fl.gov; BCHATTAW@co.escambia.fl.us; jaalexander@sjcfl.us; mashuler@fairpoint.net; MShivers@myglades.com; Gerard.Mallet@charlottecountyfl.gov; Scott Canaday; David Casto; cevan@sheriffcitrus.org; jerri.kaplan@hardeecounty.net; johnmacdonald@levydisaster.com; jill.newman@hardeecounty.net; bek.parker@bakerso.com; lnelson@flaglercounty.org; emgmgnt@sjcfl.us; MLOberdorfer@NassauSO.com; rsmith@gcfr.org; Cooksey, Samantha; paulwomble@polk-county.net; parrishr@stlucieco.org; slerner@seminolecountyfl.gov; Rachel Jackson; emiller@marionso.com; lwilcoxen@pascocountyfl.net; TCanelli@scgov.net; vilchezg@stlucieco.org; jbowlin@marionso.com; patrick.fuller@charlottecountyfl.gov; brandi.frame@hendryfla.net; lmarker@bakerso.com; bhardin@baycountyfl.gov; sherschenhorn@broward.org; swyllie@sheriffcitrus.org; maria.haney@claycountygov.com; Lauren.Bonica@colliercountyfl.gov; ZGainer@coj.net; TDTOMPKINS@myescambia.com; em1frank@fairpoint.net; DSantana@co.hernando.fl.us; williamst@HCFLGov.net; Hawker, Miranda C; jgussler@lakecountyfl.gov; dquimby@leegov.com; nagyj@leoncountyfl.gov; leathakeene@levydisaster.com; pstefanski@marionso.com; Roberto.Cepeda@miamidade.gov; haskins-anna@monroecounty-fl.gov; ahoward@co.okeechobee.fl.us; Carmen Weatherford; SpecialNeeds@osceola.org; kwall@pbcgov.org; ema@pinellascounty.org; JudyRobinson@polk-county.net; mazle.holder@putnam-fl.com; GinnyP@santarosa.fl.gov; grahamj@unionsheriff.us; lkuzma@volusia.org; marving@miccosukeetribe.com; Eve Rainey; Jeanne Eckes-Roper; wendy_russell@bradfordsheriff.org; Luis.hernandez@brevardfl.gov; bjordan@sheriffcitrus.org; RRussell@co.hernando.fl.us; Pedigo, Ryan J.; brittany.lozada@miamidade.gov; kalson-vince@monroecounty-fl.gov; Todd Stalbaum; mserfustini@pinellascounty.org; LaTosha Reiss; debg@santarosa.fl.gov; ParrisR@hcflgov.net; john.scott@brevardcounty.us; bpickering@flaglercounty.org; wjohnson@martin.fl.us; myersk@stlucieco.org; jlord@flaglercounty.org; Schaudel, James; Scott, Katie E; TSMEAD@myescambia.com; Sharon.Hingson@suwanneesheriff.com; bill.litton@osceola.org; Massoud-Matt@MonroeCounty-FL.Gov; robin.peiffer@suwanneesheriff.com; Sison, Allyson R.; ahassell@lakecountyfl.gov; Renee Lowe; madisoncoem2@embarqmail.com; lafayem@windstream.net; Pelletier, Dan; Sussman, Andrew; Williams, Ted; director@holmescountyem.net; Laurie, Christine; Roberts, James; Margaret S Hart; Fiske, Jodie; Lambert, Gina; Titus, Tasha S; EMA, EMA; Creech, Denise R; EmergencyManagementEmployees; Serfustini, Mecca R; bryan.otoole@putnam-fl.com; April.McQuaig@hardeecounty.net; Brad C. Hattaway; Sullivan, Robert; Scott, John; Reiss, Latosha; Lisa Poziomek; calhounemc@gmail.com; Perea, Aurelio O; DL DEPCS00 BPR Regional-County Planners; DL DOH CHD Administrators_Directors; Kimbrel, Nicole H; Silverstein, Judith L; McCray, Debra; Risher, Valerie J; Levings, Margaret A; Paula Carroll; Connie Welch; Demott, Monica; Long, Jessica L; Krista Ditoro; Frankie Lumm; Snead, Jordan A; Marr, Kathleen J; Chmiel, J David; Vick, Stephanie; Garcia, Mary L; Hoskins, Ashley J; Strokin, Natasha M; Gifford, Jeremy X; Stewart, Lewis Shayne; Street, Karen K; Ming, Randy S; Hess, Erin E; DuBois, Adam J; Courson, Sandi C; Exline, Timothy; Smith, Kathy J; Hamlett, Elizabeth(Chd48); Sykes, Michael R; Cook, Kevan D; Lanza, John J; Crain, Pamela A; Chirinos, Peter P; Milanese, Megan; Miller, Jason S; Mooney, Dayle; Vaughn, Freda G; Paterniti, Beth A; Horner, Jennifer E; Sudden, Terri M; Gountas, Ioannis; Smith, Jennifer M; Williams, Lydia K; Zelnick, Sanford D; Huard, Gerald S.; Webb, Robert K; Bencie, Jennifer L; Rich, Don; Fey, Eric S; Baird, Angela T.; Collinge, Deborah; Bartels, Amy; Skau, David M; Day, Patricia; Medved, Daniel T; Rubio, Tito G.; Laucevicius, Rachell A; SantanaReyes, Yamilet; Lopez, Jose M; Mattei, Nina L; Stahl, Maria A; Nickola-Williams, Noreen B; Crowe, David R; Rutledge, Laura X; Turchetta, James P; Walsh, Donna; Paula J. Sellek; Baltzley, Edwin W; Snyder, Robert E; Welter, Bonnie J; Reese, Suzette W; Nealon Joseph; Butler, Lola J; Herrera, Luis; Bartha, Caroline T; Hardacre, Tod B; Eichler, Fred V; Pepe, Joseph D; Martin, Sandy K; Batts, Howell T; Roberts, Kyle B; Davis, Terri C; Clark, Tricia L; Johns, Amie G; Joseph, Jerry A.; Vreeland, Lisa M; Rolle, Pauline J; Meyers, Matt D; Jeffers, Carol R; Austin, James E; Osman, Ihab N; Long, Jason E; Barnes, Brenda L; Leigh Webb; Huffman, Heather E; Morales, Jose A; Blevins, Allison M; Sewell, Susie W; Waldron, Kerry S; Boswell, Patricia; Moffses, Thomas P; Sandoval, Randi C; Wright, Cyna; Allicock, Dawn; Veneman, Robert J; Quigley, Jacob B; Cobb, Joseph L; Pietrangelo, Joseph; Combs, Sue S; Duncan, Jordan D; Holt, Douglas A. (Doug); Verlaan, Thomas D; McMillion, Barbara J; Rodriguez, Genevie N; Park-O"Hara, Sandra L; Locke, Barbara L; Kallay, Ruth; Howe, Albert L; McCluskey, Vianca; Yeager, Kaila E; Mitchell, Halle M; Brad Baker; Powell, Joseph M; Kelly, Christine L; McBride, Laura J; Bracken, Jennifer C; Owen, Kristina J; swarner@baycountyfl.gov; Kayla Kinsey; James, Nasseam McPherson; Andre, Lisa A; Kirsch, Holly S; Kevin Peters; Bielling, Jeffery; Van Alstine, Randy L.; Ritten, William T; Roberts, Eric P; Sumner, Samuel M; Bechtel, Stephanie R; Campbell, Sieglinde D; Hartwell, Paige M; Newhouse, Brandi; Arant, Jennifer S; Senyshyn, William; Jackson, Iris F; Brandow, Jennifer; Hartzell, Vivian; Casey, Kristin; Johnson, Adam C; Lane, Susan M; Flaherty, Terrie; Foster, Kena K; Lutchman, Shamilla N; Office of Emergency Management; Olson, Jan E; Courtney C. Wildes; Hobby, Tonya X; Wiser, Robert H; Dulmage, Philip; Black, Melanie A; Kossler, Kimberly; Roberson, Angela C; Beck, Pam; Otis, Aaron; Barley, Kathryn C; Warren, Skyler C; Luce, Christie; Benefield, Dustin B; O"Rourke, Christopher P; Elkins, Vickie; Linnens, Robert L; Rodriguez, Carolyn; Guerrero, Rangel; Higginbotham, William T; Baumgardner, Kedra S; Blood, Joshua; Padro, Noemi; kbAUMGARDNER@ISF.COM; Harkrider, Tommy G; Bailey, William H; Hodges, Zachary L; Hinds, Sarah JQ; Choe, Ulyee; Myers, Paul D; Bradley, Edward; Hazel, Richard C; Eadie, Bob; Mehta, Udgit P; Valentine, Kathryn; McDonald, Linda A; Kissler, Aaron X; Adams, Ruth C

Subject: Special Needs Registry

Attachments: 2020-02-11 Registry Workgroup Agenda.doc

Good Afternoon All,

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Please find attached the agenda for tomorrow's call. There will not be any webinar information as there is no demonstrations to show the workgroup.

Monthly SNR Workgroup Conference Call

888-585-9008

Participant(Conf. Rm#): 269-597-735

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Special Needs Registry Workgroup Conference Call AGENDA

February 11, 2020

10:00 a.m. – 11:00 a.m. EDT

Call In # 888-585-9008
Participant(Conf. Rm#): 269-597-735

Topic	Speaker
Introduction	**Nicole Kimbrel**
Feedback from Testing • Testing statistics	**Kedra**
Go Live for the New System • Go Live date is March 18. • Will be contacting the counties that have said they will use the system to discuss migration of your data. • For those who are TBD, will be contacting you to discuss your options. • For those who are not using the system, we will provide instructions on how to confirm the link to your system is correct.	**Nicole Kimbrel**
March Meeting • New invitation for group	**Nicole Kimbrel**
Closing	**Nicole Kimbrel**

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From: Pathology (CDC)
To: BPHL13FL@flhealth.gov
Cc: jchapman@med.miami.edu; Elesi.Quaye@flhealth.gov; Stanek, Danielle (CDC flhealth.gov); Blackmore, Carina (CDC flhealth.gov); Edhelene.Rico@flhealth.gov; Alvaro.Mejia-Echeverry@flhealth.gov; pedro.noya-chaveco@flhealth.gov; Schmitz, Ann (CDC flhealth.gov); Qvarnstrom, Yvonne (CDC/DDPHSIS/CGH/DPDM); Leishmania (CDC); Shieh, Wun-Ju (CDC/DDID/NCEZID/DHCPP); Zaki, Sherif (CDC/DDID/NCEZID/DHCPP); Reagan-Steiner, Sarah (CDC/DDID/NCEZID/DHCPP); Matkovic, Eduard (CDC/DDID/NCEZID/DHCPP); Benoit, Tina (CDC/DDID/NCEZID/DHCPP)
Subject: Specimen Receipt Notice: IDPB 2020-0171
Date: Wednesday, February 12, 2020 2:07:00 PM
Sensitivity: Confidential

IMPORTANT: It is imperative that you save, print, or archive this email for future reference/correspondence.

Dr. Stephen White,
This is to notify you that IDPB received 1 block and 1 stained slide on A.F. (MRF20000021, UB20-97) on 02/12/20.
If you have any questions, refer to IDPB case **2020-0171** when contacting the case pathologist, **Dr. Eduard Matkovic**.

****

Eduard Matkovic, M.D. | Pathology Fellow | Tel: 404-639-0549 | Fax: 404-639-3043 | Eduard.Matkovic@cdc.hhs.gov |
Centers for Disease Control and Prevention | Infectious Diseases Pathology Branch (IDPB) | 1600 Clifton Rd NE, MS: H18-SB | Atlanta, GA 30329-4027 |

****

Report Password: the password to open the password protected Pathology Report PDF (Preliminary/Final/Addendum) for this case will be provided in a separate email after you receive the Final Pathology Report Email and will be a unique 12 digit number. If additional specimens are subsequently received on the same case by IDPB, the password will remain unchanged. Animal case reports will not have password protection.

Specimen Receipt Notice: the official contact(s) at the Health Departments (if known) will be cc'd on IDPB's Specimen Receipt Notice emails, in addition to cc'ing other case specific relevant parties. The same official contact(s) at the Health Departments (if known) will continue to receive IDPB's Final Pathology Reports once finalized.

ePathology Service: IDPB now offers telepathology consultation through our ePathology service. This is not a substitute for diagnostic testing by our laboratory, but facilitates rapid initial evaluation of images or scanned slides prior to submission of case materials for testing. Please visit the ePathology website at http://www.cdc.gov/ncezid/dhcpp/idpb/epathology/index.html for more information.

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From:	Kopp, Edgar W
To:	sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Pritchard, Scott; Cannons, Andrew C; Heberlein-Larson, Lea A.
Subject:	Specimen Submission for COVID-19 PUI ID# 0001287
Date:	Thursday, February 20, 2020 7:43:16 PM

FedEx tracking number 777820256263
Sender's name: Edgar Kopp

From: Pritchard, Scott
Sent: Wednesday, February 19, 2020 3:41 PM
To: Cannons, Andrew C <Andrew.Cannons@flhealth.gov>; Kopp, Edgar W <Edgar.Kopp@flhealth.gov>; Heberlein-Larson, Lea A. <Lea.Heberlein-Larson@flhealth.gov>
Cc: Blackmore, Carina <Carina.Blackmore@flhealth.gov>; Leapley, Andrea C <Andrea.Leapley@flhealth.gov>; Lewandowski, Patty A <Patty.Lewandowski@flhealth.gov>; Rubino, Heather <Heather.Rubino@flhealth.gov>
Subject: Specimen Submission COVID-19 PUI ID# 0001287

Here are the details for an incoming PUI from Hillsborough county.

Scott Pritchard, MPH
Interim Director
Infectious Disease Prevention and Investigations Section
Bureau of Epidemiology
850-245-4406

From: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Sent: Wednesday, February 19, 2020 3:37 PM
To: CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>; Pritchard, Scott <Scott.Pritchard@flhealth.gov>; CDC IMS Logistics Transportation <eocevent306@cdc.gov>; Hyde, Allen W. (CDC/DDPHSIS/CPR/DEO) <fnb4@cdc.gov>; Schneider, Eileen (CDC/DDID/NCIRD/DVD) <ees2@cdc.gov>; CDC IMS 2019 NCOV Response PUI <eocevent185@cdc.gov>
Subject: PUI ID# 0001287

Hello Scott:

Thank you for contacting CDC about the patient under investigation (PUI) for novel coronavirus (COVID-19). Please find summary information below to help assist in the PUI evaluation and specimen referral.

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Summary

38 yo male who resides in China (Guangzhou City) came to US on 2/3. on 2/15 he developed cough, congestion, rash and subjective fever. Patient presented to ED for evaluation. Decision made to admit patient but patient signed himself out AMA. Specimen x 3 were collected prior to his signing himself out. Denied other risk factors (travel to Wuhan or Hubei province; contacts to a known case).

CDC COVID-19 ID #0001287

POC Details

Name: Scott Pritchard

Location: Florida

Phone: 850-251-5558

Email: scott.pritchard@flhealth.gov

Additional information

Guidance for health departments to submit PUI information to CDC can be found here. Include the CDC COVID-19 ID issued to you by CDC in the top right box and on all specimen forms. The PUI form should be submitted as soon as able and need not wait for specimen shipping. Instructions on how to submit the PUI form are located at the top of the form.

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

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

Please see the attached *2019 Novel Coronavirus (nCoV) Specimen Submission Guidelines* for detailed guidance on specimen shipment, packaging, and documentation. Please ensure that the patient information on the specimen tube exactly matches the 50.34 DASH Form, or the

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CDC may have to reject the specimen or testing may be delayed.

For questions about specimen collection or completing the 50.34 Form, please see https://www.cdc.gov/laboratory/specimen-submission/help-faqs.html.

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

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

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

Thank you,

CDC IMS 2019 NCOV Response PUI Team

2019 Novel Coronavirus Response

eocevent185@cdc.gov

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From:	Cannons, Andrew C
To:	sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Pritchard, Scott; Heberlein-Larson, Lea A.; Kopp, Edgar W
Subject:	Specimen Submission for COVID-19 PUI ID# FL2783039 & FL2783057
Date:	Thursday, February 27, 2020 3:35:58 PM

Senders Name: Edgar Kopp
FedEx Tracking Number: 777882281733

Andrew C. Cannons, Ph.D., HCLD(ABB)
Laboratory Director, Bureau of Public Health Laboratories -Tampa
Division of Disease Control and Health Protection
Florida Department of Health
E-mail: andrew.cannons@flhealth.gov

Phone: (813) 233-2277
Fax: (813) 233-2379
Cell: (813) 956-8850

How am I doing? Please let me know by taking this short survey. Thank you!

Bureau of Public Health Laboratories

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From:	Kopp, Edgar W
To:	sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Pritchard, Scott; Heberlein-Larson, Lea A.; Herriman, Robert E; Cannons, Andrew C
Subject:	Specimen Submission for COVID-19 PUI ID# FL2785091
Date:	Thursday, March 12, 2020 5:09:51 PM

FedEx tracking number 770005225073
Sender's name: Edgar Kopp

Andrew C. Cannons, Ph.D., HCLD(ABB)
Laboratory Director, Bureau of Public Health Laboratories -Tampa
Division of Disease Control and Health Protection
Florida Department of Health
E-mail: andrew.cannons@flhealth.gov

Phone: (813) 233-2277
Fax: (813) 233-2379
Cell: (813) 956-8850

How am I doing? Please let me know by taking this short survey. Thank you!

Bureau of Public Health Laboratories

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From:	Cannons, Andrew C
To:	Kopp, Edgar W; sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Rubino, Heather; Pritchard, Scott; Heberlein-Larson, Lea A.
Subject:	Specimen Submission for COVID-19 PUI ID# FL2786318
Date:	Tuesday, March 3, 2020 11:55:17 AM

FedEx tracking number 777911072788
Sender's name: Edgar Kopp

Andrew C. Cannons, Ph.D., HCLD(ABB)
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How am I doing? Please let me know by taking this short survey. Thank you!

Bureau of Public Health Laboratories

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From:	Cannons, Andrew C
To:	Kopp, Edgar W; sgk5@cdc.gov; eocevent177@cdc.gov; eocevent185@cdc.gov
Cc:	Blackmore, Carina; Leapley, Andrea C; Lewandowski, Patty A; Pritchard, Scott; Heberlein-Larson, Lea A.; Herriman, Robert E
Subject:	Specimen Submission for COVID-19 PUI ID# FL2792318: FL2792316: FL2785125: FL2786318: FL2792718
Date:	Wednesday, March 11, 2020 3:55:18 PM

FedEx tracking number 777994873679
Sender's name: Edgar Kopp

Andrew C. Cannons, Ph.D., HCLD(ABB)
Laboratory Director, Bureau of Public Health Laboratories -Tampa
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Florida Department of Health
E-mail: andrew.cannons@flhealth.gov

Phone: (813) 233-2277
Fax: (813) 233-2379
Cell: (813) 956-8850

How am I doing? Please let me know by taking this short survey. Thank you!

Bureau of Public Health Laboratories

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	State Health Official & State Epi Touchbase
Date:	Thursday, March 12, 2020 5:32:53 PM
Attachments:	Considerations for school closure Draft 031220 Updated.pdf
Importance:	High

Dear Colleagues:

Thank you for your participation in today's state health official and state epidemiologist touch base. Please see the attached "**Interim Considerations for School Closures**" guidance. Feel free to send any questions to preparedness@cdc.gov.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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Considerations for School Closure

Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).

2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).

3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

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School Decision Tree

All Schools Regardless of Community Spread

Confirmed person with COVID-19 in building? → Assess Risk → *Short (potential 2-5 Day) Building Dismissal to Clean/Disinfect/Contact Trace in consultation with local health officials*

No Community Spread

- Prepare
- Teach and reinforce healthy hygiene
- Develop information sharing systems
- Intensify cleaning and disinfection
- Monitor for absenteeism
- Assess group gatherings and events – consider postponing non-critical gatherings and events
- Require sick students and staff stay home
- Establish procedures for someone becoming sick at school

→ *Monitor changes in community spread*

Minimal to Moderate OR Substantial Community Spread

Is community spread Minimal to Moderate or Substantial?

M/M

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building.
- Consider ways to accommodate needs of children and families at high risk.

S

- Coordinate with local health officials.
- Implement multiple social distancing strategies for gatherings, classrooms, and movement through the building WITH EXTENDED SCHOOL DISMISSALS.
- Consider ways to accommodate needs of children and families at high risk.

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Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	• **Impact on disease** ○ Allows for decontamination ○ Allows time for epidemical evaluation and conact tracing; further action can be scaled based on epi investigation.	• **Impact on disease** ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students.	• May occur frequently during a wide-spread outbreak
Short-term (2 weeks closure)	• **Impact on disease** ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • **Impact on families** ○ Children may be less impacted by social isolation from their peers for shorter time frames • **Impact on school** ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Key services are interrupted for students (e.g., meals, other social,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

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	○ Given current timing, some schools may be able to take advantage of spring break closures ○ Provides protection for older staff and students and staff with underlying medical conditions	physical health, and mental health services, after school programs) ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Potential academic impact because of the disruption to the continuity of learning • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	
Medium-term (4 weeks closure)	• **Impact on disease** ○ Provides more protection for older staff and students and staff with underlying medical conditions • **Impact on schools** ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice	• **Impact on disease** ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • **Impact on families** ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services,	• Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

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		after school programs) are put at greater risk ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. • **Impact on schools** ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Economic impact if school staff are not paid during school closure must be considered.
Long-term (8 weeks, 20 weeks closure)	• **Impact on disease** ○ Modeling data for other respiratory infections where children have	• **Impact on disease** ○ Longer closures may result in more students congregating outside of	• Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried

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	higher disease impacts, suggests that longer closures are may have greater impact in terms of overall transmission. Provides substantial protection for older staff and students and staff with underlying medical conditions
	• **Impact on schools**
	  ○ Schools without distance learning may see closures of this length as reason to implement distance learning approaches they may not have previously had or used
		school (e.g., other students' homes, shopping malls)
		  ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage.
		• **Impact on families**
		  ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at substantial risk
		  ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs)
		  ○ Student engagement with schools and peers diminishes, which could increase anxiety and other mental health and emotional problems.
		  ○ High school seniors likely to lose ability to participate in their prom, graduation etc.
		• **Impact on schools**
		  ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements
			workers who may have more flexible leave and telework opportunities)
			• If a school closes for this length of time, schools must consider ways to continue key services
			• Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled.
			• Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure.
			• Given current timing, 20 week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid June.
			• A 20 week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well
			• Economic impact if school staff are not paid during school closure must be considered.

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		○ Loss of educational progress, even having to add an extra semester or year to graduate or move up a grade ○ Staff within the schools may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ○ Maintaining communication with school staff, families, and students becomes substantially more difficult as the school closure lengthens. • **Impact on health care** ○ Available health care workforce is decreased as HCW stay home with children.	

Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

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From:	Koneff, Douglas A
To:	Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ); Eleni Kalisch; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); CGRCU-Internal; O"Reilly, Kevin M; WHA-BSC-only; CGRCU-CAReps
Cc:	Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject:	Status of Chile charter (Silver Express pax)
Date:	Wednesday, March 18, 2020 8:59:14 AM

I am slimming the chain to take our overseas colleagues off for right now. Please add DHS and others in the US as needed. Adding the State Department COVID coordination unit and consular reps.

Eleni - we understand the charter from Chile is scheduled to land in MIA between 1200-1300 EDT, and that FL state authorities have said non FL residents will not be allowed to continue onward to home unless moved to another charter.

Can you give us the latest? We are concerned both about Amcits on this flight as well as future charters by RC or other charters seeking to land in FL.

Thanks - Doug

Get Outlook for iOS

From: Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>
Sent: Tuesday, March 17, 2020 10:37 PM
To: Eleni Kalisch; Sparks, Tyler K; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED); Popp, William W; Barrett, John M (Recife); Dubois, Amy E; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Koneff, Douglas A; Brizzee, David N; Clatanoff, Charles M (Santiago); (U) Ortiz, Abdias; Cassano, Jeremy J; Hunt, Baxter (Santiago); Archuleta, Mary Suzanne; Listerman, Allison Werner
Cc: Eidex, Rachel B (Dar es Salaam - CDC); Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT); scott.rivkees@flhealth.gov; Klevos, Andrew (CDC/DDID/NCEZID/DGMQ); Decenteceo, Michelle (CDC/DDID/NCEZID/DGMQ)
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Dear Eleni,
Please clarify your request and the plan – which passengers are you referring to? The air ambulance passengers or the ones who are not ill and are coming in the larger charter?

As I wrote earlier, CDC will not be conducting any health screening. For the passengers who are not arriving by air ambulance, CBP/CWMD would screen the passengers based on their own protocol. CDC Quarantine Station staff will be available to respond to any illness events, as requested by CBP.

For the air ambulance, they need assessment – I understood that you have made arrangements with Dr. Barth Green/University of Miami, who is not affiliated with CDC. He/his team would make an assessment of those 6 individuals.

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From: Eleni Kalisch <ekalisch@rccl.com>
Sent: Tuesday, March 17, 2020 10:20 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel Barwick (CDC/DDID/NCEZID/DGMQ) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Michelle –

Slight change of plans. Upon arrival at MIA, Royal Caribbean will now be arranging individual charter flights for the passengers who are cleared by CDC to return to their home cities/states.

Our team has asked that CDC provide something in writing tomorrow that we can provide to the charter companies indicating that the passenger(s) boarding the charter flights have been cleared to fly commercially. We do not want the charters to deny boarding to these passengers simply because they have arrived in MIA from a cruise ship.

Thanks,

Eleni

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Eleni Kalisch
Sent: Tuesday, March 17, 2020 7:32 PM
To: Sparks, Tyler K <SparksTK@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>;

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Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>; scott.rivkees@flhealth.gov
Subject: RE: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

At long last, we have confirmation of the first charter flight to Miami:

The American guests from Silver Explorer will be departing Puerto Montt to Miami confirmed to depart at 12AM local time arriving in MIA at 910AM. Tail is CCBGD.

More details to follow!

Eleni P. Kalisch | Vice President | Federal Relations
Royal Caribbean Cruises Ltd. | 1050 Caribbean Way, Miami FL 33132
Tel: 305.539.6799 | Cell: 786.253.5305 | ekalisch@rccl.com

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 3:27 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>; Eleni Kalisch <ekalisch@rccl.com>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: [EXTERNAL] Re: Royal Caribbean Ships off Brazil/Chile

Sorry - now with Eleni from RC. Again, due-outs are:

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship

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Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

From: Sparks, Tyler K
Sent: Monday, March 16, 2020 2:41 PM
To: Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Archuleta, Mary Suzanne <ArchuletaMS@state.gov>; Listerman, Allison Werner <ListermanAW@state.gov>
Cc: Eidex, Rachel B (Dar es Salaam - CDC) <zvd3@cdc.gov>; Weinberg, Michelle (CDC/DDID/NCEZID/DGMQ) <mpw5@cdc.gov>; Casillas, Shannon (CDC/DDPHSIS/CGH/DGHT) <yqj1@cdc.gov>
Subject: RE: Royal Caribbean Ships off Brazil/Chile

Alright, with Elena from Royal Caribbean think we have the right folks on here now.

Tyler Sparks
Senior Brazil Desk Officer
WHA/BSC

On March 16, 2020 at 2:31:37 PM EDT, Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov> wrote:

> added Rachel , Michelle and Shannon
>
> ***Currently detailed to the COVID-19 Response***
>
> Cindy R. Friedman, MD
>
> Centers for Disease Control and Prevention
>
> 1600 Clifton Road
>
> Atlanta, GA 30329

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470-487-4373

From: Sparks, Tyler K <SparksTK@state.gov>
Sent: Monday, March 16, 2020 2:20 PM
To: Popp, William W <PoppWW@state.gov>; Barrett, John M (Recife) <BarrettJM@state.gov>; Dubois, Amy E <DuboisAE@state.gov>; Moriarty, Leah (CDC/DDPHSIS/CGH/DPDM) <wvp4@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>; Koneff, Douglas A <KoneffD@state.gov>; Brizzee, David N <BrizzeeDN@state.gov>; Clatanoff, Charles M (Santiago) <ClatanoffCM@state.gov>; (U) Ortiz, Abdias <Abdias.Ortiz@cbp.dhs.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Hunt, Baxter (Santiago) <HuntJB@state.gov>; Cassano, Jeremy J <CassanoJJ@state.gov>; Friedman, Cindy R. (CDC/DDID/NCEZID/DFWED) <ccf6@cdc.gov>; Rotz, Lisa (CDC/DDID/NCEZID/DGMQ) <ler8@cdc.gov>
Subject: Royal Caribbean Ships off Brazil/Chile

All -

Thank you for joining the call today. Leah - I don't believe I have everyone from CDC who was on the call, including Rachel - please add if that's the case.

I've listed the do-outs that I'm tracking below, and this chain can serve as the new, smaller group of folks working on the Brazil/Chile RC ships.

- State - send CDC global ship tracking list; create small-group email distro;
- CDC - send Royal Caribbean and Amy Dubois/HHS protocols for screening; Make determination on screening protocols for passengers from a "healthy" ship
- Royal Caribbean - send #s of Canadians to CDC; update on infection status; send manifests for four ships

Tyler

Tyler Sparks
U.S. Department of State
Senior Brazil Desk Officer
WHA/BSC
SparksTk@state.gov

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CONFIDENTIALITY NOTE: This message may contain confidential or legally privileged information. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on these contents is strictly prohibited and may be unlawful. If you have received this communication in error, please notify us immediately by responding to this e-mail and then delete it from your system.

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From: Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD)
To: Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD)
Cc: ExecutiveOffice@astho.org; Montero, Jose (CDC/DDPHSIS/CSTLTS/OD)
Subject: Survey Extension until March 3rd: Help CDC Improve its Project Officer Support
Date: Monday, February 24, 2020 3:17:24 PM
Attachments: Survey Distribution Instructions.pdf

Dear Colleagues,

I wanted to personally thank you for your participation in this process.

I recognize that many of you are involved with the COVID-19 response and your time is very valuable. Please take this last opportunity to forward this survey on to the appropriate program contacts and encourage your colleagues to provide their honest feedback.

- The assessment should take no longer than 25 minutes to complete.
- Information collected will be kept on secure, password protected servers accessible only to ASTHO project team members. All information you provided will be analyzed and reported in the aggregate with no identifying information attached. So CDC will NOT know the individual State source.

With your programs' input we will better understand which project officer services are successful and those that need improvement. We will use the aggregate data to create best practices and provide training to support CDC efforts to provide outstanding technical assistance to our funding recipients in the future.

Assessment Link: Take the Assessment

I look forward to seeing you in Colorado in July!

Sincerely,

Steve

Steven L Reynolds, MPH
Deputy Director
Center for State, Tribal, Local, and Territorial Support
Centers for Disease Control and Prevention
404-394-9159

From: ASTHO Executive Office <g>
Sent: Monday, February 24, 2020 10:01 AM
To: ASTHO Executive Office <ExecutiveOffice@astho.org>
Cc: Research and Evaluation <ResearchandEvaluation@astho.org>; Suja Shunmugavelu

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<sshunmugavelu@astho.org>; Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD) <slr6@cdc.gov>
Subject: Survey Extension until March 3rd: Help CDC Improve its Project Officer Support

Dear Senior Deputies,

This email is another request for action and a follow-up to the CDC Project Officer survey launched in January (announcement email is attached). **Please note the survey has been extended until Tuesday, March 3rd.**

For those of you who have already distributed this evaluation to the appropriate points of contact within your agency, we appreciate your support. At this time we ask that you remind your staff about this survey by simply forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department.

As a reminder, ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements and grants. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

This survey should be completed by health agency staff who work on and serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements or grants (full list of selected cooperative agreements/grants is attached).

Our ask of you: Please remind your staff about this survey by forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department for their response. The invitation content to request participation is provided below the signature on this email. Feel free to directly forward this email to the intended recipients or create a new outreach message using the content below.

Thank you for your assistance.

Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308
www.astho.org | Twitter | Facebook | Blog

EMAIL FOR SURVEY RESPONDENT:

Instructions for survey respondent: The Association of State and Territorial Health Officials

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(ASTHO), in partnership with the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support is administering an assessment to health departments in all 50 states and the District of Columbia related to satisfaction with the services and support provided by CDC project officers.

Results from the assessment will be used by CDC to improve project officer support to state health agencies. Participation is voluntary, and your feedback will inform continued project officer development and training.

In order to participate in this voluntary assessment, please click the hyperlink provided in this email to be redirected to the web-based assessment. The assessment should take no longer than 25 minutes to complete. All responses are immediately saved and can be changed at any time. However, once the assessment is submitted, you will be unable to modify any responses. Also, you are not required to complete the assessment in one sitting. When finished responding to all relevant questions, click the **SUBMIT** button at the end of the assessment to submit your responses.

Information collected will be kept on secure, password protected servers accessible only to ASTHO project team members. All information you provided will be analyzed and reported in the aggregate with no identifying information attached.

Follow this link to the Assessment: Take the Assessment

Please submit responses to this assessment no later than March 3, 2020.

Note: The survey is designed for respondents to consider only one project officer within each selected cooperative agreement and grant. If your agency has more than one project officer for the Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations (DP17-1701), we invite your agency's appropriate point of contact to complete separate survey entries for each project officer.

Additionally, a few of the HIV, Viral Hepatitis, TB, and STD cooperative agreements have been updated with the current cooperative agreement numbers. The updated names and numbers are in the attached survey distribution instructions. If you already submitted responses under a prior cooperative agreement number you do not need to re-submit.

If you experience problems with the web-based assessment or have any questions, please contact Allen Rakotoniaina at researchandevaluation@astho.org for technical assistance.

Thank you in advance for your participation.

Disclaimer

AMERICAN OVERSIGHT

The information contained in this communication from the sender is confidential. It is intended solely for use by the recipient and others authorized to receive it. If you are not the recipient, you are hereby notified that any disclosure, copying, distribution or taking action in relation of the contents of this information is strictly prohibited and may be unlawful.

This email has been scanned for viruses and malware, and may have been automatically archived by **Mimecast Ltd**, an innovator in Software as a Service (SaaS) for business. Providing a **safer** and **more useful** place for your human generated data. Specializing in; Security, archiving and compliance. To find out more Click Here.

AMERICAN OVERSIGHT

ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements. This survey should be completed by health agency staff who serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements.

Instructions for survey distribution: We ask that you please forward the invitation email to the primary staff working on the following cooperative agreements for their response:

COOPERATIVE AGREEMENT NUMBER	PROGRAM/PROJECT TITLE
CE14-1401	Rape Prevention and Education Program
CK14-1401	Epidemiology and Lab Capacity for Infectious Diseases
DP18-1815	Diabetes and Heart Disease & Stroke Prevent Programs-Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke
DP15-1509	National State Based Tobacco Control Programs
DP15-1513	Behavioral Risk Factor Surveillance System (BRFSS)
DP16-001	Pregnancy Risk Assessment Monitoring System (PRAMS)
DP17-1701	Cancer Prevention and Control Programs for State, Territorial, and Tribal Organizations
IP19-1901 (NOFO NUMBER FOR PRIOR CYCLE WAS IP13-1301)	Immunizations and Vaccines for Children Program
OT18-1805	Preventive Health and Health Services Block Grant
PS17-1702	Improving Hepatitis B and C Care Cascades: Focus on Increased Testing and Diagnosis, and Application
PS17-1703	Strengthening Surveillance in Jurisdictions with High Incidence of Hepatitis C Virus (HCV) and Hepatitis B Virus (HBV) Infections
PS18-1802	Integrated HIV Surveillance and Prevention Programs for Health Departments
PS19-1901	Strengthening STD Prevention and Control for Health Departments
PS20-2001 (NOFO NUMBER FOR PRIOR CYCLE WAS PS15-1501)	Tuberculosis Elimination and Laboratory Cooperative Agreement
TP19-1901 (NOFO NUMBER FOR PRIOR CYCLE WAS TP12-1201)	Public Health Emergency Preparedness (PHEP)
EH17-1701	Childhood Lead Poisoning Prevention Program
EH17-1702	Enhancing Innovation and Capabilities of the Environmental Public Health Tracking Network
DD17-1701	Early Hearing Detection and Intervention Program
DD16-1605	Surveillance, Intervention, and Referral to Services and Activities for Infants with Microcephaly or Other Adverse Outcomes Linked with the Zika Virus

AMERICAN OVERSIGHT

Survey announcement shared with ASTHO's Senior Deputy Peer Network on Thursday, January 19th

Dear Senior Deputies,

ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

To capture this information, ASTHO will be fielding a survey on Tuesday, January 14 inviting the primary program staff who work on ***and*** *serve as the primary point of contact with the CDC project officer for the select CDC-funded cooperative agreements or grants listed below to share their feedback.*

As your agency's senior deputy, you will receive an invitation to complete the survey and we ask that you ***please forward the invitation to the primary staff working on the various cooperative agreements*** *for their response. The respondents to the survey should be the primary staff working on each of the listed cooperative agreements.*

Responses will remain confidential, and data will be analyzed and aggregated by ASTHO. Results will be used by CDC to inform future training and identification of best practices and opportunities for improvement in the support provided by CDC to state health departments.

Questions about the project?

For questions about the project or survey, contact Emily Peterman, Director of Research & Evaluation (epeterman@astho.org).

Thank you,
Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: *2231 Crystal Drive, Suite 450, Arlington, VA 22202*
Regional Office: *600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308*
www.astho.org | Twitter | Facebook | Blog

AMERICAN OVERSIGHT

From:	ASTHO Executive Office
To:	ASTHO Executive Office
Cc:	Research and Evaluation; Suja Shunmugavelu; Reynolds, Steven L. (CDC/DDPHSIS/CSTLTS/OD)
Subject:	Survey Extension until March 3rd: Help CDC Improve its Project Officer Support
Date:	Monday, February 24, 2020 10:02:56 AM
Attachments:	Survey Distribution Instructions.pdf

Dear Senior Deputies,

This email is another request for action and a follow-up to the CDC Project Officer survey launched in January (announcement email is attached). **Please note the survey has been extended until Tuesday, March 3rd.**

For those of you who have already distributed this evaluation to the appropriate points of contact within your agency, we appreciate your support. At this time we ask that you remind your staff about this survey by simply forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department.

As a reminder, ASTHO is partnering with the Centers for Disease Control and Prevention (CDC) to evaluate satisfaction with the services and support provided by CDC project officers on select cooperative agreements and grants. CDC management will use the results to identify and implement strategies for improving CDC project officer support to state health departments.

This survey should be completed by health agency staff who work on and serve as the primary point of contact for the CDC project officer for select CDC-funded cooperative agreements or grants (full list of selected cooperative agreements/grants is attached).

Our ask of you: Please remind your staff about this survey by forwarding the survey invitation to the primary staff working on the select cooperative agreements or grants within your health department for their response. The invitation content to request participation is provided below the signature on this email. Feel free to directly forward this email to the intended recipients or create a new outreach message using the content below.

Thank you for your assistance.

Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450, Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000, Atlanta, GA 30308
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AMERICAN OVERSIGHT

EMAIL FOR SURVEY RESPONDENT:

Instructions for survey respondent: The Association of State and Territorial Health Officials (ASTHO), in partnership with the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support is administering an assessment to health departments in all 50 states and the District of Columbia related to satisfaction with the services and support provided by CDC project officers.

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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AMERICAN OVERSIGHT

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Questions about the project?

For questions about the project or survey, contact Emily Peterman, Director of Research & Evaluation (epeterman@astho.org).

Thank you,
Suja Shunmugavelu

Suja Shunmugavelu
Gender Pronouns: She/Her/Hers
Senior Director, Engagement
(571) 527-3149 | (310) 766-2614 Mobile
Association of State and Territorial Health Officials
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AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Tim.Hatch@adph.state.al.us; [Andy.Mullins@adph.state.al.us]; john.hooper@adph.state.al.us; Jim.Craig@msdh.ms.gov; wayne.vaughn@msdh.ms.gov; christy.craft@msdh.ms.gov; Combs, Brian (CDC/dhhs.nc.gov); Stephanie Anspaugh-Naples (Stephanie.Anspaugh-Naples@flhealth.gov); Clement, Kimberly D; amanda.b.williford@dhhs.nc.gov; Blair, Jamie D.; Harbison, Dave A.; peter.koonz@tn.gov; paul.petersen@tn.gov; sean.j.kice@tn.gov; Christie Luce - Florida Department of Health (Christie.luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSS/CGPO/DSLR); Bivkaes, Scott A; Samantha.Cooksey@flhealth.gov; Gillis, Rebecca L (CHFS DPH EPR); jamesr.house@ky.gov; Hume, Robbie ; Jasie.Logsdon@ky.gov; Johnson, Rick D (CHFS DPH EPR); Kik, Angela M.; White, Connie (CDC/ky.gov); K.T.McKnight - Georgia Department of Health (Kytheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Cc: Rreach, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Phillip; Teague, Brian; D'Angelo, Joseph ; Dellamura, Joseph ; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; BRDC LOGS Supply Box
Subject: swab delivery
Date: Wednesday, March 25, 2020 8:01:05 PM

Good evening,
I received word that the following locations have received the following states received 4000 swabs today. The locations are listed below.

Swab delivery info from today

Organization Name	Testing Status	State/Local	Primary E-Mail	Primary Phone	Address	City	State	Zip	Shipping POC	Email	Phone	Tracking information for swab shipments from PBM/LifeSign	Status
Alabama Bureau of Clinical Laboratories	Testing	State	sharon.massingale@adph.state.al.us	334.260.3400 (3493)	1637 Mitchell Young Road	Montgomery	AL	36108				170397531128	delivered 3/24/2020
Georgia Public Health Laboratory	Testing	State	efranko@dhr.state.ga.us	404.327.7900	1749 Clairmont Road	Decatur	GA	30032				170397531209	delivered 3/24/2020
Kentucky Division of Laboratory Service	Testing	State	vaneet.arora@ky.gov	502.564.4446	100 Sower Blvd.	Frankfort	KY	40601				170397531264	delivered 3/24/2020
Mississippi Public Health Laboratory	Testing	State	daphne.ware@msdh.ms.gov	601.576.7582	570 East Woodrow Wilson Blvd	Jackson	MS	39216				170397531323	delivered 3/24/2020
North Carolina State Laboratory of Public Health	Testing	State	Scott.Shone@dhhs.nc.gov	919.807.8940	306 N Wilmington Street	Raleigh	NC	27611				170397531367	delivered 3/24/2020
South Carolina Public Health Laboratory	Testing	State	kanh@dhec.sc.gov	803.896.0965	8231 Parklane Road	Columbia	SC	29223				170397531448	delivered 3/24/2020
Tennessee Department of Health: Laboratory Services	Testing	State	richard.steece@tn.gov	615.262.6301	630 Hart Lane	Nashville	TN	37243				170397531610 170397531621 170397531632 170397531643	delivered 3/24/2020

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: Eckes, Jeanne (OS/ASPR/EMMO)
To: Tim.Hatch@adph.state.al.us; [Andy.Mullins@adph.state.al.us]; john.hooper@adph.state.al.us; Jim.Craig@msdh.ms.gov; wayne.vaughn@msdh.ms.gov; christy.craft@msdh.ms.gov; Combs, Brian; Stephanie Anspaugh-Naples (Stephanie.Anspaugh-Naples@flhealth.gov); Clement, Kimberly D; amanda.b.williford@dhhs.nc.gov; Blair, Jamie D.; Harbison, Dave A.; peter.koonz@tn.gov; paul.petersen@tn.gov; sean.j.kice@tn.gov; Christie.Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSS/CPR/DSLR); Rykaes, Scott A; Samantha.Cooksey@flhealth.gov; Gillis, Rebecca L (CHPS PPH EPR); jamesr.house@ky.gov; Hume, Robbie .; Jasie Logdson (Jasie.Logsdon@ky.gov); Johnson, Rick D (CHPS DPH EPR); Kik, Angela M.; White, Connie (CHPS PH) (Connie.White@ky.gov); K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Cc: Strzech, Gracia (DHS/FEMA); Manny J. Toro (manny.toro@fema.dhs.gov); Samaan, Robert (DHS/FEMA); robert.p.ashe.mil@mail.mil; Stacy Gunnin (Stacy.Gunnin@fema.dhs.gov); IMT2 Administration and Finance (OS/ASPR); Barton, Jessie-Kate (OS/ASPR/EMMO); Ramirez, Gabriela (OS/ASPR/EMMO); R4 PHUL (FEMA.DHS.GOV); FEMA-R4-RRCC-SITL; FEMA-R4-WatchUnit (fema.dhs.gov); Maiden, Shawn; Strouse, Phillip; Teague, Brian; D'Angelo, Joseph .; Dellamura, Joseph .; FEMA-LRC-Chief (fema.dhs.gov); Hare, Kertz; Hecht, Randall; BRDC LOGS Supply Box
Subject: swab delivery
Date: Wednesday, March 25, 2020 8:00:48 PM

Good evening,
I received word that the following locations have received the following states received 4000 swabs today. The locations are listed below.

Swab delivery info from today

Organization Name	Testing Status	State/Local	Primary E-Mail	Primary Phone	Address	City	State	Zip	Shipping POC	Email	Phone	Tracking information for swab shipments from PBM/LifeSign	Status
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Jeanne

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R4-phul@fema.dhs.gov
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cell: 404.772.9701
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Alternate phone numbers
cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: TELE-TOWN HALL TONIGHT WITH SEC. AZAR
Date: Sunday, March 15, 2020 4:06:54 PM

The HHS Office of Intergovernmental and External Affairs would like to invite you to join a tele-town hall with Secretary Alex Azar **TODAY** at **7:00 PM ET** regarding the testing for COVID-19 in the United States. The call will provide information to state public health officials, clinical laboratories, and healthcare systems to best serve the public health interests of the American public during the COVID-19 emergency. The Secretary will be joined by additional officials who are leading the Administration's efforts to combat COVID-19's spread in the United States.

THIS INVITE SHOULD NOT BE FORWARDED OUTSIDE OF YOUR ORGANIZATION. But, to provide for a robust call, please ensure that the appropriate person from your organization is on the call. Ideally this person will have a grasp of the technical and operational issues of testing for the organization or jurisdiction. If there is an organization that you work with that you believe should receive this invite, please reply directly with that suggestion.

CLICK HERE to register for the call.

Sincerely,
Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: TELE-TOWN HALL TONIGHT WITH SEC. AZAR
Date: Sunday, March 15, 2020 4:08:48 PM

The HHS Office of Intergovernmental and External Affairs would like to invite you to join a tele-town hall with Secretary Alex Azar **TODAY** at **7:00 PM ET** regarding the testing for COVID-19 in the United States. The call will provide information to state public health officials, clinical laboratories, and healthcare systems to best serve the public health interests of the American public during the COVID-19 emergency. The Secretary will be joined by additional officials who are leading the Administration's efforts to combat COVID-19's spread in the United States.

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Darcie

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

From: Baker, Michael (OS/IEA)
To: Baker, Michael (OS/IEA)
Subject: TELE-TOWN HALL TONIGHT WITH SEC. AZAR
Date: Sunday, March 15, 2020 4:06:27 PM

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Sincerely,
Darcie

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Director, Intergovernmental Affairs
U.S. Department of Health and Human Services

AMERICAN OVERSIGHT

From: Rivkees, Scott A
To: jsb6@cdc.gov
Subject: test data by state
Date: Wednesday, March 25, 2020 8:00:18 AM

Dear Joe

Please let me know when the # of tests performed per state data will be available.

Thanks

Scott

Scott A. Rivkees, M.D.
Surgeon General
Florida Department of Health

Scott.Rivkees@flhealth.gov
Office: 850-245-4210
Cell: 850-408-9735



Please note that under Florida law correspondence, which is not confidential or exempt pursuant to the Florida Statutes, is a public record made available upon request.

AMERICAN OVERSIGHT

From: Otis, Aaron
To: Bowman, Thomas; Mann, Travis (OS/ASPR/EMMO)
Cc: McCoy, Steve; Blackmore, Carina
Subject: Testing of Florida Resident
Date: Saturday, March 14, 2020 5:30:33 PM

Tom,

I confirmed with our State Epidemiologist and Deputy Secretary for Health we will NOT be requesting testing of the 53 Floridians prior to transport.

Aaron

CDR Aaron B. Otis
Public Health Advisor
Bureau of Preparedness and Response
Division of Emergency Preparedness and Community Support
Florida Department of Health

United States Public Health Service
CDC Public Health Advisor

4052 Bald Cypress Way Bin A23
Tallahassee, Florida 32399

aaron.otis@flhealth.gov
850-617-1534
850-445-1380 Mobile
850-245-4580 Fax

DOH Mission Statement: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

PLEASE NOTE: Florida has very broad public records laws. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to disclosure.

How am I doing? Please let me know by taking this short survey. Thank you!
http://survey.doh.state.fl.us/survey/entry.jsp?id=1389303062486

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Cc:	Trent-Adams, Sylvia (HHS/OASH)
Subject:	Thank you - and follow-up email
Date:	Tuesday, March 17, 2020 6:58:19 PM

Dear State Health Officials –

Thank you so much for listening to HHS on the ASTHO call earlier this evening. As we mentioned, our goal is to increase the synergy between the testing operations that have stood up and the rollout of the HHS testing sites across the country. We hope to highlight locations for testing for COVID-19 everywhere in the nation. If you are willing and able to share the information from testing sites in your states, we would greatly appreciate it. Please find below some of the key pieces of information that we are seeking.

- Facility Name
- Facility Address
    - Street Address
    - City
    - County
    - State
    - Zip code
- Phone Number (if applicable)
- Days/Hours of Operation
- Requirements for Testing, *if any* (i.e. note from physician, age, symptoms, travel)
- Drive-thru, walk-in, or other? (If other, please specify.)

We thank you for your continued partnership and support. ASTHO and its members have always been a key partner of HHS, and we appreciate everything that you do. Please don't hesitate to reach out to me if there are any questions. I can be reached via email or my phone number below.

Thank you!
Michael

Michael Baker
Office of Intergovernmental and External Affairs
Office of the Secretary
U.S. Department of Health and Human Services
202-439-7829

AMERICAN OVERSIGHT

From: TMS Mailbox (CDC)

To: CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; DeNauro, Robin (CDC/DDPHSS/CSELS/DSEPD) (CTR); Pevzner, Eric (CDC/DDPHSS/CSELS/DSEPD); CDC EISO Class 2018; Carroll, Dianna D. (CDC/DDPHSS/CSELS/DSEPD); Eaton, Danice (CDC/DDPHSS/CSELS/DSEPD); Robinson, Byron (CDC/DDPHSS/CSELS/DSEPD); Bosch, Stacey A. (CDC/DDPHSS/CSELS/DSEPD); Bisgard, Kris (CDC/DDPHSS/CSELS/DSEPD); Wright, Jennifer G. (CDC/DDPHSS/CSELS/DSEPD); Beavers, Suzanne (CDC/DDPHSS/CSELS/DSEPD); Liang, Jennifer (FDA/CDER); Cohen, Larry (CDC/DDPHSS/CSELS/DSEPD); Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD); CDC EISO EAC Roster 2018; Lee, Beth (CDC/DDPHSS/CSELS/DSEPD); Henning, Tara C. (CDC/DDPHSS/CSELS/DSEPD); Broughton, Latwanda (CDC/DDPHSS/CSELS/DSEPD); Hamilton, Takiyyah (CDC/DDPHSS/CSELS/DSEPD) (CTR); Alvarez, Cindy (CDC/DDPHSS/CSELS/DSEPD); Kennedy, Cynthia (CDC/DDPHSS/CSELS/DSEPD); Arvelo, Wences (CDC/DDPHSS/CSELS/DSEPD); Teresa and John Horan; Ralph H. Henderson,M.D.; Davis, Meagan (CDC/DDPHSS/CSELS/DSEPD); Amos, Renee J. (CDC/DDPHSS/CSELS/DSEPD) (CTR); Bradley, Seliscia A. (CDC/DDPHSS/CSELS/DSEPD); Cordeira, Kelly (CDC/DDPHSS/CSELS/DSEPD); Wiese, Nicholas (CDC/DDID/NCEZID/DHCPP); Mayer, Oren (CDC/DDID/NCEZID/DHCPP); York, Shannon (CDC/DDPHSS/CSELS/DSEPD); Chastain Potts, Shelby (CDC/DDID/NCEZID/DHCPP); Hott, Amanda (CDC/DDID/NCHHSTP/DTE); Woodson, Evonne (CDC/DDID/NCHHSTP/DSTDP); Stokes, Kindra (CDC/DDPHSS/CSELS/DLS); Scherer, Erin (CDC/DDID/NCIRD/DBD); Jacobs, Jesica (CDC/DDPHSS/CSELS/DSEPD); Buono, Sean (CDC/DDID/NCIRD/DBD); Carlson, Christina (CDC/DDPHSIS/CGH/DPDM); Freeman, Brandi (CDC/DDID/NCIRD/DVD); Levinson, Kara (CDC/DDPHSS/CSELS/DSEPD); Wadhwa, Ashutosh (CDC/DDID/NCEZID/DHQP); Barkley, Joi (CDC/DDPHSS/CSELS/DSEPD) (CTR); CDC LLS Class 2018; CDC LLS Class 2019; CDC EISO Class 2019

Subject: THIS SEMINAR HAS BEEN CANCELLED: TMS Presents: Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

Attachments: image003.jpg

AS A RESULT OF THE COVID-19 RESPONSE, THIS SEMINAR HAS BEEN CANCELLED.

Maureen will be asked to present her work at a later date.

Knowledge Bank: Building Virtual Pathology Biorepositories to Research Cancer Epidemiology

SPEAKER

Maureen Miller, MD MPH

EIS officer in the National Center for Chronic Disease Prevention and Health Promotion

Attendance Options and Continuing Education

* Remote options: • IPTV <http://cdciptv.cdc.gov/> • Envision <http://crss.cdc.gov/EnvisionList.aspx> • Adobe webinar <https://virtualsepd.adobeconnect.com/tms2/>

• Audio conference (1-866-761-5101, passcode “8445480#”)

* Continuing education (CE) is available; see the TMS CE instructions <http://intranet.cdc.gov/csels/dsepd/pdfs/HowToGetContinuingEd.pdf> .

* See the TMS schedule and CE statements <http://intranet.cdc.gov/csels/dsepd/ewb/tuesday-monthly-seminars.html> .

* There is no cost for this activity.

AMERICAN OVERSIGHT



AMERICAN OVERSIGHT

From:	Cantrell, Kimberly (CDC/DDPHSIS/CSTLTS/OD)
To:	CDC IMS State Coordination Task Force (SCTF) MCCM LNO
Cc:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Time Sensitive Request Due 3/3/2020: Request for Primary and Secondary Point of Contact for any Supply Chain Issues within your State.
Date:	Friday, February 28, 2020 1:30:41 PM

Greetings PHEP Directors & State Epidemiologists –

The outbreak of COVID-19 in China has led to a disruption in the global supply chain of personal protective equipment (PPE). CDC recognizes that healthcare facilities may experience temporary shortages even if they do not care for patients with COVID-19. CDC has released guidance for optimizing the use of N95 respirators, which includes some recommendations that may be applicable to other types of PPE, including surgical masks. CDC also has guidance regarding who needs and does not need PPE to help prevent excessive use of PPE.

As you are aware, this is a delicate system with many factors. When CDC receives notifications from healthcare systems about supply chain shortages, we encourage the Healthcare Coalition Partners to work together to problem solve within the coalition and/or wider state system. Further we encourage the healthcare systems to reach out to the state health department to collaborate and problem solve.

We have heard from the healthcare system partners that have contacted us that they are unsure whom to contact in the state health department about supply chain shortages in their facilities. As a way to help mitigate this, **we are asking you to reply to eocsctfmccmlno@cdc.gov no later than March 3, 2020, with an identified primary and secondary point of contact for any supply chain issues within your state.**

Please provide the following information:

- **Name/Agency**
- **Title**
- **Email Address**
- **24/7 phone number**

If you have any questions, you may contact Jaime Jones-Wormley, CDC State Coordination Task Force Liaison to the Medical Care and Countermeasures Task Force at eocsctfmccmlno@cdc.gov.

Thank you for your efforts to support the COVID-19 response.

Kimberly Cantrell
State Coordination Task Force
Centers for Disease Control and Prevention
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov
(this email was sent as a BCC to the PHEP Directors and State Epidemiolgists)

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	Christie.Luce@flhealth.gov; Blackmore, Carina (CDC flhealth.gov)
Cc:	jennifer.coulter@flhealth.gov; CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Time Sensitive Request: DCIPHER Rights for the two 2019-nCoV modules (Florida)
Date:	Wednesday, February 12, 2020 4:41:31 PM
Attachments:	Florida.xlsx

Greetings PHEP Directors and State Epidemiologists,

As we prepare to use DCIPHER for the 2019-nCoV response (e.g., data collection, transmission, and data sharing), we are seeking additional information about the type of access for the users you previously identified for the nCoV 2019 DCIPHER platform.

The "access group" options are described here:

1. **Access to DCIPHER to VIEW (only) data**. Role allows individual to see a view of different reports and analyses for their jurisdiction's information and any aggregate national report that may be created.
2. **Access to DCIPHER for DATA ENTRY and EDITING**. Role allows individual to directly enter information into DCIPHER, edit data, see all data associated with the jurisdiction, in addition to viewing/creating different reports and analyses.

In the attachment, please complete information in the last two columns (epi and monitoring), select either **view** or **data entry/editing** for each user.

Please return your response to eocsctftfcoord@cdc.gov as soon as possible so we can configure the platform to support your jurisdictions' access requests.

Warm Regards,

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

AMERICAN OVERSIGHT

	A	B	C	D	E	F
1	OrgState	First Name	Last Name	Email Address	OrgName	Access Granted to 2019-nCoV
2	Florida	Ruth	Adams	Ruth.Adams@flhealth.gov	Florida Department of Health	No
3	Florida	Stephanie	Anspaugh-Naples	stephanie.anspaugh-naples@flhealth.gov	Florida Department of Health	No
4	Florida	Sebastian	Arenas	Sebastian.Arenas@flhealth.gov	Florida Department of Health	No
5	Florida	Elizabeth	Beshearse	elizabeth.beshearse@flhealth.gov	Florida Department of Health	No
6	Florida	Dean	Bodager	Dean.Bodager@flhealth.gov	Florida Department of Health	No
7	Florida	Laura	Castro	laura.castro@flhealth.gov	Florida Department of Health	No
8	Florida	Oscar	Celorio	Oscar.Celorio@flhealth.gov	Florida Department of Health	No
9	Florida	Georgianne	Cherry	Georgianne.Cherry@flhealth.gov	Florida Department of Health	No
10	Florida	Peter	Chirinos	peter.chirinos@flhealth.gov	Florida Department of Health in Palm Beach County	No
11	Florida	Deborah	Collinge	deborah.collinge@FLHealth.gov	Orange County Health Department	No
12	Florida	Kevan	Cook	Kevan.Cook@flhealth.gov	Florida Department of Health	No
13	Florida	Jennifer	Coulter	jennifer.coulter@flhealth.gov	Florida Department of Health, Bureau of Preparedness and Resposne	No
14	Florida	Jenny	Crain	jenny.crain@flhealth.gov	Florida State Department of Health	No
15	Florida	Jason	Crowe	jason.crowe@fdacs.gov	Florida Department of Agriculture and Consumer Services	No
16	Florida	Jamie	DeMent	Jamie.DeMent@flhealth.gov	Florida Department of Health	No
17	Florida	Nychie	Dotson	nychie.dotson@flhealth.gov	Florida Department of Health	No
18	Florida	Philip	Dulmage	philip.dulmage@flhealth.gov	Florida Department of Health	No
19	Florida	Timothy	Exline	timothy.exline@flhealth.gov	Florida Department of Health	No
20	Florida	Paul	Fiorella	paul.fiorella@flhealth.gov	Florida Dept of Health	No
21	Florida	Scott	Fryberger	scott.fryberger@flhealth.gov	Florida Department of Health-Seminole County	No
22	Florida	Teresa	Gorden	Teresa.Gorden@flhealth.gov	Florida Department of Health	No
23	Florida	Gayle	Guidash	Gayle.Guidash@flhealth.gov	Department of Health in Pinellas	No
24	Florida	Ashley	Hoskins	Ashley.Hoskins@flhealth.gov	Florida Department of Health	No
25	Florida	Brandi	Keels	brandi.keels@flhealth.gov	Florida Department of Health	No
26	Florida	Nicole	Kikuchi	Nicole.Kikuchi@flhealth.gov	Florida Department of Health	No
27	Florida	Kamal	King	Kamal.King@flhealth.gov	Broward Department of Health	No
28	Florida	Lea	Knezevich	Lea.knezevich@flhealth.gov	Florida Department of Health In Hernando County	No
29	Florida	Shamilla	Lutchman	shamilla.lutchman@flhealth.gov	Florida Department of Health	No
30	Florida	Christie	Mathison	Christie.Mathison@flhealth.gov	Florida Department of Health	No
31	Florida	Nina	Mattei	nina.mattei@flhealth.gov	Florida Department of Health in Hernando County	No
32	Florida	Katherine	McCombs	katherine.mccombs@vdh.virginia.gov	FL Department of Health	No
33	Florida	Rafael	Mendoza	Rafael.Mendoza@flhealth.gov	Florida Department of Health - Broward County	No
34	Florida	Megan	Milanese	Megan.Milanese@flhealth.gov	Florida Department of Health in Lake County	No
35	Florida	Denita	Mitchell	denita.mitchell@flhealth.gov	Florida Department of Health	No
36	Florida	Sasha	Nelson	Sasha.Nelson@flhealth.gov	Florida Department of Health	No
37	Florida	Ihab	Osman	Ihab.Osman@FLHealth.gov	Florida Department of Health	No
38	Florida	Aaron	Otis	aaron.otis@flhealth.gov	Centers for Disease Control and Prevention	No
39	Florida	Noemi	Padro	Noemi.Padro@flhealth.gov	Florida Department of Health - Hillsborough	No
40	Florida	Ryan	Pedigo	Ryan.Pedigo@flhealth.gov	FL DOH - Hillsborough	No
41	Florida	William	Ritten	William.Ritten@flhealth.gov	Department of Health in Lake County	No
42	Florida	Jordan	Snead	Jordan.Snead@flhealth.gov	Florida Department of Health Pasco County	No
43	Florida	Kimberly	Stockdale	Kimberly.Stockdale@flhealth.gov	FL Department of Health	No

AMERICAN OVERSIGHT

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1	Epi Forms	Movement and Monitoring Form
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AMERICAN OVERSIGHT

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44	Florida	Natasha	Strokin	Natasha.Strokin@flhealth.gov	Florida Department of Health in Miami-Dade	No
45	Florida	Terri	Sudden	Terri.Sudden@flhealth.gov	Florida Department of Health in Broward	No
46	Florida	Gastrude	Tassy Toussaint	Gastrude.Tassy-Toussaint@flhealth.gov	Florida Department of Health in Miami-Dade	No
47	Florida	Samantha	Taylor	samantha.taylor@flhealth.gov	Florida Department of Health - Seminole County	No
48	Florida	Mackenzie	Tewell	Mackenzie.Tewell@azdhs.gov	Florida Department of Health in Hillsborough County	No
49	Florida	James	Turchetta	James.Turchetta@flhealth.gov	Florida Department of Health in Broward County	No
50	Florida	Ana	Urueta	Ana.Urueta@flhealth.gov	Florida Department of Health in Pinellas County	No
51	Florida	Kaila	Yeager	Kaila.Yeager@flhealth.gov	Florida Department of Health in Pinellas County	No

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); CDC IMS State Coordination Task Force (SCTF) Operations; Byrd, Shirley K. (CDC/OCOO/OFR/OGS); Roush, Sandra (CDC/DDID/NCIRD/OD); Brammer, Lynnette (CDC/DDID/NCIRD/ID); Gross, Melanie S. (CDC/DDID/NCIRD/ID)
Subject:	Today at 2pm EST_All state call hosted by SCTF re: 2019-nCoV
Date:	Monday, February 10, 2020 11:55:57 AM

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

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

Participant Information

Bridgeline: 1(800)-857-6697
Participant Passcode: 1324420

For your convenience, call series dates are provided below.

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

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From:	O"Connor, Angelica (CDC/DDID/NCEZID/DPEI) on behalf of Epidemiology and Laboratory Capacity for Infectious Diseases (CD (CDC)
Cc:	Brathwaite, Wayne (CDC/DDID/NCEZID/DPEI); Downing, Janice S. (CDC/DDID/NCEZID/DPEI); Ganim, Alexandra M. (CDC/DDID/NCEZID/DPEI); Njoroge, Charlene F. (CDC/DDID/NCEZID/DPEI); Nonnenmacher, Patrick (CDC/DDID/NCEZID/DPEI); Pullman, "Amy" (Amanda) (CDC/DDID/NCEZID/DPEI); Shultz, Alvin (CDC/DDID/NCEZID/DPEI); Simpson, De"Lisa D. (CDC/DDID/NCEZID/DPEI); Snow, Jason N. (CDC/DDID/NCEZID/DPEI); CDC IMS State Coordination Task Force (SCTF) Operations; Byrd, Shirley K. (CDC/OCOO/OFR/OGS); Roush, Sandra (CDC/DDID/NCIRD/OD)
Subject:	Today at 2pm EST_All state call hosted by SCTF re: 2019-nCoV
Date:	Monday, February 3, 2020 11:41:53 AM
Importance:	High

Greetings,
We were just made aware of an all-state call that will be held today at 2pm EST and the topic is the Novel Coronavirus (2019-nCoV). The call is hosted by the CDC State Coordination Task Force (SCTF) and not the ELC; however, the content may be of interest.

The ELC role in our agency's response to this effort is still evolving but we will keep you posted with any information that is relevant to your program and ELC activities.

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

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

Participant Information

Bridgeline: 1(800)-857-6697
Participant Passcode: 1324420

For your convenience, call series dates are provided below.

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

CDC State Coordination Task Force (SCTF) - Operations
eocsctfops@cdc.gov
https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html

AMERICAN OVERSIGHT

From: Stevens, Lee (OS/IEA)
To: Johnston, Darcie (HHS/IEA); Stevens, Lee (OS/IEA)
Subject: Tools to Support Medicaid and CHIP - COVID-19
Date: Monday, March 23, 2020 1:18:46 PM

Dear Governors and State Health Officials:

The Trump Administration has released new tools to strip away regulatory red tape and unleash new resources to support state Medicaid and Children's Health Insurance Programs (CHIP) during the 2019 Novel Coronavirus (COVID-19) outbreak. Because of the President's bold action in declaring COVID-19 a national emergency, CMS now has a full suite of tools available to maximize responsiveness to state needs. The agency has created four checklists that together will make up a comprehensive Medicaid COVID-19 federal authority checklist to make it easier for states to receive federal waivers and implement flexibilities in their program.

The tools include:

- **1115 Waiver Opportunity and Application Checklist**
- **1135 Waiver Opportunity and Application Checklist**
- **1915(c) Appendix K Template**
- **Medicaid Disaster State Plan Amendment Template**

You can find a copy of the press release here: **https://www.cms.gov/newsroom/press-releases/trump-administration-releases-covid-19-checklists-and-tools-accelerate-relief-state-medicaid-chip**

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit **www.coronavirus.gov.** For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the, please visit the **Current Emergencies Website.**

Sincerely,

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

AMERICAN OVERSIGHT

From:	Soda, Elizabeth (CDC/DDID/NCEZID/DHQP)
To:	Blackmore, Carina (CDC flhealth.gov)
Cc:	Jones, Christopher M. (CDC/DDNID/NCIPC/OD); CDC IMS 2019 NCOV Response Healthcare IPC Field Unit; CDC IMS 2019 NCOV Response At Risk
Subject:	Touch base with FL

Please feel free to forward

.....

Join Skype Meeting <https://webconf.cdc.gov/lxn9/YRCSB0K8>

Trouble Joining? Try Skype Web App <https://webconf.cdc.gov/lxn9/YRCSB0K8?sl=1>

Join by phone

(404) 553-8912,,6336505# (Atlanta Dial-in Conference Region)	English (United States)
(855) 348-8390,,6336505# (Atlanta Dial-in Conference Region)	English (United States)

Find a local number <https://webaudio.cdc.gov?id=6336505>

Conference ID: 6336505

Forgot your dial-in PIN? <https://webaudio.cdc.gov> |Help <https://o15.officeredir.microsoft.com/r/rlidLync15?clid=1033&p1=5&p2=2009>

[!OC([1033])!]

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AMERICAN OVERSIGHT

From:	Adedeji, Cleopatra Y. (CDC/DDPHSIS/CSTLTS/DPPS) on behalf of DSLRCrisisCoag (CDC)
To:	Fleming, John (CDC houstontx.gov); Smith, Marquis - HHD; Schultz,Lisa (DSHS); Osborne,Lisette (DSHS); Anna Eisenberg - TX; Blackmore, Carina (CDC flhealth.gov); Catherine Brown - MA; Rustin, Chrs (CDC dph.ga.gov); Doris Brown - LA; Joann Schulte - Houston; Kara Loewe - FL; Katrina Plummer - MA; Mahsa Yazdy - MA; Mardrah Starks-Robinson - LA; Marla Wallace - FL; Kelly, Rosmarie (CDC dph.ga.gov); Sandra Harris - LA; Tifany Nguyen - GA; Varnado, Wendy (CDC msdh.ms.gov)
Cc:	Sevak, Krunal (CDC/DDPHSIS/CSTLTS/DPPS); Hansen, Sabrina (CDC/DDPHSIS/CSTLTS/DPPS); VanMaldeghem, Kelley (CDC/DDPHSIS/CSTLTS/OD) (CTR); Dacuan, Lindsay Barr (CDC/DDPHSIS/CSTLTS/OD) (CTR); Regan, Kelly Ann (CDC/DDPHSIS/CSTLTS/DPPS); Crockett, James B. (CDC/DDPHSIS/CSTLTS/DPPS)
Subject:	TP18-1802 Crisis CoAg: Hurricane Recovery Update
Date:	Monday, March 23, 2020 4:31:52 PM

Dear Colleagues,

CDC is aware that the public health system response to COVID-19 has resulted in many changes that impact hurricane-related projects funded under the TP18-1802 Crisis Cooperative Agreement.

Provided below is additional guidance to ensure maximum flexibility as you navigate necessary modifications to project activities:

1. **Canceling Convenings:** CDC, in accordance with the President's Coronavirus Guidelines for America -- 15 Days to Slow the Spread of Coronavirus (COVID-19), recommends that individuals and organizations cancel or postpone in-person events that consist of 10 people or more throughout the United States for the next 15 days. When feasible, organizers may modify events to be virtual. Please note that this interim guidance is based on what is currently known about the Coronavirus Disease 2019 (COVID-19). CDC will update this interim guidance as needed and as additional information becomes available.
    a. **Costs Incurred for Canceled or Postponed Convenings:** Recipients will be permitted to drawdown funds to cover nonrefundable costs incurred for previously approved Hurricane recovery related activities now canceled or postponed due to COVID-19. Recipients should make every effort to minimize costs associated with activities (i.e., seek reimbursement for flights, negotiate postponing meetings vs canceling, etc.).
    b. **Redirection of Funds:** To accommodate alterations to project activities, recipients may submit a request to redirect funds as needed. Please follow the steps outlined in the attachment *"Redirection of Funds Guidance"* to submit your request and receive prior written approval from CDC. As a reminder:
        i. Redirections that *exceed* 25% or $250,000 (or whichever is less) of the total approved budget should be submitted through GrantSolutions as a ***Budget Redirection Amendment*** which is a formal prior approval action completed by the Grants Management Specialist (GMS).
        ii. Redirections that are *less than* 25% or $250,000 (or whichever is less) of the total approved budget should be submitted in GrantSolutions as

AMERICAN OVERSIGHT

a ***Grant Note*** which should include written prior approval received from relevant Technical Monitor(s).

It is important to note that you <u>may not</u> redirect 1802 Hurricane Crisis funds to COVID-19 response activities. Funds may only be redirected to support other Hurricane recovery related activities and projects that are within scope of the award.

2. **No Cost Extension (NCE) Requests:** Per OMB's memorandum *"Administrative Relief for Recipients and Applicants of Federal Financial Assistance Directly Impacted by the Novel Coronavirus (COVID-19) due to Loss of Operations"* released on March 19th**,** TP18-1802 Hurricane recipients are eligible for a 'No Cost Extension' *up to* twelve (12) months for activities scheduled to end by or before December 31, 2020. Financial and performance reports will be due 90 days following the *end date of the extension*. For guidance on how to submit your request through GrantSolutions, please refer to the attached job aid.

   Along with the required components of NCE request(s), we ask that you also include a statement of how COVID-19 response has impacted the Hurricane-related projects for which extension is being sought. This will serve as formal documentation of the need for an NCE.

Thank you for your continued partnership and all that your organization does to protect our nation's public health. We encourage you to monitor this dynamic situation by visiting www.cdc.gov/COVID19 for the latest information and guidance. Please do not hesitate to reach out to your respective Project Officers with any questions or concerns.

Kind Regards,
Hurricane Crisis Cooperative Agreement Team

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, Atlanta, GA 30329

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Tuesday, March 10 - CDC COVID-19 Key Points & Updated Interim Infection Prevention & Control Guidance
Date:	Wednesday, March 11, 2020 1:06:02 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_10_2020 FINAL.pdf

Dear Colleagues,

Please see the attached CDC COVID-19 daily key points from Tuesday, March 10.

We would also like to draw your attention to the **"Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings"**. You can reference the guidance here. For your convenience, a summary of the changes are provided below:

- Updated PPE recommendations for the care of patients with known or suspected COVID-19
- Considerations for designating entire units within the facility, with dedicated healthcare personnel (HCP), to care for known or suspected COVID-19 patients and options for extended use of respirators, facemasks, and eye protection on such units.
- Updated recommendations regarding need for an airborne infection isolation room (AIIR).

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC Daily Key Points
Coronavirus Disease 2019 ("COVID-19") Outbreak
March 10, 2020 as of 10:20pm

Updated text is shown in colored text.

SNAPSHOT

- CDC has reported:
  - 647 confirmed and presumptive positive cases of COVID-19
  - 25 COVID-19 related deaths
  - 36 jurisdictions reporting

MAIN KEY POINTS

- There is an expanding global outbreak of respiratory illness called COVID-19 caused by a novel (new) coronavirus.
- Community spread is being detected in a growing number of places, including in the states of California, Washington and New York in the United States.
- There are 647 reported U.S. cases of COVID-19 from 34 states, New York City and the District of Columbia. New states reporting cases since yesterday include Louisiana and Ohio.
- The potential public health threat posed by COVID-19 is high, both globally and to the United States.
- More cases of COVID-19 are expected in the United States in the coming days, including more instances of community spread.
- As the outbreak continues, at some point, widespread transmission of COVID-19 in the United States is expected occur.
- Many people will get sick, but based on what is known about this virus, most people will not develop serious illness.
- Based on data out of China, where this virus first emerged, older adults and persons of all ages who have serious long-term health problems seem to be at higher risk for more serious COVID-19 illness.
  - It's important that people who are at higher risk of serious COVID-19 illness take special precautions to reduce their risk of getting sick.
  - CDC has guidance for what people at higher risk should do at this time.
- Public health efforts at this time are focused concurrently on containing spread of this virus and mitigating the impact of this virus.
- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

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SITUATION UPDATE

- 647 reported cases of COVID-19 have been detected in Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York (and New York City), North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 83 of these cases occurred through person-to-person spread.
    - 36 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.
    - 528 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 9, there are 79 state and local public health labs in 50 states and the District of Columbia that have successfully verified and are currently using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 9, 2020, CDC and local and state public health laboratories had tested a total of 8,854 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.
- CDC also recommends that older adults and travelers with underlying health issues avoid situations that put them at increased risk for more severe disease, including avoiding non-essential travel on long plane trips.

NEW GUIDANCE

- On March 10, CDC published updated Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings.
- Respiratory protection of healthcare workers is a priority and is especially important during aerosol-generating procedures for patients.
- Healthcare facilities are increasingly unable to procure reliable and sufficient infection control supplies, including N95 respirators.
- Because of supply demands associated with the COVID-19 response, CDC is updating its interim COVID-19 infection control guidance for the healthcare setting.
    - The aim of the revised interim guidance is to prioritize the use of N95 respirators and other respiratory protection devices during high-risk procedures, while still protecting

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healthcare personnel with facemasks and eye protection during other routine patient care activities in the setting of temporary respirator shortages.
    - This interim guidance aims to support healthcare facilities in practical decision-making at the local level.
    - This guidance also outlines multiple interventions that can be used to enhance protection of healthcare personnel.
- The spread of COVID-19 can be stopped in many ways, such as prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- Employers and healthcare workers should remember the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
    - All healthcare facilities should be reviewing their infection control supply inventories and taking steps to optimize supplies. This is particularly true for facilities that perform aerosol-generating procedures, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
    - The anticipated timeline for return to routine levels of PPE is not known.
- CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available. CDC has also provided a companion checklist to help healthcare facilities prioritize the implementation of the strategies.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not currently have respiratory protection programs or fit-tested HCP.
    - These facilities would not be able to implement all of the recommended infection control interventions in the previous version of this guidance.
    - Without respiratory protection programs and fit testing, unnecessary transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.

PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- Right now, some people are at higher risk of exposure/infection, including:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of having been exposed.

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PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness.
- The people who are at greatest risk are those who are older and those who have serious long-term health conditions like diabetes, heart disease, or lung disease.
- This seems to be a disease that affects adults, and older adults, most seriously.
    - Starting at age 60, there is an increasing risk of severe disease and the risk increases with age.
    - The highest risk of serious illness and death is in people older than 80 years.
- People with serious underlying health conditions also are more likely to develop serious outcomes including death.
- Reports out of China that looked at more than 70,000 COVID-19 patients found that about 80% of illness was mild and people recovered. 15% to 20% developed serious illness.
- Of the more than 70,000 cases, only about 2% were in people younger than 19.
- These are early data and more information from countries outside of China, including experience here in the United States, will inform the public health response as time goes on. For now, data suggest that measures should be taken to protect America's oldest population, who are most vulnerable to severe COVID-19 illness.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and
        - People who have been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)

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        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
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    - CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

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From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Tuesday, March 10 - CDC COVID-19 Key Points & Updated Interim Infection Prevention & Control Guidance
Date:	Wednesday, March 11, 2020 1:13:59 AM
Attachments:	CDC_COVID-19_Daily Key Points__3_10_2020 FINAL.pdf

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To:	CDC IMS State Coordination Task Force (SCTF) Lead
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- There is no vaccine to protect against COVID-19 and no medications approved to treat it.
- Nonpharmaceutical interventions are actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of respiratory illnesses like COVID-19.
- Currently, nonpharmaceutical interventions are the most important response strategy against COVID-19.
- All communities can take measures to reduce the spread of COVID-19. Everyone has a role to play in getting ready and staying healthy.

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SITUATION UPDATE

- 647 reported cases of COVID-19 have been detected in Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York (and New York City), North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.
    - 83 of these cases occurred through person-to-person spread.
    - 36 cases occurred in persons who had traveled to international areas with sustained (ongoing) transmission.
    - 528 cases are still being investigated to determine the source of exposure.
- CDC has developed a map of the U.S. that shows affected states and how many COVID-19 cases they have reported.
- Because states are reporting their results directly and publicly, sometimes in near real-time, CDC case counts may be different from what states, local authorities, or media are reporting.
    - In the event of a discrepancy between case counts reported by state or local public health officials versus CDC-reported numbers, the numbers reported by states should be considered the most up to date.
- As of the evening of March 9, there are 79 state and local public health labs in 50 states and the District of Columbia that have successfully verified and are currently using COVID-19 diagnostic tests.
- CDC has developed a map showing which states and territories have one or more laboratories that have successfully verified and are currently using COVID-19 diagnostic tests.
    - This list is provided by the Association of Public Health Laboratories (APHL).
    - The same page includes information on the number of COVID-19 specimens tested.
- As of the evening of March 9, 2020, CDC and local and state public health laboratories had tested a total of 8,854 specimens.
- CDC is reviewing and updating travel notices almost on a daily basis.
- On March 8, CDC recommended travelers, particularly those with underlying health issues, defer all cruise ship travel worldwide.
- CDC also recommends that older adults and travelers with underlying health issues avoid situations that put them at increased risk for more severe disease, including avoiding non-essential travel on long plane trips.

NEW GUIDANCE

- On March 10, CDC published updated Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings.
- Respiratory protection of healthcare workers is a priority and is especially important during aerosol-generating procedures for patients.
- Healthcare facilities are increasingly unable to procure reliable and sufficient infection control supplies, including N95 respirators.
- Because of supply demands associated with the COVID-19 response, CDC is updating its interim COVID-19 infection control guidance for the healthcare setting.
    - The aim of the revised interim guidance is to prioritize the use of N95 respirators and other respiratory protection devices during high-risk procedures, while still protecting

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healthcare personnel with facemasks and eye protection during other routine patient care activities in the setting of temporary respirator shortages.
    - This interim guidance aims to support healthcare facilities in practical decision-making at the local level.
    - This guidance also outlines multiple interventions that can be used to enhance protection of healthcare personnel.
- The spread of COVID-19 can be stopped in many ways, such as prompt screening and triage, limiting personnel in the room, hand hygiene, source control, and effective environmental cleaning.
- Employers and healthcare workers should remember the hierarchy of controls.
    - PPE is only one aspect of patient and worker safety and involves a high level of worker involvement and is highly dependent on proper fit and correct use.
    - All healthcare facilities should be reviewing their infection control supply inventories and taking steps to optimize supplies. This is particularly true for facilities that perform aerosol-generating procedures, so that appropriate PPE will be available for high-risk procedures now and as potential COVID-19 cases increase.
- Healthcare administrators should continue to do everything possible to acquire the needed supplies to protect their staff and patients.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19.
    - The anticipated timeline for return to routine levels of PPE is not known.
- CDC has posted information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air purifying respirators [PAPRs]) when N95s are not available. CDC has also provided a companion checklist to help healthcare facilities prioritize the implementation of the strategies.
- The majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not currently have respiratory protection programs or fit-tested HCP.
    - These facilities would not be able to implement all of the recommended infection control interventions in the previous version of this guidance.
    - Without respiratory protection programs and fit testing, unnecessary transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care may occur.
    - In areas with community transmission, acute-care facilities will be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization.

PEOPLE AT HIGHER RISK OF EXPOSURE/INFECTION

- Right now, some people are at higher risk of exposure/infection, including:
    - People in communities where ongoing community spread with the virus that causes COVID-19 has been reported are at elevated though still relatively low risk of exposure.
    - Healthcare workers caring for patients with COVID-19 are at elevated risk of exposure.
    - Close contacts of persons with COVID-19 also are at elevated risk of exposure.
    - Travelers returning from affected international locations where community spread is occurring also are at elevated risk of having been exposed.

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PEOPLE AT HIGHER RISK OF SERIOUS COVID-19 ILLNESS

- Early information out of China, where COVID-19 first started, shows that some people are at higher risk of getting very sick from this illness.
- The people who are at greatest risk are those who are older and those who have serious long-term health conditions like diabetes, heart disease, or lung disease.
- This seems to be a disease that affects adults, and older adults, most seriously.
    - Starting at age 60, there is an increasing risk of severe disease and the risk increases with age.
    - The highest risk of serious illness and death is in people older than 80 years.
- People with serious underlying health conditions also are more likely to develop serious outcomes including death.
- Reports out of China that looked at more than 70,000 COVID-19 patients found that about 80% of illness was mild and people recovered. 15% to 20% developed serious illness.
- Of the more than 70,000 cases, only about 2% were in people younger than 19.
- These are early data and more information from countries outside of China, including experience here in the United States, will inform the public health response as time goes on. For now, data suggest that measures should be taken to protect America's oldest population, who are most vulnerable to severe COVID-19 illness.

WHAT YOU CAN DO

- Everyone can do their part to help respond to this emerging public health threat:
    - Individuals and communities should familiarize themselves with recommendations to protect themselves and their community from getting and spreading respiratory illnesses like COVID-19.
    - Older people and people with severe chronic conditions should take special precautions because they are at higher risk of developing serious COVID-19 illness.
    - If you are a healthcare provider, be on the look-out for:
        - People who recently traveled from China or another affected area and who have symptoms associated with COVID-19, and
        - People who have been in close contact with someone with COVID-19 or patients with pneumonia of unknown cause. (Consult the most recent definition for patients under investigation [PUIs].)
    - If you are a healthcare provider or a public health responder caring for a COVID-19 patient, please take care of yourself and follow recommended infection control procedures.
    - If you are a close contact of someone with COVID-19 and develop symptoms of COVID-19, call your healthcare provider and tell them about your symptoms and your exposure. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.
    - If you are a resident in a community where there is ongoing spread of COVID-19 and you develop COVID-19 symptoms, call your healthcare provider and tell them about your symptoms. They will decide whether you need to be tested. Keep in mind that there is no treatment for COVID-19 and people who are mildly ill are able to isolate at home.

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- For people who are ill with COVID-19, but are not sick enough to be hospitalized, please follow CDC guidance on how to reduce the risk of spreading your illness to others. People who are mildly ill with COVID-19 are able to isolate at home during their illness.
- If you have been in China or another affected area or have been exposed to someone sick with COVID-19 in the last 14 days, you will face some limitations on your movement and activity. Please follow instructions during this time. Your cooperation is integral to the ongoing public health response to try to slow spread of this virus.

CDC ACTIONS

- The federal government is working closely with state, local, tribal, and territorial partners, as well as public health partners, to respond to this public health threat.
- The public health response is multi-layered, with the goal of detecting and minimizing introductions of this virus in the United States to reduce the spread and the impact of this virus.
- CDC is operationalizing all of its pandemic preparedness and response plans, working on multiple fronts to meet these goals, including specific measures to prepare communities to respond to local transmission of the virus that causes COVID-19.
- Pandemic guidance developed in anticipation of an influenza pandemic is being repurposed and adapted for a COVID-19 pandemic.
- Public health partners are encouraged to review their pandemic preparedness plans at this time.
- CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in more parts of the United States.
- CDC's Action for Preparing Communities for Potential Spread of COVID-19 include:
    - Preparing first responders, healthcare providers, and health systems
    - Reinforcing state, territorial, and local public health readiness
    - Supporting communities, businesses, and schools

COMMUNITY BASED INTERVENTIONS (AKA COMMUNITY MITIGATION)

- Americans should be prepared for the possibility of a COVID-19 outbreak in their community. Everyone has a role to play.
- Currently, a vaccine is not available for COVID-19. Until a vaccine is developed, community-based interventions, such as school dismissals, event cancellations, social distancing, and plans to work remotely, can help slow the spread of coronavirus.
- Your local public health department and community partners have been preparing for an event like COVID-19 and have plans in place. Now is a good time for businesses, community and faith-based organizations, schools, and health-care systems to reexamine their preparedness plans to make sure they are ready.
- Strong community partnerships between local health departments, the health care sector, faith-based organizations, and other community partners are vital for this response, and will be necessary to prepare for and coordinate if an outbreak occurs.
    - Community-based interventions can be grouped in three categories:
        - Personal protective measures (e.g., voluntary home isolation of ill persons, voluntary home quarantine of exposed household members, covering nose/mouth when coughing or sneezing, hand hygiene, using face masks in community settings when ill)

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        - Community measures aimed at increasing social distancing (e.g., school dismissals, social distancing in workplaces, postponing or cancelling mass gatherings)
        - Environmental measures (e.g., routine cleaning of frequently touched surfaces)
    - CDC has recommendations to protect yourself and your community from getting and spreading respiratory illnesses like COVID-19.

For more information please visit the Coronavirus Disease 2019 Outbreak Page at: www.cdc.gov/COVID19.

AMERICAN OVERSIGHT

From:	Lushbaugh, Justin (CDC/DDNID/NCBDDD/DHDD)
To:	Claudia.Johnson@ky.gov; Pier, Kristi (CDC maryland.gov); Cramer, Steve (CDC health.mo.gov); Paras, Kathy (CDC utah.gov); Kamp, Susan (CDC vermont.gov); Laurie.Eldridge-Auffant@adph.state.al.us; Roberson, Shamarial (CDC flhealth.gov); bryan.russell@flhealth.gov; maggie.ferguson@idph.iowa.gov; jhall@ku.edu; Kbruns@ku.edu; hoffmana5@michigan.gov; Manning, Mary (CDC state.mn.us); Bluhm, Jim JB (CDC state.mn.us); Meg.Traci@mso.umt.edu; Susan.havercamp@osumc.edu; vanessas@uark.edu; Rodrigo.Monterrey@MassMail.State.MA.US; Barbara.wallace@health.ny.gov; weaverro@ohsu.edu; SMCDERMO@mailbox.sc.edu; devlinj@mailbox.sc.edu; Barb.Locker@ky.gov; Allison.perline@vermont.gov; Wimberley, Richard (CDC michigan.gov); HWelch@mt.gov; erin.ashinghurst@maryland.gov; bdkilpat@uark.edu; ann.robinson@osumc.edu; Kimberly.Phillips@unh.edu; holly.teal@health.ny.gov; Brenda.Maley@health.mo.gov; Kimberley.Warsett@state.ma.us; hornerjo@ohsu.edu; nettie.romanzo-smith@health.ny.gov; Evan.England@unh.edu; nassira.d.nicola@state.ma.us; aBraner@utah.gov; ctamayo@phhp.ufl.edu; Rachael.Austin@health.ny.gov; Patrick.Hodge@flhealth.gov; Casey, Margaret MC (CDC health.ny.gov); maureen.spence@health.ny.gov; rodrigo.monterrey@state.ma.us; LeeC@michigan.gov; anna.fuller@uky.edu; lindsey.c.mullis@uky.edu; chithra.adams@uky.edu; David.Ellsworth@odh.ohio.gov; Edward.Clark@flhealth.gov; FrameA@michigan.gov; Bishop, Susan (CDC state.mn.us); emily.smoak@state.mn.us; Mackenzie.Jones@mt.gov; Schulte, Ann (MDH); Crotty, Anne E
Cc:	Tilahun, Selam (MDH); Erin Taylor; Owens, Jasmine R. (CDC/DDNID/NCBDDD/DHDD)
Subject:	Upcoming COCA Call
Date:	Monday, March 23, 2020 10:30:35 AM

Good morning, all:

I hope this message finds each of you doing well.

Please see the below message:

Information for partners

Updated website content now available:

- Are you at higher risk for severe illness: This is an updated landing page.
- People who are at higher risk for severe illness. Based on the data we are seeing, this is the updated list of risk factors for severe illness.

COCA call tomorrow:

COCA Call - CDC Clinician Outreach and Communication Activity

Underlying Medical Conditions and People at Higher Risk for Coronavirus Disease 2019 (COVID-19)

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Overview

During this COCA call, presenters will focus on current information about people who are higher risk for COVID-19 complications because of their age or underlying medical conditions, particularly those that are not well-controlled.

Due to the high demand we anticipate for this COCA Call, we encourage participants to consider viewing on Facebook. To see the call live, please click on COCA's Facebook Page.

There will only be a few slides for this COCA Call. Slides will not advance during the presentation portion of this webinar. You can find the slides under the "Call Materials" tab here.

Advanced registration is not required.

If you are unable to attend the live COCA Call, it will be available for viewing on the COCA website a few hours after the live event ends. It will be available for viewing **immediately after** the live event ends at 3:00 P.M. ET on COCA's Facebook page.

Continuing Education will not be offered for this COCA Call.



Date: Tuesday, March 24, 2020
Time: 2:00pm–3:00pm (ET)

You may participate in this COCA Call via the Zoom platform or via Facebook Live.

Please note, the Zoom access links and dial-in information for this COCA Call have been changed. The corrected information is below:

https://www.zoomgov.com/j/1613416798

Or iPhone one-tap:
US: +16692545252,,1613416798# or +16468287666,,1613416798#

Or Telephone:
US: +1 669 254 5252 or +1 646 828 7666

Webinar ID: 161 341 6798

International numbers available:
https://www.zoomgov.com/u/acMT9czZKu

Presenters

John T. Brooks, MD
Chief Medical Officer, COVID-19 Response
Centers for Disease Control and Prevention

Georgina Peacock, MD, MPH, FAAP
COVID-19 Response, At Risk Task Force Lead

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Centers for Disease Control and Prevention

Sapna Bamrah Morris MD, MBA, FIDSA CAPT, U.S. Public Health Service
COVID-19 Response Health Systems Worker Safety Task Force, Clinical Team
Centers for Disease Control and Prevention

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

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

- CDC Clinician Outreach and Communication Activity Facebook page—connect with COCA on Facebook
- Clinician Outreach and Communication Activity—resources for healthcare providers
- COCA RSS Feed—subscribe to be notified of conference calls, updates, and CDC guidance for health providers
- Crisis & Emergency Risk Communication Training—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication
- Health Alert Network—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories

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Questions or Problems | Unsubscribe

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From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: UPDATE: Grand Princess Quarantine Orders Lifted
Date: Wednesday, March 25, 2020 9:09:43 PM

Dear Colleagues:

This week, CDC will lift quarantine orders for more than 1,300 people who have been quarantined from the Grand Princess cruise ship. As a top priority, CDC's COVID-19 response team will begin transmitting data to states of individuals who tested positive, including the following: contact information, date of test, date of result, and date of release. Many were asymptomatic and chose to be tested voluntarily. In addition, most were released from isolation based on the release of new clinical criteria. However, due to delayed test results from various laboratories processing the samples, some individuals had test results returned after they were released from quarantine. Lastly, following this notification you will begin to receive data on individuals with pending tests or extended quarantine periods. We are working with HHS/ASPR to transmit the results of pending tests to all departed passengers and any additional positive tests to the states.

Feel free to send any questions to preparedness@cdc.gov. Thank you!

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Updated CDC COVID-19 Guidance: Evaluating and Reporting Persons Under Investigation (PUI)
Date:	Thursday, February 27, 2020 4:26:05 PM
Importance:	High

Dear Colleagues:

CDC has posted updated Criteria to Guide Evaluation of PUI for COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Revisions were made on February 27, 2020, to reflect the following:

Information updated in the "Criteria to Guide Evaluation of PUI for COVID-19" section.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: State and Local Readiness (CDC)
Subject: Updated CDC COVID-19 Guidance: Evaluating and Reporting Persons Under Investigation (PUI)
Date: Thursday, February 27, 2020 4:27:57 PM

Dear Colleagues:

CDC has posted updated Criteria to Guide Evaluation of PUI for COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Revisions were made on February 27, 2020, to reflect the following:

Information updated in the "Criteria to Guide Evaluation of PUI for COVID-19" section.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

AMERICAN OVERSIGHT

From:	State and Local Readiness (CDC)
To:	State and Local Readiness (CDC)
Subject:	Updated CDC COVID-19 Guidance: Evaluating and Reporting Persons Under Investigation (PUI)
Date:	Thursday, February 27, 2020 4:23:34 PM
Importance:	High

Dear Colleagues:

CDC has posted updated Criteria to Guide Evaluation of PUI for COVID-19.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Revisions were made on February 27, 2020, to reflect the following:

Information updated in the "Criteria to Guide Evaluation of PUI for COVID-19" section.

Thank you,

State Coordination Task Force

Sent by BCC to PHEP Directors, SHOS, State Epis, Non-governmental Partners, STLTs, and BCHC

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From:	Gronostaj, Michael (CDC/DDPHSS/CSELS/DSEPD)
To:	CDC EISO Class 2018; CDC EISO Class 2019; CDC LLS Class 2018; CDC LLS Class 2019
Cc:	Epi Aid (CDC); LLS (CDC); CDC EISO Supervisors 2018; CDC EISO Supervisors 2019; CDC LLS Supervisor 2018; CDC LLS Supervisors 2019
Subject:	Updated Guidance for Returning CDC Staff from 2019-nCoV Domestic Field Deployments
Date:	Friday, February 7, 2020 2:44:49 PM

Hello EIS/LLS,

OSSAM, after consulting with infection prevention and control subject matter experts, has updated the February 1, 2020, Guidance for Returning CDC Staff from 2019-nCoV Domestic Field Deployments with more detailed instructions based on new public guidance released by CDC this week.

Please use the new Guidance for Returning CDC Staff from 2019-nCoV Domestic Field Deployments to better understand requirements of CDC staff returning from 2019-nCoV domestic deployments. CDC is currently developing guidance for those returning from overseas deployments.

For all employees returning from China (e.g., on leave), supervisors should follow published CDC guidance found in the new public guidance. This provides important information regarding returning to work for employees who recently arrived in the U.S. from China (e.g., employees categorized as Medium or High risk).

Please contact your Management Officer if you have questions regarding telework or other workplace flexibilities.

Please direct health and safety questions to OSSAM at EOCevent300@cdc.gov.

Distributed by:
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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	UPDATED Risk Assessment and Management Guidance
Date:	Thursday, March 5, 2020 11:10:42 PM

Dear Colleagues:

CDC's **"**Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures" has been updated and is now available online. You can find the guidance here. This link includes a summary of updates to the guidance. Please let us know if you have any questions.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

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(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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From:	State and Local Readiness (CDC)
To:	CDC IMS State Coordination Task Force (SCTF) Lead
Subject:	Updated Summary Key Points 2019-nCoV, January 31, 2020
Date:	Saturday, February 1, 2020 7:36:14 PM
Attachments:	CDC_2019-nCoV Daily Key Points__1_31_2020_corrected.pdf

Good Evening,

Please note - A correction was made to the 2019-nCoV summary key points from yesterday. Attached, you will find the latest **UPDATED** version. Feel free to share amongst your staff and appropriate parties.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

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CDC 24/7
PROTECTING AMERICA'S SAFETY, HEALTH, AND SECURITY

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

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CDC Daily Key Points — CORRECTED
2019 Novel Coronavirus (2019-nCoV)

January 31, 2020

MAIN KEY POINTS

- There is an expanding outbreak centered in China of respiratory illness caused by a novel (new) coronavirus abbreviated "2019-nCoV."
- This virus is spreading from person-to-person in China. A growing number of counties are reporting cases in travelers from China.
- Some limited person-to-person spread has been reported in countries outside of China. Spread from an infected person who did not have symptoms to another person has been reported as well (i.e., asymptomatic spread).
- On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency for the United States to aid the nation's healthcare community in responding to 2019 novel coronavirus.
- Also on January 31, the President of the United States signed a presidential "Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus."
- Measures were announced at a press briefing by members of the President's Coronavirus Task Force.
- This announcement follows the decision by the International Health Regulations Emergency Committee of the World Health Organization (WHO) to declare the outbreak a "public health emergency of international concern" (PHEIC).
- The situation is rapidly changing and we are monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this – when a new virus is emerging to infect people – are always concerning. Some people might be worried about this virus and how it may impact Americans.
    - While this situation poses a very serious public health threat, CDC believes the immediate risk to the U.S. public continues to be low at this time.
    - Risk also depends on exposure. People exposed to ill persons are at greater risk of infection. (For example, healthcare workers and family members caring for people with 2019-CoV.)
    - However, the situation is evolving, and risk will depend on how well the virus spreads, how widely it spreads, and how sick it makes people.
- CDC has activated its Emergency Operations Center and is implementing an aggressive public health response in collaboration with federal, state and local partners.
- The goal of the ongoing U.S. public health response is to prevent sustained spread of 2019-nCov in this country. Strong measures now may blunt the impact of the virus on the United States.
- The coming days and weeks are likely to bring more confirmed cases of 2019-nCoV in the United States and globally.

SITUATION UPDATE

- On January31, 2020, CDC issued federal quarantine orders to all 195 persons repatriated to the U.S. from Wuhan, China this week under statutory authority of the Health and Human Services Secretary. The quarantine will

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last 14 days from when the plane left Wuhan, China. This action is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.
- A New England Journal of Medicine letter to the Editor on January 30, 2020 reported on a case of 2019-nCoV infection acquired outside of Asia in which transmission appears to have occurred during the incubation period in the index patient.
- To date, 25 international locations (in addition to the U.S.) have reported confirmed cases of 2019-nCoV infection, including most recently Italy, Russia, Sweden and the United Kingdom.
- As of January 31, 2020, 7 infections with 2019-nCoV have been reported in the U.S. in four states – Arizona, California, Illinois, and Washington.
- The 6th infection with nCoV was detected in IL in a contact of the first 2019-nCoV patient and represents the first instance of person-to-person spread in the United States with this virus. The second IL patient reportedly had prolonged and close contact with the first patient.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. 2019-nCoV patients to detect person-to-person spread.
- CDC will continue to lean forward on public health response efforts to protect Americans. We are working closely with state and local health departments and have teams on standby to deploy if needed. Our public health goal continues to be to protect the health of Americans by preventing community spread with this virus.
- CDC will work through WHO China country office to support Chinese public health counterparts and help improve understanding of this new disease, including learning more about transmissibility and severity. One Beijing-based CDC expert is currently working with WHO in China and additional CDC headquarters experts are being identified and prepared for deployment.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
    - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
    - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
    - If you are a healthcare provider caring for a 2019-nCoV patient, please take care of yourself and follow recommended infection control procedures.
    - For people who may have 2019-nCoV infection, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance in on the CDC website.

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- For people who have had close contact with someone infected with 2019-nCoV who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a 2019-nCoV patient.

TRAVEL

- On January 31, 2020, the White House 2019 Novel Coronavirus Task Force held a press conference to announce the implementation of new travel policies.

For more information please visit the 2019 Novel Coronavirus Outbreak Page at: https://www.cdc.gov/coronavirus/2019-ncov/index.html

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	Updated: Community Based Testing Site (CBTS) Concept of Operations and Operating Criteria
Date:	Wednesday, March 25, 2020 6:20:01 PM
Attachments:	COVID-19 Community-Based Testing Sites CONOP 2020.03.24 v5.pptx FEMA CBTS Flyer_2_Web.pdf FEMA CBTS Flyer_2_Print.pdf

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May be dupe to some…..apologies

*****The CBTS Task Force updated its guidance for community-based testing sites. Please review and disseminate the attached guidance and fact sheet to help support questions from your state/local health partners.*****

Please see included the criteria and ConOps for operating a Community Based Testing Site. The Criteria outlines simple requirements for remaining in compliance with the program. This step was necessary due to a number of State modifications to the program that introduced compliances issues causing sites to be put on pause or taking off line. The updated ConOp streamlines the CBTS process and reduces potential exposure to the operators.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
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Alternate phone numbers

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cell: 202.322.1930 AT&T (primary)
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OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

COVID-19 COMMUNITY-BASED TESTING SITES

Concept of Operations Version 2

24MAR20

1

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COVID-19 CONTENTS

- Site Establishment and Logistical Support
- Pre-Screening Criteria
- Operations
- Data Requisition Forms
- Laboratory and Shipment Processes
- Resupply Process
- Reporting

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COVID-19 PURPOSE, SCOPE AND CRITERIA

Purpose

The purpose of the Concept of Operations is to provide specific operating guidance in the Whole Community approach to planning, establishing, supporting and operating Community-Based Testing Sites (CBTS) in response to COVID-19.

Scope

The CBTS concept provides communities the ability to establish stand alone and mobile test sites in order to service populations and individuals of immediate needs which includes: symptomatic populations consisting healthcare workers and first responders or who within 14 days of symptom onset had close contact with a suspect or laboratory-confirmed COVID-19 patient, and symptomatic individuals from high risk populations.

Criteria

1. Receive supplies from the federal government.
2. Ensure there is at least one United States Public Health Service (USPHS) officer at each site.
3. Use the lab ordering, sampling and packaging process established by the federal government.
4. Use the shipping company chosen by the federal government to pick up and deliver labs to the lab company selected by the federal government.
5. Use the federally contracted Call Center that will contact individuals with their results.

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COMMUNITY SITE AND PATIENT TESTING GUIDELINES

Site Location

In order to maximize resources and develop a holistic understanding of positive cases, State, Local, Tribal, and Territory partners, in coordination with Department of Health and Human Services and FEMA established CBTS based on a combination of high risk or affected areas and areas with higher vulnerable populations (I.e. 65+ yo) areas. It is important that sites support a whole community assessment of potentially affected areas. This provides an understanding of the magnitude of the impact within the area. Sites should take into consideration other planning factors such as, vulnerable populations, accessibility, traffic control and other measures that may impact throughput. In addition, sites must be accessible to all potential patients.

Screening Criteria

Priority 1	Priority 2	Priority 3
Hospitalized patients	Patients in long-term care facilities with symptoms	**Critical infrastructure workers with symptoms**
Healthcare facility workers with symptoms	**Patients over age 65 years with symptoms**	**Individuals who do not meet any of the above categories with symptoms**
	Patients with underlying conditions with symptoms	**Healthcare facility workers and first responders**
	First responders with symptoms	**Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations**

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SITE LOGISTICAL SUPPORT CONSIDERATIONS

The federal government has identified the commitment to support over 40 sites across the United States. States begin testing select healthcare workers involved in direct patient care (hospital staff, clinicians, and long-term care facilities) and first responders and then immediately transition to testing individuals who are at high risk for serious complications [subject to change based on DHHS and CDC guidance].

Logistical Requirements and Support

The federal government has procured a defined list of items required for initial CBTS through the Strategic National Stockpile as well as the private market. Continued logistical site support requirements need to follow the logistical support process flow.

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INITIAL FEDERALLY SUPPLIED SUPPLIES
(FOR 1 SITE FOR 1 WEEK)

- Unit = the entire list on the right, which is enough to run 1 testing site for a week of 2,500 tests
- Each Unit will be delivered in 6 different shipments
- If a state is getting 2 units, it will receive 12 shipments, etc.
- States, such as TX, will receive bulk shipment and are required to breakdown shipment to support each location with 1 unit

Initial Shipment: Essential Medical Supplies

Item	Target Quantity	Unit of Measure	Frequency	Supplier
Test Kits (e-swab or UVT)	2,500	Each	Weekly	Federal
Matched standard code-128 barcodes with unique numbers and 10-16 characters (Manreadable)	2,500	Pairs	Weekly	Federal
Non-contact infrared thermometer	4	Each	One-time	Federal
Gloves (Nitrile) *for those with allergies	10,000	Each	Weekly	Federal
Gloves (Latex) 6,700 per size	20,100	Each	Weekly	Federal
Scrub top (all sizes) 100-Medium, 100-Large, 100-2XL	300	Each	Launder	Federal
Scrub pants (all sizes) 100-Medium, 100-Large, 100-2XL	300	Each	Launder	Federal
PAPRs	5	Each	Weekly	Federal
Faceshields	500	Each	Weekly	Federal
N-95 Respirators (S, M, L)	4,480	Each	Weekly	Federal
Surgical Gowns	500	Each	Weekly	Federal
Tyvek Suits - Size L	250	Each	Weekly	Federal
Tyvek Suits - Size XXL	250	Each	Weekly	Federal
Tyvek Pullover Hoods/Shrouds/Headcovers (contingent upon type of PAPRs received/available)	1,000	Each	Weekly	Federal
Goggles (Anti-fog)	300	Each	Weekly	Federal
Tyvek Sleeves	20,000	Each	Weekly	Federal
Red Uline Garbage Cans	10	Each	Weekly	Federal
Biohazard Bags (25/wk x2 = 50 boxes)	50	Boxes	Weekly	Federal
Earloops Surgical Masks	1,000	Each	Weekly	Federal
Plastic Aprons (Not Surgical Aprons)	10,000	Each	Weekly	Federal
Specimen Transport Bag with requisition pouch. 6 x 9" polyethylene specimen bags	2,500	Each	Weekly	Federal
Insulated Foam Shipping Kit - 30 1/4 x 14 1/2 x 16"	1,575	Each	Weekly	Federal
Single-Use Cold Packs - 12 oz	9,450	Each	Weekly	Federal
UN3373 Biological Substance, Category B Air labels	1575	Each	Weekly	Federal
Tamper-Evident Tape, 3" x 110 yds	225	Each	Weekly	Federal
Telatemp Heat Indicator	1,575	Each	Weekly	Federal
Sharps containers	25	Each	Weekly	Federal
Whirl Pak Bags	2,500	Each	Weekly	Federal

Based on PPE reductions, resupply of N-95 masks will be 70 per week, per unit.

Available from National Stockpile

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LOGISTICS SUPPORT
(RECOMMENDATIONS, PROVIDED LOCALLY)

Overall Supplies

Item	Estimated Quantity	Unit of Measure	Frequency
Large Tent 19x35 (insulated) w/ Enviornmental Control Unit	5	Each	One-time
Mifi/ Wireless Internet for 10 users	1	Each	Ongoing
Surge Protectors	10	Each	One-time
Extension Cord 25ft	10	Each	One-time
Chalk	10	boxes	One-time
Cablepath Tape	5	rolls	One-time
Fire Extinguishers (A/B/C)	5	Each	One-time
Pallet Jacks	2	Each	One-time
Trash Bags (weekly)	50	boxes	Weekly
Copier/Scanners/Printers	3	Each	One-time
Toner cartridges	3	Each	Re-supply
Duct Tape	4	rolls	One-time
Folding Chairs	50	Each	One-time
Folding Tables	10	Each	One-time
Cross-cut Shredders	2	Each	One-time
Trash cans	8	Each	One-time
EZ Up Tents	6	Each	One-time
White Board	4	Each	One-time
Paper (weekly)	50	Reams	Re-supply
Pens (weekly)	100	Each	Re-supply
Staplers	10	Each	One-time
Folders (weekly)	10	boxes	Re-supply
8' Supersaver™ Players Bench/10W/ Backless/ Portable/ Black	6	Each	One-time
Mobile carts	10	Each	One-time
Mobile shelves	5	Each	One-time
Trade Show Litter Bags	1,000	Each	Weekly
Soap (weekly)	100	Containers	Re-supply
Carboy with spigot	5	Each	One-time
Filing Cabinent 3/4 drawers	4	Each	One-time
Refridgerators (with freezer)	2	Each	One-time
Laptop Computers + chargers	8	Each	One-time
Sharpies (thin point, regular)	200	Each	Re-supply
Whistle	10	Each	One-time
Caution tape	5	rolls	One-time
Safety Cones	100	each	One-time
broomhandle	100	Each	One-time
Safety Vest	25	Each	One-time
SIGN Forward Arrow	2	Each	One-time
SIGN Left Arrow	2	Each	One-time
SIGN Right Arrow	2	Each	One-time
SIGN No Parking	6	Each	One-time

Essential Medical Supplies

Item	Estimated Quantity	Unit of Measure	Frequency
Duct Tape Rolls (for PPE)	50	Each	Weekly
Cavicide Wipes	50	Containers	Weekly
Hand sanitizer	400	Each	Re-supply
Eye wash solution	10	Each	Re-supply
Care Touch Sterile Alcohol Prep Pads (2 Ply) - Alcohol Wipes 600 (weekly)	5	Boxes	Re-supply
Handheld Sprayer, Handheld Sprayer Type, Lawn and Garden Sprayer Application (2-gallon container with pump)	2	Each	One-time
RW Clean 25 oz Green Plastic Spray Bottle - Adjustable Nozzle - 1 count box	10	Each	One-time
Small Hand Mirrors	10	Each	One-time
Bandage Scissors	5	Each	One-time
Foot Tub Plastic Wash Basin - 6 Quart	10	Each	One-time
Buckets (5-gallon)	5	Each	One-time
Trash Pickers	5	Each	One-time
Pen Lights	10	Each	Re-supply
Bleach (weekly)	100	Containers	Re-supply
Chlorine Test Papers (100 Strips) (500 parts per million)	1	Containers	Re-supply
Facial Tissue (100 count)	10	Boxes	Weekly
Disinfecting Station (ETOH and water set-up using bucket/tub) (ex:gatorade cooler filled with alcohol or bleach solution)	7	Each	One-time
Thermometer - anything that does ambien temperature (for coolers)	4	Each	One-time
Deluxe Gauze Dressings 4x4 inch	500	Boxes	Weekly
One of the following:			
1. Rubber Gumboots (various sizes) + decon foot bath**	50	Pairs	One-time
2. Closed-toe clogs (various sizes) with Shoe Covers (if offering Closed-toe clogs)	50	Pairs	Weekly
	2,800	Each	Weekly
3. Bootie (option for personal footwear)	1,500	Each	Weekly
*Cooling vests for swabbers to wear in warm climates.**	12	Each	Re-supply
*Gondola carts**	2	Each	One-time
*Disposable Chemical Suits**	100	Each	Weekly
*Chemical resistant work gloves (all sizes)**	100	Pairs	Weekly
*Socks (mid-calf or higher)**	300	Each	Weekly
**recommended but not critical if unavailable*			

Contracted-based Services

Item	Estimated Quantity	Unit of Measure	Frequency	Notes
Biological Waste Service			Ongoing	
Dumpster Service	1	Each	Ongoing	8 Cu/yd or greater Emptied Daily
Portajons w/ Hand Wash Statuon 2 Reg 2 ADA 2 HWS	6	Each	Ongoing	Emptied/ Decon Daily
Retail Fuel Capability	1	Each	Ongoing	Truck w/ in Bed fuel tank for DS2
Fuel	100	gallons	Ongoing	daily requirement for 100 gallons DS2
5K Generator with appropate retail fuel capability	1	Each	Ongoing	
*5 KT Forklift** (can be circumvented with lift gate on transport truck to site)*	1	*Each*	*Ongoing*	
*Potential Shredder Bins **	2	Each	Ongoing	

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COVID-19 OPERATIONAL CONSIDERATIONS

States identify specific community needs based on several factors and there are specific operational processes the need to be followed in order to meet our desired end state. These include, but are not limited to, equipment conservation, testing documentation and reporting , laboratory chain of custody and testing protocols.

Specific Site Operational Considerations:

- Accessibility and Functional Capability Requirements to include emotional support animals
- Private and Public Transportation Needs and Throughput
- Adhere to State Regulated Medical Waste Procedures
- Translation services and hearing impaired
- Site Security and Local Emergency Services
- Traffic Control
- Basic Needs for Site Support Personnel (Feeding and Sanitation)
- Operations Communication Capabilities Public Communication
- Water / Feeding for Operators
- Site Support Training Requirements
- Site Sanitation and Safety Considerations
- Patient information daily tracking and reporting mechanism for results
- Training – Safety Officer
- Training – Quality Control Officer
- Recommendations for change of clothes/laundering of clothes worn during operation
- Daily tracking and reporting mechanism for results

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logging temp and registration information remains offset

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COVID-19

SITE OPERATIONS

Site Operation Process Categories

1. **Site Staff Guidelines:** Provides specific guidance on essential staffing requirements for each site.
2. **Patient Pre-Screening:** Provides guidance on initial patient screening in order to determine if follow-on testing is necessary.
3. **Site Patient Throughput and Support Personnel Responsibility Process:** Describes the recommended process to include specific roles and responsibilities of support personnel and required levels of protection.
4. **Packaging and Lab Processing:** Defines the specific packaging and lab processing requirements that must be followed, these cannot be deviated from due to contractual requirements.

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COVID-19 MINIMUM STAFFING RECOMMENDATIONS

USPHS Officers are prepared to be:

- **Site Team Lead:** Responsible for overall coordination of site and process standardization, execution of federal guidelines, and information and data management
- **Site Safety Officer:** Oversees all safety considerations for site operations.
- **Site Quality Control Officer:** Responsible for overseeing Quality Assurance through all test processes - IAW established standards.

TESTING STATIONS	STATE CBTS (1-lane operation)	STATE CBTS (2-lane operation)
Greeting/Entry	Runner: 1	Runner: 2
Assessment/Registration	Registration: 1 (+ Runner, who take temperature)	Registration: 2 (+ Runners, who take temperatures)
Data Entry (Offset, No PPE)	Data Entry for Registration: 1	Data Entry for Registration: 2
Sampling	Samplers: 2 QC: 1	Samplers: 4 QC: 2
Decontamination	Decontamination: 1	Decontamination: 2
Admin/Support Staff	Logistics: 2 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1	Logistics: 4 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1 Facilitator: 1 Water Sanitation: 3
Estimated Personnel	**13**	**26**

Estimated capability (1-lane operation): 12-24 individ
Estimated ~12 vehicles/hr at each station

2-lane operation for vehicles with driver and 1+ passenger(s): 12 (min) – **48** (max) individuals/hour

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COMMUNITY-BASED TESTING SITES (CBTS): MODIFIED CONOPS TO INCREASE PAPR USE

ESTIMATED TESTING SITE CAPACITY:

MAXIMUM 250 TESTS PER SITE, PER DAY DUE TO LAB THROUGHPUT

CDC Recommended Pre-Screening Criteria

1. **Criteria 1**: Anyone ≥65 years of age with on-site confirmed temperature of 99.6°F or greater **and** presents with respiratory symptoms.
2. **Criteria 2:** First responders, healthcare workers* (regardless of presence of symptoms). *This is only applicable to staff with direct patient contact (not those in administrative roles) or as determined at the state level.

Pre-Screening Process and Instructions

- Patients must bring:
  - Photo ID for all adults needing testing
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare or first responder ID
- Instructed not to take fever-reducing medicine within 6-8 hours prior to testing [such as Tylenol (acetaminophen) or Advil (ibuprofen)]
- If the CBTS personnel determine an individual meets the testing criteria, they will be tested. If the person does **NOT** meet the criteria, they will **NOT** be tested and be provided take-home educational material.

Definition of First Responder: Any individual responding to the public health task or mission, as determined by the jurisdiction.

Definition of Healthcare Worker: Any individual working or providing direct patient care in acute or critical settings (hospitals, clinics, long-term care facilities, emergency medicine).

**Regional/State sites can clarify or expand this classification based on needs/demand and adjust accordingly.

Minimum Personnel for 1 Lane Operations	
Entry	Runner: 1 in PAPR
Station 1	Registration: 1 Recorder in N95 respirator , coveralls, gloves. Note: Runner in PAPR takes temperature and passes documentation to patients. Recorder remains offset and records/relays registration information to Data Entry which is 15-ft offset from the vehicle lane.
Data Entry (Offset)	Registration: 2 Recorders. No PPE required.
Station 2	Swabbing: 2 PAX in PAPR QC (Labeling/Packaging): 1 PAX in PAPR
Decontamination	Decontamination Sprayer: 1 PAX in PAPR

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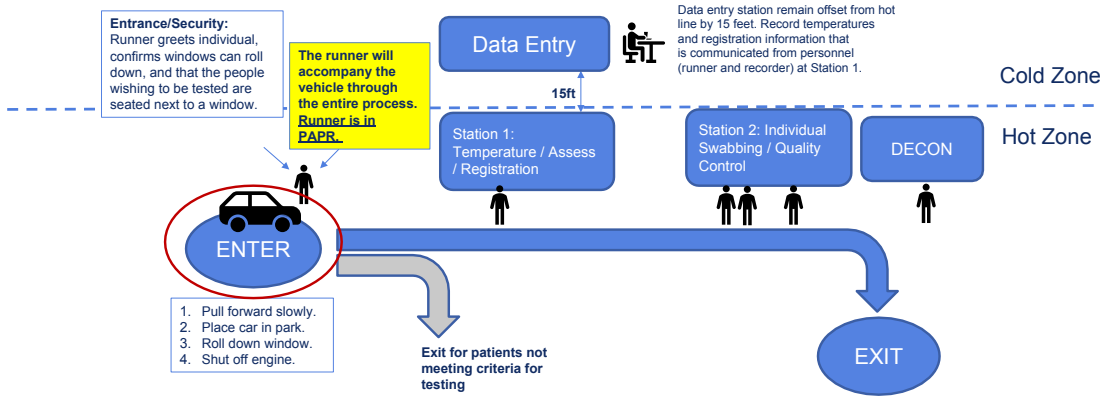
COVID-19 SITE LAYOUT

Stations for 1 Lane Process



Modifying the CBTS CONOP to only have two stations exposed to the vehicle/patients and moving those individuals to PAPRs will reduce mask requirements by 61%-98.5%. 61% assumes human error for every test requiring a change of mask every time for the individual wearing the mask. 98.5% assumes 10 errors per individual donning a mask, per day.

- Runner is in PAPR and takes temperature. (Runner stays with vehicle the entire time; guides through process. Goes through decon after vehicle departs and moves back to front.)
- Station 1 personnel includes 1 PAX in N95 mask and goggles to check identification, document/register, and relay registration details to data entry station. (Data Entry personnel (1-2PAX) are not in PPE. Their station is ~15ft offset and remains behind cold line.)
- Station 2 personnel includes 3 PAX in PAPR, i.e. 2 PAX to swab and 1 PAX to QC the sample and package.
- Decon includes 1 PAX in PAPR. Remains there to decon Station 2 personnel and runner with 10% chlorine spray after every interaction.

Total = 5 PAPRs

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COVID-19 STATION 1: TEMPERATURE VERIFICATION

Personnel Roles:

1. **Runner(s):** Take and document temperature on collection form (form holds patient ID number)

2. **Runner(s):** Provide document to vehicle providing public health information to include:
   - What should you do while you wait for test results?
   - Monitoring symptoms
   - If you test positive for COVID-19, continue to monitor your symptoms and manage appropriately
   - When can you stop isolating at home?

**Healthcare workers = personnel who are currently working in a healthcare facility, including long-term care facilities.*

Individuals Must Meet one of these Criteria:

Criteria 1:	65 years of age and older with temperature of 99.6F or greater and respiratory symptoms
Criteria 2:	First responders, Healthcare workers* (regardless of symptoms)

Individuals not meeting criteria are asked to leave the line

If you develop symptoms after leaving the site, visit **[URL TBD]** to check if you qualify for testing

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STATION 1: INDIVIDUAL REGISTRATION

Personnel Roles:

- **Recorder (1):** Document on written form demographic information for patient(s). Record unique identifier (barcode), site, date and lane number.

First	**Email**	**Form of Identification**
Last	**Address**	**Healthcare or First Responder ID**
Phone	**License Plate**	**Insurance Information**

Note: Information collected may change based on testing company requirements

- **Recorder (2) at Data Entry:** Registers document in electronic data collection tool capturing demographic information for patients to be tested

Unique Identifier (Barcode), Site, Date and Lane Info

Information flow dependent upon state requirements and processes

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COVID-19 DATA REQUISITION FORMS


COVID-19 Requisition Form


Excel file to Document Requisition Form D

Recommend sites update certain fields within the form (before printing on-site):

- **Site Location**: If Community-Based Testing Site (CBTS) has a specific name, input this here and keep it consistent throughout duration of testing. Labs will associate samples with this site specifically.
- **Site Address**: Physical location must be added within header to include city, state, zip code.
- Consider pre-populating the month and year within the form. Only date will need to be entered manually on-site
- Print estimated amount needed for operations for the week.

Every field on the attached form **is required** for the labs to be able to successfully process samples (including the fields within the header).

- LABS WILL NOT PROCESS SAMPLE IF ANY PORTION OF THIS FORM IS NOT FILLED OUT.

Sites must identify and designate a personnel member to verbally **read** the informed consent and privacy language to individuals (*verbiage is below*) before proceeding with registration and accurately identifying responses at the bottom of the form.

- For any individual requesting translation, utilize resources available, including telephonic. Collaborate with local healthcare network systems if necessary, as many have established contracts and accessibility to this.

Electronic

- This step is conducted electronically, if, and only if, there is a PHS officer on site with a federal computer. In this case, an excel file can be digitally populated with the information collection from the requisition form. This file serves as a failsafe in the event that there is an error on the handwritten document that is provided to the lab.
- The files will be maintained for 14 days. This is sufficient time for the labs to receive the requisition forms, process the results, and for the call center to return these results to the patient and to the state health department.
- The PII will not be shared with anyone with the CBTS process except the labs and the call center.
- If possible, the file will then be printed and include with the associated ULIINE shipment box including the specimens. This will allow the labs to conduct an inventory and ensure the correct number of specimens are within the box. This will also allow the labs to double check the data in case the requisition forms are not legible.
- If printing is not available, you will need to use a marker on the ULINE box to indicate the number of specimens within the box in order for the labs to conduct an inventory. Furthermore, if printing is not available the labs will be provided the site POCs in order to call and validate any illegible data on the requisition forms.

Manual

- Without a PHS with a federal computer, the excel file must be printed and manually updated.
- These forms will be shredded after 14 days. This is sufficient time for the labs to receive the requisition forms, process the results, and for the call center to return these results to the patient and to the state health department.
- This form is not to be shared with anyone other than the lab and the call center if either calls to validate illegible data.
- If possible, make a photo copy and include with the associated ULIINE shipment box including the specimens. This will allow the labs to conduct an inventory and ensure the correct number of specimens are within the box. This will also allow the labs to double check the data in case the requisition forms are not legible.
- If copying is not available, you will need to use a marker on the ULINE box to indicate the number of specimens within the box in order for the labs to conduct an inventory. Furthermore, if printing is not available the labs will be provided the site POCs in order to call and validate any eligible data on the requisition forms.

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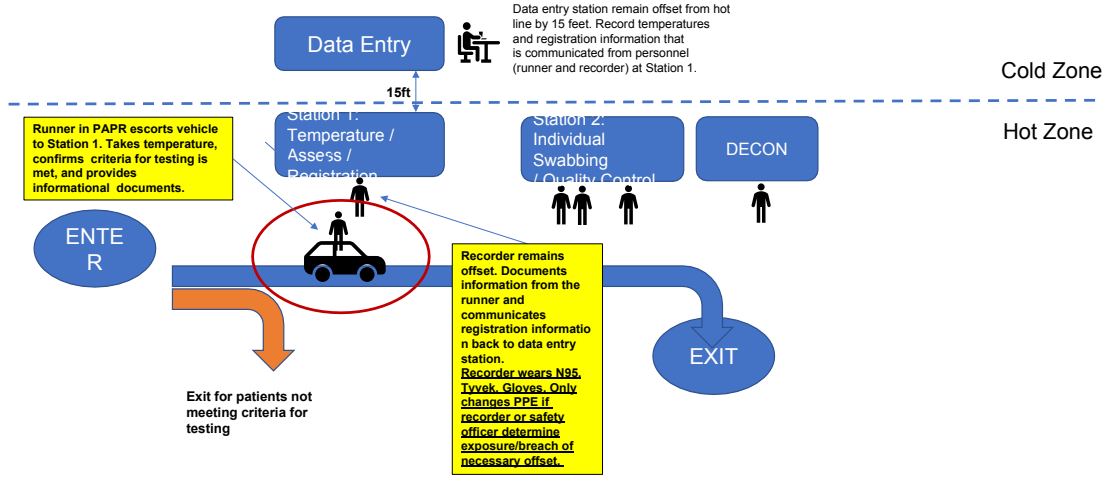
STATION 1: PATIENT PRE-SCREEN AND INITIAL DOCUMENTATION

Modified Stations for 1x Lane



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- Decon includes 1 PAX in PAPR. Remains there to decon Station 2 personnel and runner with 10% chlorine spray after every interaction.

Total = 5 PAPRs

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STATION 2: INDIVIDUAL SWABBING AND DOCUMENTATION PROCESS

Collection:

1. **Swabber confirms verbal authorization from passenger**
2. **Swabber confirms no obstruction in nares of person being swabbed (using pen light)**
3. **Swabber collects sample**
4. **Swabber bags collected sample**
    1. Offer tissue or gauze to person being swabbed
    2. Conducts swab
    3. Places swab into proper collection tube and breaks swab as needed
    4. Caps sample tube
    5. Places sealed tube in corresponding sample bag
    6. Places tube, form, and sample bag into a second bag
5. **QC officer verifies that barcodes match on sample tube and individual paperwork**
6. **Sample is deposited in the refrigerator and then transferred to the insulated shipping container with cold pack in telatemp box [must be packed by trained personnel]** **DO NOT FREEZE**
7. **Samples are mailed to corresponding lab twice daily**

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STATION 2: INDIVIDUAL SWABBING PROCESS

Primary Swabber	Decontamination Staff	Secondary Swabber	Quality Control Staff	Runner
• Issue individual tissue (clear nasal passage) • Use pen light to check for nasal obstructions. Do not force swab – if an obstruction is encountered, try the other nostril. If both nostrils are obstructed, contact on-site medical provider. • Receive collection tube/swab • Take swab of patient(s) in car • Return swab back into tube • Place barcode on the tube • Insert tube into secondary containment (sample bag) • Receive decontamination wipe to decontaminate the sample bag • Place sample bag onto temporary sample bag staging table • Work with decontamination staff to decontaminate the PAPR • Doff gloves; Don new gloves	• Observe swabbing operation for safety/occupational contamination • Provide decontamination spray without touching the swabber(s) • Assist the swabber during doffing/donning gloves	• Don PPE (i.e., replace gloves) to prepare for next vehicle • Becomes primary swabber for next vehicle	• Collects decontaminated sample bag to ensure sample ID is on the sample tube • Collects collection form from the runner • Verifies patient ID on tube and form is the same • Places form and sample bag in envelope, signs form as chain of custody, places envelope in shipping container • Confirms temperature in cooler stays within range	• Documents temperature on collection form and relevant demographic data • Provides informational documents to patients • Stays with vehicle throughout all 3 stations • Decontaminate PAPR at the Decontamination Station • Returns to Station 1 to prepare for next vehicle after decontaminating /donning new gloves

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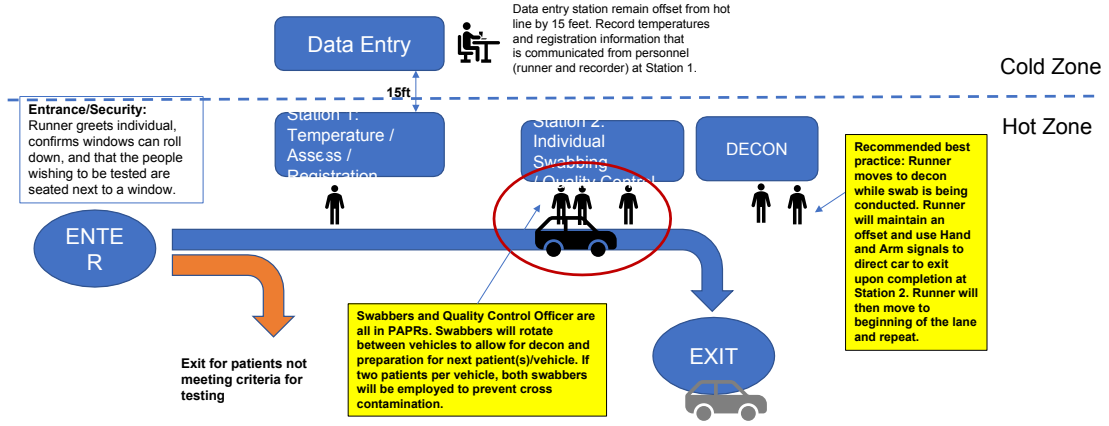
COVID-19 STATION 2: SWAB PROCESS AND DECON

Modified Stations for 1x Lane



Modifying the CBTS CONOP to only have two stations exposed to the vehicle/patients and moving those individuals to PAPRs will reduce mask requirements by 61%-98.5%. 61% assumes human error for every test requiring a change of mask every time for the individual wearing the mask. 98.5% assumes 10 errors per individual donning a mask, per day.

- Runner is in PAPR and takes temperature. (Runner stays with vehicle the entire time; guides through process. Goes through decon after vehicle departs and moves back to front.)
- Station 1 personnel includes 1 PAX in N95 mask and goggles to check identification, document/register, and relay registration details to data entry station. (Data Entry personnel (1-2PAX) are not in PPE. Their station is ~15ft offset and remains behind cold line.)
- Station 2 personnel includes 3 PAX in PAPR, i.e. 2 PAX to swab and 1 PAX to QC the sample and package.
- Decon includes 1 PAX in PAPR. Remains there to decon Station 2 personnel and runner with 10% chlorine spray after every interaction.

Total = 5 PAPRs

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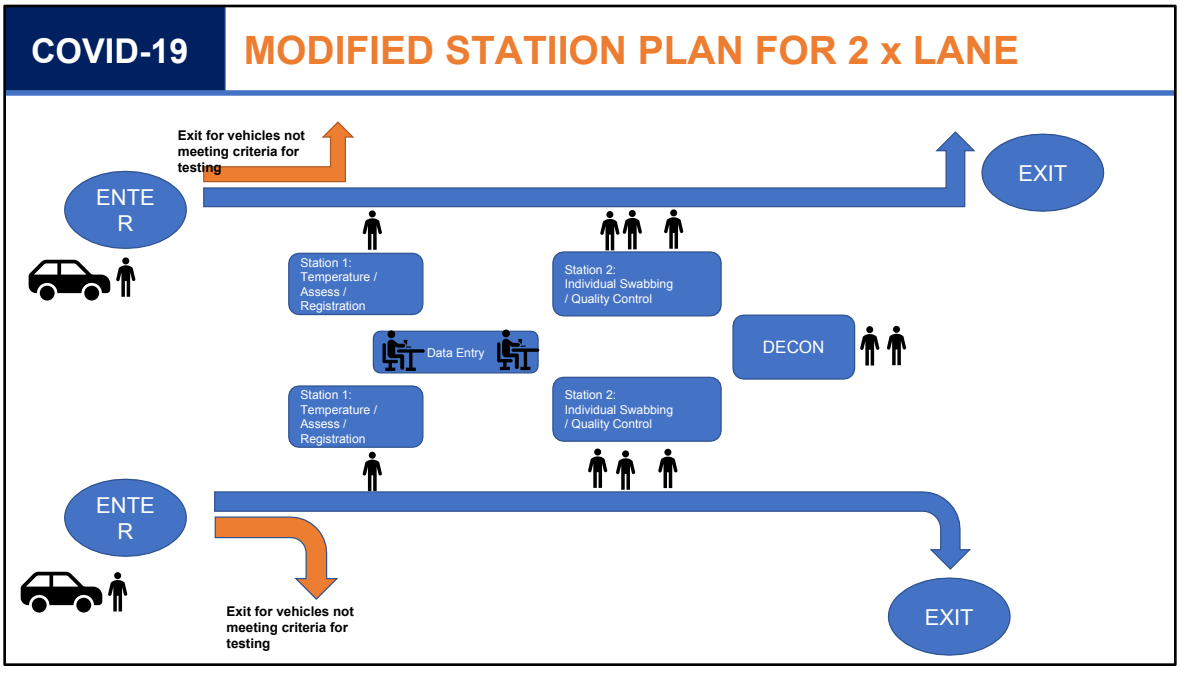
COVID-19 MODIFIED STATIION PLAN FOR 2 x LANE



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COVID-19 SPECIMEN TO LABORATORY PROCESS

Sample Test Medium Instructions

Your sampling kits contain Universal Transport Medium (UTM); please read this **CRITICAL** information:

- Storage Considerations:
  - This product must be stored in its original packaging at a temperature between
  - 2-25°C (35.6 - 77°F) until the time of use. Do not overheat or freeze prior to use.
- After collection, the specimen should be stored at 2-8°C (35.6-46.4°F) and processed within 48 hours. The specimens should not be frozen at any time.
- When shipped, sample must remain at 2-8°C (35.6-46.4°F). The sample must **not** be frozen for shipment. For full product package insert instruction: https://www.copanusa.com/wp-content/uploads/2020/02/UTM-Package-Insert.pdf

Sample Bar Code Identifier

Each individual being tested will receive a unique sample identification from the contract lab company.

- Two (2) unique adhesive **matched barcodes** will be placed on 1) the sample tube and 2) on the requisition form.
- The completed requisition form with the affixed barcode must be placed inside the bag with the sample tube.
- Site cannot proceed with operations without these barcodes.
- All samples will be identified with **two items**: a unique barcode [federally supplied] and a label with written DOB (MM/DD/YYYY) of individual being tested [which must me locally supplied].
- The barcodes must meet the following specifications:
  - Must have a human readable string (16 character max)
  - Must be Code 128 (barcode standard)

Required supplies have been put on state supply list: paper/printers for forms, barcodes, labels (for DOB on sample), pens.

Shipping Process

- Maintain specimens 35.6-46.4°F prior to shipping. The specimens must be placed in the ULINE boxes and packed with cold packs, then close the box with shipping tape, prior to FEDEX's arrival to the site. DO NOT FREEZE
- ULINE boxes are the only authorized method of shipment. They have a cooler within the cardboard box.
- FEDEX will provide the shipping labels.
- FEDEX will be provided the site POC in order to directly coordinate for pick-up twice a day. When the site confirms they will go live the next day, this triggers the CBTS TF to contact FEDEX and turn-on the contract for pick-up of the specimens twice a day. Failure to notify the CBTS TF that your site is going live, may result in specimens not being picked up on the first day of operation.





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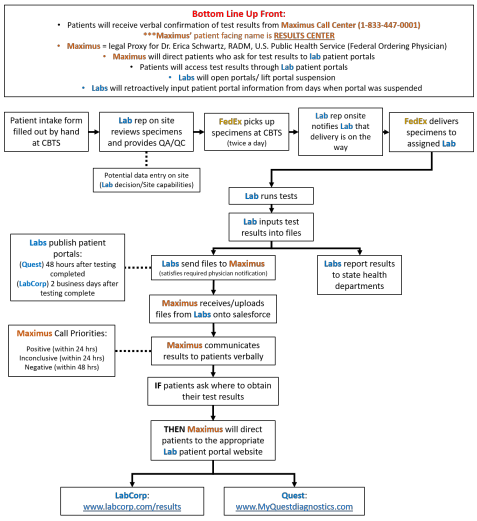
COVID-19 PATIENT INTAKE FORM ≠ PATIENT HAS RESULTS



Q: Where/How do I obtain my COVID-19 test results?

A (LabCorp): Your COVID-19 sample was processed by LabCorp. To access your results, you can go to www.labcorp.com/results. Once you arrive at this website, you can Register for an account, or, if you already have an account with LabCorp, you can simply Sign In.

A (Quest): Your COVID-19 sample was processed by Quest Diagnostics. To access your test results, you can go to www.MyQuestdiagnostics.com. Once you arrive at this website, you can Create an Account, or, if you already have an account with Quest Diagnostics, you can simply Sign In.

Q: What information do I need to Create an Account?

A (LabCorp): You will need to enter the following information to create an account:
- First Name, Last Name
- Gender
- DOB
- Address (Street, City, State, Zip Code)
- Phone Number
- Email Address
- SSN

A (Quest): You will need to enter the following information to create an account:
- Full Name
- DOB
- Full Address (including city, state, zip code)
- Phone Number (10-digit)

Q: What information do I need to Sign Into an existing account?

A (LabCorp): You will need to enter the following information to sign into an existing account: your email and the password you created.

A (Quest): You will need to enter the following information to sign into an existing account: the username and password you created.

Q: When will my results be available?

A (LabCorp): Your results will be available on the LabCorp patient portal 2 business days after your results are in

A (Quest): Your results will be available on the Quest patient portal 48 hours after your results are in.

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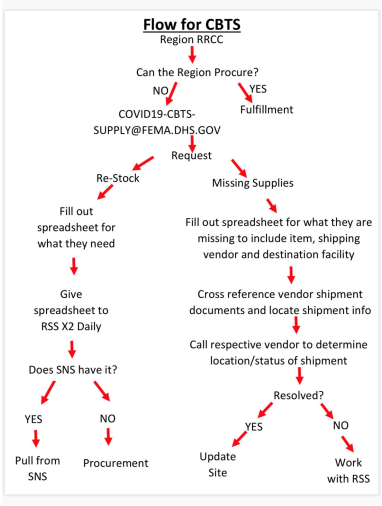
COVID-19 RESUPPLY PROCESS

Supply Order Form



Logistics Tracking Cell

Operational hours 0800-2000 7 Days

COVID19-CBTS-SUPPLY@FEMA.DHS.GOV

202-212-3491

Use this cell for all inquires as to status of shipments, and resupply requests

Please have an active needs list (PPE items) and Current on hand inventory by **1900 daily.**

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COVID-19 REPORTING

- Report Process:
  - By Region
  - Region POC provides update (identify who is talk each time)
  - Other sections brief by exception or specific data topics
- Daily Report:
  - Site Updates (New openings, future openings, and closings)
  - 10:30 only Previous days close out (# Total/# screen/# processed) by category (Health Care/1st Responders/Other)
  - Site staffing report (# Federal/#State)
  - Logistical critical federally provided item status for 250 through put
    - Green (Can operate next 3 days)
    - Yellow (Can operate next 2 days)
    - Red (Can operate 1 day)
  - Other Issues affecting operations

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	A	B	C	D	E	F
1	Site ID/Number	Site Location	Site Address (complete with city, state, zip)	Collection Date (MM/DD/YYYY)	Collection Time (HH:MM)	Language (other than English)
2	*CVS 10596*	*COVID-19 Community Based Testing Site*	*720 Boston Turnpike, Shrewbury, MA, 01545*	*3/19/2020*	*3:45:00 PM*	
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25	*Individual Sites need to document the DAILY total number of individuals tested on-site. See Instructional document for further details.					

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	G	H	I	J	K	L	M	N
1	LAST NAME	FIRST NAME	Gender (Male, Female or Not Specified)	DOB	ADDRESS	CITY	STATE	ZIP CODE
2	*Smith*	*John*		*1/1/2001*	*123 Main Street, #1*	*Shrewbury*	*MA*	*15450*
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
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22								
23								
24								
25								

AMERICAN OVERSIGHT

	O	P	Q	R	S	T	U	V
1	PHONE (Primary)	Insurance Carrier Name	Group #	Member/Individual #	Verbal Consent? (Y/N)	Private Act? (Y/N)	Unique Sample Barcode #	Sample Sent to Lab?
2	*123-456-7891*	*Blue Cross*	*Federal*	*12345678*	*YES*	*YES*	*10101019876*	*YES*
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								

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	A	B	C
1	DATE	# Tested	# Not Qualified
2	3/18/2020	22	2

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Intended Use of the Handouts Provided to Community-based Testing Sites:

These three documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below site capacity numbers

2) Information:

Purpose: To provide individuals who, due to capacity issues or not meeting site testing criteria, will not be tested at the site with useful information on what to do next.

Instructions:

Hand out this document to the following:

- people who are in line but will not receive testing because we have exceeded capacity
- people who are in line but will not receive testing because they do not meet site testing requirements

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested guidance on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

Hand out this document at the final station and instruct people to keep the paper until they receive the test results.

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Site Location:
Site Address:

COVID-19 by PCR Requisition Form

No other test may be ordered on this COVID-19 by PCR requisition form

Ordering Physician: Dr. Erica Schwartz, MD **Ordering Physician NPI:** 1427034826 **Quest Account Number:** 73916469 **LabCorp Account Number:** 32044780 **Result to:** Maximus	**CPT Code:** 87635 **Test Name:** COVID-19 by PCR **Sample Type:** Nasopharyngeal **ICD-10 Code:** Z03.818

1. DATE of Collection (MM/DD/YYYY) **2.TIME of Collection** **3. Language** (if not English)

/ / 2020 MM / DD / YYYY		

4. LAST NAME		**5. FIRST NAME**	**6. GENDER**	**7. DOB**
		Male Female Not Specified	/ / MM / DD / YYYY	

8. ADDRESS	**9. CITY**

10. STATE	**11. ZIP CODE**	**12. PHONE (primary)**
		Cell / Home

13. Insurance Carrier Name	14. Group Number

15. Member/Individual Number

Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode or Unique Identifier affixed below

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FEMA

COVID-19
Community-Based Testing Sites (CBTS)

FACT SHEET

States and the private sector have teamed up with the federal government to provide testing to Americans who need it the most. Community-based Testing Sites (CBTSs) are a tool for states, local public health systems and healthcare systems to use as they work together to stop the spread of COVID-19 in their communities.

Criteria

In order for a testing site to qualify as a CBTS, it must:

1. Receive supplies from the federal government.
2. Ensure there is at least one United States Public Health Service (USPHS) officer at each site.
3. Use the lab ordering, sampling and packaging process established by the federal government.
4. Use the shipping company chosen by the federal government to pick up and deliver labs to the lab company selected by the federal government.
5. Use the federally contracted Call Center that will contact individuals with their results.

SCREENING CRITERIA

Priority 1	Priority 2	Priority 3
▪ Hospitalized patients ▪ Healthcare facility workers with symptoms	▪ Patients in long-term care facilities with symptoms ▪ Patients over age 65 years with symptoms ▪ Patients with underlying conditions with symptoms ▪ First responders with symptoms	▪ Critical infrastructure workers with symptoms ▪ Individuals who do not meet any of the above categories with symptoms ▪ Healthcare facility workers and first responders ▪ Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

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FEMA

COVID-19
Community-Based Testing Sites (CBTS)

Requirements for Supply

- Sites, states and regions should attempt to procure all supplies, including personal protective equipment (PPE) locally.
- Requests for PPE are consolidated at the regional level through the Regional Response Coordination Center (RRCC).
- Submit one form per CBTS per day. Complete each section of the form to ensure a correct and complete order. Include CBTS location in the subject line of the email. Regions must submit the form to CBTS Task Force by 7pm EST daily.
- Send completed form to COVID19-CBTS-SUPPLY@FEMA.DHA.GOV.

Future Transition Expectations

- Each CBTS will transition USPHS personnel roles and responsibility to local personnel.
- FEMA will work with regional logistical personnel to develop a process to procure all PPE through standing FEMA processes.
- States will be able to send labs for testing to a lab of their choice.
- States will determine if they would like to use a locally run call center or use the regular state notification processes for results.

RFIs

If state and regional leadership are not able to answer a question, submit an RFI to: fema-cbts-rfi@fema.dhs.gov

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FEMA

COVID-19
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FEMA

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From:	Eckes, Jeanne (OS/ASPR/EMMO)
To:	Christie Luce - Florida Department of Health (Christie.Luce@flhealth.gov); Eckes, Jeanne (OS/ASPR/EMMO); Otis, Aaron (CDC/DDPHSIS/CPR/DSLR); Rivkees, Scott A; Samantha.Cooksey@flhealth.gov; K T McKnight - Georgia Department of Health (Kutheria.Mcknight@dph.ga.gov); kelly.nadeau@dph.ga.gov; Prince, Margaret; Scott Minarcine - (Scott.Minarcine@dph.ga.gov)
Subject:	Updated: Community Based Testing Site (CBTS) Concept of Operations and Operating Criteria
Date:	Wednesday, March 25, 2020 6:17:31 PM
Attachments:	COVID-19 Community-Based Testing Sites CONOP 2020.03.24 v5.pptx FEMA CBTS Flyer_2_Web.pdf FEMA CBTS Flyer_2_Print.pdf

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May be dupe to some…..apologies

*****The CBTS Task Force updated its guidance for community-based testing sites. Please review and disseminate the attached guidance and fact sheet to help support questions from your state/local health partners.*****

Please see included the criteria and ConOps for operating a Community Based Testing Site. The Criteria outlines simple requirements for remaining in compliance with the program. This step was necessary due to a number of State modifications to the program that introduced compliances issues causing sites to be put on pause or taking off line. The updated ConOp streamlines the CBTS process and reduces potential exposure to the operators.

Regards,
Jeanne

COVID-19 Response-RRCC HHS Agency Representative
R4-phul@fema.dhs.gov
(please cc all correspondence to this ESF 8 desk address)

HHS R-IV RRCC Atlanta
FEMA RRCC Atlanta, GA
770.220.5434 or 770.220.5576

61 Forsyth Street, SW Suite 5B95
Atlanta, GA 30303

cell: 404.772.9701
email: Jeanne.eckes@hhs.gov
email: ASPR.R4@hhs.gov
HSDN: Jeanne.eckesroper@dhs.sgov.gov

Alternate phone numbers

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cell: 202.322.1930 AT&T (primary)
cell: 202.909.6950 Verizon (secondary)

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OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

COVID-19 COMMUNITY-BASED TESTING SITES

Concept of Operations Version 2

24MAR20

1

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COVID-19

CONTENTS

- Site Establishment and Logistical Support
- Pre-Screening Criteria
- Operations
- Data Requisition Forms
- Laboratory and Shipment Processes
- Resupply Process
- Reporting

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COVID-19 PURPOSE, SCOPE AND CRITERIA

Purpose

The purpose of the Concept of Operations is to provide specific operating guidance in the Whole Community approach to planning, establishing, supporting and operating Community-Based Testing Sites (CBTS) in response to COVID-19.

Scope

The CBTS concept provides communities the ability to establish stand alone and mobile test sites in order to service populations and individuals of immediate needs which includes: symptomatic populations consisting healthcare workers and first responders or who within 14 days of symptom onset had close contact with a suspect or laboratory-confirmed COVID-19 patient, and symptomatic individuals from high risk populations.

Criteria

1. Receive supplies from the federal government.
2. Ensure there is at least one United States Public Health Service (USPHS) officer at each site.
3. Use the lab ordering, sampling and packaging process established by the federal government.
4. Use the shipping company chosen by the federal government to pick up and deliver labs to the lab company selected by the federal government.
5. Use the federally contracted Call Center that will contact individuals with their results.

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COVID-19

COMMUNITY SITE AND PATIENT TESTING GUIDELINES

Site Location

In order to maximize resources and develop a holistic understanding of positive cases, State, Local, Tribal, and Territory partners, in coordination with Department of Health and Human Services and FEMA established CBTS based on a combination of high risk or affected areas and areas with higher vulnerable populations (I.e. 65+ yo) areas. It is important that sites support a whole community assessment of potentially affected areas. This provides an understanding of the magnitude of the impact within the area. Sites should take into consideration other planning factors such as, vulnerable populations, accessibility, traffic control and other measures that may impact throughput. In addition, sites must be accessible to all potential patients.

Screening Criteria

Priority 1	Priority 2	Priority 3
Hospitalized patients	Patients in long-term care facilities with symptoms	**Critical infrastructure workers with symptoms**
Healthcare facility workers with symptoms	**Patients over age 65 years with symptoms**	**Individuals who do not meet any of the above categories with symptoms**
	Patients with underlying conditions with symptoms	**Healthcare facility workers and first responders**
	First responders with symptoms	**Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations**

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COVID-19

SITE LOGISTICAL SUPPORT CONSIDERATIONS

The federal government has identified the commitment to support over 40 sites across the United States. States begin testing select healthcare workers involved in direct patient care (hospital staff, clinicians, and long-term care facilities) and first responders and then immediately transition to testing individuals who are at high risk for serious complications [subject to change based on DHHS and CDC guidance].

Logistical Requirements and Support

The federal government has procured a defined list of items required for initial CBTS through the Strategic National Stockpile as well as the private market. Continued logistical site support requirements need to follow the logistical support process flow.

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COVID-19

INITIAL FEDERALLY SUPPLIED SUPPLIES
(FOR 1 SITE FOR 1 WEEK)

- Unit = the entire list on the right, which is enough to run 1 testing site for a week of 2,500 tests
- Each Unit will be delivered in 6 different shipments
- If a state is getting 2 units, it will receive 12 shipments, etc.
- States, such as TX, will receive bulk shipment and are required to breakdown shipment to support each location with 1 unit

Initial Shipment: Essential Medical Supplies

Item	Target Quantity	Unit of Measure	Frequency	Supplier
Test Kits (e-swab or UVT)	2,500	Each	Weekly	Federal
Matched standard code-128 barcodes with unique numbers and 10-16 characters (Manreadable)	2,500	Pairs	Weekly	Federal
Non-contact infrared thermometer	4	Each	One-time	Federal
Gloves (Nitrile) *for those with allergies	10,000	Each	Weekly	Federal
Gloves (Latex) 6,700 per size	20,100	Each	Weekly	Federal
Scrub top (all sizes) 100-Medium, 100-Large, 100-2XL	300	Each	Launder	Federal
Scrub pants (all sizes) 100-Medium, 100-Large, 100-2XL	300	Each	Launder	Federal
PAPRs	5	Each	Weekly	Federal
Faceshields	500	Each	Weekly	Federal
N-95 Respirators (S, M, L)	4,480	Each	Weekly	Federal
Surgical Gowns	500	Each	Weekly	Federal
Tyvek Suits - Size L	250	Each	Weekly	Federal
Tyvek Suits - Size XXL	250	Each	Weekly	Federal
Tyvek Pullover Hoods/Shrouds/Headcovers (contingent upon type of PAPRs received/available)	1,000	Each	Weekly	Federal
Goggles (Anti-fog)	300	Each	Weekly	Federal
Tyvek Sleeves	20,000	Each	Weekly	Federal
Red Uline Garbage Cans	10	Each	Weekly	Federal
Biohazard Bags (25/wk x2 = 50 boxes)	50	Boxes	Weekly	Federal
Earloops Surgical Masks	1,000	Each	Weekly	Federal
Plastic Aprons (Not Surgical Aprons)	10,000	Each	Weekly	Federal
Specimen Transport Bag with requisition pouch. 6 x 9" polyethylene specimen bags	2,500	Each	Weekly	Federal
Insulated Foam Shipping Kit - 30 1/4 x 14 1/2 x 16"	1,575	Each	Weekly	Federal
Single-Use Cold Packs - 12 oz	9,450	Each	Weekly	Federal
UN3373 Biological Substance, Category B Air labels	1575	Each	Weekly	Federal
Tamper-Evident Tape, 3" x 110 yds	225	Each	Weekly	Federal
Telatemp Heat Indicator	1,575	Each	Weekly	Federal
Sharps containers	25	Each	Weekly	Federal
Whirl Pak Bags	2,500	Each	Weekly	Federal

Based on PPE reductions, resupply of N-95 masks will be 70 per week, per unit.

Available from National Stockpile

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COVID-19

LOGISTICS SUPPORT
(RECOMMENDATIONS, PROVIDED LOCALLY)

Overall Supplies

Item	Estimated Quantity	Unit of Measure	Frequency
Large Tent 19x35 (insulated) w/ Enviornmental Control Unit	5	Each	One-time
Mifi/ Wireless Internet for 10 users	1	Each	Ongoing
Surge Protectors	10	Each	One-time
Extension Cord 25ft	10	Each	One-time
Chalk	10	boxes	One-time
Cablepath Tape	5	rolls	One-time
Fire Extinguishers (A/B/C)	5	Each	One-time
Pallet Jacks	2	Each	One-time
Trash Bags (weekly)	50	boxes	Weekly
Copier/Scanners/Printers	3	Each	One-time
Toner cartridges	3	Each	Re-supply
Duct Tape	4	rolls	One-time
Folding Chairs	50	Each	One-time
Folding Tables	10	Each	One-time
Cross-cut Shredders	2	Each	One-time
Trash cans	8	Each	One-time
EZ Up Tents	6	Each	One-time
White Board	4	Each	One-time
Paper (weekly)	50	Reams	Re-supply
Pens (weekly)	100	Each	Re-supply
Staplers	10	Each	One-time
Folders (weekly)	10	boxes	Re-supply
8' Supersaver™ Players Bench/10W/ Backless/ Portable/ Black	6	Each	One-time
Mobile carts	10	Each	One-time
Mobile shelves	5	Each	One-time
Trade Show Litter Bags	1,000	Each	Weekly
Soap (weekly)	100	Containers	Re-supply
Carboy with spigot	5	Each	One-time
Filing Cabinent 3/4 drawers	4	Each	One-time
Refridgerators (with freezer)	2	Each	One-time
Laptop Computers + chargers	8	Each	One-time
Sharpies (thin point, regular)	200	Each	Re-supply
Whistle	10	Each	One-time
Caution tape	5	rolls	One-time
Safety Cones	100	each	One-time
broomhandle	100	Each	One-time
Safety Vest	25	Each	One-time
SIGN Forward Arrow	2	Each	One-time
SIGN Left Arrow	2	Each	One-time
SIGN Right Arrow	2	Each	One-time
SIGN No Parking	6	Each	One-time

Essential Medical Supplies

Item	Estimated Quantity	Unit of Measure	Frequency
Duct Tape Rolls (for PPE)	50	Each	Weekly
Cavicide Wipes	50	Containers	Weekly
Hand sanitizer	400	Each	Re-supply
Eye wash solution	10	Each	Re-supply
Care Touch Sterile Alcohol Prep Pads (2 Ply) - Alcohol Wipes 600 (weekly)	5	Boxes	Re-supply
Handheld Sprayer, Handheld Sprayer Type, Lawn and Garden Sprayer Application (2-gallon container with pump)	2	Each	One-time
RW Clean 25 oz Green Plastic Spray Bottle - Adjustable Nozzle - 1 count box	10	Each	One-time
Small Hand Mirrors	10	Each	One-time
Bandage Scissors	5	Each	One-time
Foot Tub Plastic Wash Basin - 6 Quart	10	Each	One-time
Buckets (5-gallon)	5	Each	One-time
Trash Pickers	5	Each	One-time
Pen Lights	10	Each	Re-supply
Bleach (weekly)	100	Containers	Re-supply
Chlorine Test Papers (100 Strips) (500 parts per million)	1	Containers	Re-supply
Facial Tissue (100 count)	10	Boxes	Weekly
Disinfecting Station (ETOH and water set-up using bucket/tub) (ex:gatorade cooler filled with alcohol or bleach solution)	7	Each	One-time
Thermometer - anything that does ambien temperature (for coolers)	4	Each	One-time
Deluxe Gauze Dressings 4x4 inch	500	Boxes	Weekly
One of the following:			
1. Rubber Gumboots (various sizes) + decon foot bath**	50	Pairs	One-time
2. Closed-toe clogs (various sizes) with Shoe Covers (if offering Closed-toe clogs)	50	Pairs	Weekly
	2,800	Each	Weekly
3. Bootie (option for personal footwear)	1,500	Each	Weekly
*Cooling vests for swabbers to wear in warm climates.**	12	Each	Re-supply
*Gondola carts**	2	Each	One-time
*Disposable Chemical Suits**	100	Each	Weekly
*Chemical resistant work gloves (all sizes)**	100	Pairs	Weekly
*Socks (mid-calf or higher)**	300	Each	Weekly

**recommended but not critical if unavailable*

Contracted-based Services

Item	Estimated Quantity	Unit of Measure	Frequency	Notes
Biological Waste Service			Ongoing	
Dumpster Service	1	Each	Ongoing	8 Cu/yd or greater Emptied Daily
Portajons w/ Hand Wash Statuon 2 Reg 2 ADA 2 HWS	6	Each	Ongoing	Emptied/ Decon Daily
Retail Fuel Capability	1	Each	Ongoing	Truck w/ in Bed fuel tank for DS2
Fuel	100	gallons	Ongoing	daily requirement for 100 gallons DS2
5K Generator with appropate retail fuel capability	1	Each	Ongoing	
*5 KT Forklift** (can be circumvented with lift gate on transport truck to site)*	1	*Each*	*Ongoing*	
*Potential Shredder Bins **	2	Each	Ongoing	

AMERICAN OVERSIGHT

COVID-19 OPERATIONAL CONSIDERATIONS

States identify specific community needs based on several factors and there are specific operational processes the need to be followed in order to meet our desired end state. These include, but are not limited to, equipment conservation, testing documentation and reporting , laboratory chain of custody and testing protocols.

Specific Site Operational Considerations:

- Accessibility and Functional Capability Requirements to include emotional support animals
- Private and Public Transportation Needs and Throughput
- Adhere to State Regulated Medical Waste Procedures
- Translation services and hearing impaired
- Site Security and Local Emergency Services
- Traffic Control
- Basic Needs for Site Support Personnel (Feeding and Sanitation)
- Operations Communication Capabilities Public Communication
- Water / Feeding for Operators
- Site Support Training Requirements
- Site Sanitation and Safety Considerations
- Patient information daily tracking and reporting mechanism for results
- Training – Safety Officer
- Training – Quality Control Officer
- Recommendations for change of clothes/laundering of clothes worn during operation
- Daily tracking and reporting mechanism for results

AMERICAN OVERSIGHT



COVID-19

SITE HANDOUTS

User Guide for Handouts | What to Expect | Not Meeting Criteria | Test and Result Info Sheet

Intended Use of the Handouts Provided to Community-based Testing Sites:

These three documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below site capacity numbers

2) Information for Those Not Meeting Criteria:

Purpose: To provide individuals who, due to capacity issues or not meeting site testing criteria, will not be tested at the site with useful information on what to do next.

Instructions:

Hand out this document to the following:

* people who are in line but will not receive testing because we have exceeded capacity
* people who are in line but will not receive testing because they do not meet site testing requirements

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested guidance on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

Hand out this document at the final station and instruct people to keep the paper until they receive the test results. a

logging temp and registration information remains offset

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COVID-19

SITE OPERATIONS

Site Operation Process Categories

1. **Site Staff Guidelines:** Provides specific guidance on essential staffing requirements for each site.
2. **Patient Pre-Screening:** Provides guidance on initial patient screening in order to determine if follow-on testing is necessary.
3. **Site Patient Throughput and Support Personnel Responsibility Process:** Describes the recommended process to include specific roles and responsibilities of support personnel and required levels of protection.
4. **Packaging and Lab Processing:** Defines the specific packaging and lab processing requirements that must be followed, these cannot be deviated from due to contractual requirements.

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COVID-19 MINIMUM STAFFING RECOMMENDATIONS

USPHS Officers are prepared to be:

- **Site Team Lead:** Responsible for overall coordination of site and process standardization, execution of federal guidelines, and information and data management
- **Site Safety Officer:** Oversees all safety considerations for site operations.
- **Site Quality Control Officer:** Responsible for overseeing Quality Assurance through all test processes - IAW established standards.

TESTING STATIONS	STATE CBTS (1-lane operation)	STATE CBTS (2-lane operation)
Greeting/Entry	Runner: 1	Runner: 2
Assessment/Registration	Registration: 1 (+ Runner, who take temperature)	Registration: 2 (+ Runners, who take temperatures)
Data Entry (Offset, No PPE)	Data Entry for Registration: 1	Data Entry for Registration: 2
Sampling	Samplers: 2 QC: 1	Samplers: 4 QC: 2
Decontamination	Decontamination: 1	Decontamination: 2
Admin/Support Staff	Logistics: 2 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1	Logistics: 4 Safety Officer: 2 Admin/Planning: 1 Team Lead: 1 Facilitator: 1 Water Sanitation: 3
Estimated Personnel	**13**	**26**

Estimated capability (1-lane operation): 12-24 individ
Estimated ~12 vehicles/hr at each station

2-lane operation for vehicles with driver and 1+ passenger(s): 12 (min) – **48** (max) individuals/hour

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COVID-19

COMMUNITY-BASED TESTING SITES (CBTS): MODIFIED CONOPS TO INCREASE PAPR USE

ESTIMATED TESTING SITE CAPACITY:

MAXIMUM 250 TESTS PER SITE, PER DAY DUE TO LAB THROUGHPUT

CDC Recommended Pre-Screening Criteria

1. **Criteria 1**: Anyone ≥65 years of age with on-site confirmed temperature of 99.6°F or greater **and** presents with respiratory symptoms.
2. **Criteria 2:** First responders, healthcare workers* (regardless of presence of symptoms). *This is only applicable to staff with direct patient contact (not those in administrative roles) or as determined at the state level.

Pre-Screening Process and Instructions

- Patients must bring:
  - Photo ID for all adults needing testing
  - Health insurance card (everyone will be tested regardless if they have insurance)
  - Healthcare or first responder ID
- Instructed not to take fever-reducing medicine within 6-8 hours prior to testing [such as Tylenol (acetaminophen) or Advil (ibuprofen)]
- If the CBTS personnel determine an individual meets the testing criteria, they will be tested. If the person does **NOT** meet the criteria, they will **NOT** be tested and be provided take-home educational material.

Definition of First Responder: Any individual responding to the public health task or mission, as determined by the jurisdiction.

Definition of Healthcare Worker: Any individual working or providing direct patient care in acute or critical settings (hospitals, clinics, long-term care facilities, emergency medicine).

**Regional/State sites can clarify or expand this classification based on needs/demand and adjust accordingly.

Minimum Personnel for 1 Lane Operations	
Entry	Runner: 1 in PAPR
Station 1	Registration: 1 Recorder in N95 respirator , coveralls, gloves. Note: Runner in PAPR takes temperature and passes documentation to patients. Recorder remains offset and records/relays registration information to Data Entry which is 15-ft offset from the vehicle lane.
Data Entry (Offset)	Registration: 2 Recorders. No PPE required.
Station 2	Swabbing: 2 PAX in PAPR QC (Labeling/Packaging): 1 PAX in PAPR
Decontamination	Decontamination Sprayer: 1 PAX in PAPR

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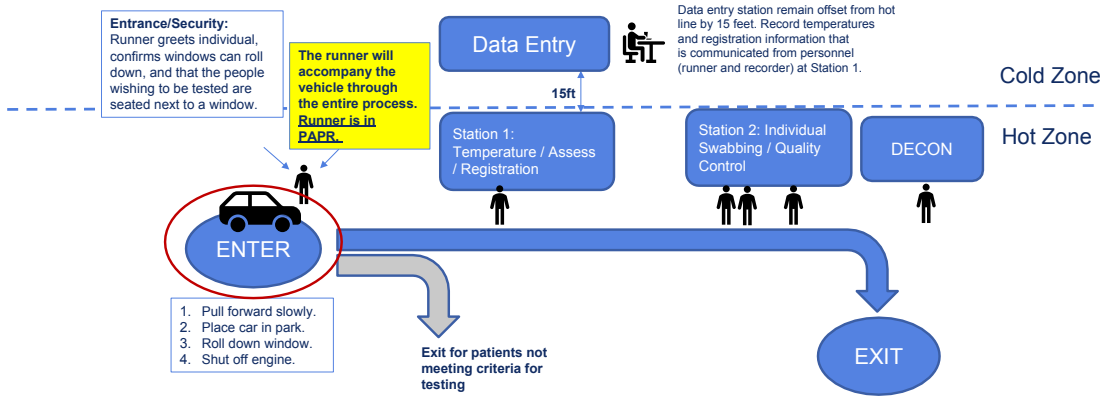
COVID-19 SITE LAYOUT

Stations for 1 Lane Process



Modifying the CBTS CONOP to only have two stations exposed to the vehicle/patients and moving those individuals to PAPRs will reduce mask requirements by 61%-98.5%. 61% assumes human error for every test requiring a change of mask every time for the individual wearing the mask. 98.5% assumes 10 errors per individual donning a mask, per day.

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- Station 2 personnel includes 3 PAX in PAPR, i.e. 2 PAX to swab and 1 PAX to QC the sample and package.
- Decon includes 1 PAX in PAPR. Remains there to decon Station 2 personnel and runner with 10% chlorine spray after every interaction.

Total = 5 PAPRs

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COVID-19 STATION 1: TEMPERATURE VERIFICATION

Personnel Roles:

1. **Runner(s):** Take and document temperature on collection form (form holds patient ID number)

2. **Runner(s):** Provide document to vehicle providing public health information to include:
   - What should you do while you wait for test results?
   - Monitoring symptoms
   - If you test positive for COVID-19, continue to monitor your symptoms and manage appropriately
   - When can you stop isolating at home?

**Healthcare workers = personnel who are currently working in a healthcare facility, including long-term care facilities.*

Individuals Must Meet one of these Criteria:

Criteria 1:	65 years of age and older with temperature of 99.6F or greater and respiratory symptoms
Criteria 2:	First responders, Healthcare workers* (regardless of symptoms)

Individuals not meeting criteria are asked to leave the line

If you develop symptoms after leaving the site, visit **[URL TBD]** to check if you qualify for testing

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COVID-19

STATION 1: INDIVIDUAL REGISTRATION

Personnel Roles:

- **Recorder (1):** Document on written form demographic information for patient(s). Record unique identifier (barcode), site, date and lane number.

First	**Email**	**Form of Identification**
Last	**Address**	**Healthcare or First Responder ID**
Phone	**License Plate**	**Insurance Information**

Note: Information collected may change based on testing company requirements

- **Recorder (2) at Data Entry:** Registers document in electronic data collection tool capturing demographic information for patients to be tested

Unique Identifier (Barcode), Site, Date and Lane Info

Information flow dependent upon state requirements and processes

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COVID-19 DATA REQUISITION FORMS


COVID-19 Requisition Form


Excel file to Document Requisition Form D

Recommend sites update certain fields within the form (before printing on-site):

- **Site Location**: If Community-Based Testing Site (CBTS) has a specific name, input this here and keep it consistent throughout duration of testing. Labs will associate samples with this site specifically.
- **Site Address**: Physical location must be added within header to include city, state, zip code.
- Consider pre-populating the month and year within the form. Only date will need to be entered manually on-site
- Print estimated amount needed for operations for the week.

Every field on the attached form **is required** for the labs to be able to successfully process samples (including the fields within the header).

- LABS WILL NOT PROCESS SAMPLE IF ANY PORTION OF THIS FORM IS NOT FILLED OUT.

Sites must identify and designate a personnel member to verbally **read** the informed consent and privacy language to individuals (*verbiage is below*) before proceeding with registration and accurately identifying responses at the bottom of the form.

- For any individual requesting translation, utilize resources available, including telephonic. Collaborate with local healthcare network systems if necessary, as many have established contracts and accessibility to this.

Electronic

- This step is conducted electronically, if, and only if, there is a PHS officer on site with a federal computer. In this case, an excel file can be digitally populated with the information collection from the requisition form. This file serves as a failsafe in the event that there is an error on the handwritten document that is provided to the lab.
- The files will be maintained for 14 days. This is sufficient time for the labs to receive the requisition forms, process the results, and for the call center to return these results to the patient and to the state health department.
- The PII will not be shared with anyone with the CBTS process except the labs and the call center.
- If possible, the file will then be printed and include with the associated ULIINE shipment box including the specimens. This will allow the labs to conduct an inventory and ensure the correct number of specimens are within the box. This will also allow the labs to double check the data in case the requisition forms are not legible.
- If printing is not available, you will need to use a marker on the ULINE box to indicate the number of specimens within the box in order for the labs to conduct an inventory. Furthermore, if printing is not available the labs will be provided the site POCs in order to call and validate any illegible data on the requisition forms.

Manual

- Without a PHS with a federal computer, the excel file must be printed and manually updated.
- These forms will be shredded after 14 days. This is sufficient time for the labs to receive the requisition forms, process the results, and for the call center to return these results to the patient and to the state health department.
- This form is not to be shared with anyone other than the lab and the call center if either calls to validate illegible data.
- If possible, make a photo copy and include with the associated ULIINE shipment box including the specimens. This will allow the labs to conduct an inventory and ensure the correct number of specimens are within the box. This will also allow the labs to double check the data in case the requisition forms are not legible.
- If copying is not available, you will need to use a marker on the ULINE box to indicate the number of specimens within the box in order for the labs to conduct an inventory. Furthermore, if printing is not available the labs will be provided the site POCs in order to call and validate any eligible data on the requisition forms.

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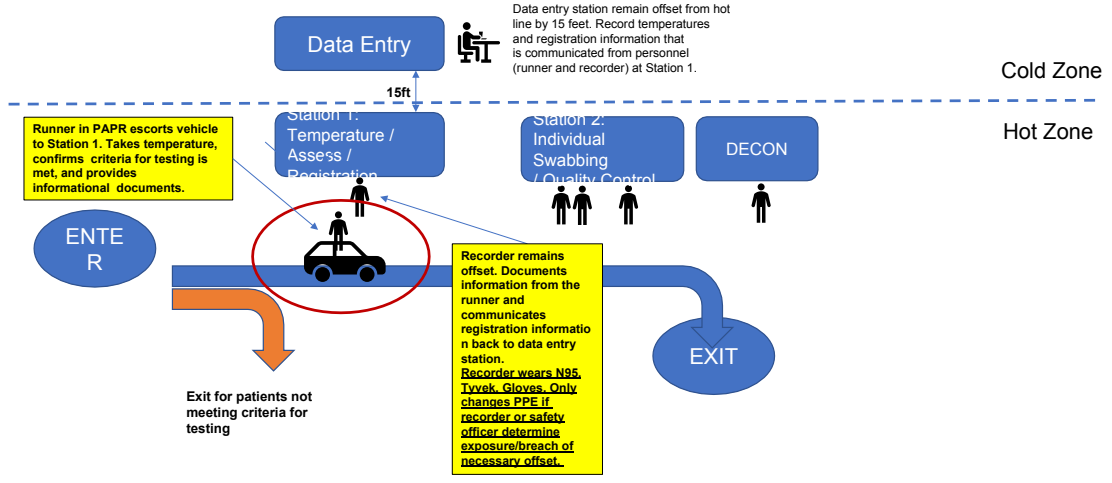
COVID-19

STATION 1: PATIENT PRE-SCREEN AND INITIAL DOCUMENTATION

Modified Stations for 1x Lane



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Total = 5 PAPRs

AMERICAN OVERSIGHT

COVID-19

STATION 2: INDIVIDUAL SWABBING AND DOCUMENTATION PROCESS

Collection:

1. **Swabber confirms verbal authorization from passenger**
2. **Swabber confirms no obstruction in nares of person being swabbed (using pen light)**
3. **Swabber collects sample**
4. **Swabber bags collected sample**
    1. Offer tissue or gauze to person being swabbed
    2. Conducts swab
    3. Places swab into proper collection tube and breaks swab as needed
    4. Caps sample tube
    5. Places sealed tube in corresponding sample bag
    6. Places tube, form, and sample bag into a second bag
5. **QC officer verifies that barcodes match on sample tube and individual paperwork**
6. **Sample is deposited in the refrigerator and then transferred to the insulated shipping container with cold pack in telatemp box [must be packed by trained personnel]** **DO NOT FREEZE**
7. **Samples are mailed to corresponding lab twice daily**

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COVID-19

STATION 2: INDIVIDUAL SWABBING PROCESS

Primary Swabber	Decontamination Staff	Secondary Swabber	Quality Control Staff	Runner
• Issue individual tissue (clear nasal passage) • Use pen light to check for nasal obstructions. Do not force swab – if an obstruction is encountered, try the other nostril. If both nostrils are obstructed, contact on-site medical provider. • Receive collection tube/swab • Take swab of patient(s) in car • Return swab back into tube • Place barcode on the tube • Insert tube into secondary containment (sample bag) • Receive decontamination wipe to decontaminate the sample bag • Place sample bag onto temporary sample bag staging table • Work with decontamination staff to decontaminate the PAPR • Doff gloves; Don new gloves	• Observe swabbing operation for safety/occupational contamination • Provide decontamination spray without touching the swabber(s) • Assist the swabber during doffing/donning gloves	• Don PPE (i.e., replace gloves) to prepare for next vehicle • Becomes primary swabber for next vehicle	• Collects decontaminated sample bag to ensure sample ID is on the sample tube • Collects collection form from the runner • Verifies patient ID on tube and form is the same • Places form and sample bag in envelope, signs form as chain of custody, places envelope in shipping container • Confirms temperature in cooler stays within range	• Documents temperature on collection form and relevant demographic data • Provides informational documents to patients • Stays with vehicle throughout all 3 stations • Decontaminate PAPR at the Decontamination Station • Returns to Station 1 to prepare for next vehicle after decontaminating /donning new gloves

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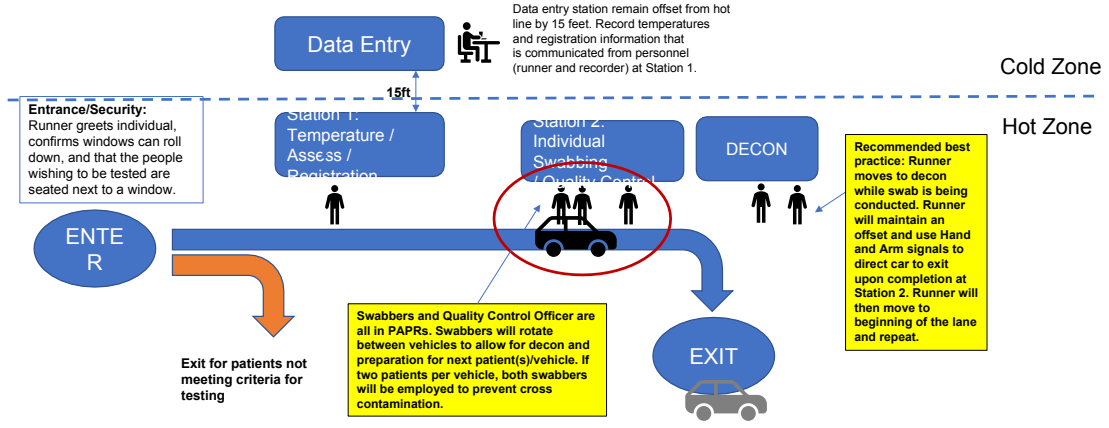
COVID-19 STATION 2: SWAB PROCESS AND DECON

Modified Stations for 1x Lane



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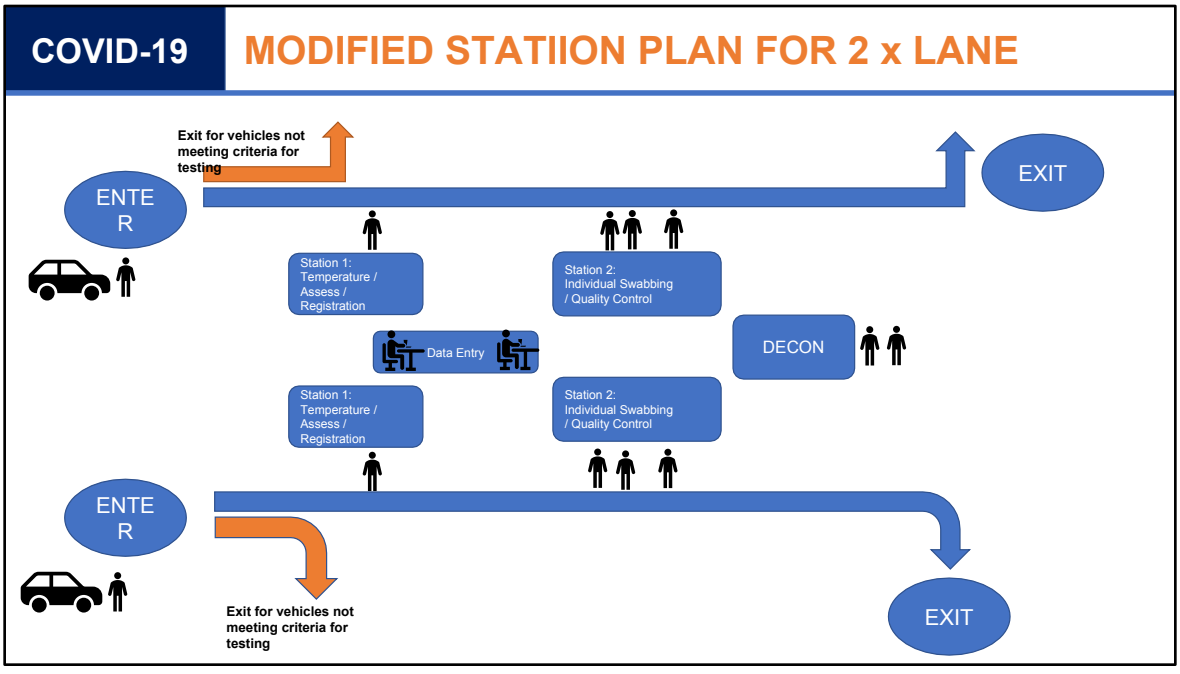
COVID-19 MODIFIED STATIION PLAN FOR 2 x LANE



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AMERICAN OVERSIGHT

COVID-19 SPECIMEN TO LABORATORY PROCESS

Sample Test Medium Instructions

Your sampling kits contain Universal Transport Medium (UTM); please read this **CRITICAL** information:

- Storage Considerations:
  - This product must be stored in its original packaging at a temperature between
  - 2-25°C (35.6 - 77°F) until the time of use. Do not overheat or freeze prior to use.
- After collection, the specimen should be stored at 2-8°C (35.6-46.4°F) and processed within 48 hours. The specimens should not be frozen at any time.
- When shipped, sample must remain at 2-8°C (35.6-46.4°F). The sample must **not** be frozen for shipment. For full product package insert instruction: https://www.copanusa.com/wp-content/uploads/2020/02/UTM-Package-Insert.pdf

Sample Bar Code Identifier

Each individual being tested will receive a unique sample identification from the contract lab company.

- Two (2) unique adhesive **matched barcodes** will be placed on 1) the sample tube and 2) on the requisition form.
- The completed requisition form with the affixed barcode must be placed inside the bag with the sample tube.
- Site cannot proceed with operations without these barcodes.
- All samples will be identified with **two items**: a unique barcode [federally supplied] and a label with written DOB (MM/DD/YYYY) of individual being tested [which must me locally supplied].
- The barcodes must meet the following specifications:
  - Must have a human readable string (16 character max)
  - Must be Code 128 (barcode standard)

Required supplies have been put on state supply list: paper/printers for forms, barcodes, labels (for DOB on sample), pens.

Shipping Process

- Maintain specimens 35.6-46.4°F prior to shipping. The specimens must be placed in the ULINE boxes and packed with cold packs, then close the box with shipping tape, prior to FEDEX's arrival to the site. DO NOT FREEZE
- ULINE boxes are the only authorized method of shipment. They have a cooler within the cardboard box.
- FEDEX will provide the shipping labels.
- FEDEX will be provided the site POC in order to directly coordinate for pick-up twice a day. When the site confirms they will go live the next day, this triggers the CBTS TF to contact FEDEX and turn-on the contract for pick-up of the specimens twice a day. Failure to notify the CBTS TF that your site is going live, may result in specimens not being picked up on the first day of operation.





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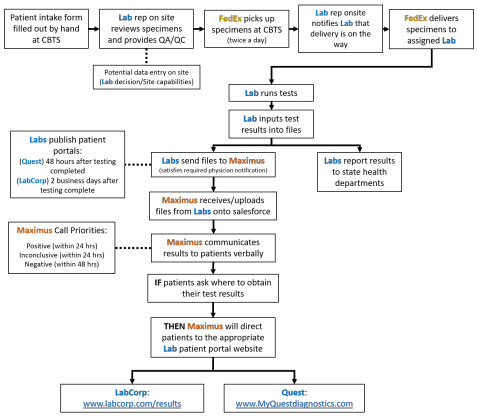
COVID-19 PATIENT INTAKE FORM ¤ PATIENT HAS RESULTS

Bottom Line Up Front:

- Patients will receive verbal confirmation of test results from **Maximus Call Center (1-833-447-0001)**
  - ***'Maximus'** patient facing name is **RESULTS CENTER**
- **Maximus** = legal Proxy for Dr. Erica Schwartz, RADM, U.S. Public Health Service (Federal Ordering Physician)
  - **Maximus** will direct patients who ask for test results to **lab** patient portals
    - Patients will access test results through **Lab** patient portals
      - **Labs** will open portals/ lift portal suspension
- **Labs** will retroactively input patient portal information from days when portal was suspended



Q: Where/How do I obtain my COVID-19 test results?

A (LabCorp): Your COVID-19 sample was processed by LabCorp. To access your results, you can go to www.labcorp.com/results. Once you arrive at this website, you can Register for an account, or, if you already have an account with LabCorp, you can simply Sign In.

A (Quest): Your COVID-19 sample was processed by Quest Diagnostics. To access your test results, you can go to www.MyQuestdiagnostics.com. Once you arrive at this website, you can Create an Account, or, if you already have an account with Quest Diagnostics, you can simply Sign In.

Q: What information do I need to Create an Account?

A (LabCorp): You will need to enter the following information to create an account:

- First Name, Last Name
- Gender
- DOB
- Address (Street, City, State, Zip Code)
- Phone Number
- Email Address
- SSN

A (Quest): You will need to enter the following information to create an account:

- Full Name
- DOB
- Full Address (including city, state, zip code)
- Phone Number (10-digit)

Q: What information do I need to Sign Into an existing account?

A (LabCorp): You will need to enter the following information to sign into an existing account: your email and the password you created.

A (Quest): You will need to enter the following information to sign into an existing account: the username and password you created.

Q: When will my results be available?

A (LabCorp): Your results will be available on the LabCorp patient portal 2 business days after your results are in

A (Quest): Your results will be available on the Quest patient portal 48 hours after your results are in.

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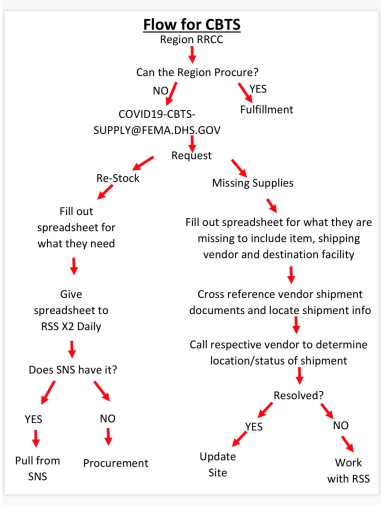
COVID-19 RESUPPLY PROCESS

Supply Order Form



Logistics Tracking Cell

Operational hours 0800-2000 7 Days

COVID19-CBTS-SUPPLY@FEMA.DHS.GOV

202-212-3491

Use this cell for all inquires as to status of shipments, and resupply requests

Please have an active needs list (PPE items) and Current on hand inventory by **1900 daily.**

AMERICAN OVERSIGHT

COVID-19 REPORTING

- Report Process:
  - By Region
  - Region POC provides update (identify who is talk each time)
  - Other sections brief by exception or specific data topics
- Daily Report:
  - Site Updates (New openings, future openings, and closings)
  - 10:30 only Previous days close out (# Total/# screen/# processed) by category (Health Care/1st Responders/Other)
  - Site staffing report (# Federal/#State)
  - Logistical critical federally provided item status for 250 through put
    - Green (Can operate next 3 days)
    - Yellow (Can operate next 2 days)
    - Red (Can operate 1 day)
  - Other Issues affecting operations

AMERICAN OVERSIGHT

	A	B	C	D	E	F
1	Site ID/Number	Site Location	Site Address (complete with city, state, zip)	Collection Date (MM/DD/YYYY)	Collection Time (HH:MM)	Language (other than English)
2	*CVS 10596*	*COVID-19 Community Based Testing Site*	*720 Boston Turnpike, Shrewbury, MA, 01545*	*3/19/2020*	*3:45:00 PM*	
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25	*Individual Sites need to document the DAILY total number of individuals tested on-site. See Instructional document for further details.					

AMERICAN OVERSIGHT

	G	H	I	J	K	L	M	N
1	LAST NAME	FIRST NAME	Gender (Male, Female or Not Specified)	DOB	ADDRESS	CITY	STATE	ZIP CODE
2	*Smith*	*John*		*1/1/2001*	*123 Main Street, #1*	*Shrewbury*	*MA*	*15450*
3								
4								
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6								
7								
8								
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24								
25								

AMERICAN OVERSIGHT

	O	P	Q	R	S	T	U	V
1	PHONE (Primary)	Insurance Carrier Name	Group #	Member/Individual #	Verbal Consent? (Y/N)	Private Act? (Y/N)	Unique Sample Barcode #	Sample Sent to Lab?
2	*123-456-7891*	*Blue Cross*	*Federal*	*12345678*	*YES*	*YES*	*10101019876*	*YES*
3								
4								
5								
6								
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8								
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18								
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21								
22								
23								
24								
25								

AMERICAN OVERSIGHT

	A	B	C
1	DATE	# Tested	# Not Qualified
2	3/18/2020	22	2

AMERICAN OVERSIGHT

Intended Use of the Handouts Provided to Community-based Testing Sites:

These three documents were developed as resources to hand out to individuals at specific points during their experience at the Community-based Testing Sites. Please review the purpose and instructions for each document.

1) What to Expect At Community-based Testing Sites

Purpose: To give individuals step-by-step instructions of what will occur during their experience at the testing site.

Instructions:

Hand out this document to the people who are in line and below site capacity numbers

2) Information:

Purpose: To provide individuals who, due to capacity issues or not meeting site testing criteria, will not be tested at the site with useful information on what to do next.

Instructions:

Hand out this document to the following:

- people who are in line but will not receive testing because we have exceeded capacity
- people who are in line but will not receive testing because they do not meet site testing requirements

3) Instructions and Test Results sheets (recommend printing double-sided)

Purpose: The instructions sheet provides individuals who have been tested guidance on what to do while they wait for test results and how their test results will be delivered. The tests results sheet provides instructions for what to do if you have tested positive and if you have tested negative.

Instructions:

Hand out this document at the final station and instruct people to keep the paper until they receive the test results.

AMERICAN OVERSIGHT

Site Location:
Site Address:

COVID-19 by PCR Requisition Form

No other test may be ordered on this COVID-19 by PCR requisition form

Ordering Physician: Dr. Erica Schwartz, MD **Ordering Physician NPI:** 1427034826 **Quest Account Number:** 73916469 **LabCorp Account Number:** 32044780 **Result to:** Maximus	**CPT Code:** 87635 **Test Name:** COVID-19 by PCR **Sample Type:** Nasopharyngeal **ICD-10 Code:** Z03.818

1. DATE of Collection (MM/DD/YYYY) **2.TIME of Collection** **3. Language** (if not English)

/ / 2020 MM / DD / YYYY		

4. LAST NAME		**5. FIRST NAME**	**6. GENDER**	**7. DOB**
		Male Female Not Specified	/ / MM / DD / YYYY	

8. ADDRESS	**9. CITY**

10. STATE	**11. ZIP CODE**	**12. PHONE (primary)**
		Cell / Home

13. Insurance Carrier Name	14. Group Number

15. Member/Individual Number

Patient has verbally provided informed consent to participate in this testing: YES NO

Patient has received a copy of the privacy notice: YES NO

Barcode or Unique Identifier affixed below

AMERICAN OVERSIGHT

FEMA

COVID-19
Community-Based Testing Sites (CBTS)

FACT SHEET

States and the private sector have teamed up with the federal government to provide testing to Americans who need it the most. Community-based Testing Sites (CBTSs) are a tool for states, local public health systems and healthcare systems to use as they work together to stop the spread of COVID-19 in their communities.

Criteria

In order for a testing site to qualify as a CBTS, it must:

1. Receive supplies from the federal government.
2. Ensure there is at least one United States Public Health Service (USPHS) officer at each site.
3. Use the lab ordering, sampling and packaging process established by the federal government.
4. Use the shipping company chosen by the federal government to pick up and deliver labs to the lab company selected by the federal government.
5. Use the federally contracted Call Center that will contact individuals with their results.

SCREENING CRITERIA

Priority 1	Priority 2	Priority 3
▪ Hospitalized patients ▪ Healthcare facility workers with symptoms	▪ Patients in long-term care facilities with symptoms ▪ Patients over age 65 years with symptoms ▪ Patients with underlying conditions with symptoms ▪ First responders with symptoms	▪ Critical infrastructure workers with symptoms ▪ Individuals who do not meet any of the above categories with symptoms ▪ Healthcare facility workers and first responders ▪ Individuals with mild symptoms in communities experiencing high numbers of COVID-19 hospitalizations

AMERICAN OVERSIGHT

FEMA

COVID-19
Community-Based Testing Sites (CBTS)

Requirements for Supply

- Sites, states and regions should attempt to procure all supplies, including personal protective equipment (PPE) locally.
- Requests for PPE are consolidated at the regional level through the Regional Response Coordination Center (RRCC).
- Submit one form per CBTS per day. Complete each section of the form to ensure a correct and complete order. Include CBTS location in the subject line of the email. Regions must submit the form to CBTS Task Force by 7pm EST daily.
- Send completed form to COVID19-CBTS-SUPPLY@FEMA.DHA.GOV.

Future Transition Expectations

- Each CBTS will transition USPHS personnel roles and responsibility to local personnel.
- FEMA will work with regional logistical personnel to develop a process to procure all PPE through standing FEMA processes.
- States will be able to send labs for testing to a lab of their choice.
- States will determine if they would like to use a locally run call center or use the regular state notification processes for results.

RFIs

If state and regional leadership are not able to answer a question, submit an RFI to: fema-cbts-rfi@fema.dhs.gov

AMERICAN OVERSIGHT

FEMA

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AMERICAN OVERSIGHT

FEMA

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AMERICAN OVERSIGHT

From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM

To: Patricia Vinson (CDC adph.state.al.us); hnidi.hedberg@alaska.gov; Uiagalelei, Eli (CDC doh.as); Snyder, Wendy (CDC azdhs.gov); Ferguson, Reva (CDC arkansas.gov); rachelle.ashe@arkansas.gov; Ullom, Peggy (CDC cdph.ca.gov); aislinn.barnett@state.co.us; Jensen, Dana (CDC ct.gov); richard.little@delaware.gov; tanya.bethel@dc.gov; Jade.Tindle@fthealth.gov; angelica.mcgrier@doh.ga.gov; tanny.vazquez@doh.pa.gov; Solomon, Fanoy (CDC fsmhealth.fm); Kaneshiro, Suzanne (CDC dphss.guam.gov); Sharon.Tangonan@doh.hawaii.gov; Peggy.Lindley@dhw.idaho.gov; Misty.Daniels@dhw.idaho.gov; Oluwaseun.Oyeniran@illinois.gov; Musgrave, Shirely (CDC illinois.gov); Barrett, Tami (CDC isdh.in.gov); Caskey, Jennifer (CDC idph.iowa.gov); Denise.Schimmel@ks.gov; ccanfieldsmither@ky.gov; Jane.Killen2@La.gov; Lawrence, Peggie (CDC maine.gov); lacey.barry1@maryland.gov; Michelle.Pringle@maryland.gov; Eva.benyenga@maryland.gov; rebecca.white@state.ma.us; Egelski@michigan.gov; Pizzuti, Sandy (CDC state.mn.us); Griffin, Jenny (CDC msdh.ms.gov); Mebruer, Debbie (CDC health.mo.gov); kacoch@mt.gov; Kellie.Richetti@mt.gov; Engel, Bonnie (CDC nebraska.gov); Magen.Schachta@nebraska.gov; jpfilippi@health.ny.gov; Bogert, Kelly (CDC dhhs.nh.gov); White, Barbara (CDC dhhs.nh.gov); deanna.morris@doh.nj.gov; Solis, Angela (CDC state.nm.us); jacki.silvia@health.ny.gov; carla.moore@dhhs.nc.gov; pthompson@nd.gov; Guerrero, Janet (CDC dph.gov.mp); Ashley.Wilson@odh.ohio.gov; mdianeh@health.ok.gov; Nest, Patricia (CDC state.or.us); tbarnettno@pa.gov; pbeene@pa.gov; Byrnes, Carolyn (CDC pa.gov); lalie.ikluk@palauhealth.org; marlinelopak@gmail.com; Menard, Rita (CDC health.ri.gov); Higgins, Teresa (CDC dhec.sc.gov); Harding, Monica (CDC state.sd.us); Stanton, Tammy (CDC tn.gov); carolyn.geter@dshs.texas.gov; sadia.ali@doh.vi.gov; louise.baa@doh.vi.gov; amaal.idheileh@doh.vi.gov; McFarlane, Lesa (CDC doh.vi.gov); tesha.plunkett@doh.vi.gov; betsycoleman@utah.gov; Gregorek, Sarah (CDC vermont.gov); Maryanne.wollman@vdh.virginia.gov; Bergener, Terry (CDC doh.wa.gov); Fisher, Andrea (CDC wv.gov); tara.vasby@dhs.wisconsin.gov

Cc: Scott.Harris@adph.state.al.us; anne.zink@alaska.gov; Nua, Motusa Tuileama (CDC doh.as); Christ, Cara (CDC azdhs.gov); Smith, Nathaniel (CDC arkansas.gov); Sonia.angell@cdph.ca.gov; jill.hunsakerryan@state.co.us; Coleman, Renee (CDC ct.gov); karyl.rattay@delaware.gov; Nesbitt, LaQuandra (CDC dc.gov); scott.rivkees@fthealth.gov; kathleen.toomey@dph.ga.gov; msamo@fsmhealth.fm; Linda.denorcey@dphss.guam.gov; bruce.s.anderson@doh.hawaii.gov; elke.shaw-tulloch@dhw.idaho.gov; Ngozi.Ezike@illinois.gov; kbox@isdh.in.gov; Qabaugh, Gerd (CDC idph.iowa.gov); lee.norman@ks.gov; adearinger@ky.gov; alexander.billioux@la.gov; nirav.shah@Maine.Gov; robert.neall@maryland.gov; fran.phillips@maryland.gov; Bharel, Monica (CDC state.ma.us); KhaldunA@michigan.gov; jan.malcolm@state.mn.us; Thomas.Dobbs@msdh.ms.gov; Randall.williams@health.mo.gov; shellahogan@mt.gov; Gholzman@mt.gov; dannette.smith@nebraska.gov; gary.anthone@nebraska.gov; Laharych@health.ny.gov; jazzam@health.ny.gov; lisa.morris@dhhs.nh.gov; Judith.Persichilli@doh.nj.gov; kathy.kunkel@state.nm.us; Zucker, Howard (CDC health.ny.gov); mark.benton@dhhs.nc.gov; Betsey.Tilson@dhhs.nc.gov; melvinstuhts@nd.gov; Muña, Esther (CDC dph.gov.mp); amy.acton@odh.ohio.gov; GaryC@health.ok.gov; Shirley, Lillian (CDC state.or.us); ralevine@pa.gov; DrRafael.Rodriguez@salud.pr.gov; Catherine.delacruz@salud.pr.gov; emais.roberts@palauhealth.org; bbillmon@hotmail.com; Alexander-Scott, Nicole (CDC health.ri.gov); rick.toomey@dhec.sc.gov; Malsam-Rysdon, Kim (CDC state.sd.us); Lisa.Piercey@tn.gov; Hellerstedt, John (CDC dshs.texas.gov); justa.encarnacion@doh.vi.gov; Miner, Joseph (CDC utah.gov); mark.levine@vermont.gov; norm.oliver@vdh.virginia.gov; Wiesman, John (CDC doh.wa.gov); cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov); Montero, Jose (CDC/DDPHSIS/CSTLTS/OD); marcus.plescia@ASTHO.com;

Subject: Urgent Request for Information: Top State/Territorial Health Official (example, Secretary, Minister or Commissioner of Health)

Date: Monday, March 2, 2020 11:39:34 AM

Good Morning,

CDC Incident Management has asked the State Coordination Task Force for contact information of the **top health official** in each jurisdiction to expedite outreach in the event of an emergencies and to provide COVID-19 updates as expeditiously as possible. To accomplish this task, I am reaching out to the SHO/THO Assistant with a cc to the SHO/THO. This information will be used in tandem with the information we have for the SHO/THO maintained by ASTHO. You all are in a great position to assist us!

We know that in many cases the top health official is the SHO/THO. If that case is , just **reply** to this email that they are the **same**.

For those where there is a person who is more senior to the SHO/THO (as a reminder, we are looking for the most senior health official), please complete the following information:

State/Territory	Highest Health Official (i.e. Commissioner/ Minister/Secretary) Name (including degrees as appropriate)	Title	Phone Number (Please provide a **number or** numbers where we can reach out ***after hour*** should the need arise for COVID-19)	Email	Executive Assistant Name	Phone Number	Email

Due to the nature of this **urgent request**, respond by **COB today**.

Thank you so much for your assistance.

If you have questions or concerns, please contact me.

Kimberly
Kimberly Cantrell
State Coordination Task Force
c: 404-232-0480
SCTF: eomssctftfcoord@cdc.gov

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Cc: Butler, Jay C. (CDC/DDID/OD)
Subject: URGENT State Health Official Message
Date: Tuesday, March 17, 2020 9:10:23 AM

Dear Colleagues:

As we continue to explore avenues to increase state access to COVID-19 testing, we would like for each state to provide the name of one institution in your jurisdiction that could perform high through-put testing if adequate reagents produced by Roche could be made available. In most instances, this will likely be an academic institution or a large medical center with advance diagnostic testing capacity. Please provide this information to Jay Butler (jcb3@cdc.gov) and Hilary Eiring (vte0@cdc.gov) in the CDC EOC as soon as possible. Thank you!

State Coordination Task Force (SCTF)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to state health officials)

AMERICAN OVERSIGHT

From: State and Local Readiness (CDC)
To: CDC IMS State Coordination Task Force (SCTF) Lead
Subject: URGENT WEB UPDATE: CDC Mass Gathering Statement
Date: Sunday, March 15, 2020 9:05:46 PM
Importance: High

Dear Colleagues:

Large events and mass gatherings can contribute to the spread of COVID-19 in the United States via travelers who attend these events and introduce the virus to new communities. Examples of large events and mass gatherings include conferences, festivals, parades, concerts, sporting events, weddings, and other types of assemblies. These events can be planned not only by organizations and communities but also by individuals.

Therefore, CDC, in accordance with its guidance for large events and mass gatherings, recommends that for the next 8 weeks, organizers (whether groups or individuals) cancel or postpone in-person events that consist of 50 people or more throughout the United States.

Events of any size should only be continued if they can be carried out with adherence to guidelines for protecting vulnerable populations, hand hygiene, and social distancing. When feasible, organizers could modify events to be virtual.

This recommendation does not apply to the day to day operation of organizations such as schools, institutes of higher learning, or businesses. This recommendation is made in an attempt to reduce introduction of the virus into new communities and to slow the spread of infection in communities already affected by the virus. This recommendation is not intended to supersede the advice of local public health officials.

Please let us know if you have any questions. Thank you.

State Coordination Task Force (SCTF)
Division of State and Local Readiness (DSLR)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

CDC 24-7 Logo__EMAIL_Small

(Sent by BCC to PHEP directors, state epidemiologists, state health officials, public health laboratory directors, and national and federal partners)

AMERICAN OVERSIGHT

From:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To:	scott.rivkees@flhealth.gov
Cc:	CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
Subject:	Viral swabs request
Date:	Saturday, March 14, 2020 5:07:53 PM

Hi Dr. Rivkees, thank you for reaching out about viral swabs. CDC is aware of the low inventory and is working quickly to increase supplies and support to the States and Locals. With a limited supply everywhere, we'll be in contact soon on submitted orders. We apologize for the delay but will contact you soon. Please don't hesitate to contact us with any other questions or needs.

Thanks, Wendy

State Coordination Task Force (SCTF)

Regional Coordination Team - eocsctftfcoord@cdc.gov

Center for Preparedness and Response (CPR)

Wendy Holmes: 404-452-9792

Get Outlook for iOS

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 10, 2020 Florida Flu Review
Date:	Wednesday, March 11, 2020 4:18:04 PM
Attachments:	Week 10, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the week 10, Florida Flu Review.

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

Ten outbreaks were reported, up from nine outbreaks in the previous week. Of the ten outbreaks reported, four were influenza-associated and six were ILI.

Two new influenza-associated pediatric deaths were reported, both in vaccinated individuals with known underlying medical conditions. Twelve influenza-associated pediatric deaths have been reported so far this season; only three children were vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection

AMERICAN OVERSIGHT

Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 10: 3/1/20-3/7/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

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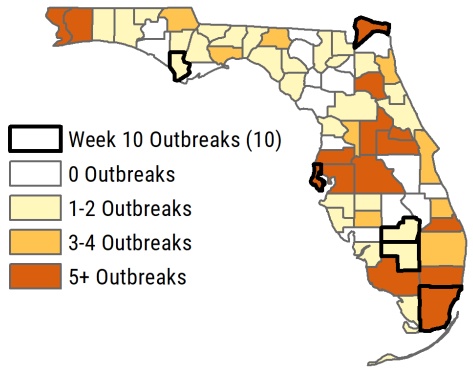
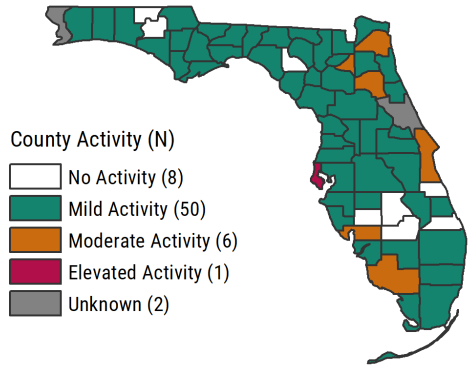
Influenza or ILI Outbreaks

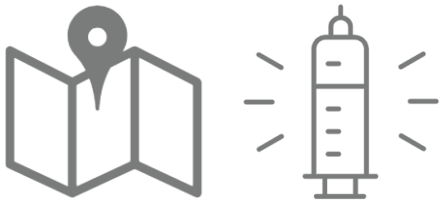
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 11, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
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AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

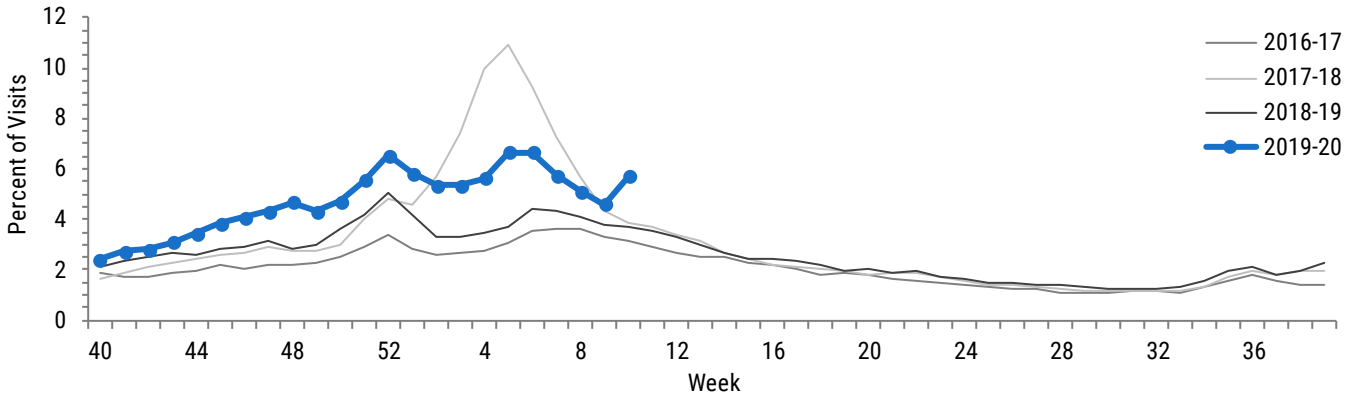
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 10, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 10, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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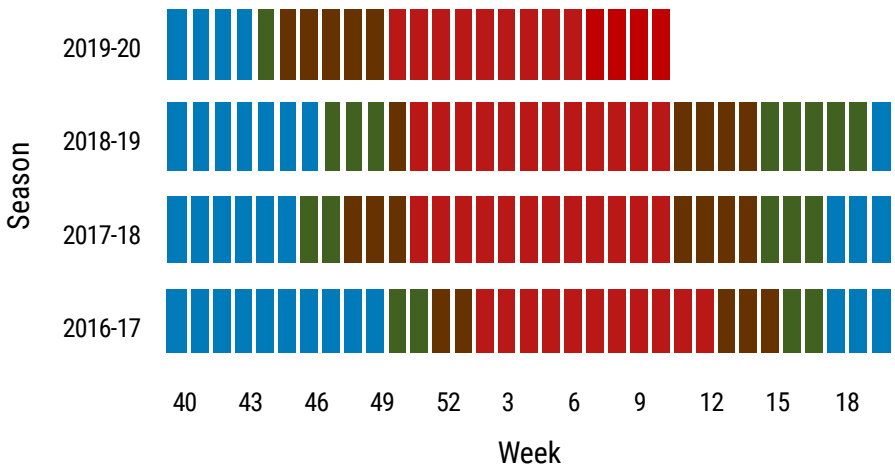
Statewide Activity

Figure 2: In week 10, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 10, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 10, **the percent of patients with ILI reported by ILINet providers statewide increased** and was within levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=8), week 40, 2016 to week 10, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

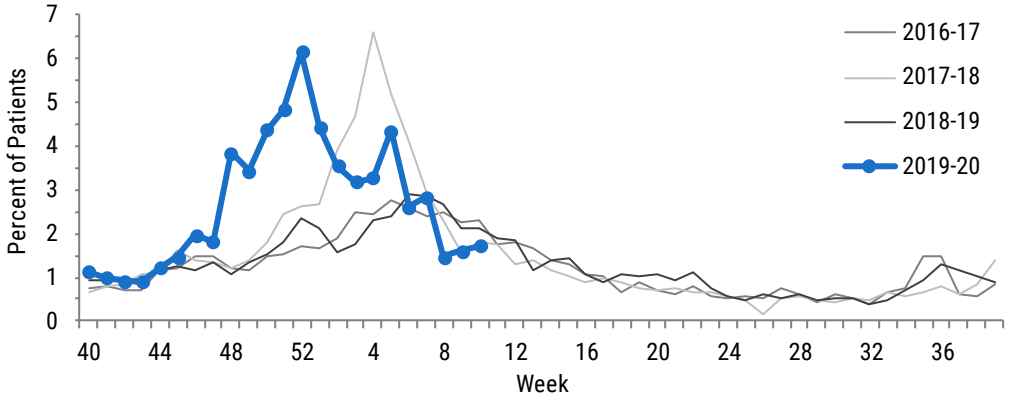
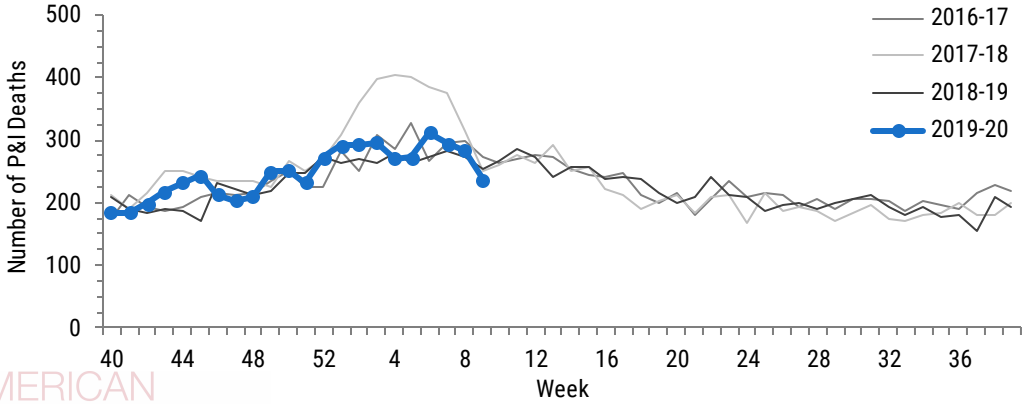


Figure 4: In week 9 (ending 2/29/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 10. Six counties reported **moderate activity,** and one county reported **elevated activity.**

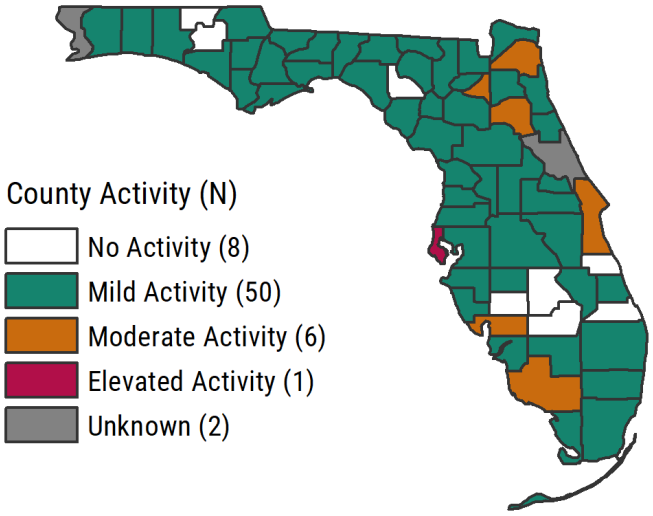
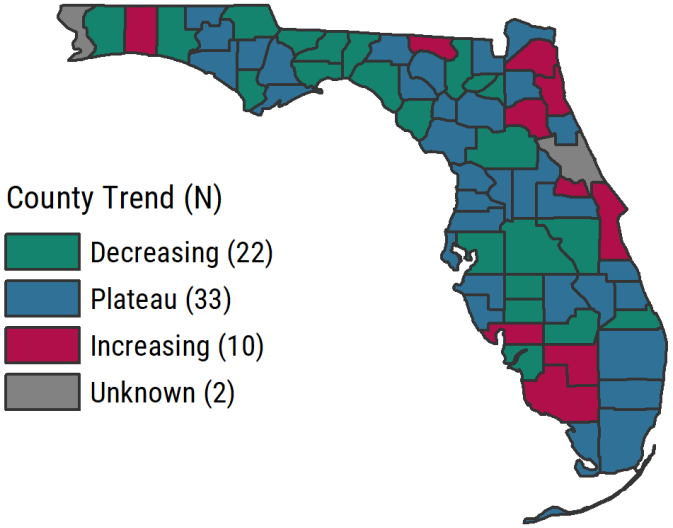
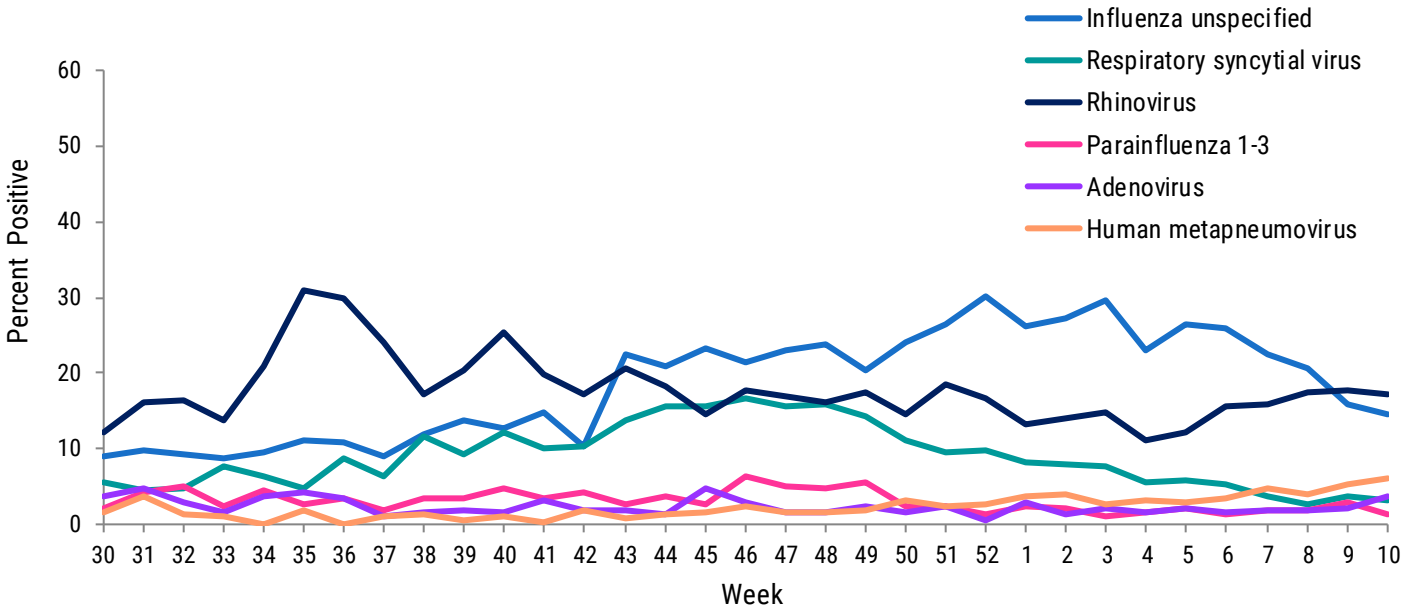


Figure 7: Most counties reported **activity at a plateau** for week 10. Ten counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 10, **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 10, 2020.

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Influenza and ILI Outbreaks

Week 10 Outbreaks at a Glance:

Number Reported:
10 Outbreaks

Influenza-Associated:
4 Outbreaks

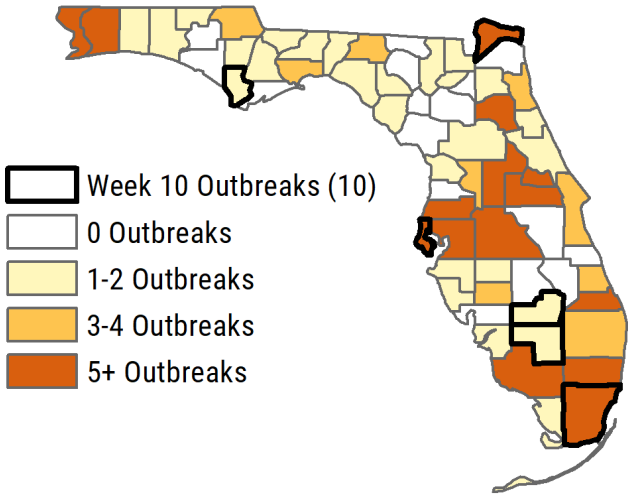
Severe Outcomes*:
0 Outbreaks

Outbreak Summary:

In week 10, four influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

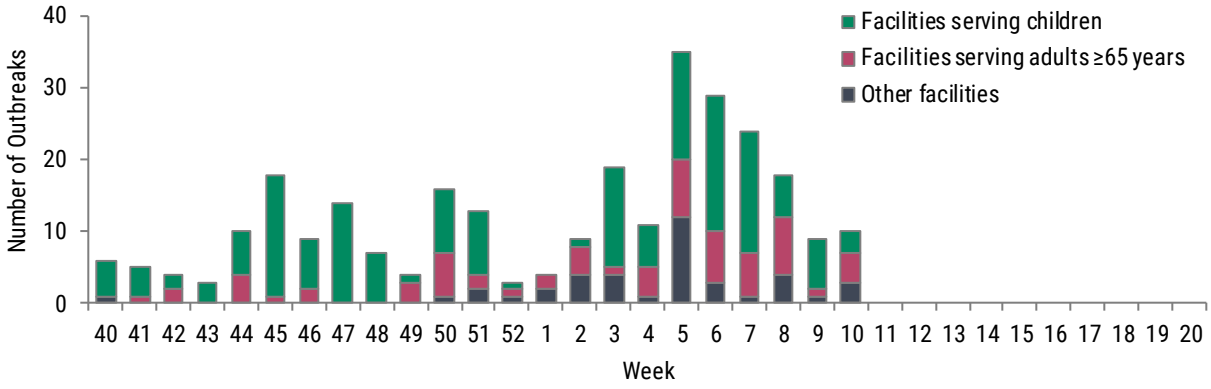
Severe outcomes* were not reported in any of these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



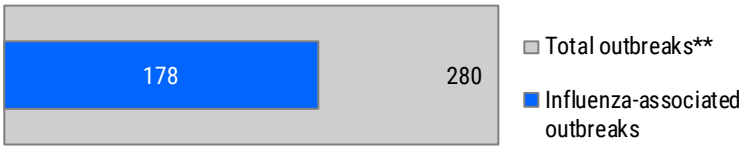
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 10 are **outlined in bold.**

Figure 9: In week 10, **four outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 10, **63.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 10, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

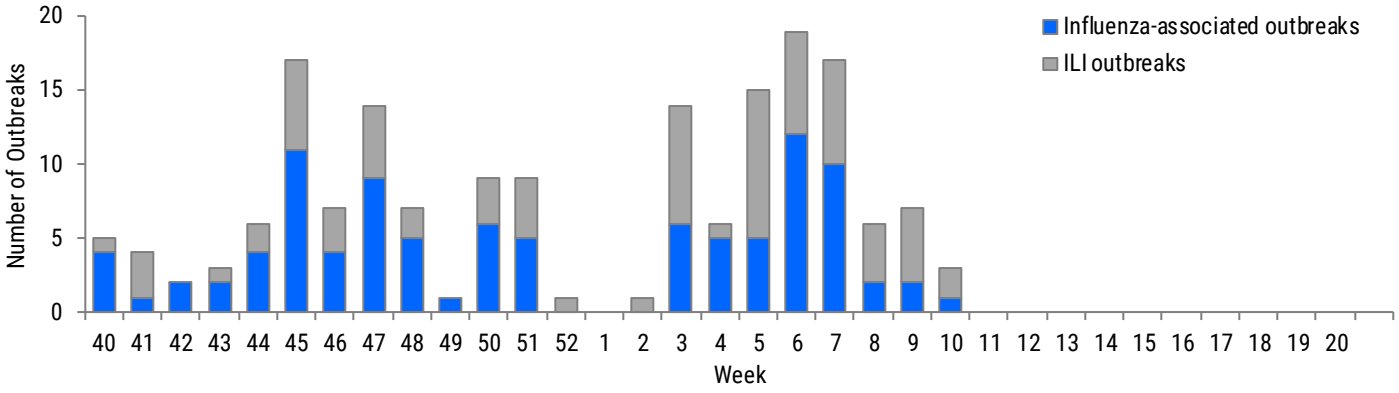
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 10, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 10, **one influenza-associated outbreak** and **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

Facilities Serving Adults ≥65 yrs.**:

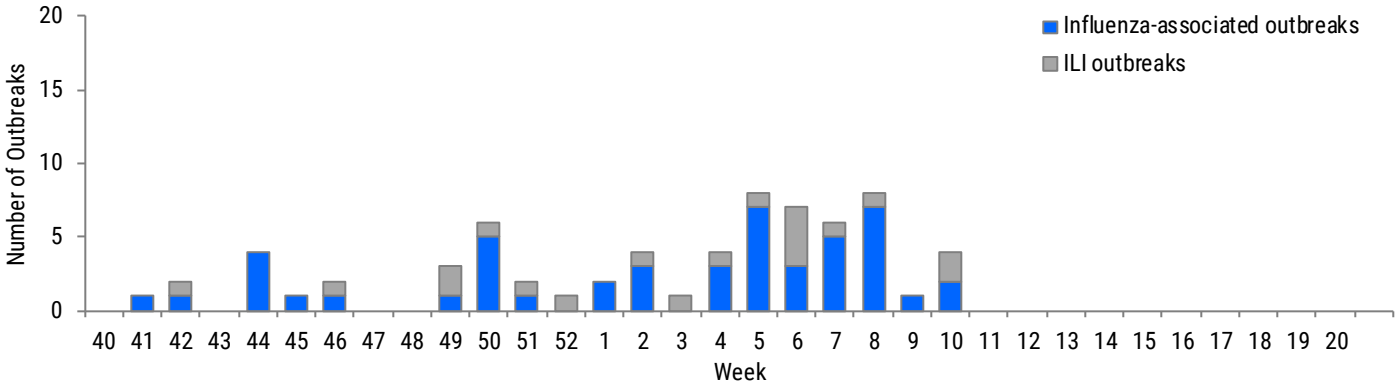
4 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 10, four new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 10, **two influenza-associated outbreaks** and **two ILI outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

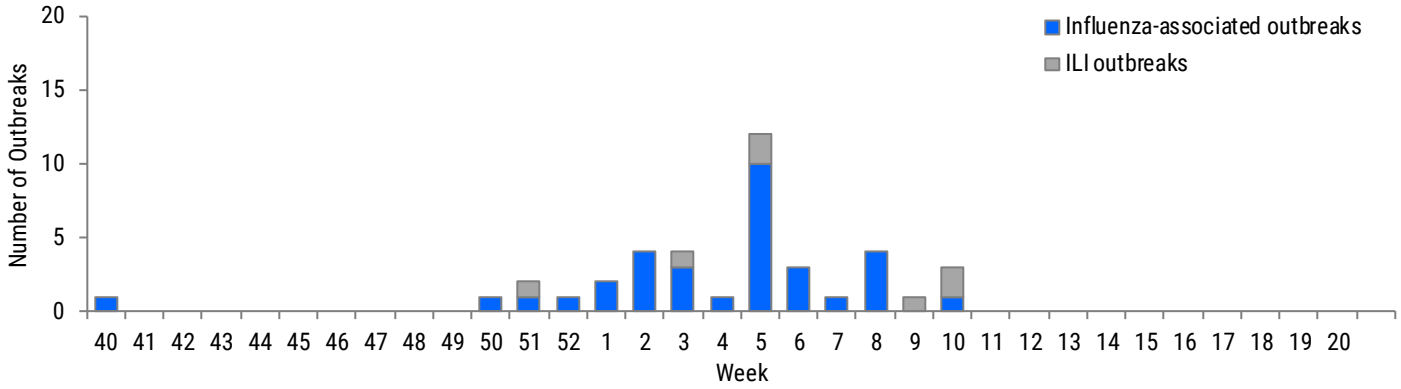
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 10, three new outbreaks of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 10, **two ILI outbreaks** and **one influenza-associated outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	133 (47.5%)	80 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (14.3%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	21 (7.5%)	10 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	15 (5.4%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	31 (11.1%)	26 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.8%)	29 influenza-associated outbreaks 4 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.4%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**280 (100.0%)**	**178 influenza-associated outbreaks** **102 ILI outbreaks**

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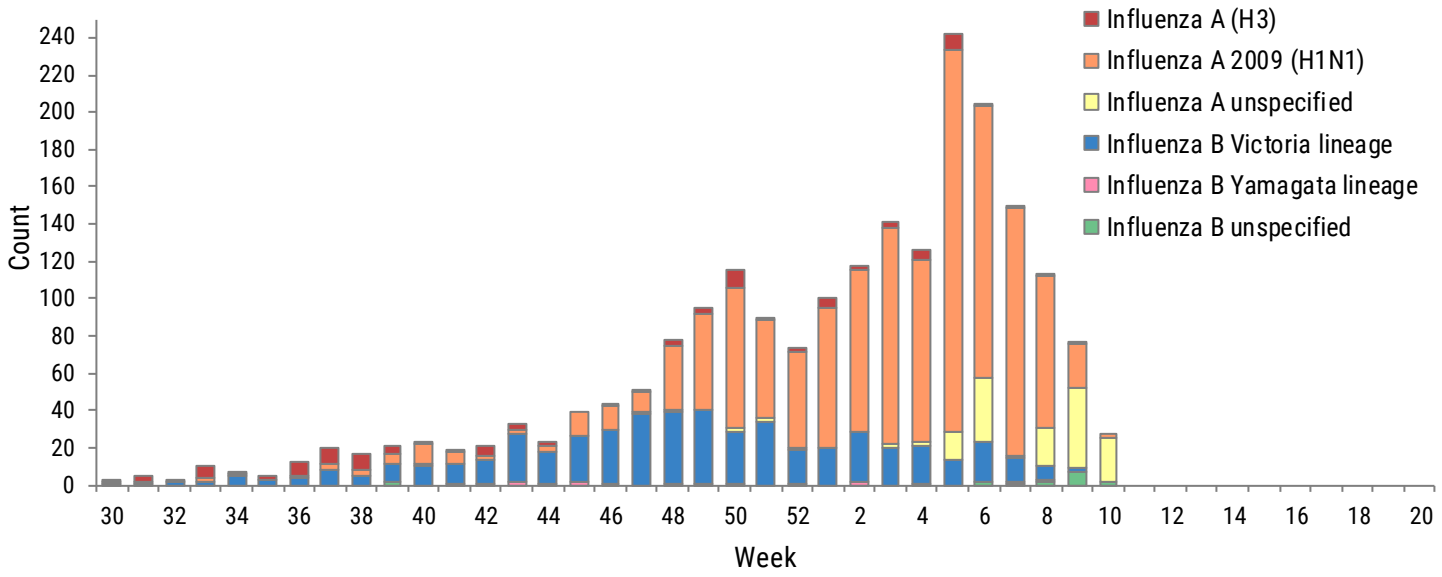
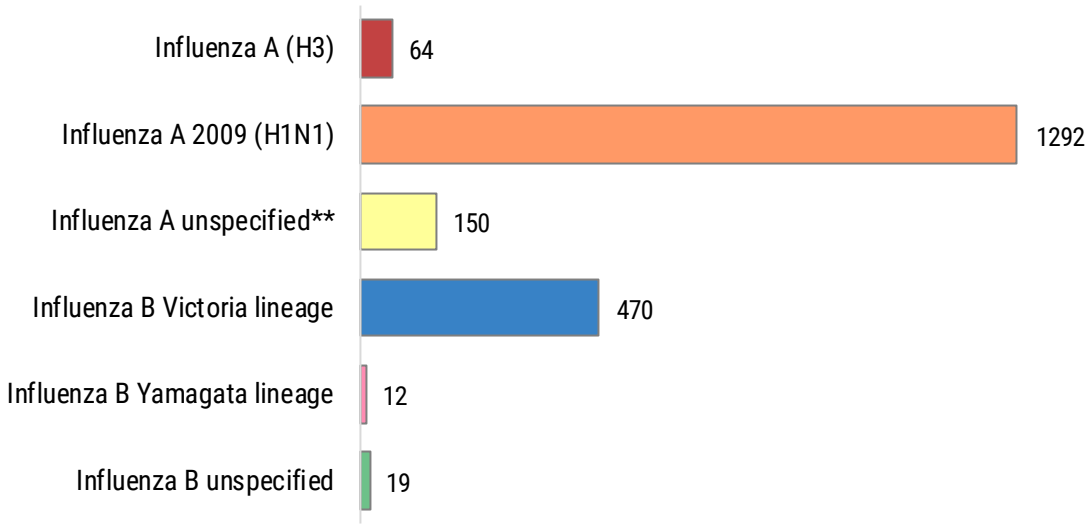
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 10, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 10, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 10, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.

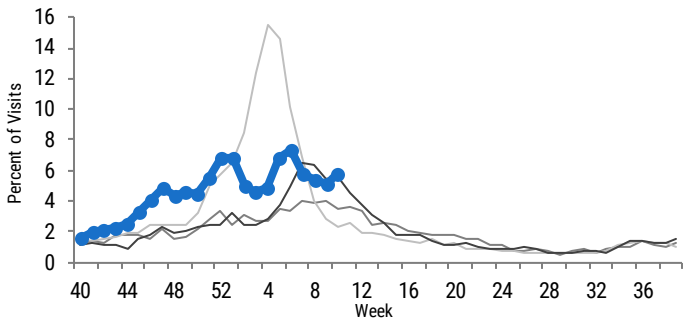


Figure 17: In **region 2, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

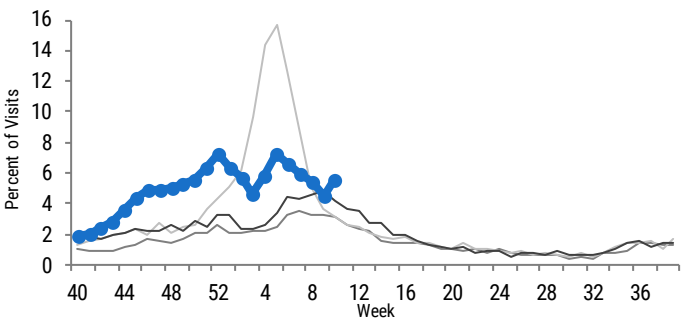


Figure 18: In **region 3, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

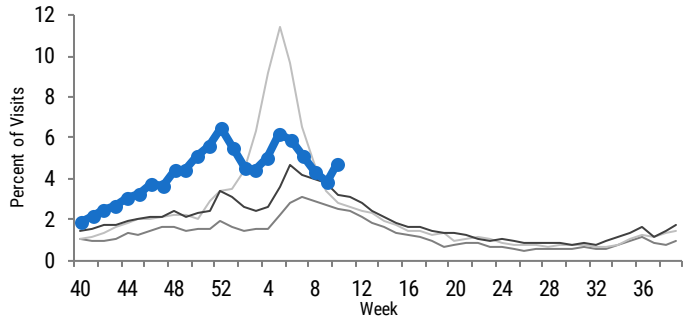


Figure 19: In **region 4, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

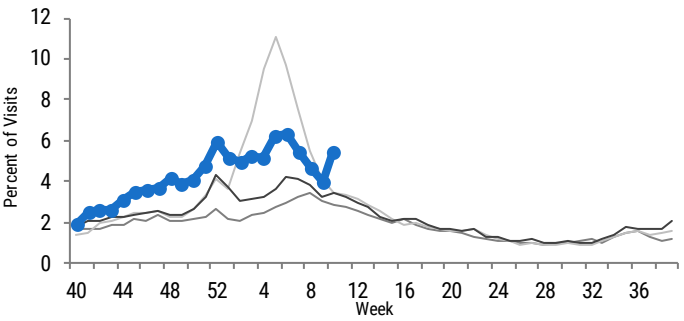


Figure 20: In **region 5, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

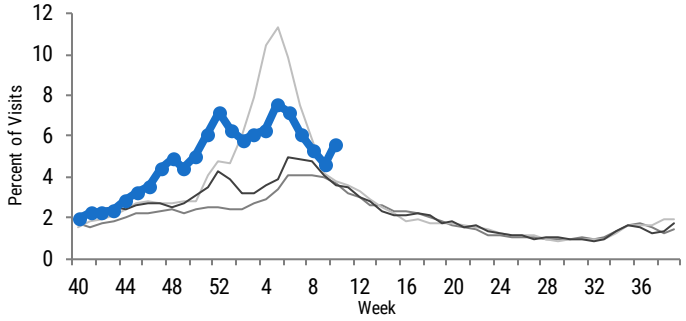


Figure 21: In **region 6, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

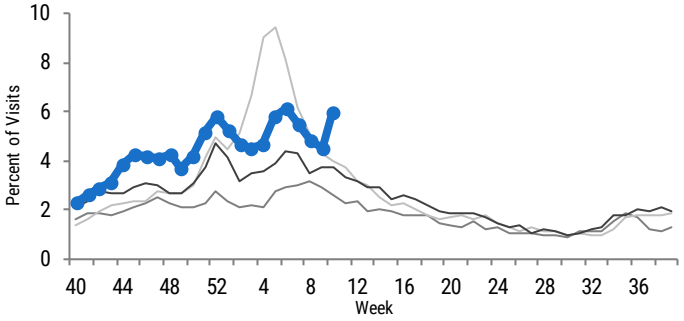
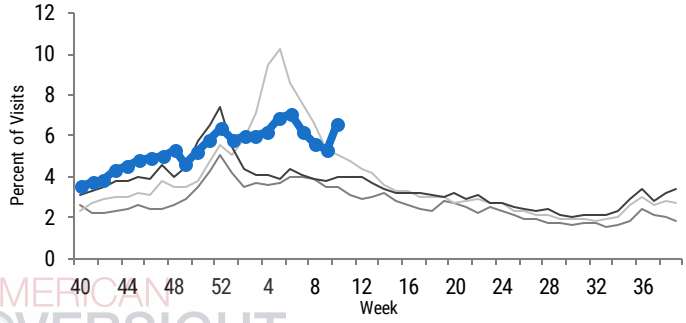


Figure 22: In **region 7, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.



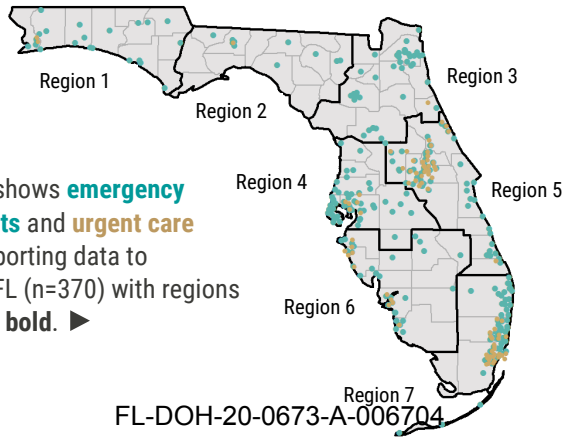


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

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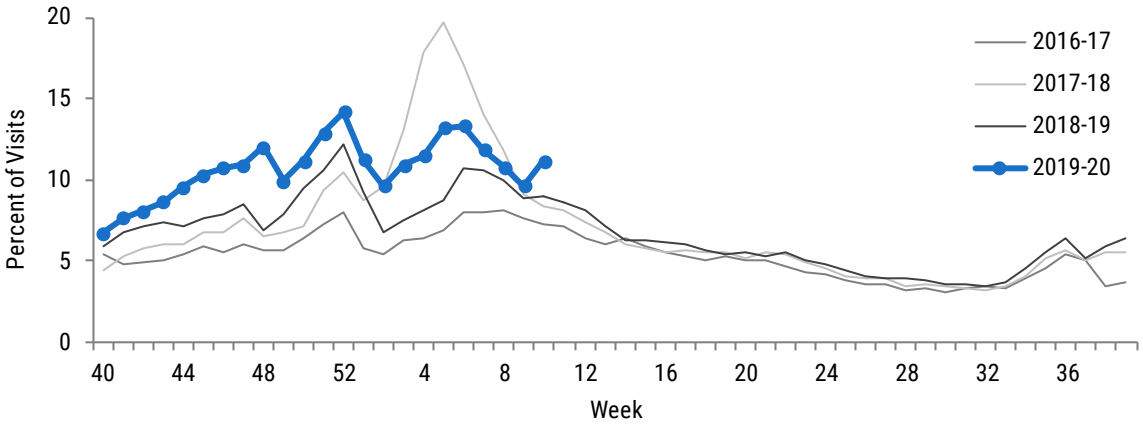
At-Risk Populations

Background: At-Risk Populations, Children

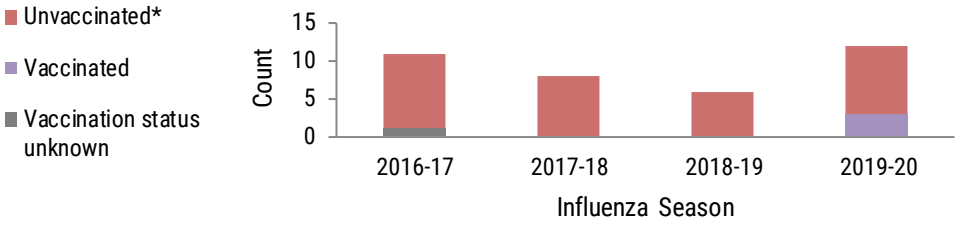
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 10, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above levels observed at this time during the 2016-17 season.

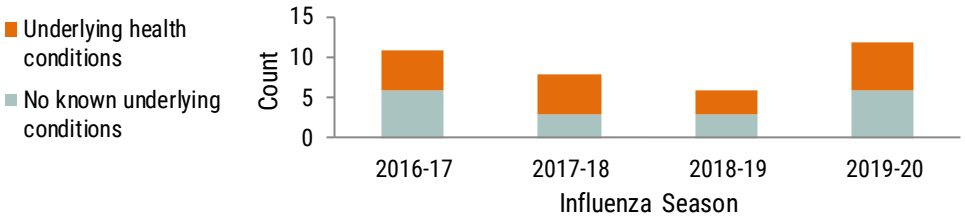


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

Figures 25-26: In week 10, **two new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 10, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 10, 2020.

In week 10, **two new influenza-associated pediatric deaths were reported**. The first death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions. The second was associated with influenza B in a child with known underlying medical conditions. Both were vaccinated for the 2019-20 season.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

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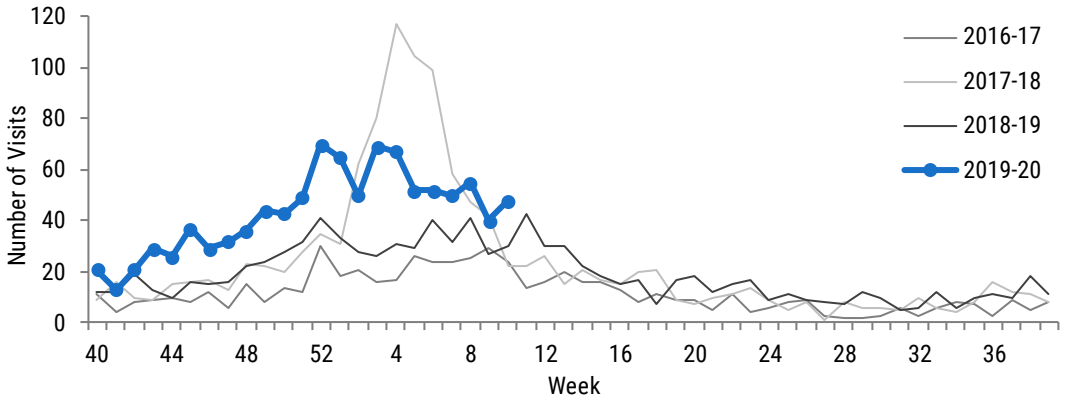
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 10, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



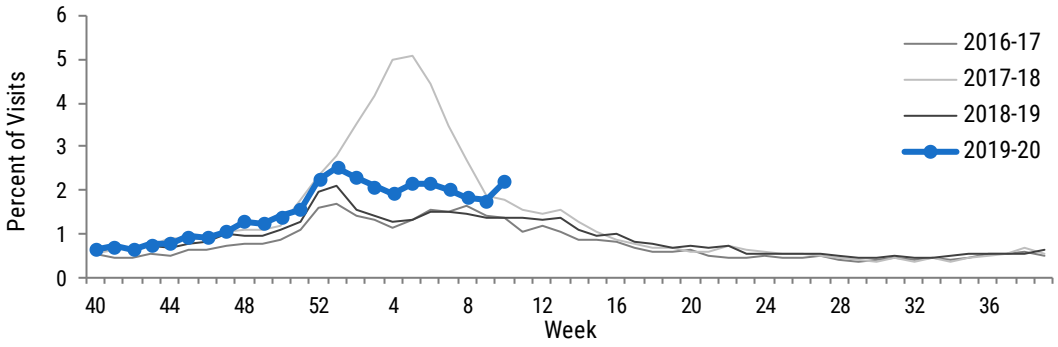
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 10, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 10, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



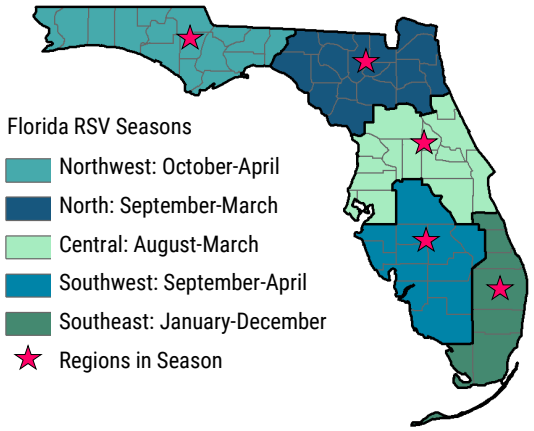
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

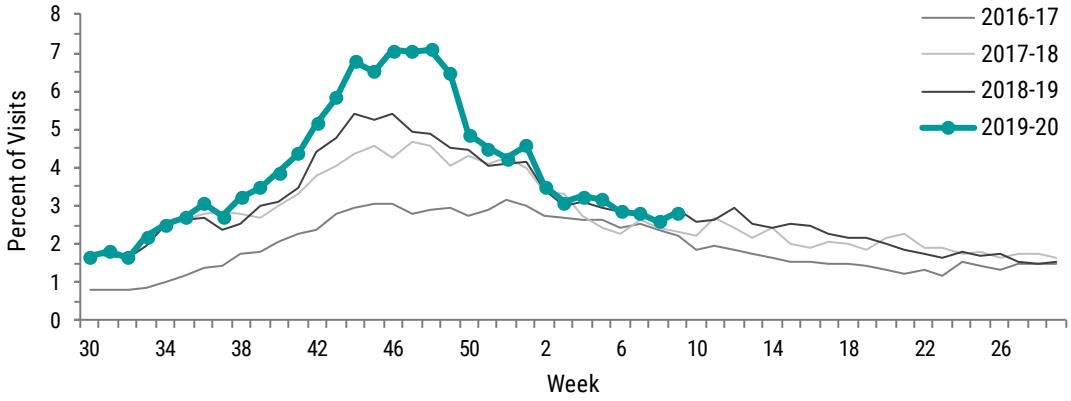
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 10 (February 23-29, 2020) Activity Summary

In week 10, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 10. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 10, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 10, 2020.

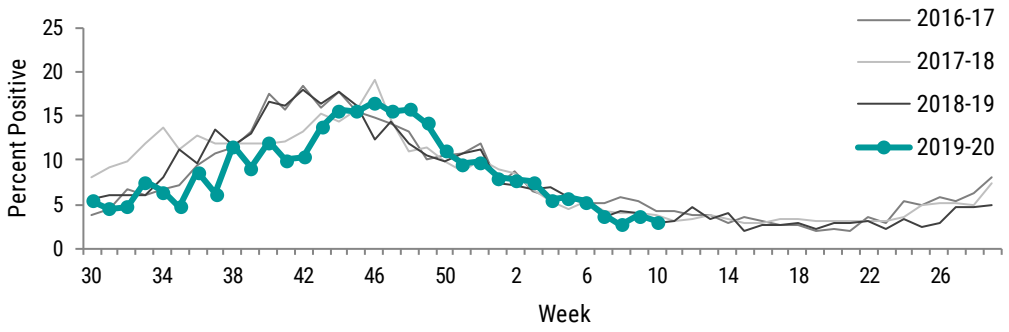
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 10, **the percent of specimens testing positive for RSV decreased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 10, 2020. ▶



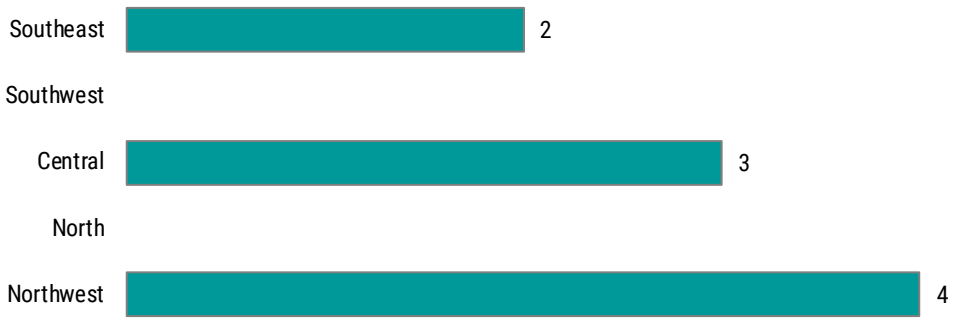
RSV-Associated Outbreaks in Week 10:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 10, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

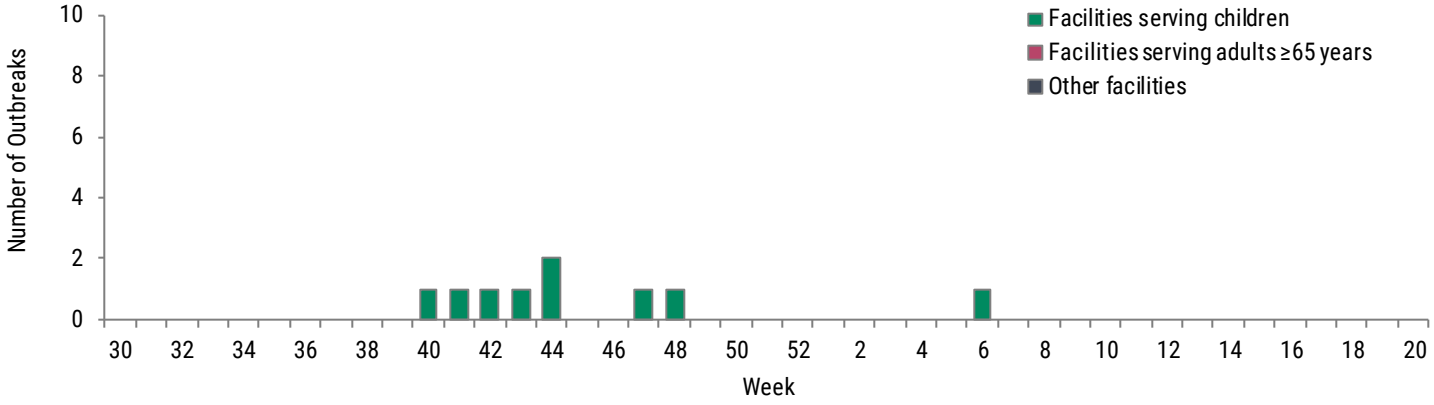
Figure 32: In week 10, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

*Regions defined in figure 29.

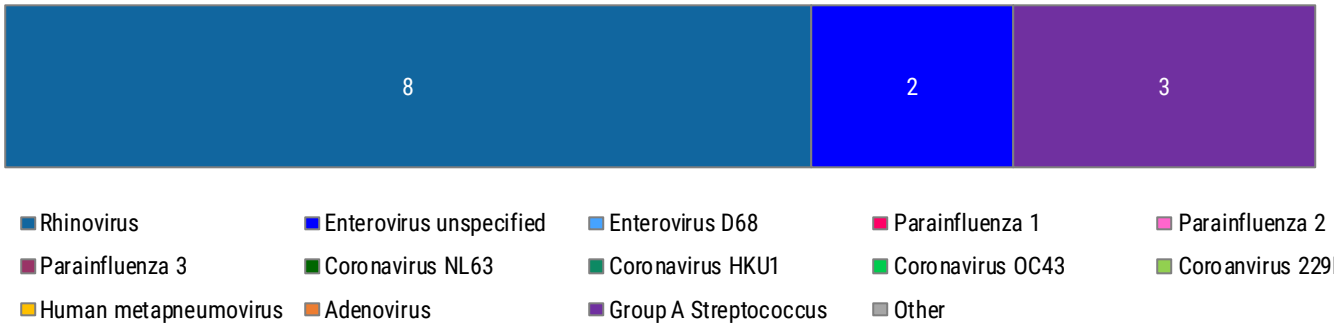
Figure 33: In week 10, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



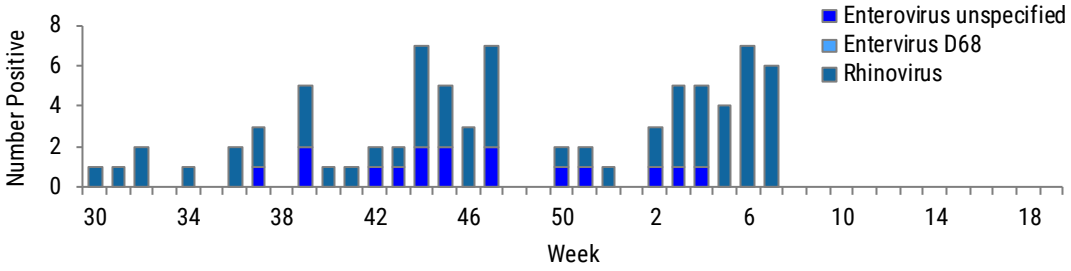
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

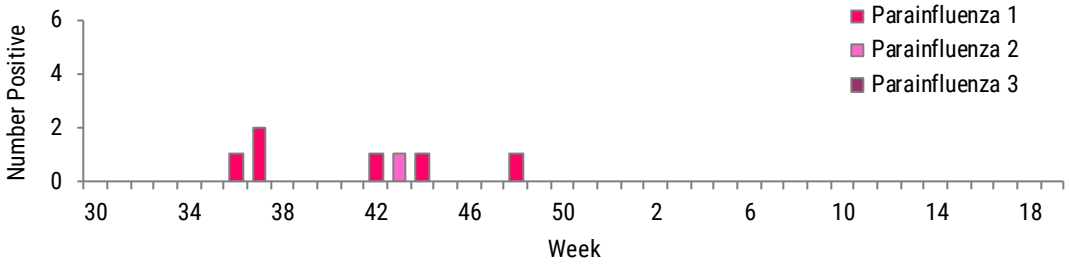


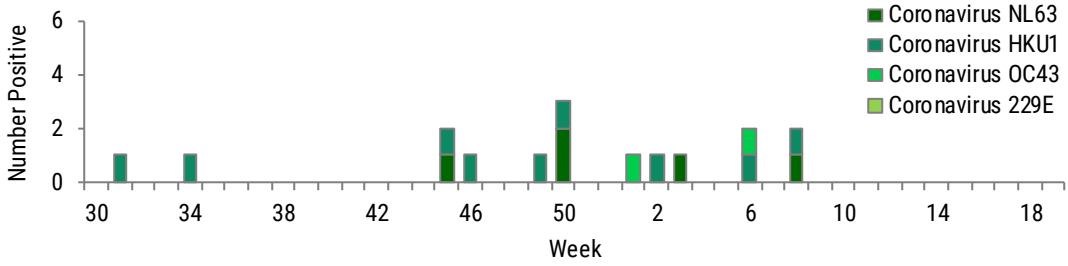
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 10, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

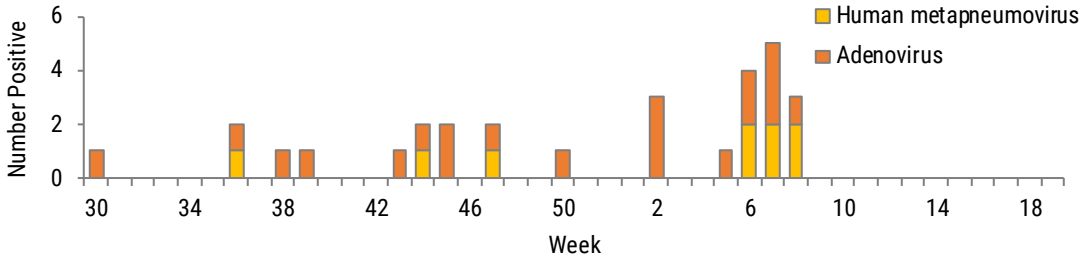
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 10, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 10, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 10, 2020 Florida Flu Review
Date:	Wednesday, March 11, 2020 4:18:09 PM
Attachments:	Week 10, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the week 10, Florida Flu Review.

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

Ten outbreaks were reported, up from nine outbreaks in the previous week. Of the ten outbreaks reported, four were influenza-associated and six were ILI.

Two new influenza-associated pediatric deaths were reported, both in vaccinated individuals with known underlying medical conditions. Twelve influenza-associated pediatric deaths have been reported so far this season; only three children were vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection

AMERICAN OVERSIGHT

Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 10: 3/1/20-3/7/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

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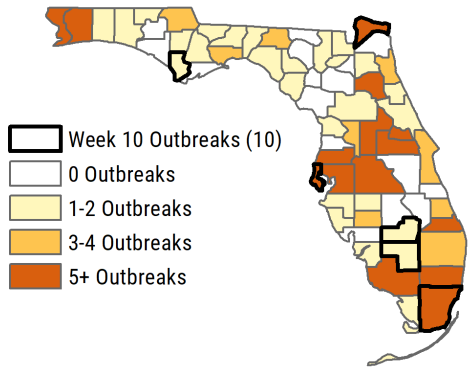
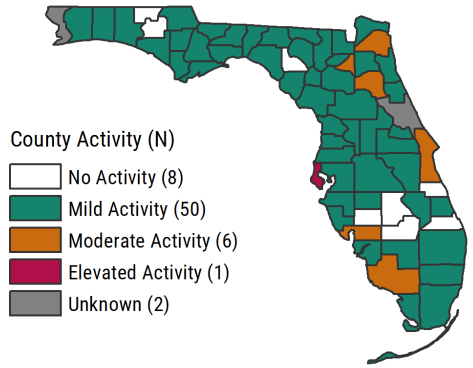
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

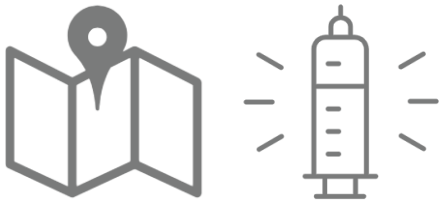
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 11, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006715

AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

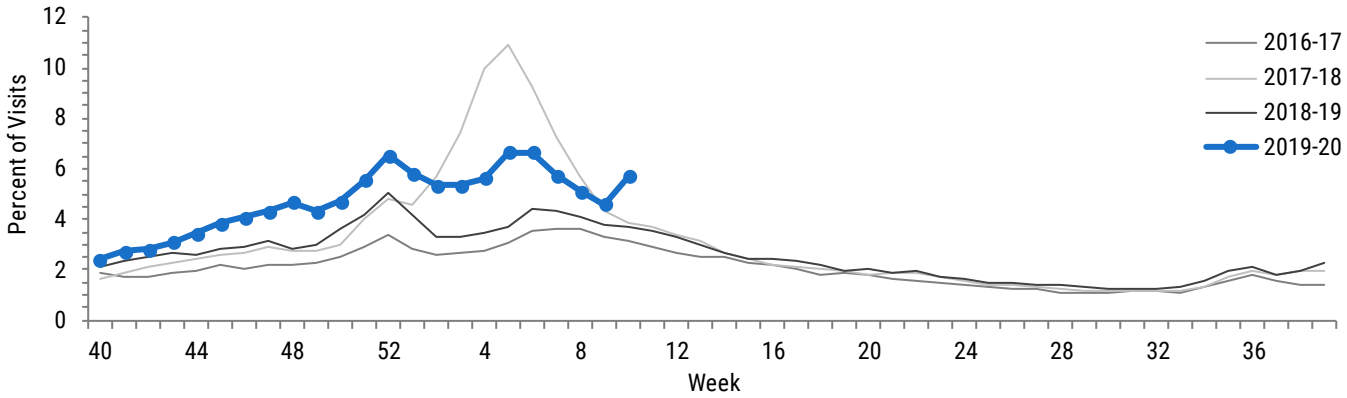
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 10, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.

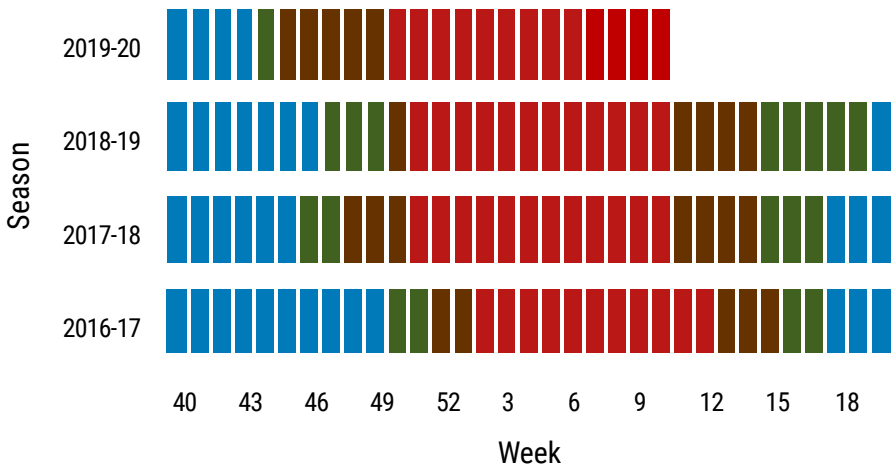


▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 10, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

AMERICAN OVERSIGHT

Statewide Activity

Figure 2: In week 10, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 10, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 10, **the percent of patients with ILI reported by ILINet providers statewide increased** and was within levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=8), week 40, 2016 to week 10, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

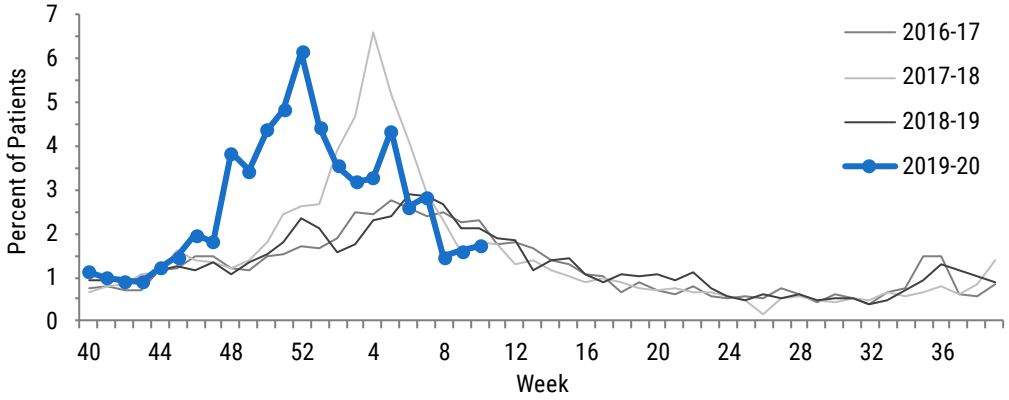
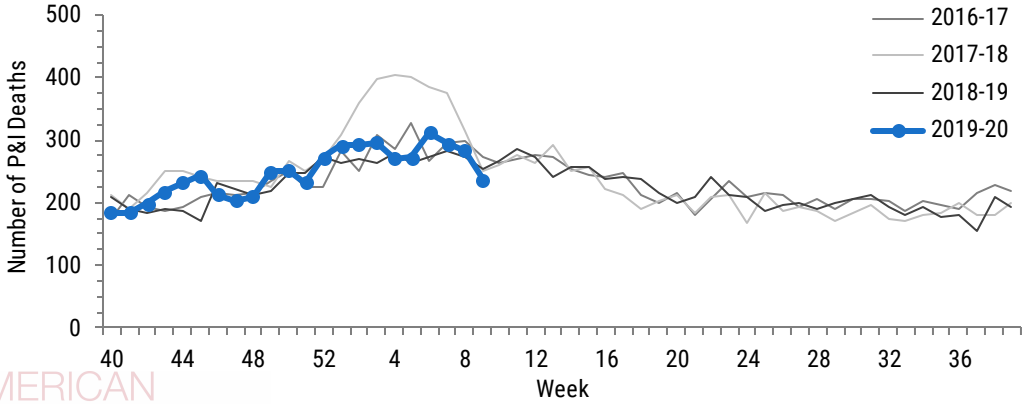


Figure 4: In week 9 (ending 2/29/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 10. Six counties reported **moderate activity,** and one county reported **elevated activity.**

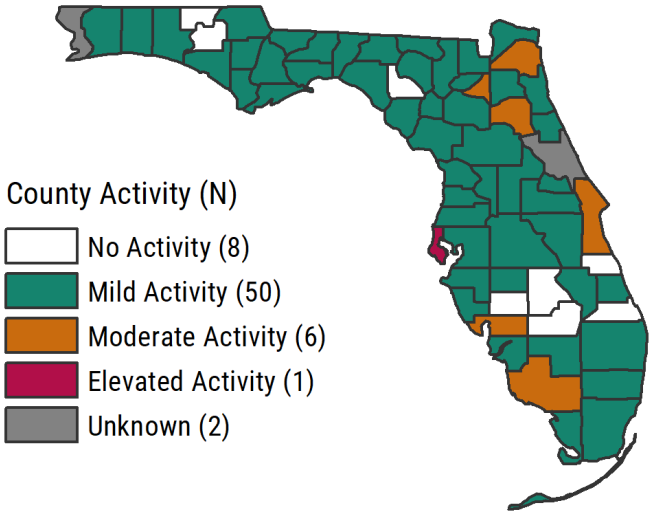
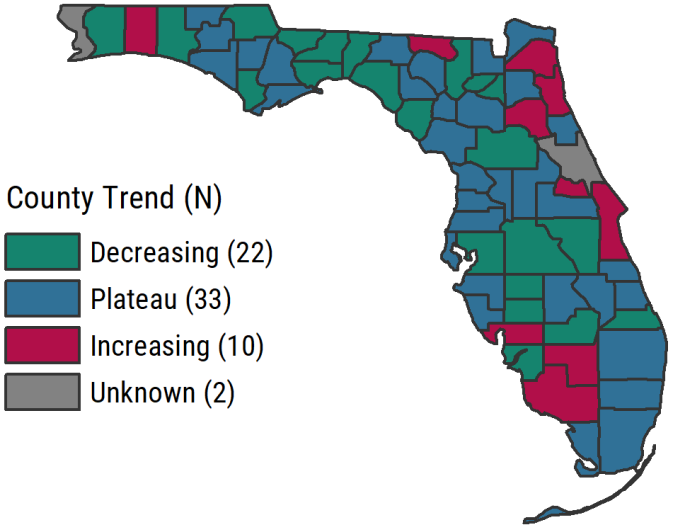
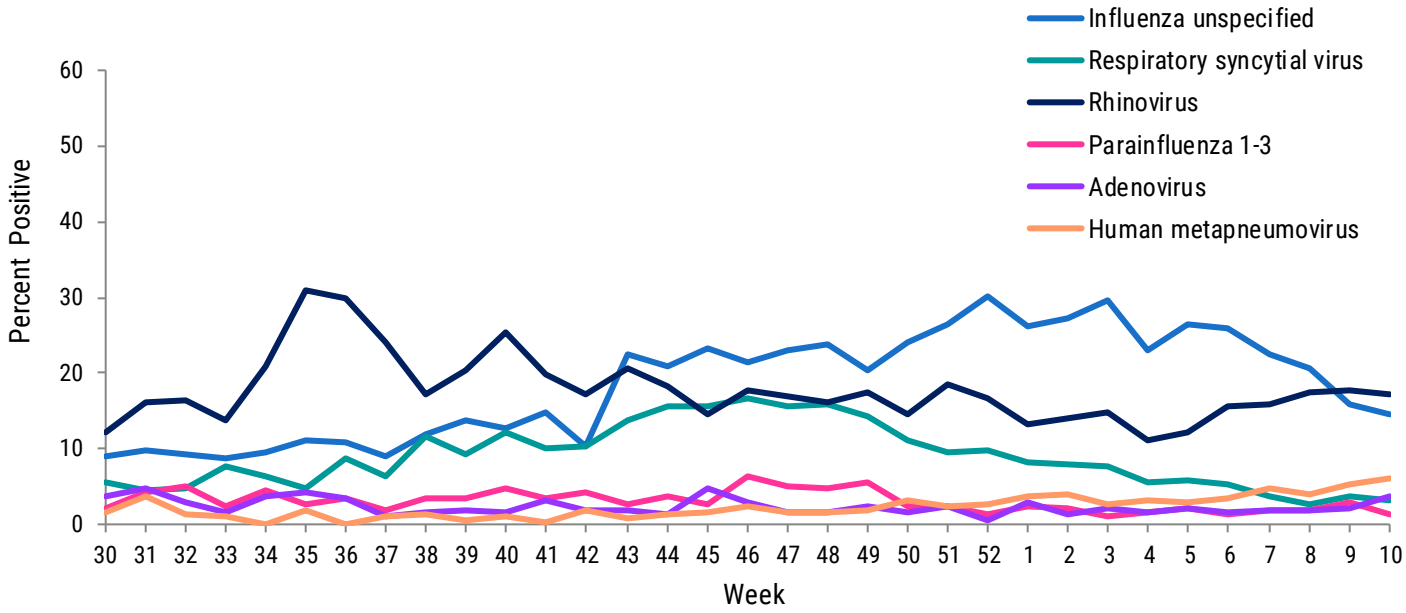


Figure 7: Most counties reported **activity at a plateau** for week 10. Ten counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 10, **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 10 Outbreaks at a Glance:

Number Reported:
10 Outbreaks

Influenza-Associated:
4 Outbreaks

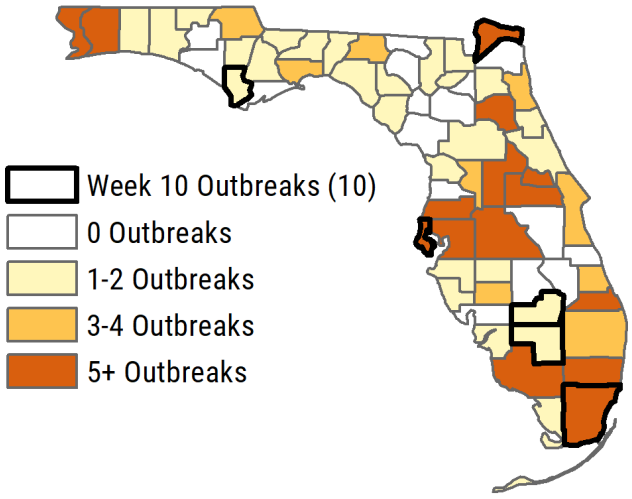
Severe Outcomes*:
0 Outbreaks

Outbreak Summary:

In week 10, four influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

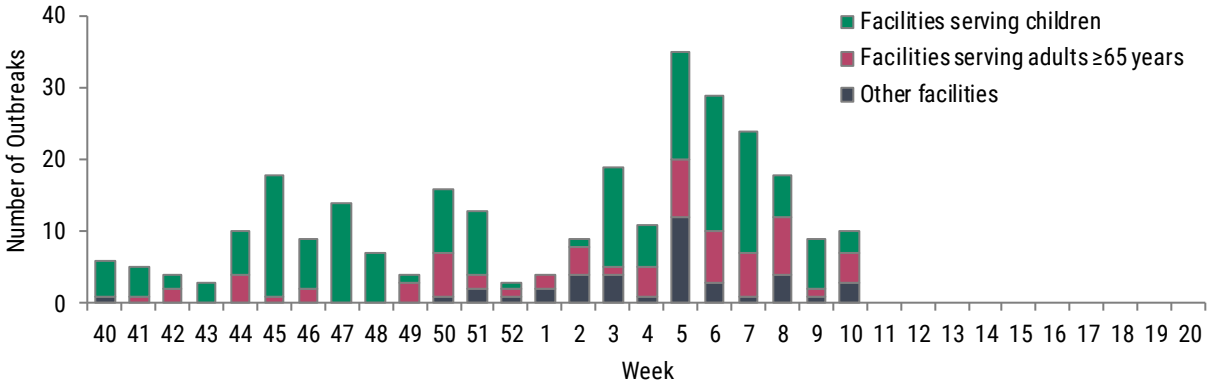
Severe outcomes* were not reported in any of these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



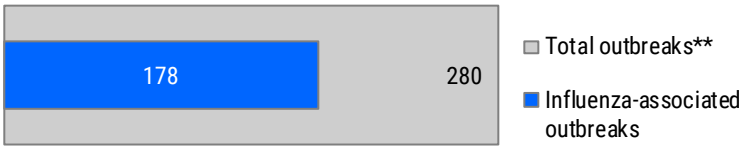
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 10 are **outlined in bold.**

Figure 9: In week 10, **four outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 10, **63.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 10, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

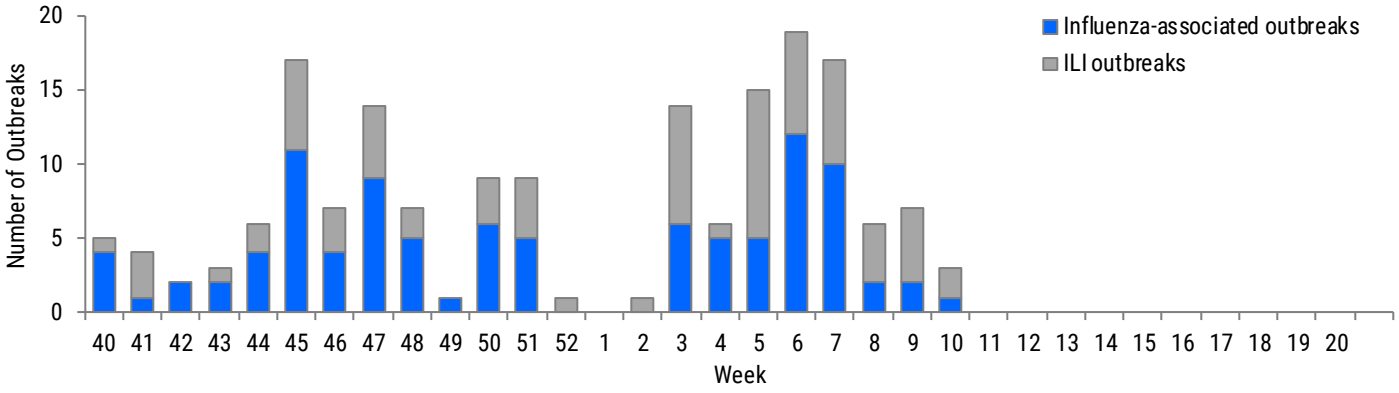
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 10, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 10, **one influenza-associated outbreak** and **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

Facilities Serving Adults ≥65 yrs.**:

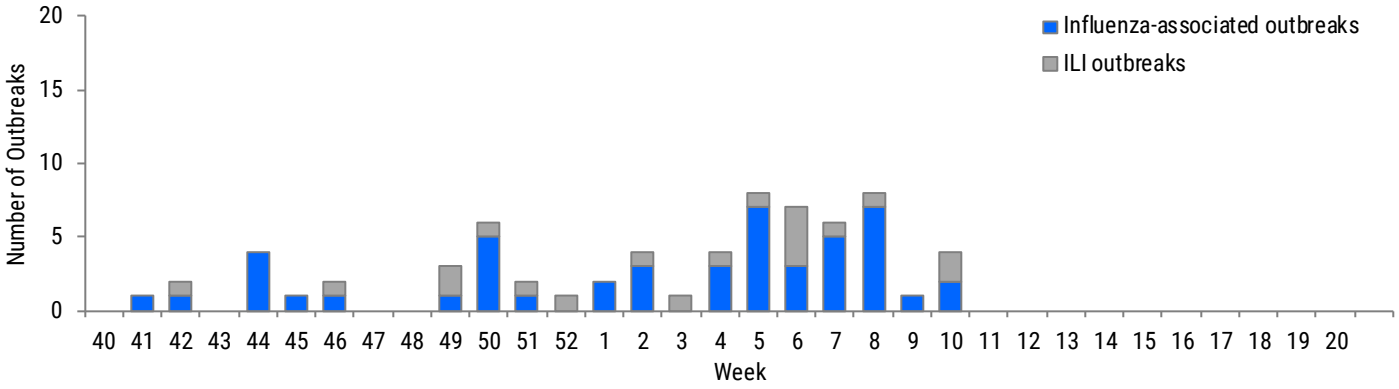
4 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 10, four new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 10, **two influenza-associated outbreaks** and **two ILI outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

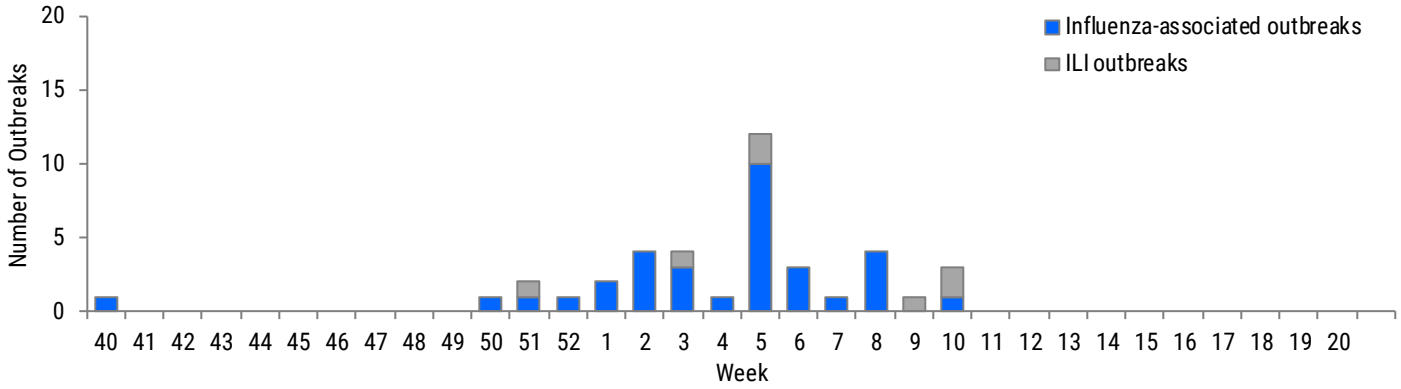
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 10, three new outbreaks of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 10, **two ILI outbreaks** and **one influenza-associated outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

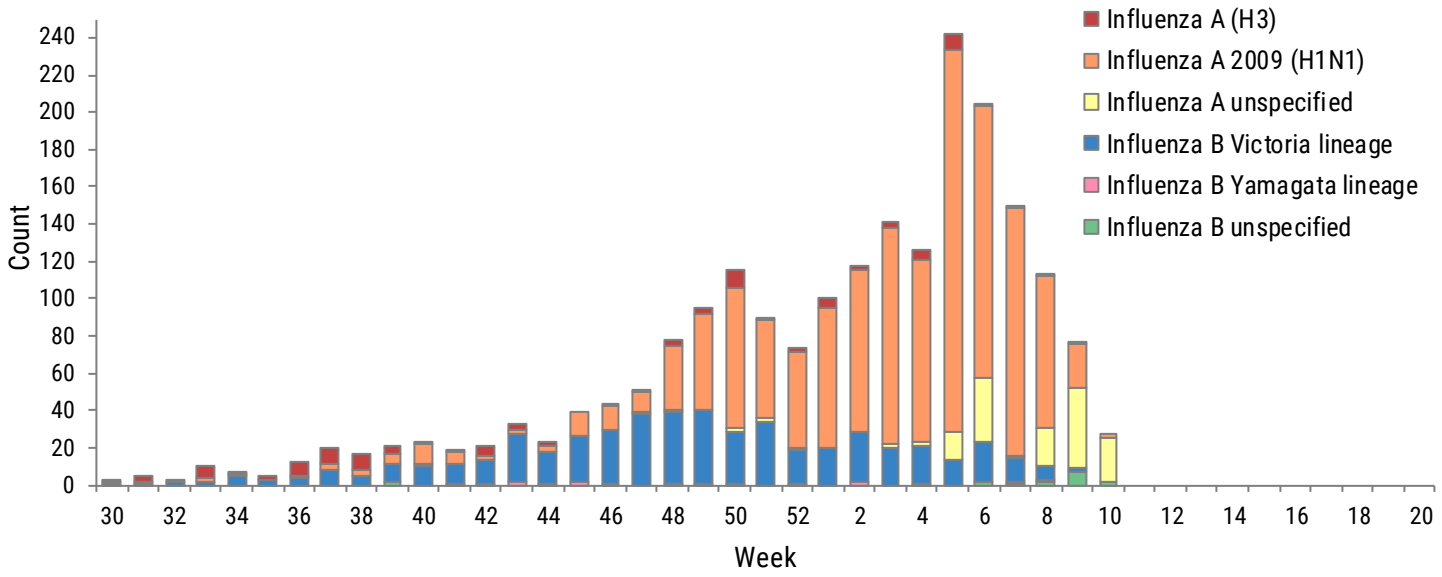
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	133 (47.5%)	80 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (14.3%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	21 (7.5%)	10 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	15 (5.4%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	31 (11.1%)	26 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.8%)	29 influenza-associated outbreaks 4 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.4%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**280 (100.0%)**	**178 influenza-associated outbreaks** **102 ILI outbreaks**

AMERICAN OVERSIGHT

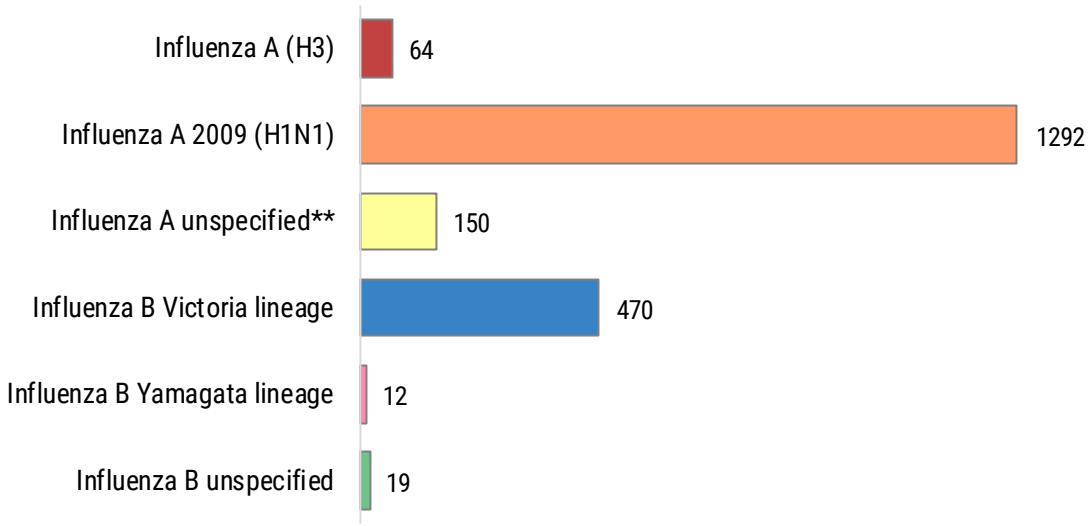
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 10, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 10, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 10, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.

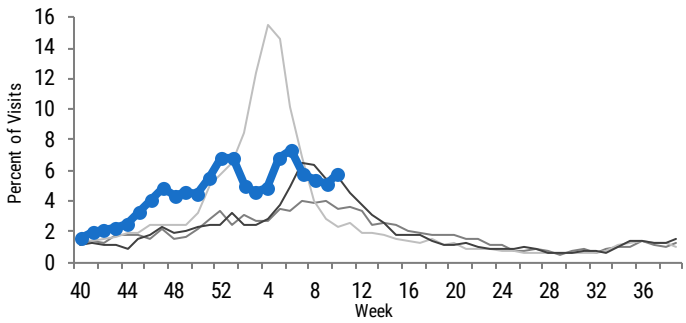


Figure 17: In **region 2, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

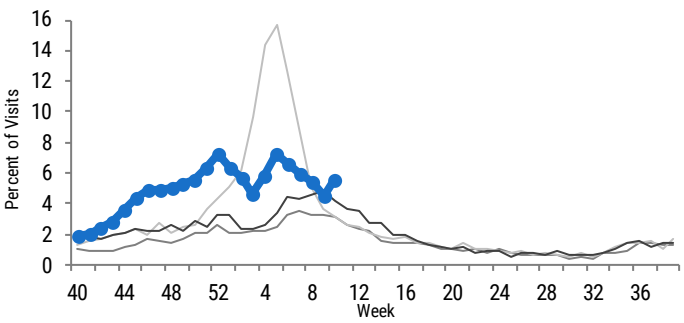


Figure 18: In **region 3, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

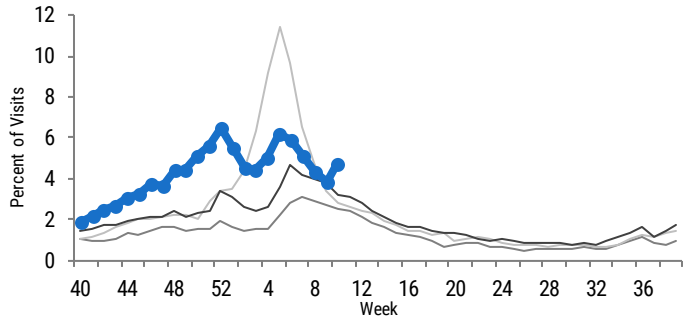


Figure 19: In **region 4, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

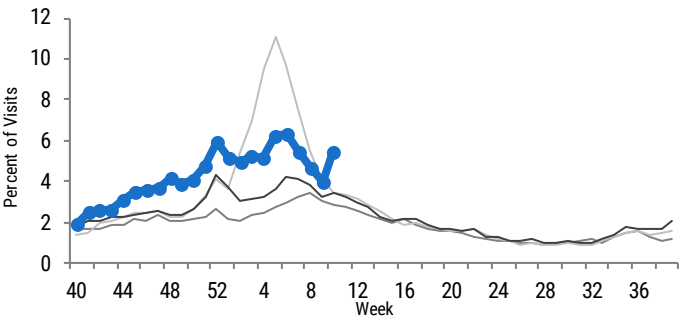


Figure 20: In **region 5, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

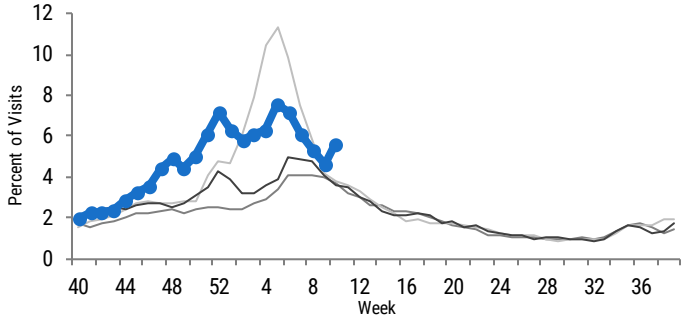


Figure 21: In **region 6, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

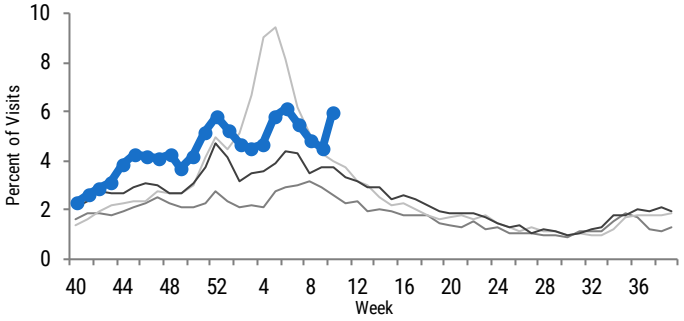
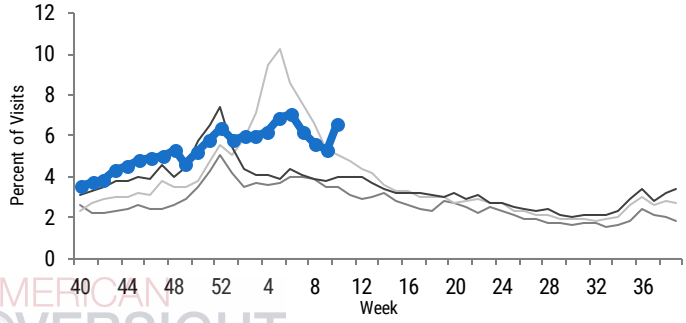


Figure 22: In **region 7, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.



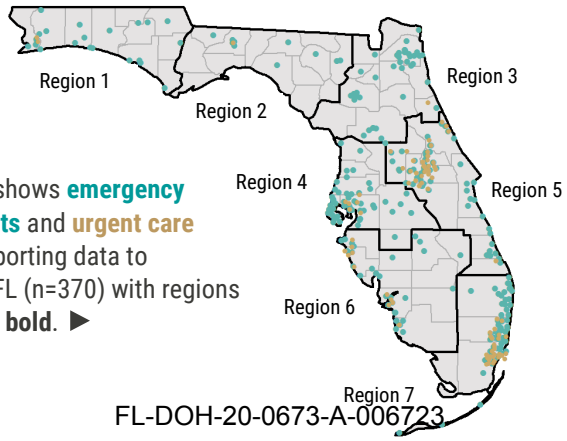


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

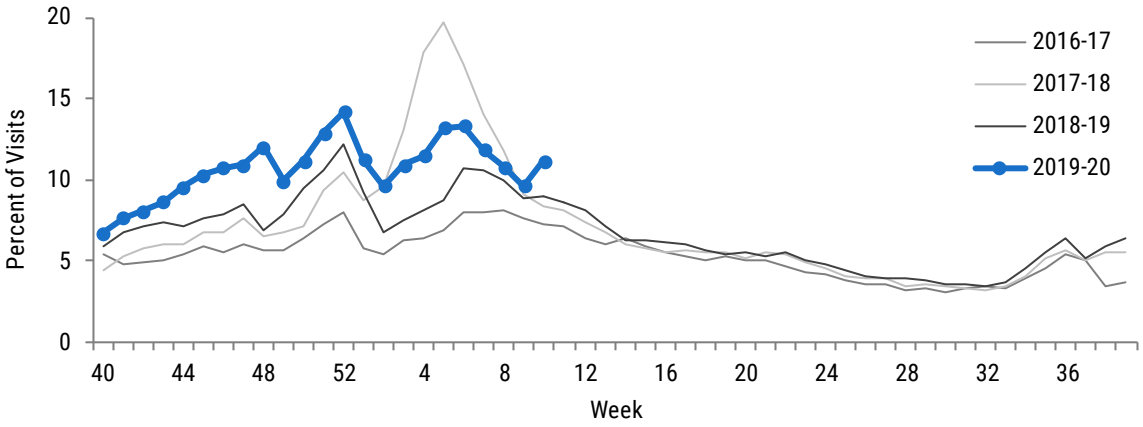
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

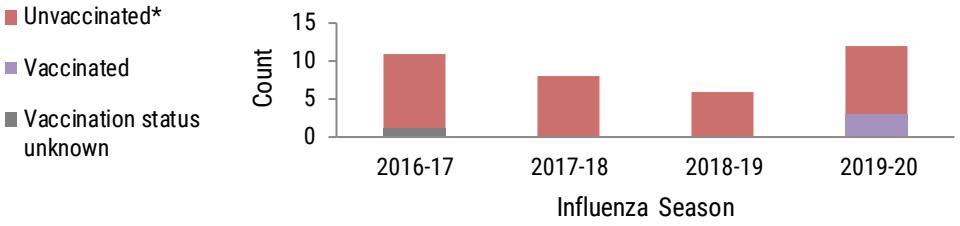
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 10, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above levels observed at this time during the 2016-17 season.

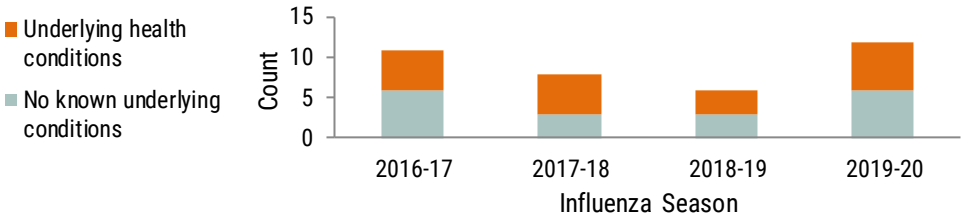


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

Figures 25-26: In week 10, **two new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 10, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 10, 2020.

In week 10, **two new influenza-associated pediatric deaths were reported**. The first death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions. The second was associated with influenza B in a child with known underlying medical conditions. Both were vaccinated for the 2019-20 season.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

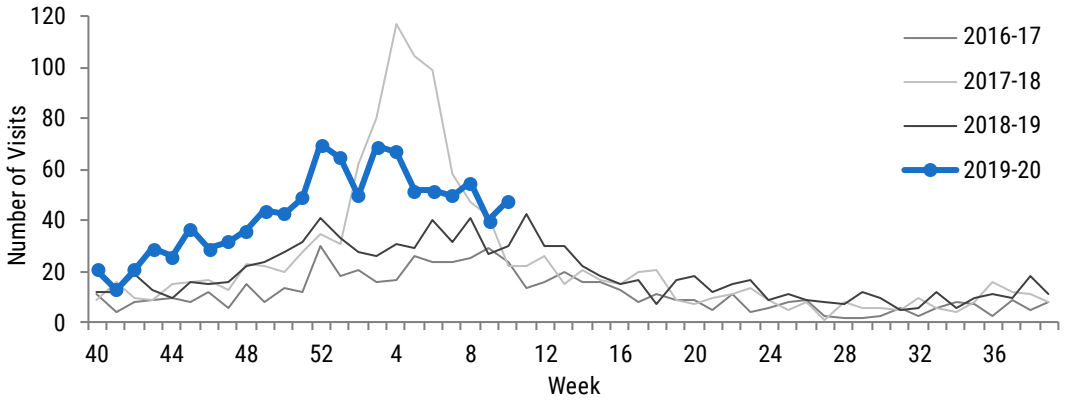
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 10, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



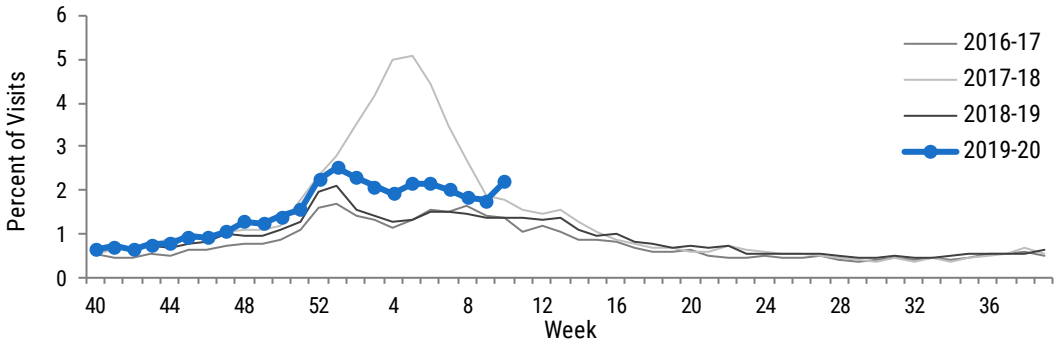
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 10, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 10, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



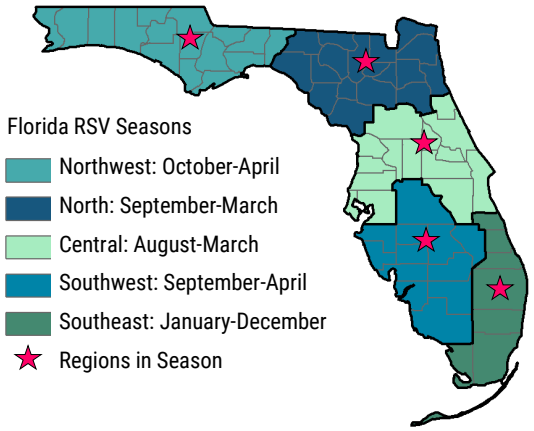
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

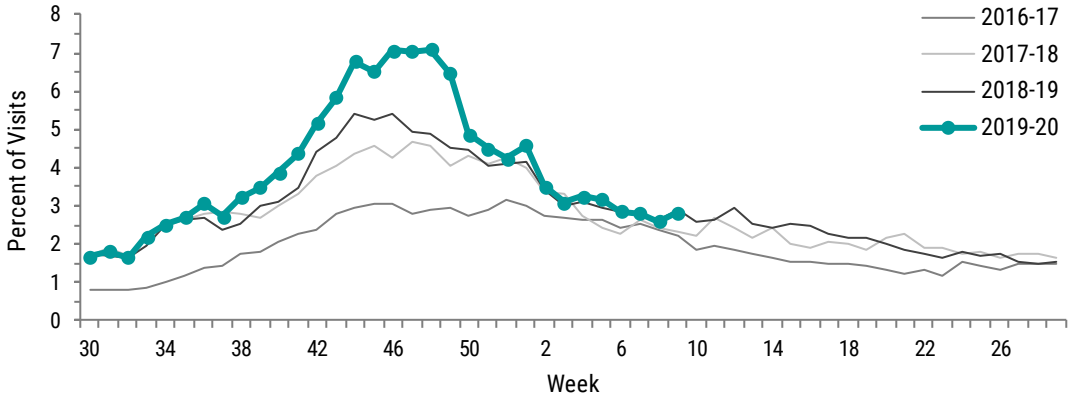
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 10 (February 23-29, 2020) Activity Summary

In week 10, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 10. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 10, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 10, 2020.

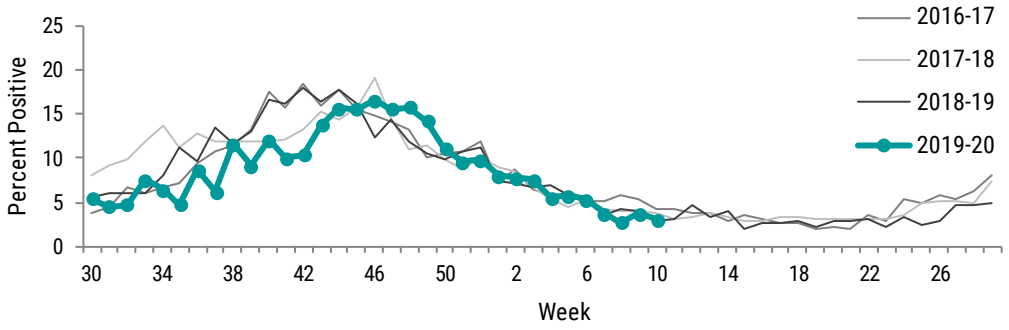
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 10, **the percent of specimens testing positive for RSV decreased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 10, 2020. ▶



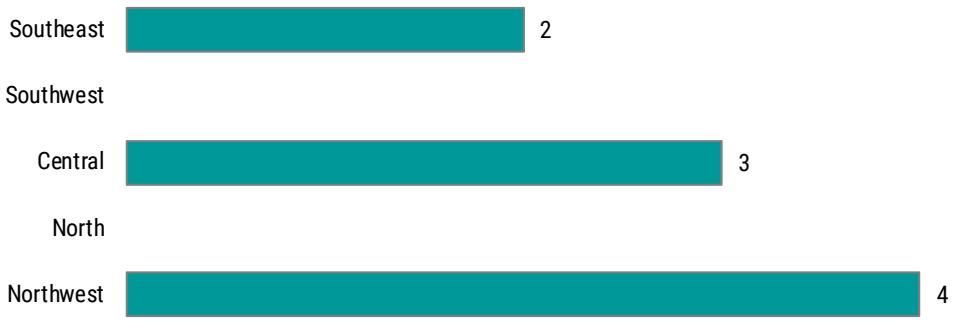
RSV-Associated Outbreaks in Week 10:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 10, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

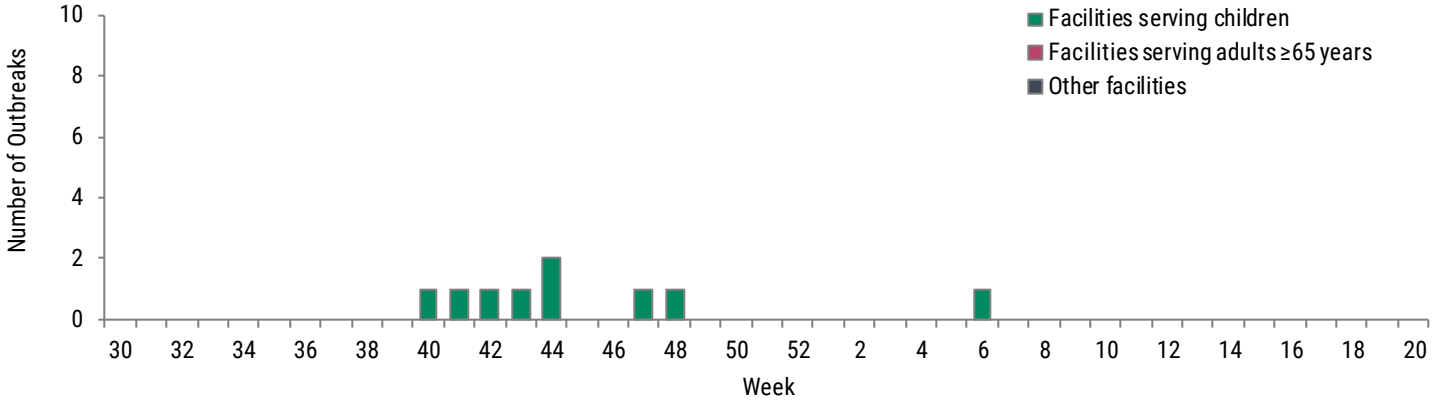
Figure 32: In week 10, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

*Regions defined in figure 29.

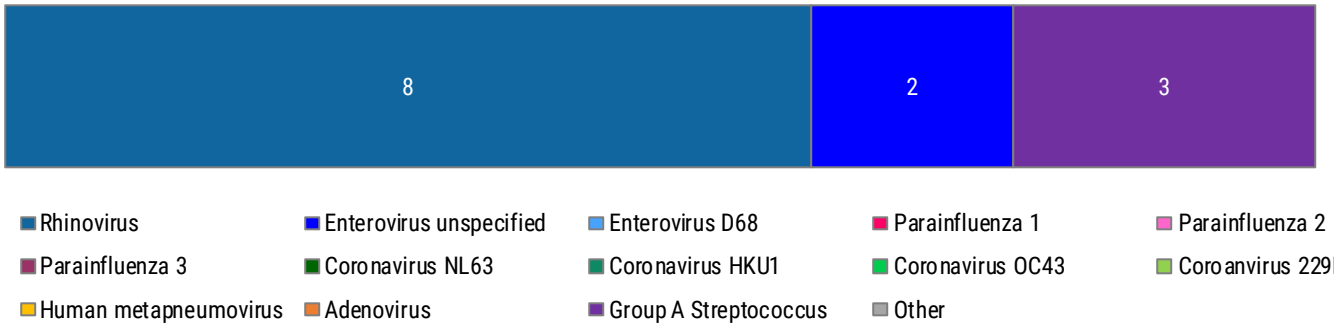
Figure 33: In week 10, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



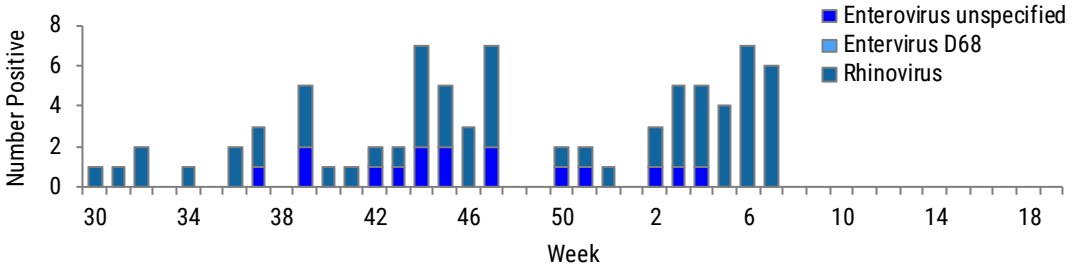
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

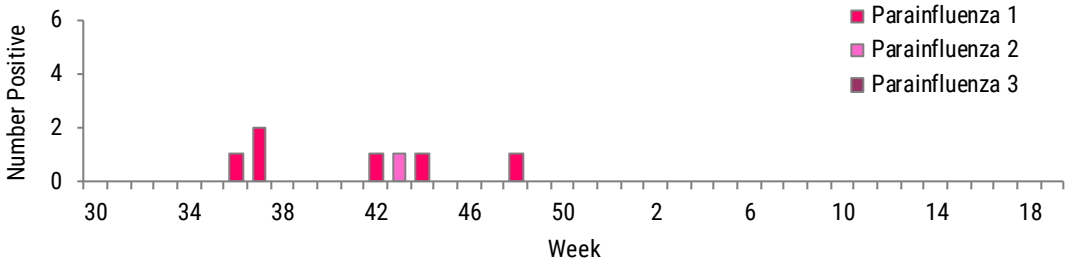


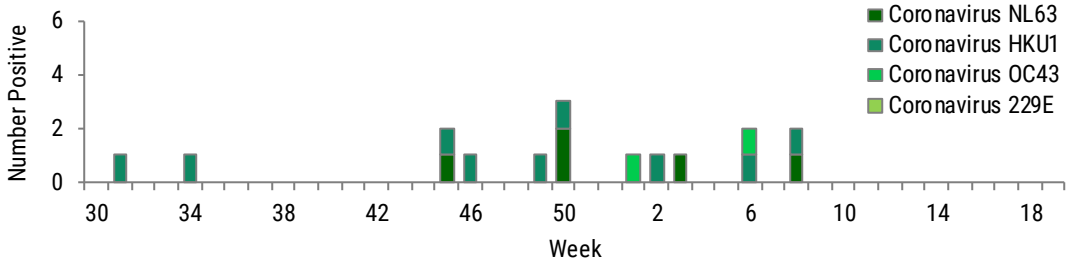
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 10, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

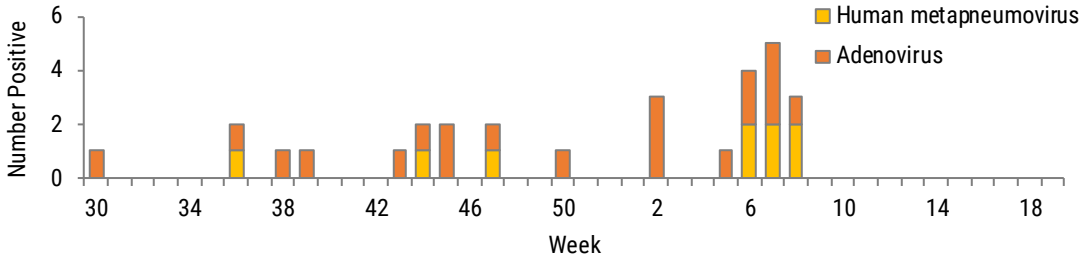
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 10, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 10, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 10, 2020 Florida Flu Review
Date:	Wednesday, March 11, 2020 4:18:09 PM
Attachments:	Week 10, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the week 10, Florida Flu Review.

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

Ten outbreaks were reported, up from nine outbreaks in the previous week. Of the ten outbreaks reported, four were influenza-associated and six were ILI.

Two new influenza-associated pediatric deaths were reported, both in vaccinated individuals with known underlying medical conditions. Twelve influenza-associated pediatric deaths have been reported so far this season; only three children were vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection

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Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 10: 3/1/20-3/7/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

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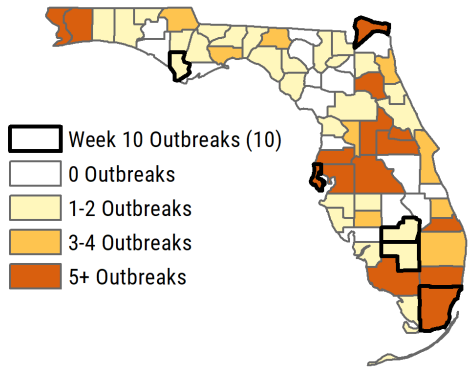
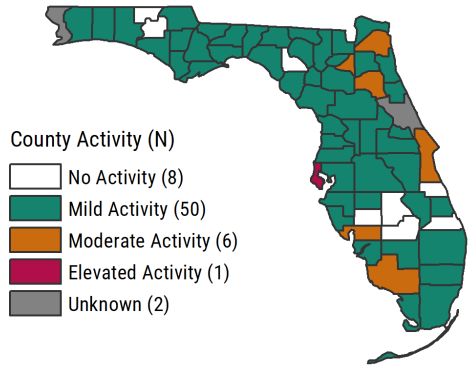
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

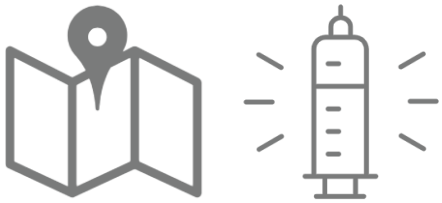
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 11, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006734

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

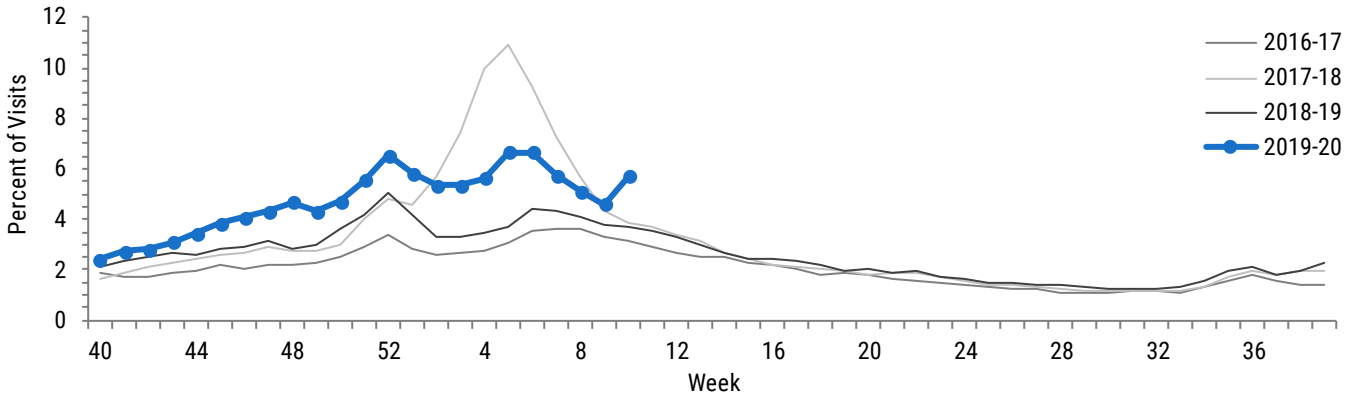
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 10, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 10, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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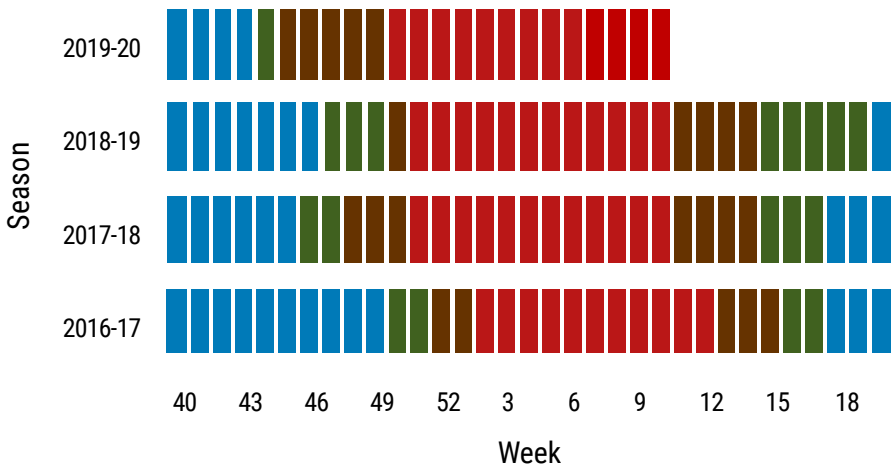
Statewide Activity

Figure 2: In week 10, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 10, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 10, **the percent of patients with ILI reported by ILINet providers statewide increased** and was within levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=8), week 40, 2016 to week 10, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

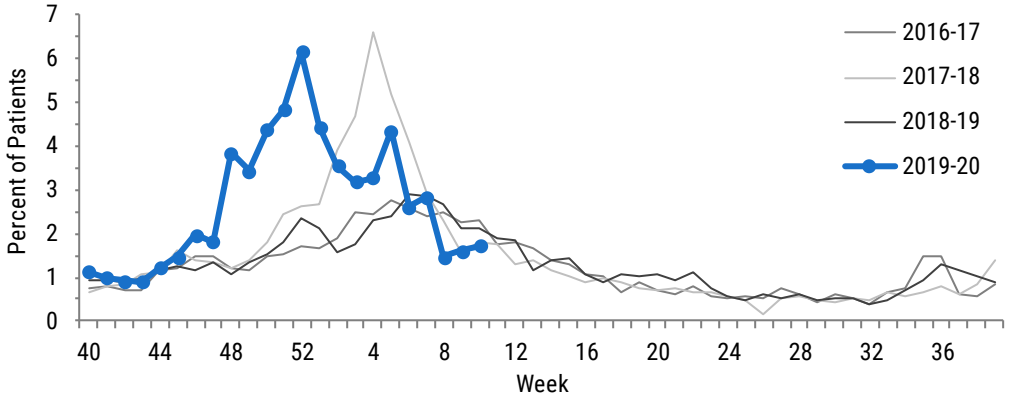
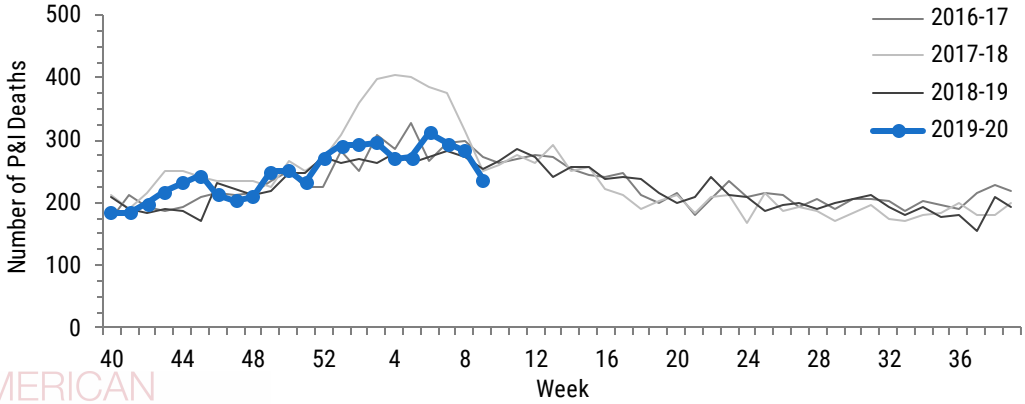


Figure 4: In week 9 (ending 2/29/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 10. Six counties reported **moderate activity,** and one county reported **elevated activity.**

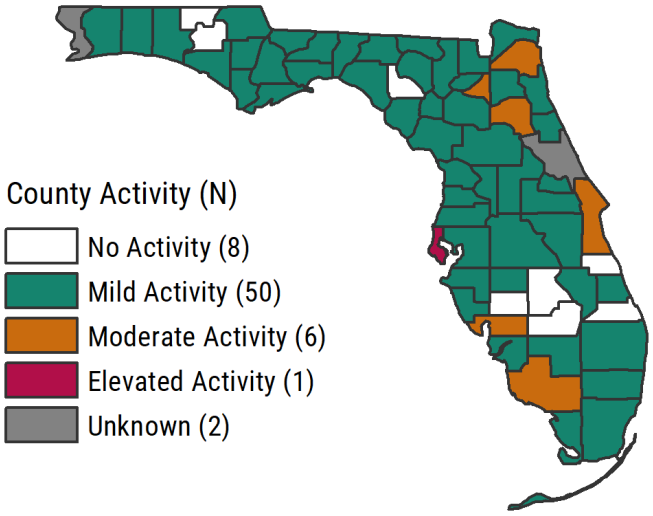
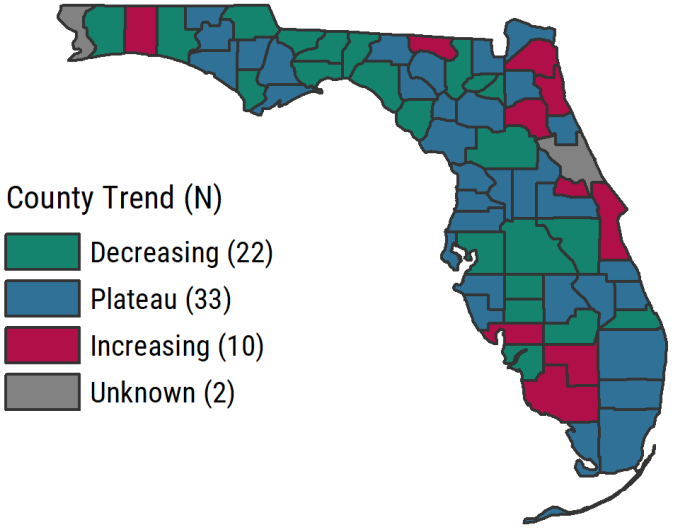
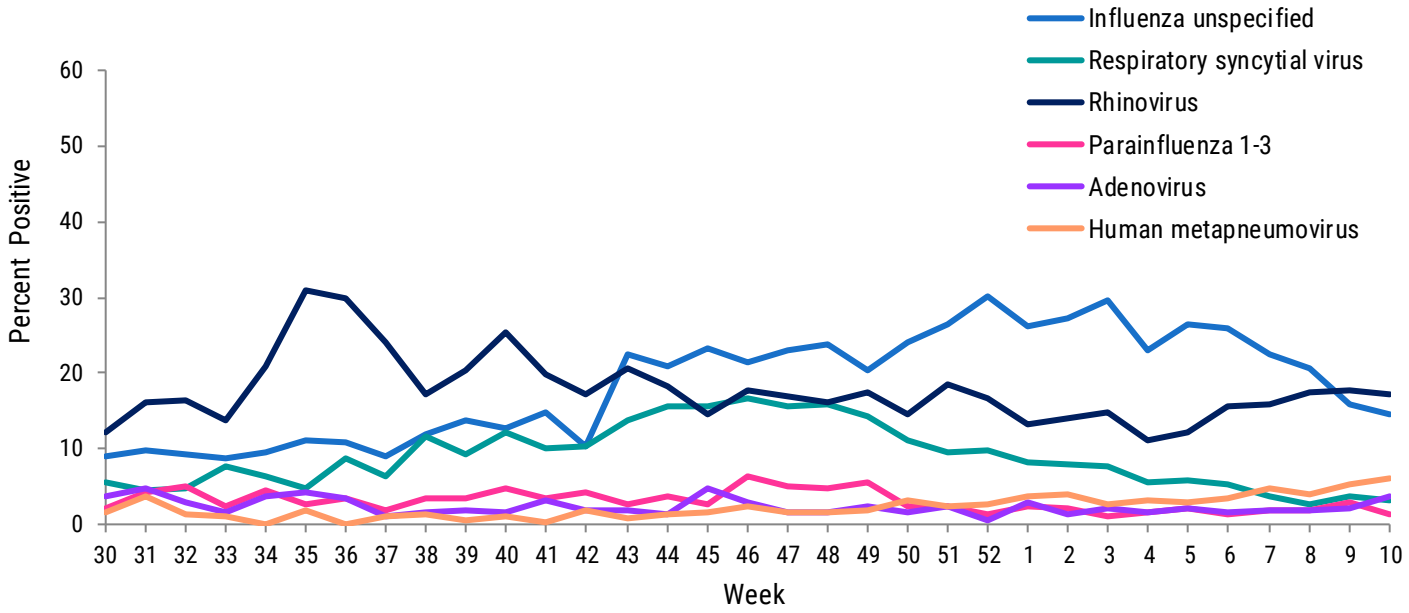


Figure 7: Most counties reported **activity at a plateau** for week 10. Ten counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 10, **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 10 Outbreaks at a Glance:

Number Reported:
10 Outbreaks

Influenza-Associated:
4 Outbreaks

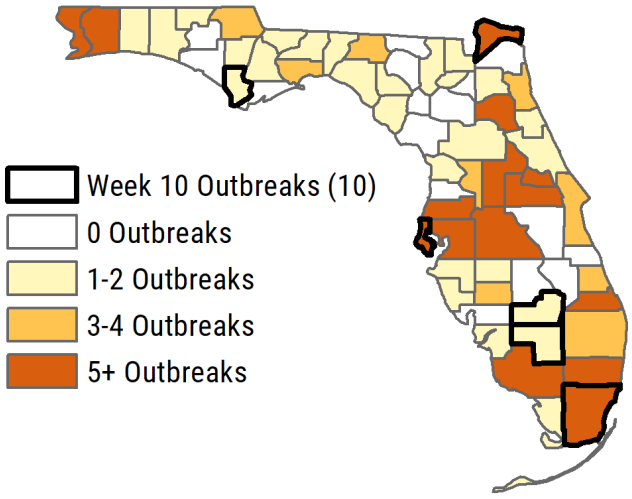
Severe Outcomes*:
0 Outbreaks

Outbreak Summary:

In week 10, four influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

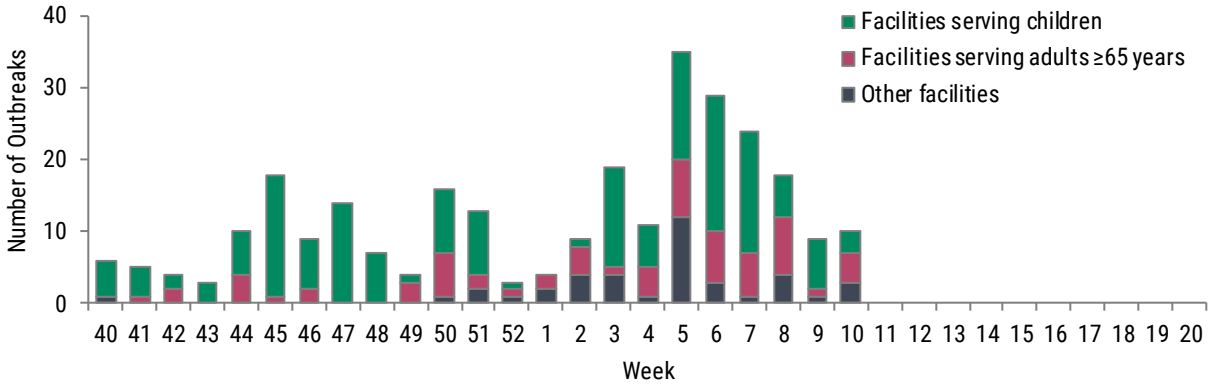
Severe outcomes* were not reported in any of these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



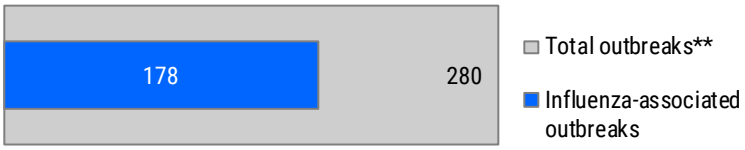
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 10 are **outlined in bold.**

Figure 9: In week 10, **four outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 10, **63.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 10, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

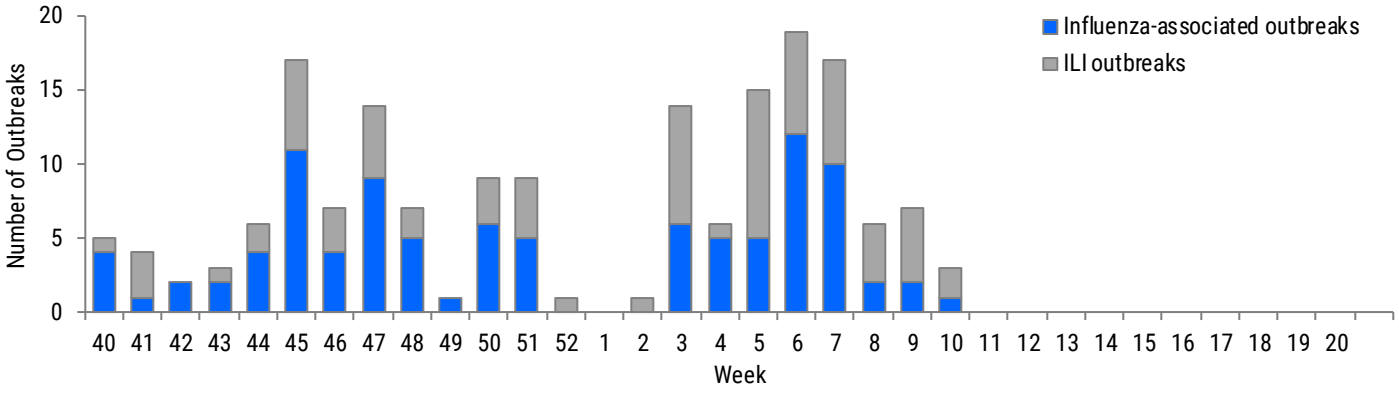
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 10, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 10, **one influenza-associated outbreak** and **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

Facilities Serving Adults ≥65 yrs.**:

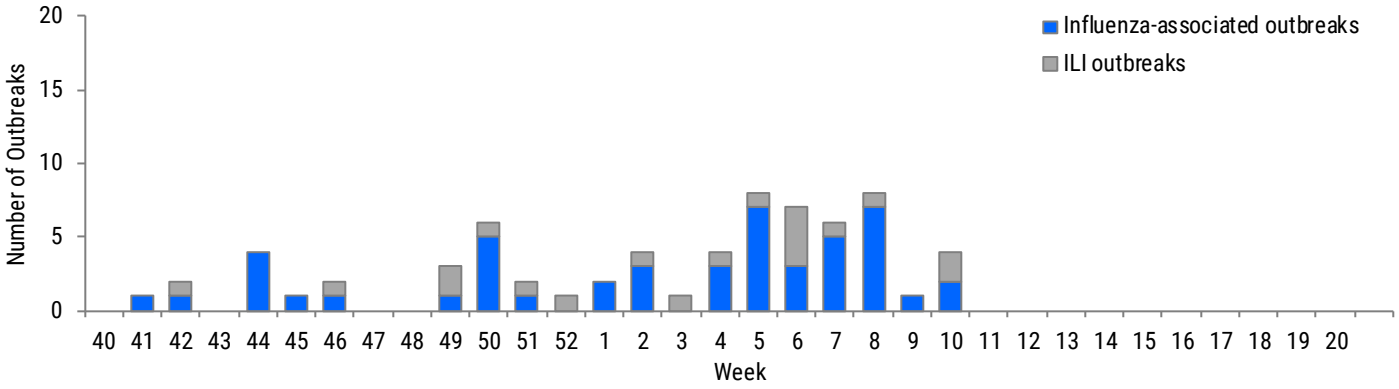
4 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 10, four new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 10, **two influenza-associated outbreaks** and **two ILI outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

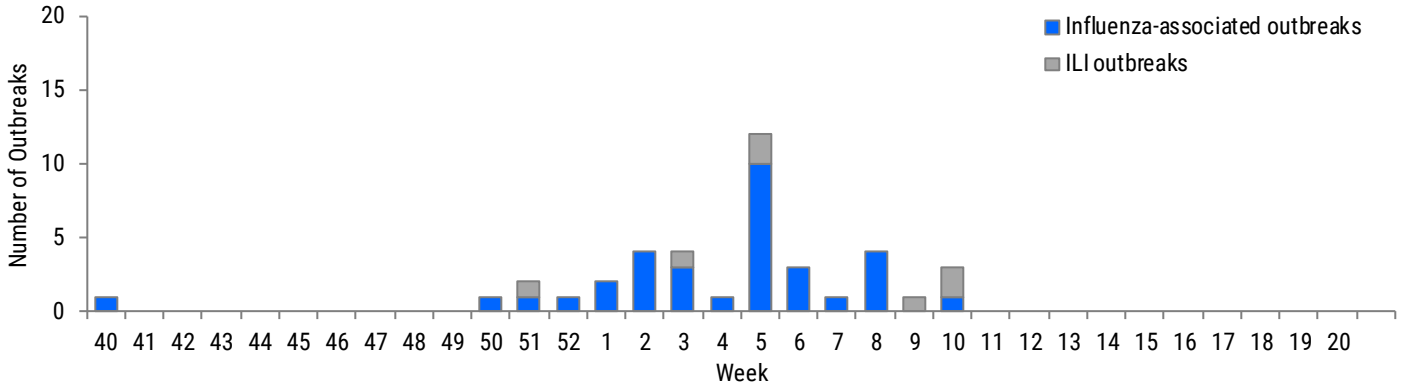
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 10, three new outbreaks of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 10, **two ILI outbreaks** and **one influenza-associated outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

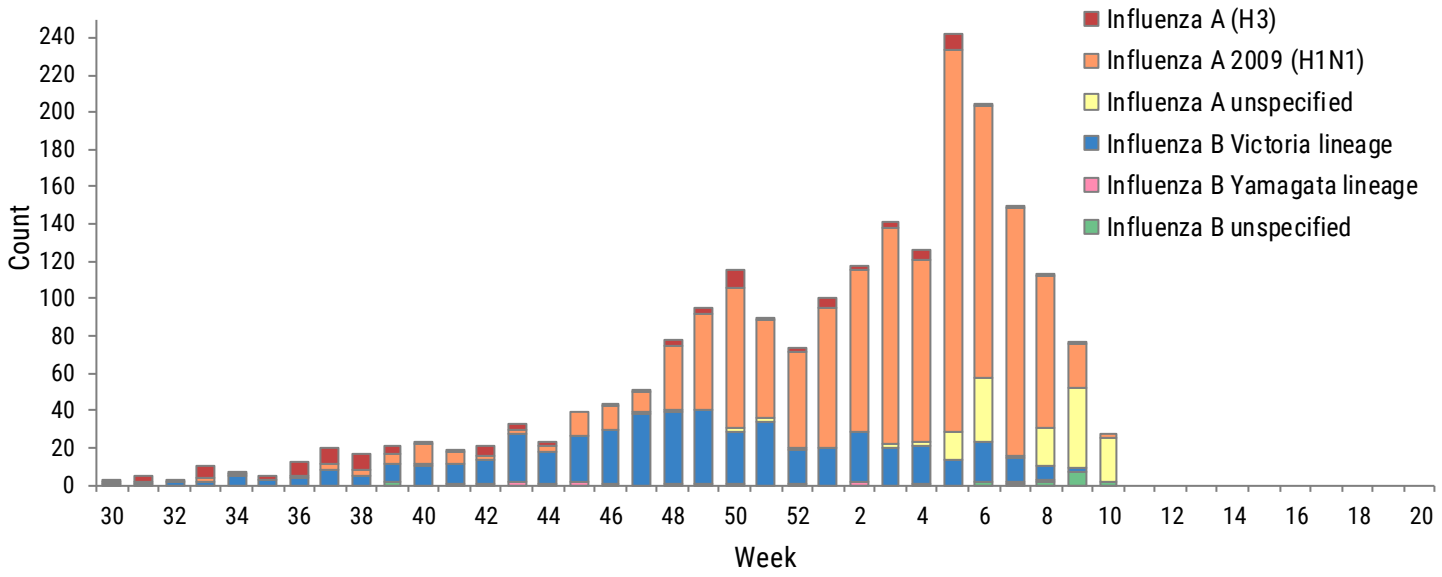
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	133 (47.5%)	80 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (14.3%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	21 (7.5%)	10 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	15 (5.4%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	31 (11.1%)	26 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.8%)	29 influenza-associated outbreaks 4 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.4%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**280 (100.0%)**	**178 influenza-associated outbreaks** **102 ILI outbreaks**

AMERICAN OVERSIGHT

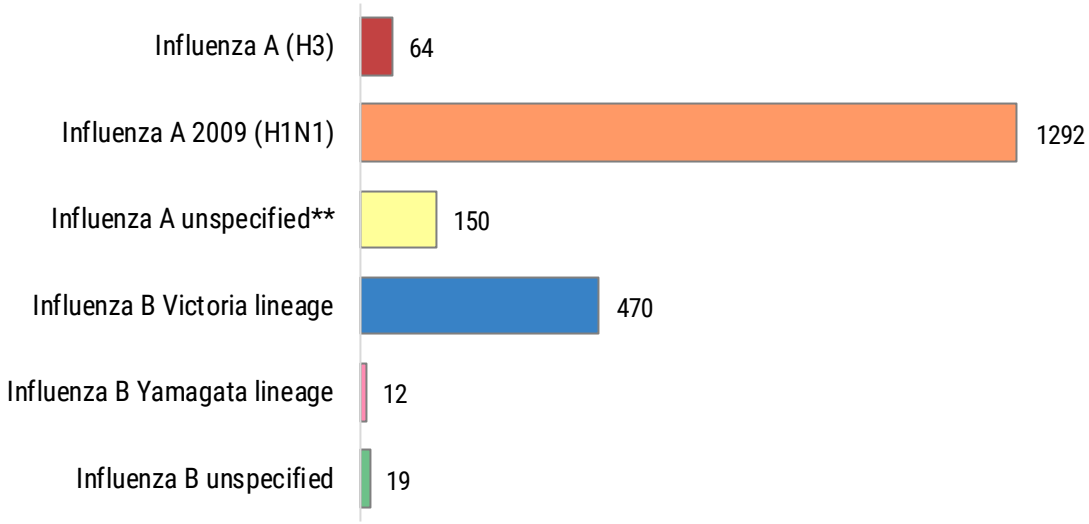
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 10, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 10, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 10, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.

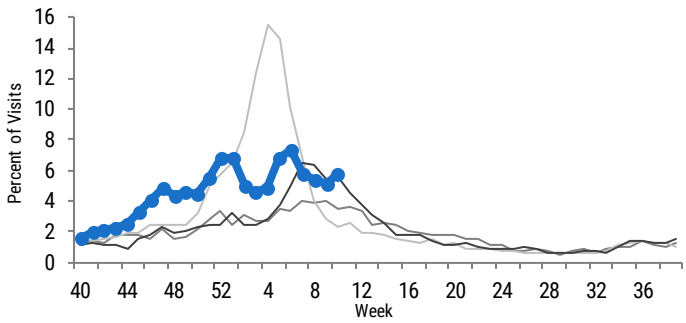


Figure 17: In **region 2, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

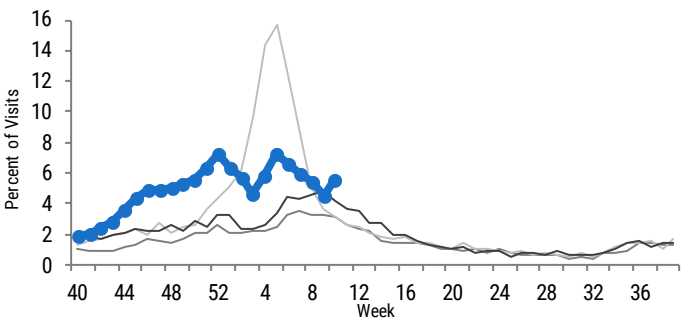


Figure 18: In **region 3, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

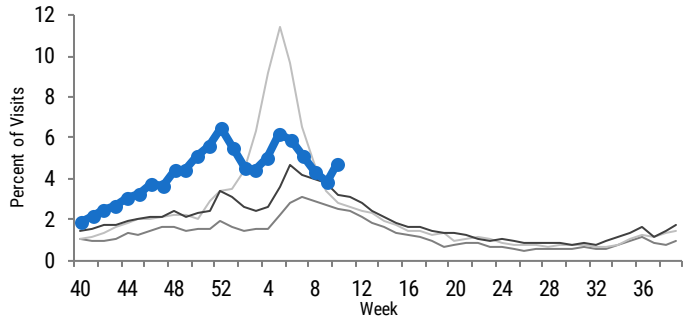


Figure 19: In **region 4, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

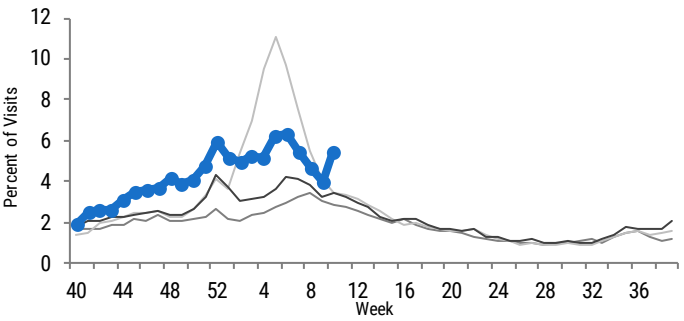


Figure 20: In **region 5, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

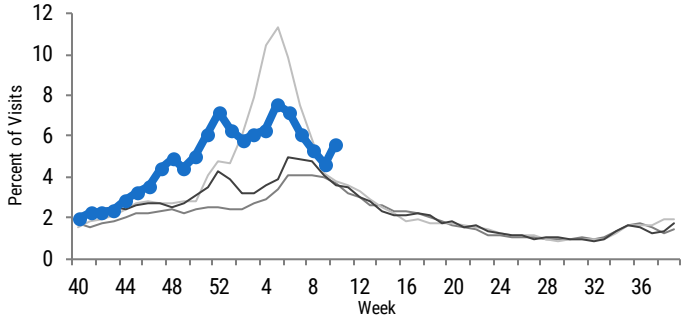


Figure 21: In **region 6, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

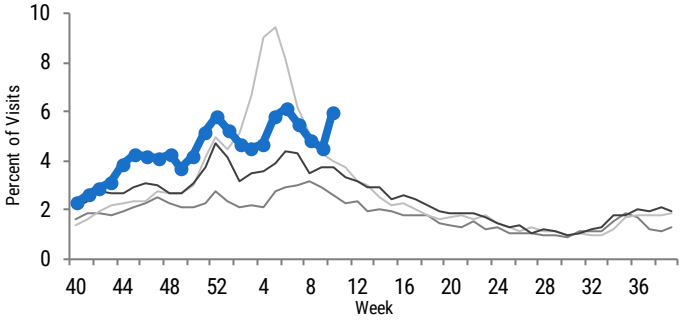
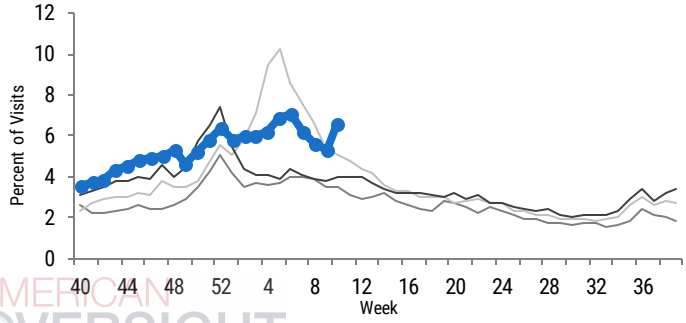


Figure 22: In **region 7, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.



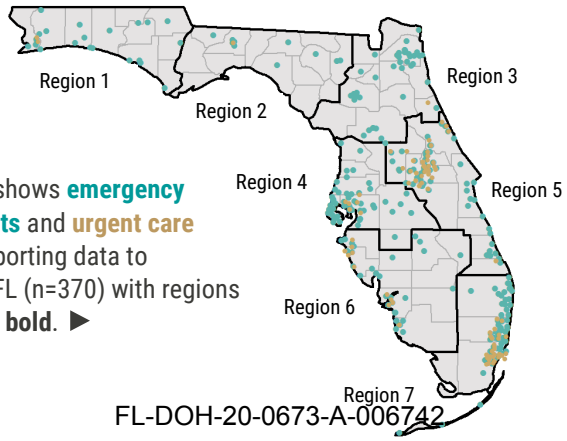


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

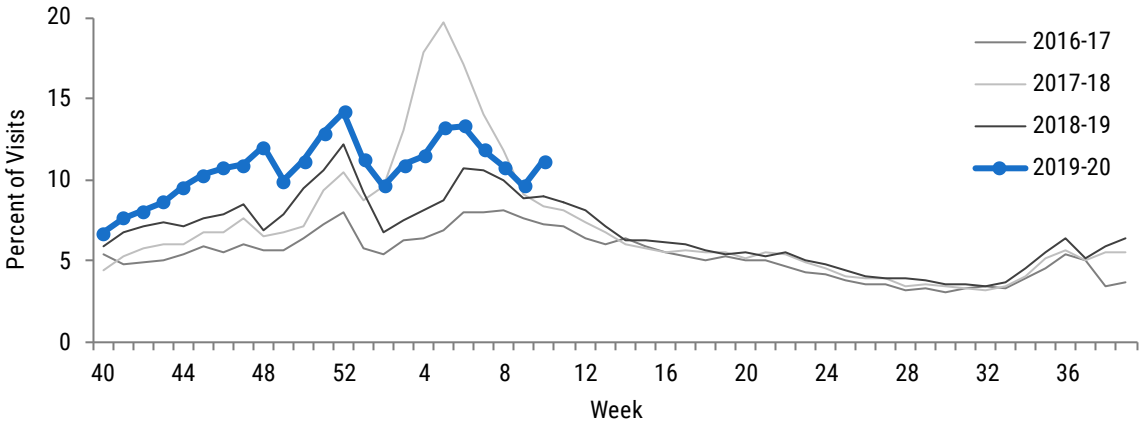
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

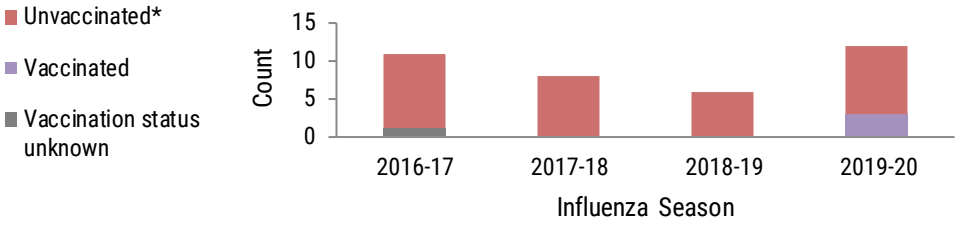
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 10, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above levels observed at this time during the 2016-17 season.

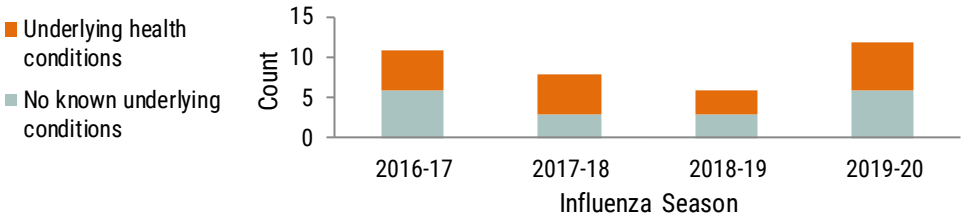


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

Figures 25-26: In week 10, **two new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 10, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 10, 2020.

In week 10, **two new influenza-associated pediatric deaths were reported**. The first death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions. The second was associated with influenza B in a child with known underlying medical conditions. Both were vaccinated for the 2019-20 season.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

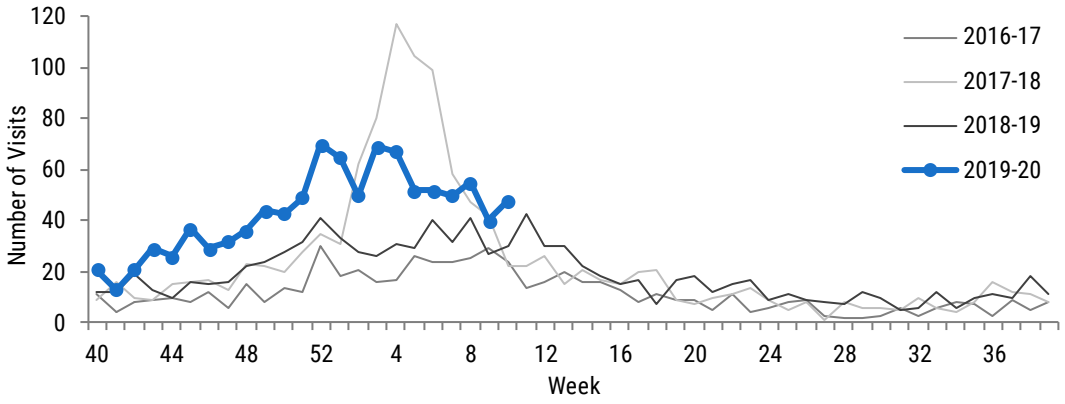
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 10, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



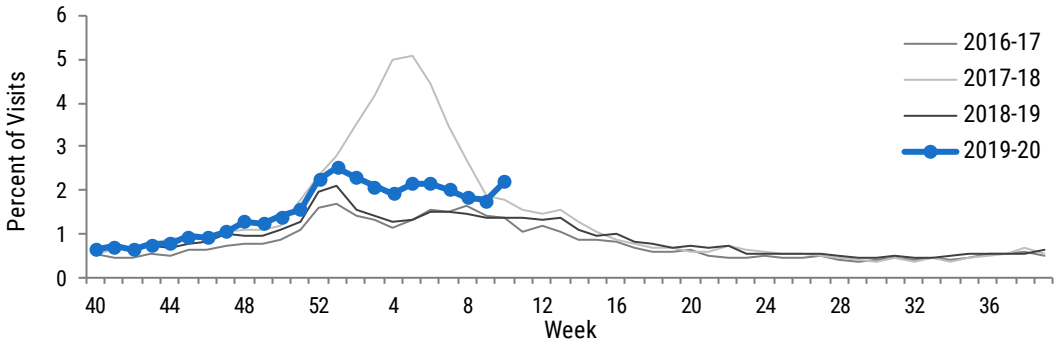
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 10, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 10, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



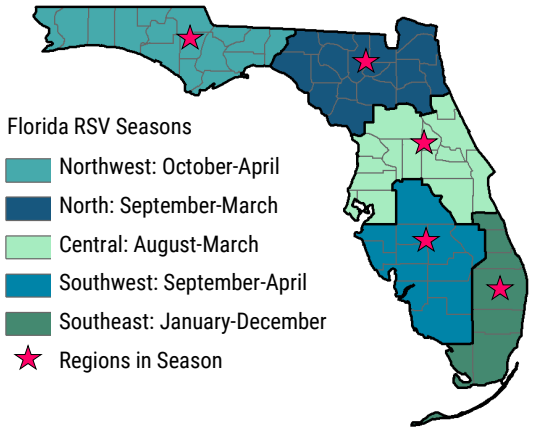
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

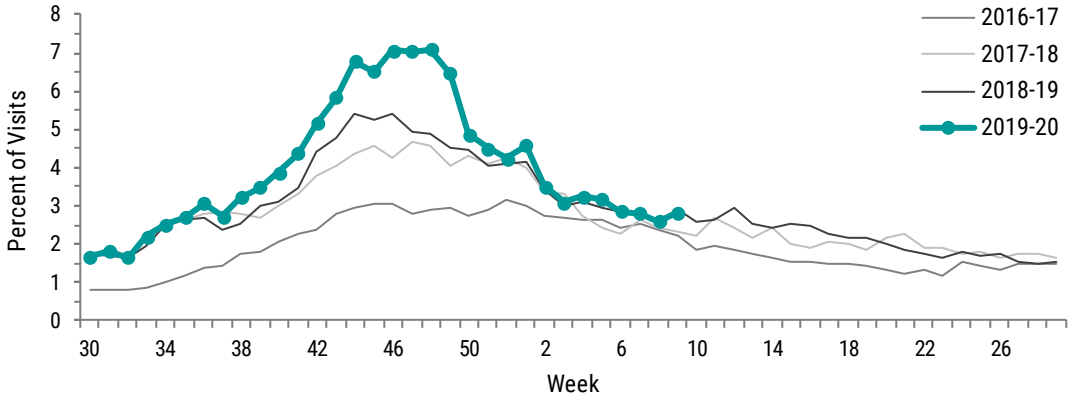
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 10 (February 23-29, 2020) Activity Summary

In week 10, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 10. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 10, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 10, 2020.

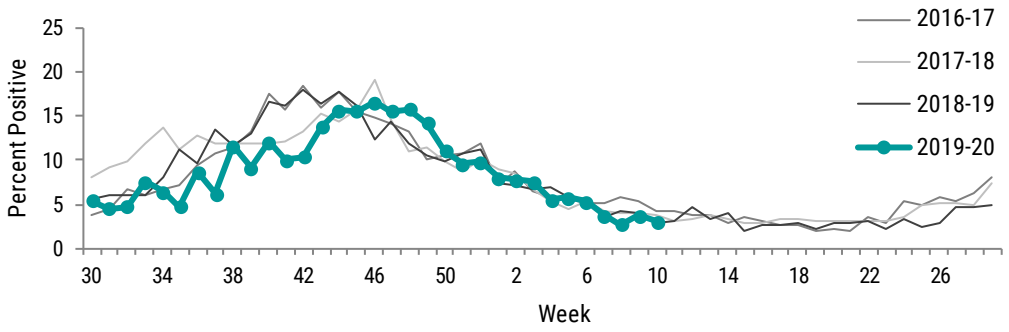
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 10, **the percent of specimens testing positive for RSV decreased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 10, 2020. ▶



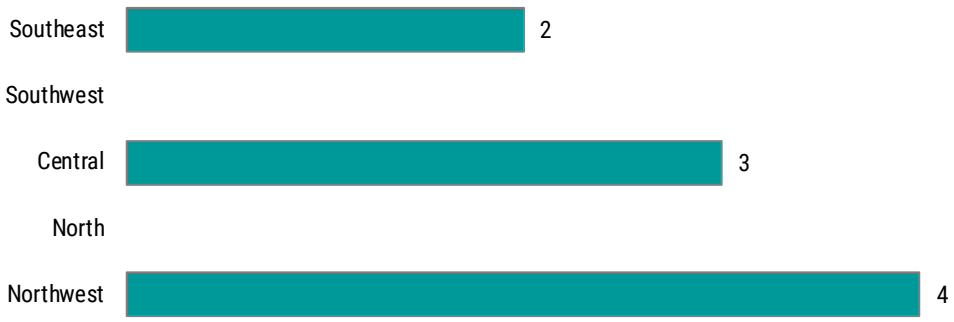
RSV-Associated Outbreaks in Week 10:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 10, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

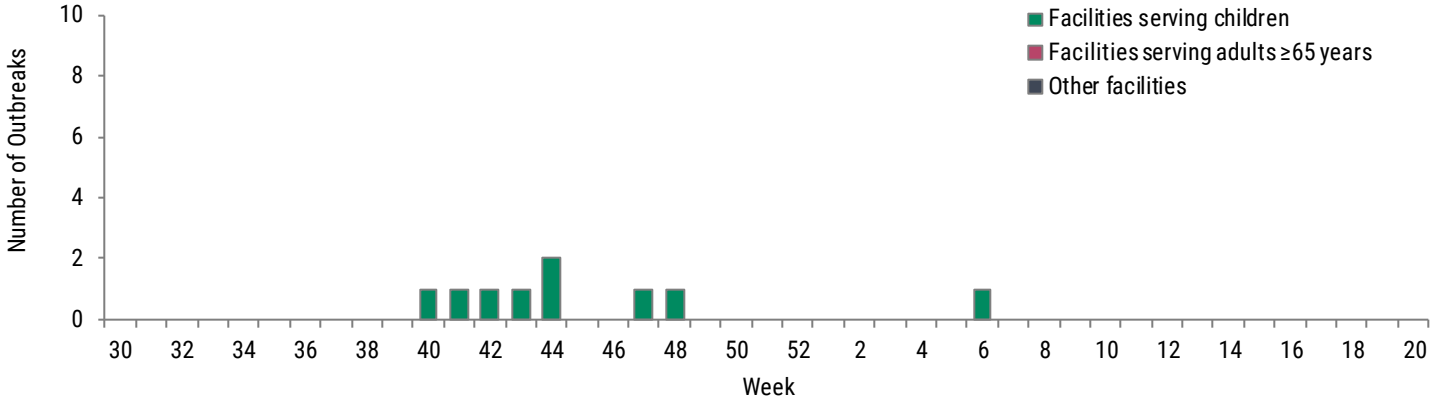
Figure 32: In week 10, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

*Regions defined in figure 29.

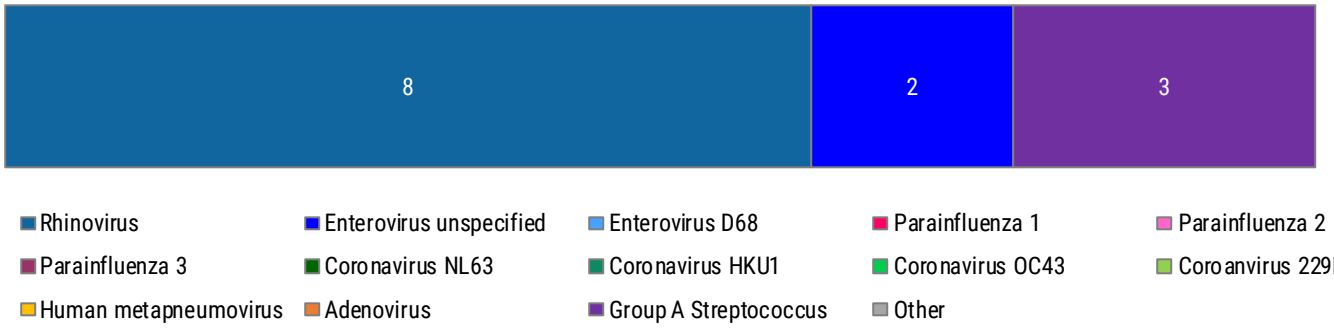
Figure 33: In week 10, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



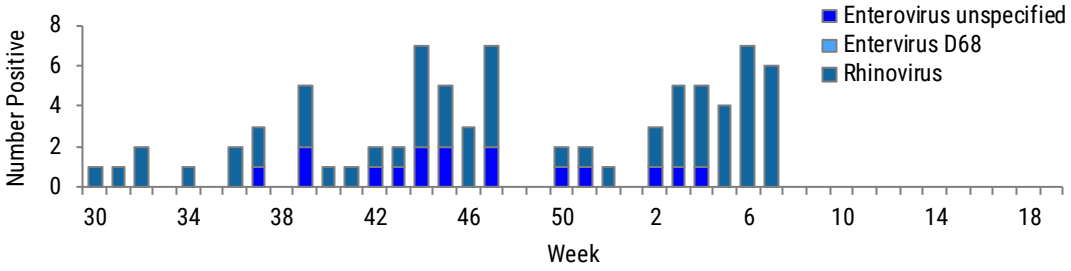
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

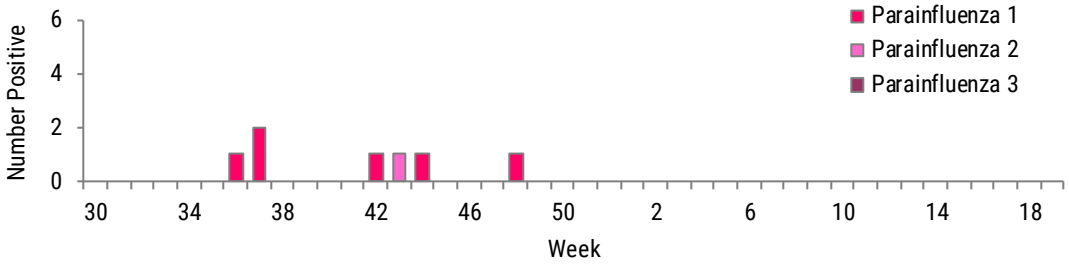


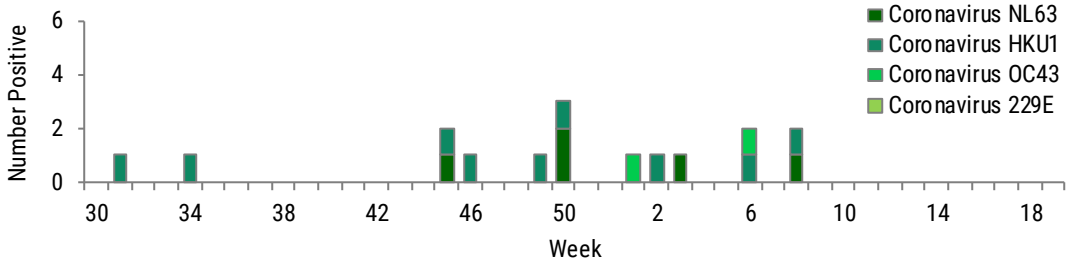
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 10, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

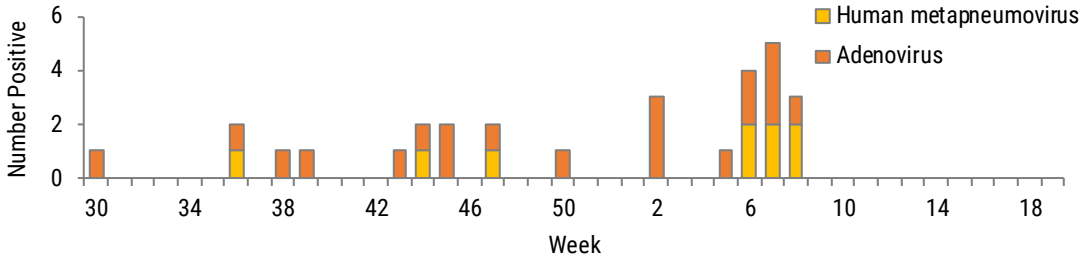
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 10, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 10, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 10, 2020 Florida Flu Review
Date:	Wednesday, March 11, 2020 4:18:04 PM
Attachments:	Week 10, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the week 10, Florida Flu Review.

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

Ten outbreaks were reported, up from nine outbreaks in the previous week. Of the ten outbreaks reported, four were influenza-associated and six were ILI.

Two new influenza-associated pediatric deaths were reported, both in vaccinated individuals with known underlying medical conditions. Twelve influenza-associated pediatric deaths have been reported so far this season; only three children were vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection

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Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 10: 3/1/20-3/7/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 10 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 10 and was above peak levels observed in the 2016-17 and 2018-19 seasons. Increases were observed in all regions of the state.

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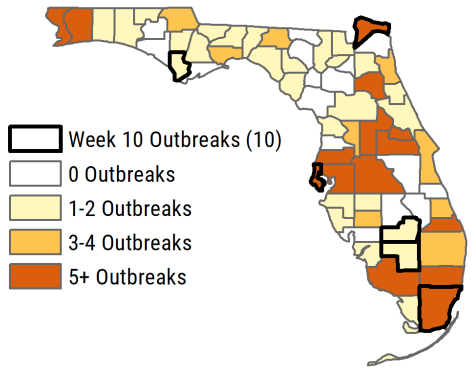
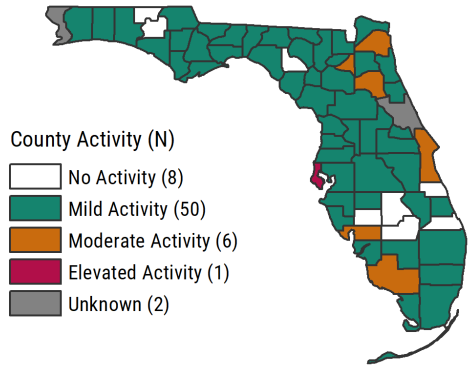
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

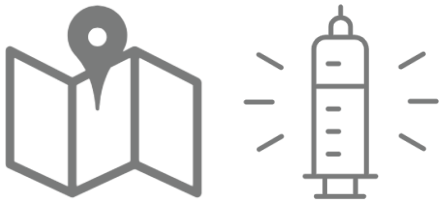
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 11, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006753

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

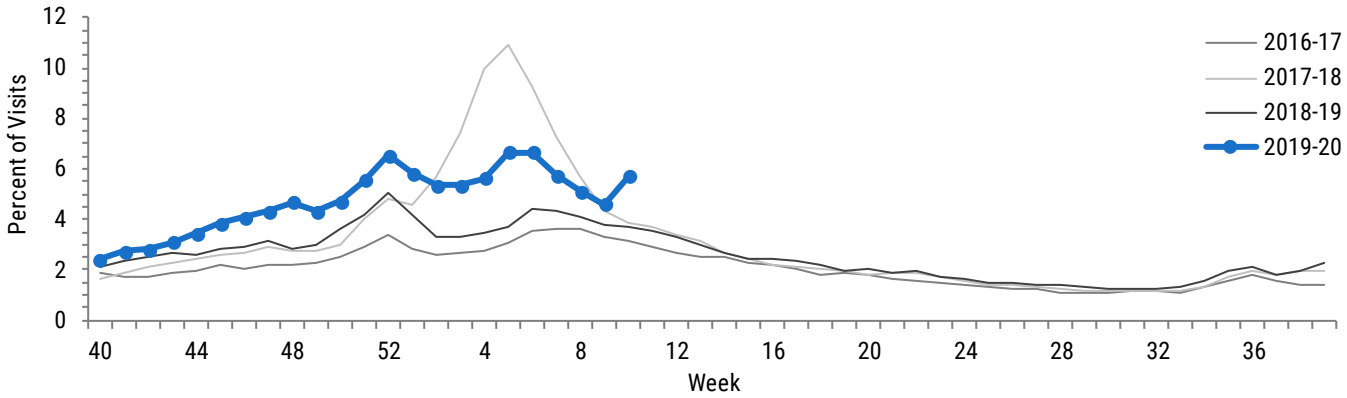
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 10, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 10, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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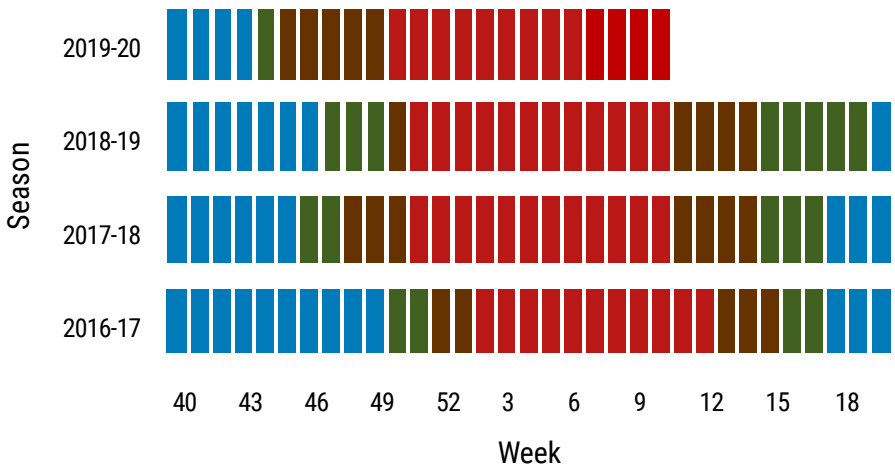
Statewide Activity

Figure 2: In week 10, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 10, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 10, **the percent of patients with ILI reported by ILINet providers statewide increased** and was within levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=8), week 40, 2016 to week 10, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

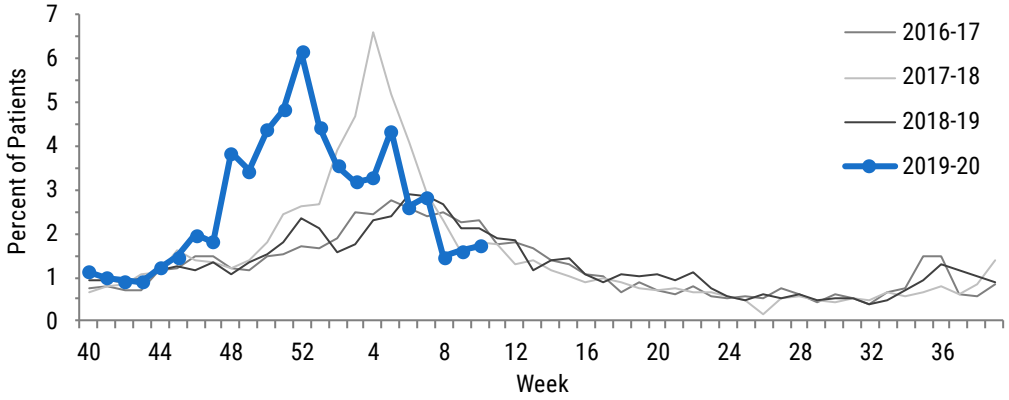
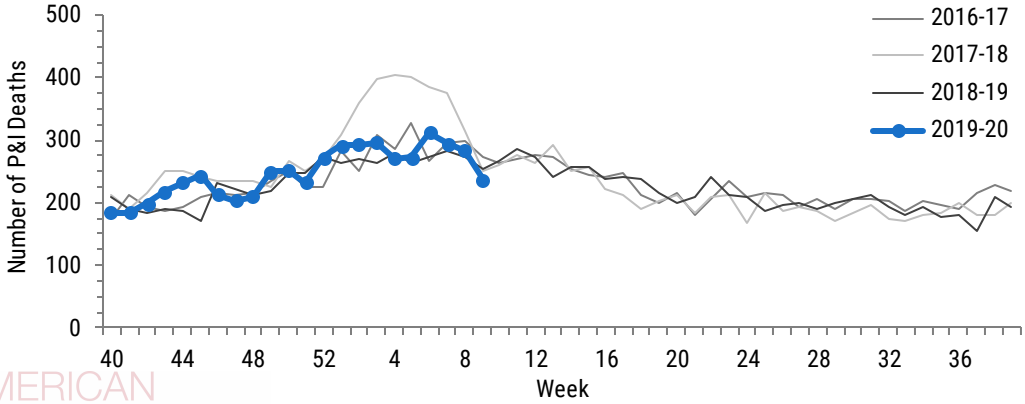


Figure 4: In week 9 (ending 2/29/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 10. Six counties reported **moderate activity,** and one county reported **elevated activity.**

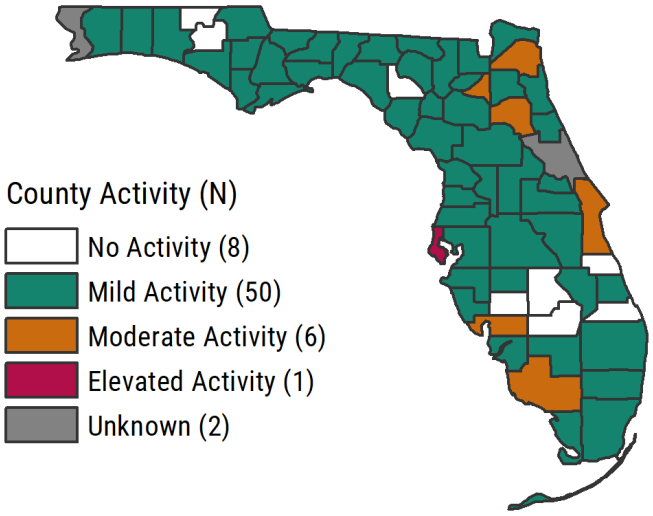
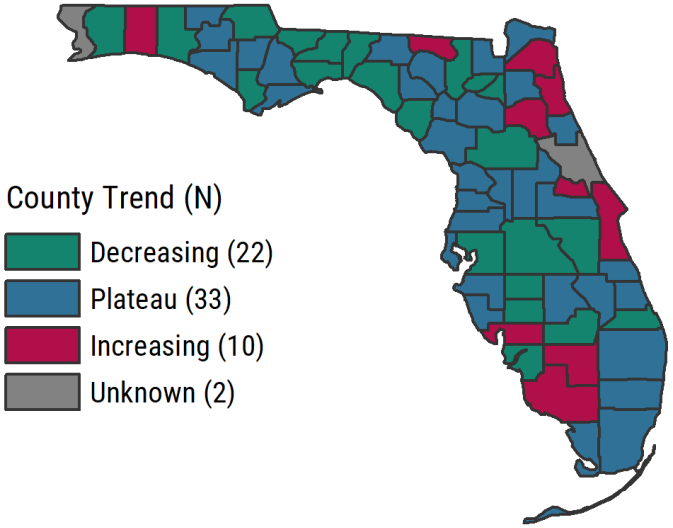
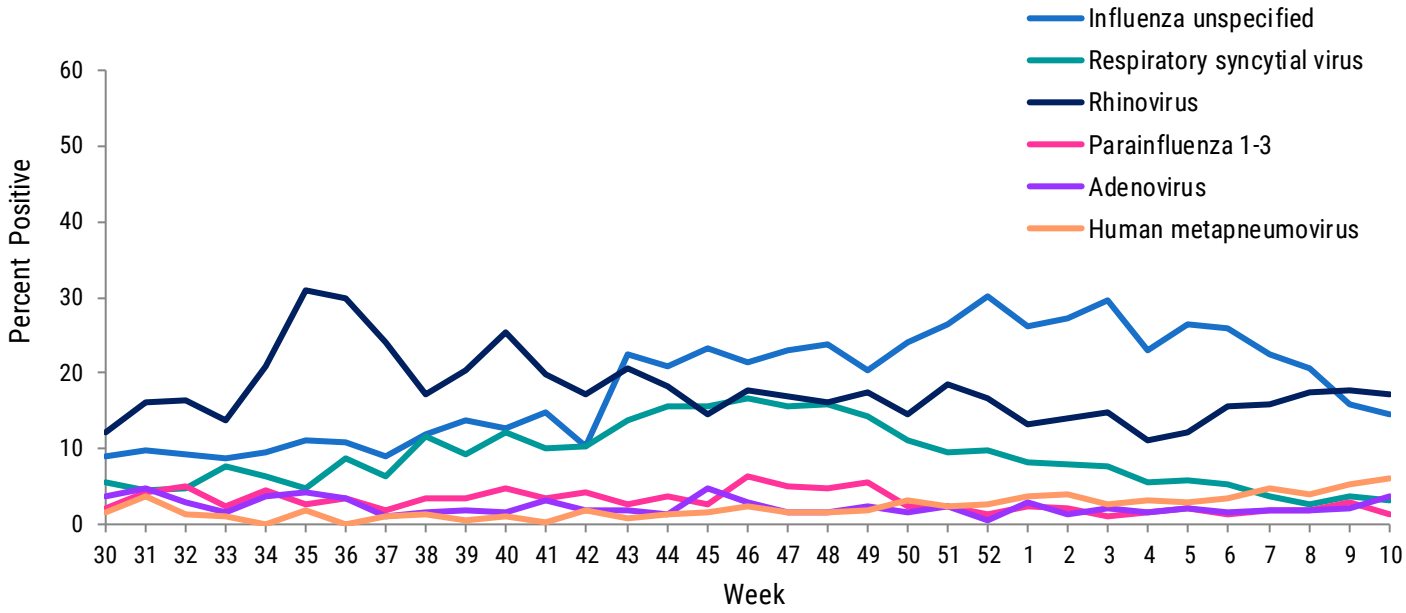


Figure 7: Most counties reported **activity at a plateau** for week 10. Ten counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 10, **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 10, 2020.

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Influenza and ILI Outbreaks

Week 10 Outbreaks at a Glance:

Number Reported:
10 Outbreaks

Influenza-Associated:
4 Outbreaks

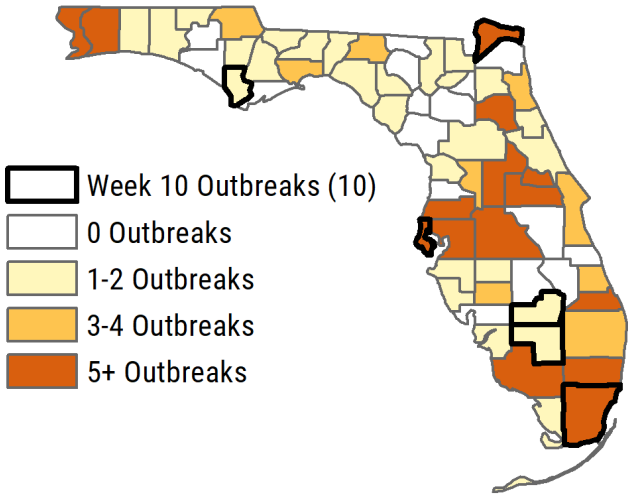
Severe Outcomes*:
0 Outbreaks

Outbreak Summary:

In week 10, four influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

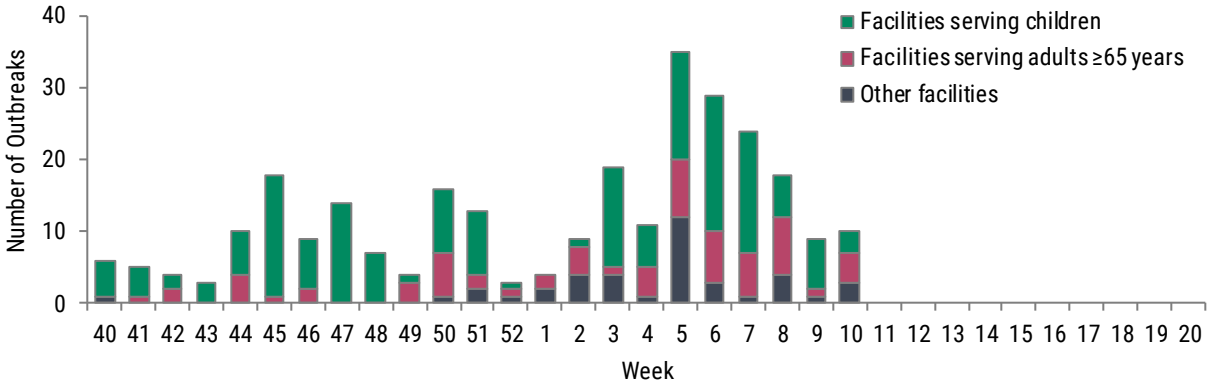
Severe outcomes* were not reported in any of these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



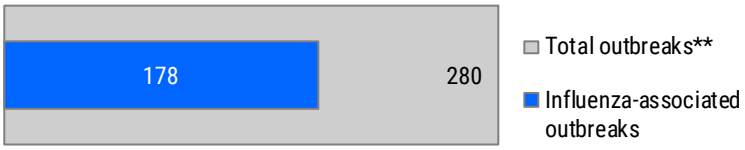
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 10 are **outlined in bold.**

Figure 9: In week 10, **four outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 10, **63.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 10, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

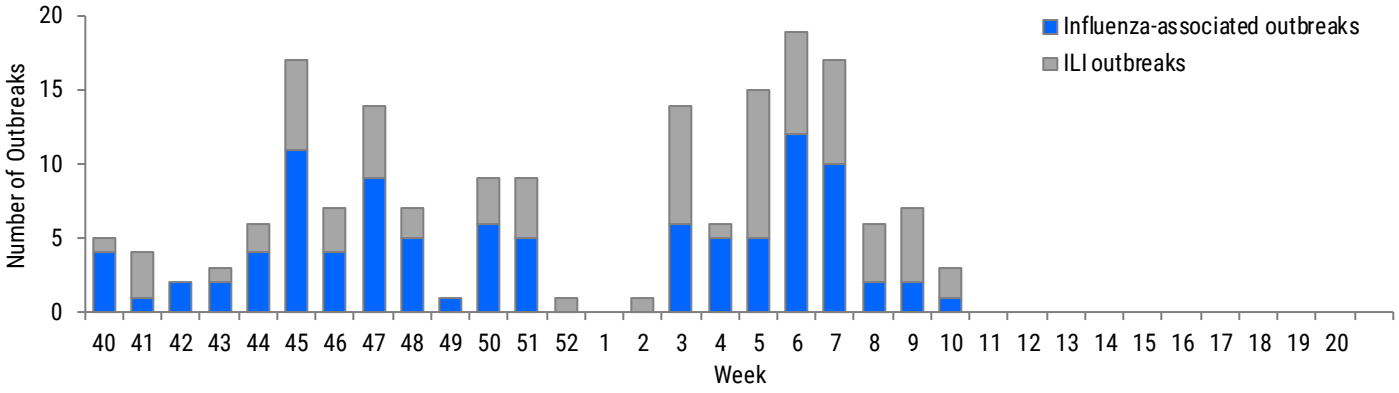
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 10, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 10, **one influenza-associated outbreak** and **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

Facilities Serving Adults ≥65 yrs.**:

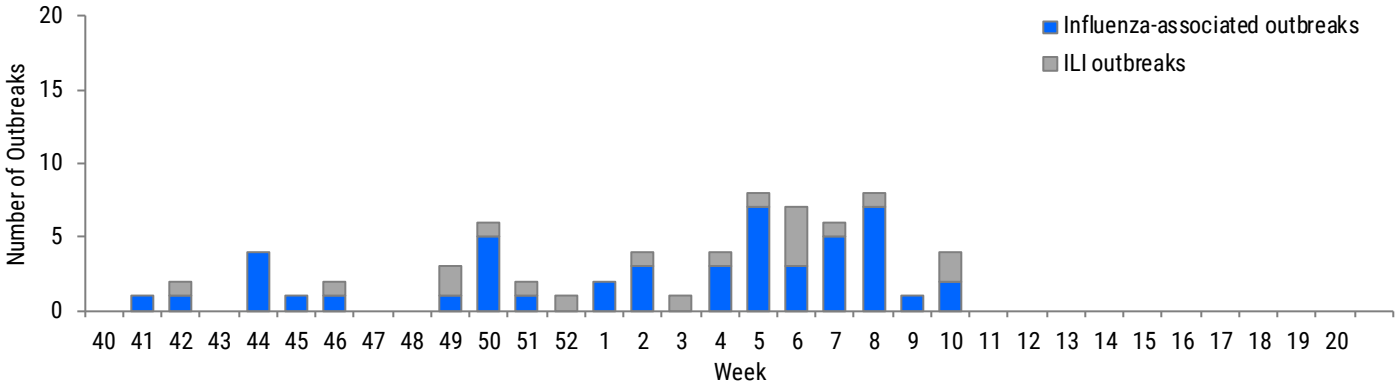
4 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 10, four new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 10, **two influenza-associated outbreaks** and **two ILI outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

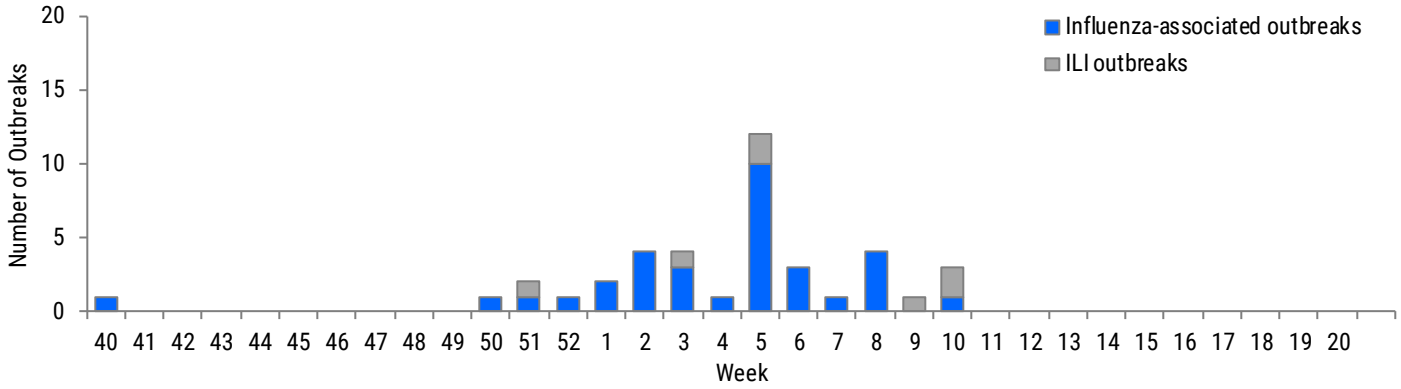
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 10, three new outbreaks of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 10, **two ILI outbreaks** and **one influenza-associated outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 10, 2020.

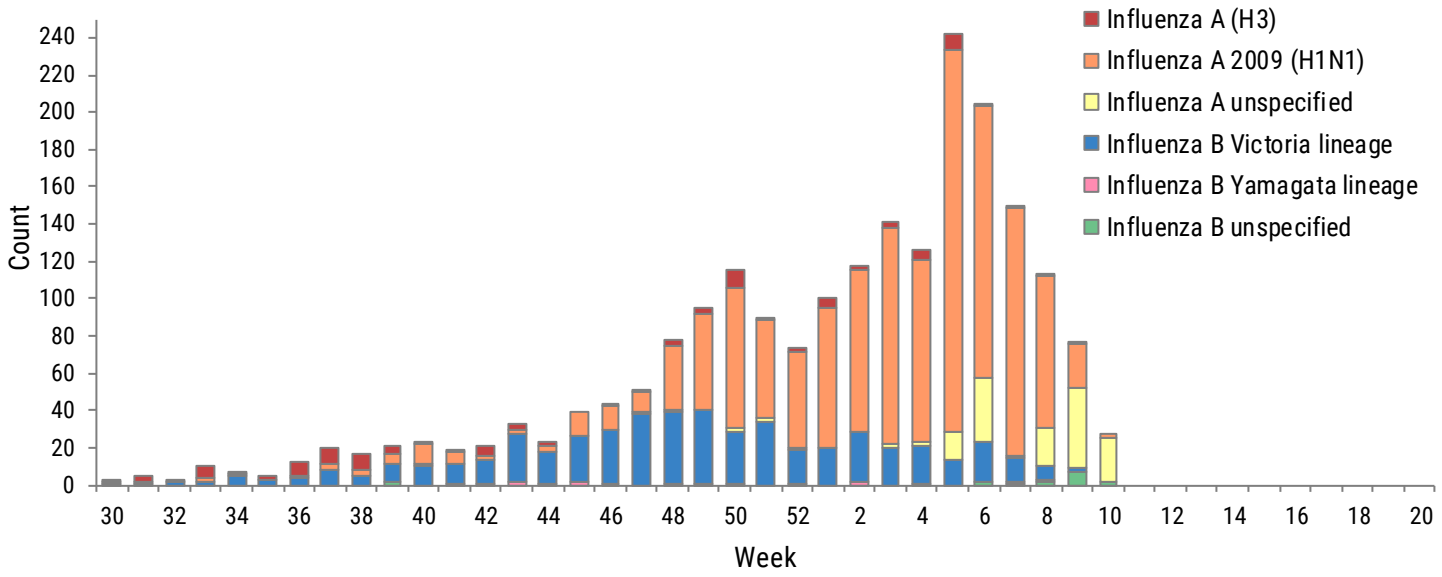
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	133 (47.5%)	80 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (14.3%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	21 (7.5%)	10 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	15 (5.4%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	31 (11.1%)	26 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.8%)	29 influenza-associated outbreaks 4 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.4%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**280 (100.0%)**	**178 influenza-associated outbreaks** **102 ILI outbreaks**

AMERICAN OVERSIGHT

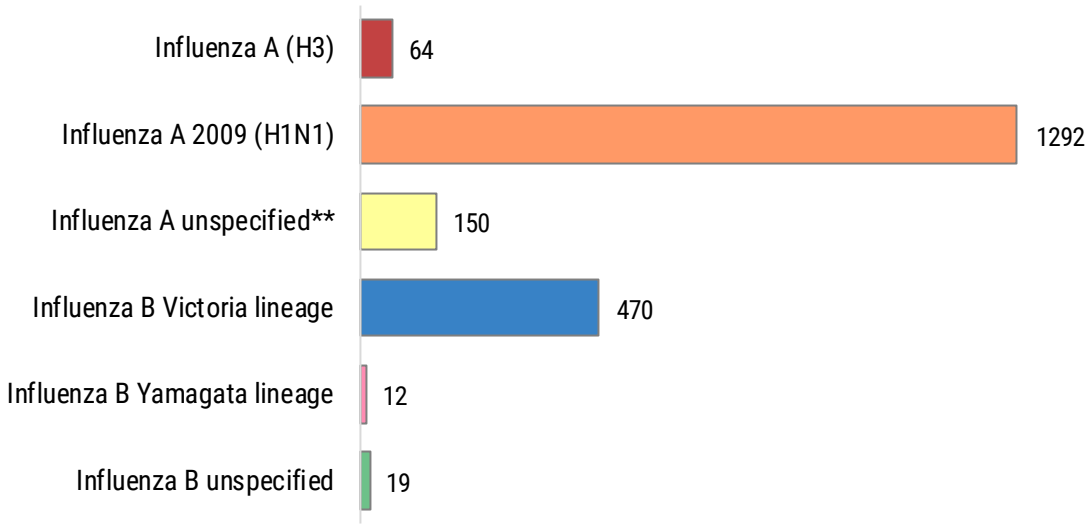
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 10, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 10, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 10, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.

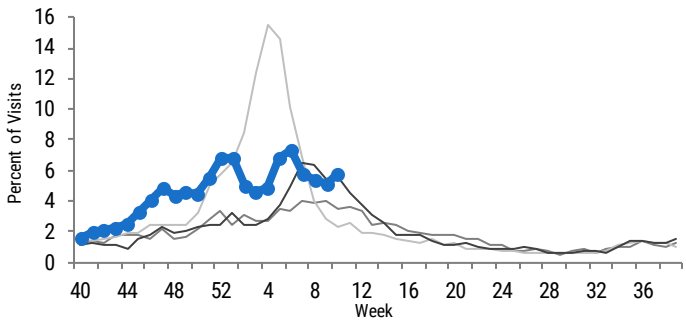


Figure 17: In **region 2, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

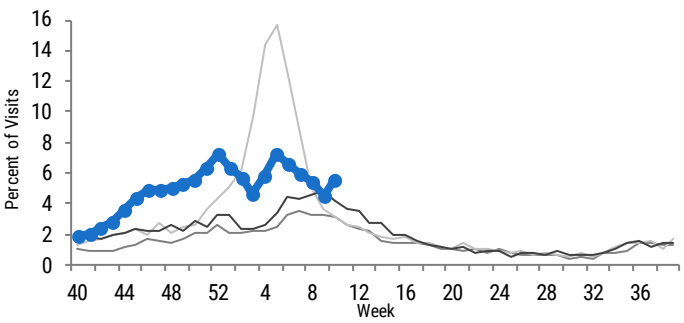


Figure 18: In **region 3, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

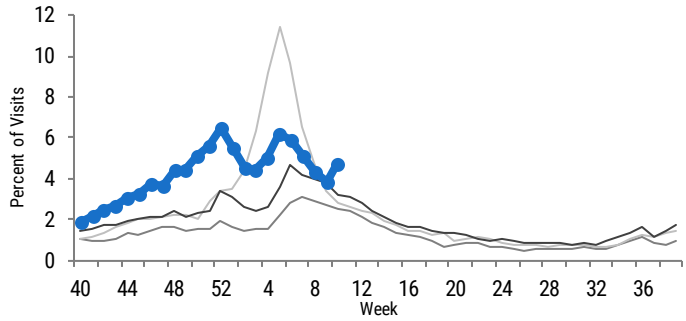


Figure 19: In **region 4, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

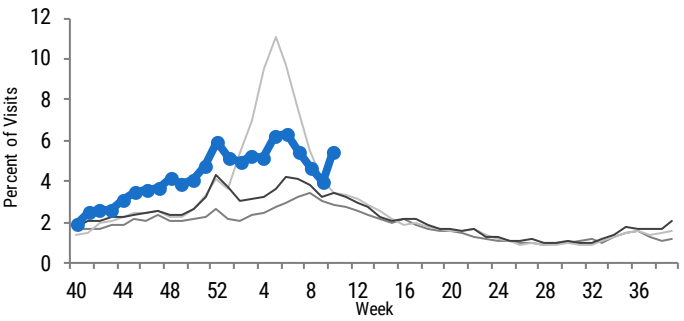


Figure 20: In **region 5, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

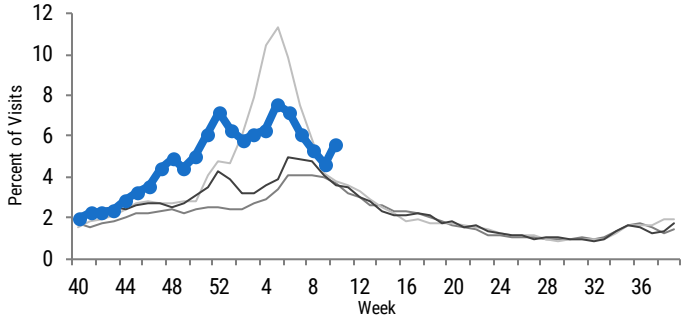


Figure 21: In **region 6, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 and 2018-19 seasons.

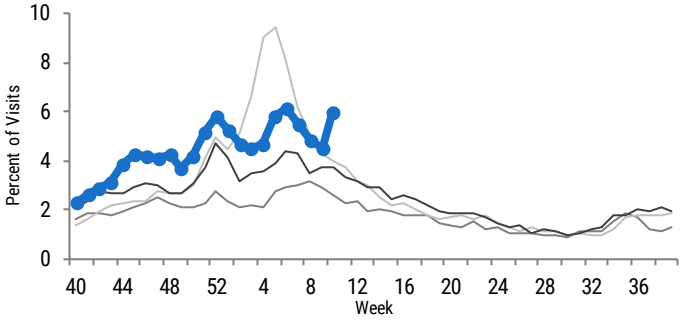
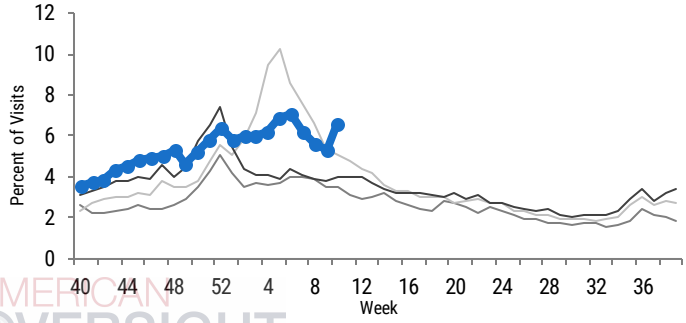


Figure 22: In **region 7, ILI activity increased** during week 10 and was above peak activity observed during the 2016-17 season.



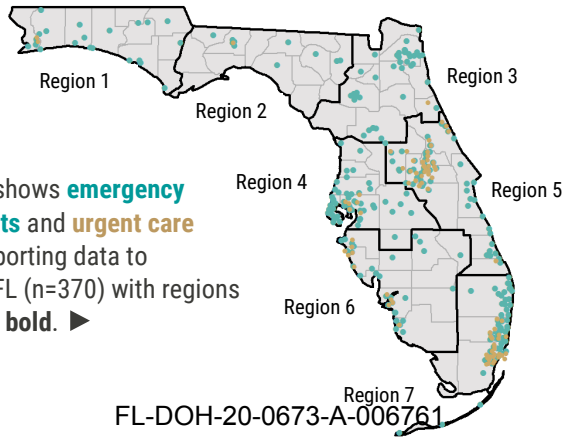


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

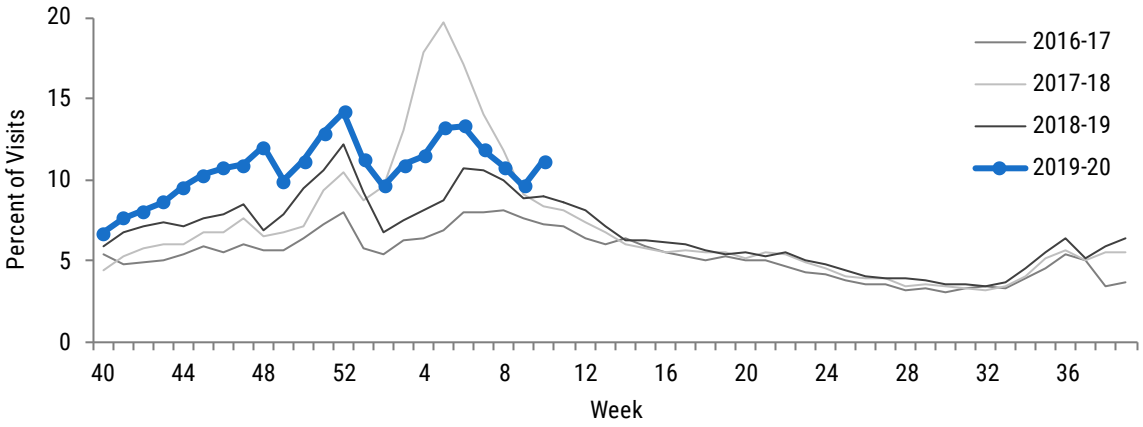
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

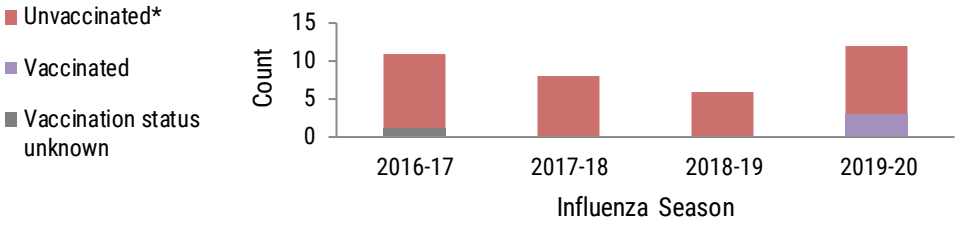
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 10, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above levels observed at this time during the 2016-17 season.

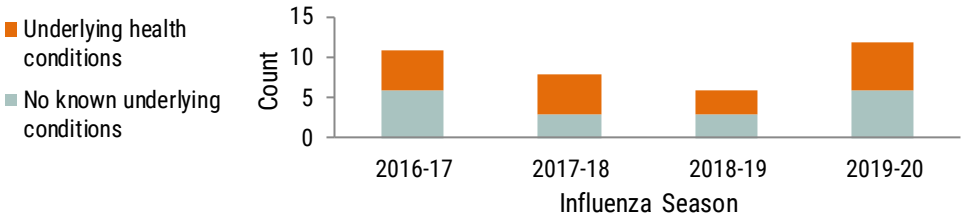


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

Figures 25-26: In week 10, **two new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 10, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 10, 2020.

In week 10, **two new influenza-associated pediatric deaths were reported**. The first death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions. The second was associated with influenza B in a child with known underlying medical conditions. Both were vaccinated for the 2019-20 season.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

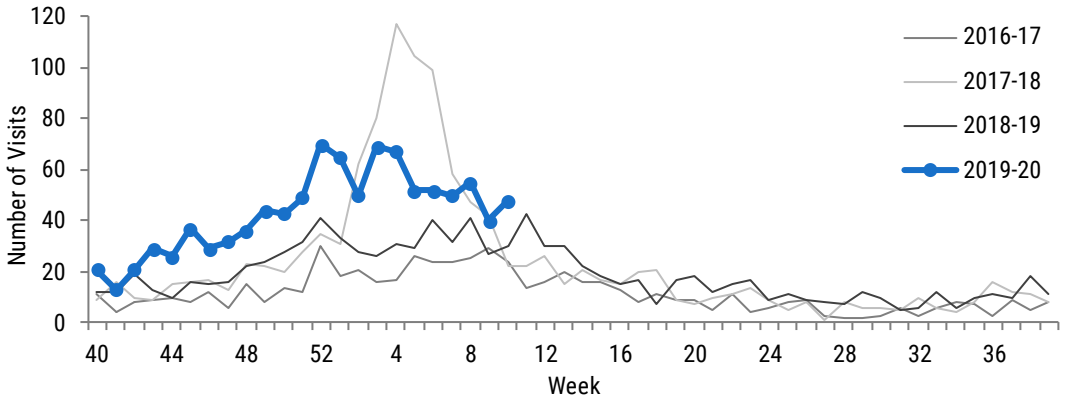
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 10, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons.



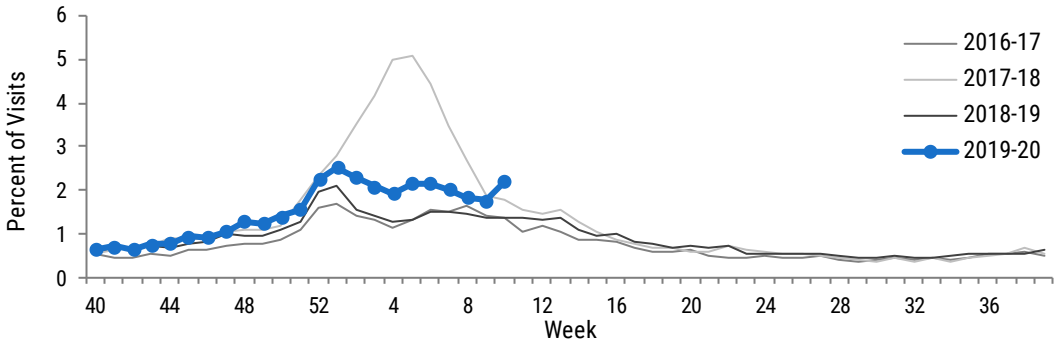
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 10, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 10, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



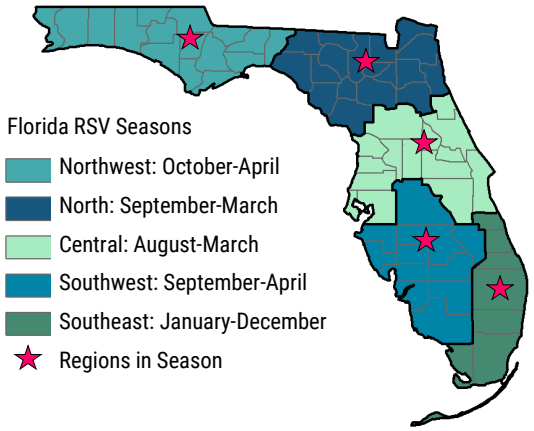
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

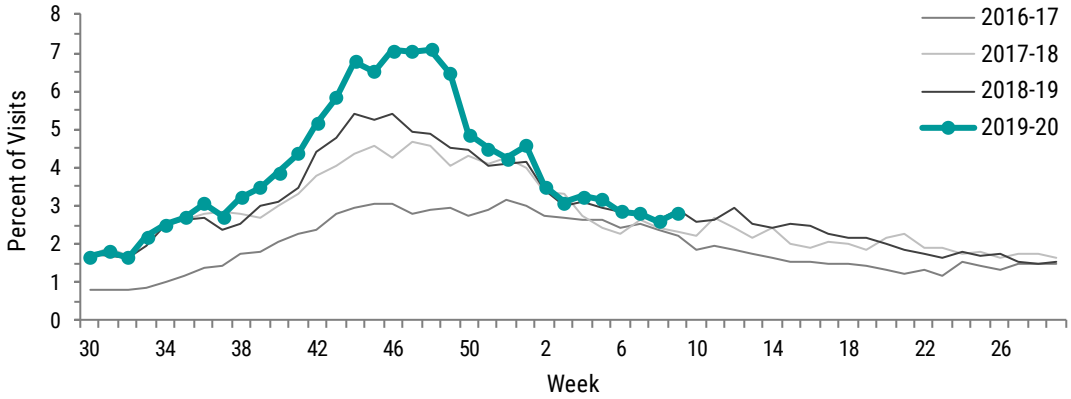
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 10 (February 23-29, 2020) Activity Summary

In week 10, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 10. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 10, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 10, 2020.

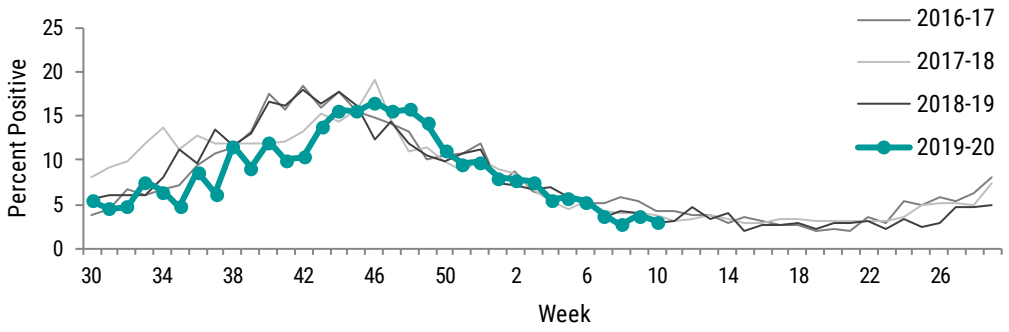
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 10, **the percent of specimens testing positive for RSV decreased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 10, 2020. ▶



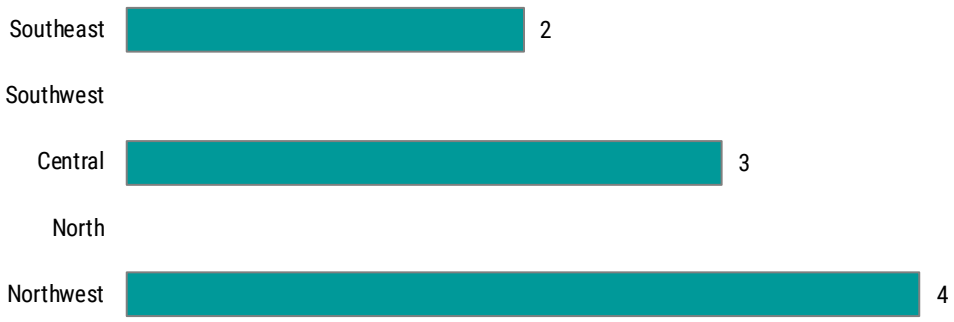
RSV-Associated Outbreaks in Week 10:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 10, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

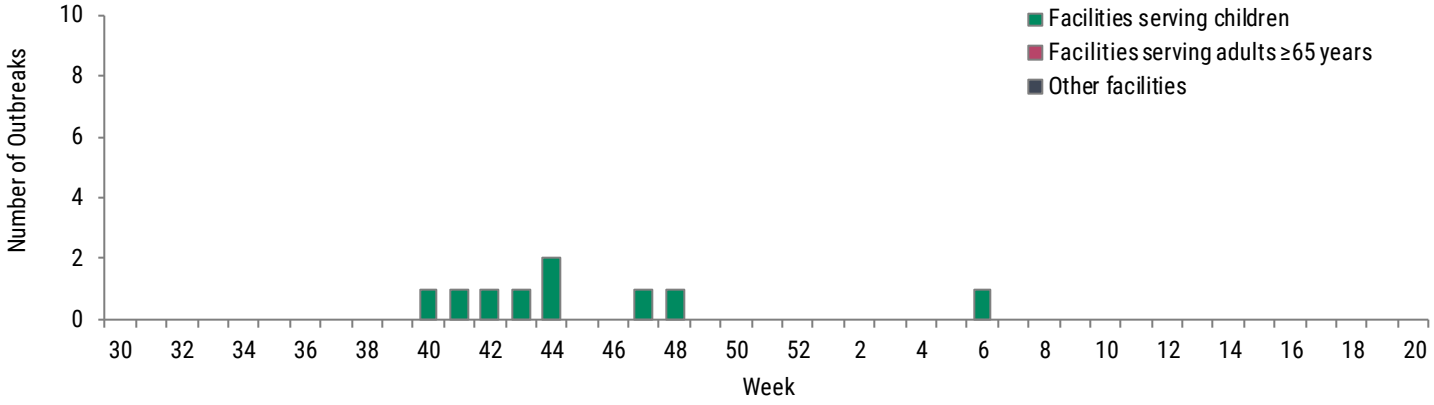
Figure 32: In week 10, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

*Regions defined in figure 29.

Figure 33: In week 10, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 10, 2020.

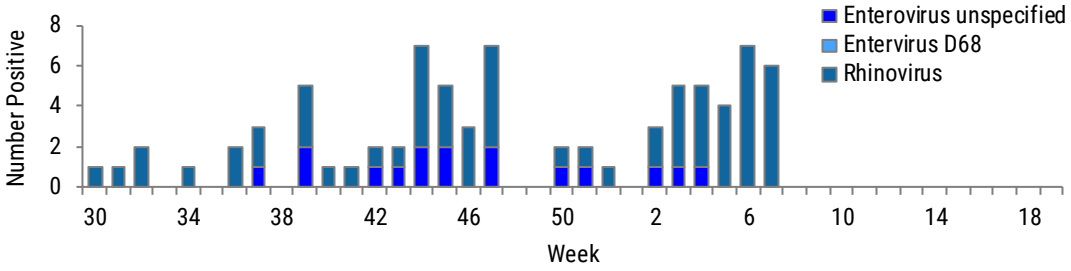
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



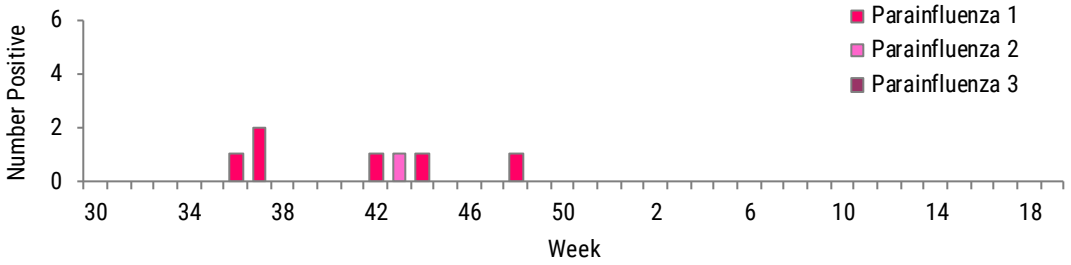
Rhinovirus | Enterovirus unspecified | Enterovirus D68 | Parainfluenza 1 | Parainfluenza 2
Parainfluenza 3 | Coronavirus NL63 | Coronavirus HKU1 | Coronavirus OC43 | Coronavirus 229E
Human metapneumovirus | Adenovirus | Group A Streptococcus | Other

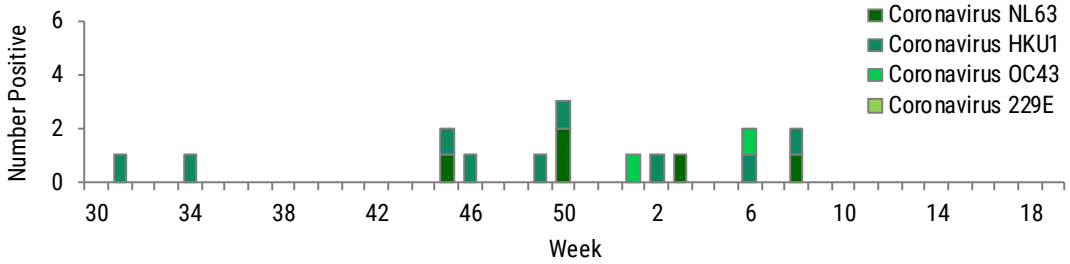
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 10, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

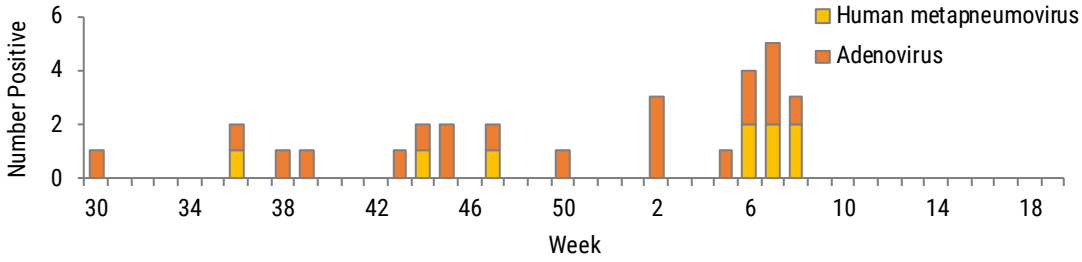
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 10, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 10, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 11, 2020 Florida Flu Review
Date:	Wednesday, March 18, 2020 4:23:20 PM
Attachments:	Week 11, 2020 Florida Flu Review.pdf

Good afternoon!

Please find attached the week 11 Florida Flu Review.

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

For questions regarding COVID-19 in Florida please email COVID-19@FLHealth.gov or call 1-866-779-6121.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, one was influenza-associated and ten were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take

AMERICAN OVERSIGHT

everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Best,

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 11: 3/15/20-3/21/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 11 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, four were influenza-associated and seven were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

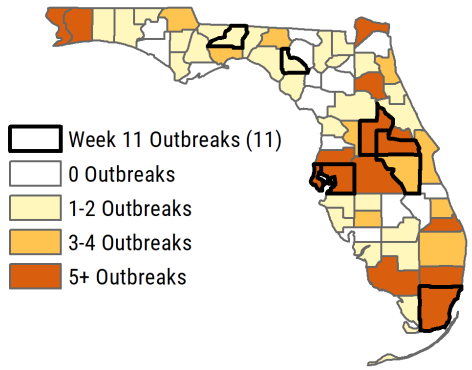
The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

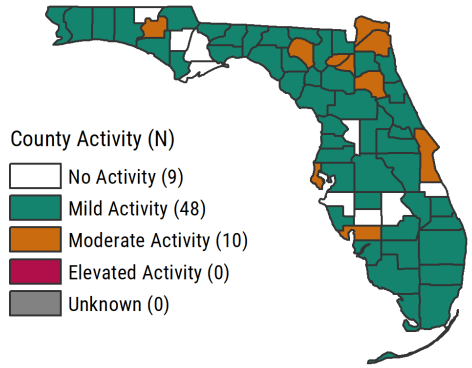
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit: VaccineFinder.org

Posted March 18, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.

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FL-DOH-20-0673-A-006772

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

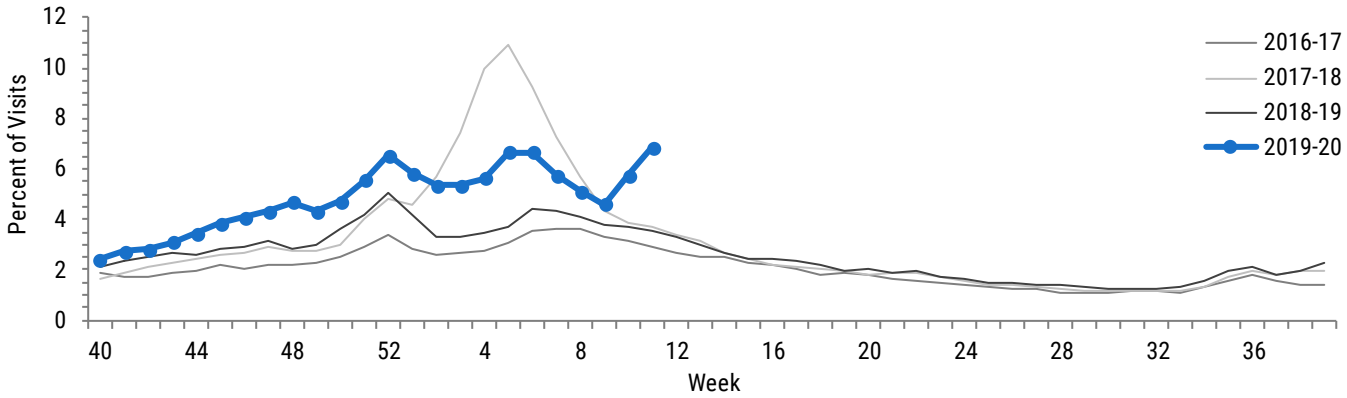
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 11, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 11, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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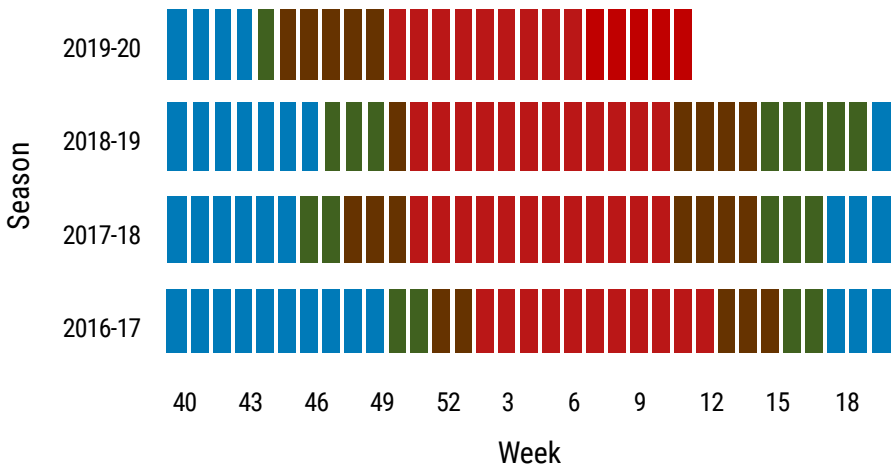
Statewide Activity

Figure 2: In week 11, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 11, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 11, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=4), week 40, 2016 to week 11, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

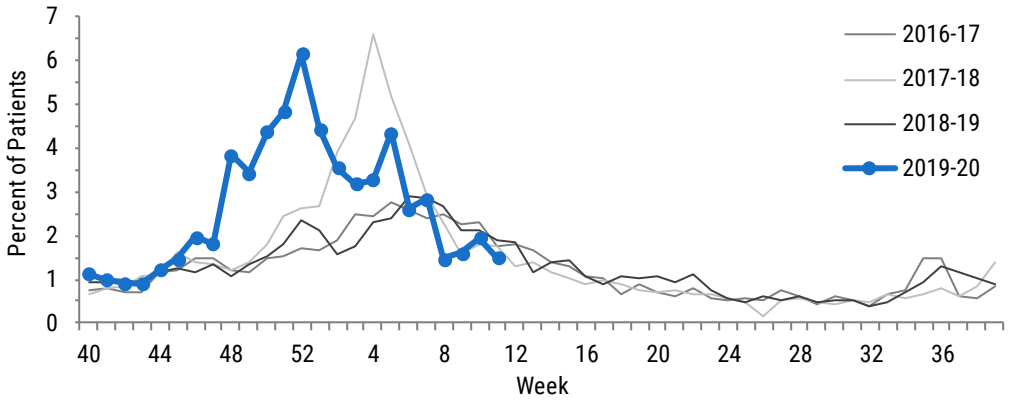
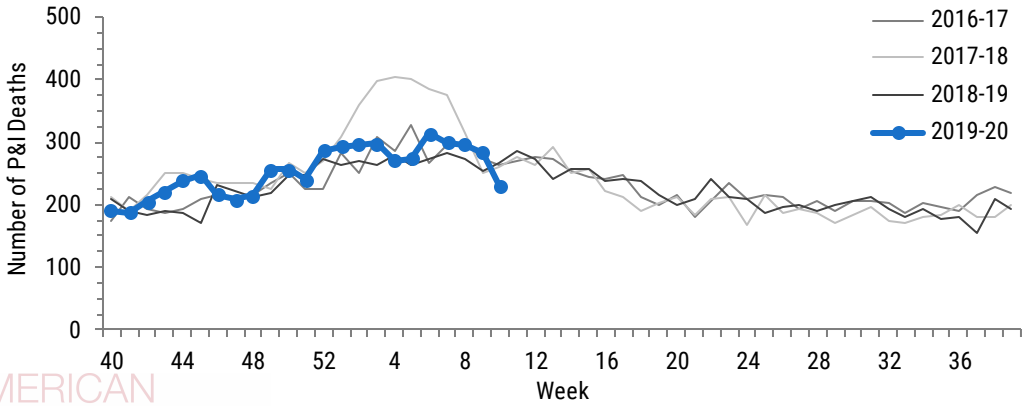


Figure 4: In week 10 (ending 3/7/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 11. Ten counties reported **moderate activity,** and no counties reported **elevated activity.**

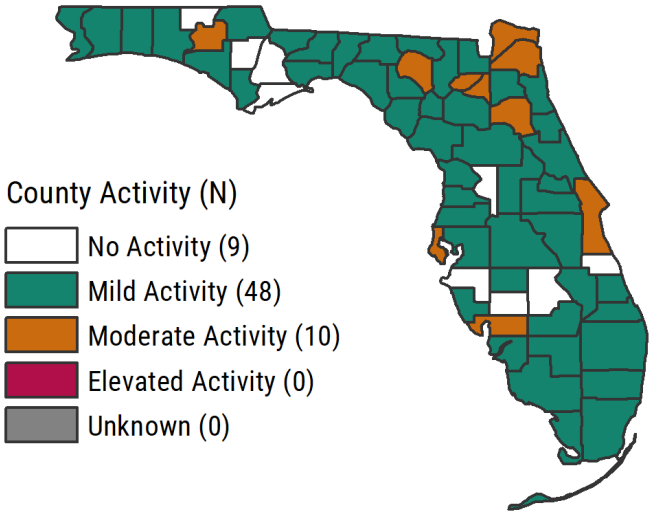
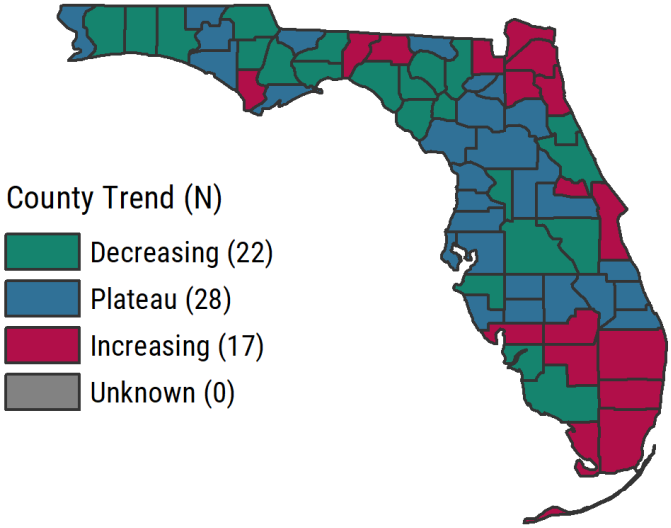
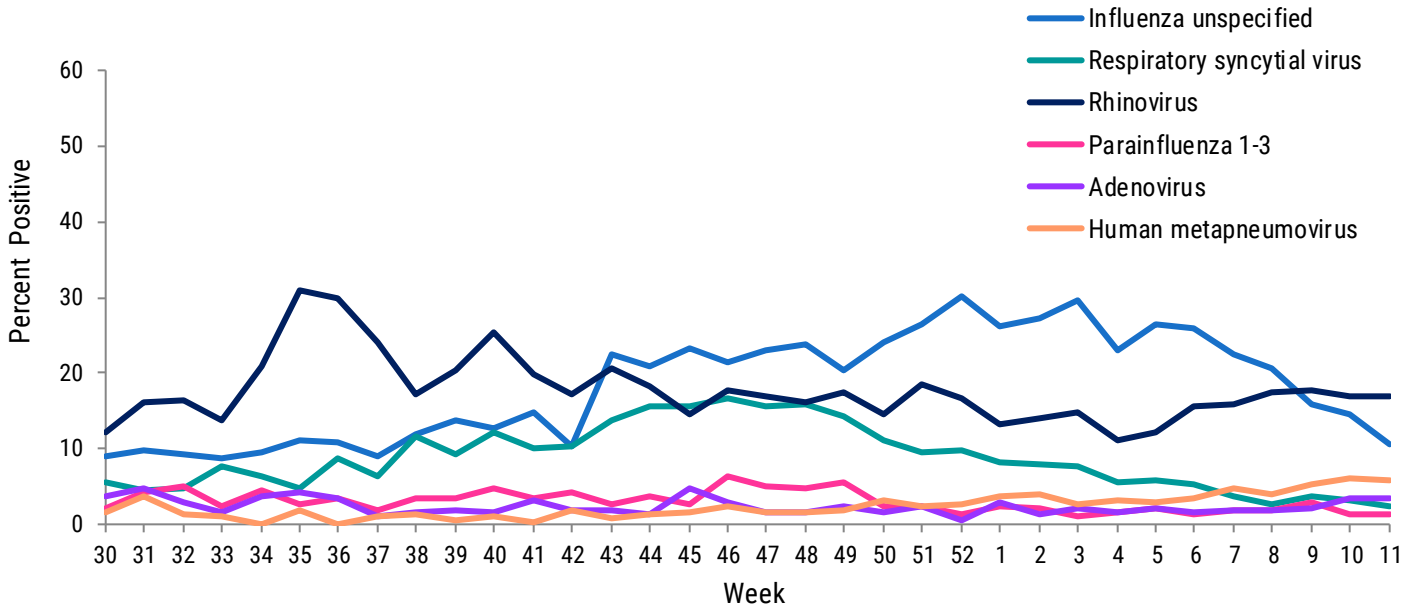


Figure 7: Most counties reported **activity at a plateau** for week 11. Seventeen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 11, the **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Week 11 Outbreaks at a Glance:

Number Reported:
11 Outbreaks

Influenza-Associated:
4 Outbreaks

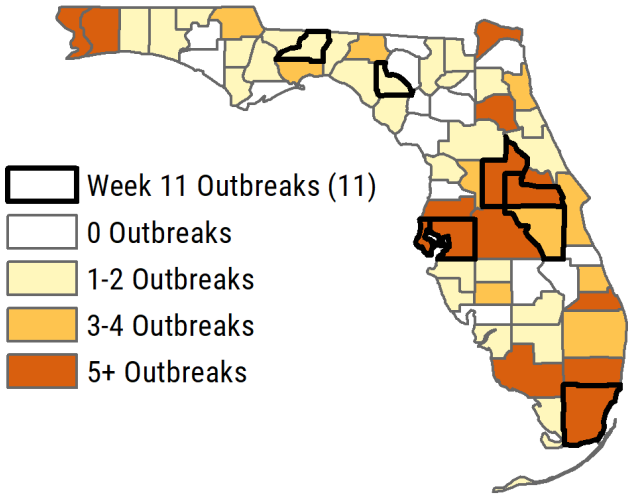
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 11, four influenza-associated and seven ILI outbreaks were reported, a slight increase from the previous week.

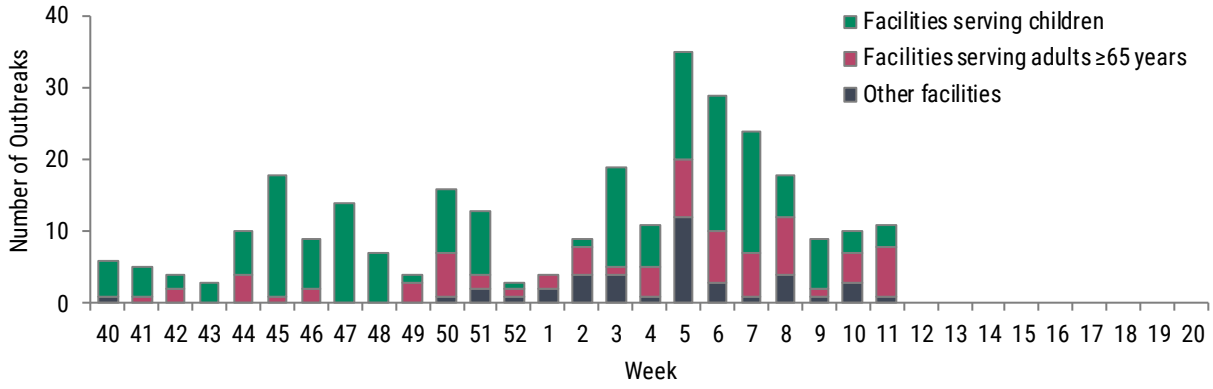
Severe outcomes* were reported in one of eleven outbreaks. One hospitalization and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



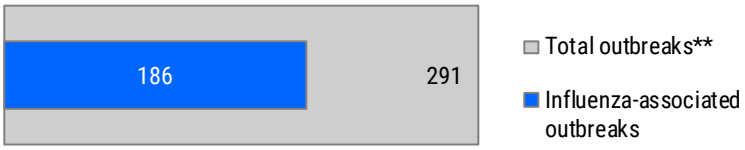
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 11 are **outlined in bold.**

Figure 9: In week 11, **seven outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 11, **63.9% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 11, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

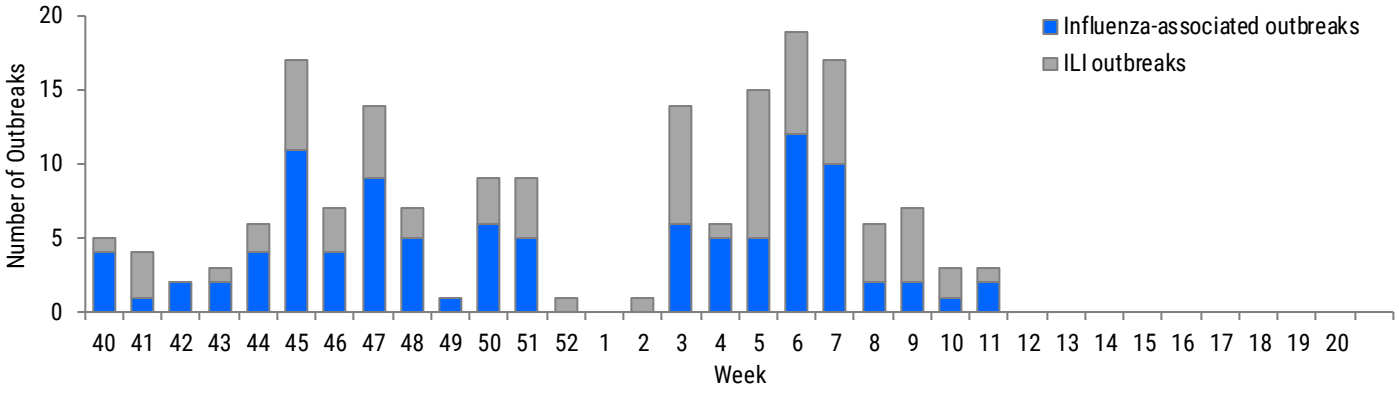
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 11, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 11, **two influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Facilities Serving Adults ≥65 yrs.**:

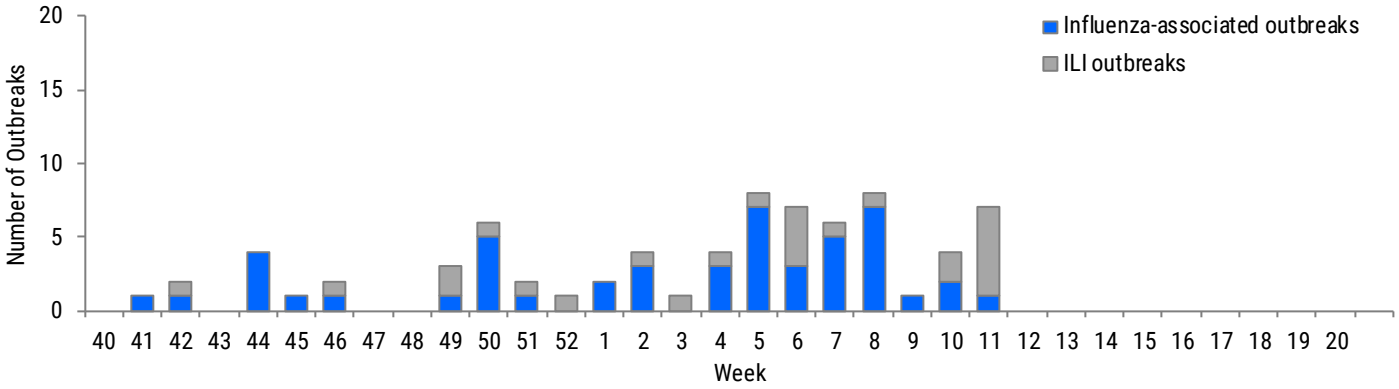
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 11, seven new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 11, **six ILI outbreaks** and **one influenza-associated outbreak** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

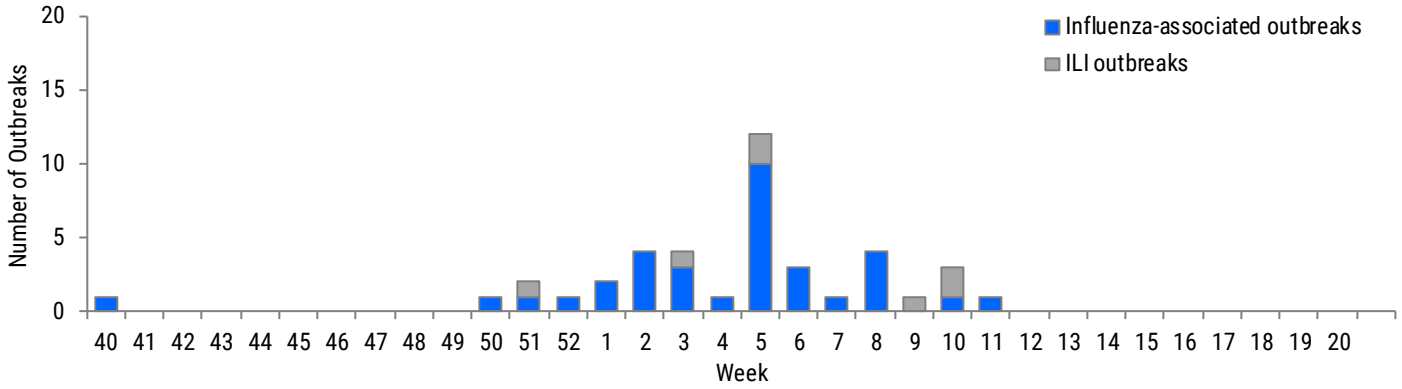
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 11, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 11, **one influenza-associated outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

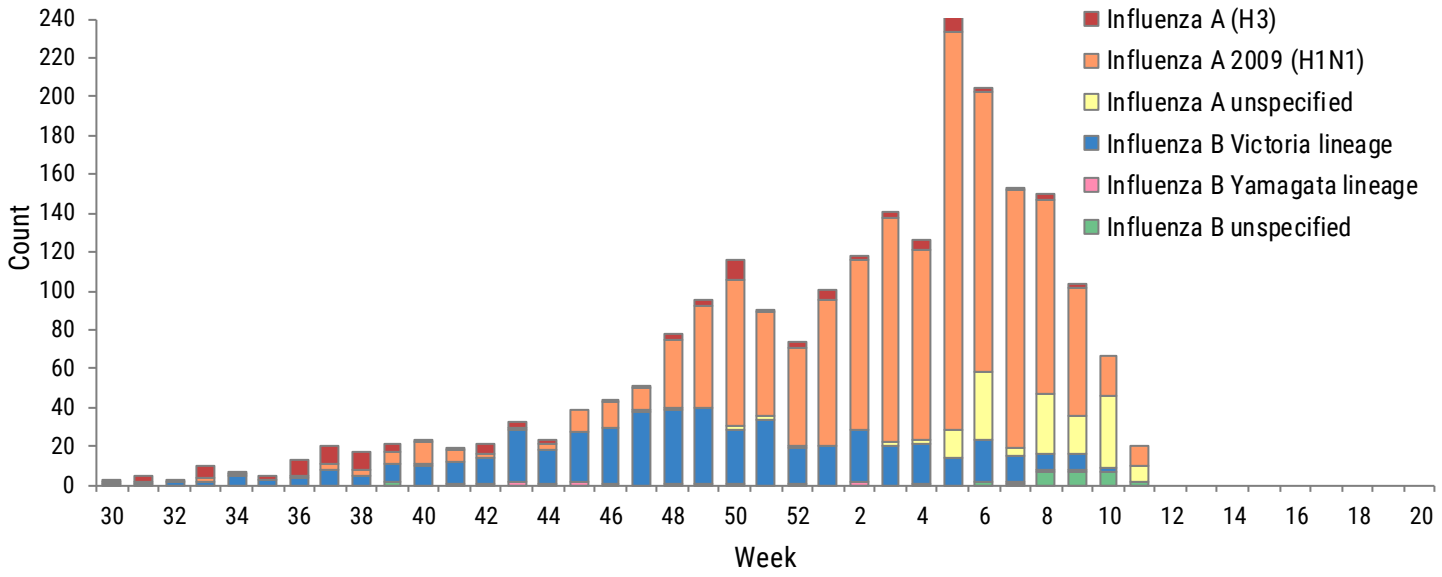
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	136 (46.7%)	83 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (13.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	23 (7.9%)	10 influenza-associated outbreaks 13 ILI outbreaks
Nursing facilities	18 (6.2%)	14 influenza-associated outbreaks 4 ILI outbreaks
Other long-term care facilities	33 (11.3%)	26 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.3%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**291 (100.0%)**	**186 influenza-associated outbreaks** **105 ILI outbreaks**

AMERICAN OVERSIGHT

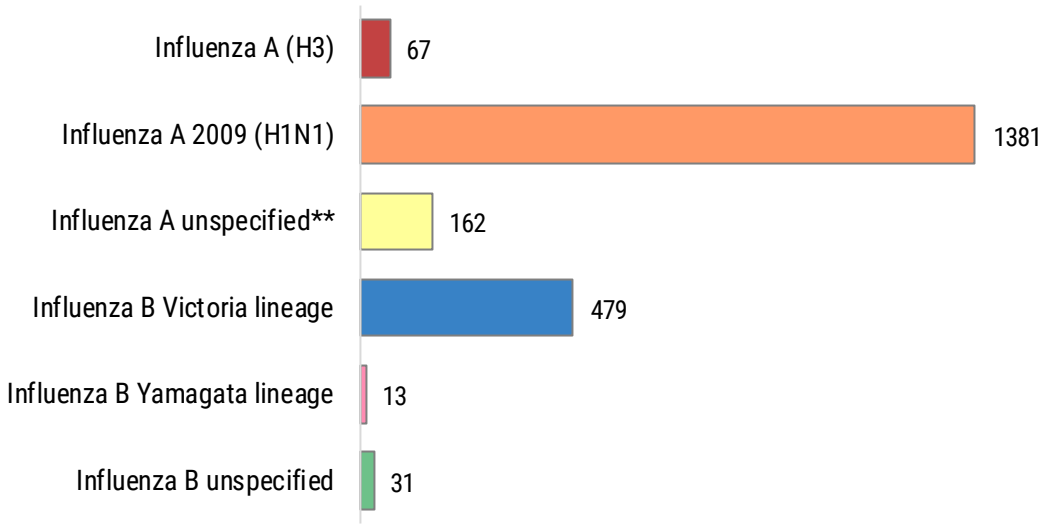
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 11, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 11, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 11, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*

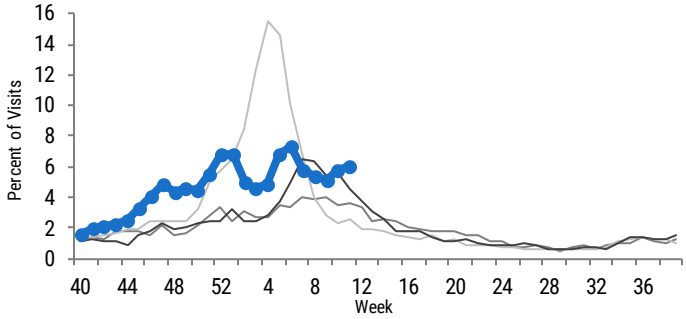


Figure 17: In **region 2, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

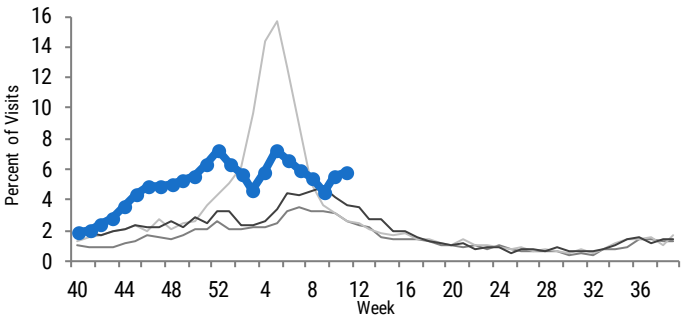


Figure 18: In **region 3, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

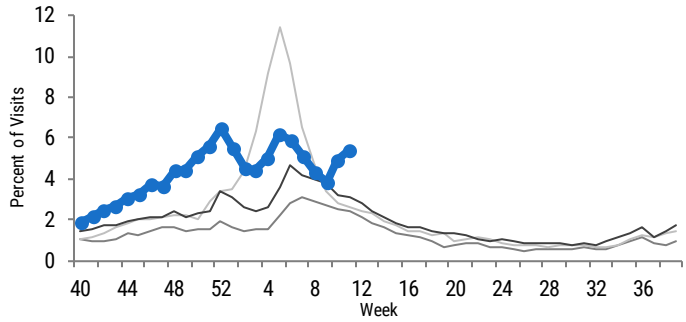


Figure 19: In **region 4, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

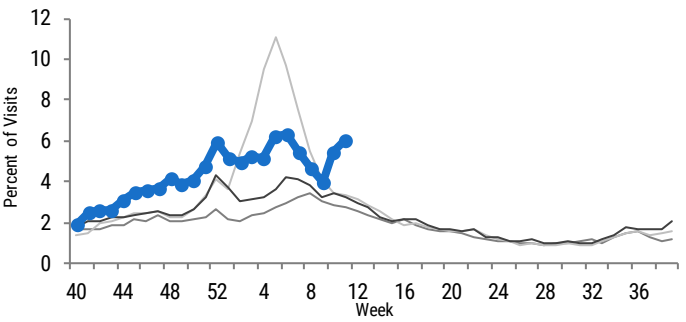


Figure 20: In **region 5, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

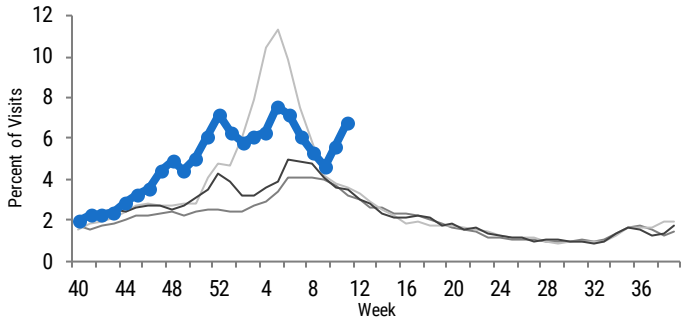


Figure 21: In **region 6, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

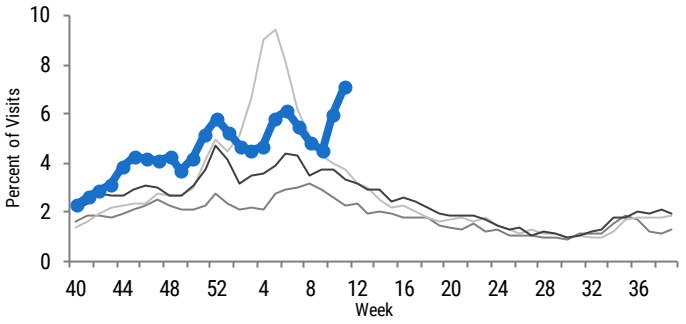
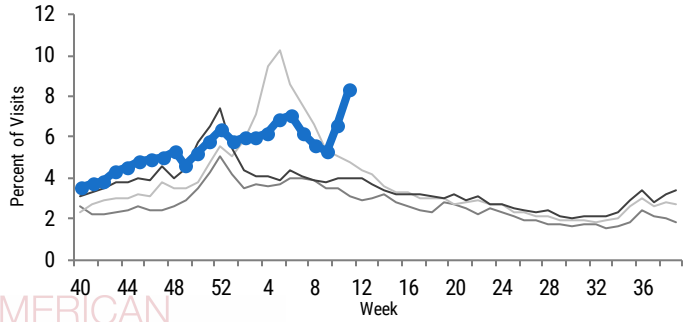


Figure 22: In **region 7, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*



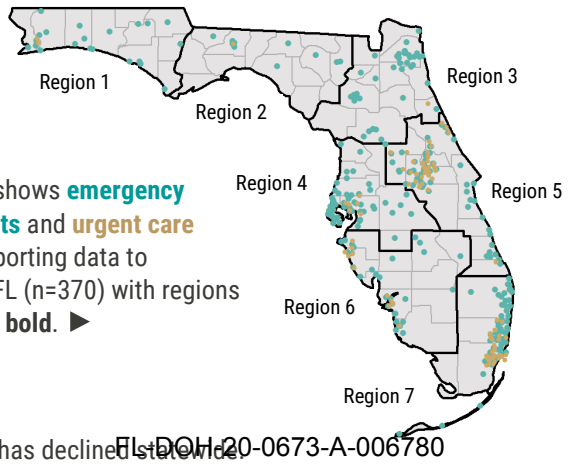


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined statewide.

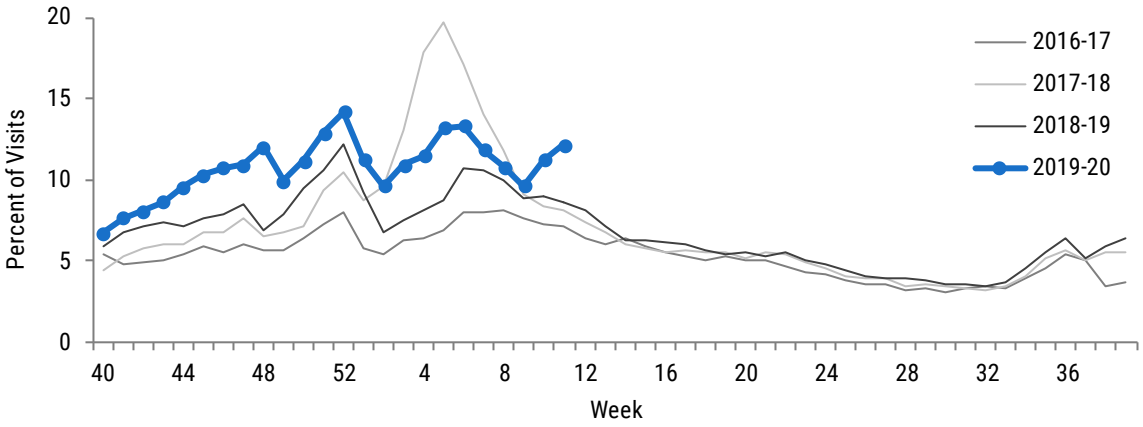
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

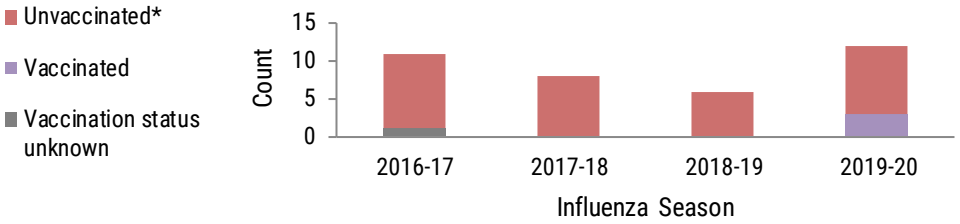
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 11, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak levels observed during the 2016-17 season. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.

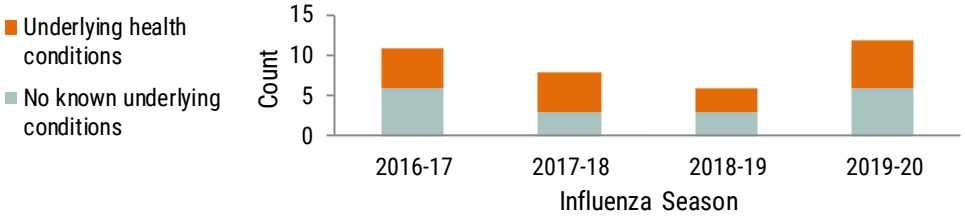


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

Figures 25-26: In week 11, **no new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 11, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 11, 2020.

In week 11, **no new influenza-associated pediatric deaths were reported**.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

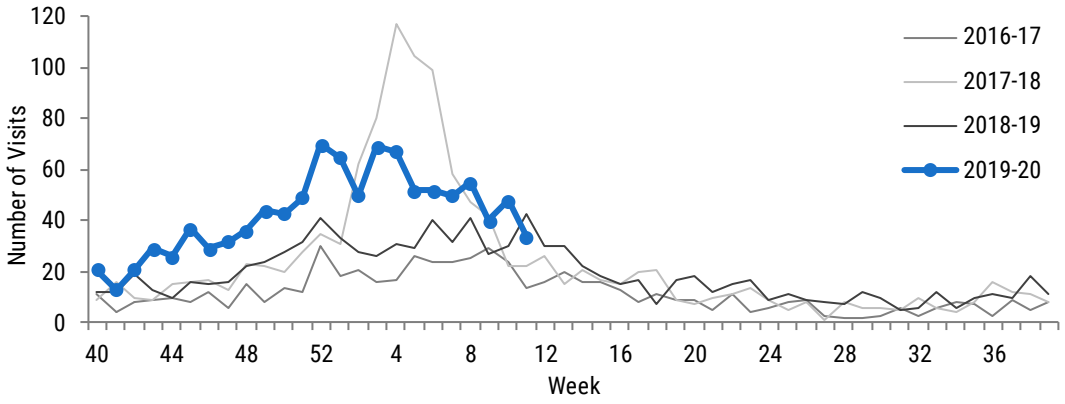
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 11, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



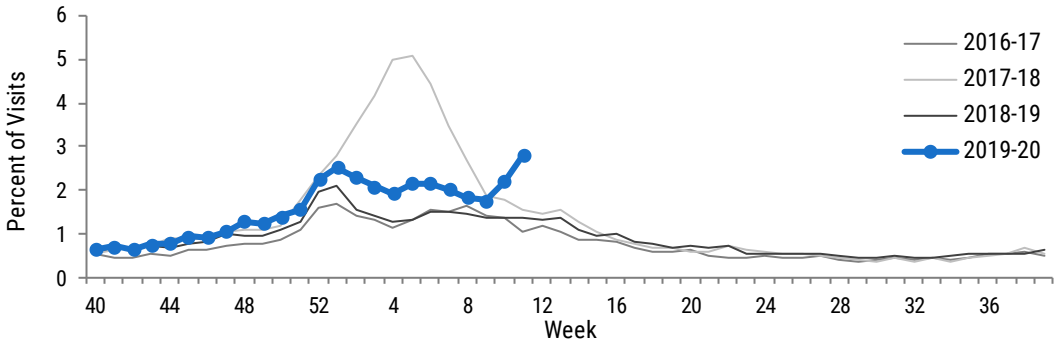
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 11, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 11, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak levels during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



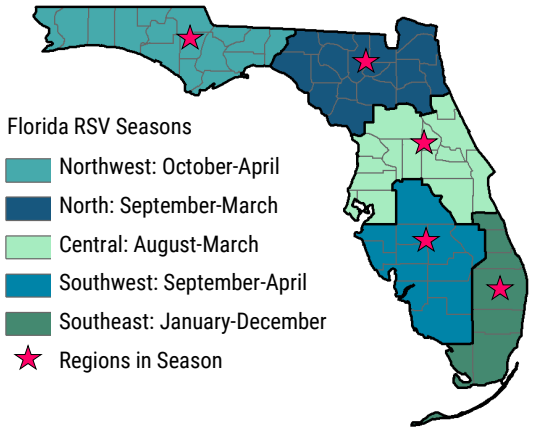
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

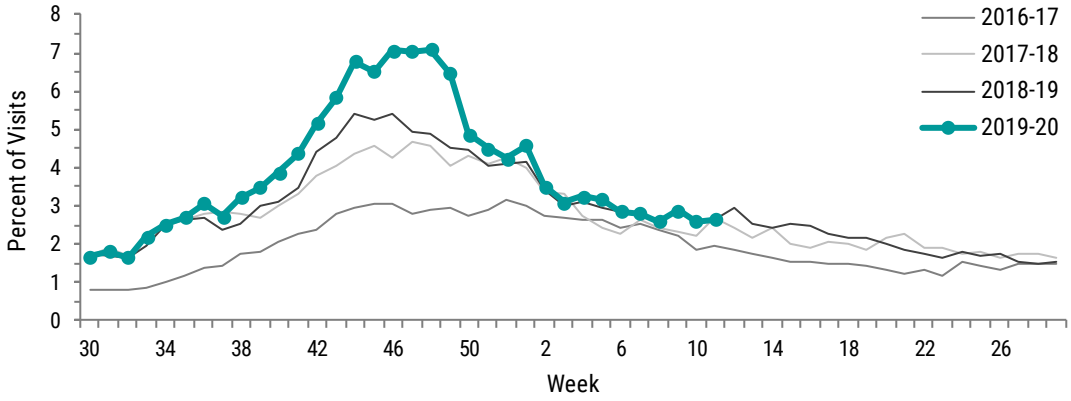
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 11 (February 23-29, 2020) Activity Summary

In week 11, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in week 11. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 11, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 11, 2020.

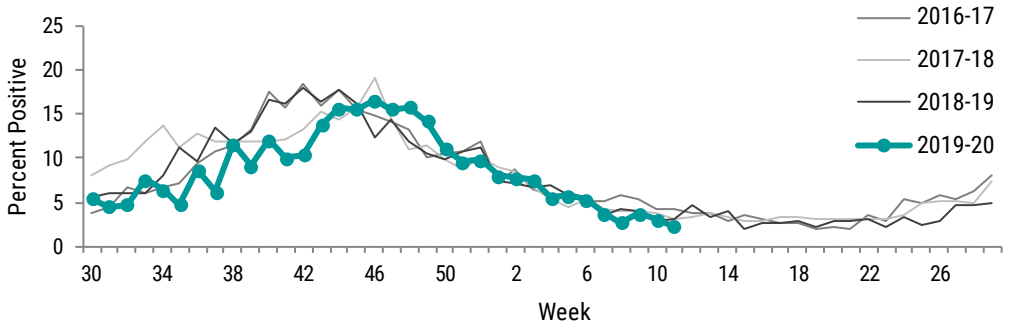
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 11, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 11, 2020. ▶



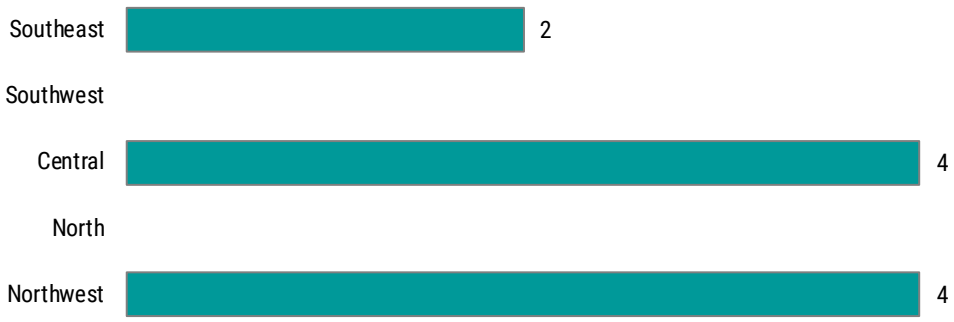
RSV-Associated Outbreaks in Week 11:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 11, one new RSV-associated outbreak was reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

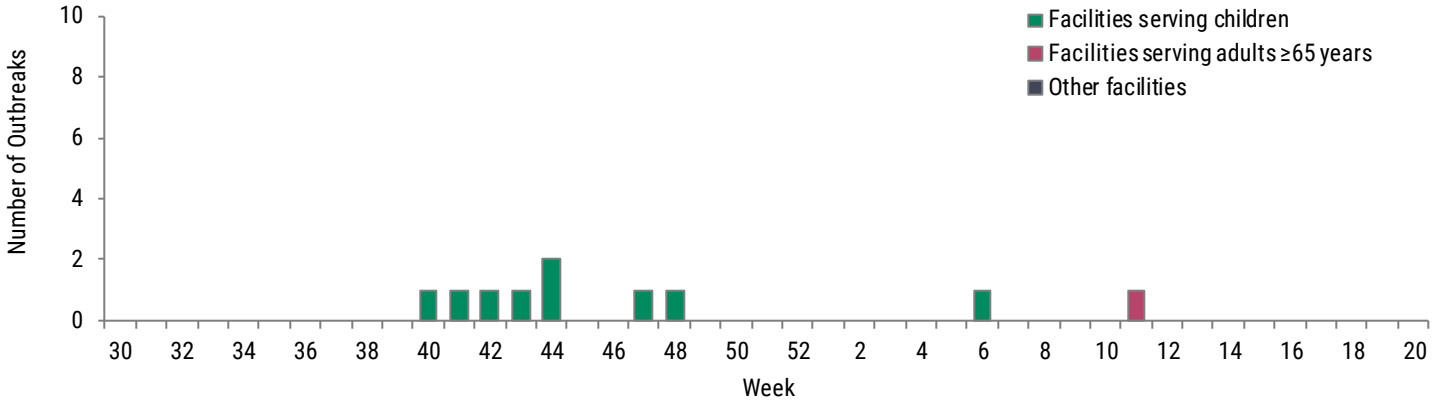
Figure 32: In week 11, one new RSV-associated outbreak was reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

*Regions defined in figure 29.

Figure 33: In week 11, one new RSV-associated outbreak was reported. This outbreak was reported in a **facility serving adults aged ≥65 years**. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

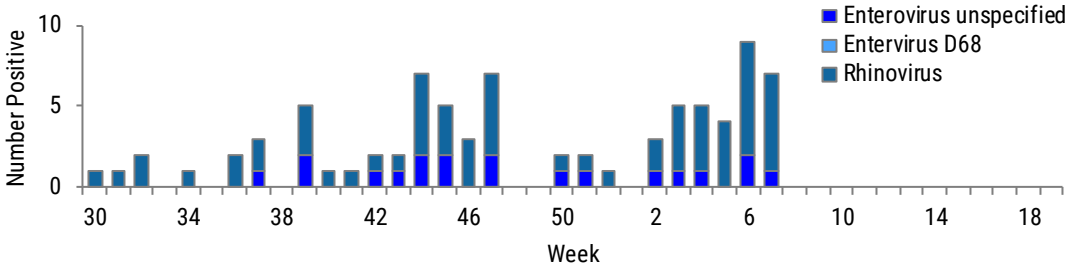
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



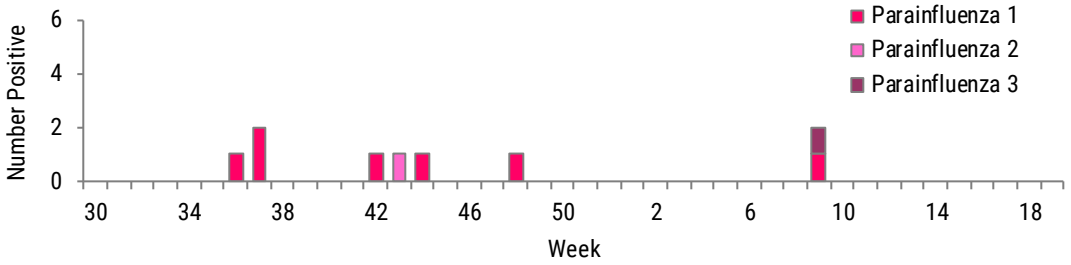
Rhinovirus | Enterovirus unspecified | Enterovirus D68 | Parainfluenza 1 | Parainfluenza 2
Parainfluenza 3 | Coronavirus NL63 | Coronavirus HKU1 | Coronavirus OC43 | Coronavirus 229E
Human metapneumovirus | Adenovirus | Group A Streptococcus | Other

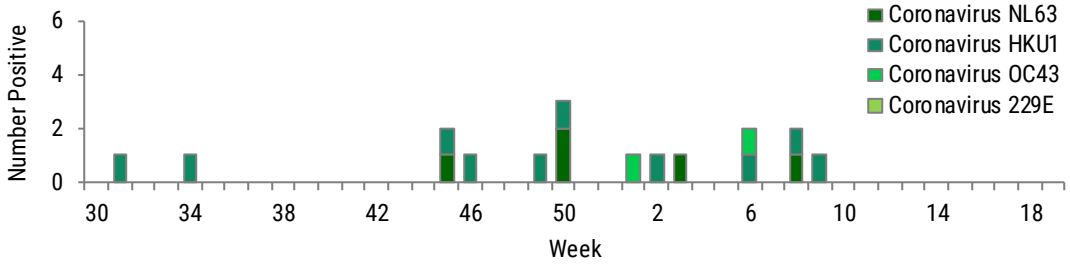
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 11, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

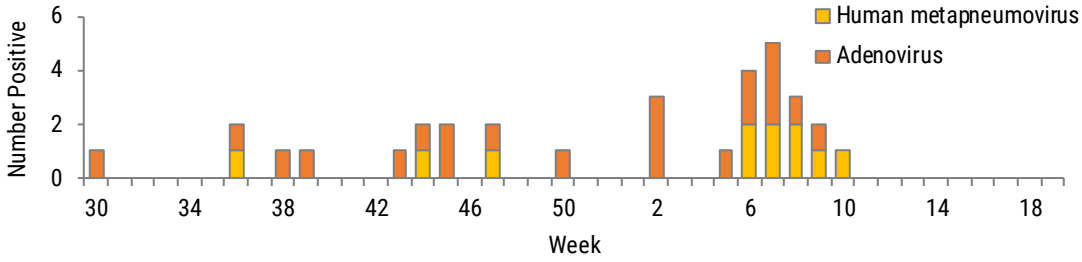
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 11, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 11, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 11, 2020 Florida Flu Review
Date:	Wednesday, March 18, 2020 4:23:27 PM
Attachments:	Week 11, 2020 Florida Flu Review.pdf

Good afternoon!

Please find attached the week 11 Florida Flu Review.

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

For questions regarding COVID-19 in Florida please email COVID-19@FLHealth.gov or call 1-866-779-6121.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, one was influenza-associated and ten were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take

AMERICAN OVERSIGHT

everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Best,

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 11: 3/15/20-3/21/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 11 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

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No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

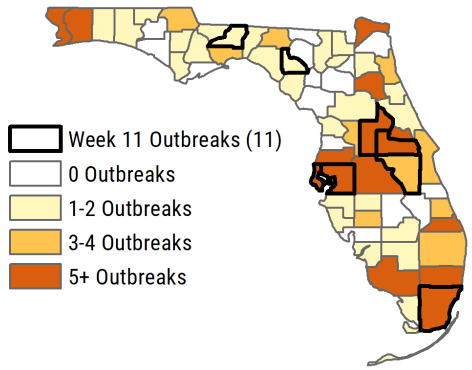
The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

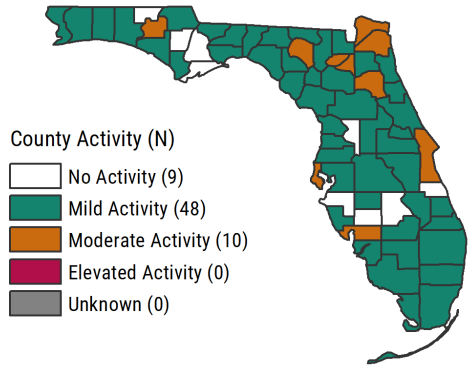
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit: VaccineFinder.org

Posted March 18, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.

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FL-DOH-20-0673-A-006791

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

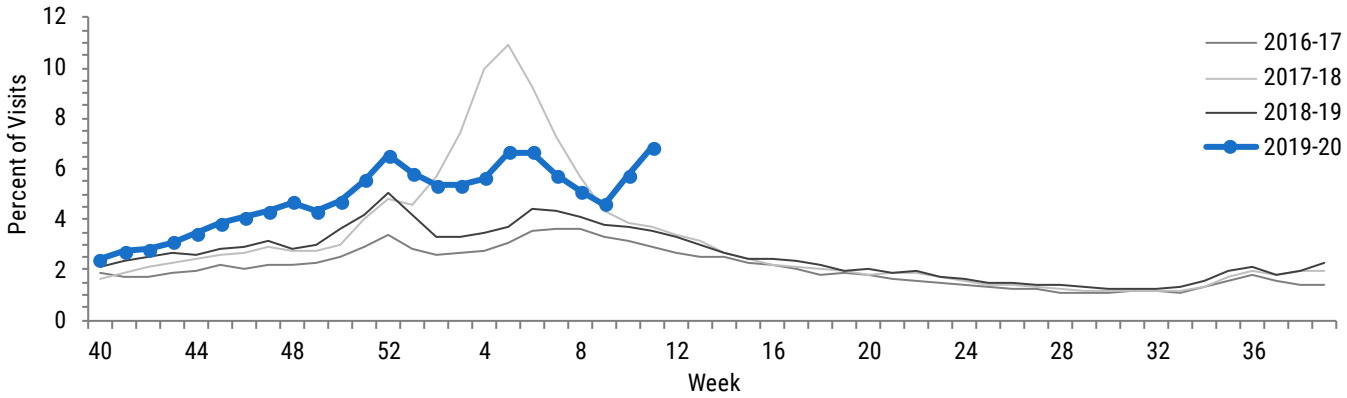
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 11, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 11, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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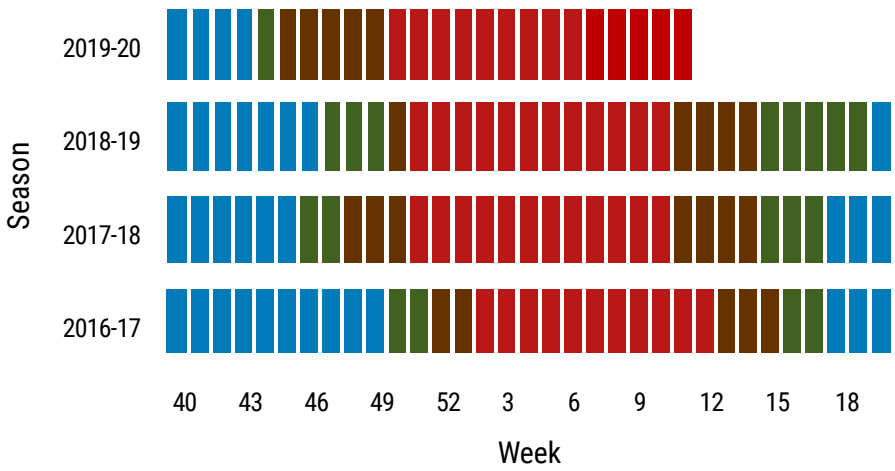
Statewide Activity

Figure 2: In week 11, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 11, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 11, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=4), week 40, 2016 to week 11, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

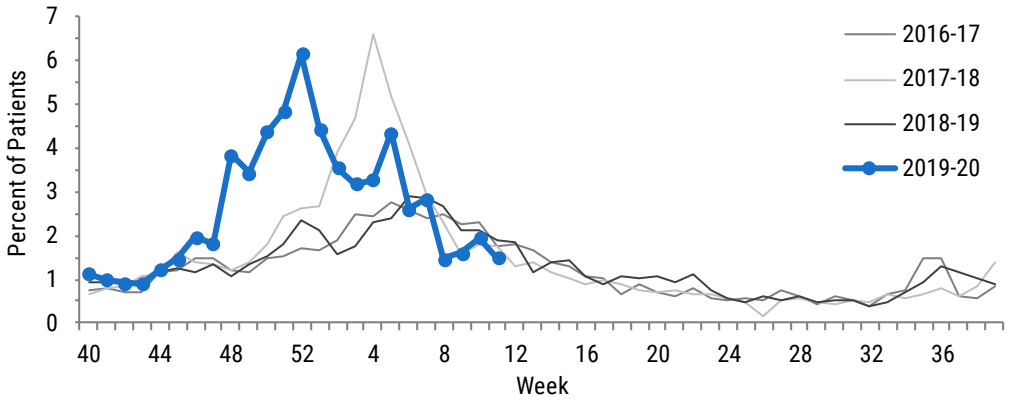
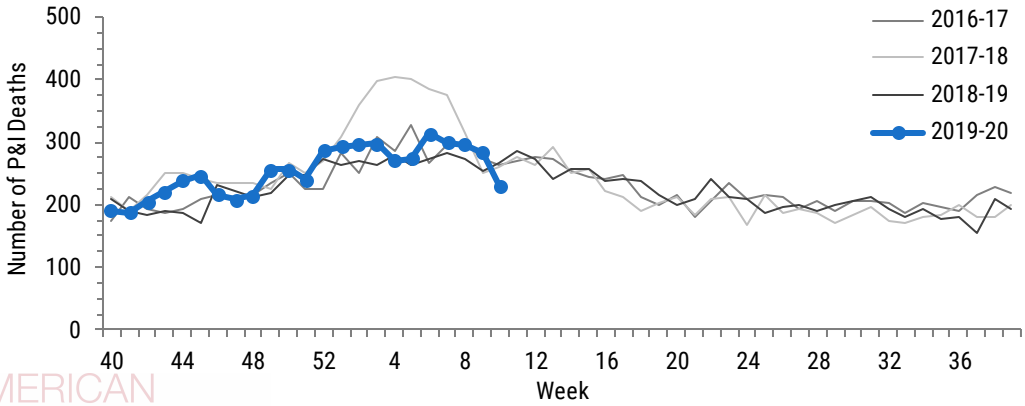


Figure 4: In week 10 (ending 3/7/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 11. Ten counties reported **moderate activity,** and no counties reported **elevated activity.**

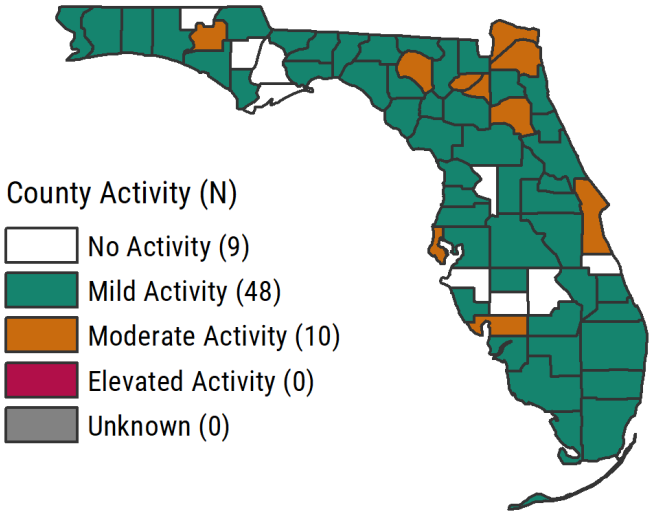
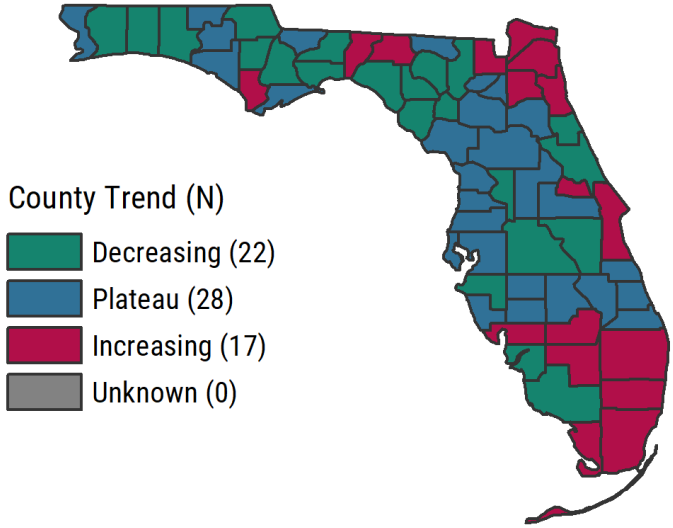
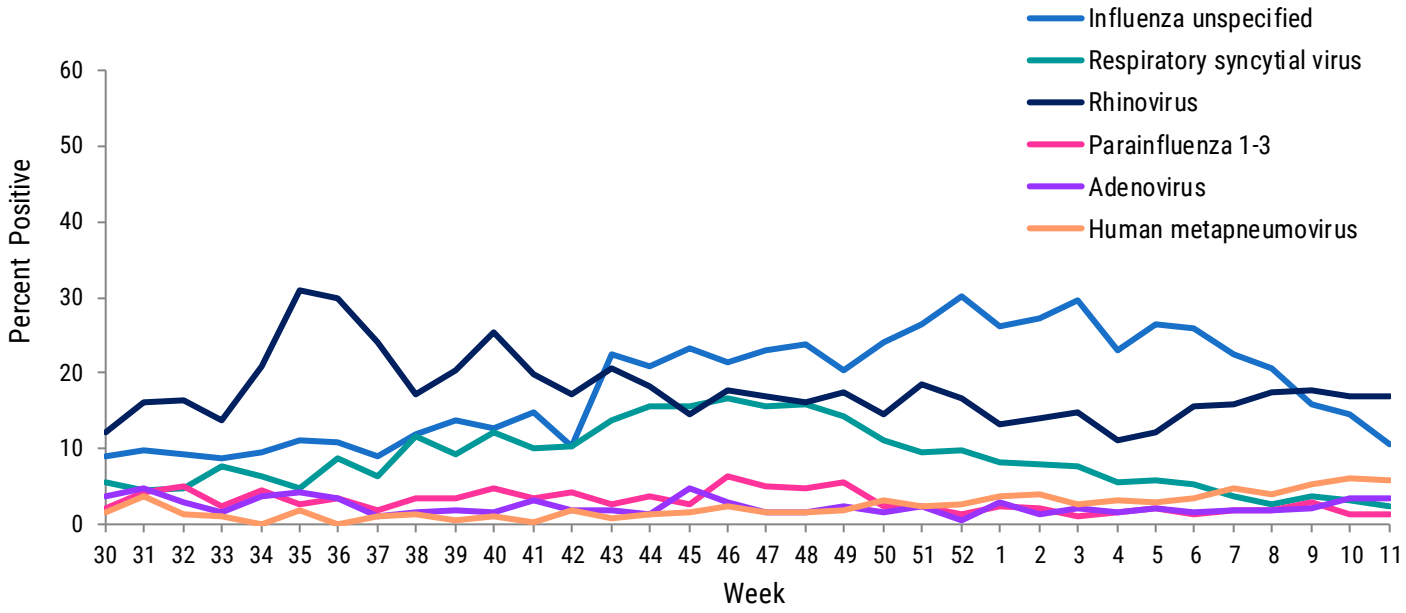


Figure 7: Most counties reported **activity at a plateau** for week 11. Seventeen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 11, the **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Week 11 Outbreaks at a Glance:

Number Reported:
11 Outbreaks

Influenza-Associated:
4 Outbreaks

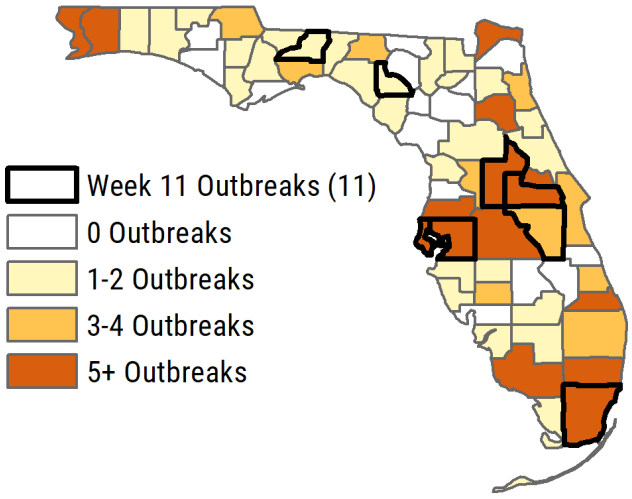
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 11, four influenza-associated and seven ILI outbreaks were reported, a slight increase from the previous week.

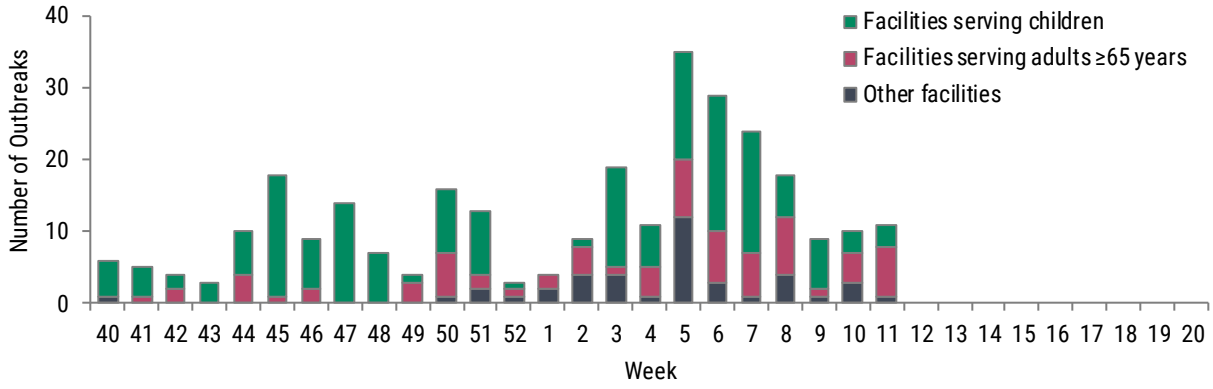
Severe outcomes* were reported in one of eleven outbreaks. One hospitalization and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



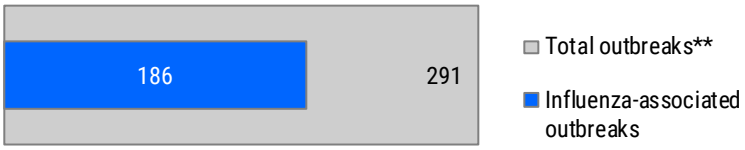
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 11 are **outlined in bold.**

Figure 9: In week 11, **seven outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 11, **63.9% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 11, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

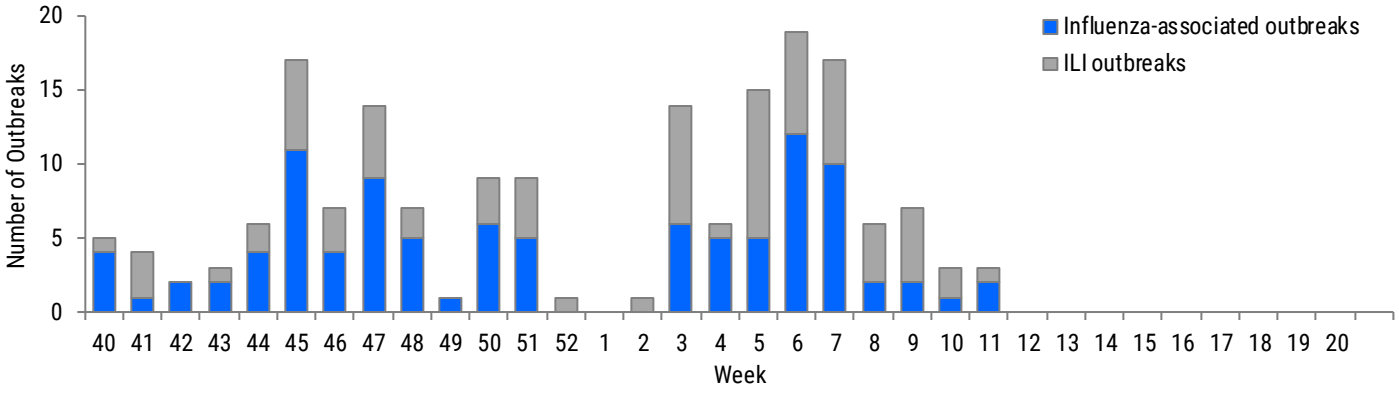
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 11, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 11, **two influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Facilities Serving Adults ≥65 yrs.**:

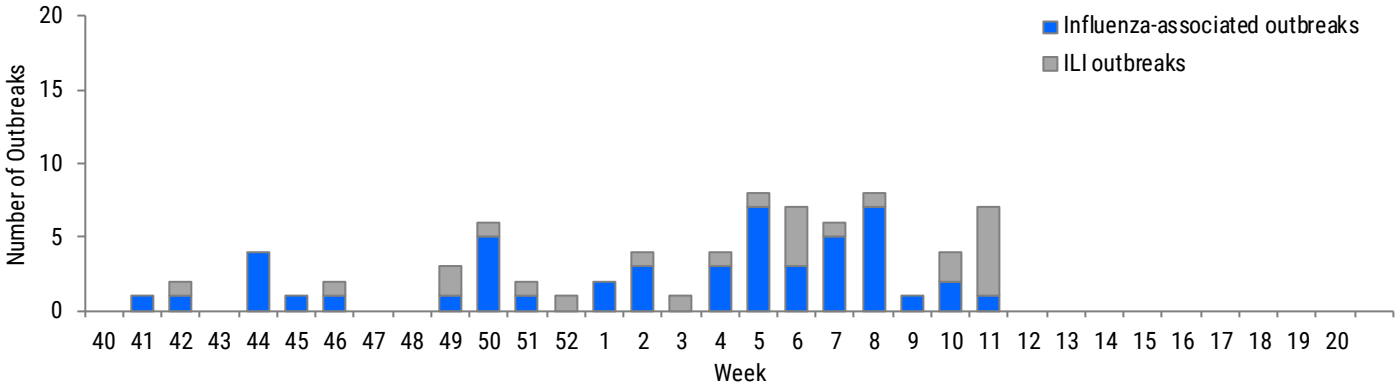
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 11, seven new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 11, **six ILI outbreaks** and **one influenza-associated outbreak** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

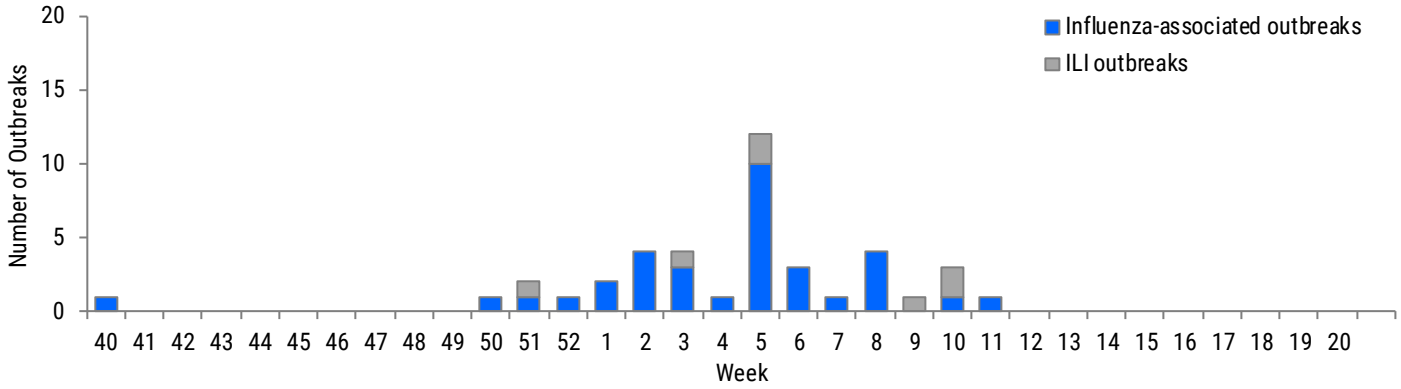
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 11, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 11, **one influenza-associated outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	136 (46.7%)	83 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (13.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	23 (7.9%)	10 influenza-associated outbreaks 13 ILI outbreaks
Nursing facilities	18 (6.2%)	14 influenza-associated outbreaks 4 ILI outbreaks
Other long-term care facilities	33 (11.3%)	26 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.3%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**291 (100.0%)**	**186 influenza-associated outbreaks** **105 ILI outbreaks**

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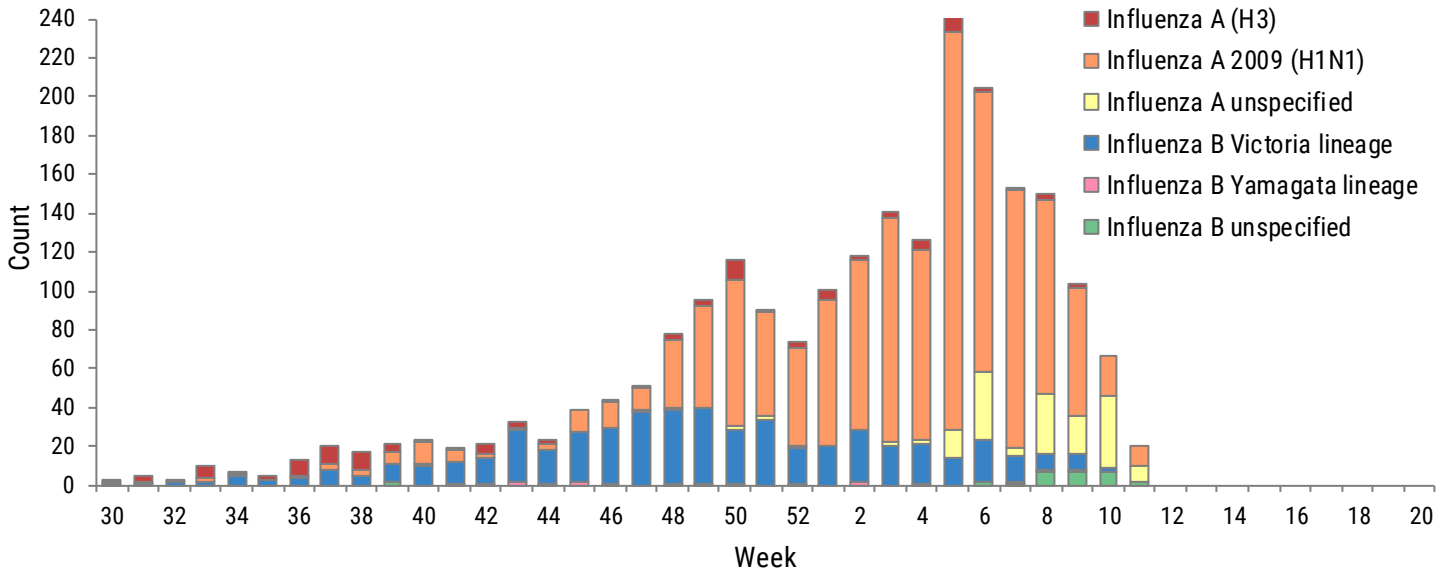
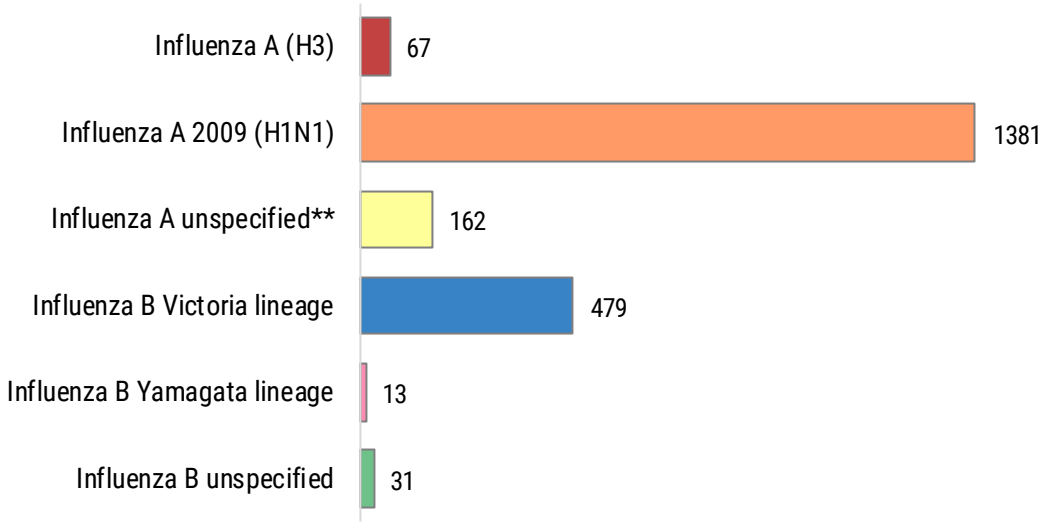
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 11, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 11, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 11, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*

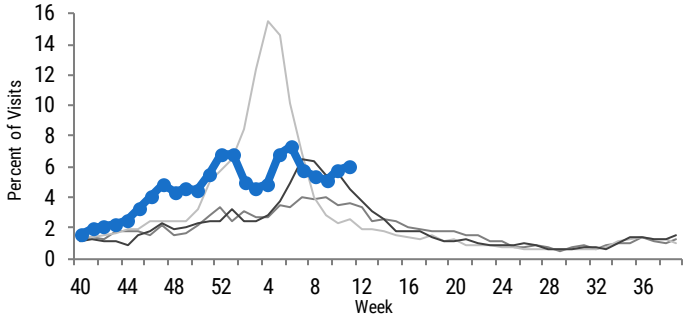


Figure 17: In **region 2, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

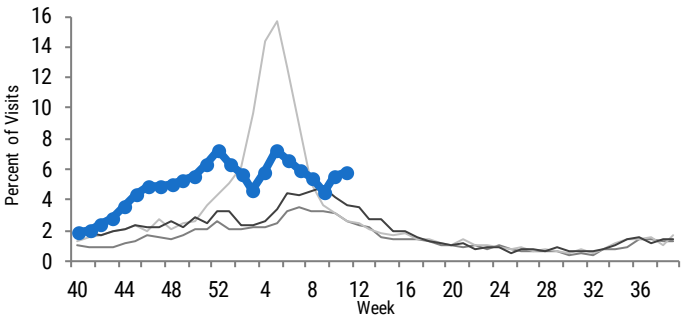


Figure 18: In **region 3, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

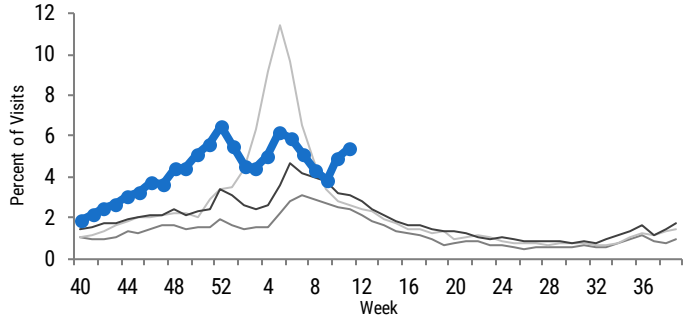


Figure 19: In **region 4, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

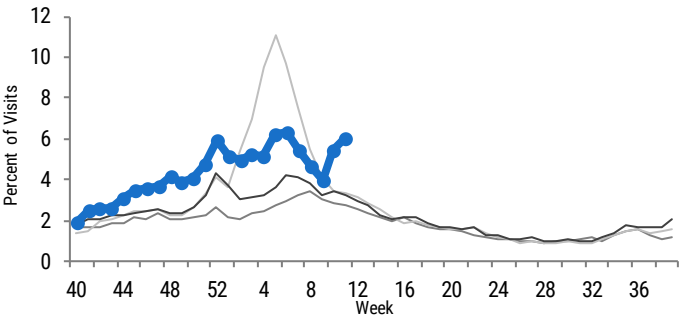


Figure 20: In **region 5, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

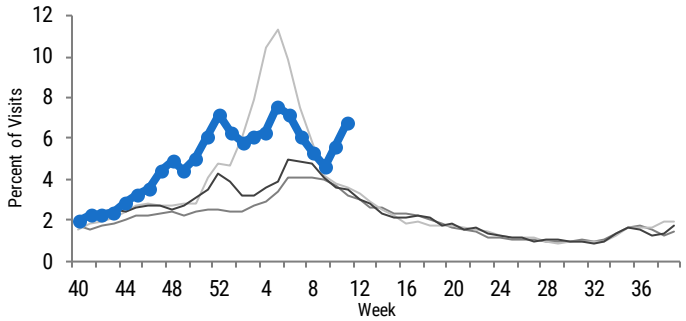


Figure 21: In **region 6, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

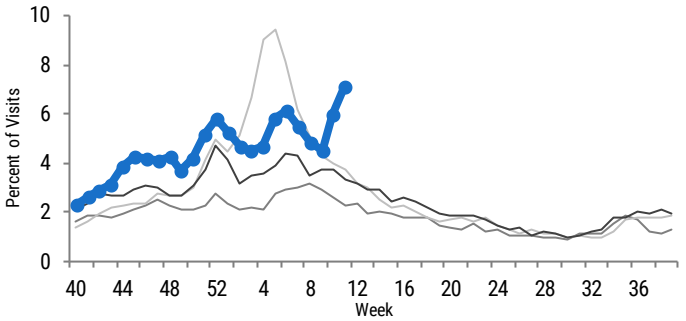
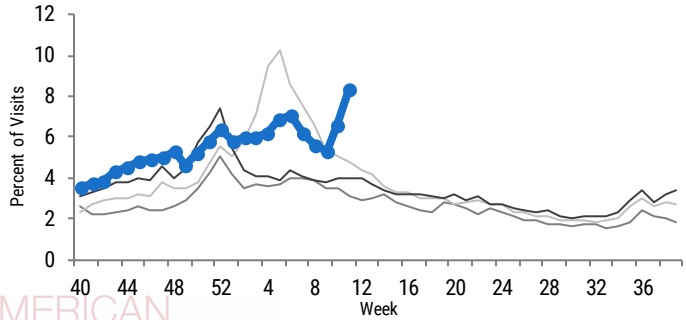


Figure 22: In **region 7, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*



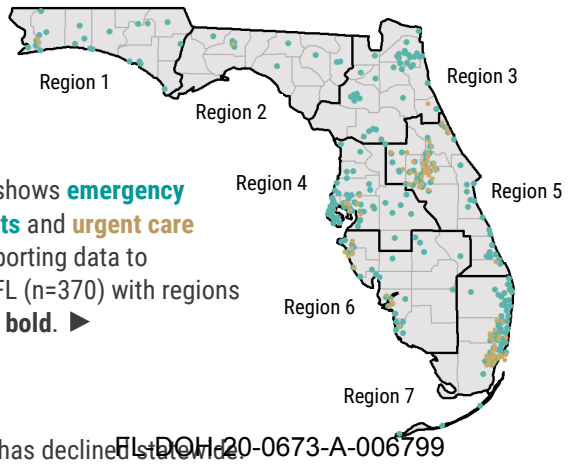


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined statewide.

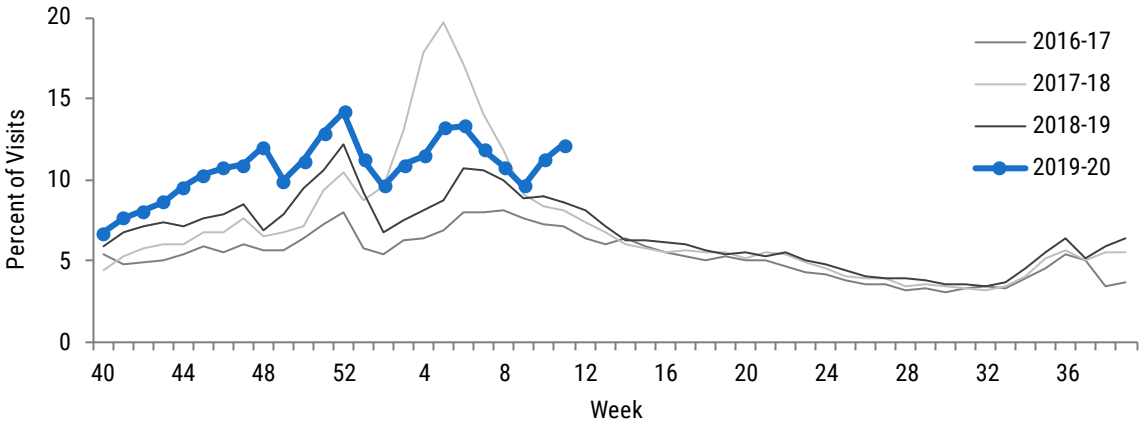
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

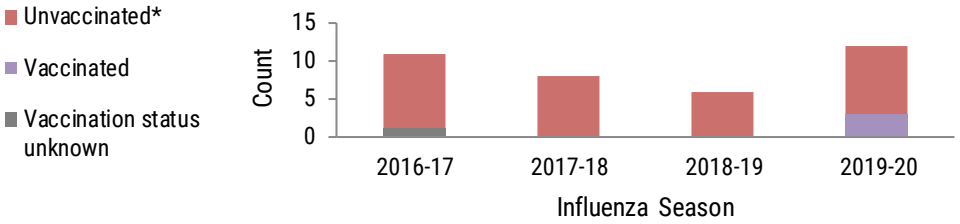
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 11, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak levels observed during the 2016-17 season. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.

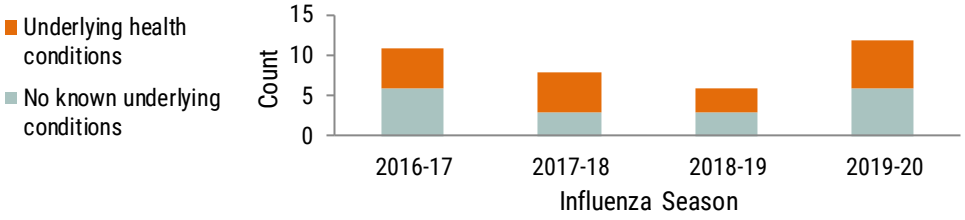


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

Figures 25-26: In week 11, **no new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 11, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 11, 2020.

In week 11, **no new influenza-associated pediatric deaths were reported**.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

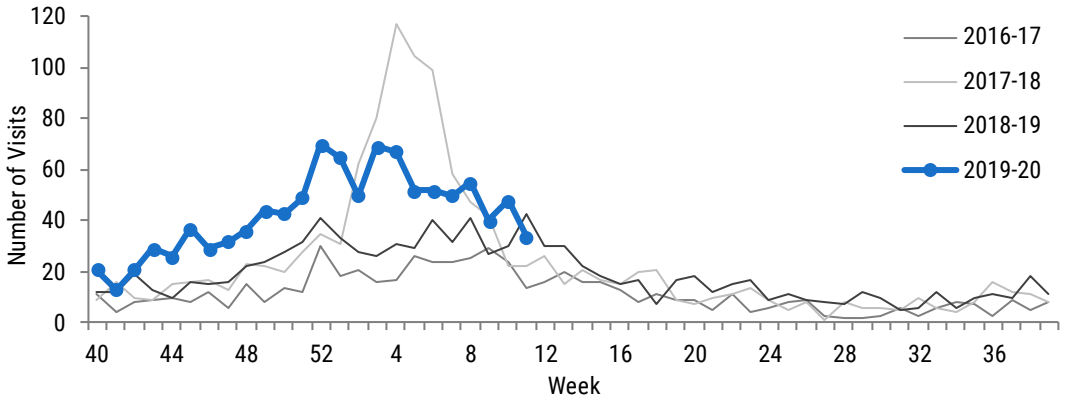
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 11, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



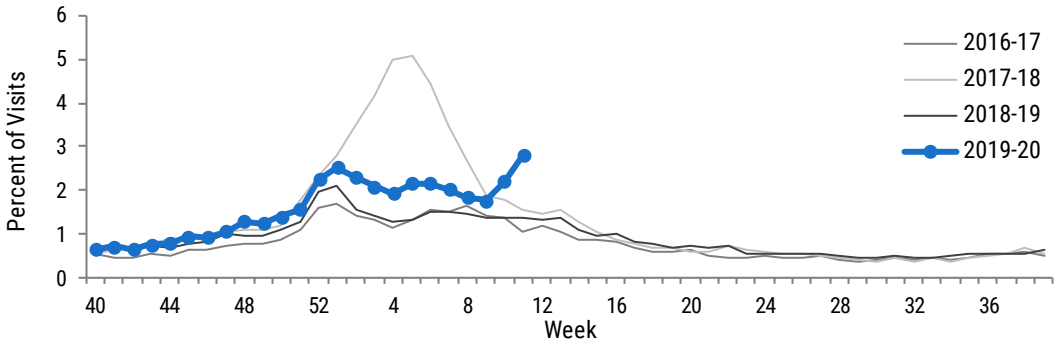
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 11, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 11, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak levels during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



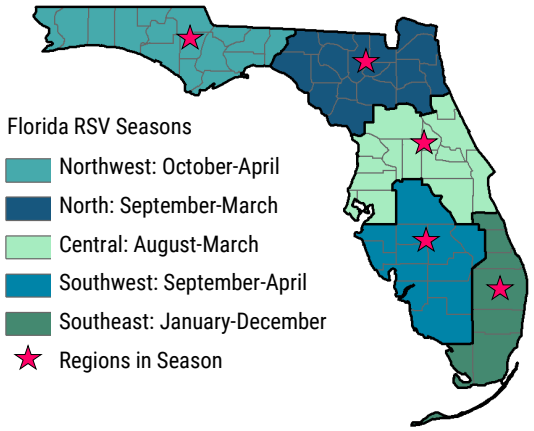
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

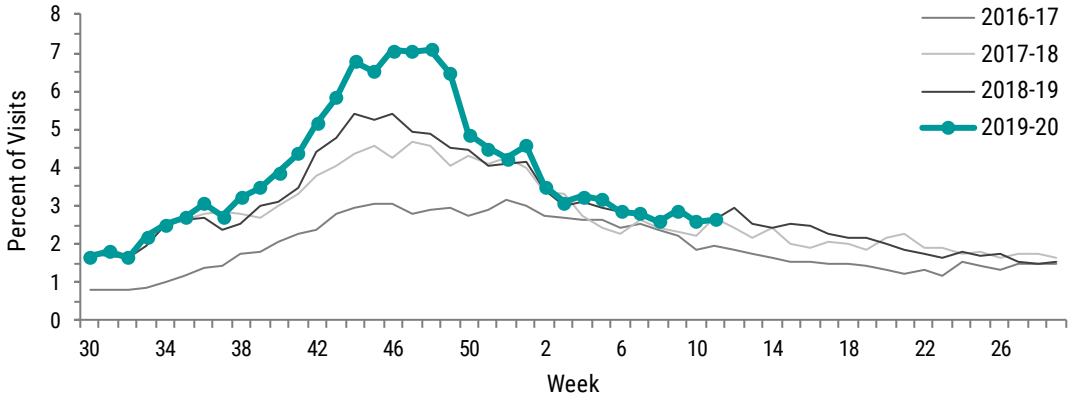
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 11 (February 23-29, 2020) Activity Summary

In week 11, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in week 11. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 11, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 11, 2020.

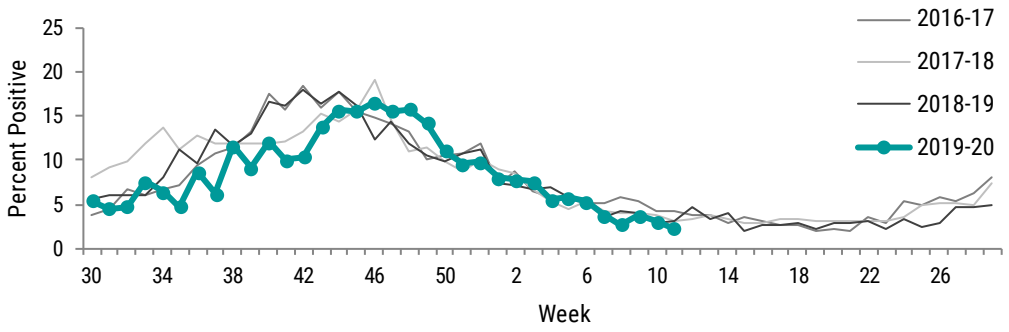
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 11, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 11, 2020. ▶



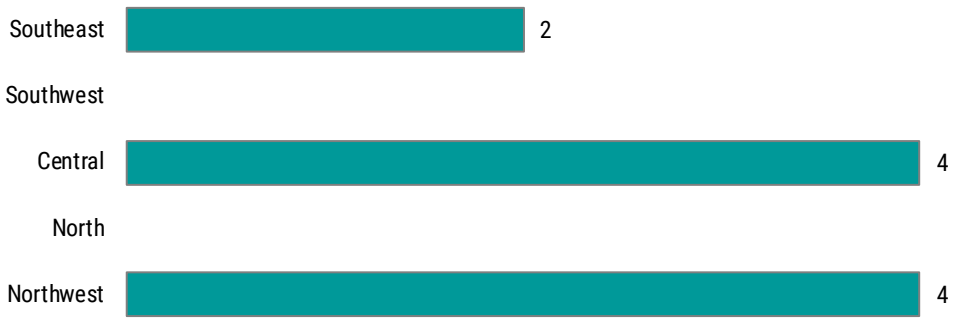
RSV-Associated Outbreaks in Week 11:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 11, one new RSV-associated outbreak was reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

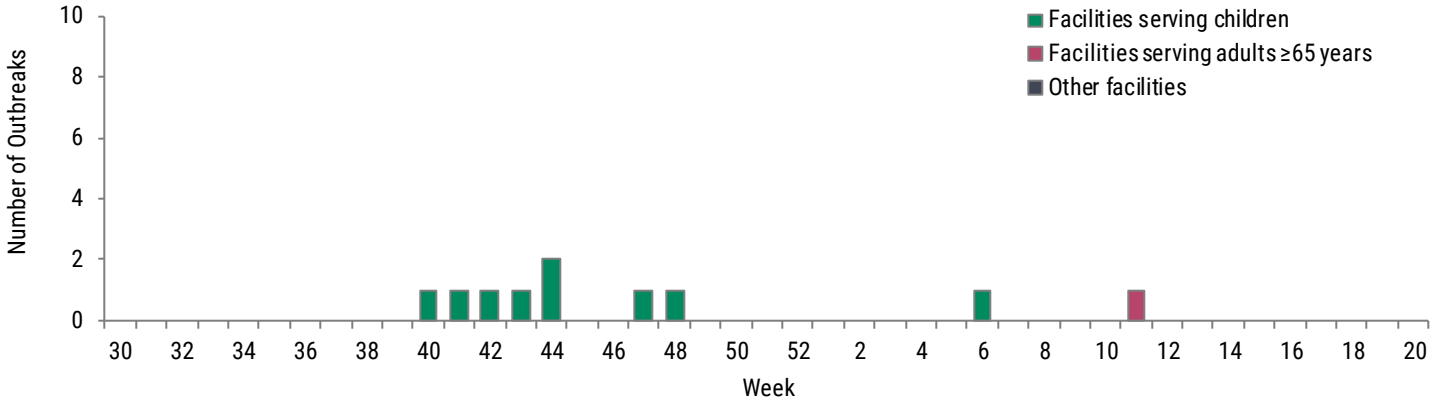
Figure 32: In week 11, one new RSV-associated outbreak was reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

*Regions defined in figure 29.

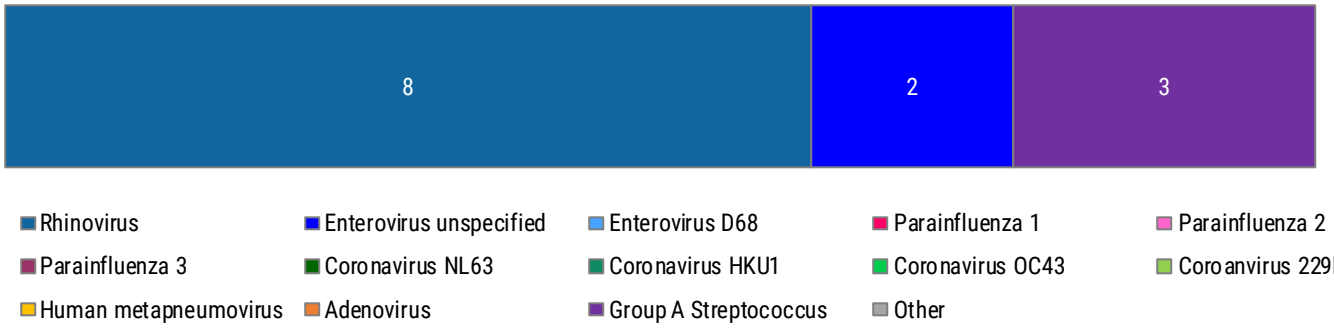
Figure 33: In week 11, one new RSV-associated outbreak was reported. This outbreak was reported in a **facility serving adults aged ≥65 years**. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**



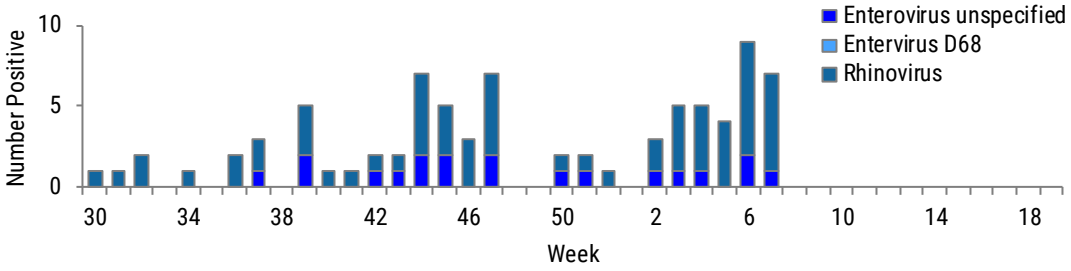
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

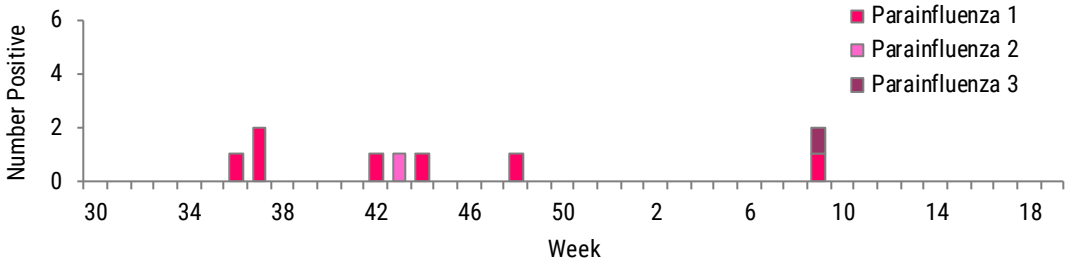


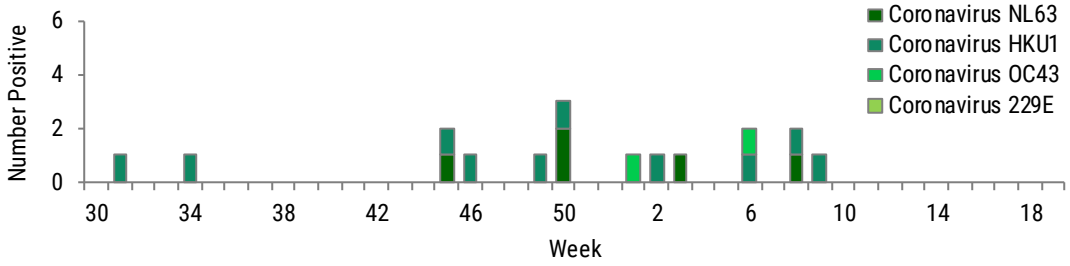
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 11, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

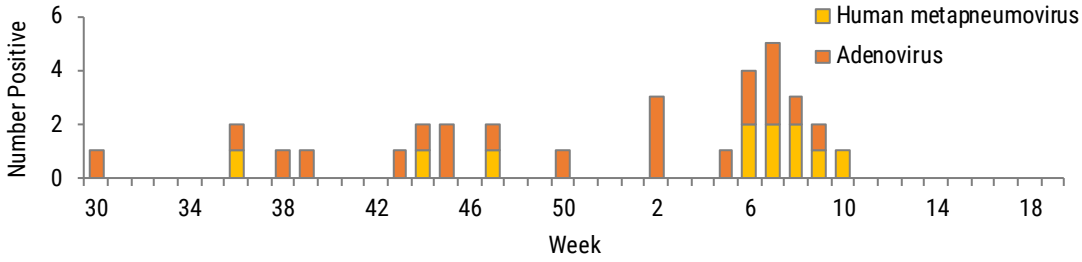
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 11, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 11, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
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Subject:	Week 11, 2020 Florida Flu Review
Date:	Wednesday, March 18, 2020 4:23:27 PM
Attachments:	Week 11, 2020 Florida Flu Review.pdf

Good afternoon!

Please find attached the week 11 Florida Flu Review.

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

For questions regarding COVID-19 in Florida please email COVID-19@FLHealth.gov or call 1-866-779-6121.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, one was influenza-associated and ten were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take

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everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Best,

Amy E. Bogucki, MPH
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Bureau of Epidemiology
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Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 11: 3/15/20-3/21/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 11 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

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Influenza A 2009 (H1N1) remained the predominant strain.

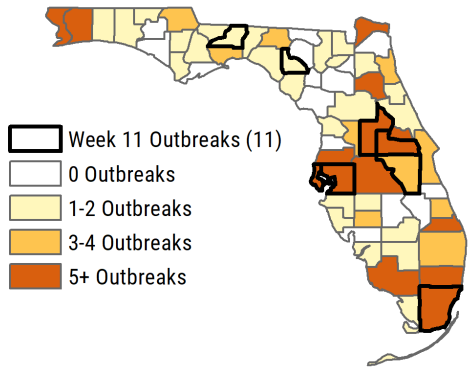
The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

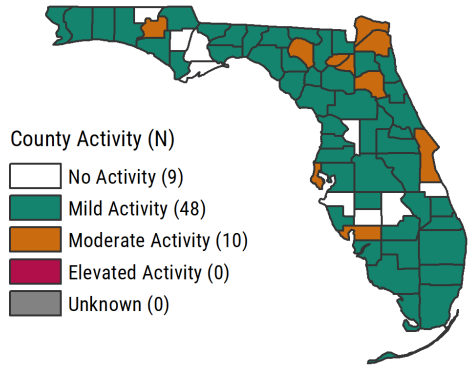
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit: VaccineFinder.org

Posted March 18, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.
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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

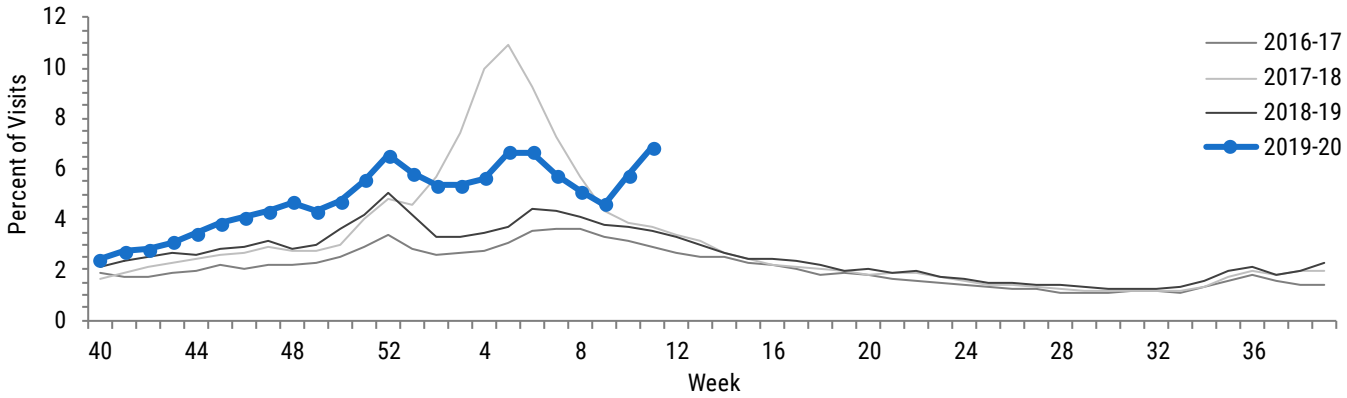
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 11, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 11, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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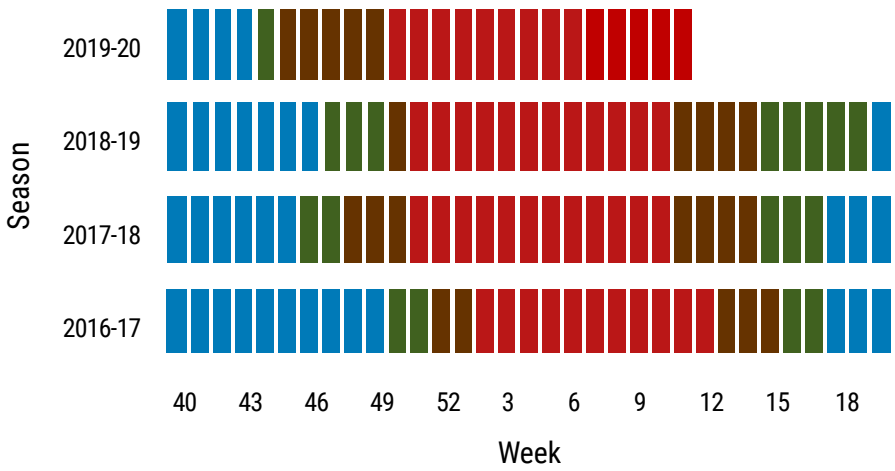
Statewide Activity

Figure 2: In week 11, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 11, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 11, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=4), week 40, 2016 to week 11, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

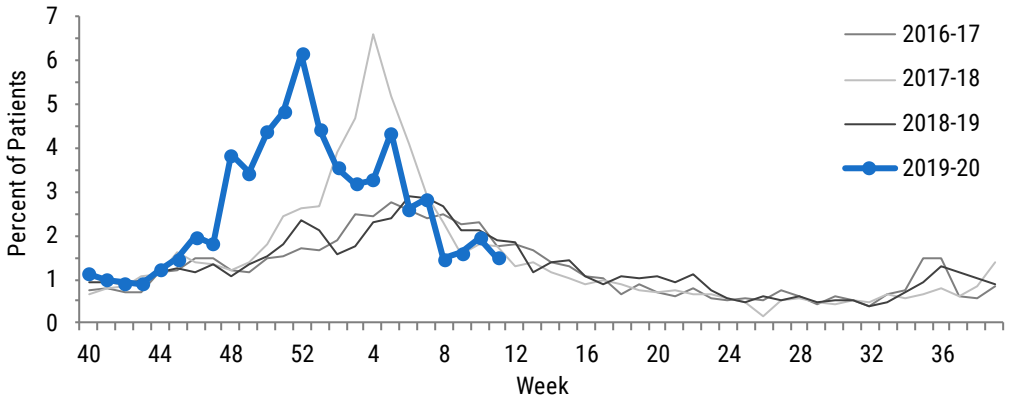
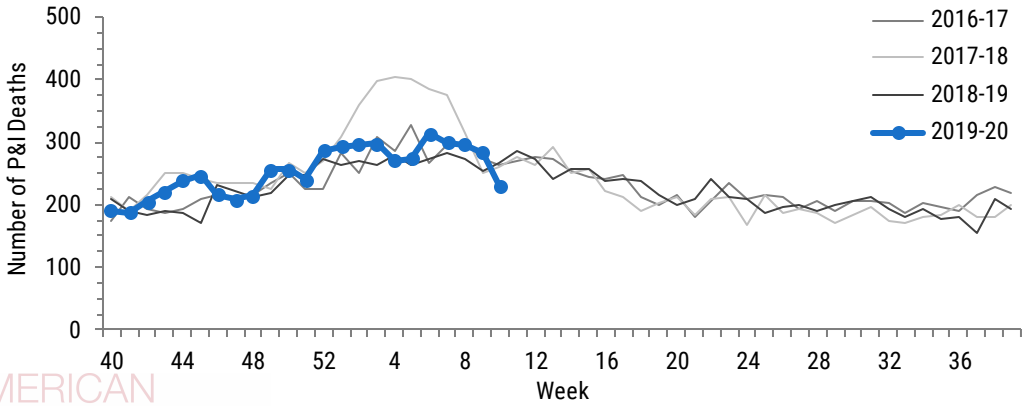


Figure 4: In week 10 (ending 3/7/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 11. Ten counties reported **moderate activity,** and no counties reported **elevated activity.**

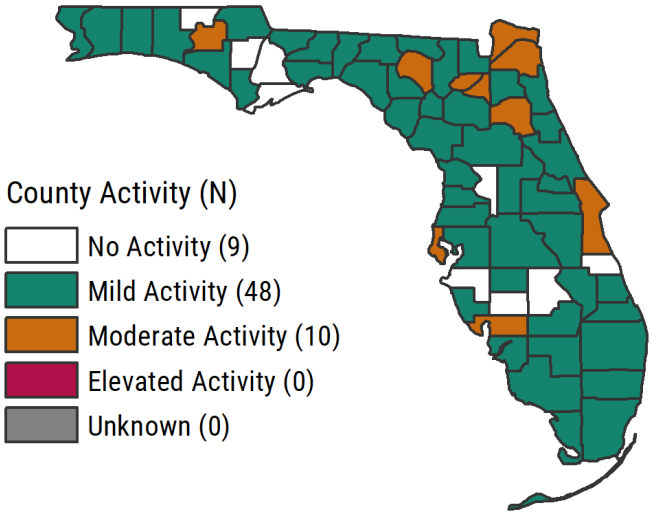
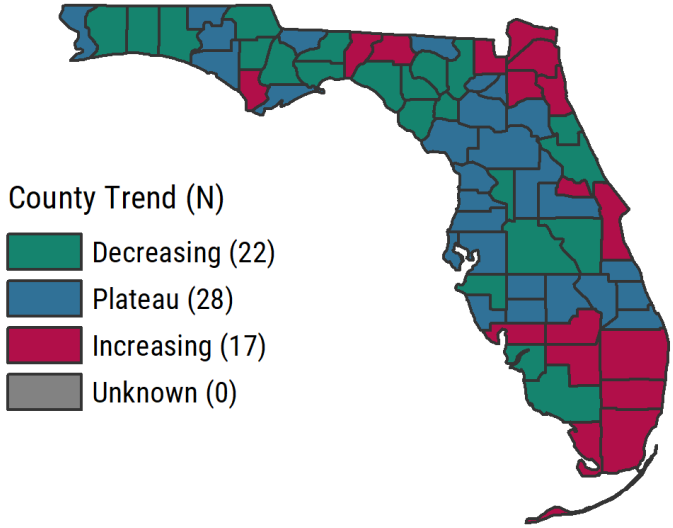
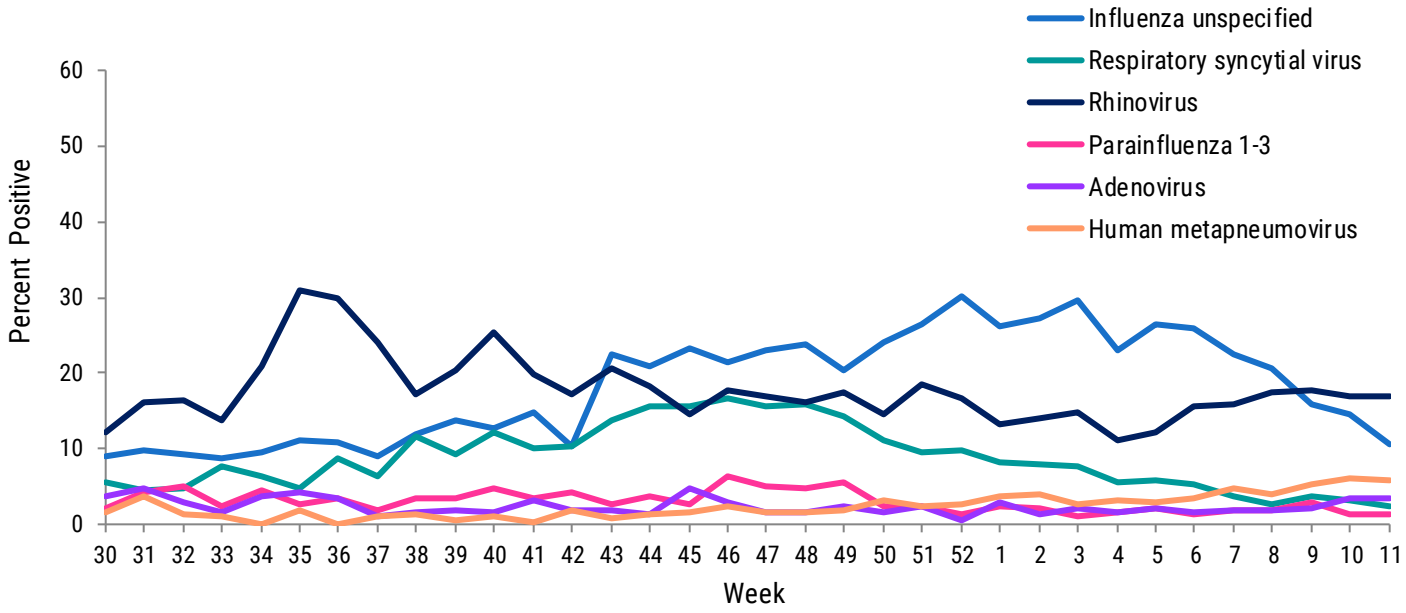


Figure 7: Most counties reported **activity at a plateau** for week 11. Seventeen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 11, the **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Week 11 Outbreaks at a Glance:

Number Reported:
11 Outbreaks

Influenza-Associated:
4 Outbreaks

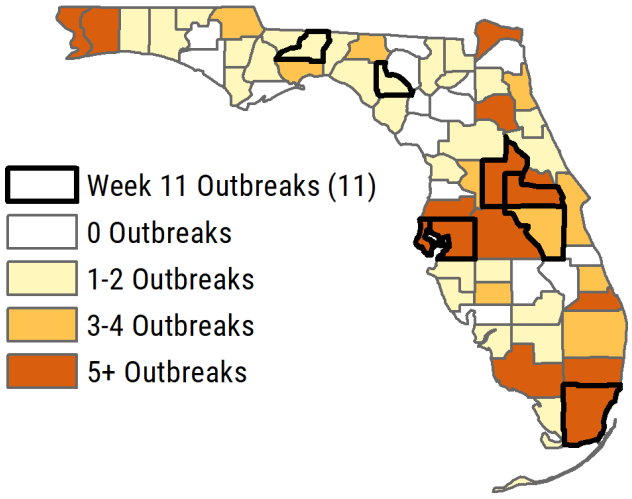
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 11, four influenza-associated and seven ILI outbreaks were reported, a slight increase from the previous week.

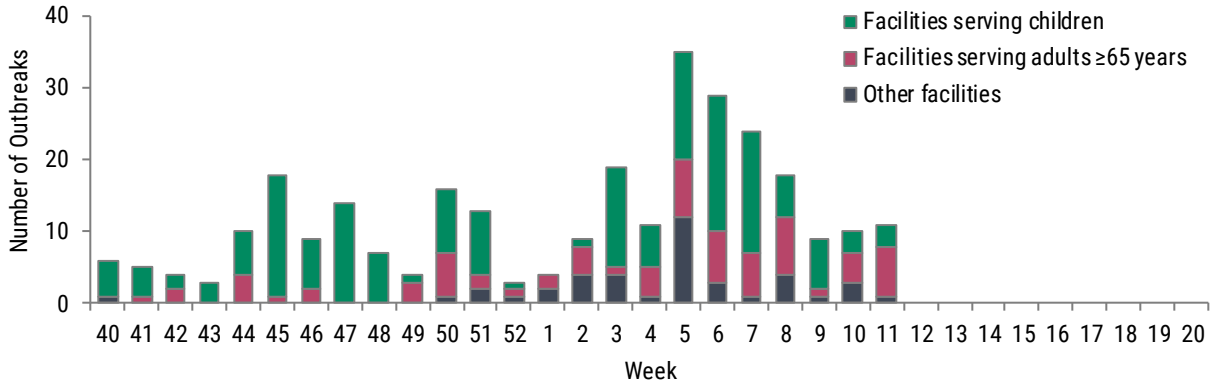
Severe outcomes* were reported in one of eleven outbreaks. One hospitalization and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



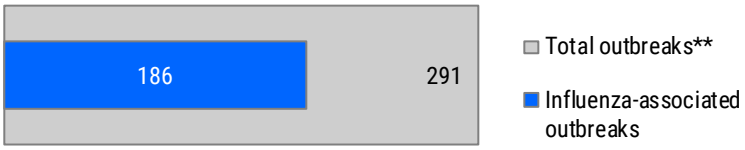
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 11 are **outlined in bold.**

Figure 9: In week 11, **seven outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 11, **63.9% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 11, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

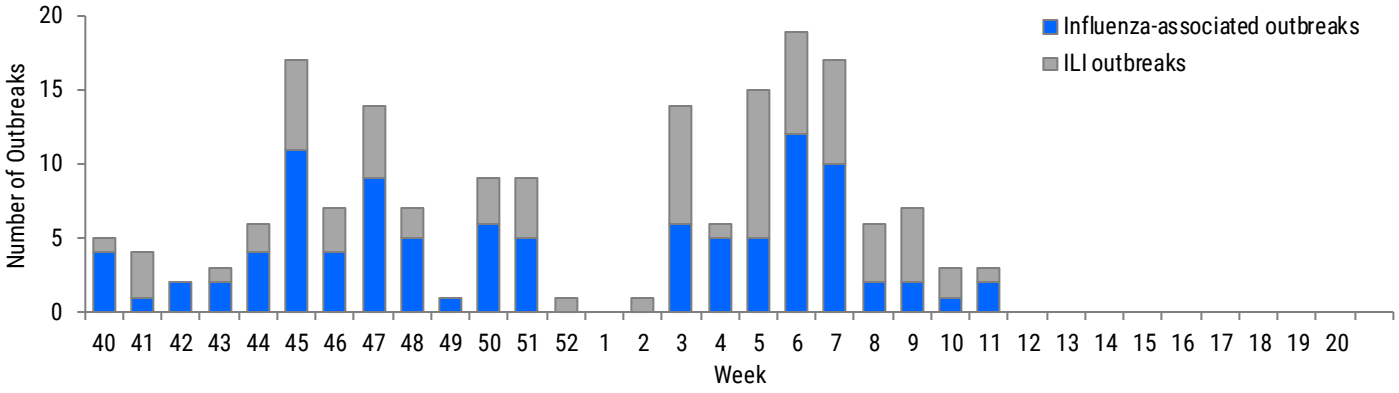
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 11, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 11, **two influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Facilities Serving Adults ≥65 yrs.**:

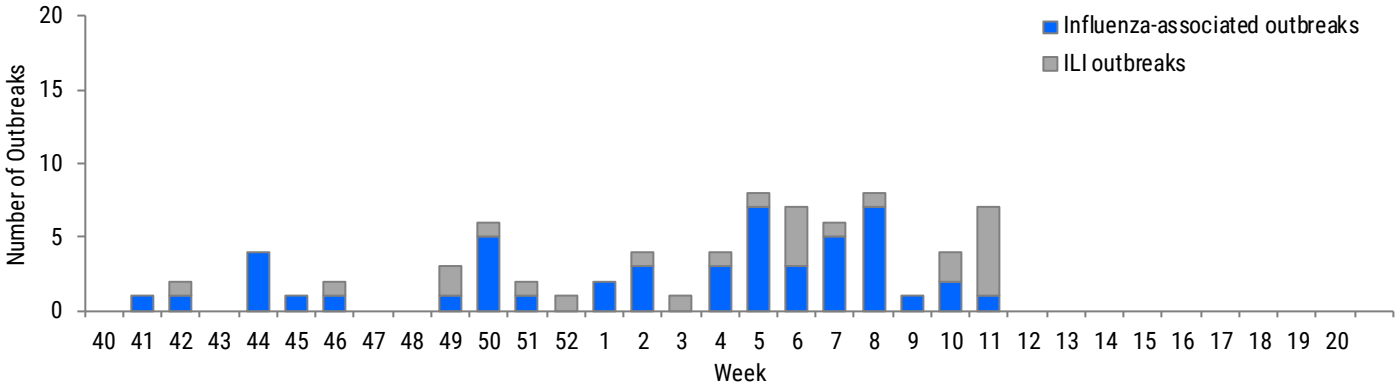
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 11, seven new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 11, **six ILI outbreaks** and **one influenza-associated outbreak** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

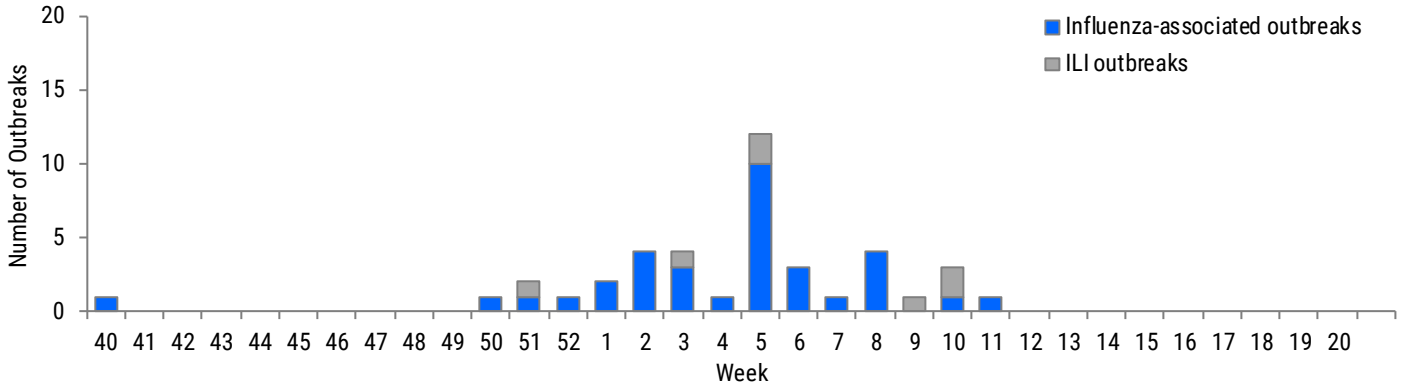
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 11, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 11, **one influenza-associated outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	136 (46.7%)	83 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (13.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	23 (7.9%)	10 influenza-associated outbreaks 13 ILI outbreaks
Nursing facilities	18 (6.2%)	14 influenza-associated outbreaks 4 ILI outbreaks
Other long-term care facilities	33 (11.3%)	26 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.3%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**291 (100.0%)**	**186 influenza-associated outbreaks** **105 ILI outbreaks**

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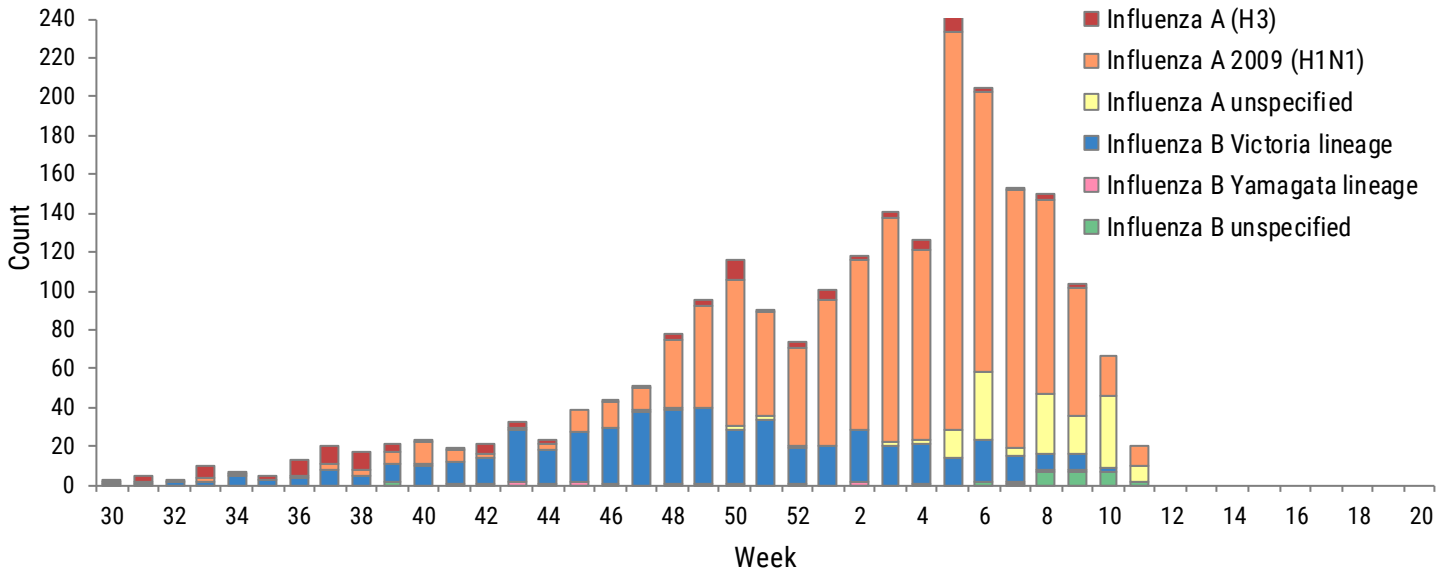
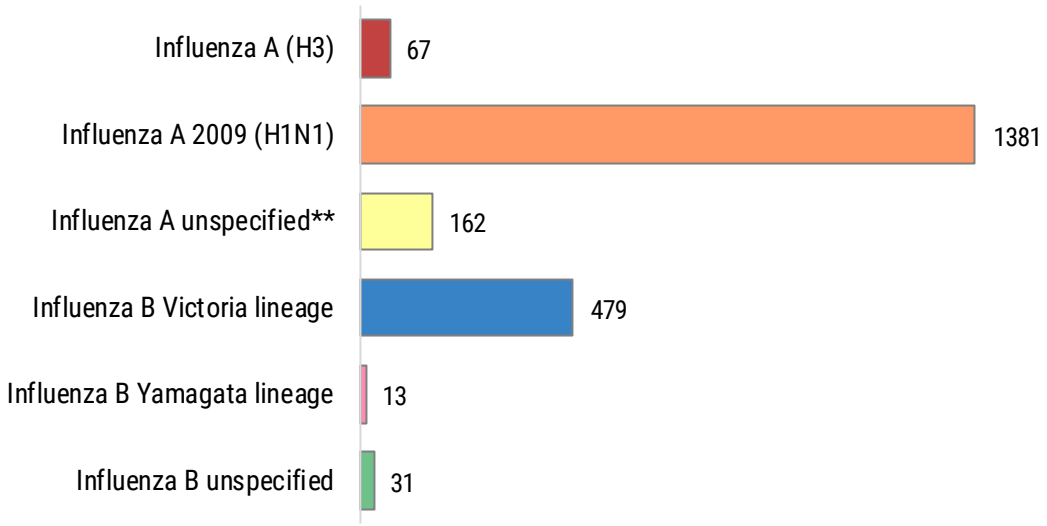
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 11, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 11, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 11, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*

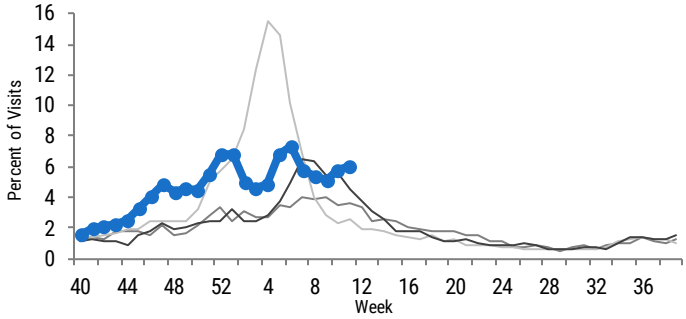


Figure 17: In **region 2, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

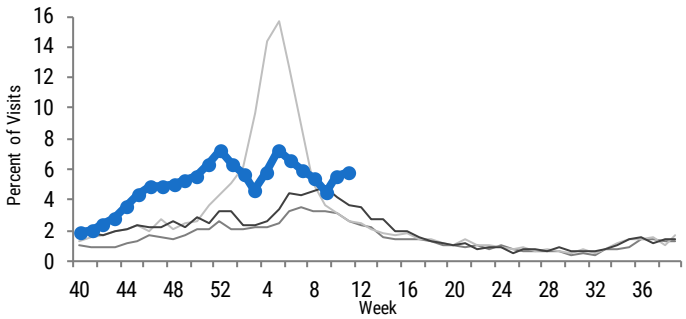


Figure 18: In **region 3, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

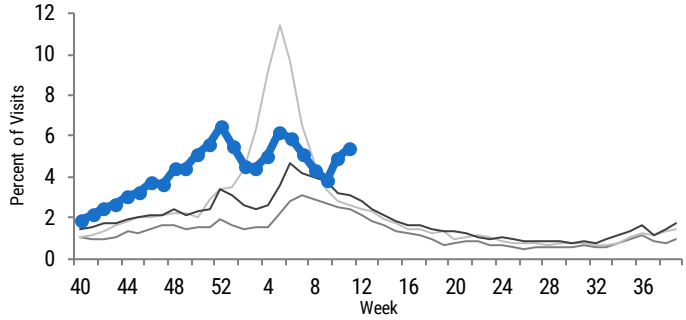


Figure 19: In **region 4, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

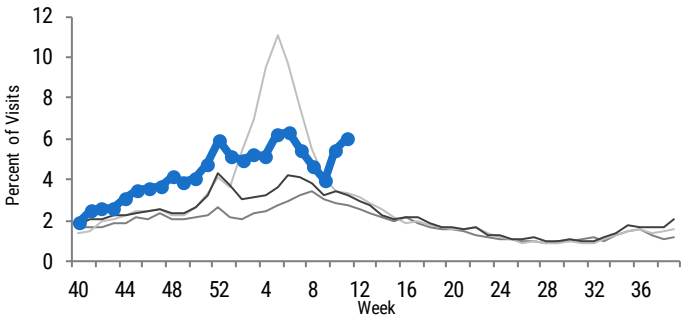


Figure 20: In **region 5, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

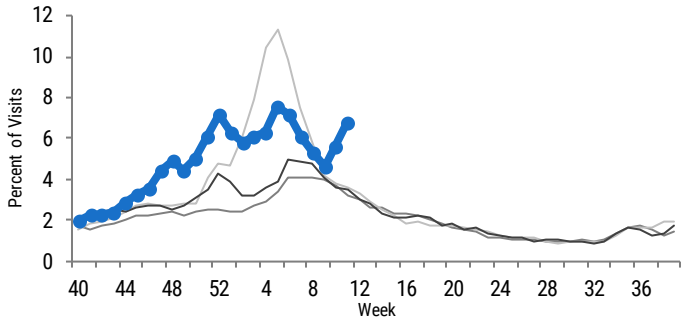


Figure 21: In **region 6, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

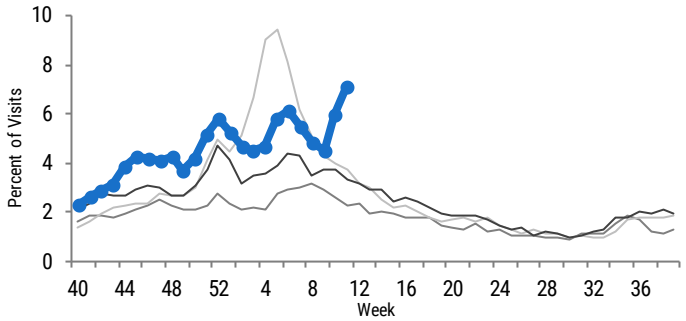
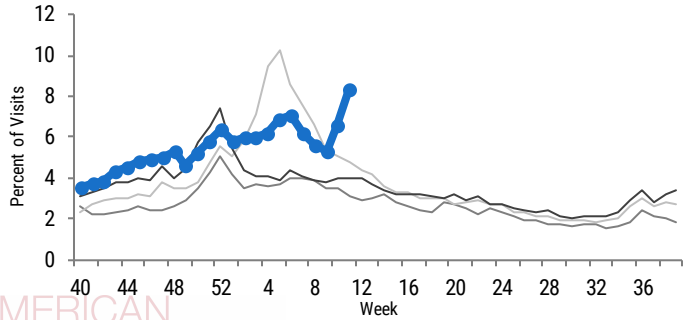


Figure 22: In **region 7, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*



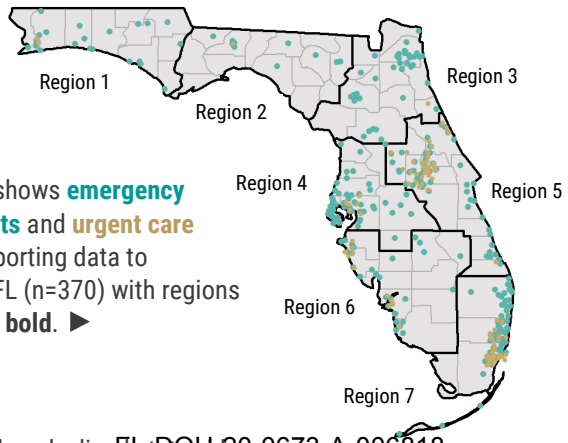


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined statewide.

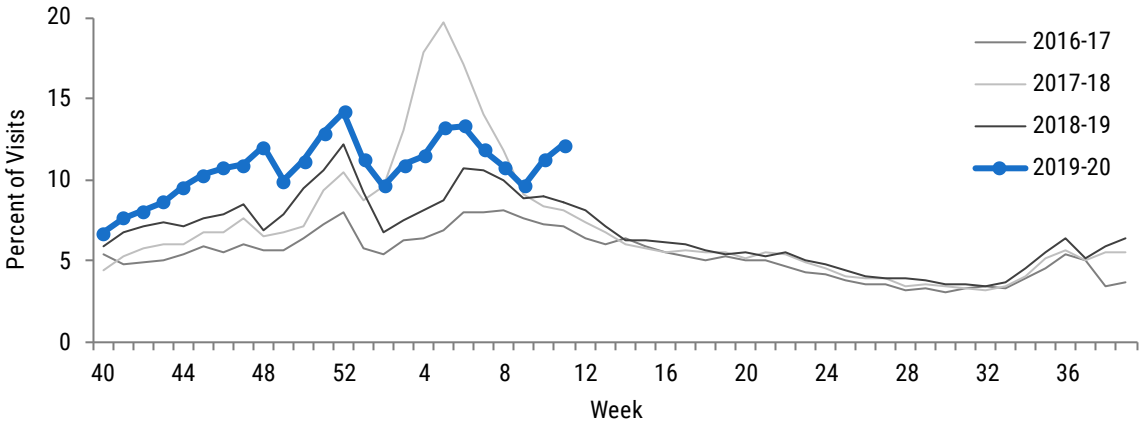
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

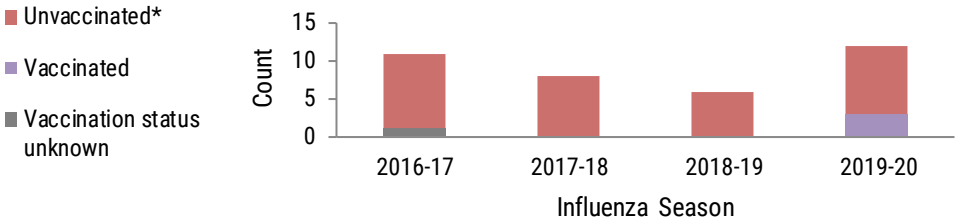
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 11, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak levels observed during the 2016-17 season. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.

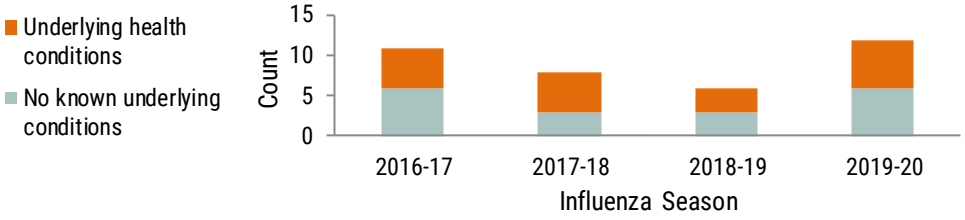


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

Figures 25-26: In week 11, **no new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 11, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 11, 2020.

In week 11, **no new influenza-associated pediatric deaths were reported**.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

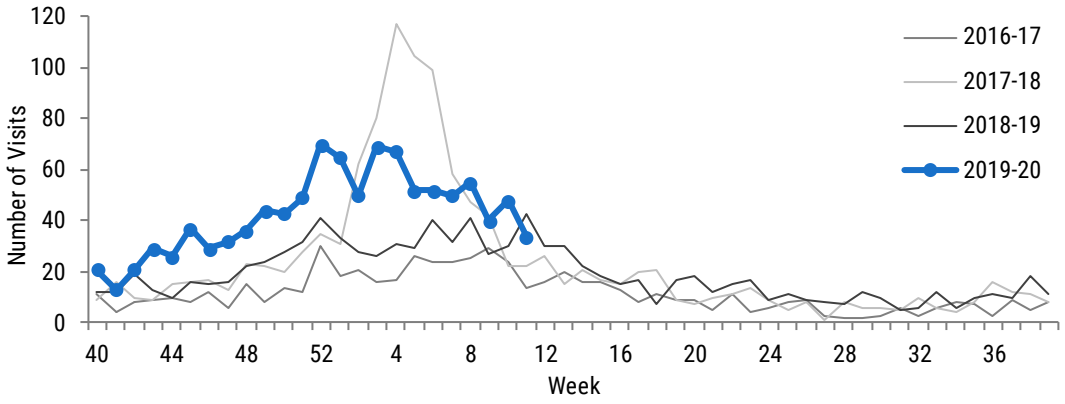
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 11, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



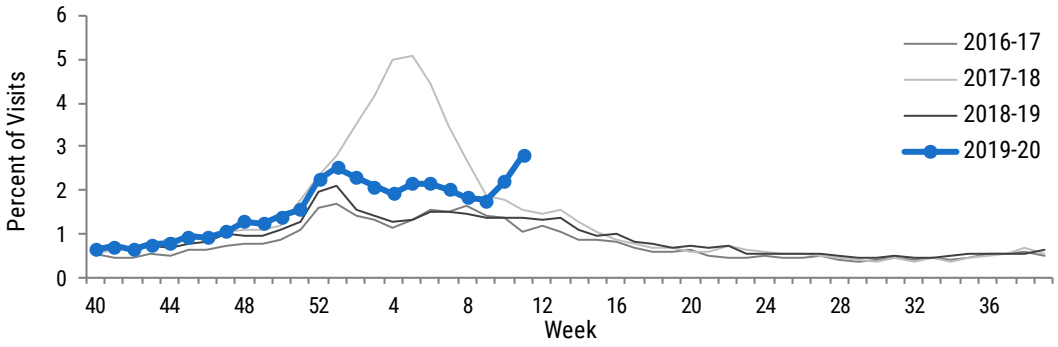
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 11, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 11, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak levels during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

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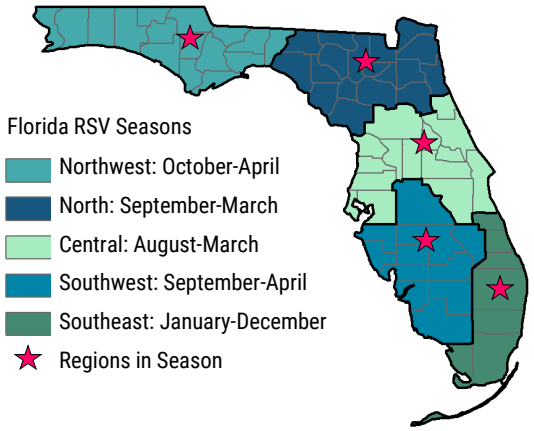
Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

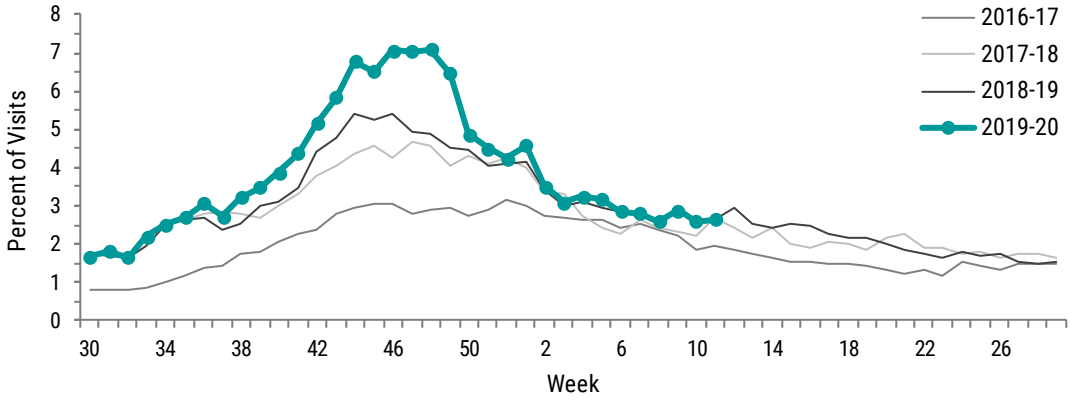
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 11 (February 23-29, 2020) Activity Summary

In week 11, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in week 11. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 11, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 11, 2020.

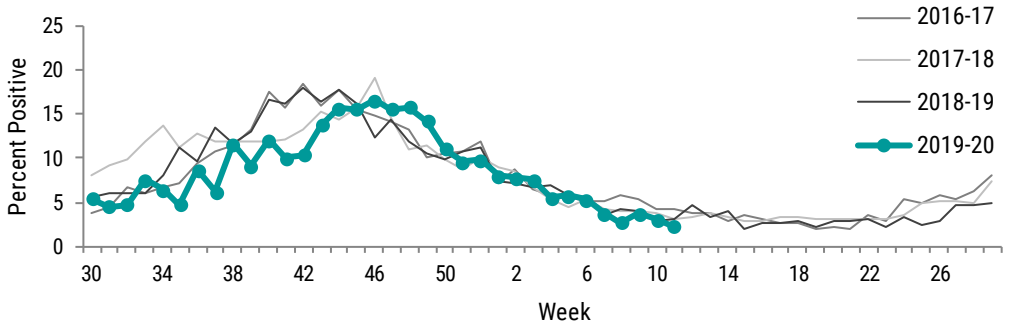
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 11, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 11, 2020. ▶



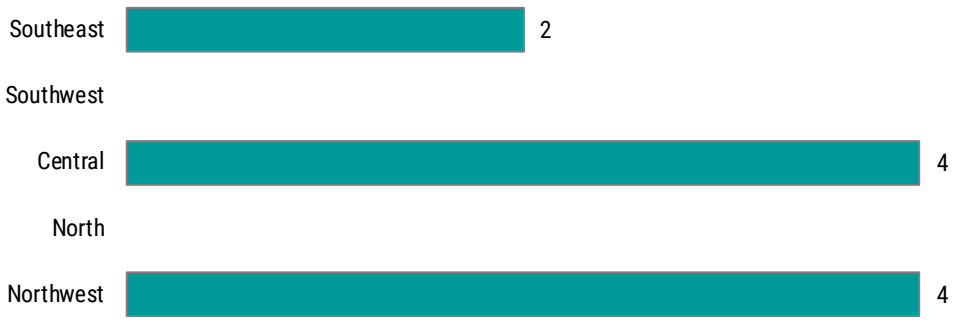
RSV-Associated Outbreaks in Week 11:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 11, one new RSV-associated outbreak was reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

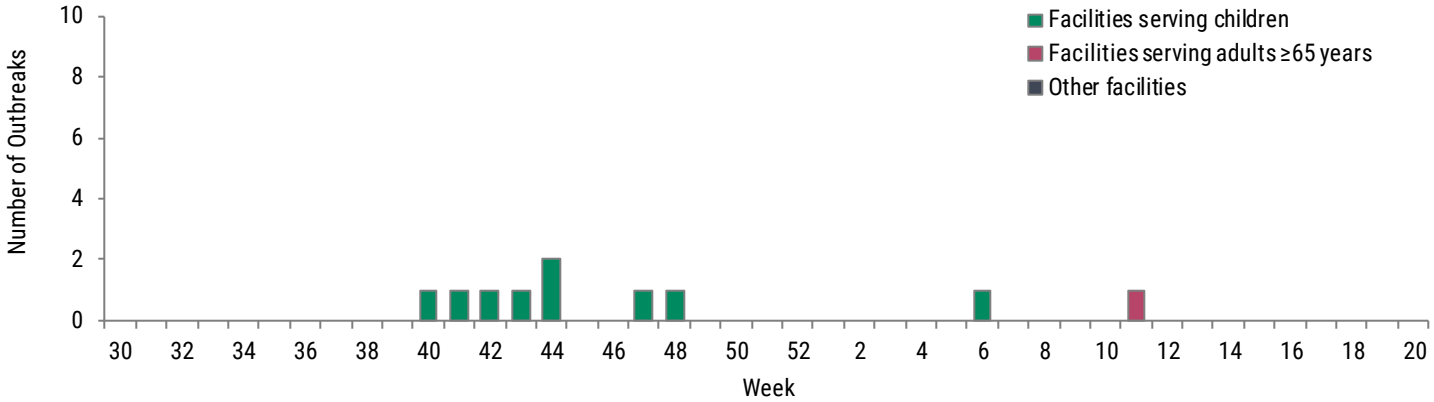
Figure 32: In week 11, one new RSV-associated outbreak was reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

*Regions defined in figure 29.

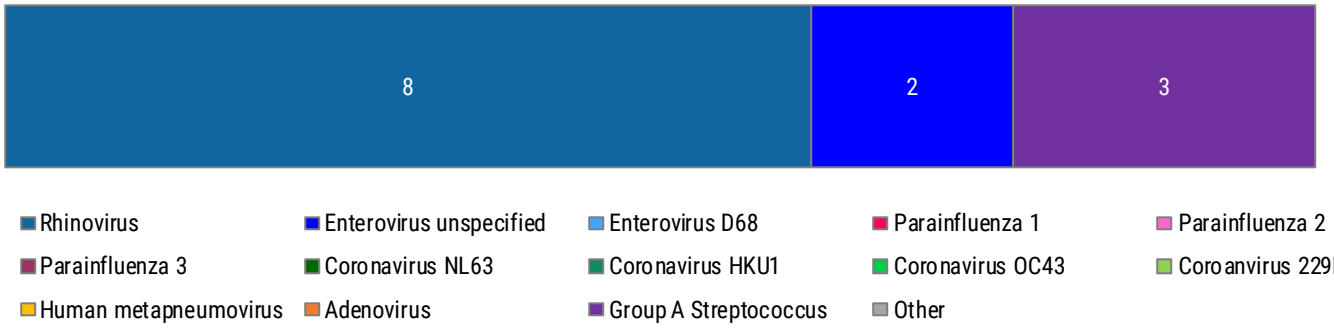
Figure 33: In week 11, one new RSV-associated outbreak was reported. This outbreak was reported in a **facility serving adults aged ≥65 years**. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**



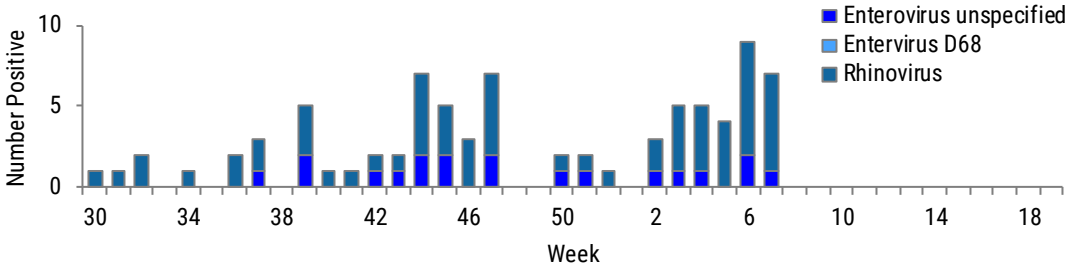
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

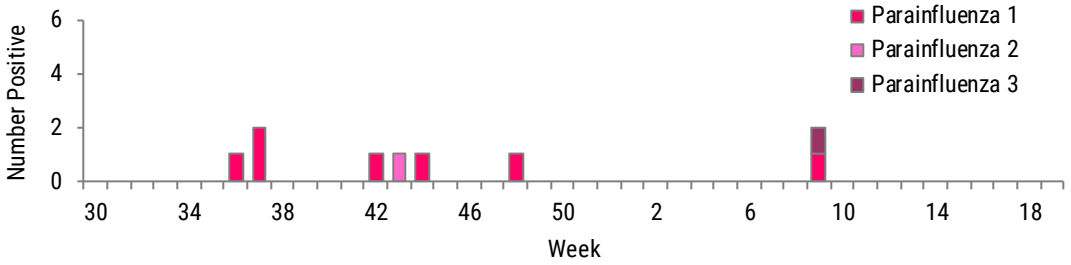


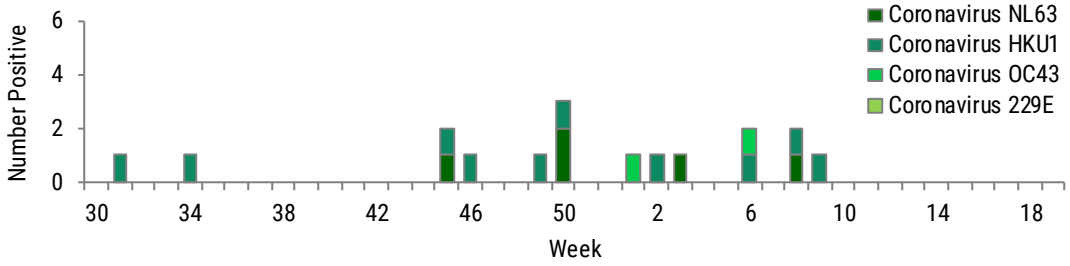
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 11, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

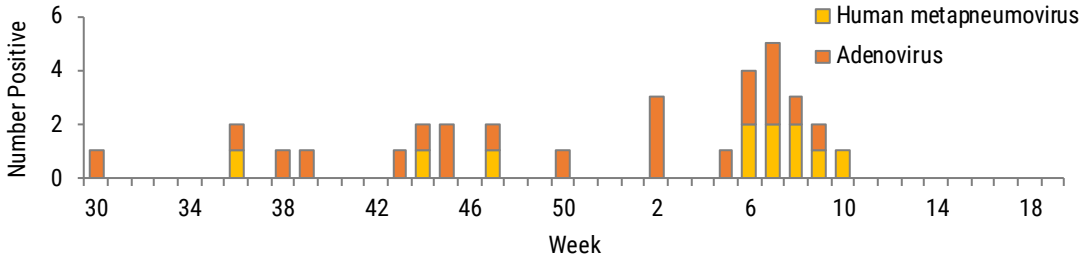
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 11, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 11, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 11, 2020 Florida Flu Review
Date:	Wednesday, March 18, 2020 4:23:20 PM
Attachments:	Week 11, 2020 Florida Flu Review.pdf

Good afternoon!

Please find attached the week 11 Florida Flu Review.

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

For questions regarding COVID-19 in Florida please email COVID-19@FLHealth.gov or call 1-866-779-6121.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, one was influenza-associated and ten were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take

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everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Best,

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Division of Disease Control and Health Protection
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Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 11: 3/15/20-3/21/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 11 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza in sentinel laboratories decreased steadily over the last three weeks. Despite this decrease in laboratory-confirmed influenza activity, the percentage of visits for ILI increased notably during those same three weeks.

Recent trends in ILI activity may be a data artifact driven by an increase in the number of people seeking care for respiratory illness in response to concerns about coronavirus disease 2019 (COVID-19). It is also possible that these data represent a true increase in ILI activity statewide. The data displayed in this report are intended to track influenza activity in Florida. For information about COVID-19 in Florida, please visit: FloridaHealth.gov/diseases-and-conditions/COVID-19/.

Eleven outbreaks were reported, up from ten outbreaks in the previous week. Of the eleven outbreaks reported, four were influenza-associated and seven were ILI.

No new influenza-associated pediatric deaths were reported. Twelve influenza-associated pediatric deaths have been reported so far this season; 75% of children were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

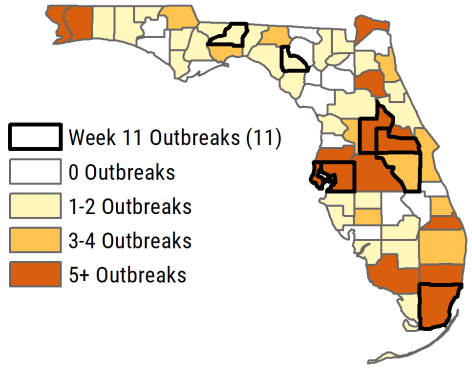
The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

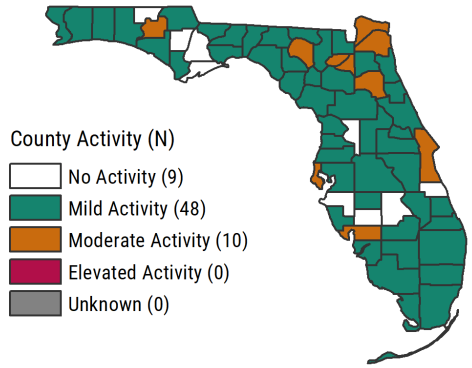
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit: VaccineFinder.org

Posted March 18, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.

AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

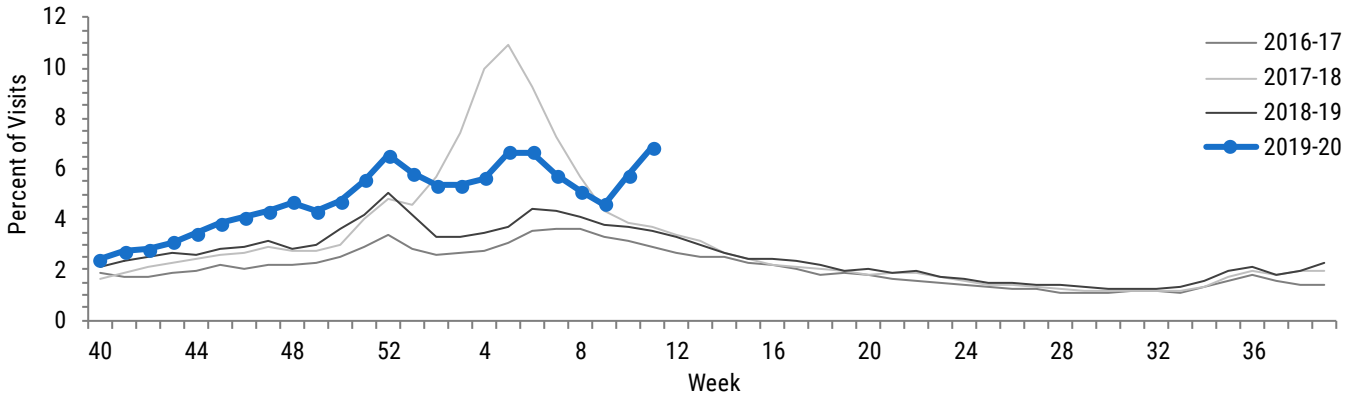
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 11, **the percent of emergency department and urgent care center visits for ILI statewide increased** and was above peak levels observed during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 11, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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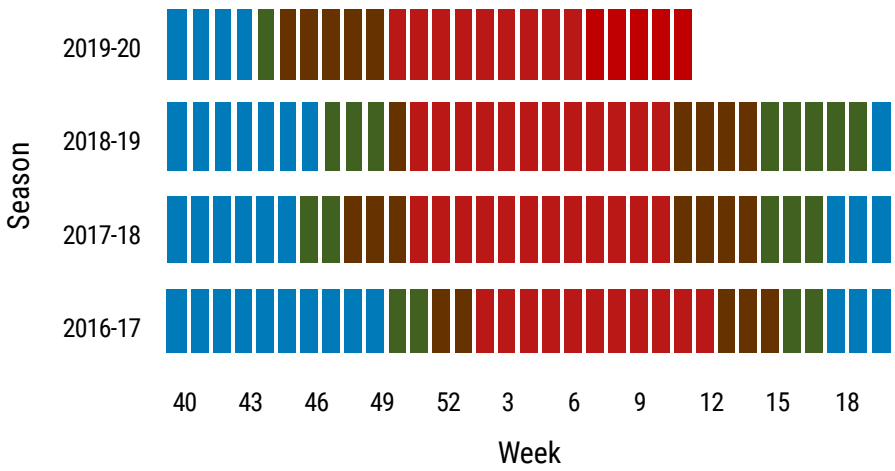
Statewide Activity

Figure 2: In week 11, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 11, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 11, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=4), week 40, 2016 to week 11, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

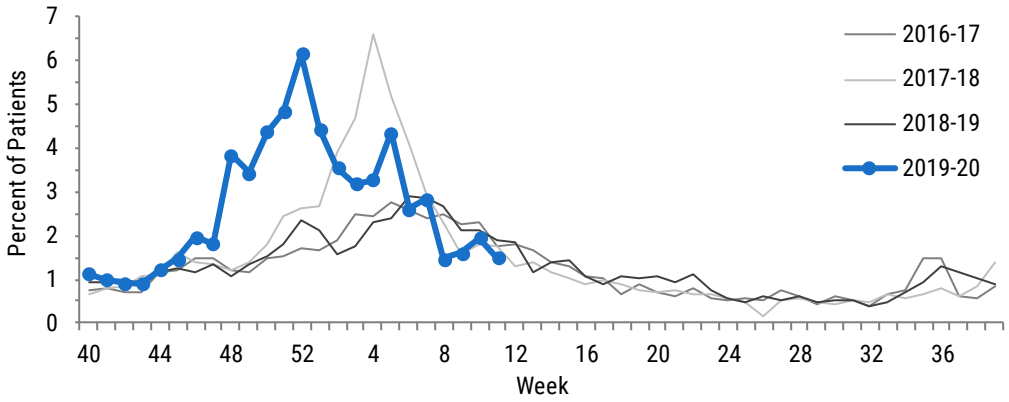
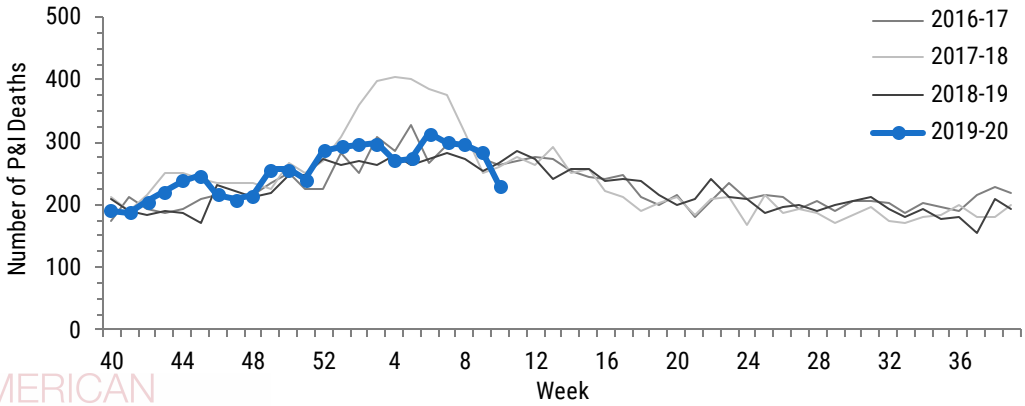


Figure 4: In week 10 (ending 3/7/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 10, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 11. Ten counties reported **moderate activity,** and no counties reported **elevated activity.**

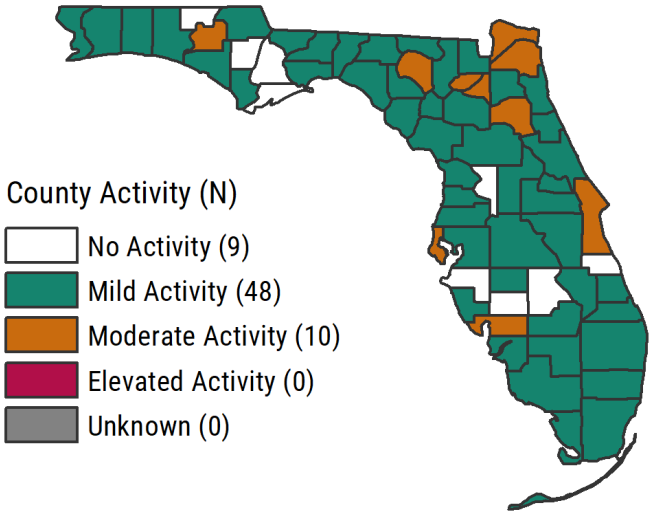
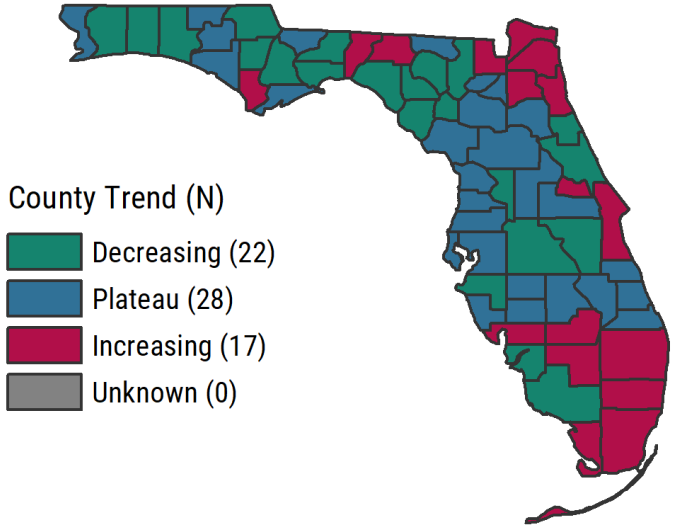
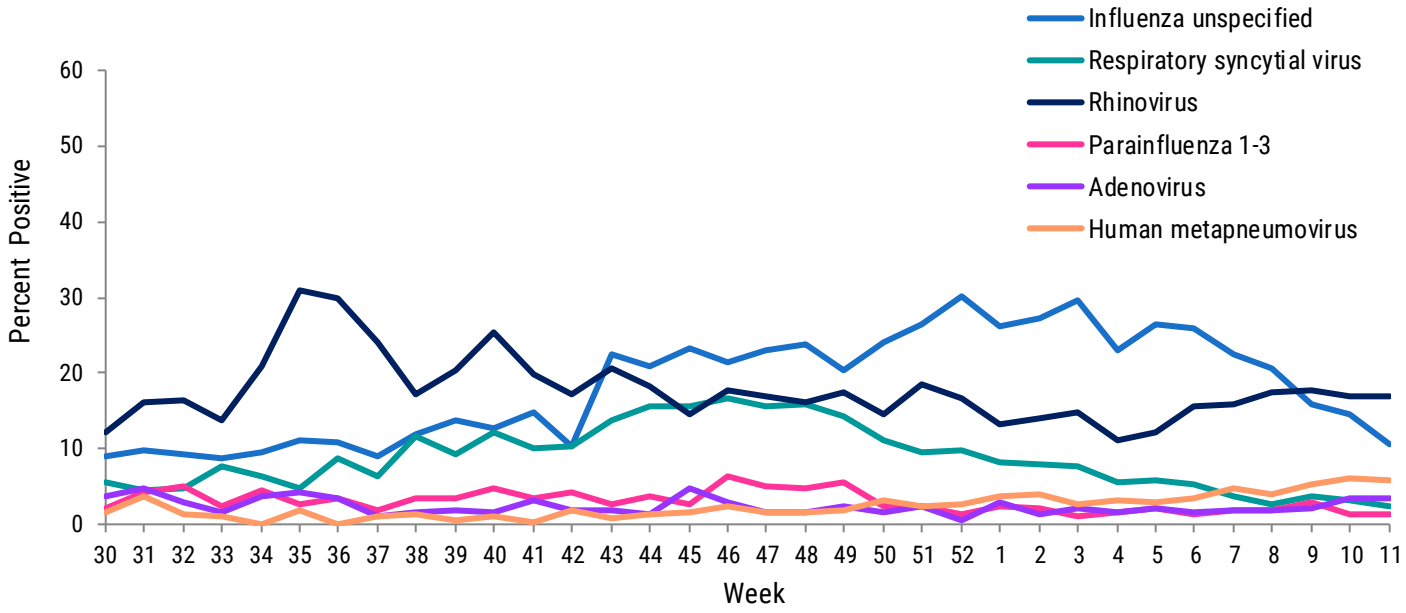


Figure 7: Most counties reported **activity at a plateau** for week 11. Seventeen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. In week 11, the **percent of specimens testing positive for rhinovirus** was higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Week 11 Outbreaks at a Glance:

Number Reported:
11 Outbreaks

Influenza-Associated:
4 Outbreaks

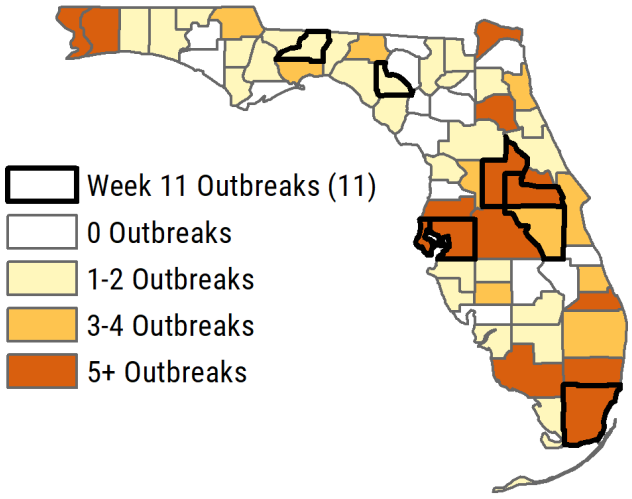
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 11, four influenza-associated and seven ILI outbreaks were reported, a slight increase from the previous week.

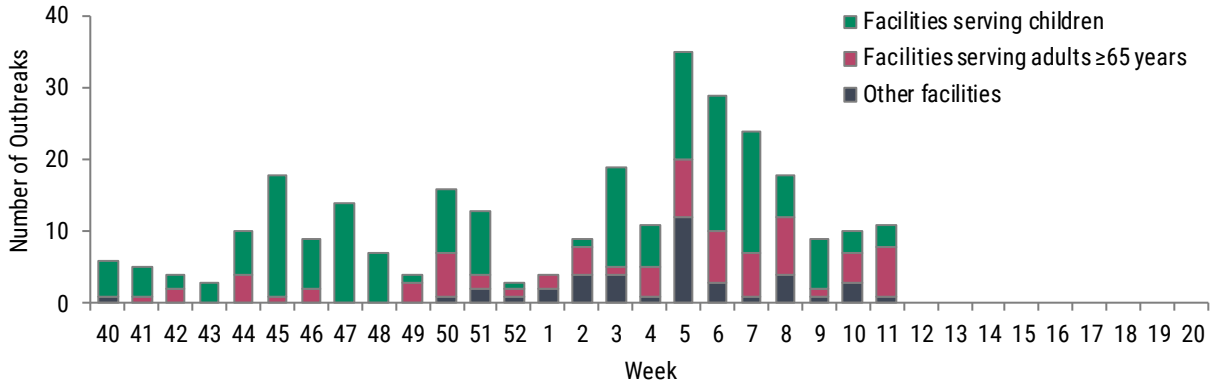
Severe outcomes* were reported in one of eleven outbreaks. One hospitalization and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities).



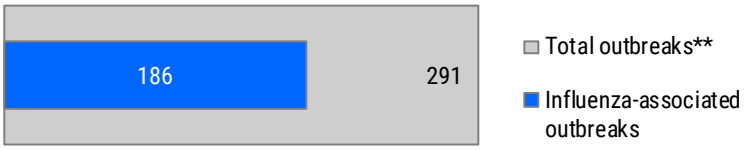
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 11 are **outlined in bold.**

Figure 9: In week 11, **seven outbreaks** were reported among **facilities serving adults aged ≥65 years, three outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 11, **63.9% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 11, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

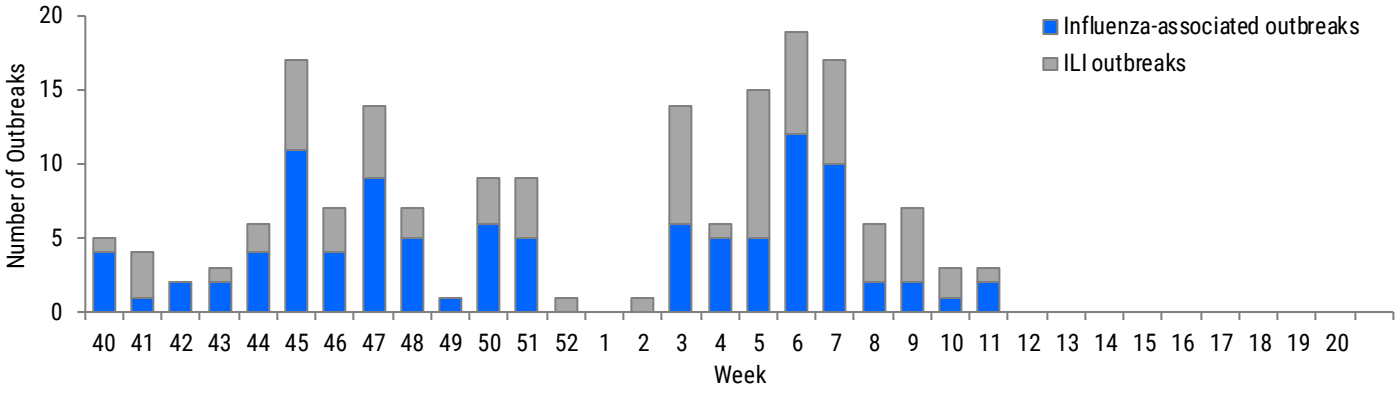
3 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 11, three new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 11, **two influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Facilities Serving Adults ≥65 yrs.**:

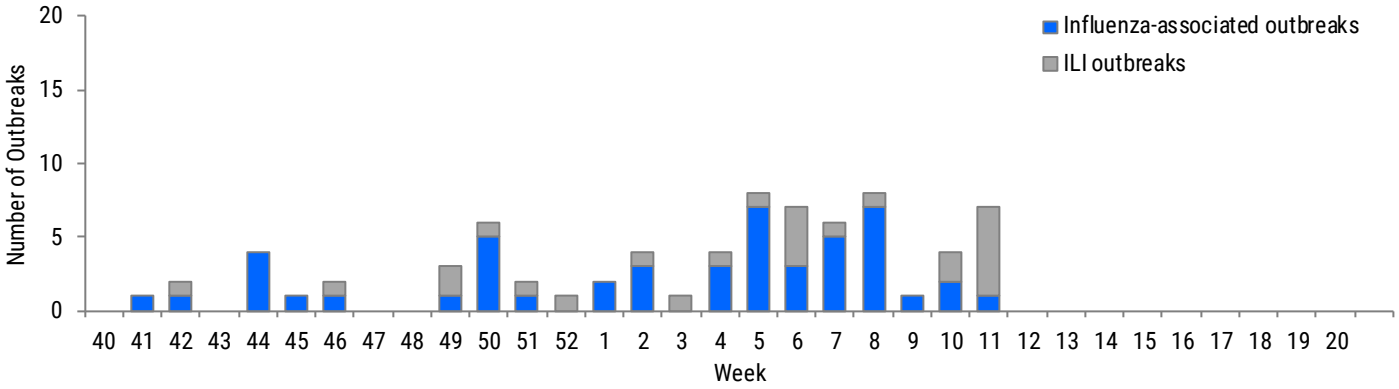
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 11, seven new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 11, **six ILI outbreaks** and **one influenza-associated outbreak** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

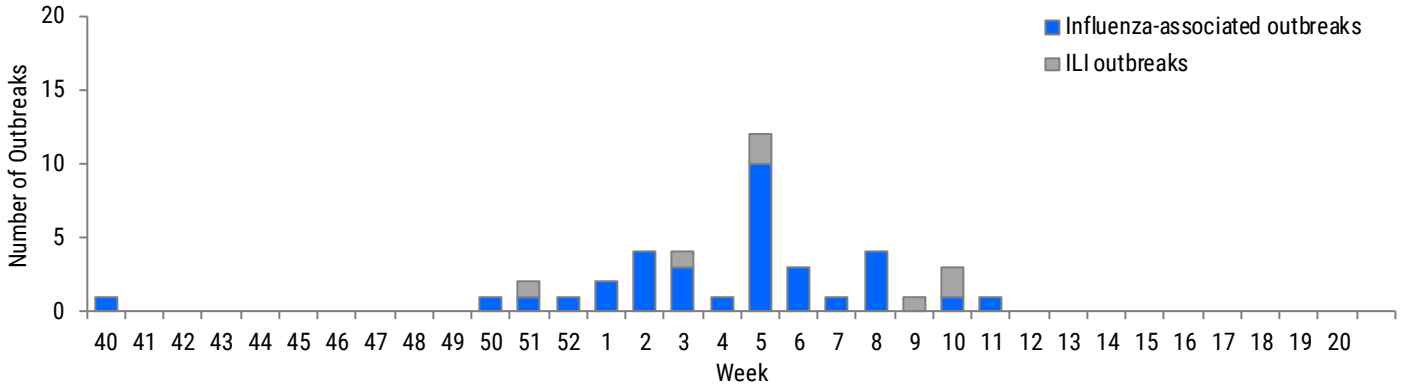
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 11, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 11, **one influenza-associated outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 11, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	136 (46.7%)	83 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	40 (13.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	23 (7.9%)	10 influenza-associated outbreaks 13 ILI outbreaks
Nursing facilities	18 (6.2%)	14 influenza-associated outbreaks 4 ILI outbreaks
Other long-term care facilities	33 (11.3%)	26 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.3%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**291 (100.0%)**	**186 influenza-associated outbreaks** **105 ILI outbreaks**

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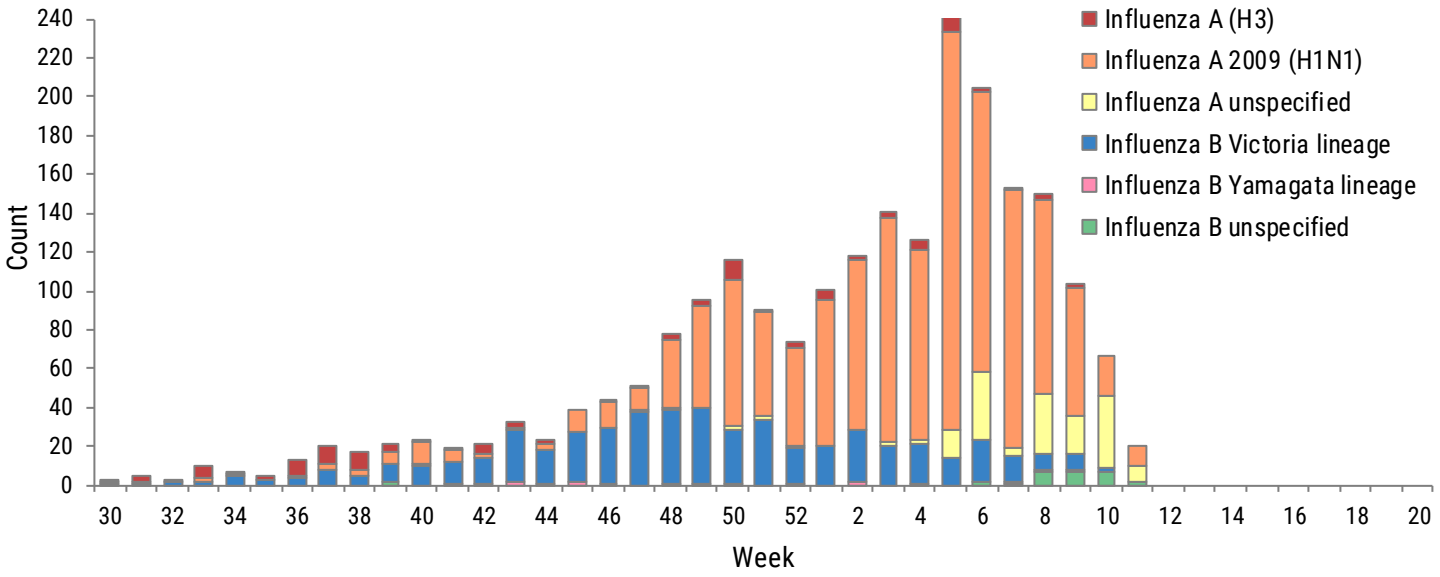
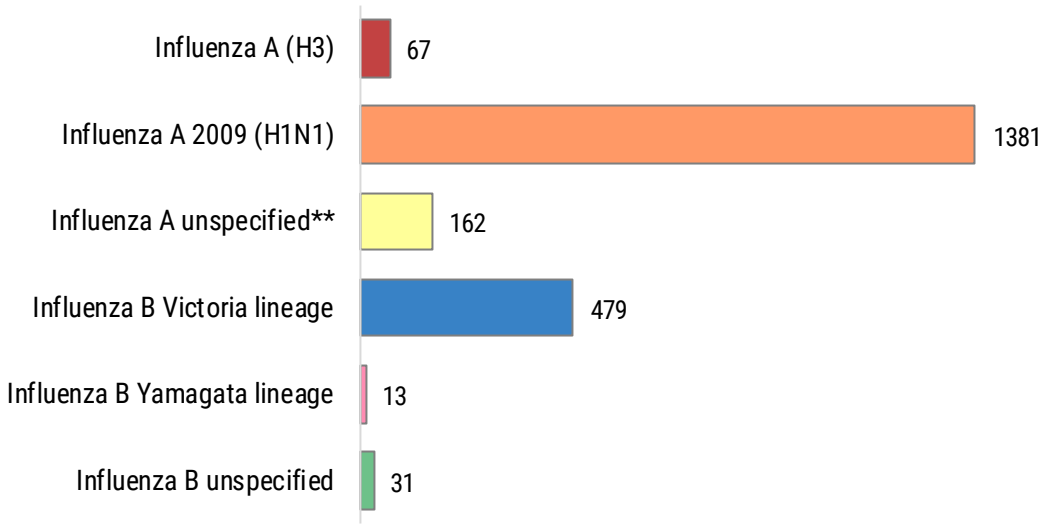
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 11, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 11, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 11, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*

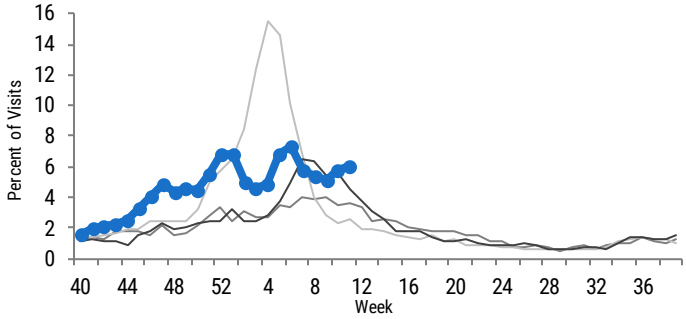


Figure 17: In **region 2, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

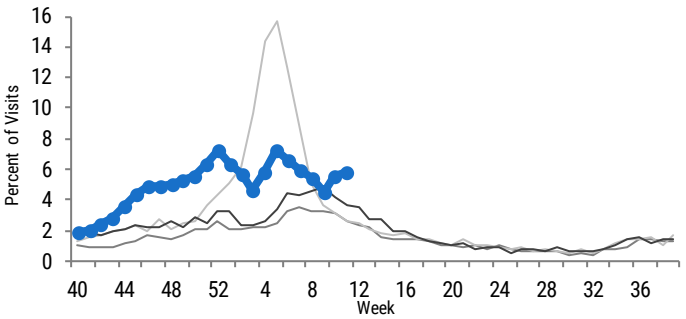


Figure 18: In **region 3, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

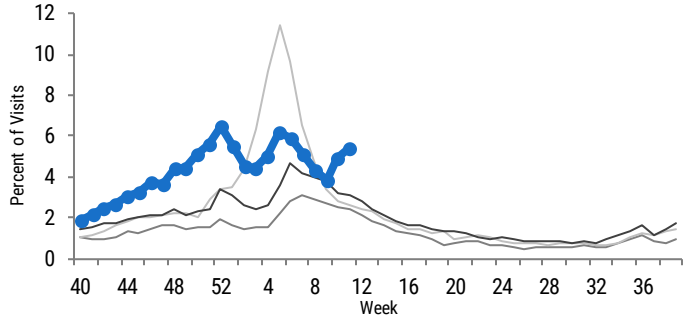


Figure 19: In **region 4, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

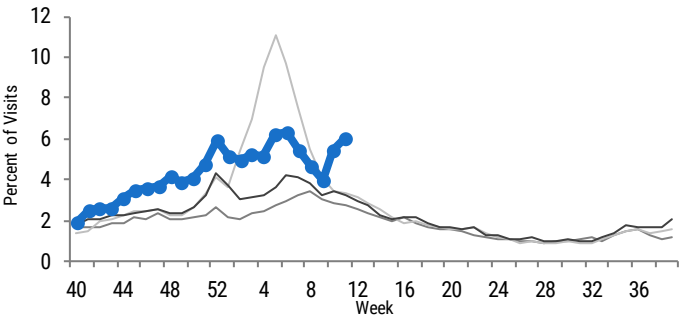


Figure 20: In **region 5, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

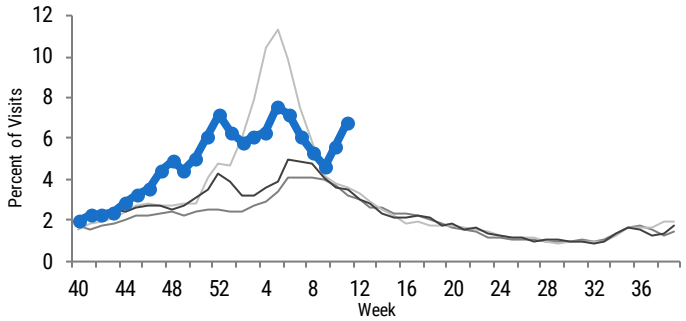


Figure 21: In **region 6, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 and 2018-19 seasons.*

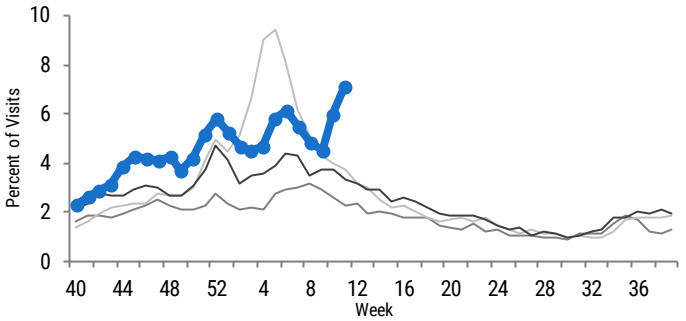
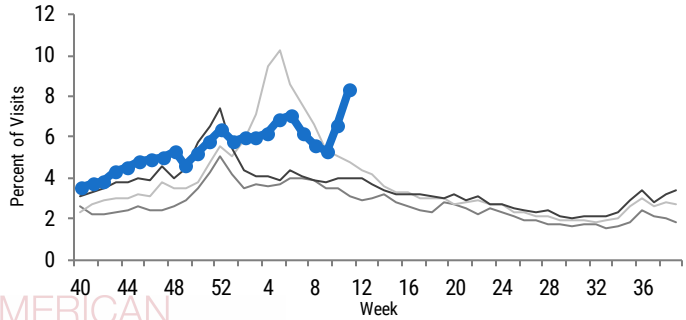


Figure 22: In **region 7, ILI activity increased** during week 11 and was above peak activity observed during the 2016-17 season.*



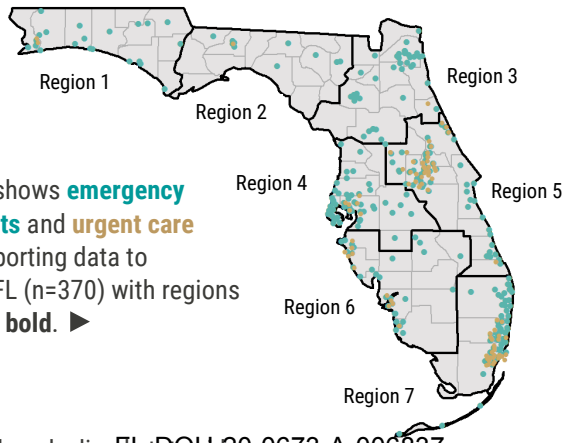


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined statewide.

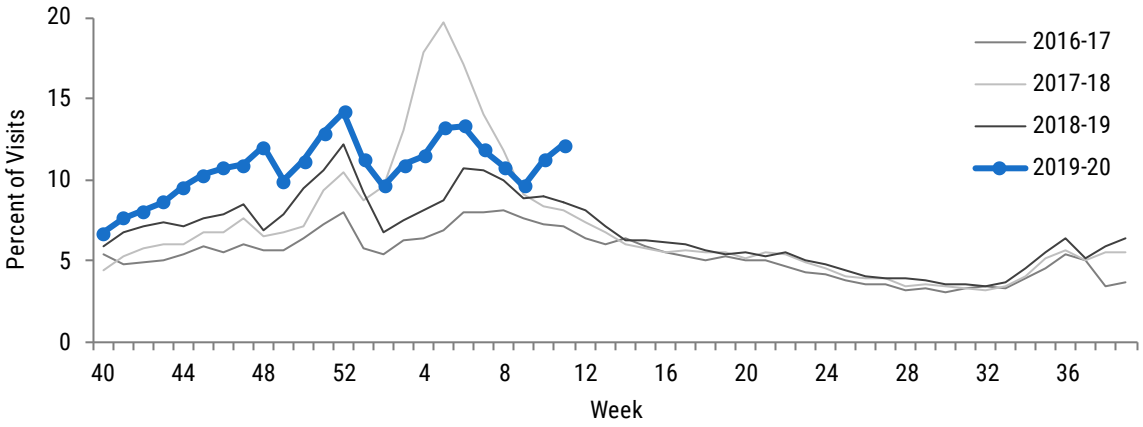
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

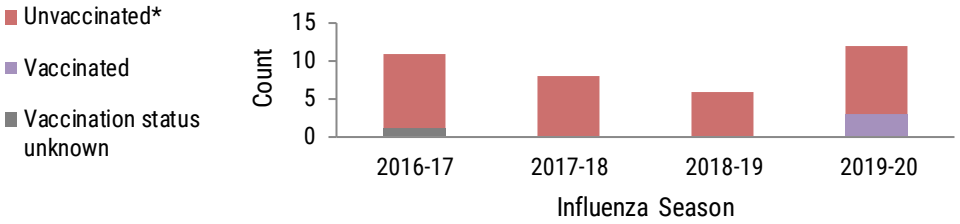
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 11, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak levels observed during the 2016-17 season. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.

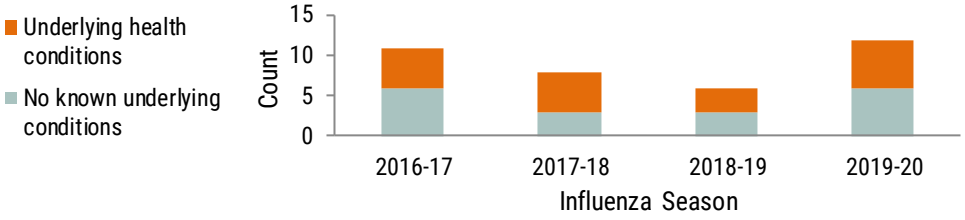


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

Figures 25-26: In week 11, **no new influenza-associated pediatric deaths were reported**. A total of 12 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 11, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 11, 2020.

In week 11, **no new influenza-associated pediatric deaths were reported**.

A total of 12 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

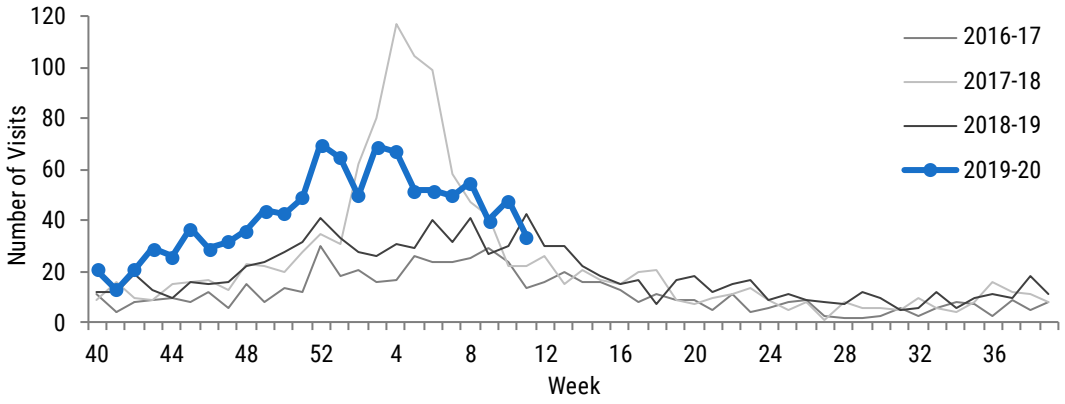
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 11, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



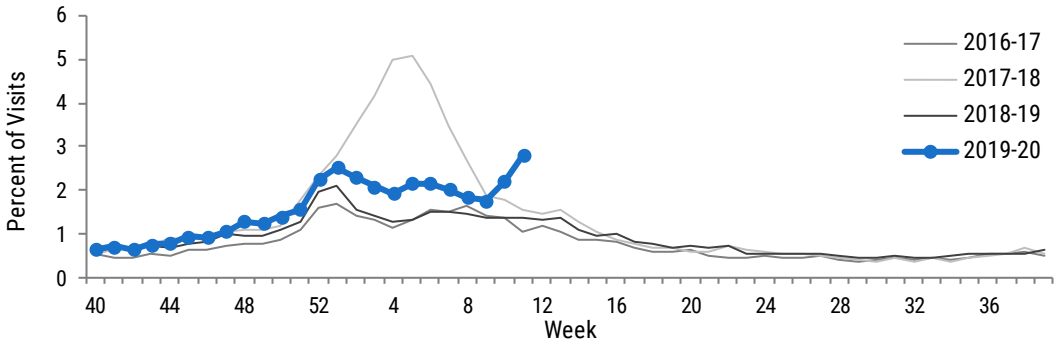
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 11, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 11, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak levels during the 2016-17 and 2018-19 seasons. While ILI activity has increased in recent weeks, laboratory-confirmed influenza activity has declined.



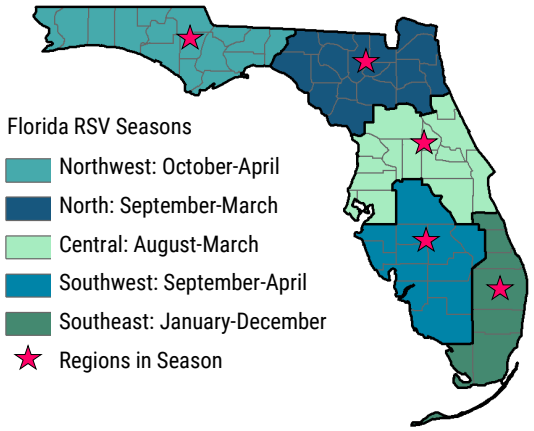
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

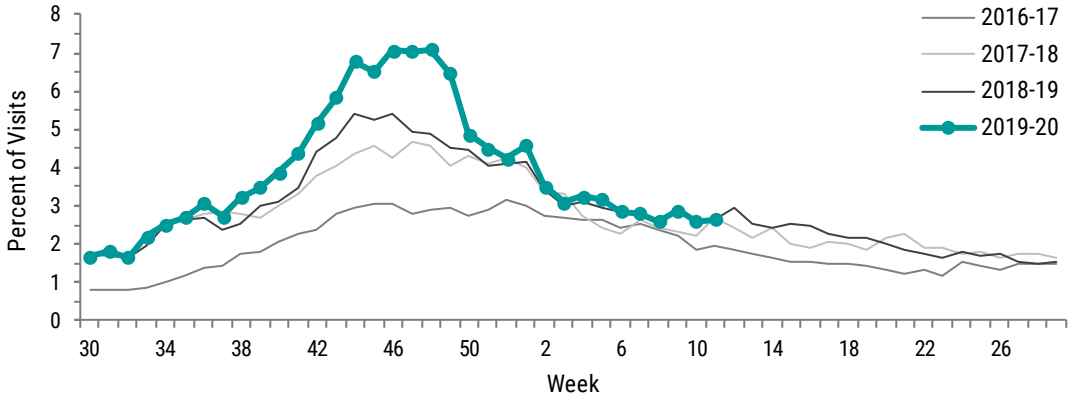
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 11 (February 23-29, 2020) Activity Summary

In week 11, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in week 11. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 11, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 11, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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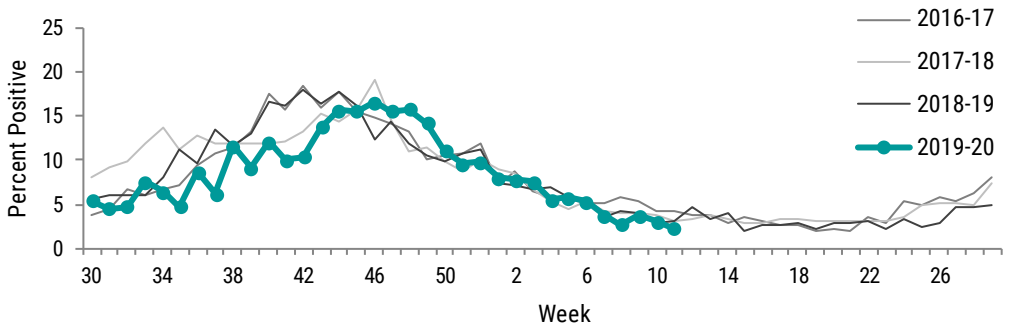
RSV Surveillance

Figure 31: In week 11, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 11, 2020. ▶



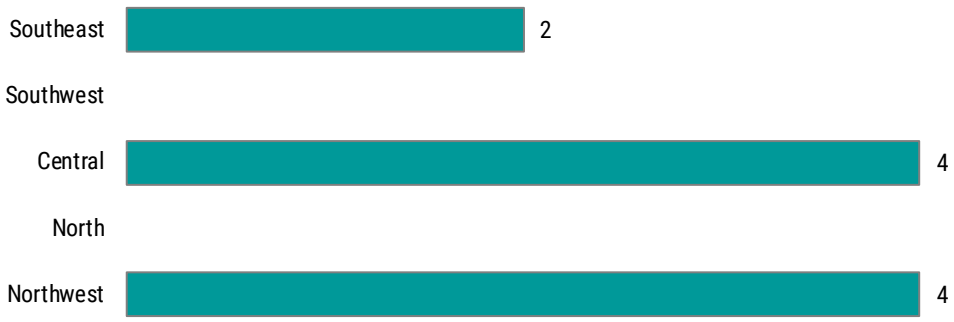
RSV-Associated Outbreaks in Week 11:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 11, one new RSV-associated outbreak was reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

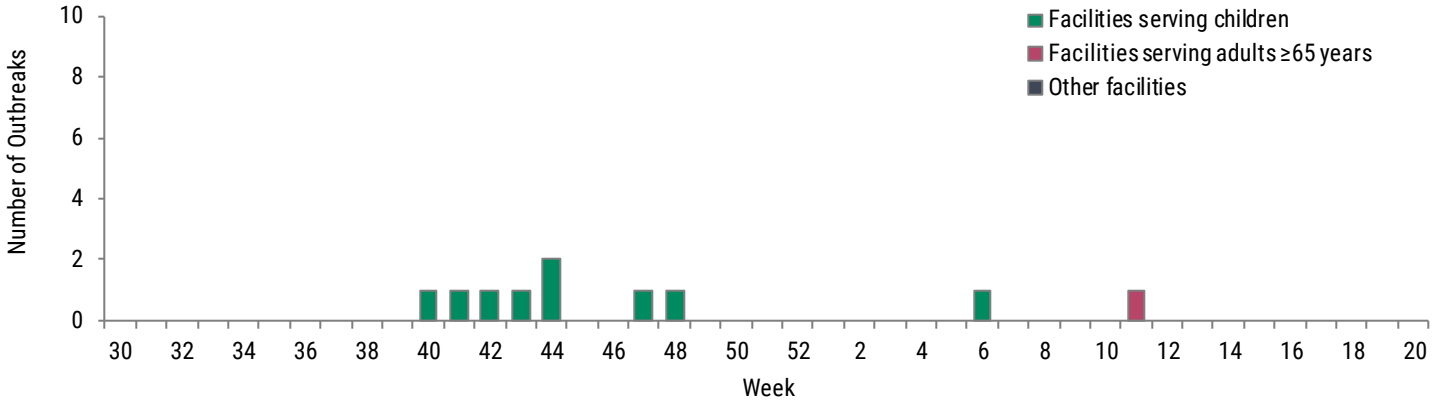
Figure 32: In week 11, one new RSV-associated outbreak was reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

*Regions defined in figure 29.

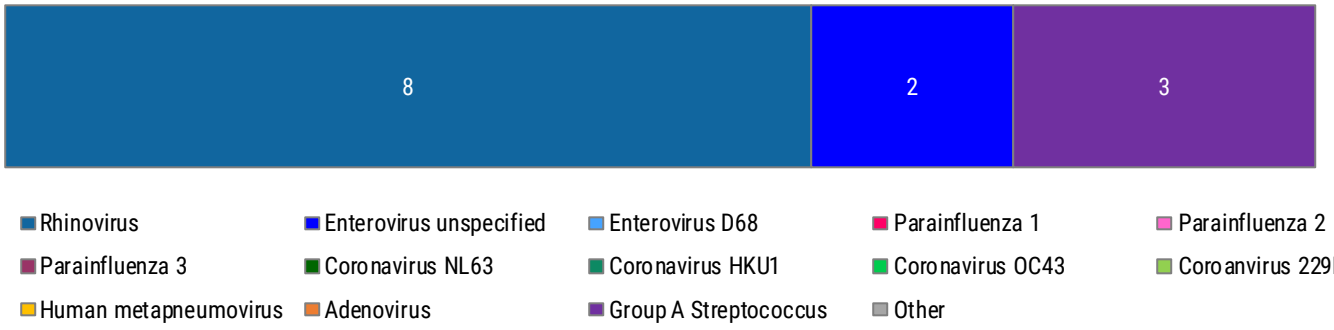
Figure 33: In week 11, one new RSV-associated outbreak was reported. This outbreak was reported in a **facility serving adults aged ≥65 years**. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**



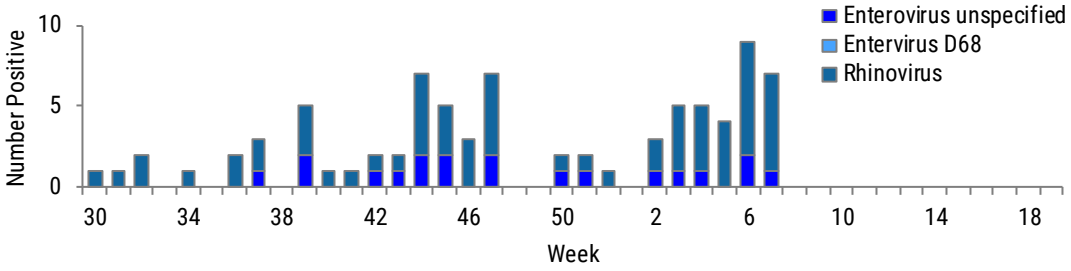
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 11, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

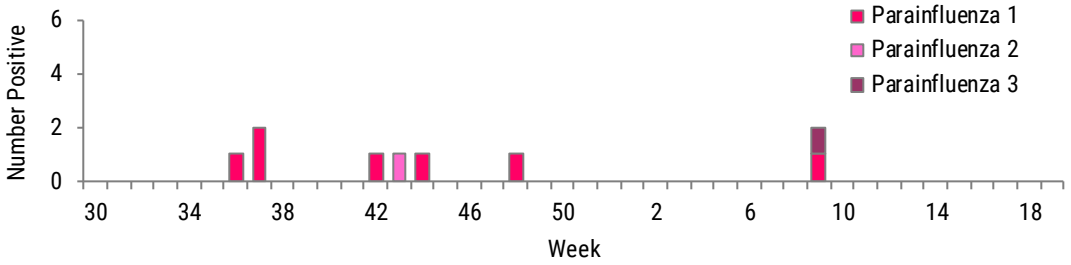


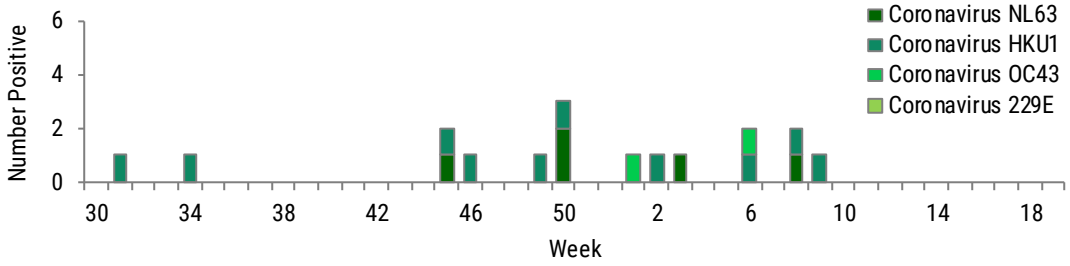
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 11, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

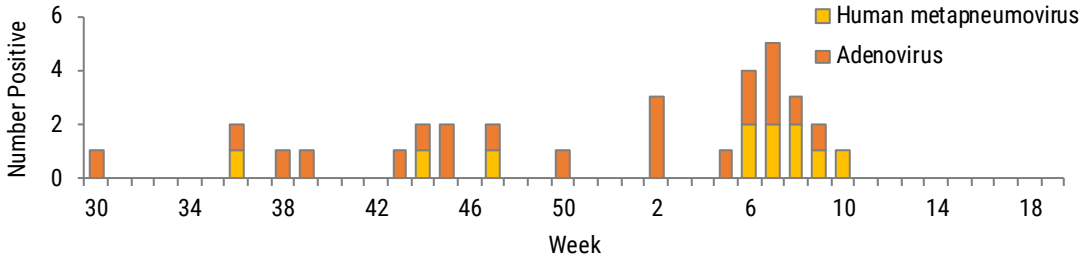
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 11, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
No notable outbreaks were reported in week 11, 2020.							

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words “influenza” or “flu” in patient chief complaints. Chief complaints with the words “fever” and “cough,” or “fever” and “sore throat” are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida’s geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county’s influenza and ILI surveillance data weekly into The Florida Department of Health’s EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida’s reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 12, 2020 Florida Flu Review
Date:	Wednesday, March 25, 2020 3:52:43 PM
Attachments:	Week 12, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 12, 2020 Florida Flu Review.

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

Likewise, the percent of emergency department and urgent care center visits with discharge diagnoses that include influenza or flu decreased in recent weeks. Activity in week 12 was similar to an average of the past three influenza seasons for this time.

Of note, some of the figures in this report that previously displayed chief complaints of ILI were updated to display discharge diagnoses of influenza or flu to better reflect influenza activity trends in Florida.

Eight outbreaks were reported, down from eleven outbreaks in the previous week. Of the eight outbreaks reported, two were influenza-associated and six were ILI.

One new influenza-associated pediatric death was reported. Thirteen influenza-associated pediatric deaths have been reported so far this season; the majority these deaths were children who were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend vaccination as long as influenza viruses are circulating. Annual vaccination is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).

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- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 12: 3/15/20-3/21/20

Geographic Spread: **Regional**

Predominant Strain: **A 2009 (H1N1)**

Influenza Activity Trend: **Decreasing**

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

Likewise, the percent of emergency department and urgent care center visits with discharge diagnoses that include influenza or flu decreased in recent weeks. Activity in week 12 was similar to an average of the past three influenza seasons for this time.

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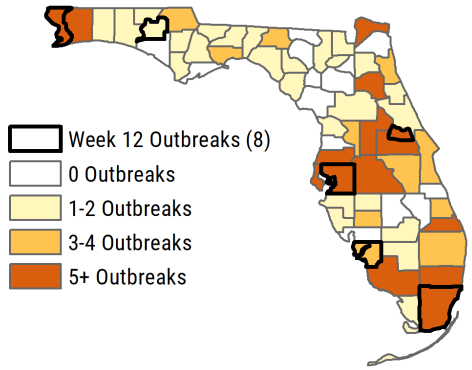
The Centers for Disease Control and Prevention (CDC) continues to recommend vaccination as long as influenza viruses are circulating. Annual vaccination is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

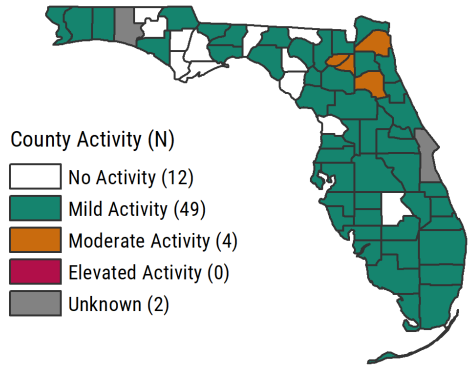
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

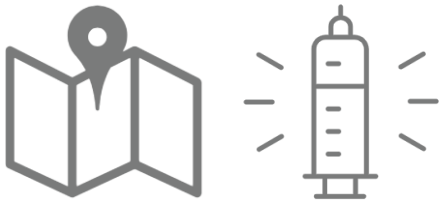
Reported as of 3/21/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

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AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

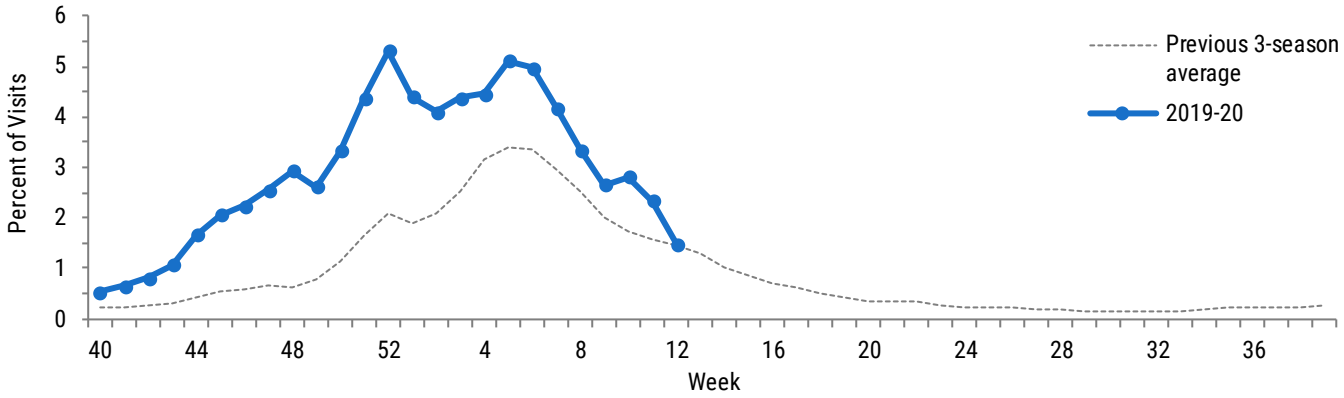
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu statewide decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



▲ **Figure 1** shows **the percent of visits with discharge diagnoses that include influenza or flu** (with certain exceptions) for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 12, 2020) and the previous three season average (2018-19, 2017-18, and 2016-17). Of note, influenza may not be laboratory-confirmed for all the visits included in this query. For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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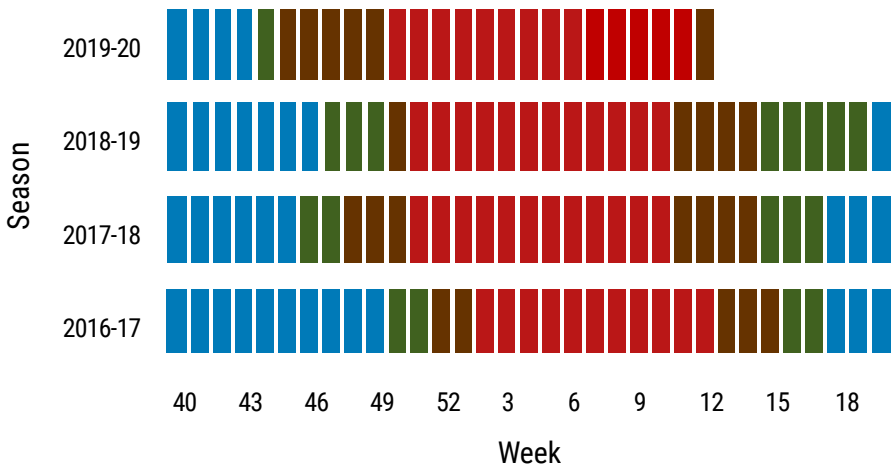
Statewide Activity

Figure 2: In week 12, Florida reported **regional geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 12, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 12, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 12, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

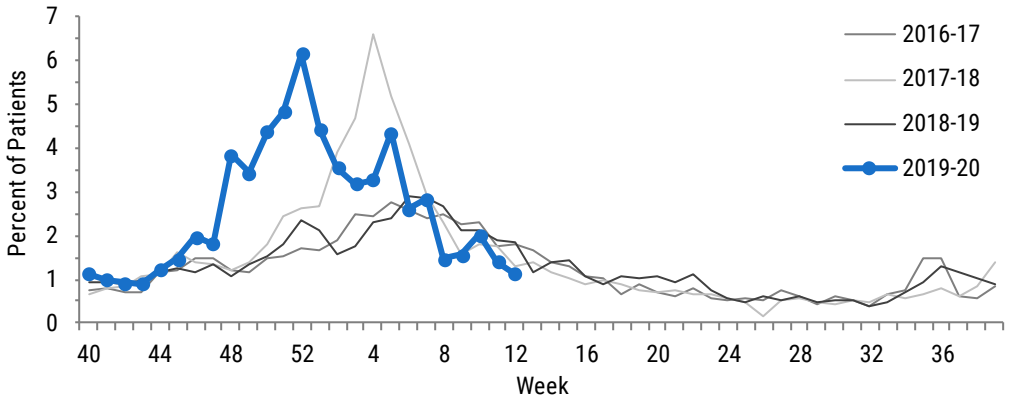
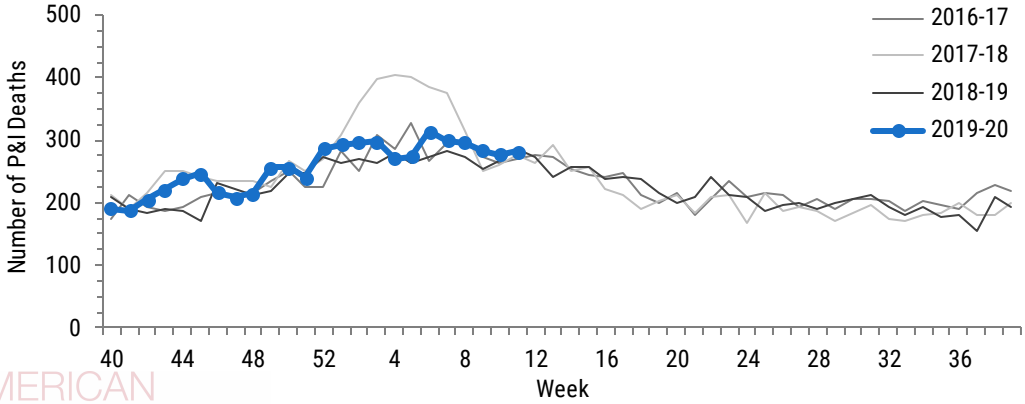


Figure 4: In week 11 (ending 3/14/20), **the number of pneumonia and influenza deaths identified statewide increased slightly** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 12. Four counties reported **moderate activity,** and no counties reported **elevated activity.**

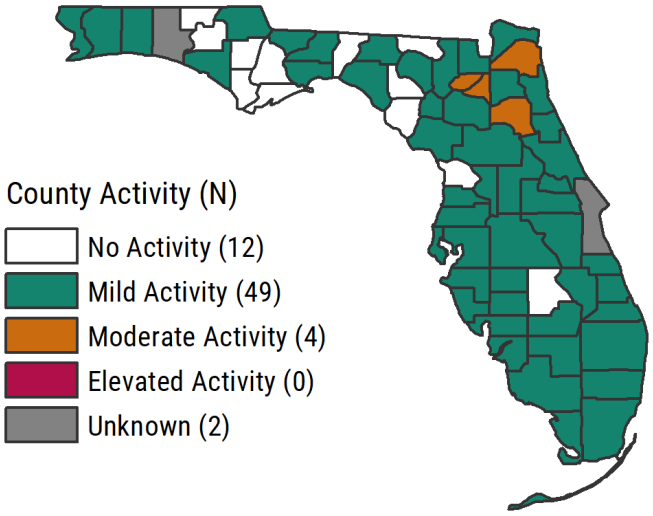
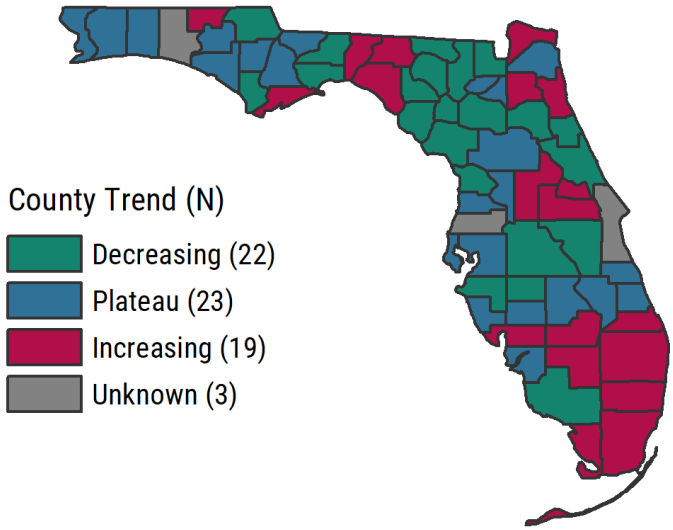
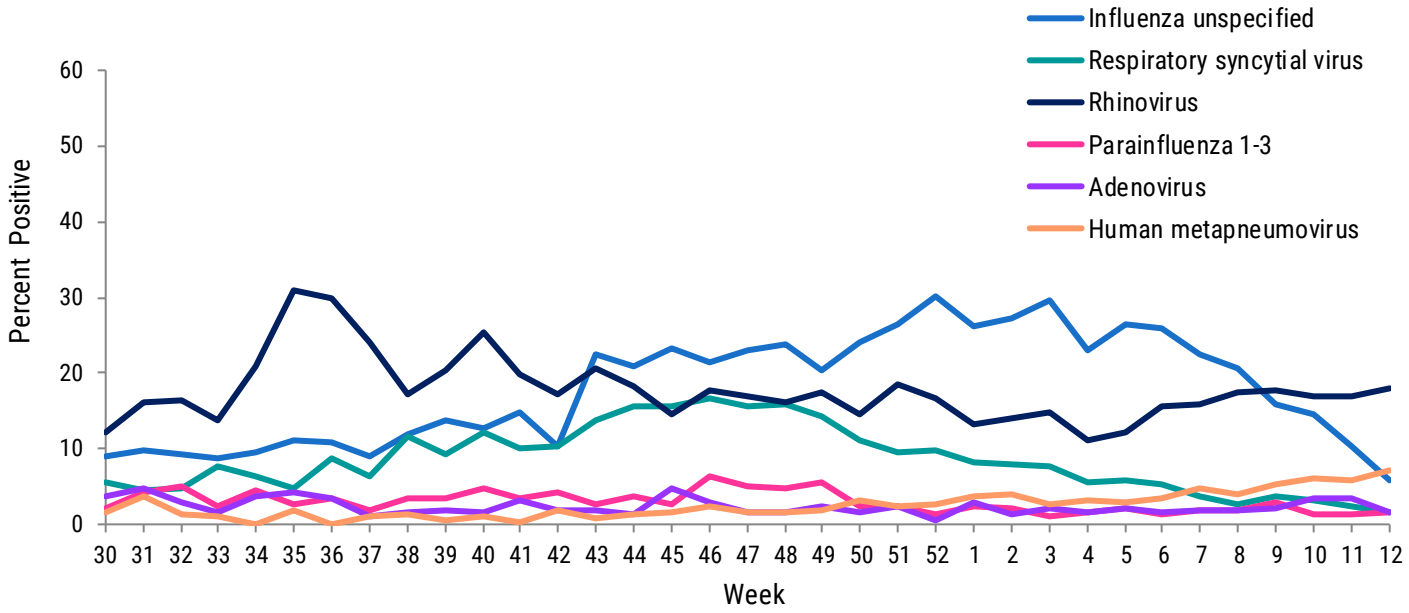


Figure 6: Most counties reported **activity at a plateau** for week 12. Nineteen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 12, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance (including influenza). The **percent of specimens testing positive for influenza decreased notably** in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 12, 2020.

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Influenza and ILI Outbreaks

Week 12 Outbreaks at a Glance:

Number Reported:
8 Outbreaks

Influenza-Associated:
2 Outbreaks

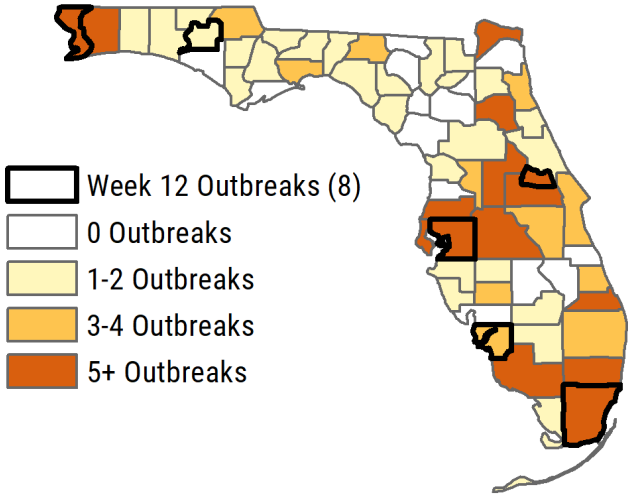
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 12, two influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

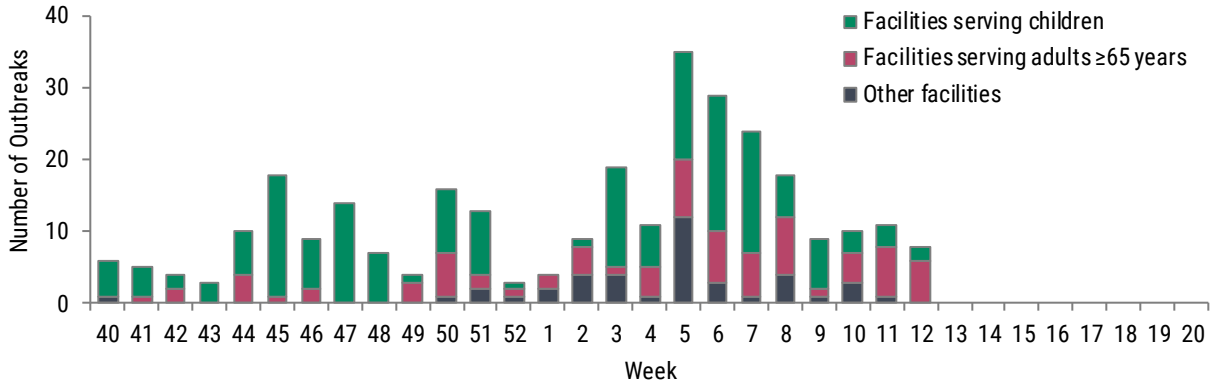
Severe outcomes* were reported in two of eight outbreaks. One or more hospitalizations and no deaths were reported in these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). Both of the outbreaks with severe outcomes in week 12 were in facilities serving adults aged ≥65 years.



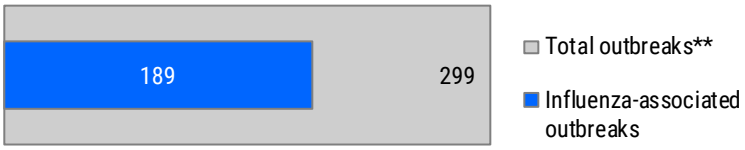
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 12 are **outlined in bold.**

Figure 9: In week 12, **six outbreaks** were reported among **facilities serving adults aged ≥65 years, two outbreaks** were reported in **facilities serving children,** and **no outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 12, **63.2% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 12, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

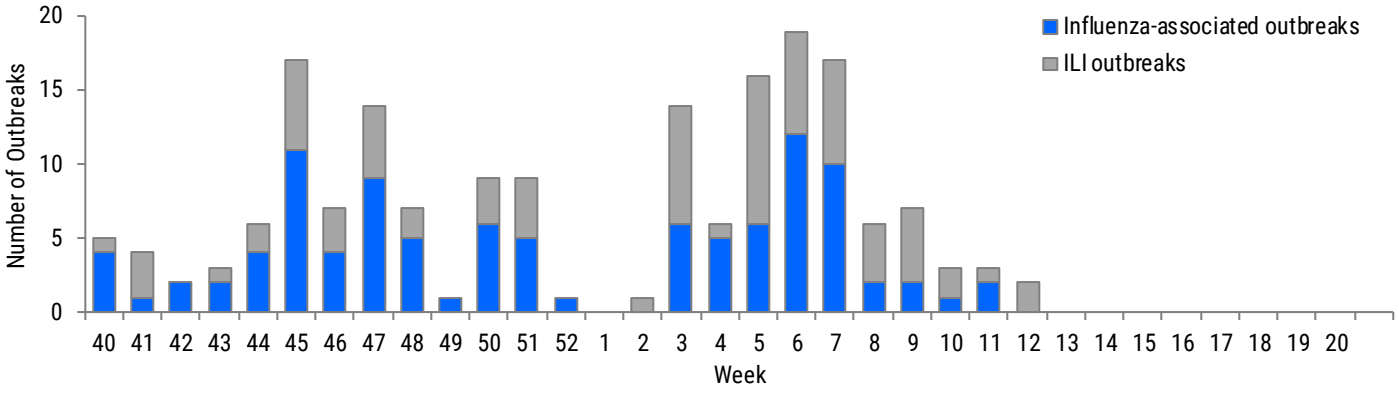
2 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 12, two new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 12, **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

Facilities Serving Adults ≥65 yrs.**:

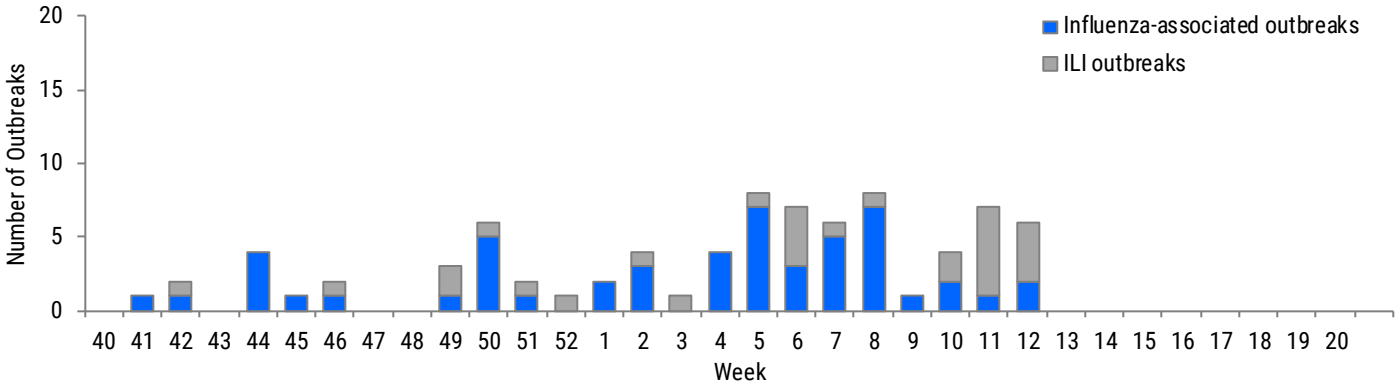
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 12, six new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 12, **four ILI outbreaks** and **two influenza-associated outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

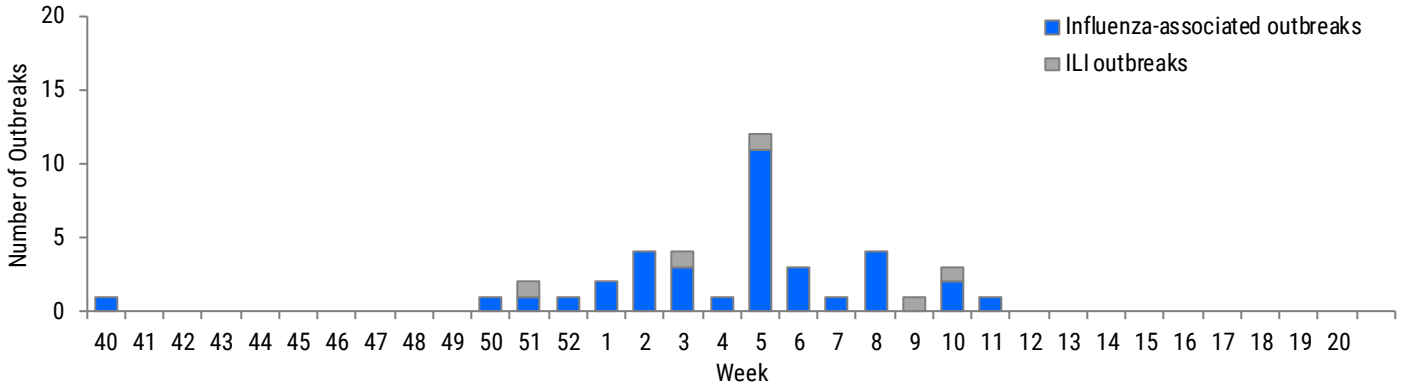
0 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 12, no new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 12, no new outbreaks were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	137 (45.8%)	84 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	41 (13.7%)	17 influenza-associated outbreaks 24 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	26 (8.7%)	12 influenza-associated outbreaks 14 ILI outbreaks
Nursing facilities	19 (6.4%)	14 influenza-associated outbreaks 5 ILI outbreaks
Other long-term care facilities	35 (11.7%)	26 influenza-associated outbreaks 9 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.0%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.0%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**299 (100.0%)**	**189 influenza-associated outbreaks** **110 ILI outbreaks**

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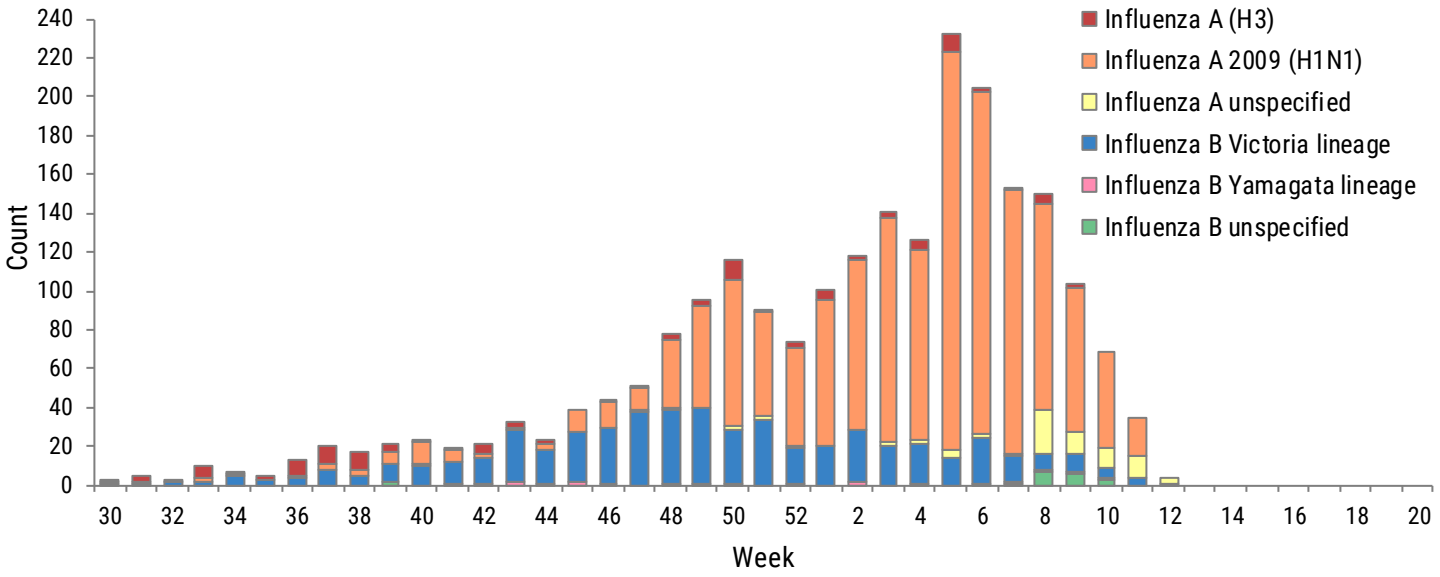
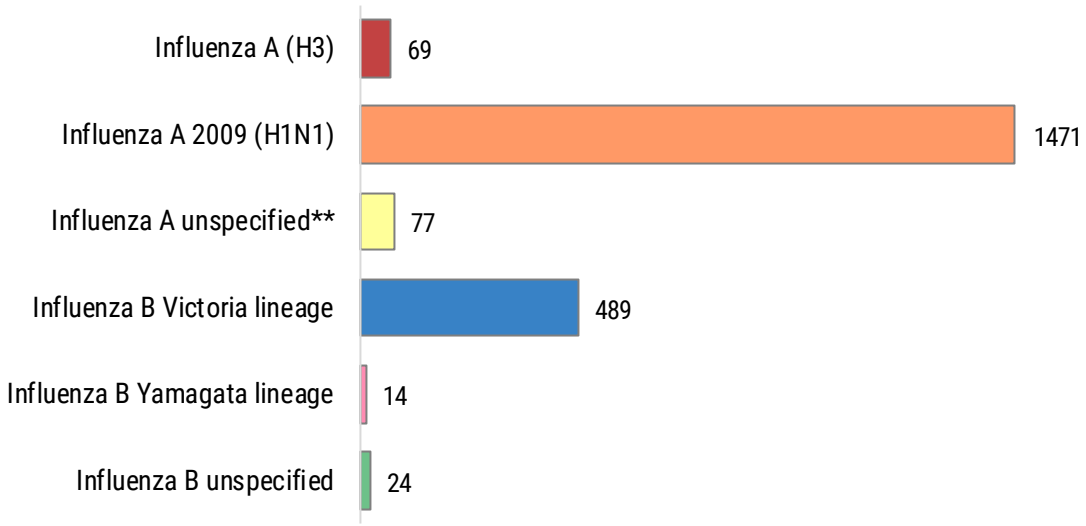
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 12, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 12, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits with discharge diagnoses of influenza or flu** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 12, 2020. Data are organized by region (see Figure 23).

2019-20
Previous 3-season average

Figure 16: In **region 1, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

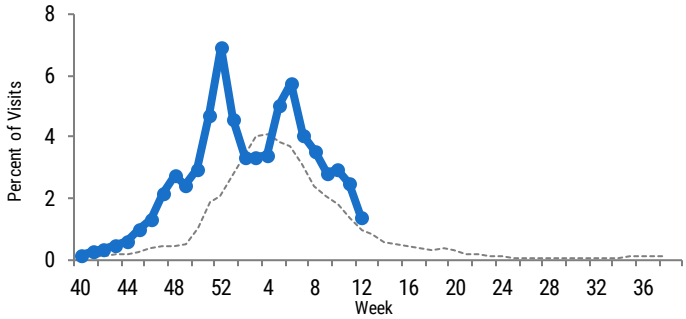


Figure 17: In **region 2, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

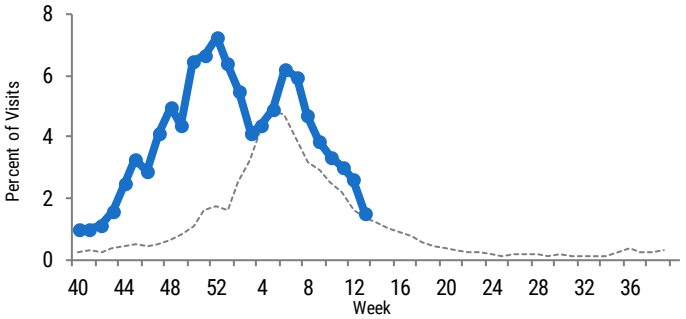


Figure 18: In **region 3, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

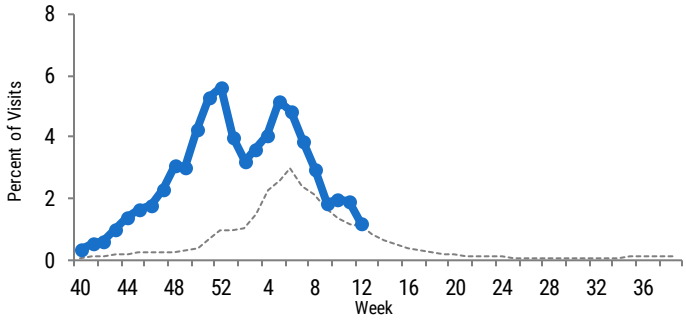


Figure 19: In **region 4, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

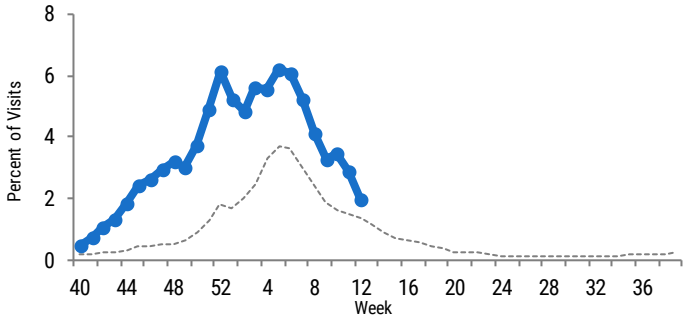


Figure 20: In **region 5, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

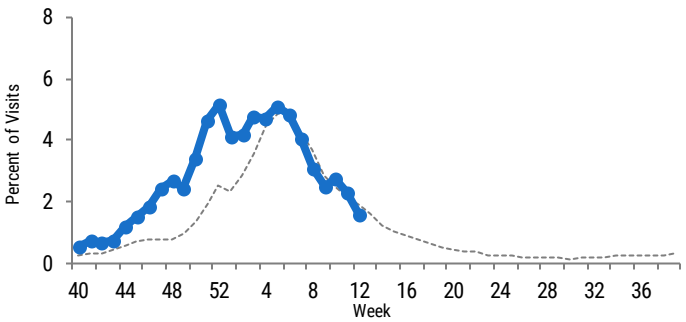


Figure 21: In **region 6, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

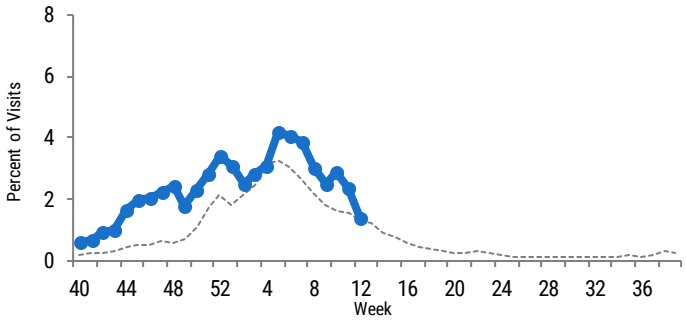
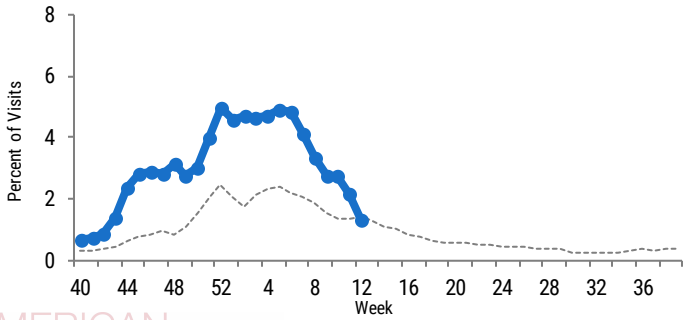


Figure 22: In **region 7, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*



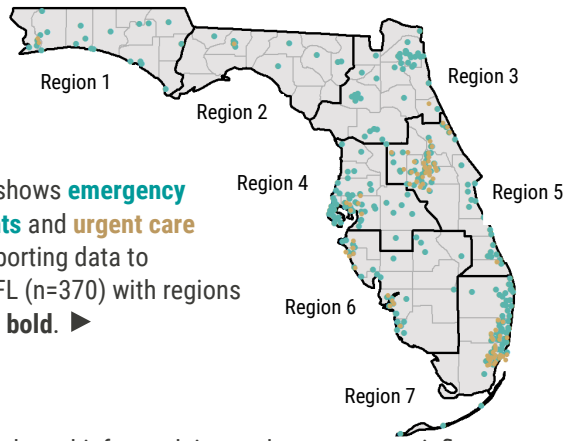


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*Of note, the queries used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

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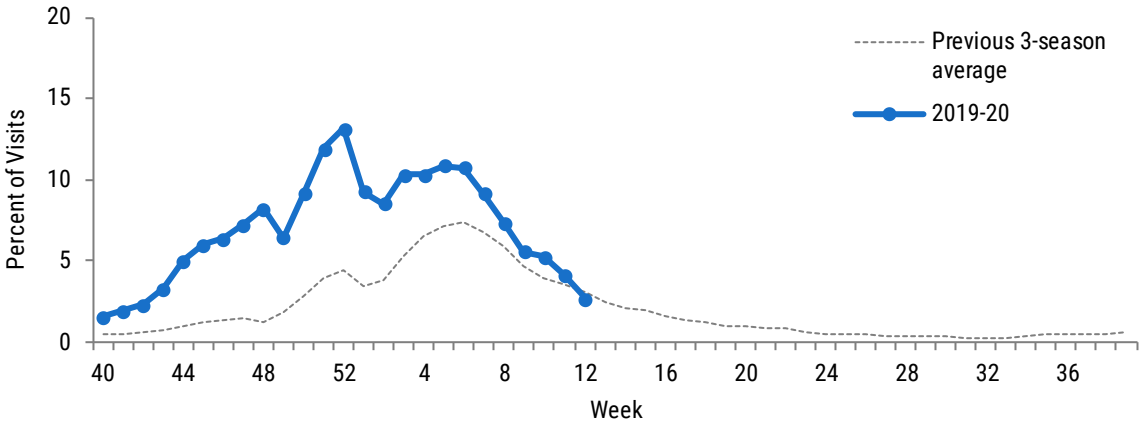
At-Risk Populations

Background: At-Risk Populations, Children

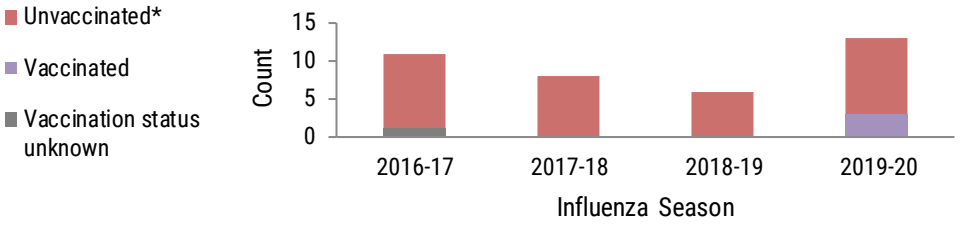
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in children <18 years decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

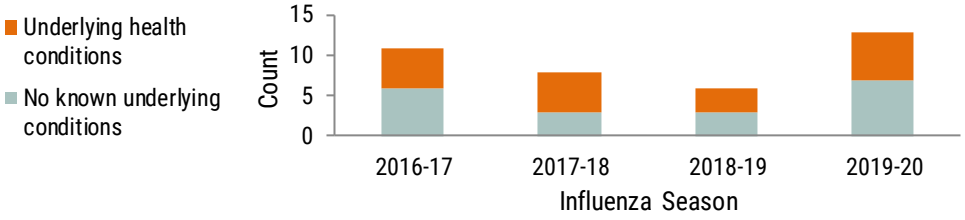


◀ **Figure 24** shows **the percent visits with discharge diagnoses that contain influenza or flu among children <18 years** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

Figures 25-26: In week 12, **one new influenza-associated pediatric death was reported**. A total of 13 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 12, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 12, 2020.

In week 12, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A unspecified in a child with no known underlying health conditions who was not vaccinated for the 2019-20 season.

A total of 13 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

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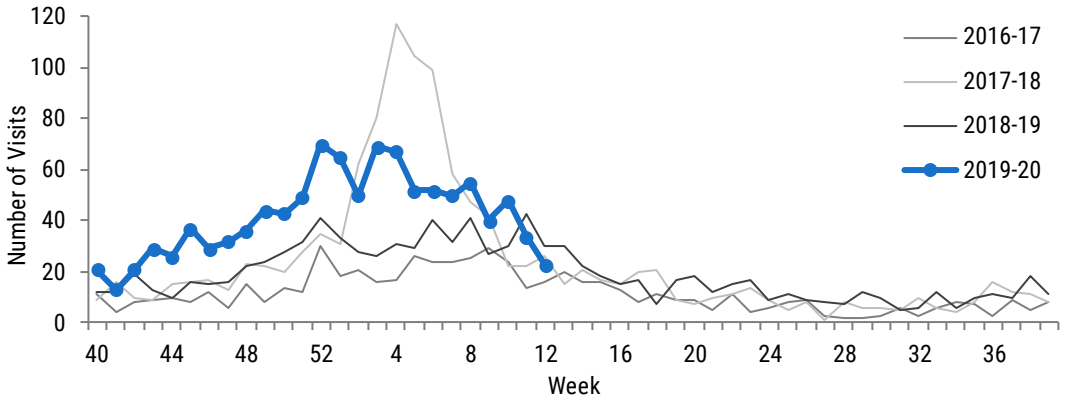
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 12, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



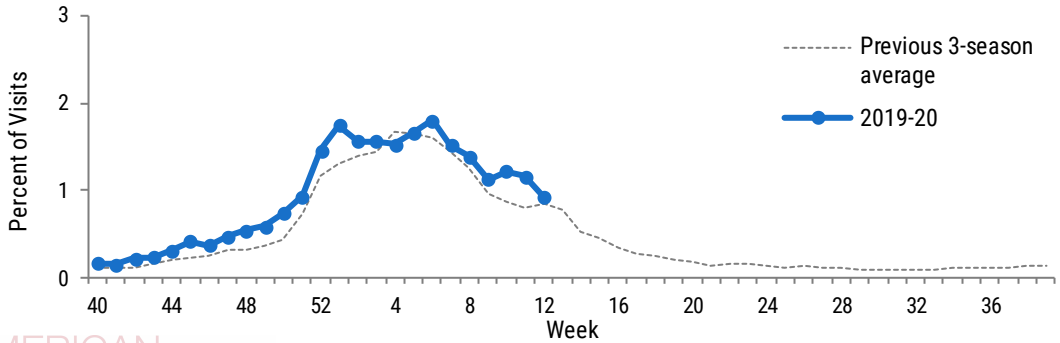
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 12, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 12, the **percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in adults ≥65 years decreased** and similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



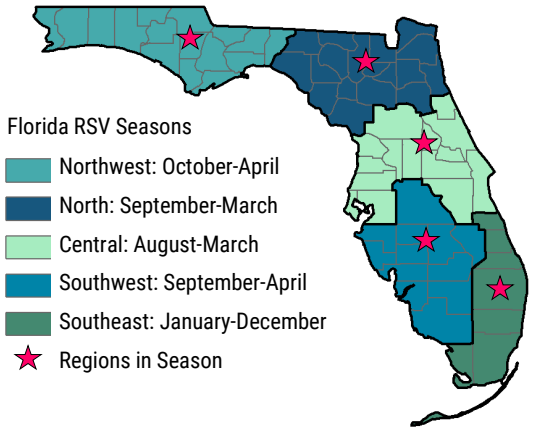
◀ **Figure 28** shows **the percent of visits with discharge diagnoses that contain influenza or flu among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

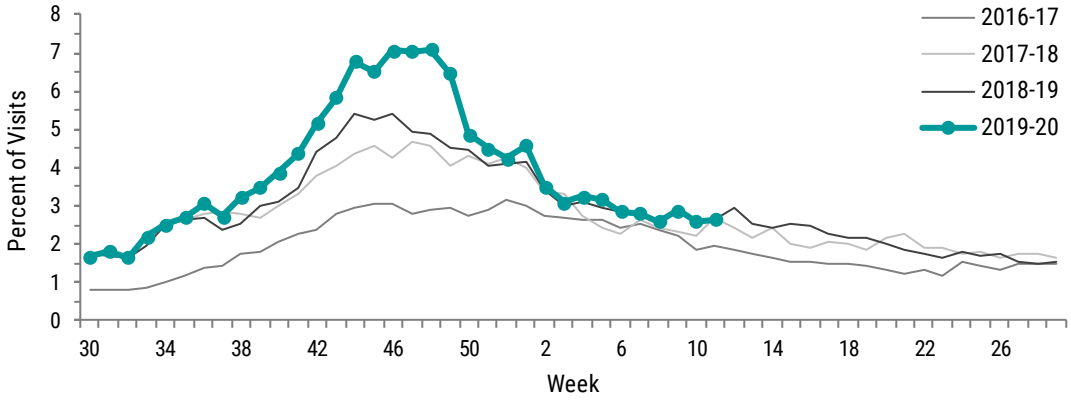
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 12 (March 15-21, 2020) Activity Summary

In week 12, RSV activity in children <5 years increased and was similar to levels observed at this time in previous seasons.

No new RSV-associated outbreaks were reported in week 12. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 12, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 12, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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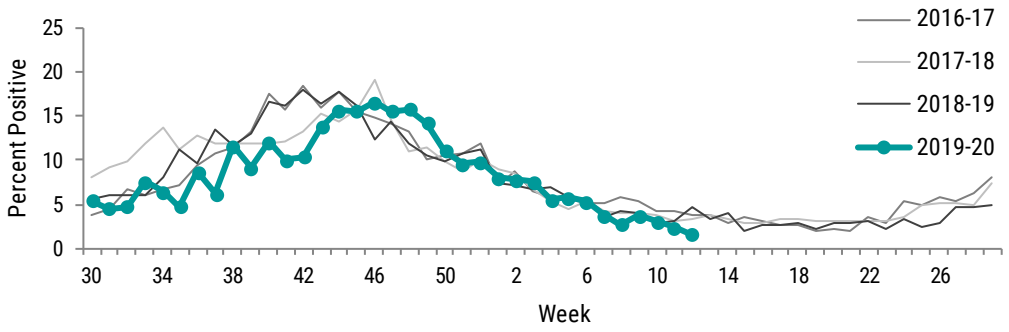
RSV Surveillance

Figure 31: In week 12, **the percent of specimens testing positive for RSV decreased.** Levels were below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 12, 2020. ▶



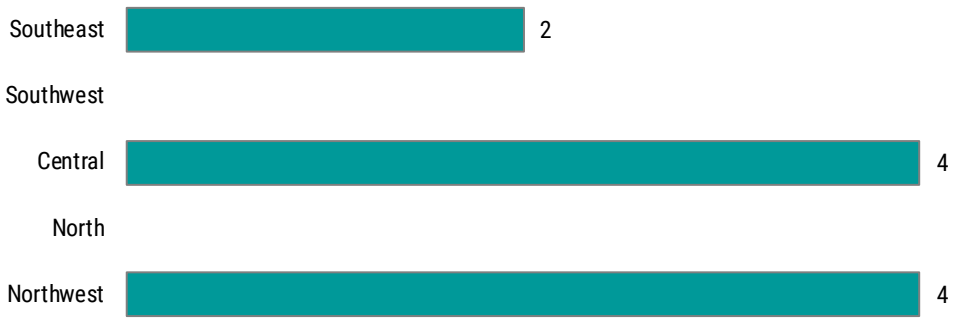
RSV-Associated Outbreaks in Week 12:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 12, no new RSV-associated outbreaks were reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

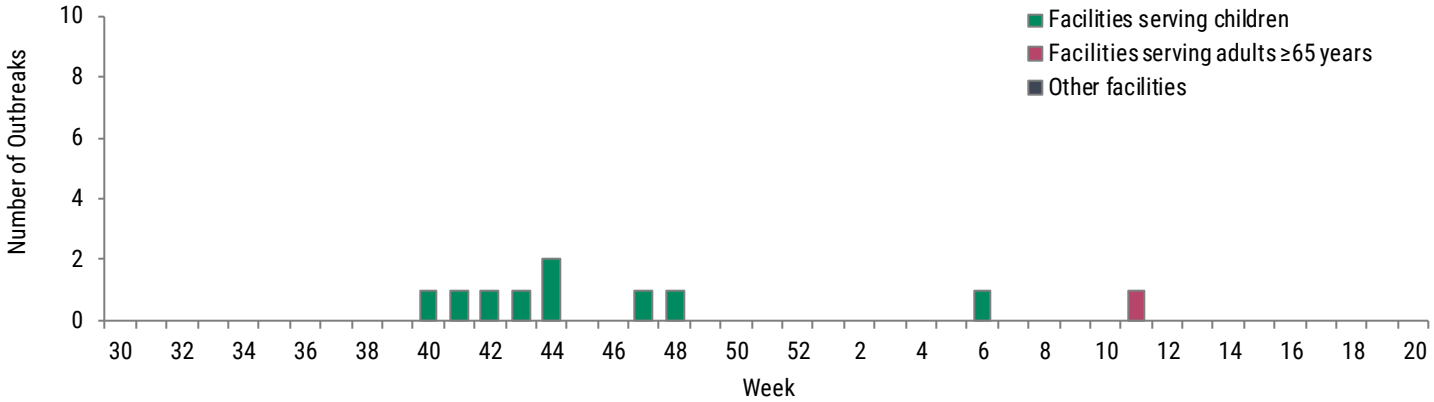
Figure 32: In week 12, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.*



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

*Regions defined in figure 29.

Figure 33: In week 12, no new RSV-associated outbreaks were reported. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**

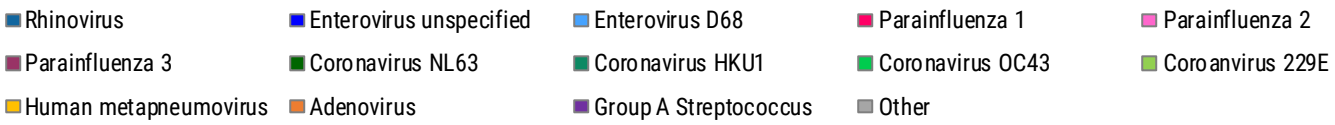


▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

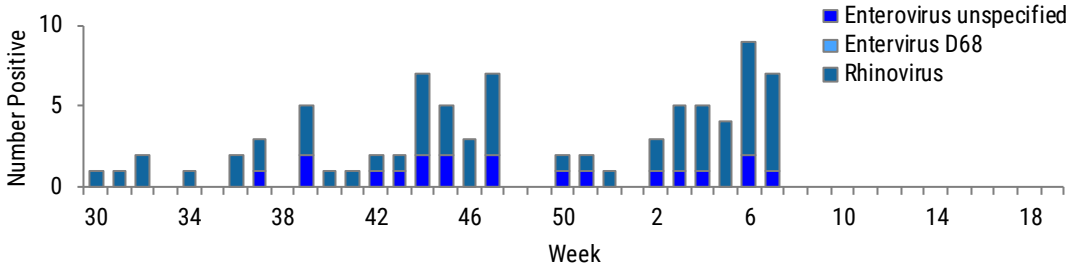
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



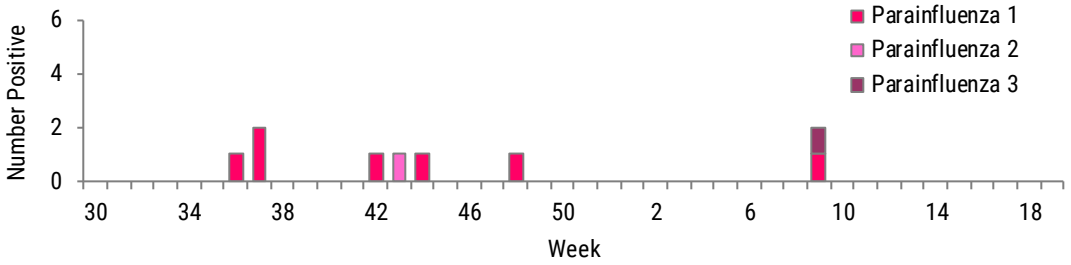


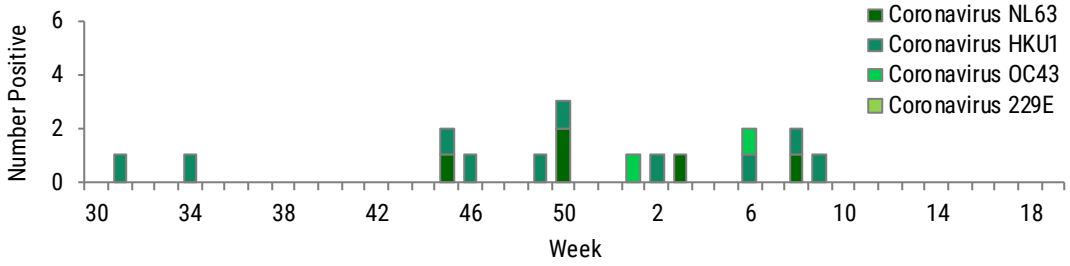
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 12, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

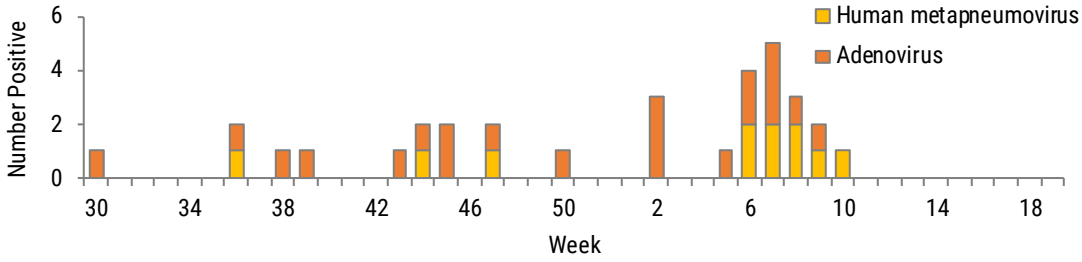
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 12, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Washington	7	2	0	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza and flu-related visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional figures, percentages are calculated as the proportion of ED and UCC visits to participating facilities that include the words “influenza” or “flu” in the discharge diagnoses (with certain exceptions).

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly influenza-like illness (ILI) and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For health care providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida’s geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county’s influenza and ILI surveillance data weekly into The Florida Department of Health’s EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida’s reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 12, 2020 Florida Flu Review
Date:	Wednesday, March 25, 2020 3:52:49 PM
Attachments:	Week 12, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 12, 2020 Florida Flu Review.

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

Likewise, the percent of emergency department and urgent care center visits with discharge diagnoses that include influenza or flu decreased in recent weeks. Activity in week 12 was similar to an average of the past three influenza seasons for this time.

Of note, some of the figures in this report that previously displayed chief complaints of ILI were updated to display discharge diagnoses of influenza or flu to better reflect influenza activity trends in Florida.

Eight outbreaks were reported, down from eleven outbreaks in the previous week. Of the eight outbreaks reported, two were influenza-associated and six were ILI.

One new influenza-associated pediatric death was reported. Thirteen influenza-associated pediatric deaths have been reported so far this season; the majority these deaths were children who were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend vaccination as long as influenza viruses are circulating. Annual vaccination is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).

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- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 12: 3/15/20-3/21/20

Geographic Spread: **Regional**

Predominant Strain: **A 2009 (H1N1)**

Influenza Activity Trend: **Decreasing**

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

Likewise, the percent of emergency department and urgent care center visits with discharge diagnoses that include influenza or flu decreased in recent weeks. Activity in week 12 was similar to an average of the past three influenza seasons for this time.

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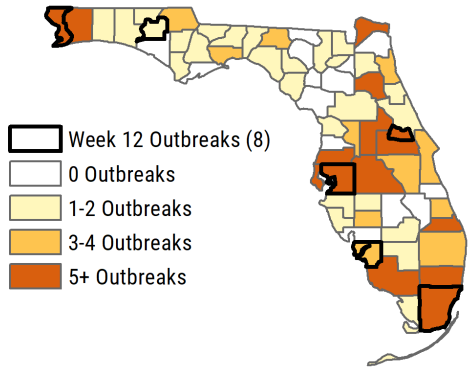
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

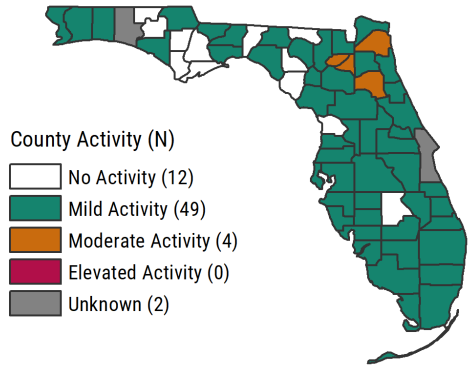
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

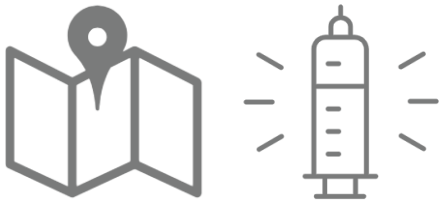
Reported as of 3/21/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 25, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Mwedu Mtenga, MPH: Casey McBride, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.
FL DOH 20-0673-A-006867

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

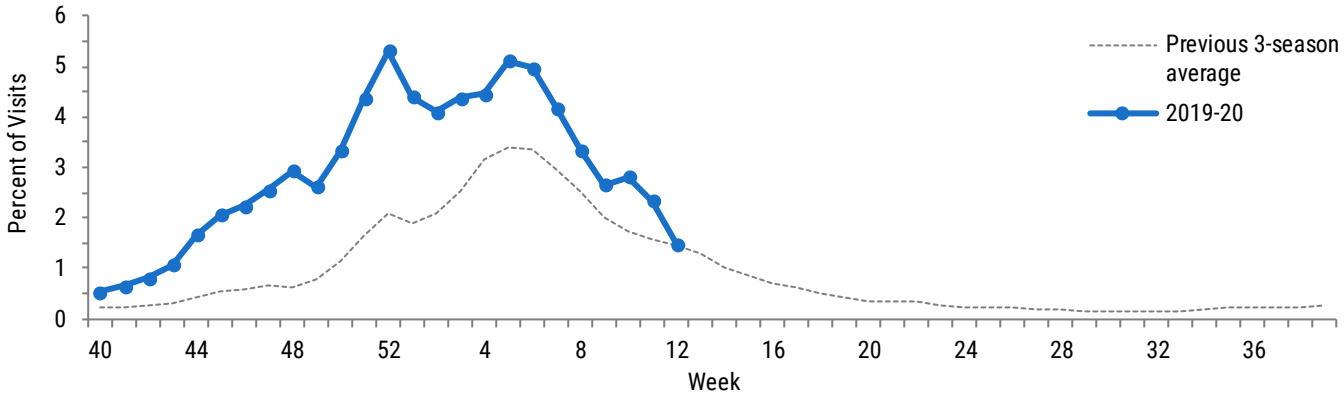
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu statewide decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

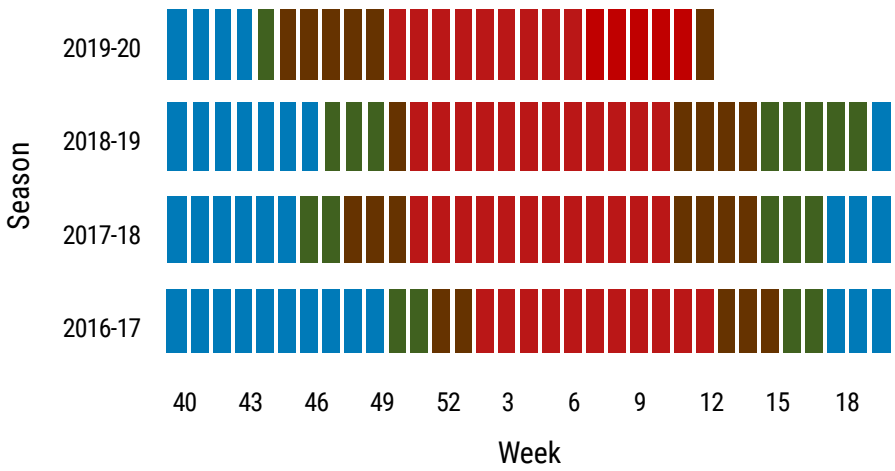


▲ **Figure 1** shows **the percent of visits with discharge diagnoses that include influenza or flu** (with certain exceptions) for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 12, 2020) and the previous three season average (2018-19, 2017-18, and 2016-17). Of note, influenza may not be laboratory-confirmed for all the visits included in this query. For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

AMERICAN OVERSIGHT

Statewide Activity

Figure 2: In week 12, Florida reported **regional geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 12, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 12, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 12, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

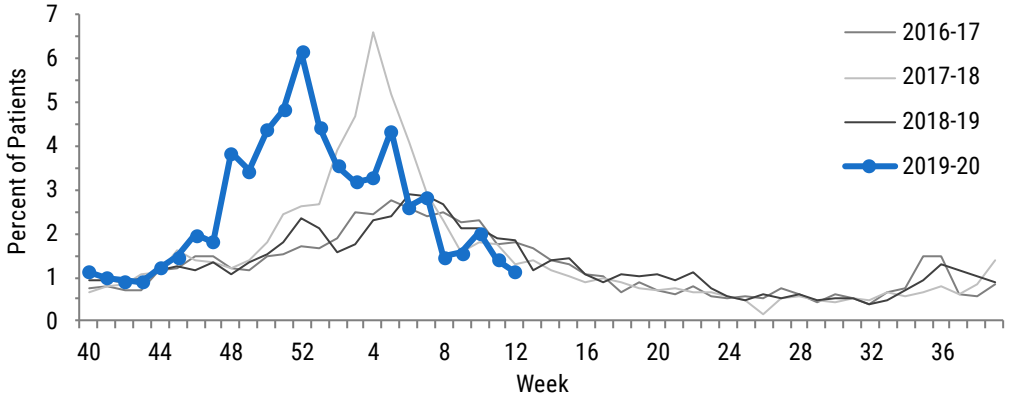
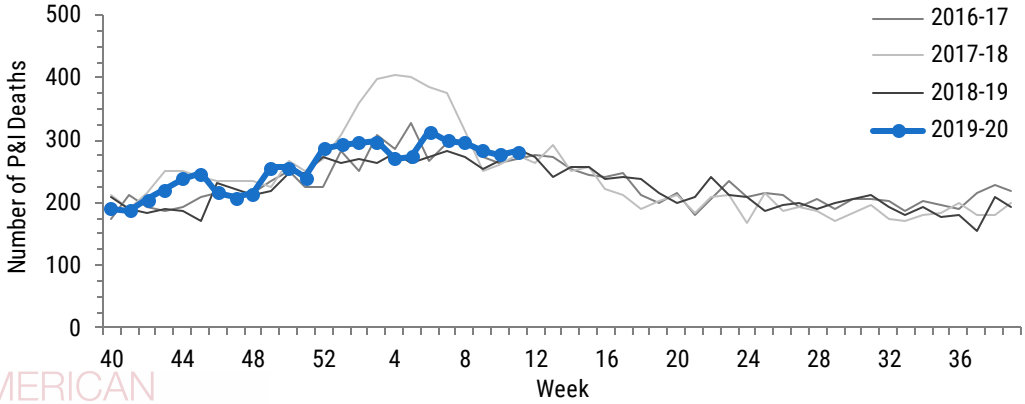


Figure 4: In week 11 (ending 3/14/20), **the number of pneumonia and influenza deaths identified statewide increased slightly** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 12. Four counties reported **moderate activity,** and no counties reported **elevated activity.**

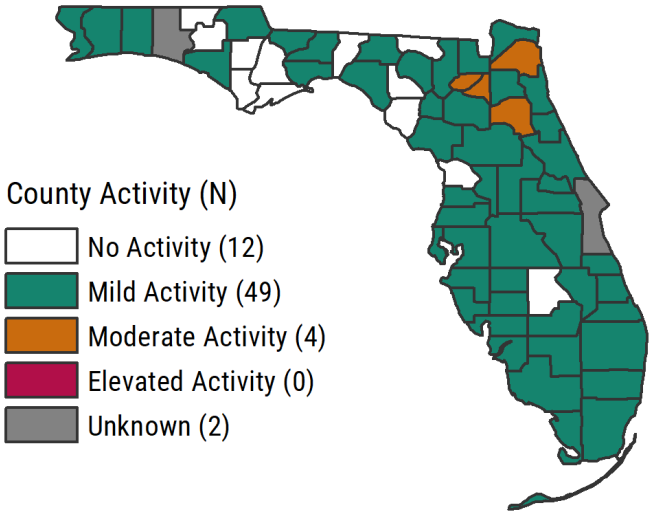
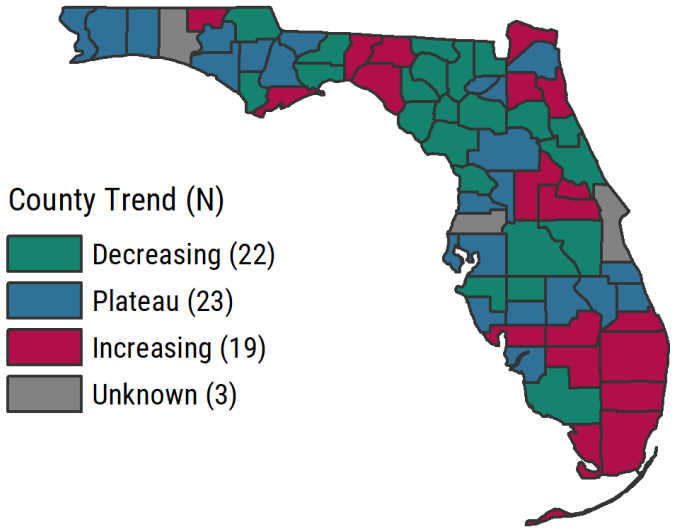
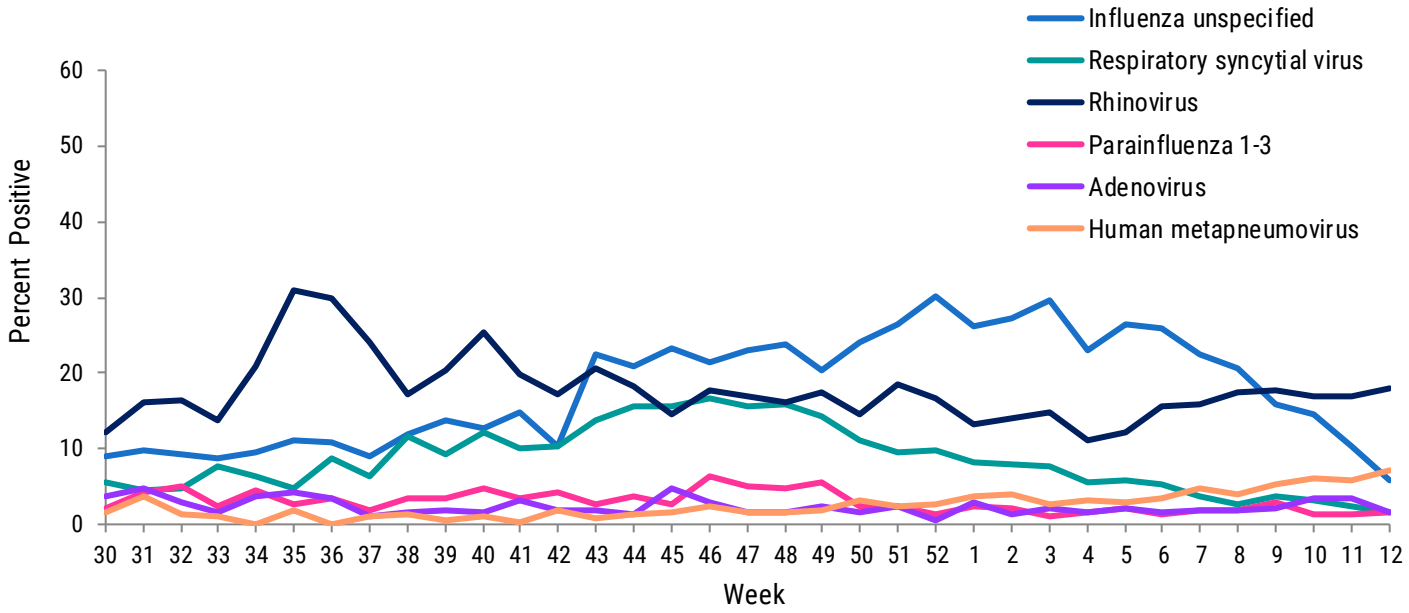


Figure 6: Most counties reported **activity at a plateau** for week 12. Nineteen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 12, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance (including influenza). The **percent of specimens testing positive for influenza decreased notably** in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 12, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 12 Outbreaks at a Glance:

Number Reported:
8 Outbreaks

Influenza-Associated:
2 Outbreaks

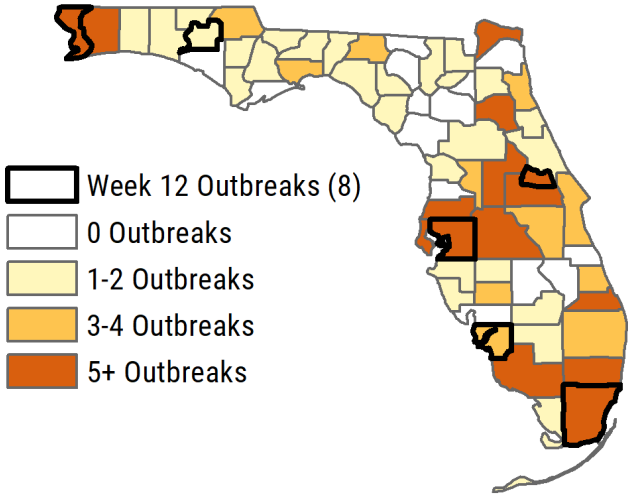
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 12, two influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

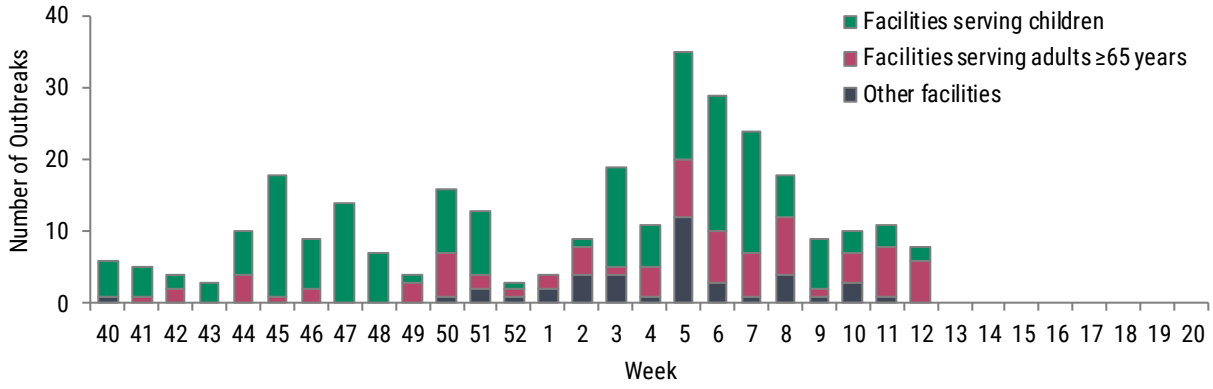
Severe outcomes* were reported in two of eight outbreaks. One or more hospitalizations and no deaths were reported in these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). Both of the outbreaks with severe outcomes in week 12 were in facilities serving adults aged ≥65 years.



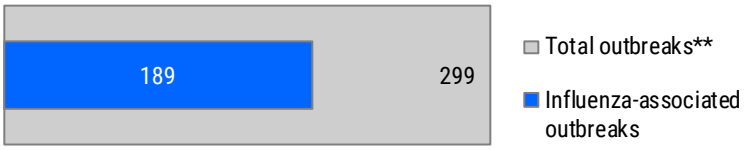
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 12 are **outlined in bold.**

Figure 9: In week 12, **six outbreaks** were reported among **facilities serving adults aged ≥65 years, two outbreaks** were reported in **facilities serving children,** and **no outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 12, **63.2% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 12, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

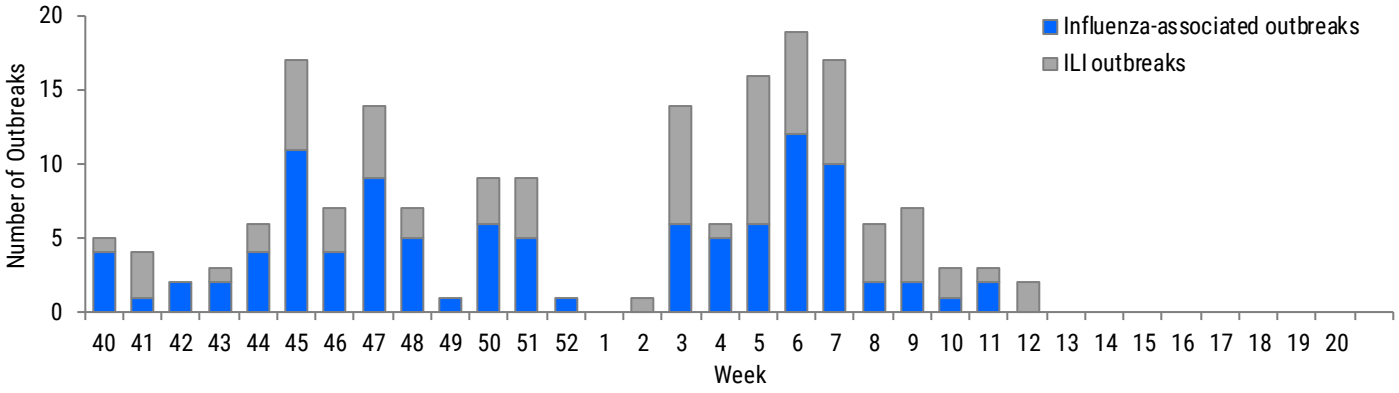
2 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 12, two new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 12, **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

Facilities Serving Adults ≥65 yrs.**:

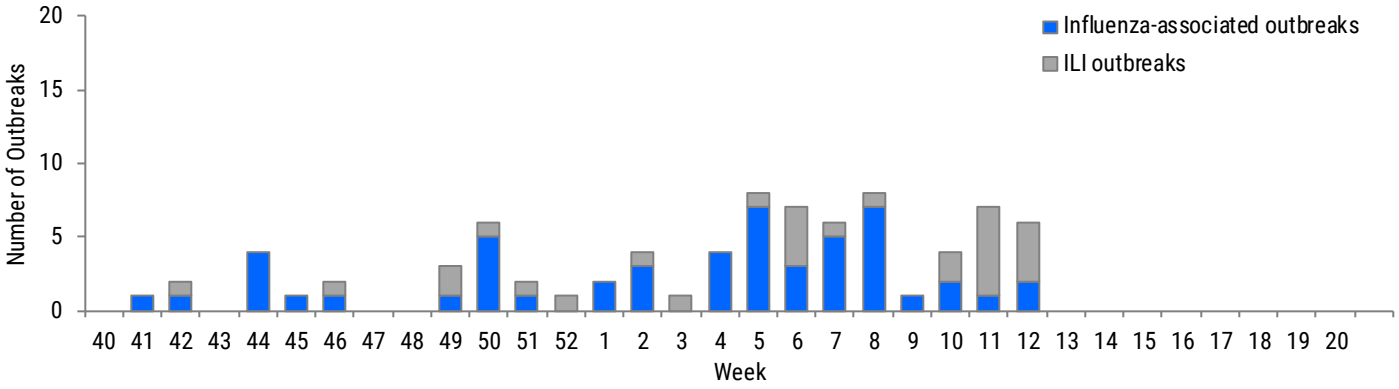
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 12, six new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 12, **four ILI outbreaks** and **two influenza-associated outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

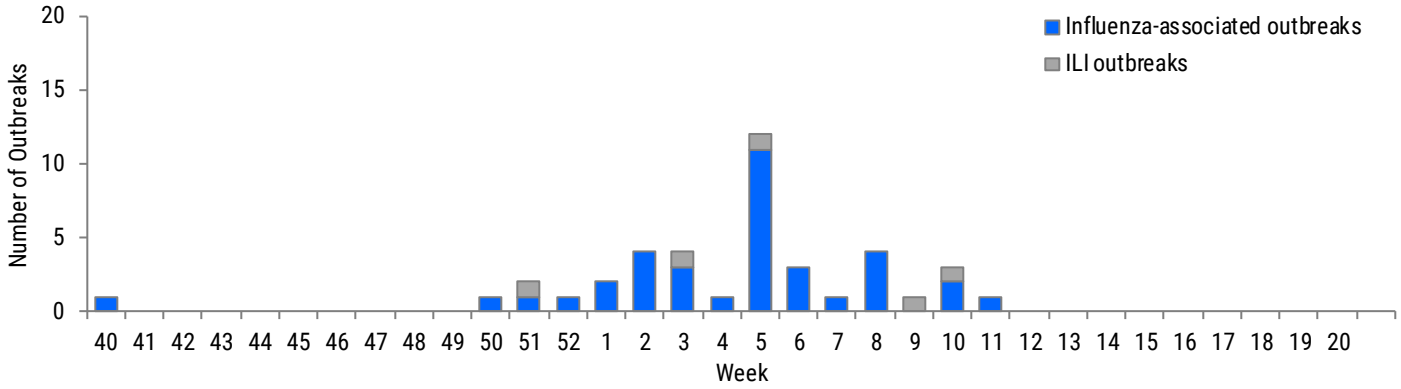
0 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 12, no new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 12, no new outbreaks were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

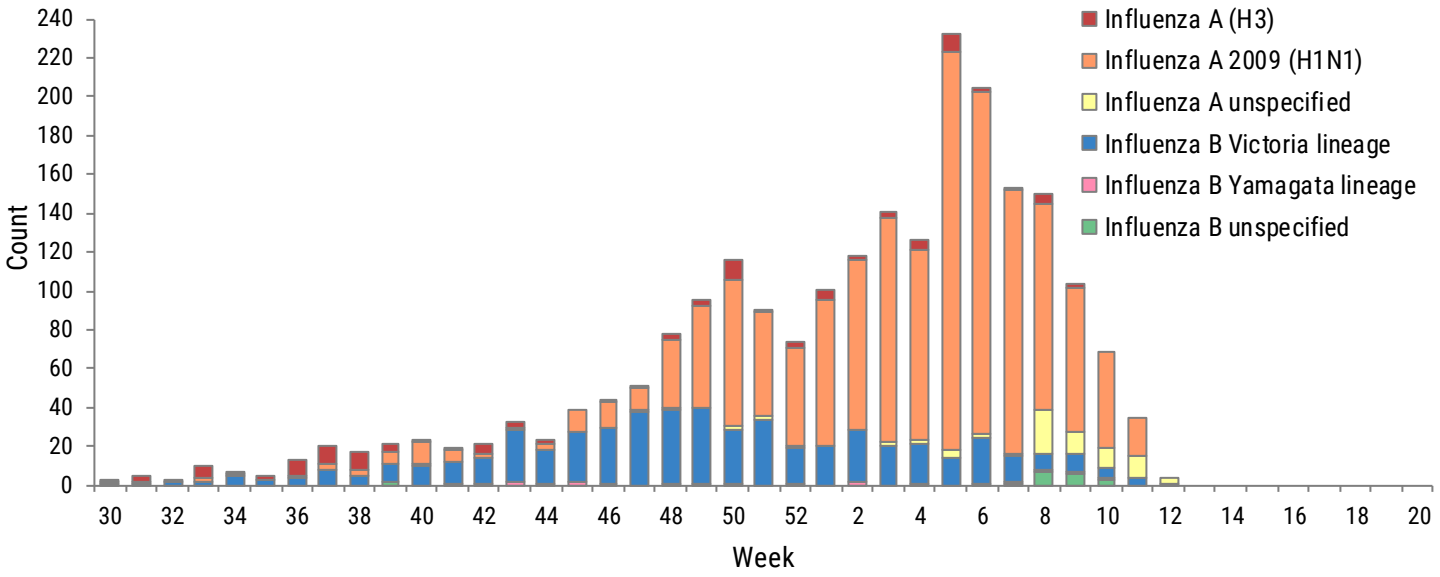
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	137 (45.8%)	84 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	41 (13.7%)	17 influenza-associated outbreaks 24 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	26 (8.7%)	12 influenza-associated outbreaks 14 ILI outbreaks
Nursing facilities	19 (6.4%)	14 influenza-associated outbreaks 5 ILI outbreaks
Other long-term care facilities	35 (11.7%)	26 influenza-associated outbreaks 9 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.0%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.0%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**299 (100.0%)**	**189 influenza-associated outbreaks** **110 ILI outbreaks**

AMERICAN OVERSIGHT

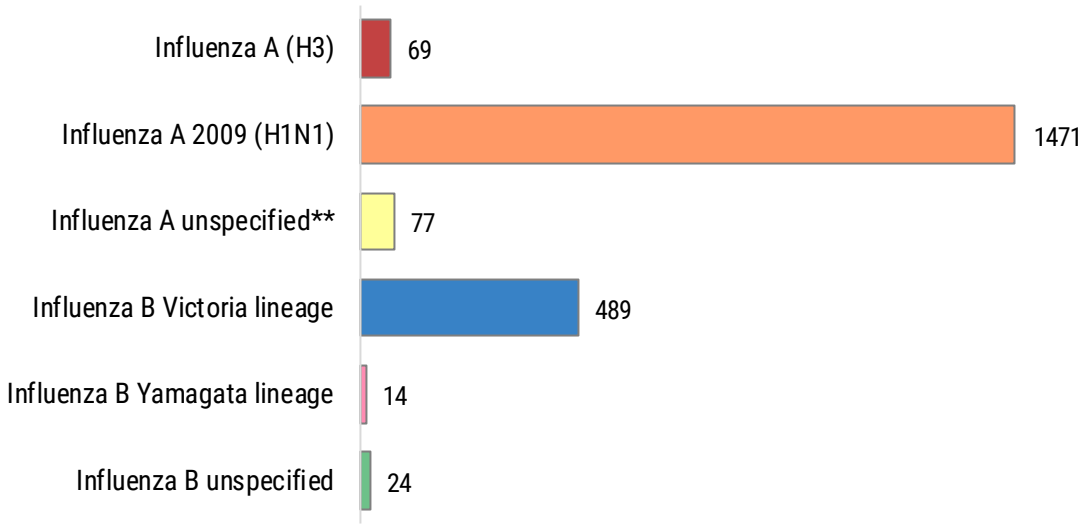
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 12, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 12, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits with discharge diagnoses of influenza or flu** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 12, 2020. Data are organized by region (see Figure 23).

2019-20
Previous 3-season average

Figure 16: In **region 1, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

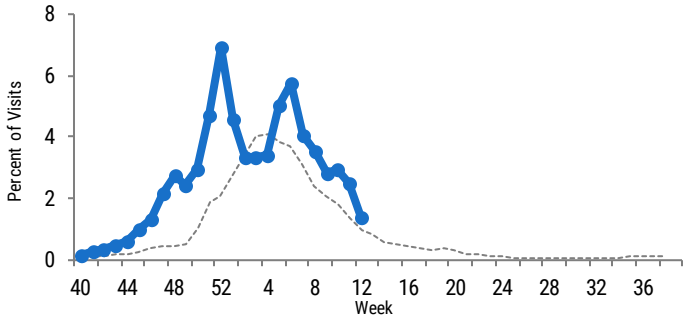


Figure 17: In **region 2, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

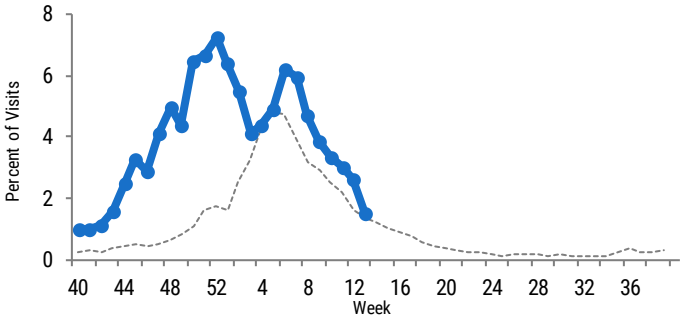


Figure 18: In **region 3, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

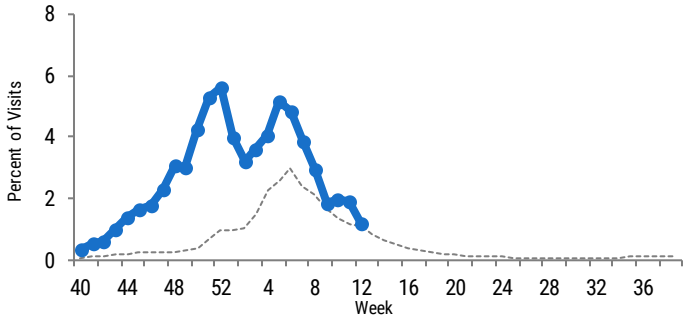


Figure 19: In **region 4, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

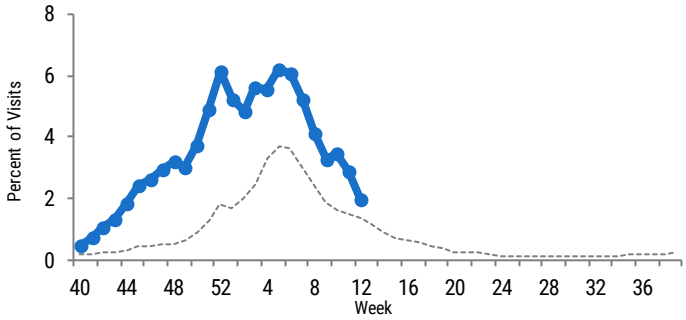


Figure 20: In **region 5, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

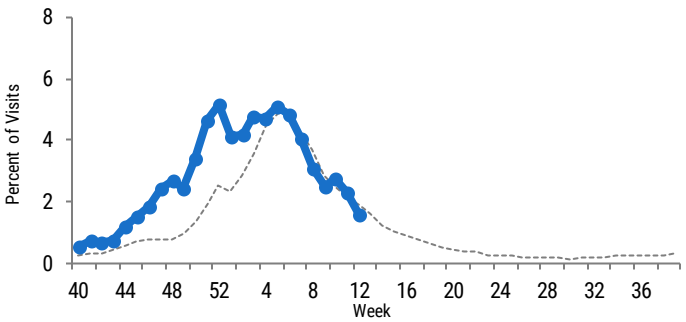


Figure 21: In **region 6, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

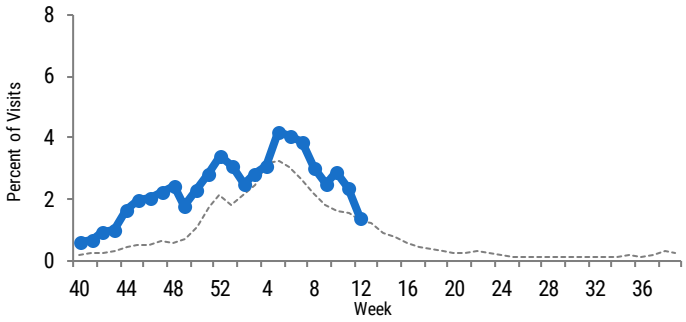
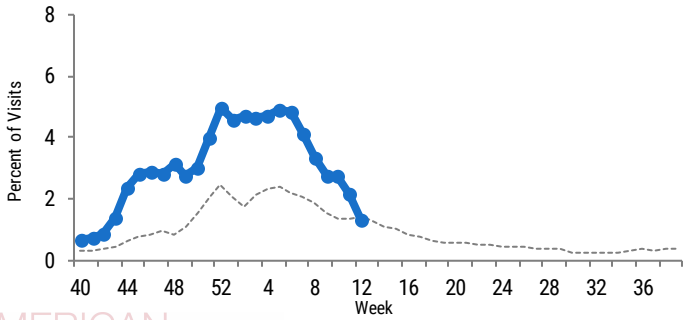


Figure 22: In **region 7, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*



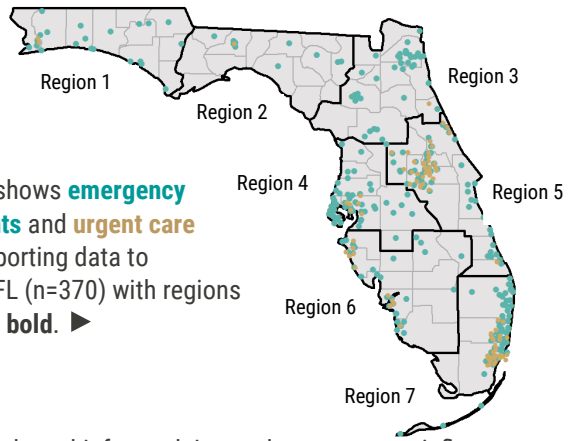


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*Of note, the queries used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

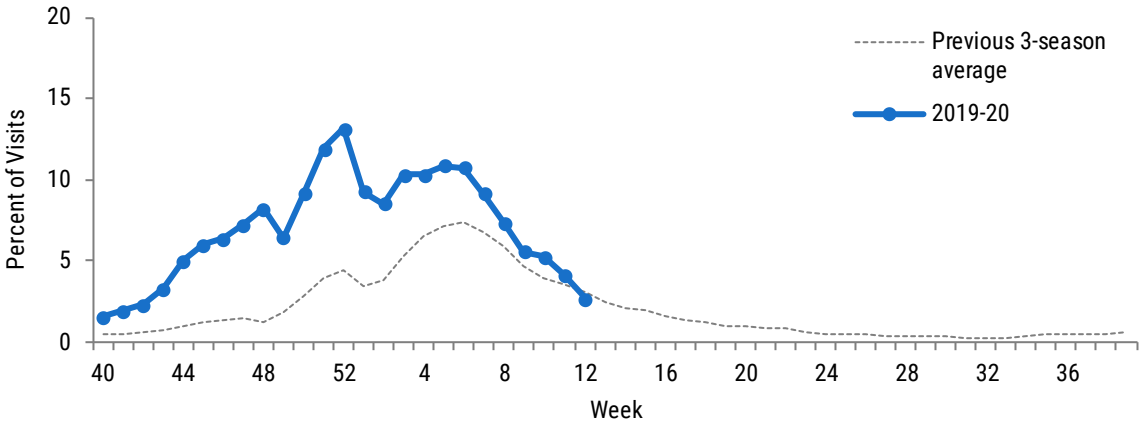
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

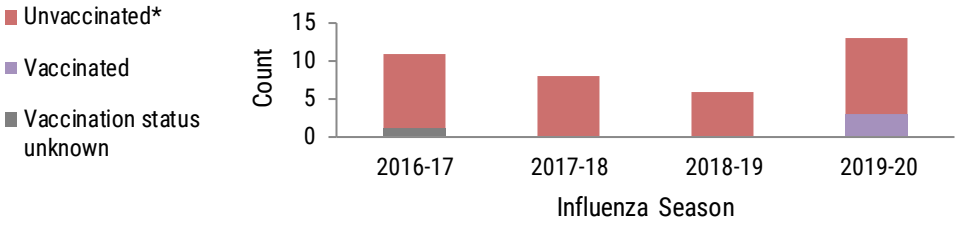
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in children <18 years decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

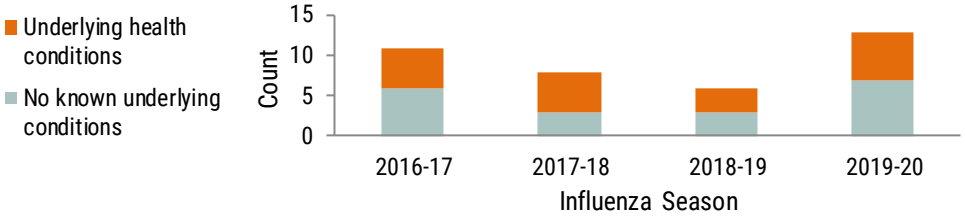


◀ **Figure 24** shows **the percent visits with discharge diagnoses that contain influenza or flu among children <18 years** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

Figures 25-26: In week 12, **one new influenza-associated pediatric death was reported**. A total of 13 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 12, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 12, 2020.

In week 12, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A unspecified in a child with no known underlying health conditions who was not vaccinated for the 2019-20 season.

A total of 13 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

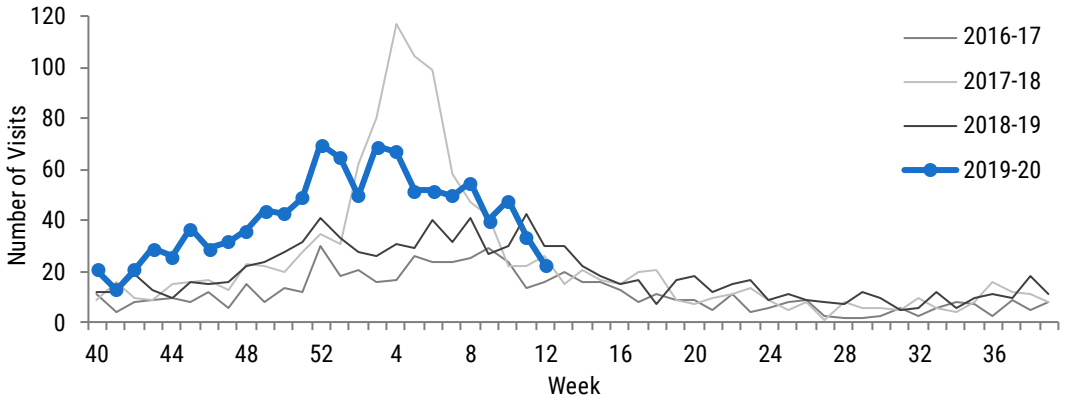
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 12, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



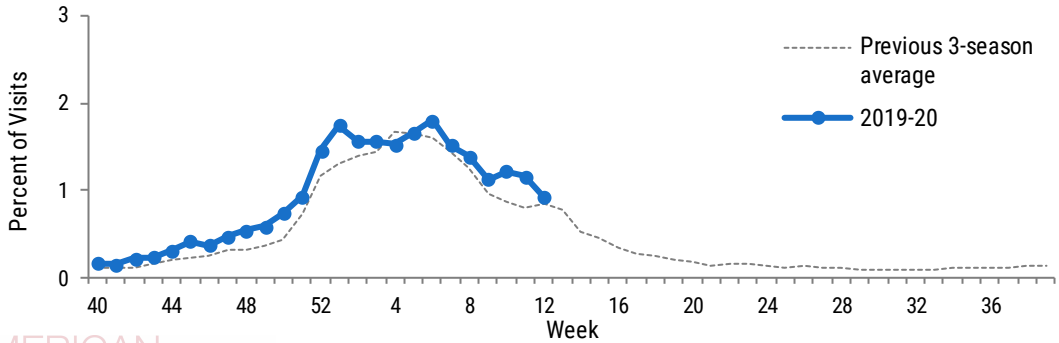
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 12, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 12, the **percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in adults ≥65 years decreased** and similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



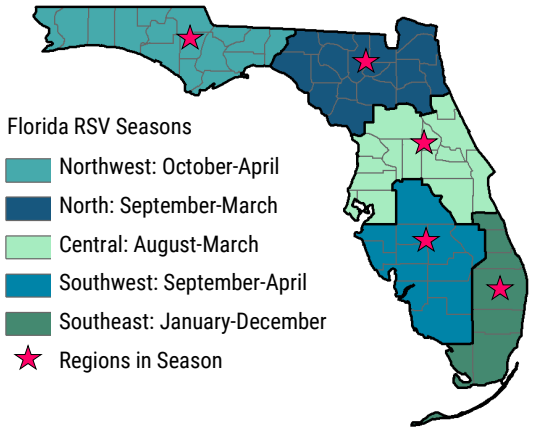
◀ **Figure 28** shows **the percent of visits with discharge diagnoses that contain influenza or flu among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

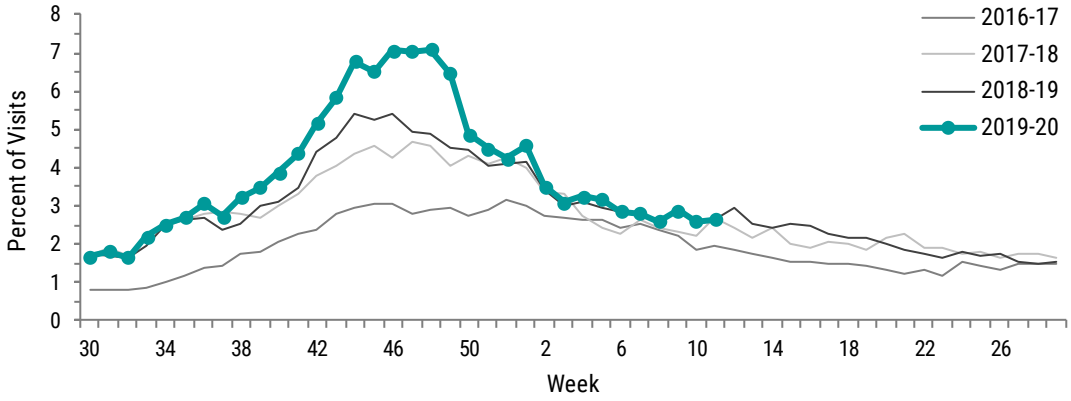
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 12 (March 15-21, 2020) Activity Summary

In week 12, RSV activity in children <5 years increased and was similar to levels observed at this time in previous seasons.

No new RSV-associated outbreaks were reported in week 12. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 12, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 12, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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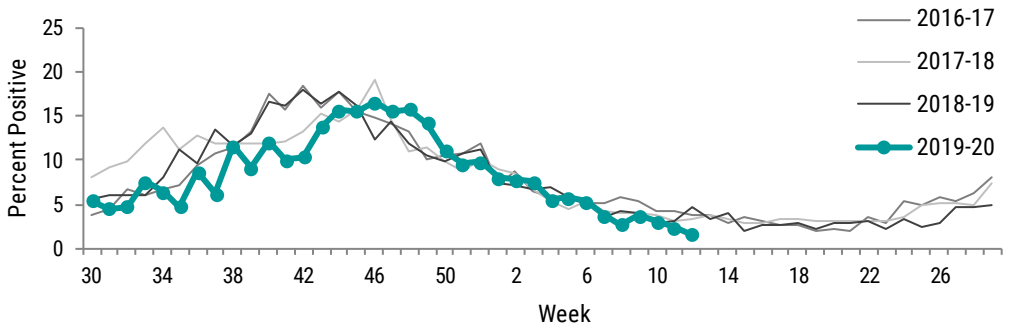
RSV Surveillance

Figure 31: In week 12, **the percent of specimens testing positive for RSV decreased.** Levels were below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 12, 2020. ▶



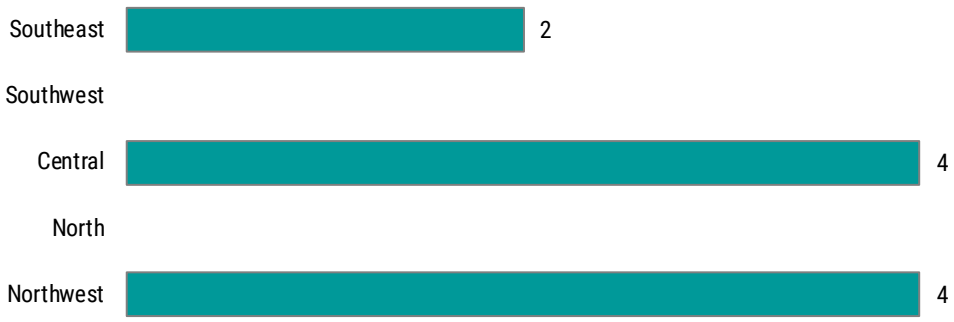
RSV-Associated Outbreaks in Week 12:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 12, no new RSV-associated outbreaks were reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

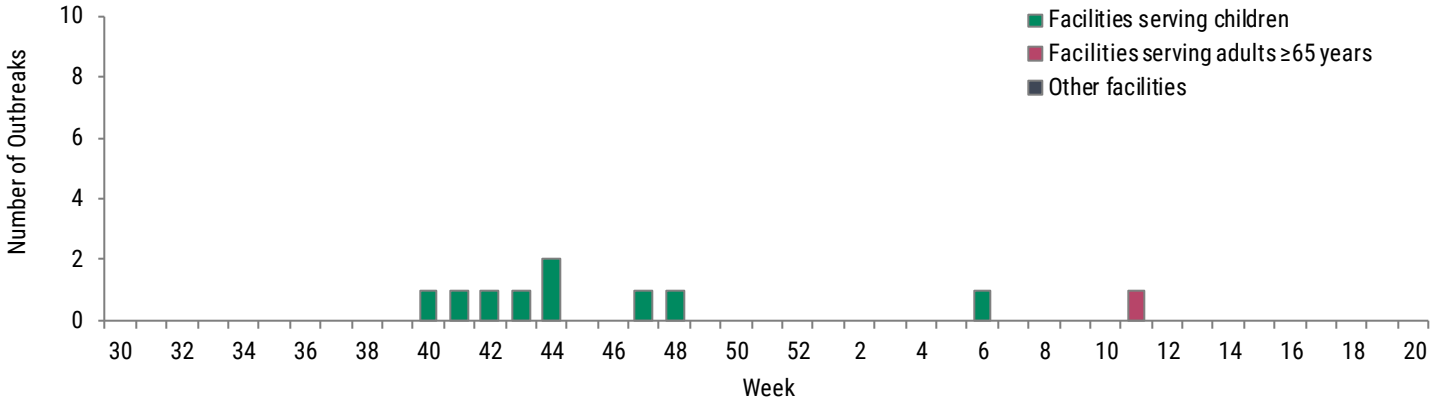
Figure 32: In week 12, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.*



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

*Regions defined in figure 29.

Figure 33: In week 12, no new RSV-associated outbreaks were reported. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

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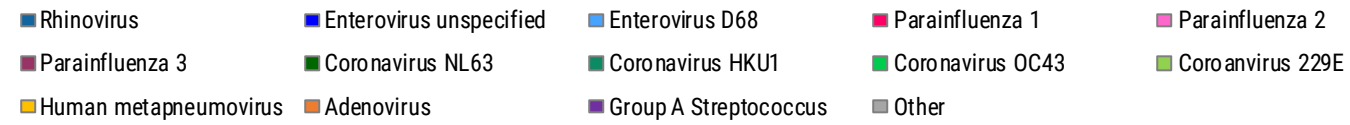
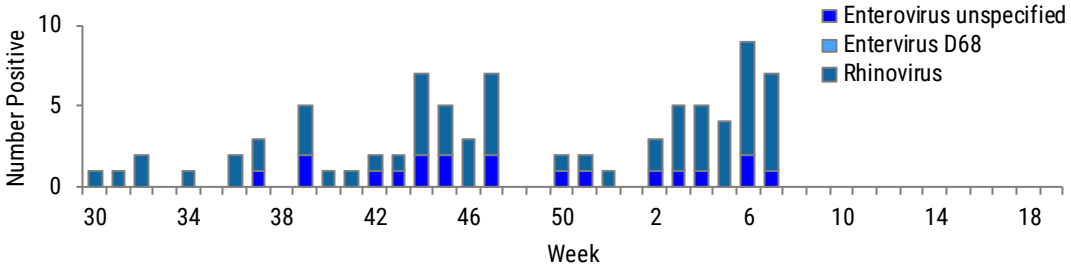
Other Respiratory Virus Surveillance



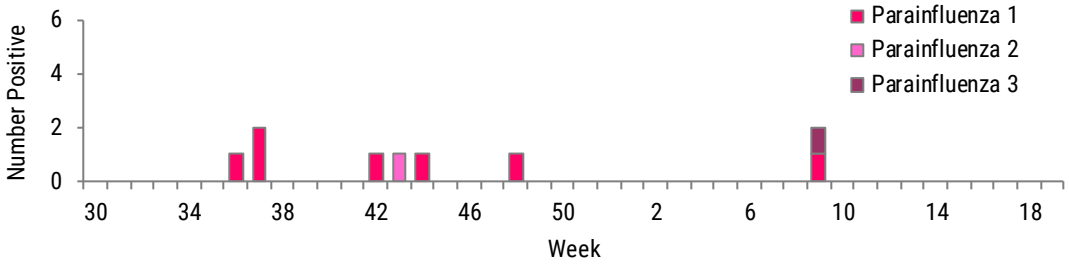


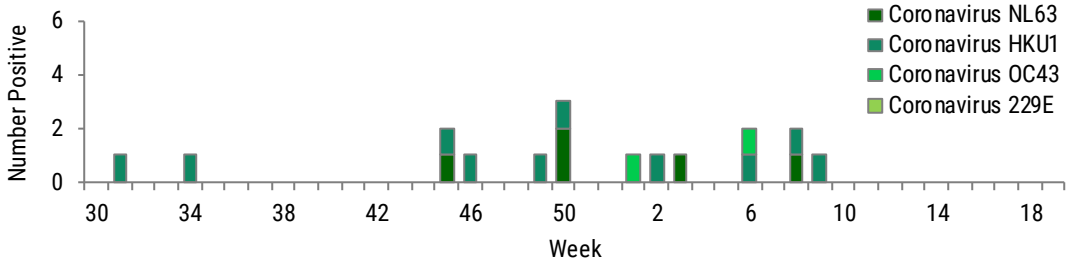
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 12, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

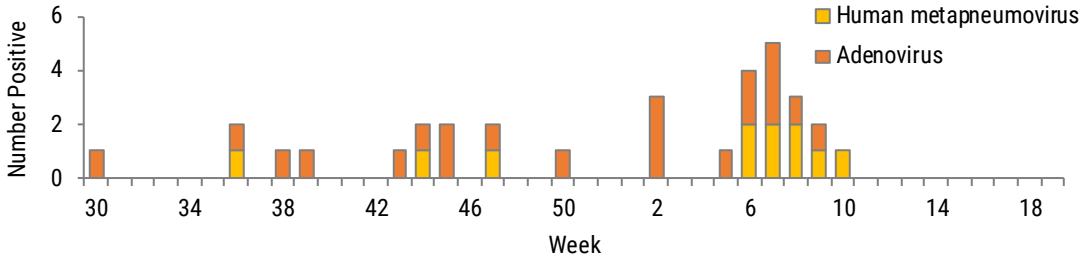
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 12, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Washington	7	2	0	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza and flu-related visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional figures, percentages are calculated as the proportion of ED and UCC visits to participating facilities that include the words “influenza” or “flu” in the discharge diagnoses (with certain exceptions).

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly influenza-like illness (ILI) and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For health care providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida’s geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county’s influenza and ILI surveillance data weekly into The Florida Department of Health’s EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida’s reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 12, 2020 Florida Flu Review
Date:	Wednesday, March 25, 2020 3:52:49 PM
Attachments:	Week 12, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 12, 2020 Florida Flu Review.

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

Likewise, the percent of emergency department and urgent care center visits with discharge diagnoses that include influenza or flu decreased in recent weeks. Activity in week 12 was similar to an average of the past three influenza seasons for this time.

Of note, some of the figures in this report that previously displayed chief complaints of ILI were updated to display discharge diagnoses of influenza or flu to better reflect influenza activity trends in Florida.

Eight outbreaks were reported, down from eleven outbreaks in the previous week. Of the eight outbreaks reported, two were influenza-associated and six were ILI.

One new influenza-associated pediatric death was reported. Thirteen influenza-associated pediatric deaths have been reported so far this season; the majority these deaths were children who were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend vaccination as long as influenza viruses are circulating. Annual vaccination is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).

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- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 12: 3/15/20-3/21/20

Geographic Spread: **Regional**

Predominant Strain: **A 2009 (H1N1)**

Influenza Activity Trend: **Decreasing**

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

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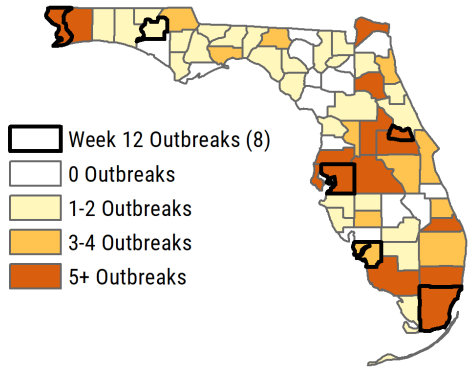
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

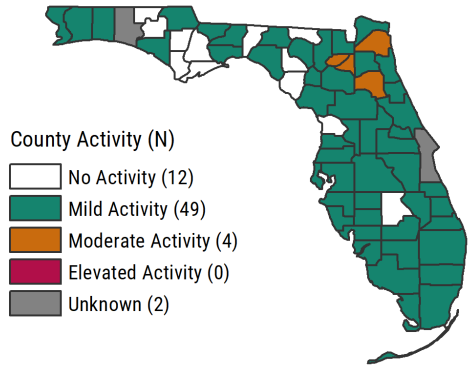
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

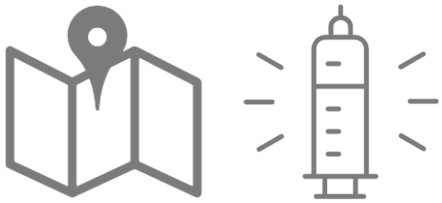
Reported as of 3/21/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 25, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Mwedu Mtenga, MPH: Casey McBride, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006886

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

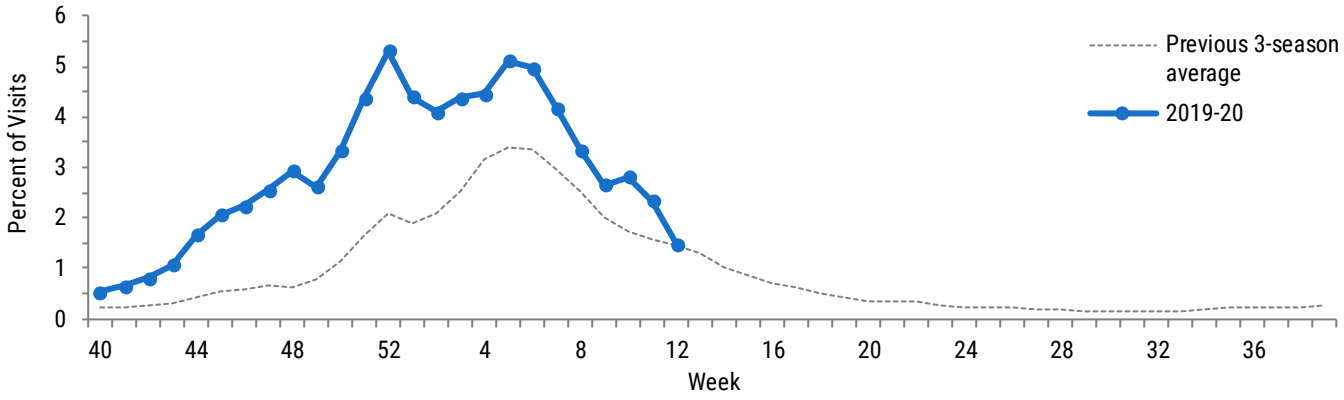
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu statewide decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



▲ **Figure 1** shows **the percent of visits with discharge diagnoses that include influenza or flu** (with certain exceptions) for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 12, 2020) and the previous three season average (2018-19, 2017-18, and 2016-17). Of note, influenza may not be laboratory-confirmed for all the visits included in this query. For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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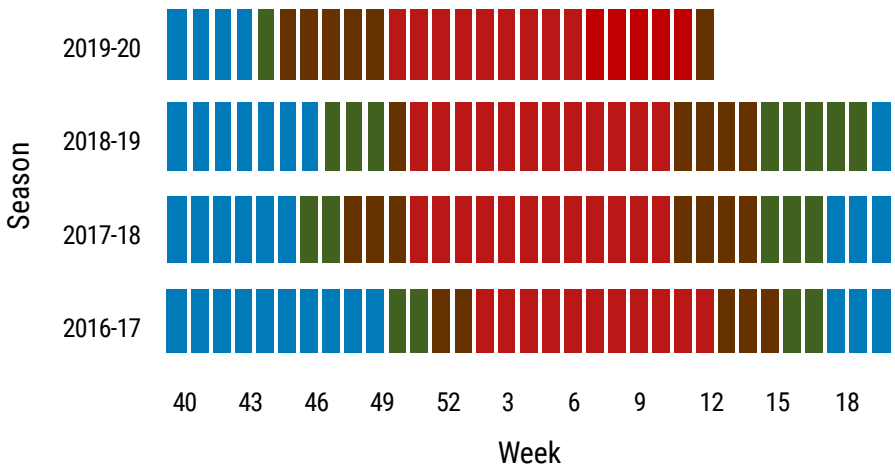
Statewide Activity

Figure 2: In week 12, Florida reported **regional geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 12, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 12, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 12, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

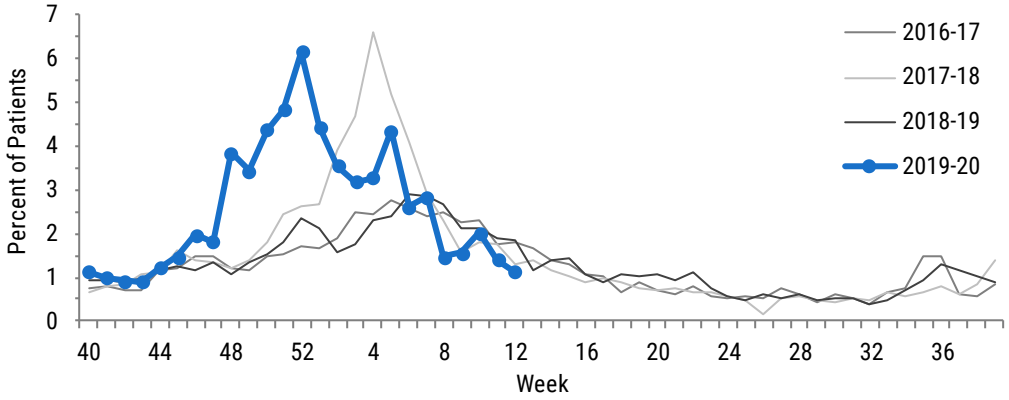
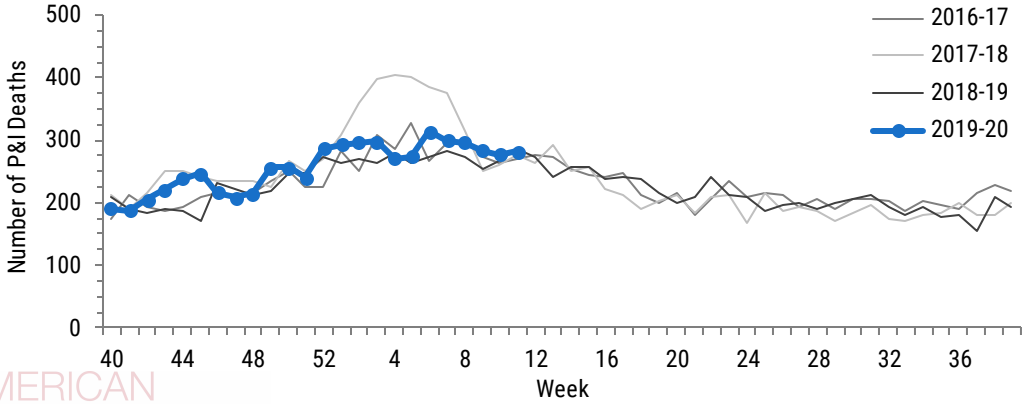


Figure 4: In week 11 (ending 3/14/20), **the number of pneumonia and influenza deaths identified statewide increased slightly** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 12. Four counties reported **moderate activity,** and no counties reported **elevated activity.**

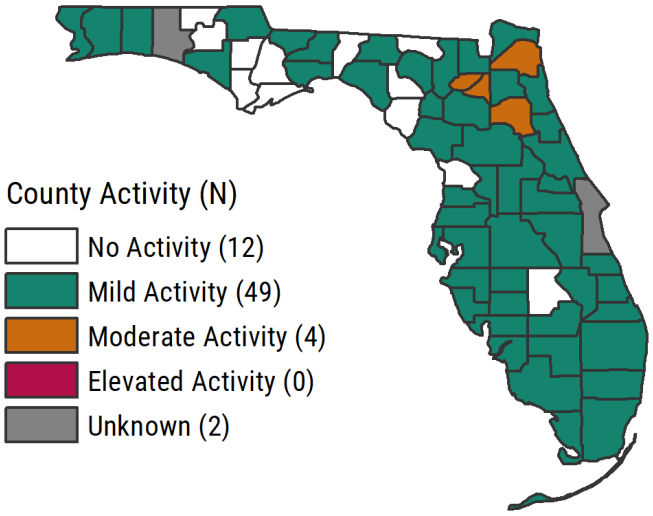
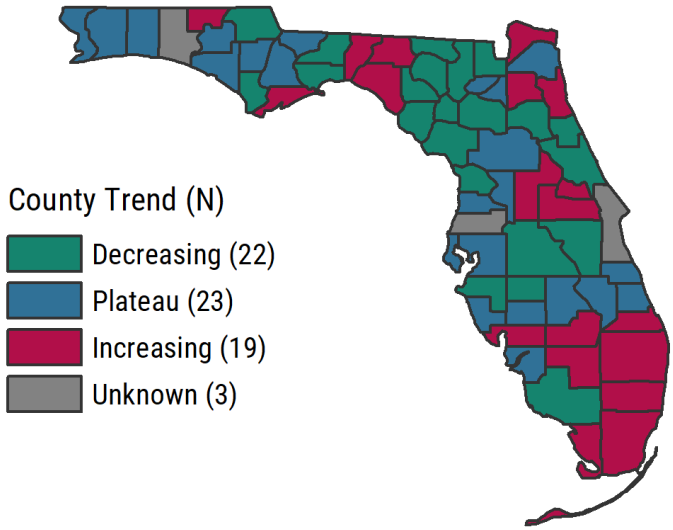
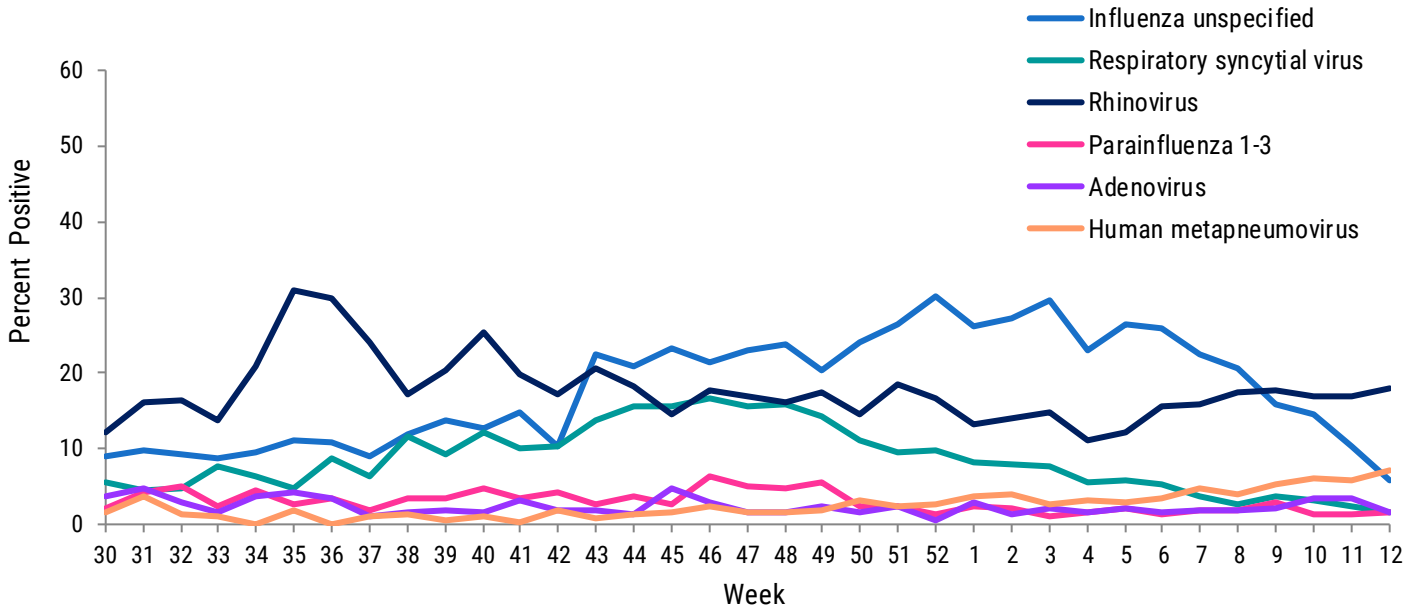


Figure 6: Most counties reported **activity at a plateau** for week 12. Nineteen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 12, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance (including influenza). The **percent of specimens testing positive for influenza decreased notably** in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 12, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 12 Outbreaks at a Glance:

Number Reported:
8 Outbreaks

Influenza-Associated:
2 Outbreaks

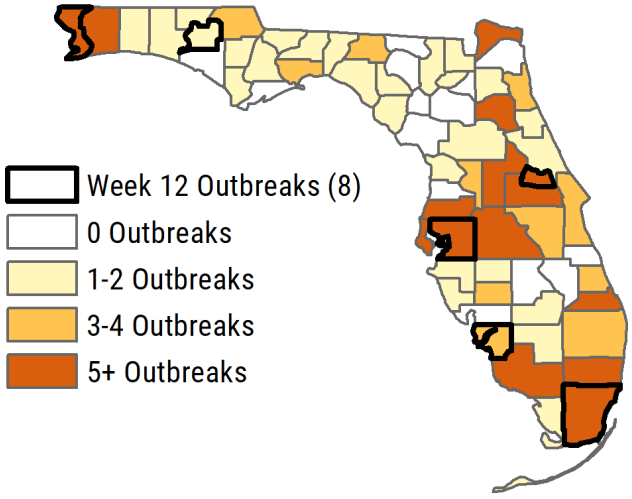
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 12, two influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

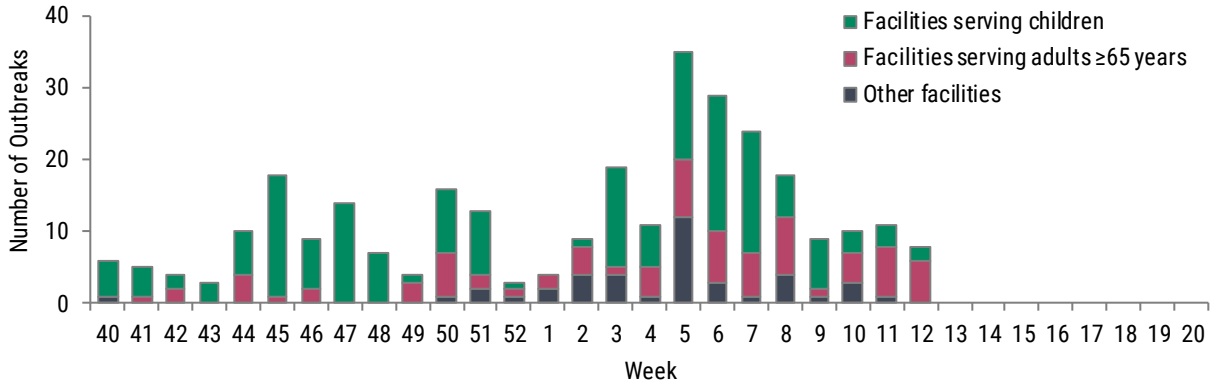
Severe outcomes* were reported in two of eight outbreaks. One or more hospitalizations and no deaths were reported in these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). Both of the outbreaks with severe outcomes in week 12 were in facilities serving adults aged ≥65 years.



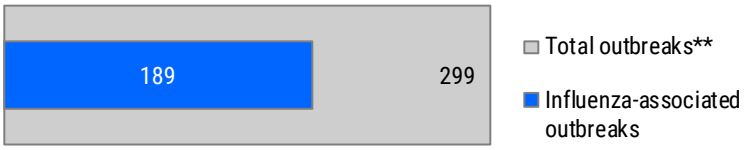
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 12 are **outlined in bold.**

Figure 9: In week 12, **six outbreaks** were reported among **facilities serving adults aged ≥65 years, two outbreaks** were reported in **facilities serving children,** and **no outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 12, **63.2% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 12, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

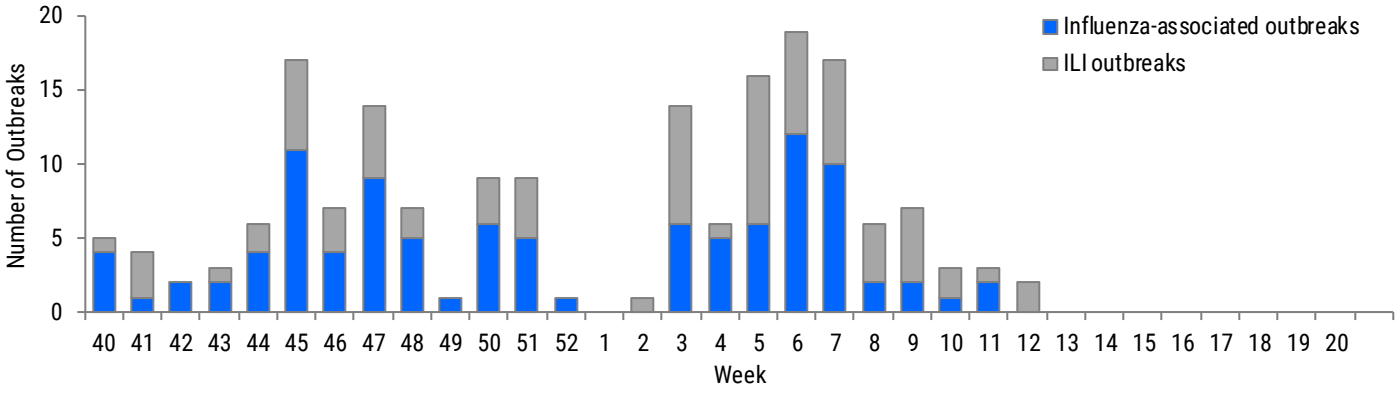
2 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 12, two new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 12, **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

Facilities Serving Adults ≥65 yrs.**:

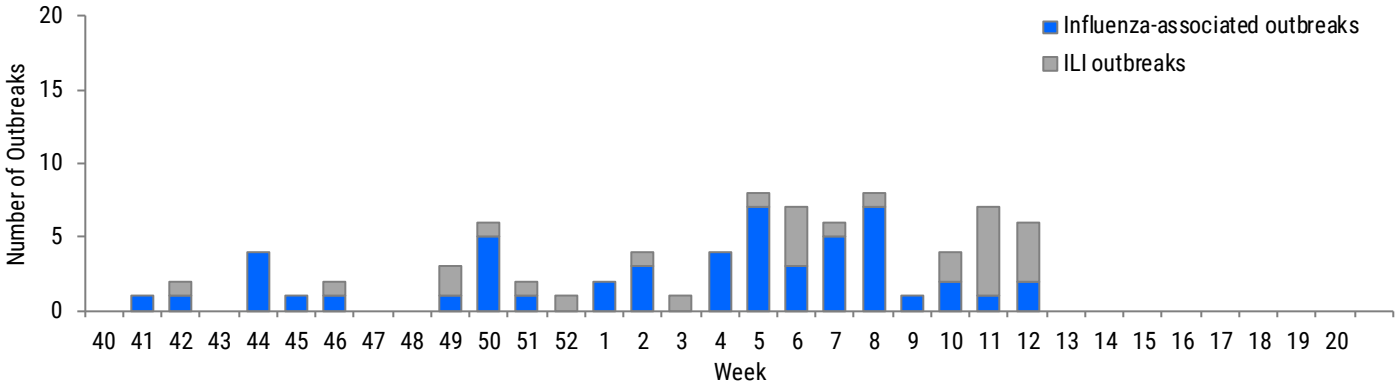
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 12, six new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 12, **four ILI outbreaks** and **two influenza-associated outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

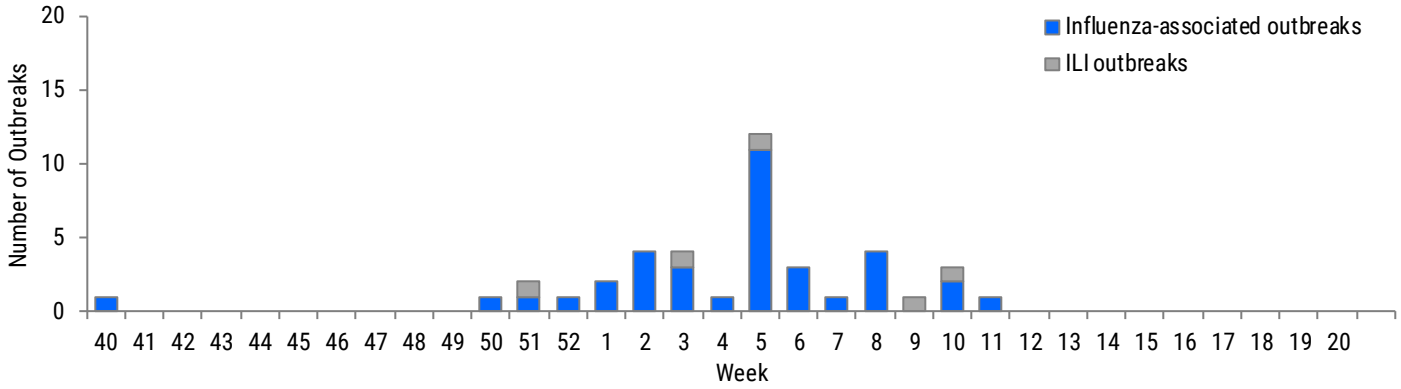
0 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 12, no new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 12, no new outbreaks were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

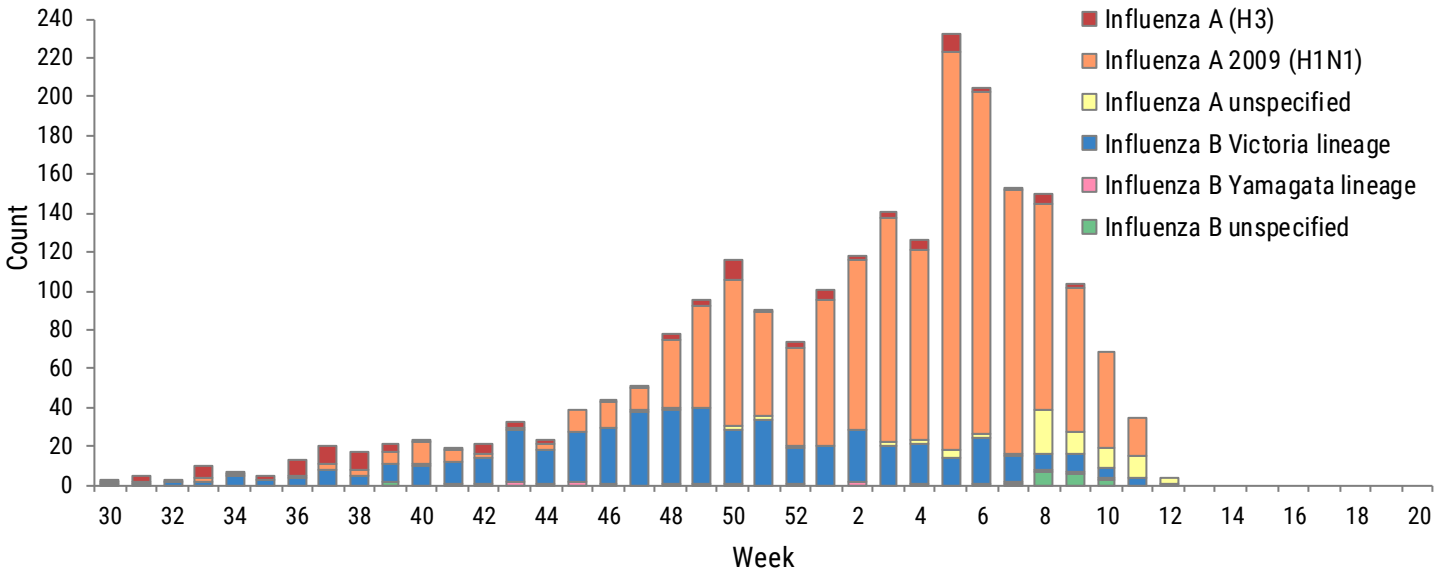
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	137 (45.8%)	84 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	41 (13.7%)	17 influenza-associated outbreaks 24 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	26 (8.7%)	12 influenza-associated outbreaks 14 ILI outbreaks
Nursing facilities	19 (6.4%)	14 influenza-associated outbreaks 5 ILI outbreaks
Other long-term care facilities	35 (11.7%)	26 influenza-associated outbreaks 9 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.0%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.0%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**299 (100.0%)**	**189 influenza-associated outbreaks** **110 ILI outbreaks**

AMERICAN OVERSIGHT

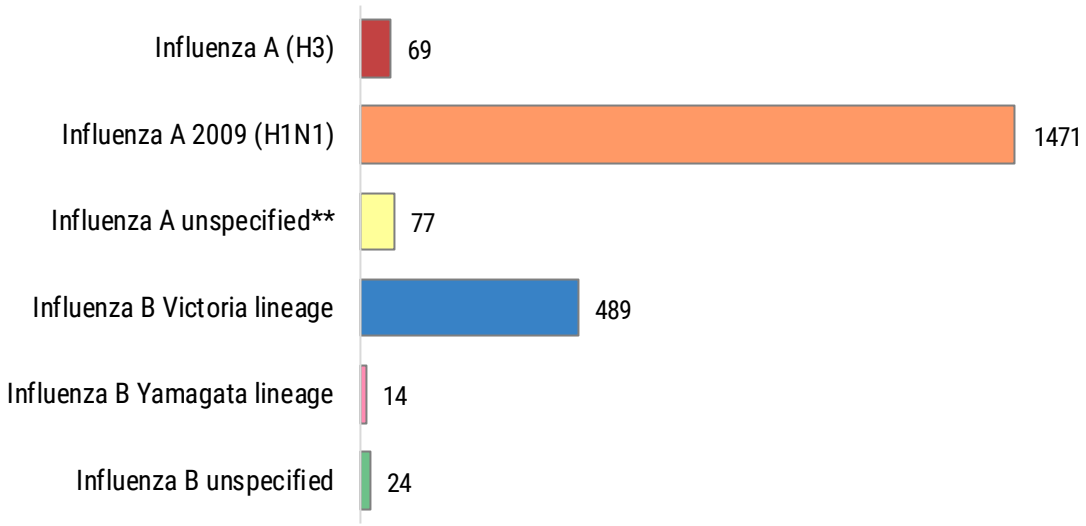
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 12, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 12, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits with discharge diagnoses of influenza or flu** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 12, 2020. Data are organized by region (see Figure 23).

2019-20
Previous 3-season average

Figure 16: In **region 1, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

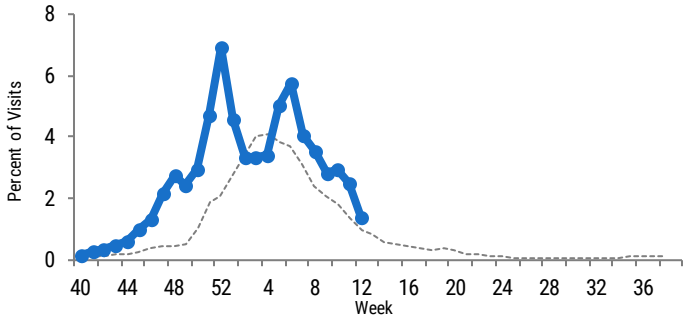


Figure 17: In **region 2, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

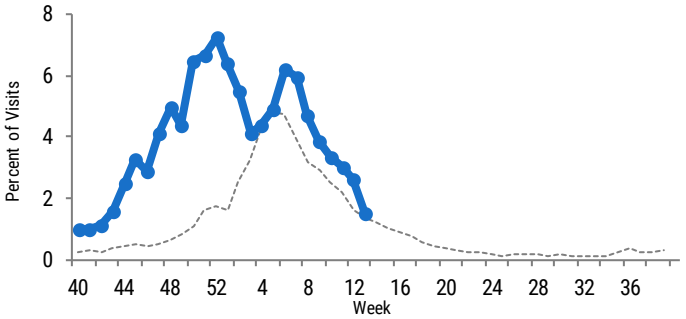


Figure 18: In **region 3, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

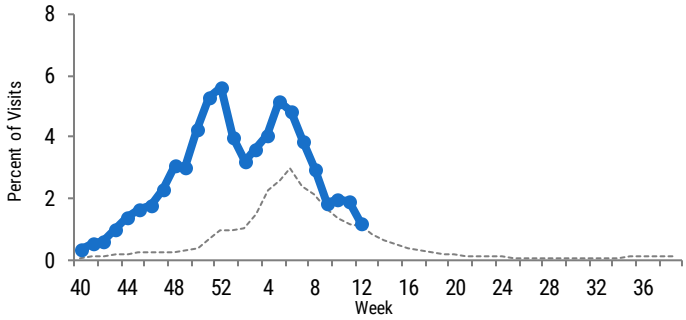


Figure 19: In **region 4, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

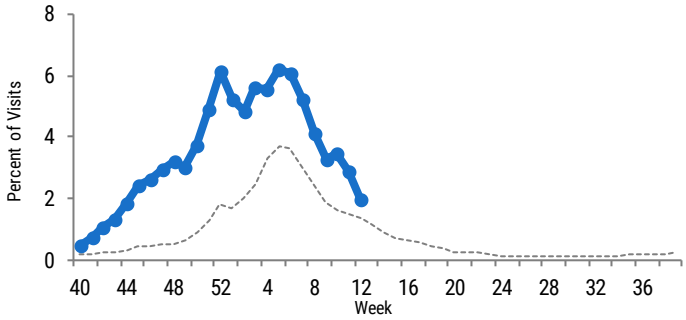


Figure 20: In **region 5, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

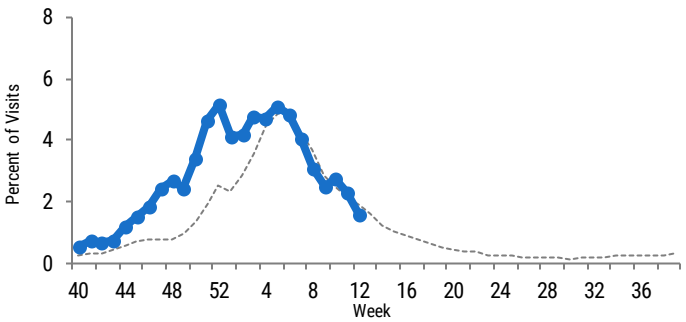


Figure 21: In **region 6, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

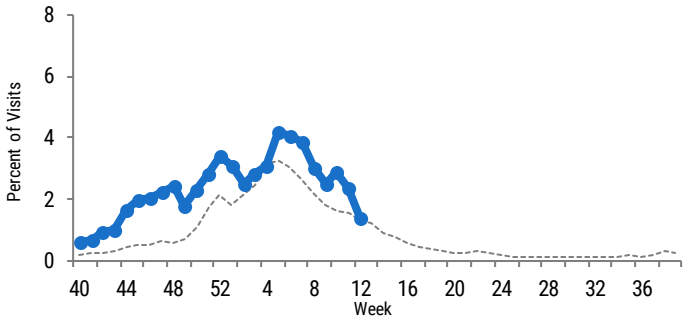
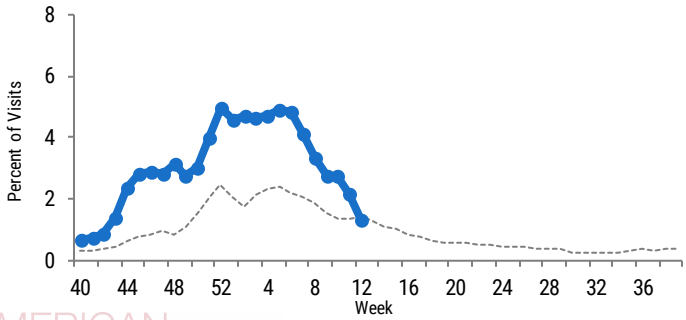


Figure 22: In **region 7, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*



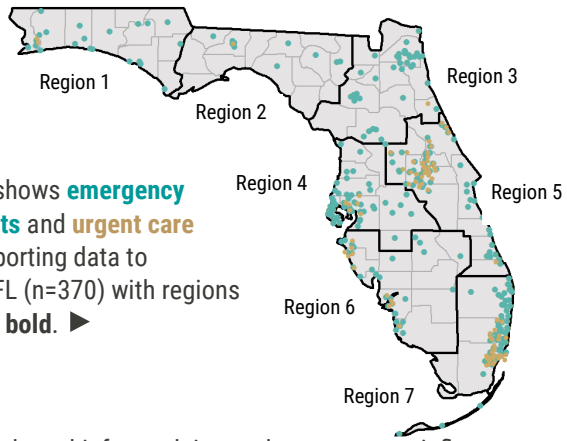


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*Of note, the queries used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

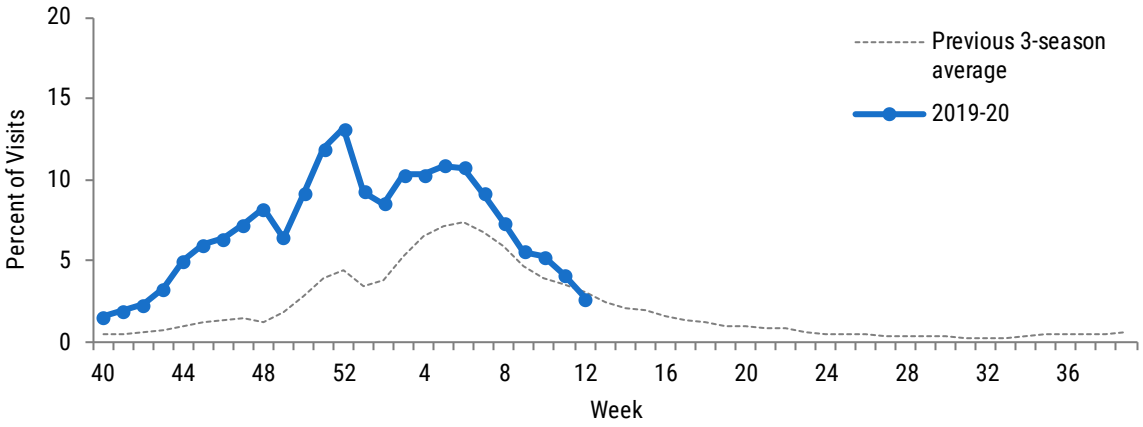
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

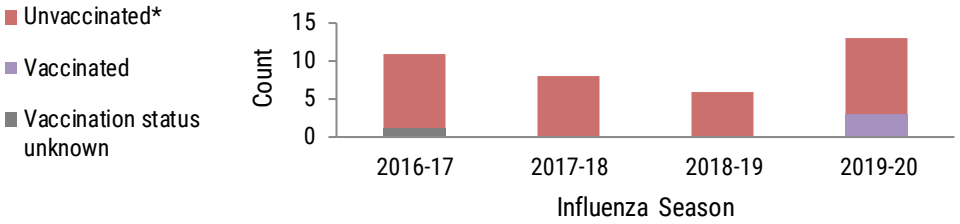
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in children <18 years decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

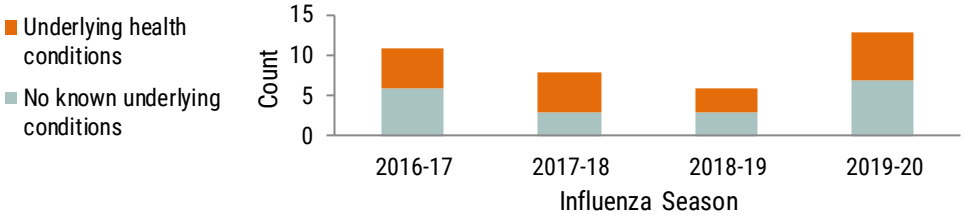


◀ **Figure 24** shows **the percent visits with discharge diagnoses that contain influenza or flu among children <18 years** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

Figures 25-26: In week 12, **one new influenza-associated pediatric death was reported**. A total of 13 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 12, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 12, 2020.

In week 12, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A unspecified in a child with no known underlying health conditions who was not vaccinated for the 2019-20 season.

A total of 13 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

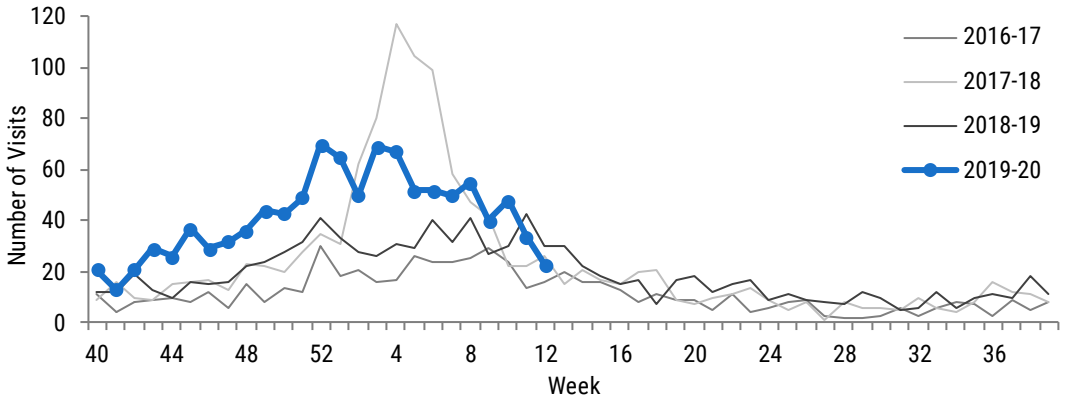
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 12, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



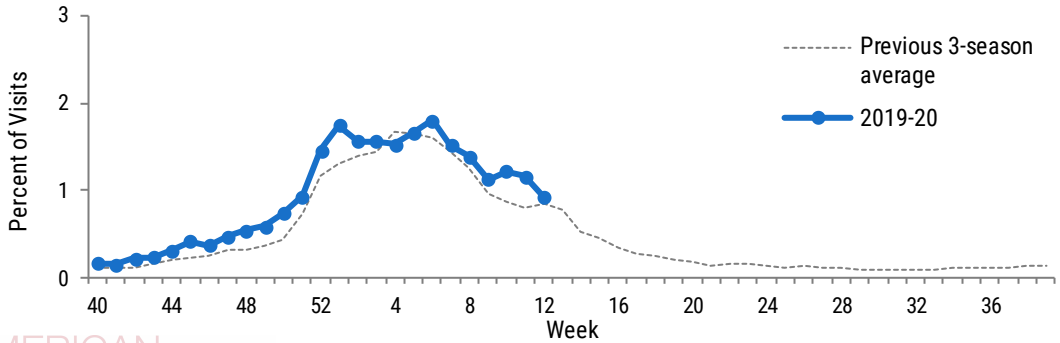
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 12, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 12, the **percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in adults ≥65 years decreased** and similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



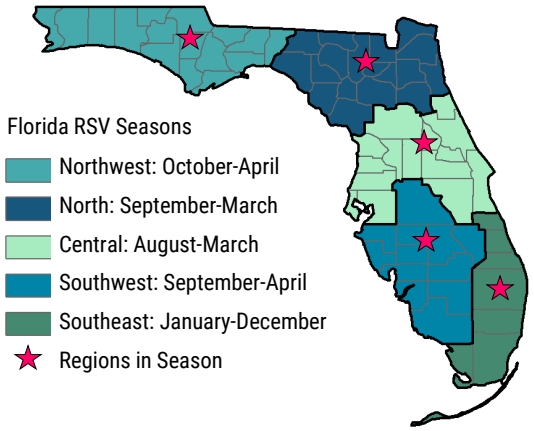
◀ **Figure 28** shows **the percent of visits with discharge diagnoses that contain influenza or flu among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

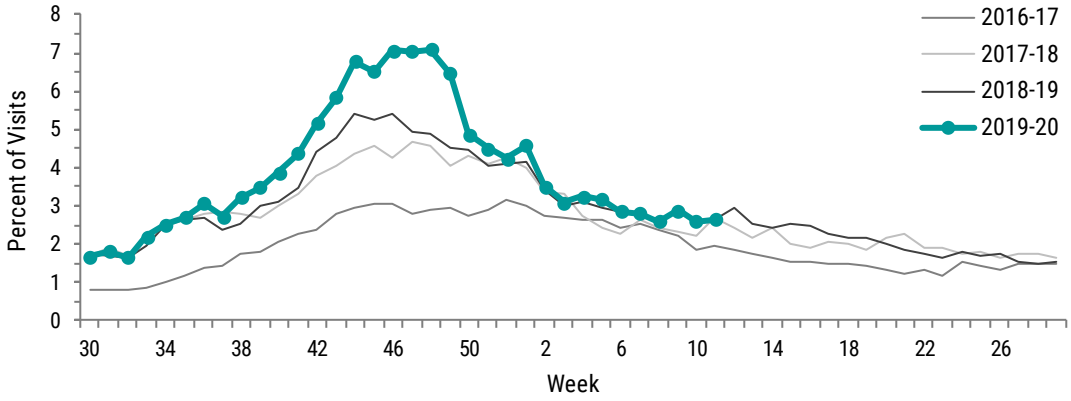
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 12 (March 15-21, 2020) Activity Summary

In week 12, RSV activity in children <5 years increased and was similar to levels observed at this time in previous seasons.

No new RSV-associated outbreaks were reported in week 12. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 12, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 12, 2020.

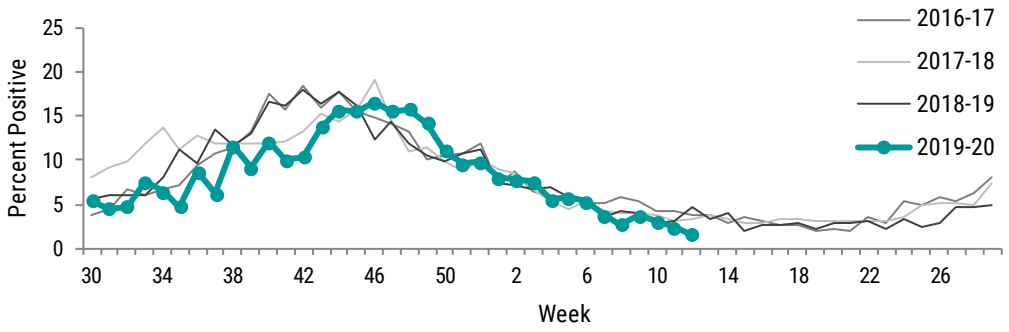
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 12, **the percent of specimens testing positive for RSV decreased.** Levels were below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 12, 2020. ▶



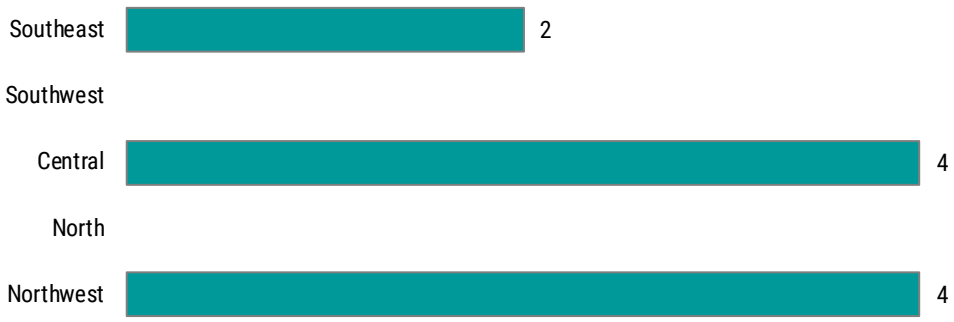
RSV-Associated Outbreaks in Week 12:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 12, no new RSV-associated outbreaks were reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

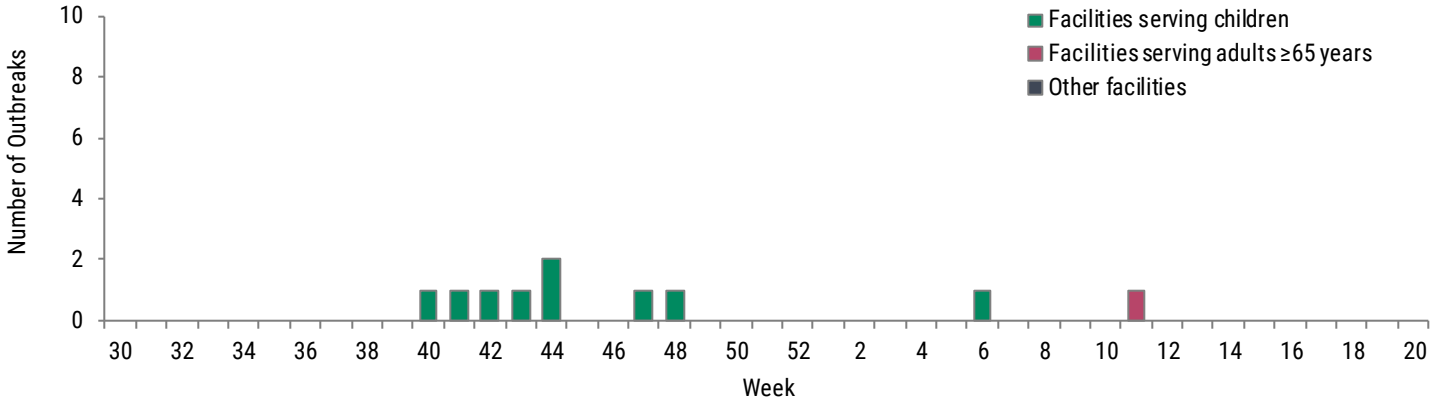
Figure 32: In week 12, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.*



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

*Regions defined in figure 29.

Figure 33: In week 12, no new RSV-associated outbreaks were reported. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

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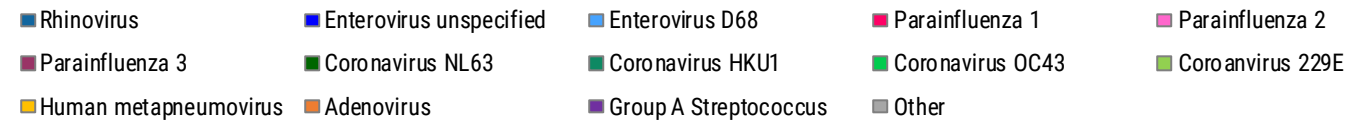
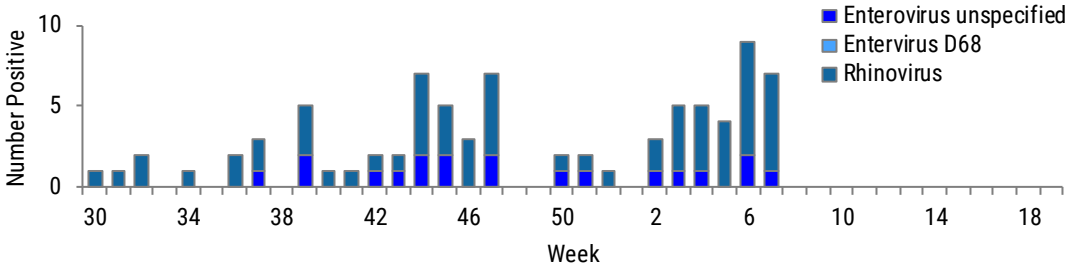
Other Respiratory Virus Surveillance



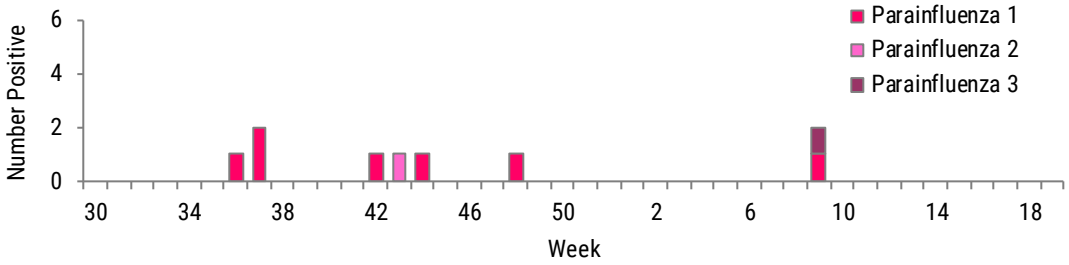


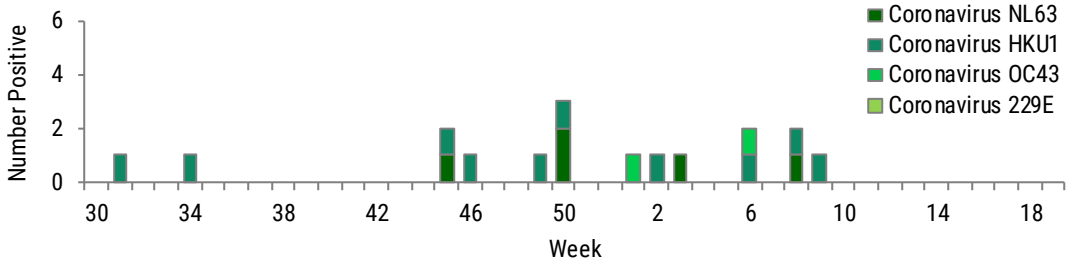
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 12, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

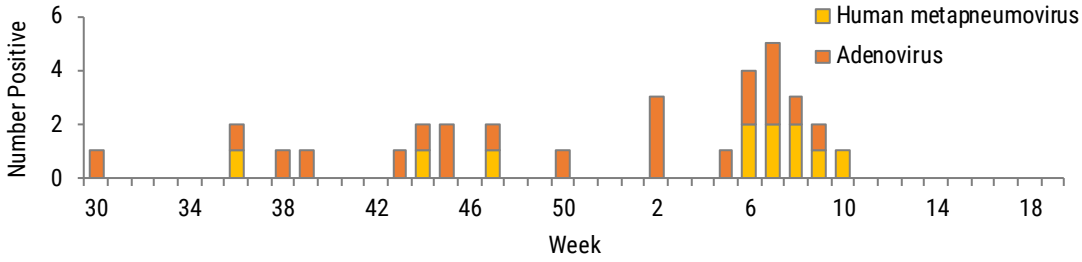
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 12, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Washington	7	2	0	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza and flu-related visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional figures, percentages are calculated as the proportion of ED and UCC visits to participating facilities that include the words “influenza” or “flu” in the discharge diagnoses (with certain exceptions).

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly influenza-like illness (ILI) and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For health care providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida’s geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county’s influenza and ILI surveillance data weekly into The Florida Department of Health’s EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida’s reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

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From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators; DL DOH CHD Nursing Directors
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 12, 2020 Florida Flu Review
Date:	Wednesday, March 25, 2020 3:52:43 PM
Attachments:	Week 12, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 12, 2020 Florida Flu Review.

Week 12 influenza & influenza-like illness (ILI) activity summary:

Statewide, the percentage of respiratory specimens testing positive for influenza continued to decrease.

Likewise, the percent of emergency department and urgent care center visits with discharge diagnoses that include influenza or flu decreased in recent weeks. Activity in week 12 was similar to an average of the past three influenza seasons for this time.

Of note, some of the figures in this report that previously displayed chief complaints of ILI were updated to display discharge diagnoses of influenza or flu to better reflect influenza activity trends in Florida.

Eight outbreaks were reported, down from eleven outbreaks in the previous week. Of the eight outbreaks reported, two were influenza-associated and six were ILI.

One new influenza-associated pediatric death was reported. Thirteen influenza-associated pediatric deaths have been reported so far this season; the majority these deaths were children who were not vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend vaccination as long as influenza viruses are circulating. Annual vaccination is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).

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- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 12: 3/15/20-3/21/20

Geographic Spread: **Regional**

Predominant Strain: **A 2009 (H1N1)**

Influenza Activity Trend: **Decreasing**

Week 12 influenza & influenza-like illness (ILI) activity summary:

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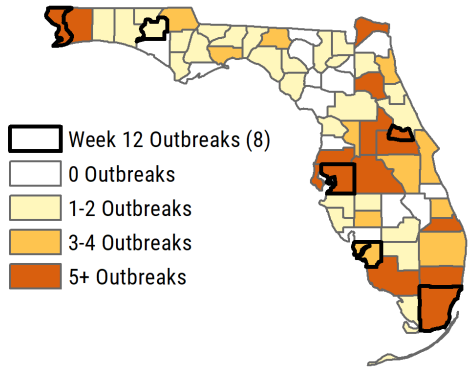
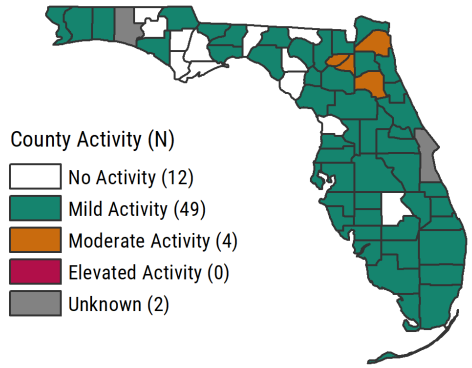
- Avoid touching your eyes, nose, and mouth.
- If you do get sick with influenza, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

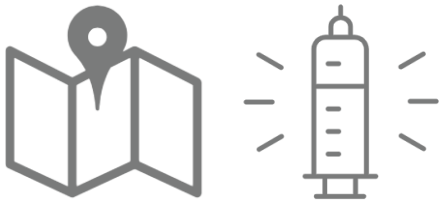
Reported as of 3/21/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 25, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Amy Bogucki, MPH; Mwedu Mtenga, MPH: Casey McBride, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Thomas Troelstrup, MPH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006905

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

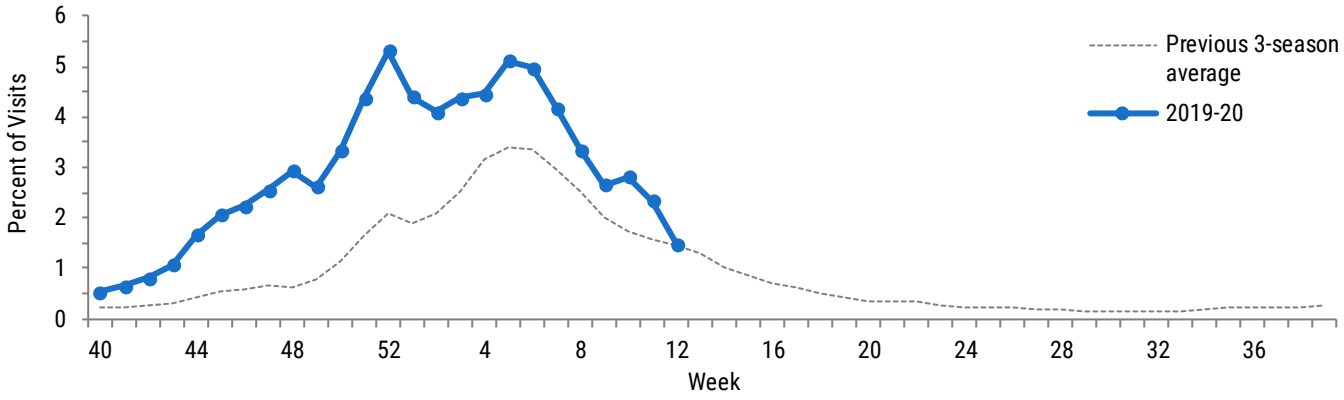
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu statewide decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



▲ **Figure 1** shows **the percent of visits with discharge diagnoses that include influenza or flu** (with certain exceptions) for facilities participating in ESSENCE-FL (n=370) statewide for the current season (week 40, 2019 to week 12, 2020) and the previous three season average (2018-19, 2017-18, and 2016-17). Of note, influenza may not be laboratory-confirmed for all the visits included in this query. For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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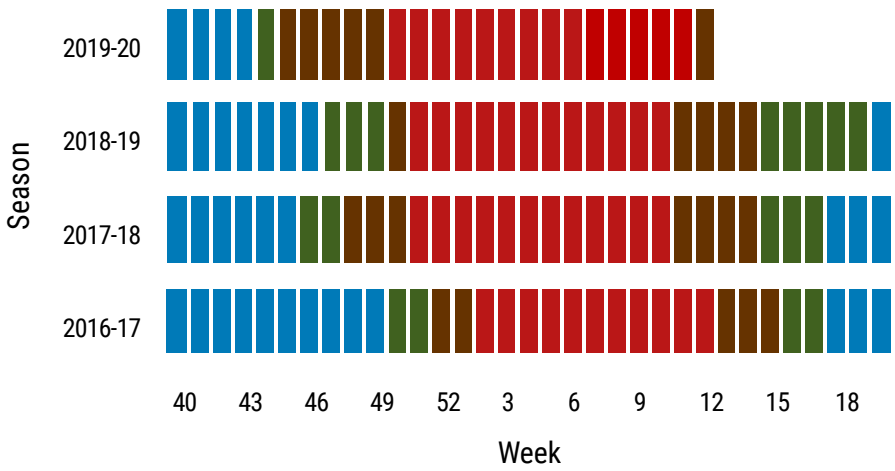
Statewide Activity

Figure 2: In week 12, Florida reported **regional geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 12, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 12, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 12, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

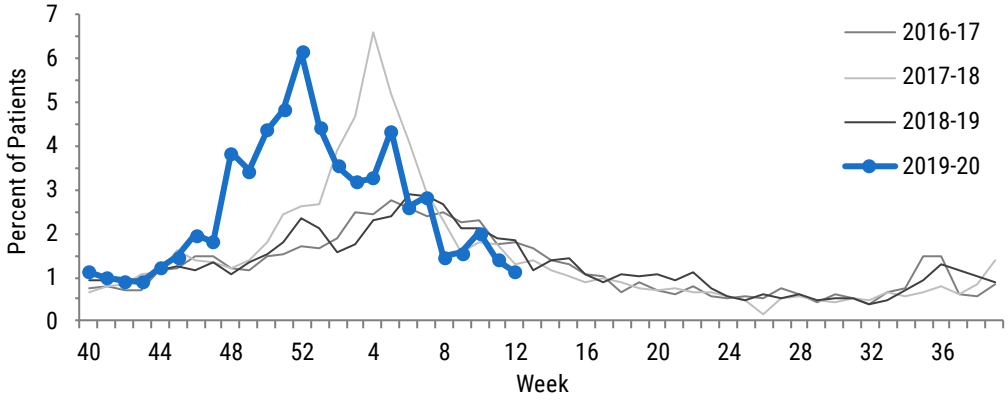
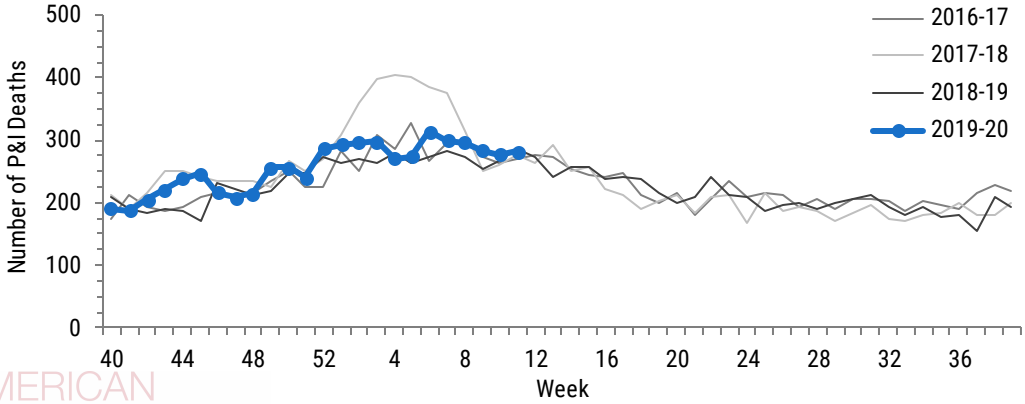


Figure 4: In week 11 (ending 3/14/20), **the number of pneumonia and influenza deaths identified statewide increased slightly** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 11, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 12. Four counties reported **moderate activity,** and no counties reported **elevated activity.**

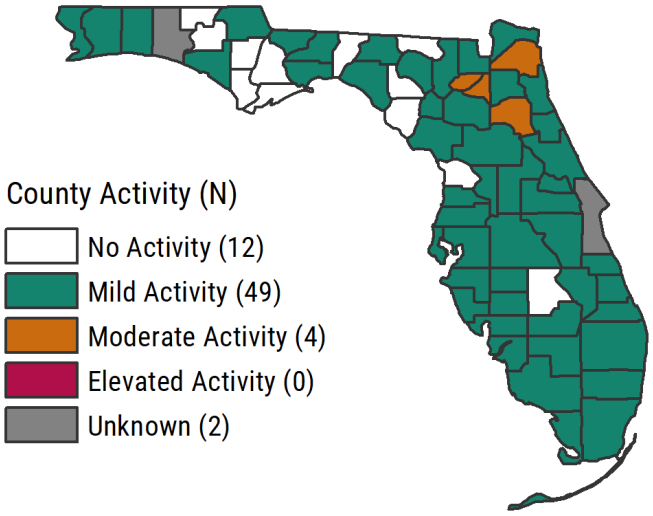
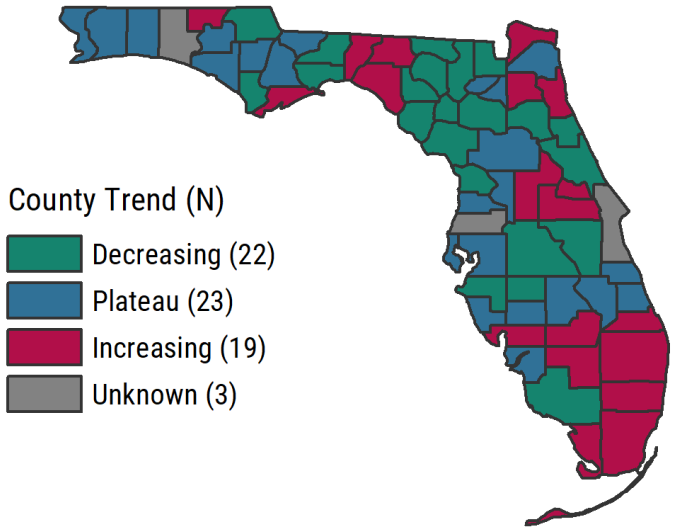
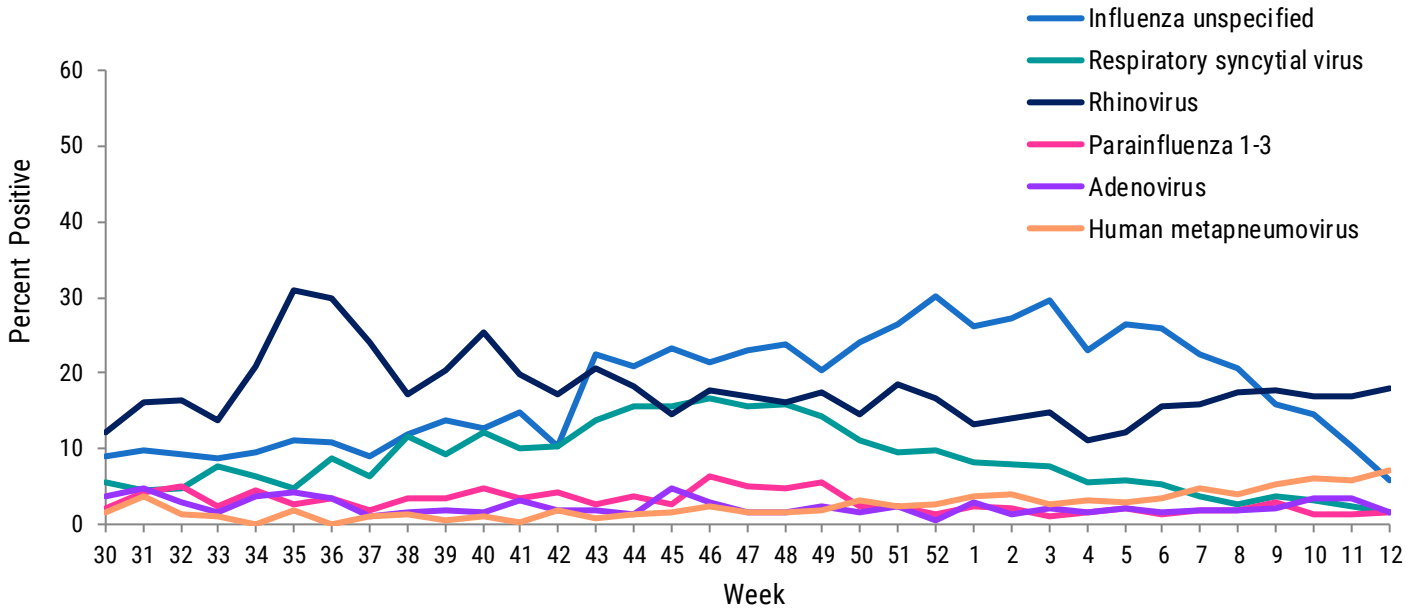


Figure 6: Most counties reported **activity at a plateau** for week 12. Nineteen counties reported **increasing activity,** and 22 counties reported **decreasing activity**.



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 12, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance (including influenza). The **percent of specimens testing positive for influenza decreased notably** in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=8), week 40, 2019 to week 12, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 12 Outbreaks at a Glance:

Number Reported:
8 Outbreaks

Influenza-Associated:
2 Outbreaks

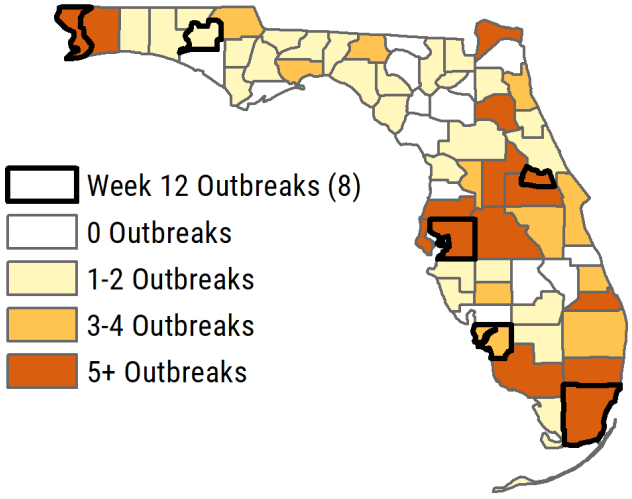
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 12, two influenza-associated and six ILI outbreaks were reported, a slight increase from the previous week.

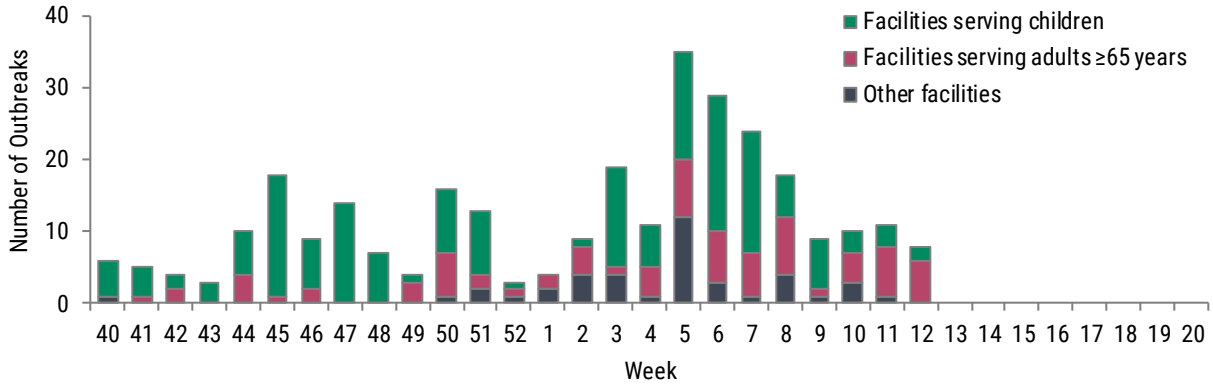
Severe outcomes* were reported in two of eight outbreaks. One or more hospitalizations and no deaths were reported in these outbreaks.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). Both of the outbreaks with severe outcomes in week 12 were in facilities serving adults aged ≥65 years.



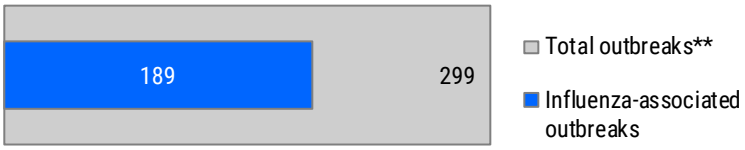
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 12 are **outlined in bold.**

Figure 9: In week 12, **six outbreaks** were reported among **facilities serving adults aged ≥65 years, two outbreaks** were reported in **facilities serving children,** and **no outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 12, **63.2% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 12, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

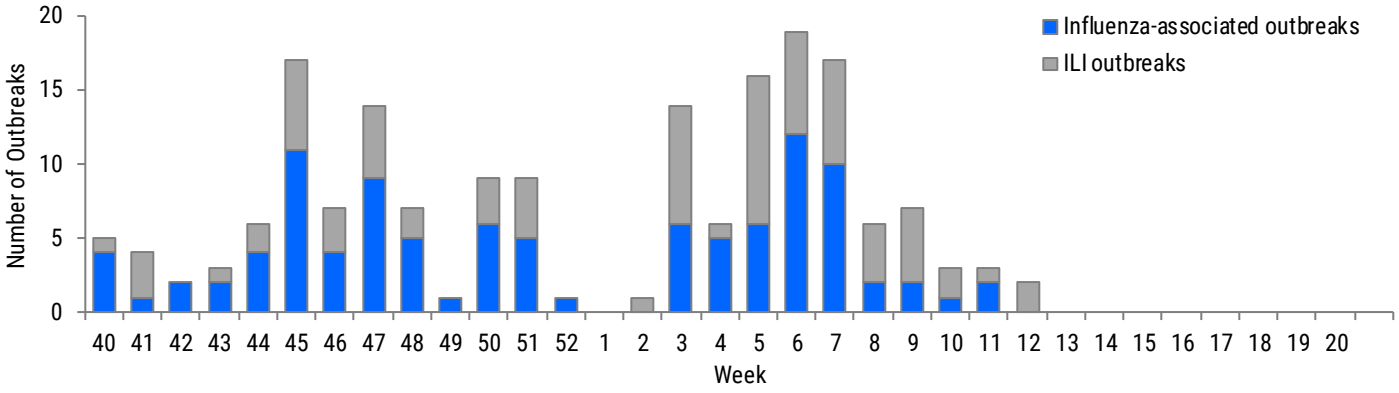
2 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 12, two new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 12, **two ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

Facilities Serving Adults ≥65 yrs.**:

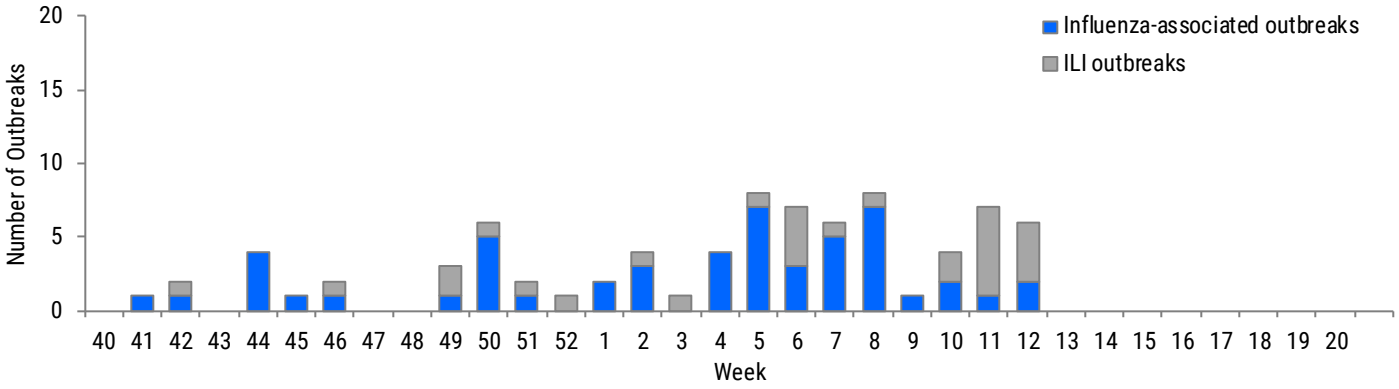
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 12, six new outbreaks of influenza or ILI were reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 12, **four ILI outbreaks** and **two influenza-associated outbreaks** were reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

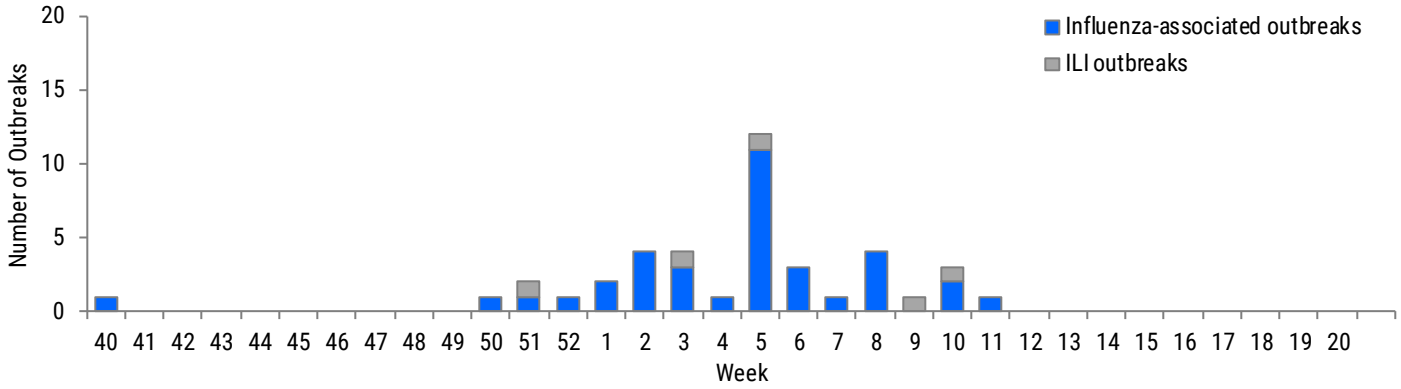
0 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 12, no new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 12, no new outbreaks were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 12, 2020.

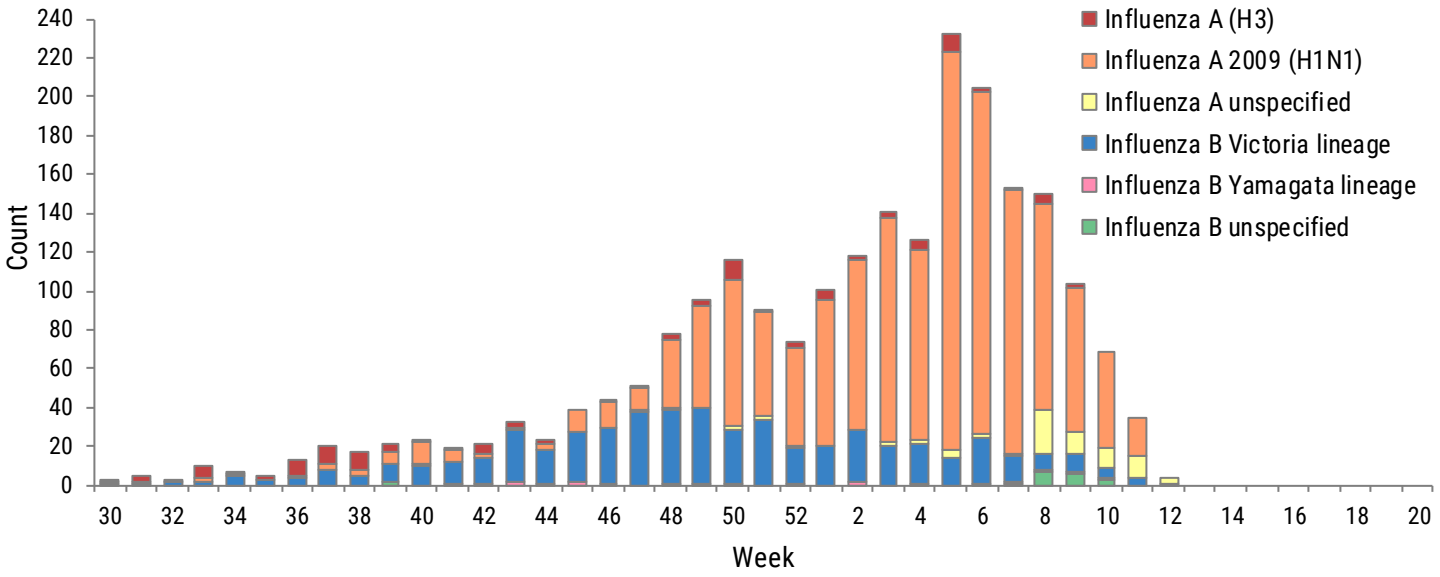
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	137 (45.8%)	84 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	41 (13.7%)	17 influenza-associated outbreaks 24 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	26 (8.7%)	12 influenza-associated outbreaks 14 ILI outbreaks
Nursing facilities	19 (6.4%)	14 influenza-associated outbreaks 5 ILI outbreaks
Other long-term care facilities	35 (11.7%)	26 influenza-associated outbreaks 9 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	33 (11.0%)	31 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.0%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	5 (1.7%)	3 influenza-associated outbreaks 2 ILI outbreaks
Total	**299 (100.0%)**	**189 influenza-associated outbreaks** **110 ILI outbreaks**

AMERICAN OVERSIGHT

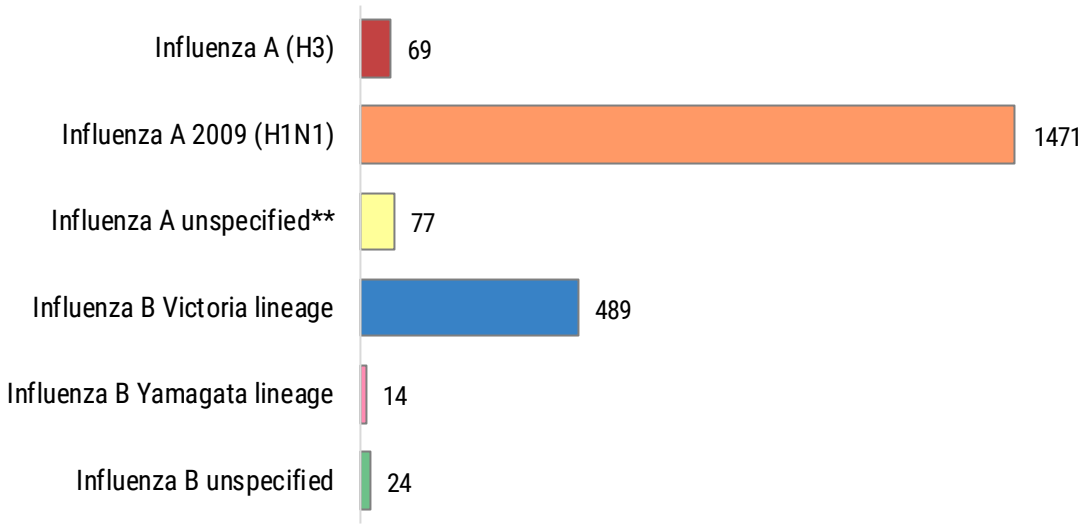
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 12, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 12, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits with discharge diagnoses of influenza or flu** at ESSENCE-FL participating facilities (n=370) from week 40, 2016 to week 12, 2020. Data are organized by region (see Figure 23).

2019-20
Previous 3-season average

Figure 16: In **region 1, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

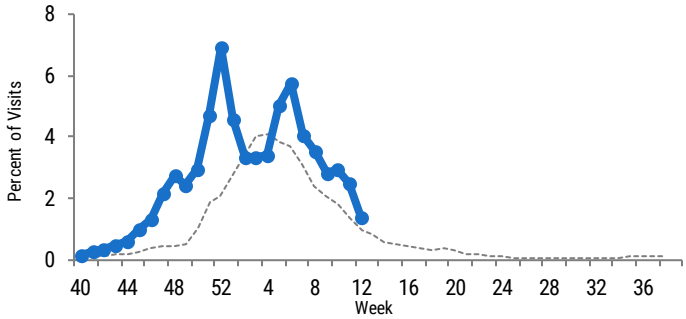


Figure 17: In **region 2, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

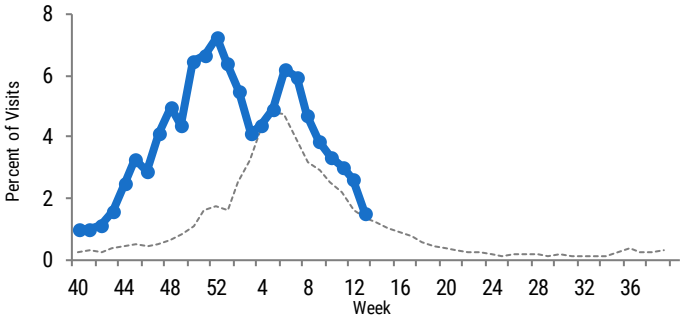


Figure 18: In **region 3, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

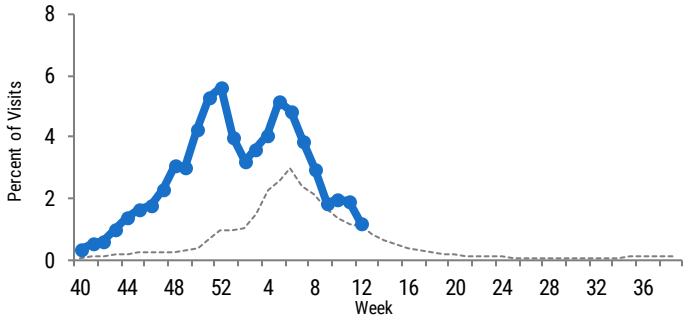


Figure 19: In **region 4, influenza and flu activity decreased** during week 12 but remained slightly above the previous three-season average for this time.*

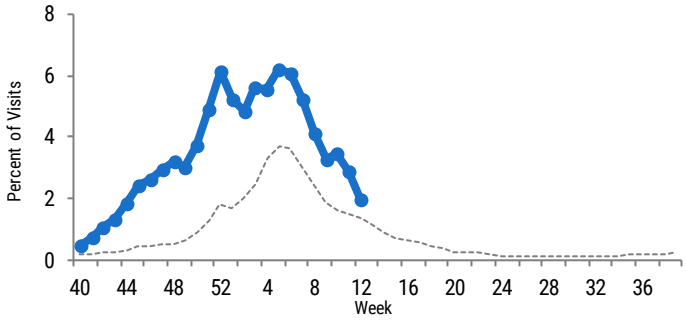


Figure 20: In **region 5, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

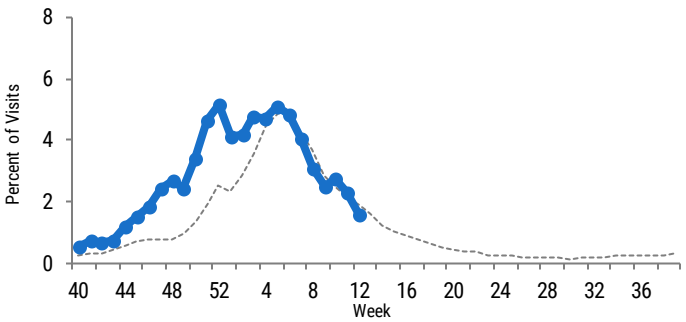


Figure 21: In **region 6, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*

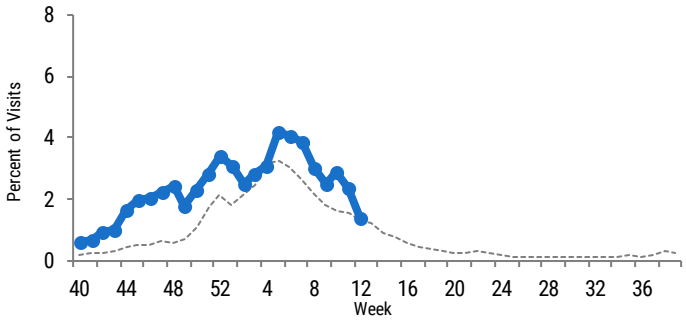
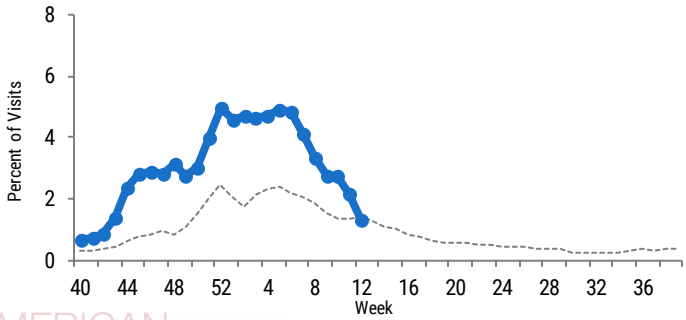


Figure 22: In **region 7, influenza and flu activity decreased** during week 12 and was similar to the previous three-season average for this time.*



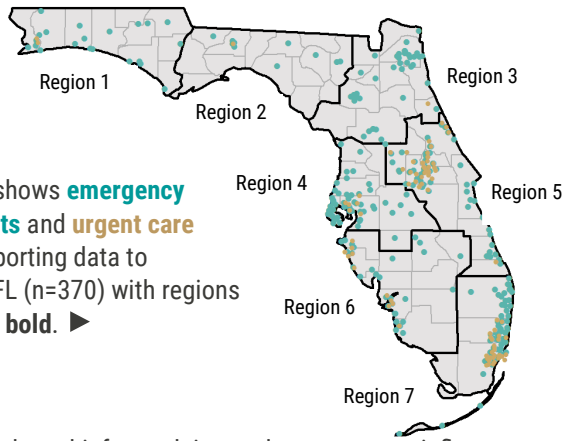


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=370) with regions **outlined in bold**. ▶

*Of note, the queries used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

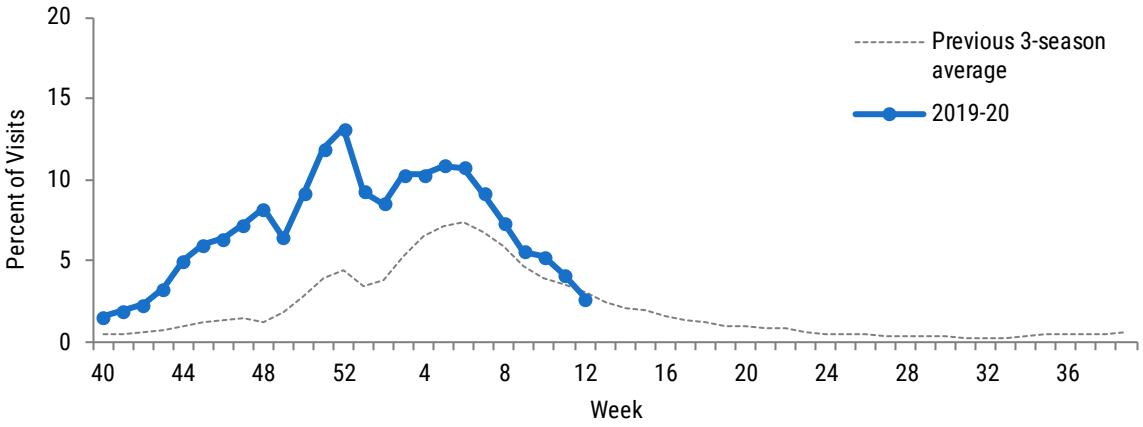
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

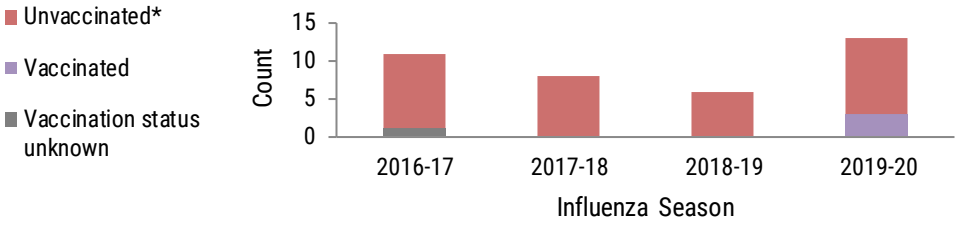
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 12, **the percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in children <18 years decreased** and was similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.

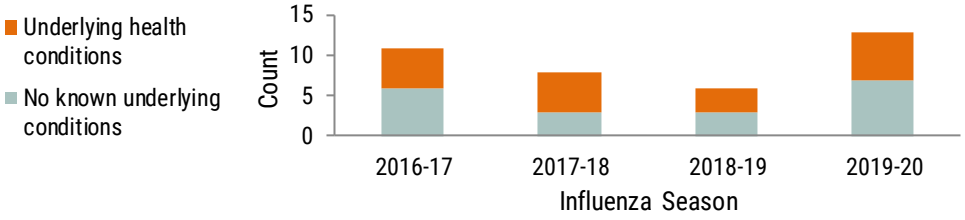


◀ **Figure 24** shows **the percent visits with discharge diagnoses that contain influenza or flu among children <18 years** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

Figures 25-26: In week 12, **one new influenza-associated pediatric death was reported**. A total of 13 influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 12, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 12, 2020.

In week 12, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A unspecified in a child with no known underlying health conditions who was not vaccinated for the 2019-20 season.

A total of 13 influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in March or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

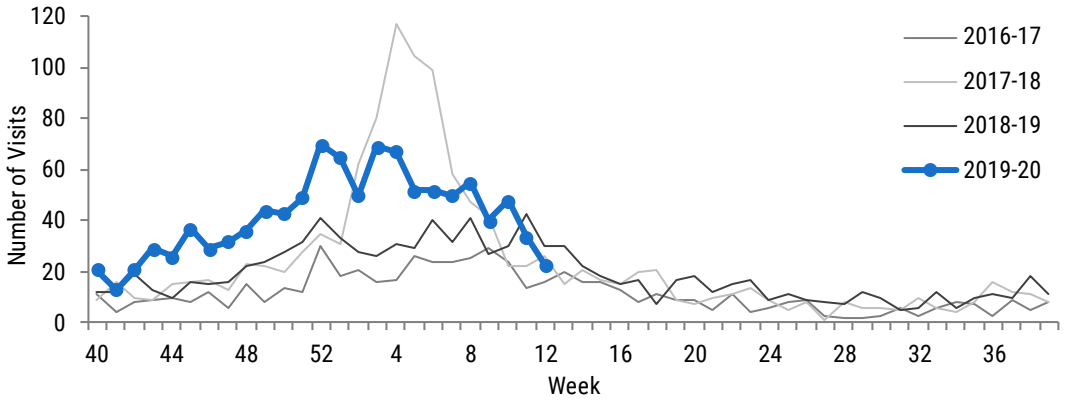
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 12, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time during previous seasons.



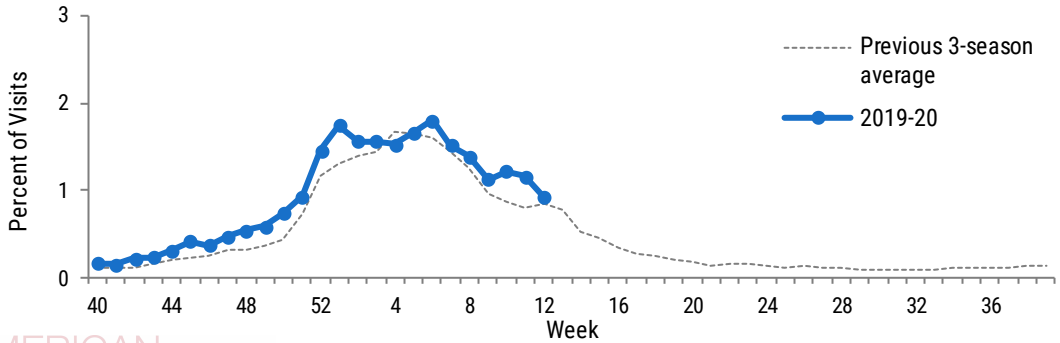
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 12, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 12, the **percent of emergency department and urgent care center visits with a discharge diagnosis of influenza or flu in adults ≥65 years decreased** and similar to the previous three-season average for this time. Of note, the query used to capture these data now utilizes discharge diagnoses rather than chief complaints to better capture influenza activity trends in Florida.



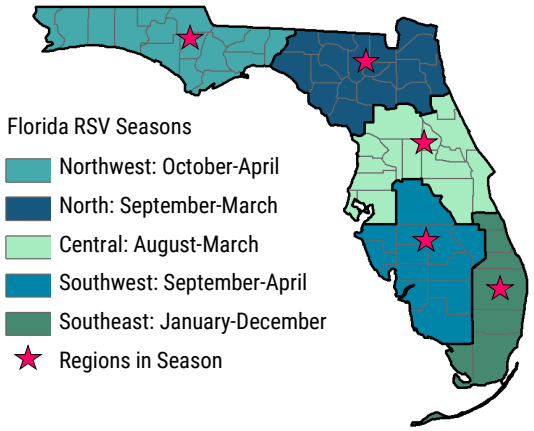
◀ **Figure 28** shows **the percent of visits with discharge diagnoses that contain influenza or flu among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, for the current season (week 40, 2019 to week 12, 2020) and the previous three-season average.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

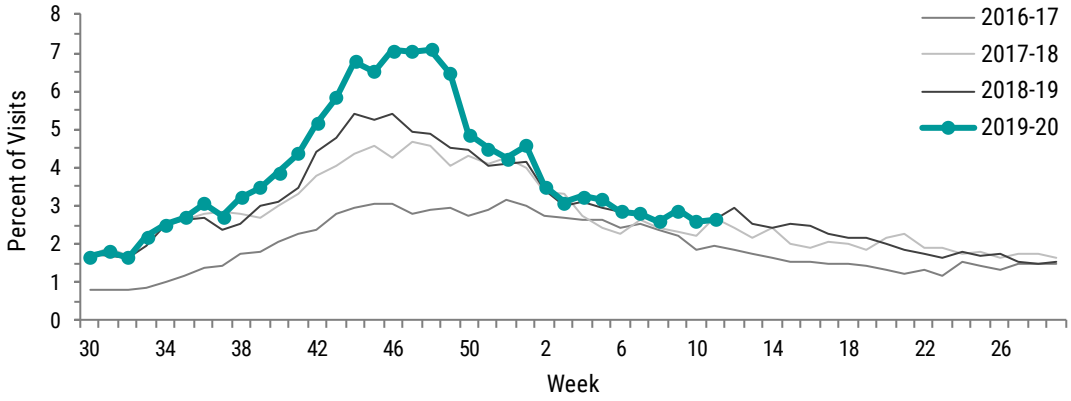
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 12 (March 15-21, 2020) Activity Summary

In week 12, RSV activity in children <5 years increased and was similar to levels observed at this time in previous seasons.

No new RSV-associated outbreaks were reported in week 12. A total of ten RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 12, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 12, 2020.

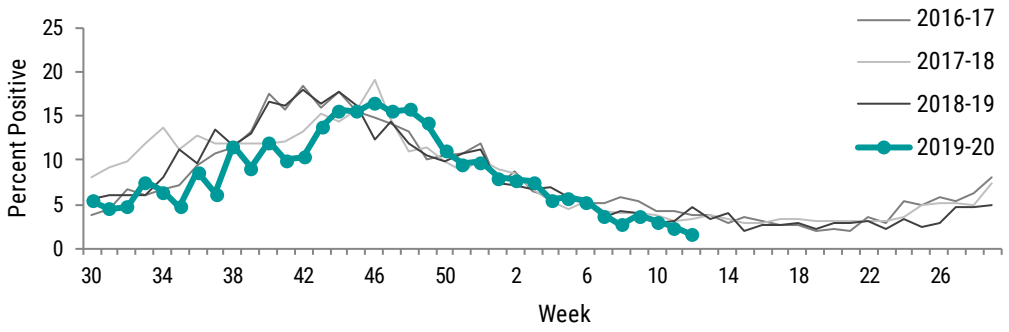
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 12, **the percent of specimens testing positive for RSV decreased.** Levels were below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=8), week 30, 2016 to week 12, 2020. ▶



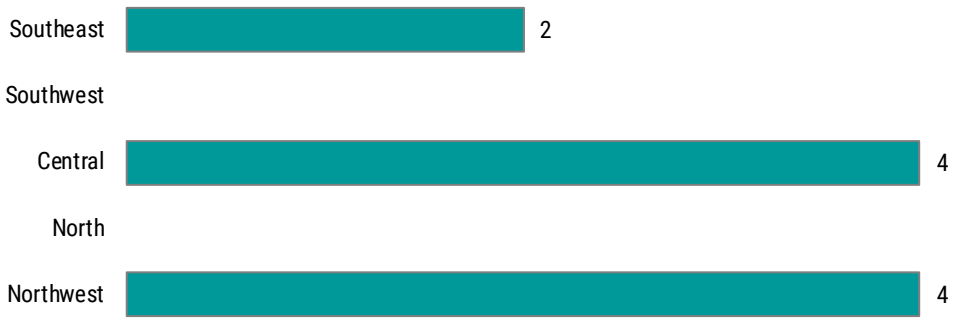
RSV-Associated Outbreaks in Week 12:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 12, no new RSV-associated outbreaks were reported. Since week 30, 2019, ten RSV-associated outbreaks have been reported.

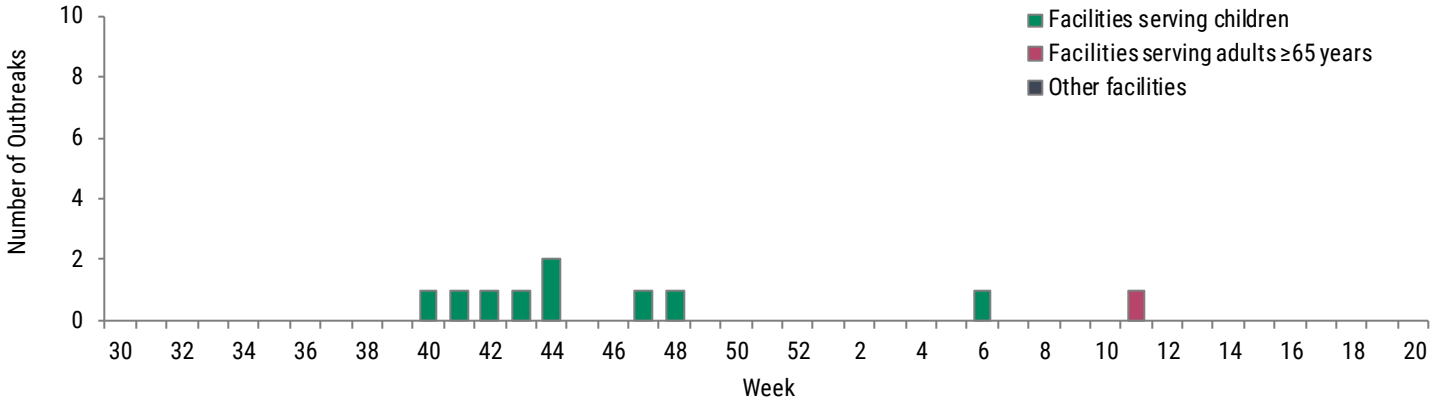
Figure 32: In week 12, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.*



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

*Regions defined in figure 29.

Figure 33: In week 12, no new RSV-associated outbreaks were reported. The majority of outbreaks reported since week 30 have been reported in **facilities serving children.**

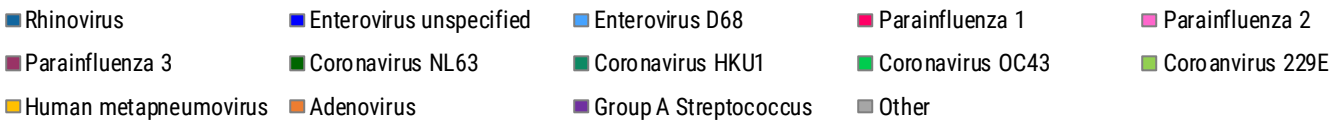


▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 12, 2020.

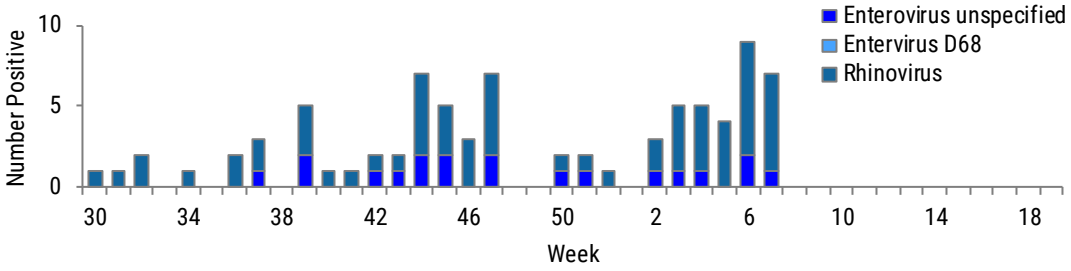
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



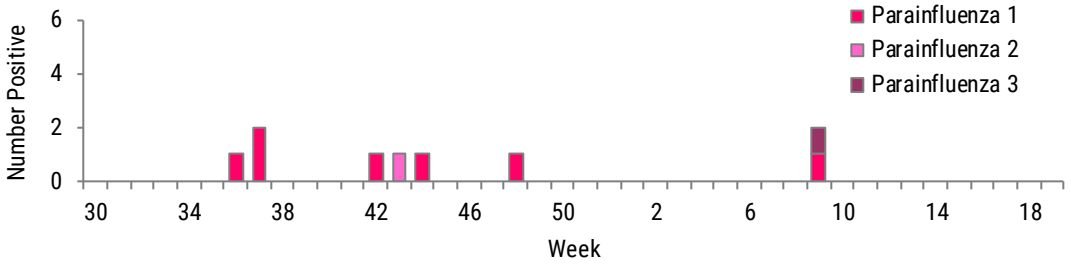


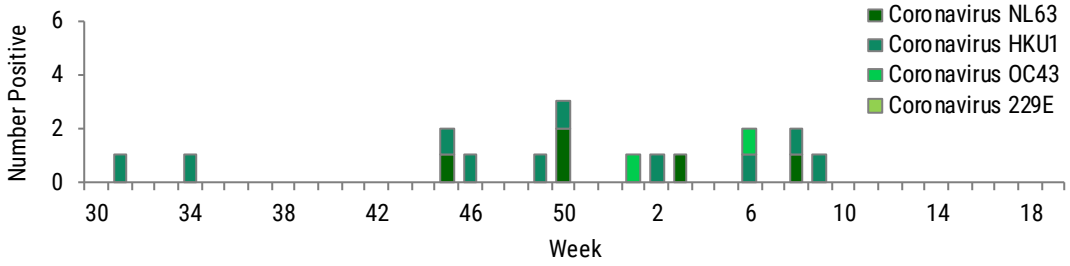
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 12, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

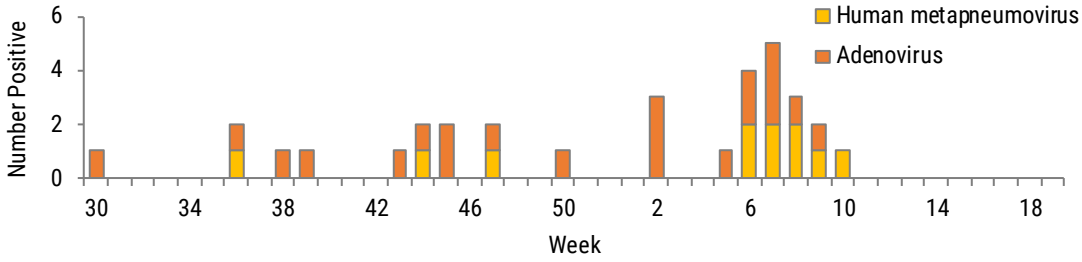
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 12, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Washington	7	2	0	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza and flu-related visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=370) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional figures, percentages are calculated as the proportion of ED and UCC visits to participating facilities that include the words “influenza” or “flu” in the discharge diagnoses (with certain exceptions).

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly influenza-like illness (ILI) and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For health care providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida’s geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county’s influenza and ILI surveillance data weekly into The Florida Department of Health’s EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida’s reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Mtenga, Mwedu; Bogucki, Amy; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 5, 2020 Florida Flu Review
Date:	Wednesday, February 5, 2020 3:40:25 PM
Attachments:	Week 5, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 5, 2020 Florida Flu Review.

Week 5 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 5 and reached the highest level observed so far this season. Notable increases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Thirty-five outbreaks were reported, up from 11 outbreaks in the previous week. Of the 35 outbreaks reported, 19 were influenza-associated and 16 were ILI.

Two new influenza-associated pediatric deaths were reported. One child was not vaccinated for the 2019-20 season, and the other was too young to be vaccinated. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 5: 1/26/20-2/1/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 5 influenza & influenza-like illness (ILI) activity summary:

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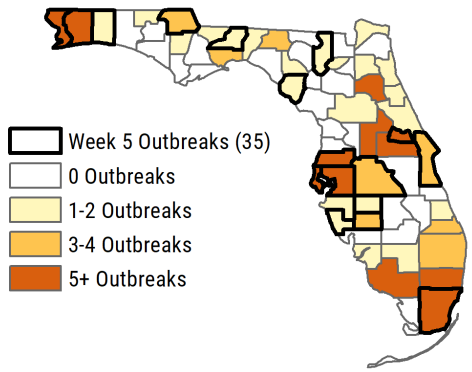
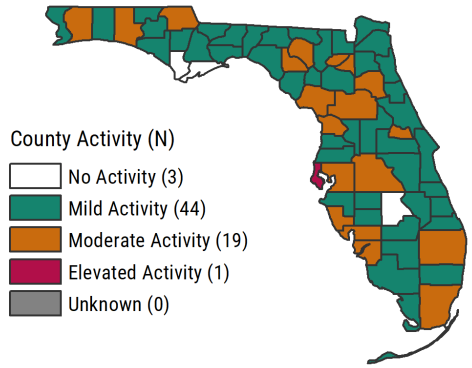
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks
Reported as of 2/1/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 5, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006924

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

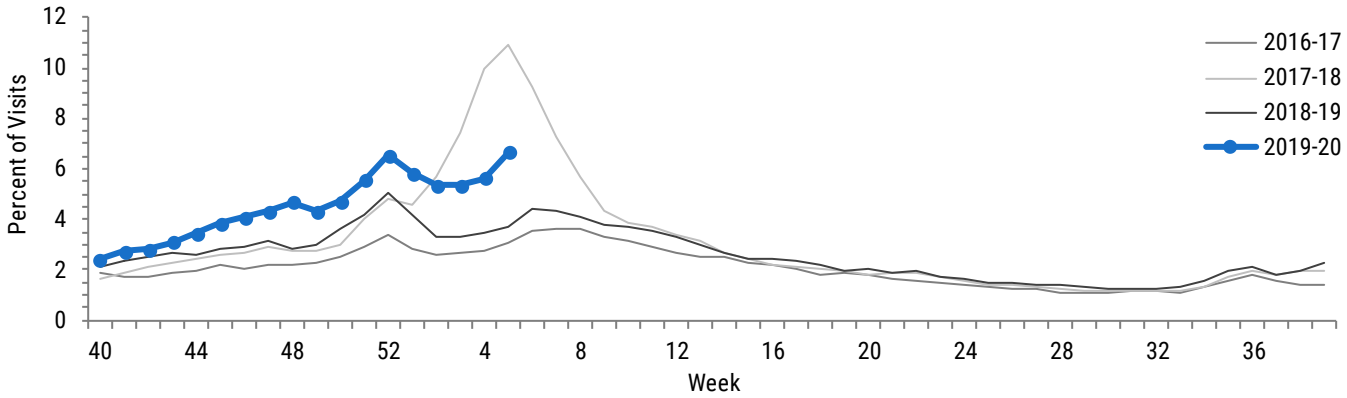
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 5, **the percent of emergency department and urgent care center visits for ILI statewide increased** and reached the highest level observed so far this season. Activity in week 5 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 5, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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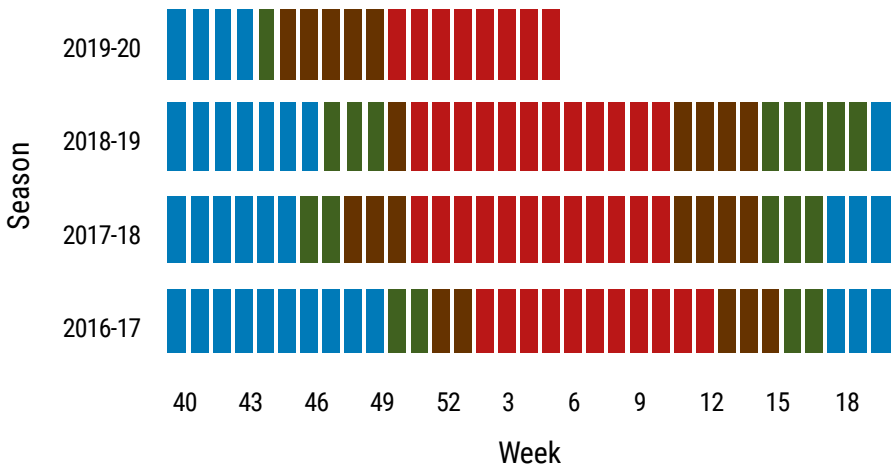
Statewide Activity

Figure 2: In week 5, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 5, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 5, **the percent of patients with ILI reported by ILINet providers statewide increased** and was above peak levels observed during the 2018-19 and 2016-17 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 5, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

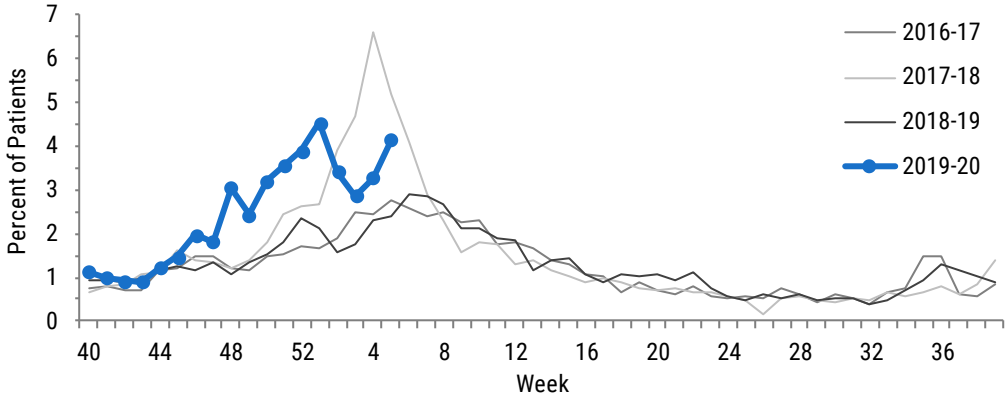
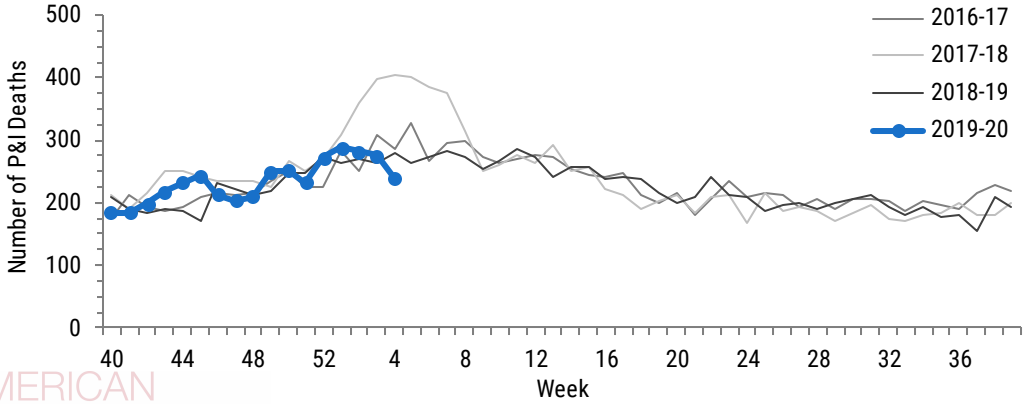


Figure 4: In week 4 (ending 1/25/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 4, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 5. Nineteen counties reported **moderate activity,** and one county reported **elevated activity.**

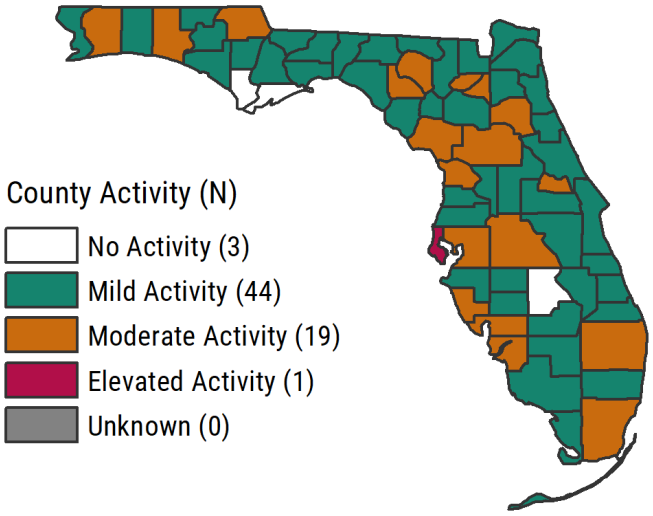
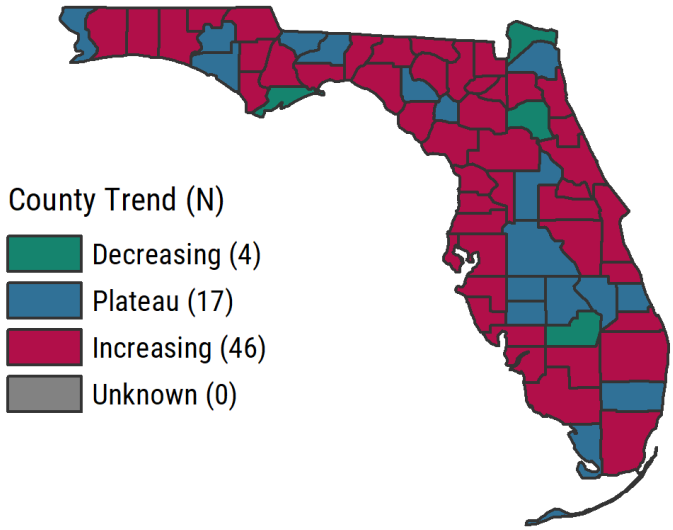
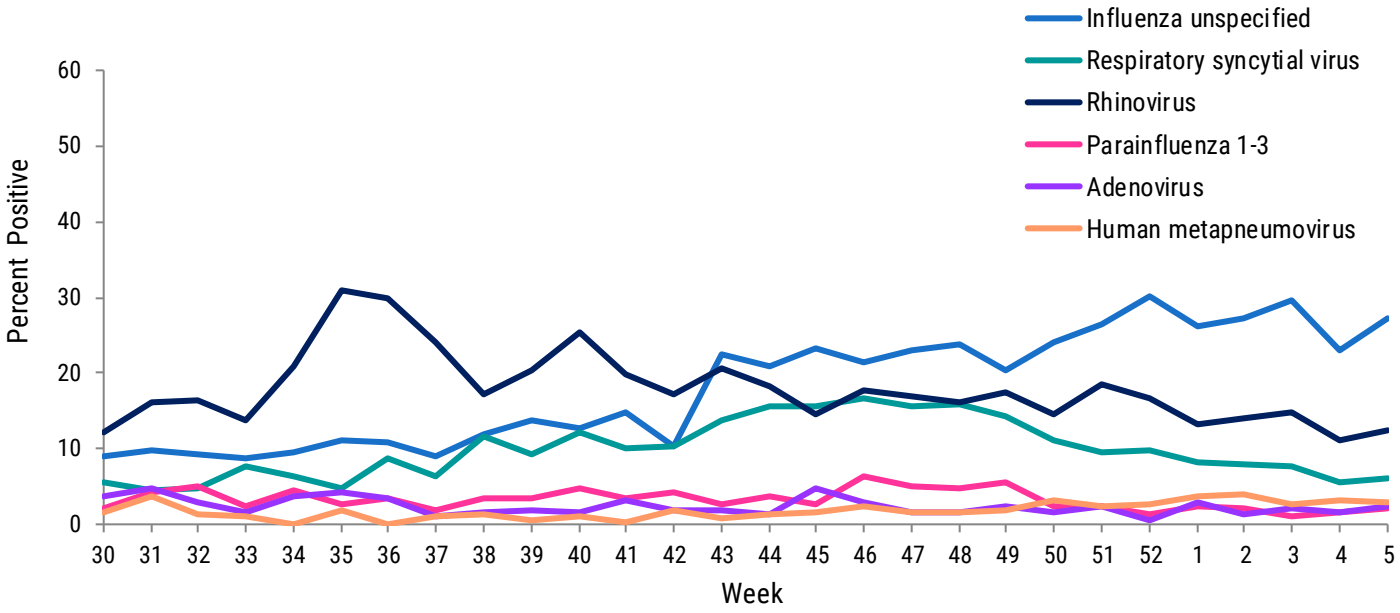


Figure 6: Most counties reported **increasing activity** in week 5. Seventeen counties reported **activity at a plateau,** and four counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 5, the **percent of specimens testing positive for influenza** **increased** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 5, 2020.

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Influenza and ILI Outbreaks

Week 5 Outbreaks at a Glance:

Number Reported:
35 Outbreaks

Influenza-Associated:
19 Outbreaks

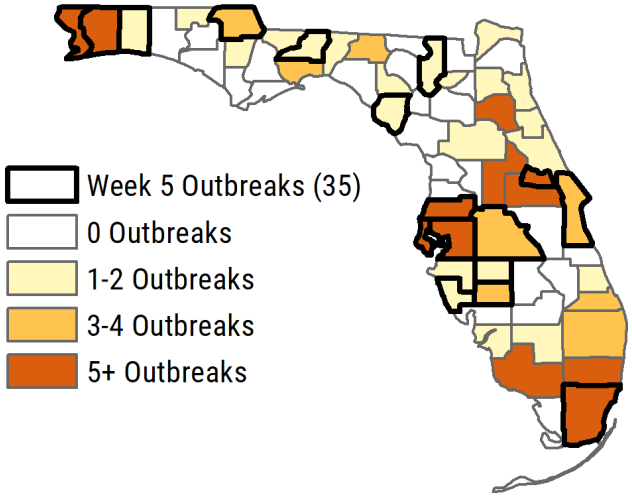
Severe Outcomes*:
5 Outbreaks

Outbreak Summary:

In week 5, 19 influenza-associated and 16 ILI outbreaks were reported, a notable increase from the previous week.

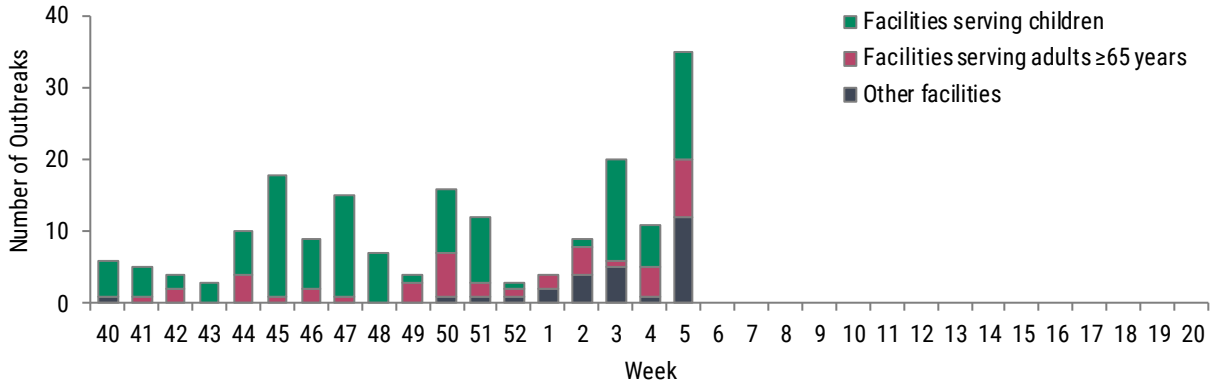
Severe outcomes* were reported in five of 35 outbreaks. One or more hospitalizations were reported in each of these five outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 5, four of the five outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



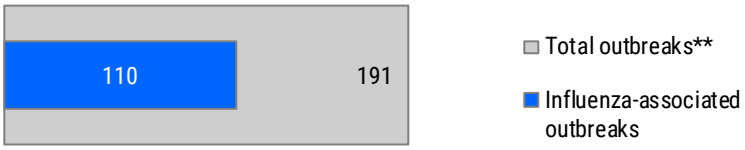
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 5 are **outlined in bold.**

Figure 9: In week 5, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, 15 outbreaks** were reported in **facilities serving children,** and **12 outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 5, **57.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 5, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

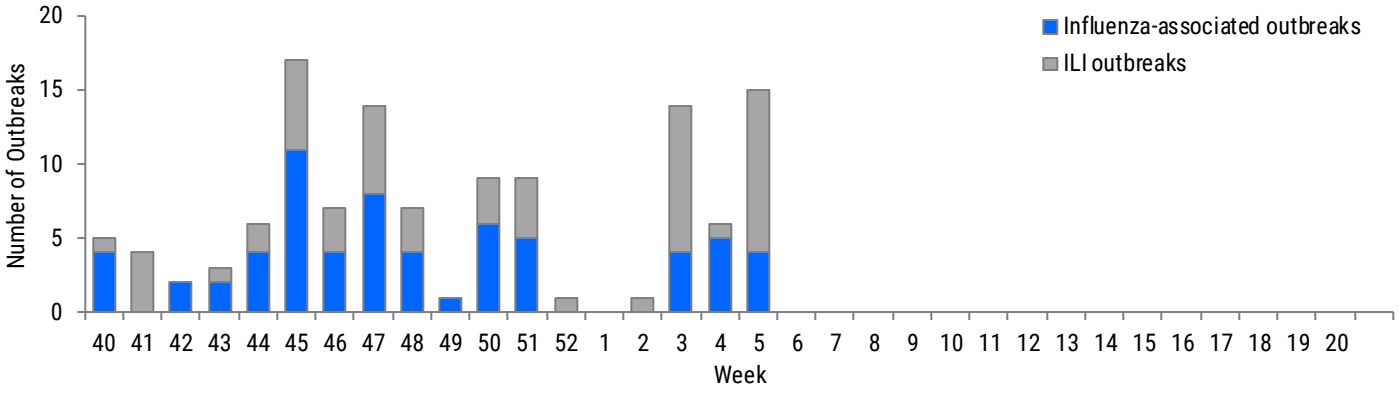
15 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 5, 15 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 5, **four influenza-associated outbreaks** and **11 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

Facilities Serving Adults ≥65 yrs.**:

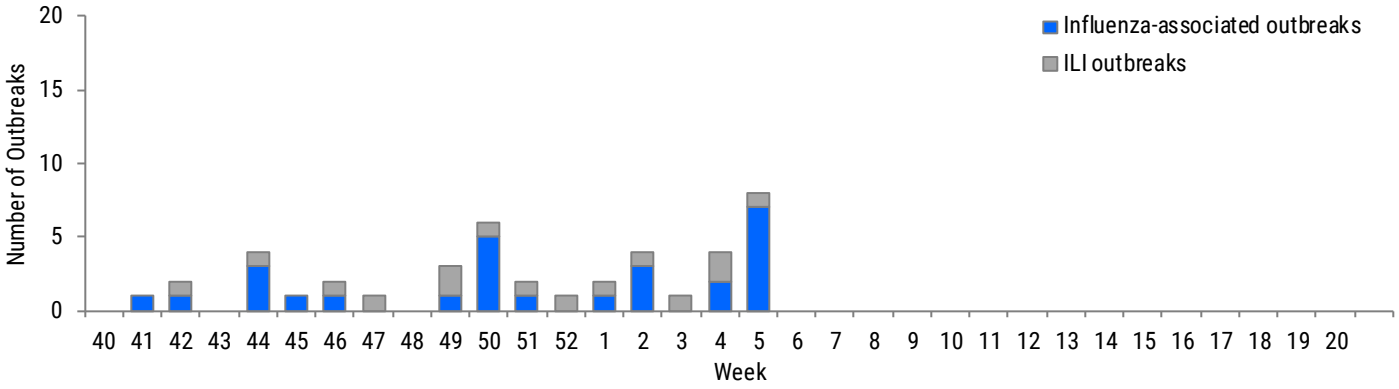
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 5, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 5, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

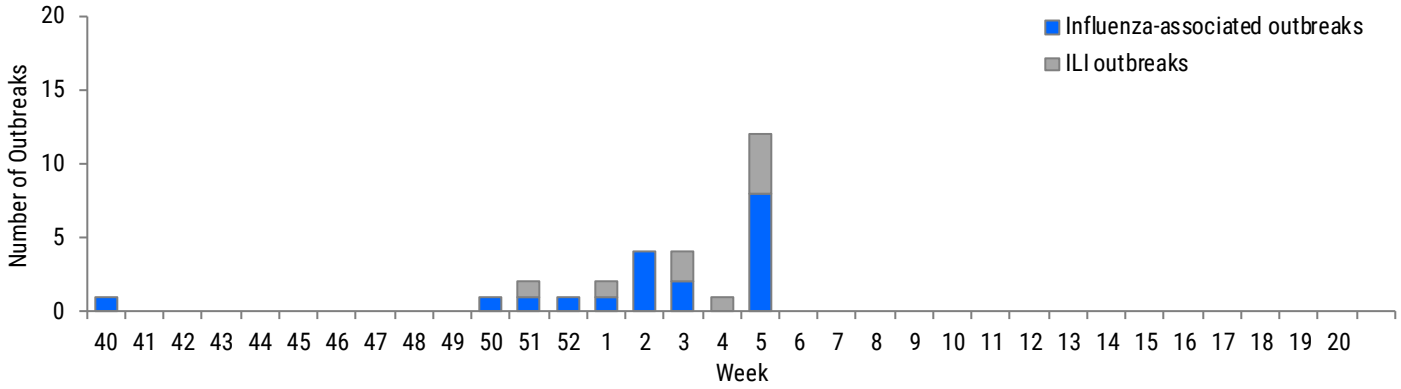
12 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 5, 12 new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 5, **eight influenza-associated outbreaks** and **four ILI outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

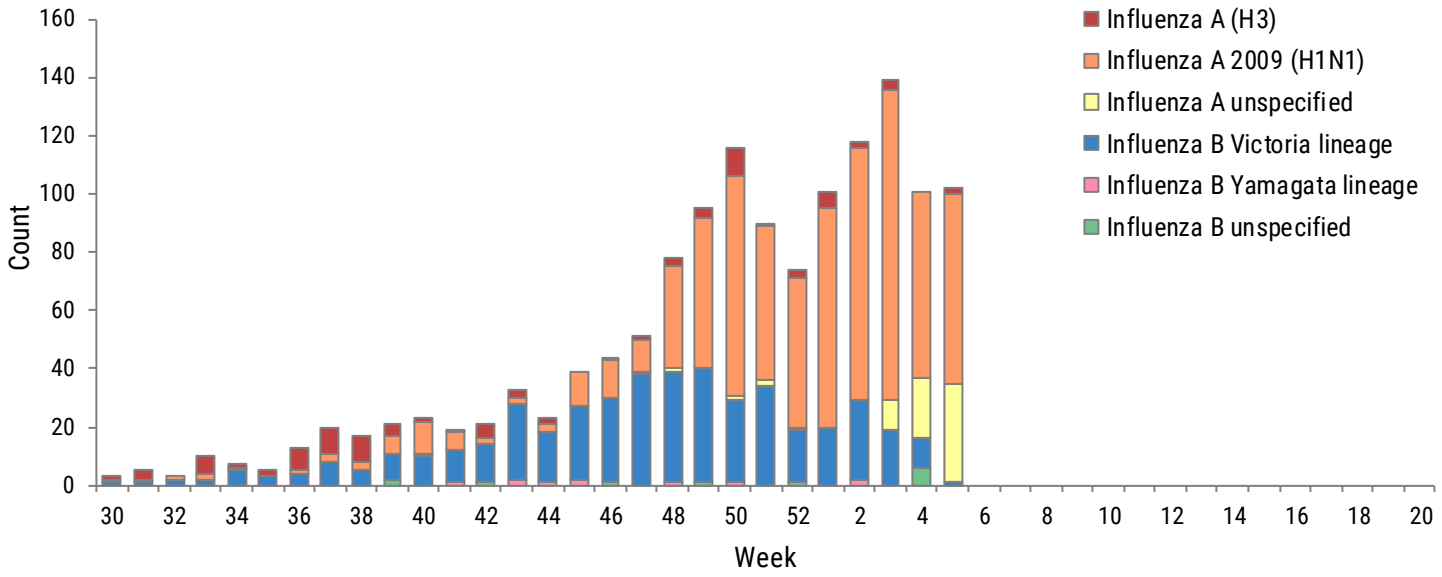
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	99 (51.8%)	55 influenza-associated outbreaks 44 ILI outbreaks
Child daycares	22 (11.5%)	9 influenza-associated outbreaks 13 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	13 (6.8%)	4 influenza-associated outbreaks 9 ILI outbreaks
Nursing facilities	10 (5.2%)	8 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	19 (9.9%)	15 influenza-associated outbreaks 4 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	24 (12.6%)	16 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (1.0%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (1.0%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**191 (100.0%)**	**110 influenza-associated outbreaks** **81 ILI outbreaks**

AMERICAN OVERSIGHT

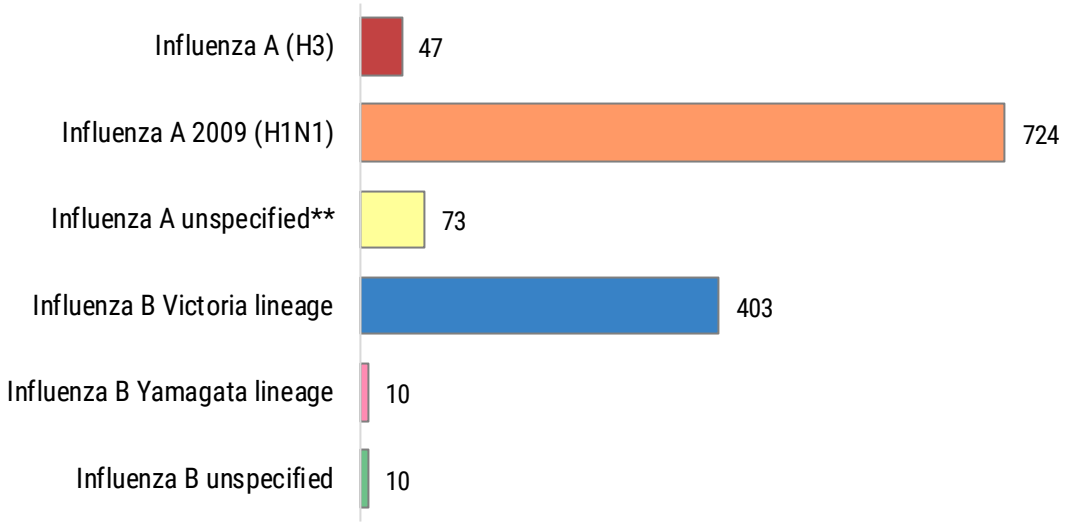
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 5, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 5, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 5, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 5 and was similar to peak levels observed during the 2018-19 season.

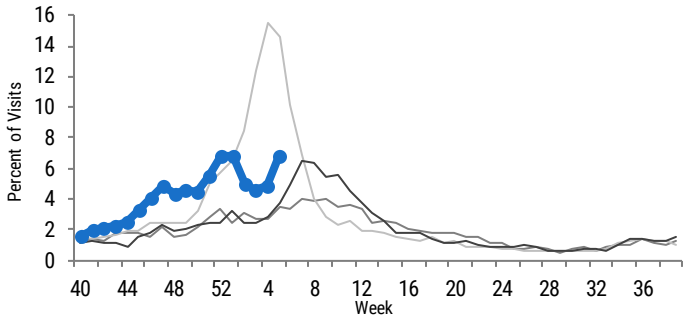


Figure 17: In **region 2, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

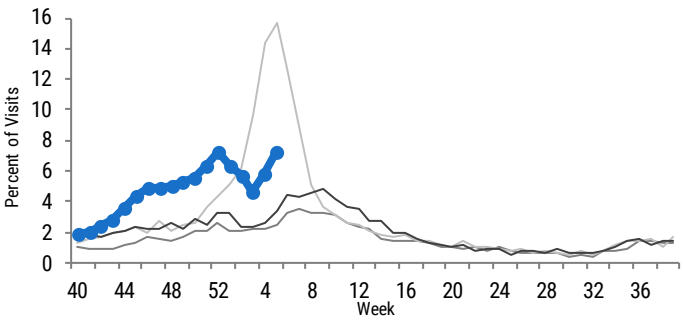


Figure 18: In **region 3, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

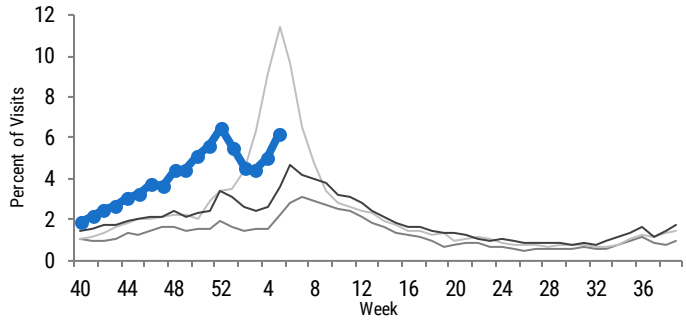


Figure 19: In **region 4, ILI activity increased** during week 5 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

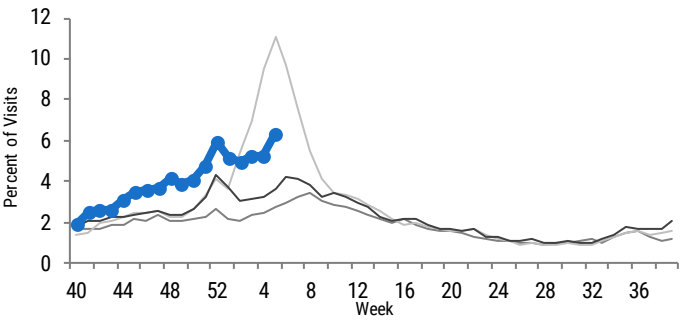


Figure 20: In **region 5, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

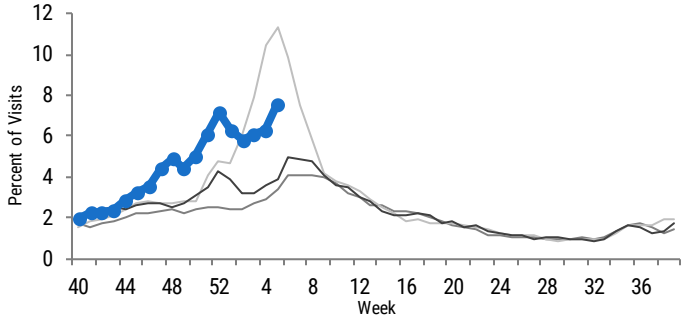


Figure 21: In **region 6, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

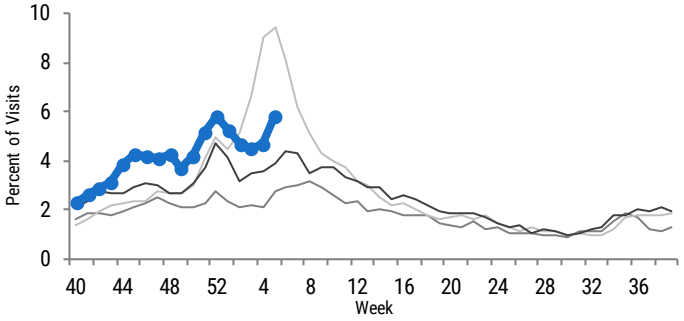
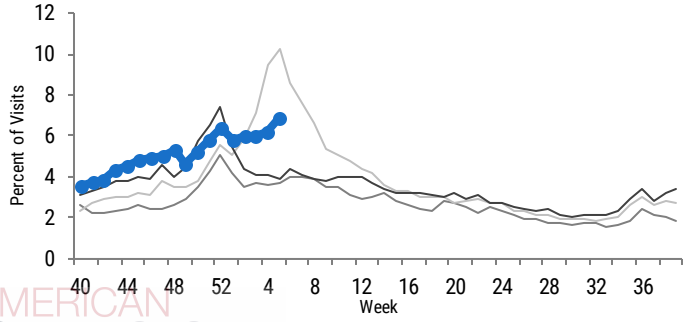


Figure 22: In **region 7, ILI activity increased** during week 5 and was similar to peak activity observed during the 2018-19 season.



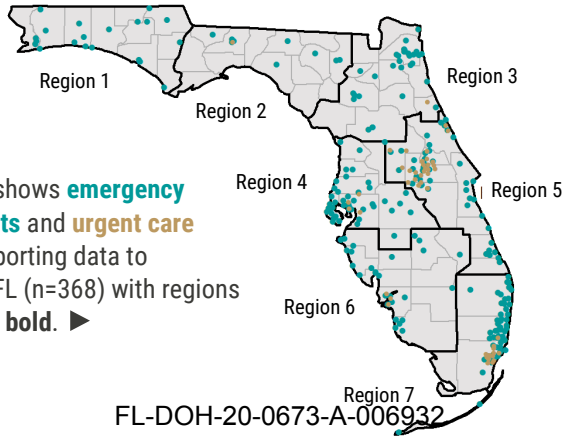


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

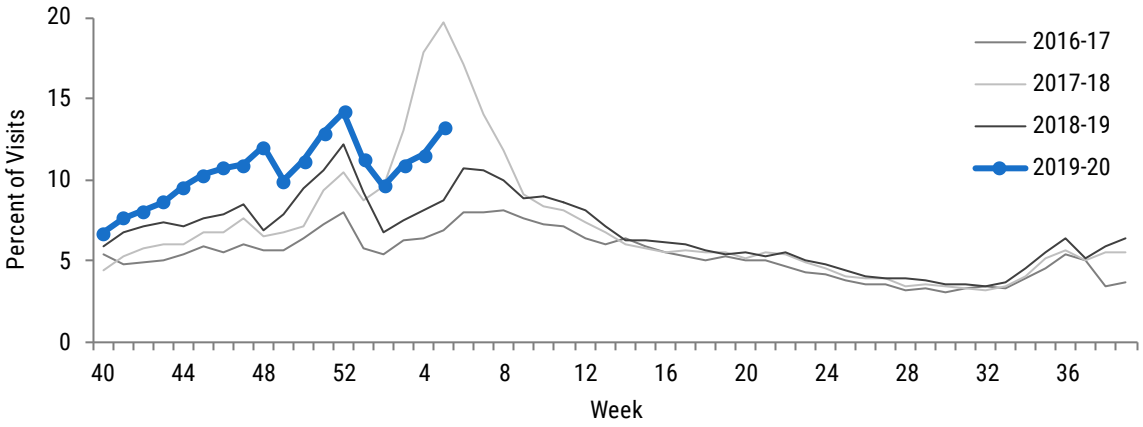
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

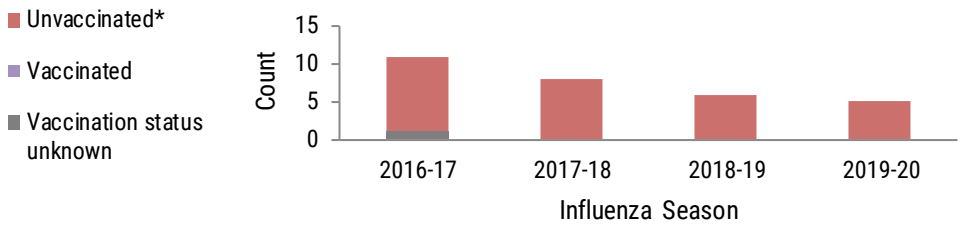
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 5, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

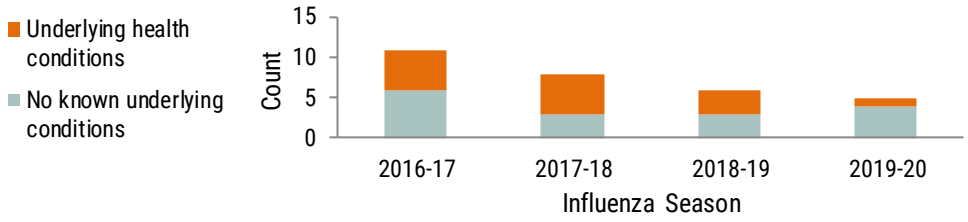


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

Figures 25-26: In week 5, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was too young to be vaccinated. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 5, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 5, 2020.

In week 4, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with an underlying medical condition. Neither child was vaccinated for the 2019-20 season.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

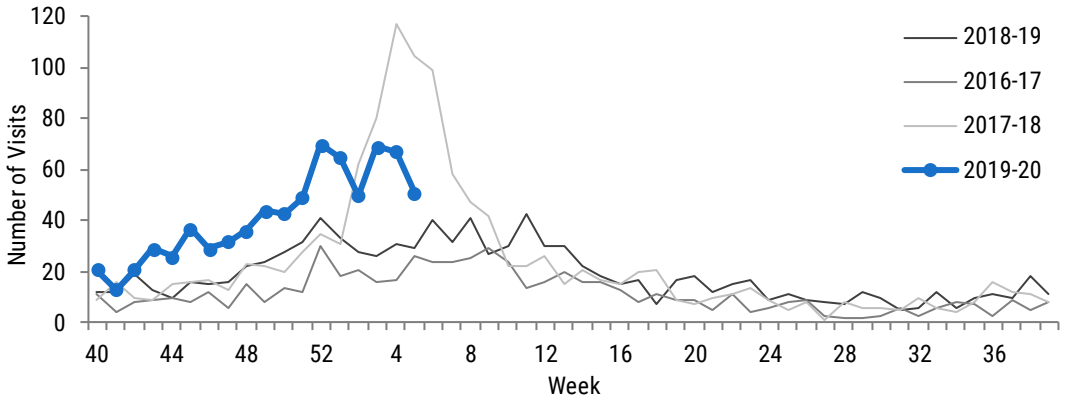
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 5, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



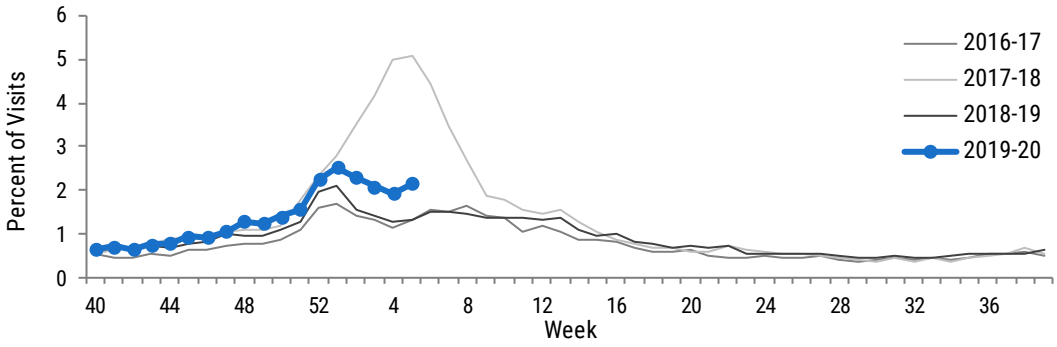
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 5, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 5, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



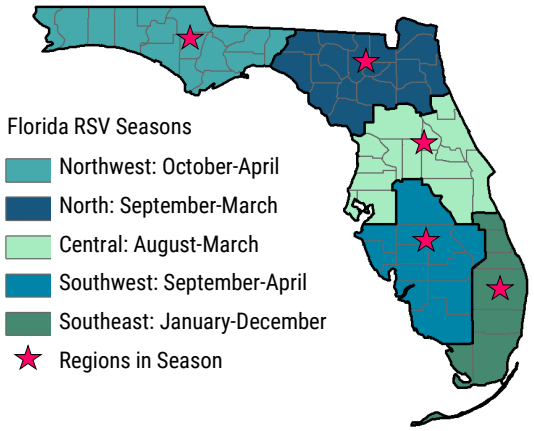
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

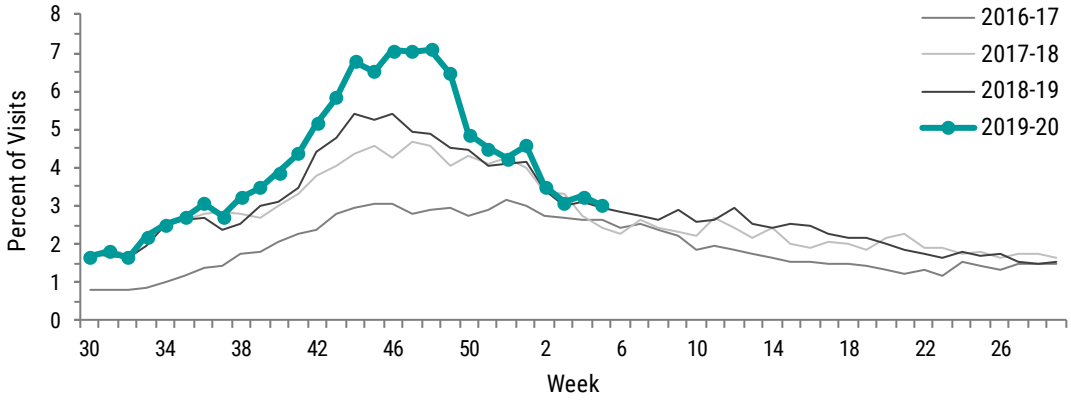
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 5 (January 26-February 1, 2020) Activity Summary

In week 5, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported. A total of eight RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 5, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 5, 2020.

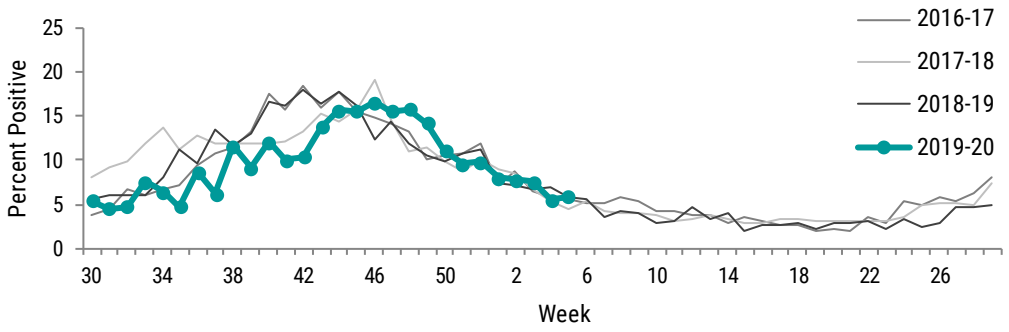
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 5, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 5, 2020. ▶



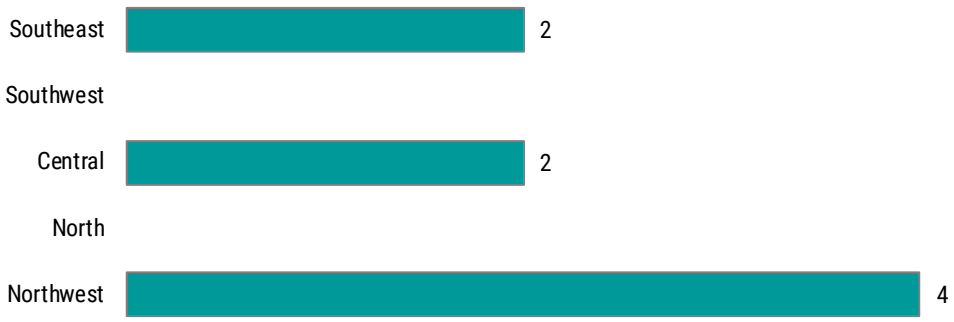
RSV-Associated Outbreaks in Week 4:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 5, no new RSV-associated outbreaks were reported. Since week 30, 2019, eight RSV-associated outbreaks have been reported.

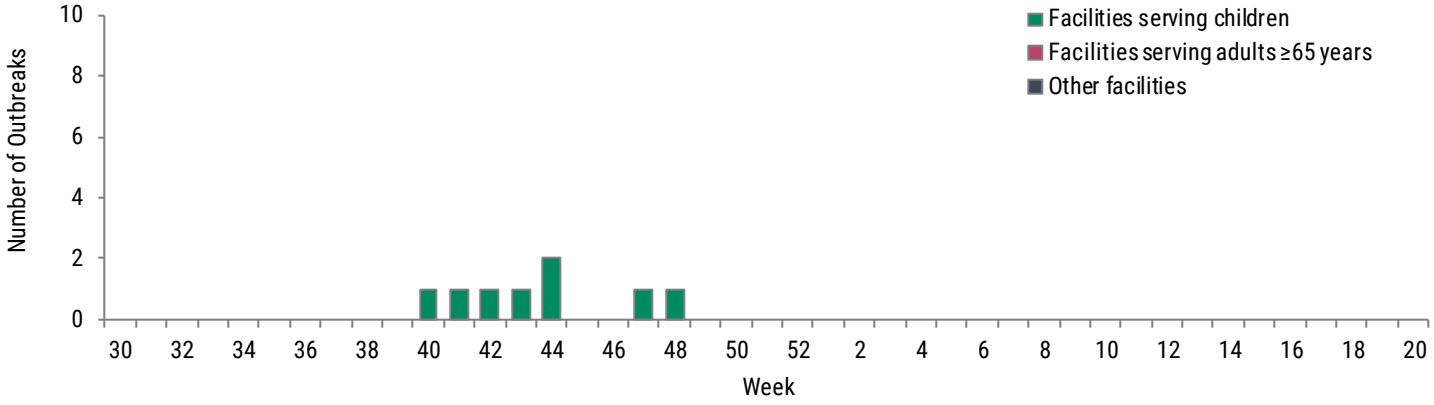
Figure 32: In week 5, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

*Regions defined in figure 29.

Figure 33: In week 5, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

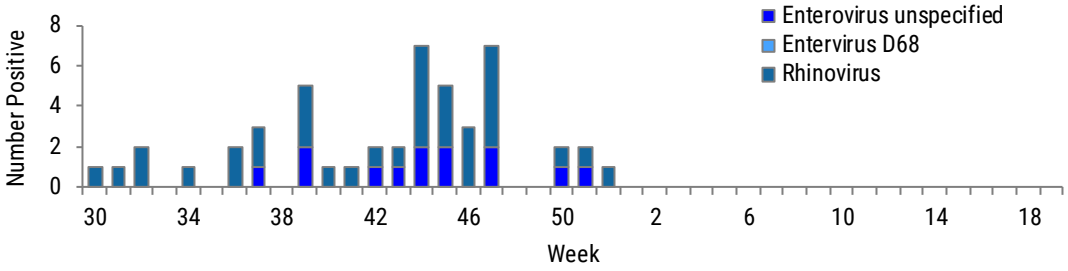
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



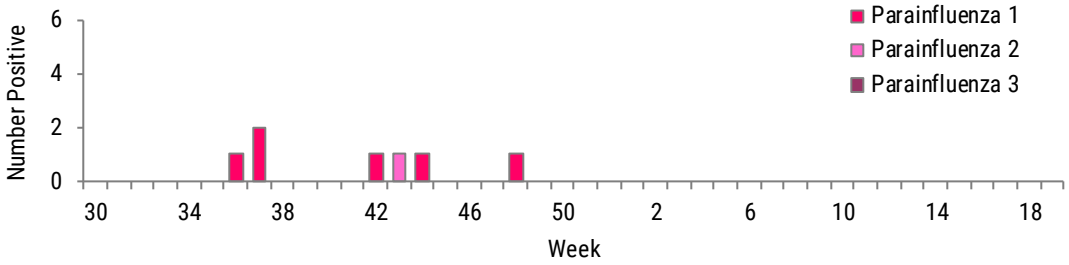
Rhinovirus | Enterovirus unspecified | Enterovirus D68 | Parainfluenza 1 | Parainfluenza 2
Parainfluenza 3 | Coronavirus NL63 | Coronavirus HKU1 | Coronavirus OC43 | Coronavirus 229E
Human metapneumovirus | Adenovirus | Group A Streptococcus | Other

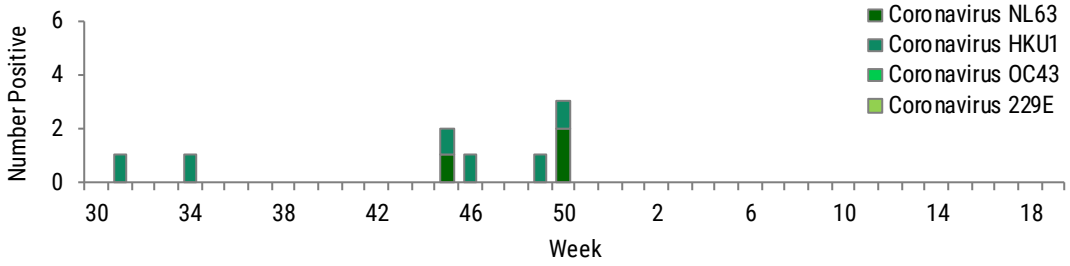
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 5, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

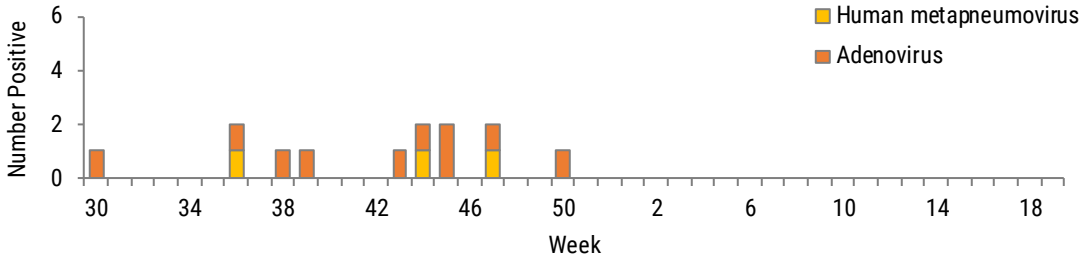
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 5, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Pinellas	3	3	0	Influenza A unspecified	Yes	Open
Primary or secondary school	Hillsborough	46	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Hillsborough	52	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Columbia	33	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Columbia	146	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Leon	35	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Santa Rosa	54	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Santa Rosa	100	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Okaloosa	88	Unknown	Unknown	Unknown	Unknown	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Mtenga, Mwedu; Bogucki, Amy; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 5, 2020 Florida Flu Review
Date:	Wednesday, February 5, 2020 3:40:32 PM
Attachments:	Week 5, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 5, 2020 Florida Flu Review.

Week 5 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 5 and reached the highest level observed so far this season. Notable increases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Thirty-five outbreaks were reported, up from 11 outbreaks in the previous week. Of the 35 outbreaks reported, 19 were influenza-associated and 16 were ILI.

Two new influenza-associated pediatric deaths were reported. One child was not vaccinated for the 2019-20 season, and the other was too young to be vaccinated. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 5: 1/26/20-2/1/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 5 influenza & influenza-like illness (ILI) activity summary:

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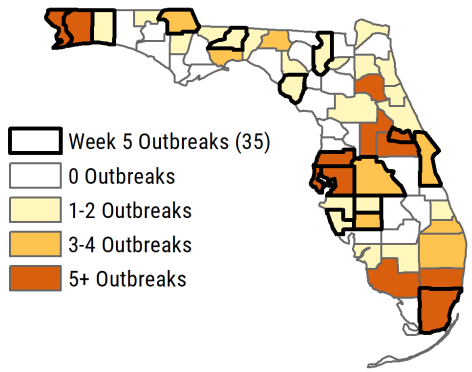
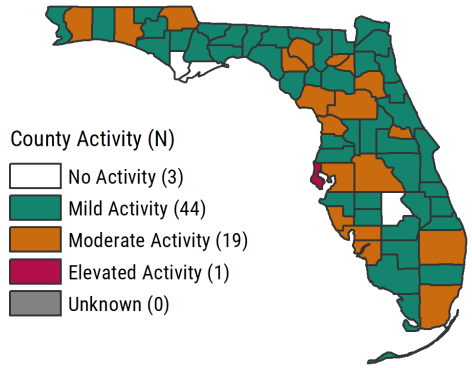
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

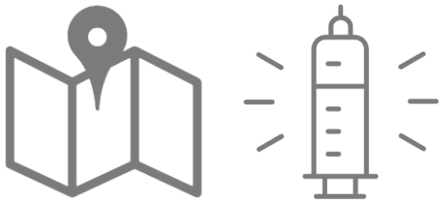
Influenza or ILI Outbreaks
Reported as of 2/1/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 5, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006943

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

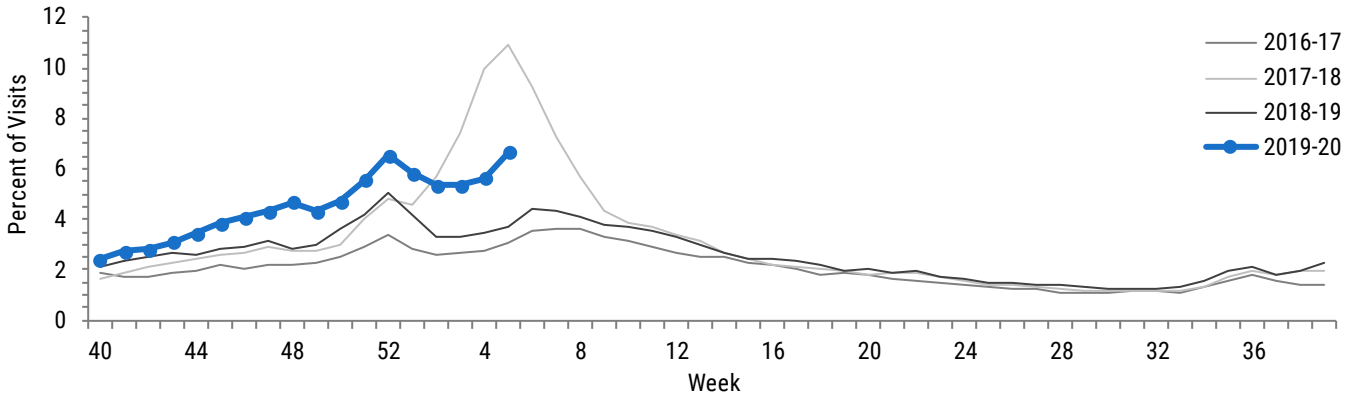
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 5, **the percent of emergency department and urgent care center visits for ILI statewide increased** and reached the highest level observed so far this season. Activity in week 5 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 5, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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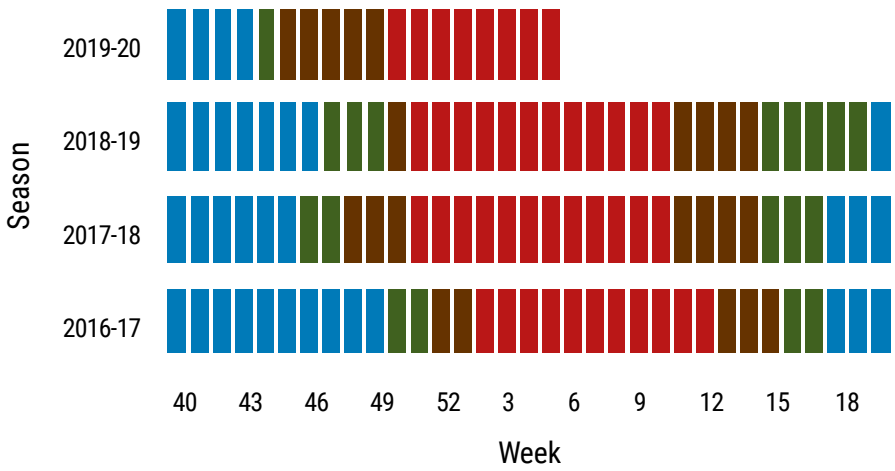
Statewide Activity

Figure 2: In week 5, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 5, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 5, **the percent of patients with ILI reported by ILINet providers statewide increased** and was above peak levels observed during the 2018-19 and 2016-17 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 5, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

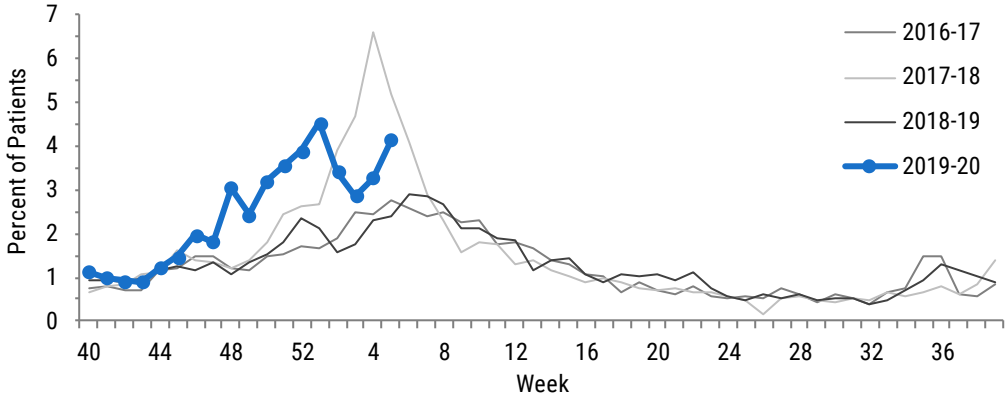
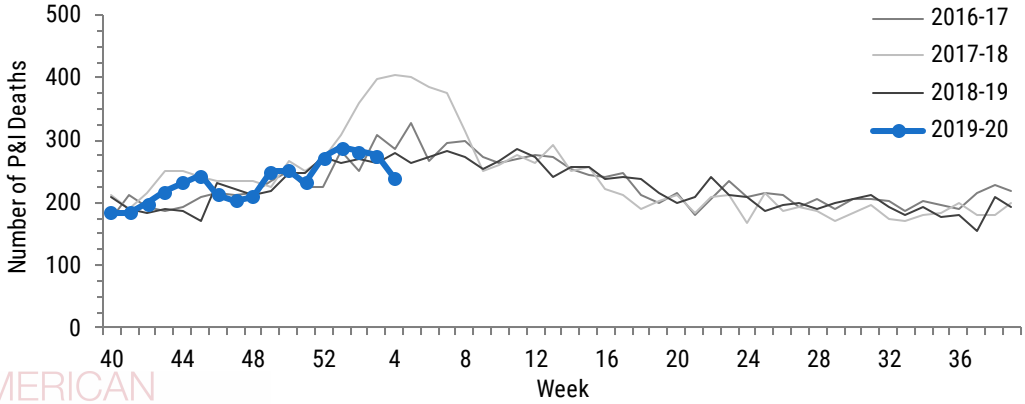


Figure 4: In week 4 (ending 1/25/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 4, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 5. Nineteen counties reported **moderate activity,** and one county reported **elevated activity.**

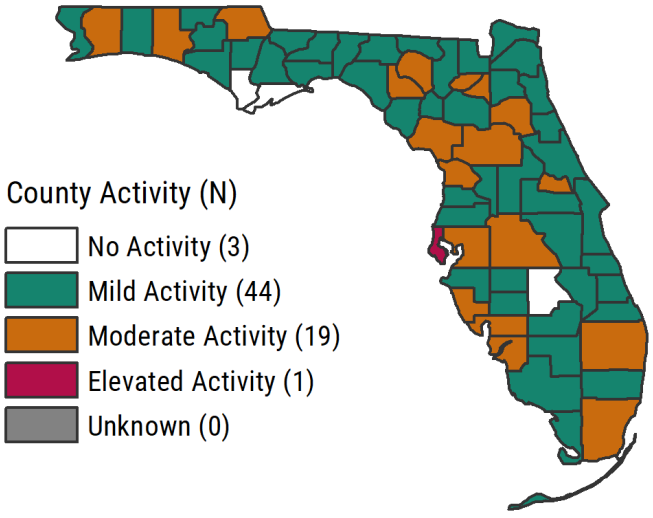
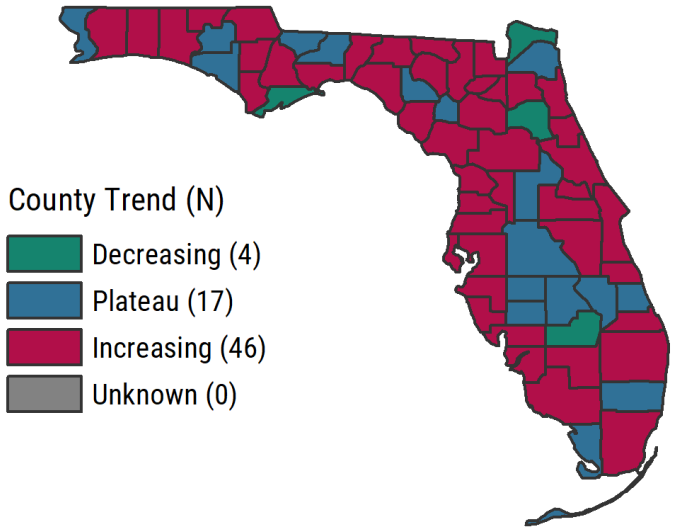
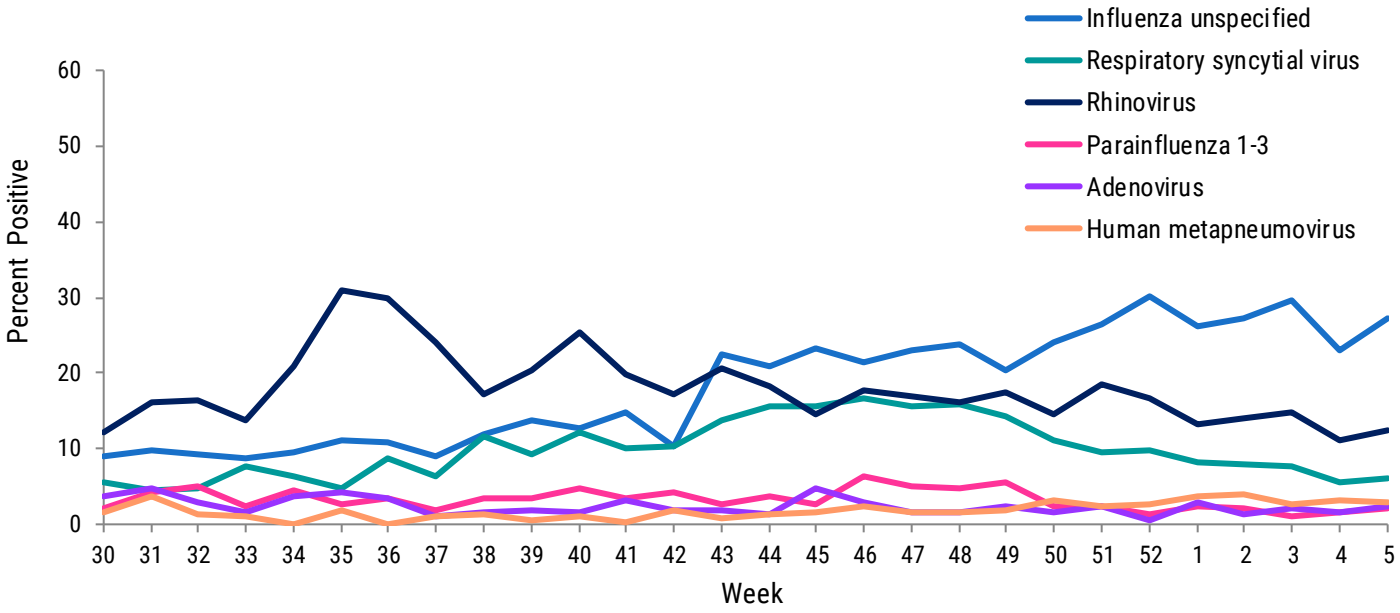


Figure 6: Most counties reported **increasing activity** in week 5. Seventeen counties reported **activity at a plateau,** and four counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 5, the **percent of specimens testing positive for influenza** **increased** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 5, 2020.

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Influenza and ILI Outbreaks

Week 5 Outbreaks at a Glance:

Number Reported:
35 Outbreaks

Influenza-Associated:
19 Outbreaks

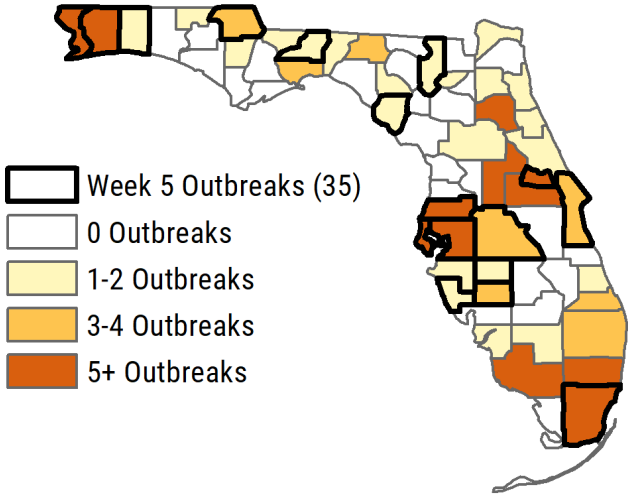
Severe Outcomes*:
5 Outbreaks

Outbreak Summary:

In week 5, 19 influenza-associated and 16 ILI outbreaks were reported, a notable increase from the previous week.

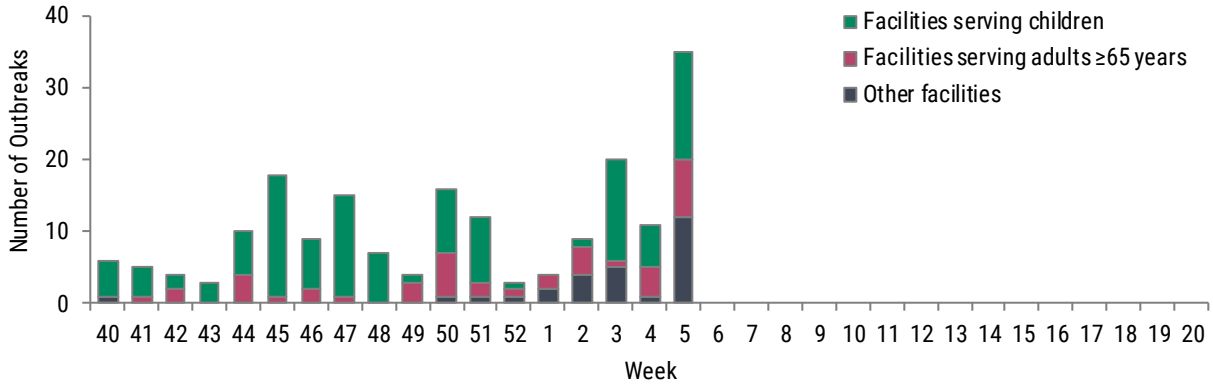
Severe outcomes* were reported in five of 35 outbreaks. One or more hospitalizations were reported in each of these five outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 5, four of the five outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



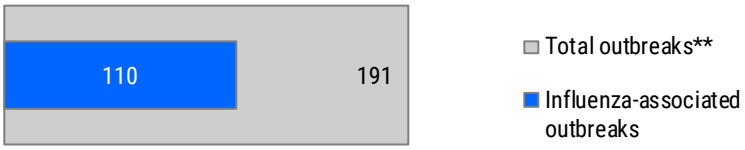
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 5 are **outlined in bold.**

Figure 9: In week 5, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, 15 outbreaks** were reported in **facilities serving children,** and **12 outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 5, **57.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 5, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

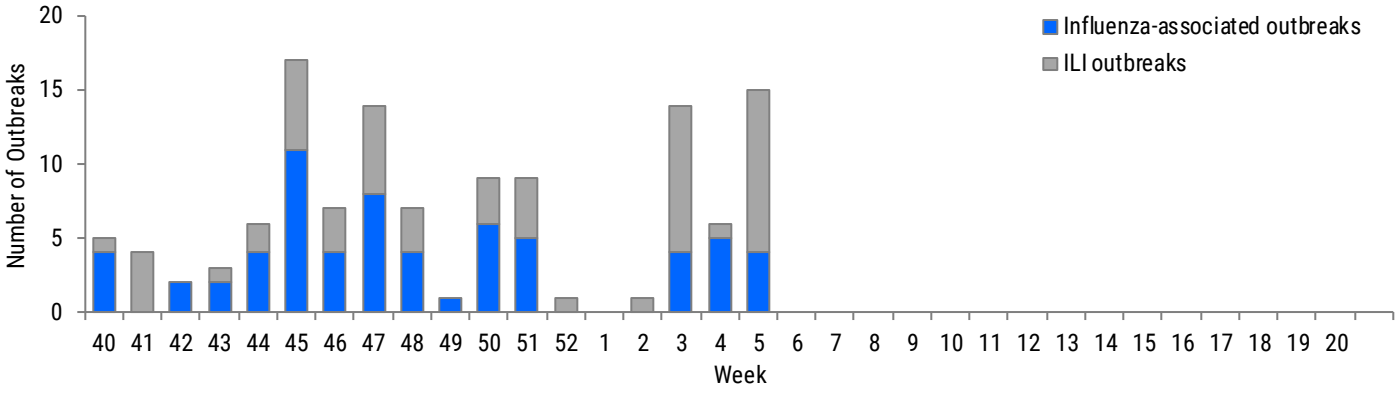
15 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 5, 15 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 5, **four influenza-associated outbreaks** and **11 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

Facilities Serving Adults ≥65 yrs.**:

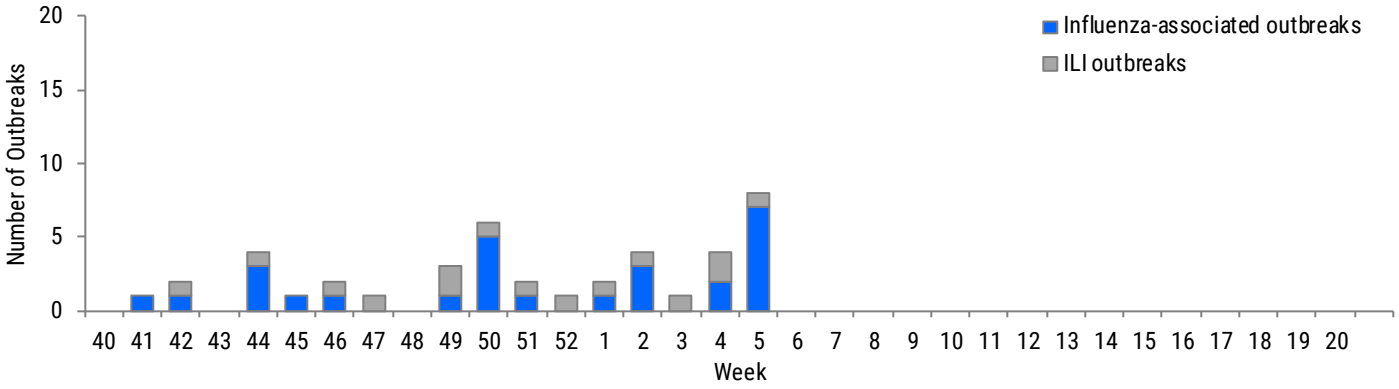
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 5, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 5, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

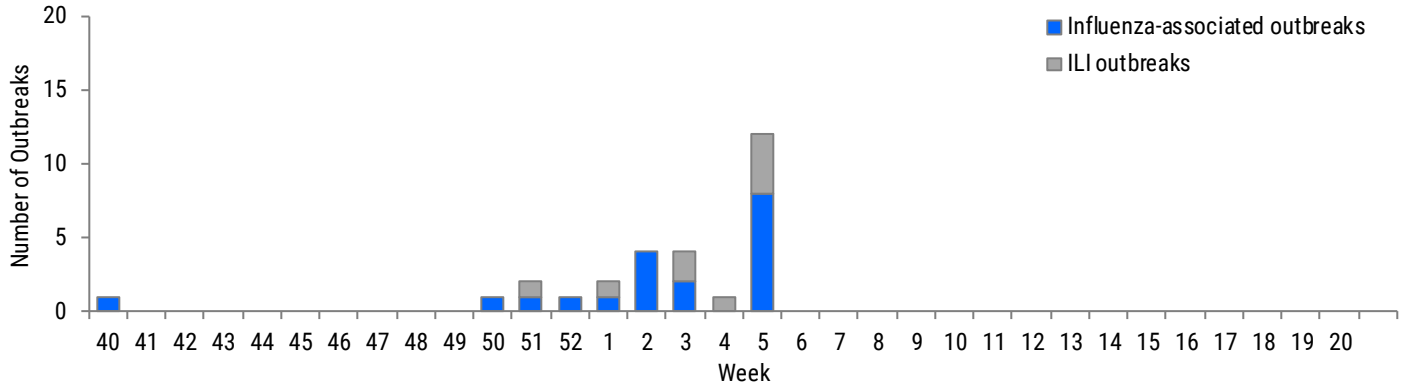
12 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 5, 12 new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 5, **eight influenza-associated outbreaks** and **four ILI outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	99 (51.8%)	55 influenza-associated outbreaks 44 ILI outbreaks
Child daycares	22 (11.5%)	9 influenza-associated outbreaks 13 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	13 (6.8%)	4 influenza-associated outbreaks 9 ILI outbreaks
Nursing facilities	10 (5.2%)	8 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	19 (9.9%)	15 influenza-associated outbreaks 4 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	24 (12.6%)	16 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (1.0%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (1.0%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**191 (100.0%)**	**110 influenza-associated outbreaks** **81 ILI outbreaks**

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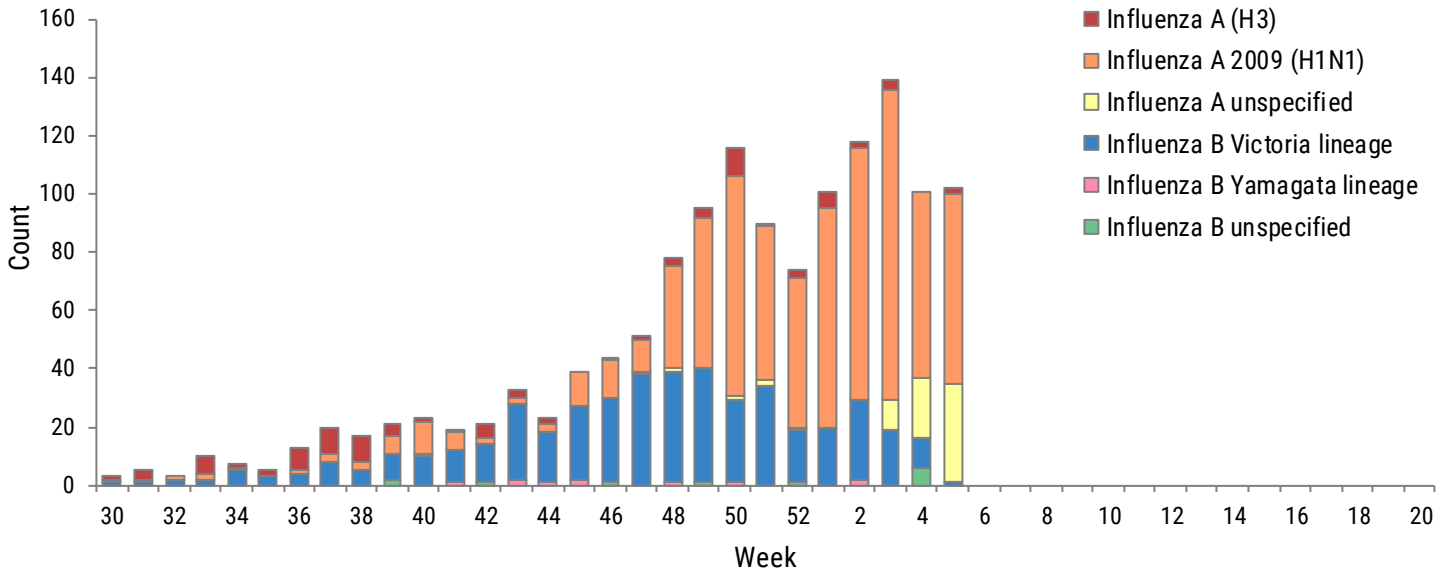
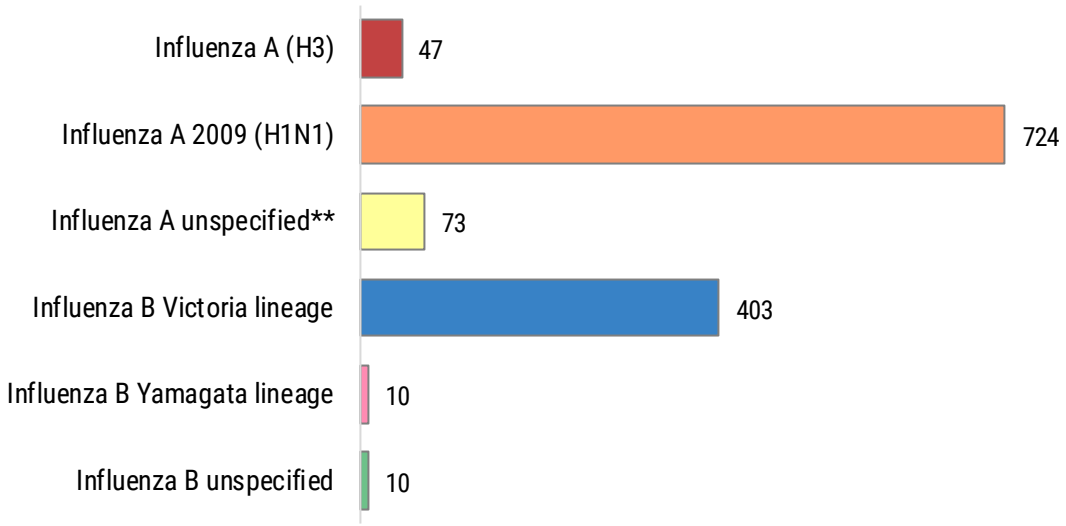
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 5, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 5, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 5, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 5 and was similar to peak levels observed during the 2018-19 season.

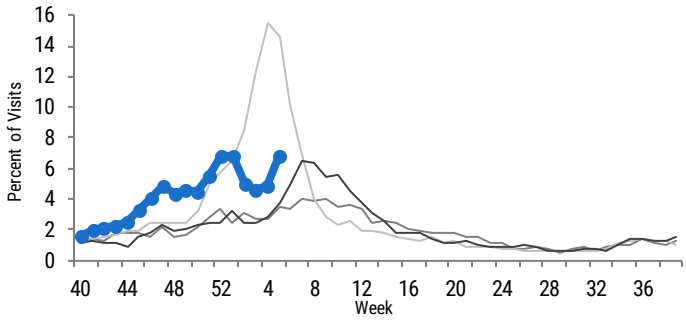


Figure 17: In **region 2, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

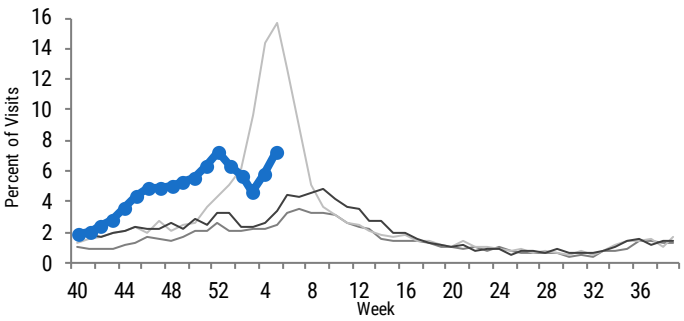


Figure 18: In **region 3, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

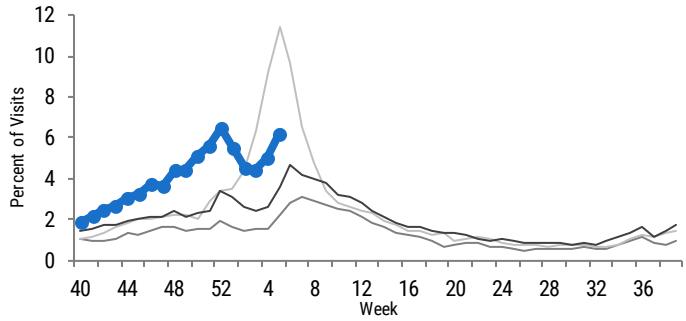


Figure 19: In **region 4, ILI activity increased** during week 5 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

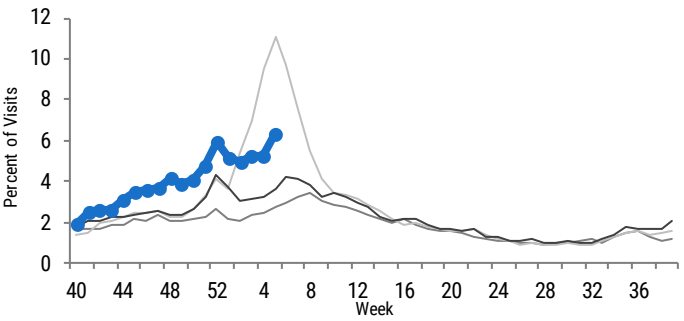


Figure 20: In **region 5, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

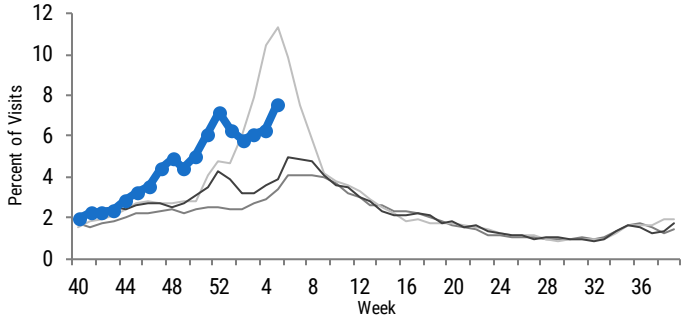


Figure 21: In **region 6, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

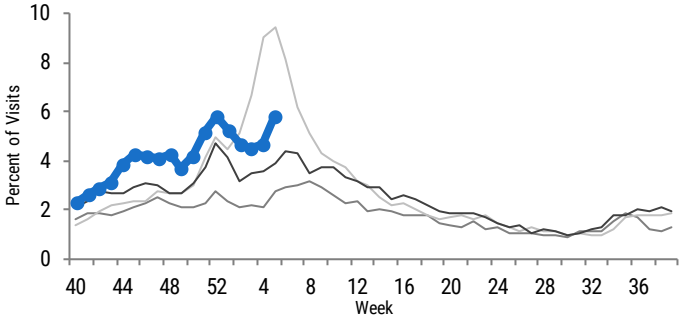
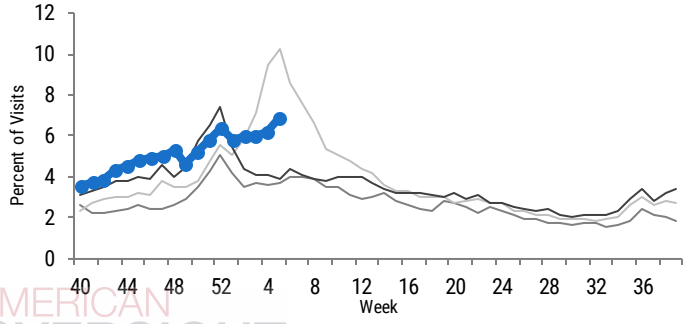


Figure 22: In **region 7, ILI activity increased** during week 5 and was similar to peak activity observed during the 2018-19 season.



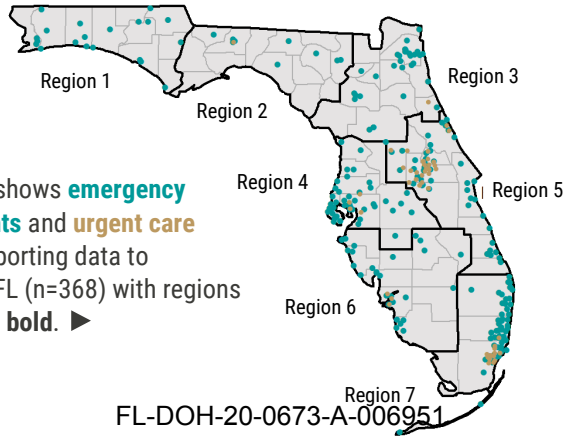


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

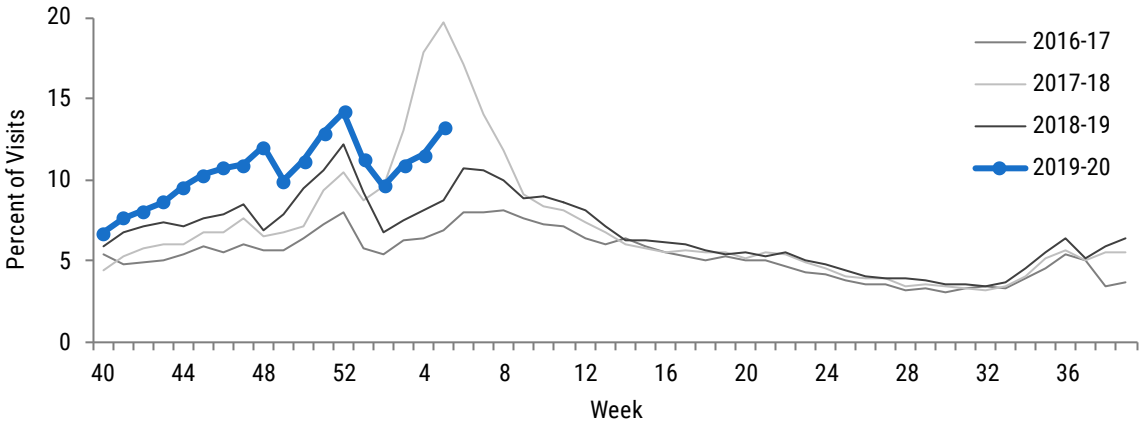
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

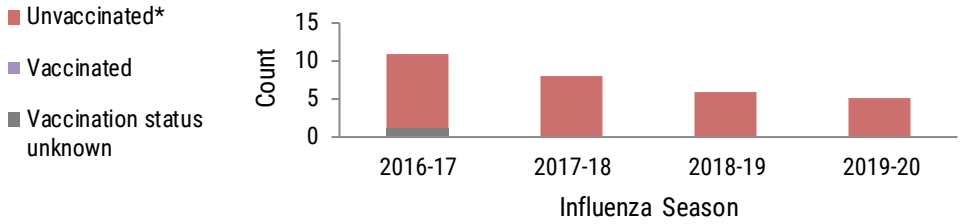
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 5, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

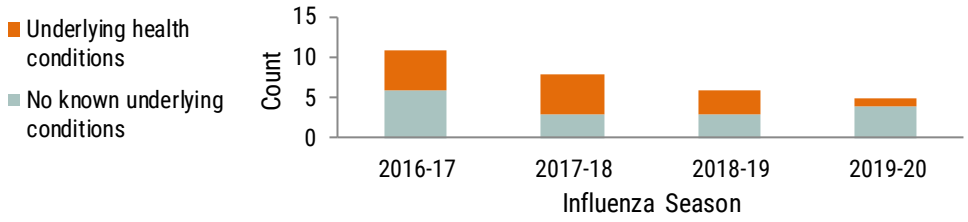


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

Figures 25-26: In week 5, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was too young to be vaccinated. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 5, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 5, 2020.

In week 4, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with an underlying medical condition. Neither child was vaccinated for the 2019-20 season.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

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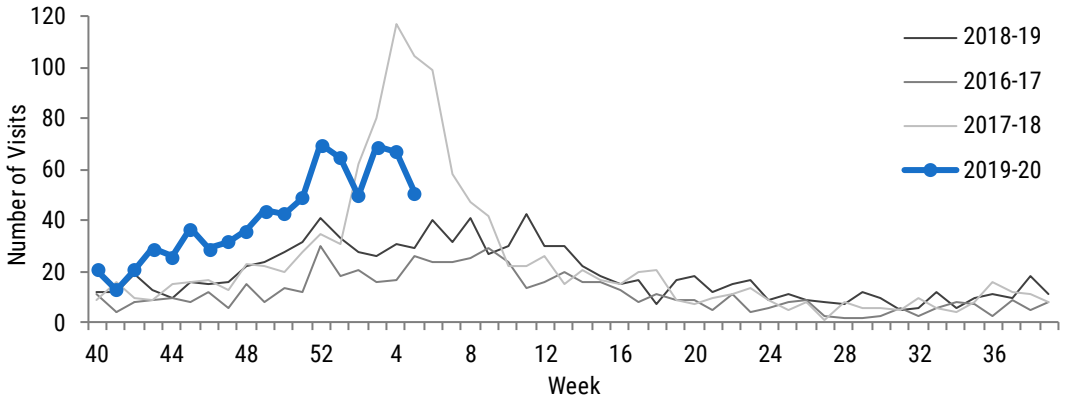
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 5, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



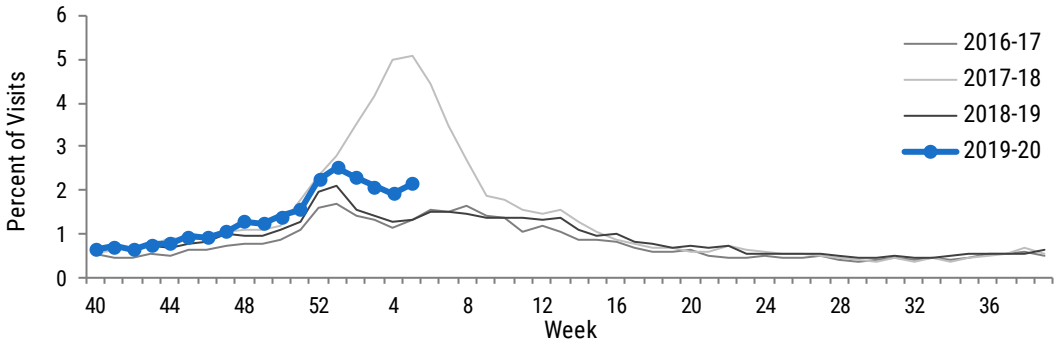
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 5, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 5, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



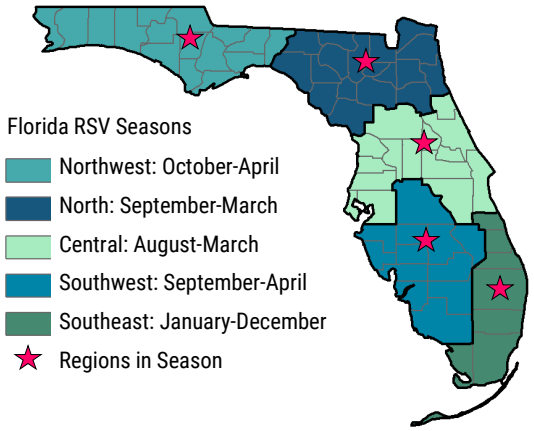
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

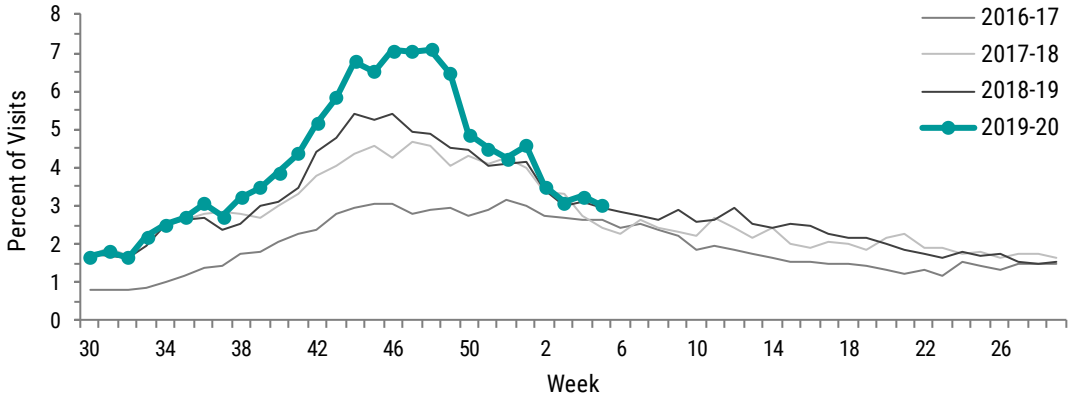
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 5 (January 26-February 1, 2020) Activity Summary

In week 5, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported. A total of eight RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 5, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 5, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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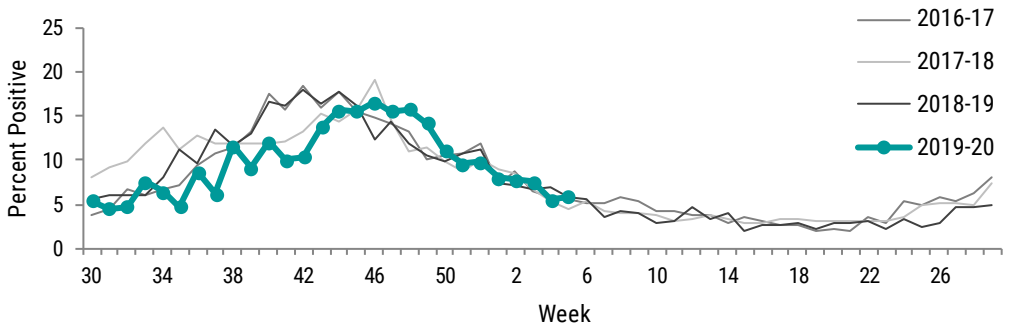
RSV Surveillance

Figure 31: In week 5, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 5, 2020. ▶



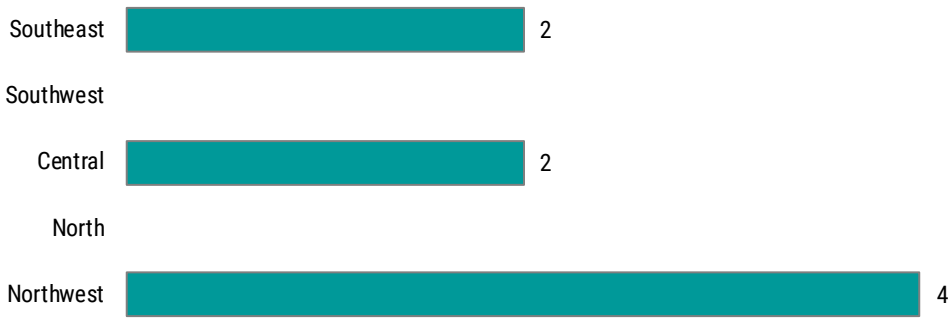
RSV-Associated Outbreaks in Week 4:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 5, no new RSV-associated outbreaks were reported. Since week 30, 2019, eight RSV-associated outbreaks have been reported.

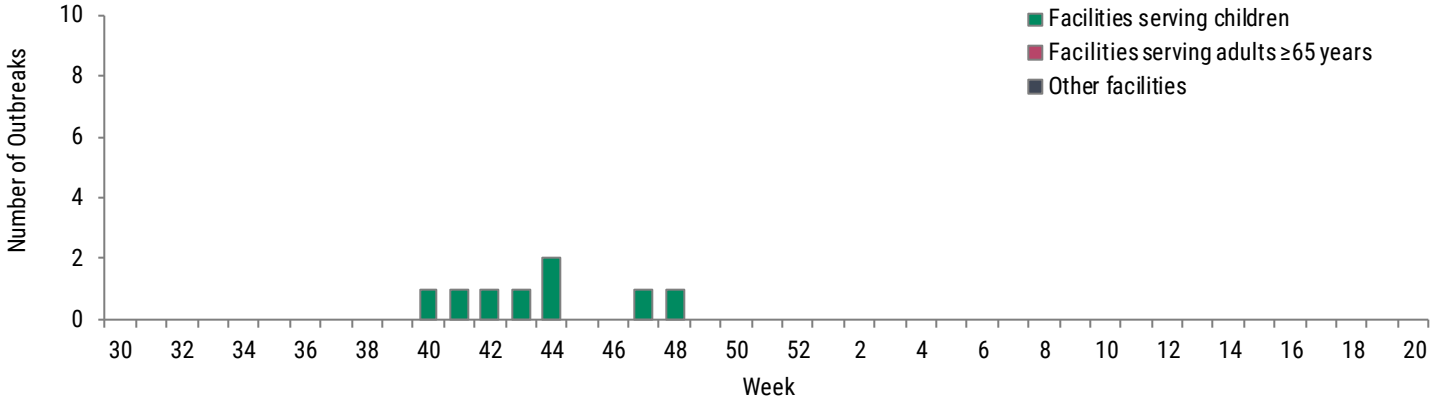
Figure 32: In week 5, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

*Regions defined in figure 29.

Figure 33: In week 5, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

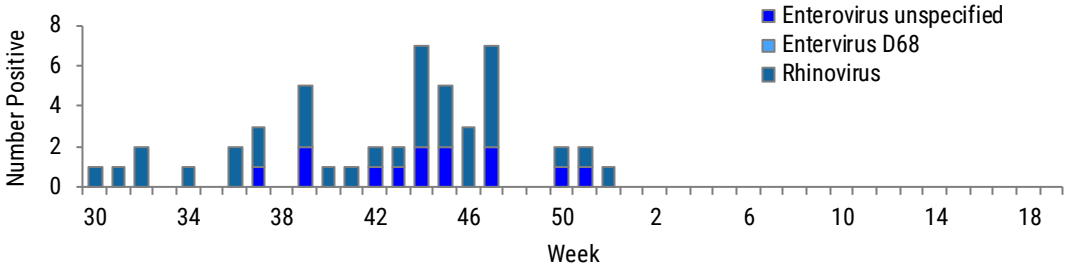
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



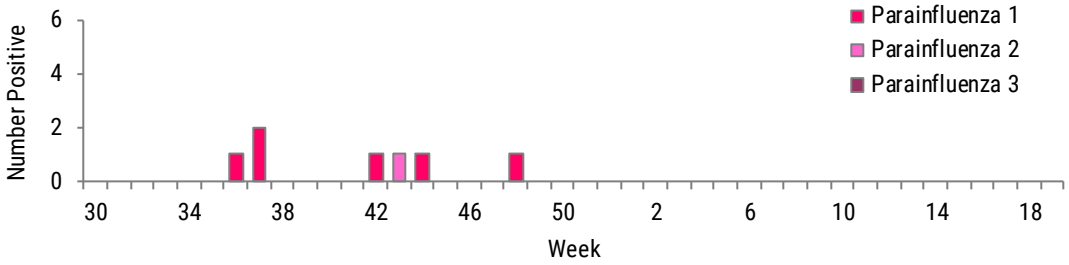
Rhinovirus | Enterovirus unspecified | Enterovirus D68 | Parainfluenza 1 | Parainfluenza 2
Parainfluenza 3 | Coronavirus NL63 | Coronavirus HKU1 | Coronavirus OC43 | Coronavirus 229E
Human metapneumovirus | Adenovirus | Group A Streptococcus | Other

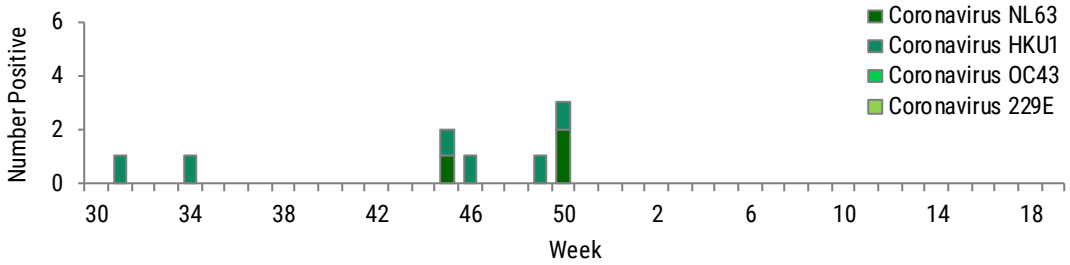
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 5, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

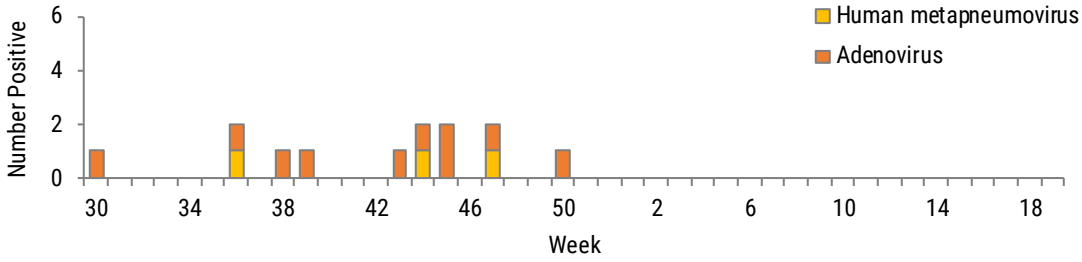
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 5, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Pinellas	3	3	0	Influenza A unspecified	Yes	Open
Primary or secondary school	Hillsborough	46	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Hillsborough	52	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Columbia	33	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Columbia	146	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Leon	35	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Santa Rosa	54	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Santa Rosa	100	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Okaloosa	88	Unknown	Unknown	Unknown	Unknown	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Mtenga, Mwedu; Bogucki, Amy; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 5, 2020 Florida Flu Review
Date:	Wednesday, February 5, 2020 3:40:32 PM
Attachments:	Week 5, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 5, 2020 Florida Flu Review.

Week 5 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 5 and reached the highest level observed so far this season. Notable increases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Thirty-five outbreaks were reported, up from 11 outbreaks in the previous week. Of the 35 outbreaks reported, 19 were influenza-associated and 16 were ILI.

Two new influenza-associated pediatric deaths were reported. One child was not vaccinated for the 2019-20 season, and the other was too young to be vaccinated. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 5: 1/26/20-2/1/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 5 influenza & influenza-like illness (ILI) activity summary:

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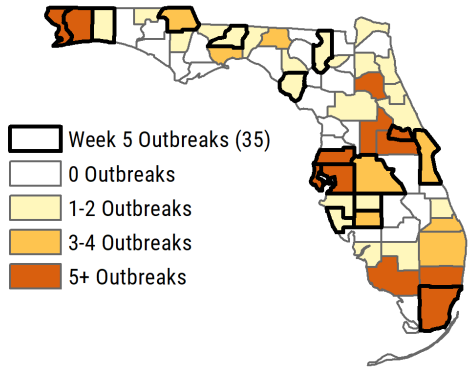
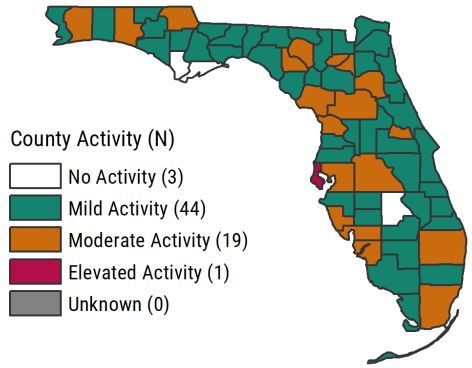
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks
Reported as of 2/1/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 5, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006962

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

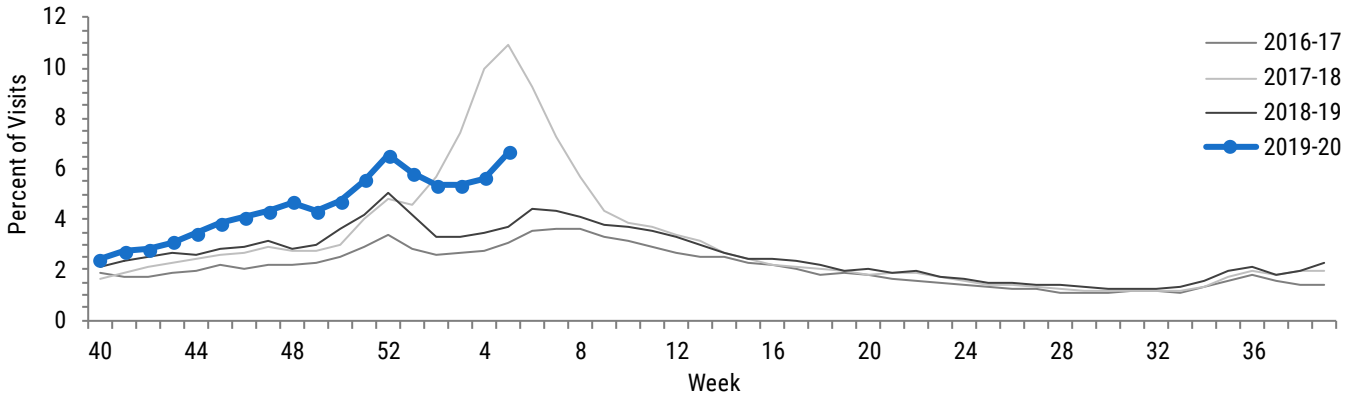
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 5, **the percent of emergency department and urgent care center visits for ILI statewide increased** and reached the highest level observed so far this season. Activity in week 5 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 5, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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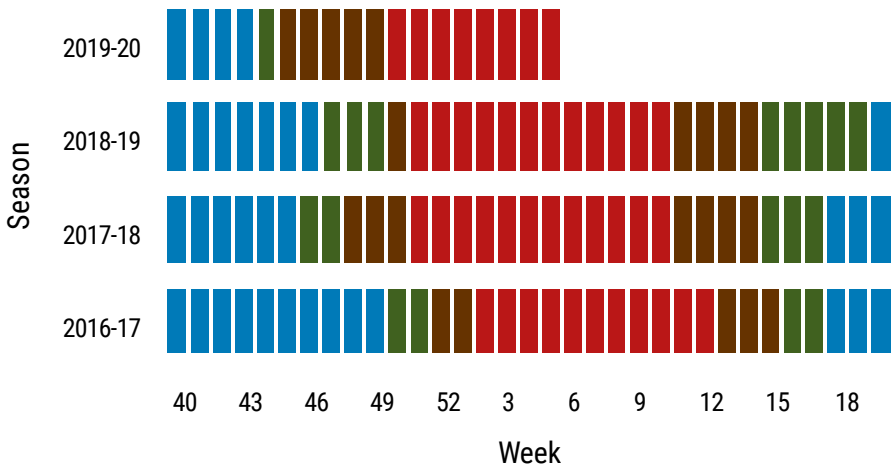
Statewide Activity

Figure 2: In week 5, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 5, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 5, **the percent of patients with ILI reported by ILINet providers statewide increased** and was above peak levels observed during the 2018-19 and 2016-17 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 5, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

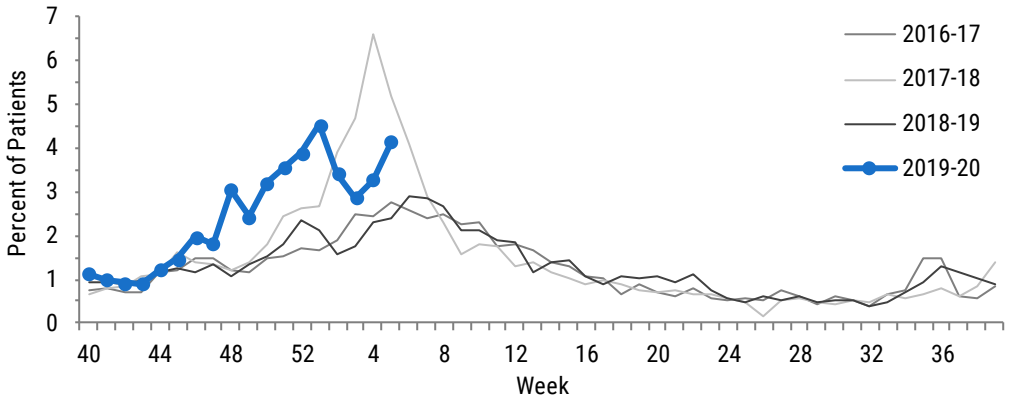
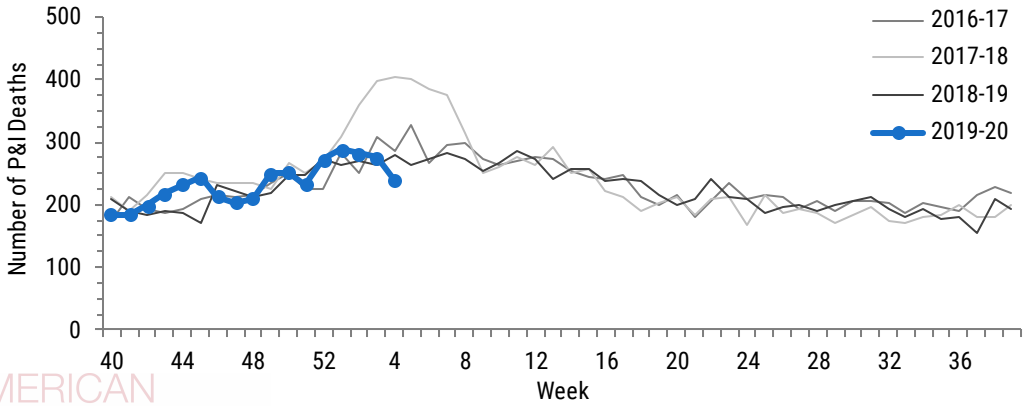


Figure 4: In week 4 (ending 1/25/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 4, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 5. Nineteen counties reported **moderate activity,** and one county reported **elevated activity.**

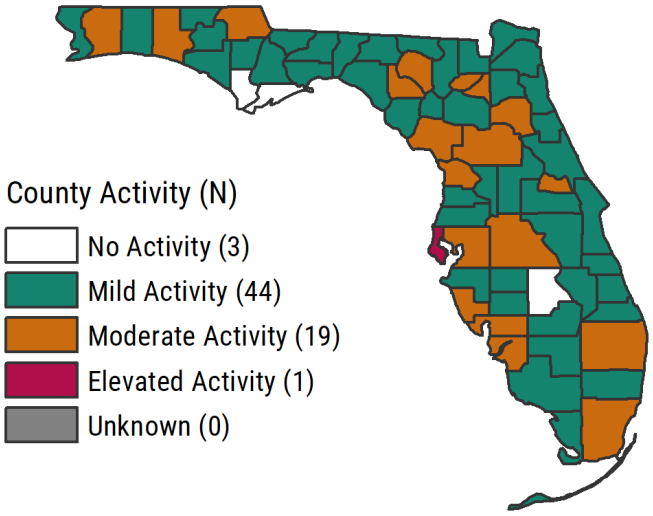
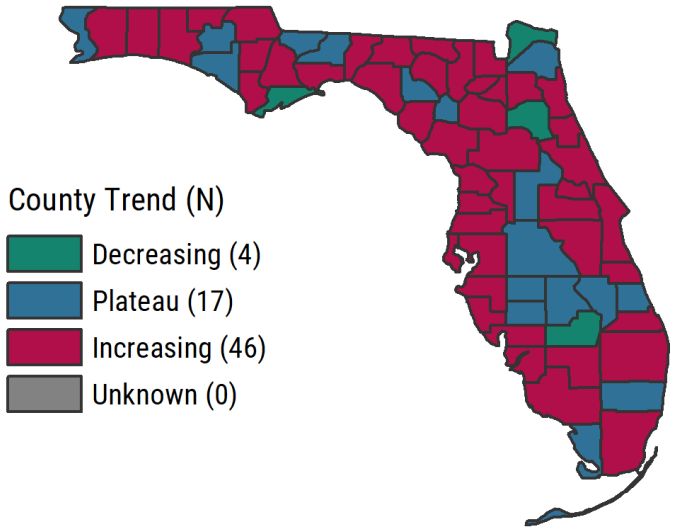
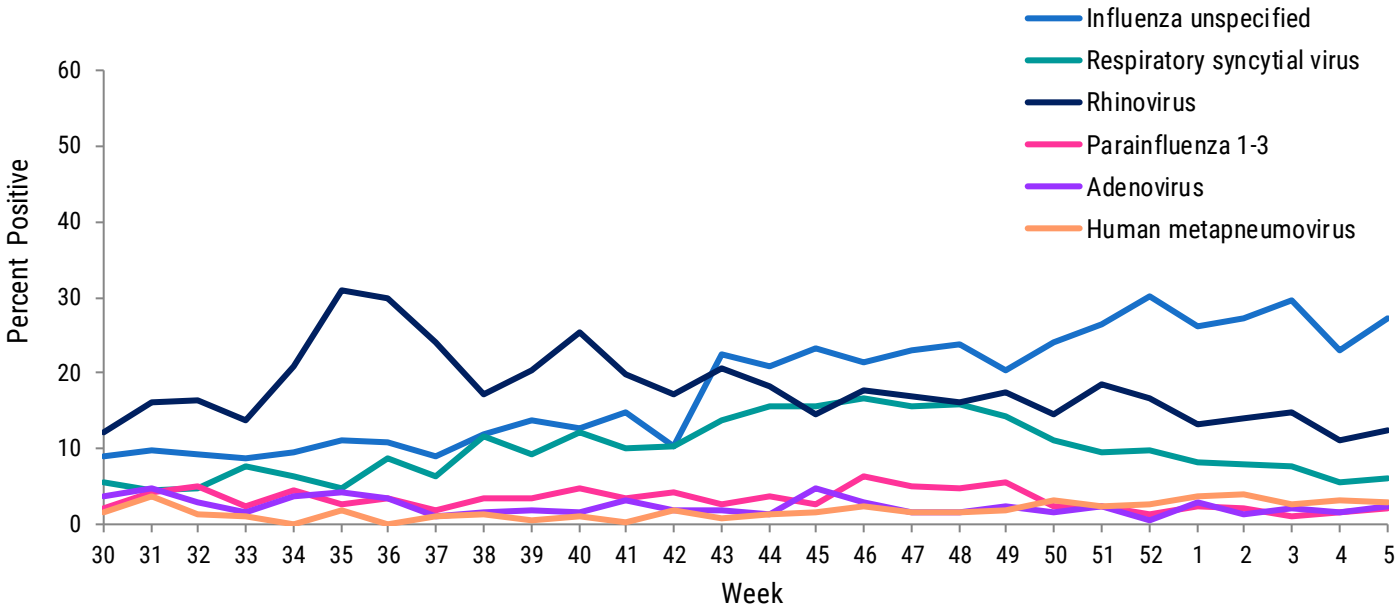


Figure 6: Most counties reported **increasing activity** in week 5. Seventeen counties reported **activity at a plateau,** and four counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 5, the **percent of specimens testing positive for influenza** **increased** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 5, 2020.

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Influenza and ILI Outbreaks

Week 5 Outbreaks at a Glance:

Number Reported:
35 Outbreaks

Influenza-Associated:
19 Outbreaks

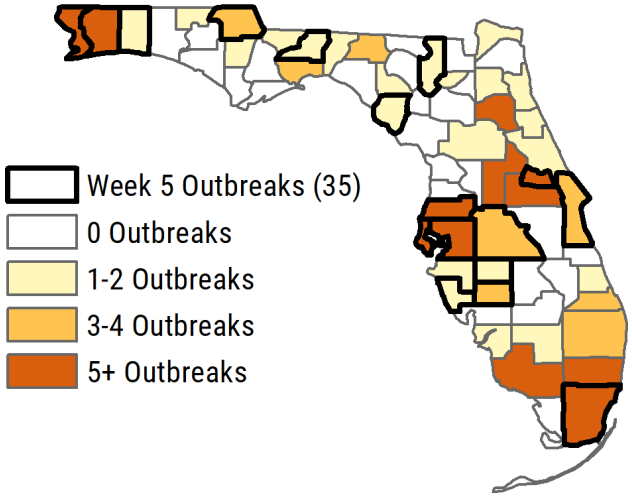
Severe Outcomes*:
5 Outbreaks

Outbreak Summary:

In week 5, 19 influenza-associated and 16 ILI outbreaks were reported, a notable increase from the previous week.

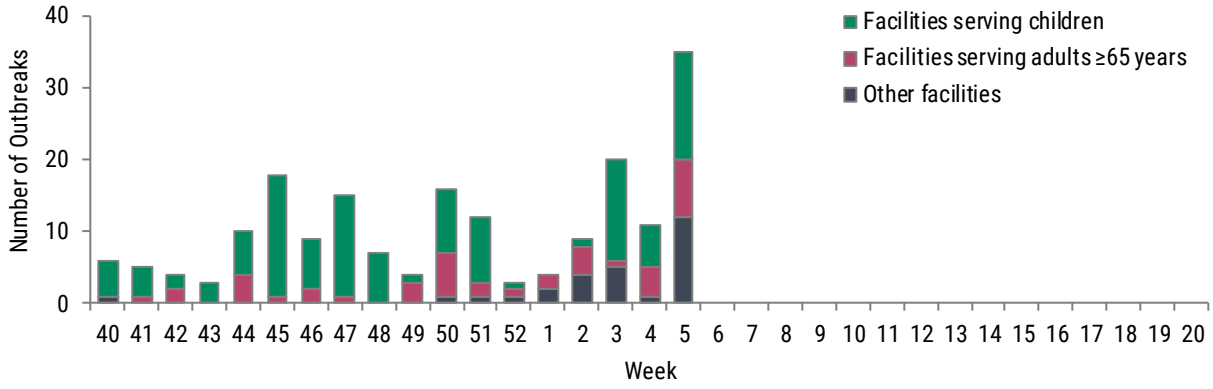
Severe outcomes* were reported in five of 35 outbreaks. One or more hospitalizations were reported in each of these five outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 5, four of the five outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



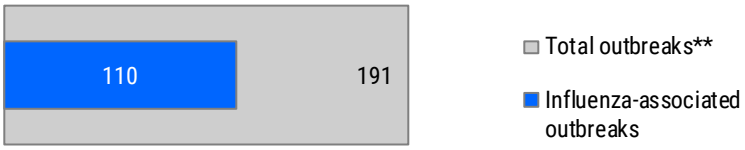
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 5 are **outlined in bold.**

Figure 9: In week 5, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, 15 outbreaks** were reported in **facilities serving children,** and **12 outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 5, **57.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 5, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

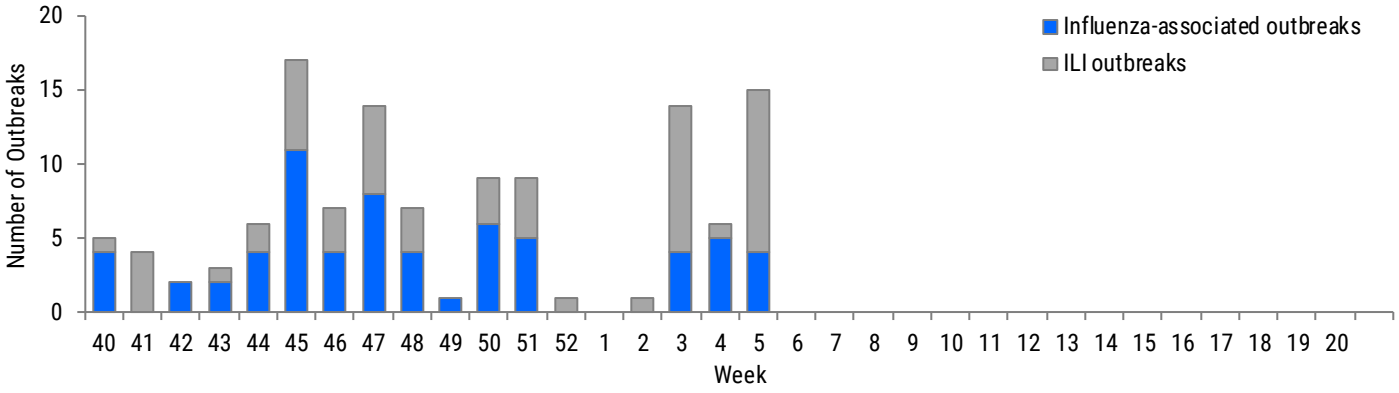
15 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 5, 15 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 5, **four influenza-associated outbreaks** and **11 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

Facilities Serving Adults ≥65 yrs.**:

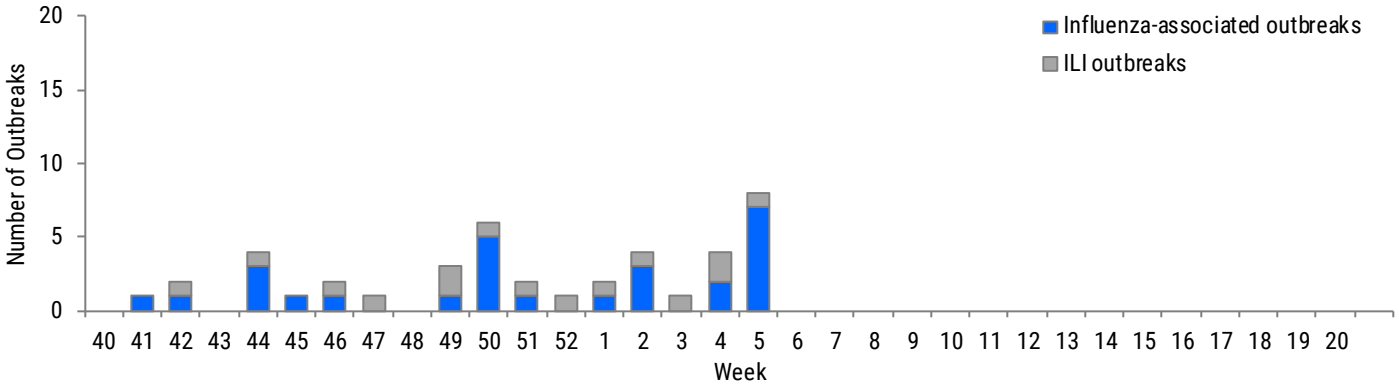
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 5, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 5, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

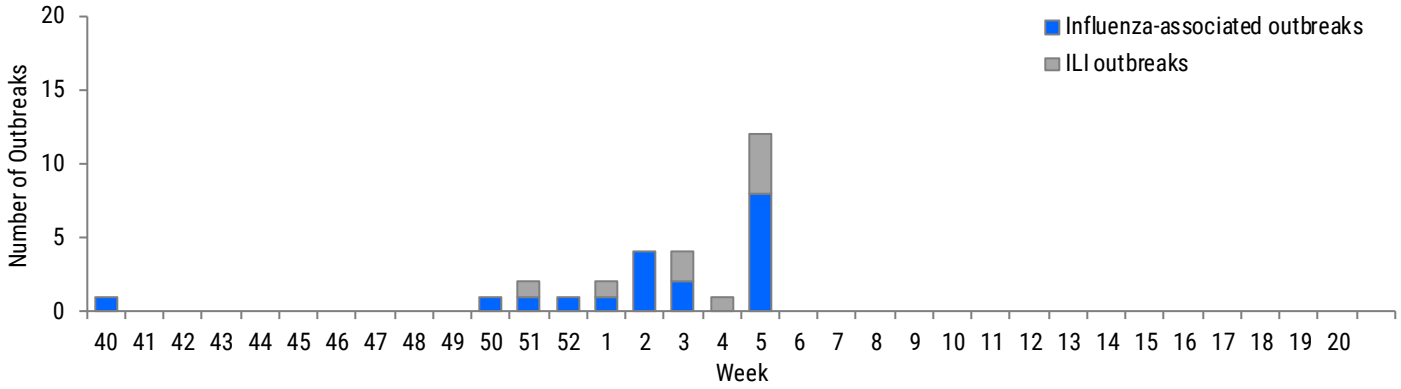
12 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 5, 12 new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 5, **eight influenza-associated outbreaks** and **four ILI outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

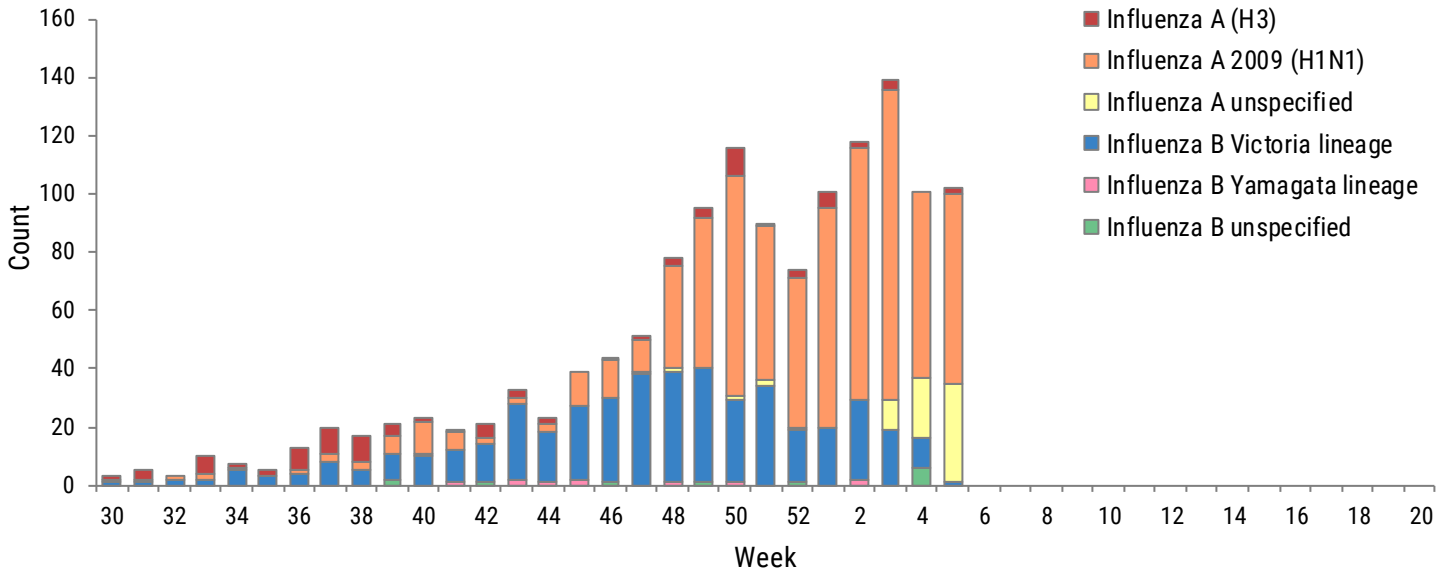
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	99 (51.8%)	55 influenza-associated outbreaks 44 ILI outbreaks
Child daycares	22 (11.5%)	9 influenza-associated outbreaks 13 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	13 (6.8%)	4 influenza-associated outbreaks 9 ILI outbreaks
Nursing facilities	10 (5.2%)	8 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	19 (9.9%)	15 influenza-associated outbreaks 4 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	24 (12.6%)	16 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (1.0%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (1.0%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**191 (100.0%)**	**110 influenza-associated outbreaks** **81 ILI outbreaks**

AMERICAN OVERSIGHT

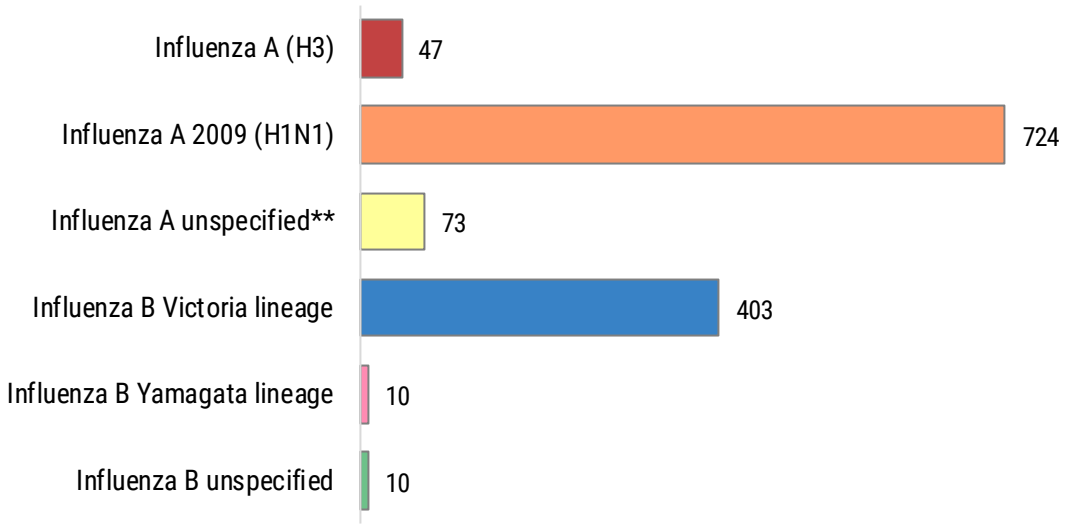
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 5, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 5, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 5, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 5 and was similar to peak levels observed during the 2018-19 season.

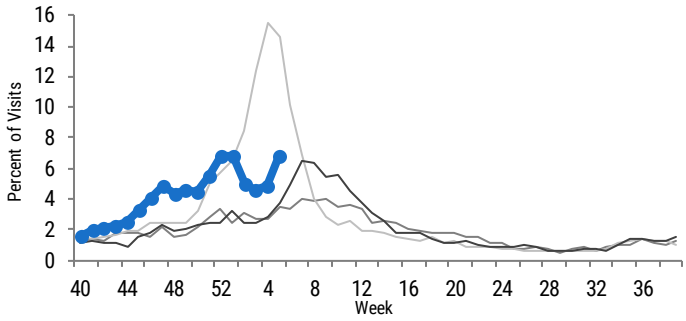


Figure 17: In **region 2, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

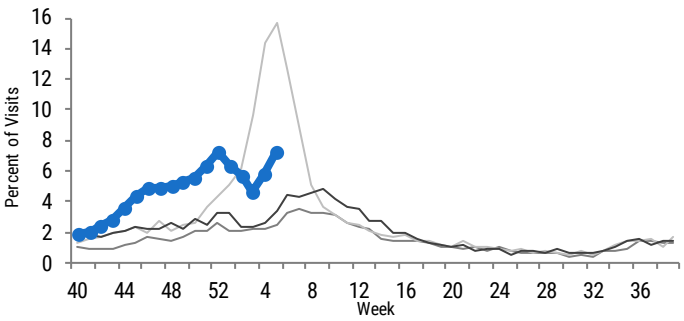


Figure 18: In **region 3, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

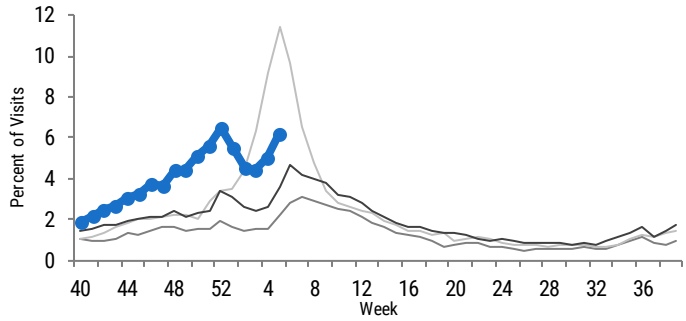


Figure 19: In **region 4, ILI activity increased** during week 5 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

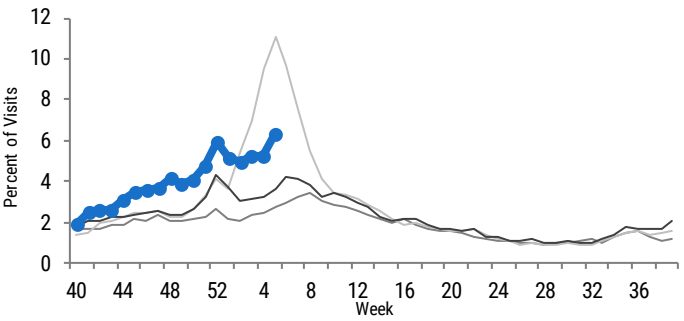


Figure 20: In **region 5, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

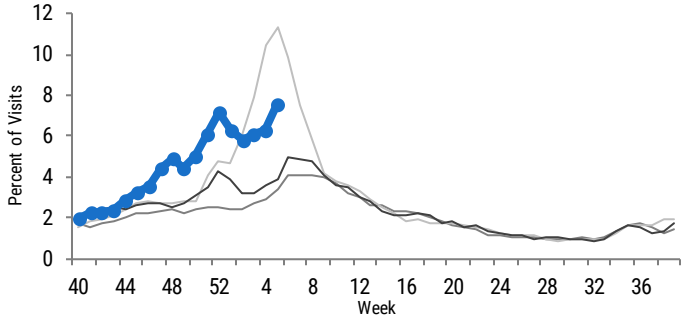


Figure 21: In **region 6, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

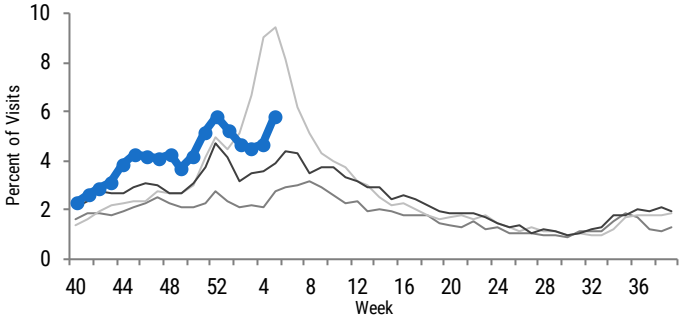
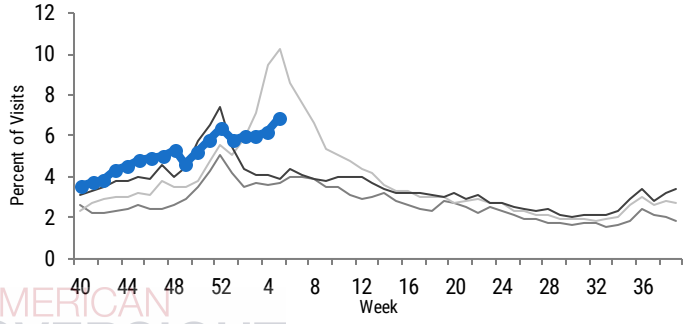


Figure 22: In **region 7, ILI activity increased** during week 5 and was similar to peak activity observed during the 2018-19 season.



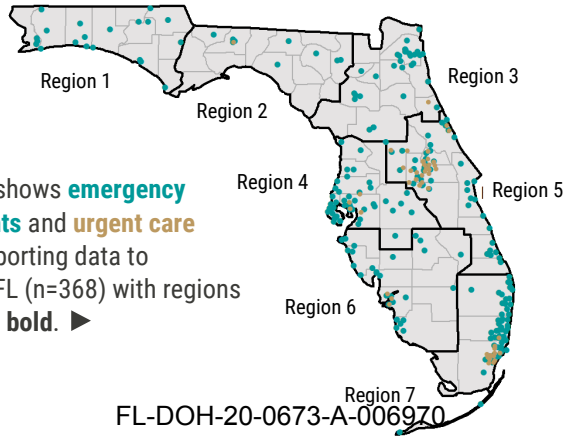


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

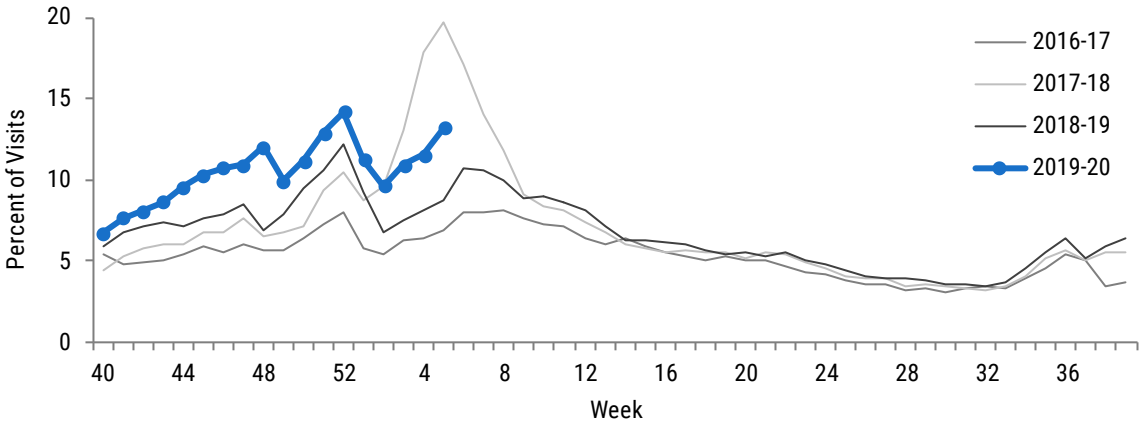
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

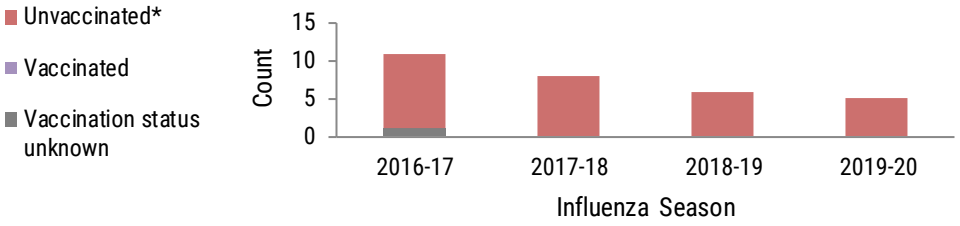
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 5, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

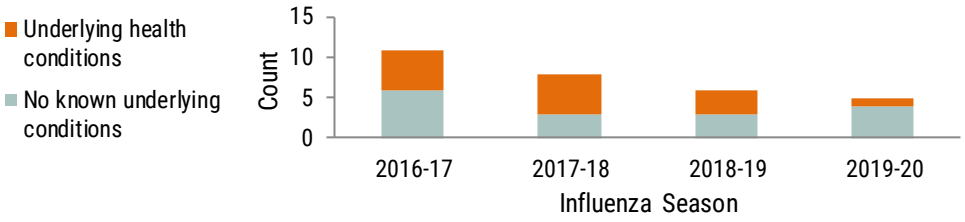


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

Figures 25-26: In week 5, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was too young to be vaccinated. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 5, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 5, 2020.

In week 4, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with an underlying medical condition. Neither child was vaccinated for the 2019-20 season.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

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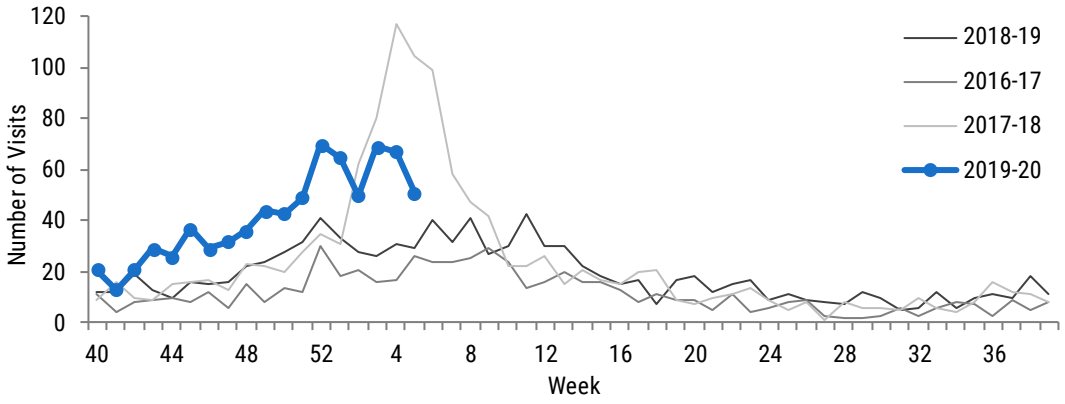
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 5, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



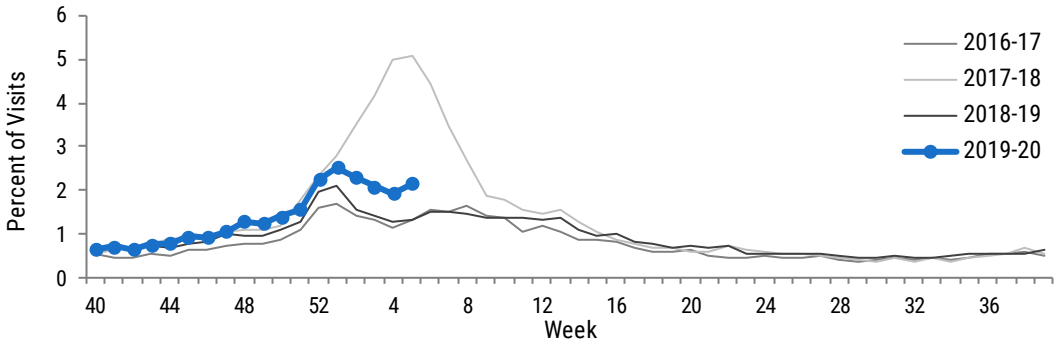
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 5, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 5, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



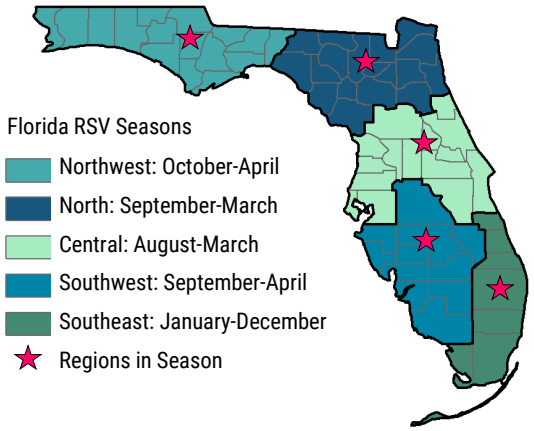
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

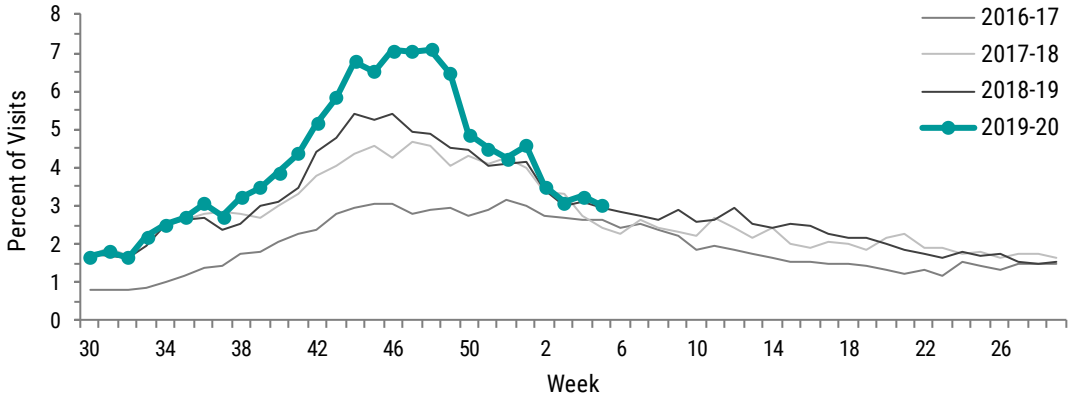
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 5 (January 26-February 1, 2020) Activity Summary

In week 5, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported. A total of eight RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 5, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 5, 2020.

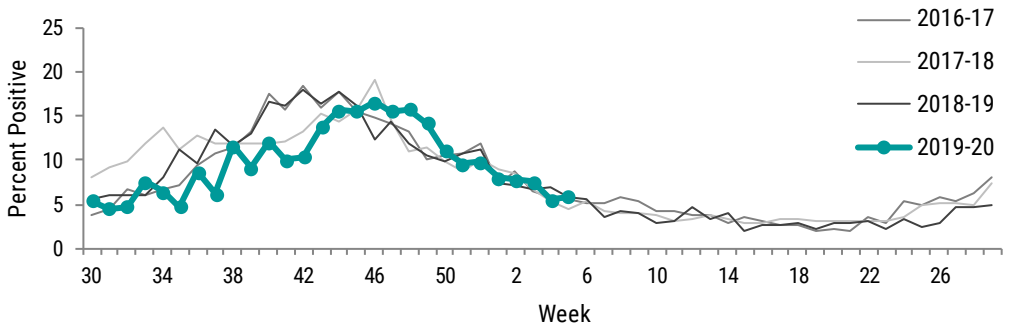
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 5, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 5, 2020. ▶



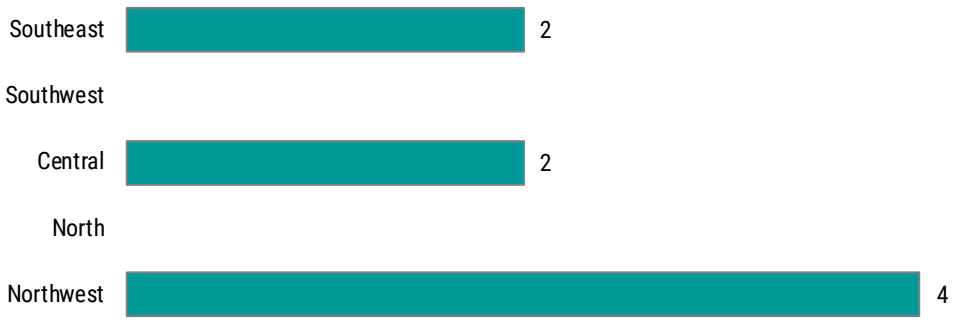
RSV-Associated Outbreaks in Week 4:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 5, no new RSV-associated outbreaks were reported. Since week 30, 2019, eight RSV-associated outbreaks have been reported.

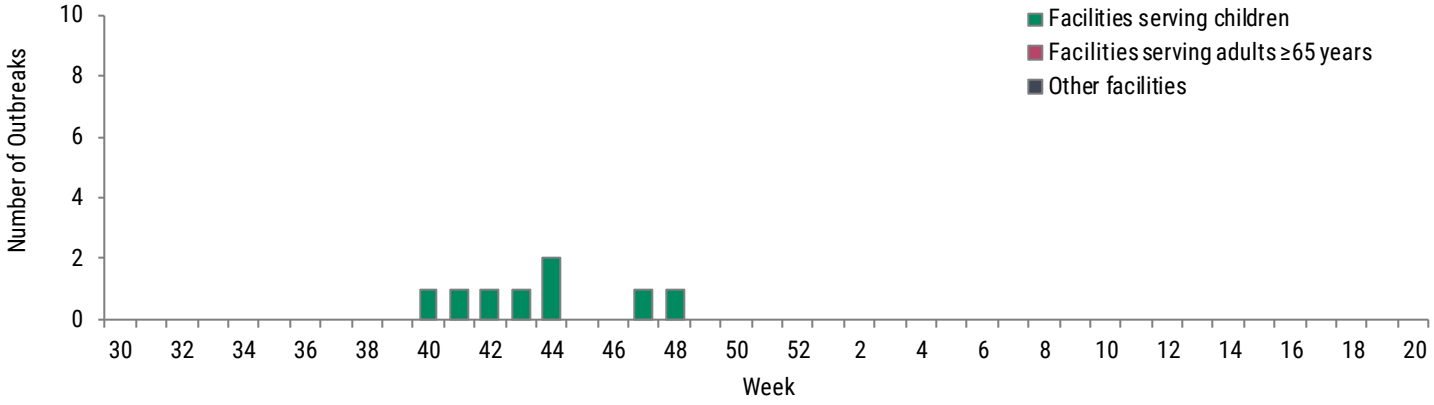
Figure 32: In week 5, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

*Regions defined in figure 29.

Figure 33: In week 5, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

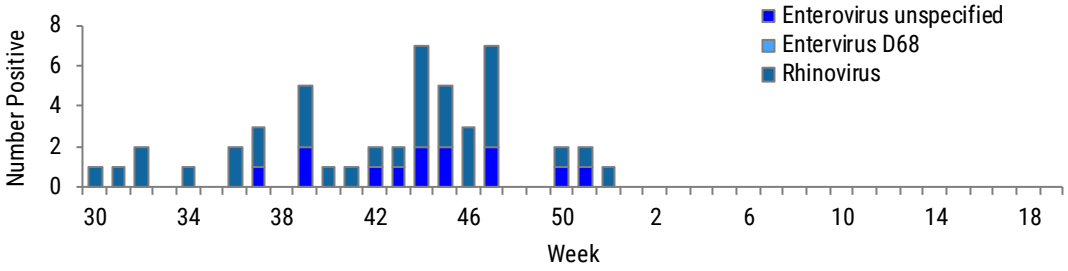
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



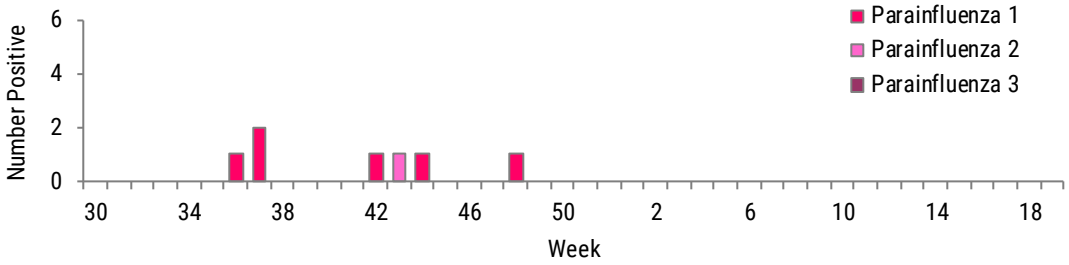
Rhinovirus | Enterovirus unspecified | Enterovirus D68 | Parainfluenza 1 | Parainfluenza 2
Parainfluenza 3 | Coronavirus NL63 | Coronavirus HKU1 | Coronavirus OC43 | Coronavirus 229E
Human metapneumovirus | Adenovirus | Group A Streptococcus | Other

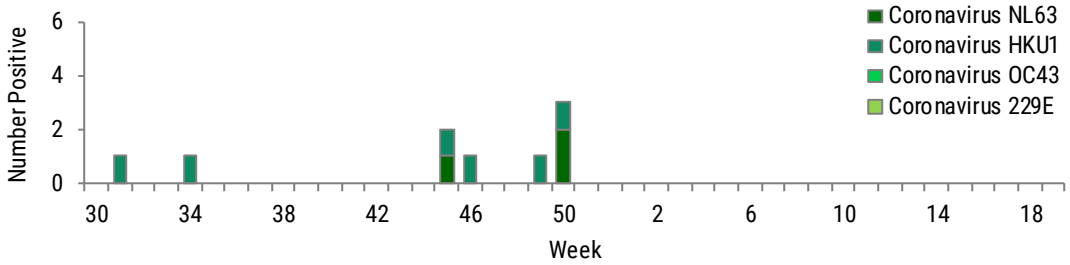
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 5, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

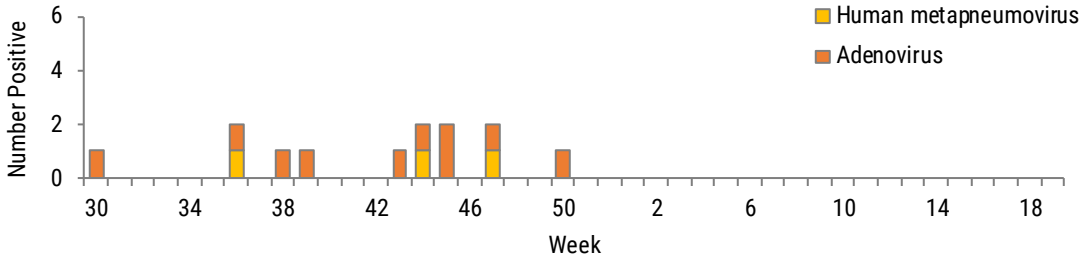
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 5, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Pinellas	3	3	0	Influenza A unspecified	Yes	Open
Primary or secondary school	Hillsborough	46	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Hillsborough	52	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Columbia	33	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Columbia	146	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Leon	35	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Santa Rosa	54	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Santa Rosa	100	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Okaloosa	88	Unknown	Unknown	Unknown	Unknown	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Munroe, Julia
To:	Mtenga, Mwedu; Bogucki, Amy; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 5, 2020 Florida Flu Review
Date:	Wednesday, February 5, 2020 3:40:25 PM
Attachments:	Week 5, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 5, 2020 Florida Flu Review.

Week 5 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 5 and reached the highest level observed so far this season. Notable increases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Thirty-five outbreaks were reported, up from 11 outbreaks in the previous week. Of the 35 outbreaks reported, 19 were influenza-associated and 16 were ILI.

Two new influenza-associated pediatric deaths were reported. One child was not vaccinated for the 2019-20 season, and the other was too young to be vaccinated. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 5: 1/26/20-2/1/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Increasing**

Week 5 influenza & influenza-like illness (ILI) activity summary:

Activity increased in week 5 and reached the highest level observed so far this season. Notable increases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

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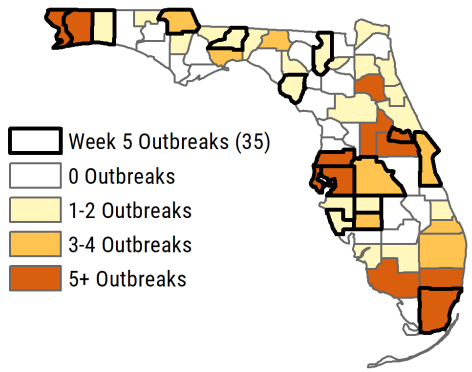
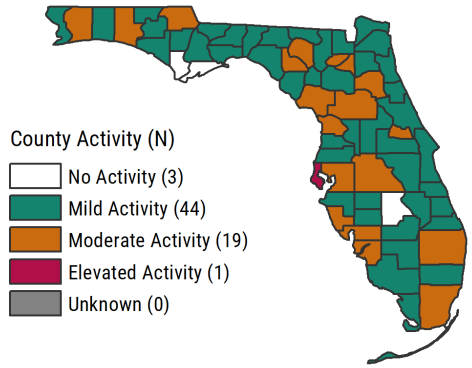
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks
Reported as of 2/1/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 5, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-006981

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

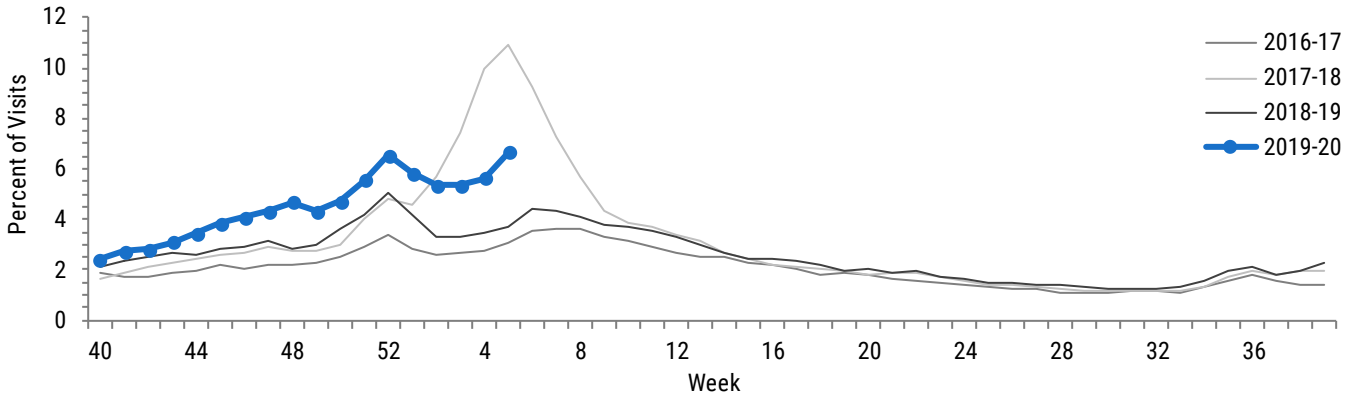
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 5, **the percent of emergency department and urgent care center visits for ILI statewide increased** and reached the highest level observed so far this season. Activity in week 5 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 5, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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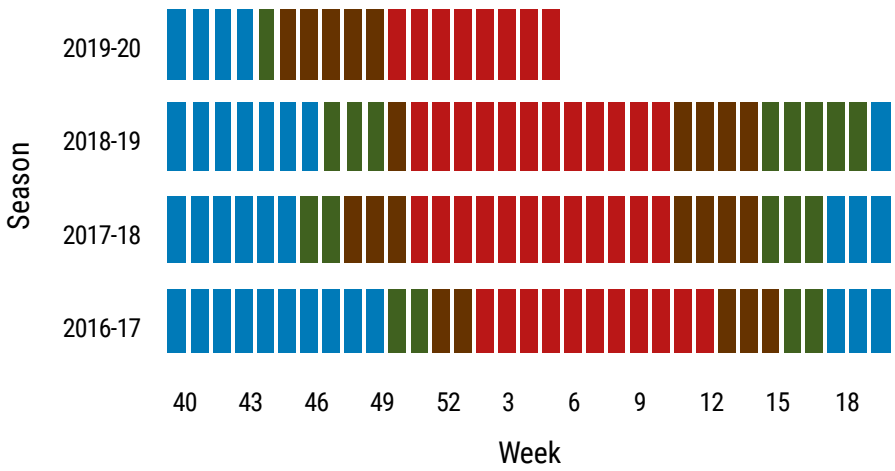
Statewide Activity

Figure 2: In week 5, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 5, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 5, **the percent of patients with ILI reported by ILINet providers statewide increased** and was above peak levels observed during the 2018-19 and 2016-17 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 5, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

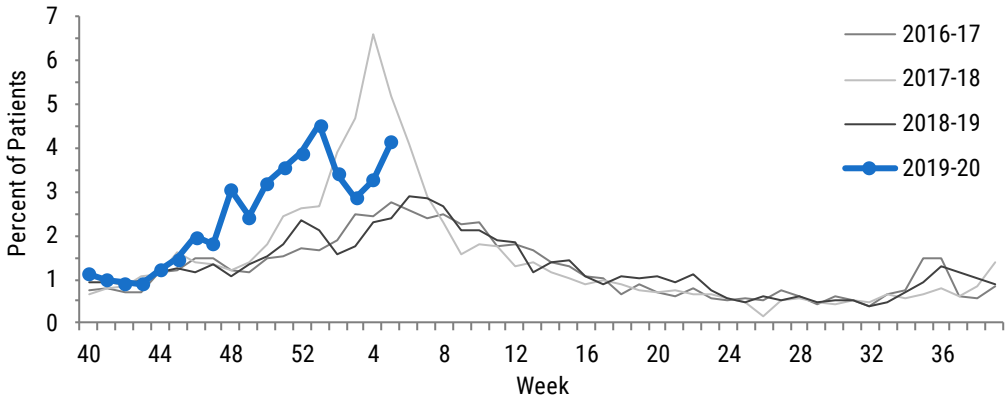
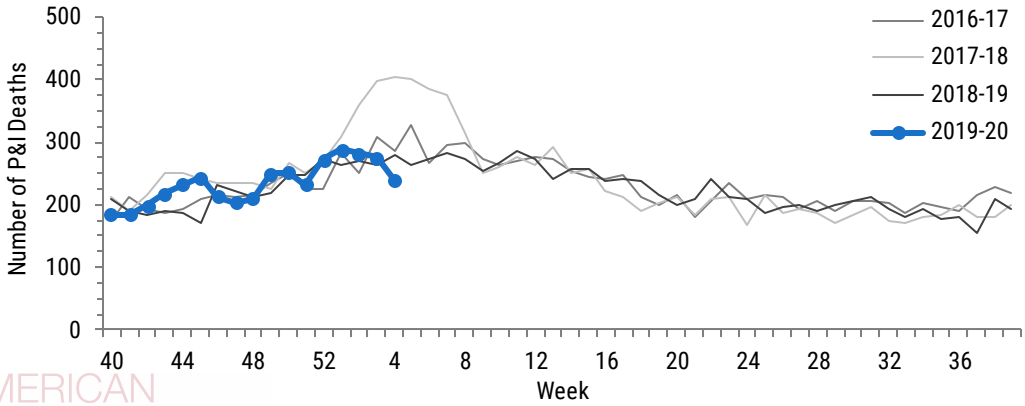


Figure 4: In week 4 (ending 1/25/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 4, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 5. Nineteen counties reported **moderate activity,** and one county reported **elevated activity.**

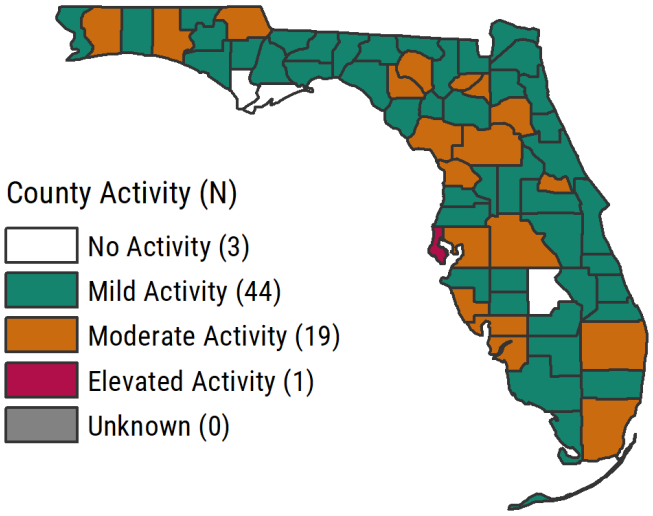
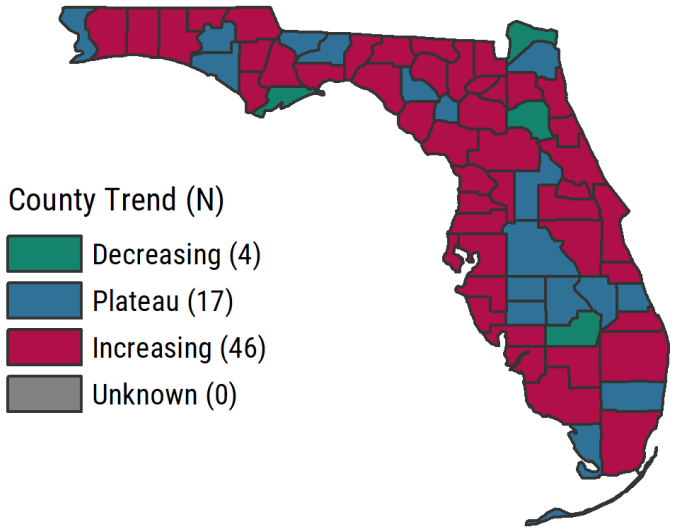
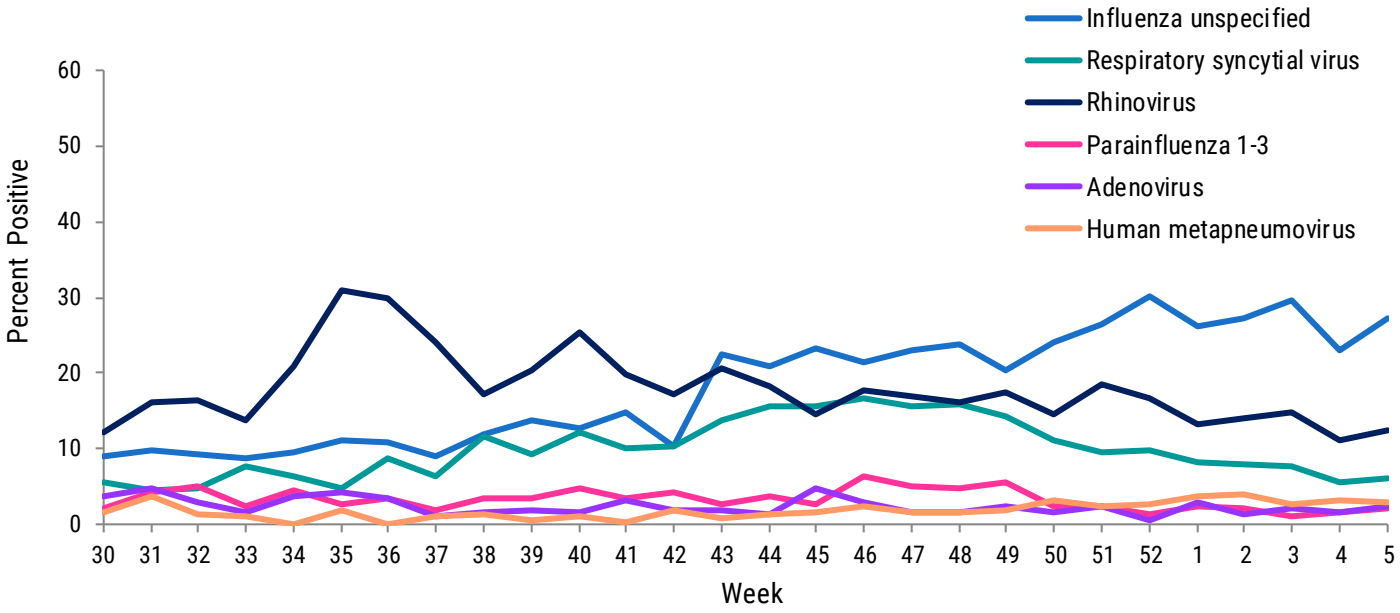


Figure 6: Most counties reported **increasing activity** in week 5. Seventeen counties reported **activity at a plateau,** and four counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 5, the **percent of specimens testing positive for influenza** **increased** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 5, 2020.

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Influenza and ILI Outbreaks

Week 5 Outbreaks at a Glance:

Number Reported:
35 Outbreaks

Influenza-Associated:
19 Outbreaks

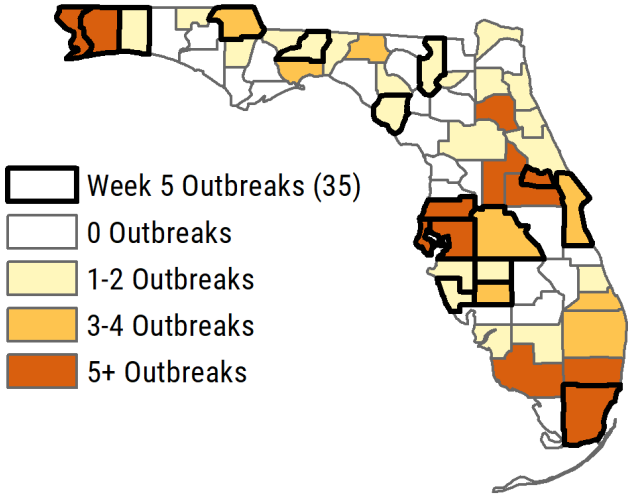
Severe Outcomes*:
5 Outbreaks

Outbreak Summary:

In week 5, 19 influenza-associated and 16 ILI outbreaks were reported, a notable increase from the previous week.

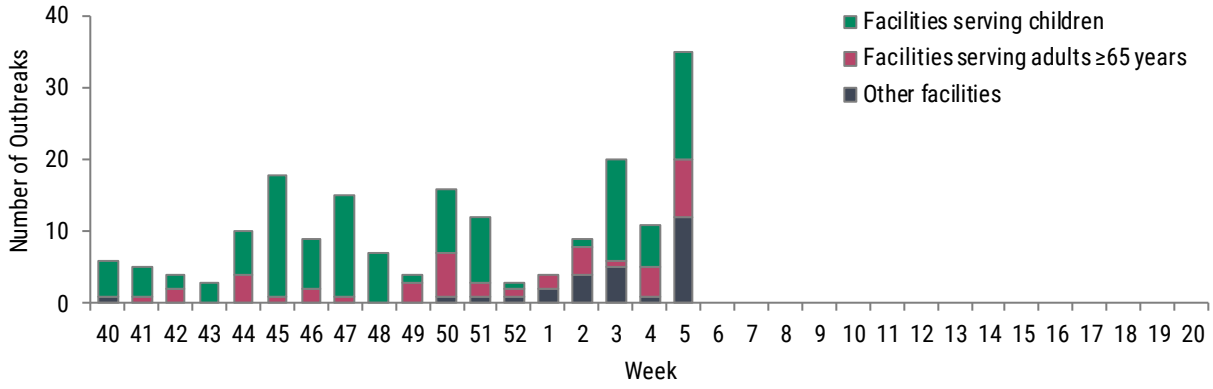
Severe outcomes* were reported in five of 35 outbreaks. One or more hospitalizations were reported in each of these five outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 5, four of the five outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



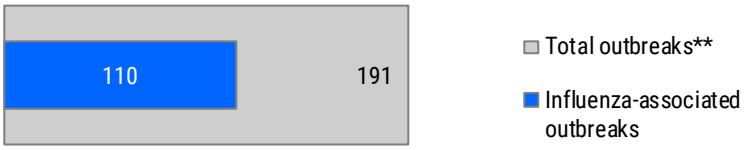
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 5 are **outlined in bold.**

Figure 9: In week 5, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, 15 outbreaks** were reported in **facilities serving children,** and **12 outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 5, **57.6% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 5, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

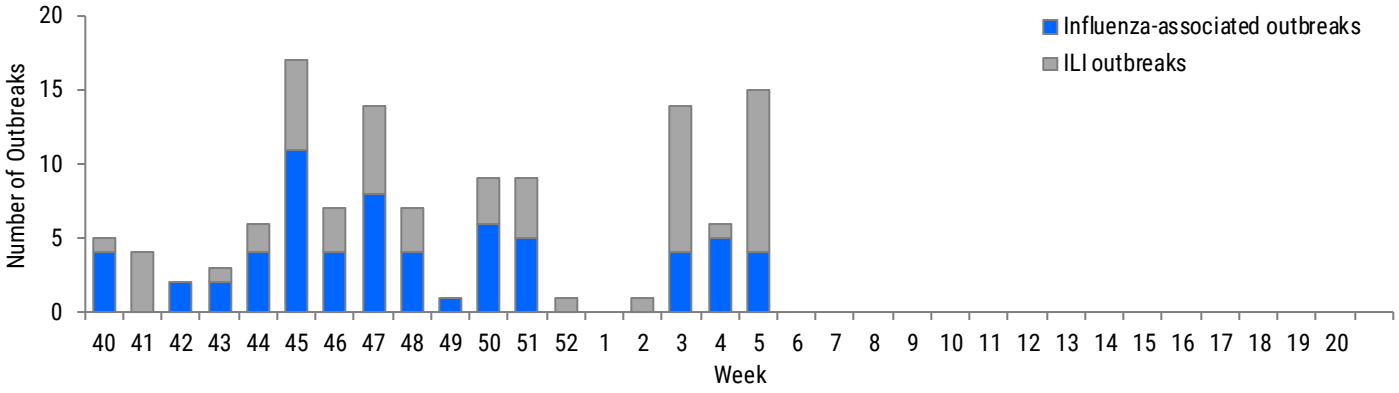
15 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 5, 15 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 5, **four influenza-associated outbreaks** and **11 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

Facilities Serving Adults ≥65 yrs.**:

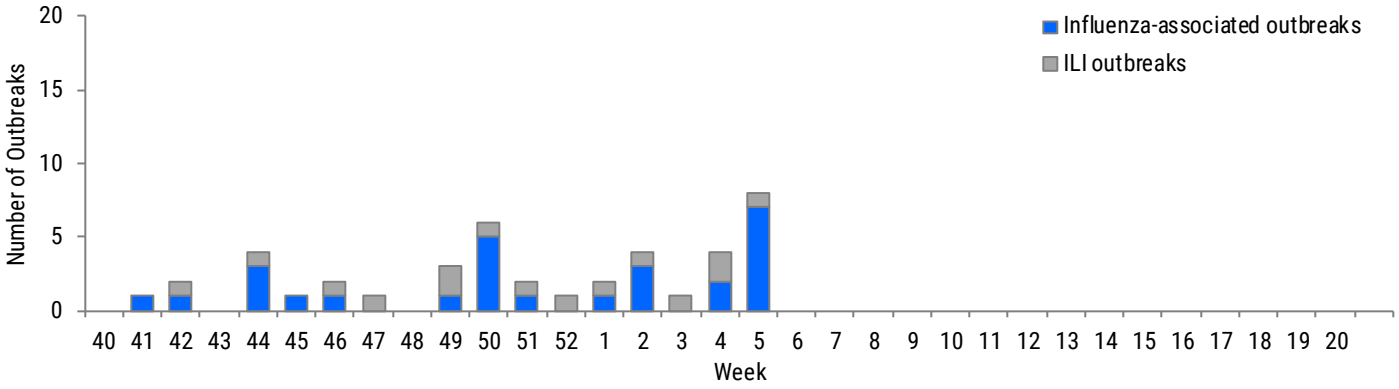
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 5, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 5, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

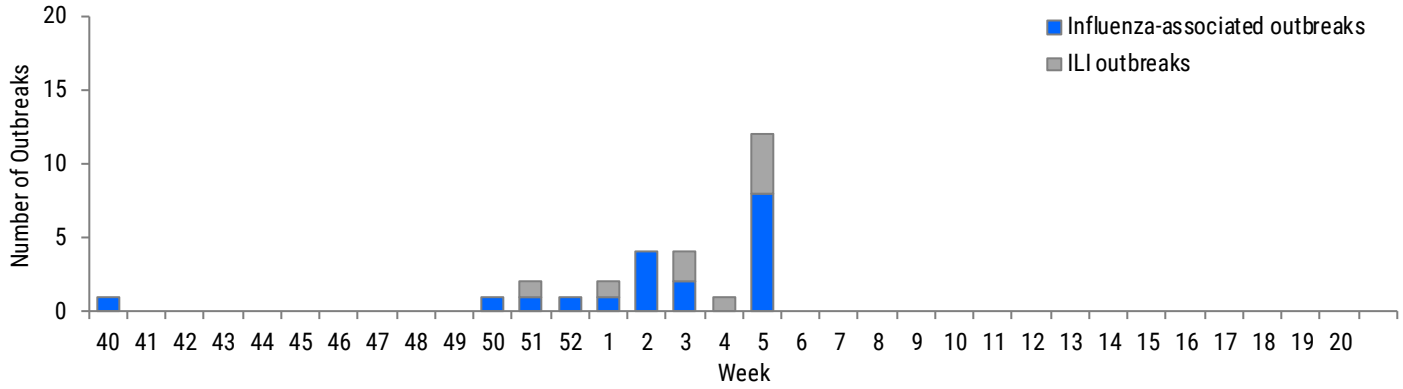
12 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 5, 12 new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 5, **eight influenza-associated outbreaks** and **four ILI outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 5, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	99 (51.8%)	55 influenza-associated outbreaks 44 ILI outbreaks
Child daycares	22 (11.5%)	9 influenza-associated outbreaks 13 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	13 (6.8%)	4 influenza-associated outbreaks 9 ILI outbreaks
Nursing facilities	10 (5.2%)	8 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	19 (9.9%)	15 influenza-associated outbreaks 4 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	24 (12.6%)	16 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (1.0%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (1.0%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**191 (100.0%)**	**110 influenza-associated outbreaks** **81 ILI outbreaks**

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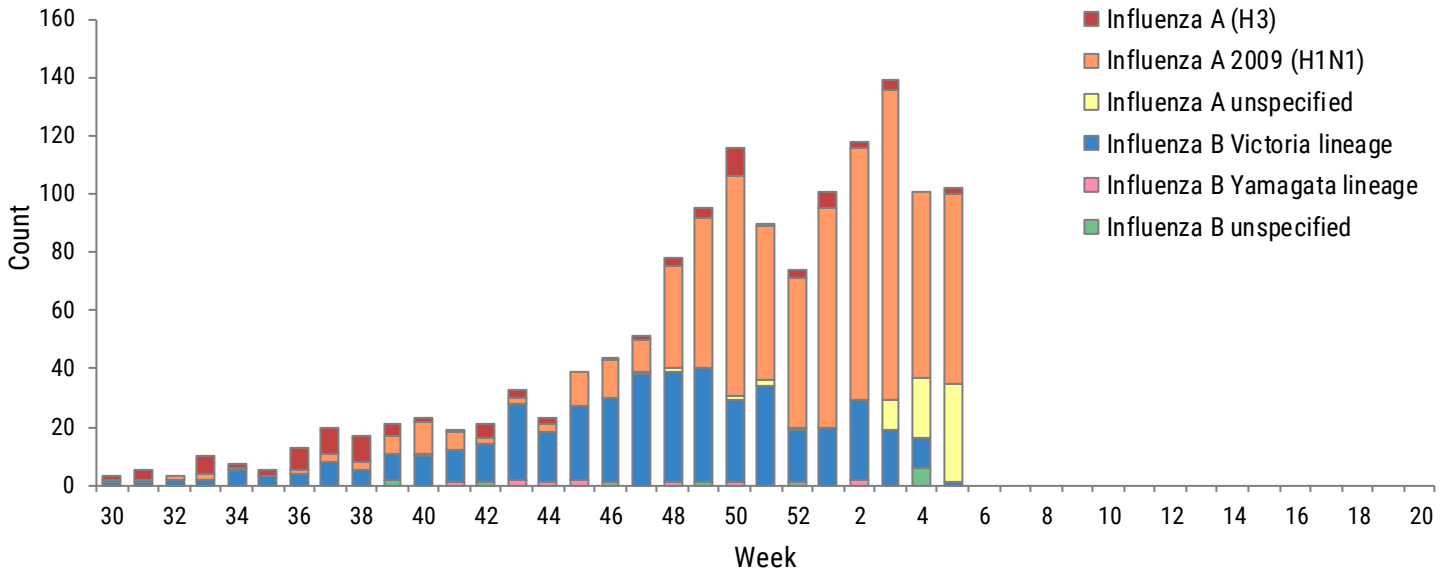
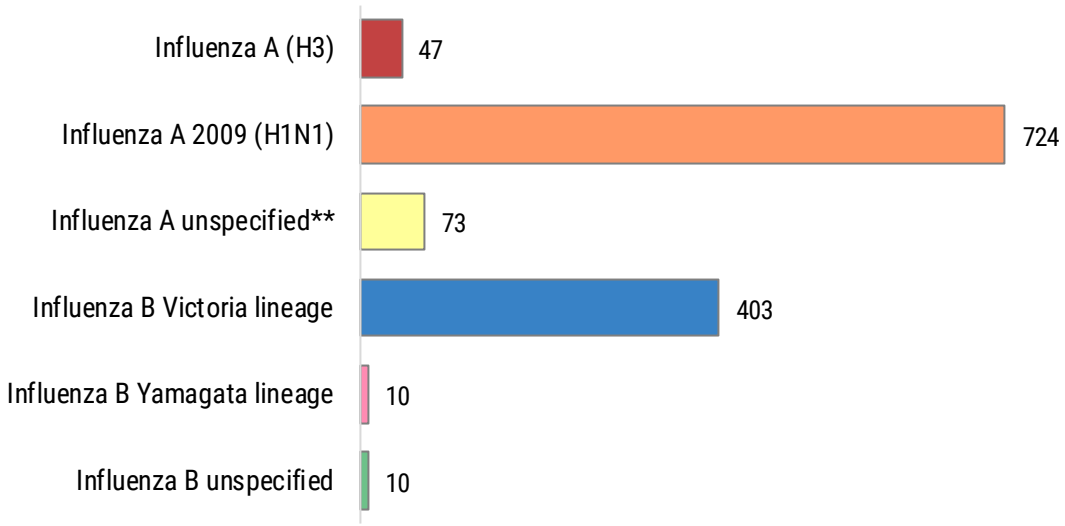
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 5, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 5, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 5, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 5 and was similar to peak levels observed during the 2018-19 season.

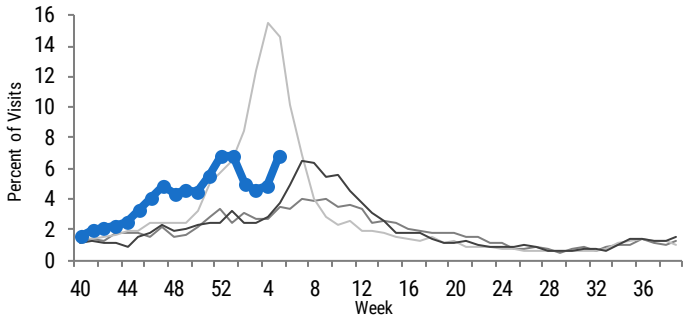


Figure 17: In **region 2, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

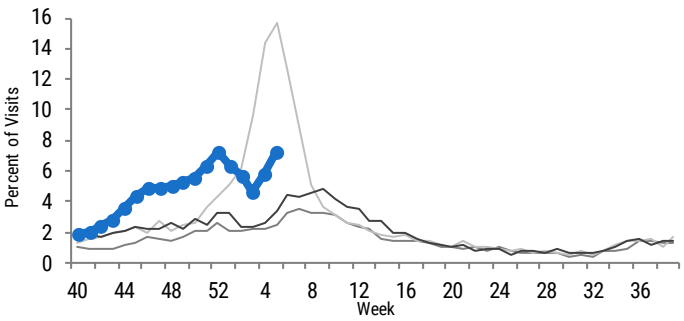


Figure 18: In **region 3, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

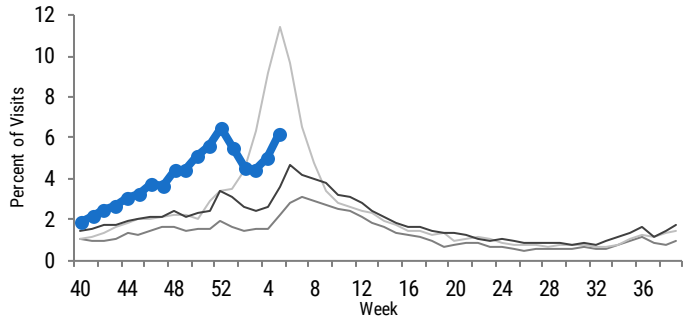


Figure 19: In **region 4, ILI activity increased** during week 5 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

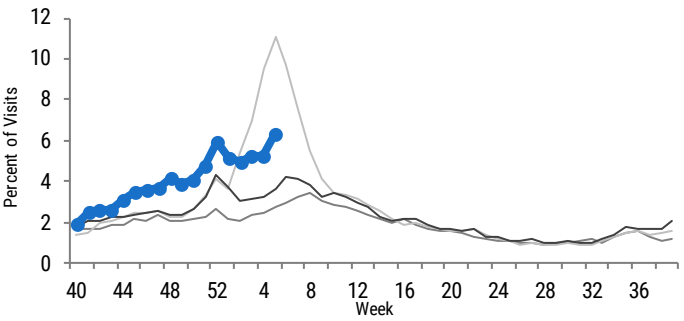


Figure 20: In **region 5, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

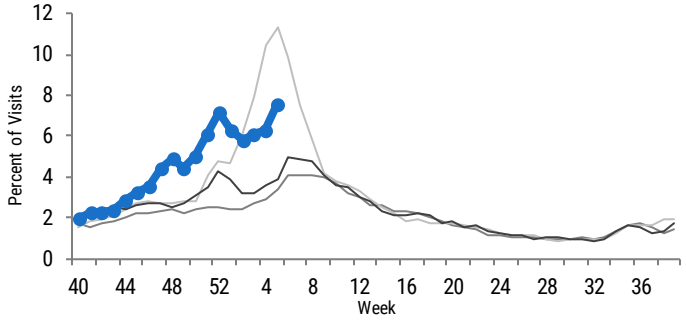


Figure 21: In **region 6, ILI activity increased** during week 5 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

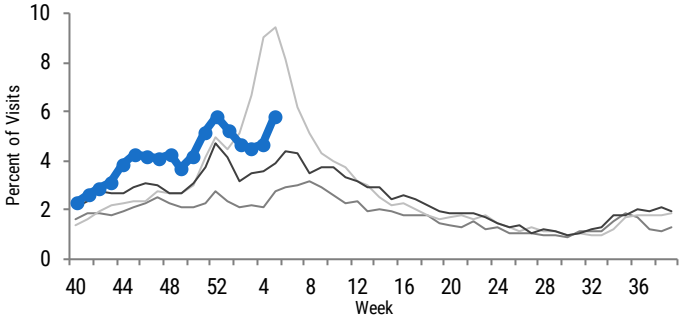
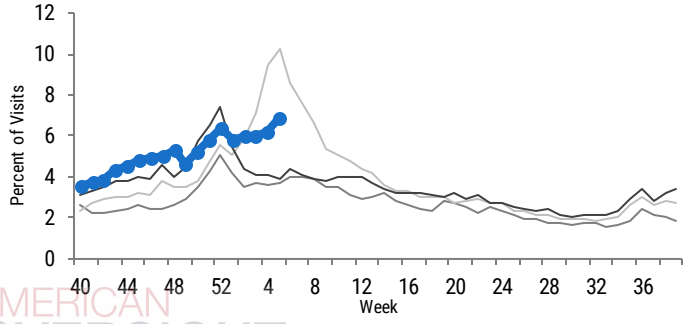


Figure 22: In **region 7, ILI activity increased** during week 5 and was similar to peak activity observed during the 2018-19 season.



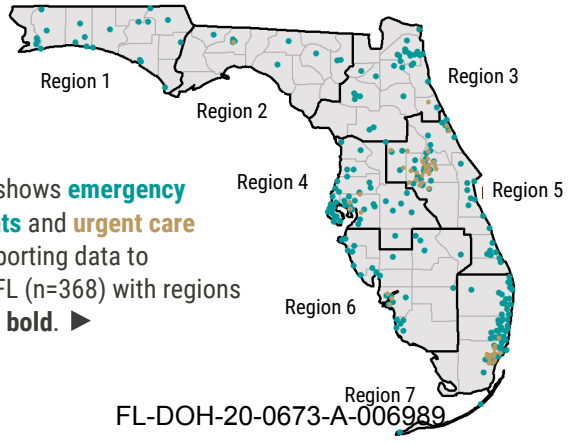


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

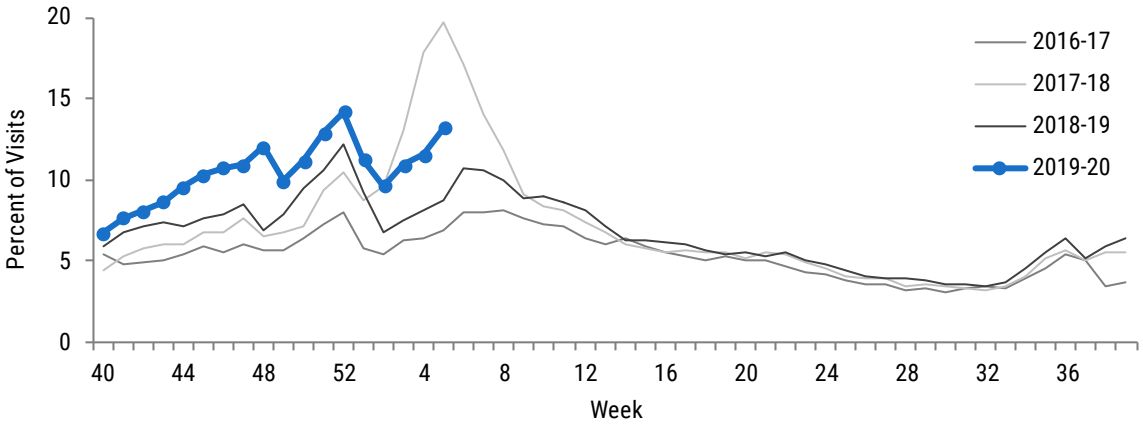
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

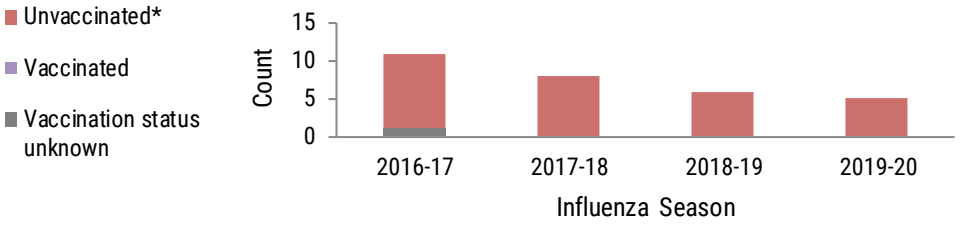
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 5, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

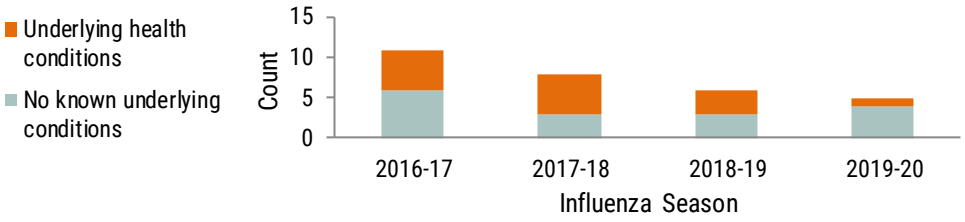


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

Figures 25-26: In week 5, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was too young to be vaccinated. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 5, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 5, 2020.

In week 4, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with an underlying medical condition. Neither child was vaccinated for the 2019-20 season.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

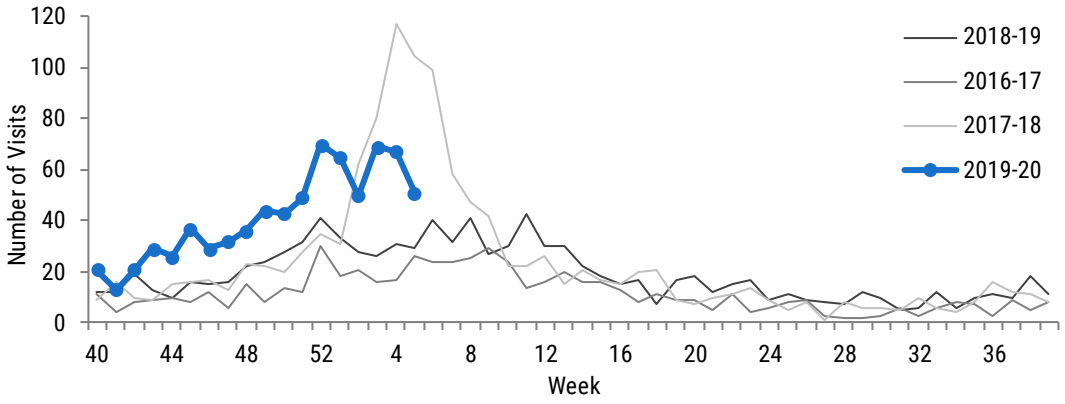
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 5, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



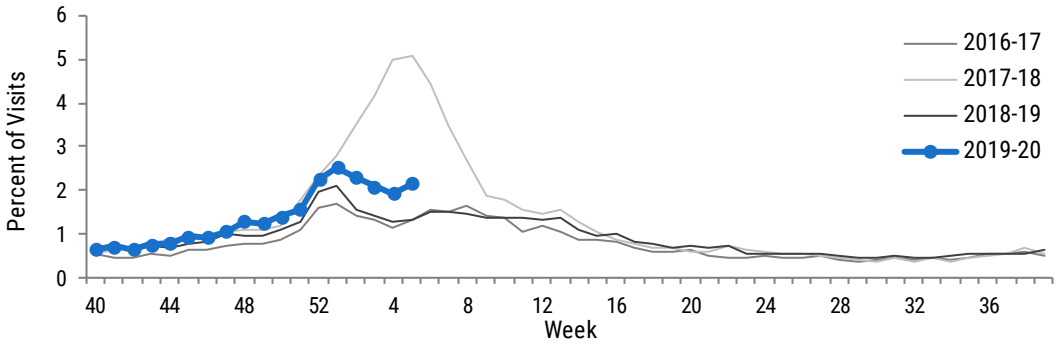
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 5, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 5, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years increased** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



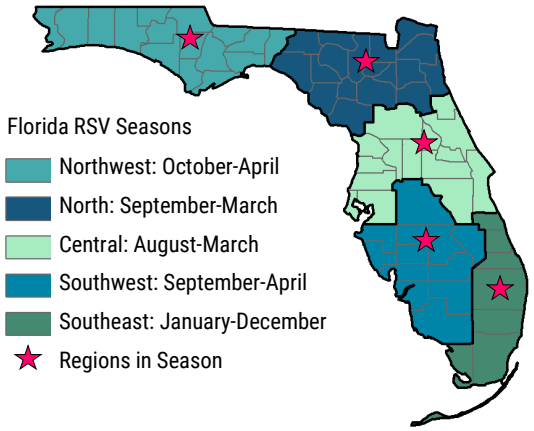
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

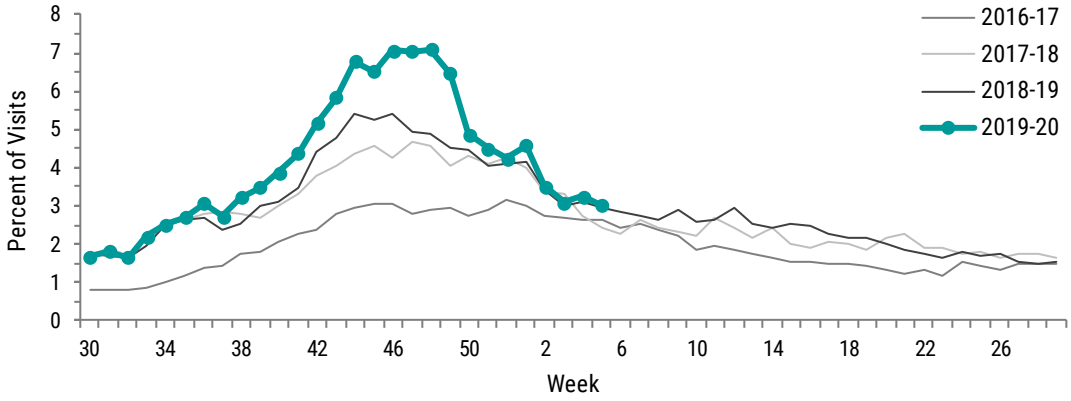
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 5 (January 26-February 1, 2020) Activity Summary

In week 5, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported. A total of eight RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 5, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 5, 2020.

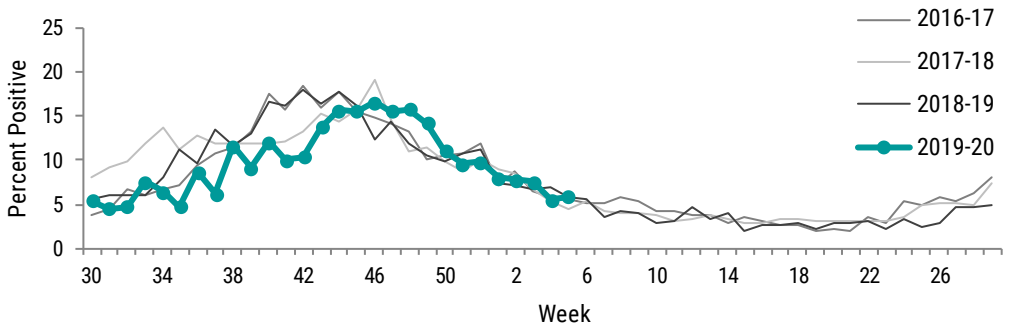
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 5, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 5, 2020. ▶



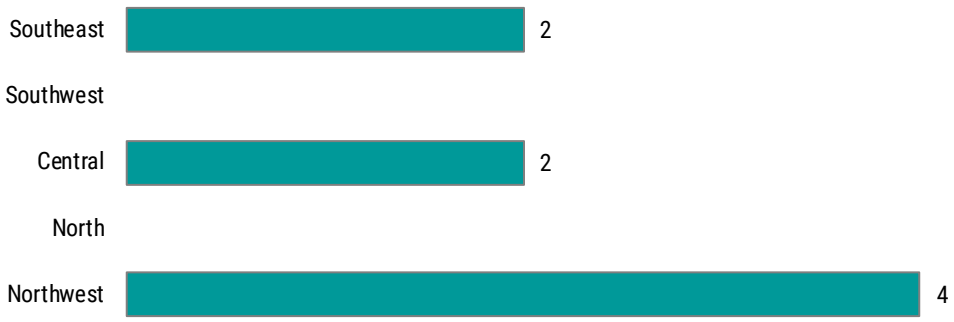
RSV-Associated Outbreaks in Week 4:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 5, no new RSV-associated outbreaks were reported. Since week 30, 2019, eight RSV-associated outbreaks have been reported.

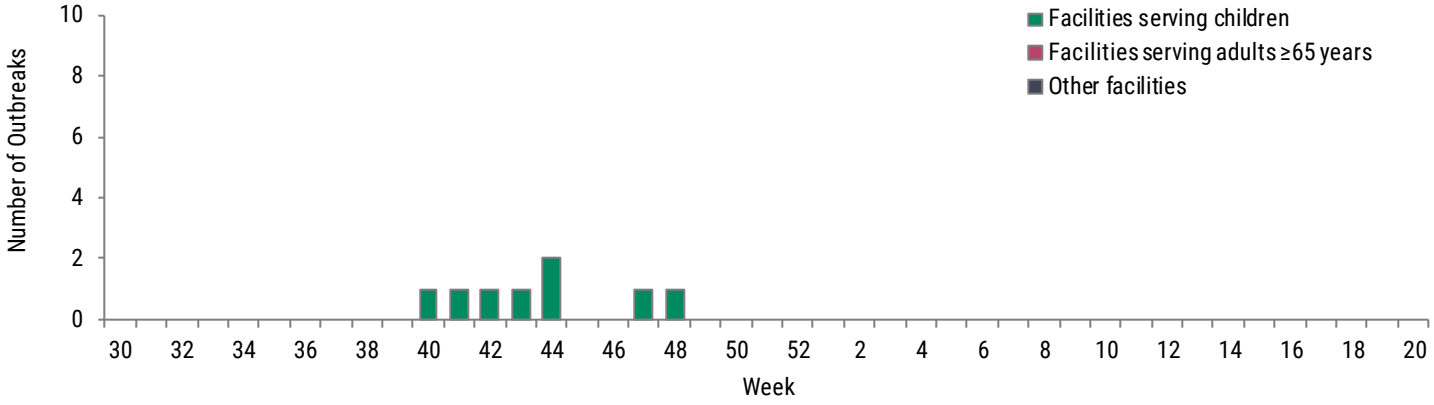
Figure 32: In week 5, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

*Regions defined in figure 29.

Figure 33: In week 5, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 5, 2020.

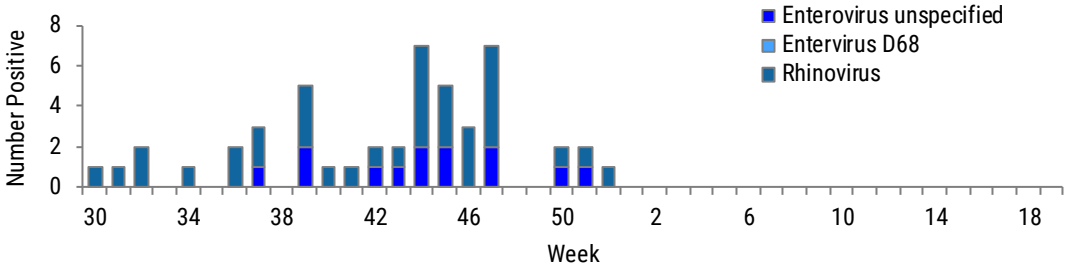
AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance



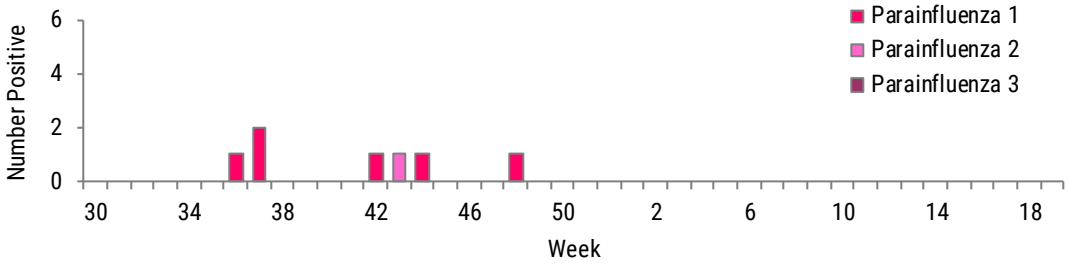
Rhinovirus | Enterovirus unspecified | Enterovirus D68 | Parainfluenza 1 | Parainfluenza 2
Parainfluenza 3 | Coronavirus NL63 | Coronavirus HKU1 | Coronavirus OC43 | Coronavirus 229E
Human metapneumovirus | Adenovirus | Group A Streptococcus | Other

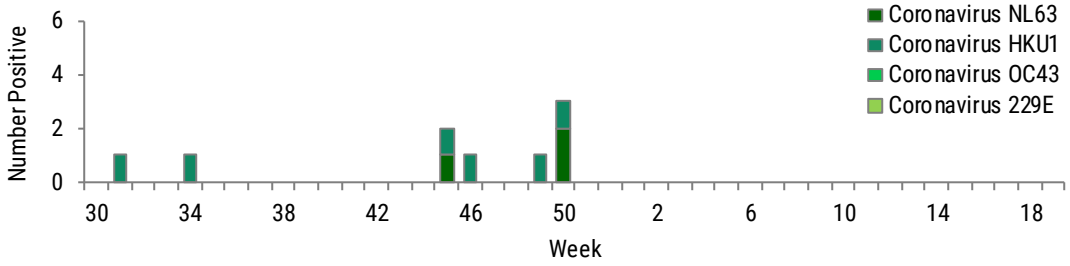
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 5, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

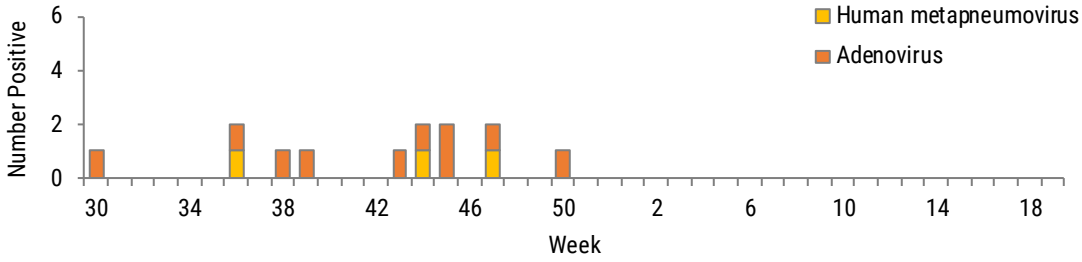
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 5, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Long-term care facility	Pinellas	3	3	0	Influenza A unspecified	Yes	Open
Primary or secondary school	Hillsborough	46	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Hillsborough	52	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Columbia	33	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Columbia	146	Unknown	Unknown	Influenza A 2009 (H1N1)	Unknown	Open
Correctional facility	Leon	35	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Santa Rosa	54	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Santa Rosa	100	Unknown	Unknown	Unknown	Unknown	Open
Primary or secondary school	Okaloosa	88	Unknown	Unknown	Unknown	Unknown	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 6, 2020 Florida Flu Review
Date:	Wednesday, February 12, 2020 4:05:49 PM
Attachments:	Week 6, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 6, 2020 Florida Flu Review.

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-nine outbreaks were reported, down from 35 outbreaks in the previous week. Of the 29 outbreaks reported, 10 were influenza-associated and 19 were ILI.

No new influenza-associated pediatric deaths were reported. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions). On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

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Thanks,
Amy

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Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 6: 2/2/20-2/8/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Stable**

Week 6 influenza & influenza-like illness (ILI) activity summary:

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-nine outbreaks were reported, down from 35 outbreaks in the previous week. Of the 29 outbreaks reported, 10 were influenza-associated and 19 were ILI.

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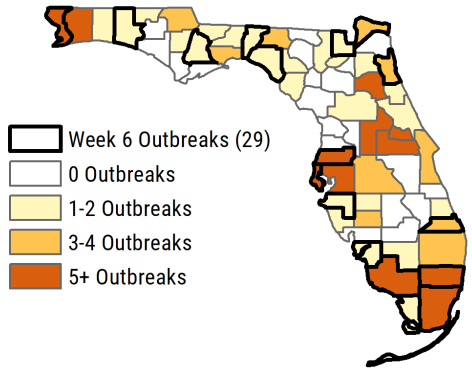
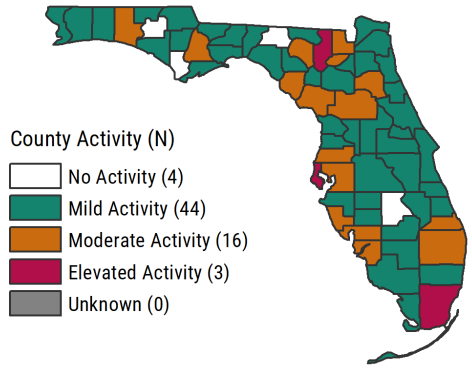
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

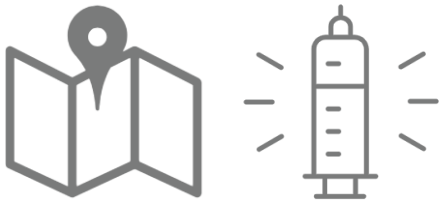
Reported as of 2/8/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 12, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007000

AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

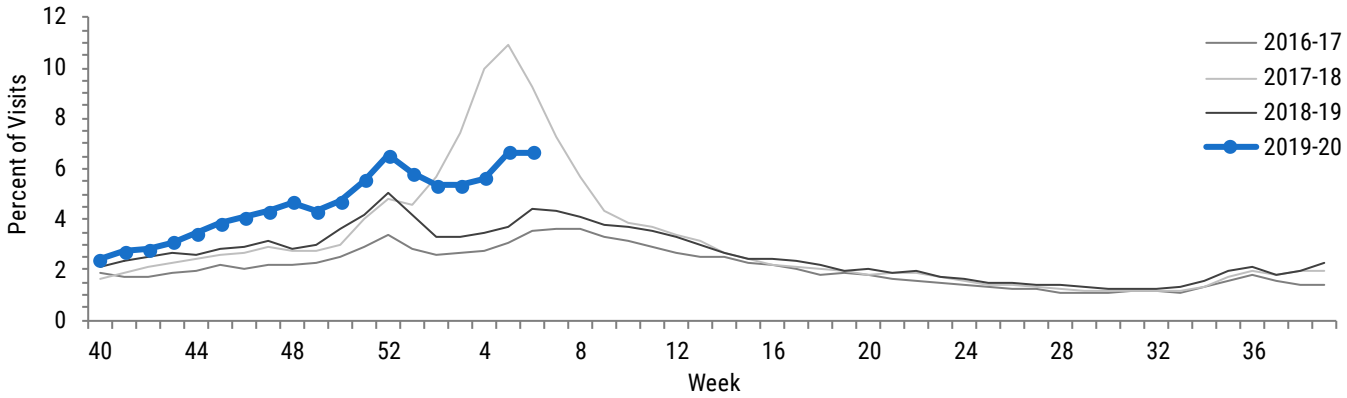
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 6, **the percent of emergency department and urgent care center visits for ILI statewide was stable** compared to the previous week and remained the highest level observed so far this season. Activity in week 6 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 6, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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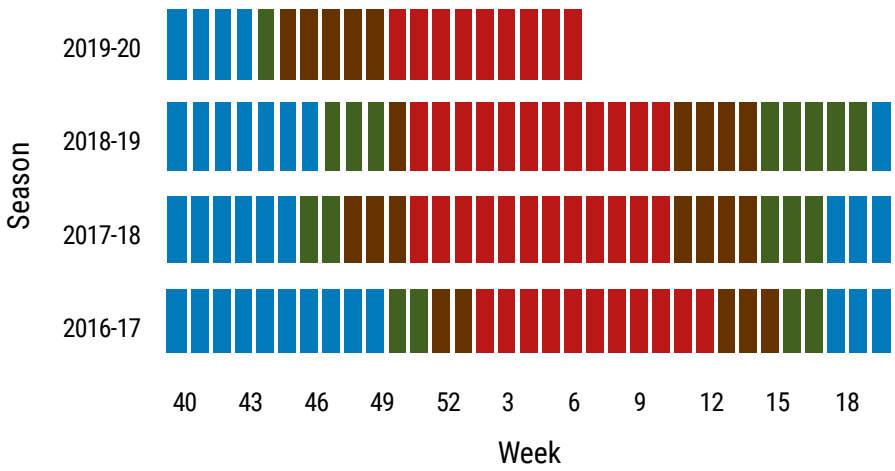
Statewide Activity

Figure 2: In week 6, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 6, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 6, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 6, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

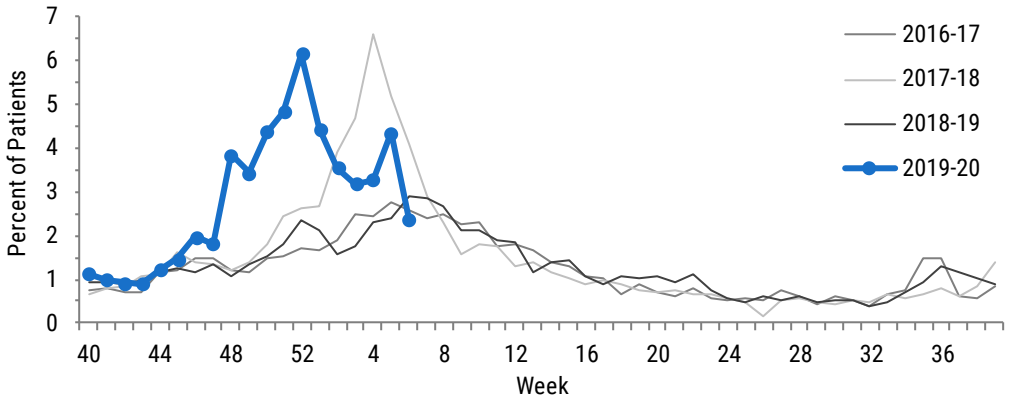
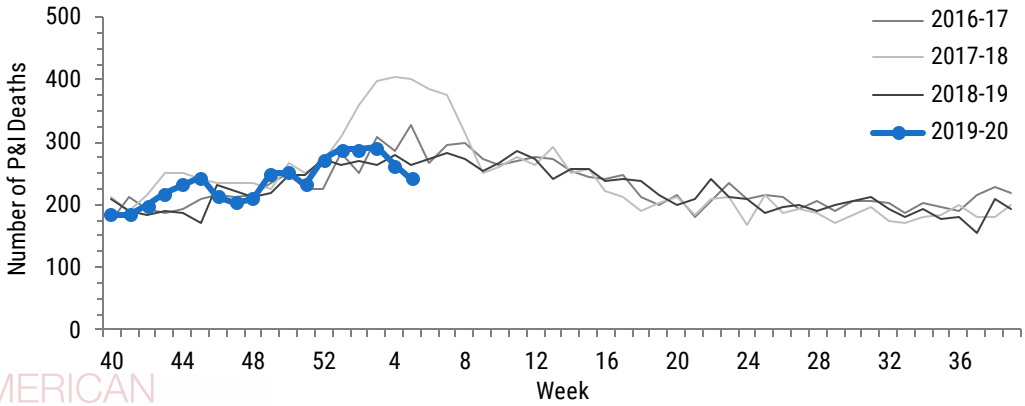


Figure 4: In week 5 (ending 2/1/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 6. Sixteen counties reported **moderate activity,** and three counties reported **elevated activity.**

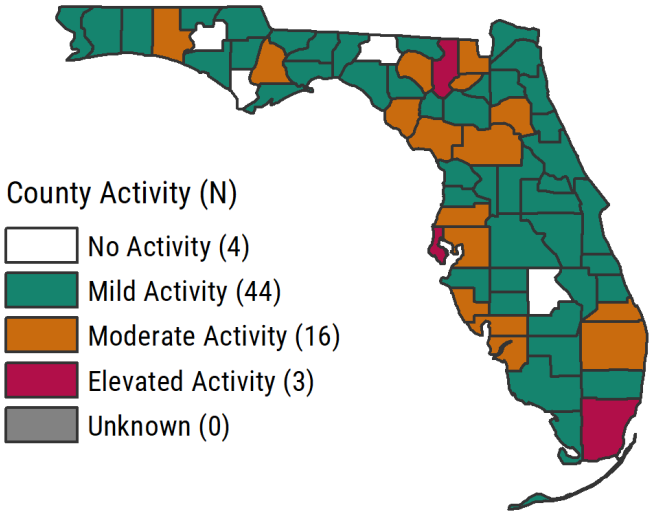
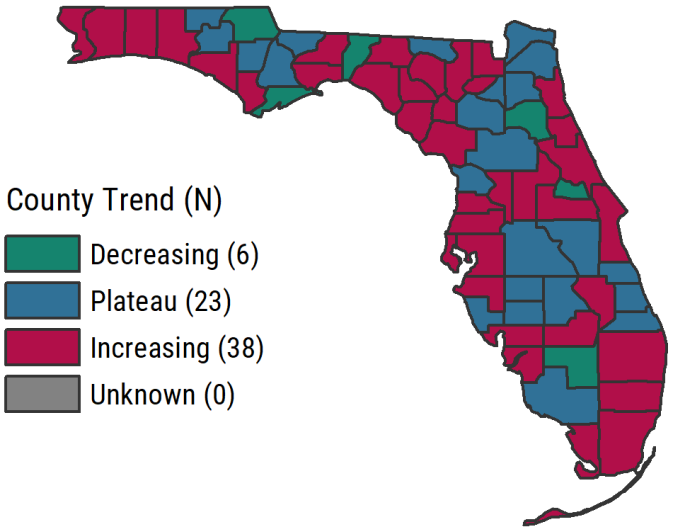
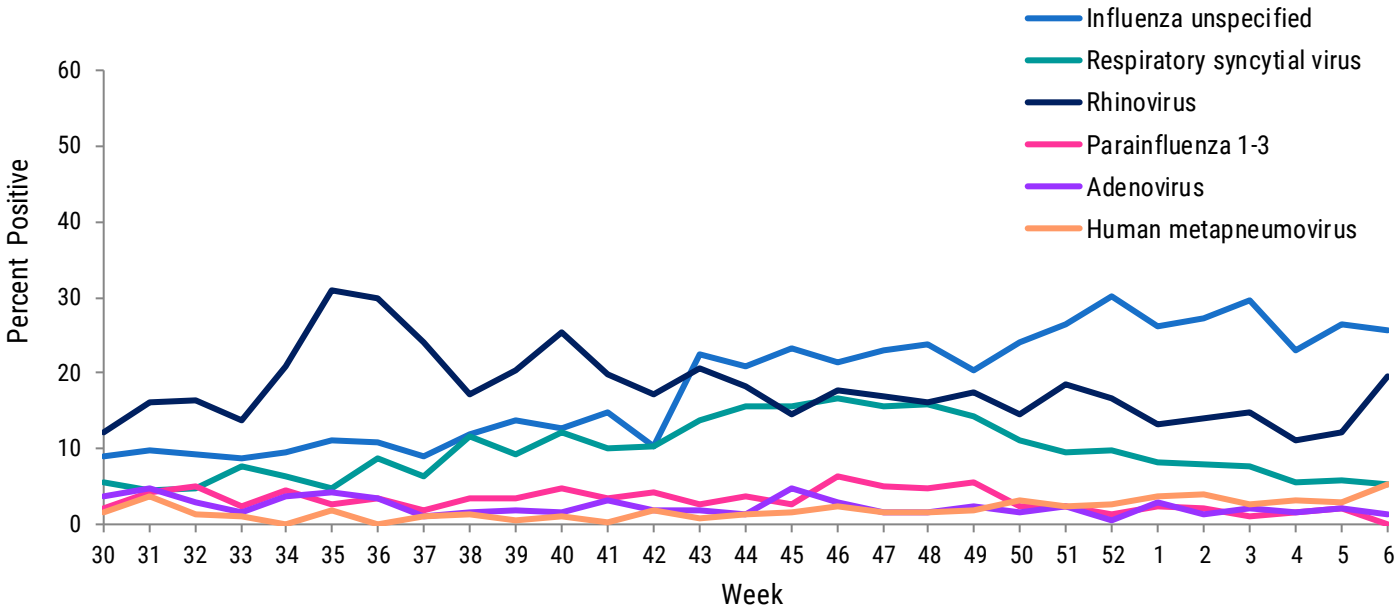


Figure 6: Most counties reported **increasing activity** in week 6. Twenty-three counties reported **activity at a plateau,** and six counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 6, the **percent of specimens testing positive for influenza decreased slightly** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 6, 2020.

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Influenza and ILI Outbreaks

Week 6 Outbreaks at a Glance:

Number Reported:
29 Outbreaks

Influenza-Associated:
10 Outbreaks

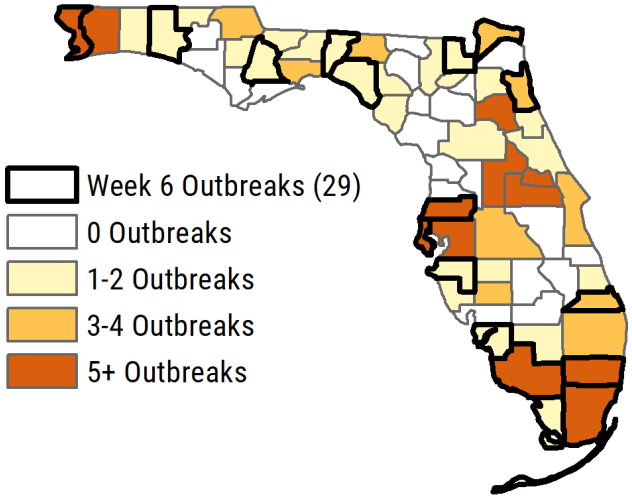
Severe Outcomes*:
3 Outbreaks

Outbreak Summary:

In week 6, 10 influenza-associated and 19 ILI outbreaks were reported, a decrease from the previous week.

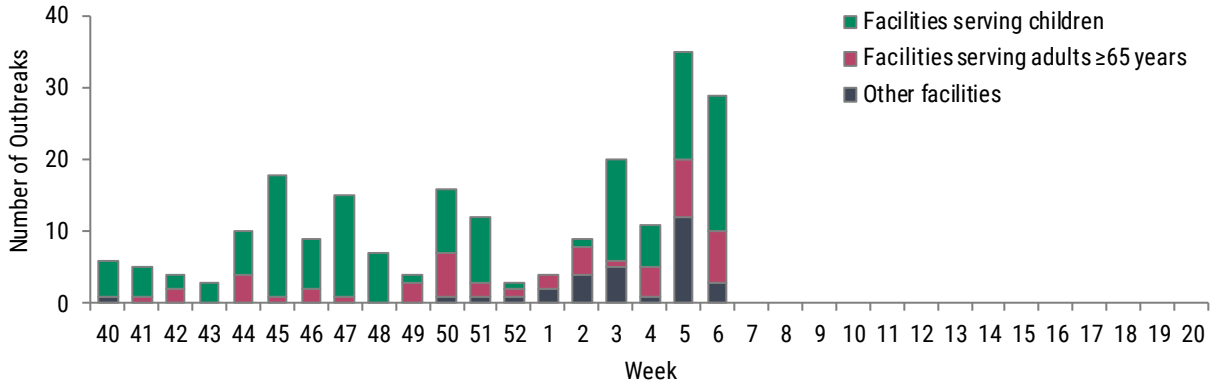
Severe outcomes* were reported in three of 29 outbreaks. One or more hospitalizations were reported in each of these three outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 6, all three outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 6 are **outlined in bold.**

Figure 9: In week 6, **seven outbreaks** were reported in **facilities serving adults aged ≥65 years, 19 outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 6, **54.5% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 6, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

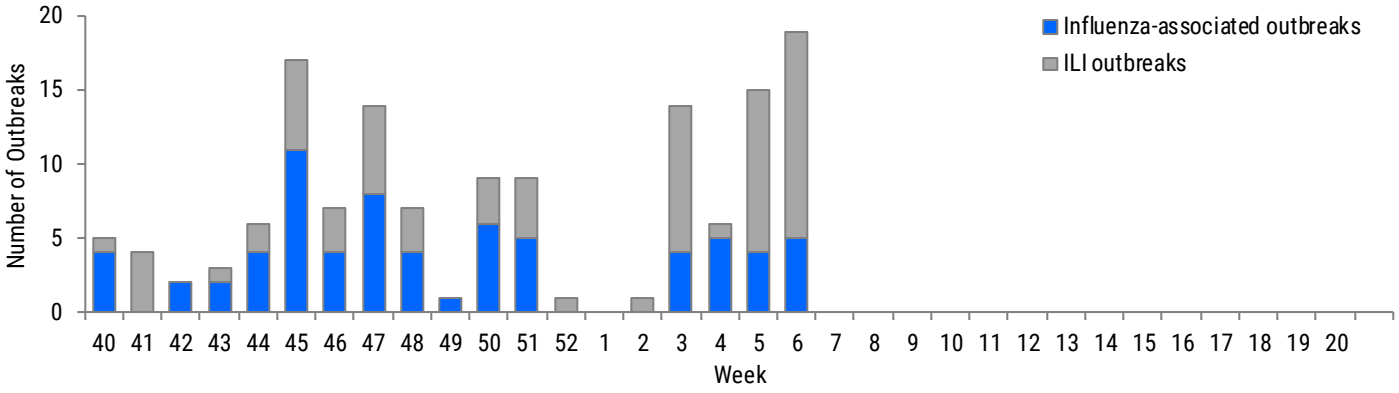
19 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 6, 19 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 6, **five influenza-associated outbreaks** and **14 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Facilities Serving Adults ≥65 yrs.**:

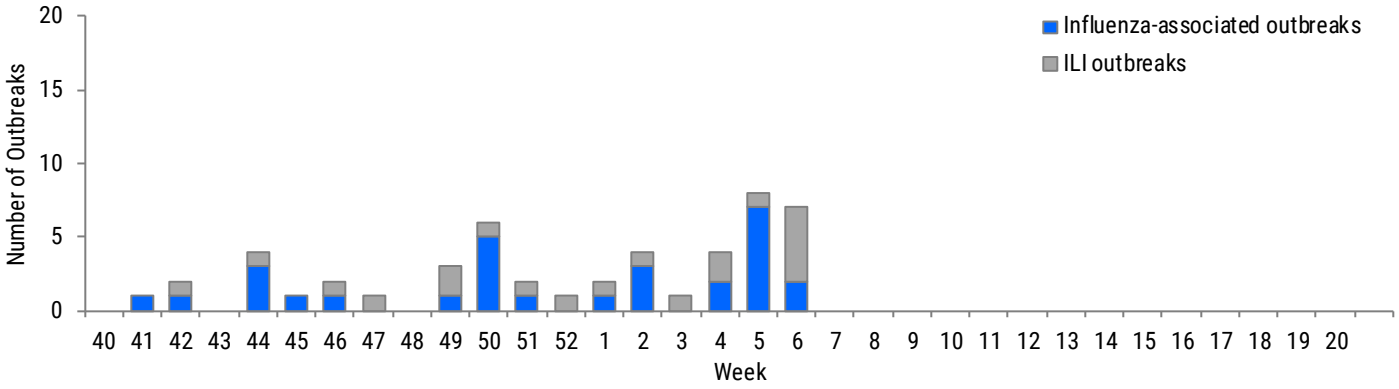
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 6, seven new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 6, **two influenza-associated outbreaks** and **five ILI outbreaks** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

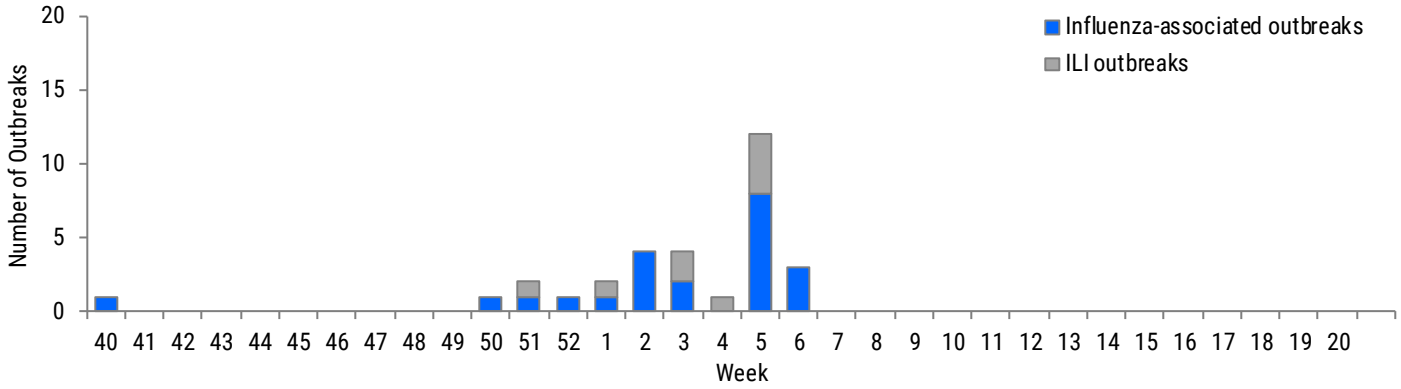
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 6, three new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 6, **three influenza-associated outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	112 (50.9%)	59 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	28 (12.7%)	10 influenza-associated outbreaks 18 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	14 (6.4%)	4 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	12 (5.5%)	9 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	23 (10.5%)	16 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (12.3%)	19 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (0.9%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (0.9%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**220 (100.0%)**	**120 influenza-associated outbreaks** **100 ILI outbreaks**

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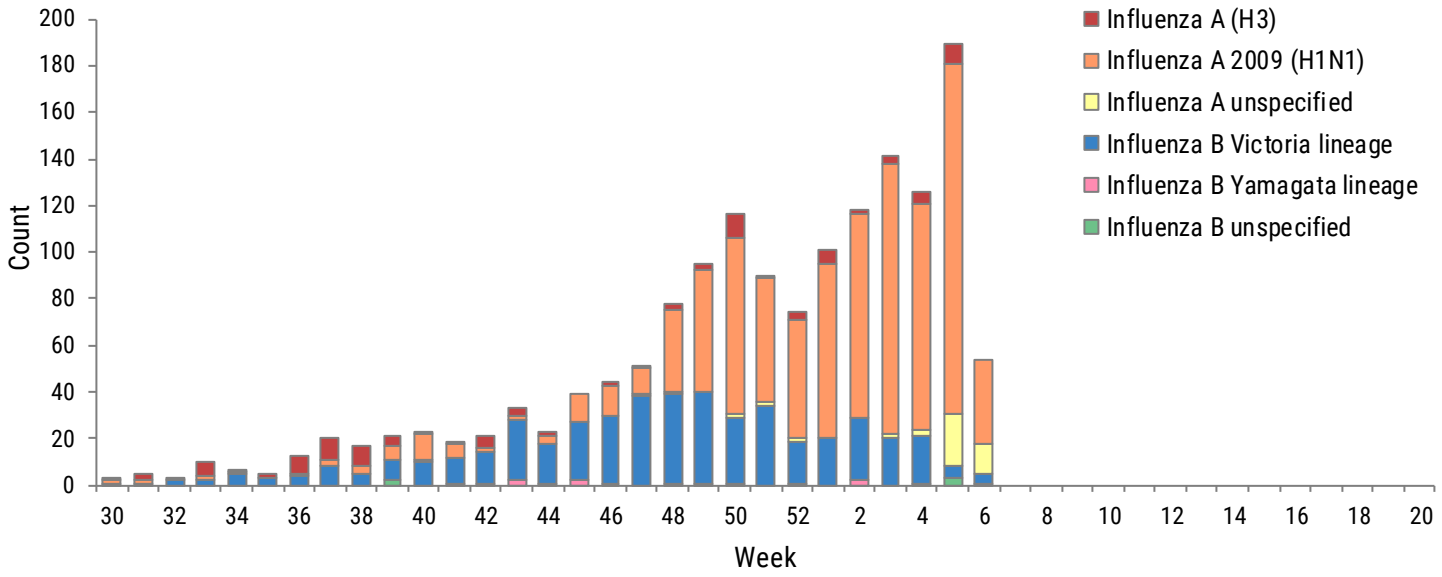
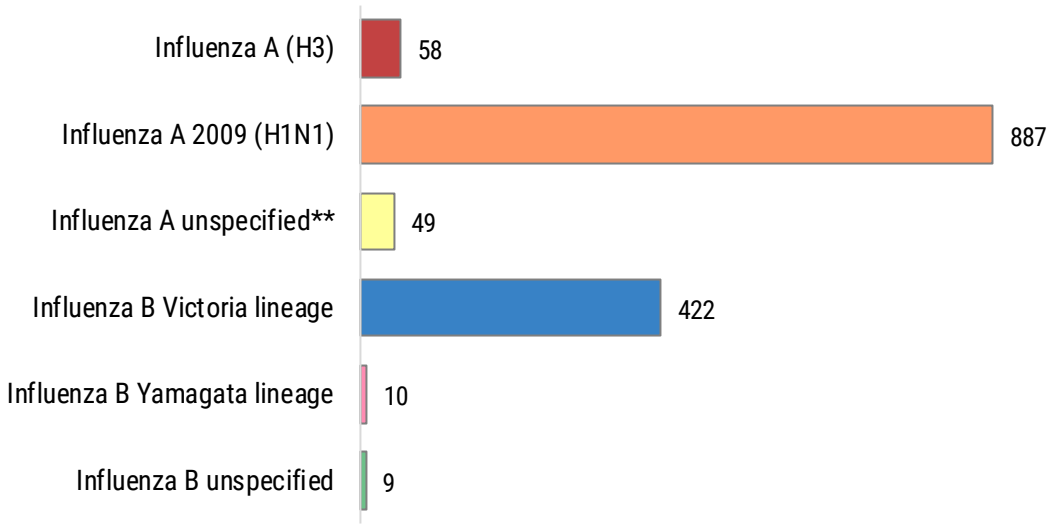
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 6, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 6, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 6, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 6 and was above peak levels observed during the 2018-19 and 2016-17 seasons.

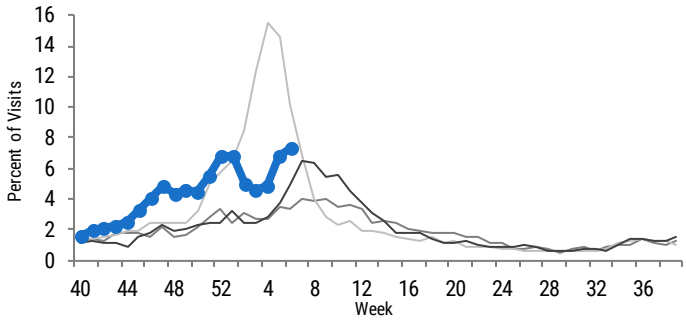


Figure 17: In **region 2, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

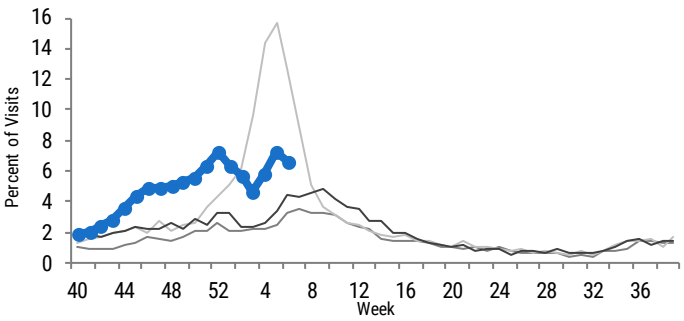


Figure 18: In **region 3, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

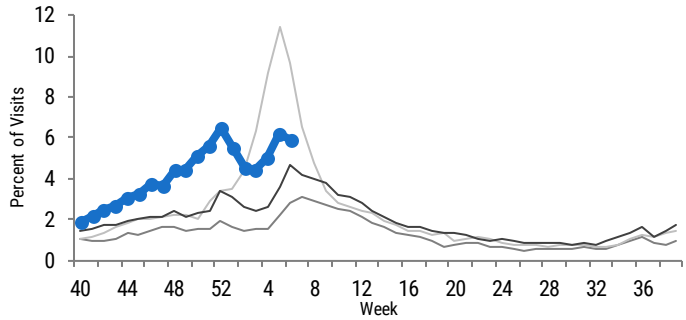


Figure 19: In **region 4, ILI activity increased** during week 6 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

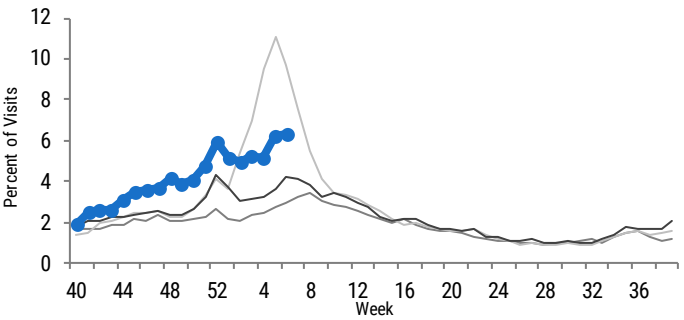


Figure 20: In **region 5, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

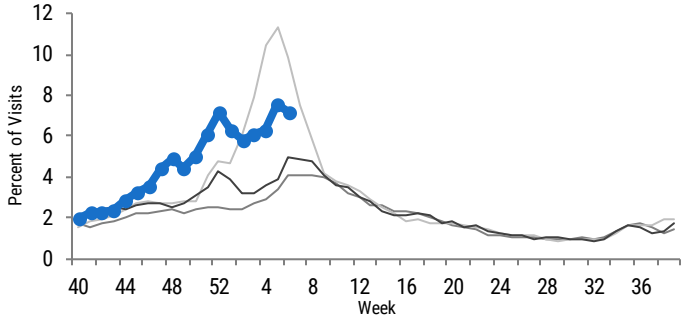


Figure 21: In **region 6, ILI activity increased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

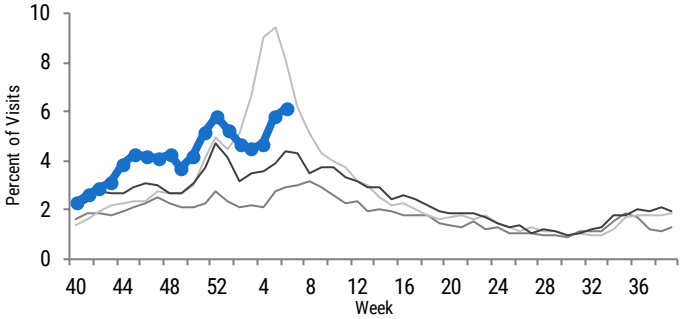
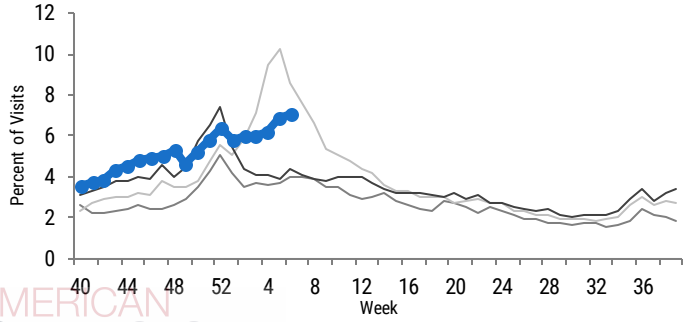


Figure 22: In **region 7, ILI activity increased** during week 6 and was similar to peak activity observed during the 2018-19 season.



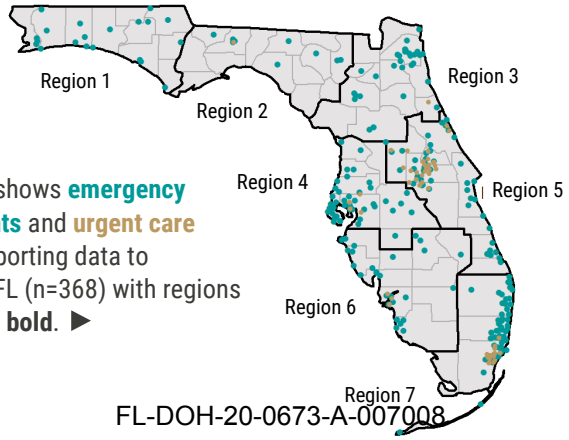


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

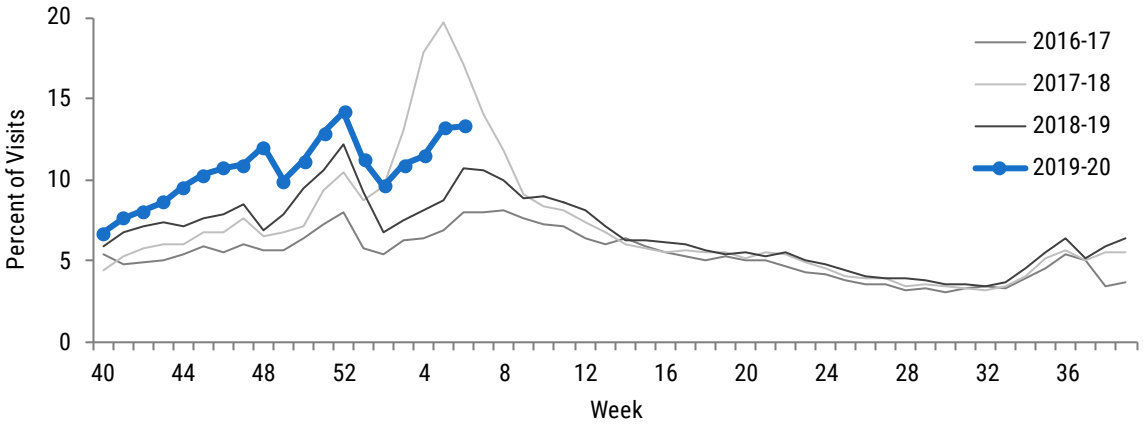
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

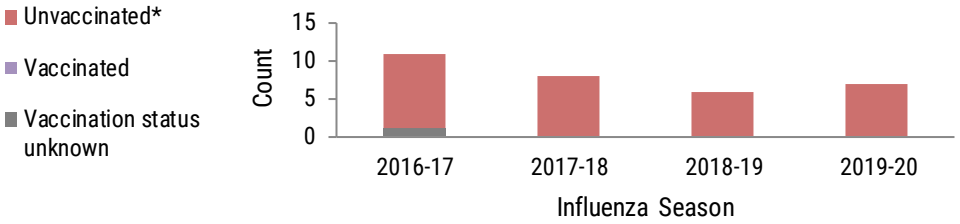
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 6, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

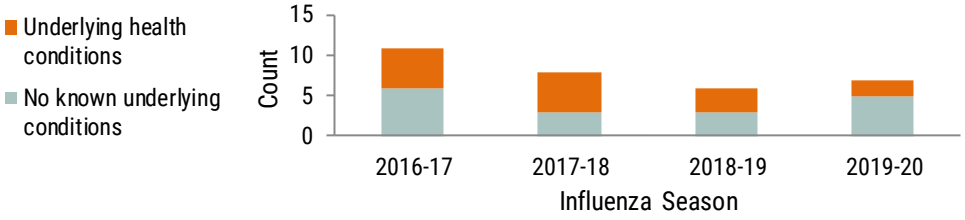


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

Figures 25-26: In week 6, **no new influenza-associated pediatric deaths were reported**. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 6, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 6, 2020.

In week 6, **no new influenza-associated pediatric deaths were reported**.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

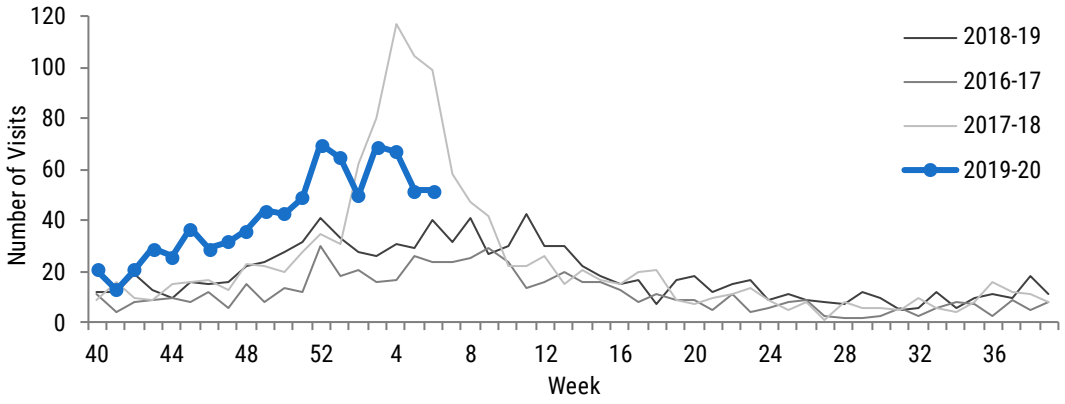
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 6, the **number of emergency department and urgent care center visits for influenza among pregnant women was stable** and was within levels observed at this time in past seasons.



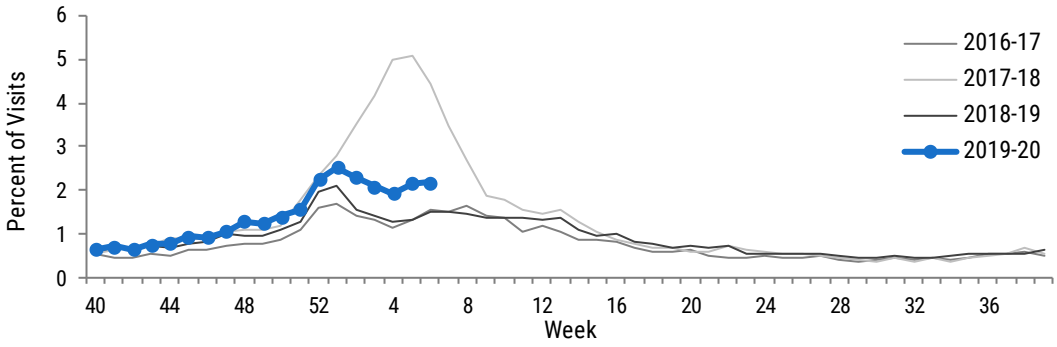
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 6, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 6, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years was stable** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



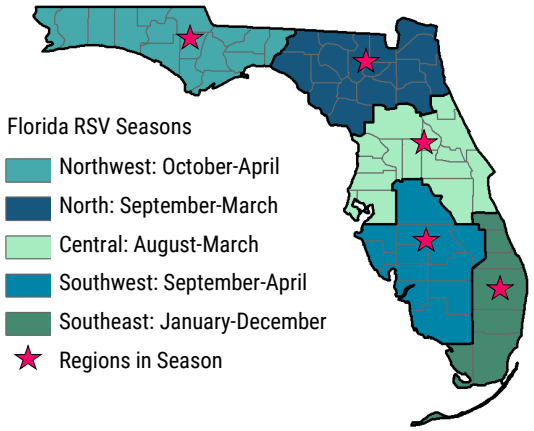
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

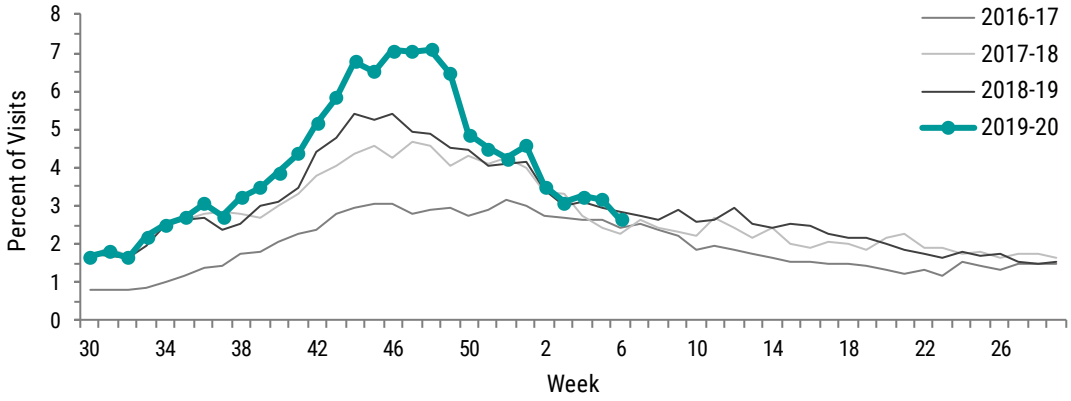
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 6 (January 26-February 1, 2020) Activity Summary

In week 6, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in a Pinellas County child daycare. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 6, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 6, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

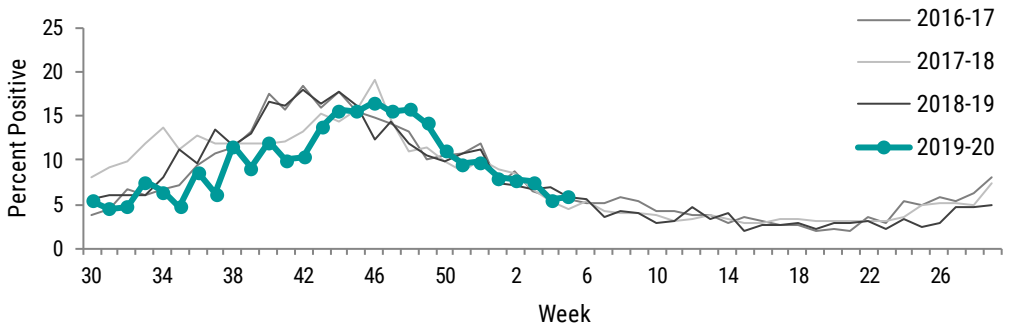
AMERICAN OVERSIGHT

Florida HEALTH

RSV Surveillance

Figure 31: In week 6, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 6, 2020. ▶



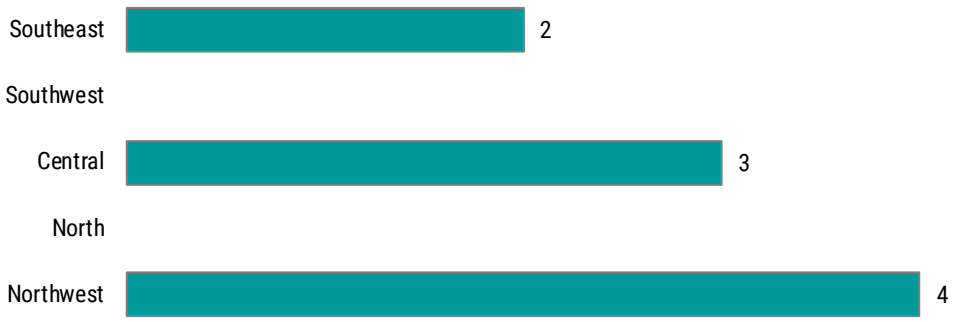
RSV-Associated Outbreaks in Week 6:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 6, one new RSV-associated outbreaks was reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

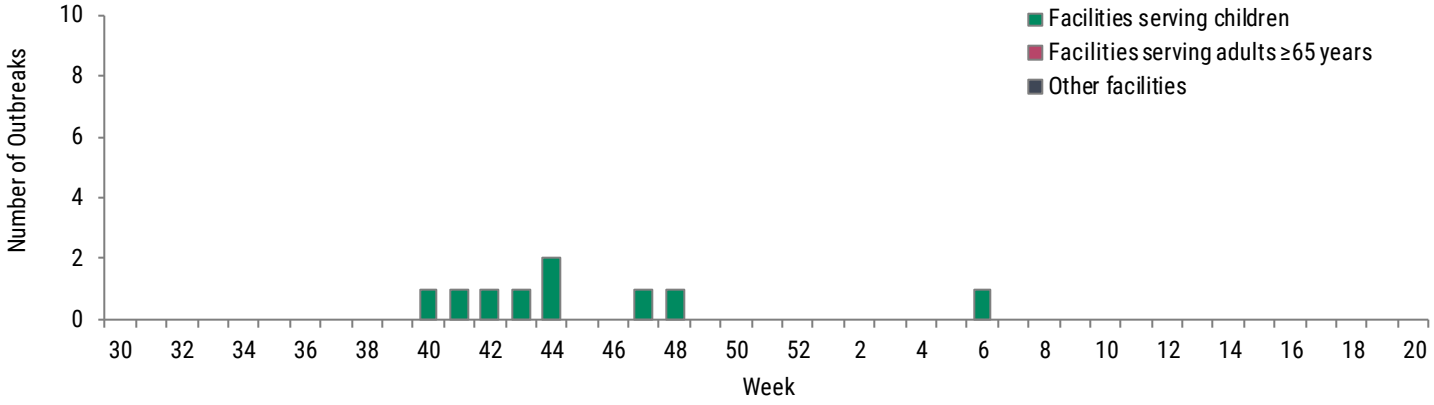
Figure 32: In week 6, **one new RSV-associated outbreak** was reported in Florida's central region. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

*Regions defined in figure 29.

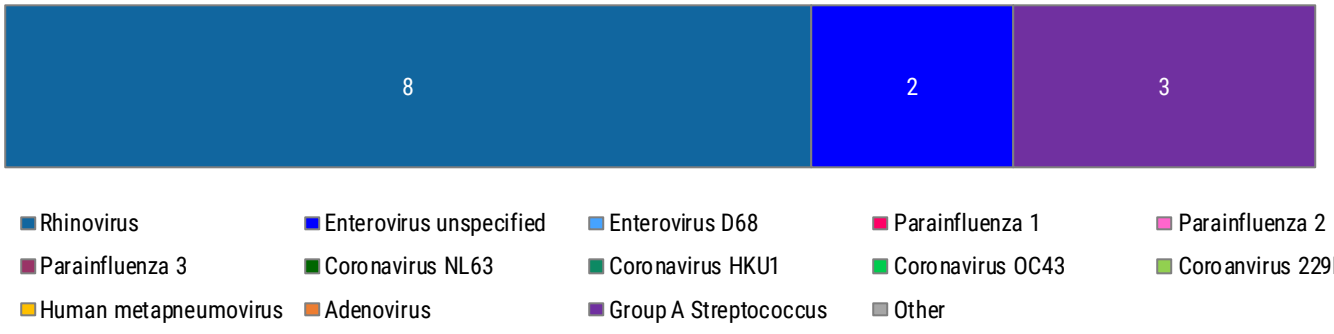
Figure 33: In week 6, one new RSV-associated outbreaks was reported in a **facility serving children.** All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



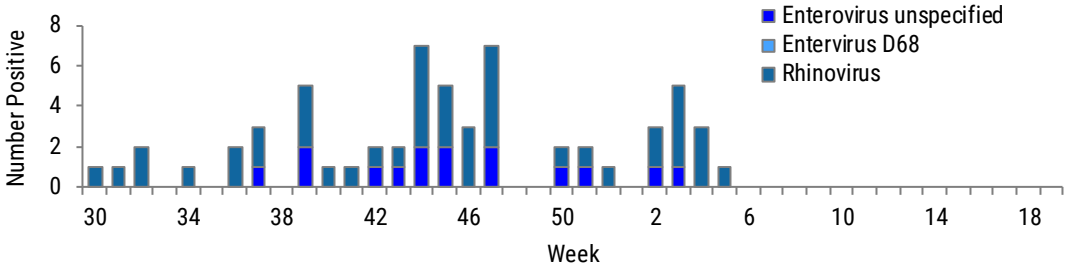
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

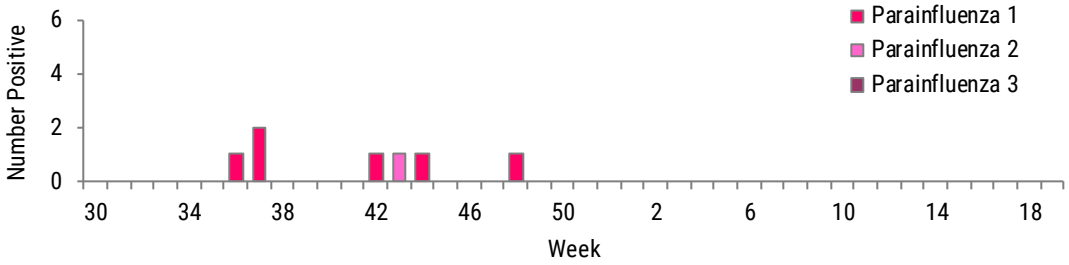


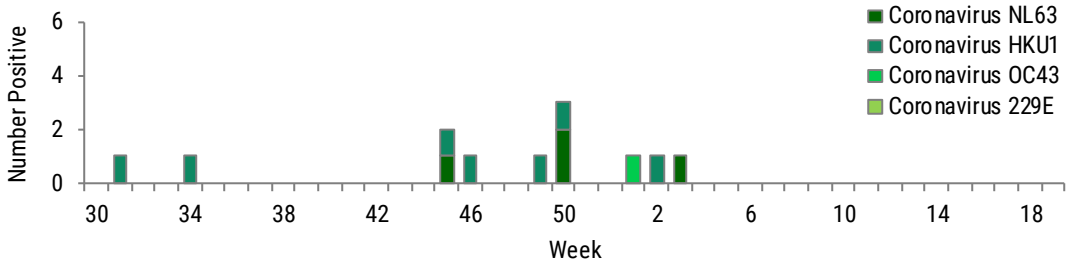
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 6, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

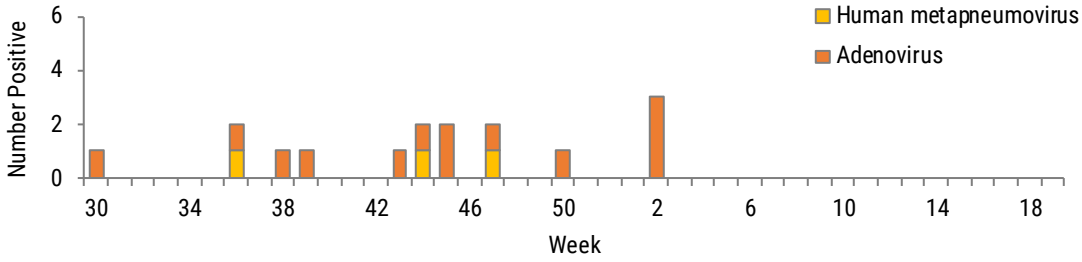
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 6, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Primary or secondary school	Pinellas	107	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Walton	60	0	0	Influenza A unspecified	Yes	Open
Correctional facility	Martin	55	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Lee	36	0	0	Unknown	Unknown	Open
Correctional facility	Liberty	31	Unknown	0	Influenza A 2009 (H1N1)	Yes	Open
Nursing facility	Monroe	5	2	Unknown	Influenza A unspecified and influenza B unspecified	Unknown	Open
Assisted living facility	Nassau	5	2	Unknown	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 6, 2020 Florida Flu Review
Date:	Wednesday, February 12, 2020 4:05:55 PM
Attachments:	Week 6, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 6, 2020 Florida Flu Review.

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-nine outbreaks were reported, down from 35 outbreaks in the previous week. Of the 29 outbreaks reported, 10 were influenza-associated and 19 were ILI.

No new influenza-associated pediatric deaths were reported. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions). On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

AMERICAN OVERSIGHT

Thanks,
Amy

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
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Florida Department of Health
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AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 6: 2/2/20-2/8/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Stable**

Week 6 influenza & influenza-like illness (ILI) activity summary:

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-nine outbreaks were reported, down from 35 outbreaks in the previous week. Of the 29 outbreaks reported, 10 were influenza-associated and 19 were ILI.

No new influenza-associated pediatric deaths were reported. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

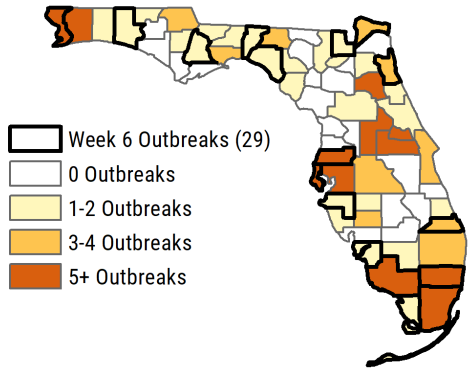
On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

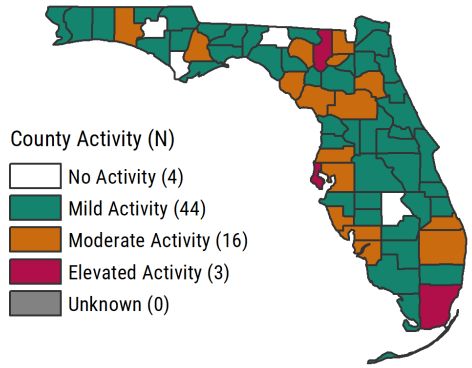
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

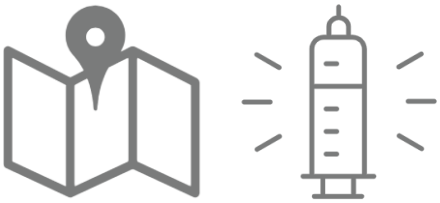
Reported as of 2/8/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 12, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

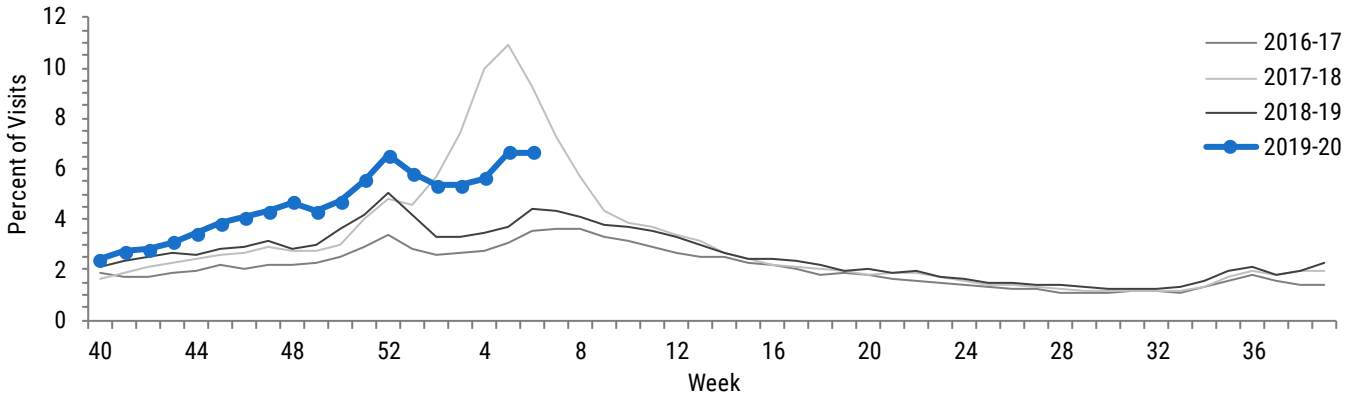
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 6, **the percent of emergency department and urgent care center visits for ILI statewide was stable** compared to the previous week and remained the highest level observed so far this season. Activity in week 6 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 6, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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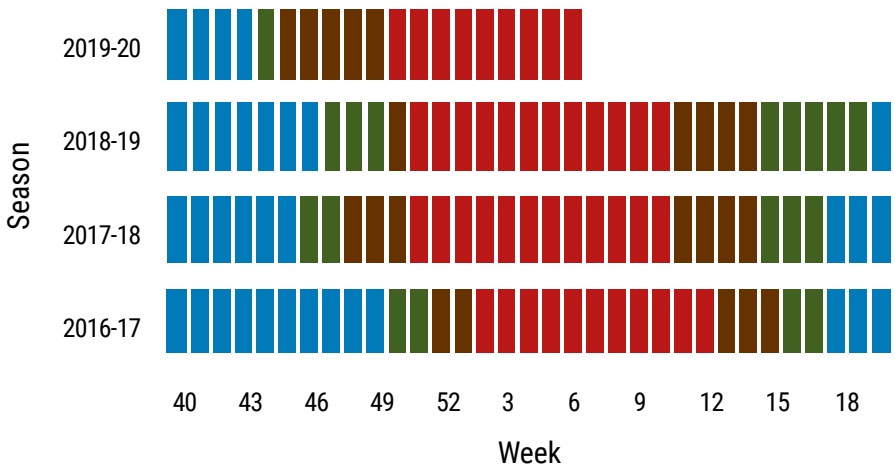
Statewide Activity

Figure 2: In week 6, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 6, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 6, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 6, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

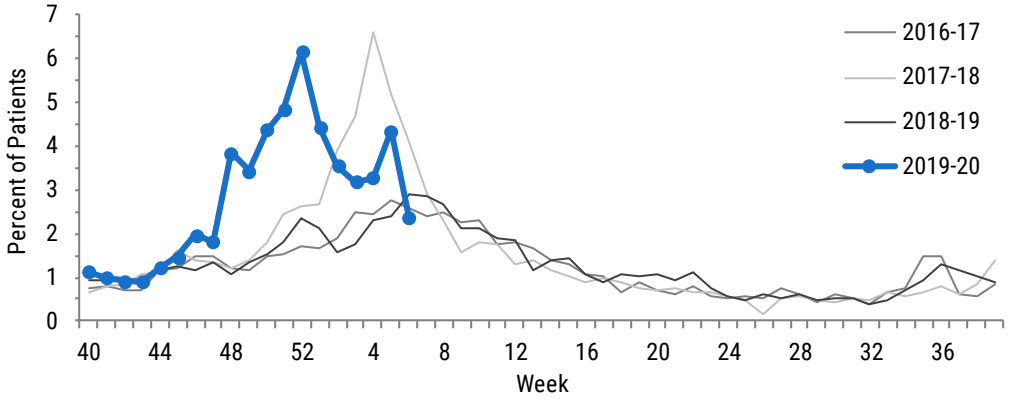
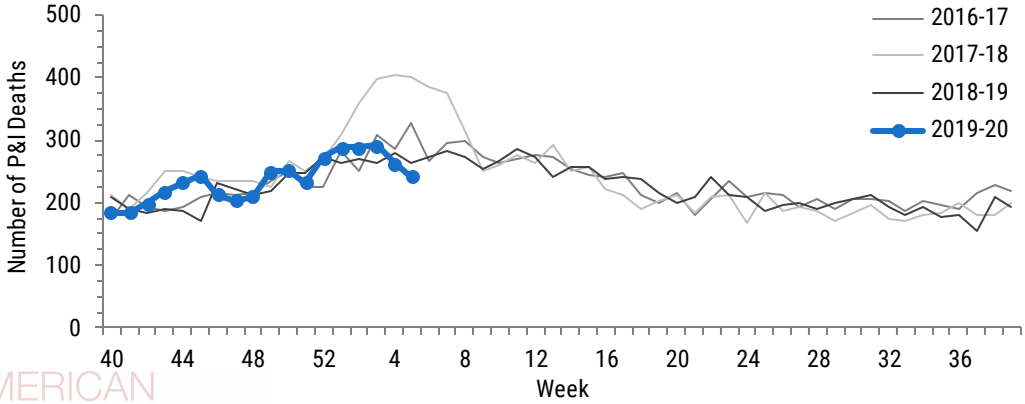


Figure 4: In week 5 (ending 2/1/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 6. Sixteen counties reported **moderate activity,** and three counties reported **elevated activity.**

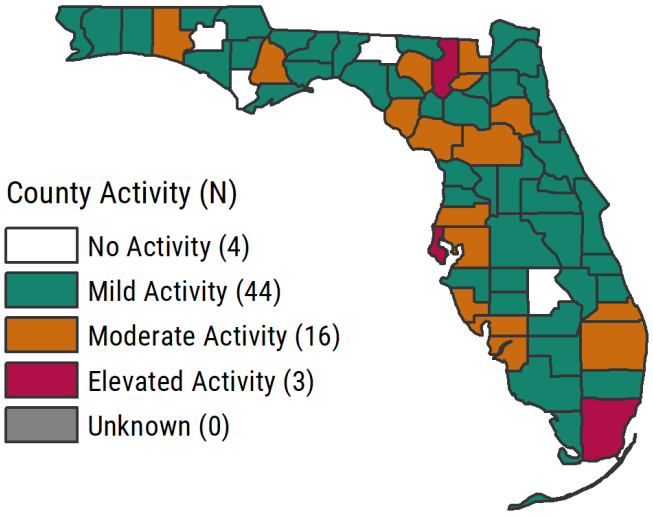
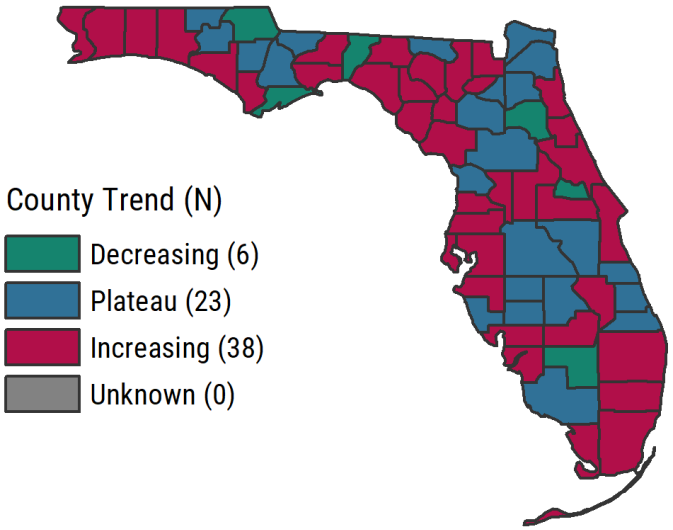
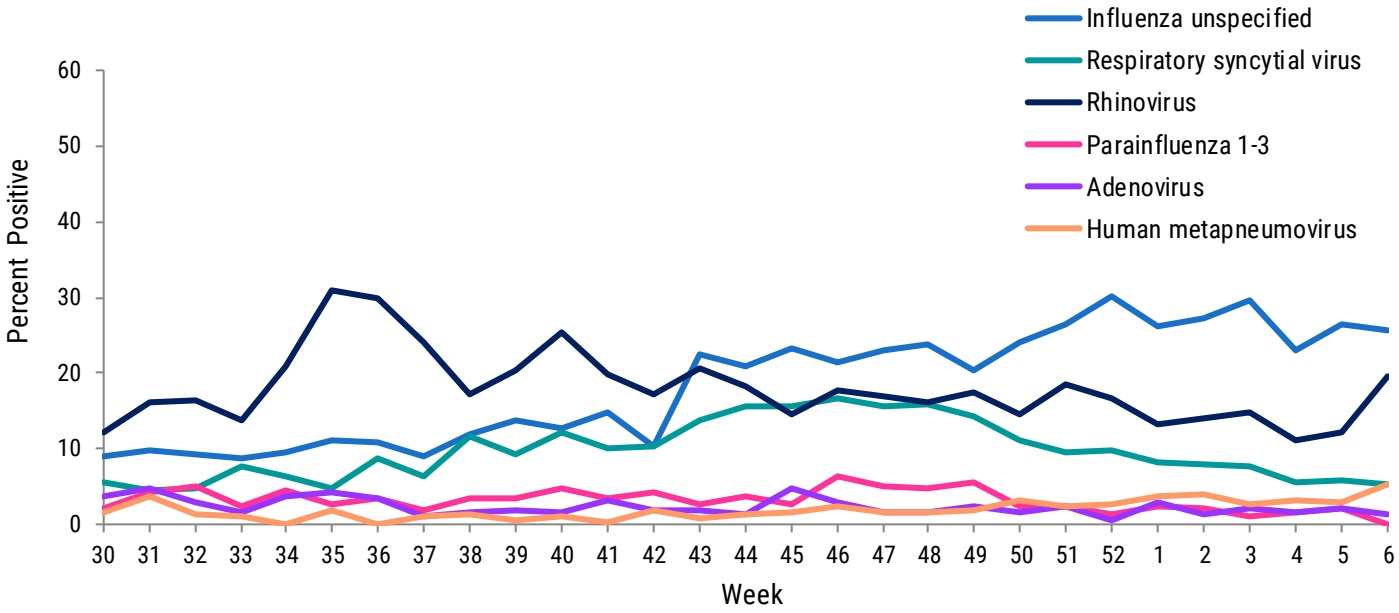


Figure 6: Most counties reported **increasing activity** in week 6. Twenty-three counties reported **activity at a plateau,** and six counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 6, the **percent of specimens testing positive for influenza decreased slightly** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 6, 2020.

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Influenza and ILI Outbreaks

Week 6 Outbreaks at a Glance:

Number Reported:
29 Outbreaks

Influenza-Associated:
10 Outbreaks

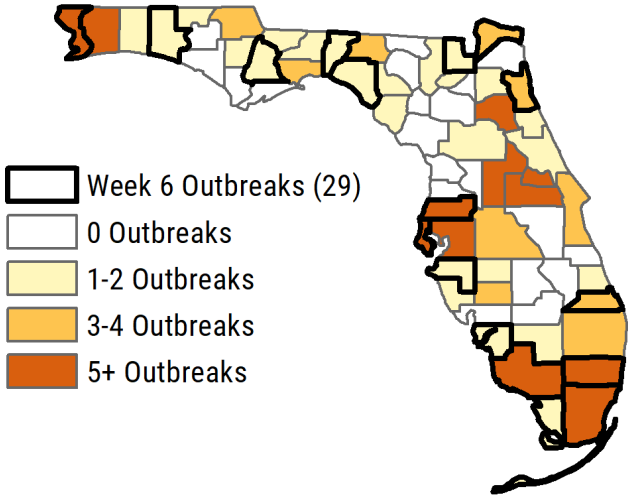
Severe Outcomes*:
3 Outbreaks

Outbreak Summary:

In week 6, 10 influenza-associated and 19 ILI outbreaks were reported, a decrease from the previous week.

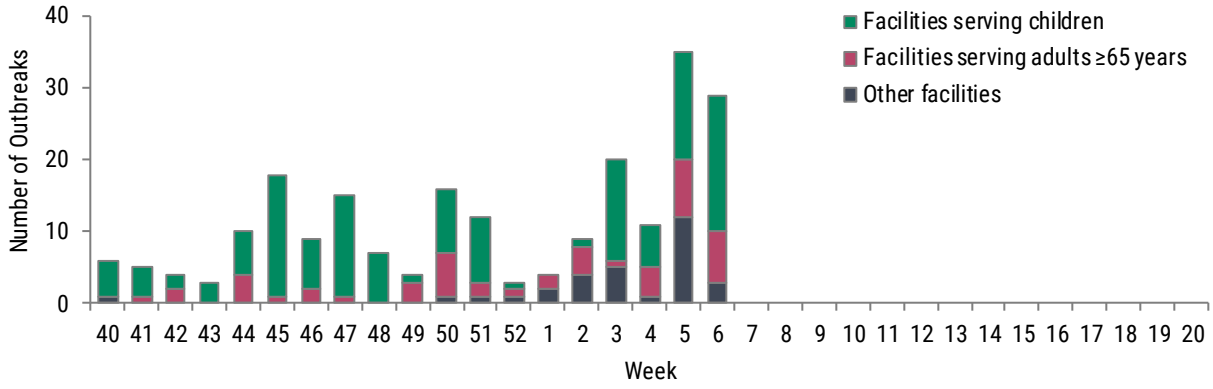
Severe outcomes* were reported in three of 29 outbreaks. One or more hospitalizations were reported in each of these three outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 6, all three outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 6 are **outlined in bold.**

Figure 9: In week 6, **seven outbreaks** were reported in **facilities serving adults aged ≥65 years, 19 outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 6, **54.5% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 6, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

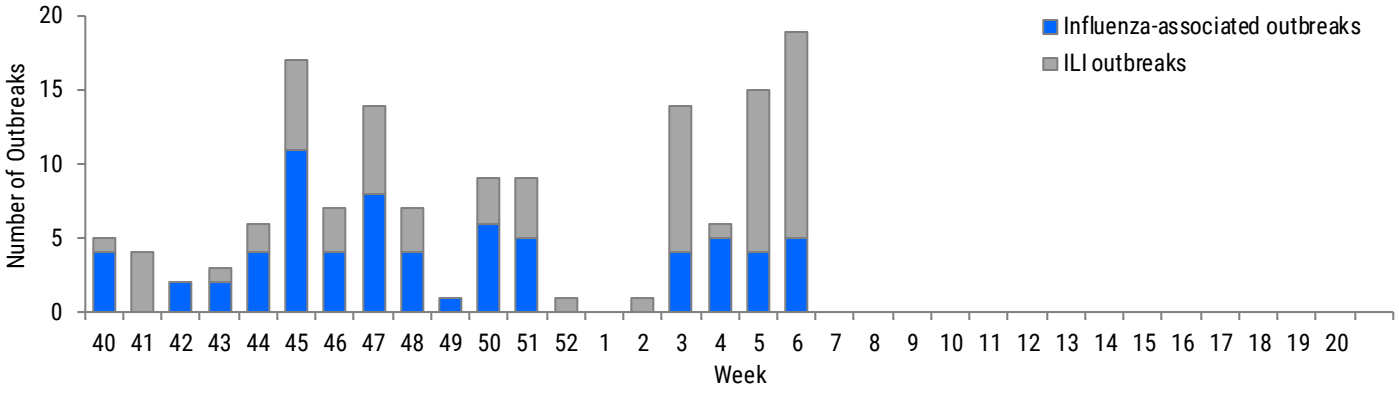
19 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 6, 19 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 6, **five influenza-associated outbreaks** and **14 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Facilities Serving Adults ≥65 yrs.**:

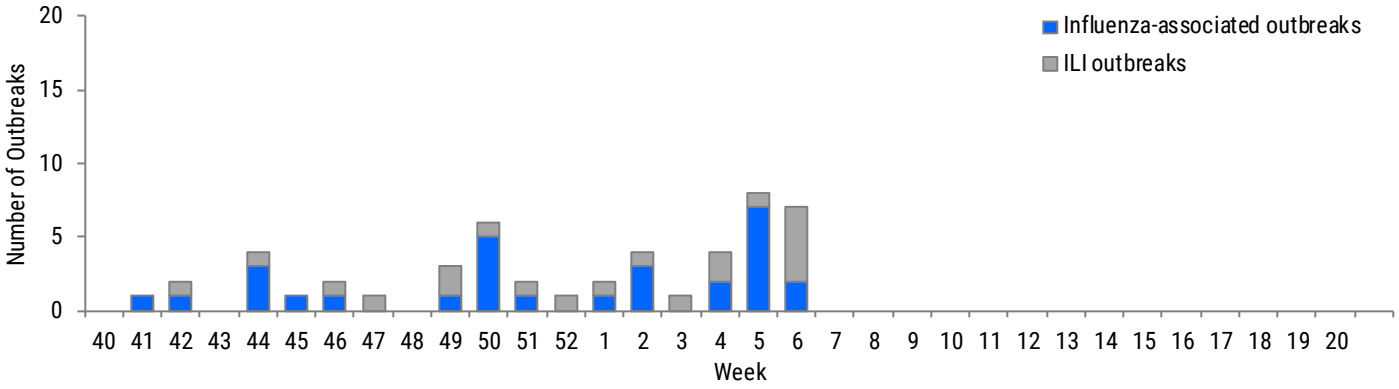
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 6, seven new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 6, **two influenza-associated outbreaks** and **five ILI outbreaks** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

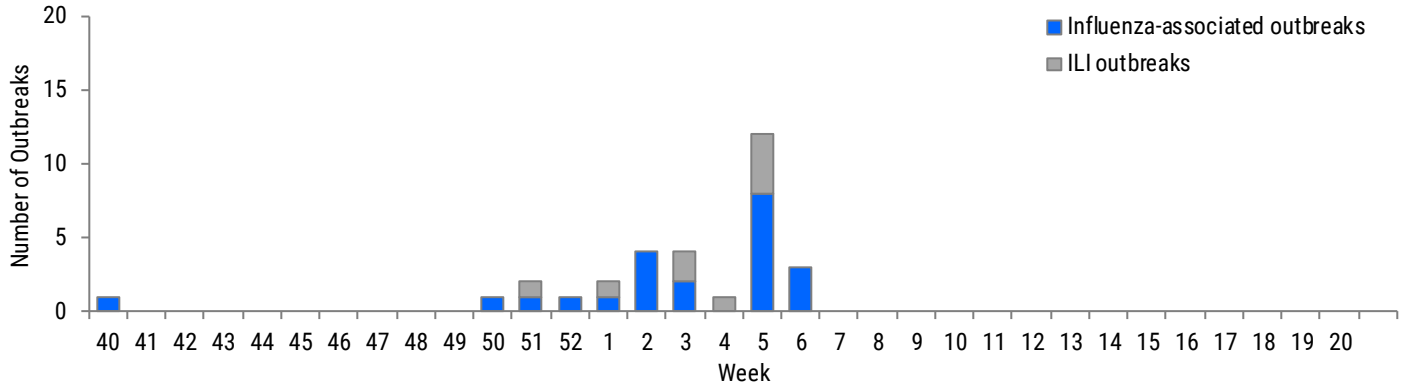
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 6, three new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 6, **three influenza-associated outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	112 (50.9%)	59 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	28 (12.7%)	10 influenza-associated outbreaks 18 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	14 (6.4%)	4 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	12 (5.5%)	9 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	23 (10.5%)	16 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (12.3%)	19 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (0.9%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (0.9%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**220 (100.0%)**	**120 influenza-associated outbreaks** **100 ILI outbreaks**

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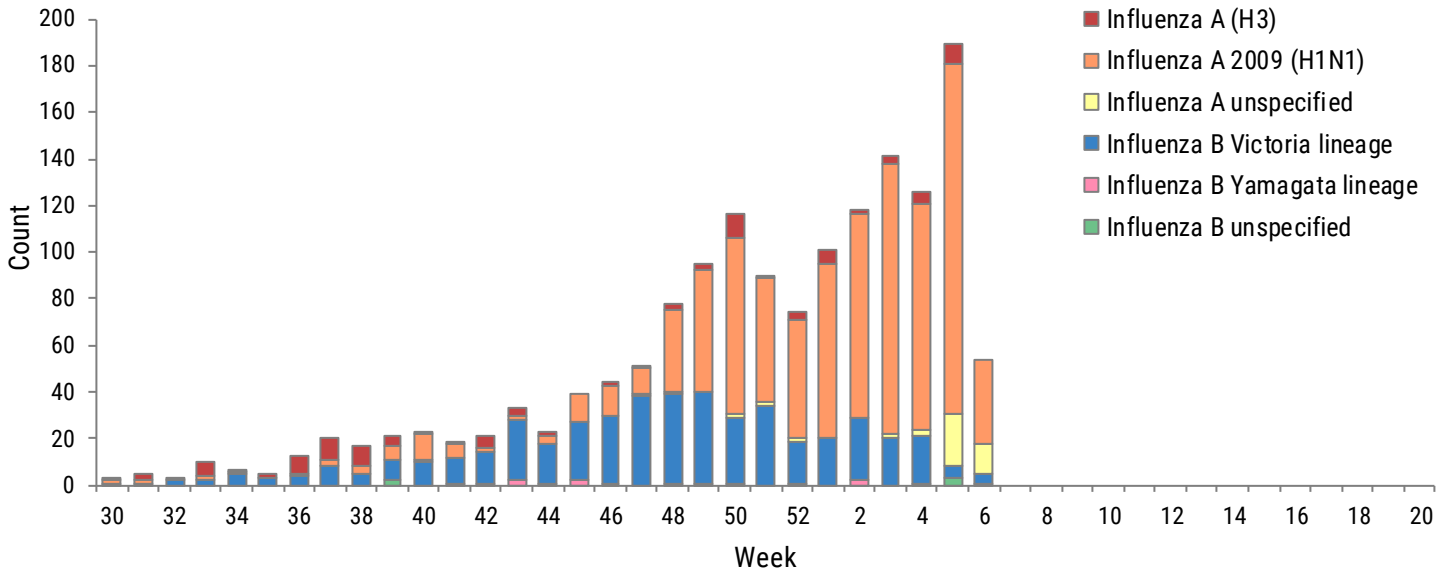
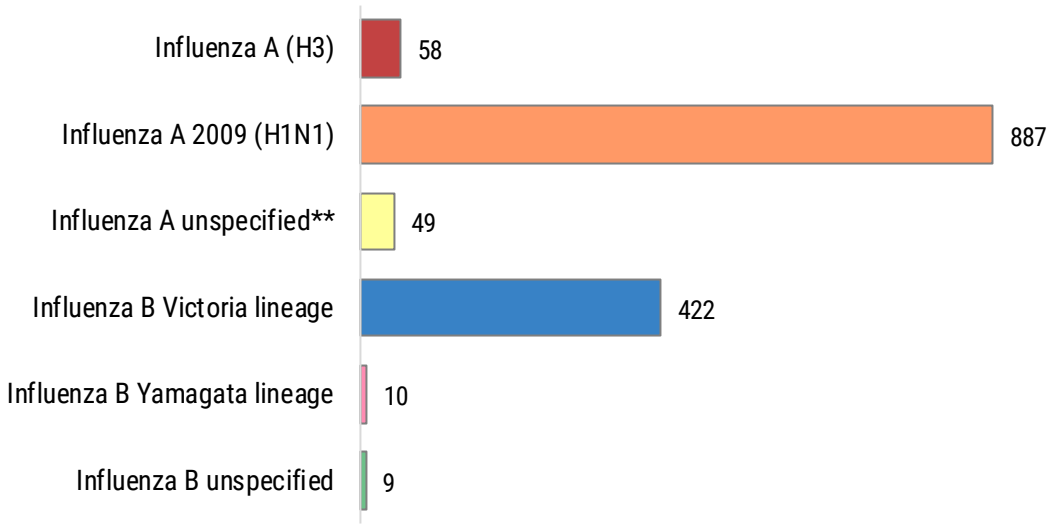
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 6, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 6, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 6, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 6 and was above peak levels observed during the 2018-19 and 2016-17 seasons.

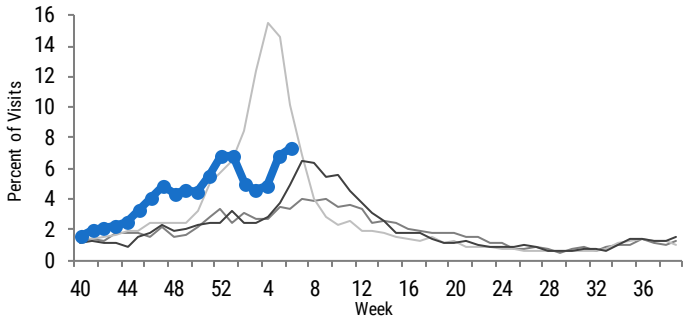


Figure 17: In **region 2, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

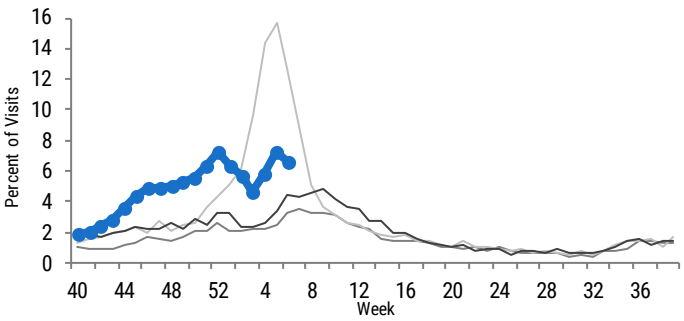


Figure 18: In **region 3, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

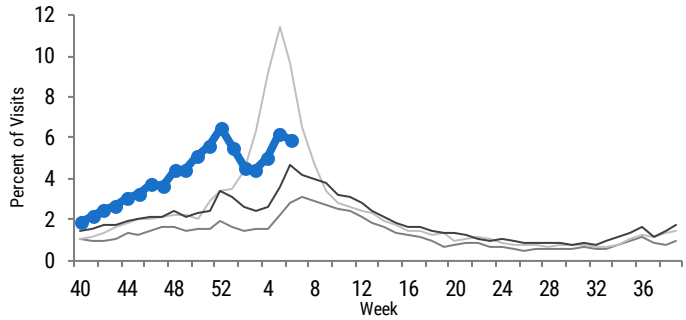


Figure 19: In **region 4, ILI activity increased** during week 6 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

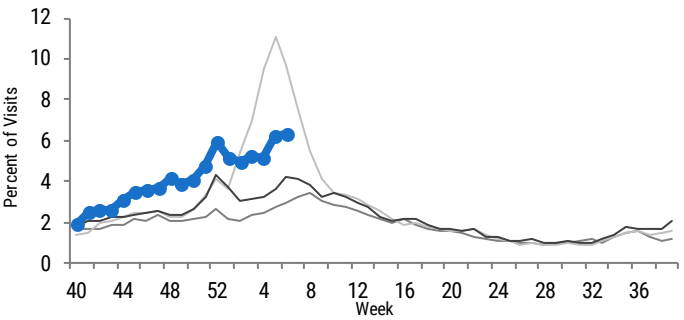


Figure 20: In **region 5, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

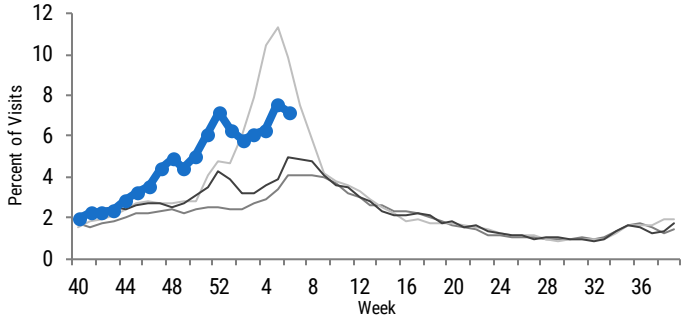


Figure 21: In **region 6, ILI activity increased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

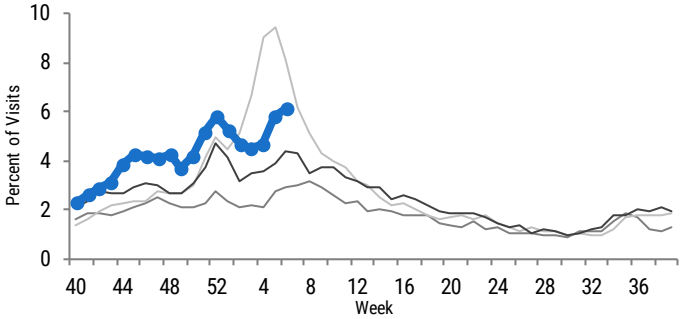
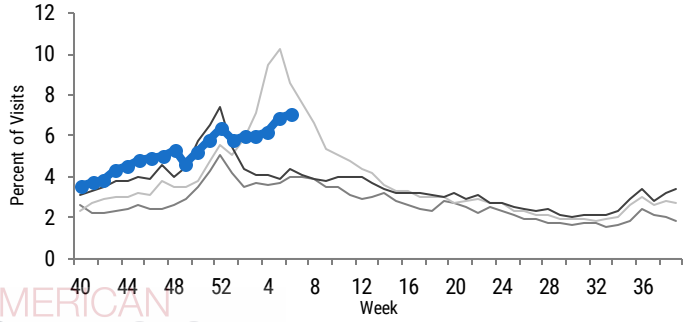


Figure 22: In **region 7, ILI activity increased** during week 6 and was similar to peak activity observed during the 2018-19 season.



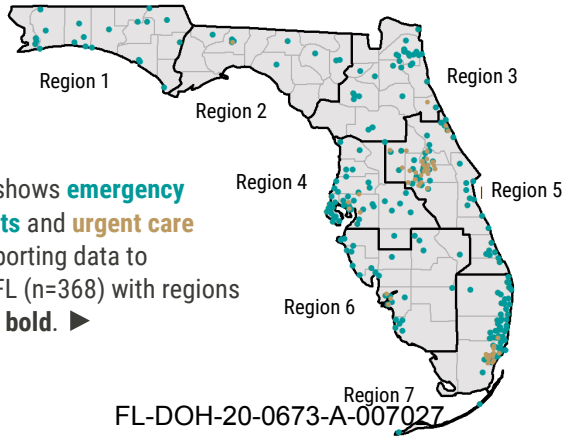


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

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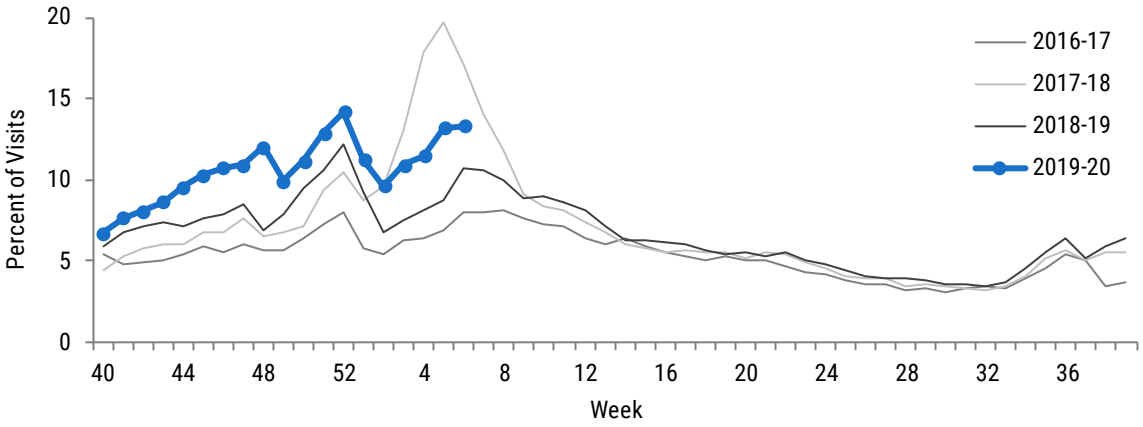
At-Risk Populations

Background: At-Risk Populations, Children

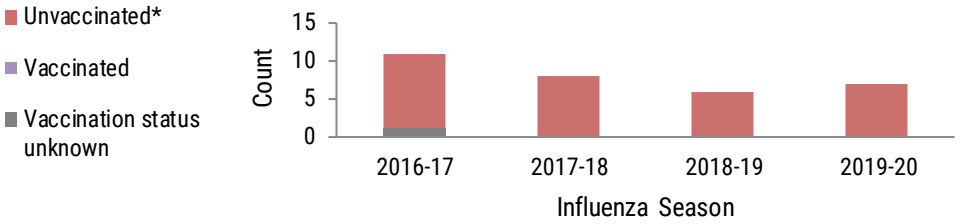
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 6, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

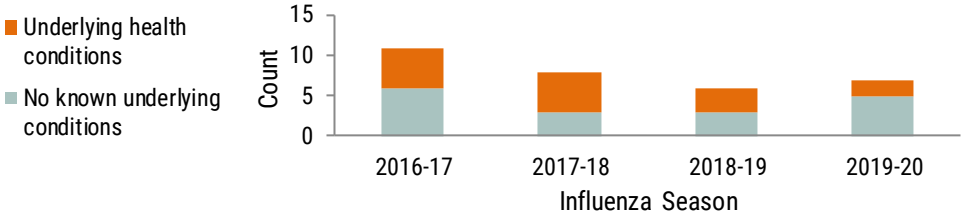


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

Figures 25-26: In week 6, **no new influenza-associated pediatric deaths were reported**. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 6, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 6, 2020.

In week 6, **no new influenza-associated pediatric deaths were reported**.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

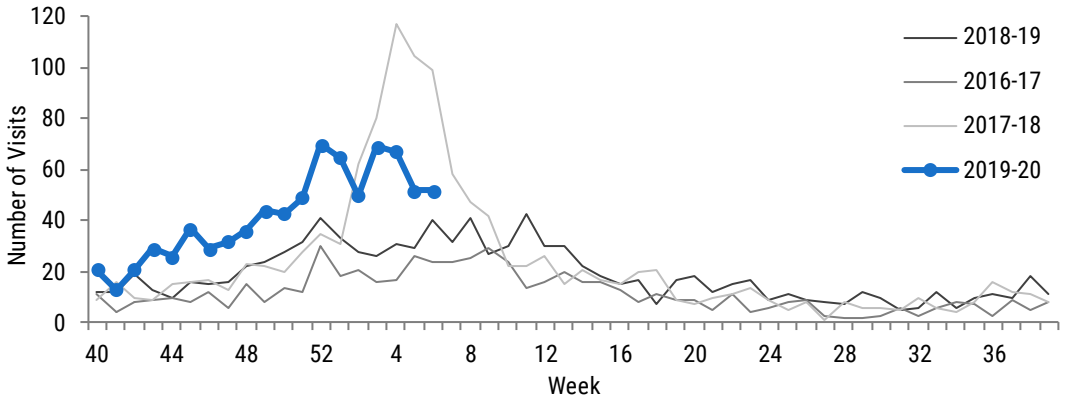
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 6, the **number of emergency department and urgent care center visits for influenza among pregnant women was stable** and was within levels observed at this time in past seasons.



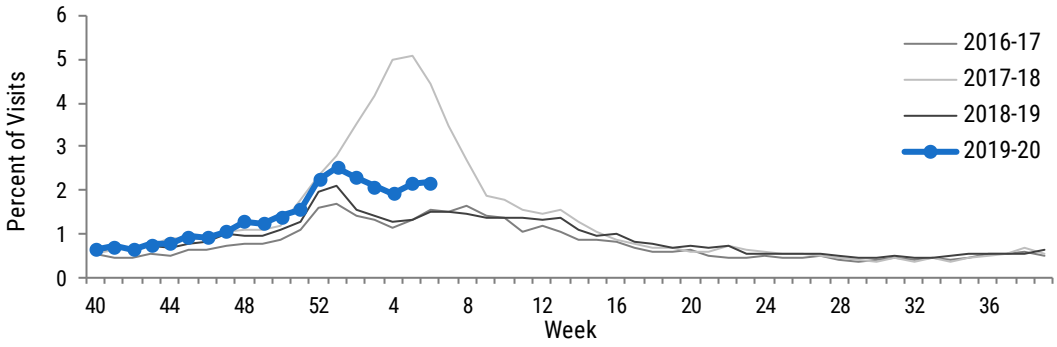
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 6, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 6, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years was stable** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



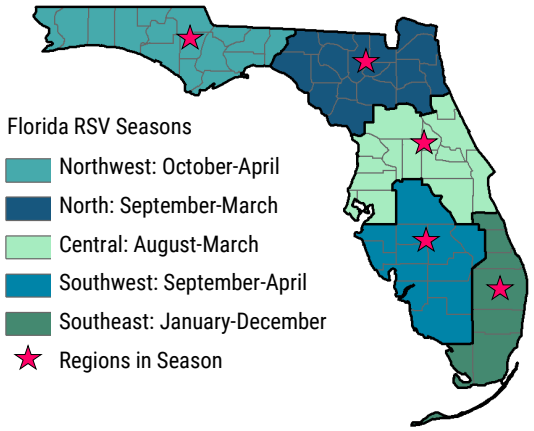
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

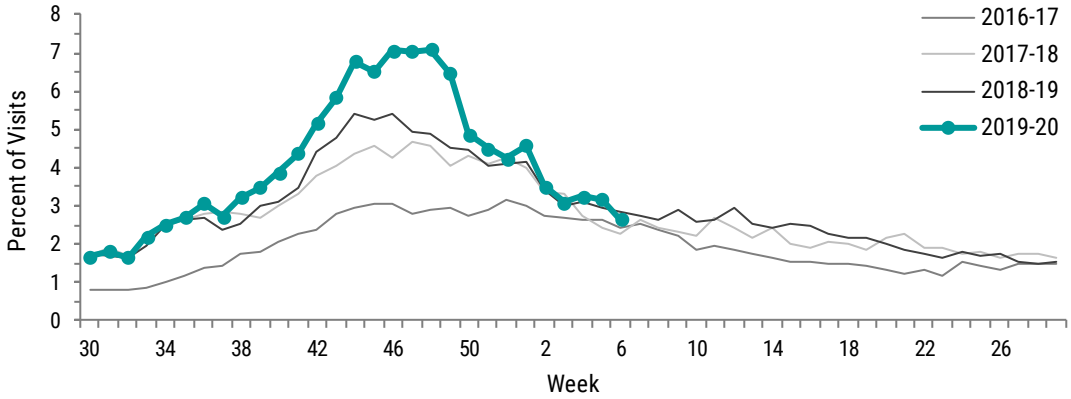
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 6 (January 26-February 1, 2020) Activity Summary

In week 6, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in a Pinellas County child daycare. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 6, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 6, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

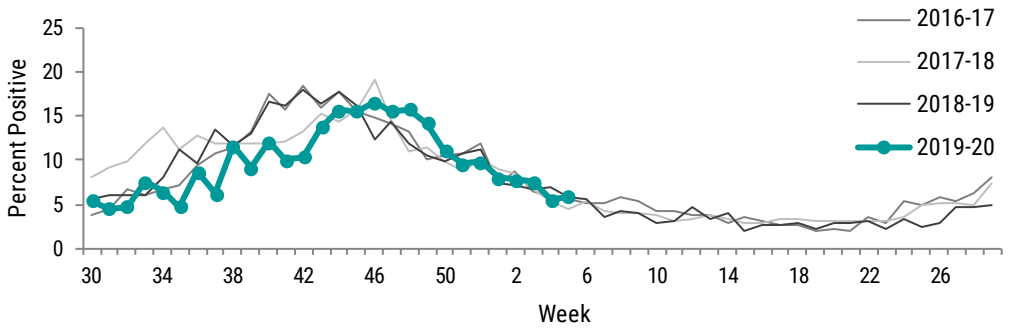
AMERICAN OVERSIGHT

Florida HEALTH

RSV Surveillance

Figure 31: In week 6, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 6, 2020. ▶



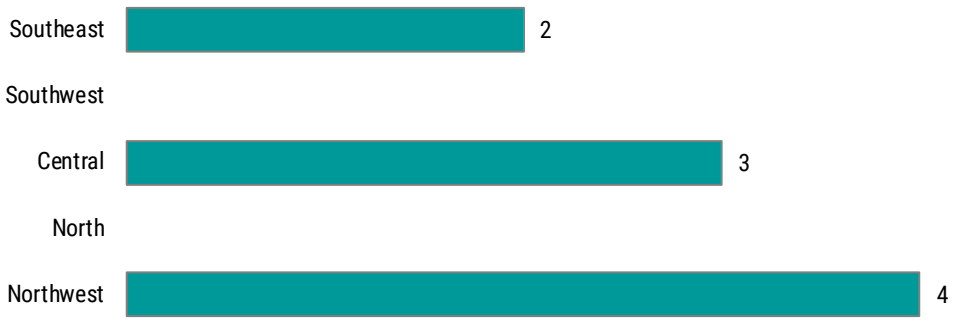
RSV-Associated Outbreaks in Week 6:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 6, one new RSV-associated outbreaks was reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

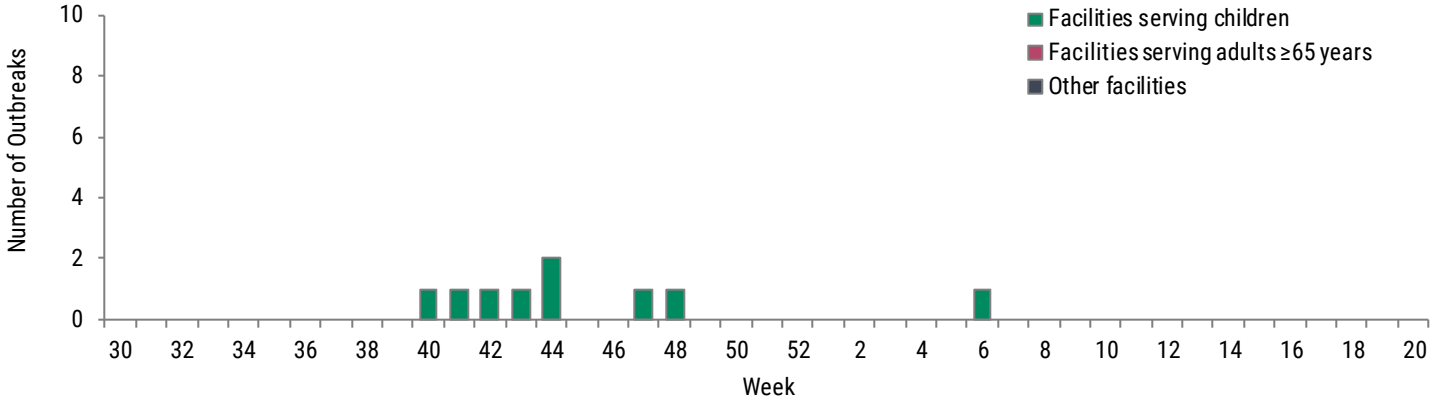
Figure 32: In week 6, **one new RSV-associated outbreak** was reported in Florida's central region. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

*Regions defined in figure 29.

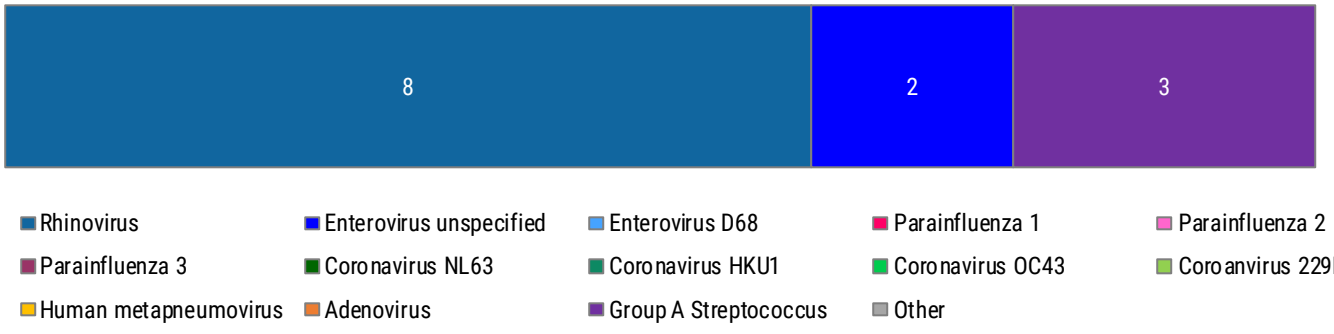
Figure 33: In week 6, one new RSV-associated outbreaks was reported in a **facility serving children.** All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



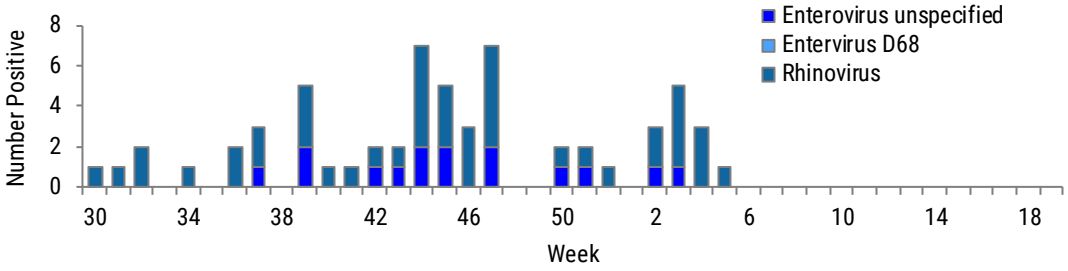
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

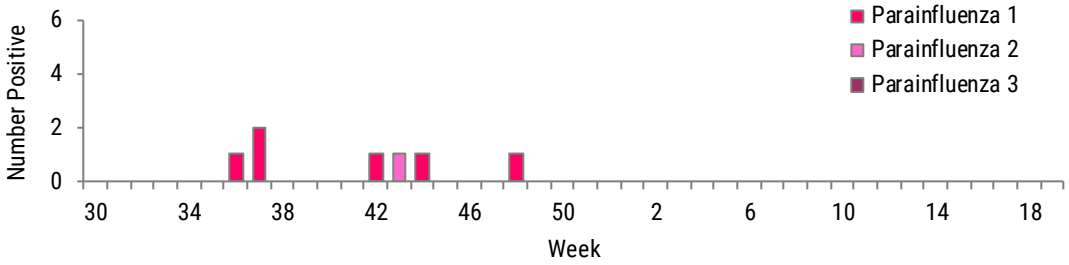


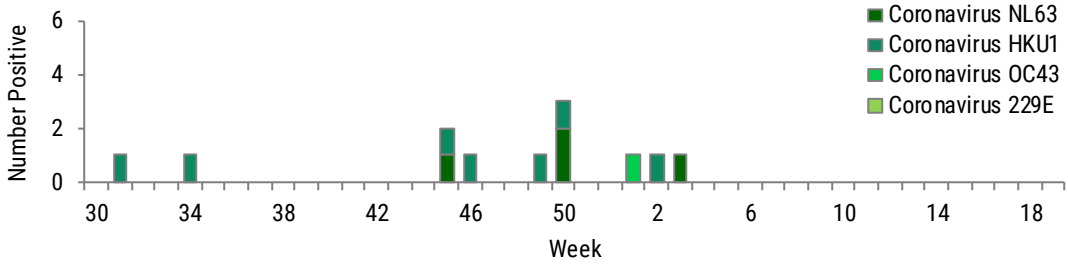
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 6, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

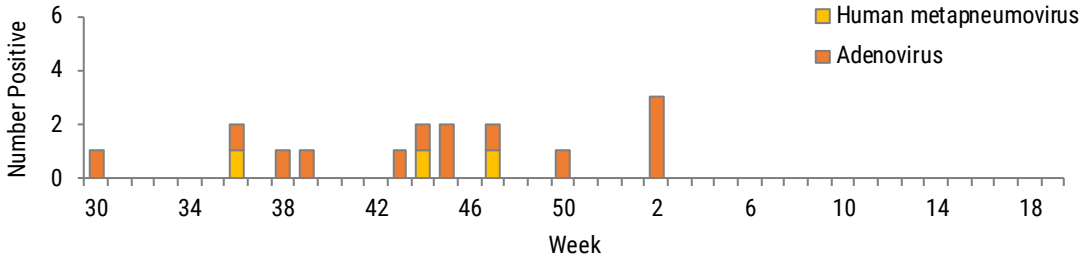
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 6, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Primary or secondary school	Pinellas	107	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Walton	60	0	0	Influenza A unspecified	Yes	Open
Correctional facility	Martin	55	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Lee	36	0	0	Unknown	Unknown	Open
Correctional facility	Liberty	31	Unknown	0	Influenza A 2009 (H1N1)	Yes	Open
Nursing facility	Monroe	5	2	Unknown	Influenza A unspecified and influenza B unspecified	Unknown	Open
Assisted living facility	Nassau	5	2	Unknown	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 6, 2020 Florida Flu Review
Date:	Wednesday, February 12, 2020 4:05:55 PM
Attachments:	Week 6, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 6, 2020 Florida Flu Review.

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-nine outbreaks were reported, down from 35 outbreaks in the previous week. Of the 29 outbreaks reported, 10 were influenza-associated and 19 were ILI.

No new influenza-associated pediatric deaths were reported. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions). On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

AMERICAN OVERSIGHT

Thanks,
Amy

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 6: 2/2/20-2/8/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Stable**

Week 6 influenza & influenza-like illness (ILI) activity summary:

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

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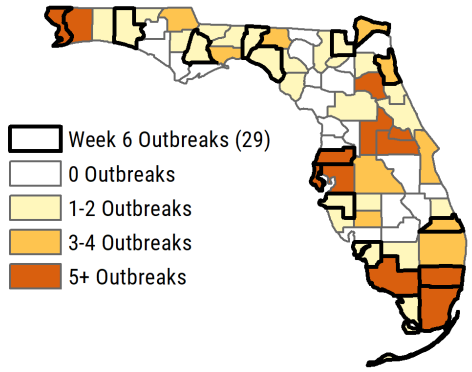
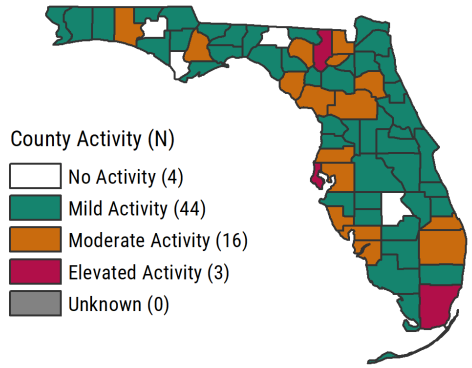
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

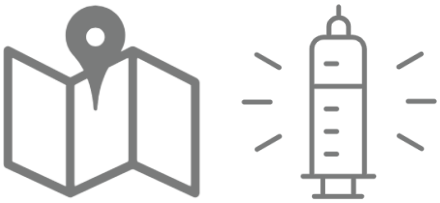
Reported as of 2/8/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 12, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

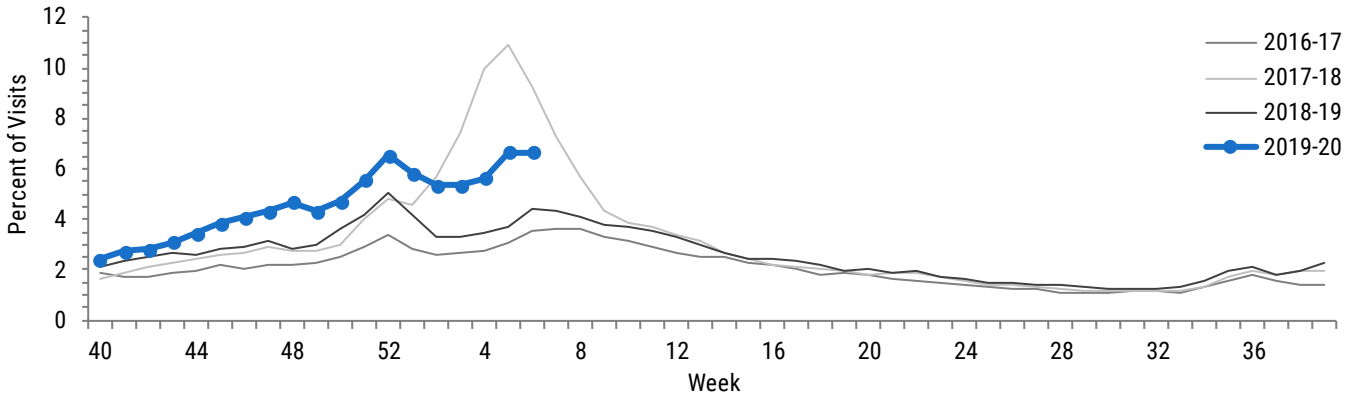
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 6, **the percent of emergency department and urgent care center visits for ILI statewide was stable** compared to the previous week and remained the highest level observed so far this season. Activity in week 6 was above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 6, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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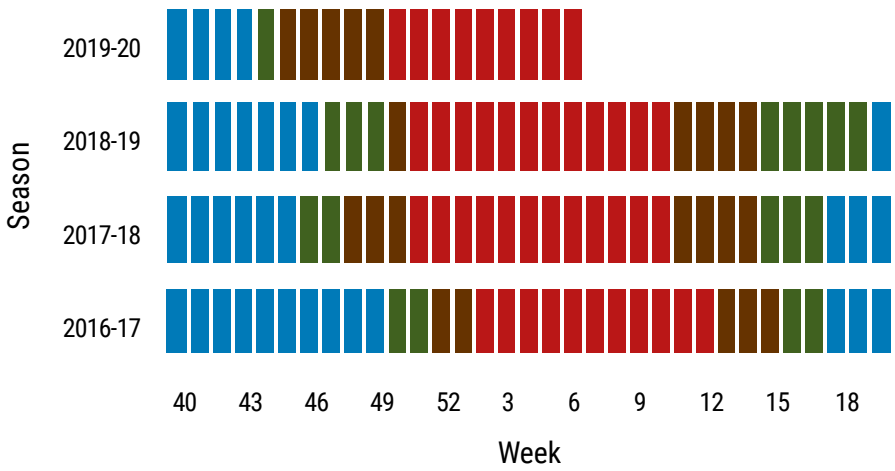
Statewide Activity

Figure 2: In week 6, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 6, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 6, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 6, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

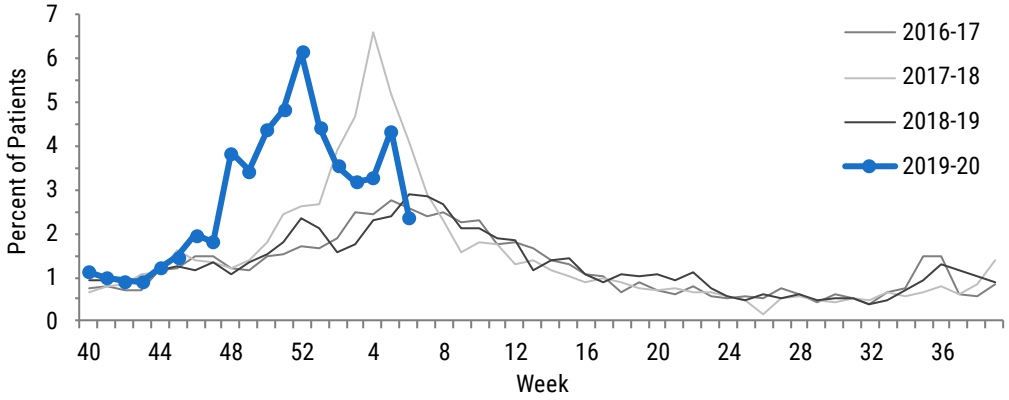
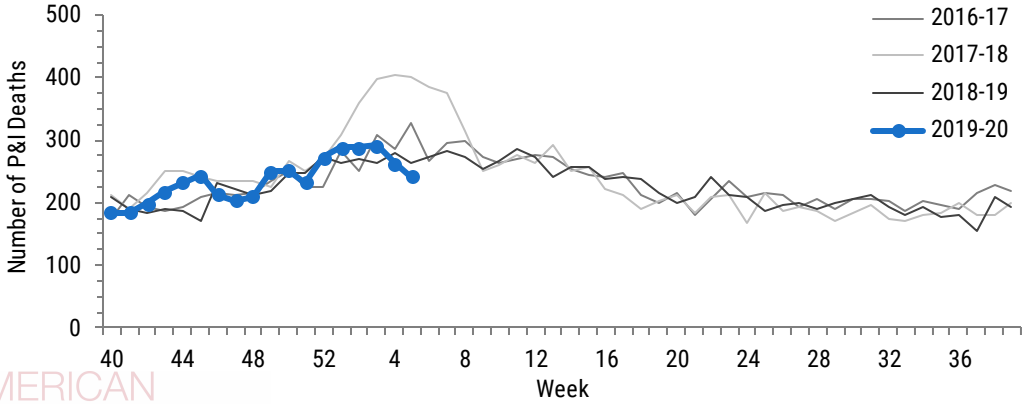


Figure 4: In week 5 (ending 2/1/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 6. Sixteen counties reported **moderate activity,** and three counties reported **elevated activity.**

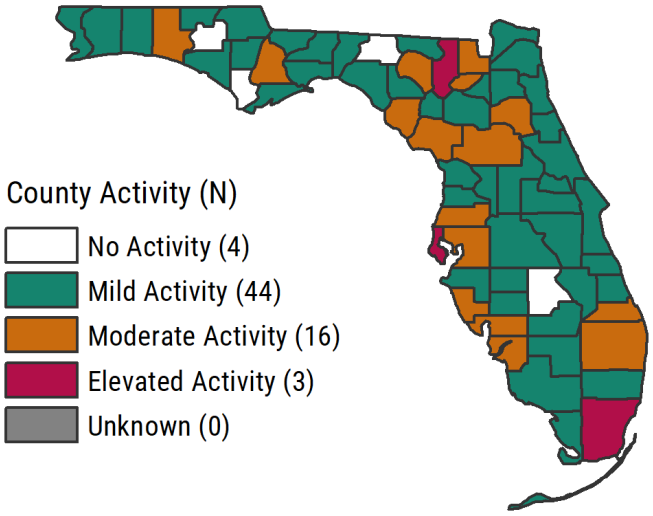
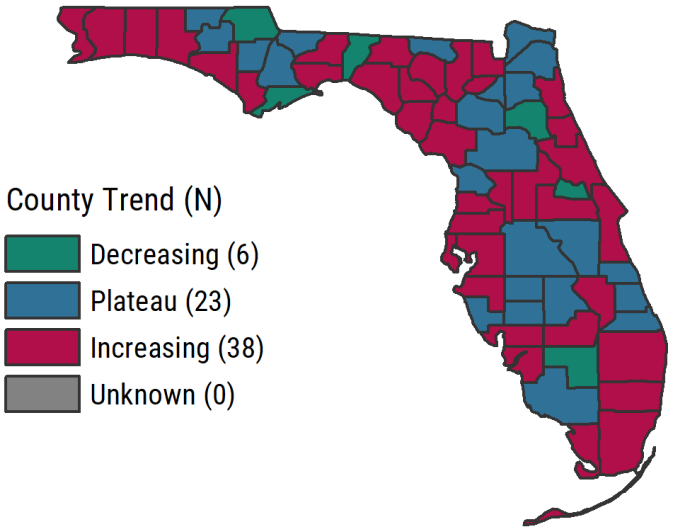
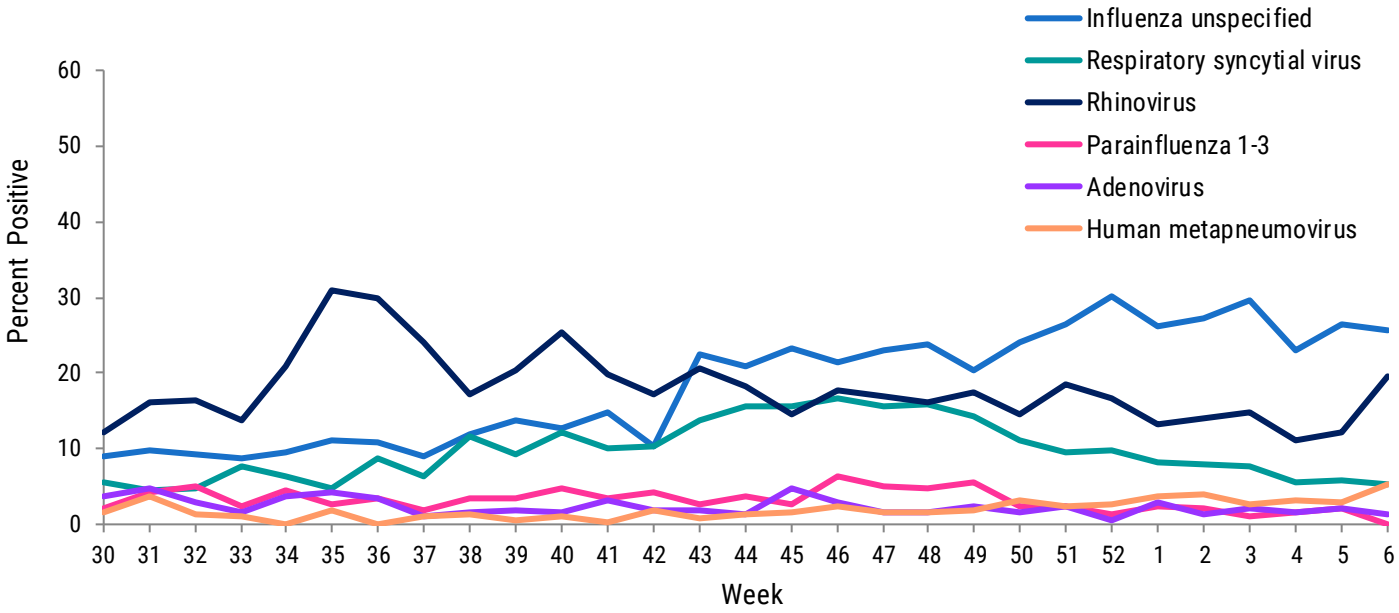


Figure 6: Most counties reported **increasing activity** in week 6. Twenty-three counties reported **activity at a plateau,** and six counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 6, the **percent of specimens testing positive for influenza** **decreased slightly** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 6, 2020.

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Influenza and ILI Outbreaks

Week 6 Outbreaks at a Glance:

Number Reported:
29 Outbreaks

Influenza-Associated:
10 Outbreaks

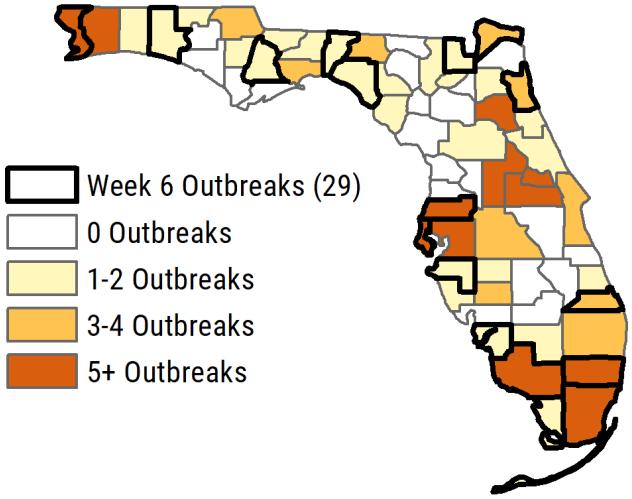
Severe Outcomes*:
3 Outbreaks

Outbreak Summary:

In week 6, 10 influenza-associated and 19 ILI outbreaks were reported, a decrease from the previous week.

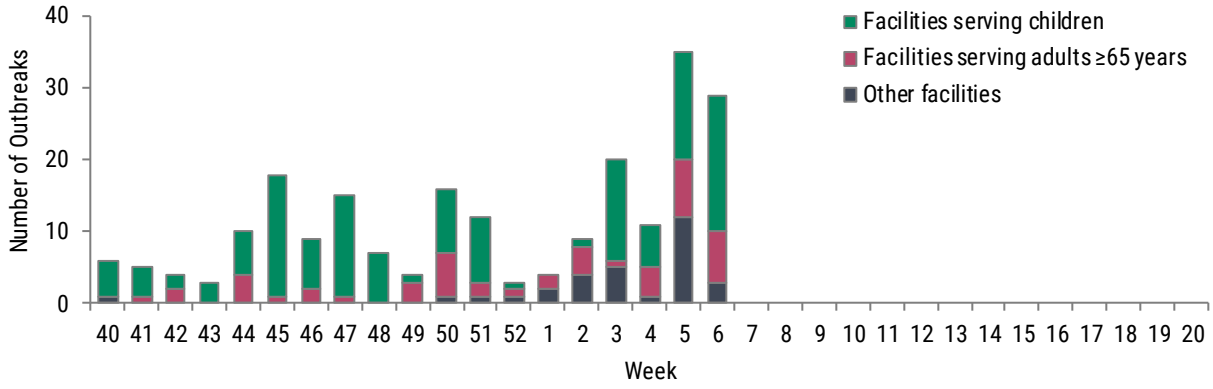
Severe outcomes* were reported in three of 29 outbreaks. One or more hospitalizations were reported in each of these three outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 6, all three outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 6 are **outlined in bold.**

Figure 9: In week 6, **seven outbreaks** were reported in **facilities serving adults aged ≥65 years, 19 outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 6, **54.5% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 6, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

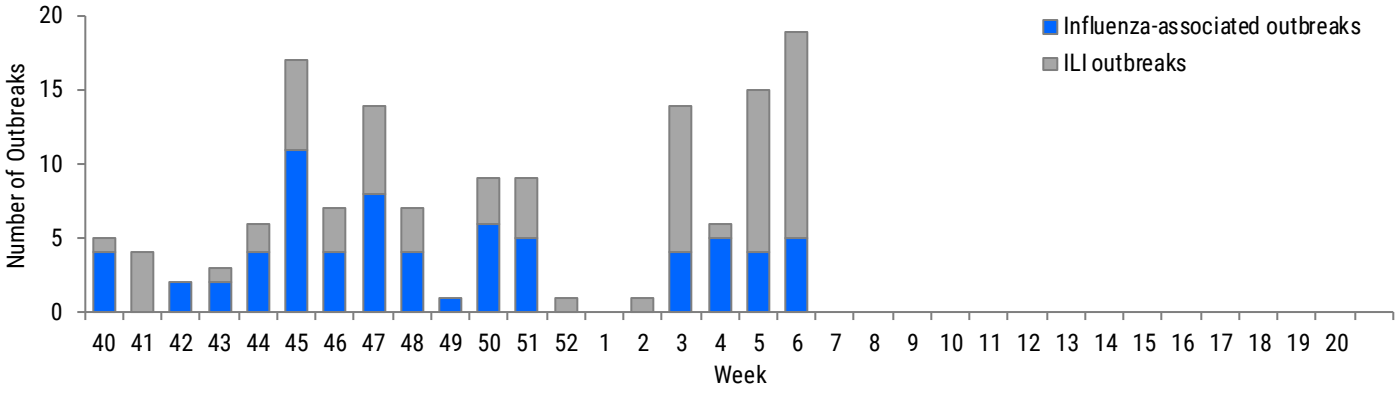
19 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 6, 19 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 6, **five influenza-associated outbreaks** and **14 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Facilities Serving Adults ≥65 yrs.**:

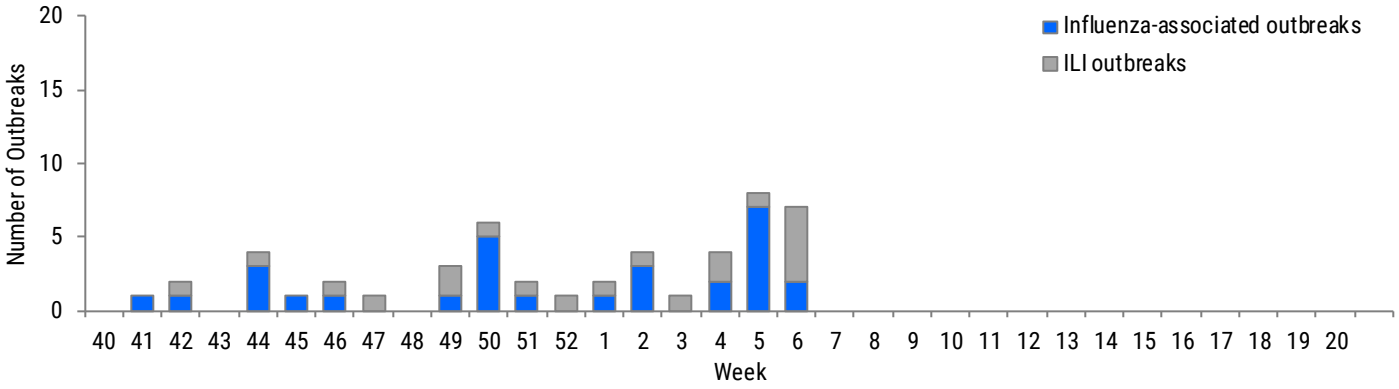
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 6, seven new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 6, **two influenza-associated outbreaks** and **five ILI outbreaks** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

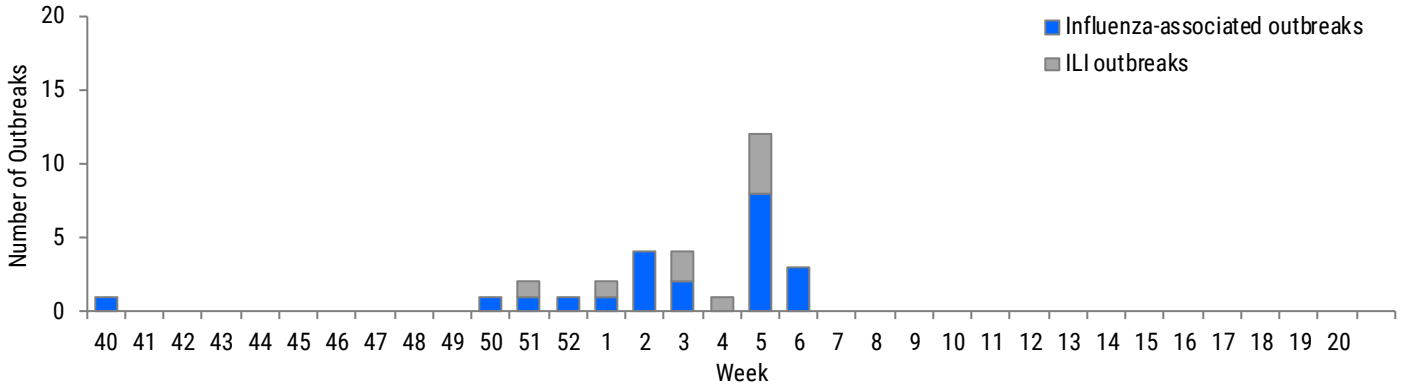
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 6, three new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 6, **three influenza-associated outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	112 (50.9%)	59 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	28 (12.7%)	10 influenza-associated outbreaks 18 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	14 (6.4%)	4 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	12 (5.5%)	9 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	23 (10.5%)	16 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (12.3%)	19 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (0.9%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (0.9%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**220 (100.0%)**	**120 influenza-associated outbreaks** **100 ILI outbreaks**

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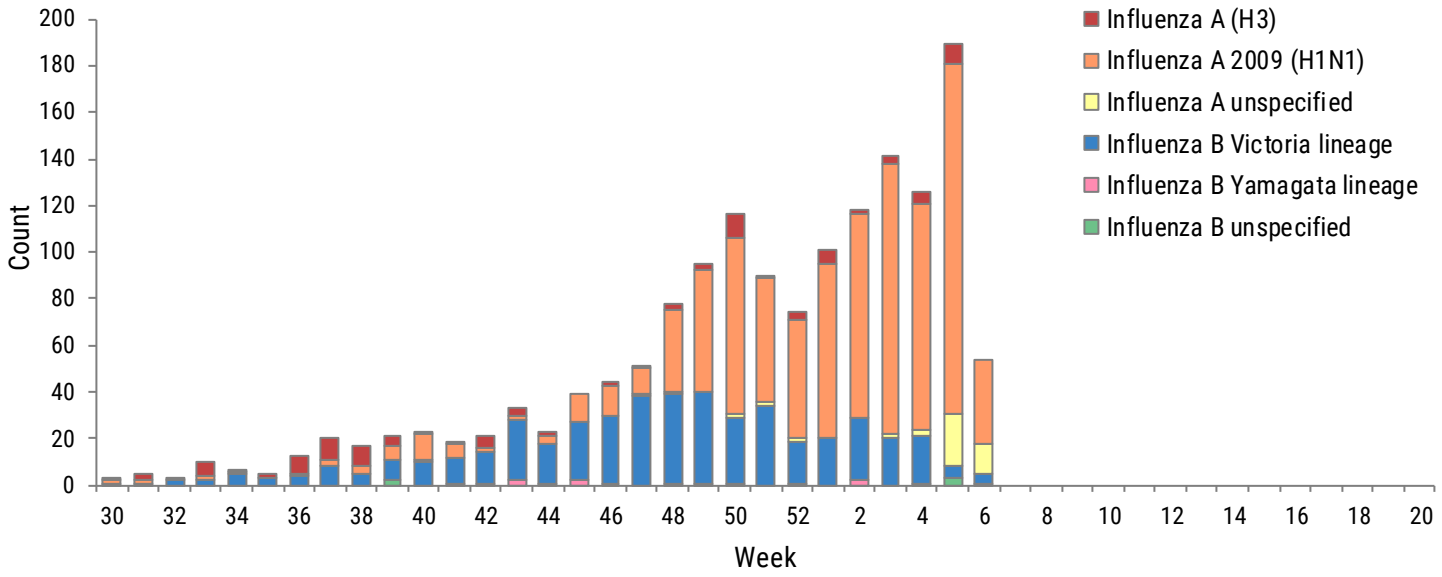
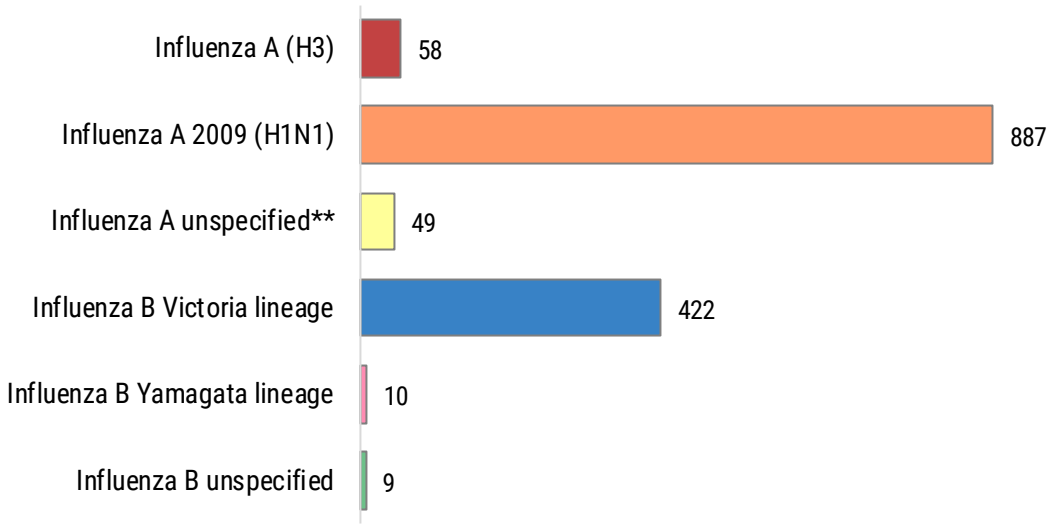
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 6, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 6, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 6, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 6 and was above peak levels observed during the 2018-19 and 2016-17 seasons.

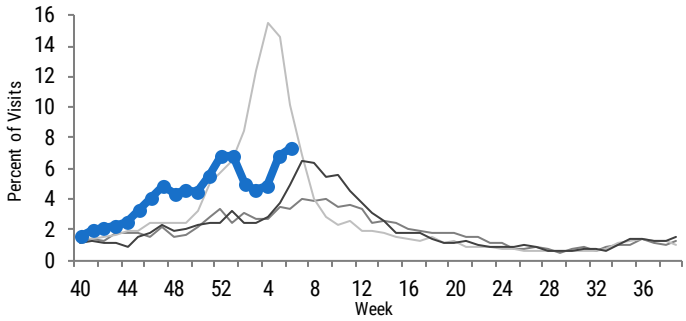


Figure 17: In **region 2, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

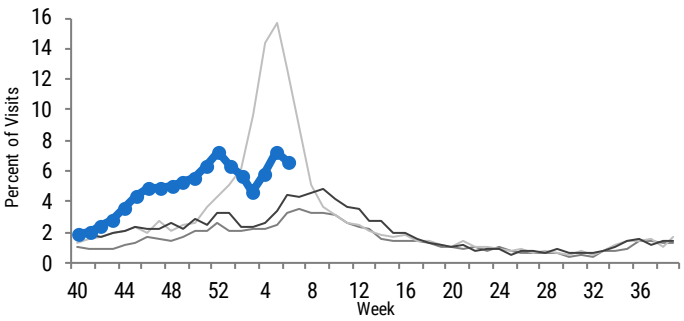


Figure 18: In **region 3, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

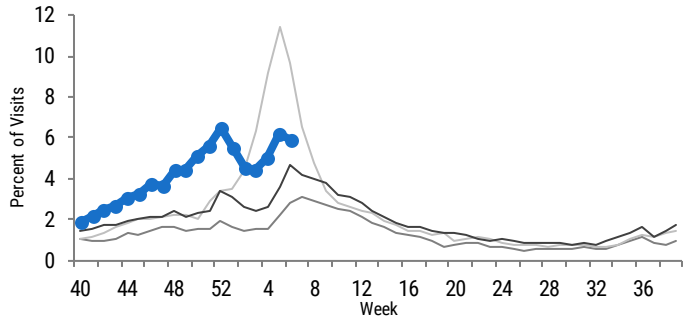


Figure 19: In **region 4, ILI activity increased** during week 6 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

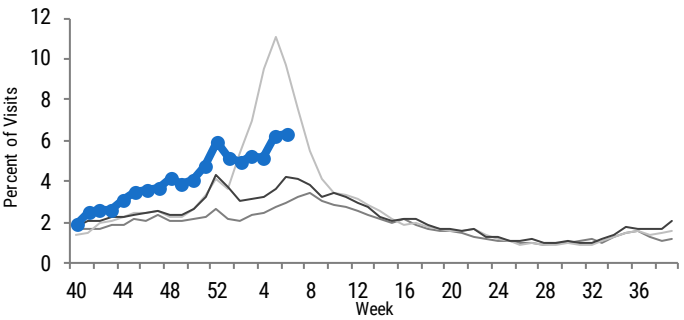


Figure 20: In **region 5, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

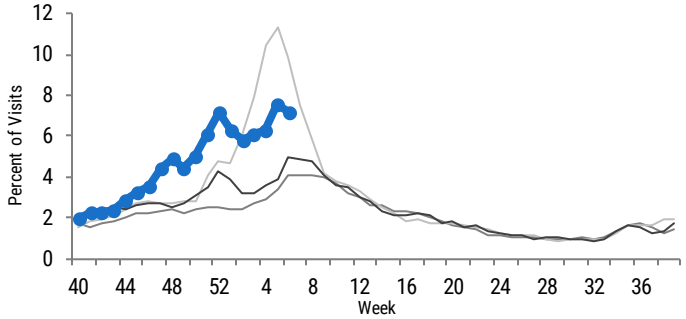


Figure 21: In **region 6, ILI activity increased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

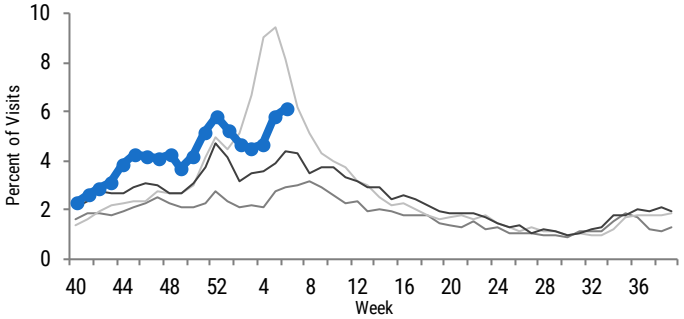
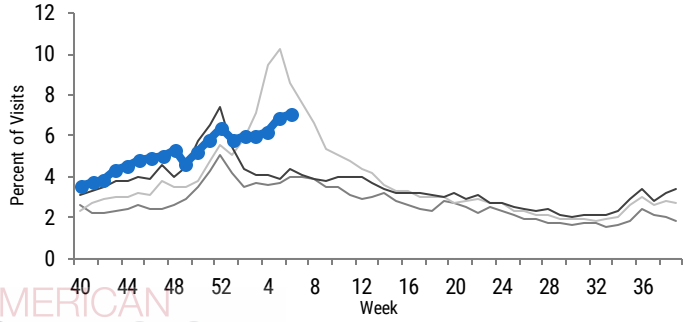


Figure 22: In **region 7, ILI activity increased** during week 6 and was similar to peak activity observed during the 2018-19 season.



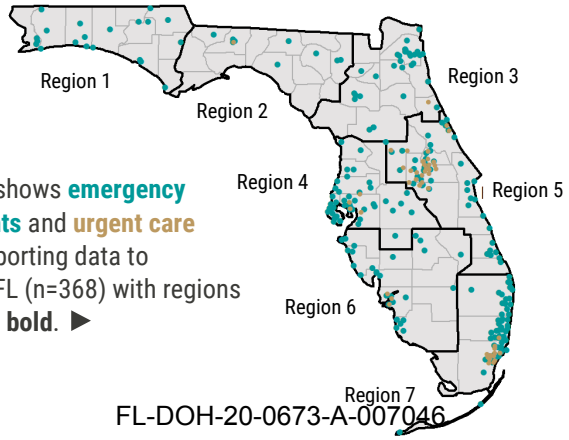


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

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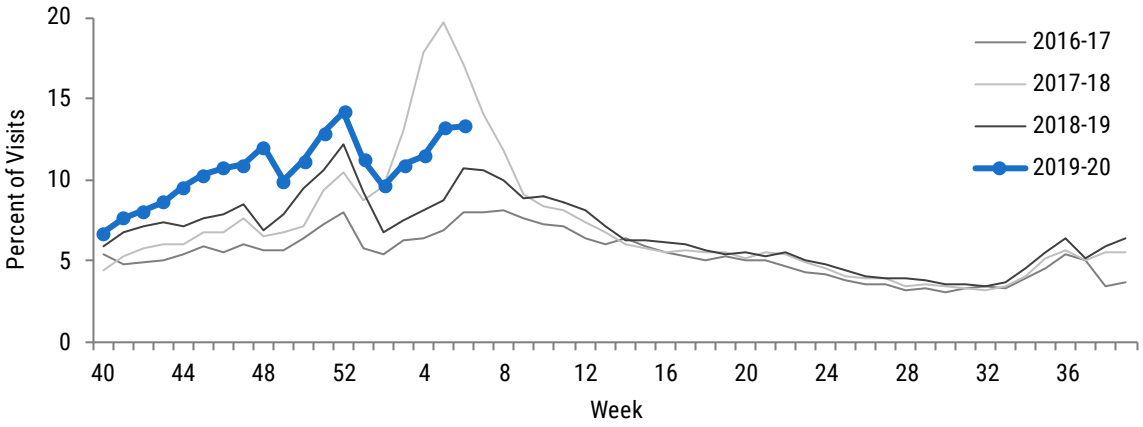
At-Risk Populations

Background: At-Risk Populations, Children

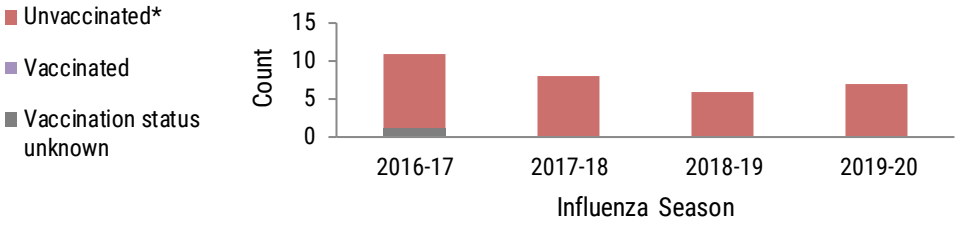
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 6, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

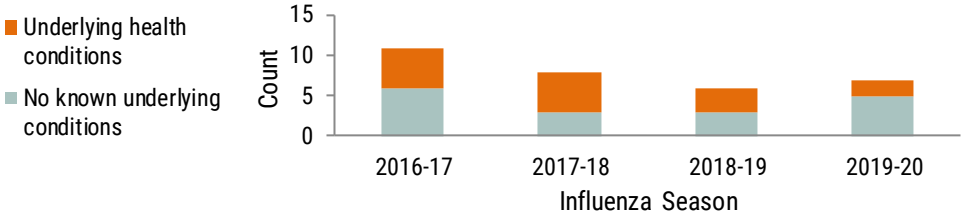


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

Figures 25-26: In week 6, **no new influenza-associated pediatric deaths were reported**. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 6, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 6, 2020.

In week 6, **no new influenza-associated pediatric deaths were reported**.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

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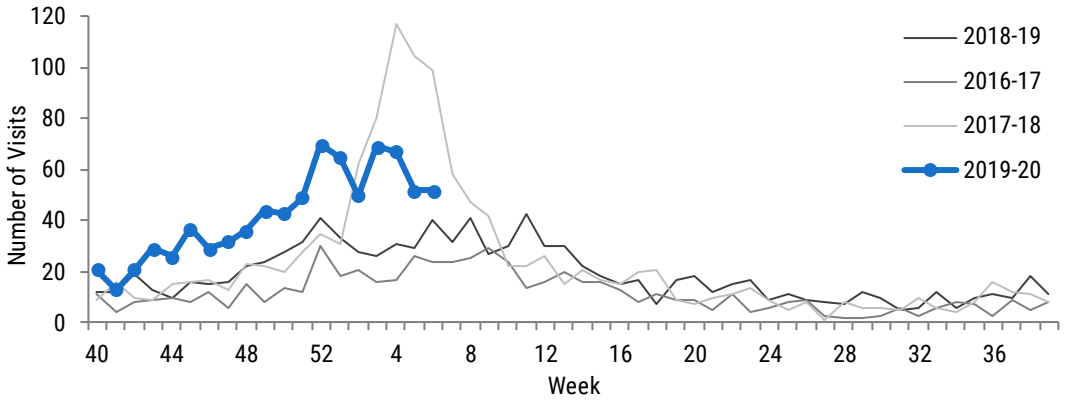
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 6, the **number of emergency department and urgent care center visits for influenza among pregnant women was stable** and was within levels observed at this time in past seasons.



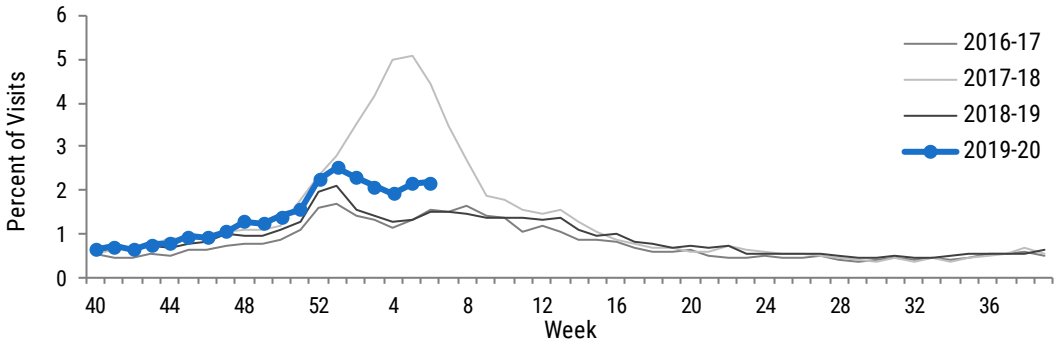
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 6, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 6, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years was stable** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



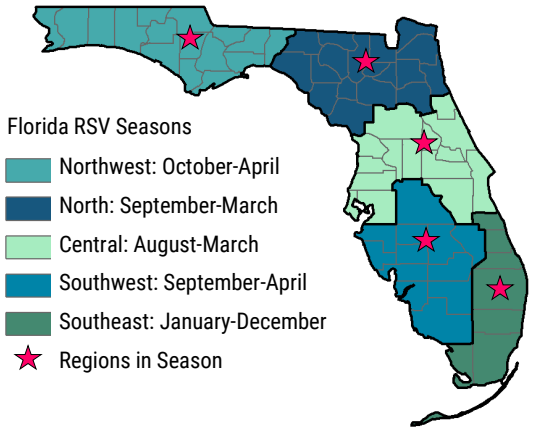
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

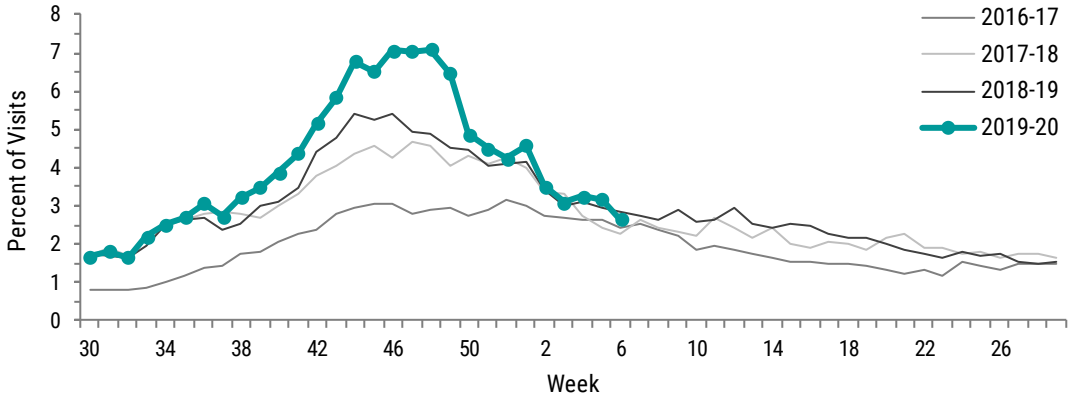
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 6 (January 26-February 1, 2020) Activity Summary

In week 6, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in a Pinellas County child daycare. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 6, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 6, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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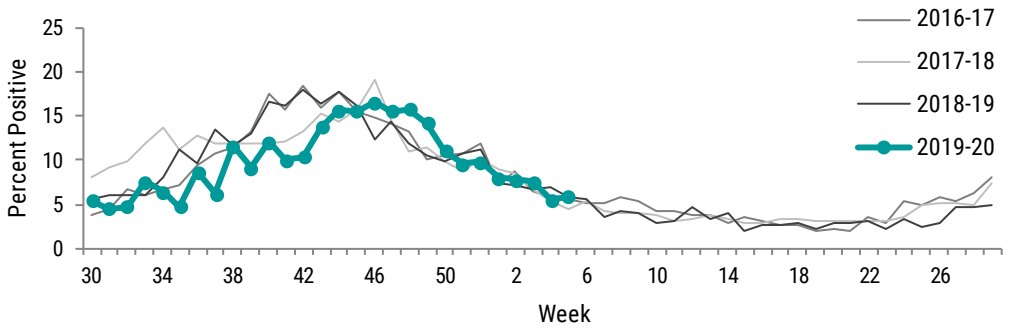
RSV Surveillance

Figure 31: In week 6, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 6, 2020. ▶



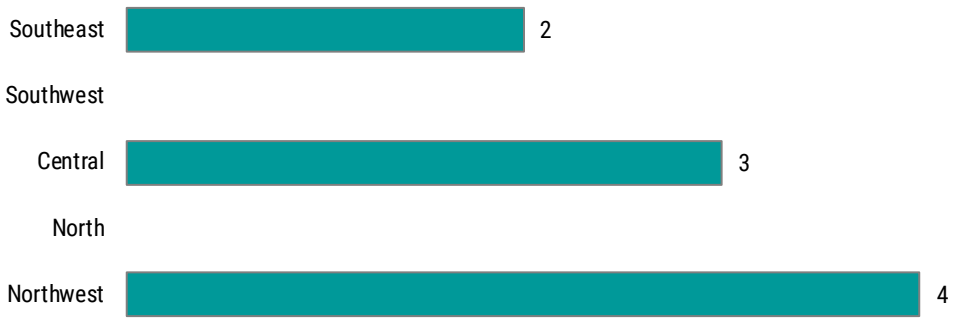
RSV-Associated Outbreaks in Week 6:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 6, one new RSV-associated outbreaks was reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

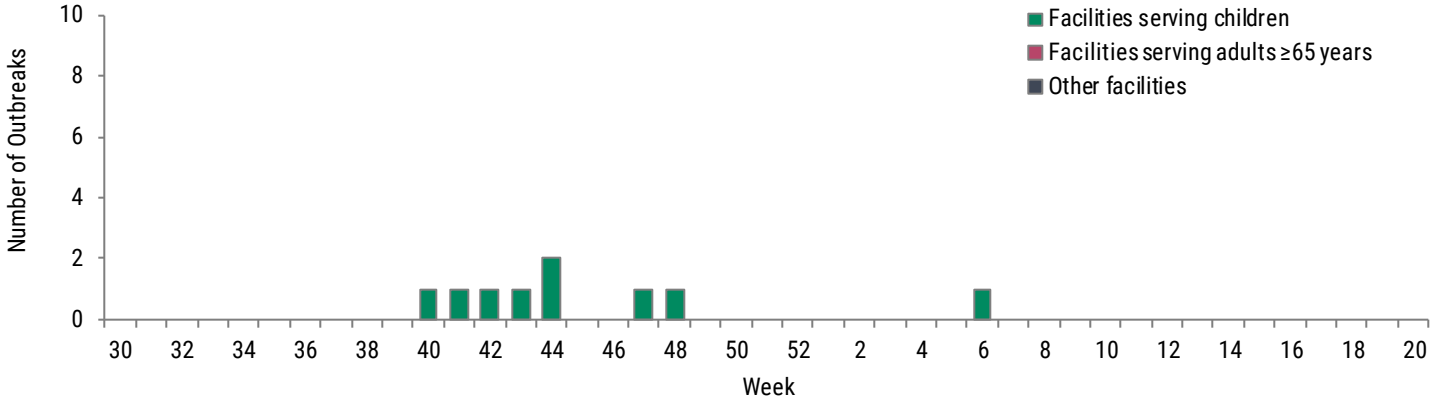
Figure 32: In week 6, **one new RSV-associated outbreak** was reported in Florida's central region. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

*Regions defined in figure 29.

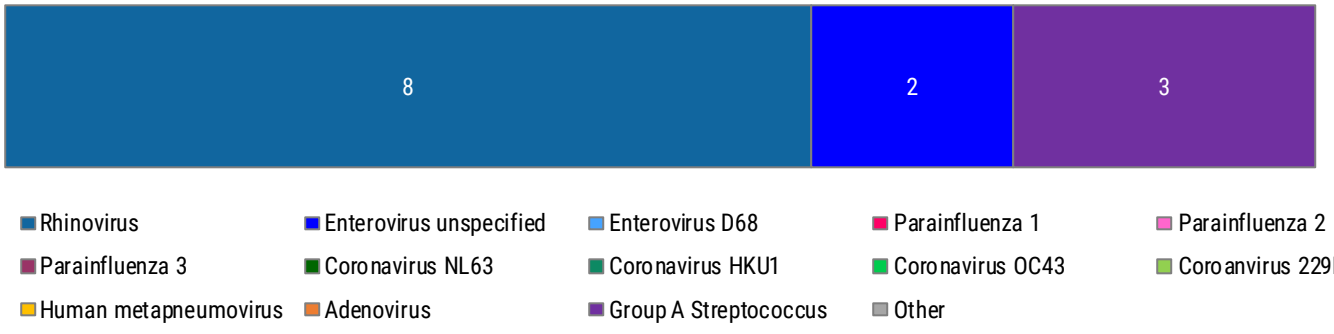
Figure 33: In week 6, one new RSV-associated outbreaks was reported in a **facility serving children.** All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



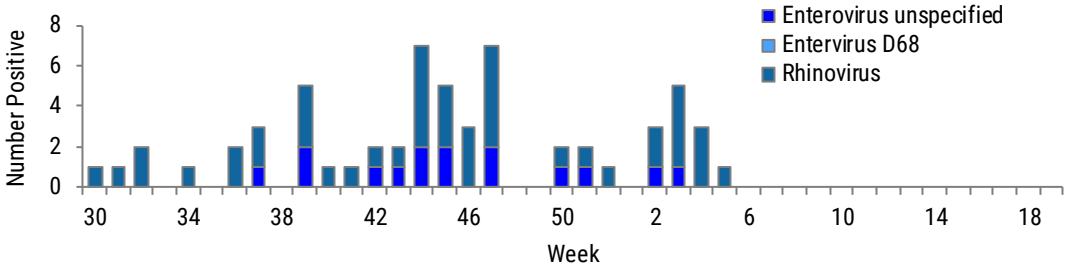
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

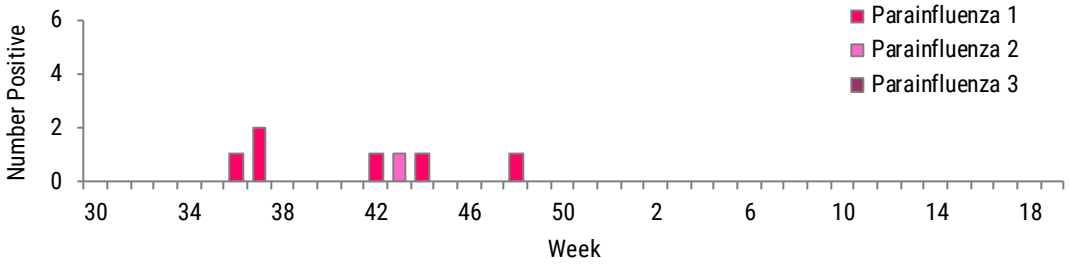


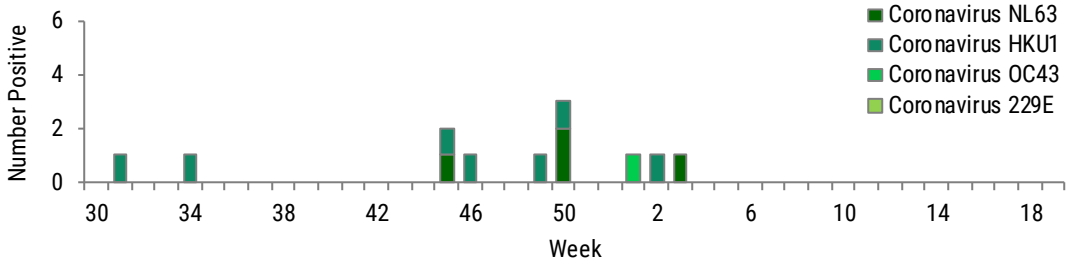
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 6, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

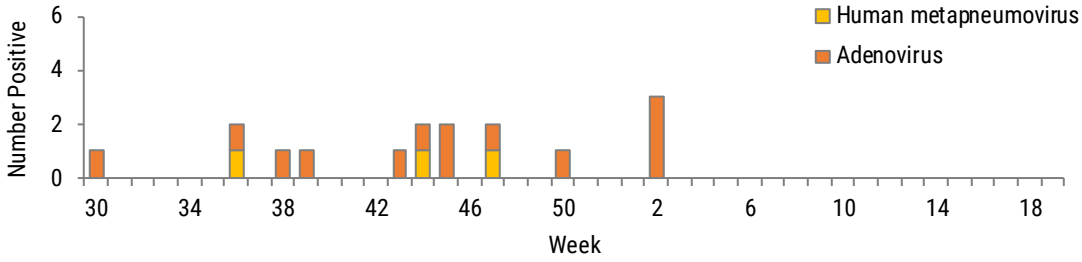
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 6, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Primary or secondary school	Pinellas	107	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Walton	60	0	0	Influenza A unspecified	Yes	Open
Correctional facility	Martin	55	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Lee	36	0	0	Unknown	Unknown	Open
Correctional facility	Liberty	31	Unknown	0	Influenza A 2009 (H1N1)	Yes	Open
Nursing facility	Monroe	5	2	Unknown	Influenza A unspecified and influenza B unspecified	Unknown	Open
Assisted living facility	Nassau	5	2	Unknown	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 6, 2020 Florida Flu Review
Date:	Wednesday, February 12, 2020 4:05:49 PM
Attachments:	Week 6, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 6, 2020 Florida Flu Review.

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-nine outbreaks were reported, down from 35 outbreaks in the previous week. Of the 29 outbreaks reported, 10 were influenza-associated and 19 were ILI.

No new influenza-associated pediatric deaths were reported. Seven influenza-associated pediatric deaths have been reported so far this season, all in unvaccinated children.

Influenza A 2009 (H1N1) remained the predominant strain. Earlier in the season, influenza B Victoria lineage viruses were predominant. Influenza B Victoria lineage viruses continue to circulate at lower levels.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. Vaccination should continue as long as influenza viruses are circulating. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions). On January 10, 2020, CDC issued a health advisory reminding clinicians that influenza B viruses can cause severe illness in people of all ages and reiterating vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

AMERICAN OVERSIGHT

Thanks,
Amy

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 6: 2/2/20-2/8/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Stable**

Week 6 influenza & influenza-like illness (ILI) activity summary:

Activity was stable in week 6 and remained at the highest level observed so far this season. Increases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

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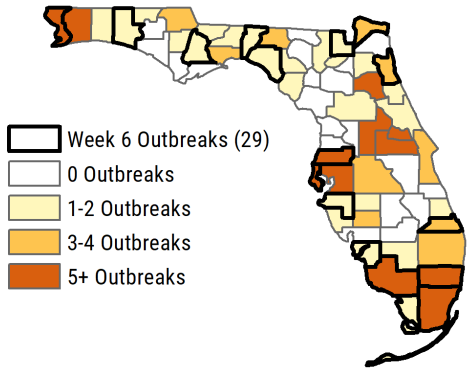
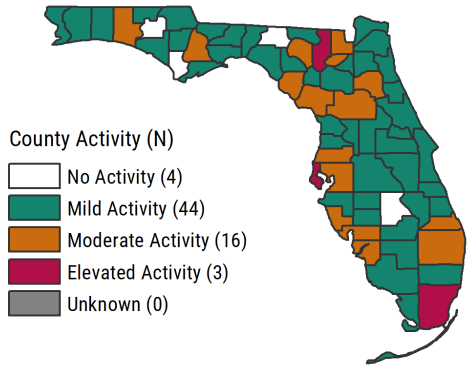
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

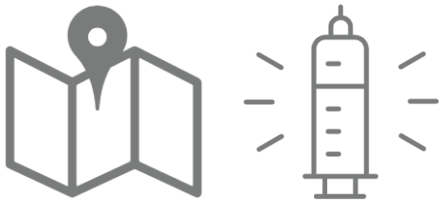
Influenza or ILI Outbreaks
Reported as of 2/8/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 12, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007057

AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

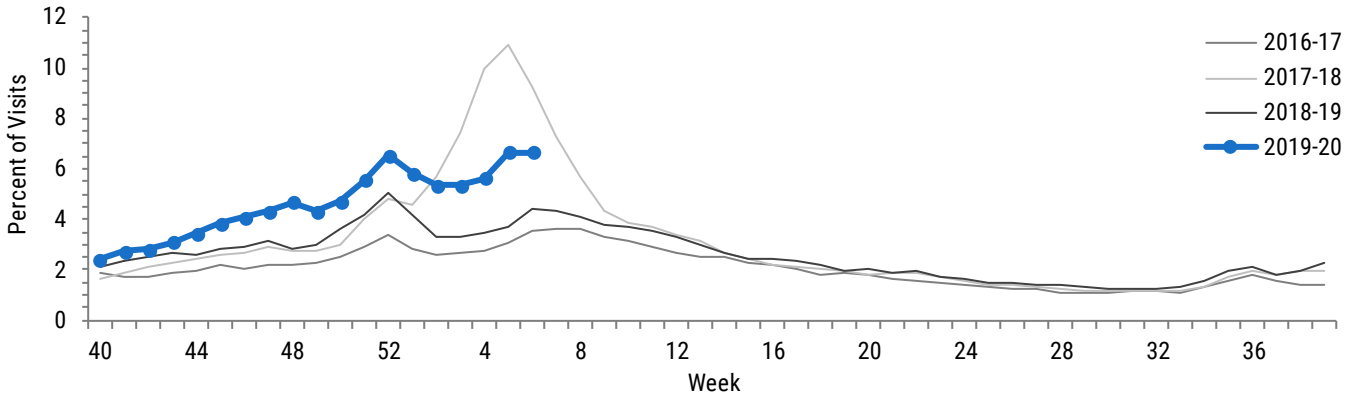
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 6, **the percent of emergency department and urgent care center visits for ILI statewide was stable** compared to the previous week and remained the highest level observed so far this season. Activity in week 6 was above peak levels observed during the 2018-19 and 2016-17 seasons.

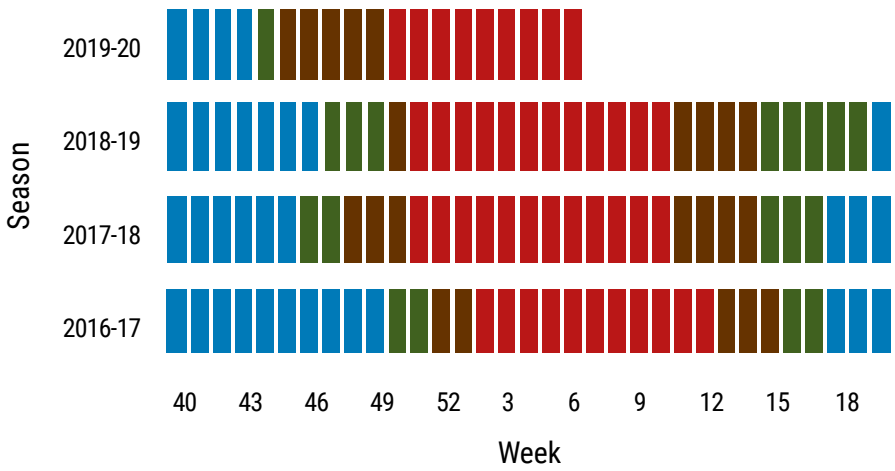


▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=368) statewide for the current season (week 40, 2019 to week 6, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

AMERICAN OVERSIGHT

Statewide Activity

Figure 2: In week 6, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 6, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 6, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 6, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

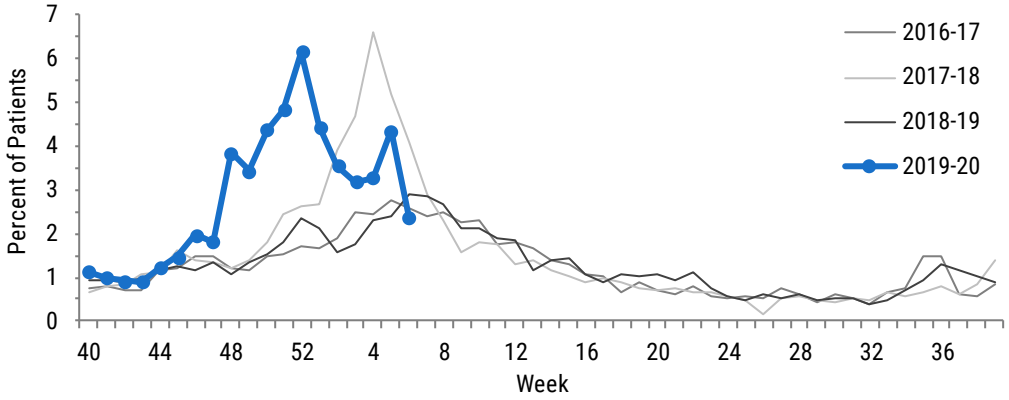
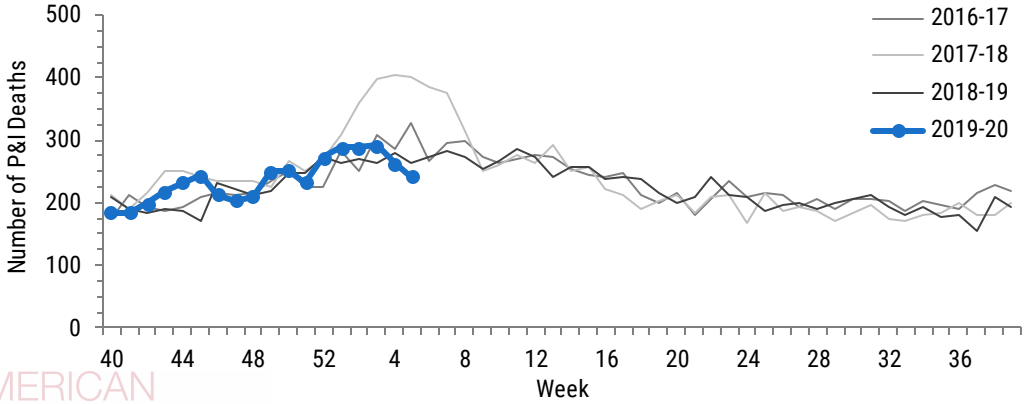


Figure 4: In week 5 (ending 2/1/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 5, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 6. Sixteen counties reported **moderate activity,** and three counties reported **elevated activity.**

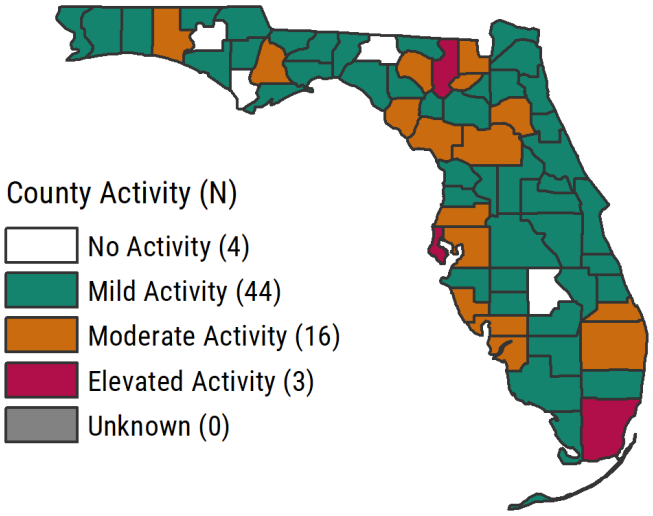
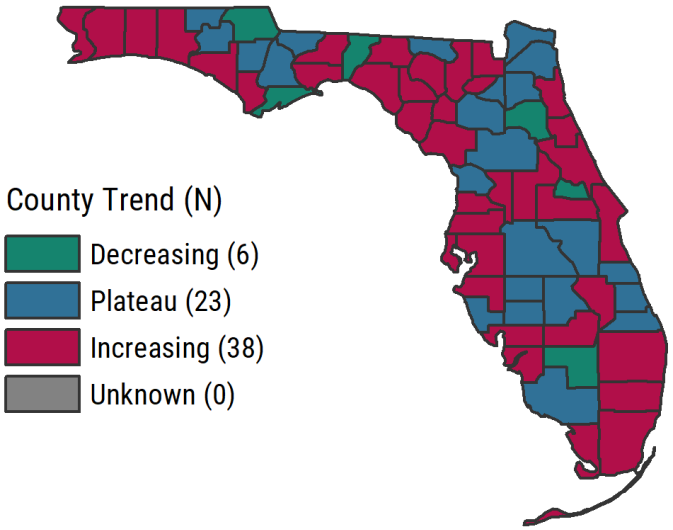
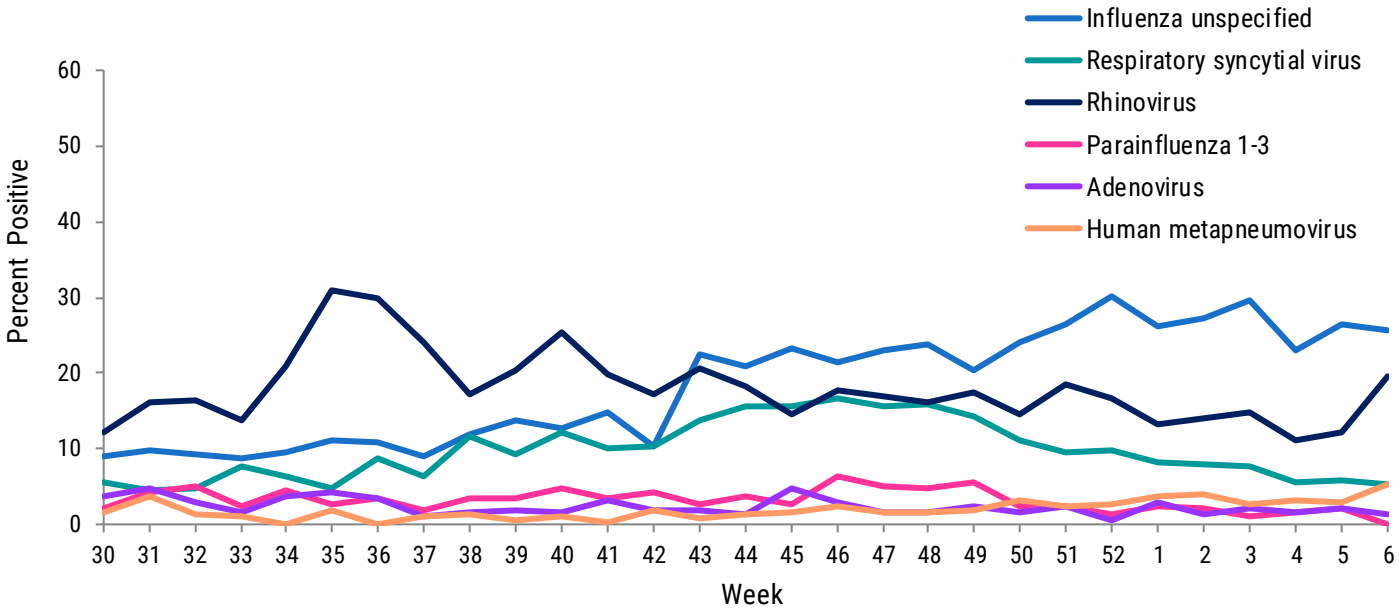


Figure 6: Most counties reported **increasing activity** in week 6. Twenty-three counties reported **activity at a plateau,** and six counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 6, the **percent of specimens testing positive for influenza** **decreased slightly** and remained higher than other respiratory viruses under surveillance.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 6, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 6 Outbreaks at a Glance:

Number Reported:
29 Outbreaks

Influenza-Associated:
10 Outbreaks

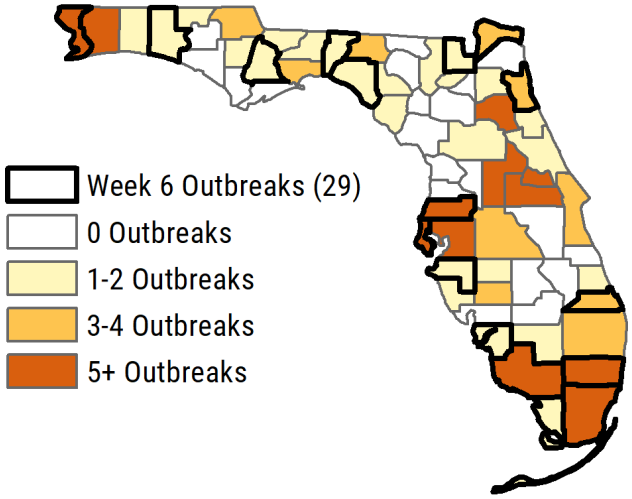
Severe Outcomes*:
3 Outbreaks

Outbreak Summary:

In week 6, 10 influenza-associated and 19 ILI outbreaks were reported, a decrease from the previous week.

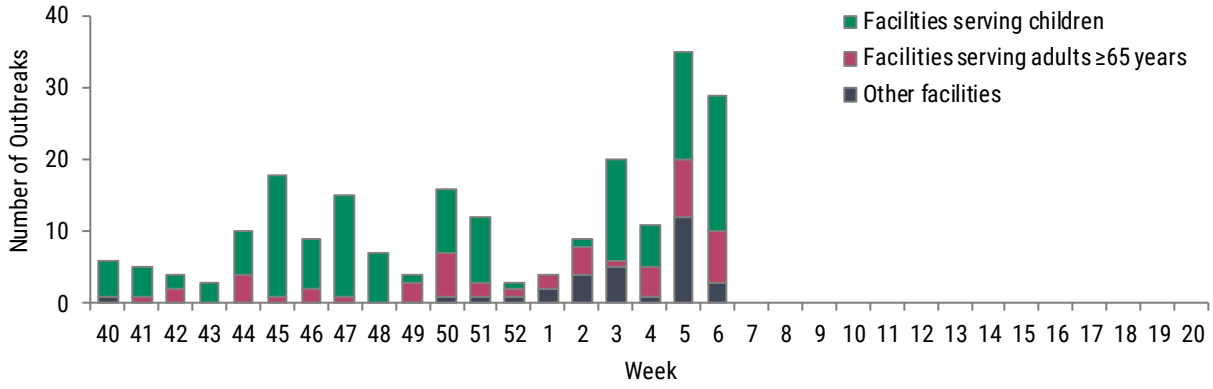
Severe outcomes* were reported in three of 29 outbreaks. One or more hospitalizations were reported in each of these three outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 6, all three outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 6 are **outlined in bold.**

Figure 9: In week 6, **seven outbreaks** were reported in **facilities serving adults aged ≥65 years, 19 outbreaks** were reported in **facilities serving children,** and **three outbreaks** were reported in **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 6, **54.5% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 6, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

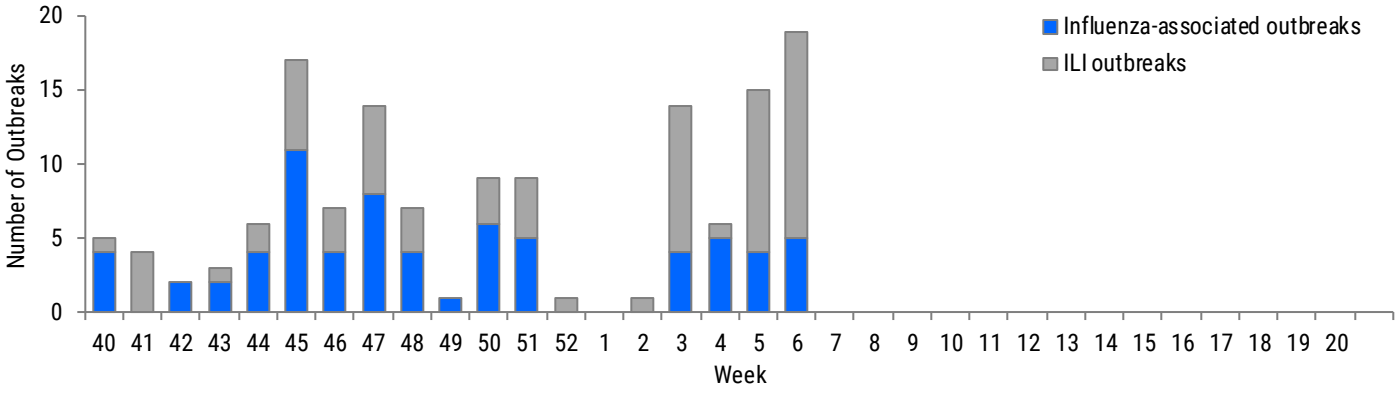
19 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 6, 19 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 6, **five influenza-associated outbreaks** and **14 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

Facilities Serving Adults ≥65 yrs.**:

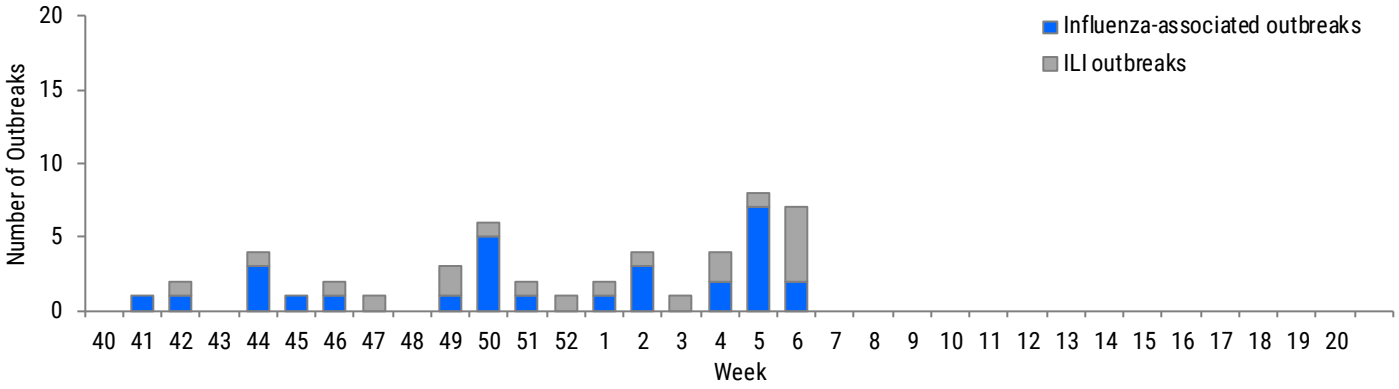
7 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 6, seven new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 6, **two influenza-associated outbreaks** and **five ILI outbreaks** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

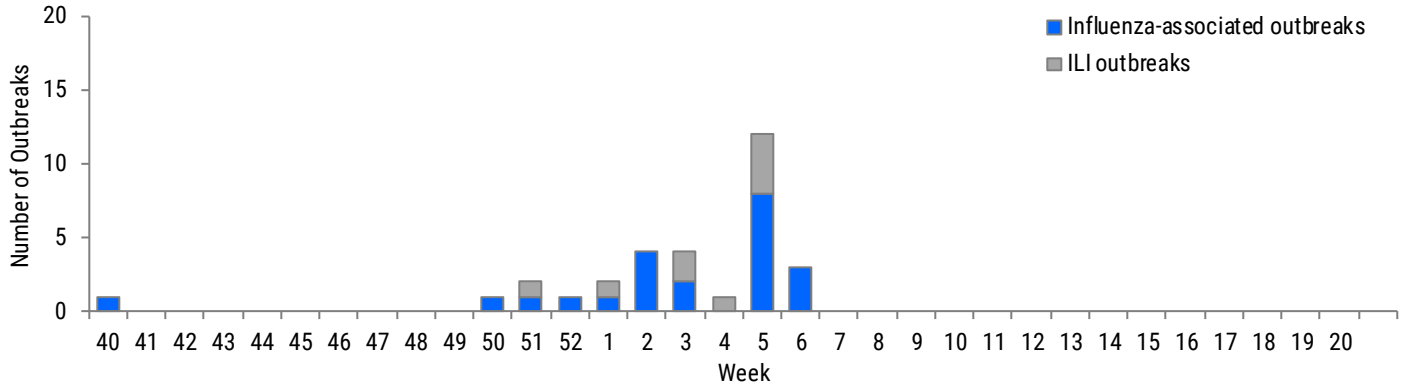
3 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 6, three new outbreaks of influenza or ILI were reported in other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 6, **three influenza-associated outbreaks** were reported in **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 6, 2020.

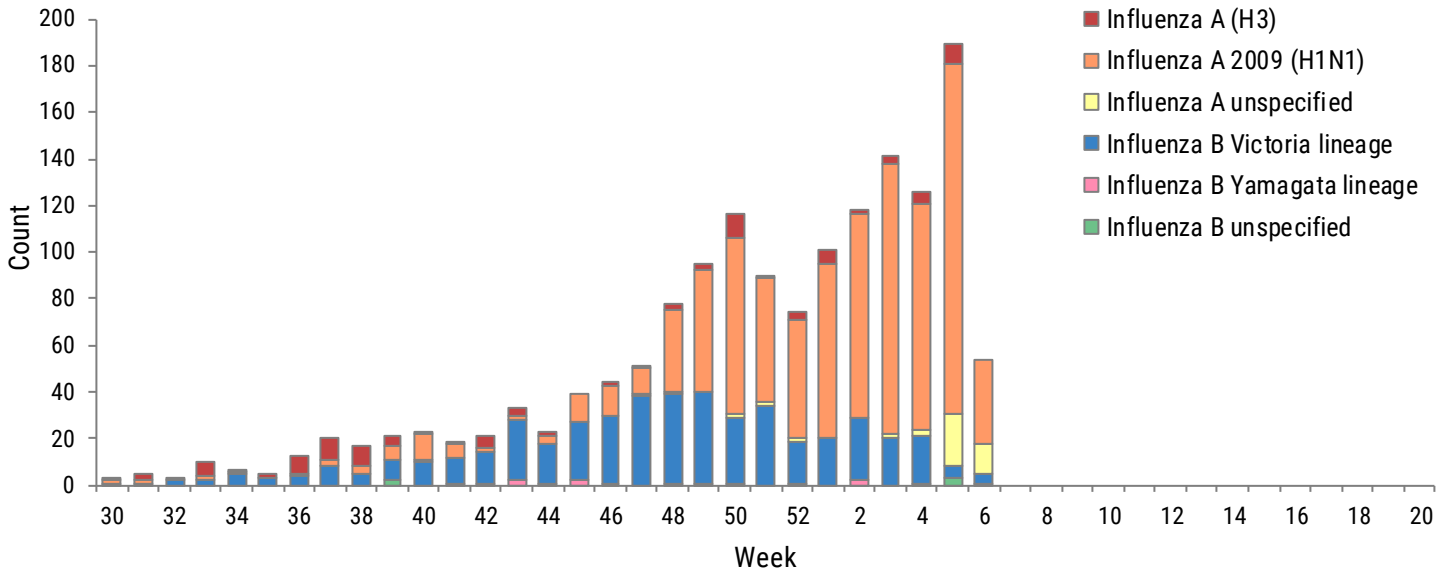
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	112 (50.9%)	59 influenza-associated outbreaks 53 ILI outbreaks
Child daycares	28 (12.7%)	10 influenza-associated outbreaks 18 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	14 (6.4%)	4 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	12 (5.5%)	9 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	23 (10.5%)	16 influenza-associated outbreaks 7 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (12.3%)	19 influenza-associated outbreaks 8 ILI outbreak
Hospitals	2 (0.9%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	2 (0.9%)	1 influenza-associated outbreak 1 ILI outbreak
Total	**220 (100.0%)**	**120 influenza-associated outbreaks** **100 ILI outbreaks**

AMERICAN OVERSIGHT

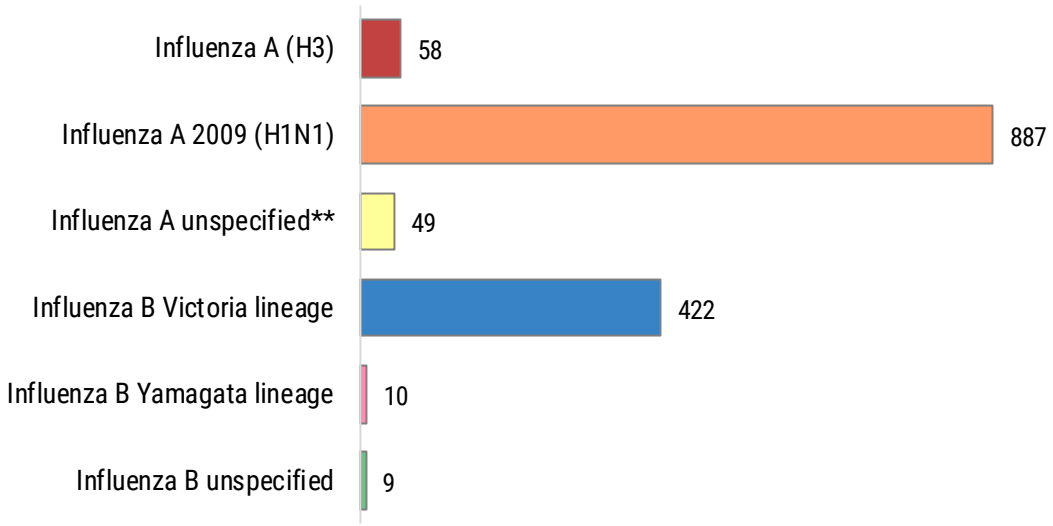
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 6, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 6, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=368) from week 40, 2016 to week 6, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity increased** during week 6 and was above peak levels observed during the 2018-19 and 2016-17 seasons.

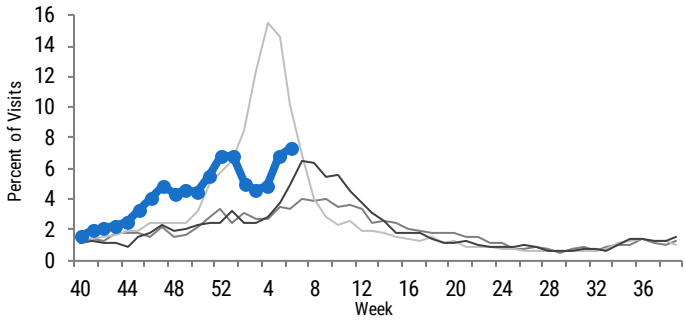


Figure 17: In **region 2, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

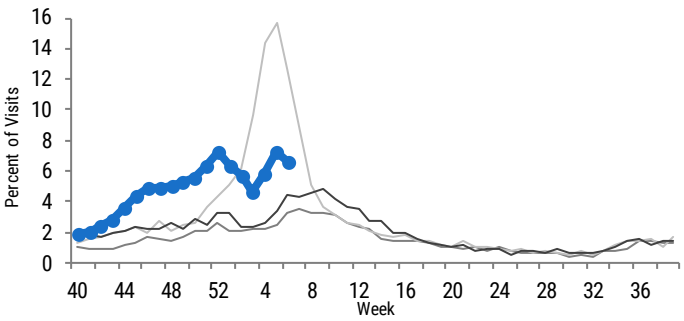


Figure 18: In **region 3, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

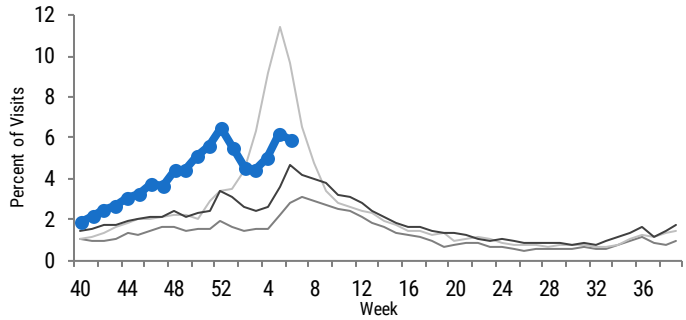


Figure 19: In **region 4, ILI activity increased** during week 6 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

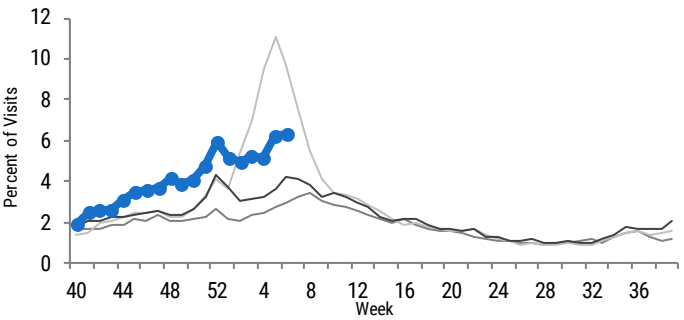


Figure 20: In **region 5, ILI activity decreased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

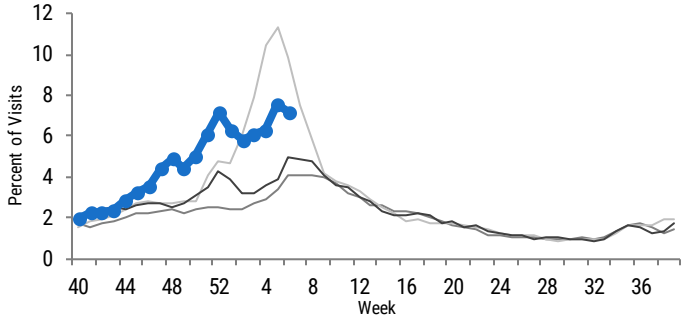


Figure 21: In **region 6, ILI activity increased** during week 6 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

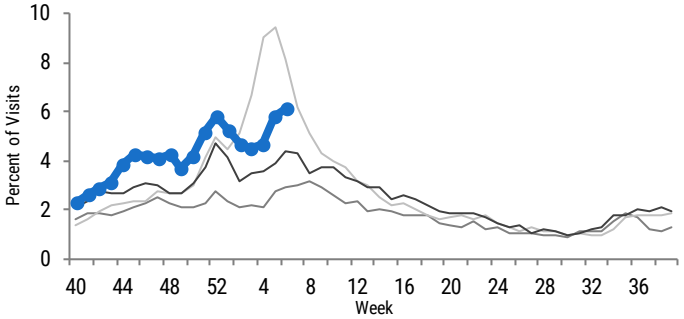
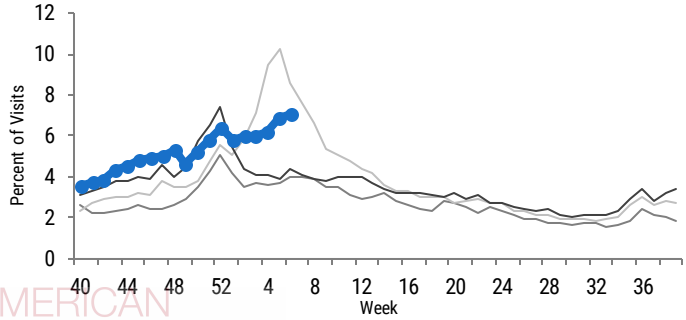


Figure 22: In **region 7, ILI activity increased** during week 6 and was similar to peak activity observed during the 2018-19 season.



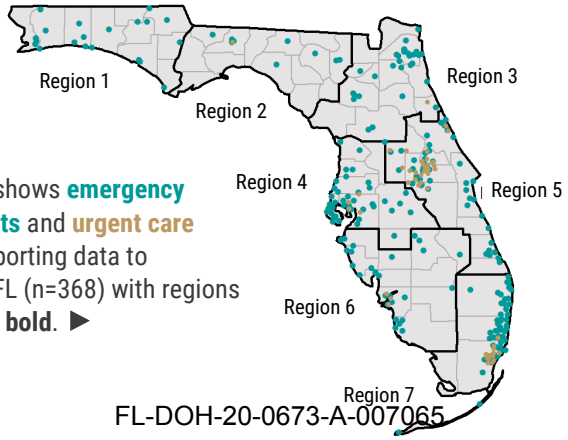


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=368) with regions **outlined in bold**. ▶

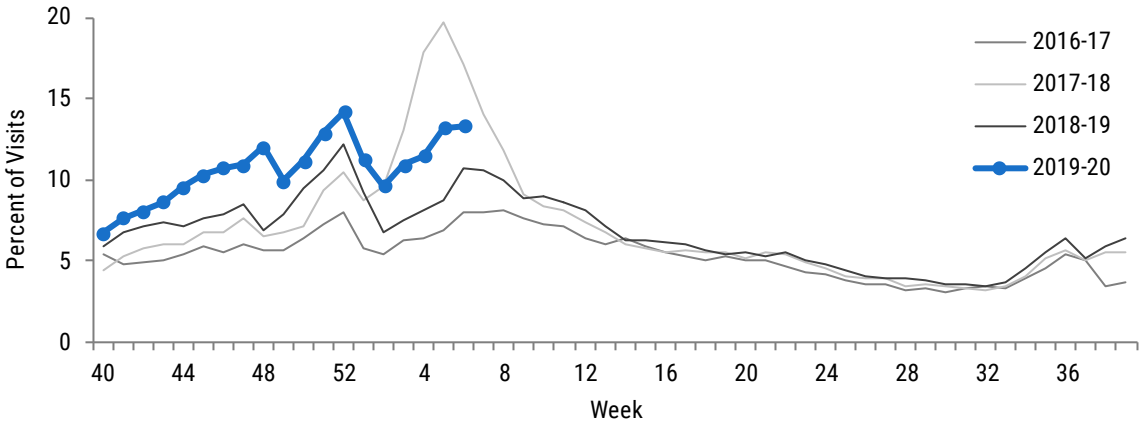
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

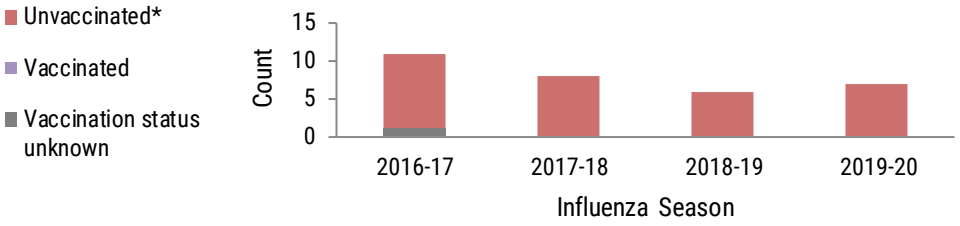
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 6, **the percent of emergency department and urgent care center visits for ILI in children <18 years increased** and was above peak activity observed during the 2018-19 and 2016-17 seasons.

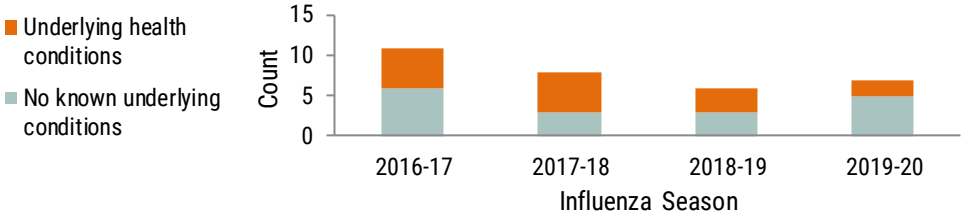


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

Figures 25-26: In week 6, **no new influenza-associated pediatric deaths were reported**. A total of seven influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 6, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 6, 2020.

In week 6, **no new influenza-associated pediatric deaths were reported**.

A total of seven influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

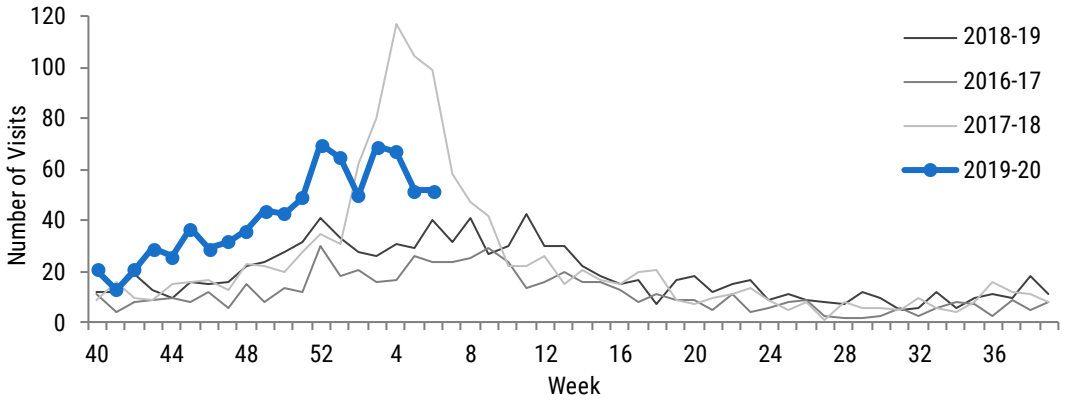
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 6, the **number of emergency department and urgent care center visits for influenza among pregnant women was stable** and was within levels observed at this time in past seasons.



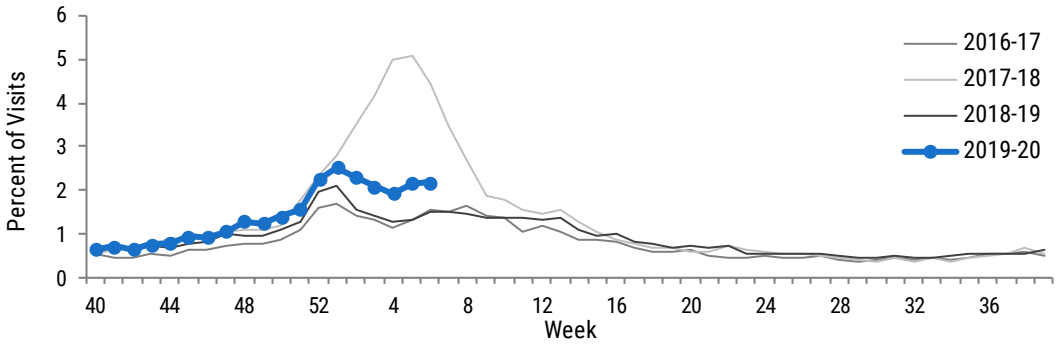
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 6, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 6, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years was stable** and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.



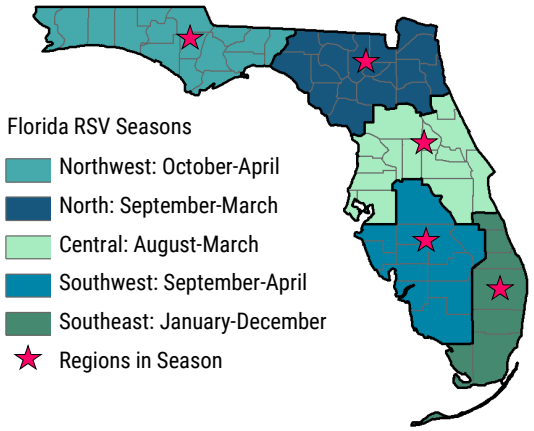
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

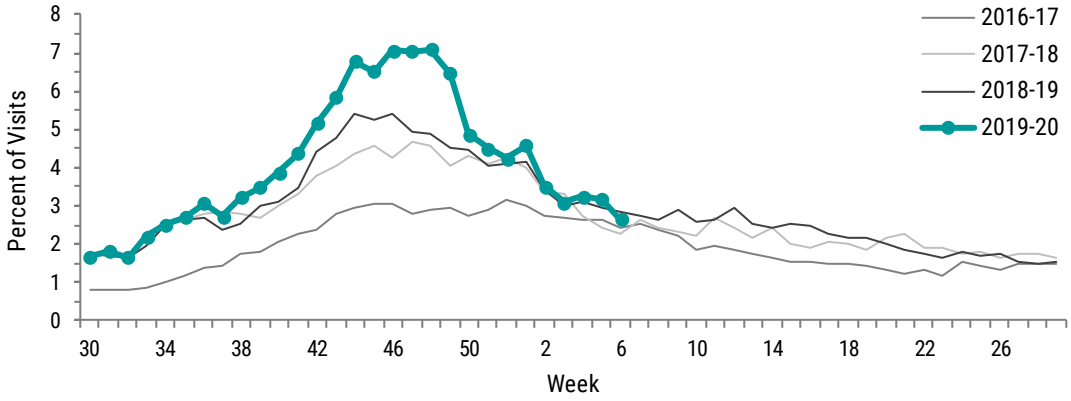
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 6 (January 26-February 1, 2020) Activity Summary

In week 6, RSV activity in children <5 years decreased and was similar to levels observed at this time in 2019.

One new RSV-associated outbreak was reported in a Pinellas County child daycare. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 6, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 6, 2020.

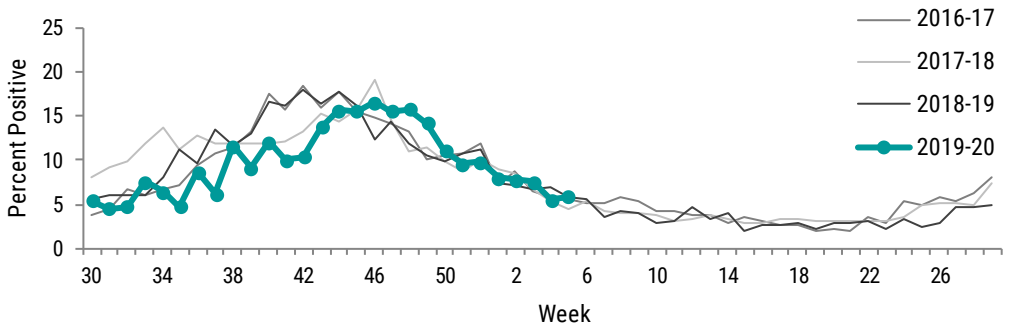
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 6, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 6, 2020. ▶



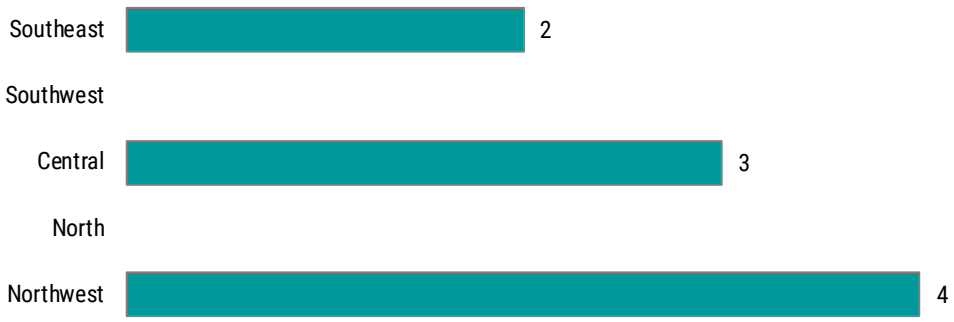
RSV-Associated Outbreaks in Week 6:

1 Outbreak

Summary of RSV-Associated Outbreaks:

In week 6, one new RSV-associated outbreaks was reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

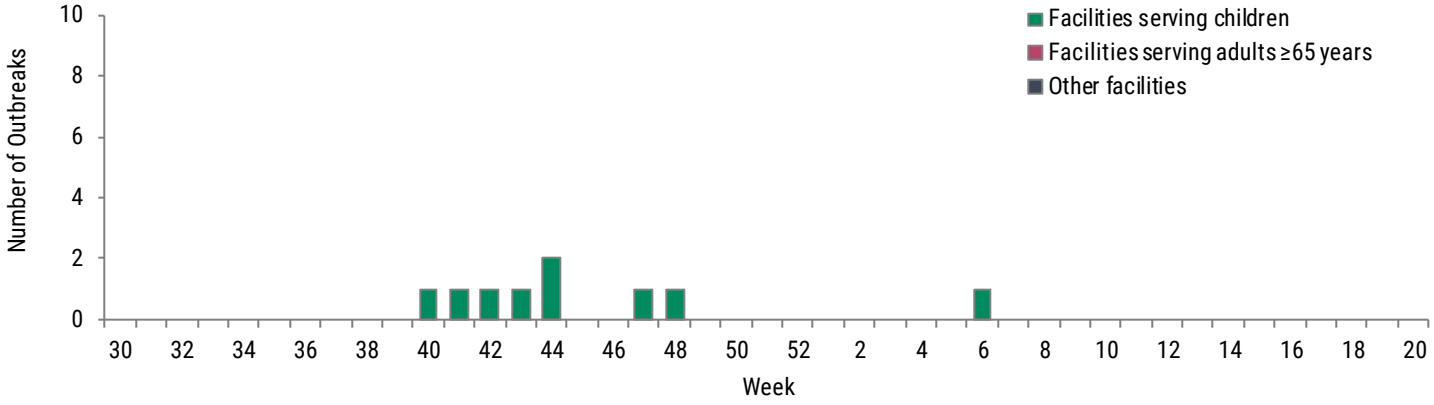
Figure 32: In week 6, **one new RSV-associated outbreak** was reported in Florida's central region. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

*Regions defined in figure 29.

Figure 33: In week 6, one new RSV-associated outbreaks was reported in a **facility serving children.** All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 6, 2020.

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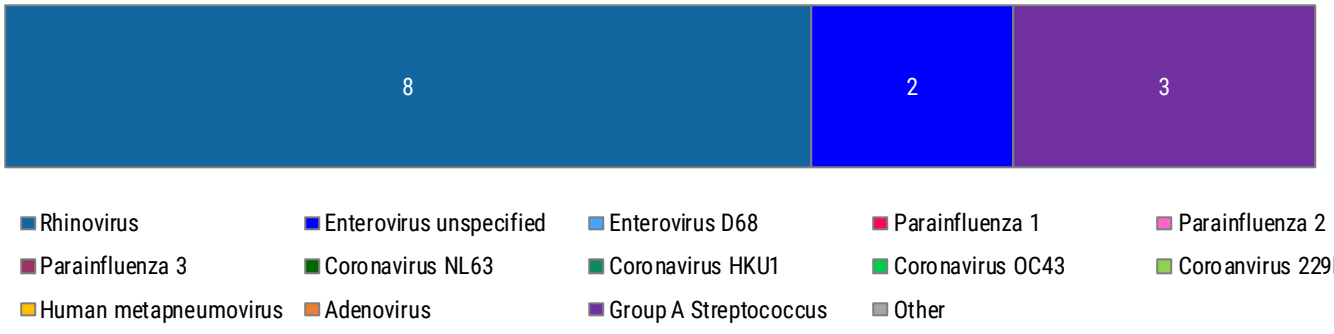
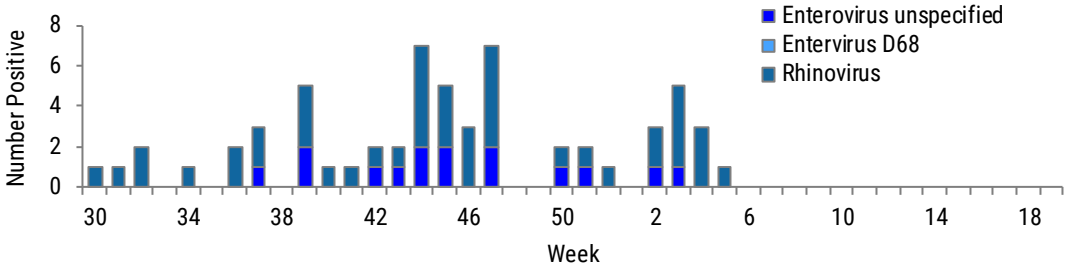
Other Respiratory Virus Surveillance

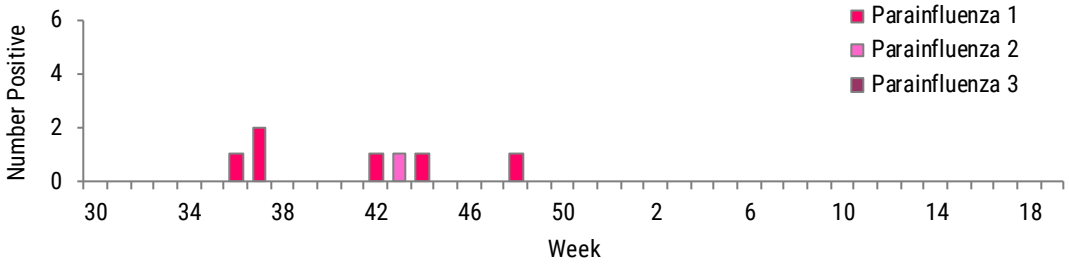


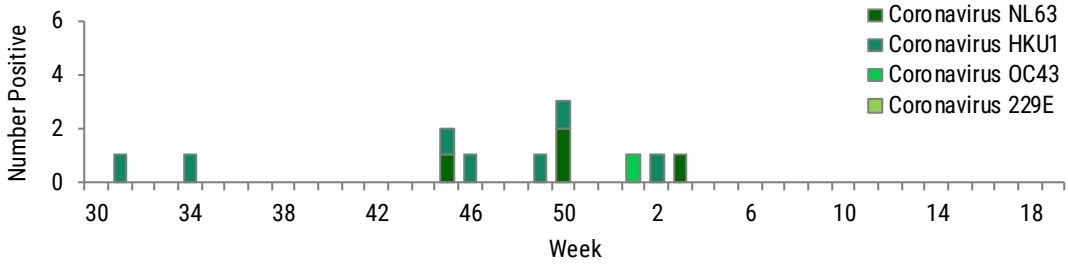
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 6, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

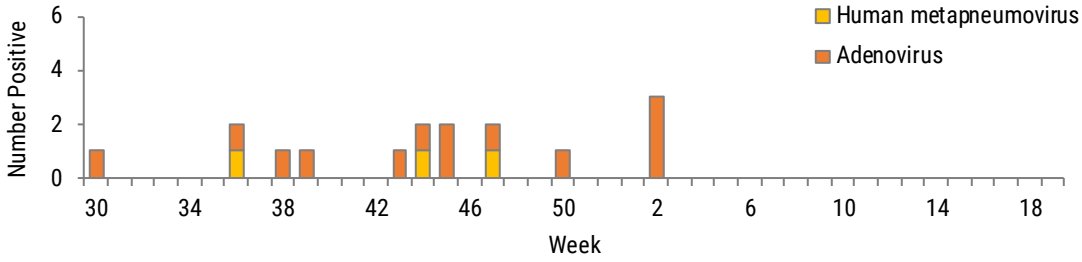
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 6, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Primary or secondary school	Pinellas	107	Unknown	Unknown	Unknown	Unknown	Open
Correctional facility	Walton	60	0	0	Influenza A unspecified	Yes	Open
Correctional facility	Martin	55	0	0	Influenza A 2009 (H1N1)	Yes	Open
Primary or secondary school	Lee	36	0	0	Unknown	Unknown	Open
Correctional facility	Liberty	31	Unknown	0	Influenza A 2009 (H1N1)	Yes	Open
Nursing facility	Monroe	5	2	Unknown	Influenza A unspecified and influenza B unspecified	Unknown	Open
Assisted living facility	Nassau	5	2	Unknown	Unknown	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=368) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

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From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 7, 2020 Florida Flu Review
Date:	Wednesday, February 19, 2020 2:53:17 PM
Attachments:	Week 7, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 7, 2020 Florida Flu Review.

Week 7 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 7 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-four outbreaks were reported, down from 29 outbreaks in the previous week. Of the 24 outbreaks reported, 12 were influenza-associated and 12 were ILI.

Two new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of

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fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 7: 2/9/20-2/15/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 7 influenza & influenza-like illness (ILI) activity summary:

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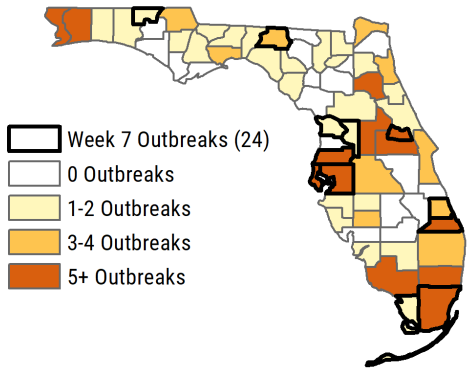
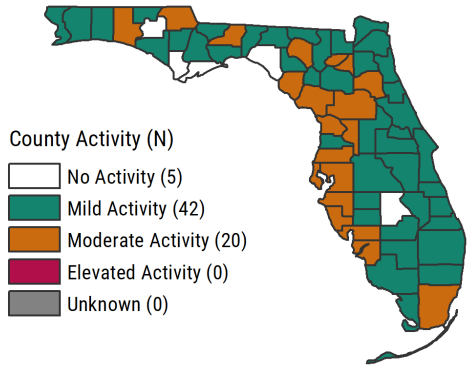
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

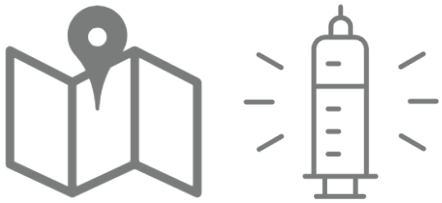
Reported as of 2/15/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 19, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.

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FL-DOH-20-0673-A-007076

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

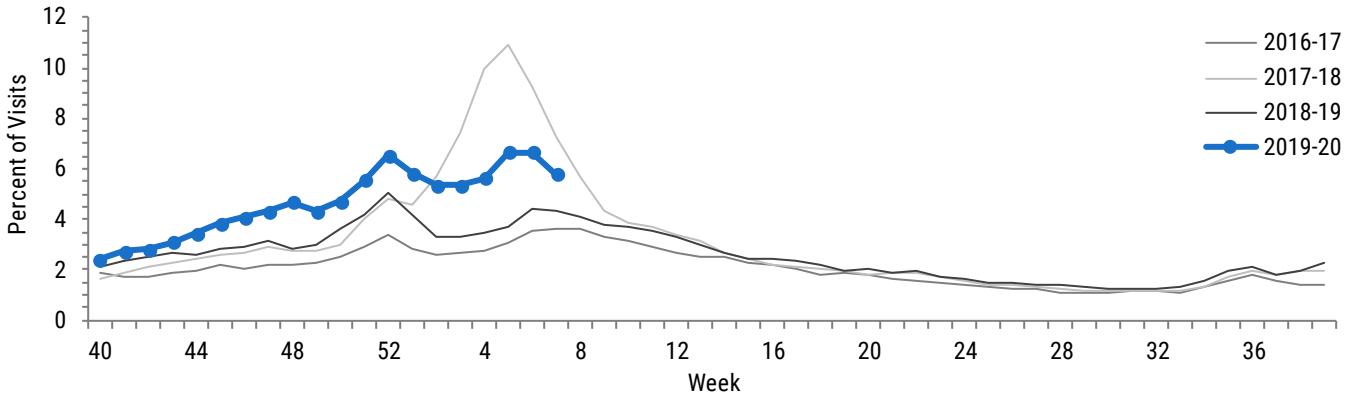
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 7, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 7, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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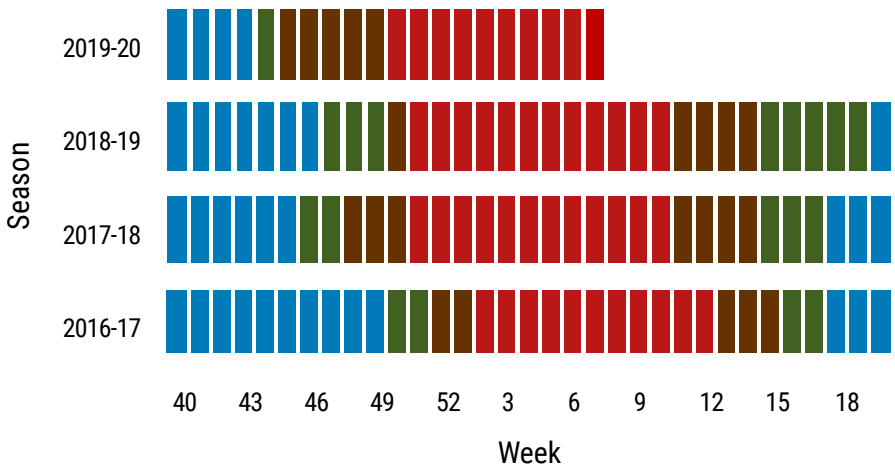
Statewide Activity

Figure 2: In week 7, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 7, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 7, **the percent of patients with ILI reported by ILINet providers statewide increased** and was similar to levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 7, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

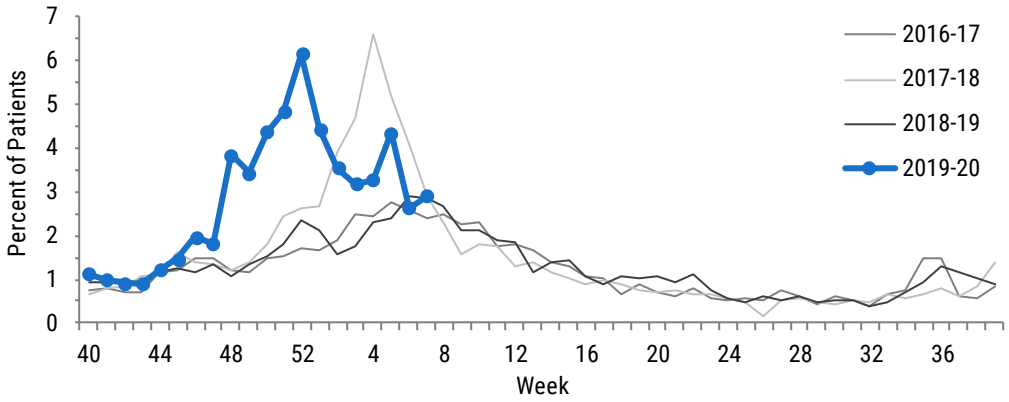
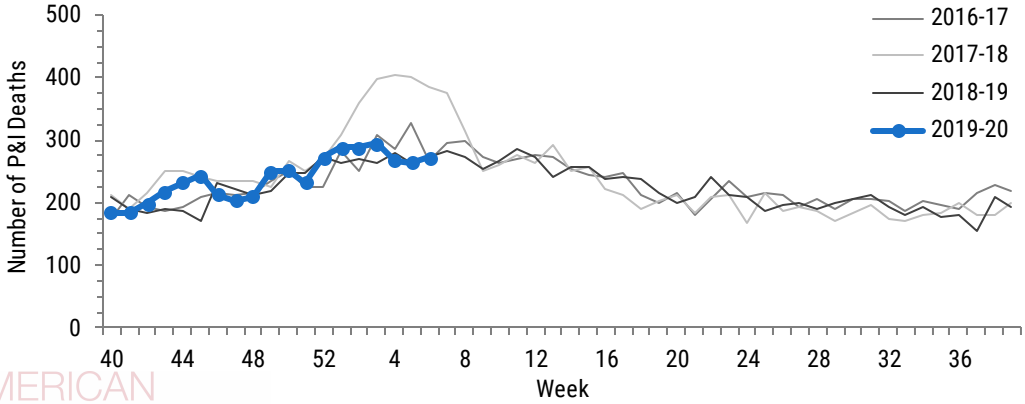


Figure 4: In week 6 (ending 2/8/20), **the number of pneumonia and influenza deaths identified statewide increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 7. Twenty counties reported **moderate activity.**

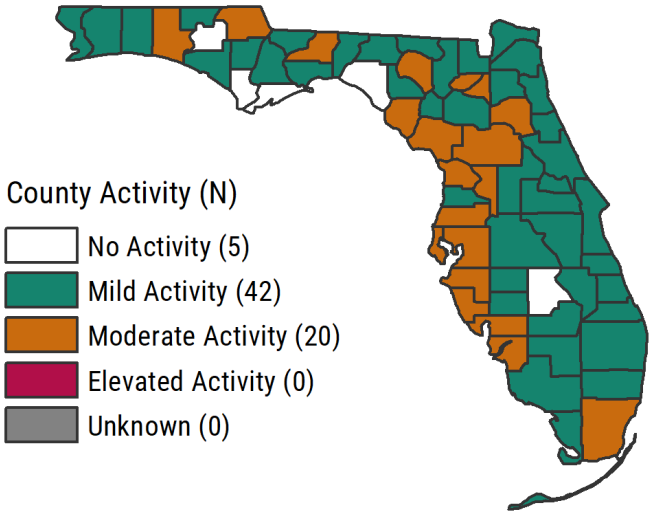
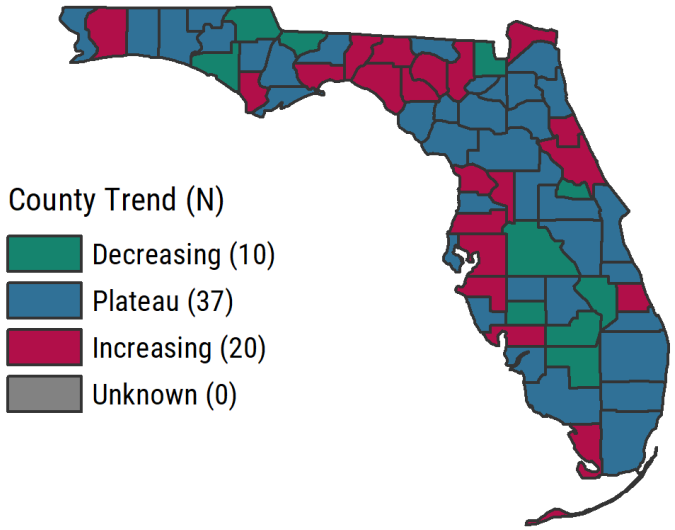
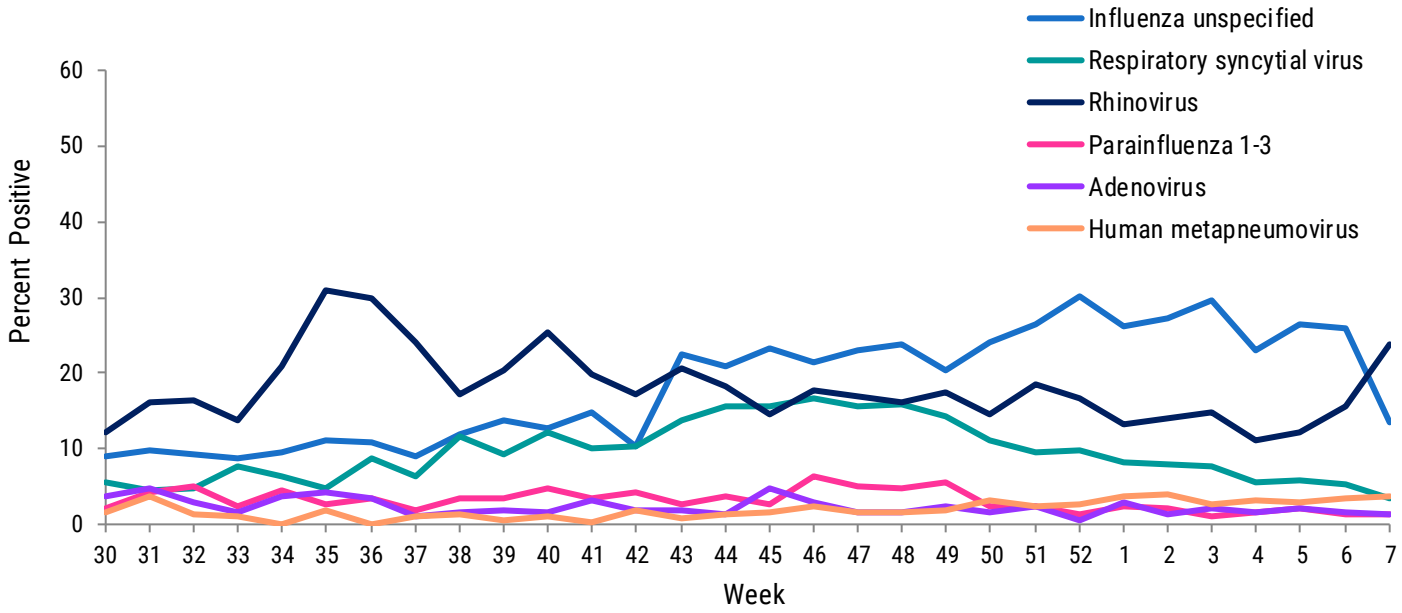


Figure 7: Most counties reported **activity at a plateau** for week 7. Twenty counties reported **increasing activity,** and ten counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 7, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance. Of note, the volume of laboratory tests reported in week 7 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 7 Outbreaks at a Glance:

Number Reported:
24 Outbreaks

Influenza-Associated:
12 Outbreaks

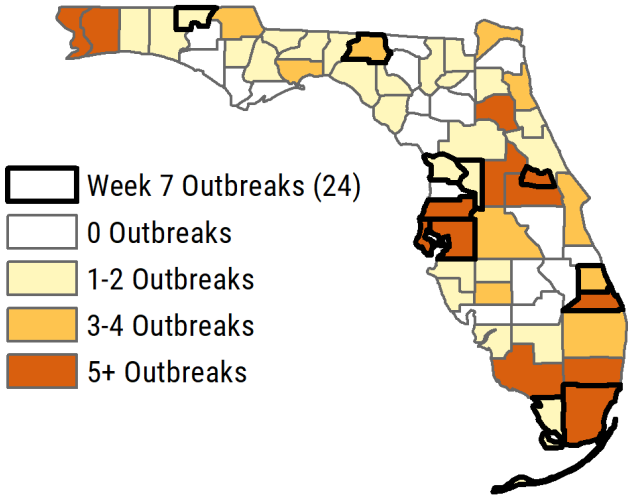
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 7, 12 influenza-associated and 12 ILI outbreaks were reported, a decrease from the previous week.

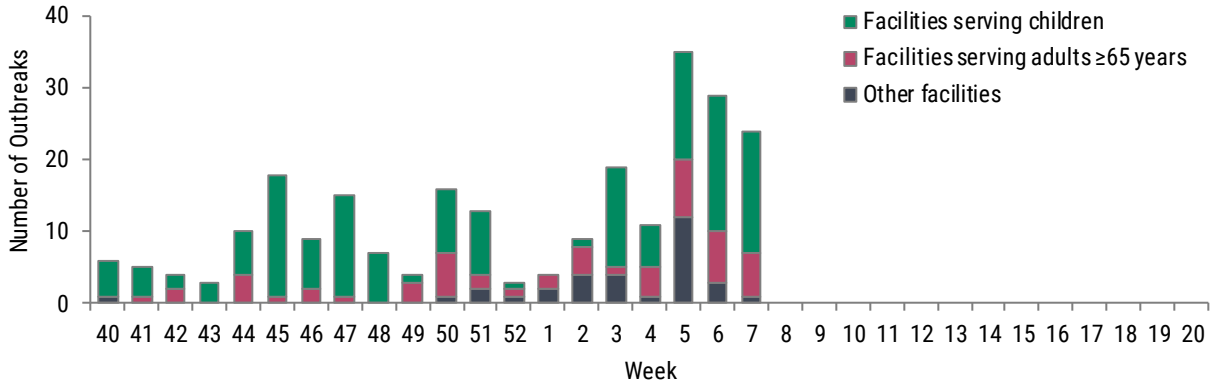
Severe outcomes* were reported in two of 24 outbreaks. One or more hospitalizations were reported in each of these two outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 7, both outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



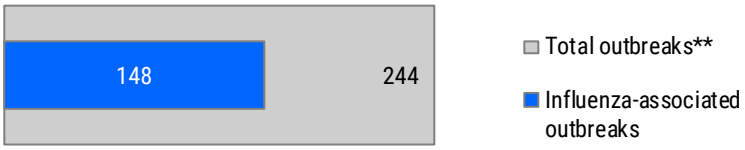
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 7 are **outlined in bold.**

Figure 9: In week 7, **six outbreaks** were reported in **facilities serving adults aged ≥65 years, 17 outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 7, **60.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 7, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

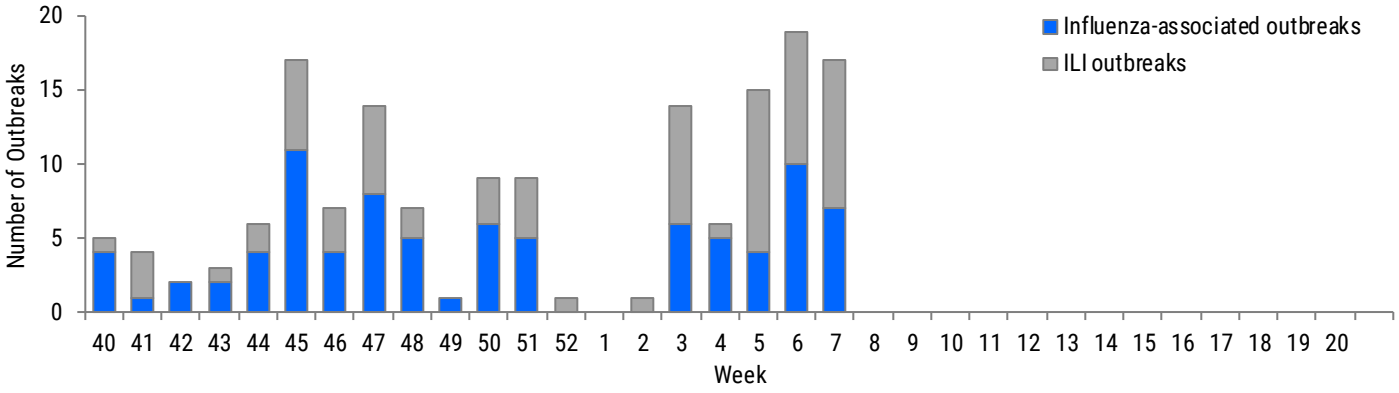
17 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 7, 17 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 7, **seven influenza-associated outbreaks** and **10 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

Facilities Serving Adults ≥65 yrs.**:

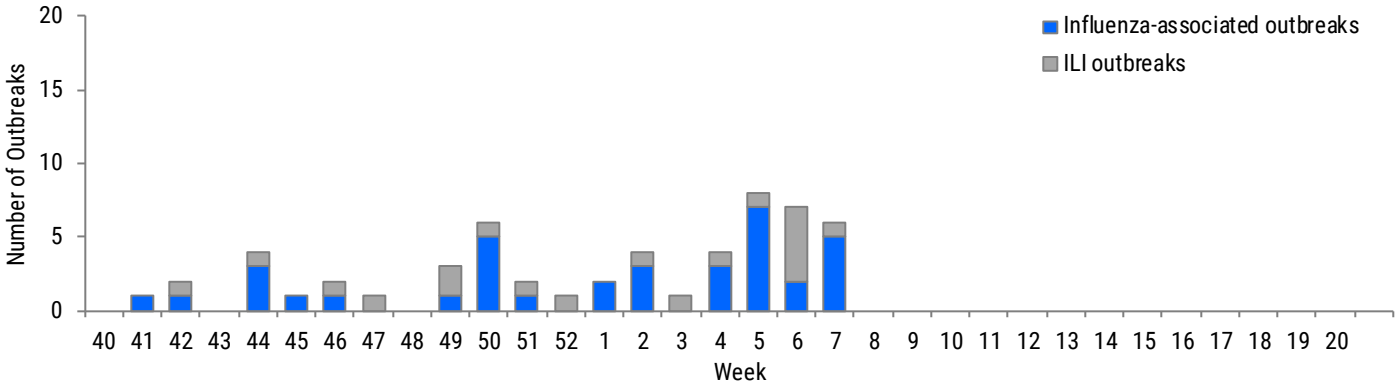
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 7, six new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 7, **five influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

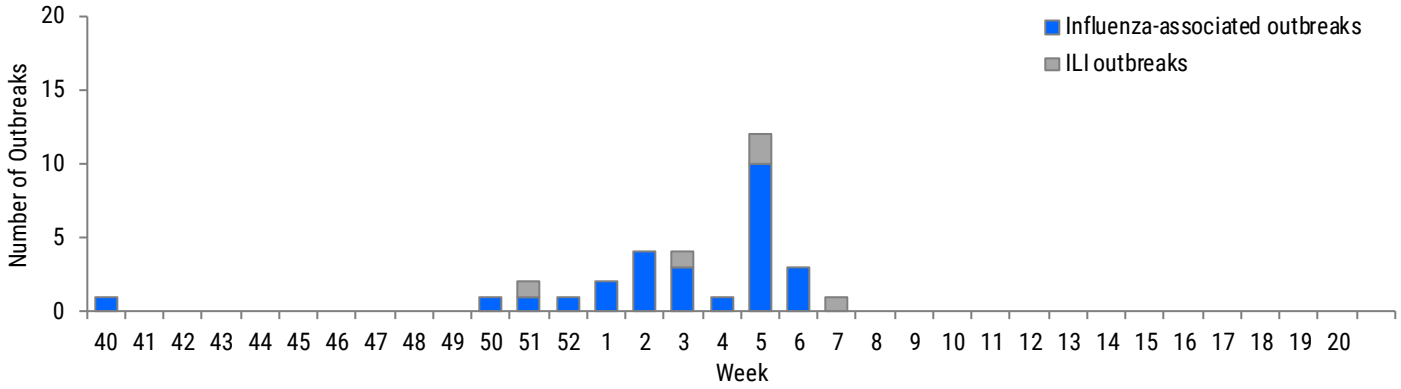
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 7, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 7, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

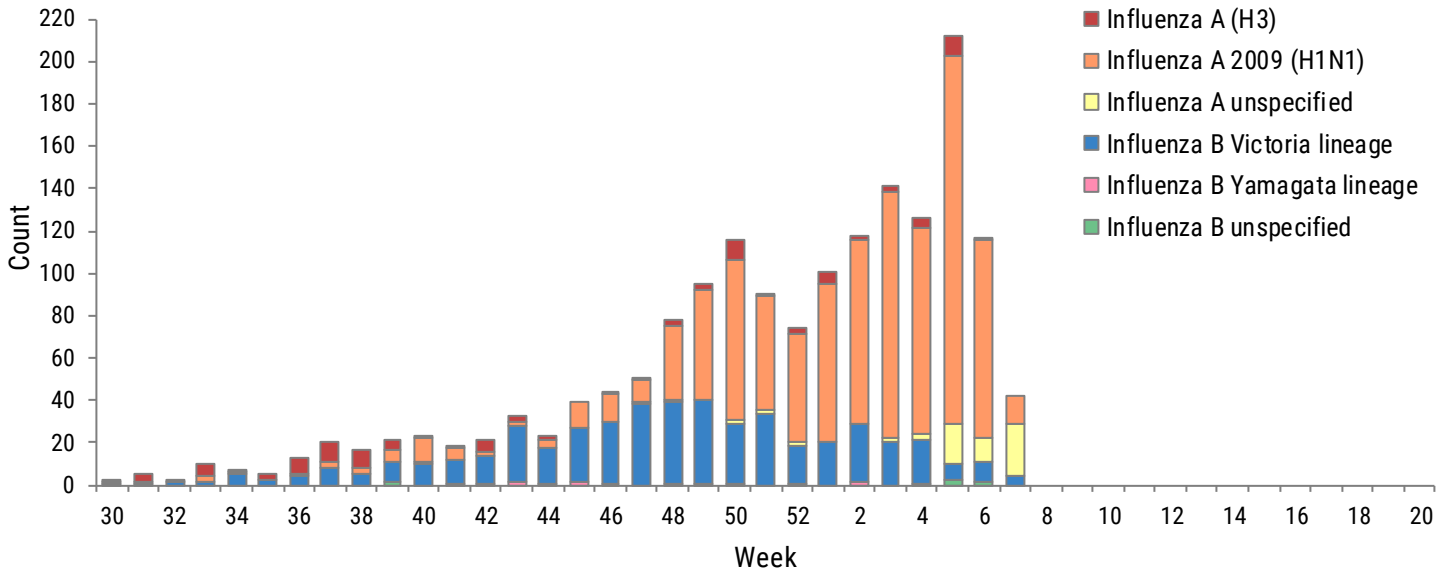
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	122 (50.0%)	71 influenza-associated outbreaks 51 ILI outbreaks
Child daycares	35 (14.3%)	14 influenza-associated outbreaks 21 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	16 (6.6%)	5 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	13 (5.3%)	11 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	26 (10.7%)	20 influenza-associated outbreaks 6 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (11.1%)	24 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	3 (1.23%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**244 (100.0%)**	**148 influenza-associated outbreaks** **96 ILI outbreaks**

AMERICAN OVERSIGHT

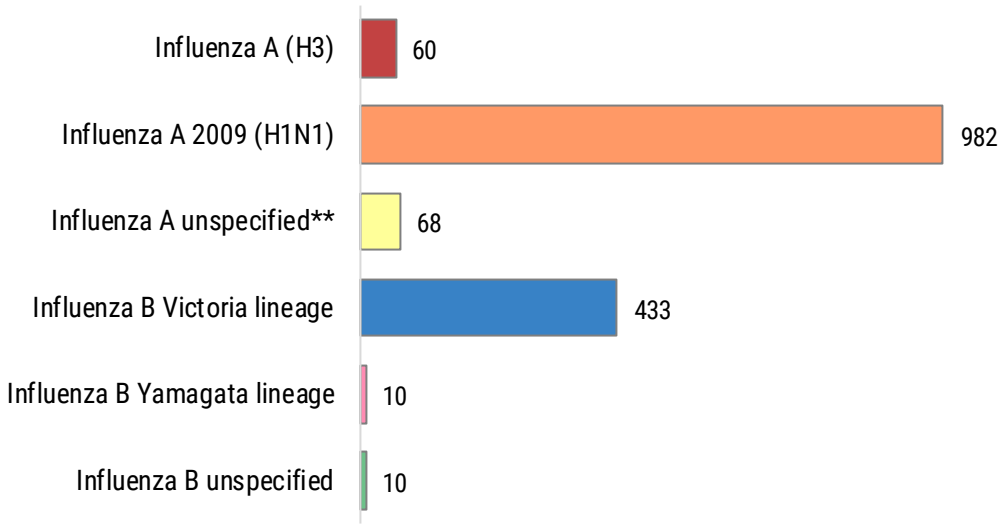
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 7, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 7, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 7, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 7 and was within levels observed at this time in previous seasons.

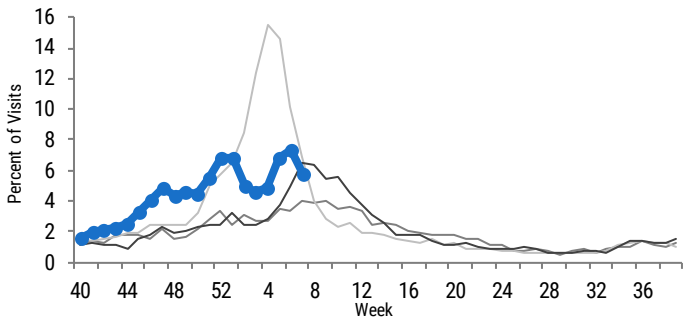


Figure 17: In **region 2, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

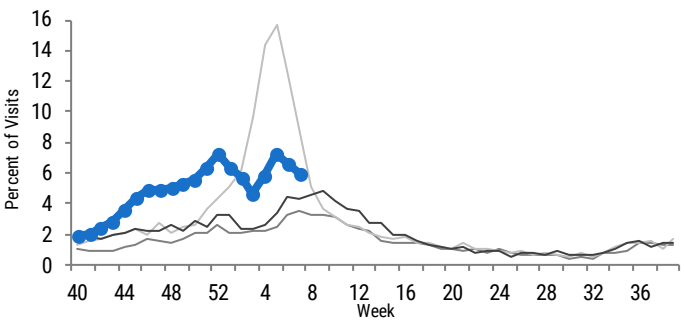


Figure 18: In **region 3, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

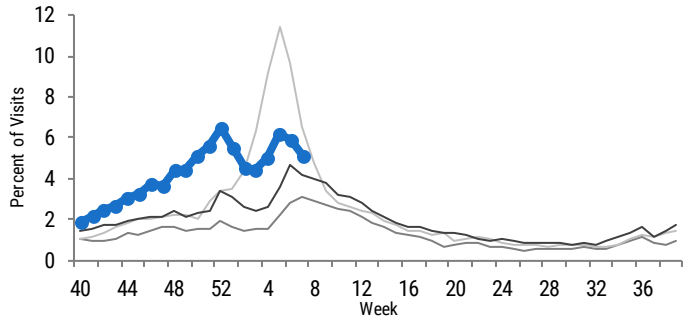


Figure 19: In **region 4, ILI activity decreased** during week 7 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

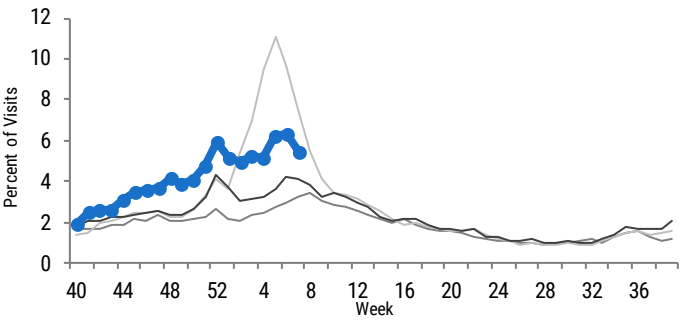


Figure 20: In **region 5, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

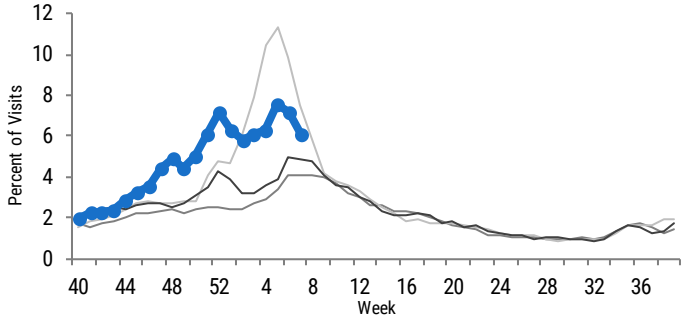


Figure 21: In **region 6, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

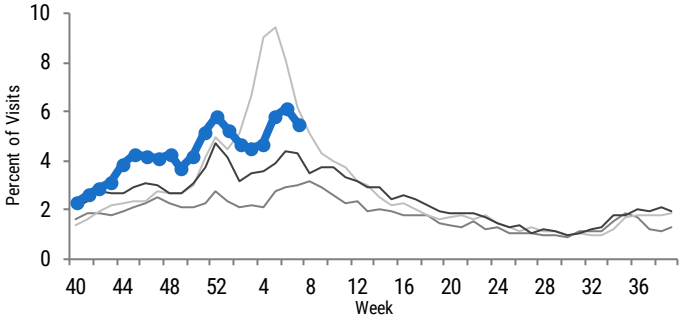
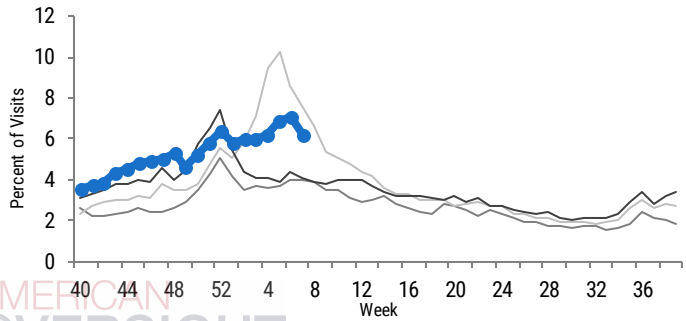


Figure 22: In **region 7, ILI activity decreased** during week 7 and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



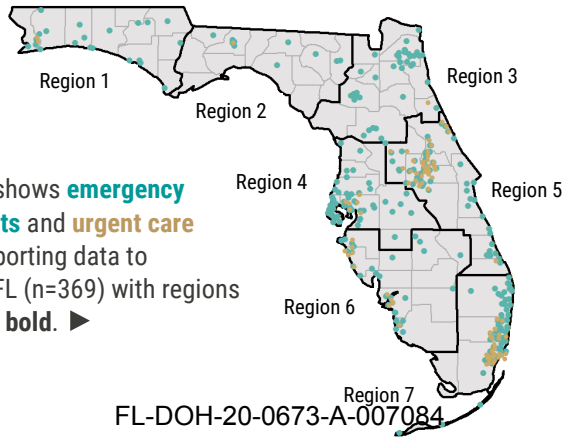


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

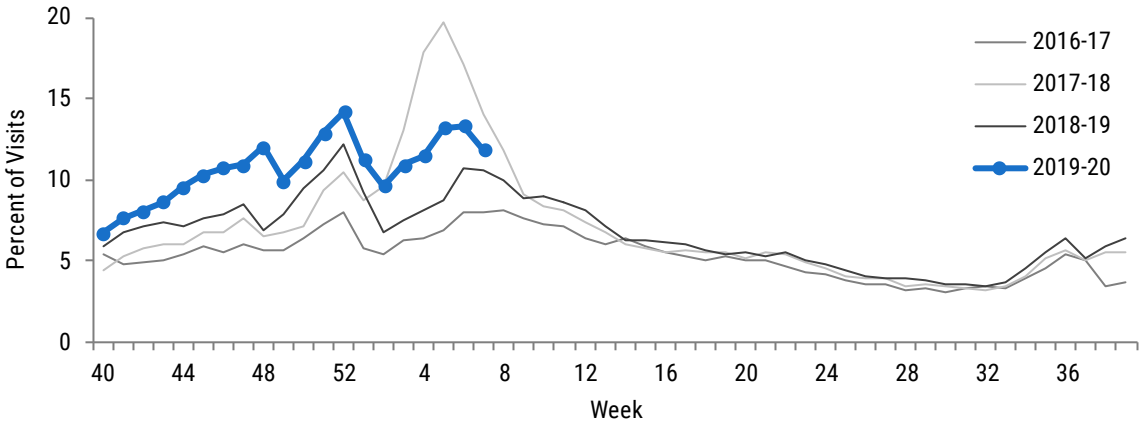
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

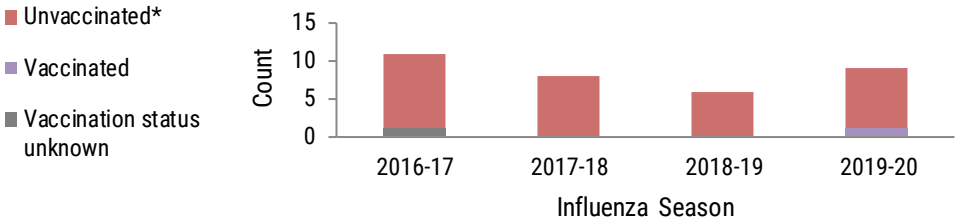
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 7, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

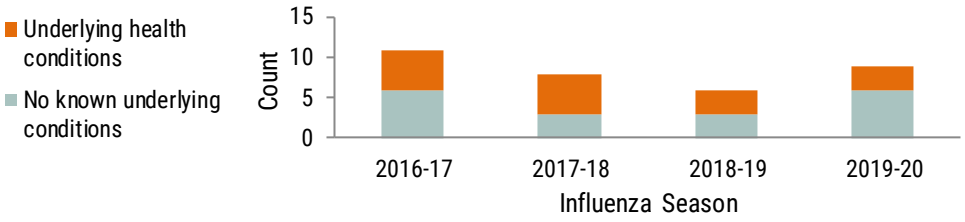


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

Figures 25-26: In week 7, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was vaccinated for the 2019-20 season. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 7, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 7, 2020.

In week 7, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with known underlying medical conditions. One child was vaccinated for the 2019-20 season.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

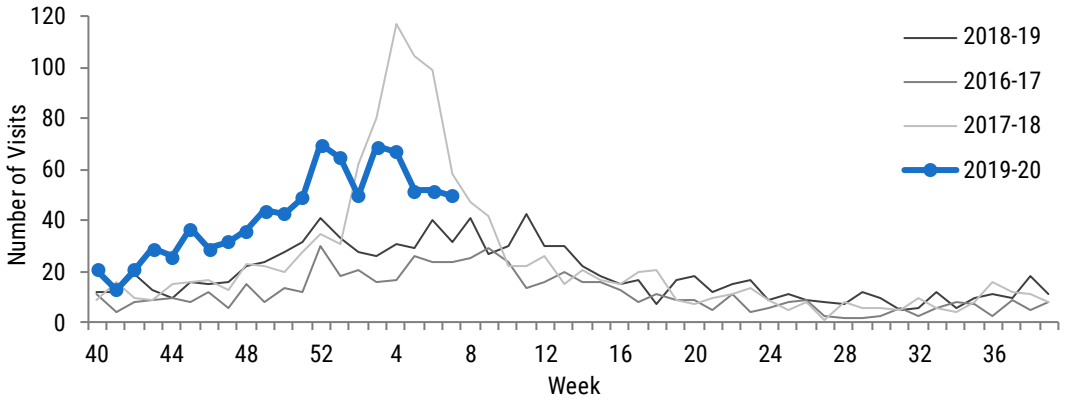
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 7, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



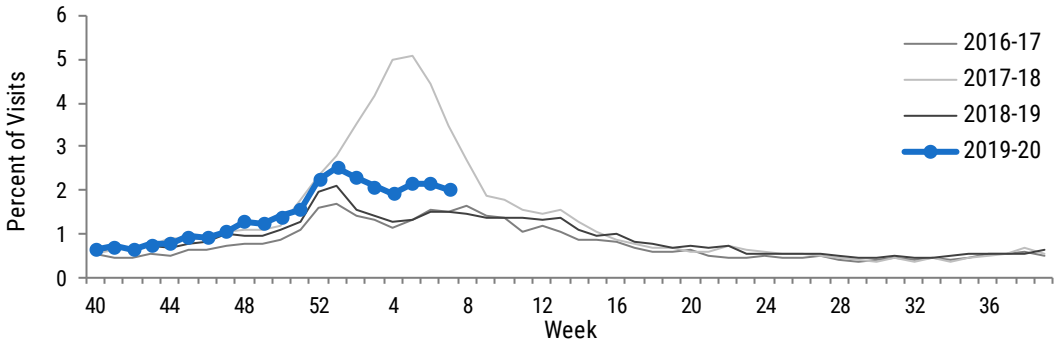
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 7, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 7, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



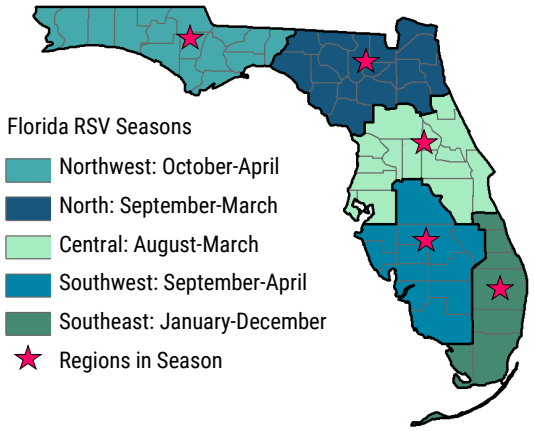
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

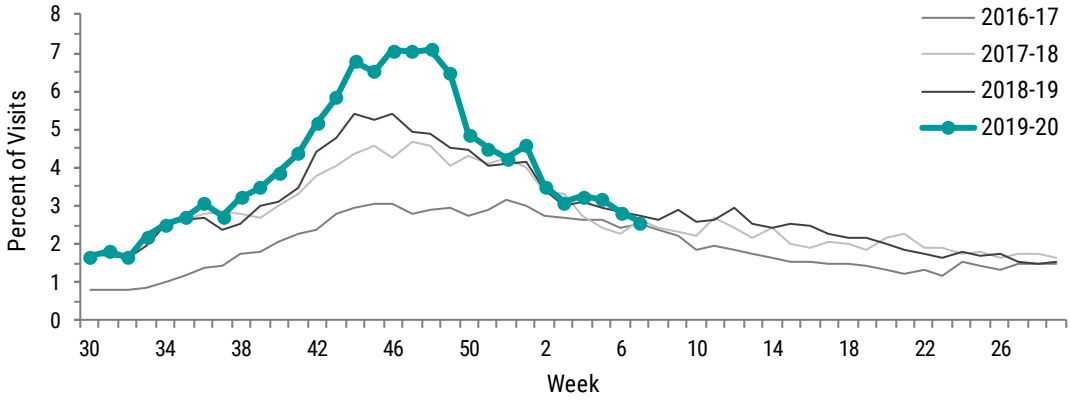
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 7 (February 9-15, 2020) Activity Summary

In week 7, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 7. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 7, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 7, 2020.

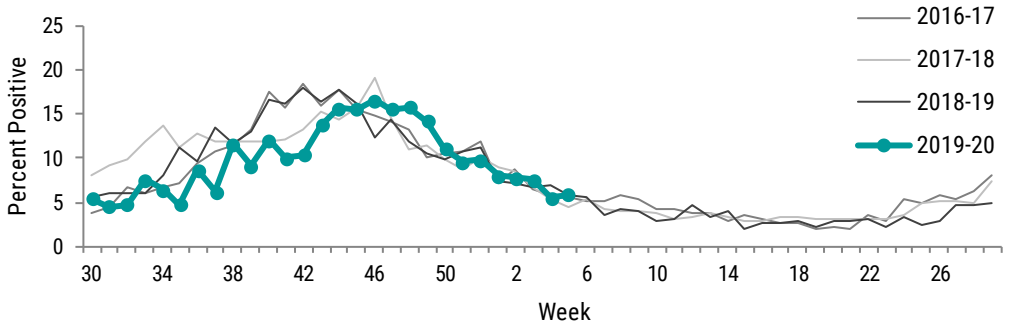
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 7, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 7, 2020. ▶



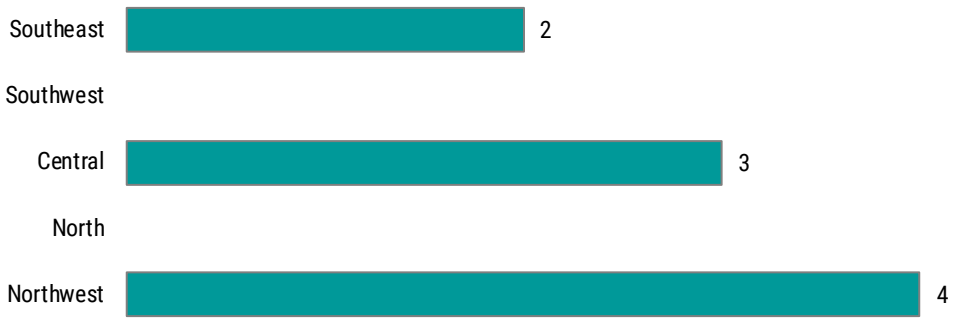
RSV-Associated Outbreaks in Week 7:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 7, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

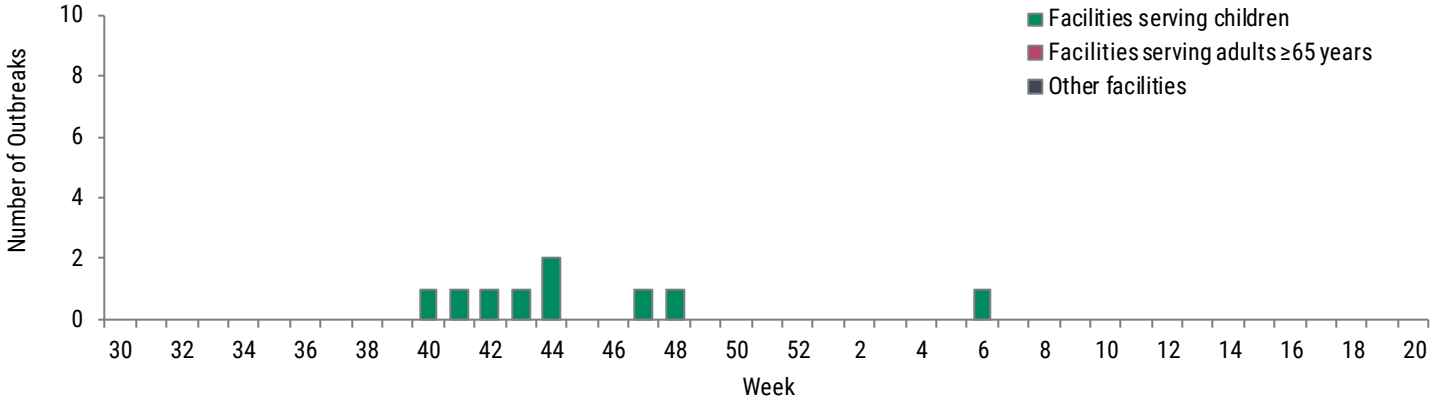
Figure 32: In week 7, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

*Regions defined in figure 29.

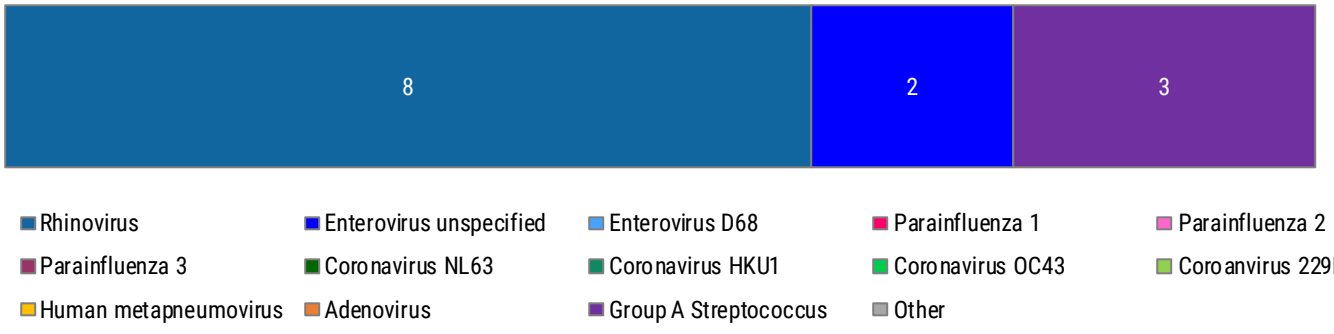
Figure 33: In week 7, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



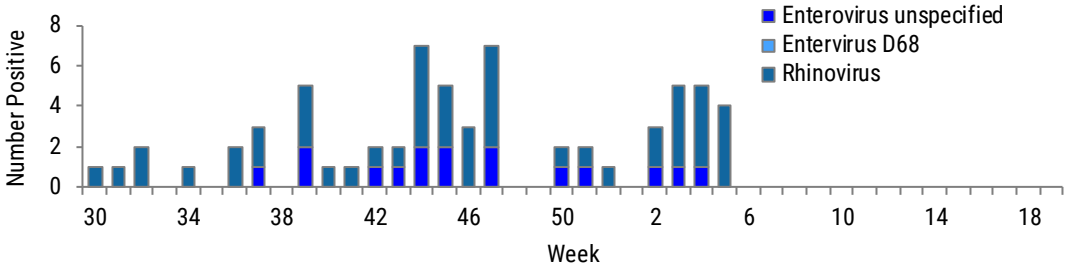
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

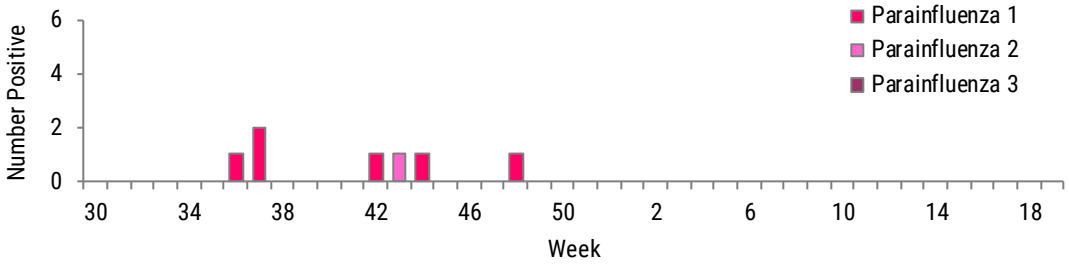


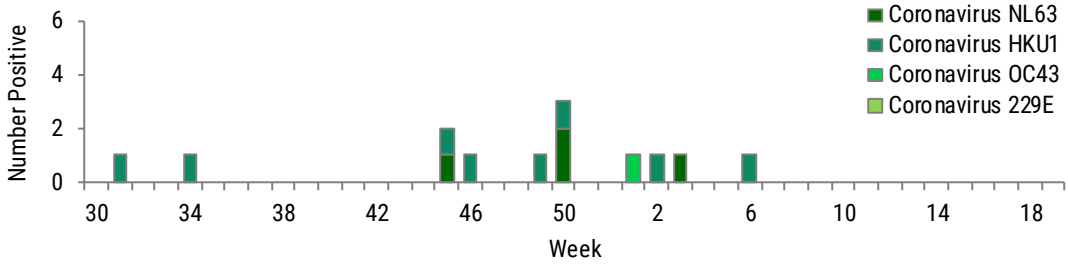
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 7, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

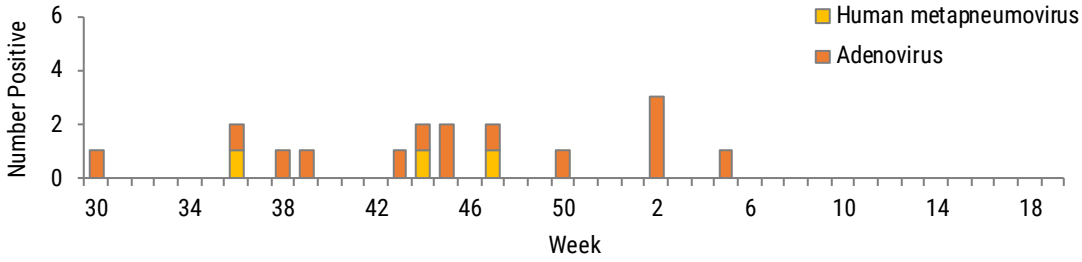
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 7, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Citrus	31	0	0	Influenza A unspecified	Yes	Closed
Long-term care facility	Madison	5	3	0	Influenza A 2009 (H1N1)	Yes	Open
Long-term care facility	Monroe	4	2	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

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From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 7, 2020 Florida Flu Review
Date:	Wednesday, February 19, 2020 2:53:23 PM
Attachments:	Week 7, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 7, 2020 Florida Flu Review.

Week 7 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 7 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-four outbreaks were reported, down from 29 outbreaks in the previous week. Of the 24 outbreaks reported, 12 were influenza-associated and 12 were ILI.

Two new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of

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fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 7: 2/9/20-2/15/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 7 influenza & influenza-like illness (ILI) activity summary:

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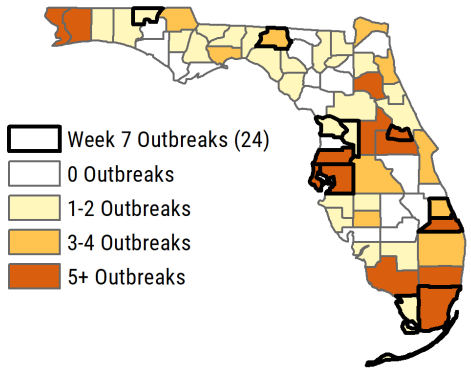
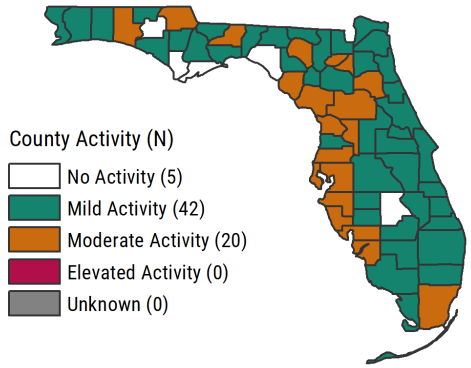
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

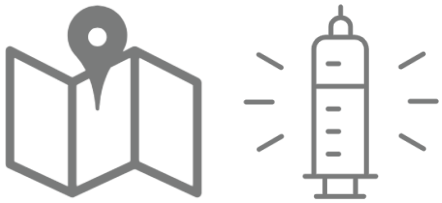
Reported as of 2/15/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 19, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007095

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

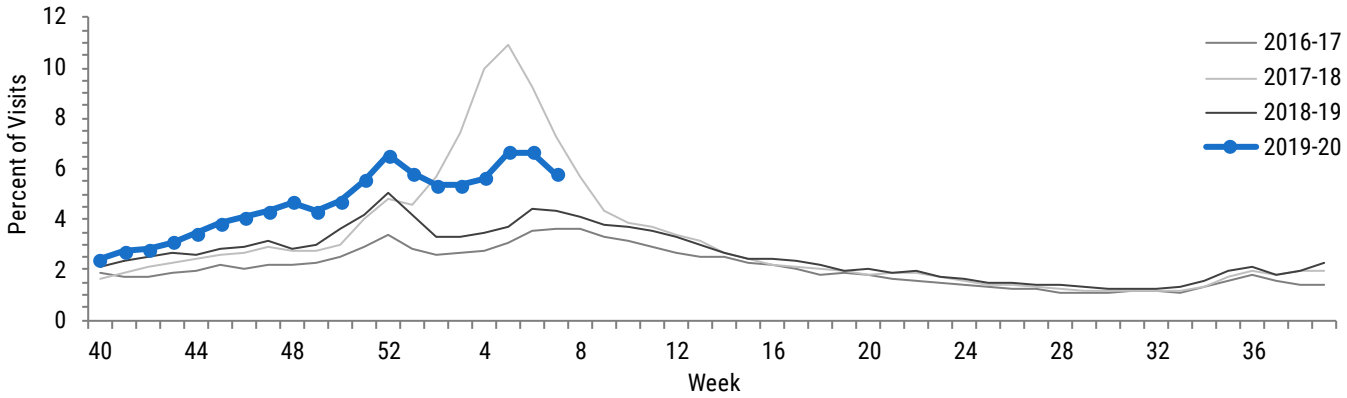
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 7, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 7, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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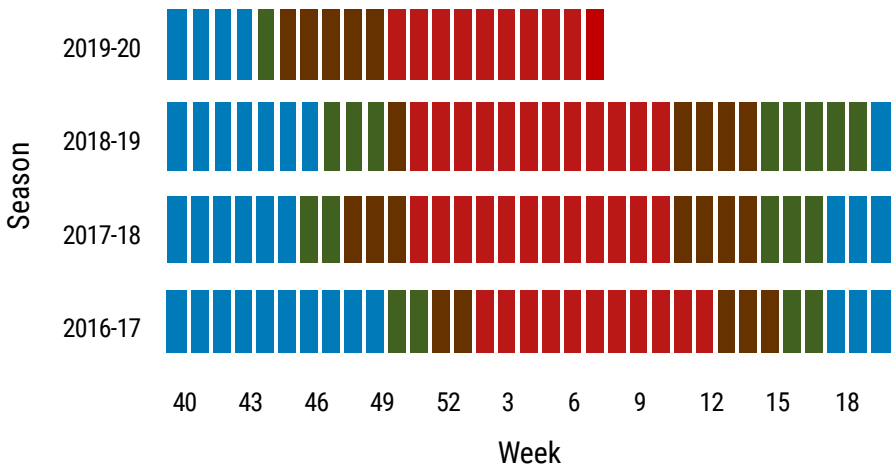
Statewide Activity

Figure 2: In week 7, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 7, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 7, **the percent of patients with ILI reported by ILINet providers statewide increased** and was similar to levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 7, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

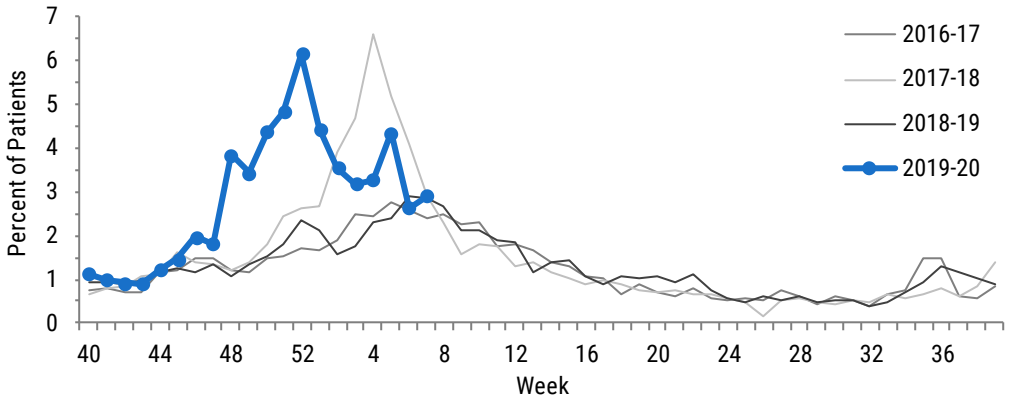
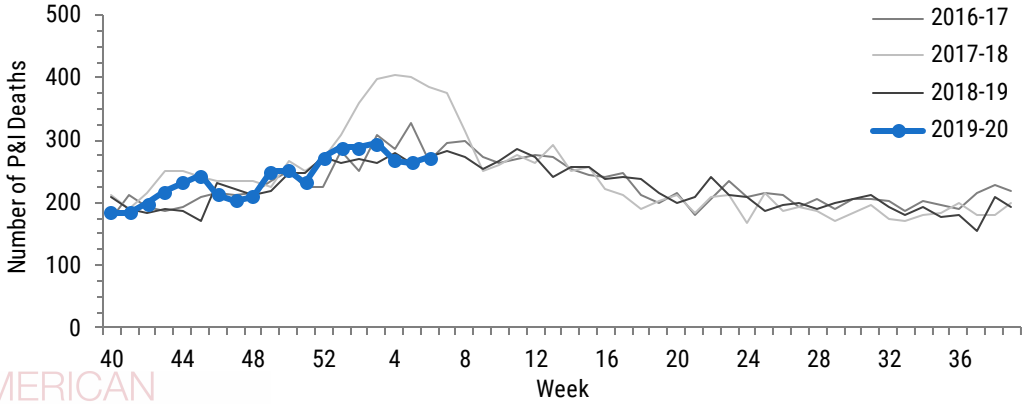


Figure 4: In week 6 (ending 2/8/20), **the number of pneumonia and influenza deaths identified statewide increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 7. Twenty counties reported **moderate activity.**

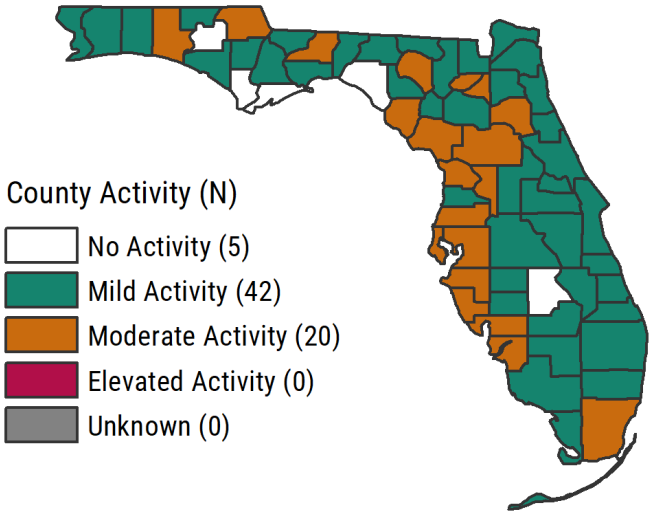
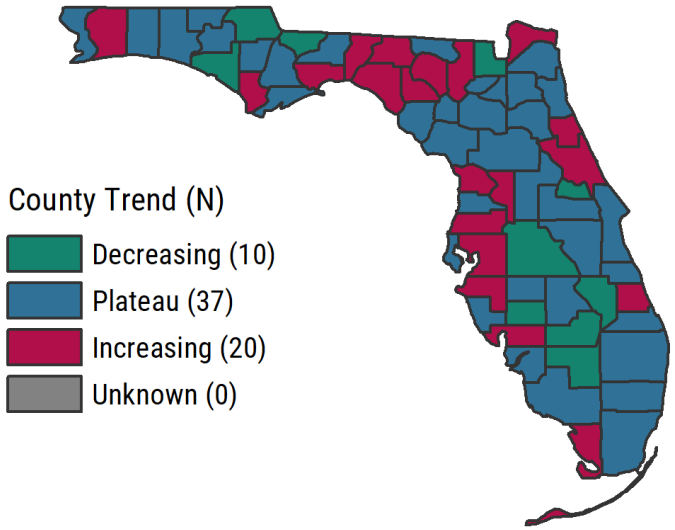
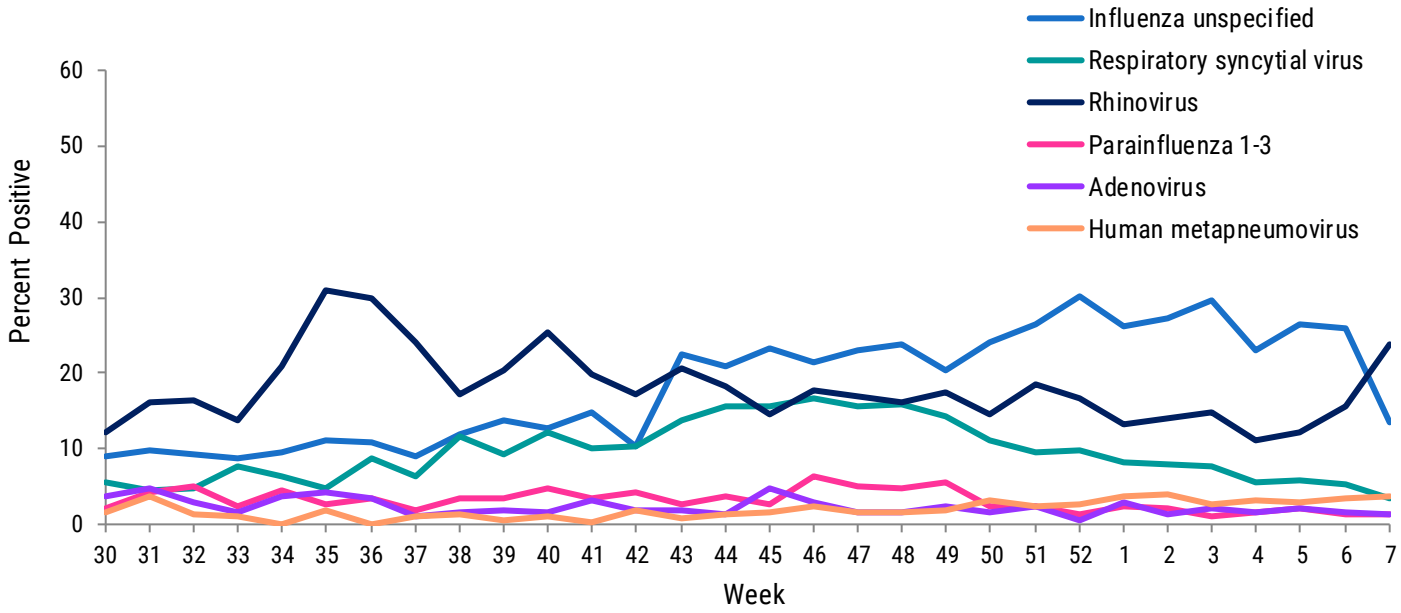


Figure 7: Most counties reported **activity at a plateau** for week 7. Twenty counties reported **increasing activity,** and ten counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 7, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance. Of note, the volume of laboratory tests reported in week 7 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 7, 2020.

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Influenza and ILI Outbreaks

Week 7 Outbreaks at a Glance:

Number Reported:
24 Outbreaks

Influenza-Associated:
12 Outbreaks

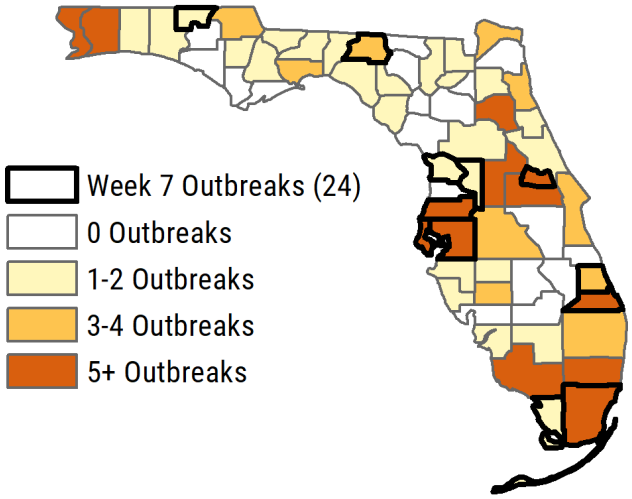
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 7, 12 influenza-associated and 12 ILI outbreaks were reported, a decrease from the previous week.

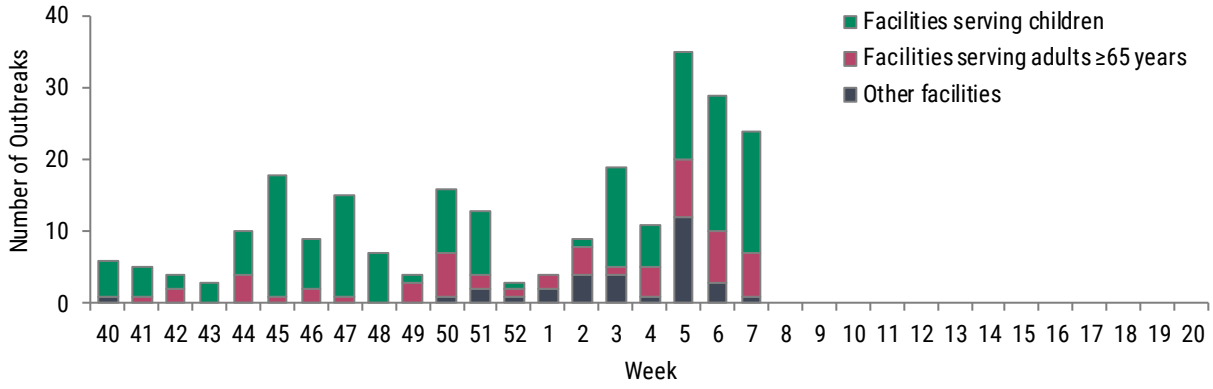
Severe outcomes* were reported in two of 24 outbreaks. One or more hospitalizations were reported in each of these two outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 7, both outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



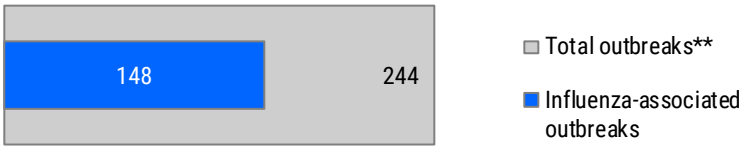
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 7 are **outlined in bold.**

Figure 9: In week 7, **six outbreaks** were reported in **facilities serving adults aged ≥65 years, 17 outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 7, **60.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 7, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

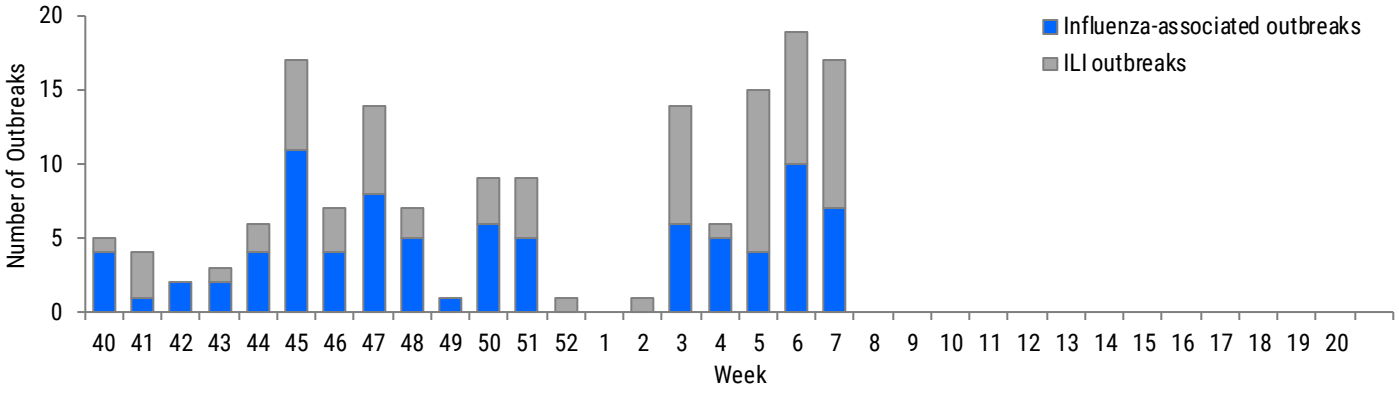
17 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 7, 17 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 7, **seven influenza-associated outbreaks** and **10 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

Facilities Serving Adults ≥65 yrs.**:

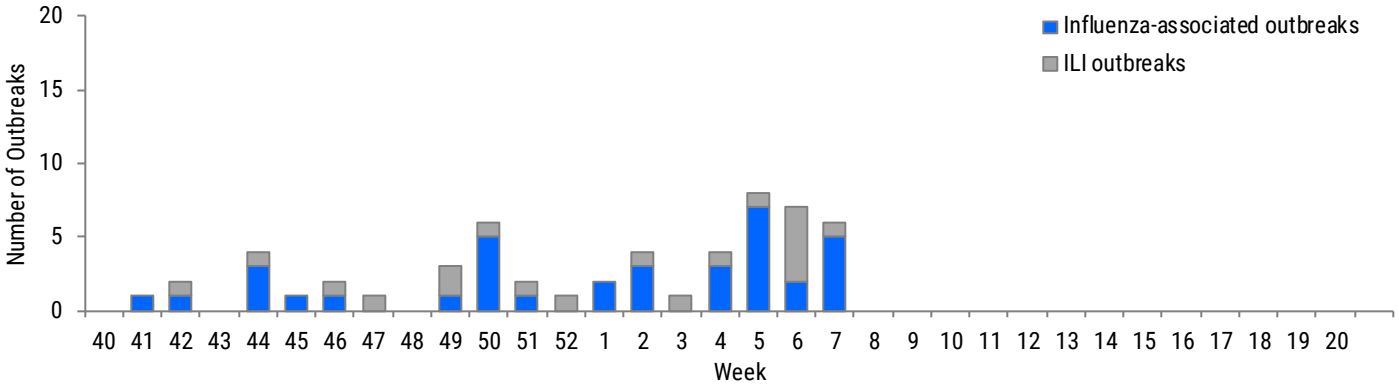
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 7, six new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 7, **five influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

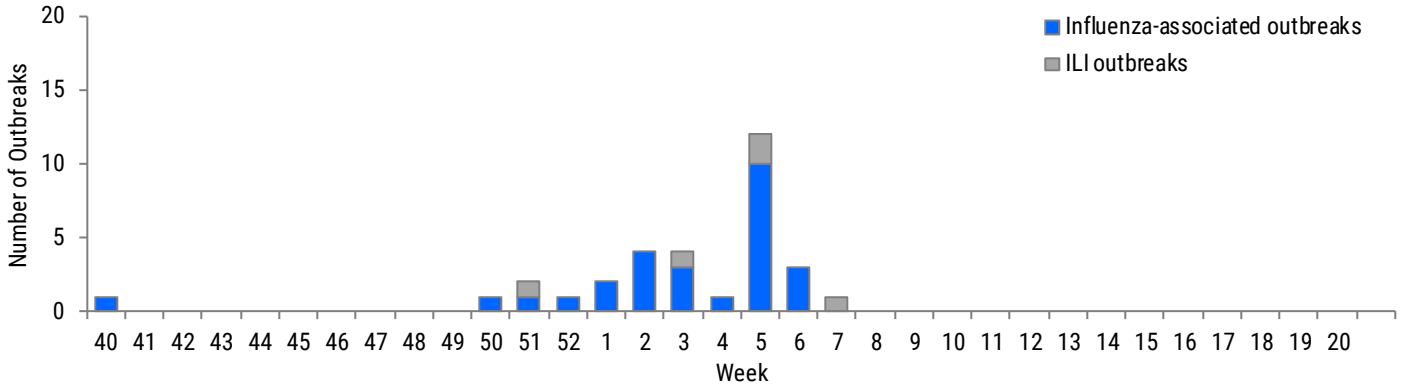
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 7, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 7, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

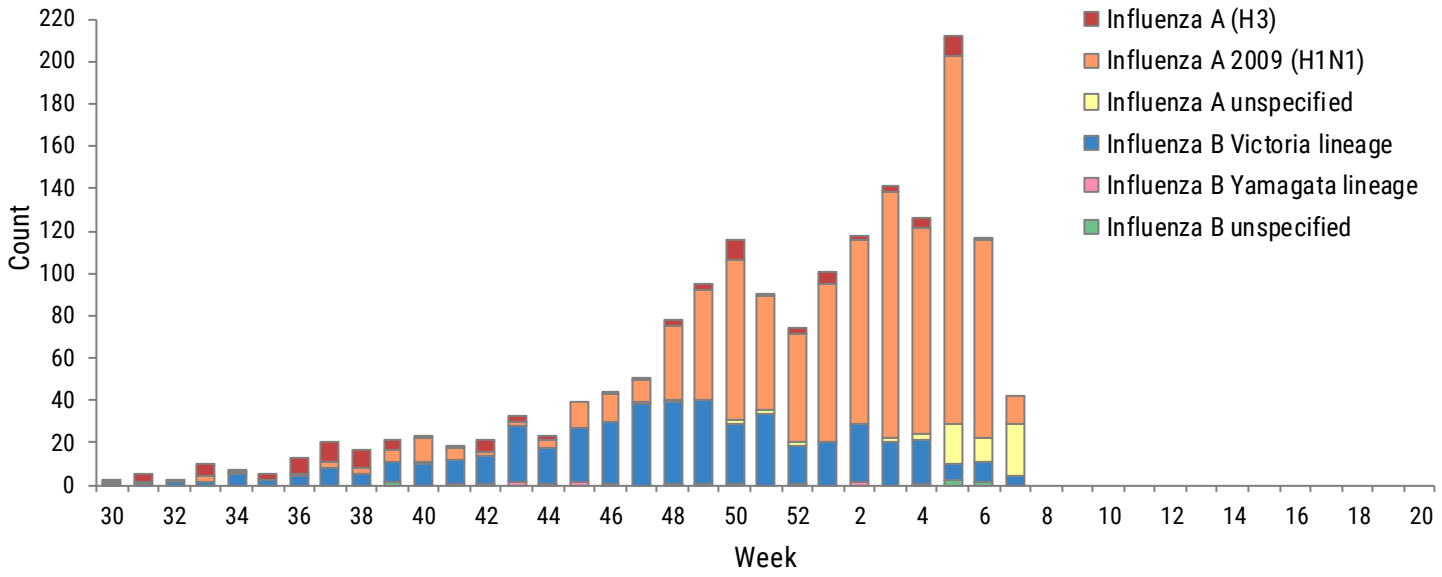
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	122 (50.0%)	71 influenza-associated outbreaks 51 ILI outbreaks
Child daycares	35 (14.3%)	14 influenza-associated outbreaks 21 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	16 (6.6%)	5 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	13 (5.3%)	11 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	26 (10.7%)	20 influenza-associated outbreaks 6 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (11.1%)	24 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	3 (1.23%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**244 (100.0%)**	**148 influenza-associated outbreaks** **96 ILI outbreaks**

AMERICAN OVERSIGHT

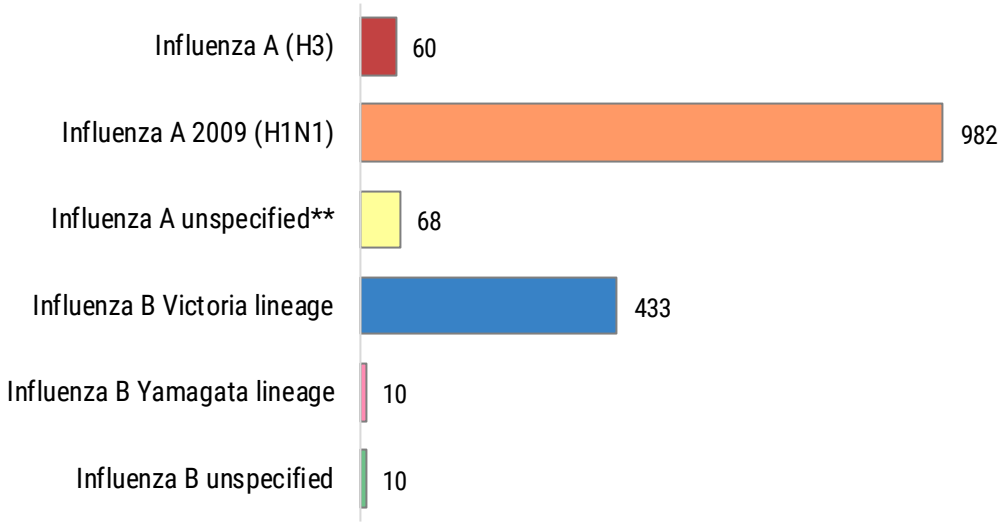
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 7, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 7, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 7, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 7 and was within levels observed at this time in previous seasons.

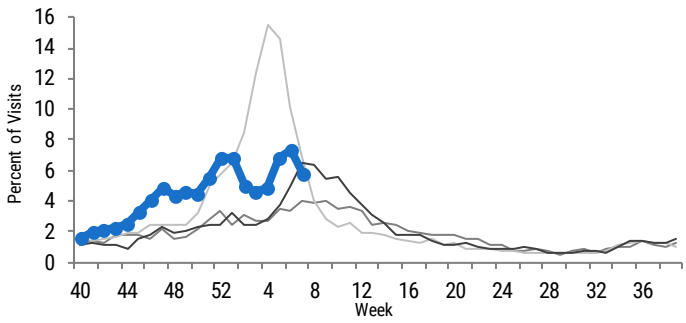


Figure 17: In **region 2, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

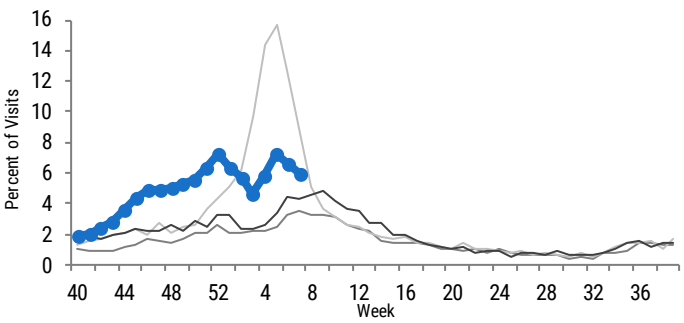


Figure 18: In **region 3, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

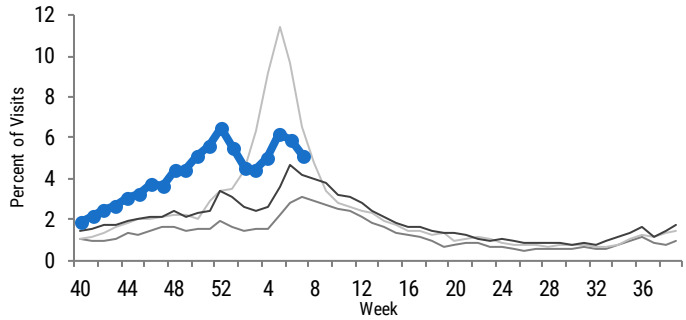


Figure 19: In **region 4, ILI activity decreased** during week 7 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

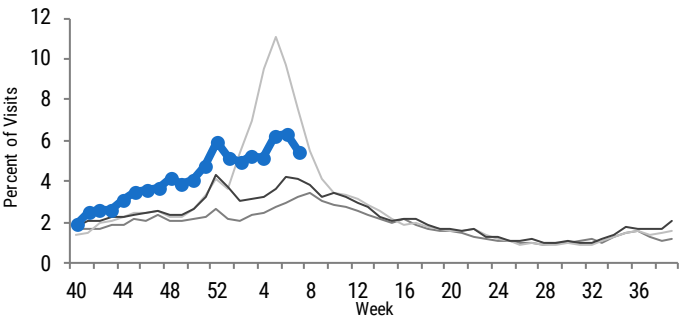


Figure 20: In **region 5, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

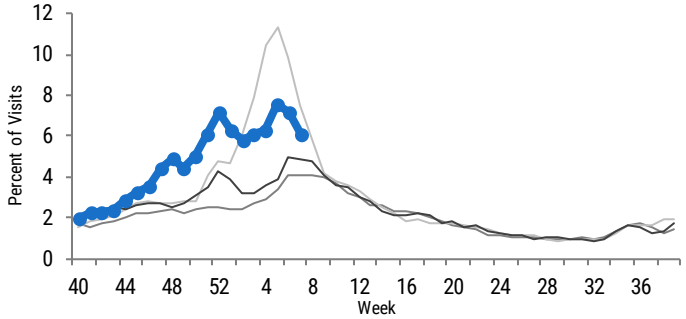


Figure 21: In **region 6, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

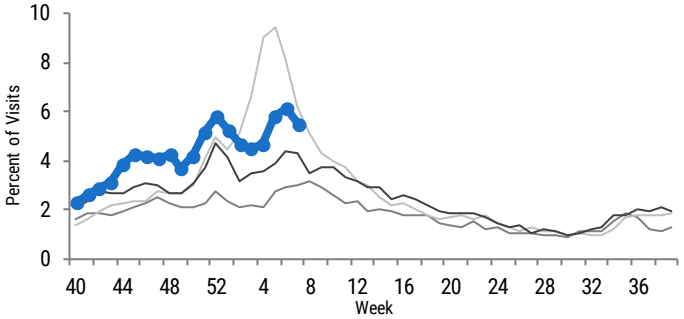
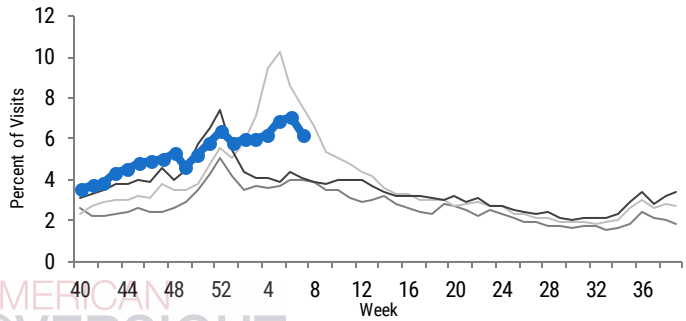


Figure 22: In **region 7, ILI activity decreased** during week 7 and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



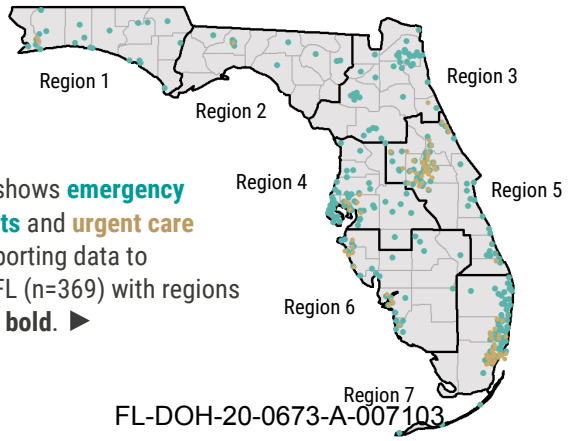


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

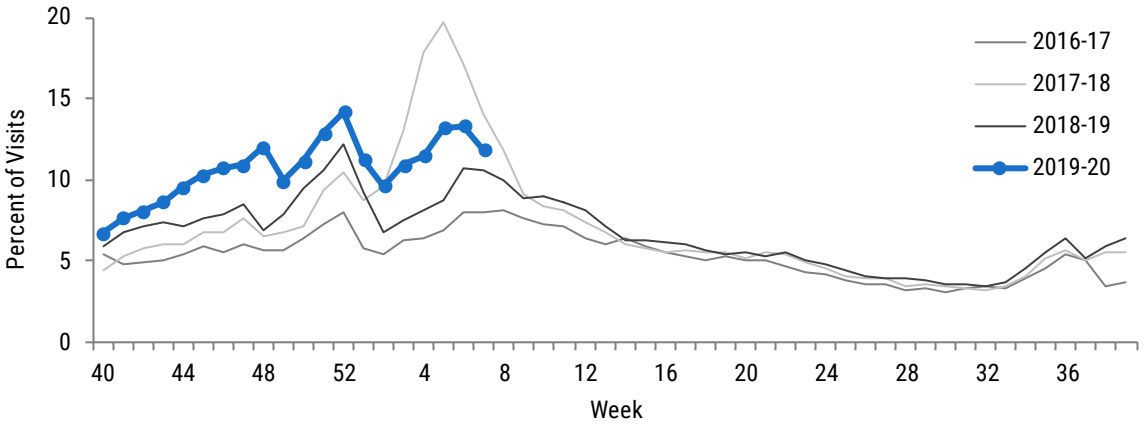
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

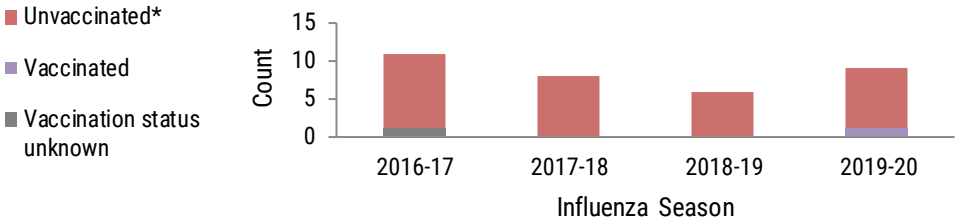
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 7, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

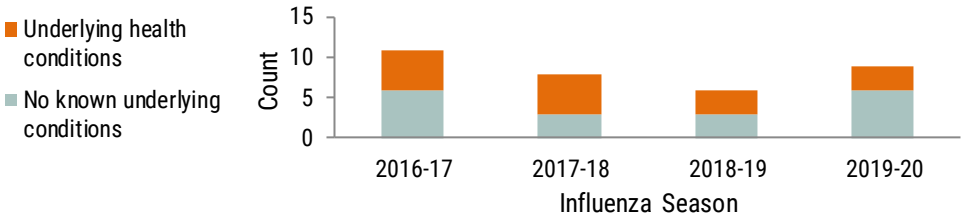


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

Figures 25-26: In week 7, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was vaccinated for the 2019-20 season. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 7, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 7, 2020.

In week 7, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with known underlying medical conditions. One child was vaccinated for the 2019-20 season.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

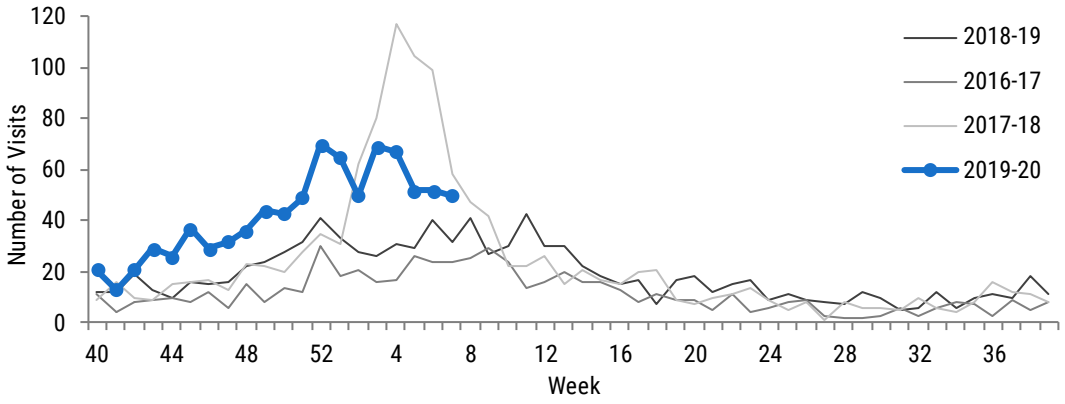
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 7, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



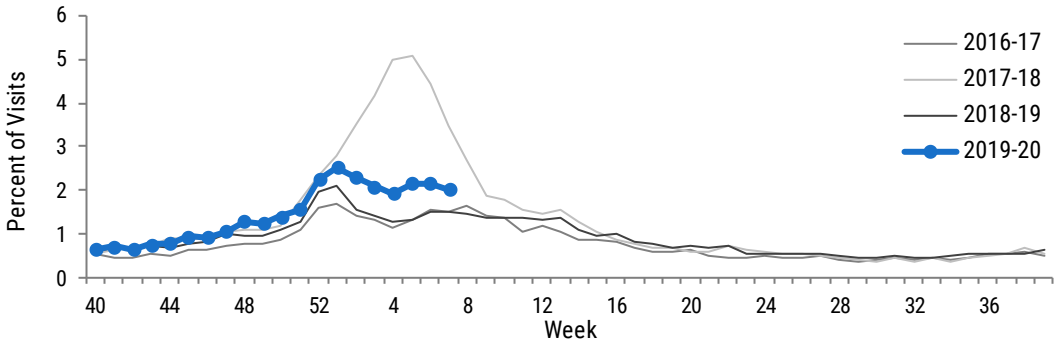
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 7, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 7, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



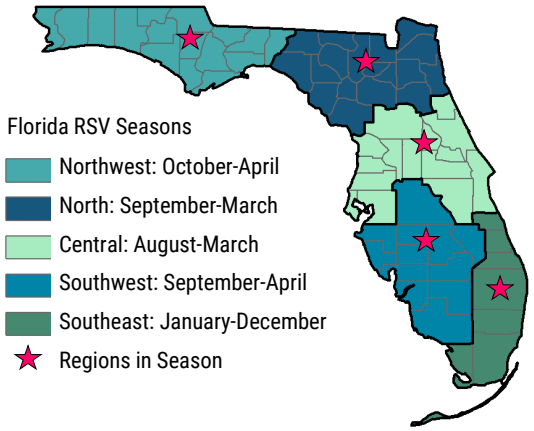
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

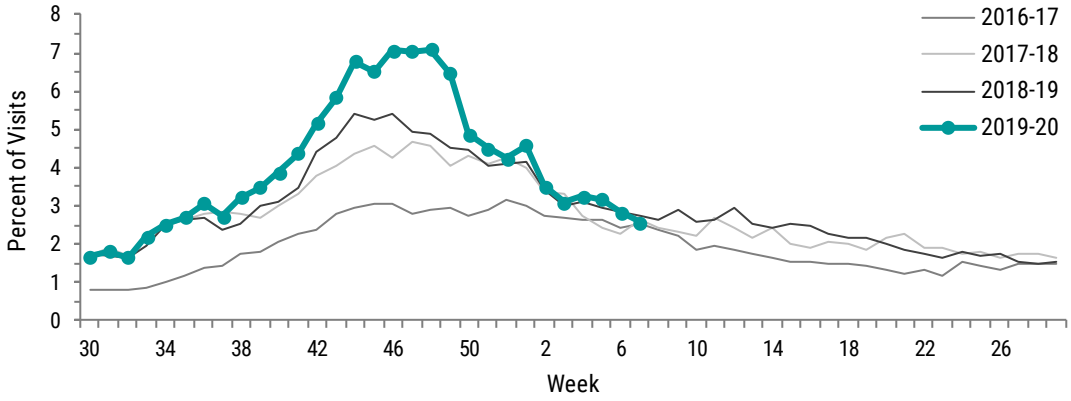
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 7 (February 9-15, 2020) Activity Summary

In week 7, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 7. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 7, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 7, 2020.

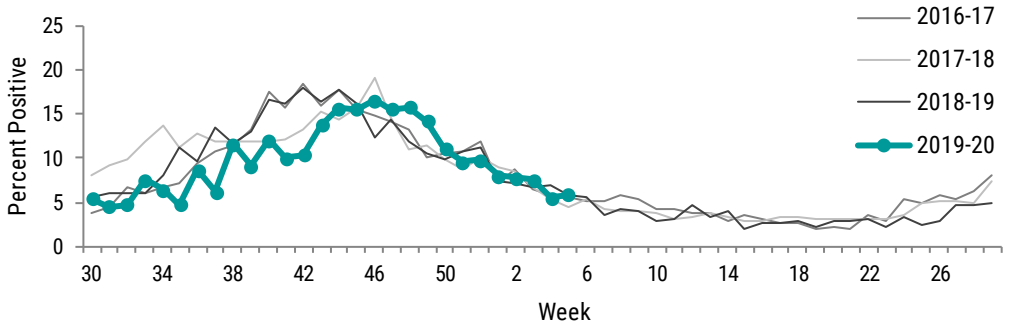
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 7, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 7, 2020. ▶



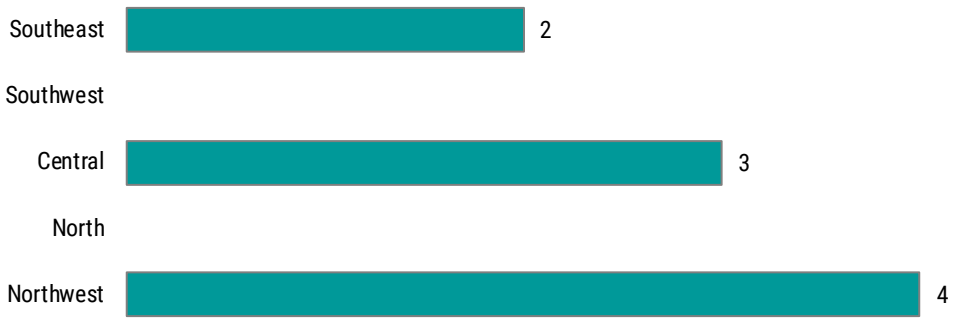
RSV-Associated Outbreaks in Week 7:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 7, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

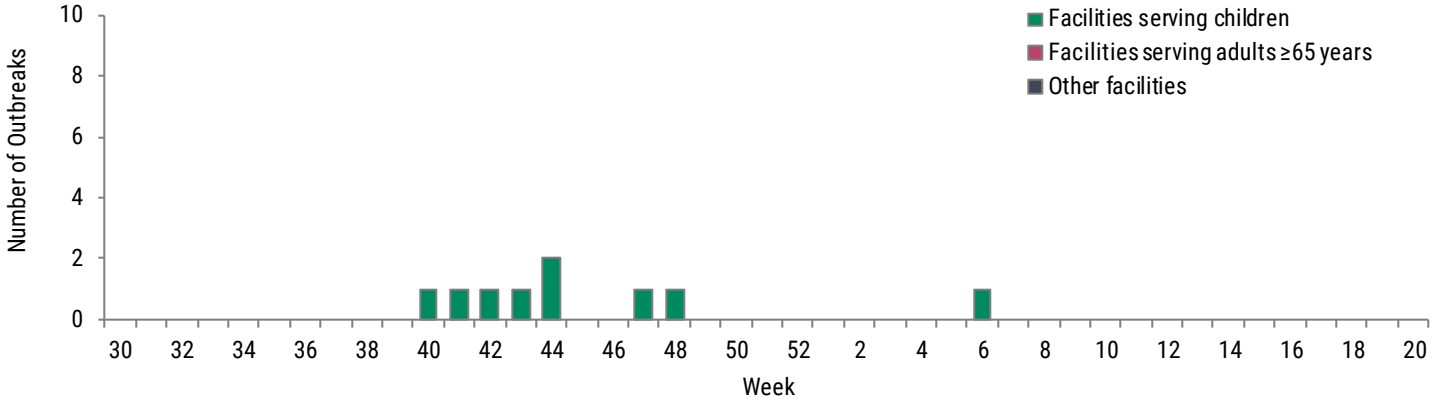
Figure 32: In week 7, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

*Regions defined in figure 29.

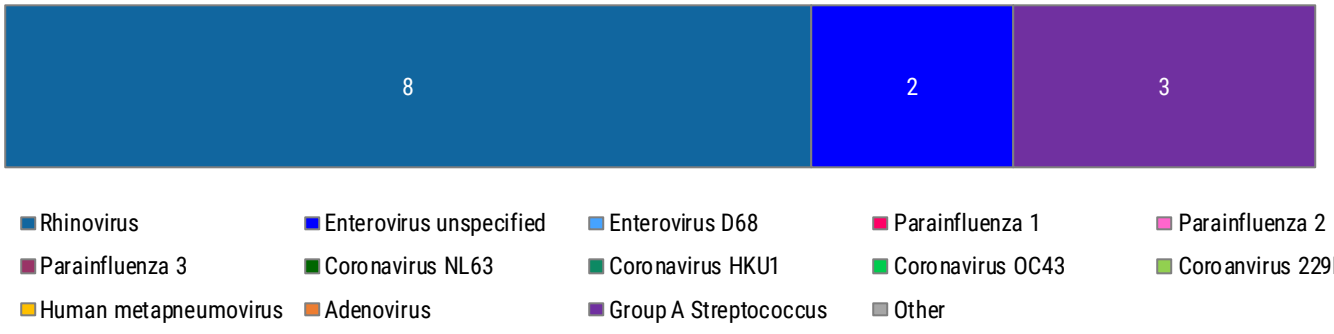
Figure 33: In week 7, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



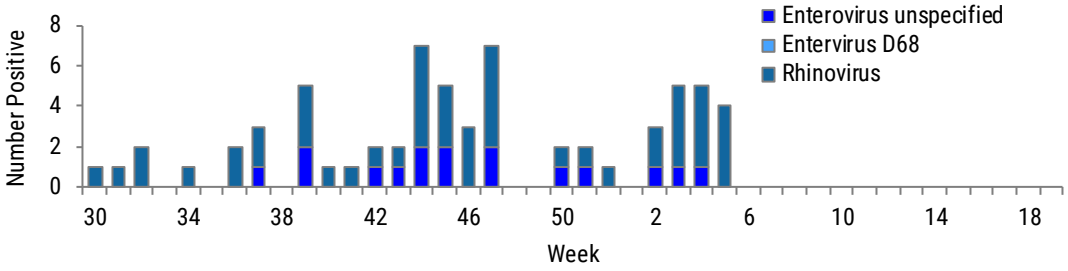
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

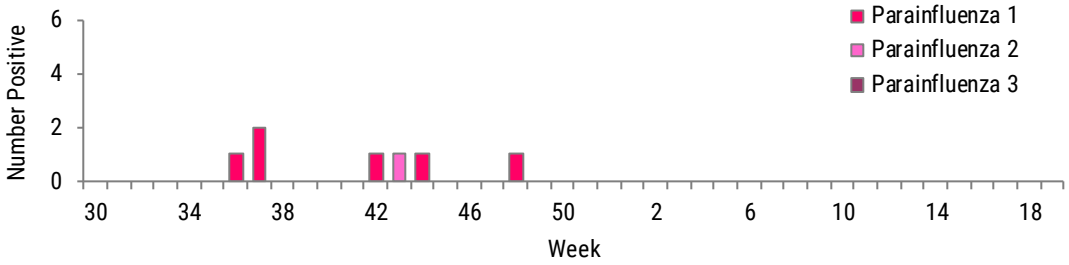


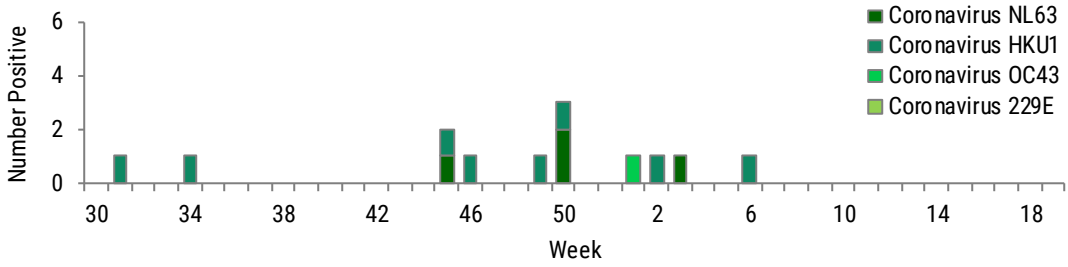
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 7, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

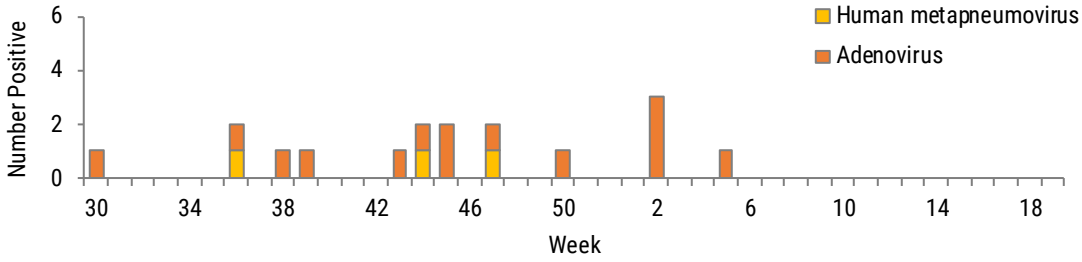
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 7, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Citrus	31	0	0	Influenza A unspecified	Yes	Closed
Long-term care facility	Madison	5	3	0	Influenza A 2009 (H1N1)	Yes	Open
Long-term care facility	Monroe	4	2	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

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Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

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From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 7, 2020 Florida Flu Review
Date:	Wednesday, February 19, 2020 2:53:23 PM
Attachments:	Week 7, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 7, 2020 Florida Flu Review.

Week 7 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 7 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-four outbreaks were reported, down from 29 outbreaks in the previous week. Of the 24 outbreaks reported, 12 were influenza-associated and 12 were ILI.

Two new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of

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fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 7: 2/9/20-2/15/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 7 influenza & influenza-like illness (ILI) activity summary:

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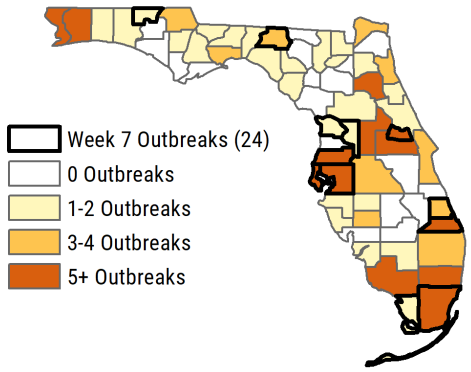
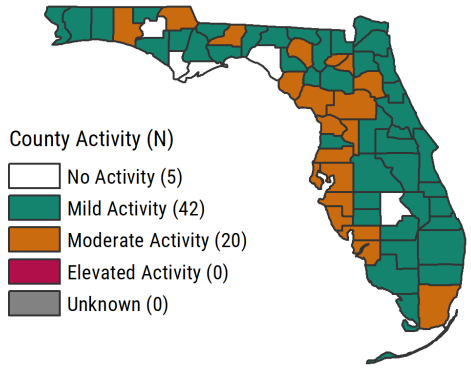
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

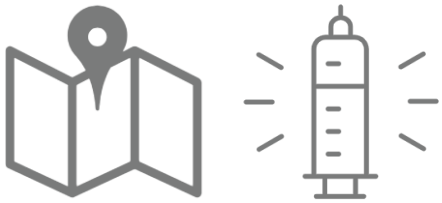
Reported as of 2/15/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 19, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007114

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

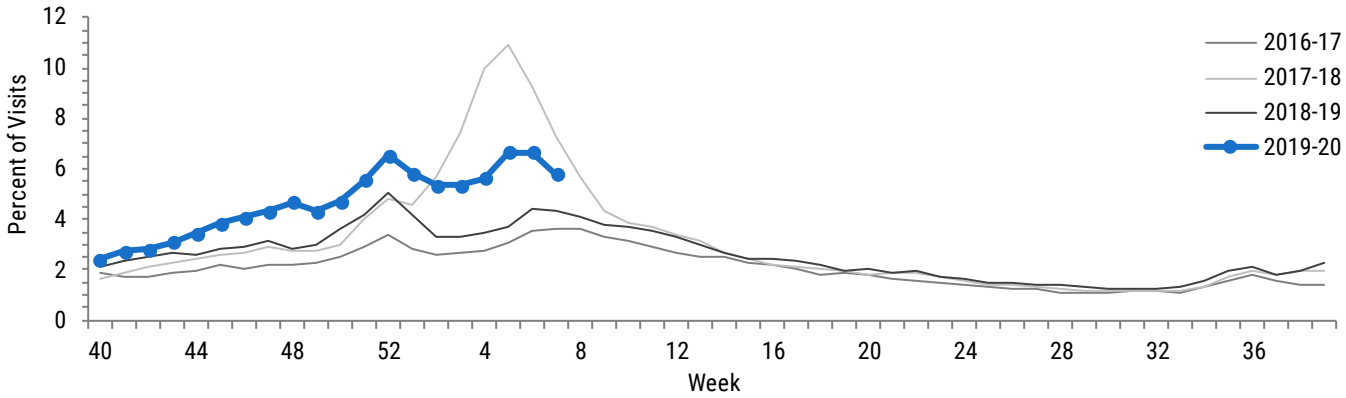
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 7, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 7, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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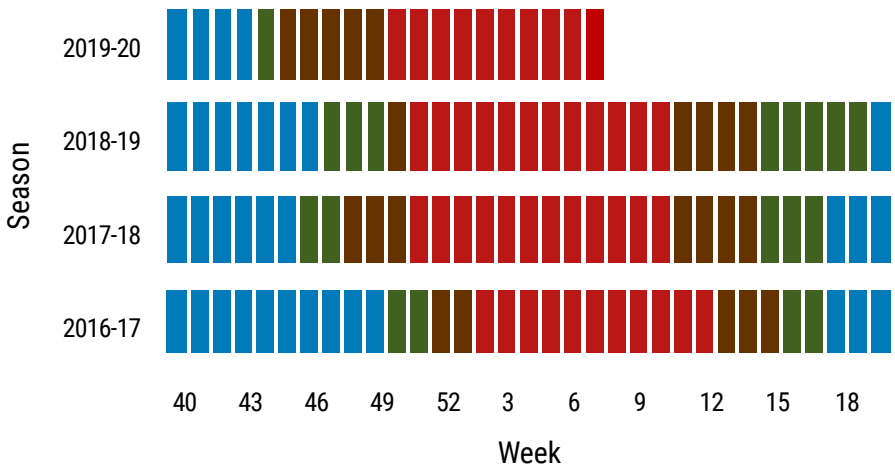
Statewide Activity

Figure 2: In week 7, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 7, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 7, **the percent of patients with ILI reported by ILINet providers statewide increased** and was similar to levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 7, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

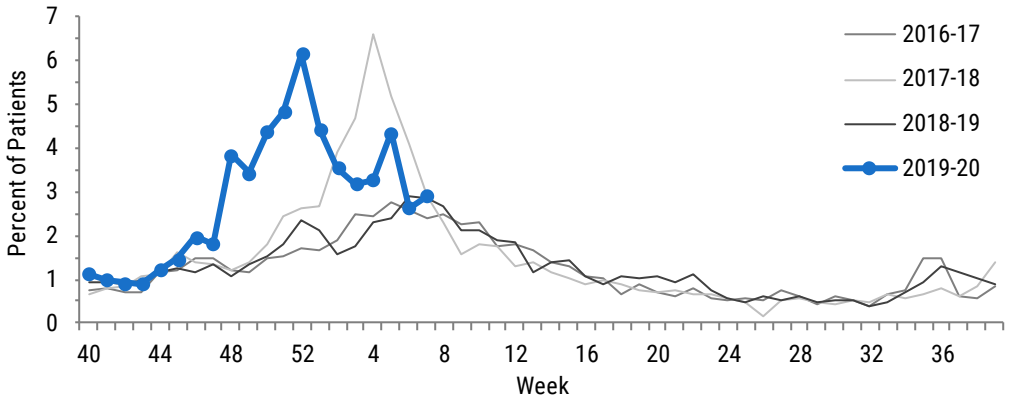
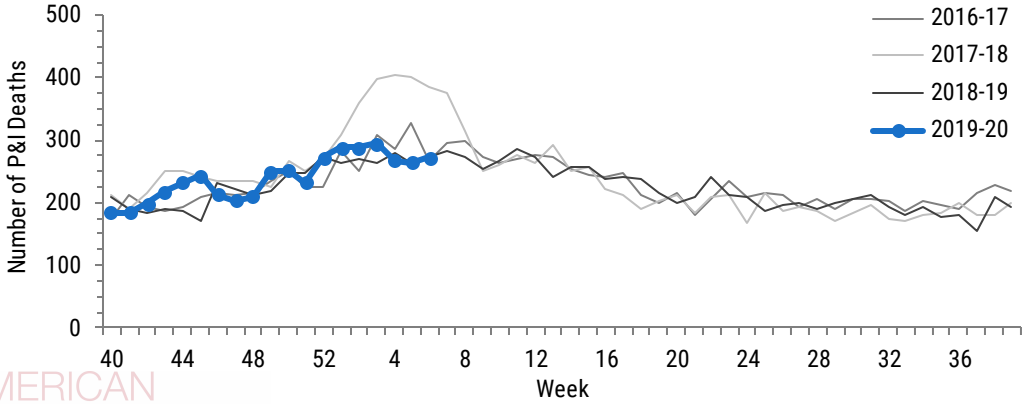


Figure 4: In week 6 (ending 2/8/20), **the number of pneumonia and influenza deaths identified statewide increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 7. Twenty counties reported **moderate activity.**

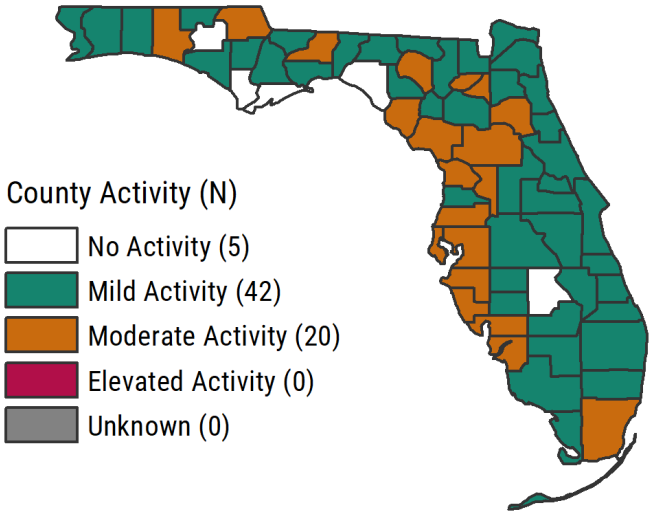
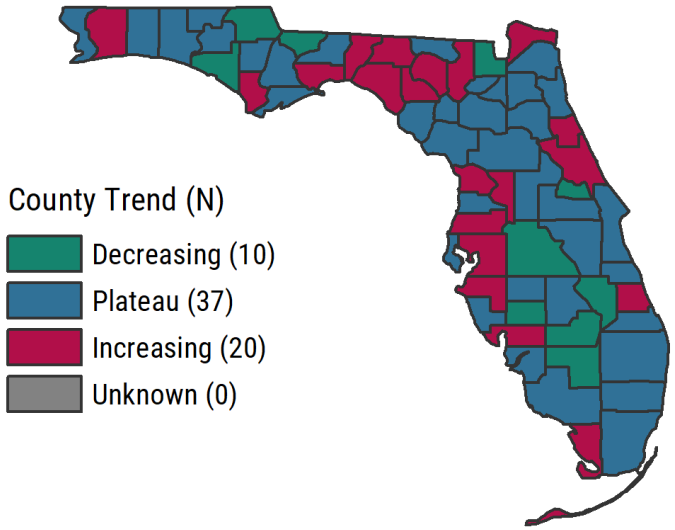
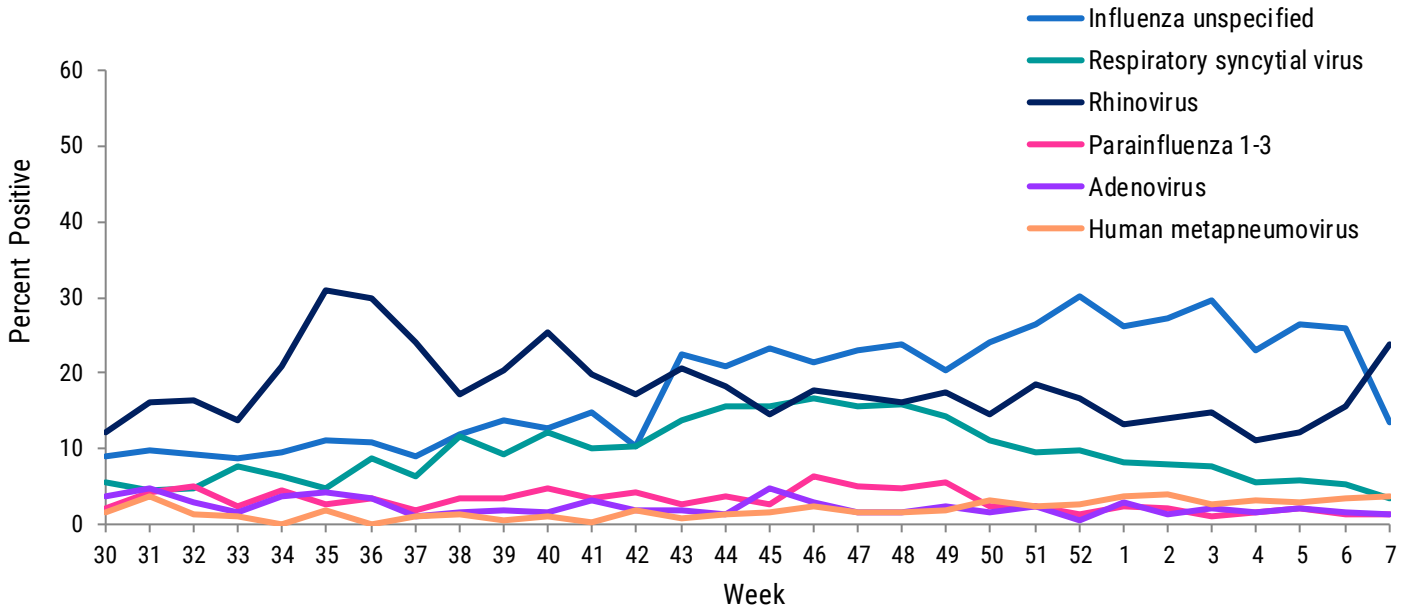


Figure 7: Most counties reported **activity at a plateau** for week 7. Twenty counties reported **increasing activity,** and ten counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 7, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance. Of note, the volume of laboratory tests reported in week 7 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 7, 2020.

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Influenza and ILI Outbreaks

Week 7 Outbreaks at a Glance:

Number Reported:
24 Outbreaks

Influenza-Associated:
12 Outbreaks

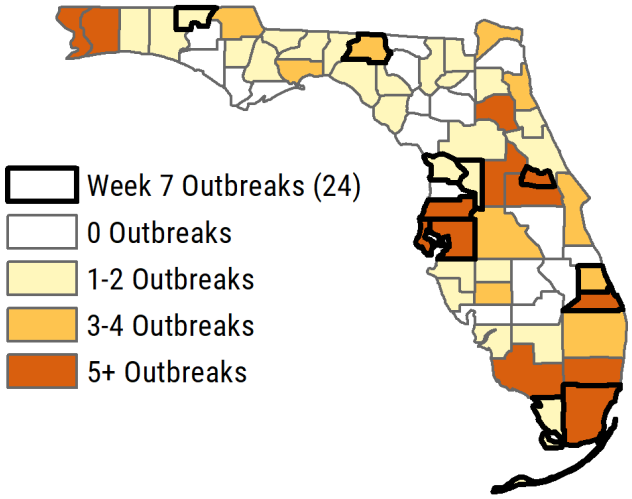
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 7, 12 influenza-associated and 12 ILI outbreaks were reported, a decrease from the previous week.

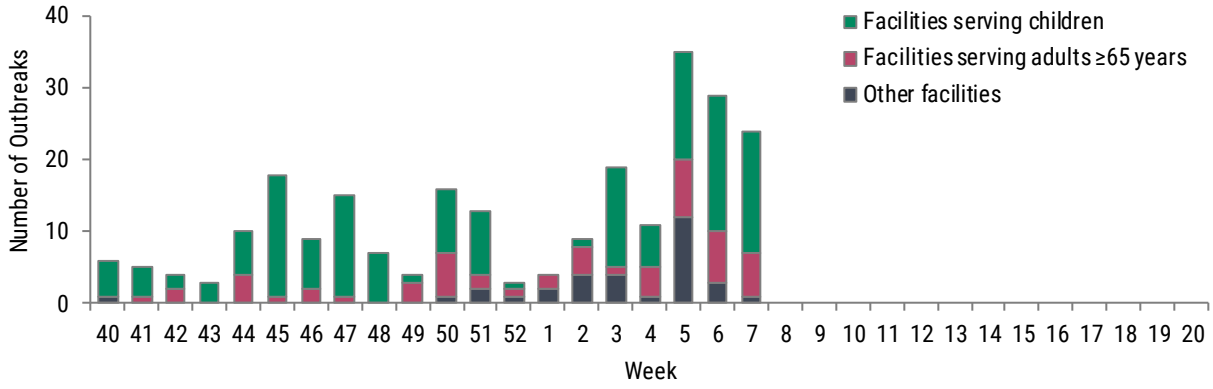
Severe outcomes* were reported in two of 24 outbreaks. One or more hospitalizations were reported in each of these two outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 7, both outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



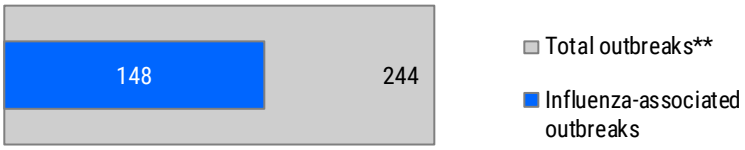
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 7 are **outlined in bold.**

Figure 9: In week 7, **six outbreaks** were reported in **facilities serving adults aged ≥65 years, 17 outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 7, **60.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 7, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

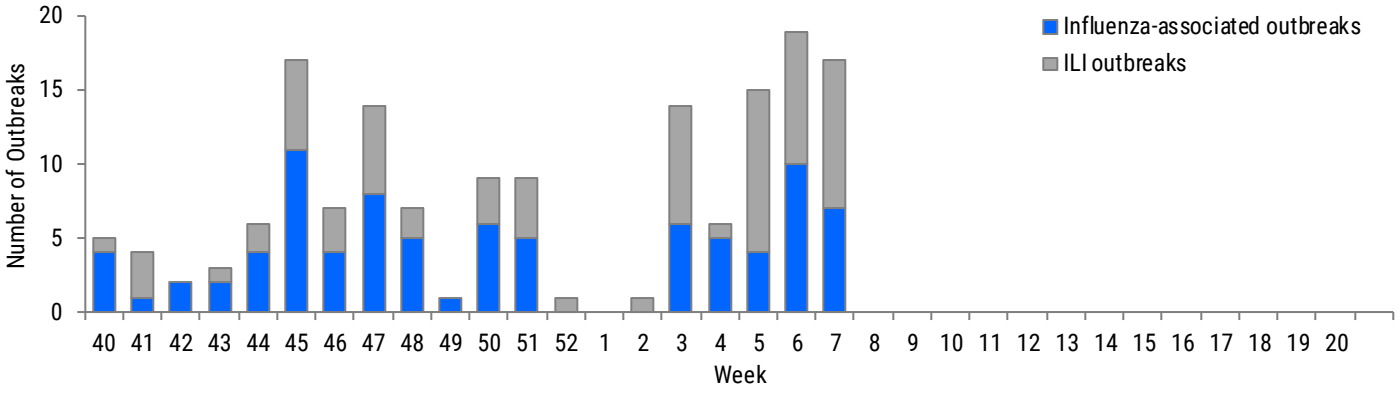
17 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 7, 17 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 7, **seven influenza-associated outbreaks** and **10 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

Facilities Serving Adults ≥65 yrs.**:

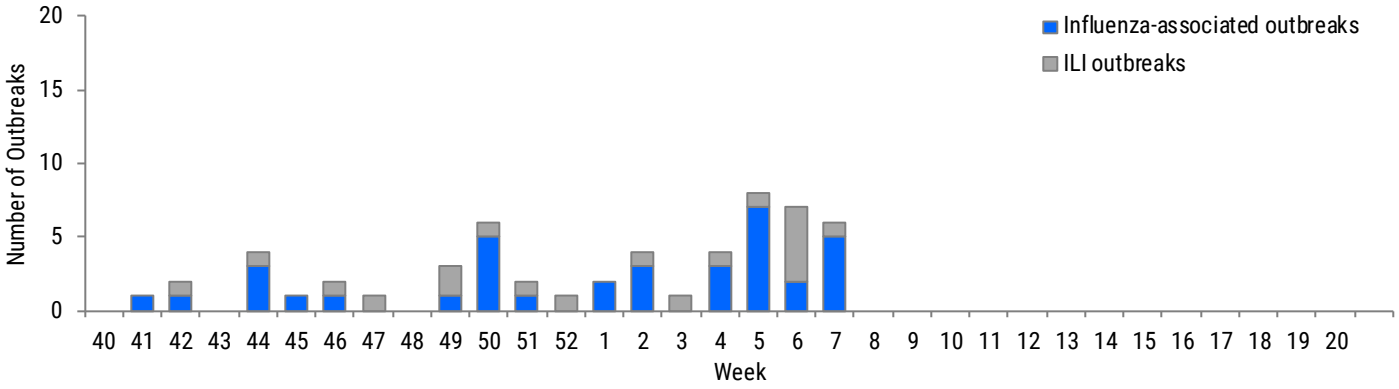
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 7, six new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 7, **five influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

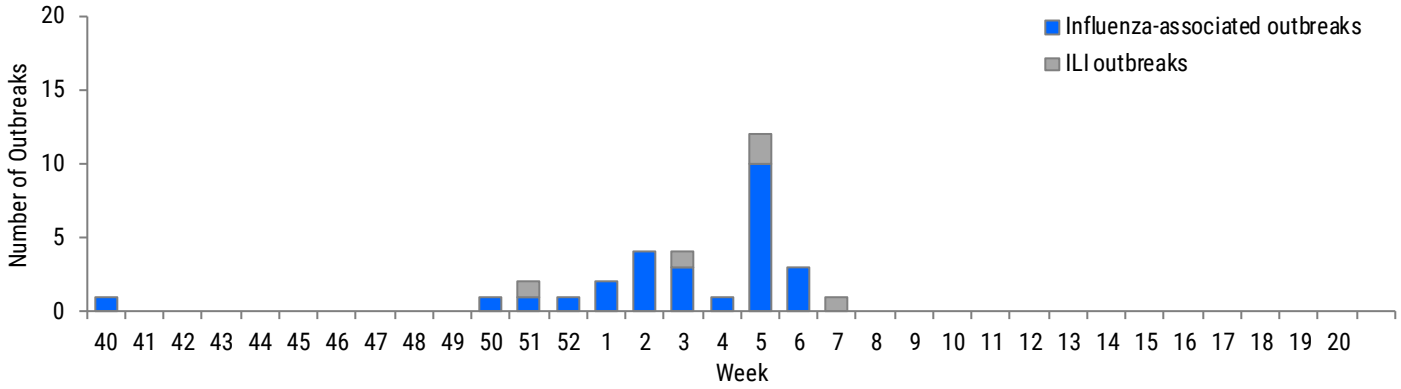
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 7, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 7, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

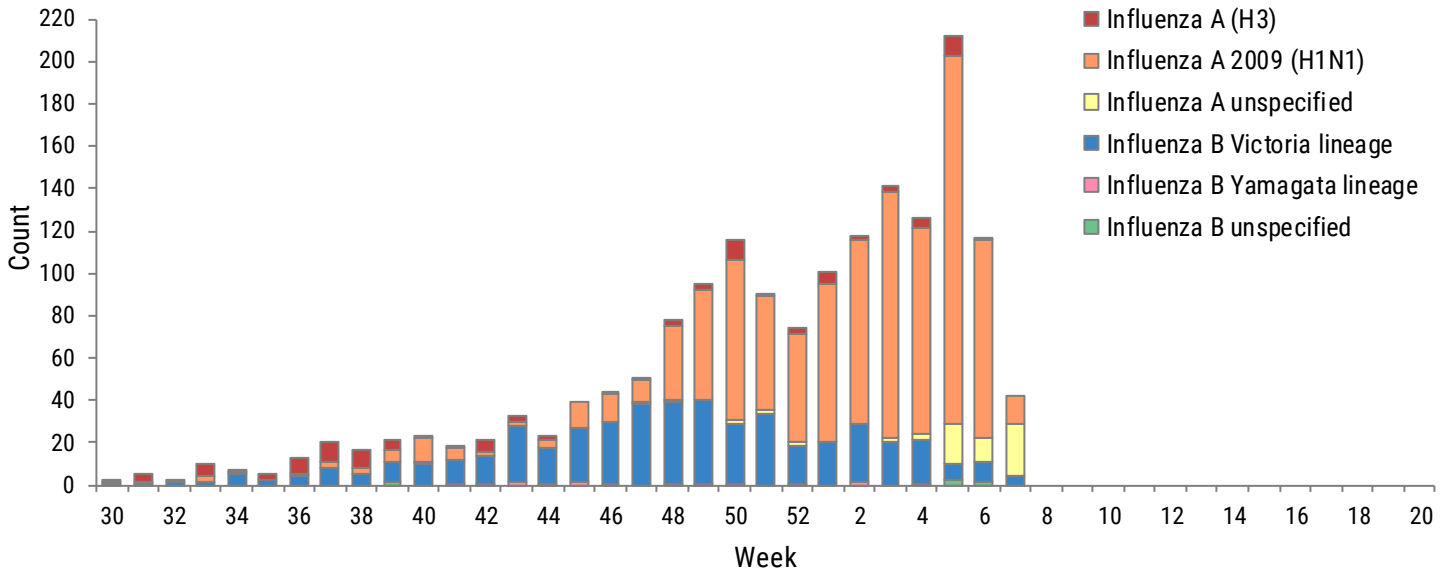
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	122 (50.0%)	71 influenza-associated outbreaks 51 ILI outbreaks
Child daycares	35 (14.3%)	14 influenza-associated outbreaks 21 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	16 (6.6%)	5 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	13 (5.3%)	11 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	26 (10.7%)	20 influenza-associated outbreaks 6 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (11.1%)	24 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	3 (1.23%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**244 (100.0%)**	**148 influenza-associated outbreaks** **96 ILI outbreaks**

AMERICAN OVERSIGHT

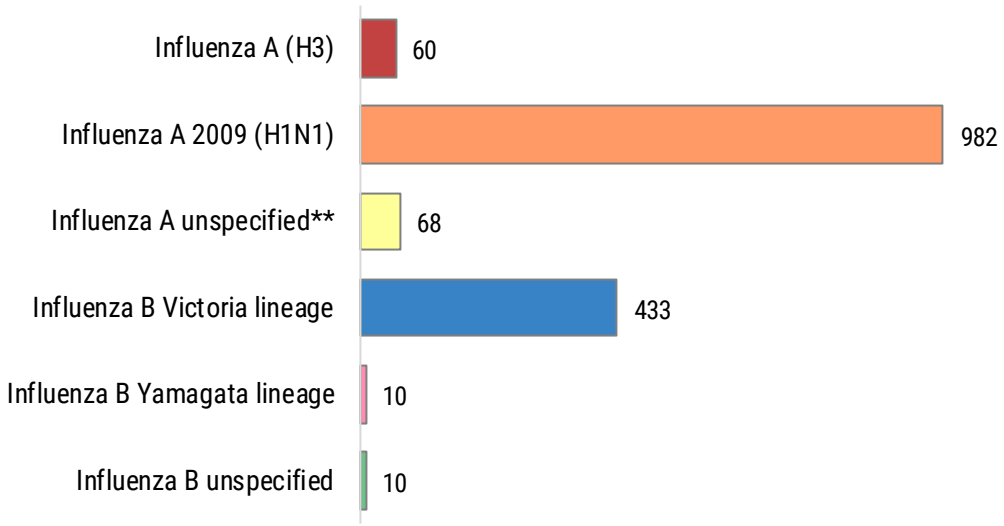
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 7, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 7, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 7, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 7 and was within levels observed at this time in previous seasons.

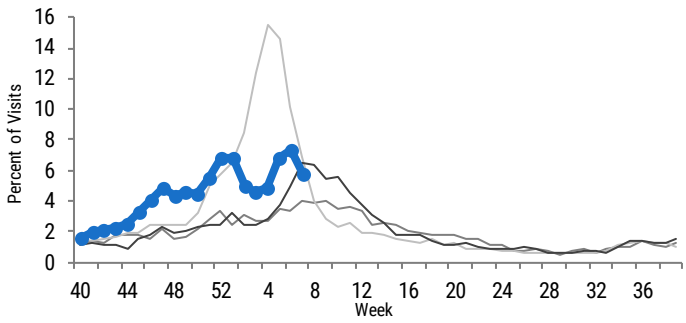


Figure 17: In **region 2, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

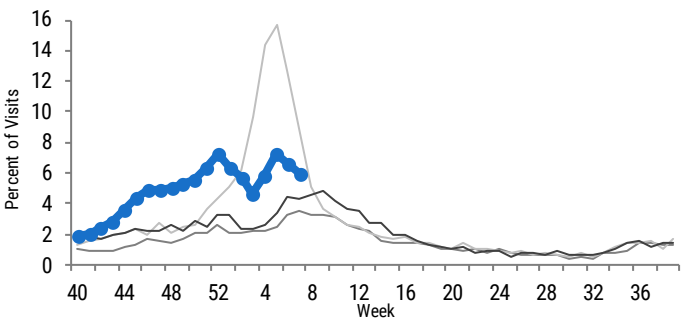


Figure 18: In **region 3, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

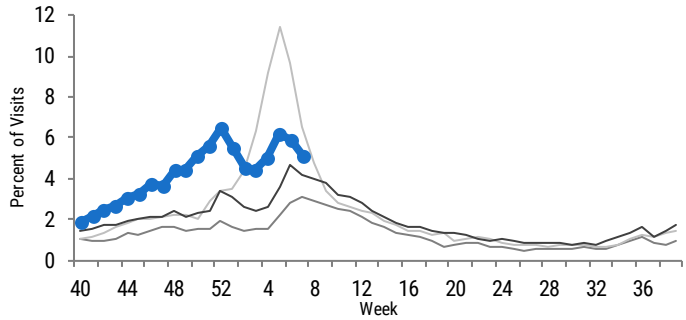


Figure 19: In **region 4, ILI activity decreased** during week 7 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

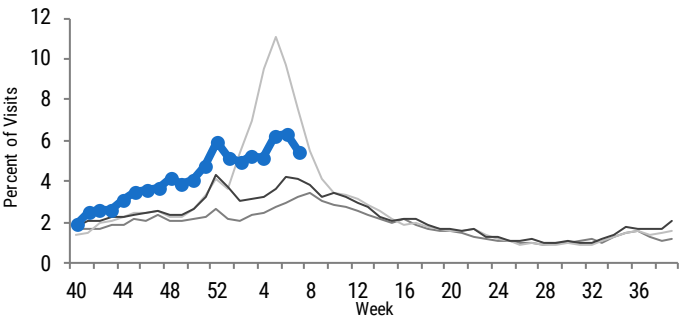


Figure 20: In **region 5, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

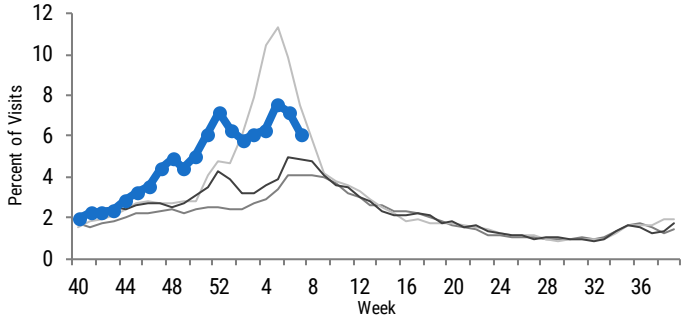


Figure 21: In **region 6, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

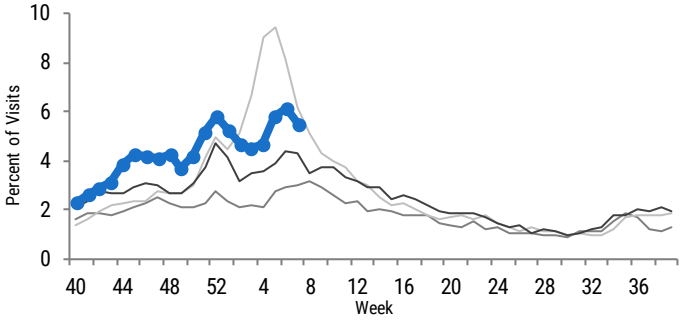
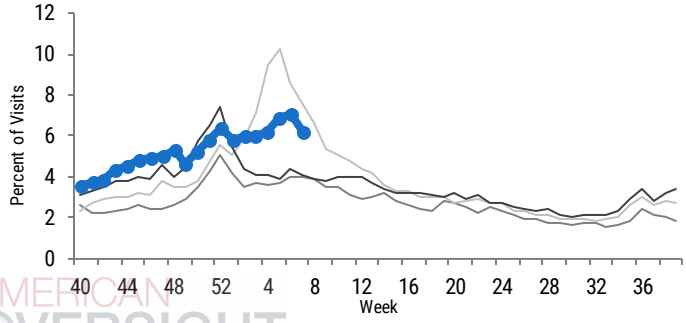


Figure 22: In **region 7, ILI activity decreased** during week 7 and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



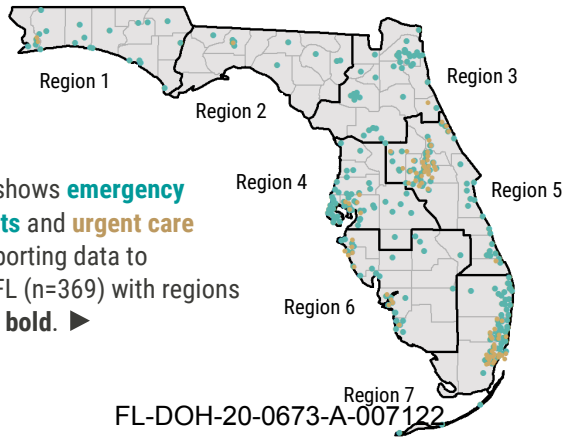


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

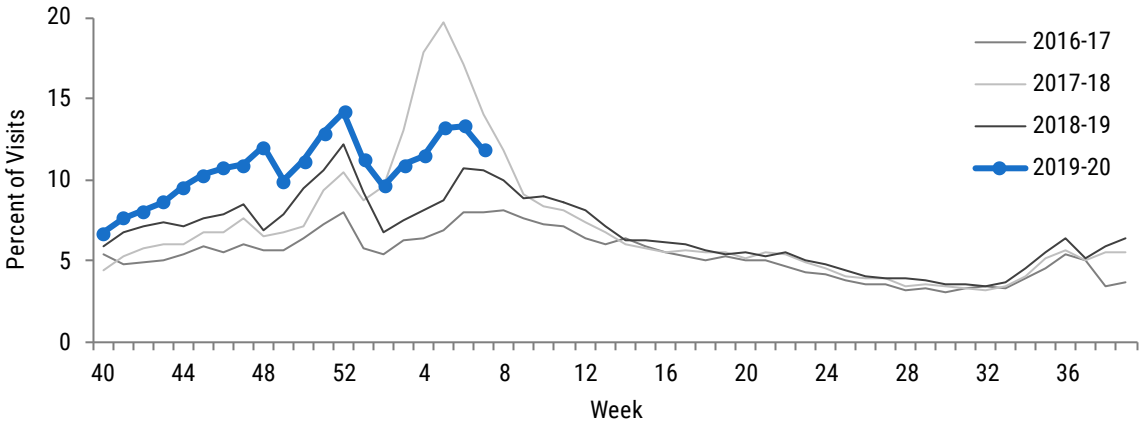
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

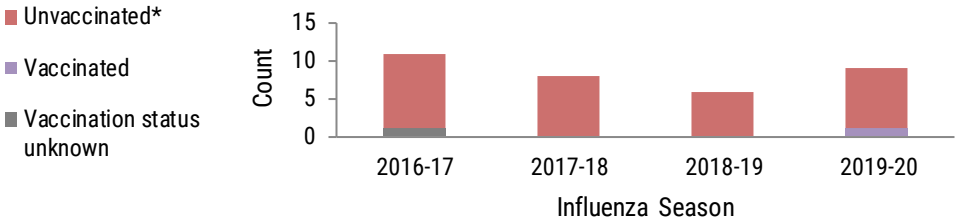
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 7, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

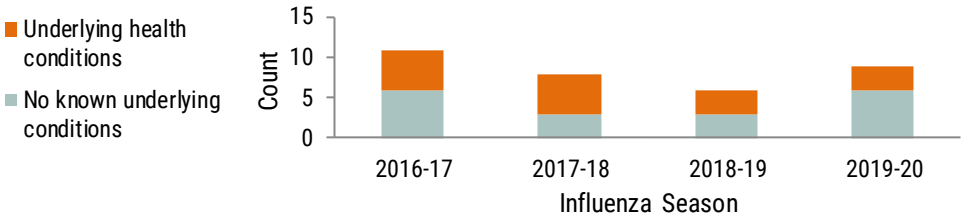


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

Figures 25-26: In week 7, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was vaccinated for the 2019-20 season. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 7, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 7, 2020.

In week 7, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with known underlying medical conditions. One child was vaccinated for the 2019-20 season.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

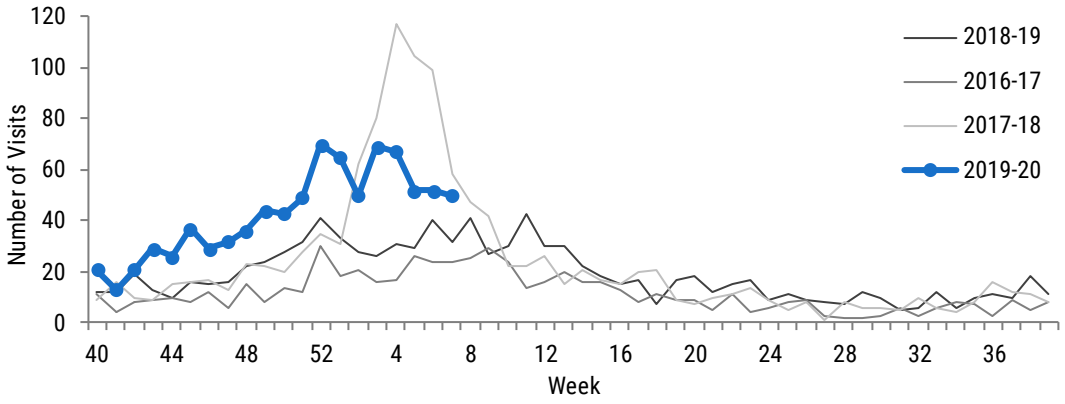
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 7, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



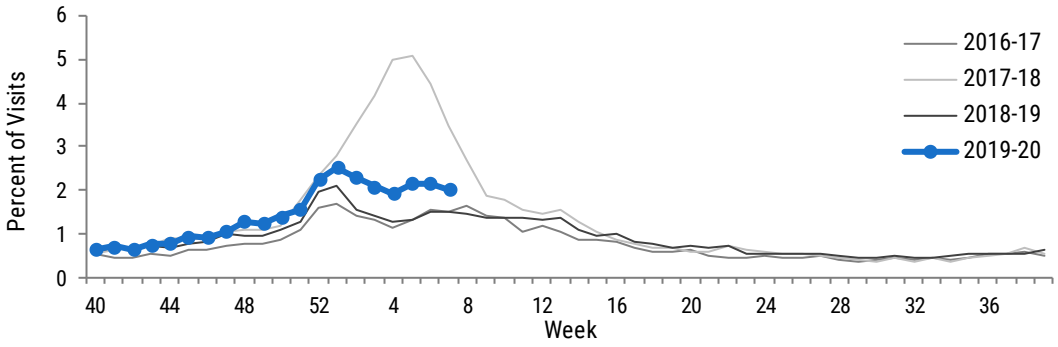
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 7, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 7, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



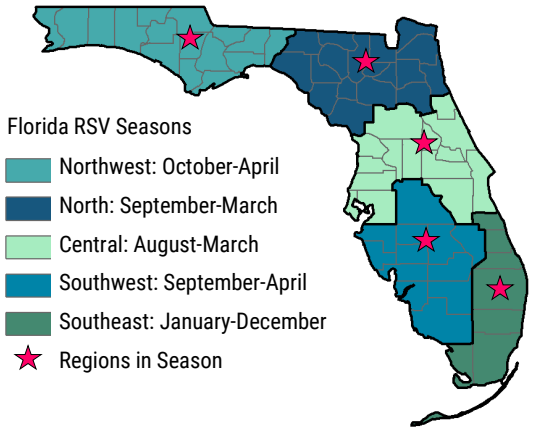
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

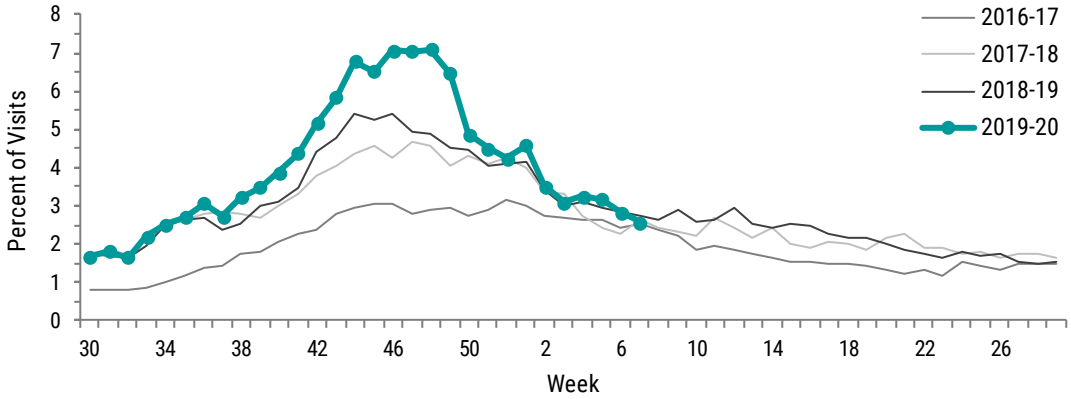
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 7 (February 9-15, 2020) Activity Summary

In week 7, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 7. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 7, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 7, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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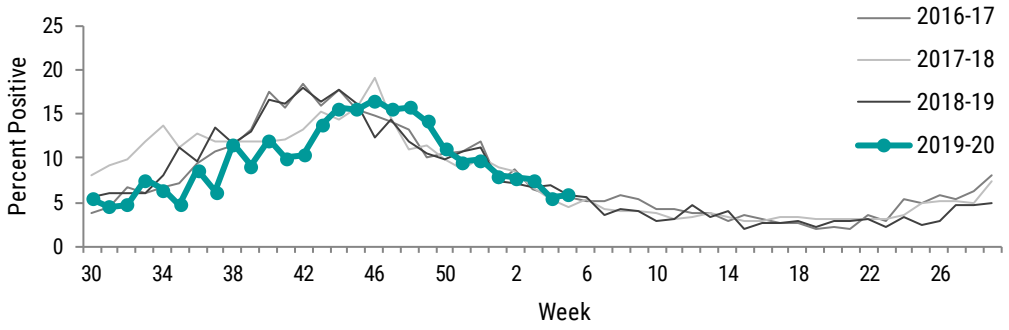
RSV Surveillance

Figure 31: In week 7, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 7, 2020. ▶



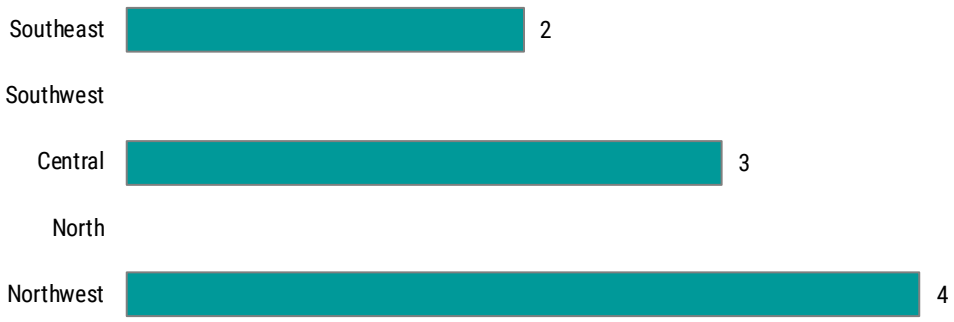
RSV-Associated Outbreaks in Week 7:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 7, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

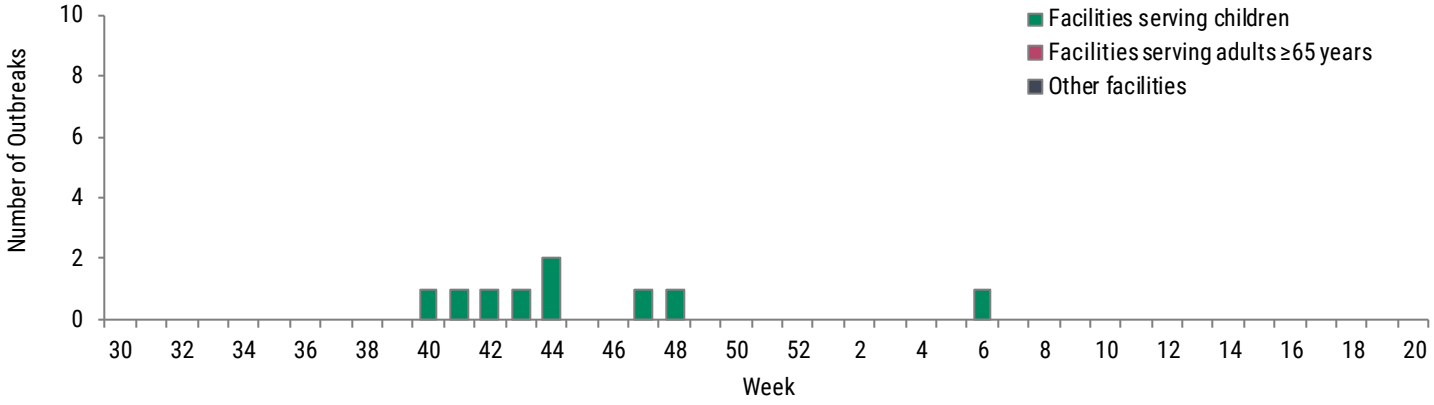
Figure 32: In week 7, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

*Regions defined in figure 29.

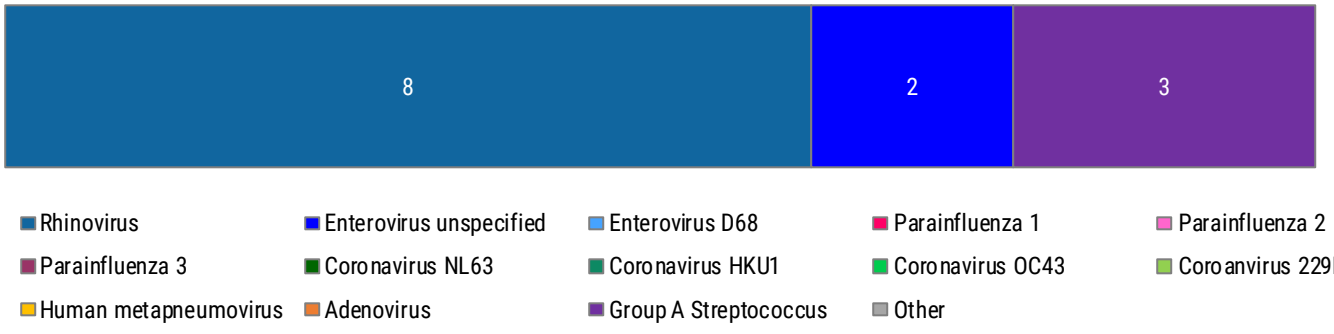
Figure 33: In week 7, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



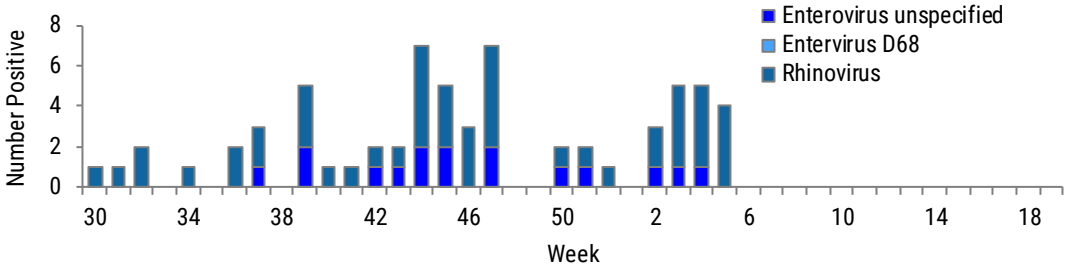
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

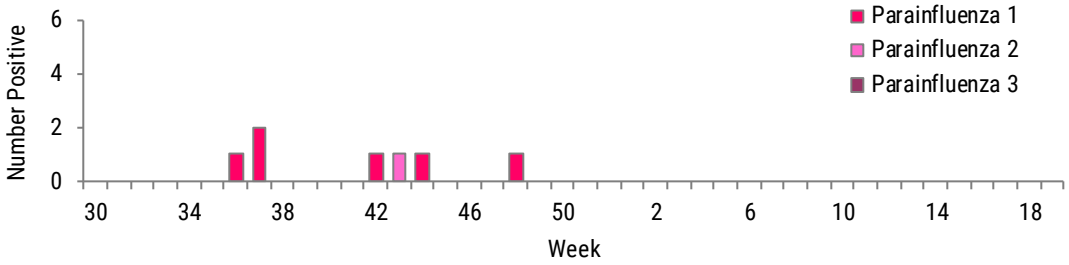


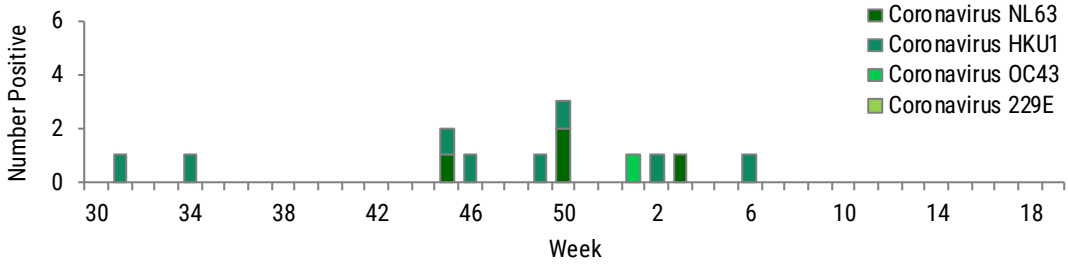
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 7, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

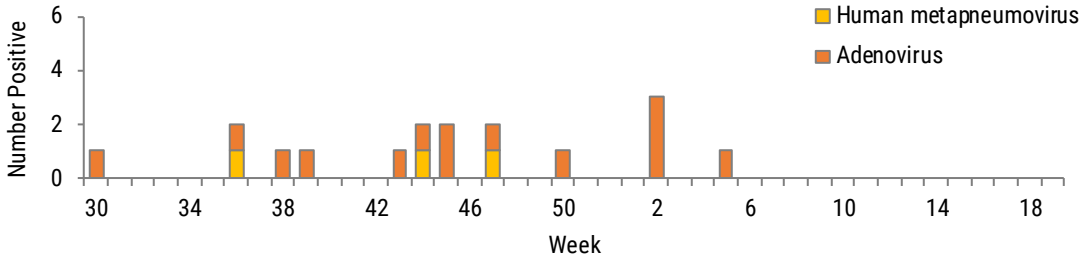
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 7, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Citrus	31	0	0	Influenza A unspecified	Yes	Closed
Long-term care facility	Madison	5	3	0	Influenza A 2009 (H1N1)	Yes	Open
Long-term care facility	Monroe	4	2	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

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From:	Munroe, Julia
To:	Bogucki, Amy; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 7, 2020 Florida Flu Review
Date:	Wednesday, February 19, 2020 2:53:17 PM
Attachments:	Week 7, 2020 Florida Flu Review.pdf

Good Afternoon!

Attached is the Week 7, 2020 Florida Flu Review.

Week 7 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 7 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in most regions of the state. Elevated activity is still expected for several more weeks.

Twenty-four outbreaks were reported, down from 29 outbreaks in the previous week. Of the 24 outbreaks reported, 12 were influenza-associated and 12 were ILI.

Two new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of

AMERICAN OVERSIGHT

fever-reducing medication).

Thank you!

Julia Munroe, MS
Respiratory Disease Epidemiologist
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Office Phone: 850-901-6936

Mission: To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 7: 2/9/20-2/15/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 7 influenza & influenza-like illness (ILI) activity summary:

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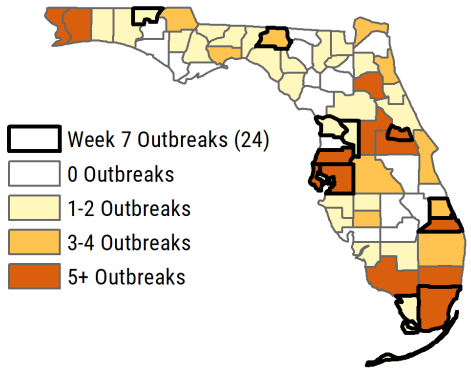
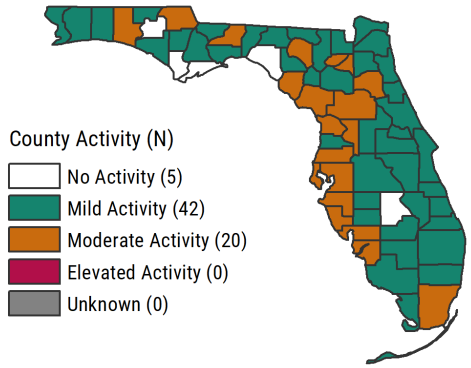
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

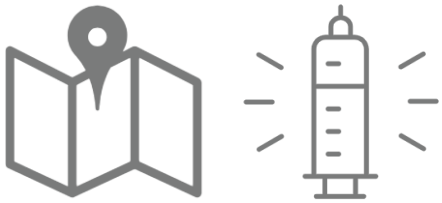
Reported as of 2/15/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 19, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

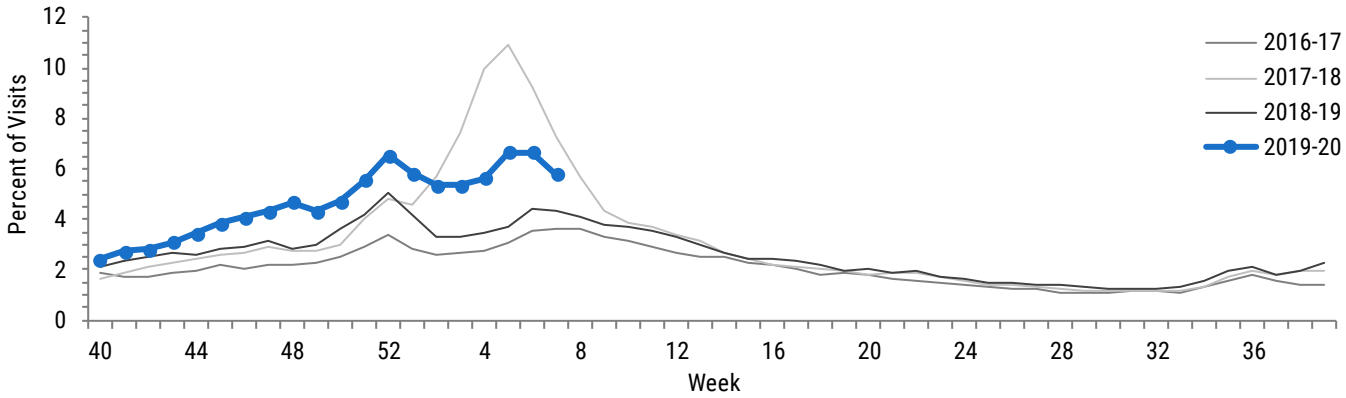
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 7, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 7, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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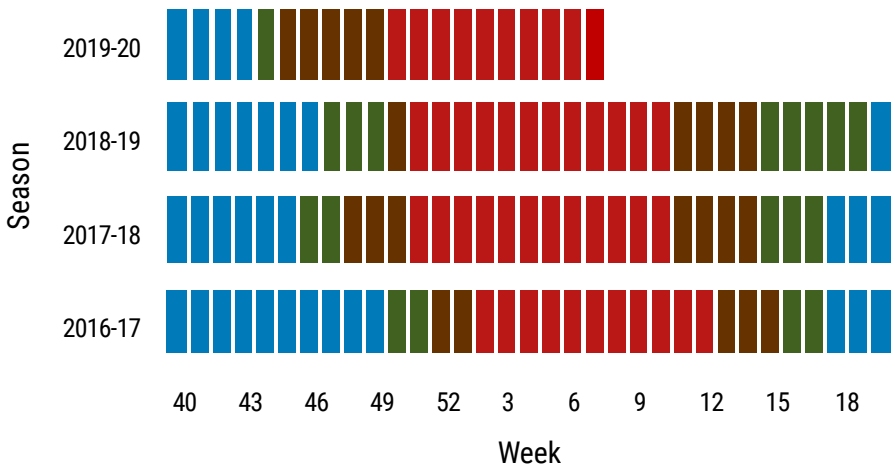
Statewide Activity

Figure 2: In week 7, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 7, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 7, **the percent of patients with ILI reported by ILINet providers statewide increased** and was similar to levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 7, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

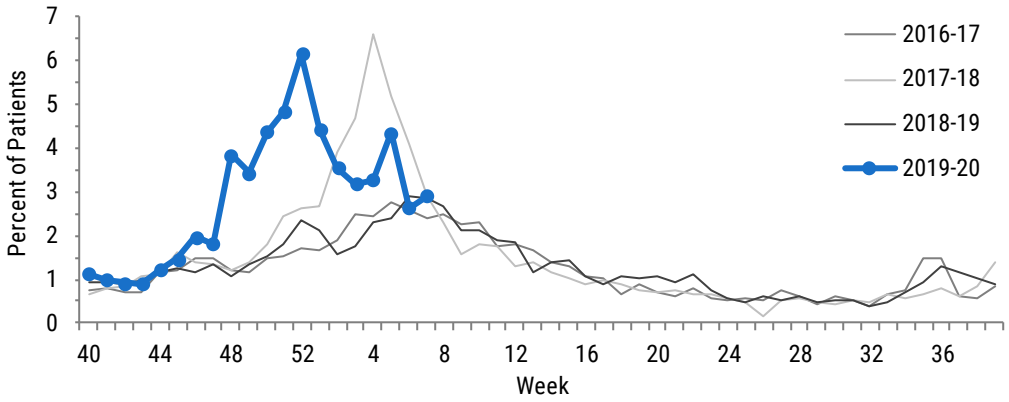
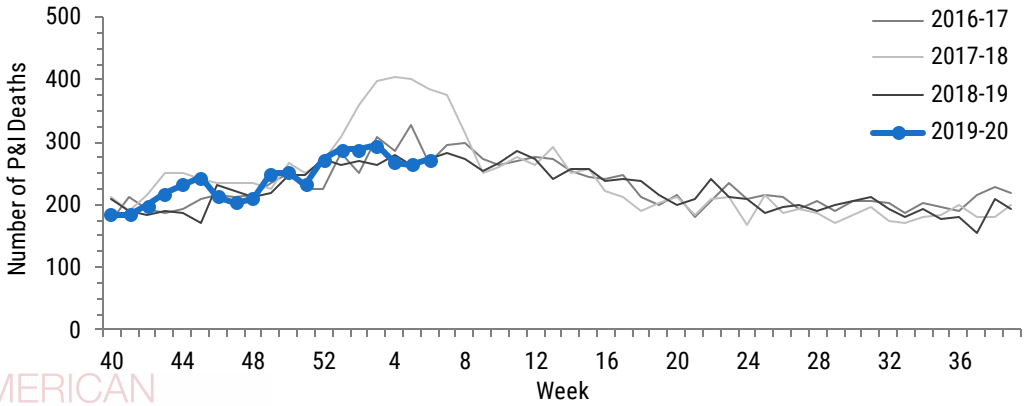


Figure 4: In week 6 (ending 2/8/20), **the number of pneumonia and influenza deaths identified statewide increased** and was similar to levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 6, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 7. Twenty counties reported **moderate activity.**

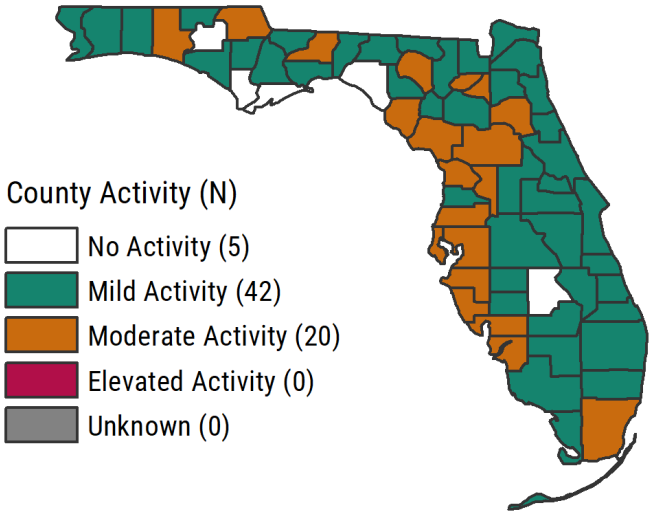
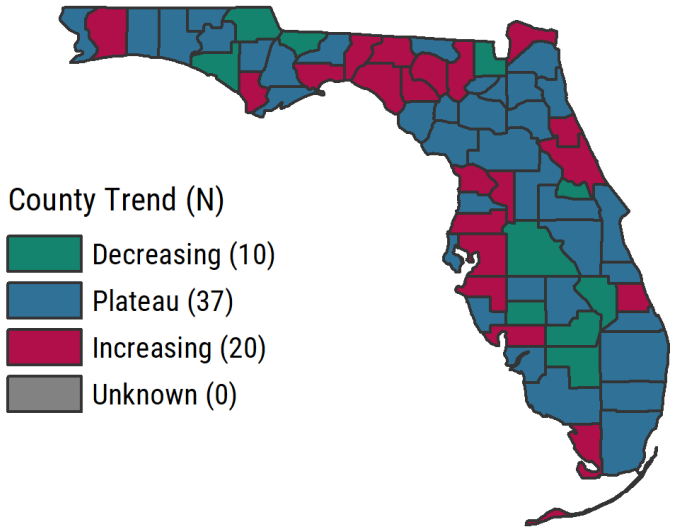
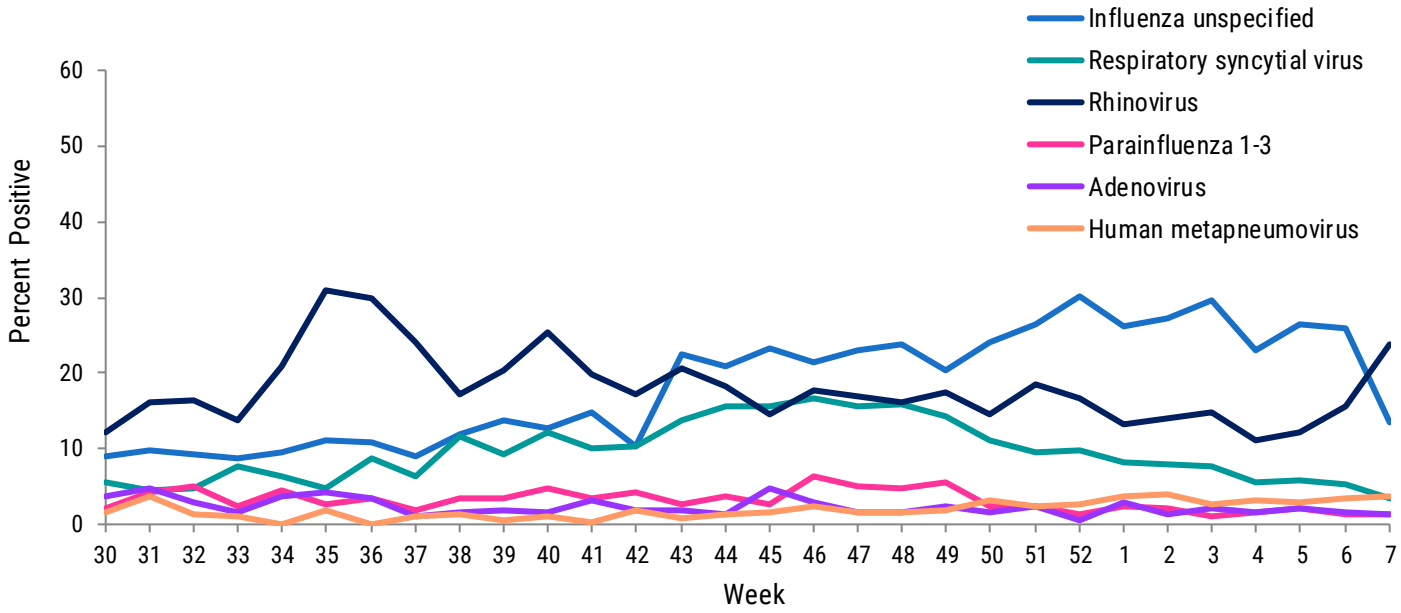


Figure 7: Most counties reported **activity at a plateau** for week 7. Twenty counties reported **increasing activity,** and ten counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 7, the **percent of specimens testing positive for rhinovirus increased** and was higher than other respiratory viruses under surveillance. Of note, the volume of laboratory tests reported in week 7 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 7, 2020.

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Influenza and ILI Outbreaks

Week 7 Outbreaks at a Glance:

Number Reported:
24 Outbreaks

Influenza-Associated:
12 Outbreaks

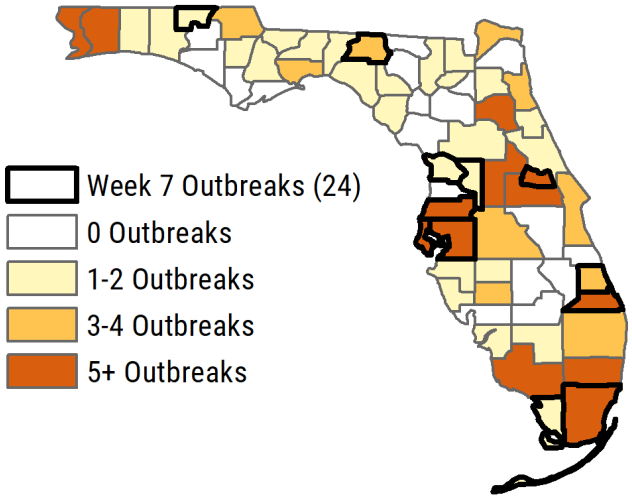
Severe Outcomes*:
2 Outbreaks

Outbreak Summary:

In week 7, 12 influenza-associated and 12 ILI outbreaks were reported, a decrease from the previous week.

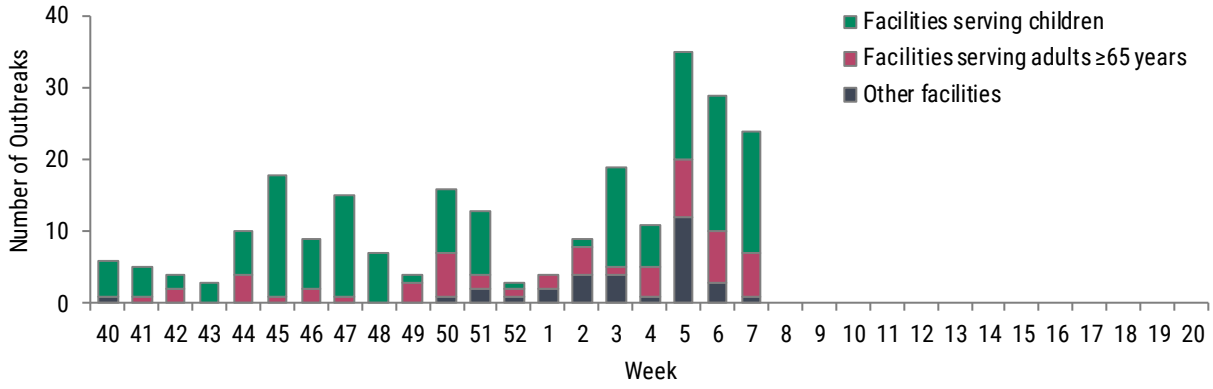
Severe outcomes* were reported in two of 24 outbreaks. One or more hospitalizations were reported in each of these two outbreaks. No deaths were reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 7, both outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



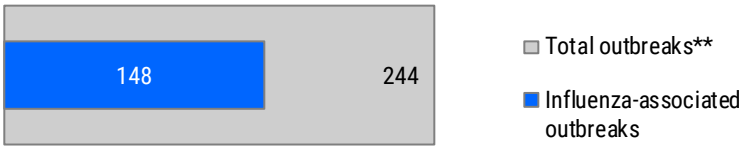
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 7 are **outlined in bold.**

Figure 9: In week 7, **six outbreaks** were reported in **facilities serving adults aged ≥65 years, 17 outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 7, **60.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 7, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

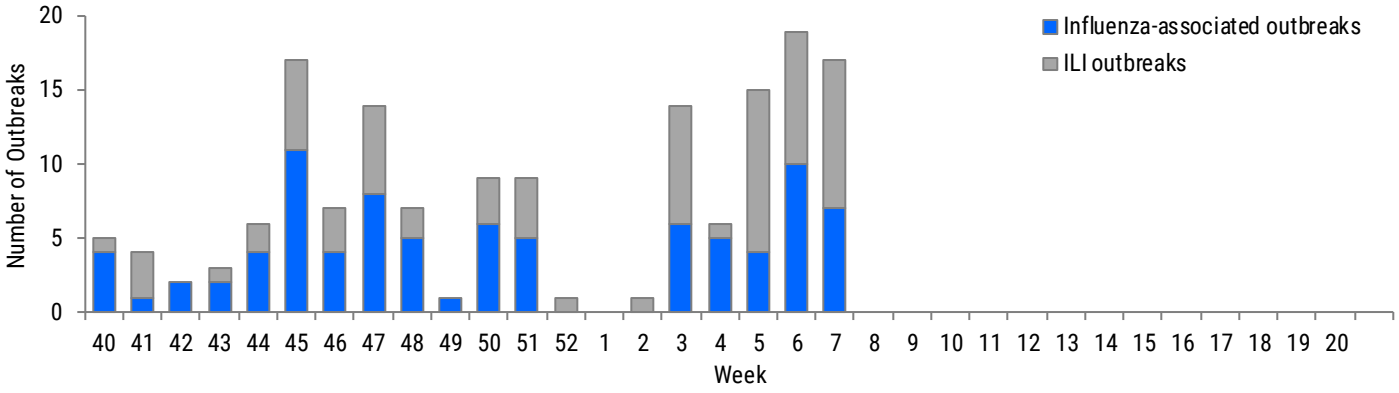
17 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 7, 17 new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 7, **seven influenza-associated outbreaks** and **10 ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

Facilities Serving Adults ≥65 yrs.**:

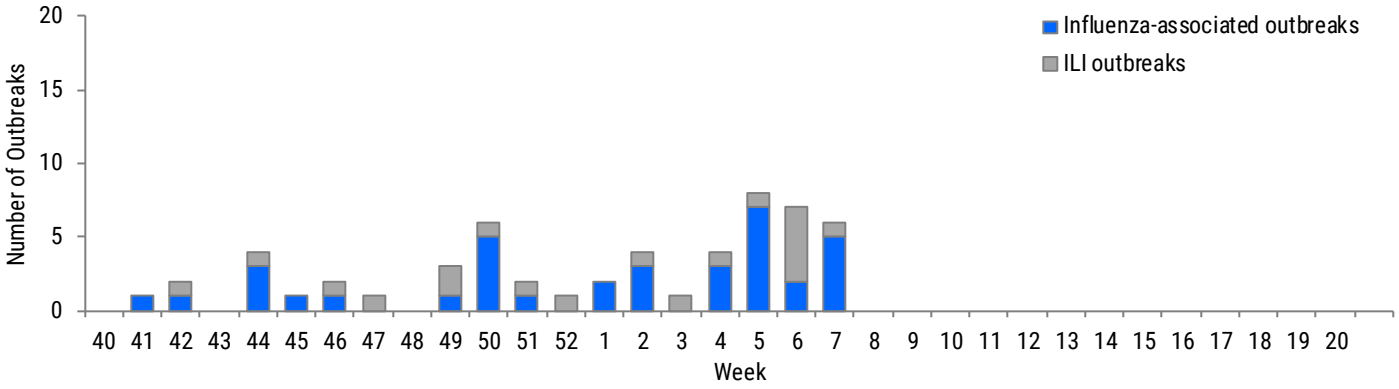
6 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 7, six new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 7, **five influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

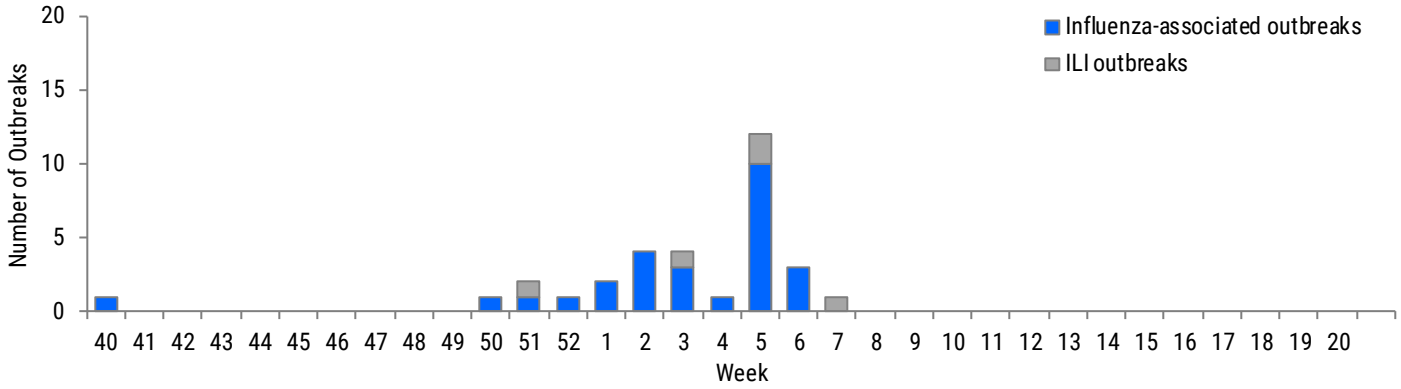
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 7, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 7, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 7, 2020.

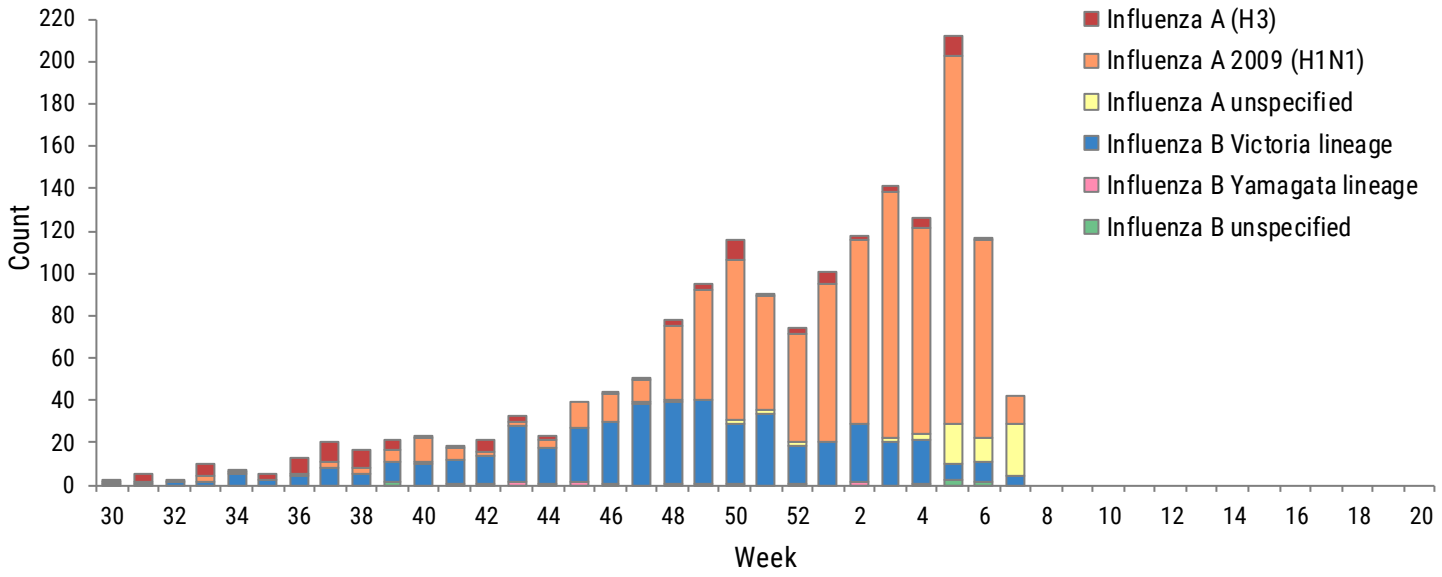
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	122 (50.0%)	71 influenza-associated outbreaks 51 ILI outbreaks
Child daycares	35 (14.3%)	14 influenza-associated outbreaks 21 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	16 (6.6%)	5 influenza-associated outbreaks 11 ILI outbreaks
Nursing facilities	13 (5.3%)	11 influenza-associated outbreaks 2 ILI outbreaks
Other long-term care facilities	26 (10.7%)	20 influenza-associated outbreaks 6 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	27 (11.1%)	24 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	3 (1.23%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**244 (100.0%)**	**148 influenza-associated outbreaks** **96 ILI outbreaks**

AMERICAN OVERSIGHT

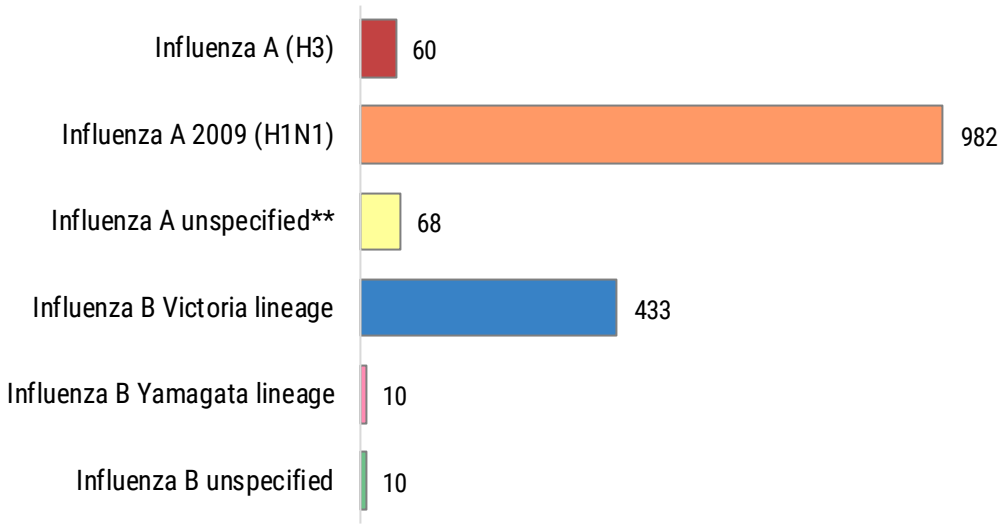
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 7, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 7, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 7, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 7 and was within levels observed at this time in previous seasons.

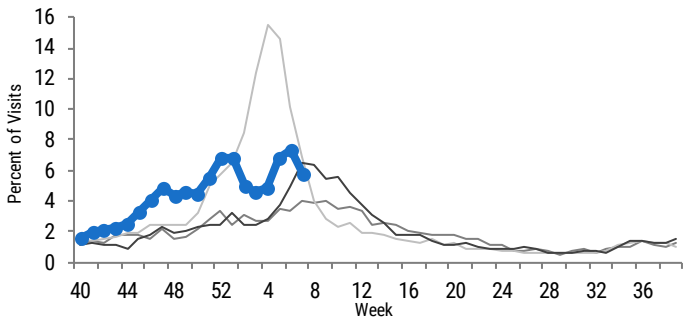


Figure 17: In **region 2, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

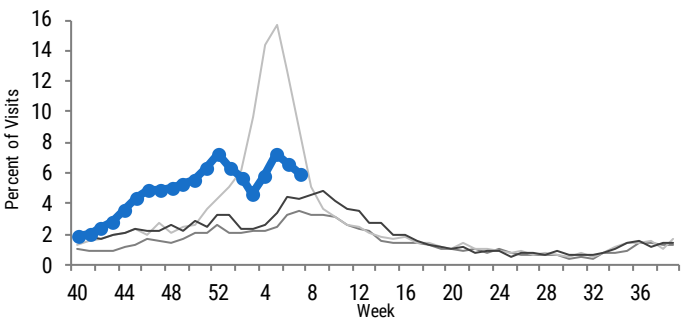


Figure 18: In **region 3, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

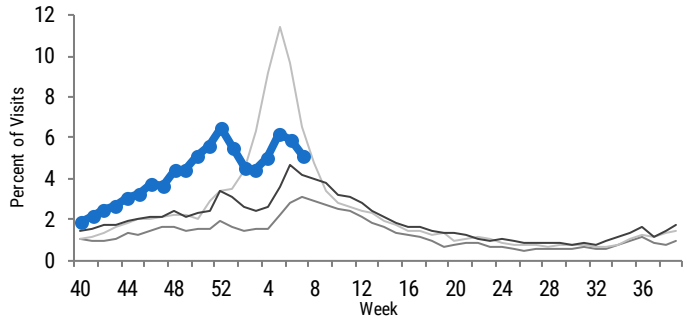


Figure 19: In **region 4, ILI activity decreased** during week 7 and was above peak activity levels observed during the 2018-19 and 2016-17 seasons.

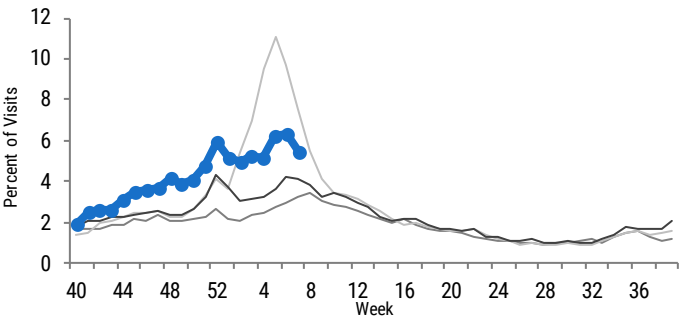


Figure 20: In **region 5, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

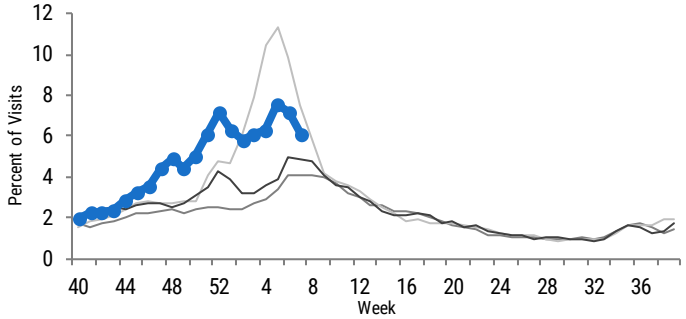


Figure 21: In **region 6, ILI activity decreased** during week 7 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

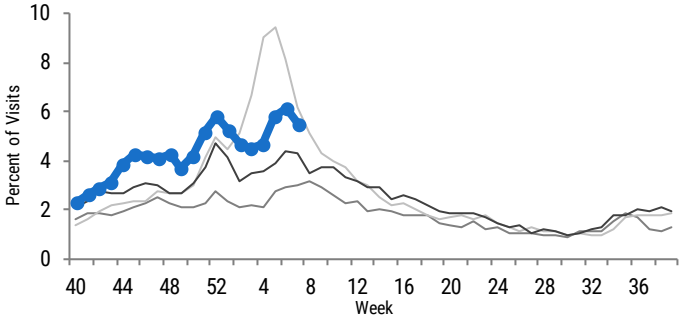
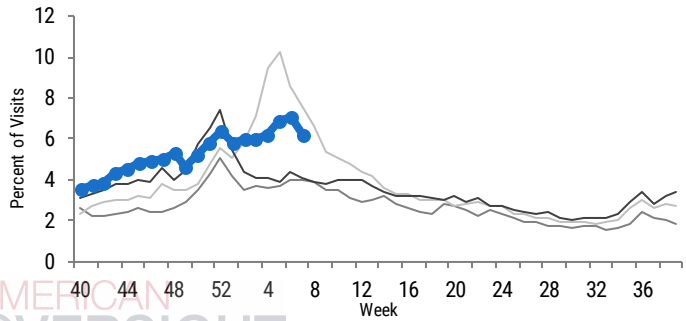


Figure 22: In **region 7, ILI activity decreased** during week 7 and was above levels observed at this time during the 2016-17 and 2018-19 seasons.



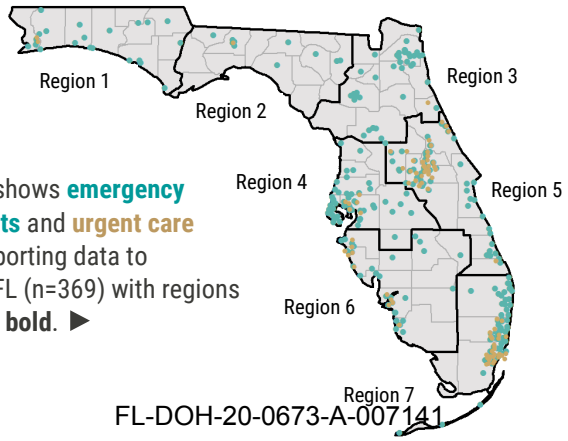


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

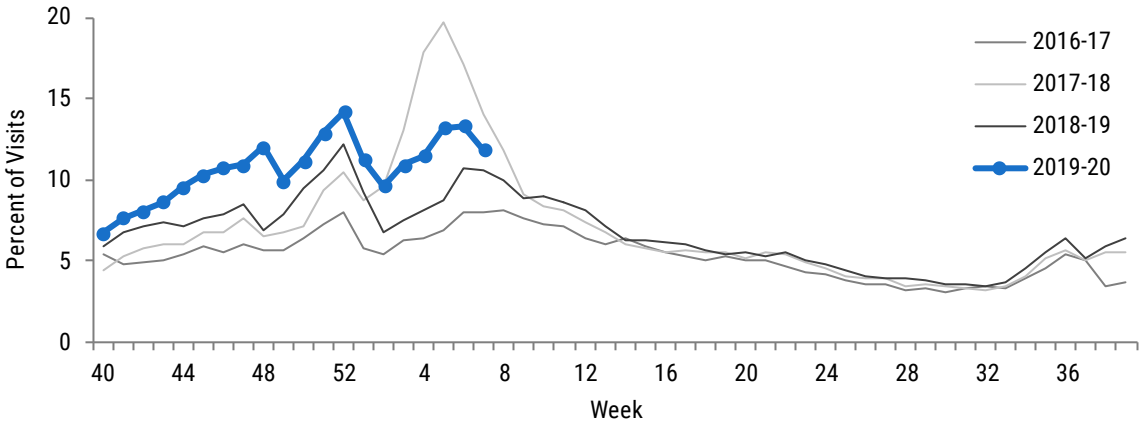
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

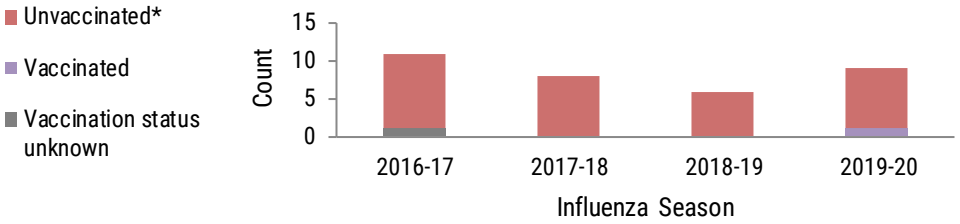
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 7, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

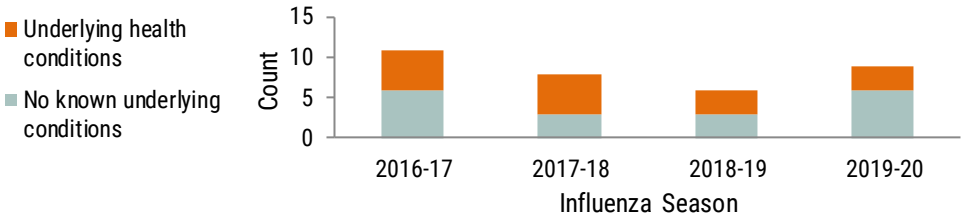


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

Figures 25-26: In week 7, **two new influenza-associated pediatric deaths were reported,** one in an unvaccinated child and one in a child who was vaccinated for the 2019-20 season. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 7, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 7, 2020.

In week 7, **two new influenza-associated pediatric deaths were reported**. One death was associated with influenza A unspecified in a child with no known underlying medical conditions. The other death was associated with influenza B unspecified in a child with known underlying medical conditions. One child was vaccinated for the 2019-20 season.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

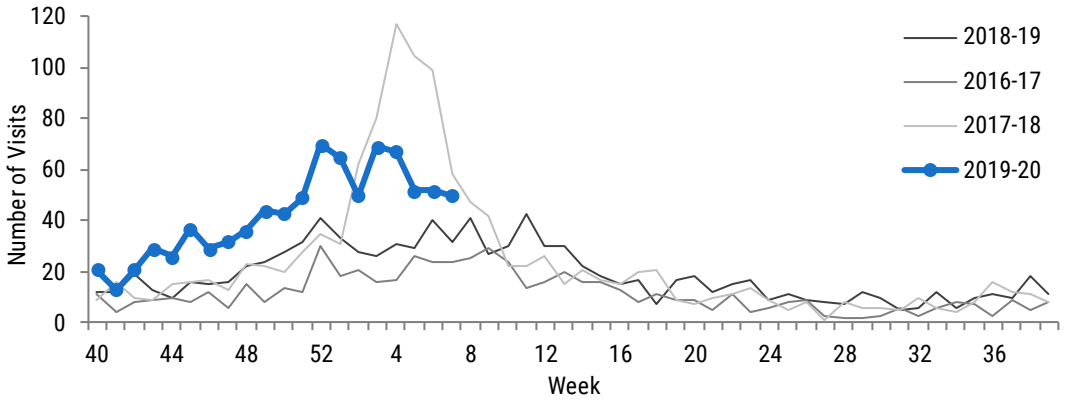
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 7, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was within levels observed at this time in past seasons.



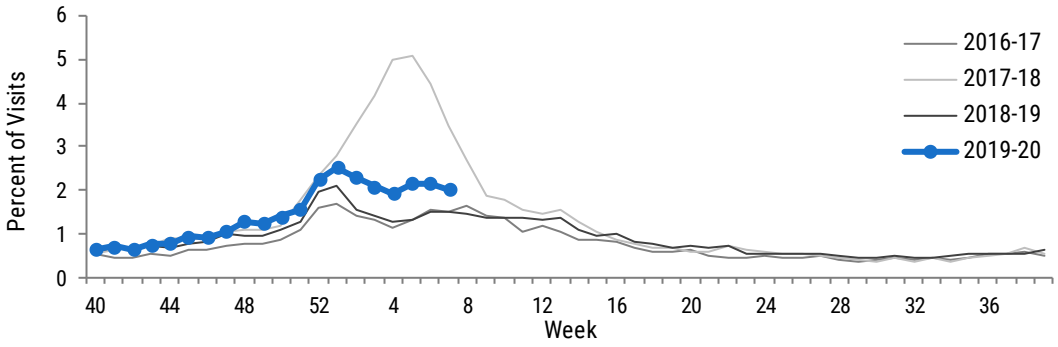
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 7, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 7, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



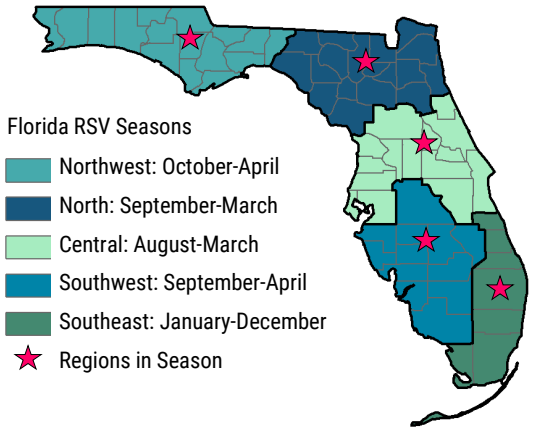
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

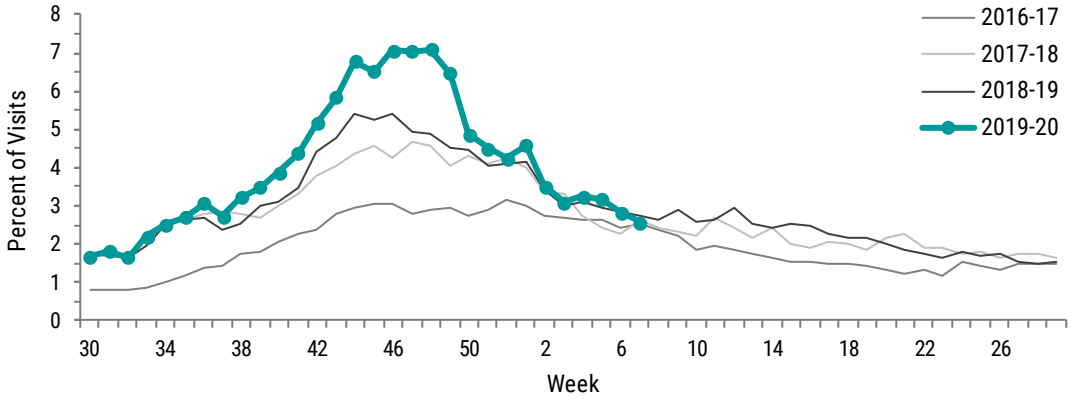
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 7 (February 9-15, 2020) Activity Summary

In week 7, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 7. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 7, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 7, 2020.

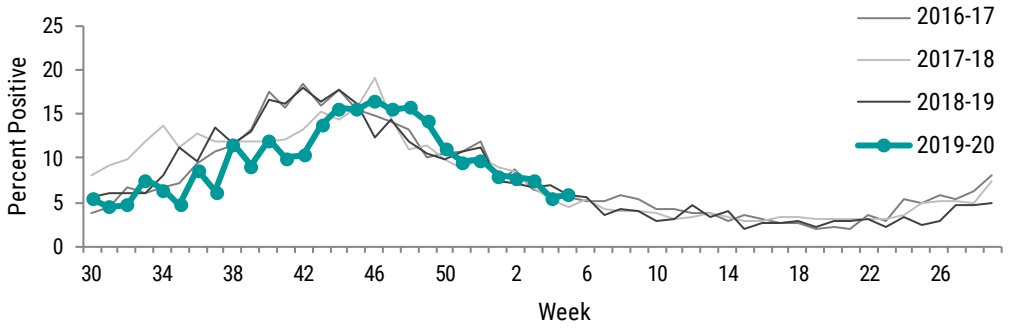
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 7, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 7, 2020. ▶



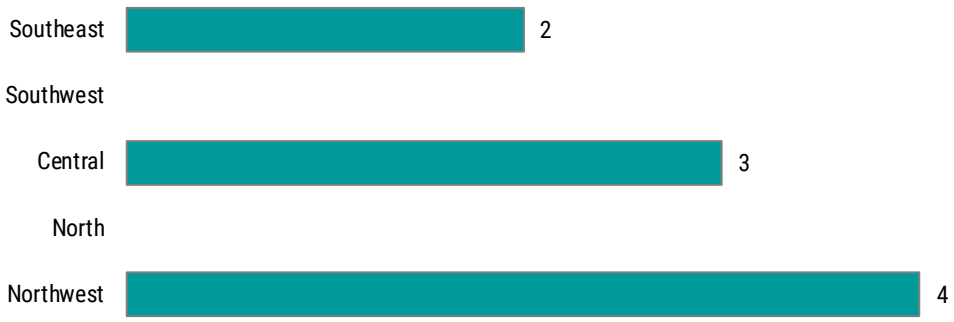
RSV-Associated Outbreaks in Week 7:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 7, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

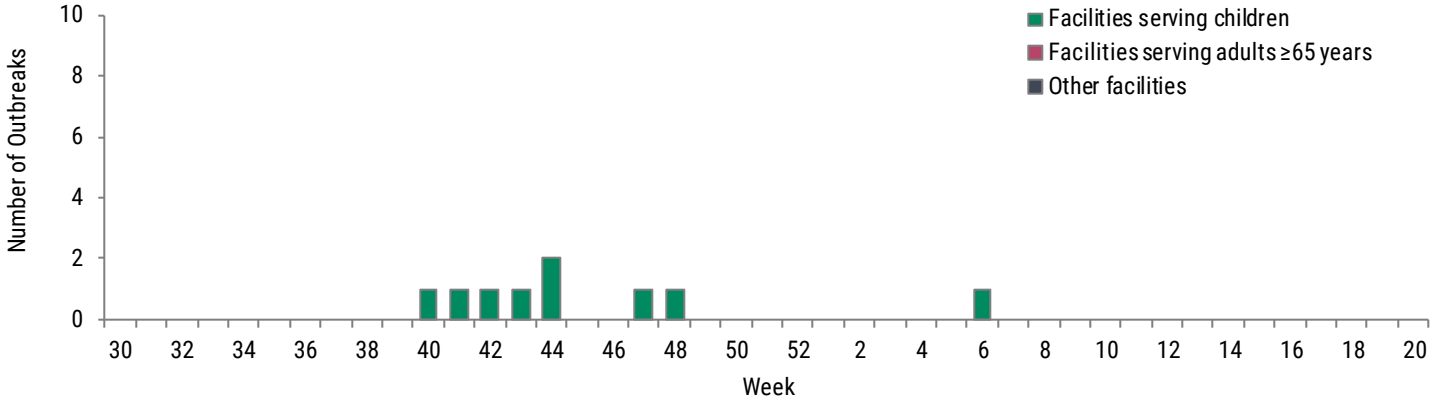
Figure 32: In week 7, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

*Regions defined in figure 29.

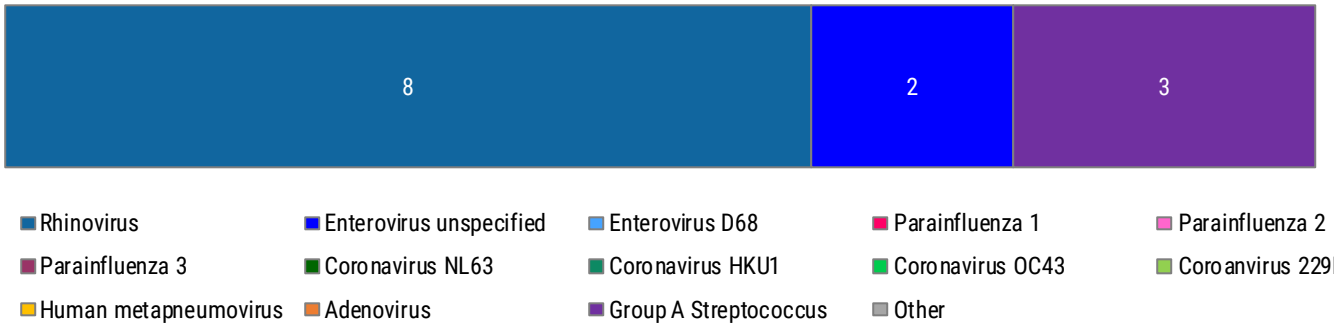
Figure 33: In week 7, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



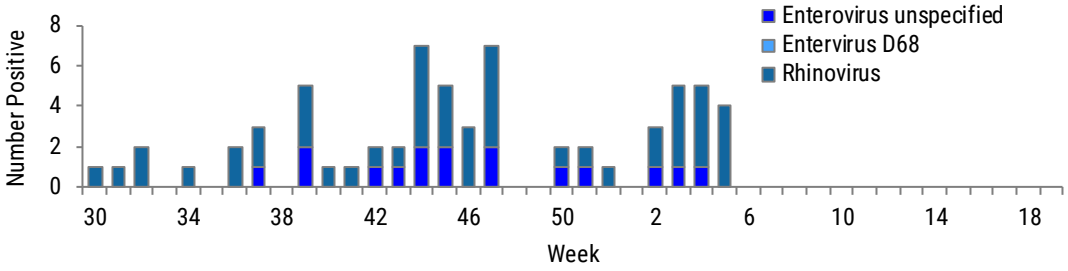
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 7, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

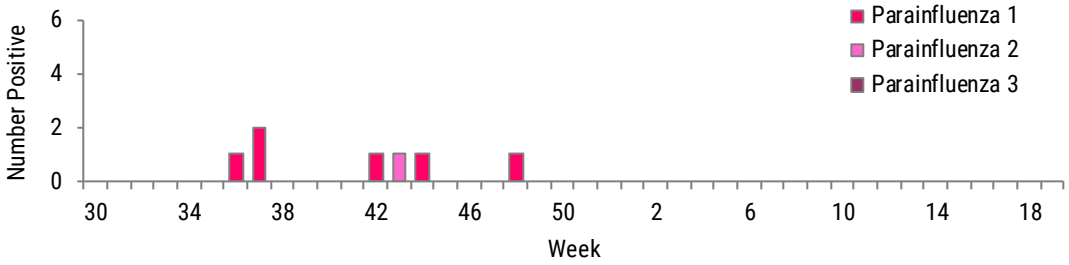


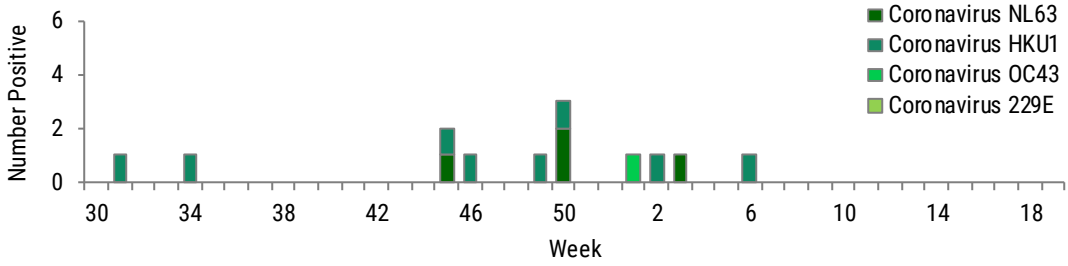
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 7, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

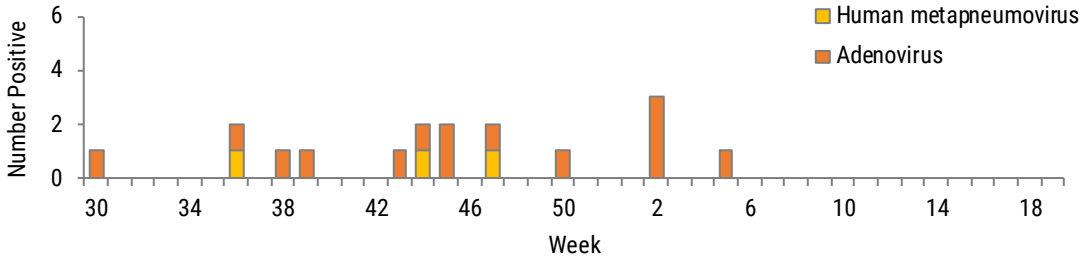
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 7, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Citrus	31	0	0	Influenza A unspecified	Yes	Closed
Long-term care facility	Madison	5	3	0	Influenza A 2009 (H1N1)	Yes	Open
Long-term care facility	Monroe	4	2	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 8, 2020 Florida Flu Review
Date:	Wednesday, February 26, 2020 2:13:11 PM
Attachments:	Week 8, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 8, 2020 Florida Flu Review.

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Eighteen outbreaks were reported, down from 24 outbreaks in the previous week. Of the 18 outbreaks reported, 12 were influenza-associated and six were ILI.

No new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On February 21, 2020, CDC issued interim vaccine effectiveness (VE) estimates for the 2019-20 influenza season. For all ages, the VE was 45% (95% confidence interval [CI] = 36-53%) against any influenza virus illness and was 55% (95% CI = 42-65%) among children six months to 17 years (www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6907a1-H.pdf).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 8: 2/16/20-2/22/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

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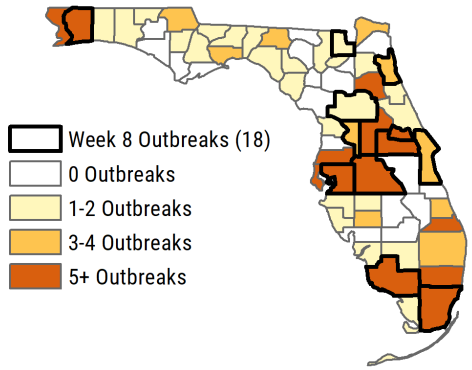
In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

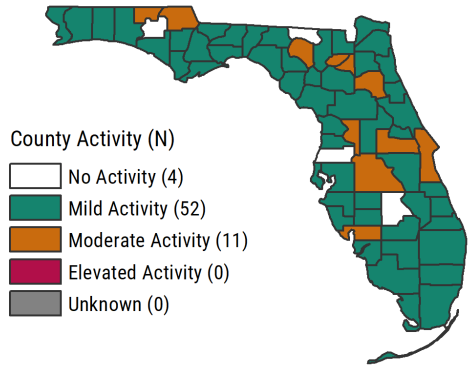
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/22/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 26, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007152
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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

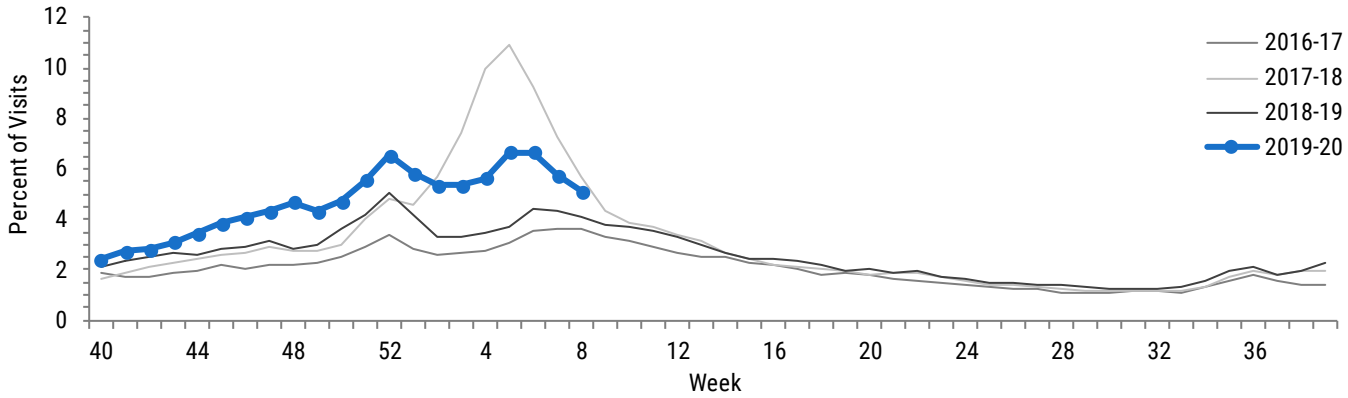
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 8, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 8, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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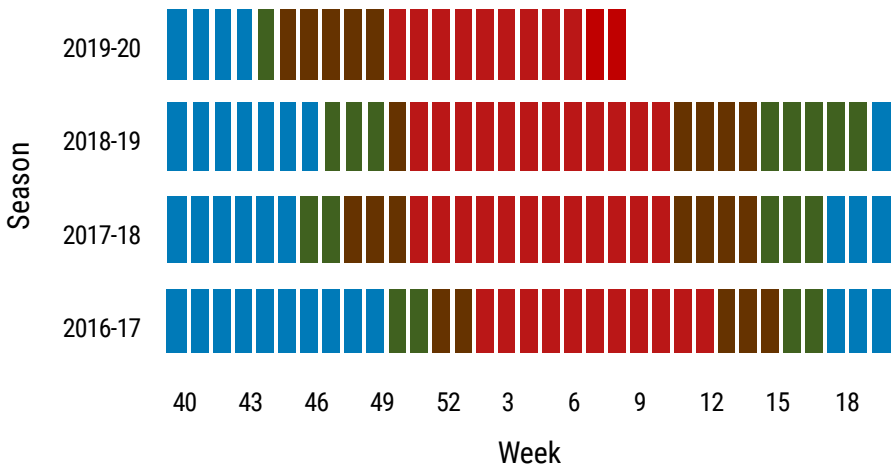
Statewide Activity

Figure 2: In week 8, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 8, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 8, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 8, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

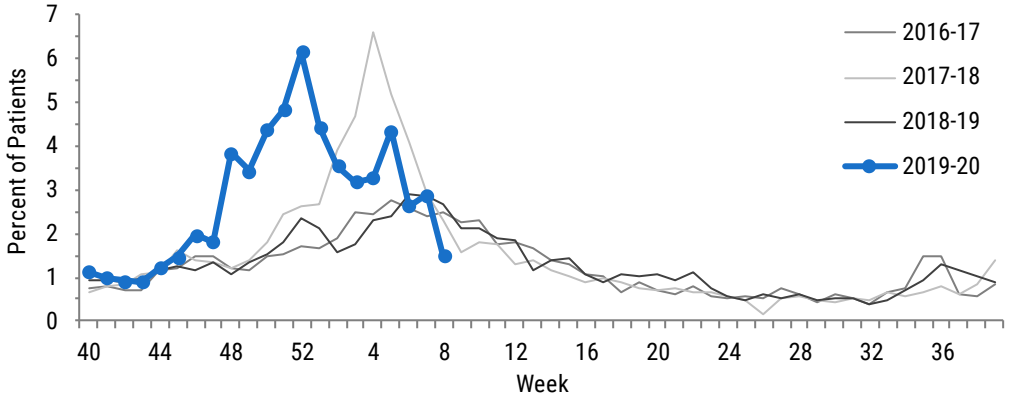
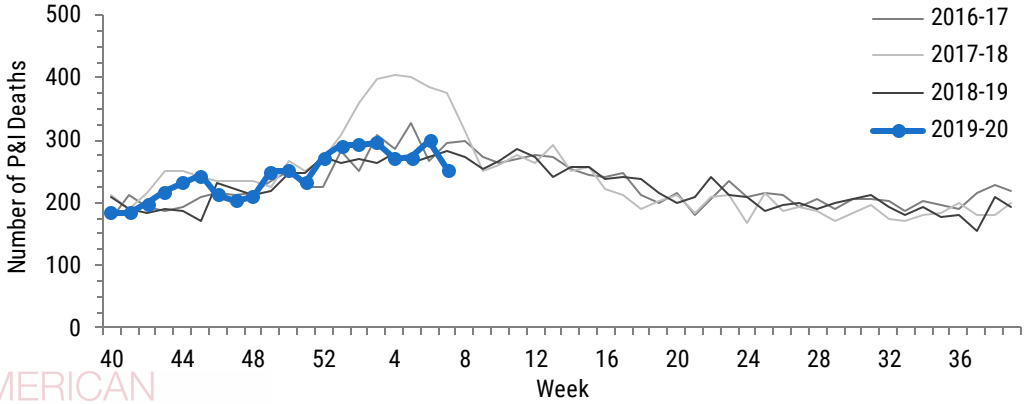


Figure 4: In week 7 (ending 2/15/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 8. Eleven counties reported **moderate activity.**

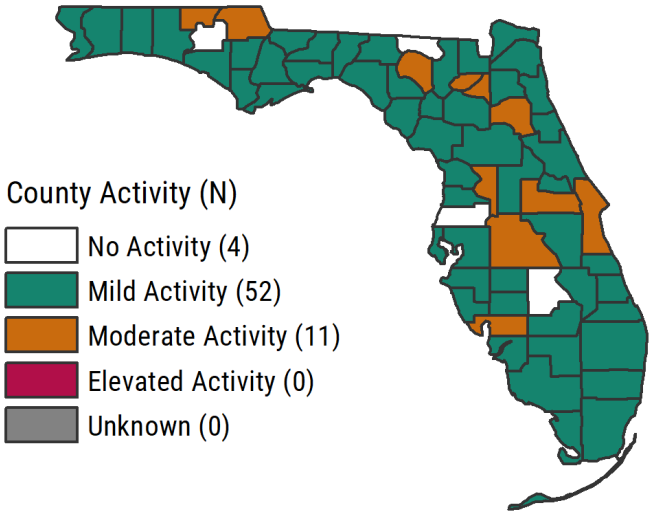
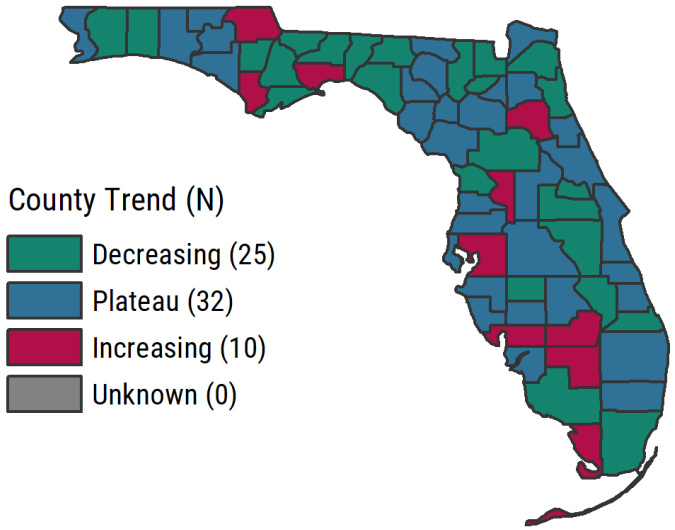
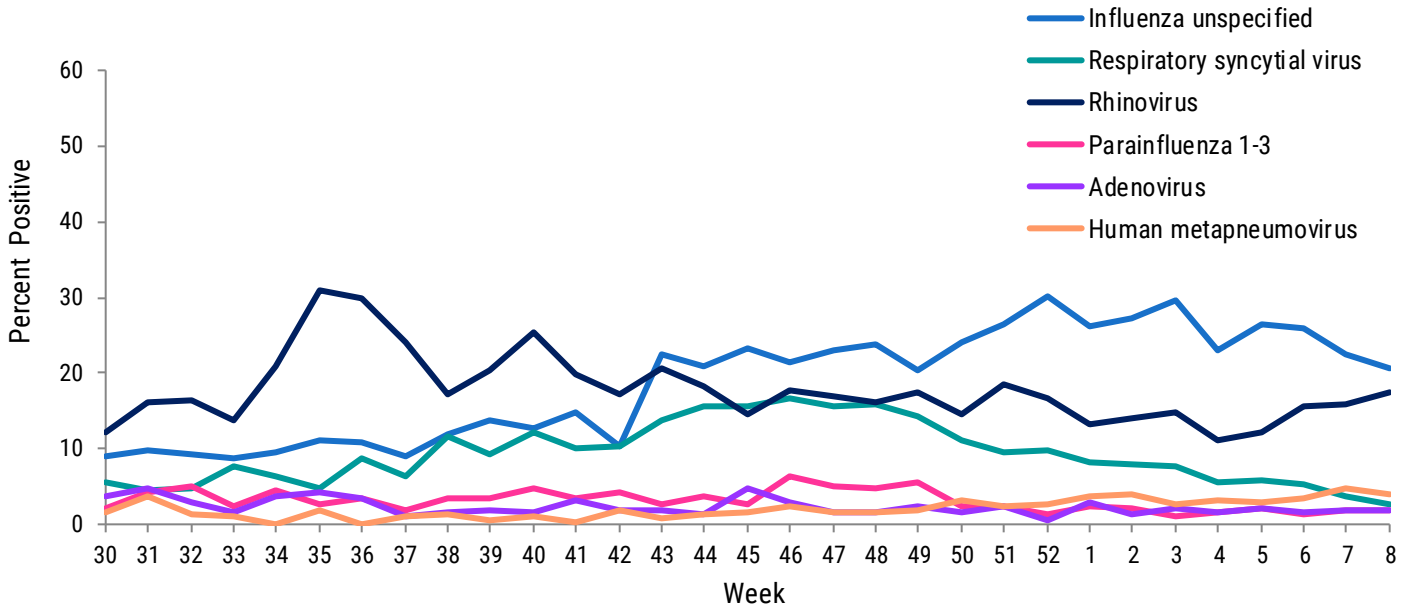


Figure 7: Most counties reported **activity at a plateau** for week 8. Ten counties reported **increasing activity,** and twenty-five counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 8, the **percent of specimens testing positive for influenza decreased** but remained higher than other respiratory viruses under surveillance. The **percent of specimens testing positive for rhinovirus** increased notably in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Week 8 Outbreaks at a Glance:

Number Reported:
18 Outbreaks

Influenza-Associated:
12 Outbreaks

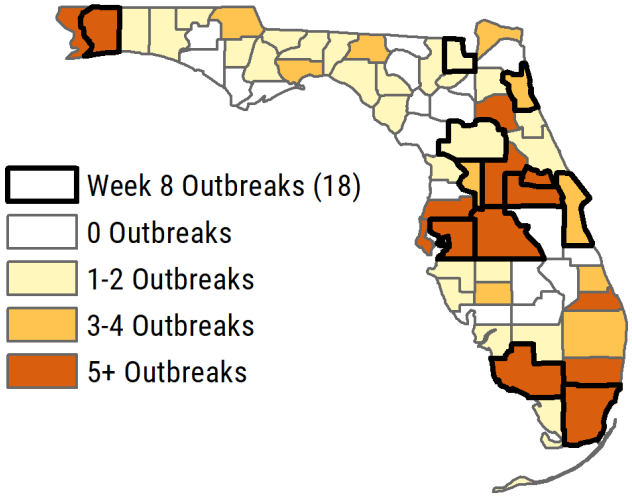
Severe Outcomes*:
4 Outbreaks

Outbreak Summary:

In week 8, 12 influenza-associated and six ILI outbreaks were reported, a decrease from the previous week.

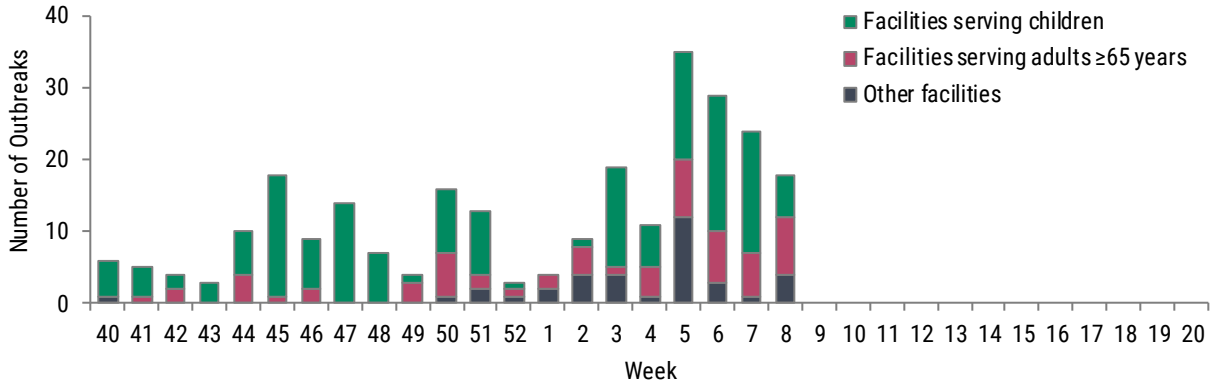
Severe outcomes* were reported in four of 18 outbreaks. One or more hospitalizations were reported in each of these four outbreaks. One death was reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 8, all four outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 8 are **outlined in bold.**

Figure 9: In week 8, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, six outbreaks** were reported in **facilities serving children,** and **four outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 8, **62.8% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 8, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

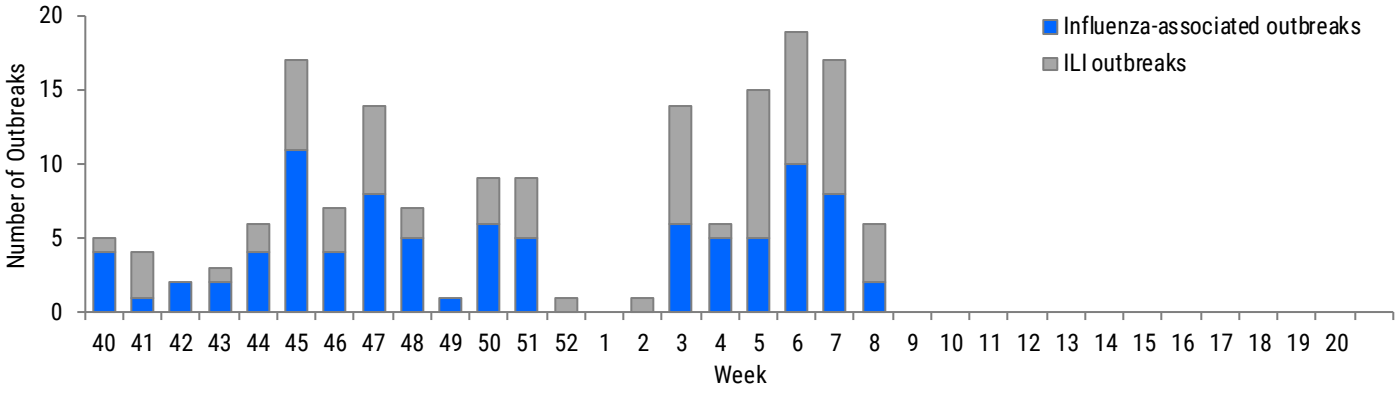
6 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 8, six new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 8, **two influenza-associated outbreaks** and **four ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Facilities Serving Adults ≥65 yrs.**:

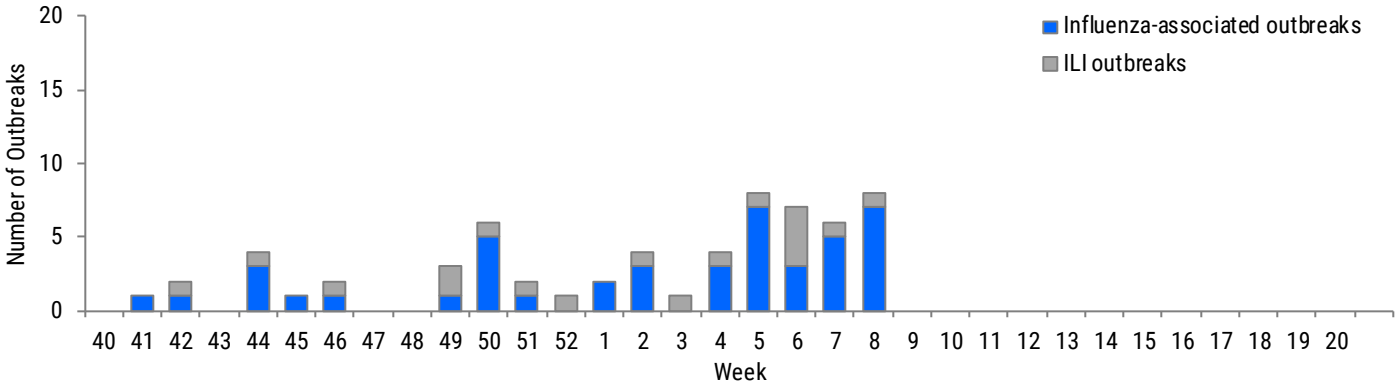
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 8, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 8, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

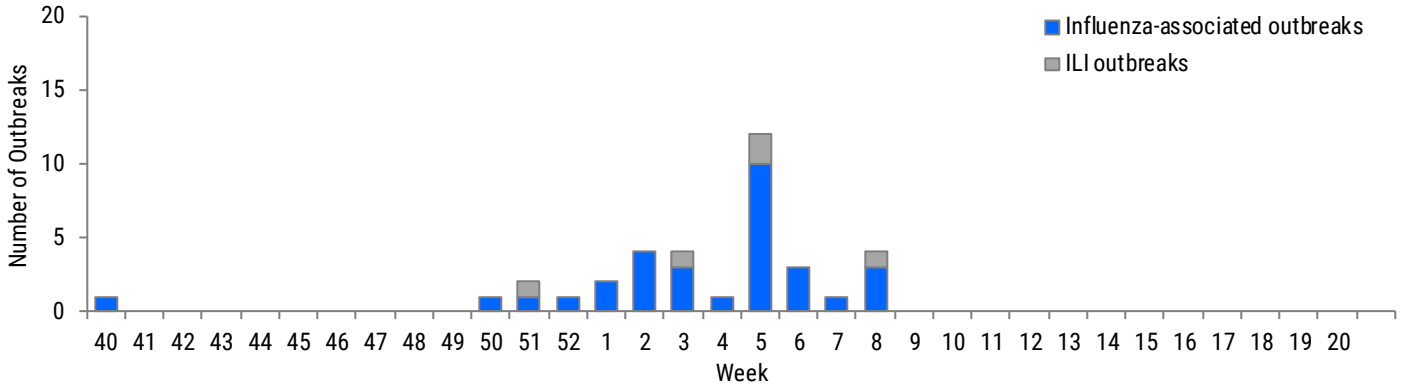
4 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 8, four new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 8, **three influenza-associated outbreaks** and **one ILI outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	126 (48.3%)	74 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	37 (14.2%)	15 influenza-associated outbreaks 22 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	18 (6.9%)	8 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.8%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (11.1%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.5%)	27 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	4 (1.5%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**261 (100.0%)**	**164 influenza-associated outbreaks** **97 ILI outbreaks**

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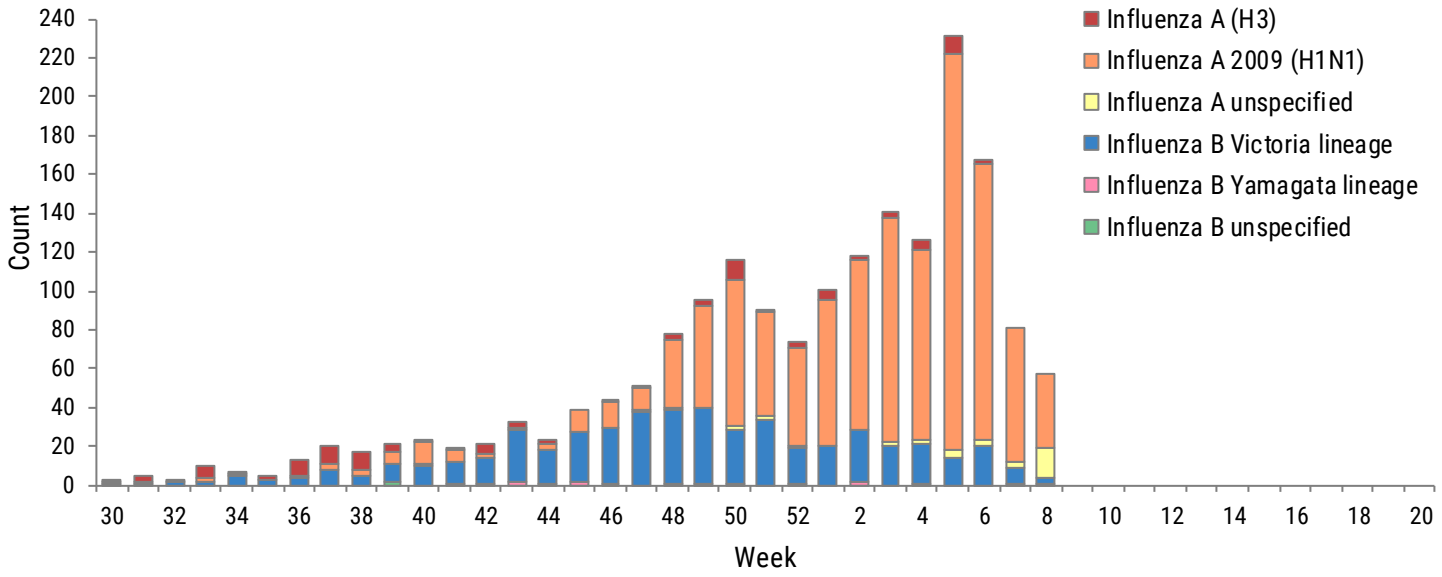
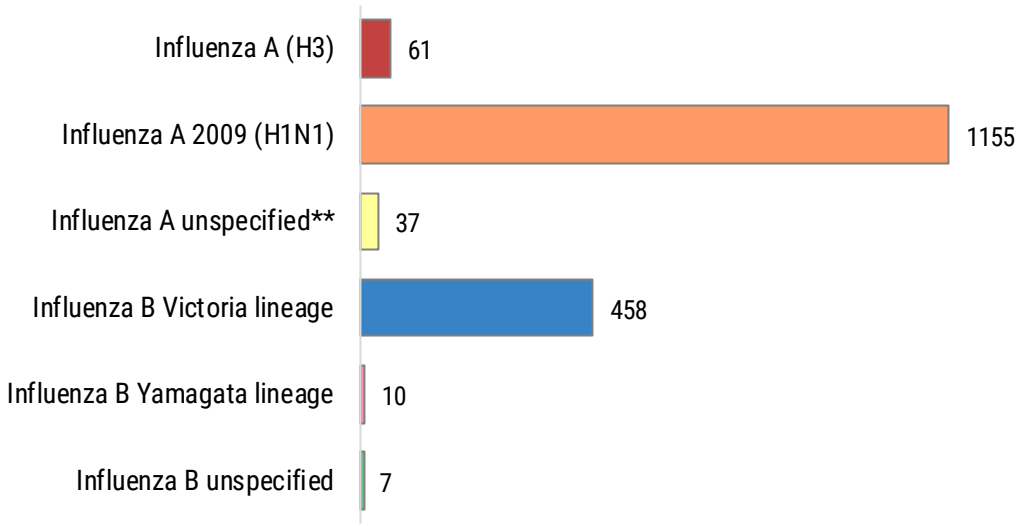
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 8, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 8, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 8, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

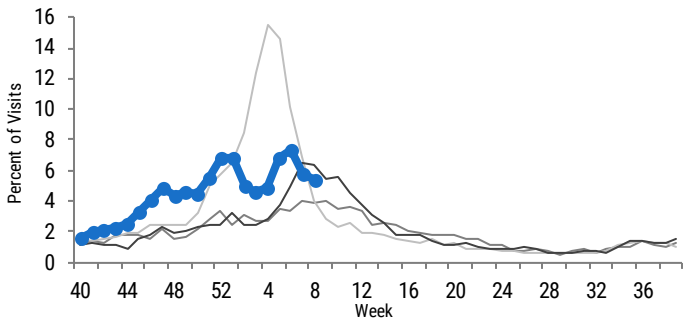


Figure 17: In **region 2, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

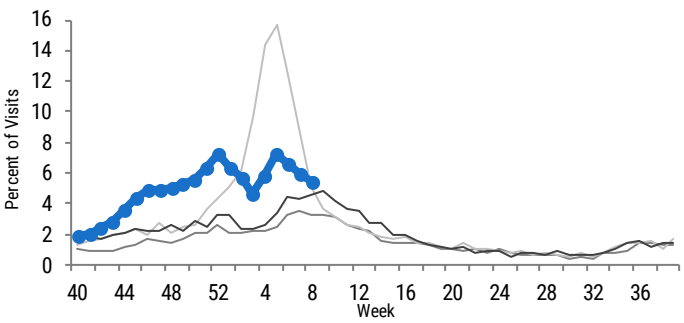


Figure 18: In **region 3, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

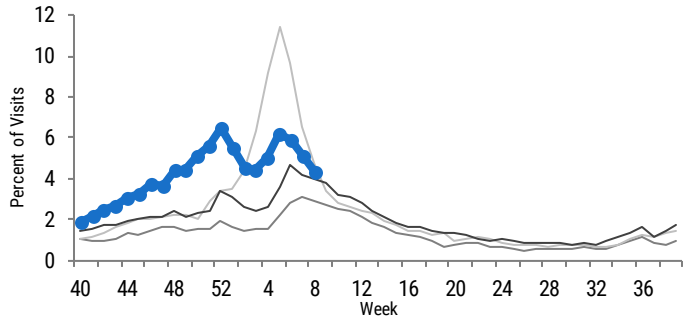


Figure 19: In **region 4, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

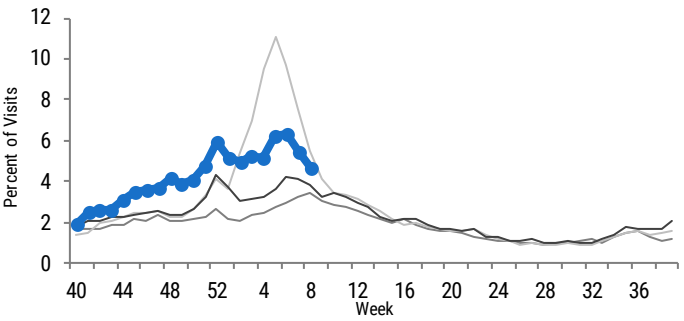


Figure 20: In **region 5, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

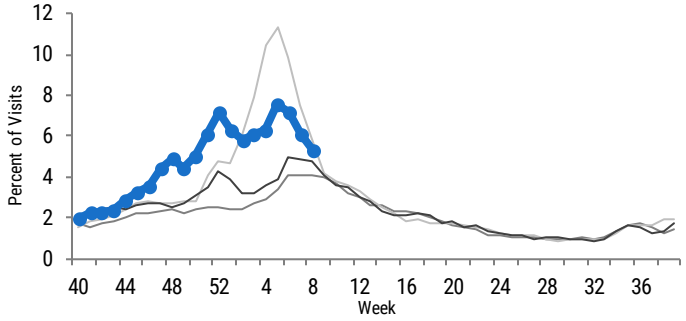


Figure 21: In **region 6, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

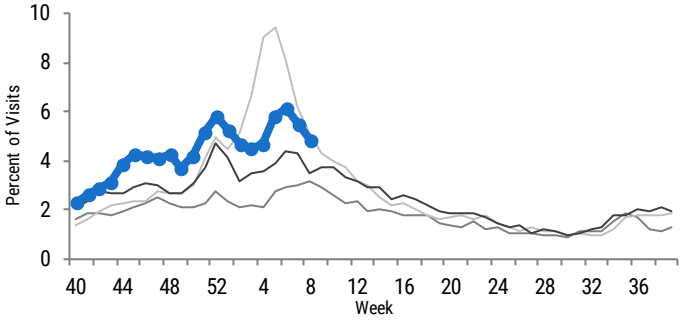
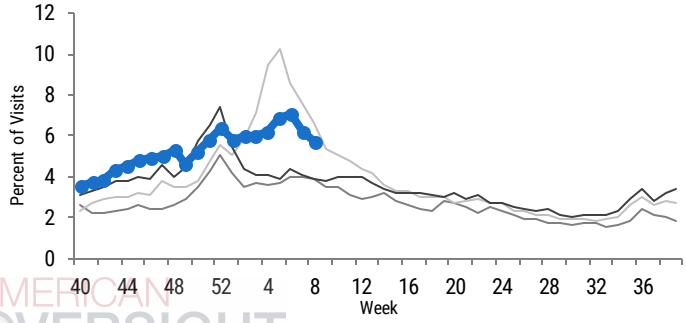


Figure 22: In **region 7, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.



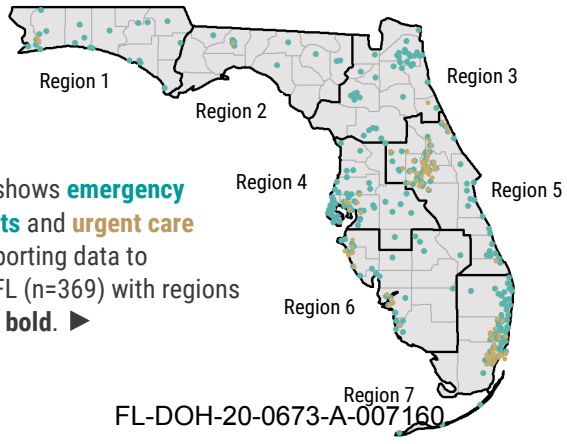


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

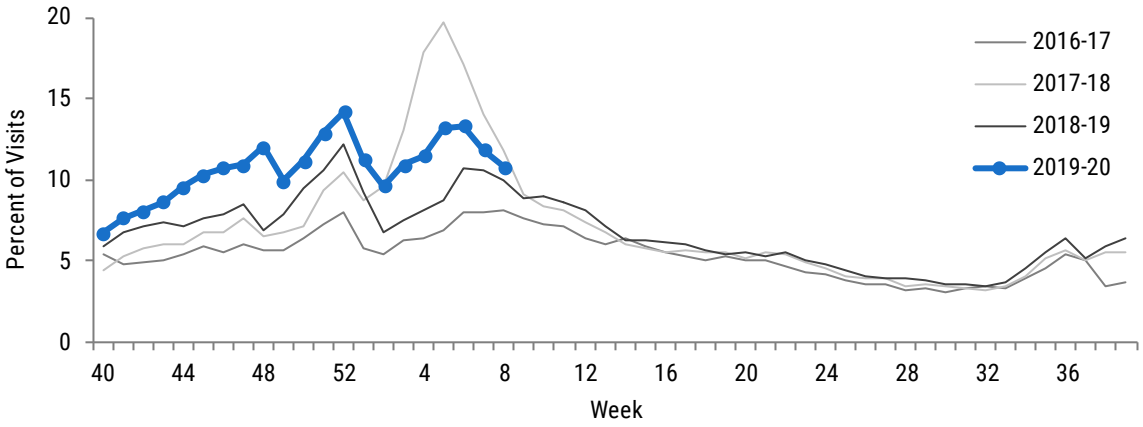
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

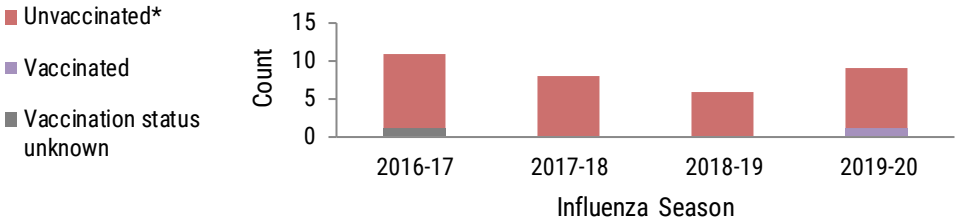
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 8, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

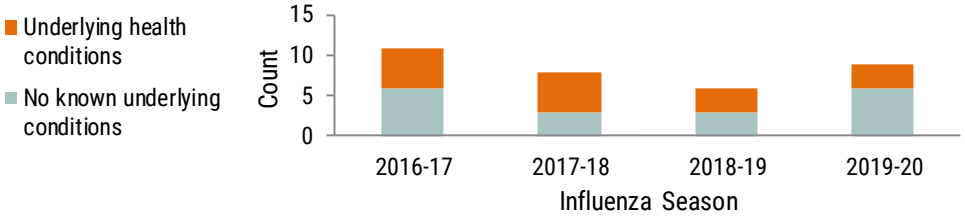


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

Figures 25-26: In week 8, **no new influenza-associated pediatric deaths were reported**. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 8, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 8, 2020.

In week 8, **no new influenza-associated pediatric deaths were reported**.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

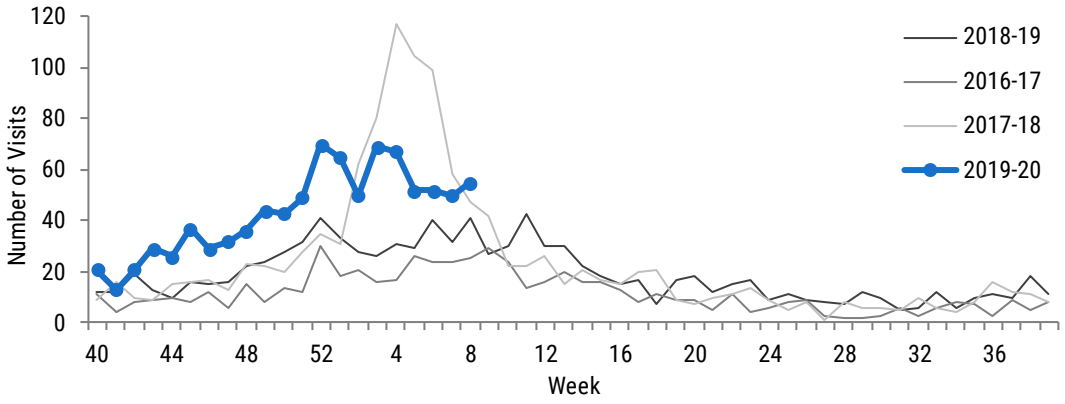
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 8, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above levels observed at this time in past seasons.



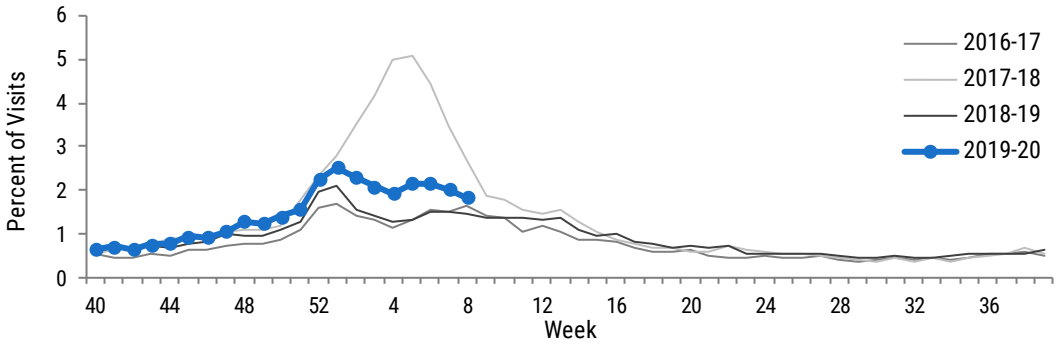
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 8, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 8, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



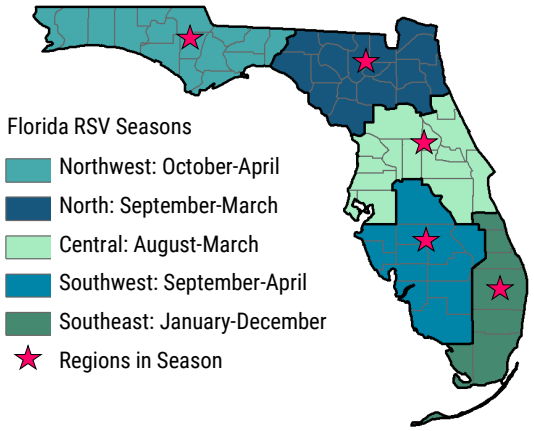
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

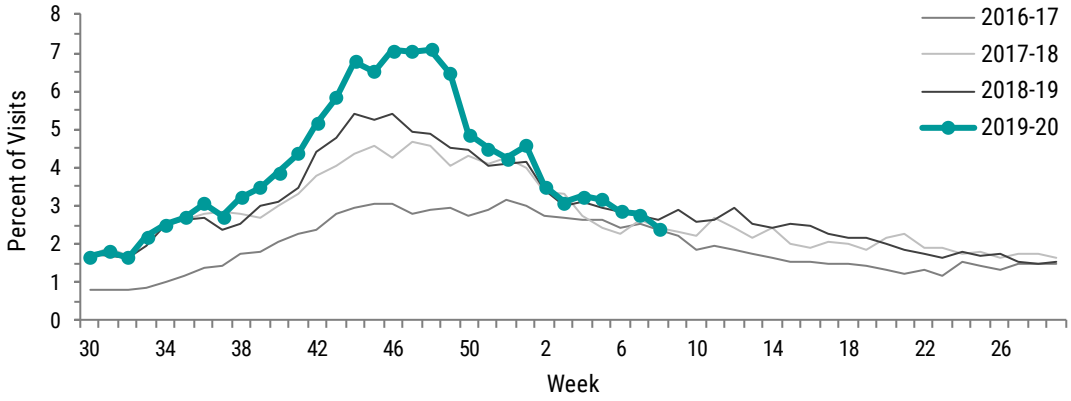
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 8 (February 16-22, 2020) Activity Summary

In week 8, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 8. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 8, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 8, 2020.

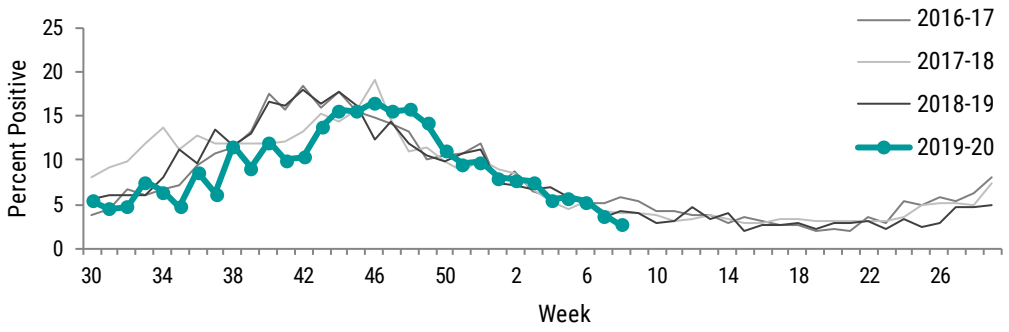
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 8, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 8, 2020. ▶



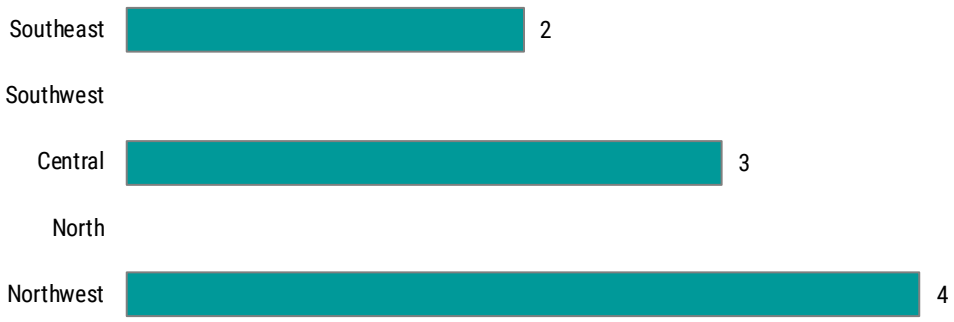
RSV-Associated Outbreaks in Week 8:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 8, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

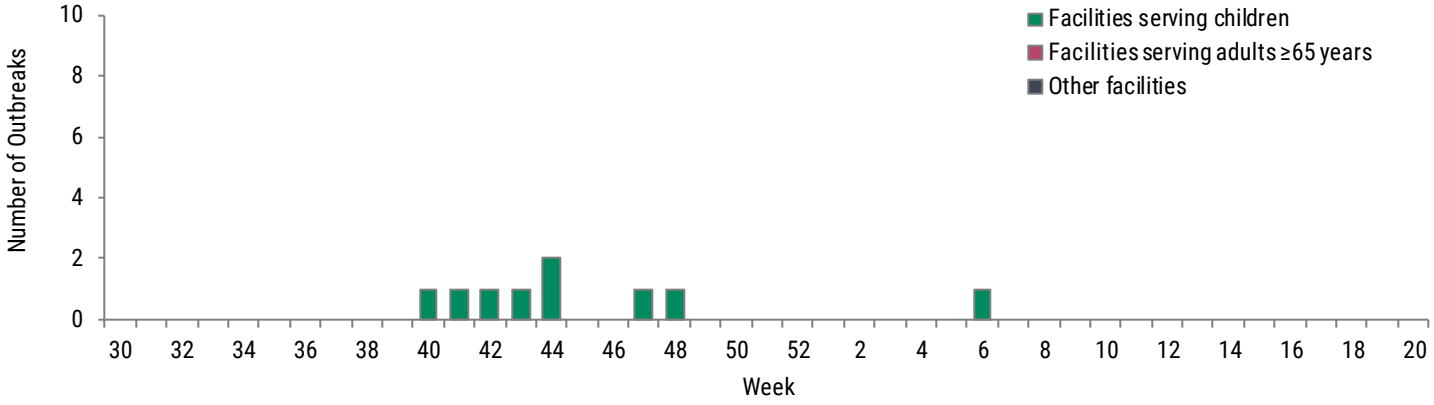
Figure 32: In week 8, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

*Regions defined in figure 29.

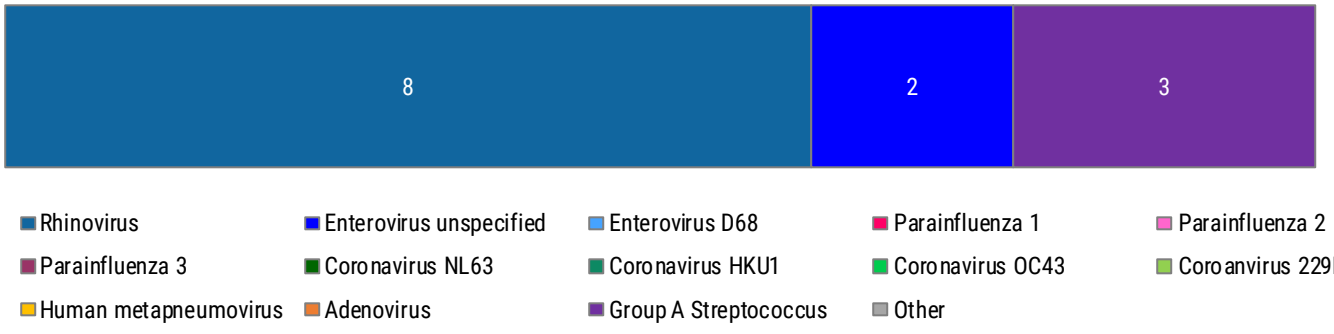
Figure 33: In week 8, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



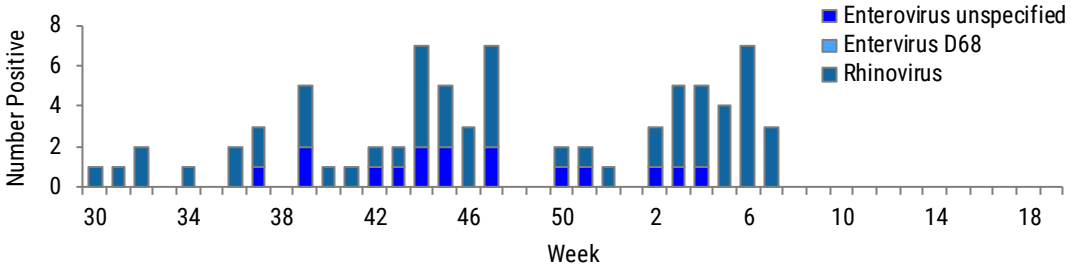
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

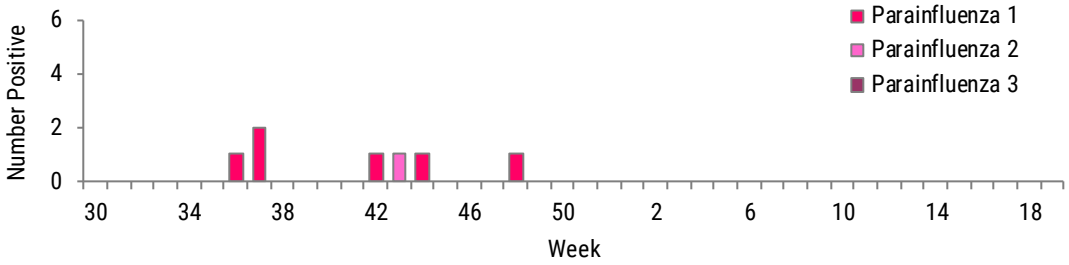


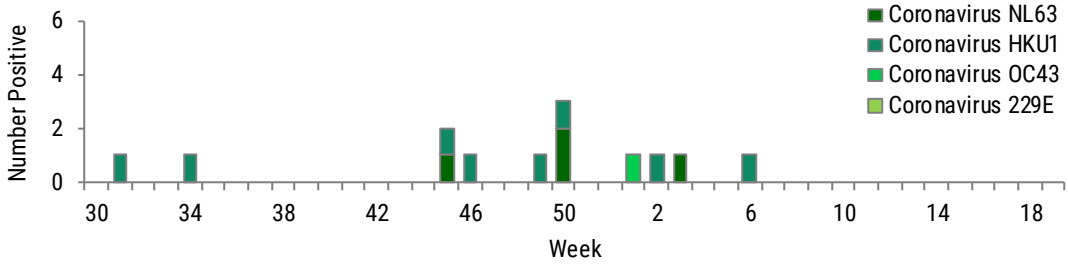
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 8, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

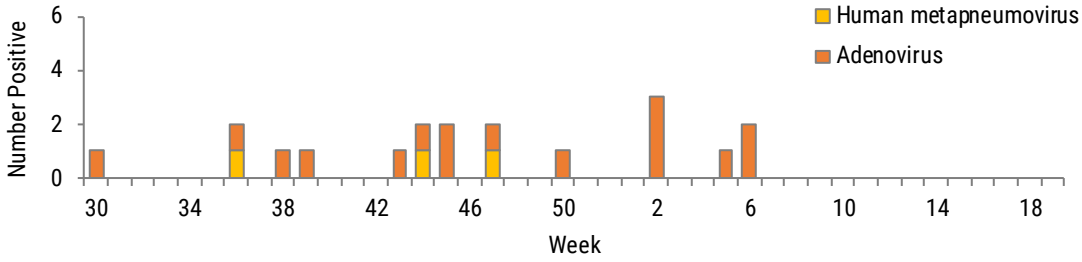
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 8, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Nursing home	Santa Rosa	54	Unknown	Unknown	Influenza A unspecified	Yes	Open
Assisted living facility	Polk	2	2	0	Influenza A unspecified	Yes	Closed
Assisted living facility	Sumter	8	4	0	Influenza A 2009 (H1N1)	Yes	Open
Assisted living facility	Seminole	12	3	1	Influenza A 2009 (H1N1)	Yes	Closed
Correctional facility	Sumter	40	Unknown	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 8, 2020 Florida Flu Review
Date:	Wednesday, February 26, 2020 2:13:17 PM
Attachments:	Week 8, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 8, 2020 Florida Flu Review.

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Eighteen outbreaks were reported, down from 24 outbreaks in the previous week. Of the 18 outbreaks reported, 12 were influenza-associated and six were ILI.

No new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On February 21, 2020, CDC issued interim vaccine effectiveness (VE) estimates for the 2019-20 influenza season. For all ages, the VE was 45% (95% confidence interval [CI] = 36-53%) against any influenza virus illness and was 55% (95% CI = 42-65%) among children six months to 17 years (www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6907a1-H.pdf).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

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- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
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Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 8: 2/16/20-2/22/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 8 influenza & influenza-like illness (ILI) activity summary:

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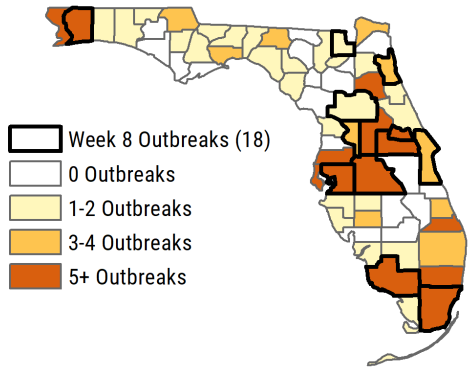
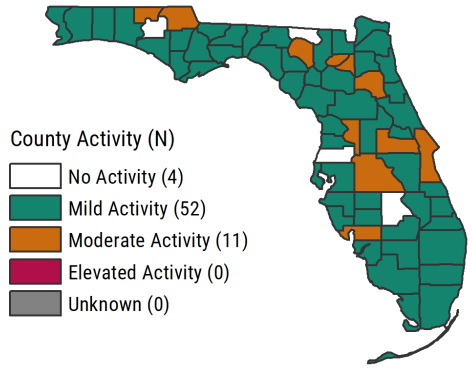
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

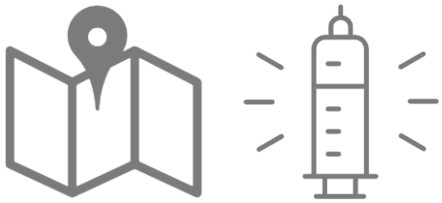
Reported as of 2/22/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 26, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007171

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

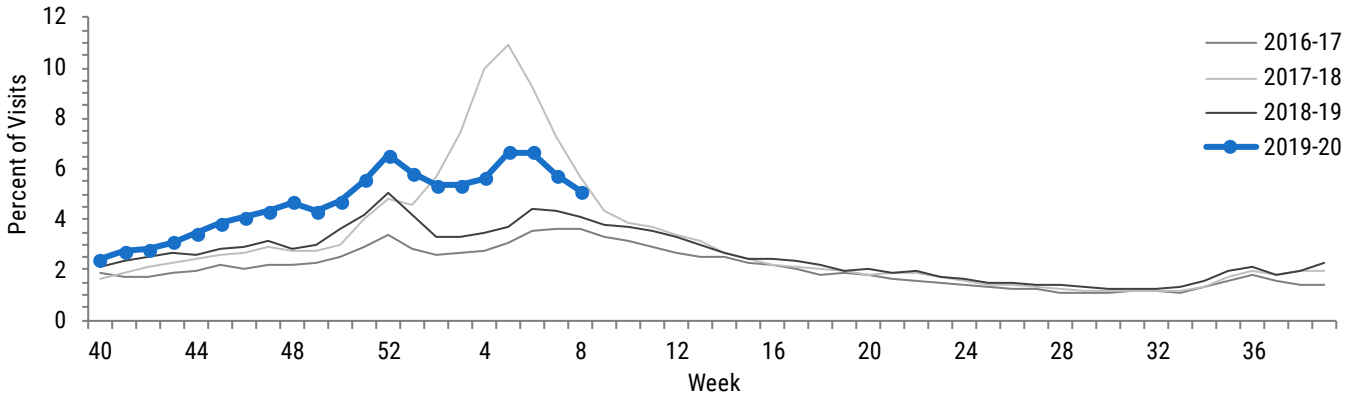
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 8, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 8, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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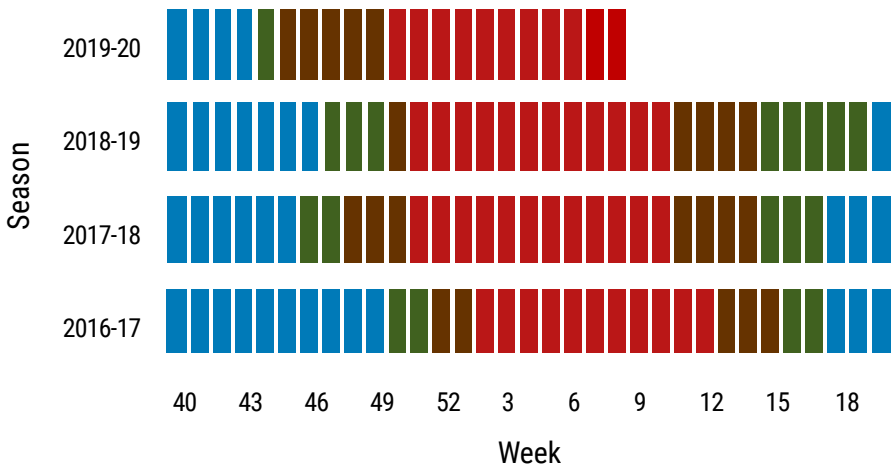
Statewide Activity

Figure 2: In week 8, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 8, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 8, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 8, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

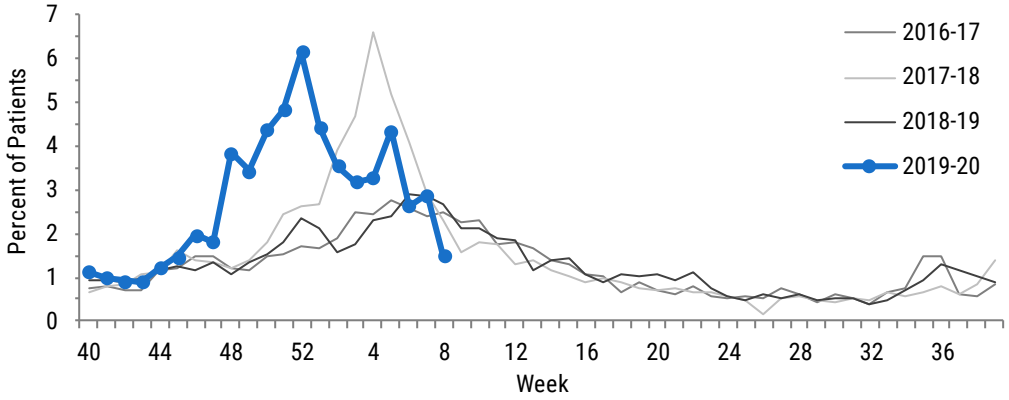
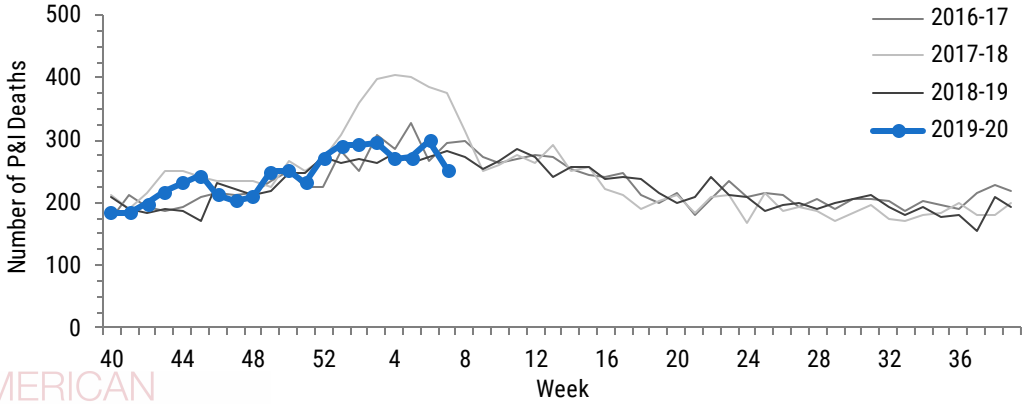


Figure 4: In week 7 (ending 2/15/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 8. Eleven counties reported **moderate activity.**

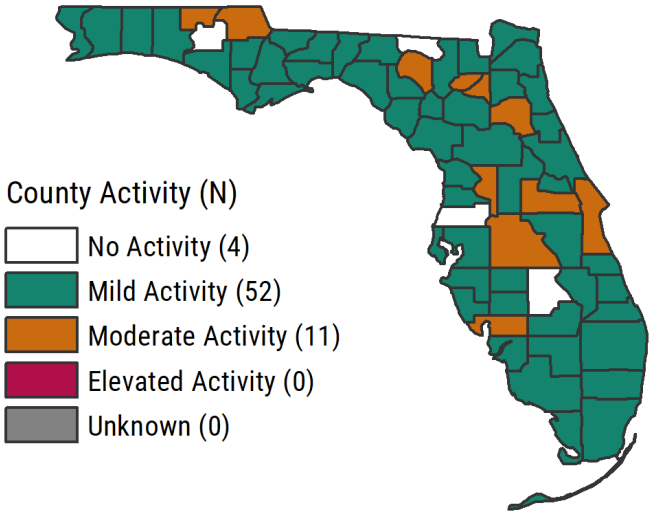
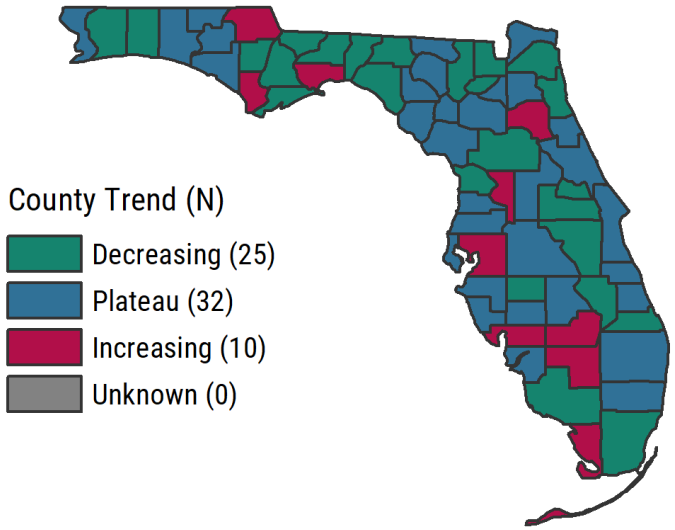
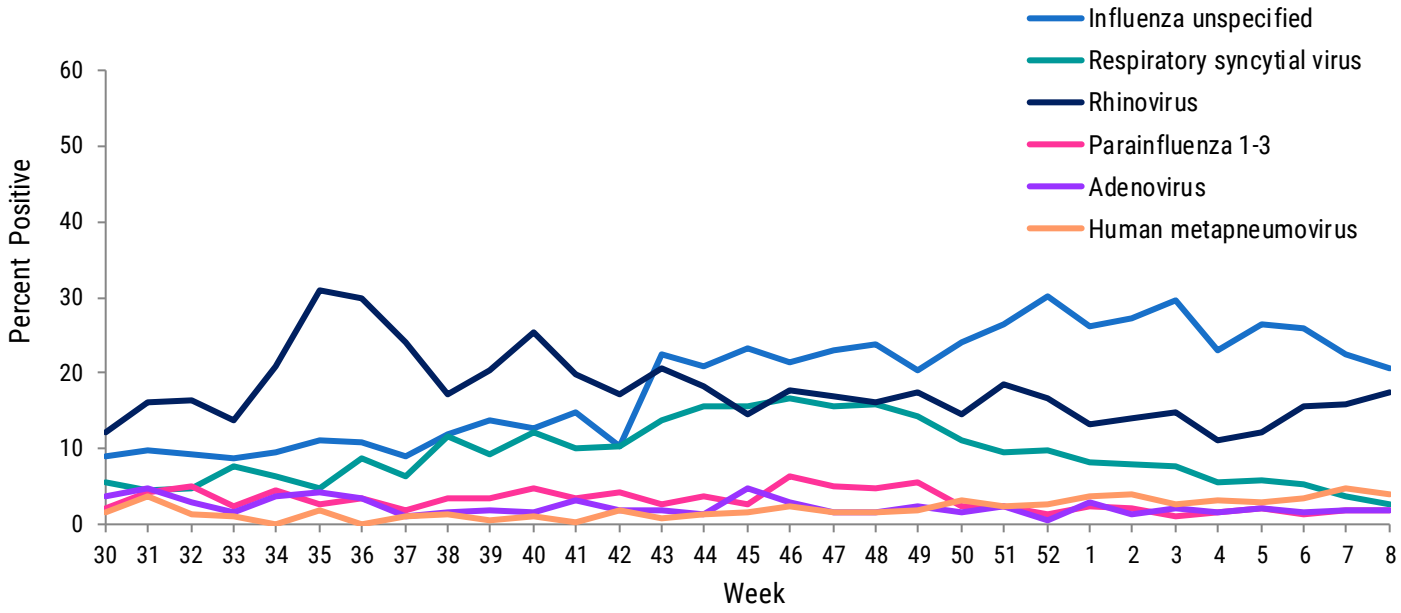


Figure 7: Most counties reported **activity at a plateau** for week 8. Ten counties reported **increasing activity,** and twenty-five counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 8, the **percent of specimens testing positive for influenza** **decreased** but remained higher than other respiratory viruses under surveillance. The **percent of specimens testing positive for rhinovirus** increased notably in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Week 8 Outbreaks at a Glance:

Number Reported:
18 Outbreaks

Influenza-Associated:
12 Outbreaks

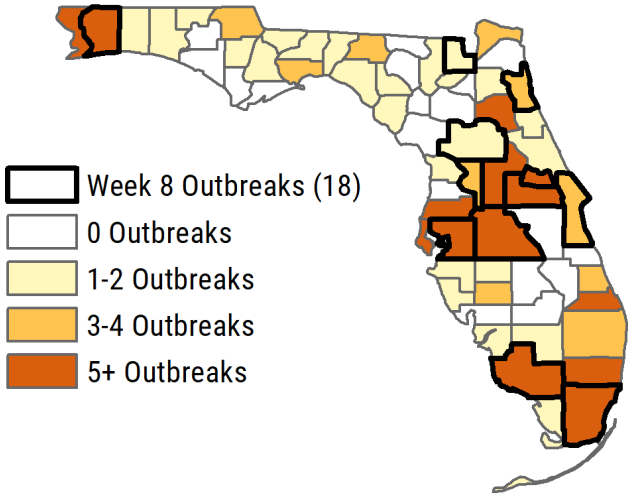
Severe Outcomes*:
4 Outbreaks

Outbreak Summary:

In week 8, 12 influenza-associated and six ILI outbreaks were reported, a decrease from the previous week.

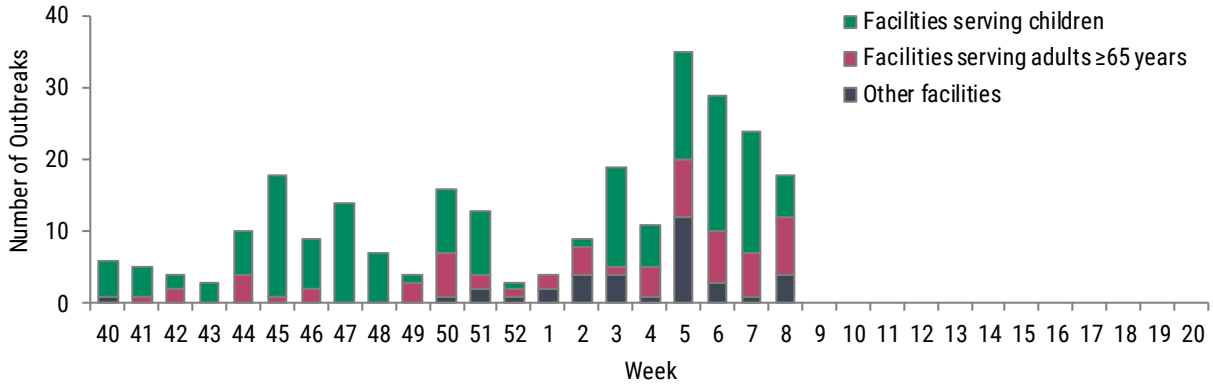
Severe outcomes* were reported in four of 18 outbreaks. One or more hospitalizations were reported in each of these four outbreaks. One death was reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 8, all four outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 8 are **outlined in bold.**

Figure 9: In week 8, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, six outbreaks** were reported in **facilities serving children,** and **four outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 8, **62.8% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 8, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

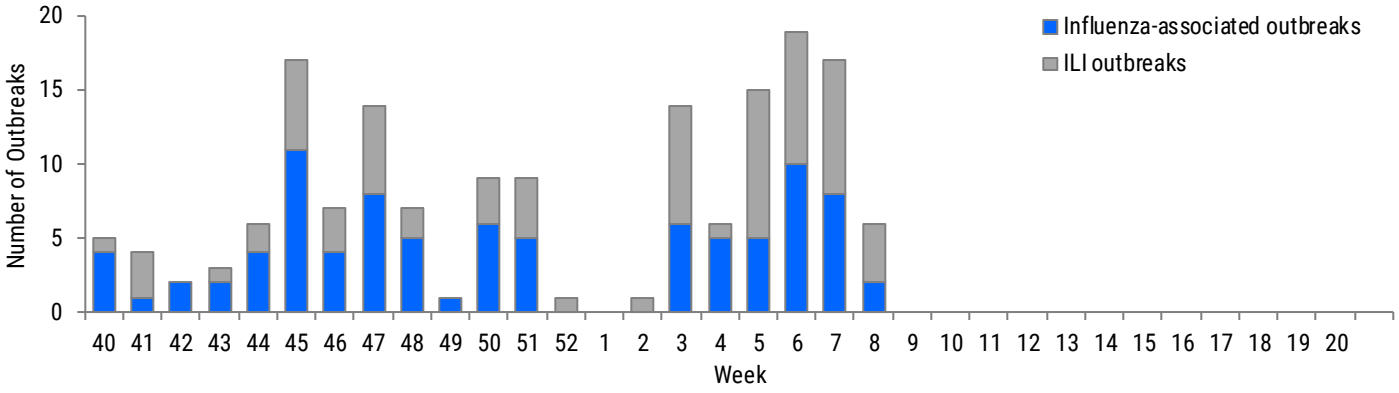
6 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 8, six new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 8, **two influenza-associated outbreaks** and **four ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Facilities Serving Adults ≥65 yrs.**:

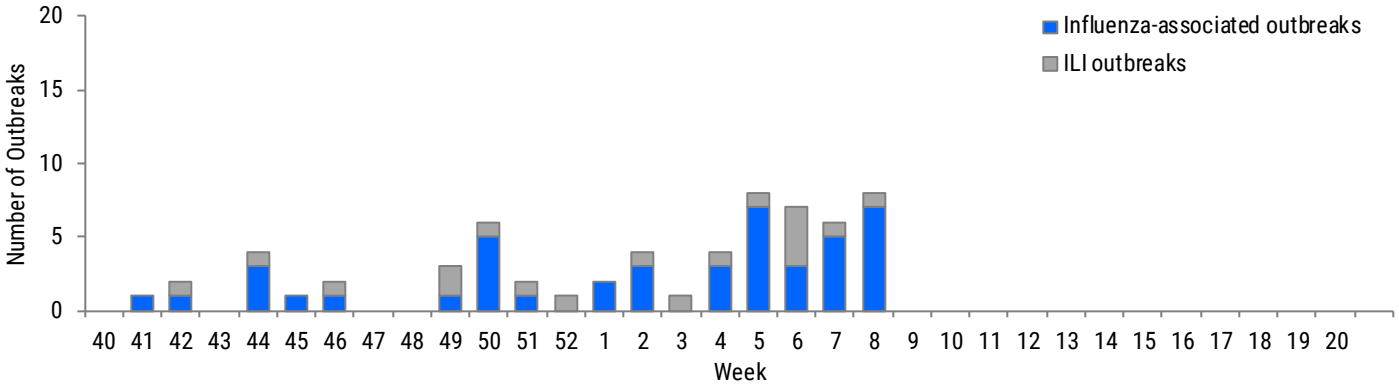
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 8, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 8, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

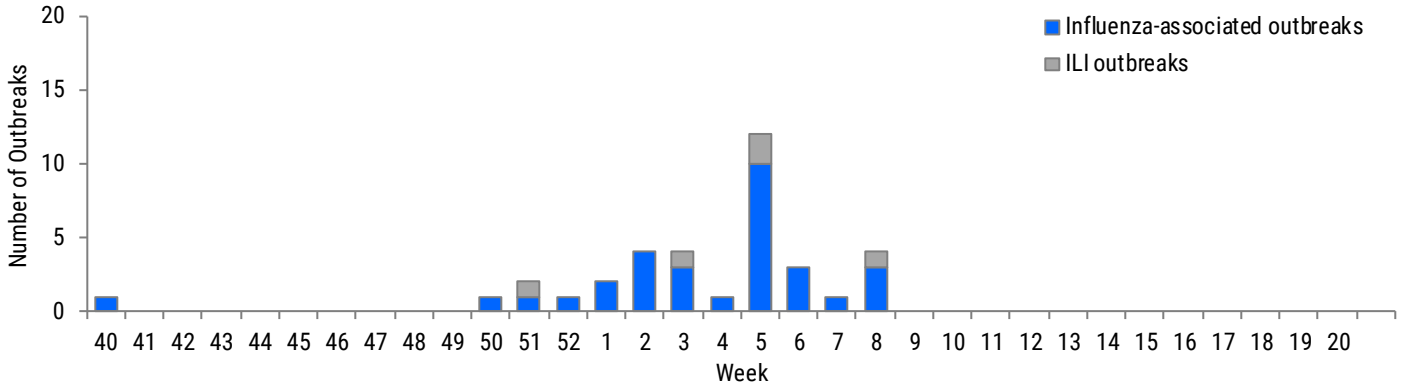
4 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 8, four new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 8, **three influenza-associated outbreaks** and **one ILI outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	126 (48.3%)	74 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	37 (14.2%)	15 influenza-associated outbreaks 22 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	18 (6.9%)	8 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.8%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (11.1%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.5%)	27 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	4 (1.5%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**261 (100.0%)**	**164 influenza-associated outbreaks** **97 ILI outbreaks**

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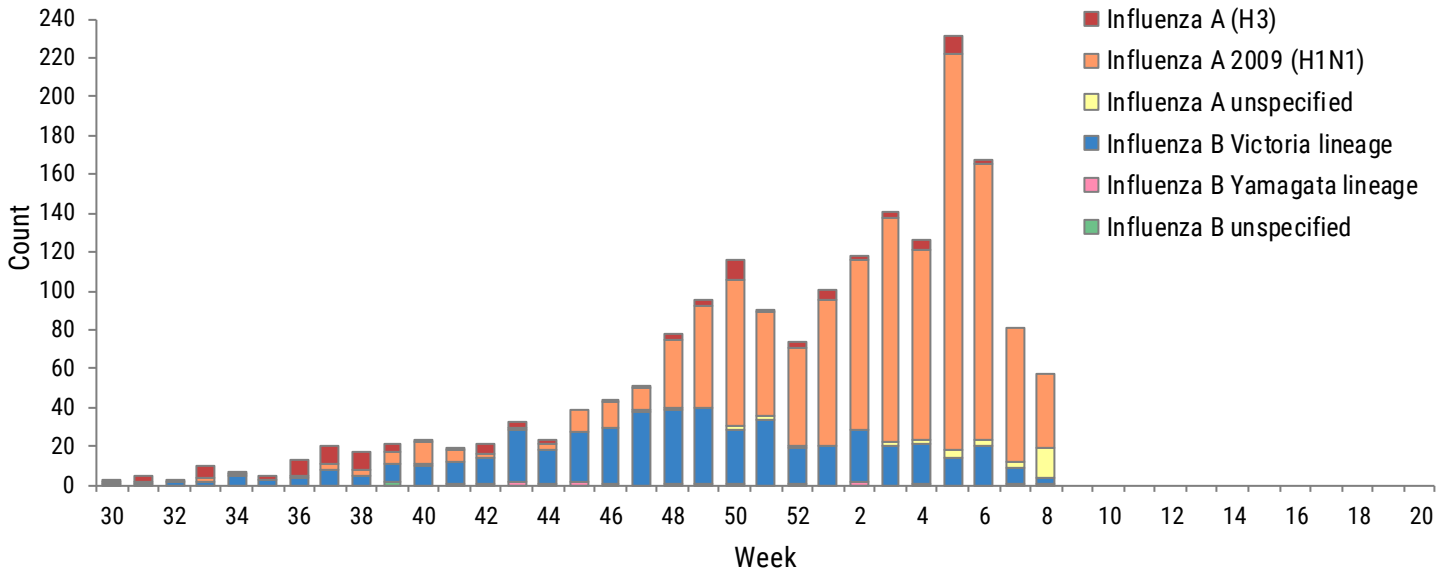
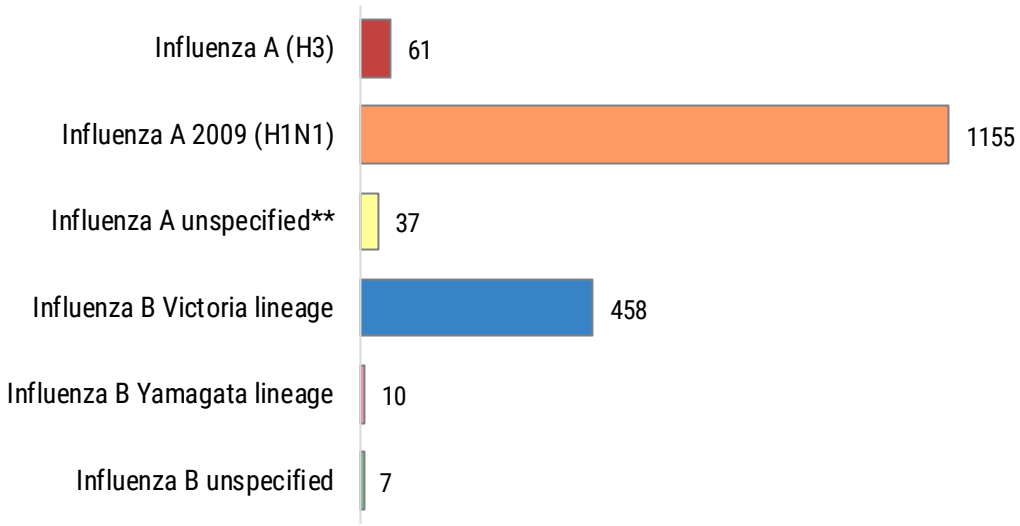
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 8, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 8, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 8, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

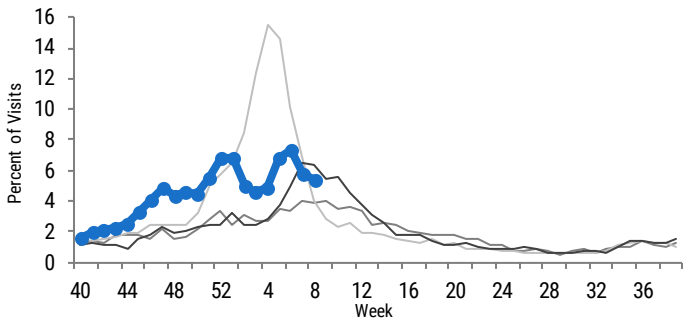


Figure 17: In **region 2, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

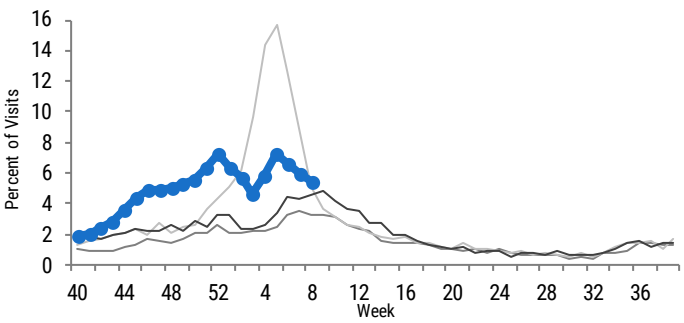


Figure 18: In **region 3, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

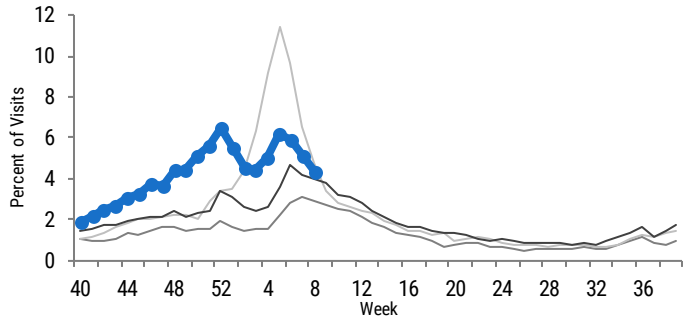


Figure 19: In **region 4, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

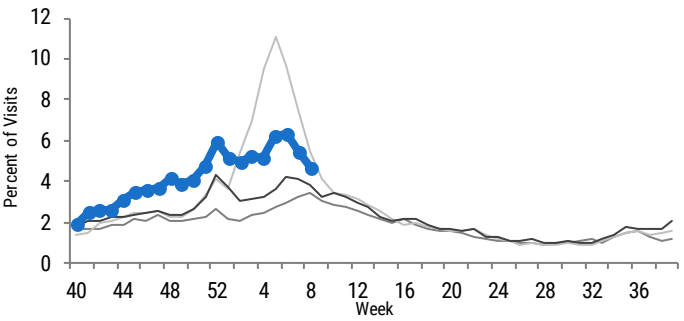


Figure 20: In **region 5, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

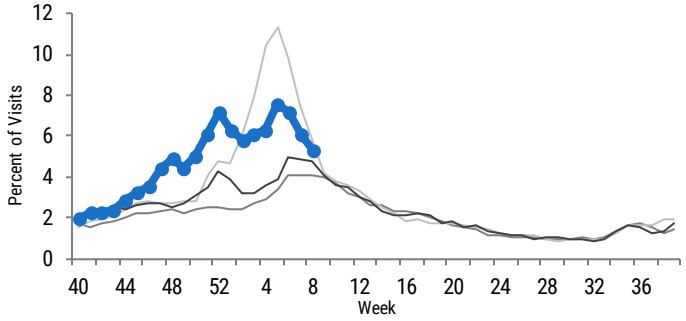


Figure 21: In **region 6, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

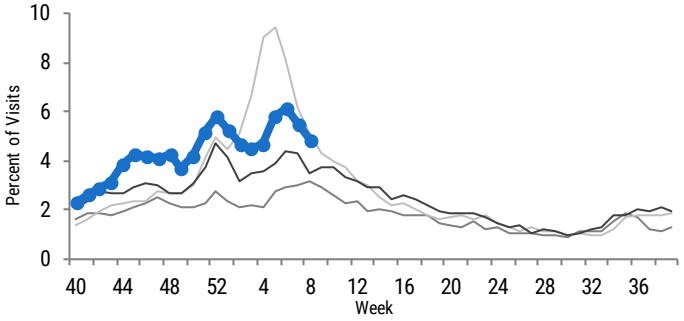
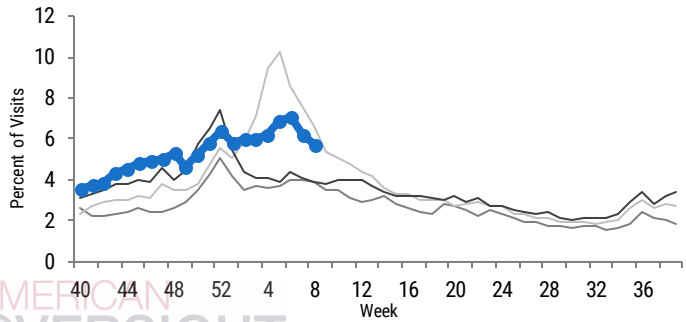


Figure 22: In **region 7, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.



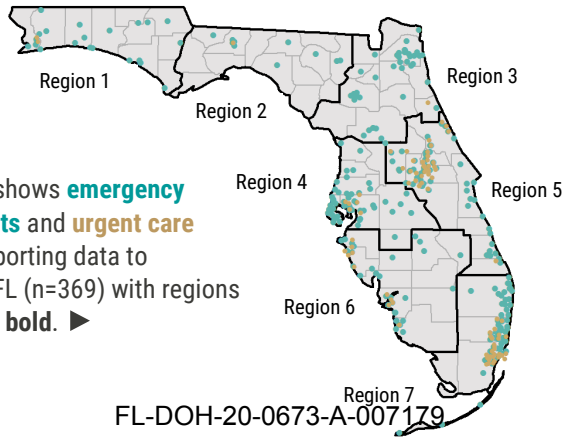


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

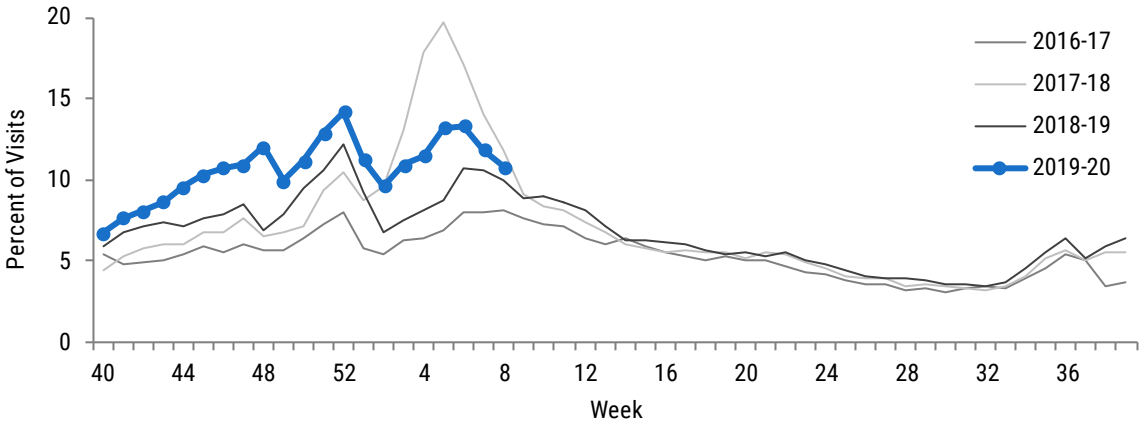
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

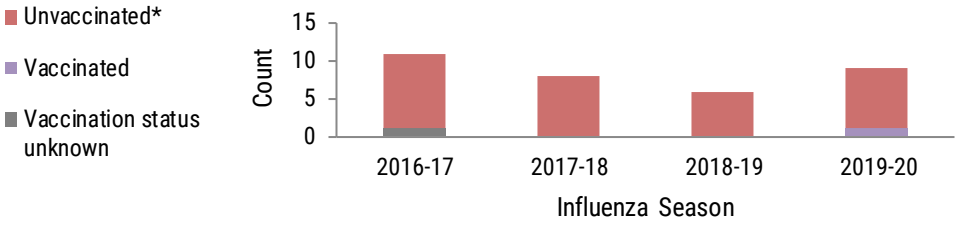
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 8, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

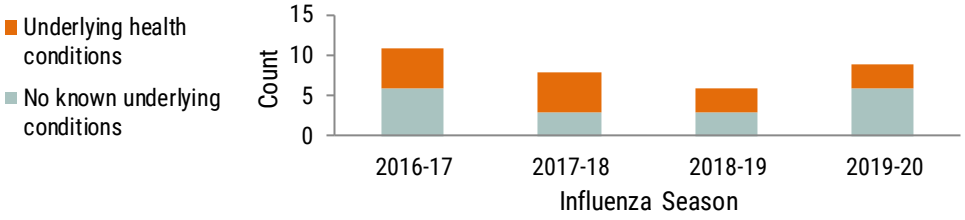


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

Figures 25-26: In week 8, **no new influenza-associated pediatric deaths were reported**. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 8, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 8, 2020.

In week 8, **no new influenza-associated pediatric deaths were reported**.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

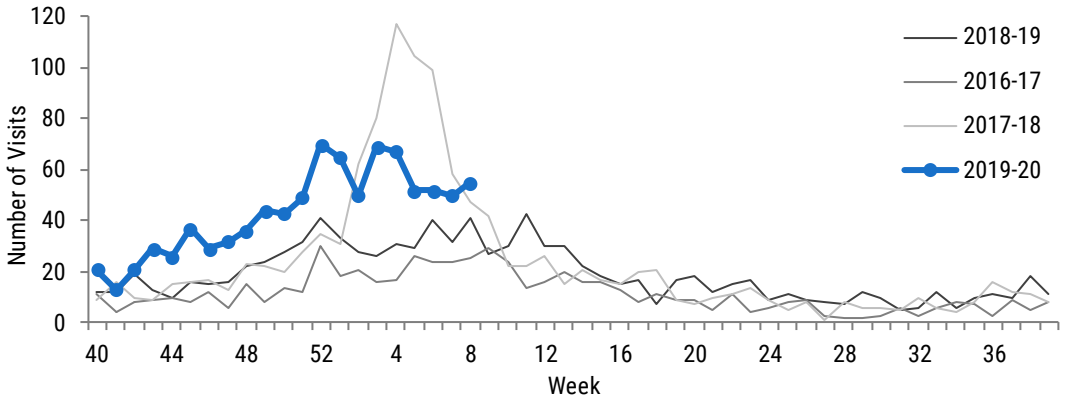
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 8, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above levels observed at this time in past seasons.



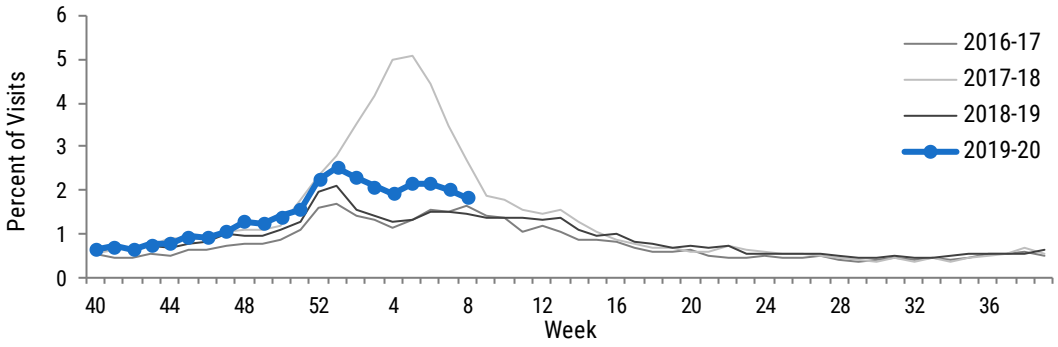
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 8, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 8, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



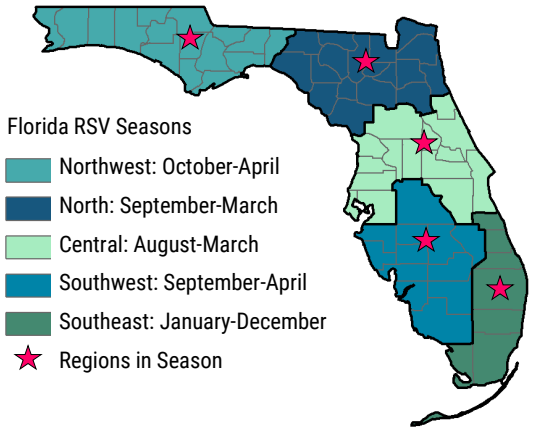
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

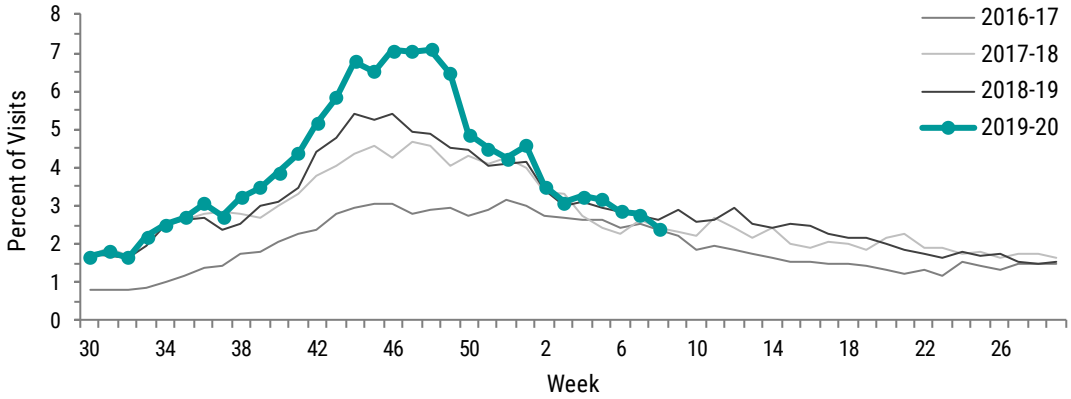
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 8 (February 16-22, 2020) Activity Summary

In week 8, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 8. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 8, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 8, 2020.

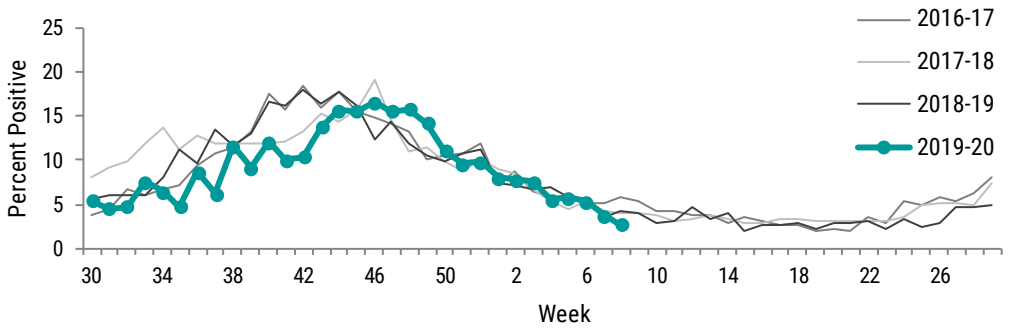
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 8, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 8, 2020. ▶



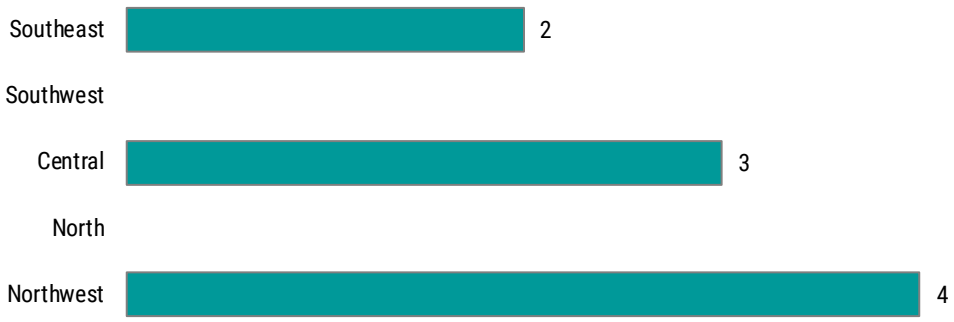
RSV-Associated Outbreaks in Week 8:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 8, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

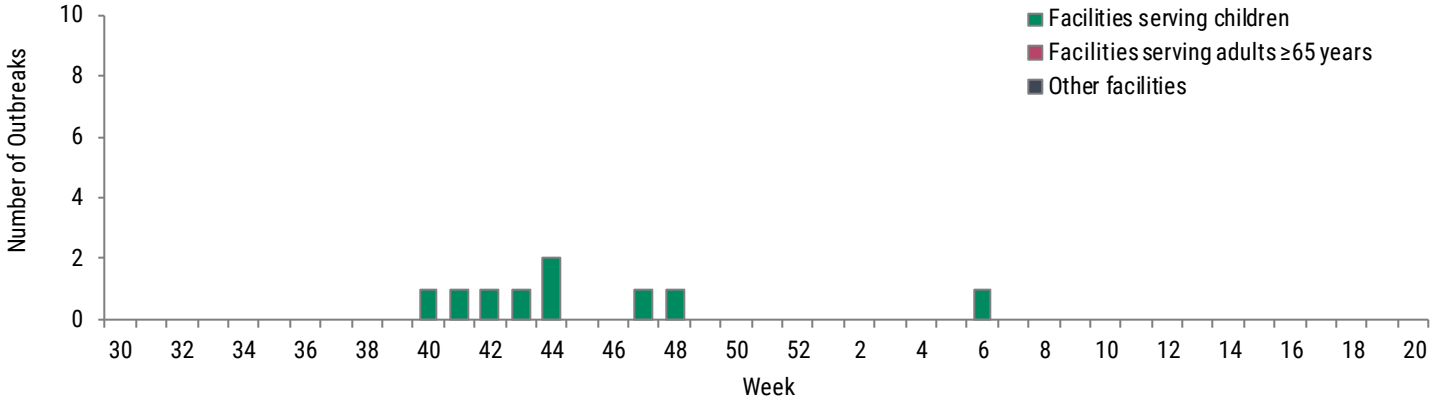
Figure 32: In week 8, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

*Regions defined in figure 29.

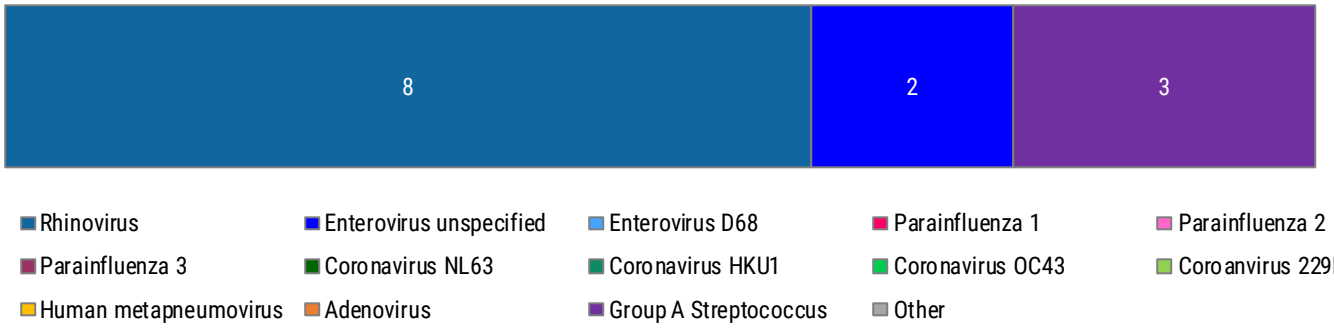
Figure 33: In week 8, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



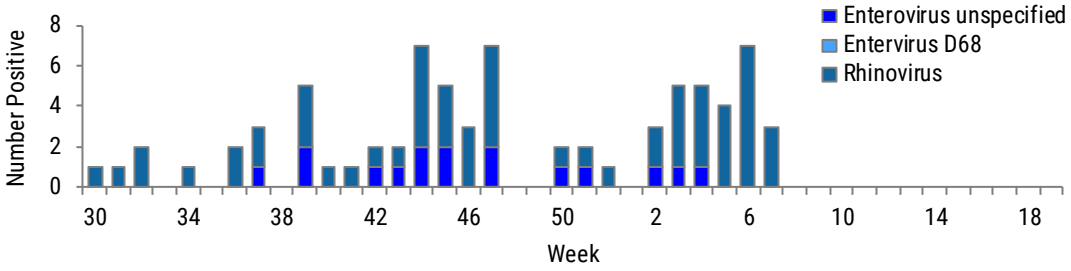
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

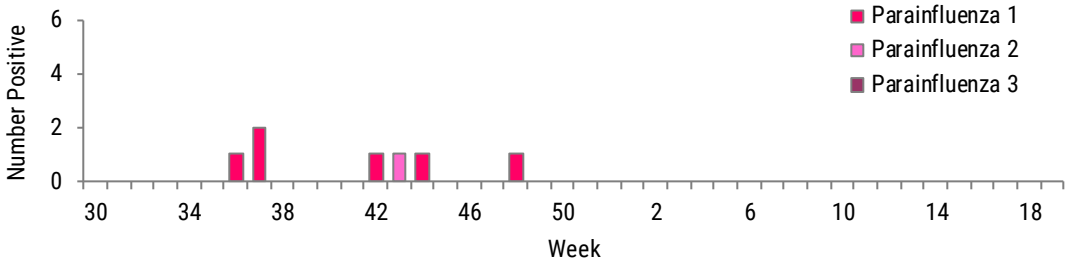


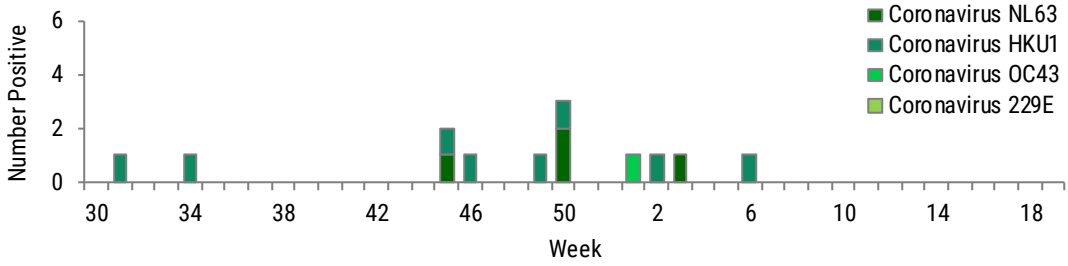
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 8, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

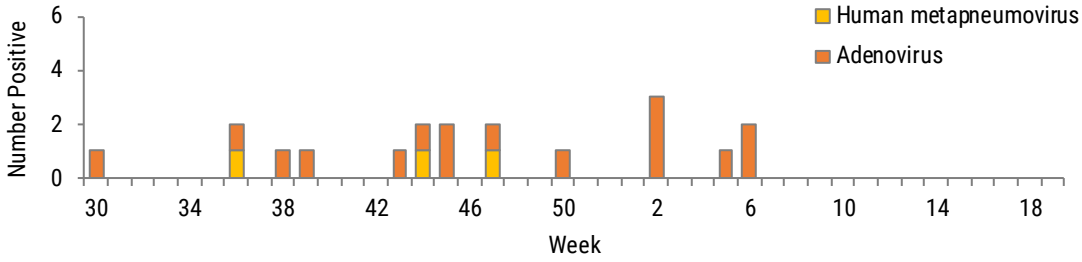
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 8, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Nursing home	Santa Rosa	54	Unknown	Unknown	Influenza A unspecified	Yes	Open
Assisted living facility	Polk	2	2	0	Influenza A unspecified	Yes	Closed
Assisted living facility	Sumter	8	4	0	Influenza A 2009 (H1N1)	Yes	Open
Assisted living facility	Seminole	12	3	1	Influenza A 2009 (H1N1)	Yes	Closed
Correctional facility	Sumter	40	Unknown	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 8, 2020 Florida Flu Review
Date:	Wednesday, February 26, 2020 2:13:17 PM
Attachments:	Week 8, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 8, 2020 Florida Flu Review.

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Eighteen outbreaks were reported, down from 24 outbreaks in the previous week. Of the 18 outbreaks reported, 12 were influenza-associated and six were ILI.

No new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On February 21, 2020, CDC issued interim vaccine effectiveness (VE) estimates for the 2019-20 influenza season. For all ages, the VE was 45% (95% confidence interval [CI] = 36-53%) against any influenza virus illness and was 55% (95% CI = 42-65%) among children six months to 17 years (www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6907a1-H.pdf).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

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Florida FLU REVIEW

Season: 2019-20

Week 8: 2/16/20-2/22/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Eighteen outbreaks were reported, down from 24 outbreaks in the previous week. Of the 18 outbreaks reported, 12 were influenza-associated and six were ILI.

No new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults ≥65 years, pregnant women, and people with underlying medical conditions).

On February 21, 2020, CDC issued interim vaccine effectiveness (VE) estimates for the 2019-20 influenza season. For all ages, the VE was 45% (95% confidence interval [CI] = 36-53%) against any influenza virus illness and was 55% (95% CI = 42-65%) among children six months to 17 years (www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6907a1-H.pdf).

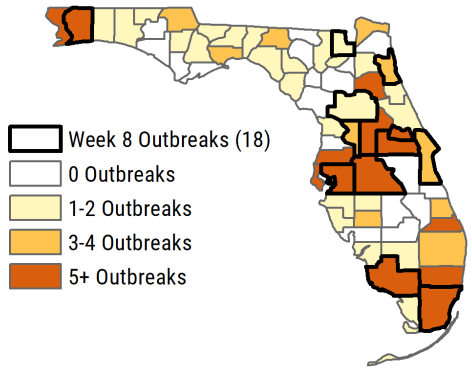
On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

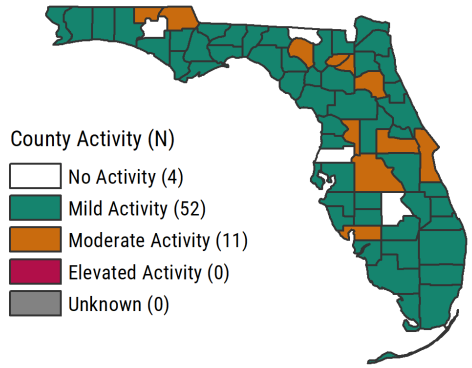
- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/22/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 26, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

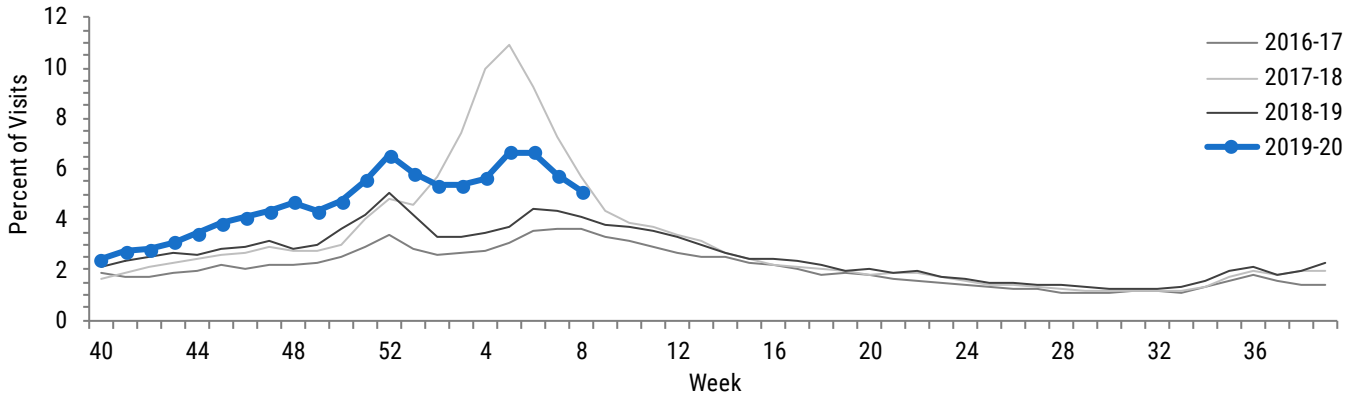
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 8, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 8, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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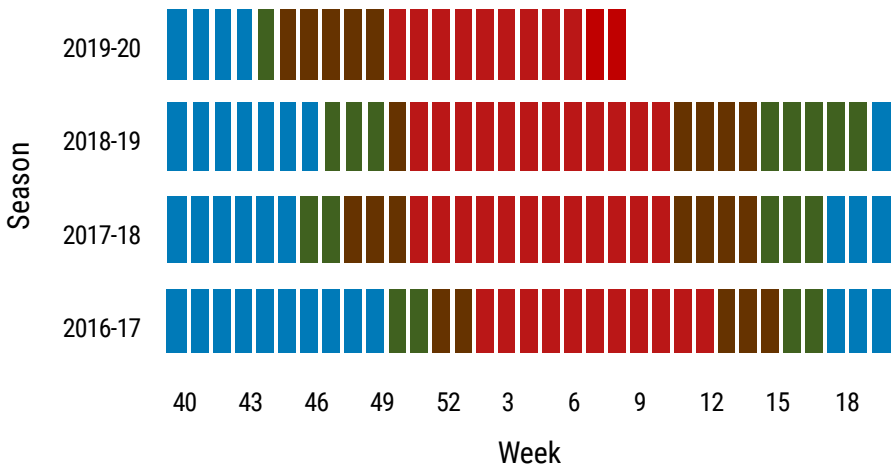
Statewide Activity

Figure 2: In week 8, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 8, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 8, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 8, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

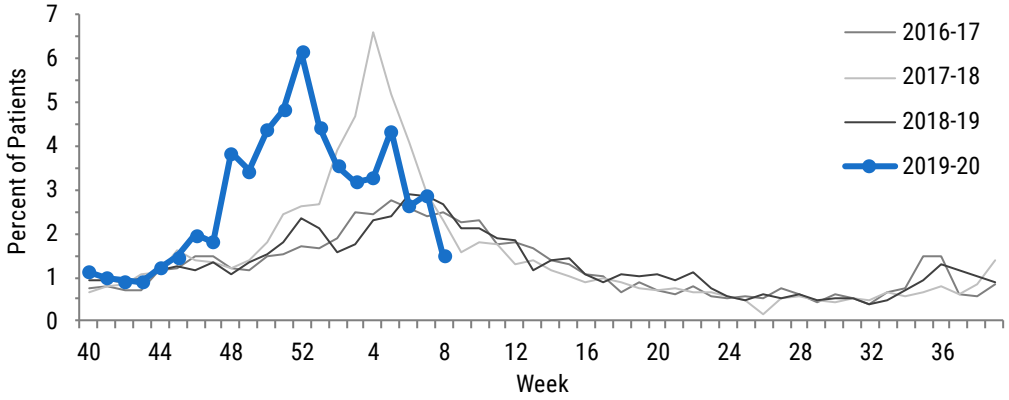
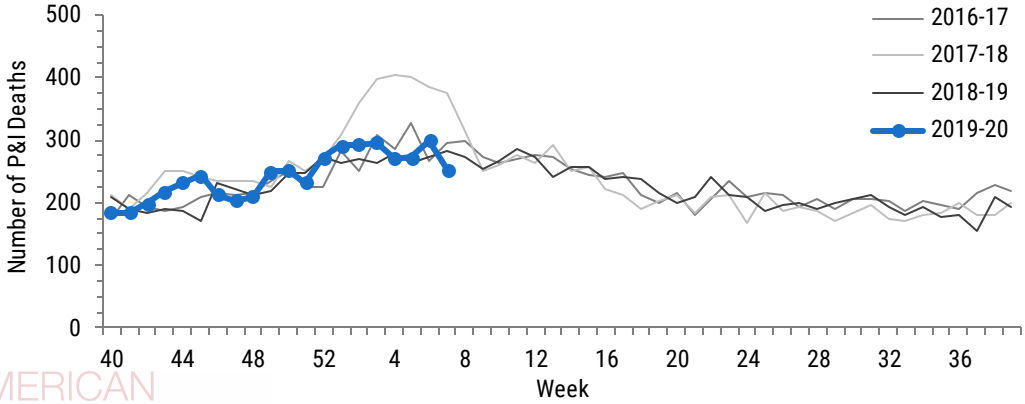


Figure 4: In week 7 (ending 2/15/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 8. Eleven counties reported **moderate activity.**

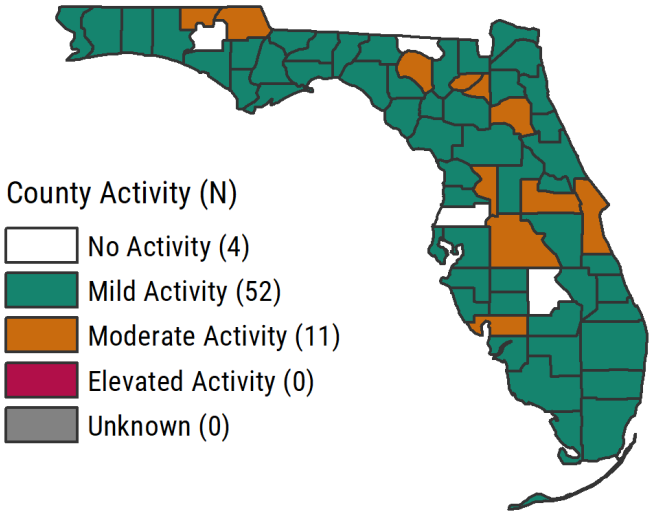
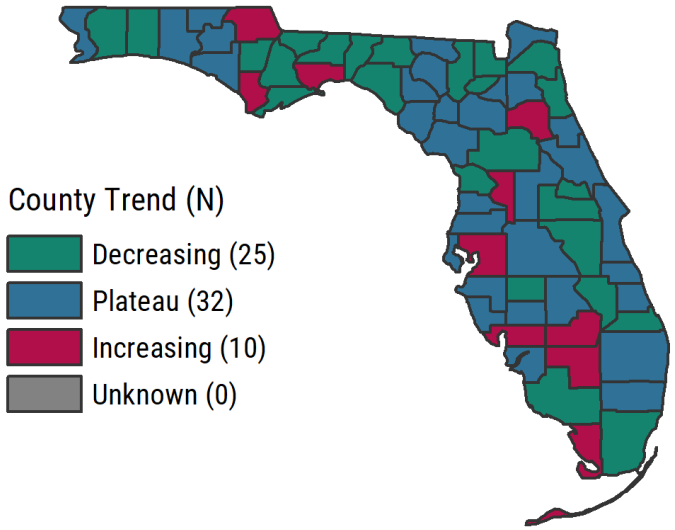
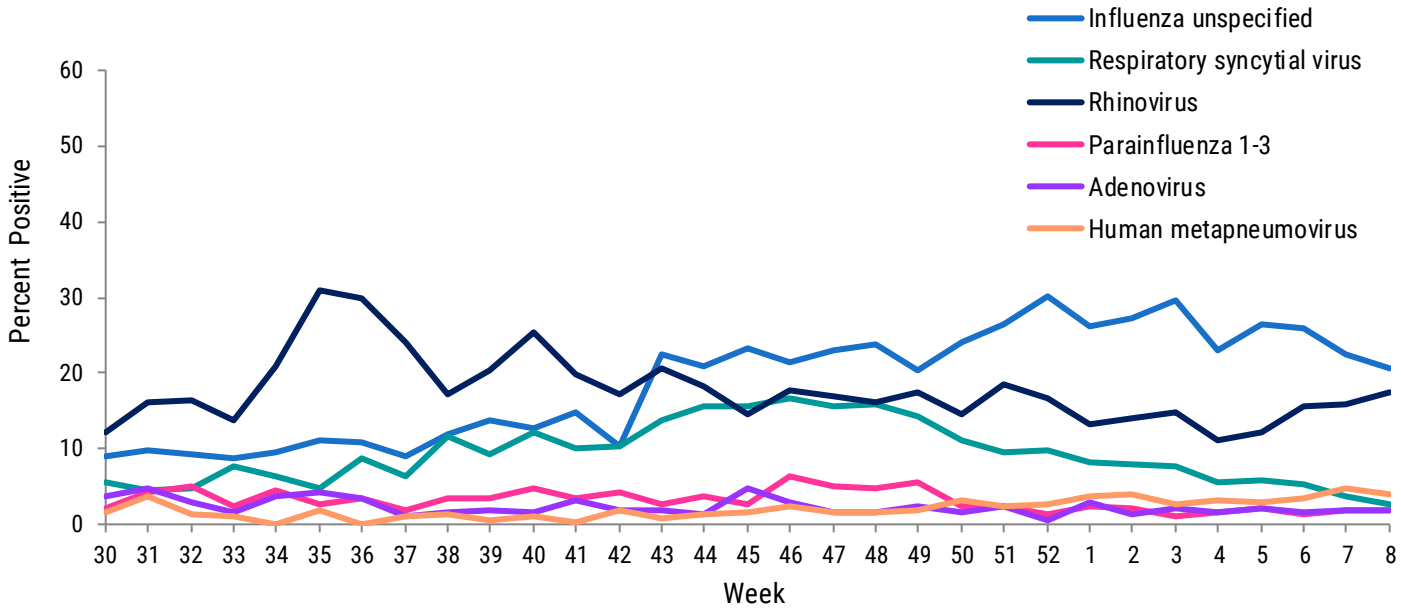


Figure 7: Most counties reported **activity at a plateau** for week 8. Ten counties reported **increasing activity,** and twenty-five counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 8, the **percent of specimens testing positive for influenza** **decreased** but remained higher than other respiratory viruses under surveillance. The **percent of specimens testing positive for rhinovirus** increased notably in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Week 8 Outbreaks at a Glance:

Number Reported:
18 Outbreaks

Influenza-Associated:
12 Outbreaks

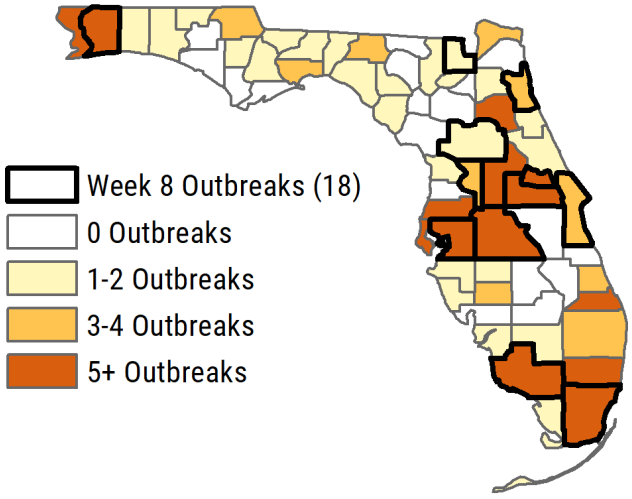
Severe Outcomes*:
4 Outbreaks

Outbreak Summary:

In week 8, 12 influenza-associated and six ILI outbreaks were reported, a decrease from the previous week.

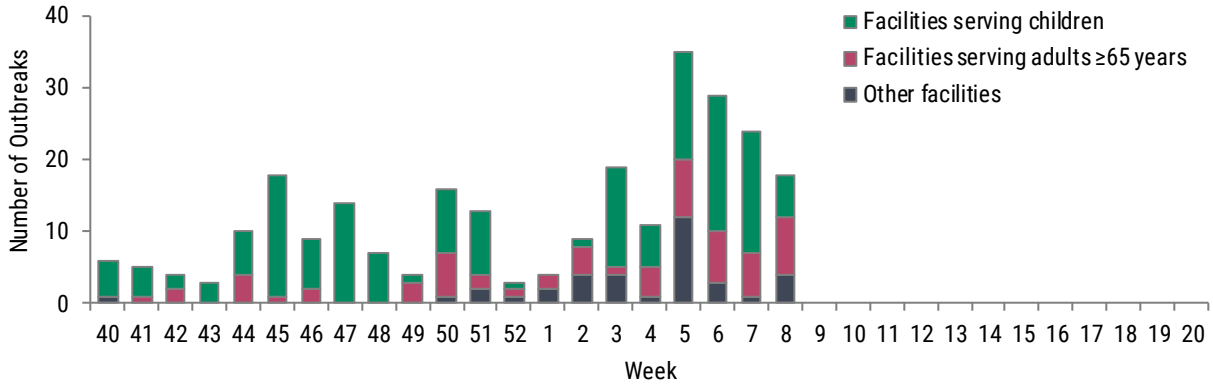
Severe outcomes* were reported in four of 18 outbreaks. One or more hospitalizations were reported in each of these four outbreaks. One death was reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 8, all four outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 8 are **outlined in bold.**

Figure 9: In week 8, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, six outbreaks** were reported in **facilities serving children,** and **four outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 8, **62.8% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 8, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

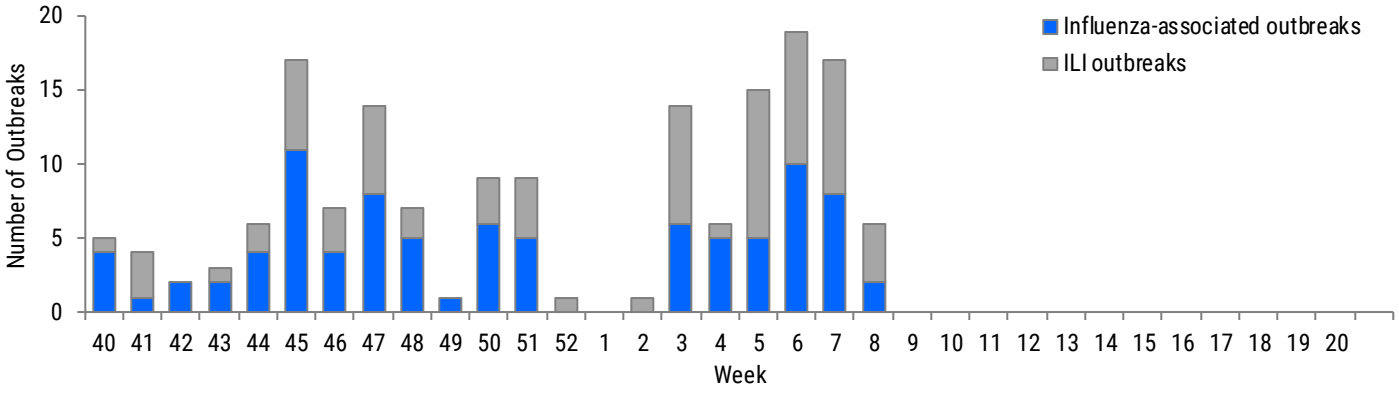
6 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 8, six new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 8, **two influenza-associated outbreaks** and **four ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Facilities Serving Adults ≥65 yrs.**:

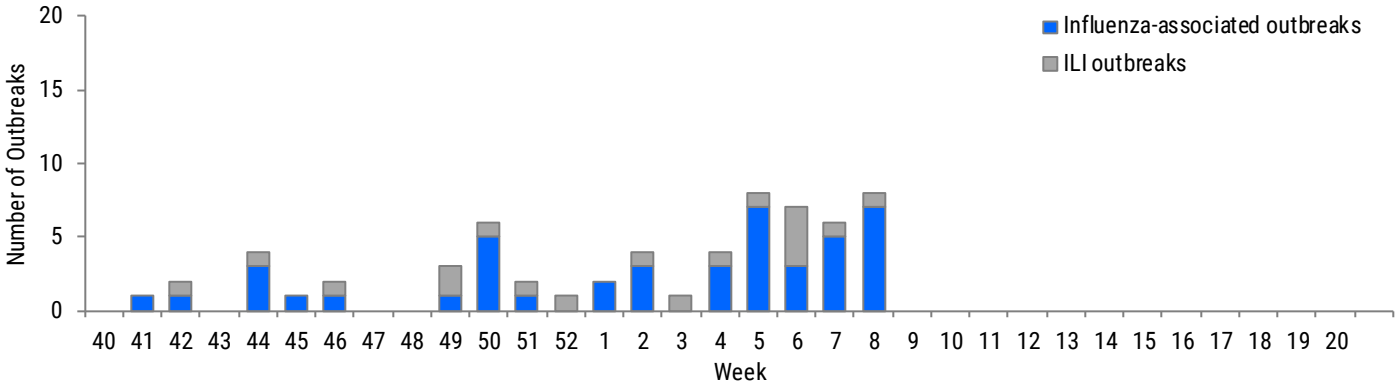
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 8, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 8, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

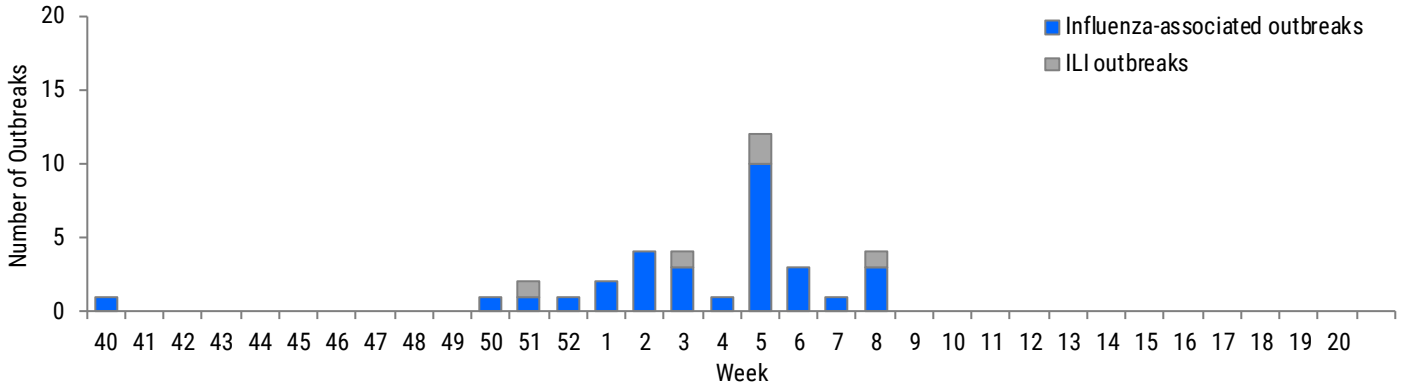
4 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 8, four new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 8, **three influenza-associated outbreaks** and **one ILI outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	126 (48.3%)	74 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	37 (14.2%)	15 influenza-associated outbreaks 22 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	18 (6.9%)	8 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.8%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (11.1%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.5%)	27 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	4 (1.5%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**261 (100.0%)**	**164 influenza-associated outbreaks** **97 ILI outbreaks**

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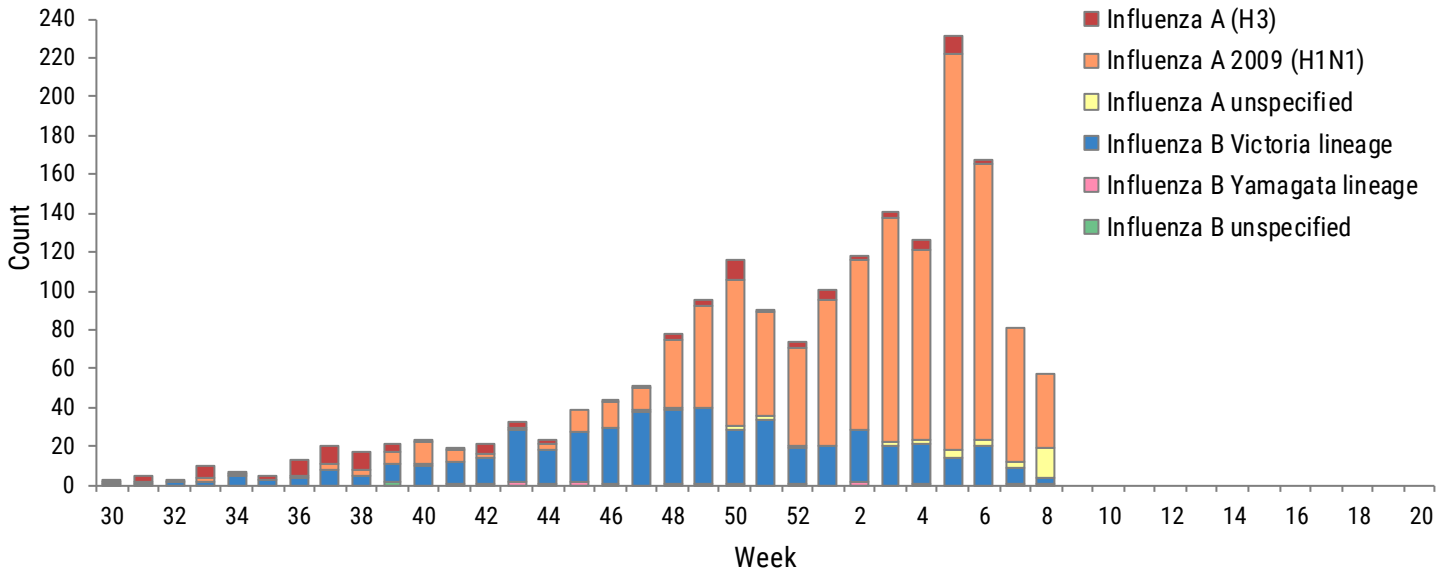
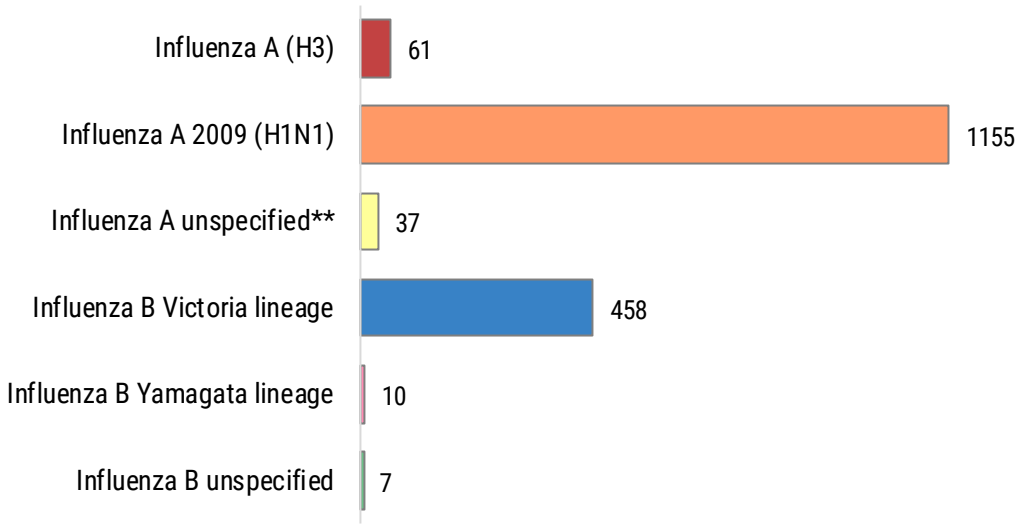
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 8, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 8, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 8, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

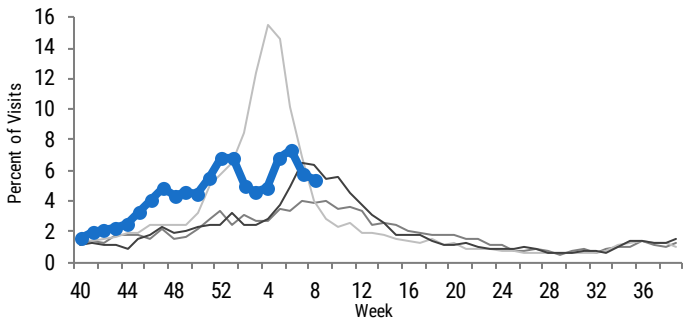


Figure 17: In **region 2, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

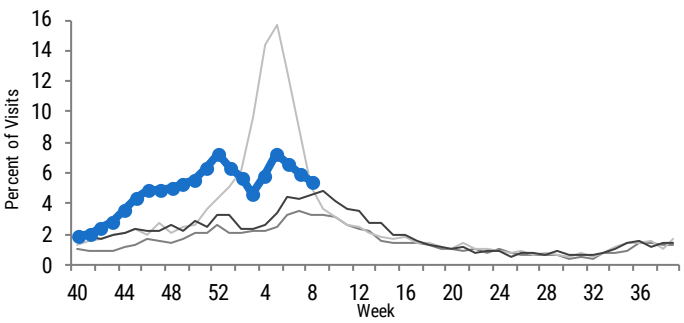


Figure 18: In **region 3, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

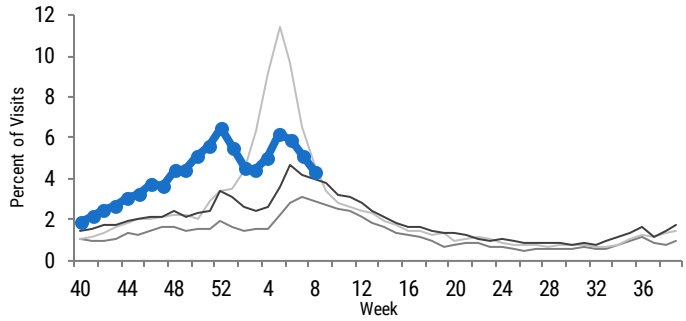


Figure 19: In **region 4, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

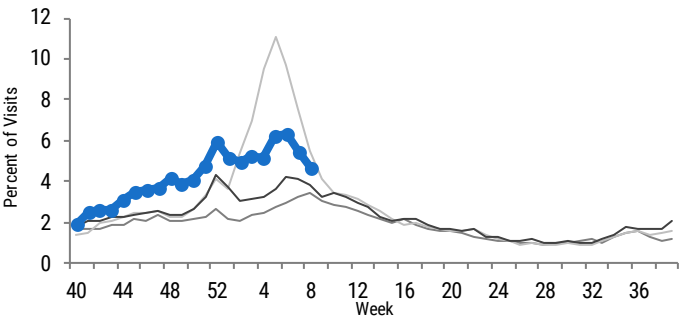


Figure 20: In **region 5, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

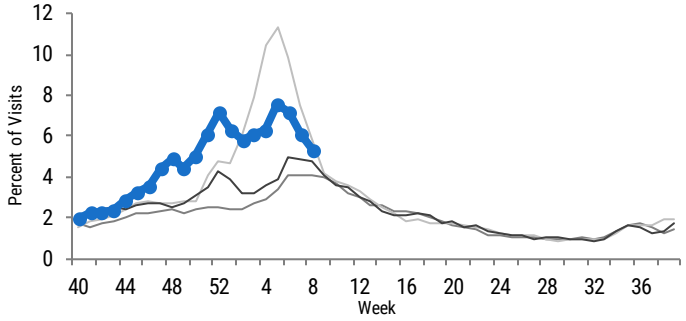


Figure 21: In **region 6, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

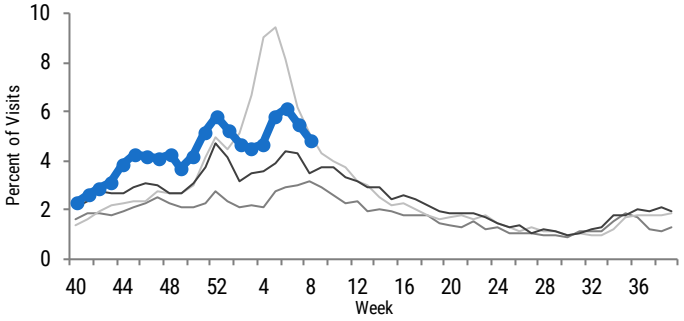
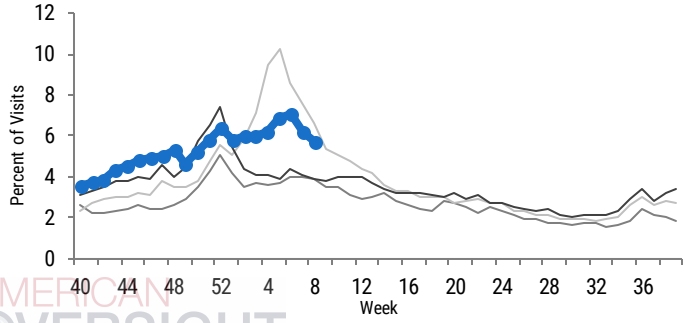


Figure 22: In **region 7, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.



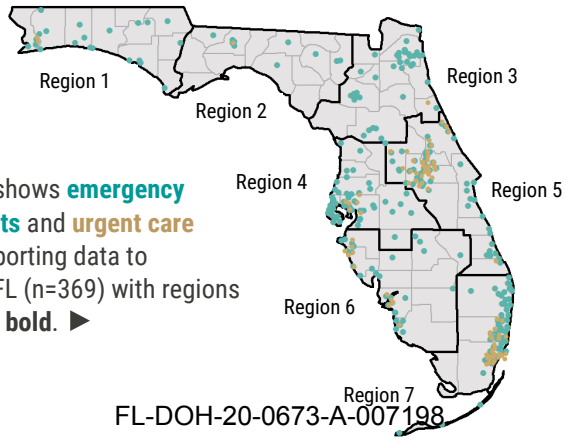


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

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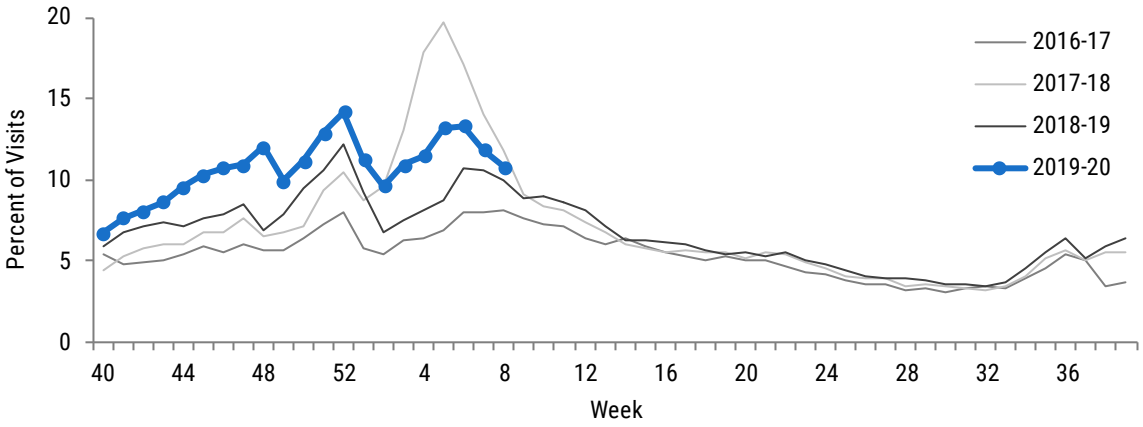
At-Risk Populations

Background: At-Risk Populations, Children

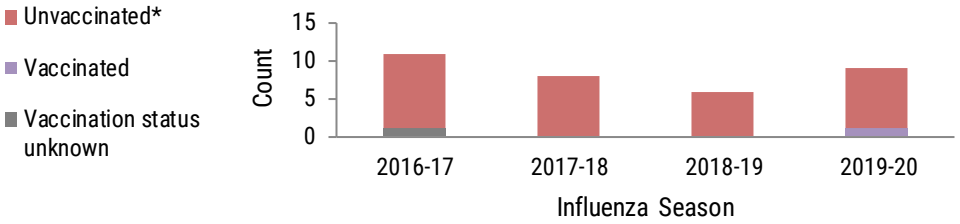
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 8, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

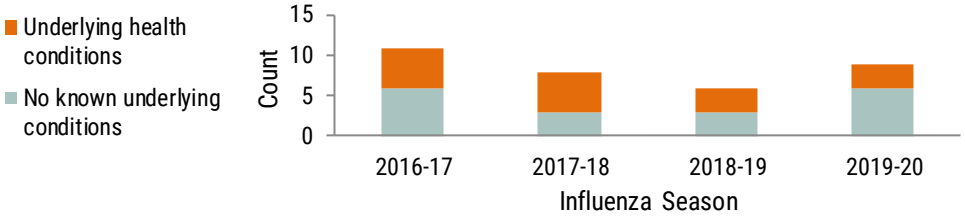


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

Figures 25-26: In week 8, **no new influenza-associated pediatric deaths were reported**. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 8, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 8, 2020.

In week 8, **no new influenza-associated pediatric deaths were reported**.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm.

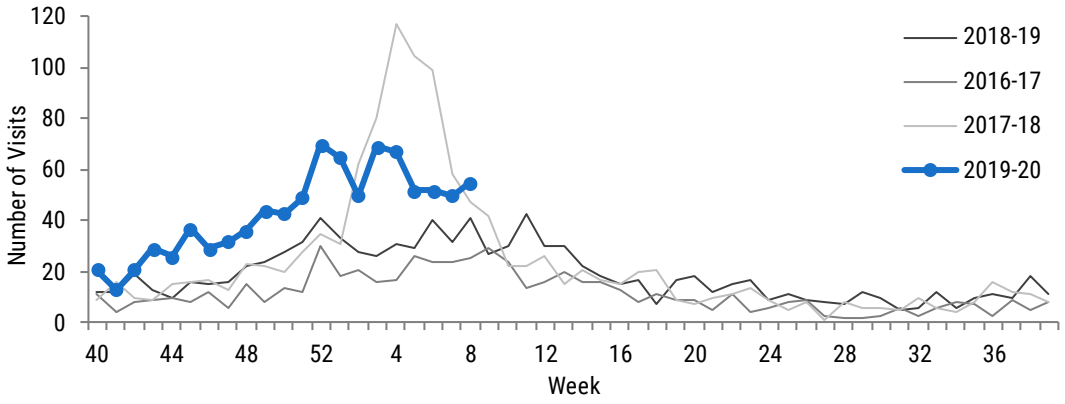
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 8, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above levels observed at this time in past seasons.



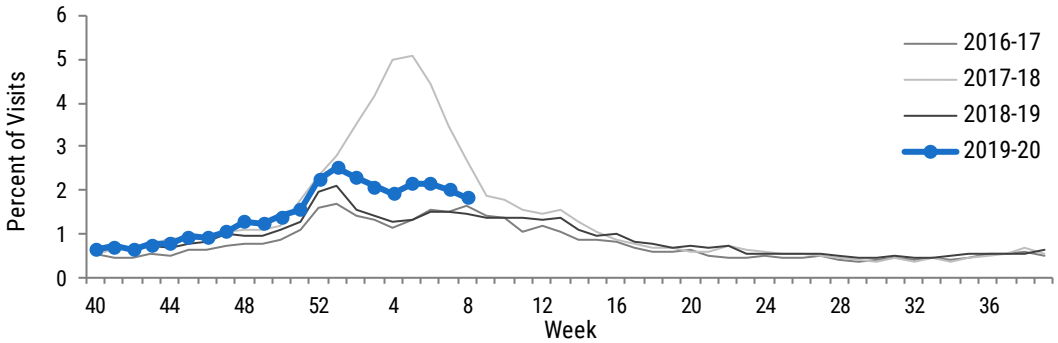
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 8, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 8, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



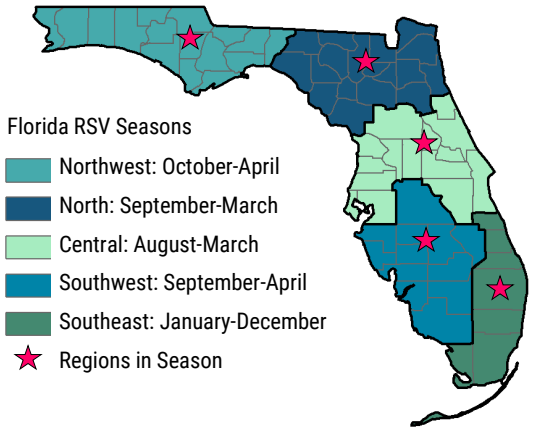
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

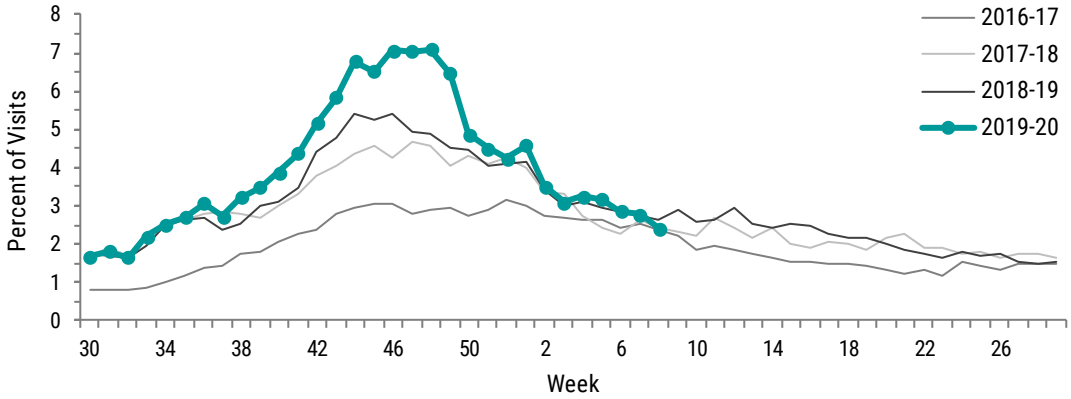
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 8 (February 16-22, 2020) Activity Summary

In week 8, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 8. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 8, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 8, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

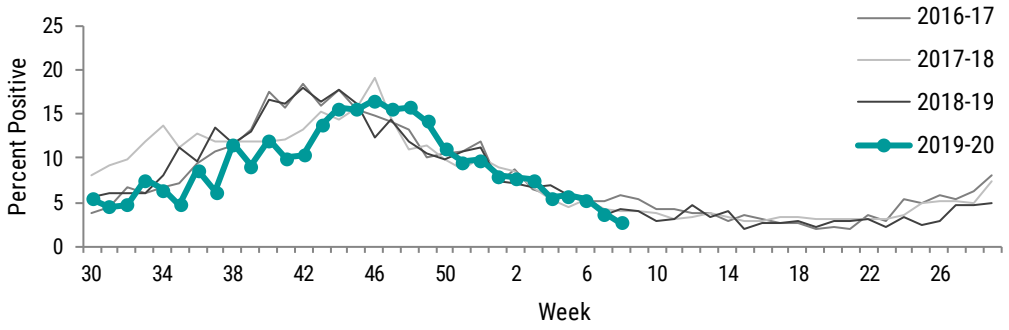
AMERICAN OVERSIGHT

Florida HEALTH

RSV Surveillance

Figure 31: In week 8, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 8, 2020. ▶



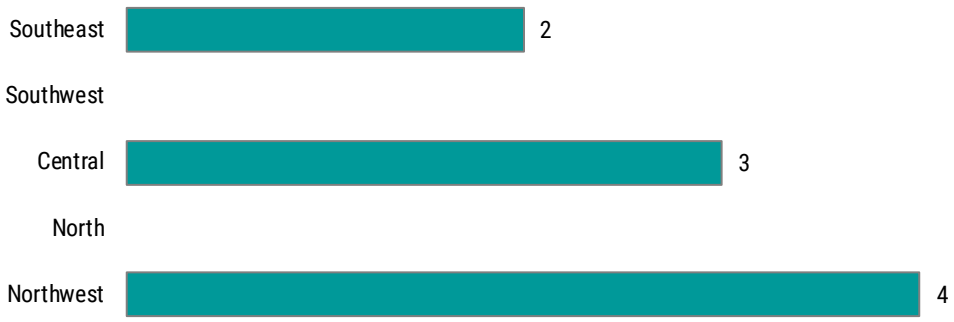
RSV-Associated Outbreaks in Week 8:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 8, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

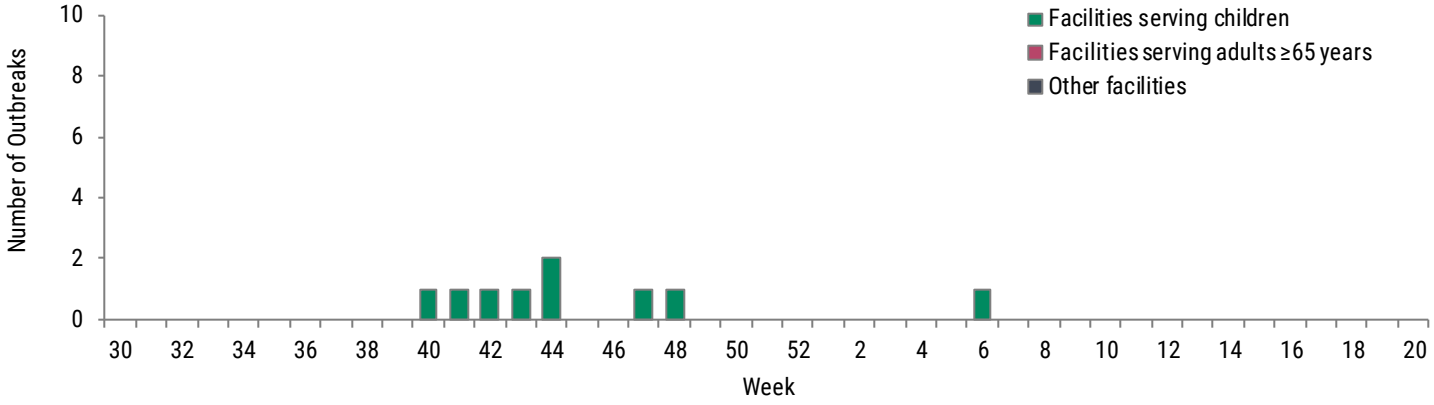
Figure 32: In week 8, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

*Regions defined in figure 29.

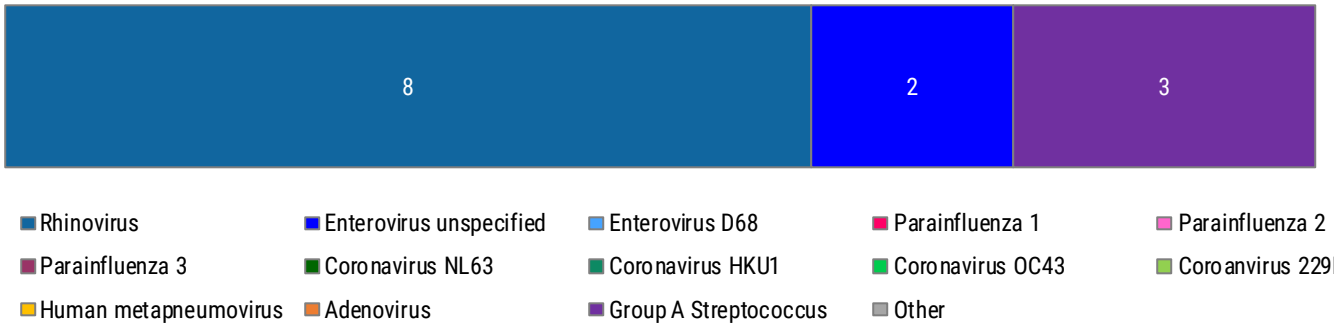
Figure 33: In week 8, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



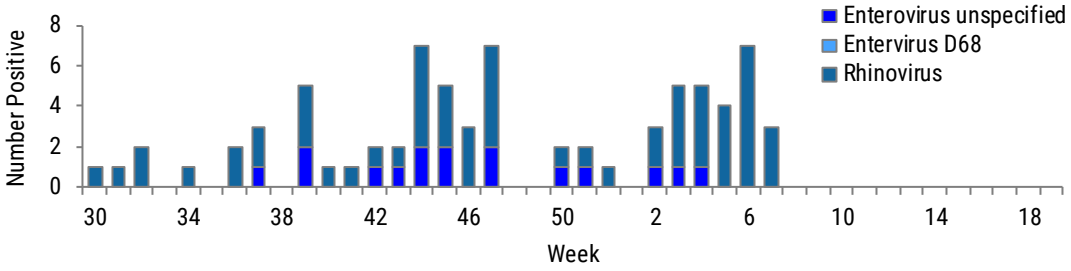
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

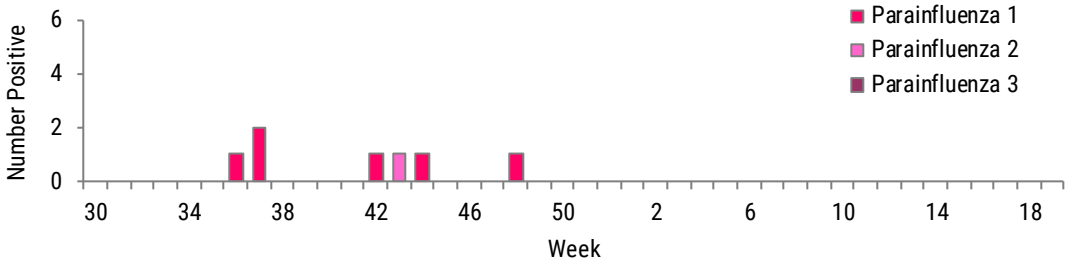


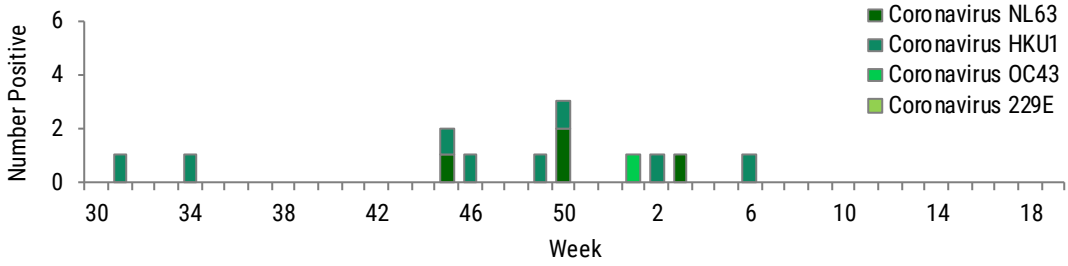
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 8, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

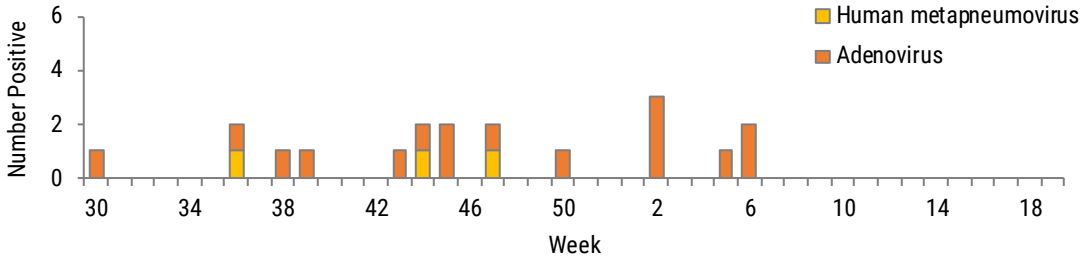
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 8, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Nursing home	Santa Rosa	54	Unknown	Unknown	Influenza A unspecified	Yes	Open
Assisted living facility	Polk	2	2	0	Influenza A unspecified	Yes	Closed
Assisted living facility	Sumter	8	4	0	Influenza A 2009 (H1N1)	Yes	Open
Assisted living facility	Seminole	12	3	1	Influenza A 2009 (H1N1)	Yes	Closed
Correctional facility	Sumter	40	Unknown	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 8, 2020 Florida Flu Review
Date:	Wednesday, February 26, 2020 2:13:11 PM
Attachments:	Week 8, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 8, 2020 Florida Flu Review.

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Eighteen outbreaks were reported, down from 24 outbreaks in the previous week. Of the 18 outbreaks reported, 12 were influenza-associated and six were ILI.

No new influenza-associated pediatric deaths were reported. Nine influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On February 21, 2020, CDC issued interim vaccine effectiveness (VE) estimates for the 2019-20 influenza season. For all ages, the VE was 45% (95% confidence interval [CI] = 36-53%) against any influenza virus illness and was 55% (95% CI = 42-65%) among children six months to 17 years (www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6907a1-H.pdf).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

AMERICAN OVERSIGHT

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 8: 2/16/20-2/22/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 8 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 8 and remained above peak levels observed in the 2016-17 and 2018-19 seasons. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

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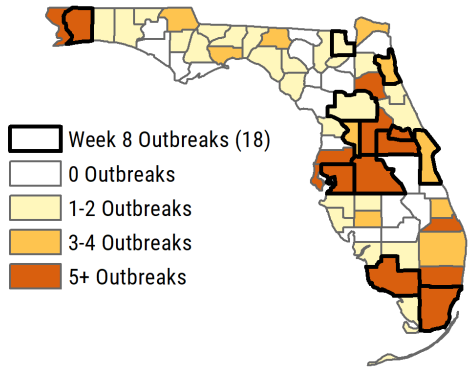
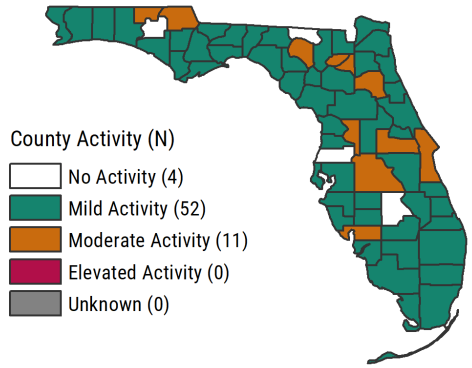
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

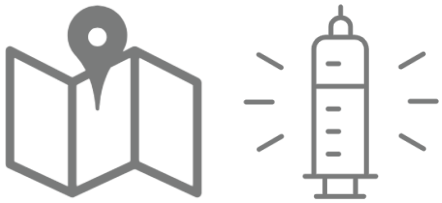
Reported as of 2/22/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted February 26, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

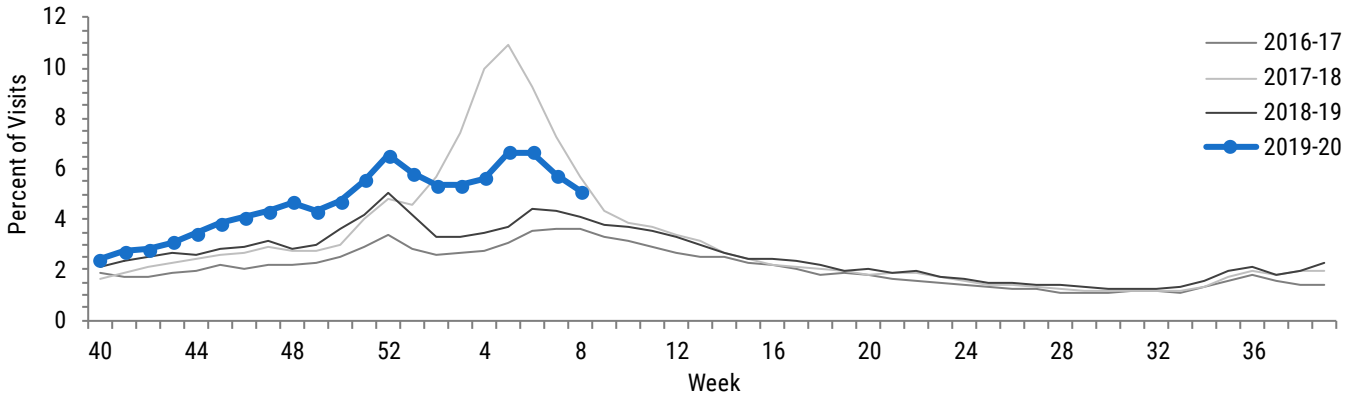
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 8, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2018-19 and 2016-17 seasons.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 8, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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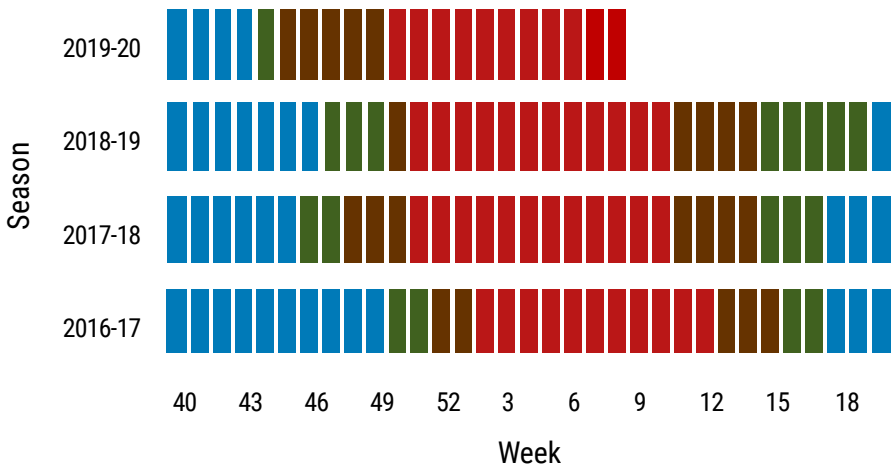
Statewide Activity

Figure 2: In week 8, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 8, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 8, **the percent of patients with ILI reported by ILINet providers statewide decreased** and was below levels observed during previous seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=9), week 40, 2016 to week 8, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

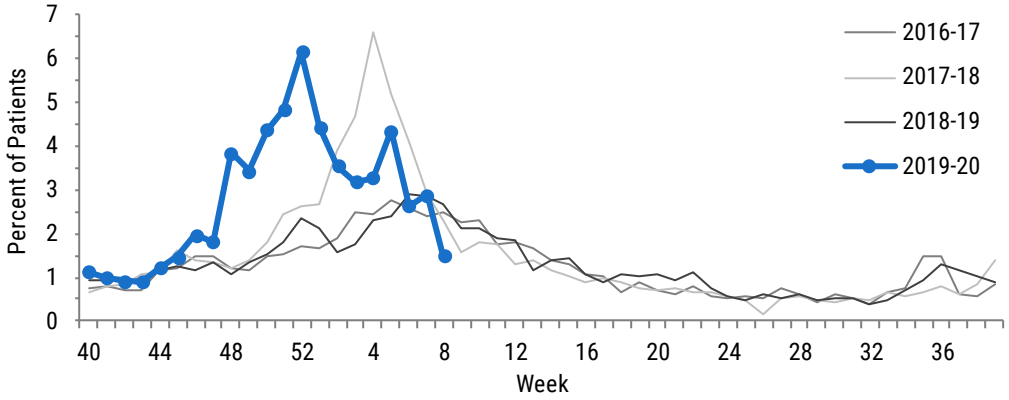
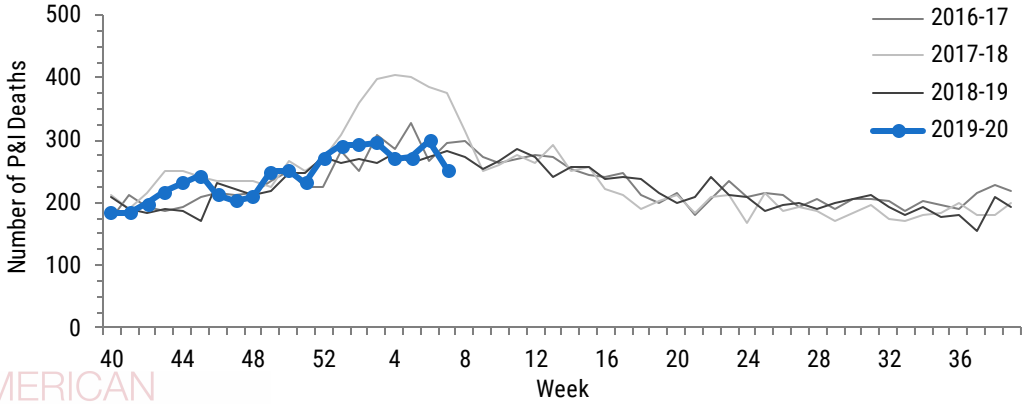


Figure 4: In week 7 (ending 2/15/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 7, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 8. Eleven counties reported **moderate activity.**

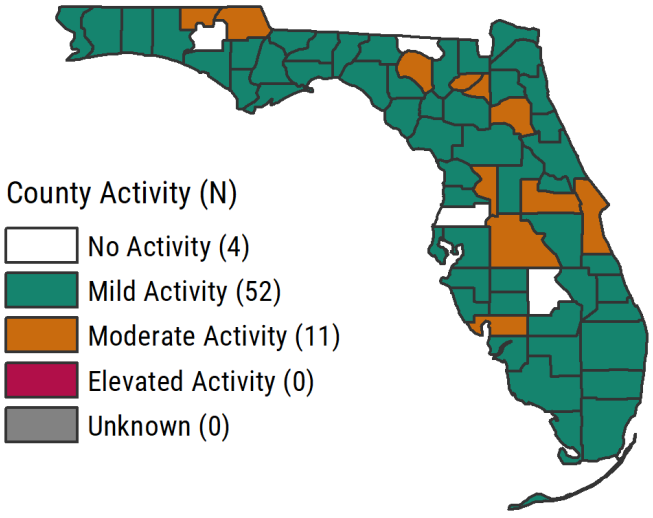
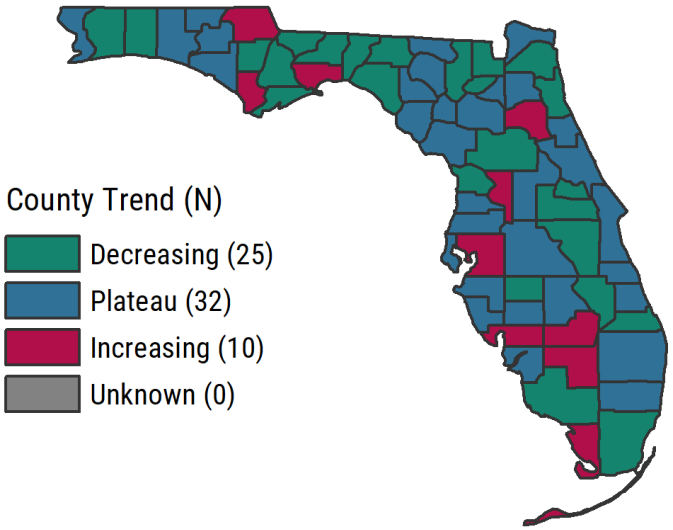
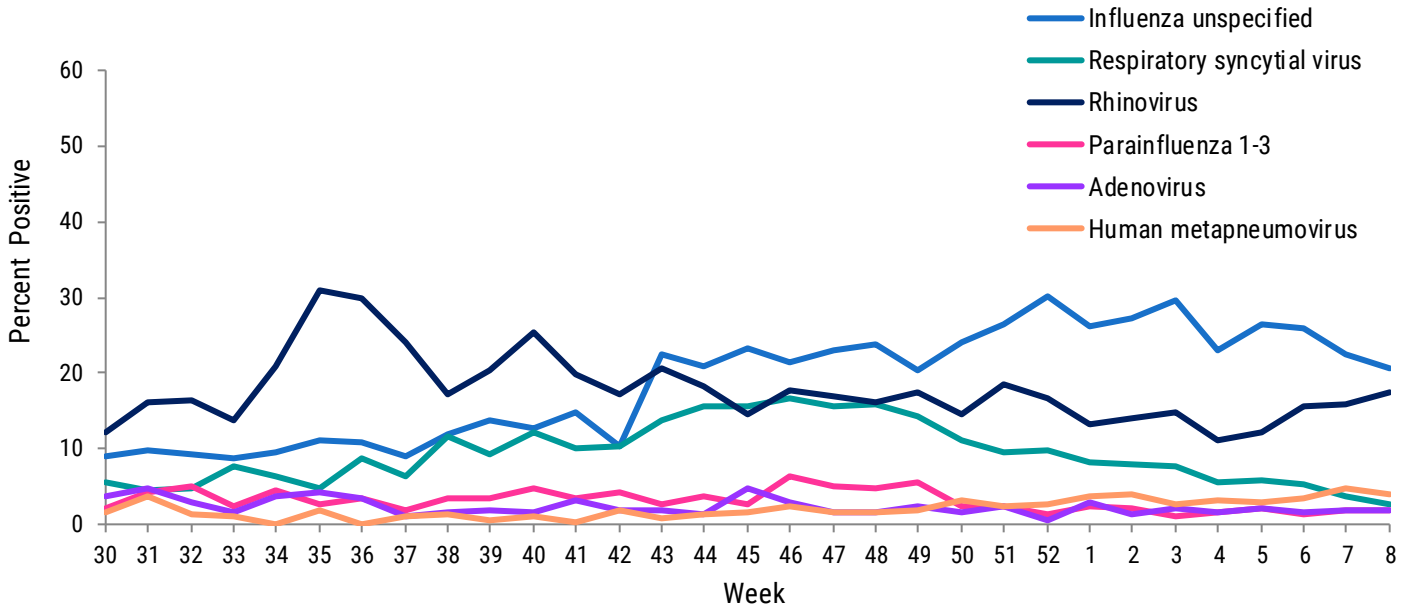


Figure 7: Most counties reported **activity at a plateau** for week 8. Ten counties reported **increasing activity,** and twenty-five counties reported **decreasing activity.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: In week 8, the **percent of specimens testing positive for influenza** **decreased** but remained higher than other respiratory viruses under surveillance. The **percent of specimens testing positive for rhinovirus** increased notably in recent weeks.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=9), week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Week 8 Outbreaks at a Glance:

Number Reported:
18 Outbreaks

Influenza-Associated:
12 Outbreaks

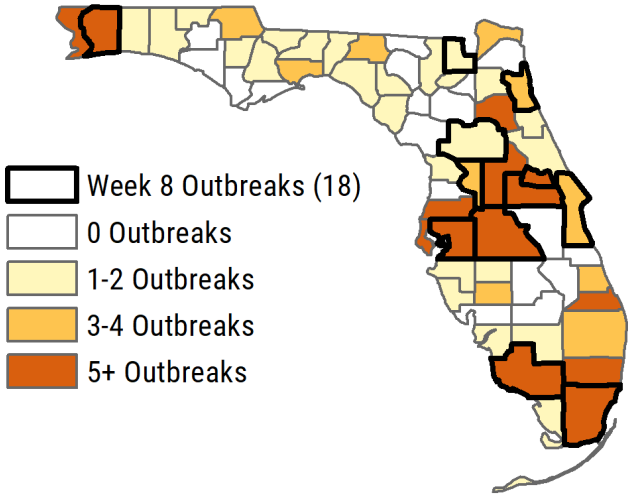
Severe Outcomes*:
4 Outbreaks

Outbreak Summary:

In week 8, 12 influenza-associated and six ILI outbreaks were reported, a decrease from the previous week.

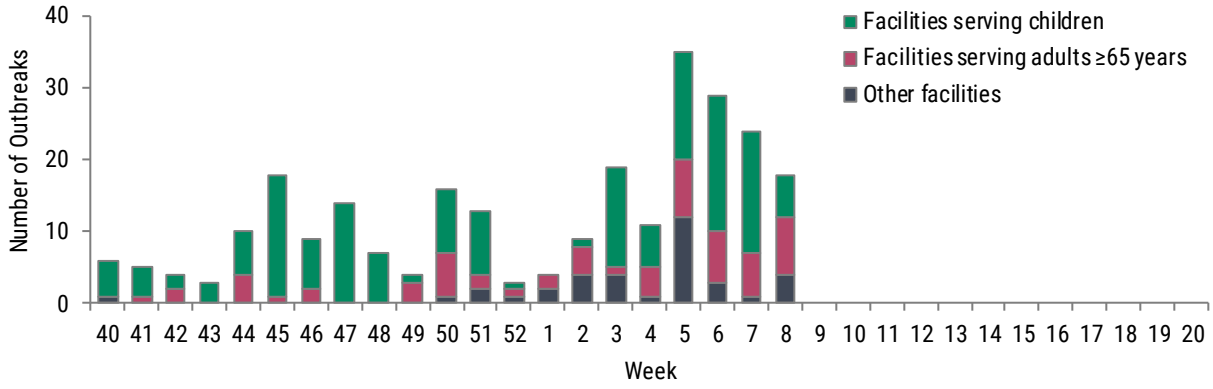
Severe outcomes* were reported in four of 18 outbreaks. One or more hospitalizations were reported in each of these four outbreaks. One death was reported.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 8, all four outbreaks with severe outcomes were in facilities serving adults aged ≥65 years.



▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 8 are **outlined in bold.**

Figure 9: In week 8, **eight outbreaks** were reported in **facilities serving adults aged ≥65 years, six outbreaks** were reported in **facilities serving children,** and **four outbreaks** were reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 8, **62.8% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 8, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

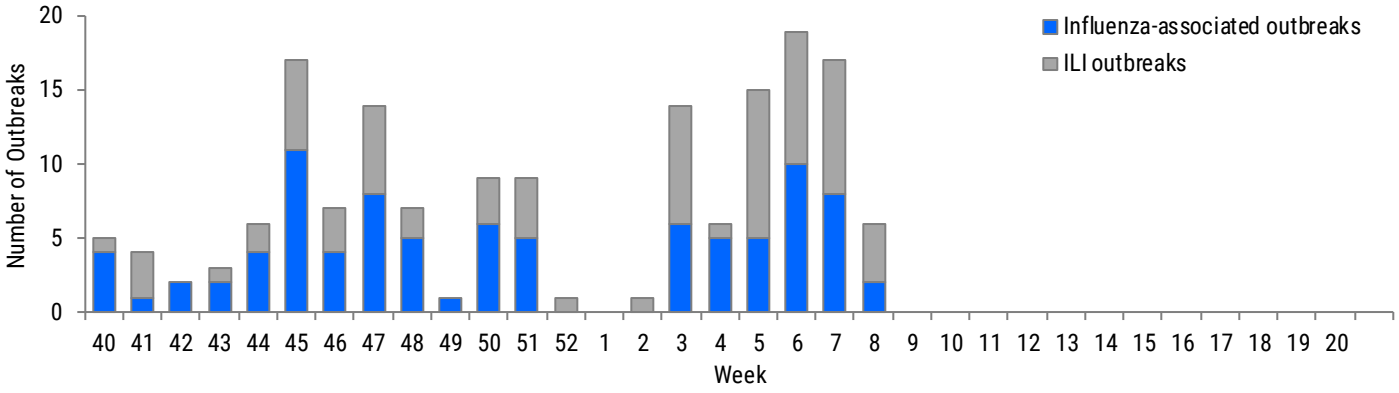
6 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 8, six new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 8, **two influenza-associated outbreaks** and **four ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Facilities Serving Adults ≥65 yrs.**:

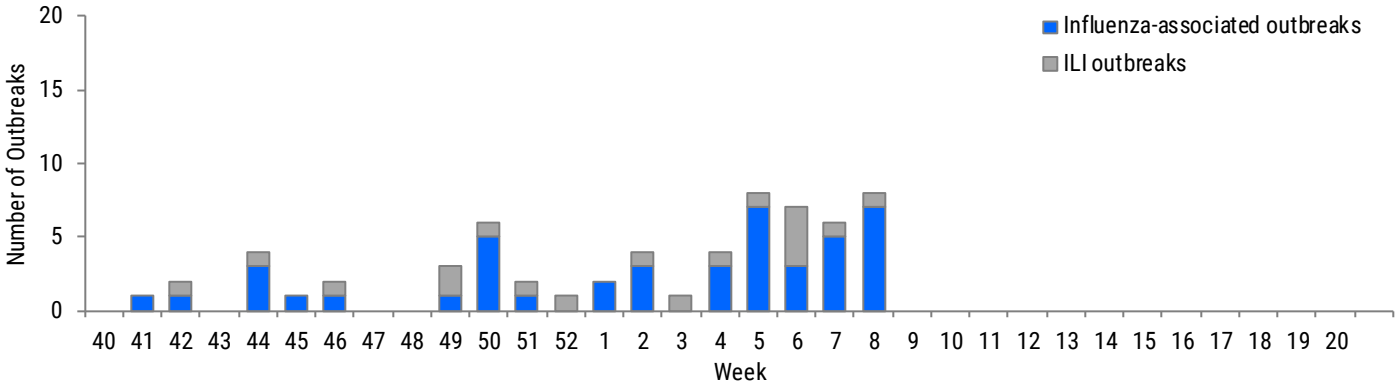
8 Outbreaks

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 8, eight new outbreaks of influenza or ILI were reported in facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 8, **seven influenza-associated outbreaks** and **one ILI outbreak** were reported in **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

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Influenza and ILI Outbreaks

Other Facilities*:

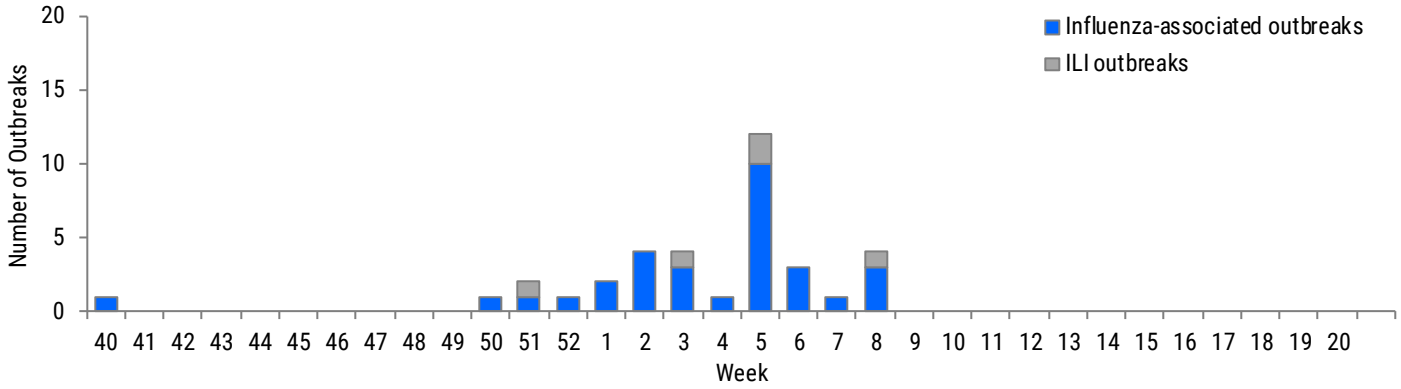
4 Outbreaks

Summary of Outbreaks in Other Facilities:

In week 8, four new outbreaks of influenza or ILI were reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 8, **three influenza-associated outbreaks** and **one ILI outbreak** were reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 8, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	126 (48.3%)	74 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	37 (14.2%)	15 influenza-associated outbreaks 22 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	18 (6.9%)	8 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.8%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (11.1%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.5%)	27 influenza-associated outbreaks 3 ILI outbreak
Hospitals	2 (0.8%)	2 influenza-associated outbreaks 0 ILI outbreaks
Additional facility types	4 (1.5%)	1 influenza-associated outbreak 2 ILI outbreaks
Total	**261 (100.0%)**	**164 influenza-associated outbreaks** **97 ILI outbreaks**

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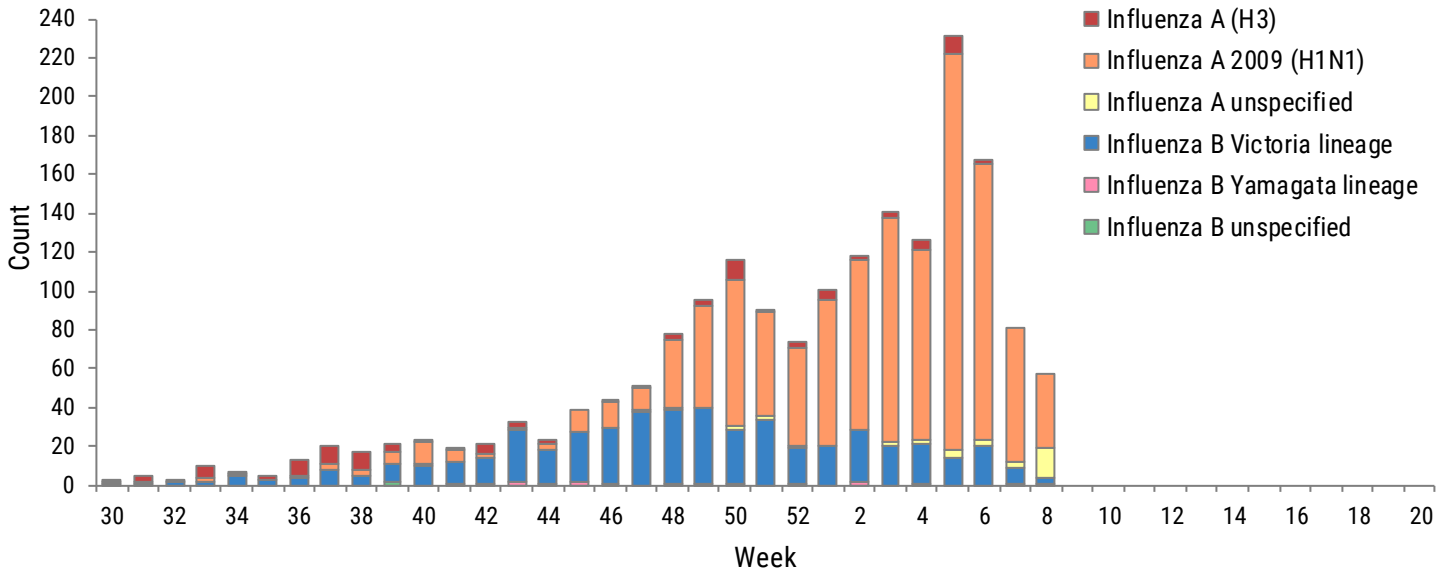
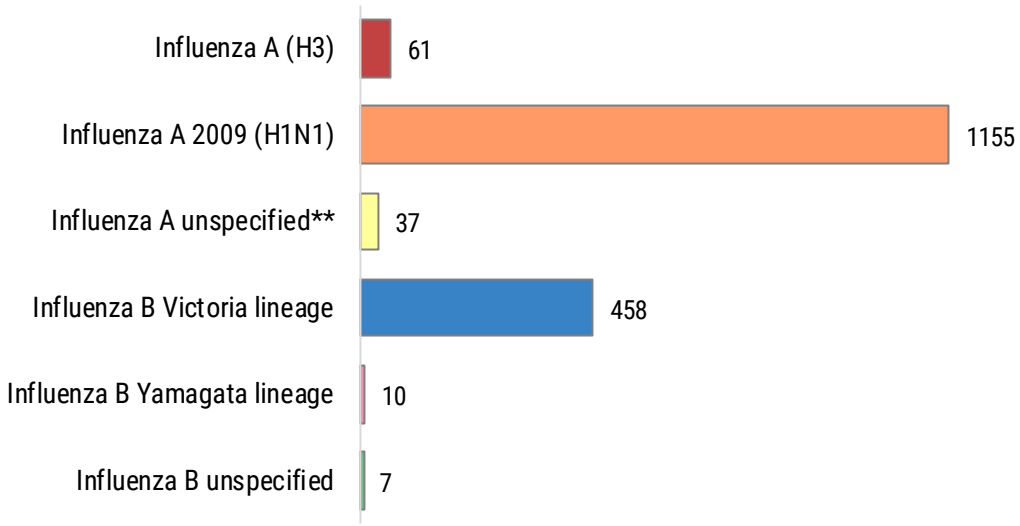
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 8, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 8, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

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Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 8, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

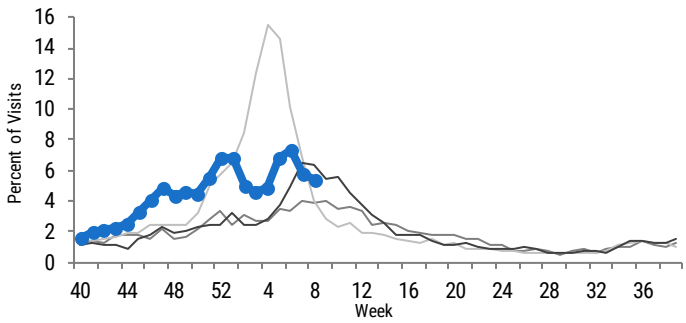


Figure 17: In **region 2, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

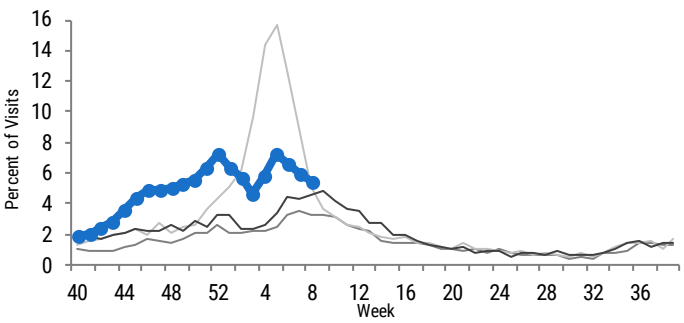


Figure 18: In **region 3, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.

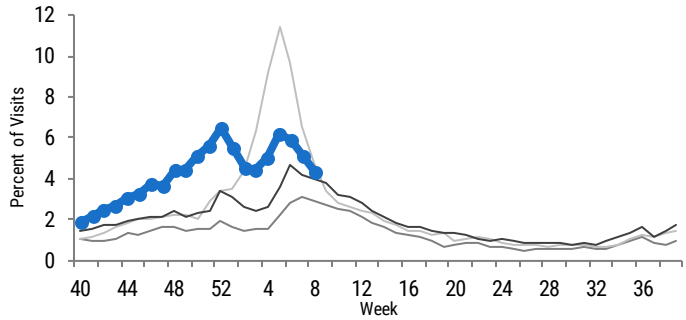


Figure 19: In **region 4, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

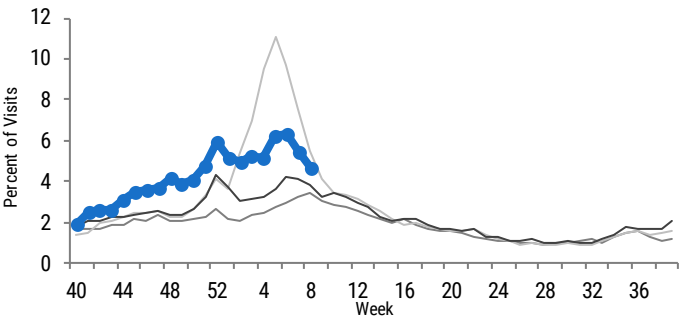


Figure 20: In **region 5, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

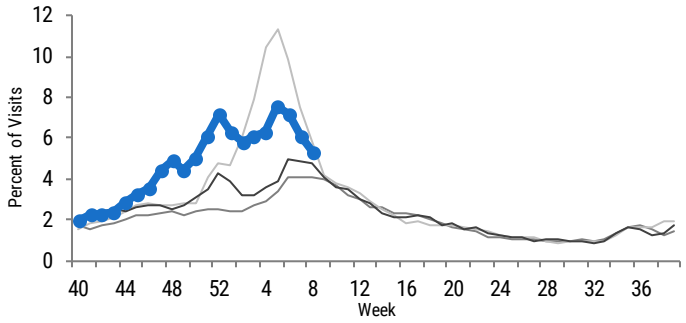


Figure 21: In **region 6, ILI activity decreased** during week 8 and was above peak activity observed during the 2018-19 and 2016-17 seasons.

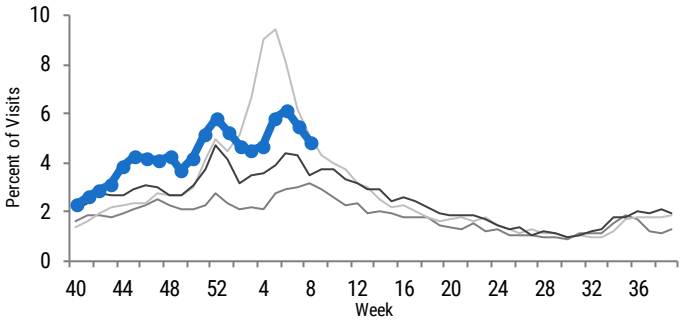
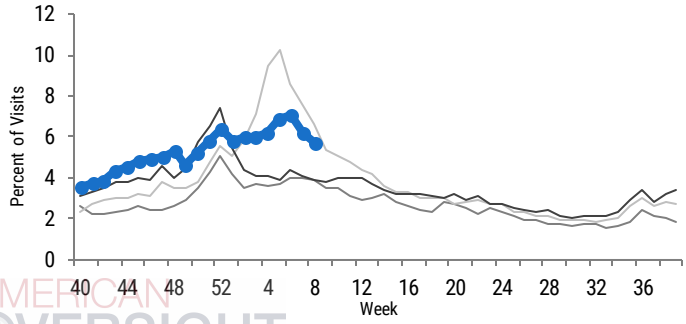


Figure 22: In **region 7, ILI activity decreased** during week 8 and was above peak activity observed during the 2016-17 season.



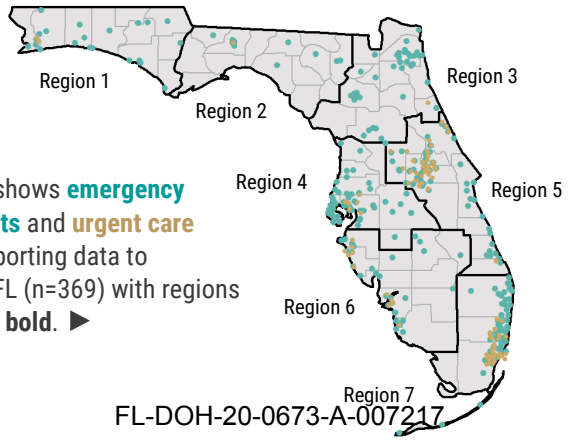


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

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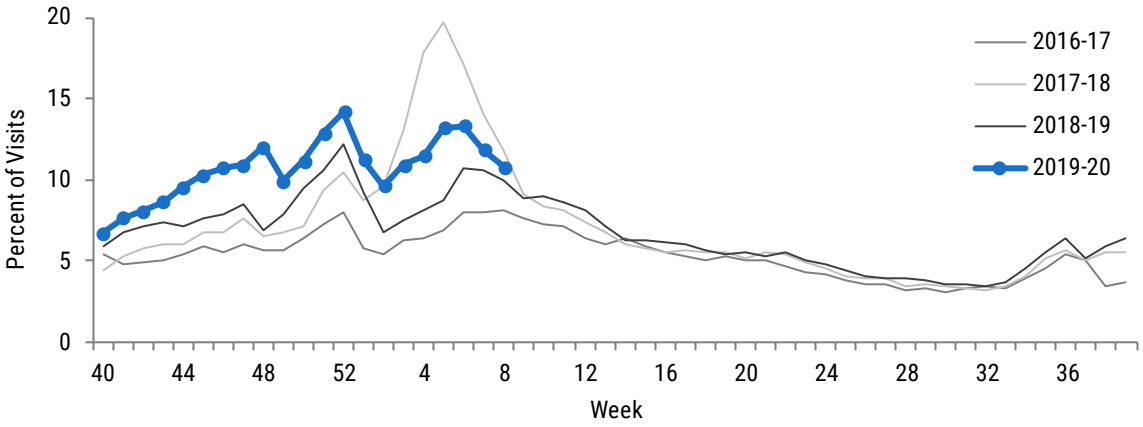
At-Risk Populations

Background: At-Risk Populations, Children

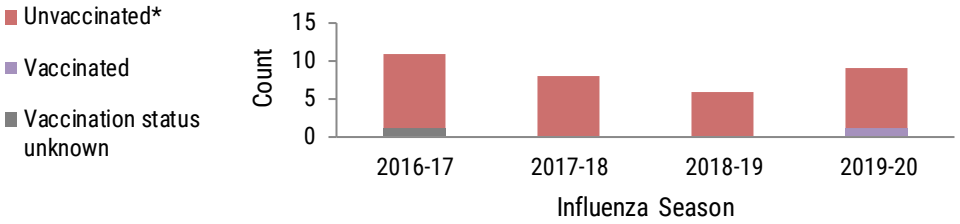
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 8, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.

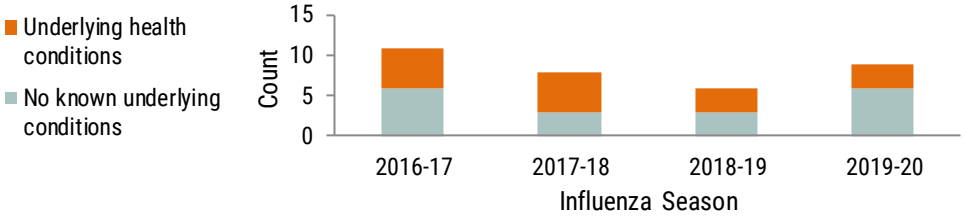


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

Figures 25-26: In week 8, **no new influenza-associated pediatric deaths were reported**. A total of nine influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 8, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 8, 2020.

In week 8, **no new influenza-associated pediatric deaths were reported**.

A total of nine influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

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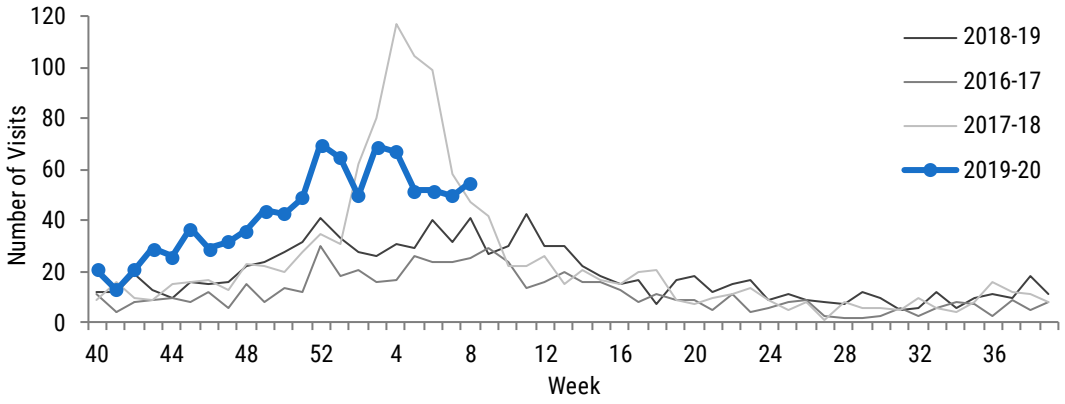
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 8, the **number of emergency department and urgent care center visits for influenza among pregnant women increased** and was above levels observed at this time in past seasons.



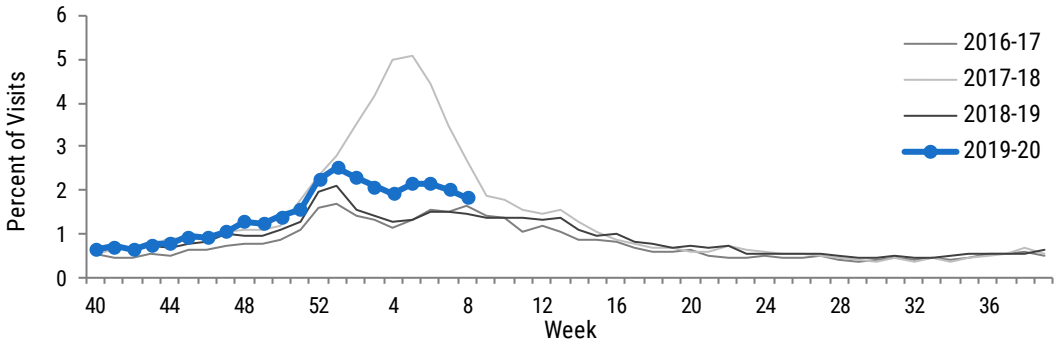
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 8, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 8, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2018-19 and 2016-17 seasons.



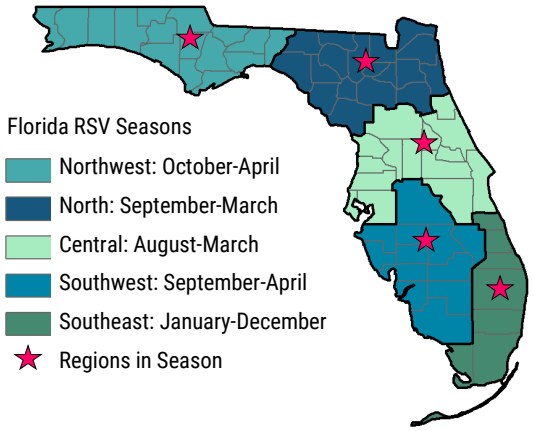
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

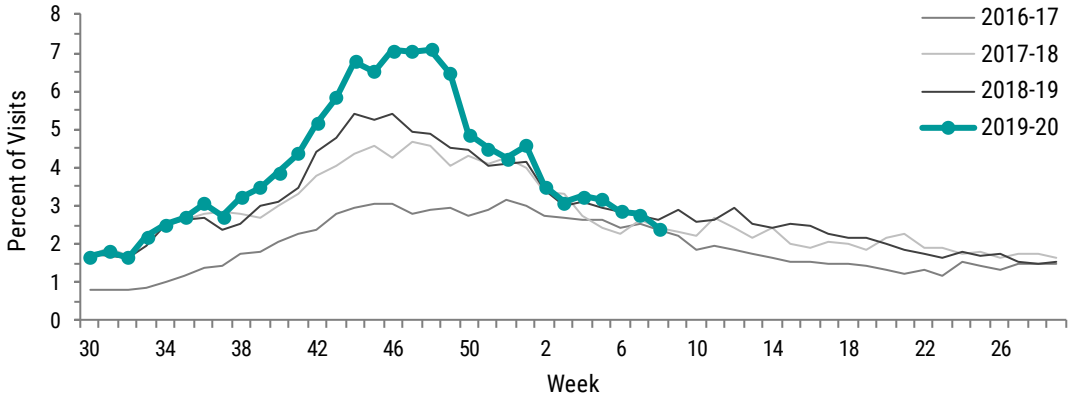
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 8 (February 16-22, 2020) Activity Summary

In week 8, RSV activity in children <5 years decreased and was similar to levels observed at this time in past seasons.

No new RSV-associated outbreaks were reported in week 8. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 8, **the percent of emergency department and urgent care center visits for RSV among children <5 years decreased** and was similar to levels observed at this time in past seasons.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 8, 2020.

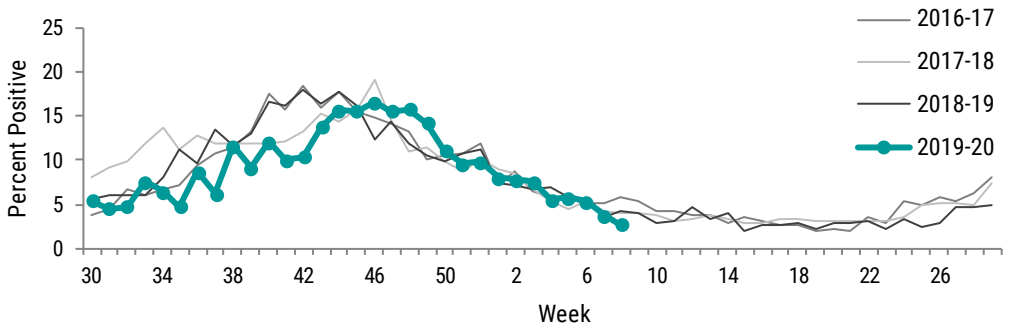
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 8, **the percent of specimens testing positive for RSV decreased.** Levels were slightly below those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=9), week 30, 2016 to week 8, 2020. ▶



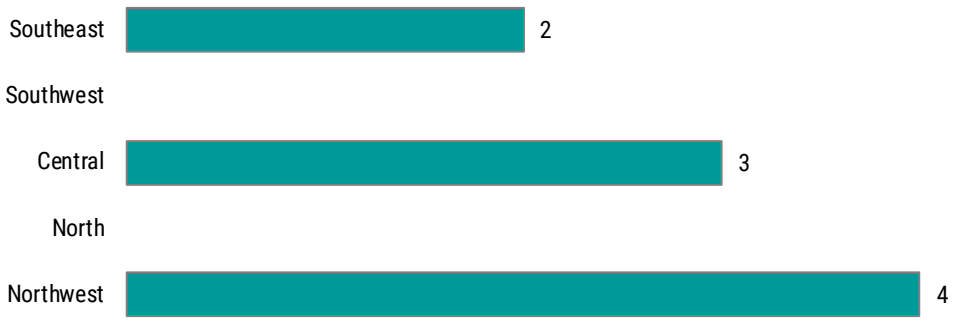
RSV-Associated Outbreaks in Week 8:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 8, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

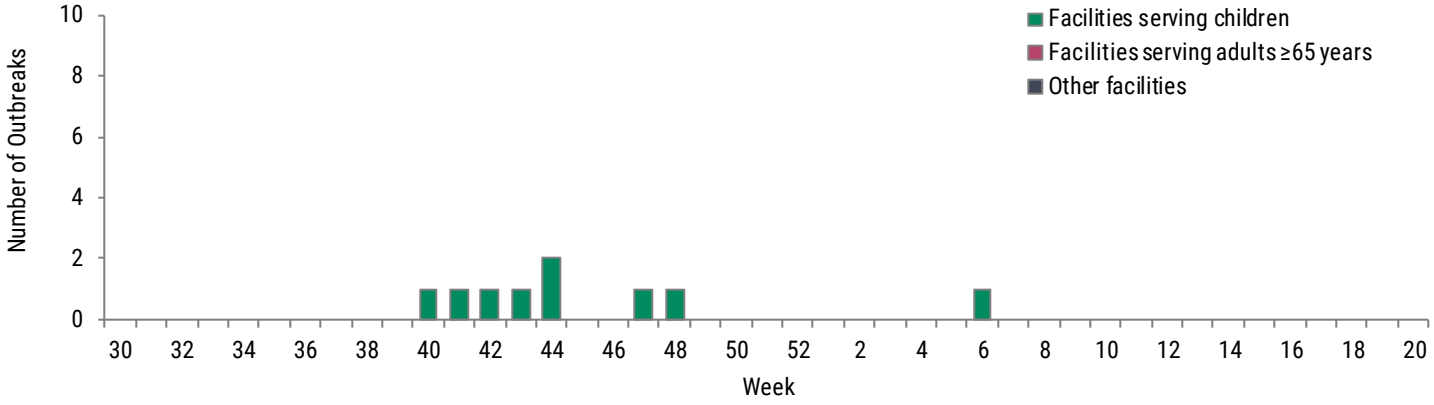
Figure 32: In week 8, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

*Regions defined in figure 29.

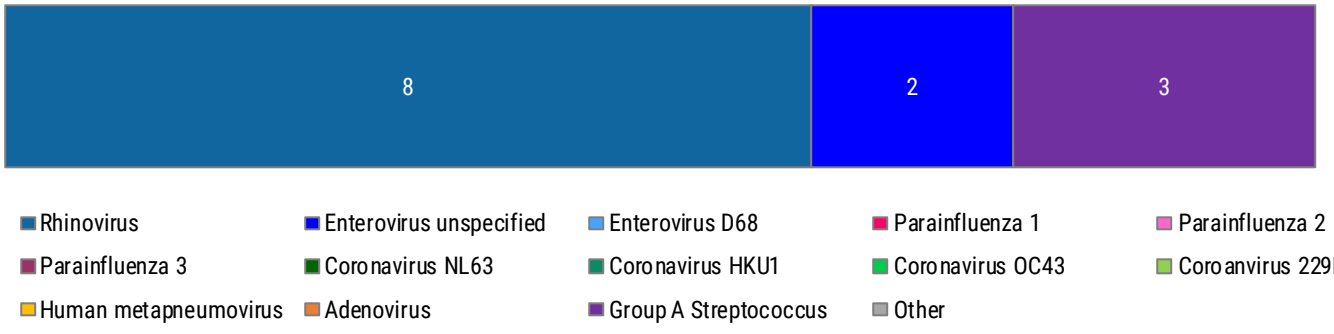
Figure 33: In week 8, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



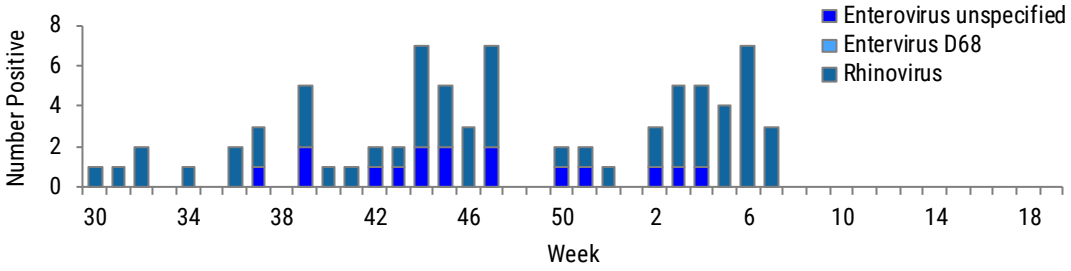
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 8, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

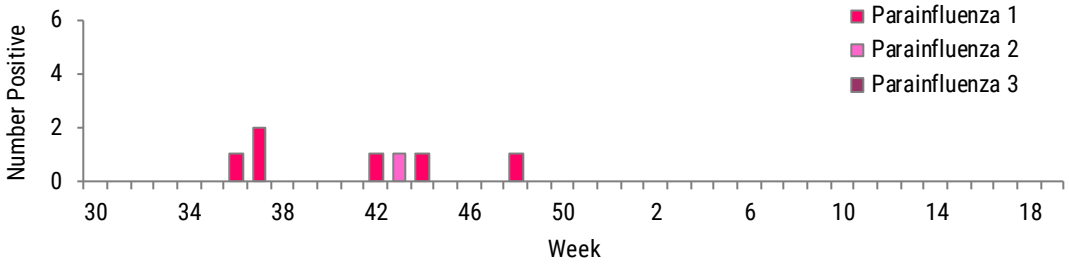


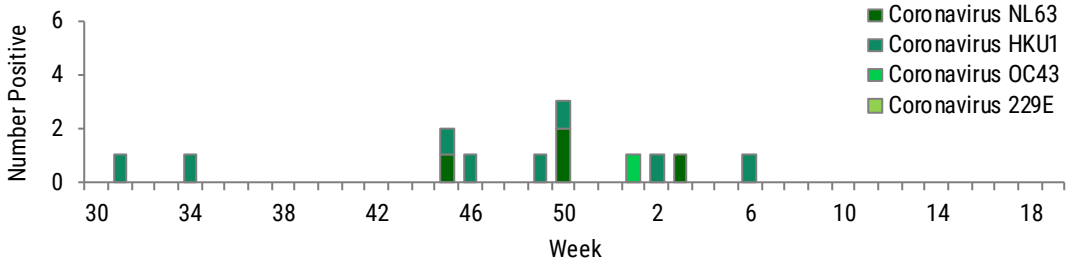
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 8, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

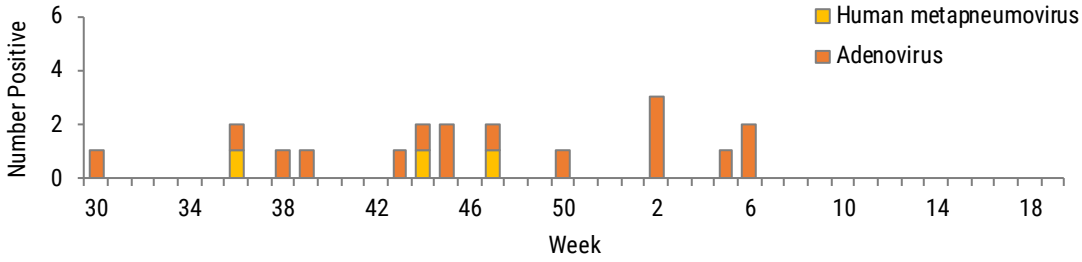
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 8, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Nursing home	Santa Rosa	54	Unknown	Unknown	Influenza A unspecified	Yes	Open
Assisted living facility	Polk	2	2	0	Influenza A unspecified	Yes	Closed
Assisted living facility	Sumter	8	4	0	Influenza A 2009 (H1N1)	Yes	Open
Assisted living facility	Seminole	12	3	1	Influenza A 2009 (H1N1)	Yes	Closed
Correctional facility	Sumter	40	Unknown	Unknown	Influenza A unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 9, 2020 Florida Flu Review
Date:	Wednesday, March 4, 2020 2:45:57 PM
Attachments:	Week 9, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 9, 2020 Florida Flu Review.

Week 9 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 9 but remained above peak levels observed in the 2016-17 season. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Nine outbreaks were reported, down from 18 outbreaks in the previous week. Of the nine outbreaks reported, two were influenza-associated and seven were ILI.
One new influenza-associated pediatric death was reported in an unvaccinated child with underlying medical conditions. Ten influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

AMERICAN OVERSIGHT

Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
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Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

AMERICAN OVERSIGHT

Florida FLU REVIEW

Season: 2019-20

Week 9: 2/23/20-2/29/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 9 influenza & influenza-like illness (ILI) activity summary:

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In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

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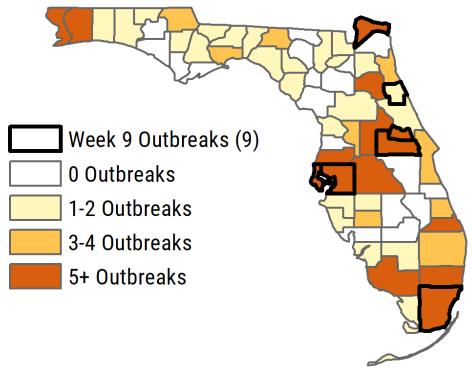
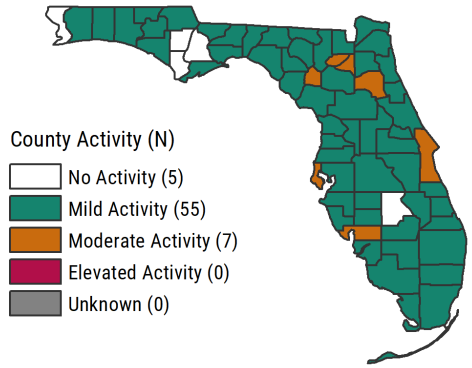
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator

Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 4, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)[CM]; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007228

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

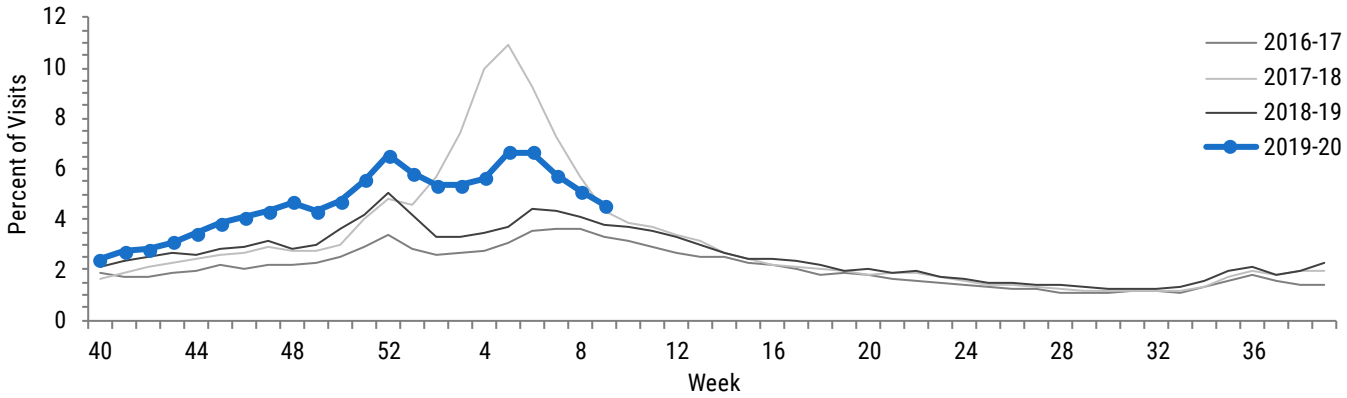
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 9, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2016-17 season.

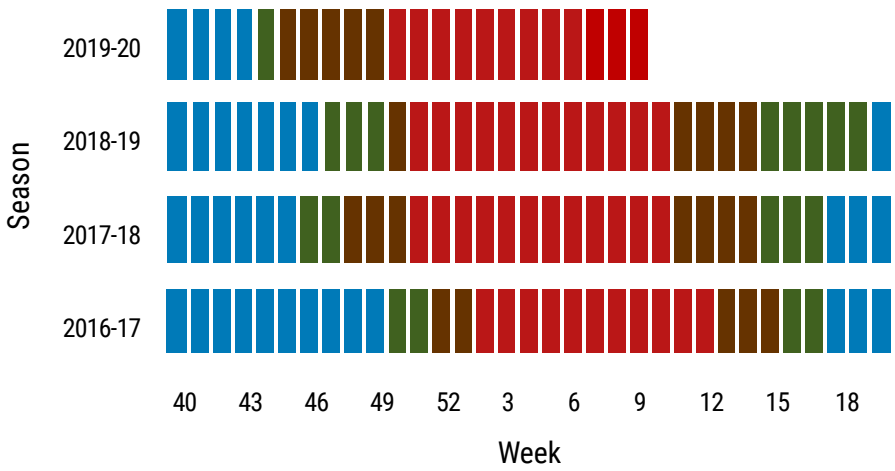


▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 9, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

AMERICAN OVERSIGHT

Statewide Activity

Figure 2: In week 9, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 9, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 9, **the percent of patients with ILI reported by ILINet providers statewide increased** and was below levels observed during the 2016-17 and 2018-19 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 9, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

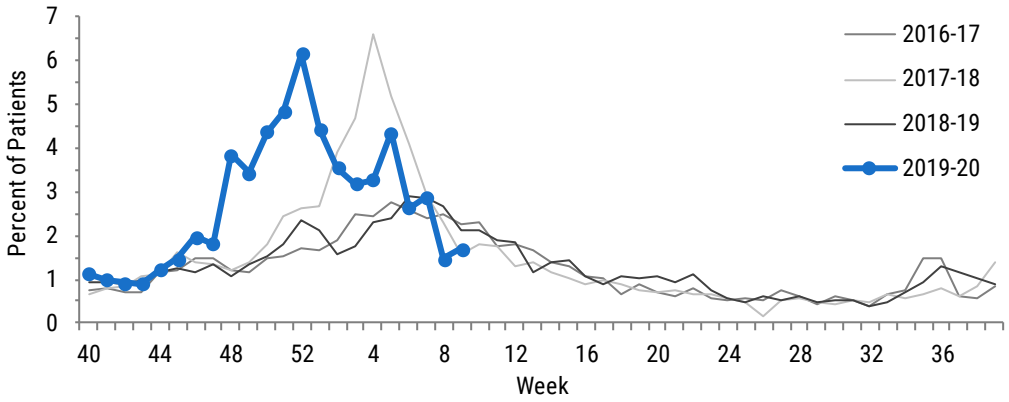
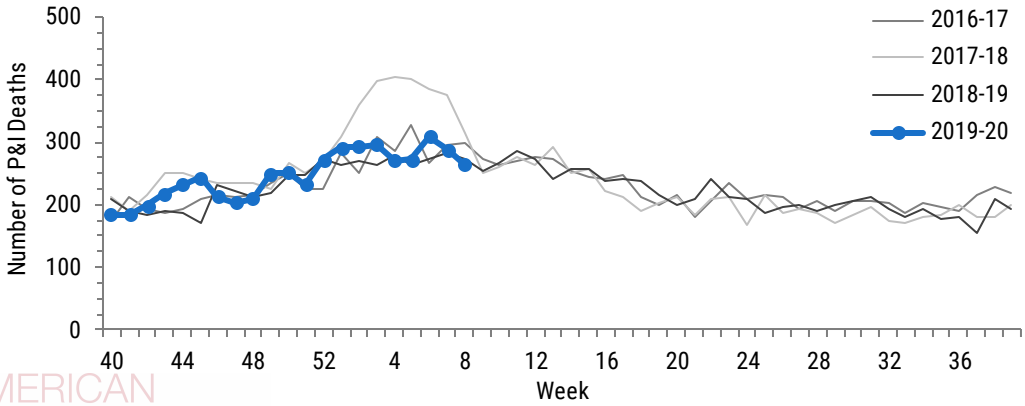


Figure 4: In week 8 (ending 2/22/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

AMERICAN OVERSIGHT

County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 9. Seven counties reported **moderate activity.**

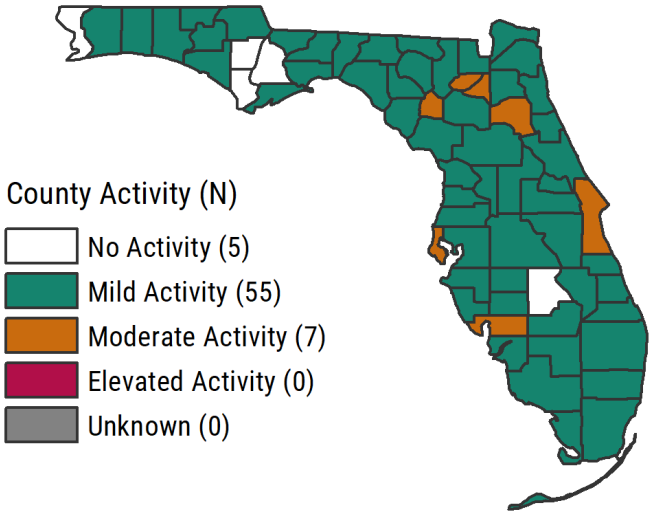
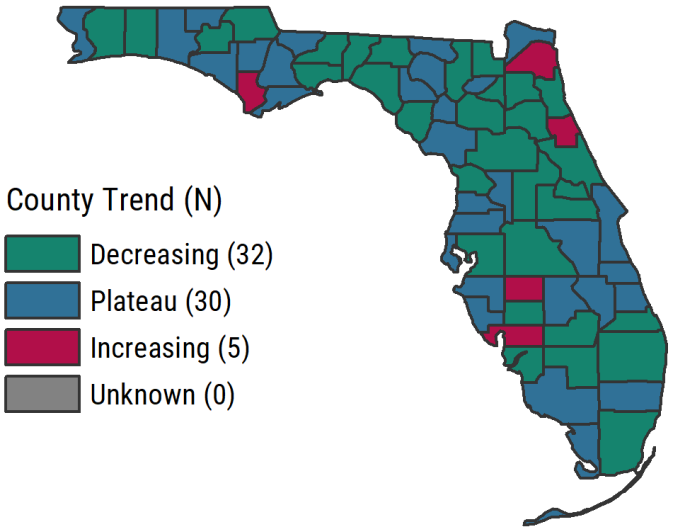
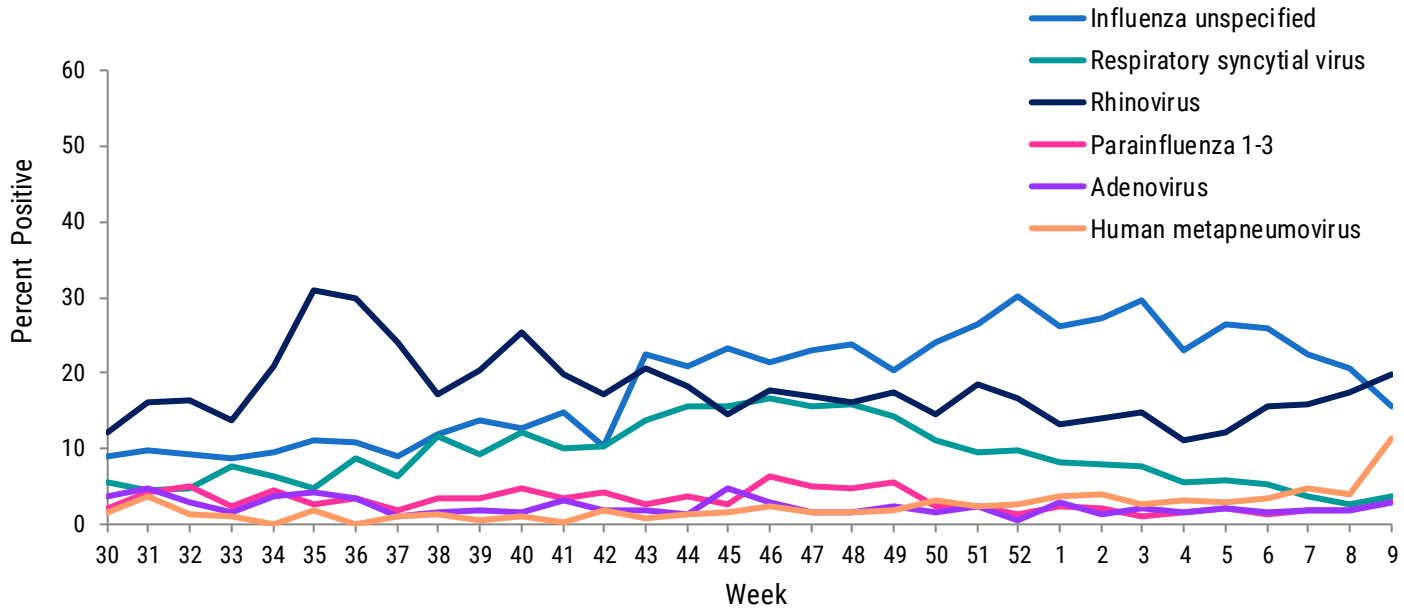


Figure 7: Most counties reported **decreasing activity** for week 9. Five counties reported **increasing activity,** and thirty counties reported **activity at a plateau.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. Of note, the volume of laboratory tests reported in week 9 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 9 Outbreaks at a Glance:

Number Reported:
9 Outbreaks

Influenza-Associated:
2 Outbreaks

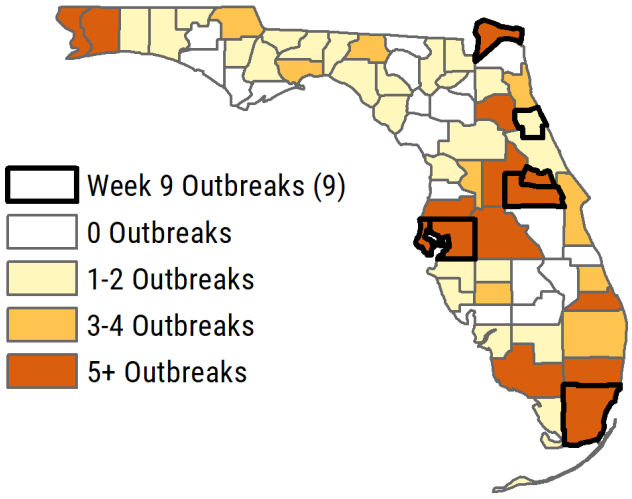
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 9, two influenza-associated and seven ILI outbreaks were reported, a decrease from the previous week.

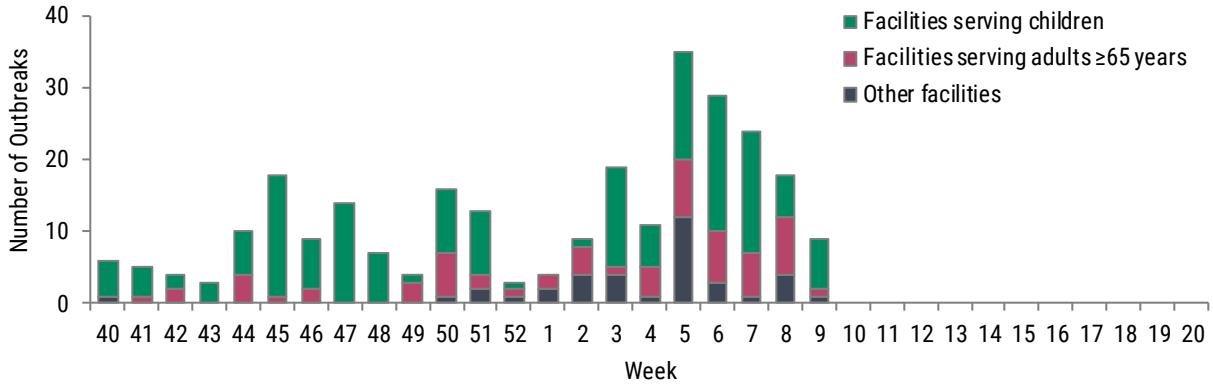
Severe outcomes* were reported in one of nine outbreaks. Two hospitalizations and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 9, the outbreak with severe outcomes was in a facility serving adults aged ≥65 years.



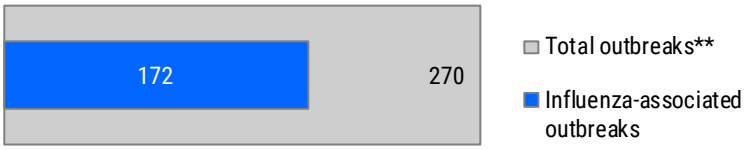
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 9 are **outlined in bold.**

Figure 9: In week 9, **one outbreak** was reported among **facilities serving adults aged ≥65 years, seven outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 9, **63.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 9, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

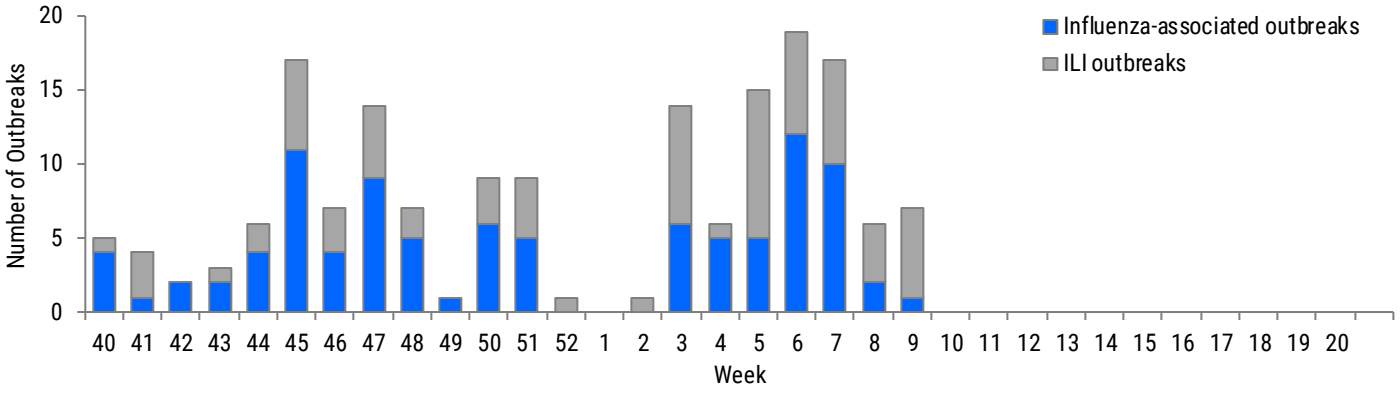
7 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 9, seven new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 9, **one influenza-associated outbreak** and **six ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

Facilities Serving Adults ≥65 yrs.**:

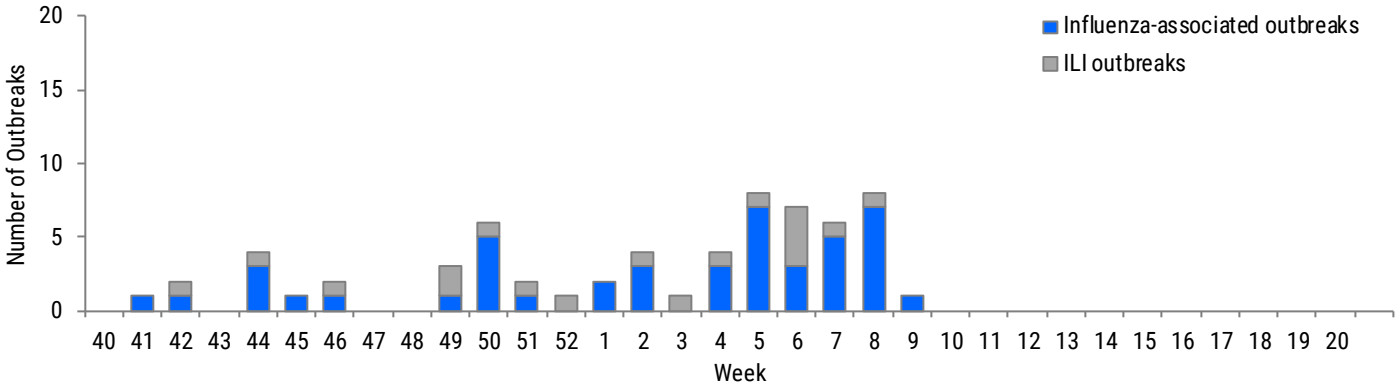
1 Outbreak

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 9, one new outbreak of influenza or ILI was reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 9, **one influenza-associated outbreak** was reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

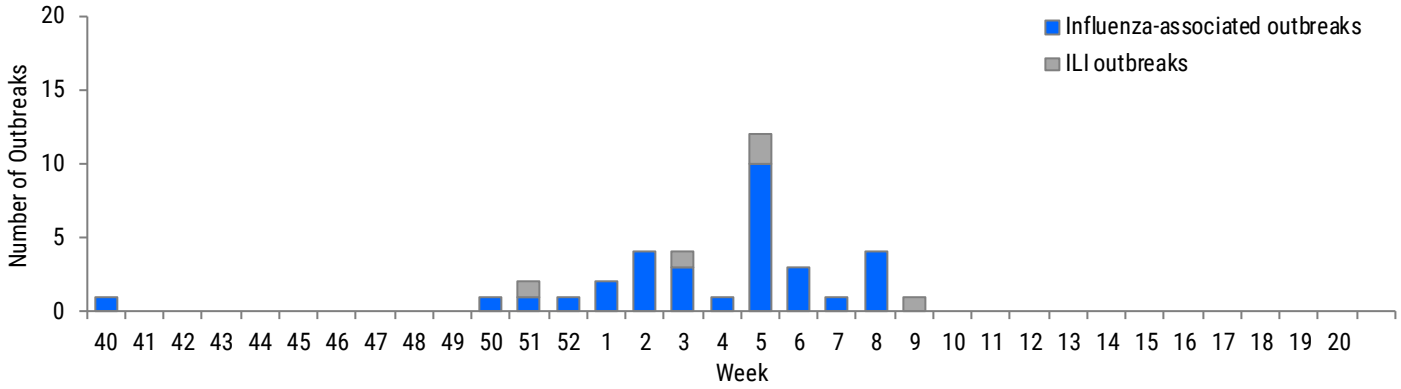
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 9, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 9, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

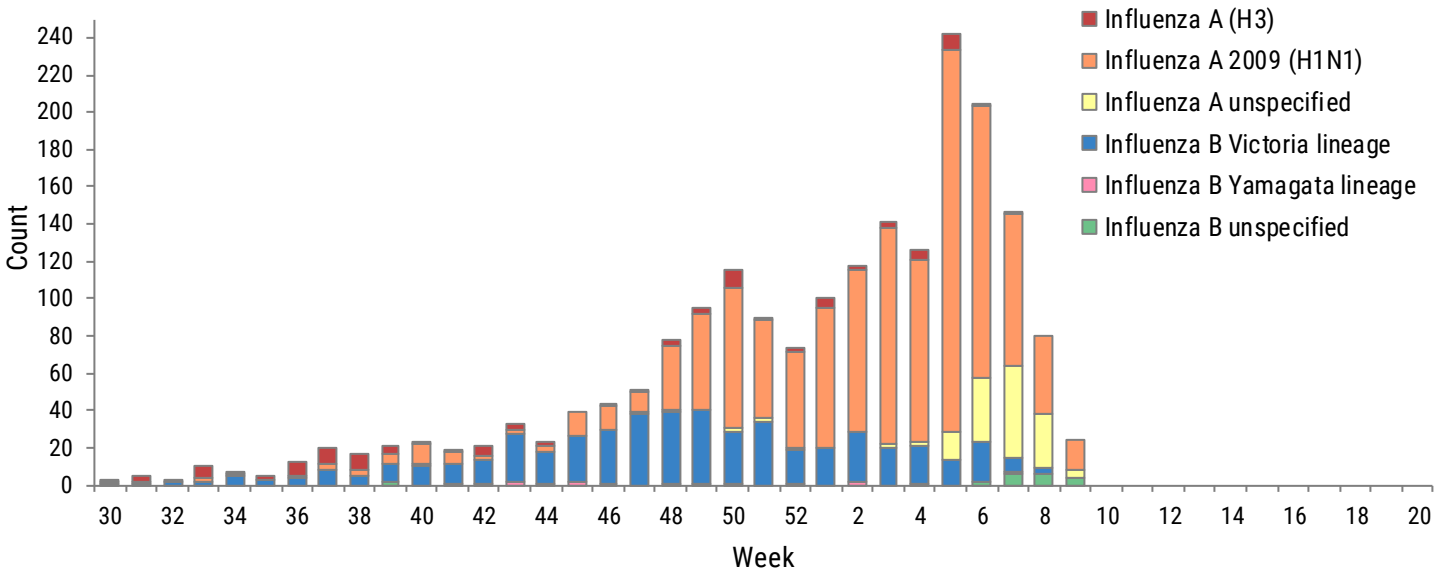
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	130 (48.2%)	78 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	40 (14.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	19 (7.0%)	9 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.6%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (10.7%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.1%)	28 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.5%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**270 (100.0%)**	**172 influenza-associated outbreaks** **98 ILI outbreaks**

AMERICAN OVERSIGHT

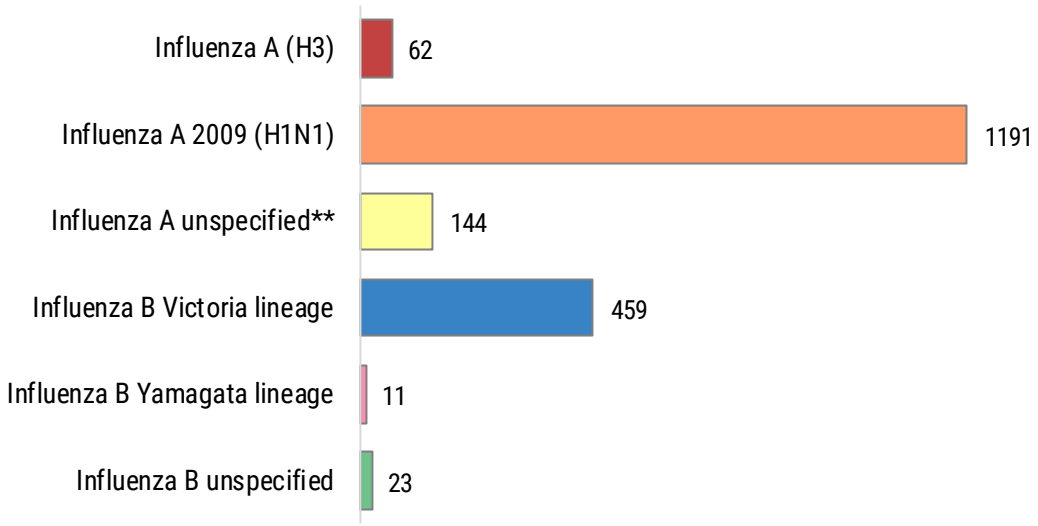
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 9, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 9, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 9, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

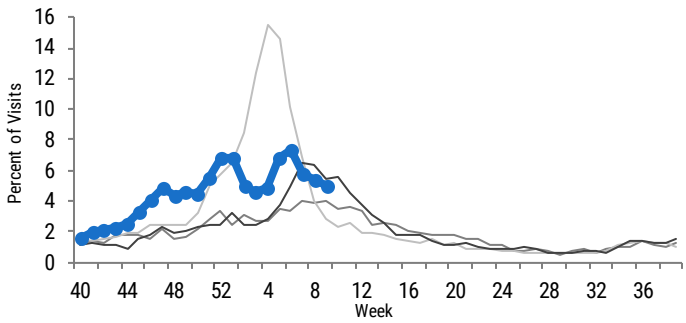


Figure 17: In **region 2, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

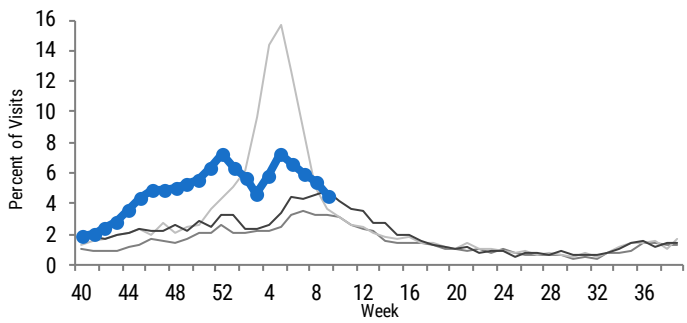


Figure 18: In **region 3, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

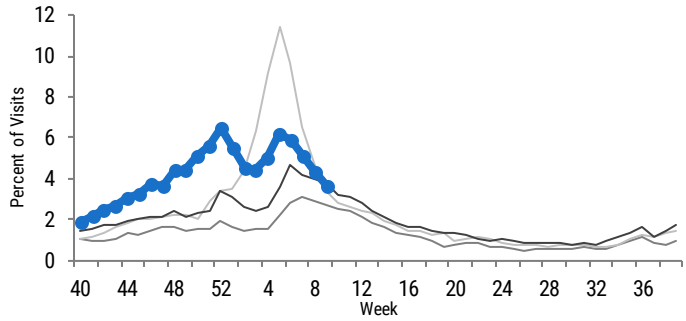


Figure 19: In **region 4, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

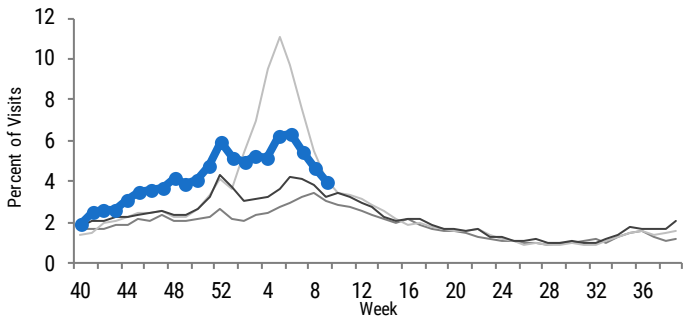


Figure 20: In **region 5, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

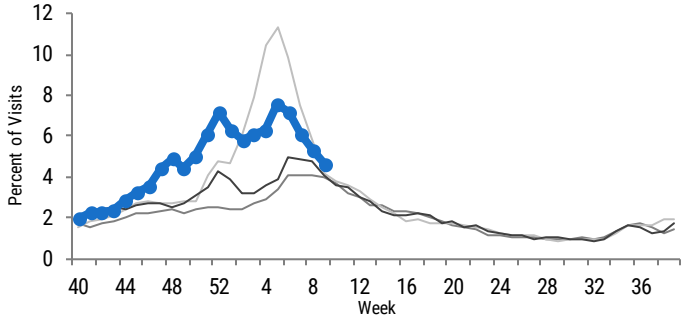


Figure 21: In **region 6, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

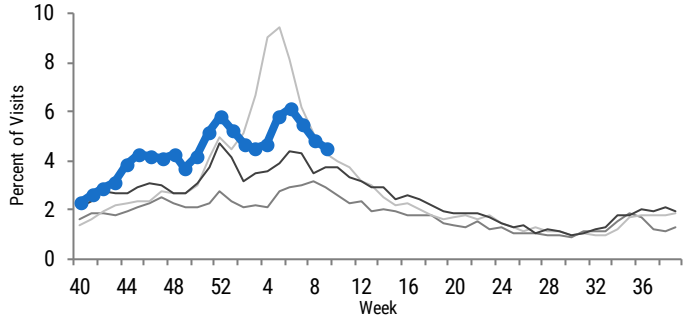
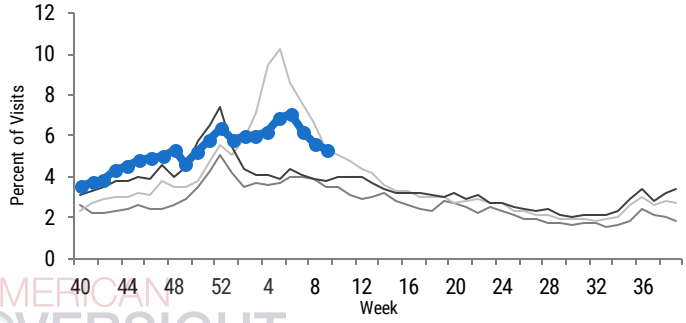


Figure 22: In **region 7, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.



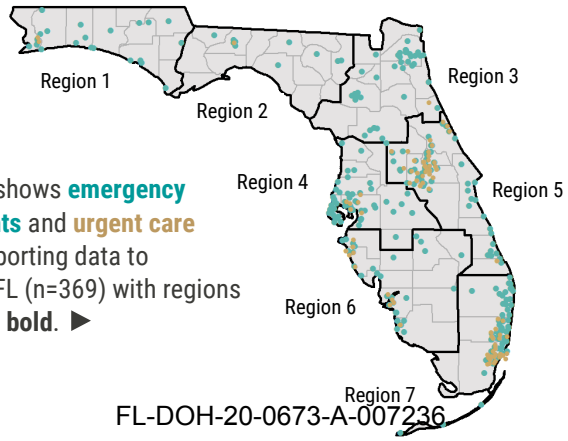


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

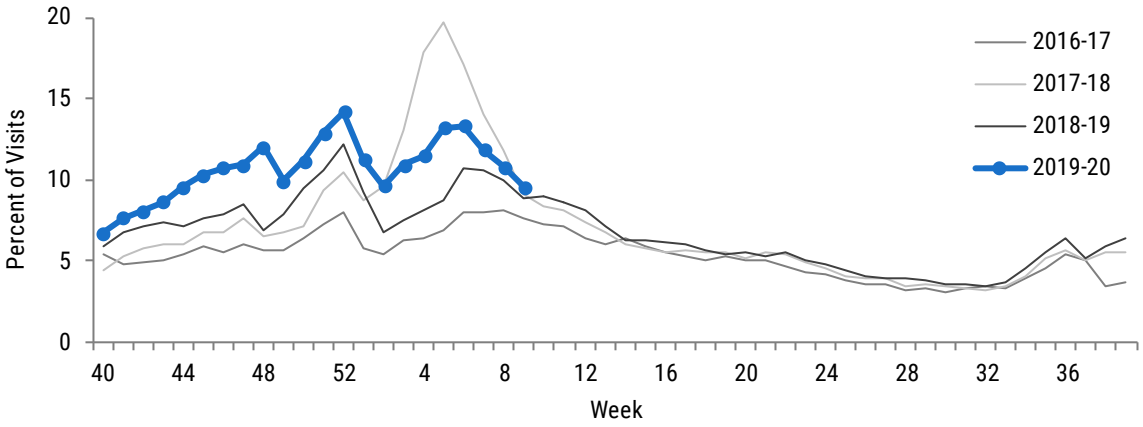
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

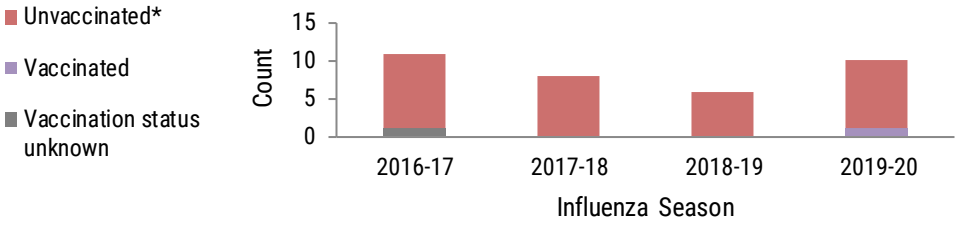
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 9, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2016-17 season.

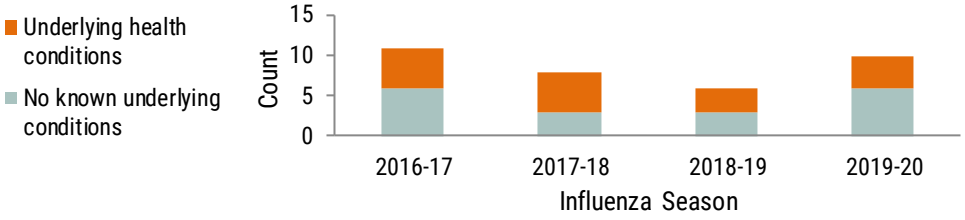


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

Figures 25-26: In week 9, **one new influenza-associated pediatric death was reported**. A total of ten influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 9, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 9, 2020.

In week 9, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions who was not vaccinated for the 2019-20 season.

A total of ten influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

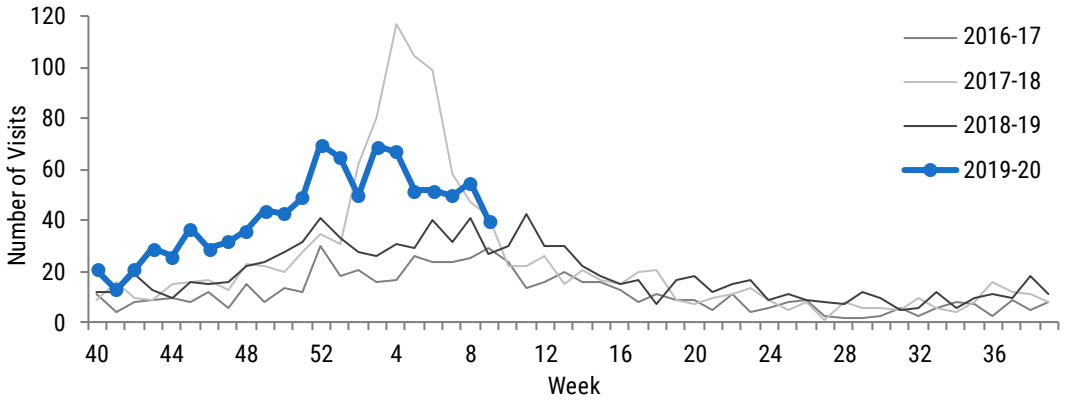
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 9, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was above peak levels observed during the 2016-17 season.



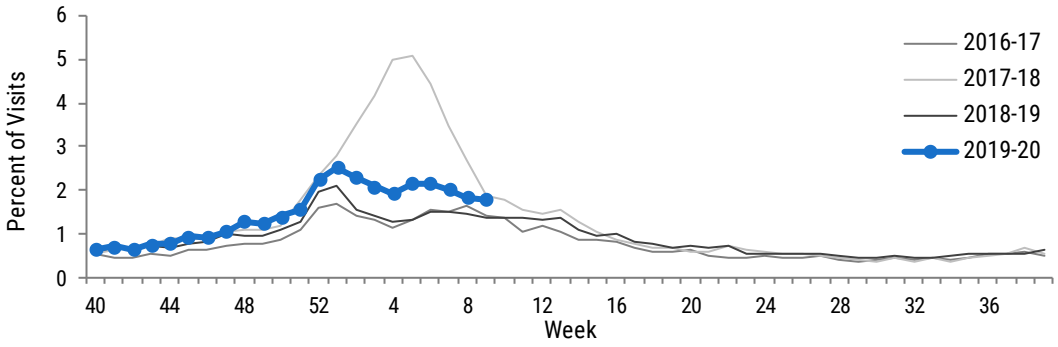
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 9, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 9, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2016-17 season.



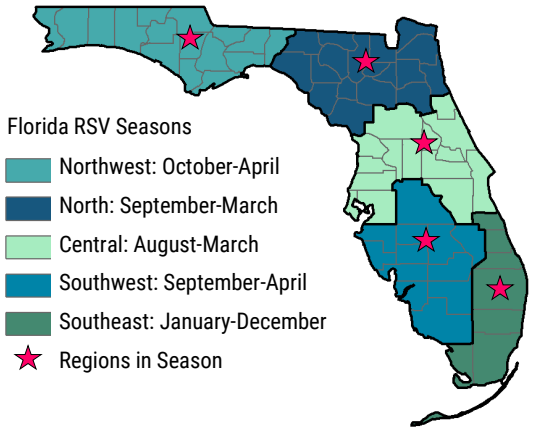
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

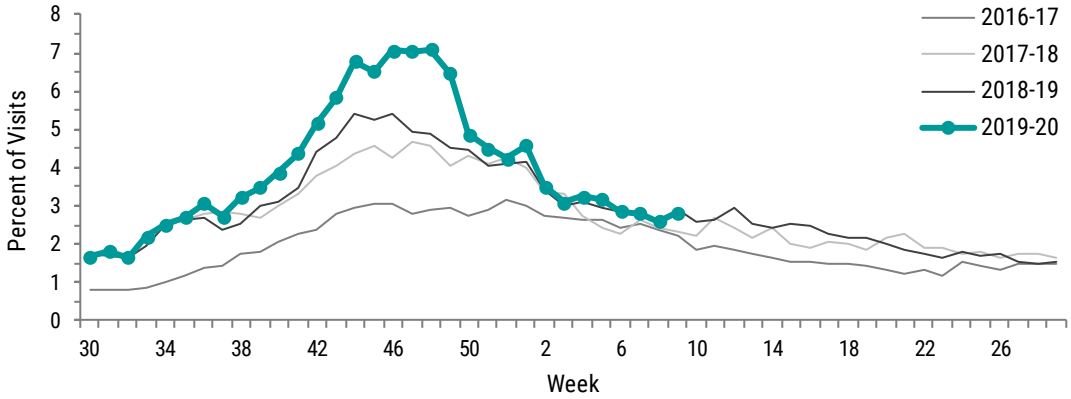
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 9 (February 23-29, 2020) Activity Summary

In week 9, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 9. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 9, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 9, 2020.

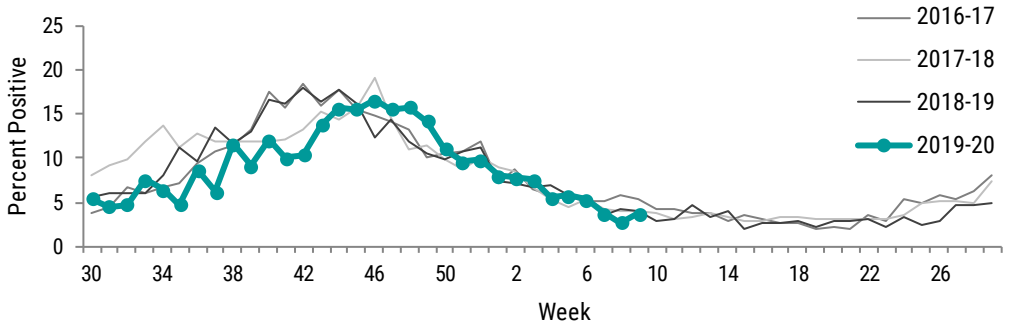
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 9, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 9, 2020. ▶



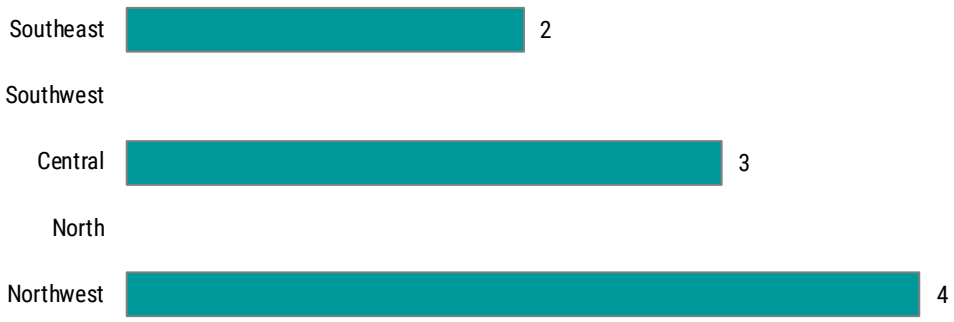
RSV-Associated Outbreaks in Week 9:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 9, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

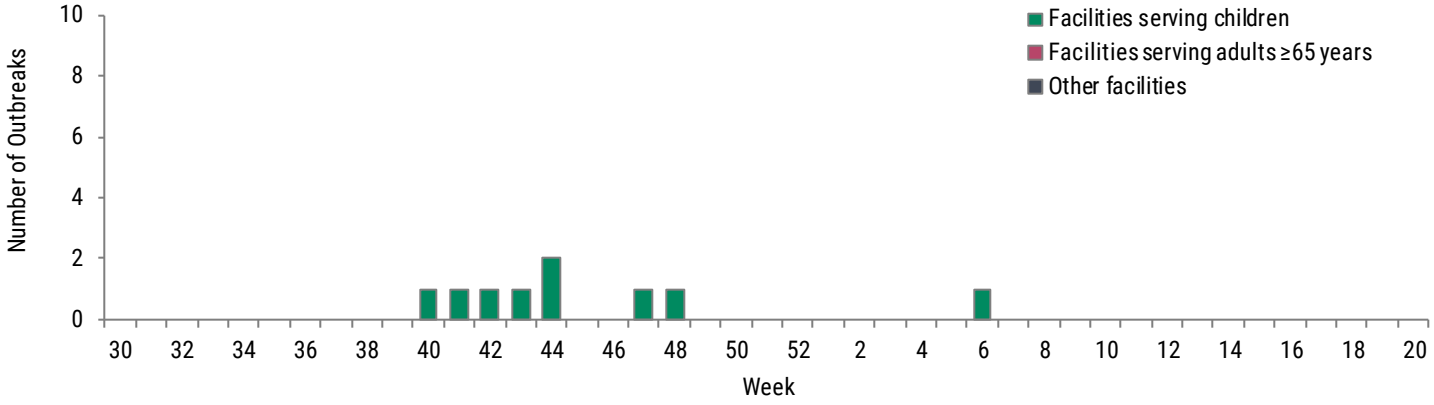
Figure 32: In week 9, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

*Regions defined in figure 29.

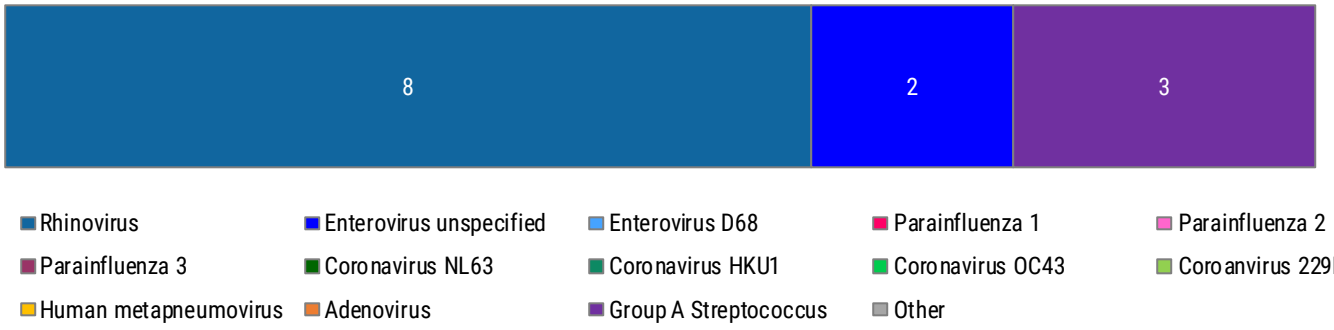
Figure 33: In week 9, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



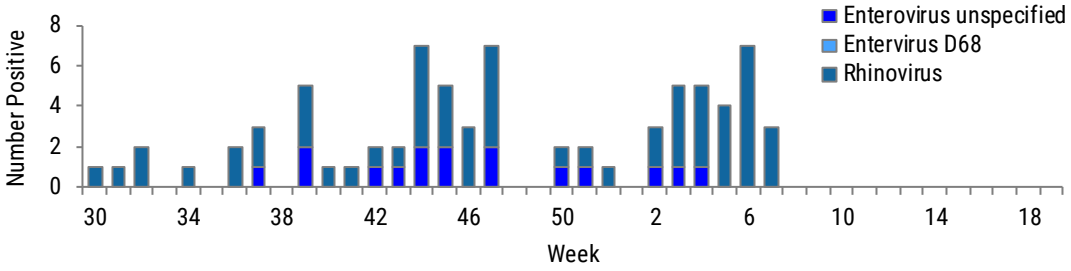
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

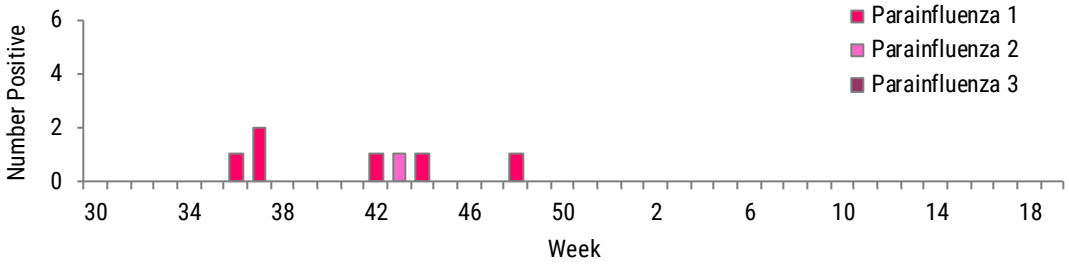


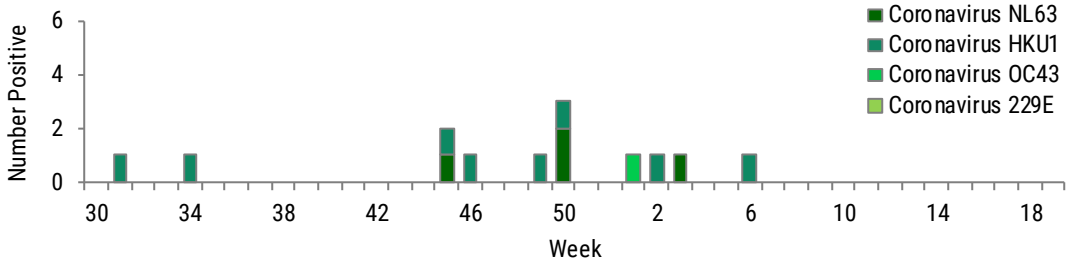
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 9, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

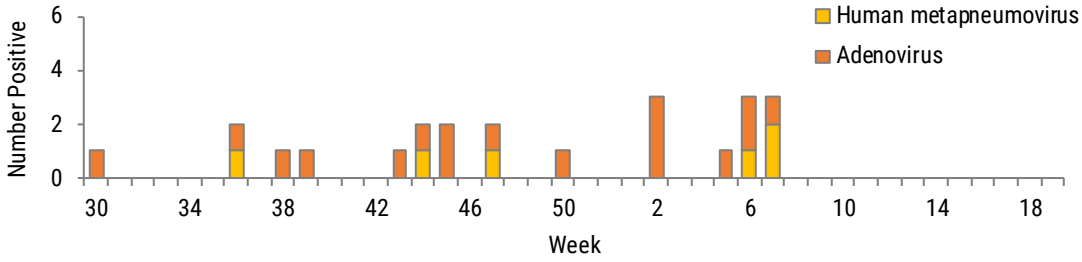
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 9, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Pinellas	3	2	Unknown	Influenza unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 9, 2020 Florida Flu Review
Date:	Wednesday, March 4, 2020 2:46:03 PM
Attachments:	Week 9, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 9, 2020 Florida Flu Review.

Week 9 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 9 but remained above peak levels observed in the 2016-17 season. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Nine outbreaks were reported, down from 18 outbreaks in the previous week. Of the nine outbreaks reported, two were influenza-associated and seven were ILI.
One new influenza-associated pediatric death was reported in an unvaccinated child with underlying medical conditions. Ten influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

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Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 9: 2/23/20-2/29/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 9 influenza & influenza-like illness (ILI) activity summary:

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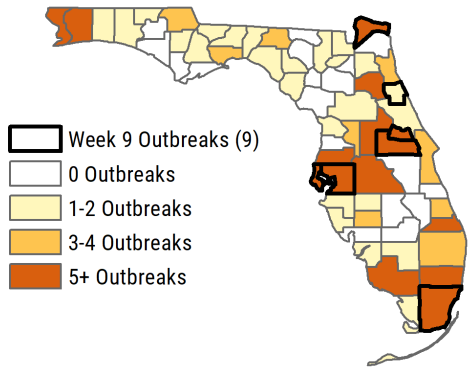
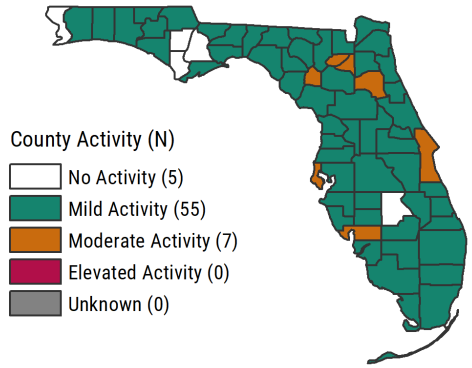
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

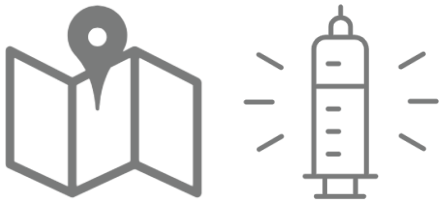
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 4, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007247

AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

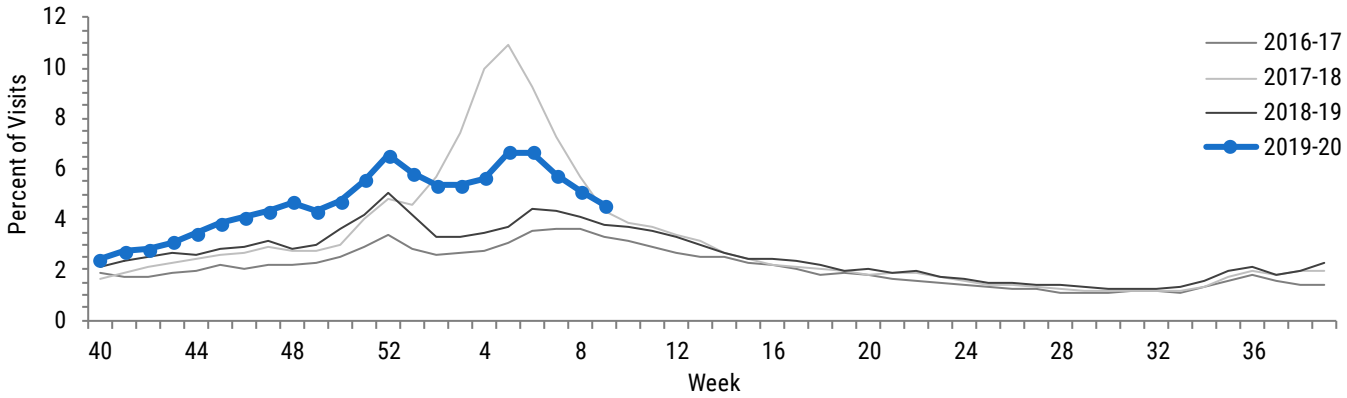
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 9, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2016-17 season.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 9, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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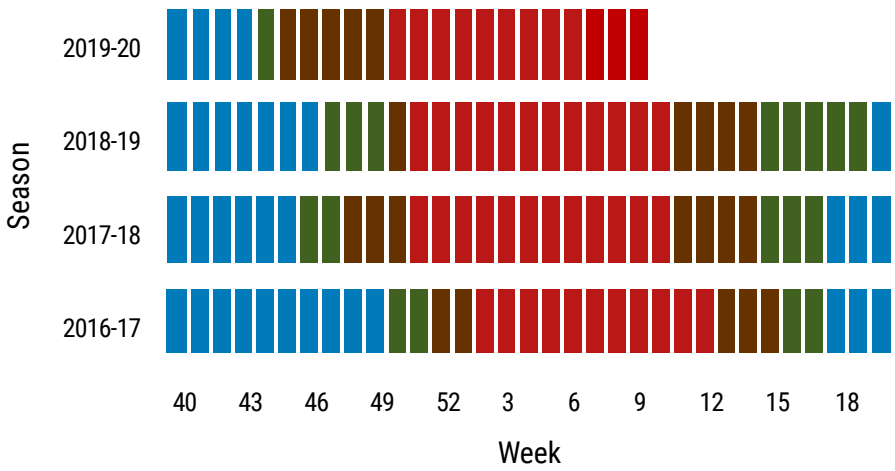
Statewide Activity

Figure 2: In week 9, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 9, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 9, **the percent of patients with ILI reported by ILINet providers statewide increased** and was below levels observed during the 2016-17 and 2018-19 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 9, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

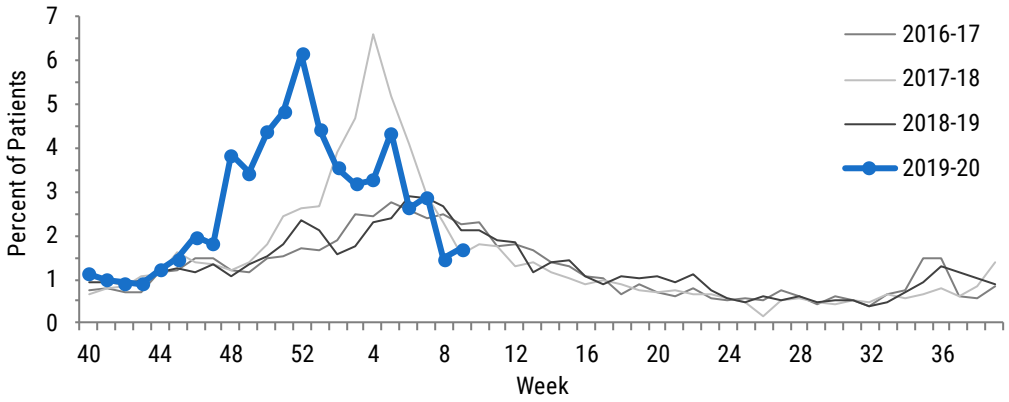
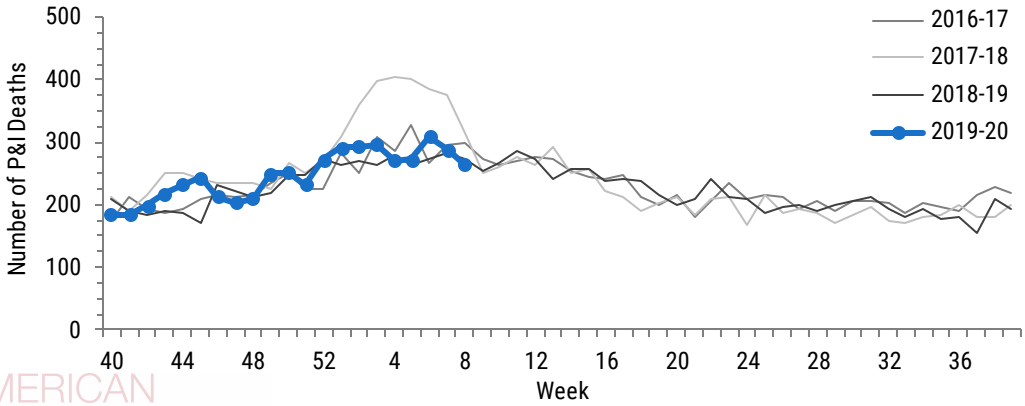


Figure 4: In week 8 (ending 2/22/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 9. Seven counties reported **moderate activity.**

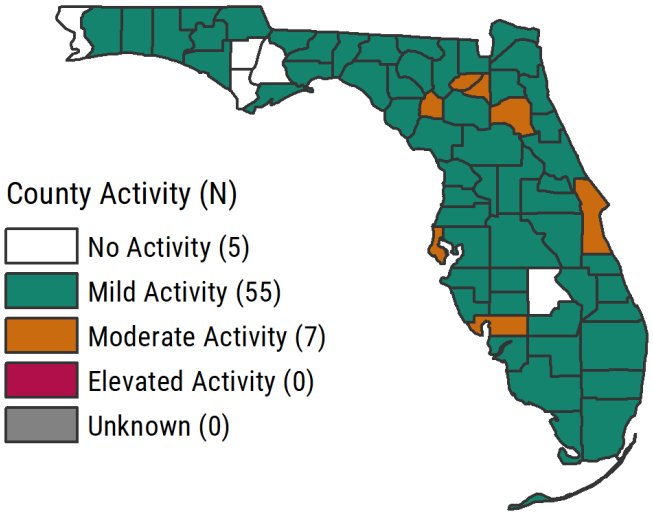
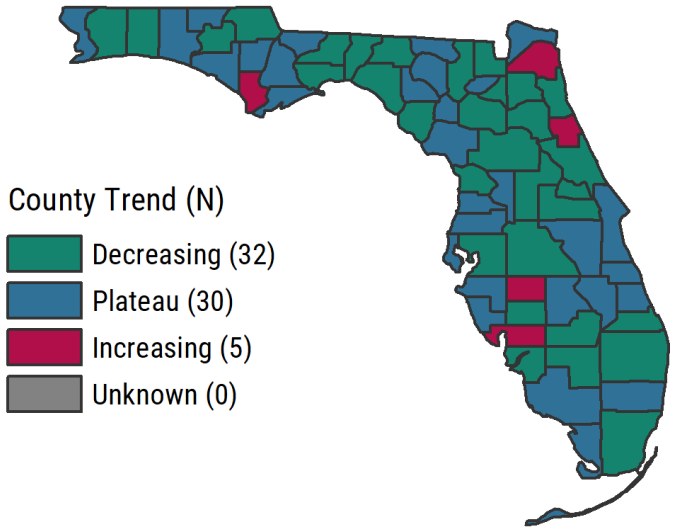
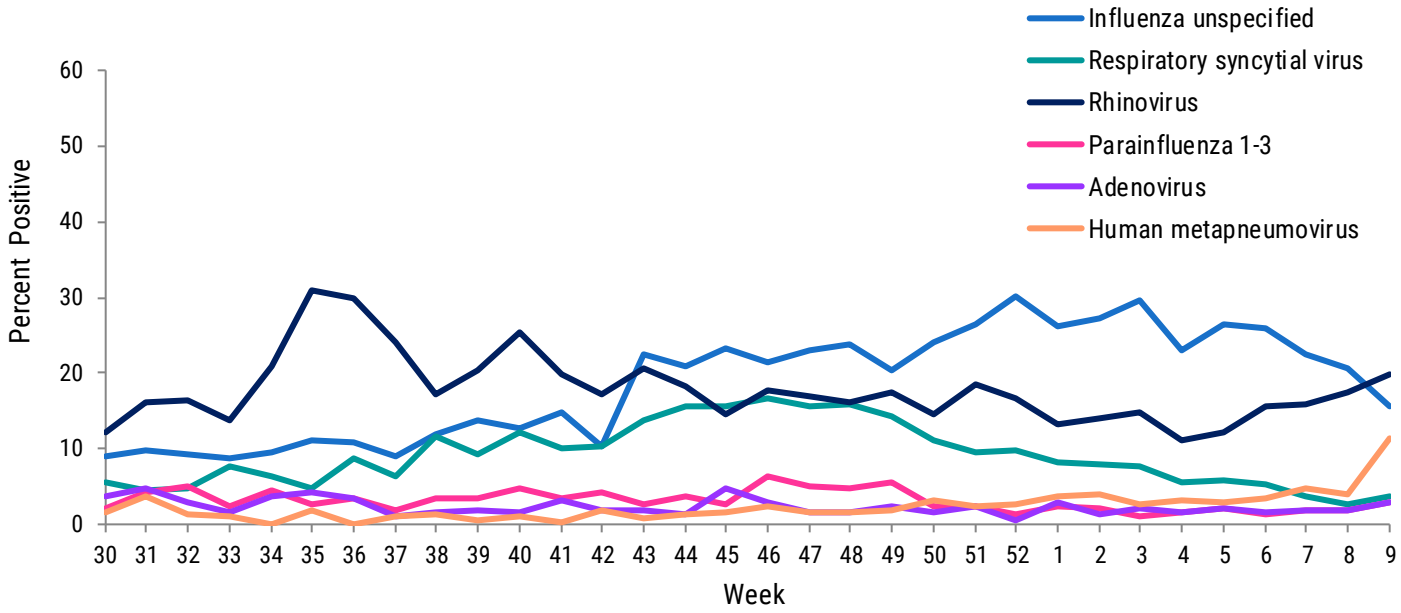


Figure 7: Most counties reported **decreasing activity** for week 9. Five counties reported **increasing activity,** and thirty counties reported **activity at a plateau.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. Of note, the volume of laboratory tests reported in week 9 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Week 9 Outbreaks at a Glance:

Number Reported:
9 Outbreaks

Influenza-Associated:
2 Outbreaks

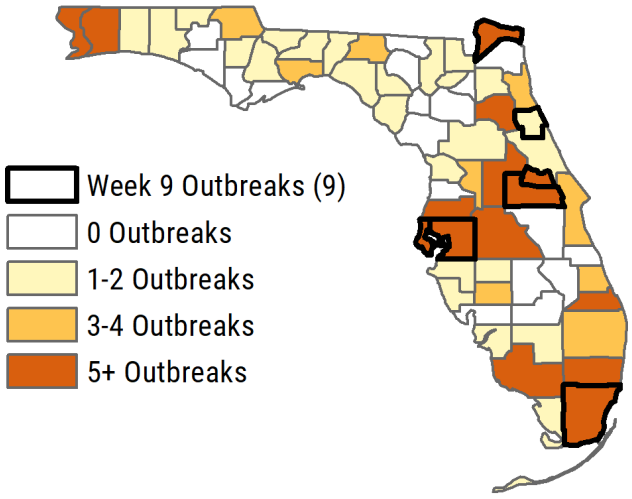
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 9, two influenza-associated and seven ILI outbreaks were reported, a decrease from the previous week.

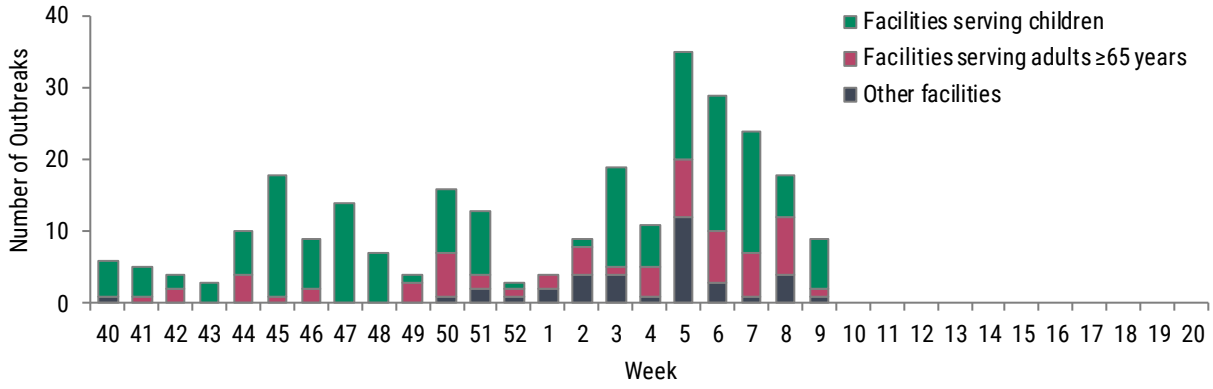
Severe outcomes* were reported in one of nine outbreaks. Two hospitalizations and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 9, the outbreak with severe outcomes was in a facility serving adults aged ≥65 years.



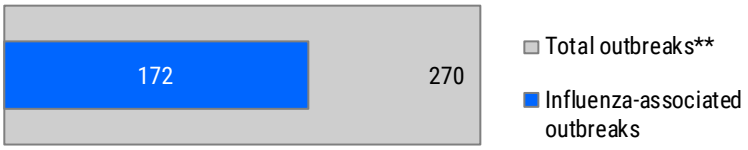
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 9 are **outlined in bold.**

Figure 9: In week 9, **one outbreak** was reported among **facilities serving adults aged ≥65 years, seven outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 9, **63.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 9, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

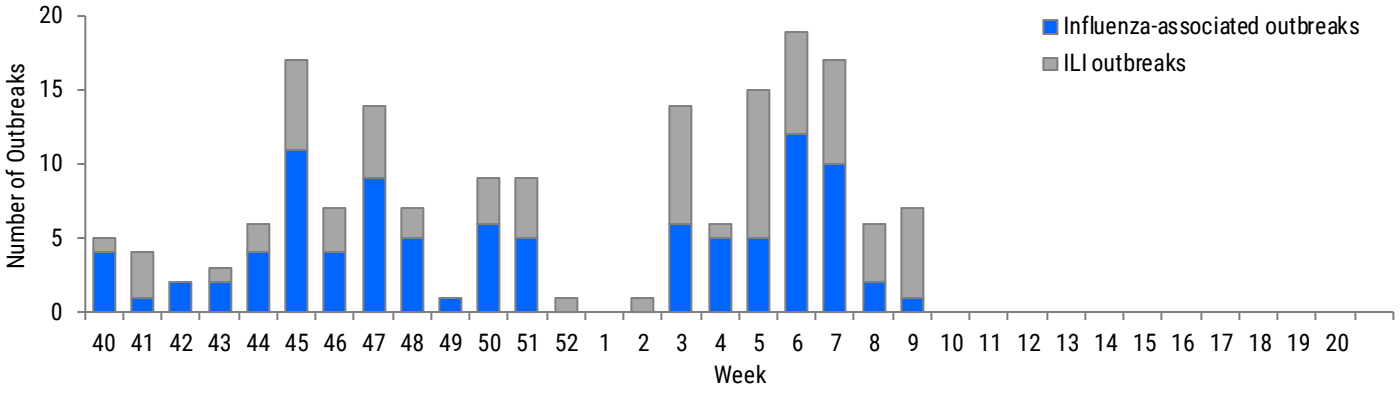
7 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 9, seven new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 9, **one influenza-associated outbreak** and **six ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

Facilities Serving Adults ≥65 yrs.**:

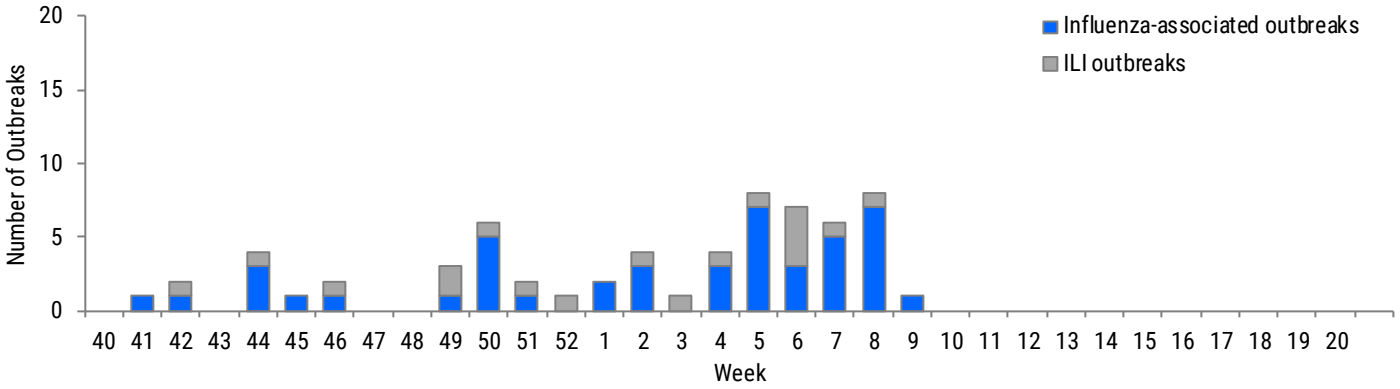
1 Outbreak

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 9, one new outbreak of influenza or ILI was reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 9, **one influenza-associated outbreak** was reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

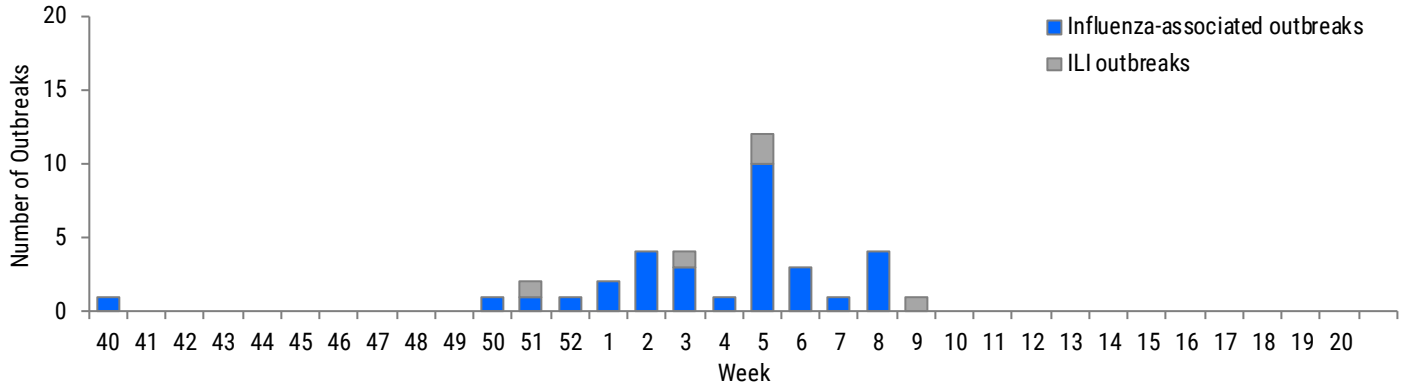
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 9, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 9, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

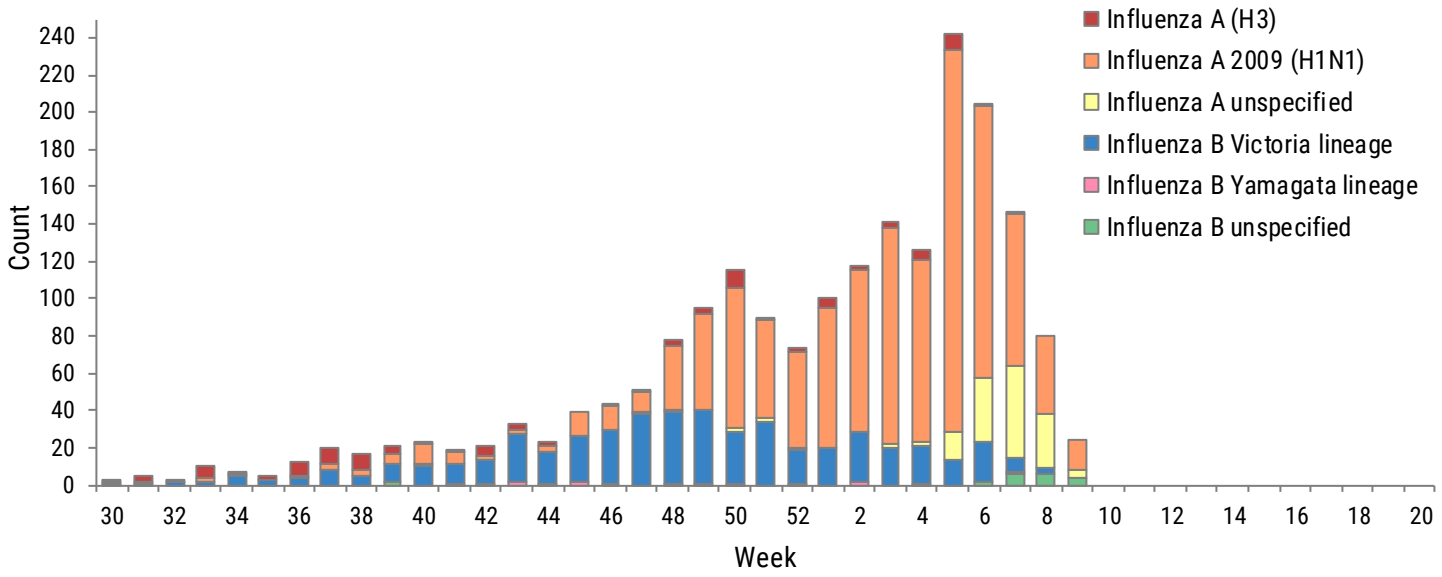
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	130 (48.2%)	78 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	40 (14.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	19 (7.0%)	9 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.6%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (10.7%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.1%)	28 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.5%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**270 (100.0%)**	**172 influenza-associated outbreaks** **98 ILI outbreaks**

AMERICAN OVERSIGHT

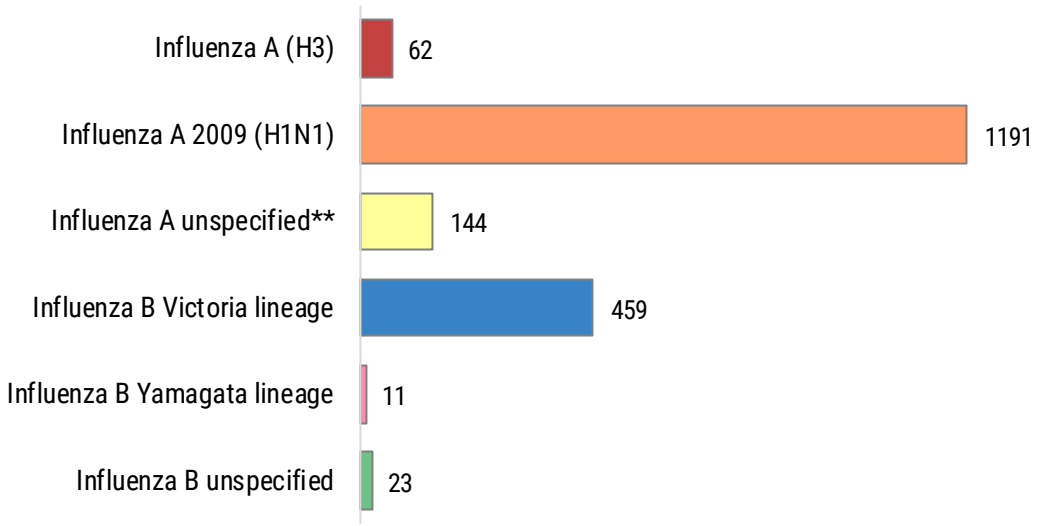
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 9, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 9, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 9, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

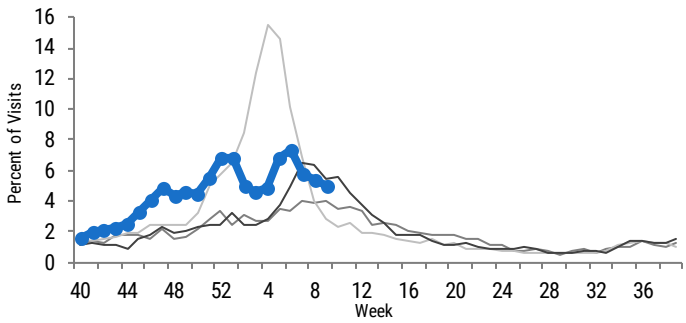


Figure 17: In **region 2, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

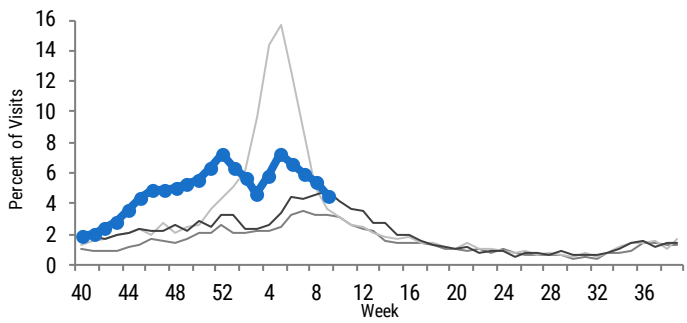


Figure 18: In **region 3, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

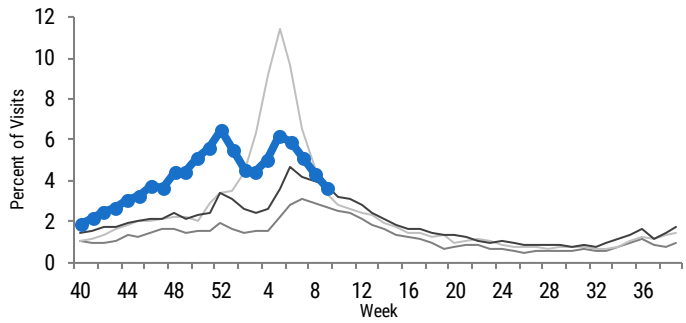


Figure 19: In **region 4, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

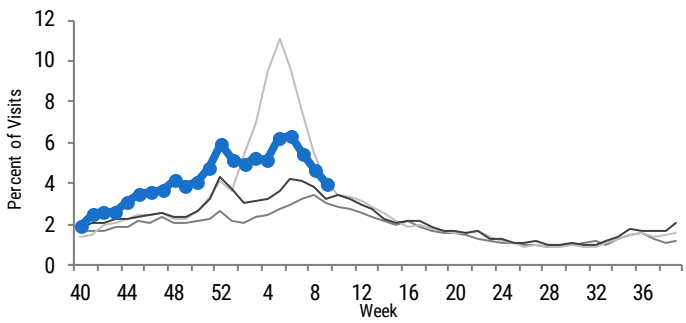


Figure 20: In **region 5, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

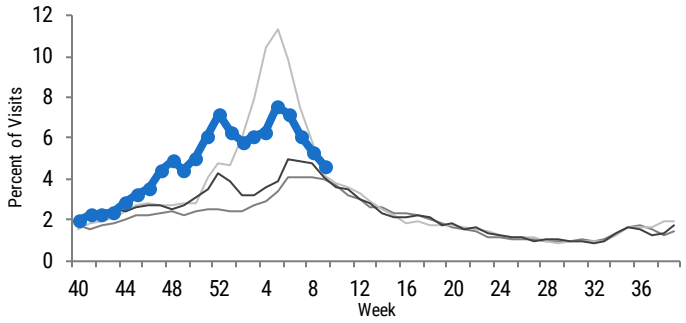


Figure 21: In **region 6, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

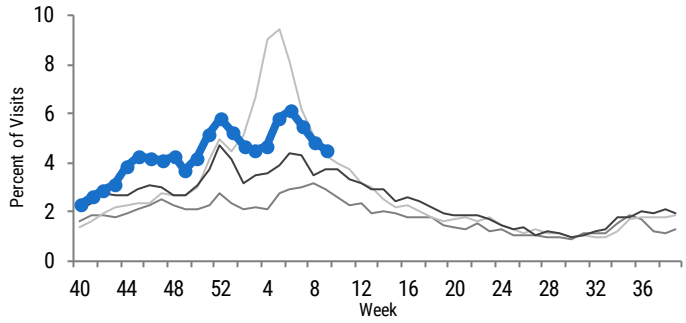
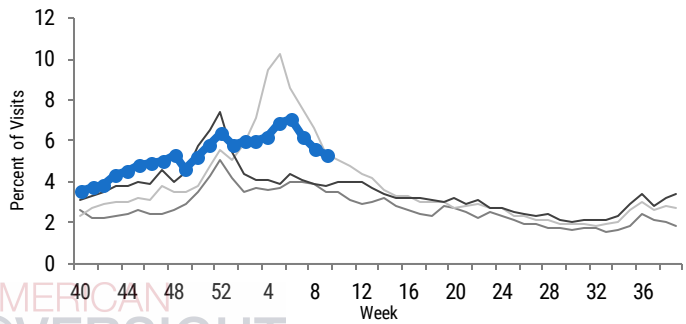


Figure 22: In **region 7, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.



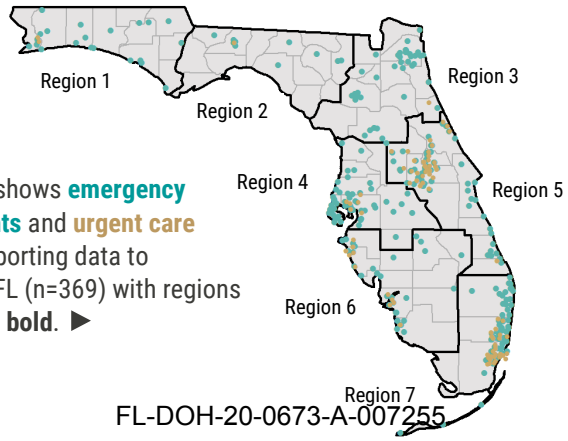


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

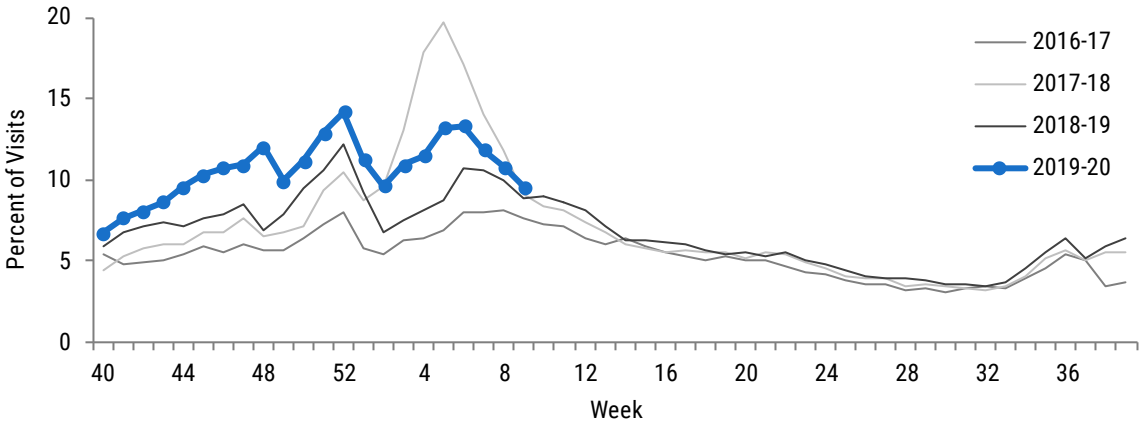
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

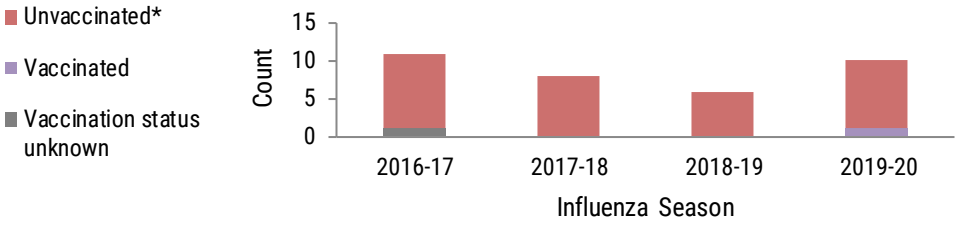
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 9, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2016-17 season.

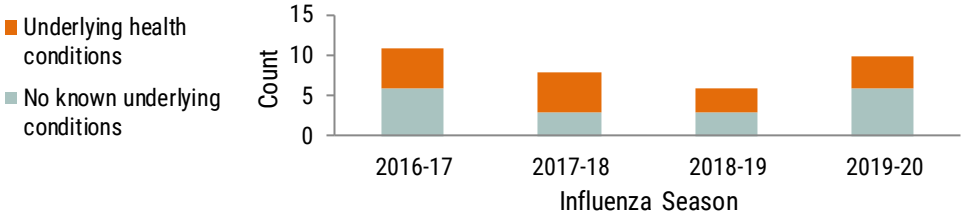


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

Figures 25-26: In week 9, **one new influenza-associated pediatric death was reported**. A total of ten influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 9, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 9, 2020.

In week 9, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions who was not vaccinated for the 2019-20 season.

A total of ten influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

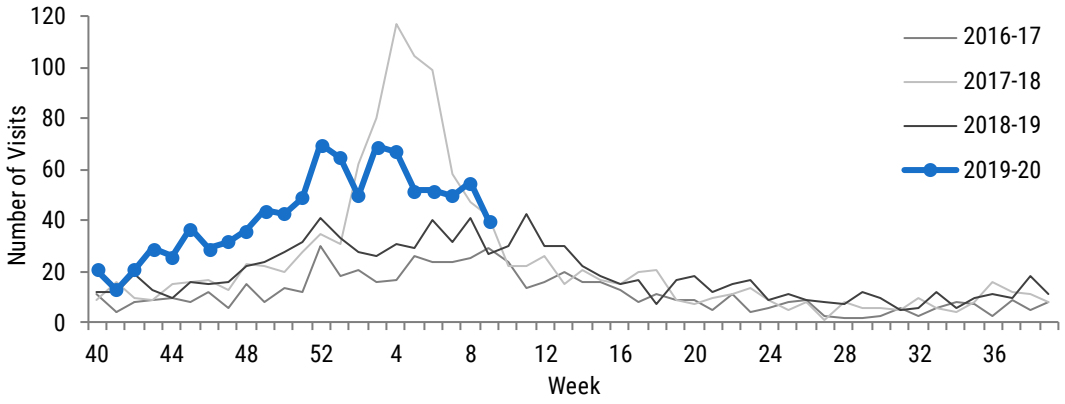
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 9, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was above peak levels observed during the 2016-17 season.



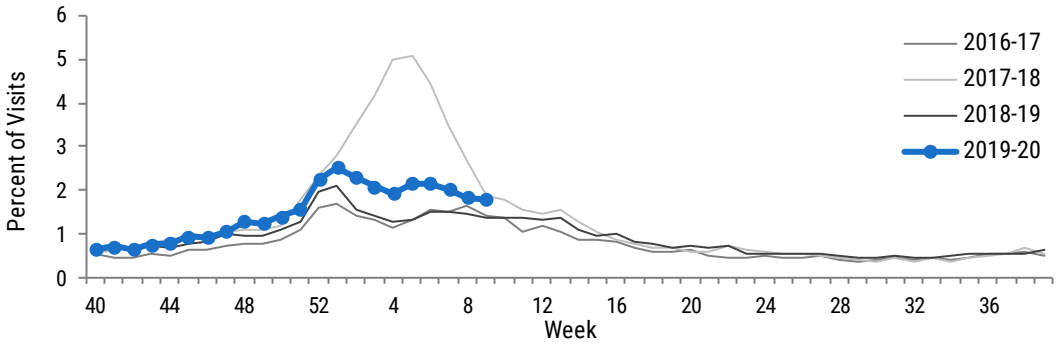
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 9, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 9, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2016-17 season.



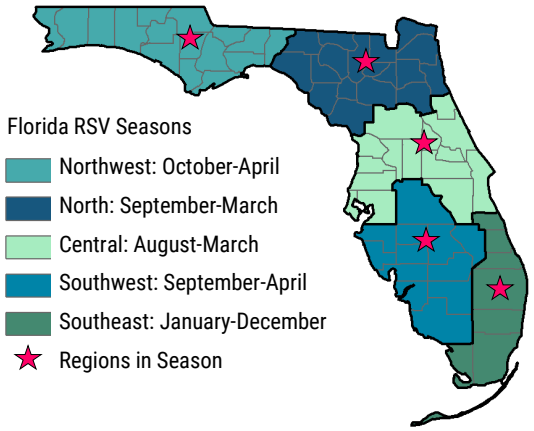
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

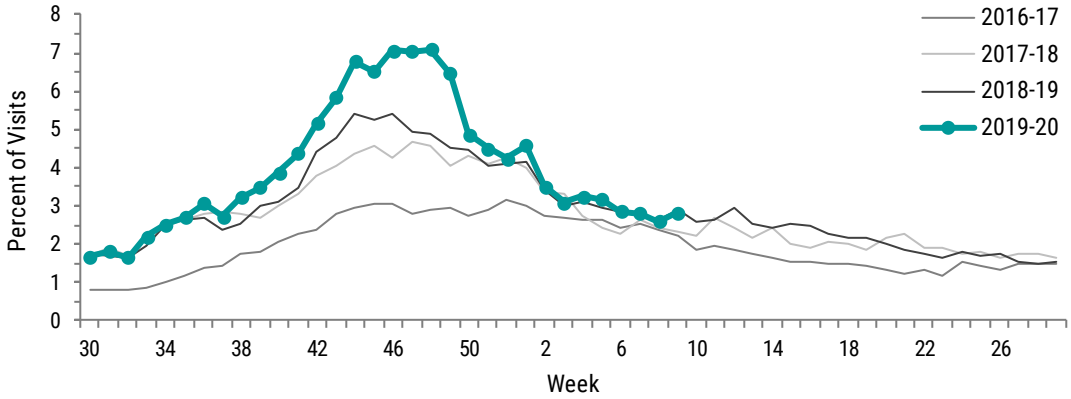
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 9 (February 23-29, 2020) Activity Summary

In week 9, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 9. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 9, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 9, 2020.

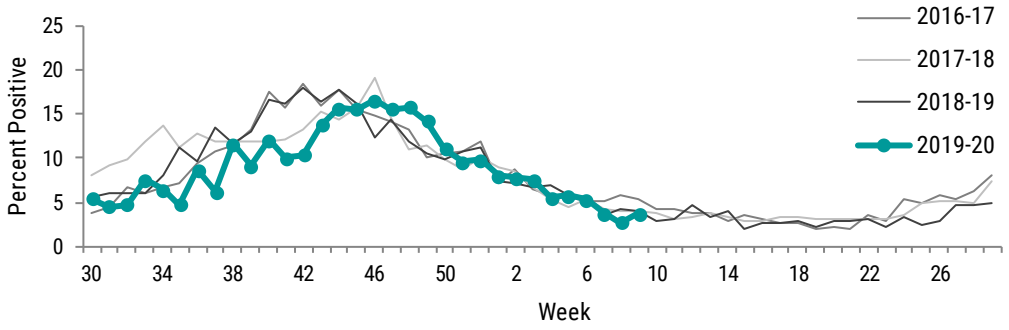
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 9, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 9, 2020. ▶



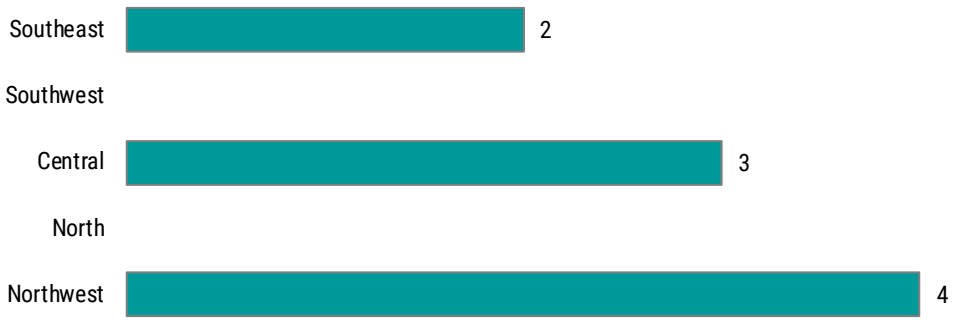
RSV-Associated Outbreaks in Week 9:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 9, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

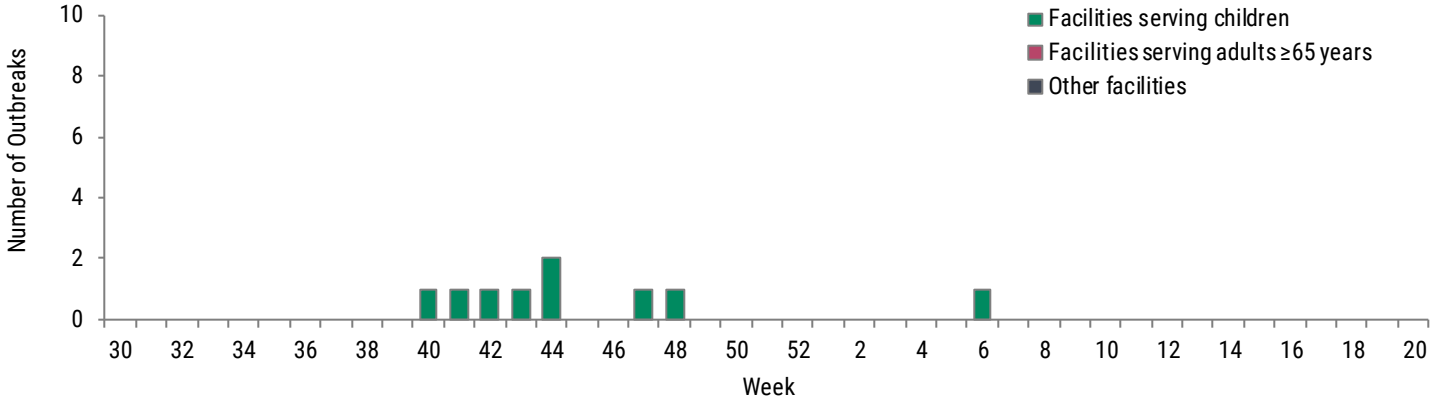
Figure 32: In week 9, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

*Regions defined in figure 29.

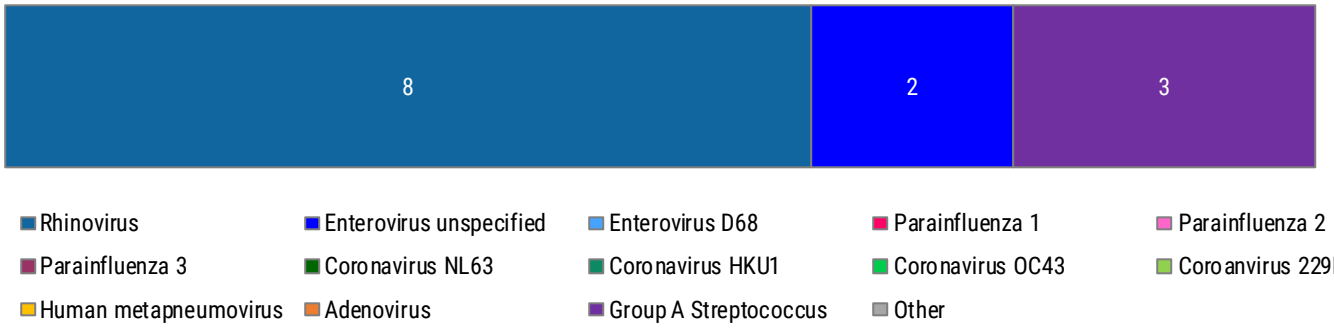
Figure 33: In week 9, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



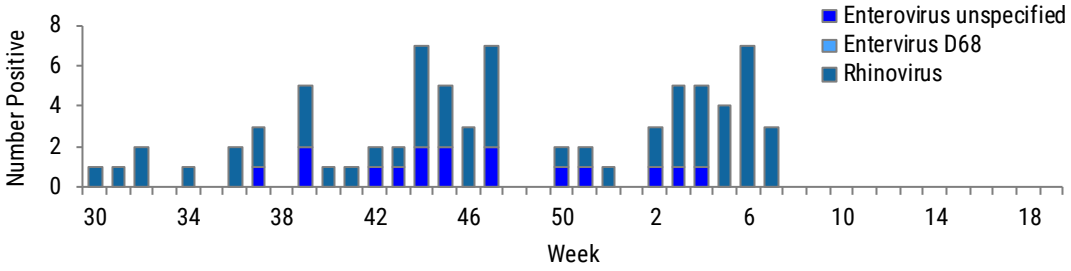
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

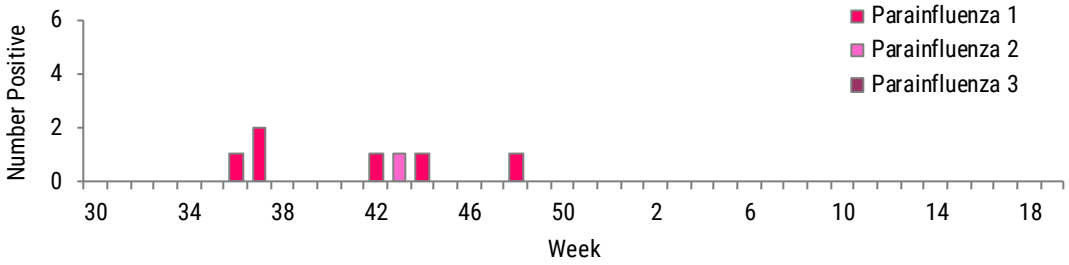


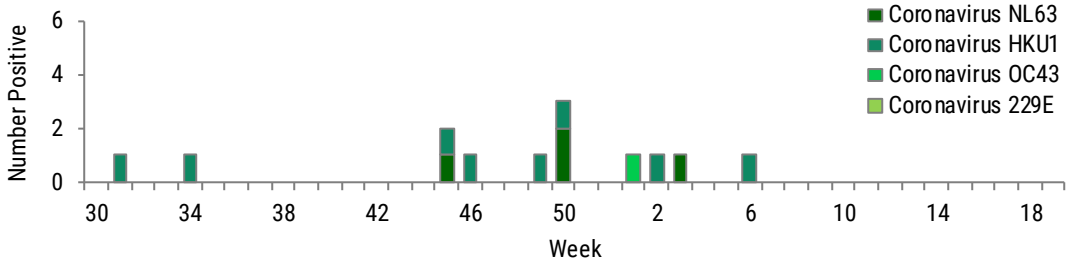
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 9, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

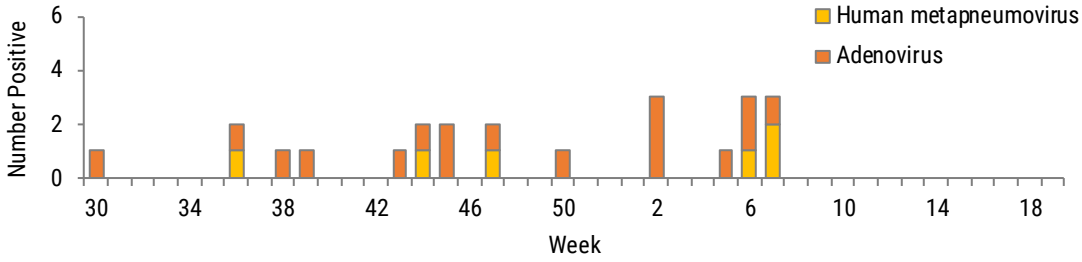
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

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Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 9, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Pinellas	3	2	Unknown	Influenza unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

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Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 9, 2020 Florida Flu Review
Date:	Wednesday, March 4, 2020 2:46:03 PM
Attachments:	Week 9, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 9, 2020 Florida Flu Review.

Week 9 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 9 but remained above peak levels observed in the 2016-17 season. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Nine outbreaks were reported, down from 18 outbreaks in the previous week. Of the nine outbreaks reported, two were influenza-associated and seven were ILI.
One new influenza-associated pediatric death was reported in an unvaccinated child with underlying medical conditions. Ten influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

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Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 9: 2/23/20-2/29/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 9 influenza & influenza-like illness (ILI) activity summary:

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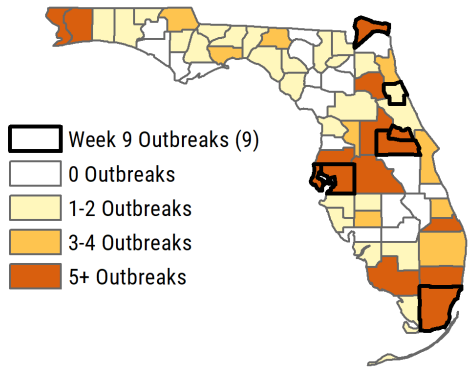
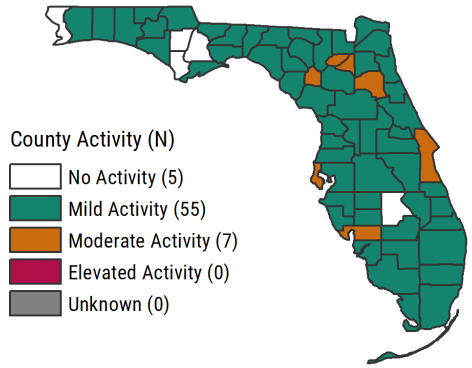
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

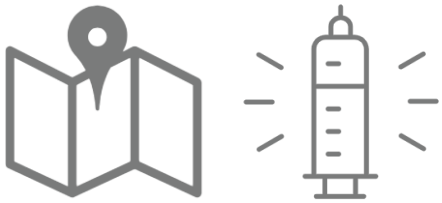
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 4, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007266

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

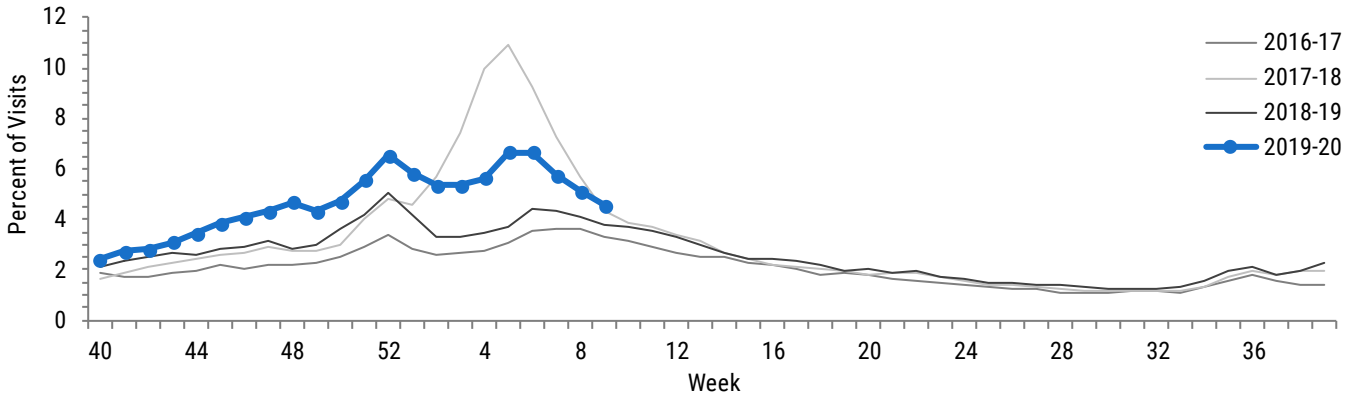
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 9, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2016-17 season.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 9, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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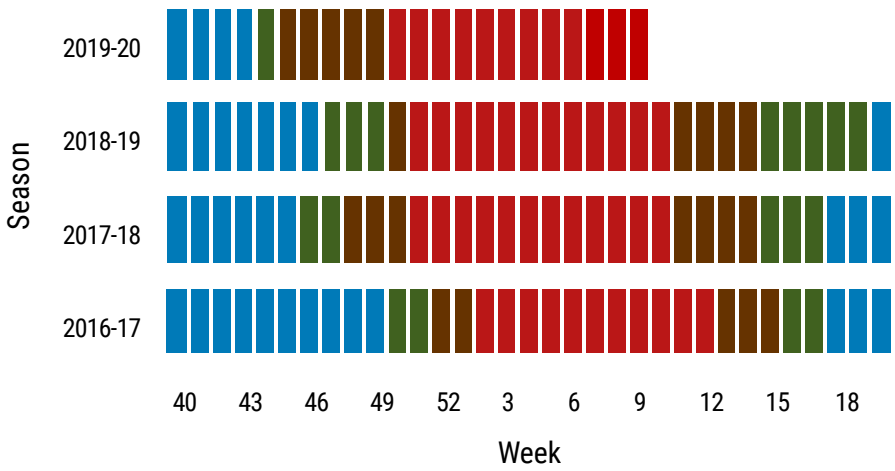
Statewide Activity

Figure 2: In week 9, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 9, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 9, **the percent of patients with ILI reported by ILINet providers statewide increased** and was below levels observed during the 2016-17 and 2018-19 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 9, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

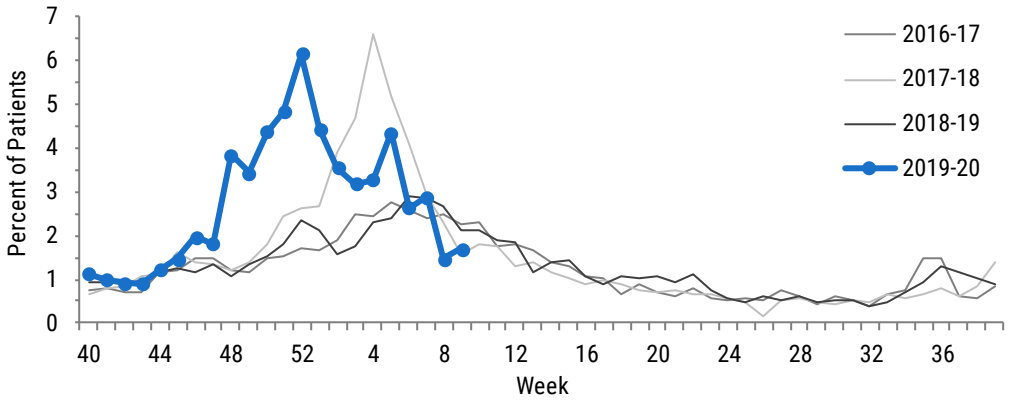
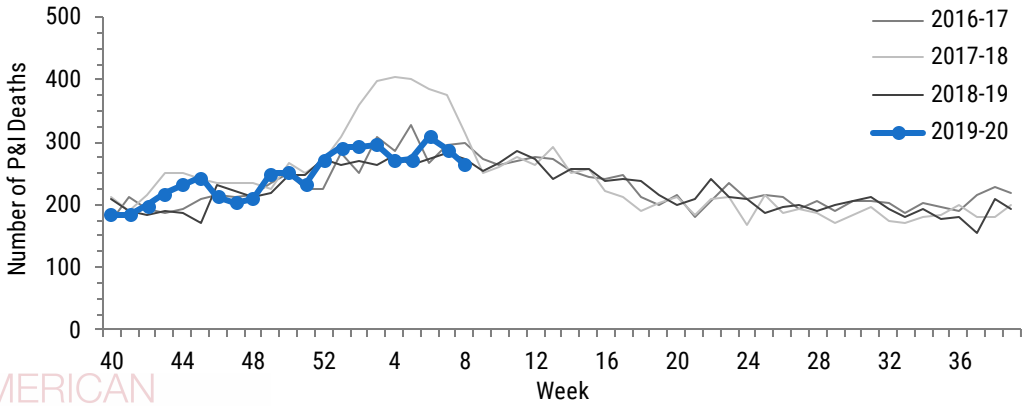


Figure 4: In week 8 (ending 2/22/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 9. Seven counties reported **moderate activity.**

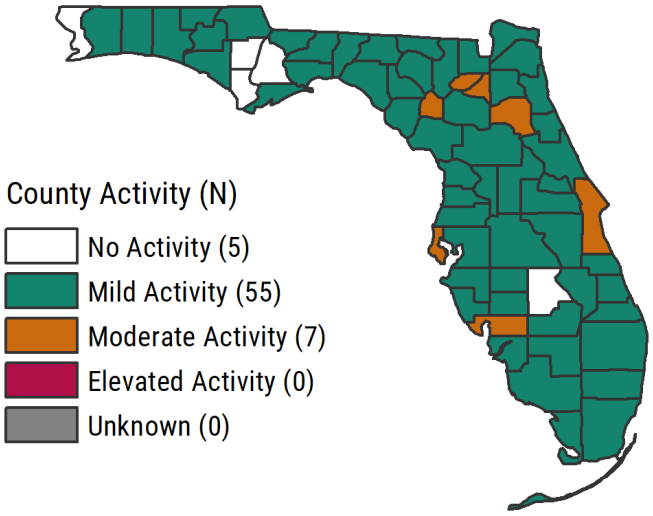
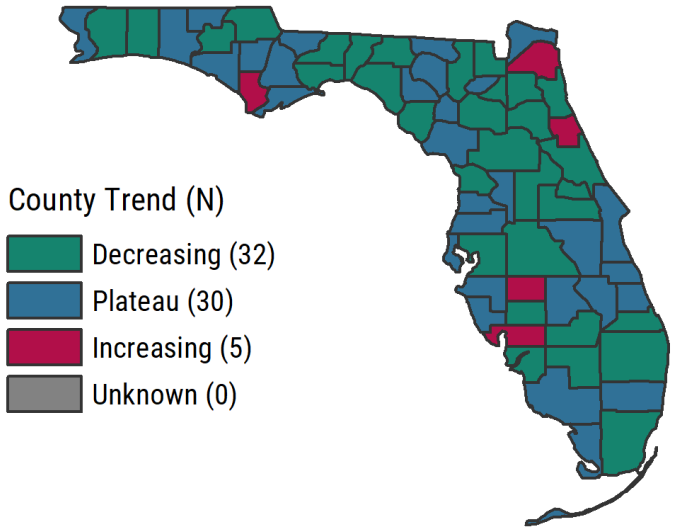
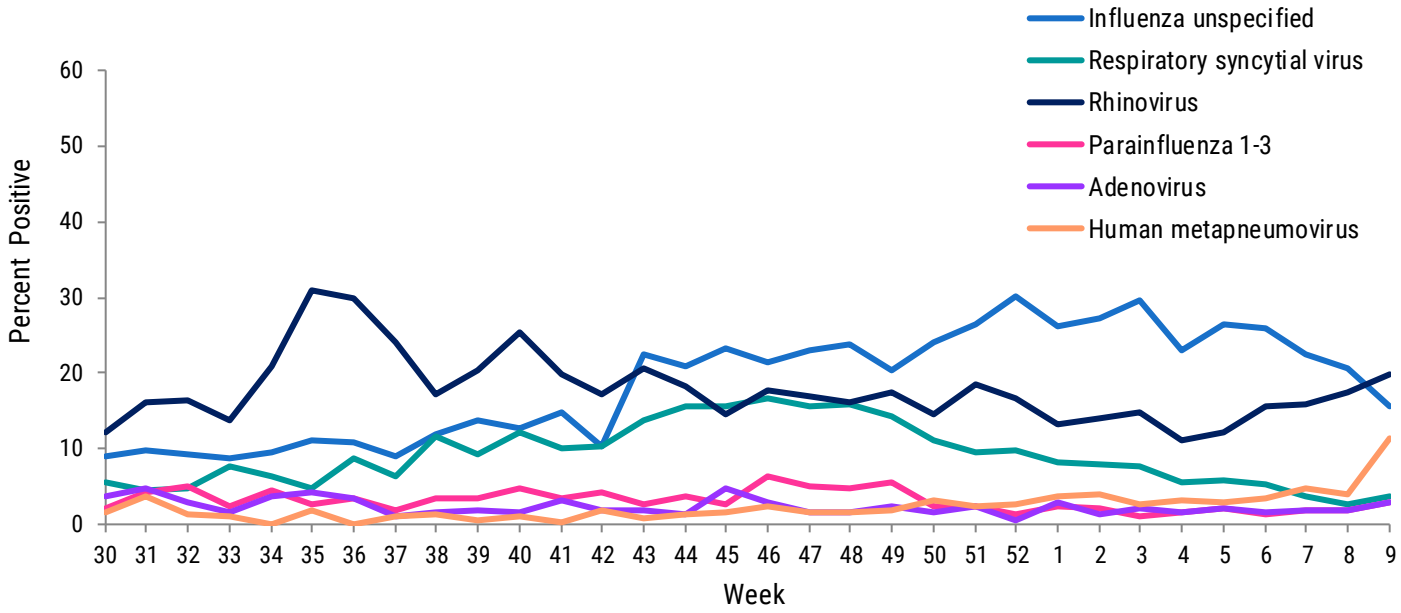


Figure 7: Most counties reported **decreasing activity** for week 9. Five counties reported **increasing activity,** and thirty counties reported **activity at a plateau.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. Of note, the volume of laboratory tests reported in week 9 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 9, 2020.

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Influenza and ILI Outbreaks

Week 9 Outbreaks at a Glance:

Number Reported:
9 Outbreaks

Influenza-Associated:
2 Outbreaks

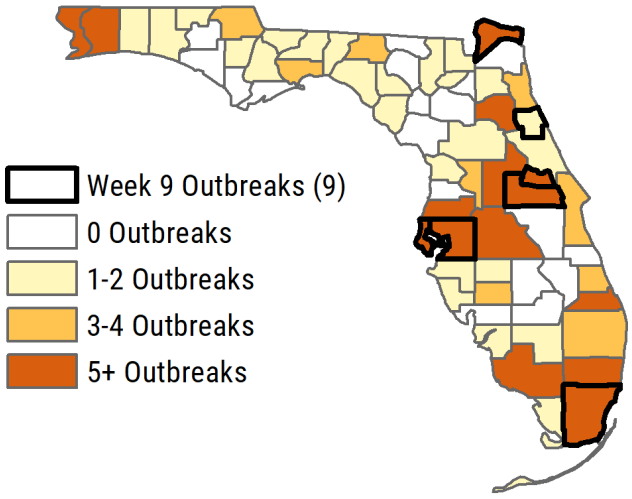
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 9, two influenza-associated and seven ILI outbreaks were reported, a decrease from the previous week.

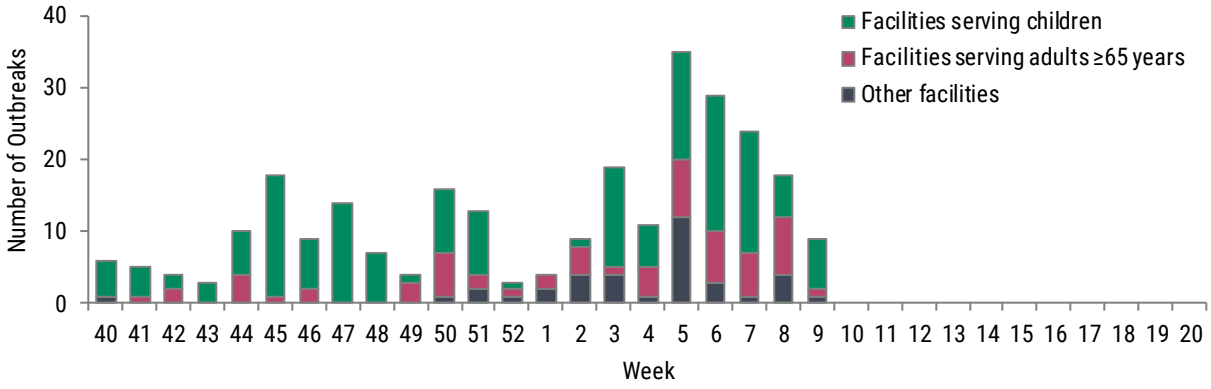
Severe outcomes* were reported in one of nine outbreaks. Two hospitalizations and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 9, the outbreak with severe outcomes was in a facility serving adults aged ≥65 years.



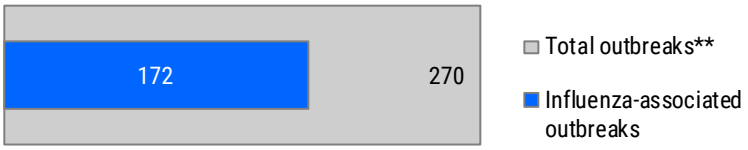
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 9 are **outlined in bold.**

Figure 9: In week 9, **one outbreak** was reported among **facilities serving adults aged ≥65 years, seven outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 9, **63.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 9, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Facilities Serving Children*:

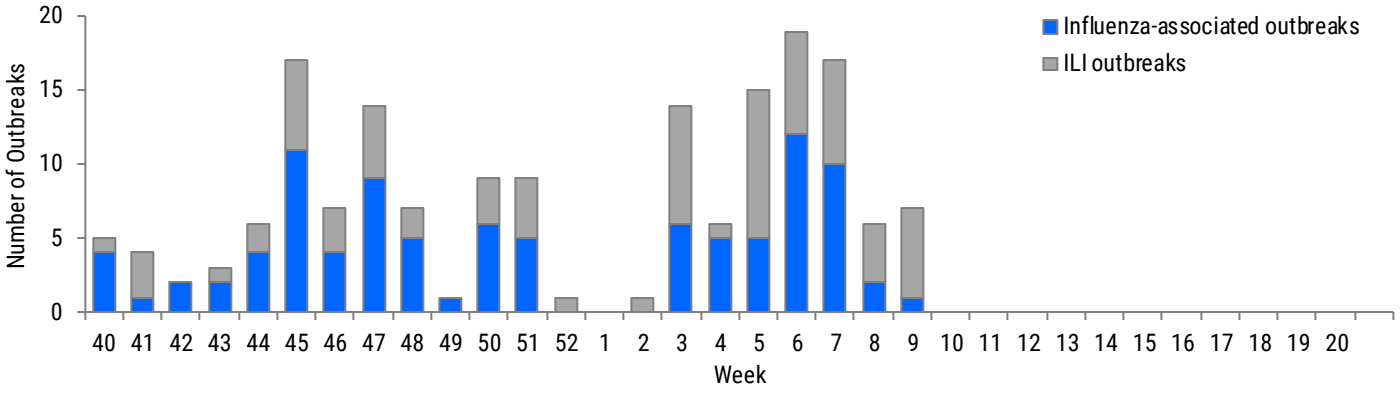
7 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 9, seven new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 9, **one influenza-associated outbreak** and **six ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

Facilities Serving Adults ≥65 yrs.**:

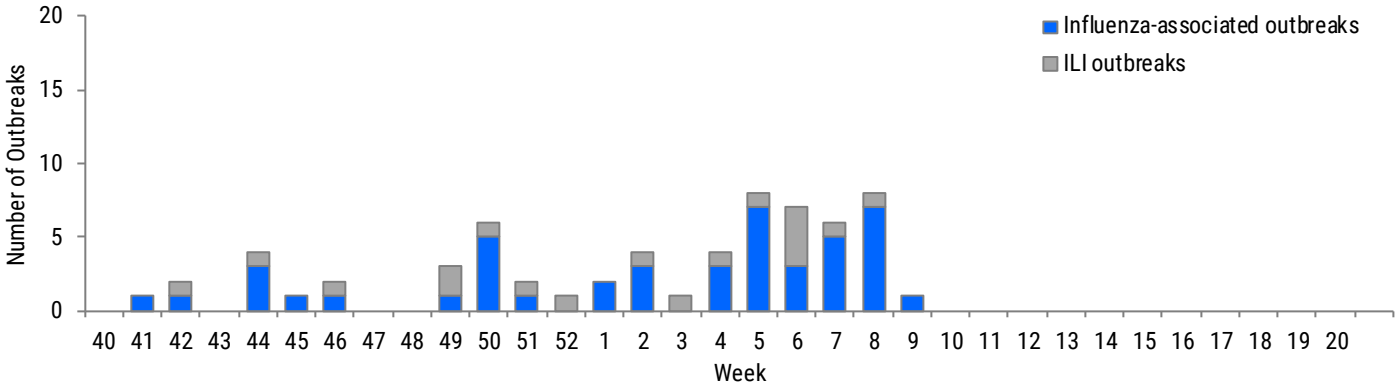
1 Outbreak

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 9, one new outbreak of influenza or ILI was reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 9, **one influenza-associated outbreak** was reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

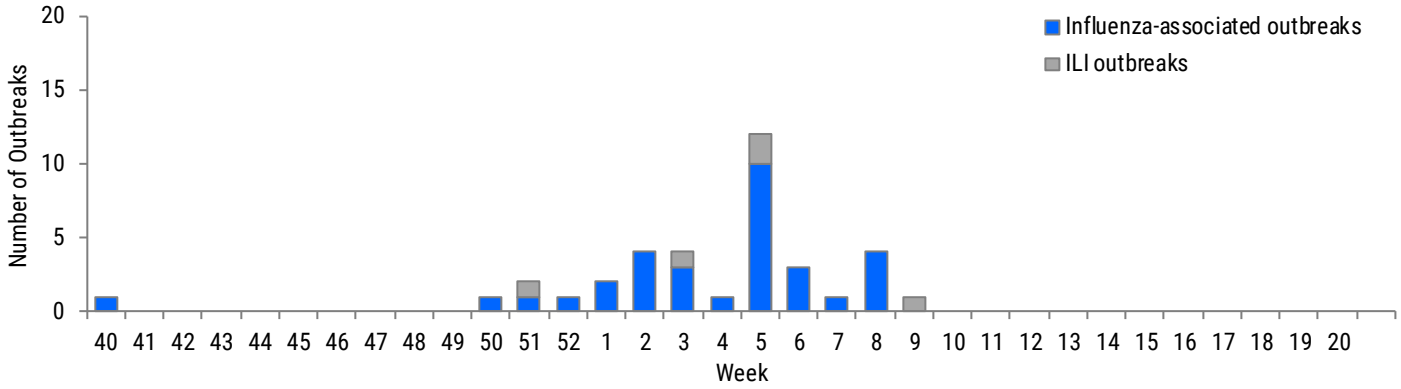
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 9, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 9, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

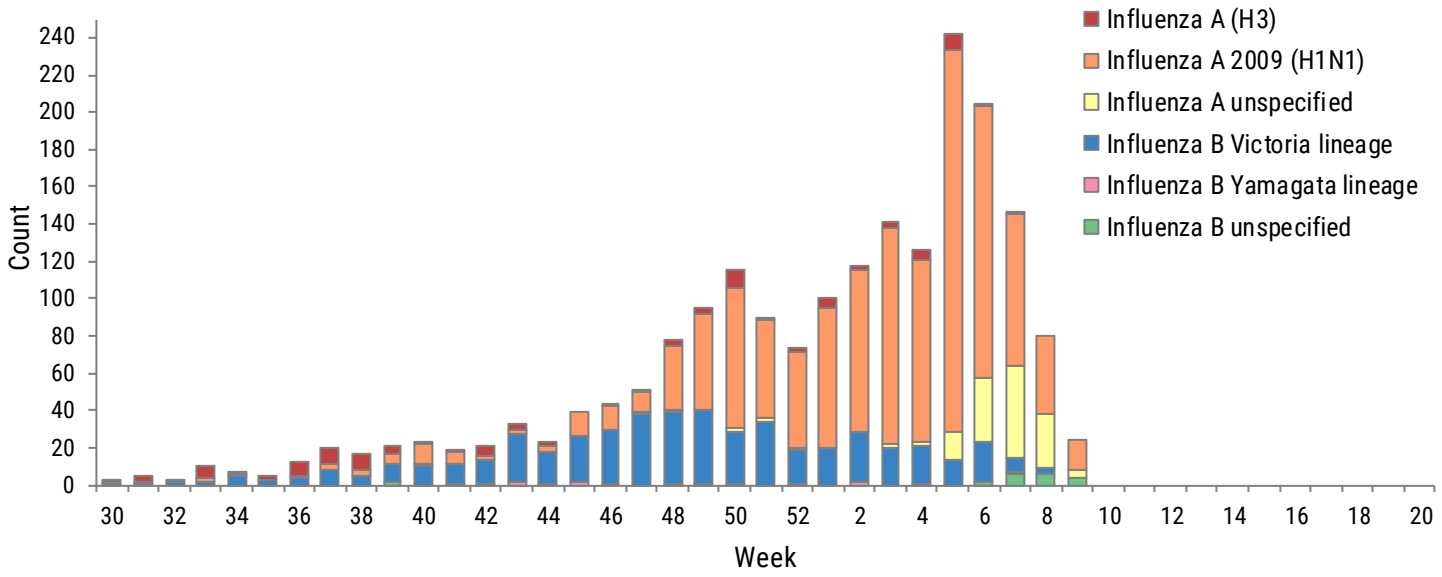
Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	130 (48.2%)	78 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	40 (14.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	19 (7.0%)	9 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.6%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (10.7%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.1%)	28 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.5%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**270 (100.0%)**	**172 influenza-associated outbreaks** **98 ILI outbreaks**

AMERICAN OVERSIGHT

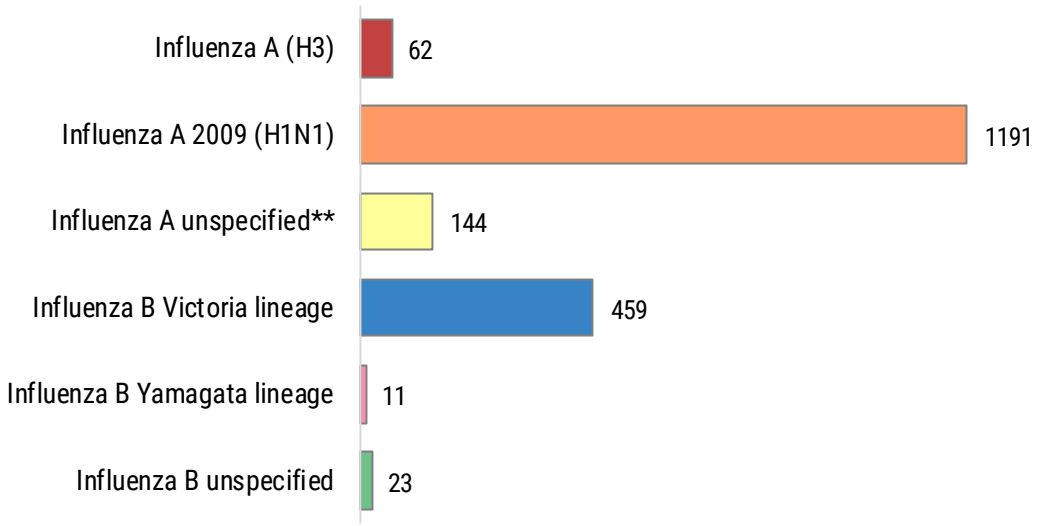
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 9, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 9, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 9, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

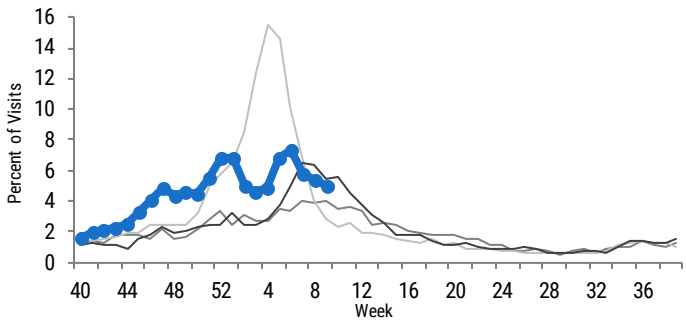


Figure 17: In **region 2, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

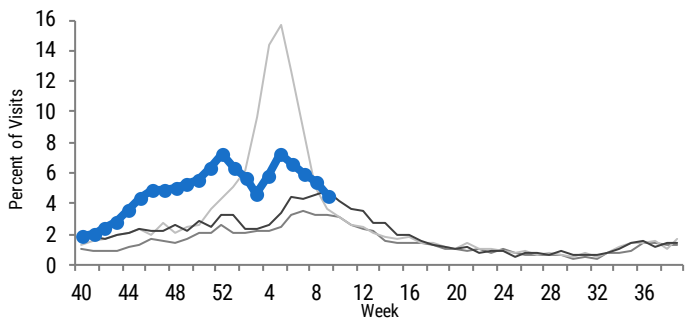


Figure 18: In **region 3, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

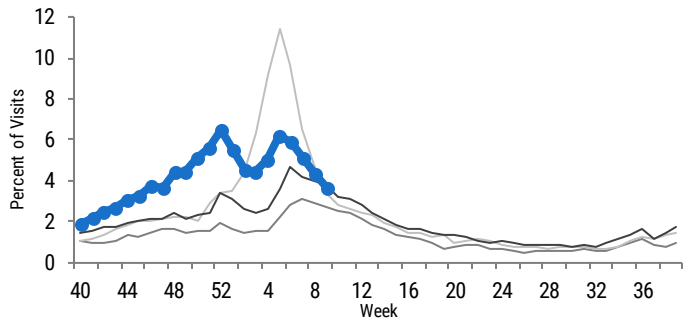


Figure 19: In **region 4, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

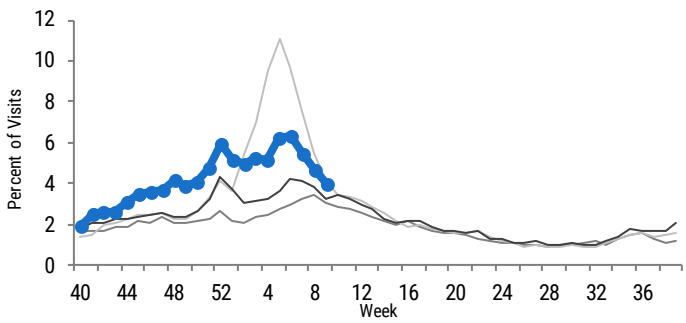


Figure 20: In **region 5, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

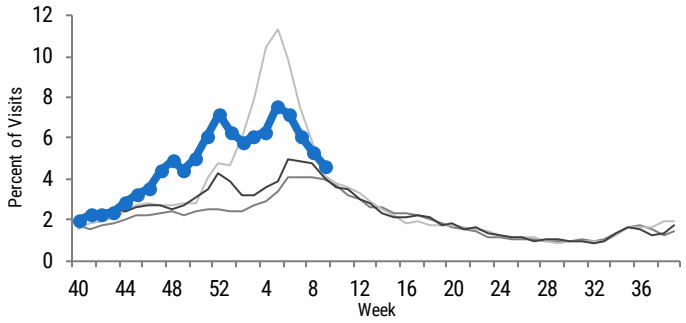


Figure 21: In **region 6, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

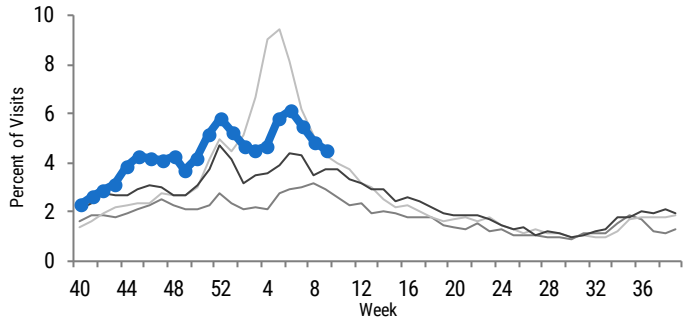
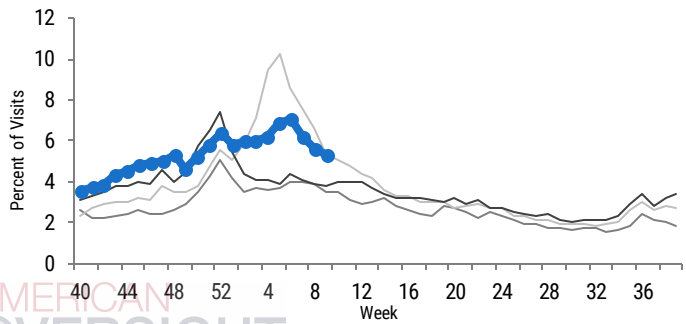


Figure 22: In **region 7, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.



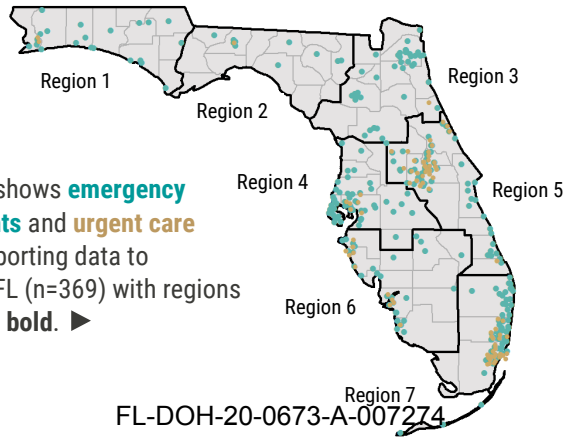


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

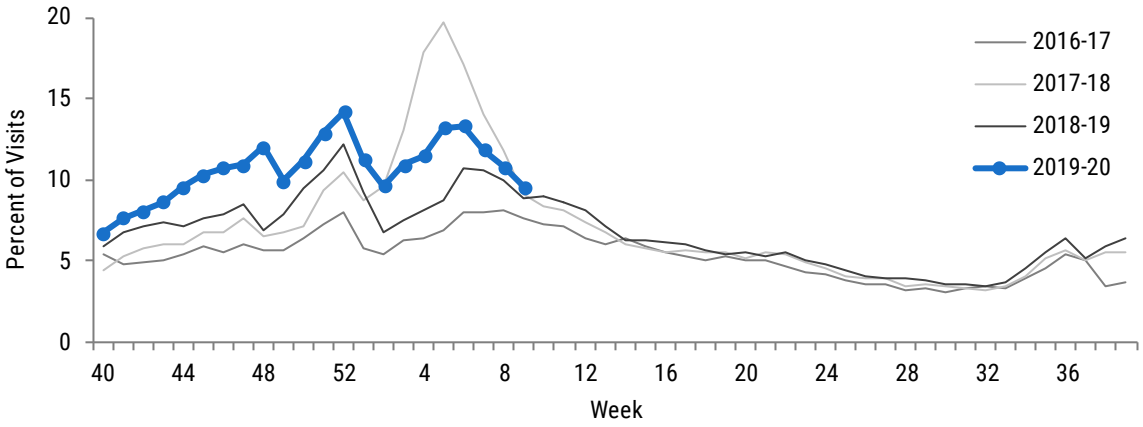
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

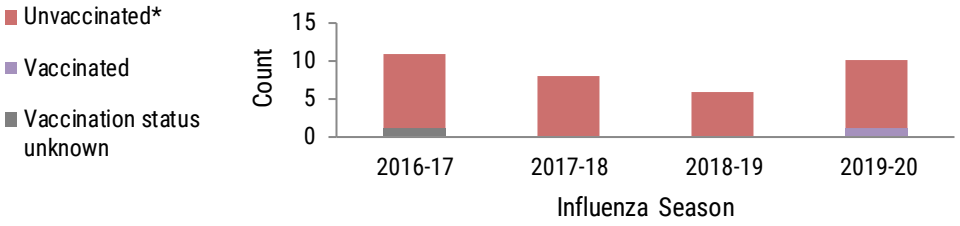
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 9, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2016-17 season.

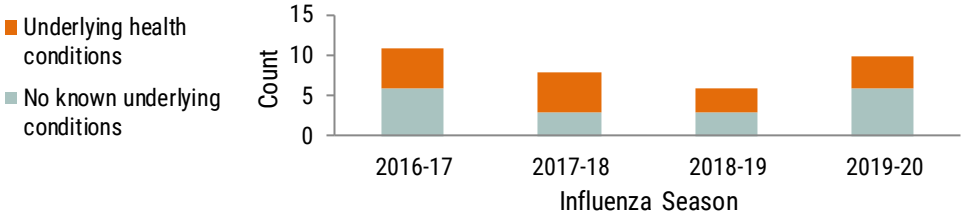


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

Figures 25-26: In week 9, **one new influenza-associated pediatric death was reported**. A total of ten influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 9, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 9, 2020.

In week 9, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions who was not vaccinated for the 2019-20 season.

A total of ten influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

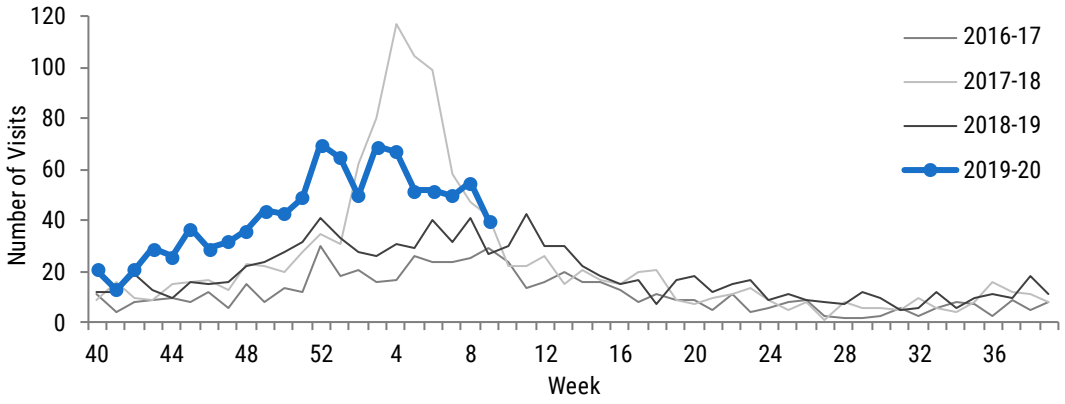
AMERICAN OVERSIGHT

At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 9, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was above peak levels observed during the 2016-17 season.



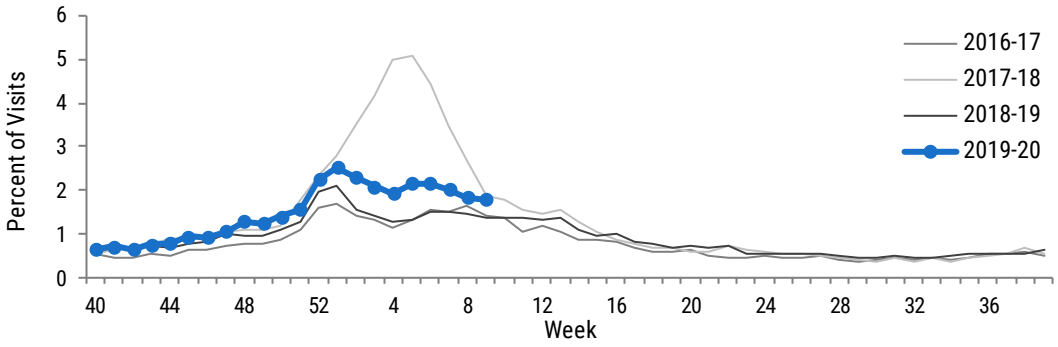
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 9, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 9, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2016-17 season.



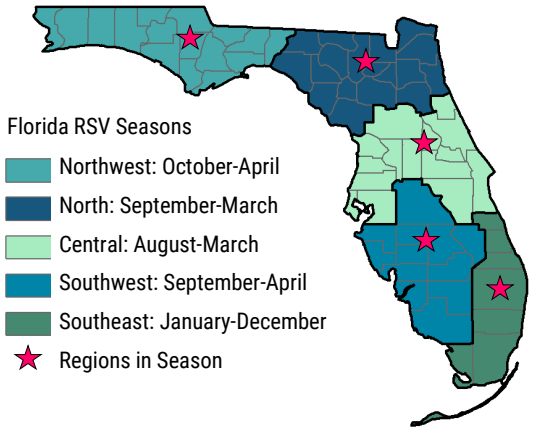
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

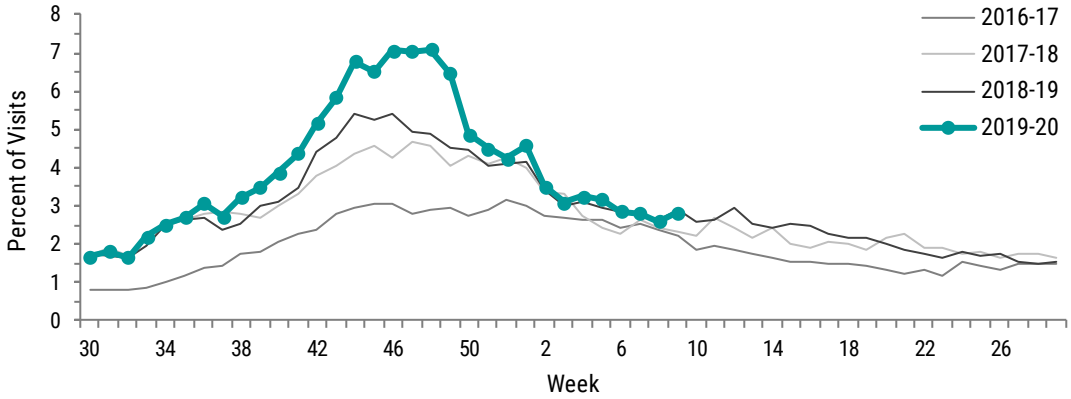
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 9 (February 23-29, 2020) Activity Summary

In week 9, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 9. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 9, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 9, 2020.

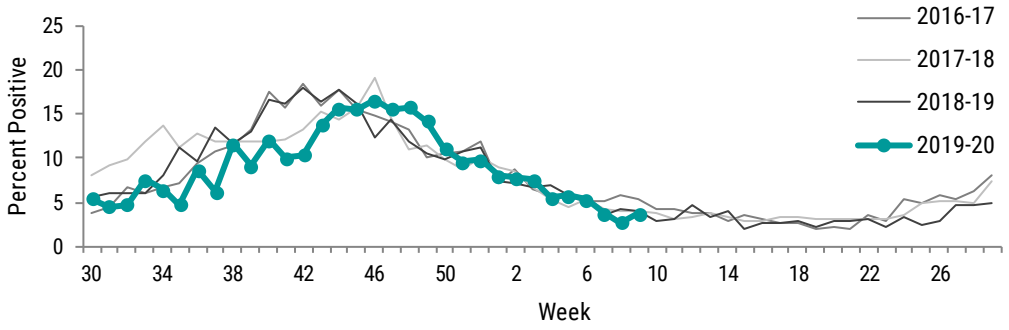
*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

AMERICAN OVERSIGHT

RSV Surveillance

Figure 31: In week 9, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 9, 2020. ▶



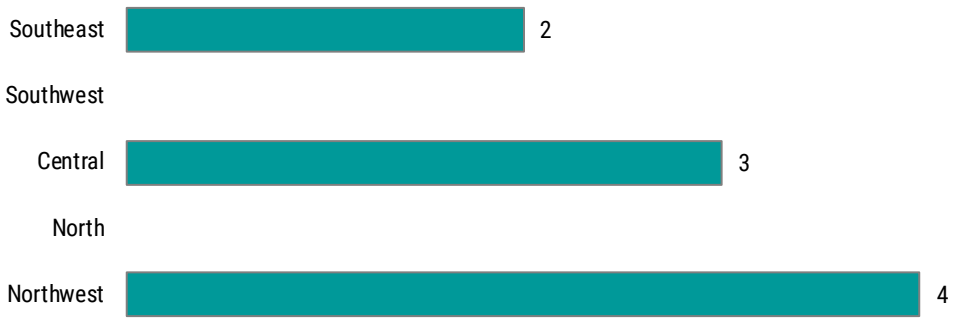
RSV-Associated Outbreaks in Week 9:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 9, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

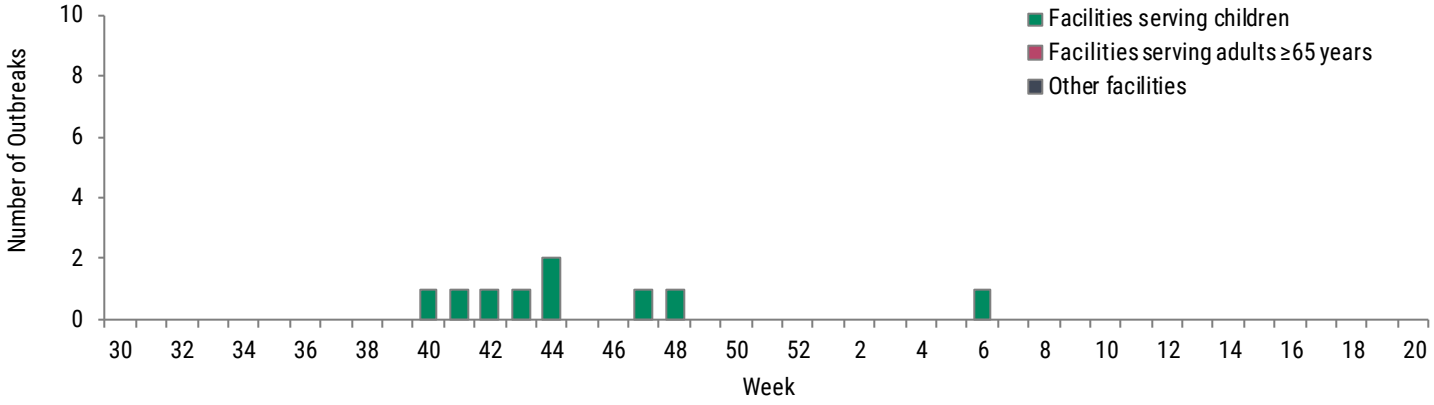
Figure 32: In week 9, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

*Regions defined in figure 29.

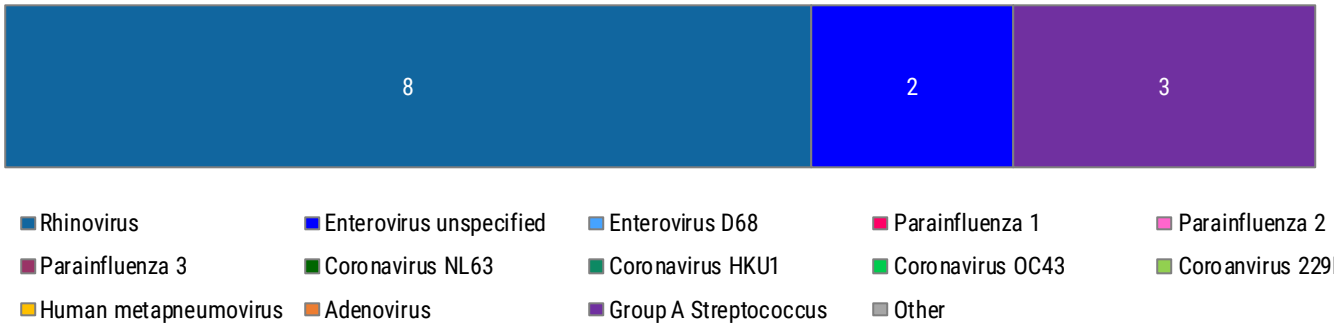
Figure 33: In week 9, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



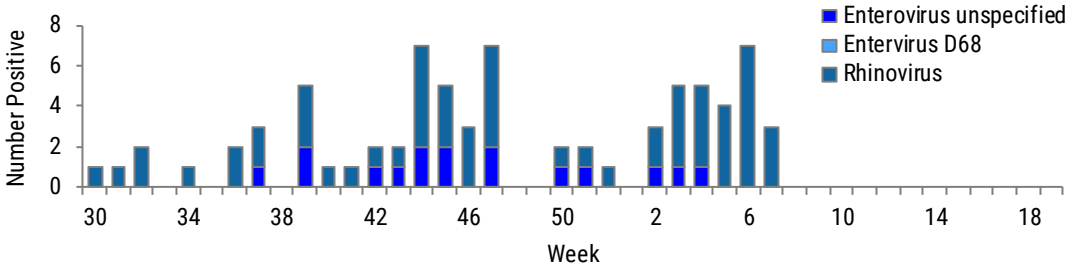
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

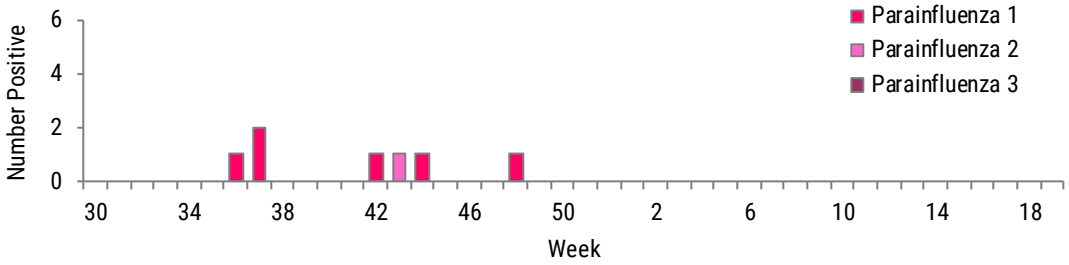


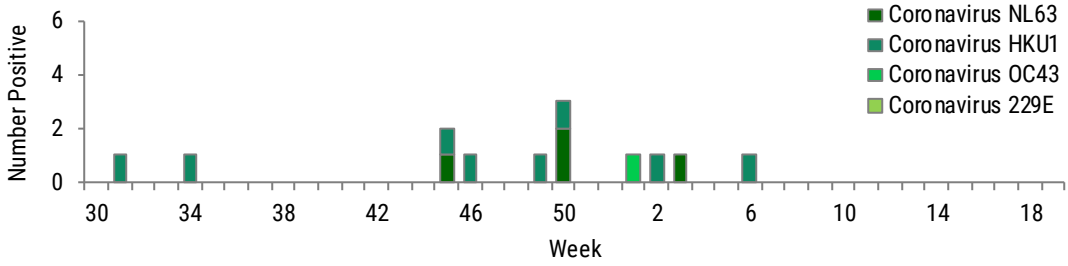
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 9, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

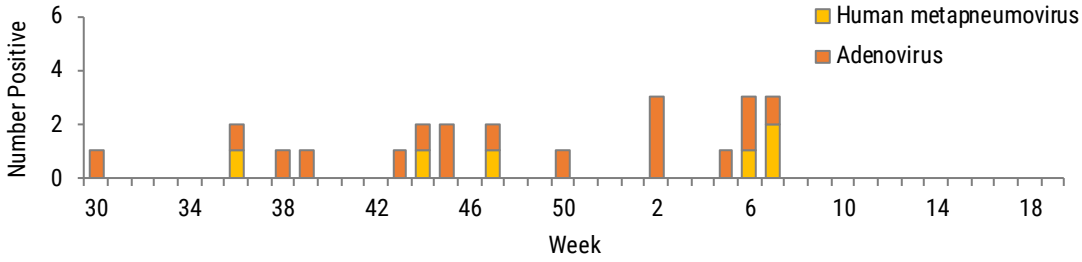
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 9, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Pinellas	3	2	Unknown	Influenza unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Bogucki, Amy
To:	Munroe, Julia; Mtenga, Mwedu; Rubino, Heather; DL HSD IMM Adult Nurses Only; DL DCBE Flu Report; DL DCBE All Epi Contacts; DL DCBE Primary Epi CHD Contacts; DL DOH CHD Administrators_Directors; DL DCBE Flu Coordinators
Cc:	DL CHD Medical Directors; Fox, Brian; Forrest, Jamie; "eocepirgn4@cdc.gov"; Blackmore, Carina; Pelayo, Patricia A; Tosh.Pritish@mayo.edu; Patricia.Barrett@doh.state.nj.us; Luis.Berrios@watsonclinic.com; megan.exantus@jaxhealth.com; duvalwatchofficer@coj.net; Cason, Emily; nwhisenhan@fhcp.com; lcobbe@pasco.k12.fl.us; Knox, Nancy A; Wydotis, Michael D; jprieto@bondclinic.com; Ann Margaret Villar; Daniel.Haight@myLRH.org; ldrmanms@hotmail.com; Carson, Margaret G; Katheryn.Bruhn@rogershospital.org; Donna.Bhisitkul@myLRH.org; Fitzgibbons, Aleksandra; Dittmar, Nancelyn G; nalini.gumbs@walgreens.com; frances.grinstead@pathogend.com; robert.meli@regalaif.com; Folkner, James E; biru.yang@houstontx.gov; kellysue@ufl.edu; brittanima@ufl.edu; Stevens, Danielle L; Rozwadowski, Faye; jhamilton@cste.org; Hoagland, Jill A; Johnson, Brittany J; Agens, Mary; Ruethemann, April; Torres, Yari; Jentie Williams; Troelstrup, Thomas; PHILIP DUNN; Slade, Tania
Subject:	Week 9, 2020 Florida Flu Review
Date:	Wednesday, March 4, 2020 2:45:57 PM
Attachments:	Week 9, 2020 Florida Flu Review.pdf

Good afternoon!

Attached is the Week 9, 2020 Florida Flu Review.

Week 9 influenza & influenza-like illness (ILI) activity summary:

Activity decreased in week 9 but remained above peak levels observed in the 2016-17 season. Decreases were observed in all regions of the state. Elevated activity is still expected for several more weeks.

Nine outbreaks were reported, down from 18 outbreaks in the previous week. Of the nine outbreaks reported, two were influenza-associated and seven were ILI.
One new influenza-associated pediatric death was reported in an unvaccinated child with underlying medical conditions. Ten influenza-associated pediatric deaths have been reported so far this season; only one child was vaccinated for the 2019-20 season.

Influenza A 2009 (H1N1) remained the predominant strain.

The Centers for Disease Control and Prevention (CDC) continues to recommend that people who have not yet been vaccinated do so as soon as possible. It is especially important for people at higher risk for complications (children, adults =65 years, pregnant women, and people with underlying medical conditions).

On January 10, 2020, CDC issued a health advisory reminding clinicians to reiterate vaccination and antiviral treatment recommendations (emergency.cdc.gov/han/HAN00425.asp).

In addition to getting vaccinated, the Florida Department of Health recommends you take everyday precautions to prevent the spread of influenza and other respiratory viruses:

- Wash your hands often with soap and water (if soap is not available, use an alcohol-based sanitizer).
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

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Thank you!

Amy E. Bogucki, MPH
Surveillance Epidemiologist - VPDs
Bureau of Epidemiology
Division of Disease Control and Health Protection
Florida Department of Health
Email: amy.bogucki@flhealth.gov
Phone: (850) 901 - 6938

Please note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your email communication may therefore be subject to public disclosure.

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Florida FLU REVIEW

Season: 2019-20

Week 9: 2/23/20-2/29/20

Geographic Spread: **Widespread**

Predominant Strain: **A 2009 (H1N1)**

ILI Activity Trend: **Decreasing**

Week 9 influenza & influenza-like illness (ILI) activity summary:

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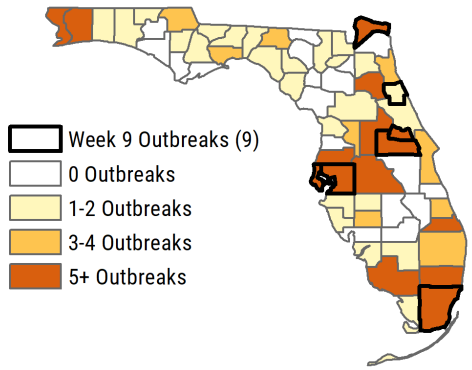
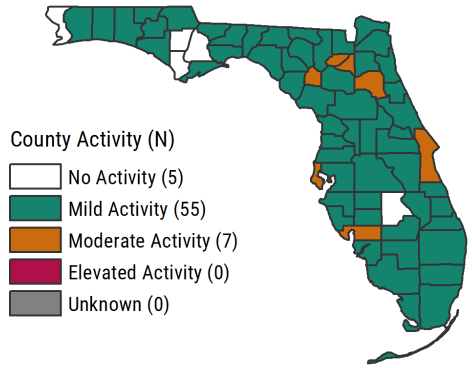
- Avoid touching your eyes, nose, and mouth.
- If you do get sick, stay home until fever-free for at least 24 hours (without the use of fever-reducing medication).

Influenza or ILI Outbreaks

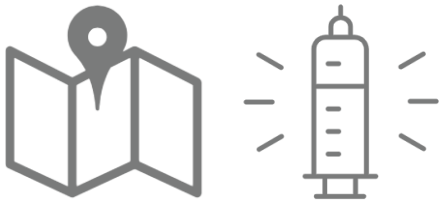
Reported as of 2/29/20



County Influenza Activity



Flu Shot Locator



Your flu shot is the first and most important step to fight the flu.
To locate a vaccine near you, visit:
VaccineFinder.org

Posted March 4, 2020 on the Bureau of Epidemiology (BOE) website: FloridaHealth.gov/FloridaFlu
Produced by the BOE, Florida Department of Health
Contributors: Julia Munroe, MS; Katie Kendrick, MPH; Heather Rubino, PhD; Amy Bogucki, MPH; Casey McBride, MPH; Mwedu Mtenga, MPH; Samuel P. Prahlow, MPH; Lea Heberlein-Larson, DrPH, CPH, SM(ASCP)CM; Edgar Kopp, MS, MT(AAB); Valerie Mock, BS; Pam Colarusso, MSH; Leah Eisenstein, MPH.
FL-DOH-20-0673-A-007285

AMERICAN OVERSIGHT

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Background

Influenza, or flu, is a respiratory infection caused by a variety of influenza viruses. Most experts believe influenza viruses spread primarily by droplets made when infected people cough, sneeze, or talk. Less often, a person might become infected with influenza by touching a surface or object contaminated with influenza virus and then touching their own mouth, eyes, or nose.

The best way to prevent influenza infection is to get vaccinated each year. Influenza vaccines protect against the three or four influenza viruses research suggests will be most common.

Influenza Surveillance

Individual cases of influenza are not reportable in Florida with the exception of novel influenza A (a new subtype of influenza A) and influenza-associated pediatric deaths. All outbreaks, including those due to influenza or influenza-like illness (ILI), are reportable in Florida.

Influenza surveillance is conducted to detect changes in the influenza virus. These data are used to help determine the annual northern hemisphere vaccine composition and to prepare for potential pandemics.

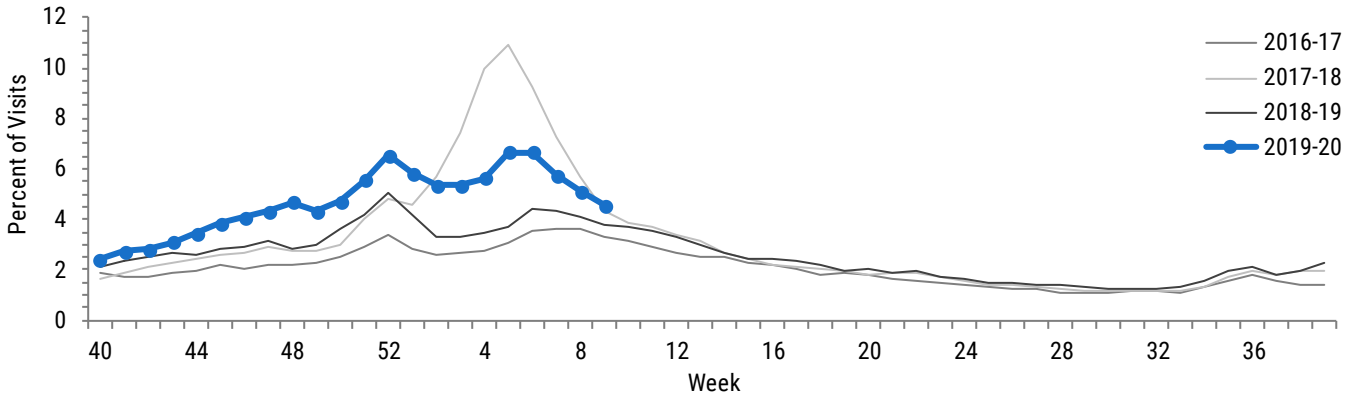
Surveillance is also conducted to identify any unusually severe presentations of influenza, detect outbreaks, and determine the onset, peak, and wane of the influenza season to assist with influenza prevention, particularly in high-risk populations like the very young, adults aged ≥65 years, and pregnant women.

The influenza reporting year is defined by standard reporting weeks outlined by the Centers for Disease Control and Prevention, where every year has 52 or 53 reporting weeks. Increased surveillance for influenza in Florida for the 2019-20 season began in week 40 (starting on September 29, 2019) and will extend through week 20 (ending May 16, 2020). This report is produced by the Florida Department of Health on a weekly basis during the regular influenza season and an abbreviated report is published on a biweekly basis during the summer months.

Surveillance case definitions for ILI vary slightly across surveillance systems. **For more information on Florida's influenza surveillance systems and associated case definitions, see page 16.**

Statewide Activity

Figure 1: In week 9, **the percent of emergency department and urgent care center visits for ILI statewide decreased** but remained above peak levels observed during the 2016-17 season.



▲ **Figure 1** shows **the percent of visits for ILI** for facilities participating in ESSENCE-FL (n=369) statewide for the current season (week 40, 2019 to week 9, 2020) and the last three seasons (2018-19, 2017-18, and 2016-17). The ESSENCE-FL ILI syndrome captures visits with chief complaints that include the words "influenza" or "flu," or chief complaints that include the words "fever" and "cough," or "fever" and "sore throat." For more information on the use of ESSENCE-FL for influenza and ILI surveillance, see page 16.

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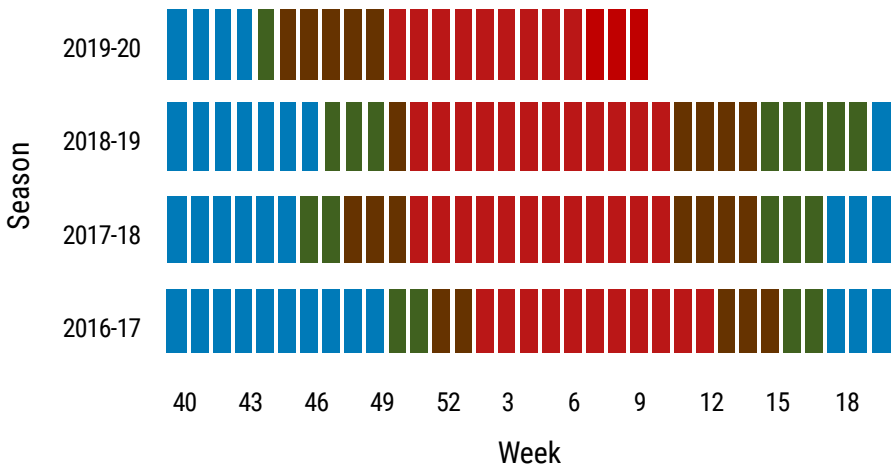
Statewide Activity

Figure 2: In week 9, Florida reported **widespread geographic spread of influenza** to the Centers for Disease Control and Prevention.



◀ **Figure 2** shows Florida's self-reported **geographic spread of influenza** as reported to the Centers for Disease Control and Prevention, week 40, 2016 to week 9, 2020.

Defining geographic spread of influenza:

Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI.

Local: outbreaks of influenza or increases in ILI and recent laboratory confirmed influenza in at least two but less than half the regions of the state.

Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.

Widespread: Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

Figure 3: In week 9, **the percent of patients with ILI reported by ILINet providers statewide increased** and was below levels observed during the 2016-17 and 2018-19 seasons. Of note, the number of reporting providers remained low in recent weeks.

Figure 3 shows the **percent of patients with influenza-like illness (ILI)** reported statewide by ILINet providers (n=7), week 40, 2016 to week 9, 2020. ▶

For ILINet, ILI is defined as a fever ≥100°F in conjunction with sore throat or cough in the absence of another known cause.

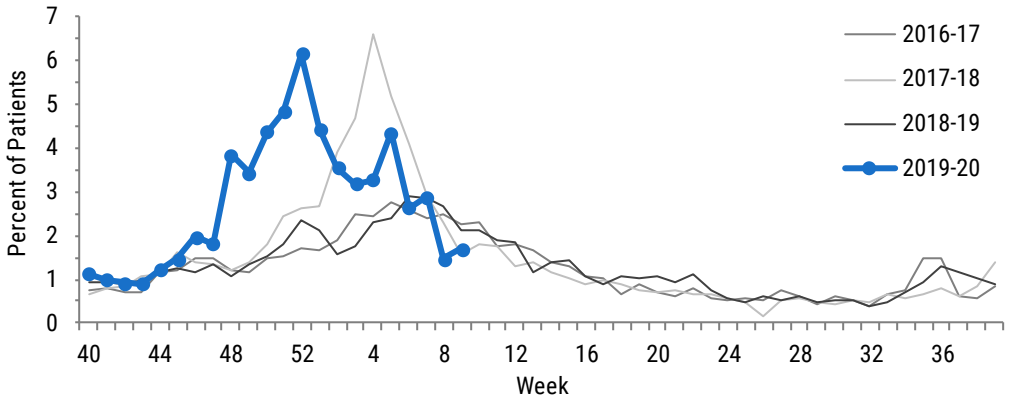
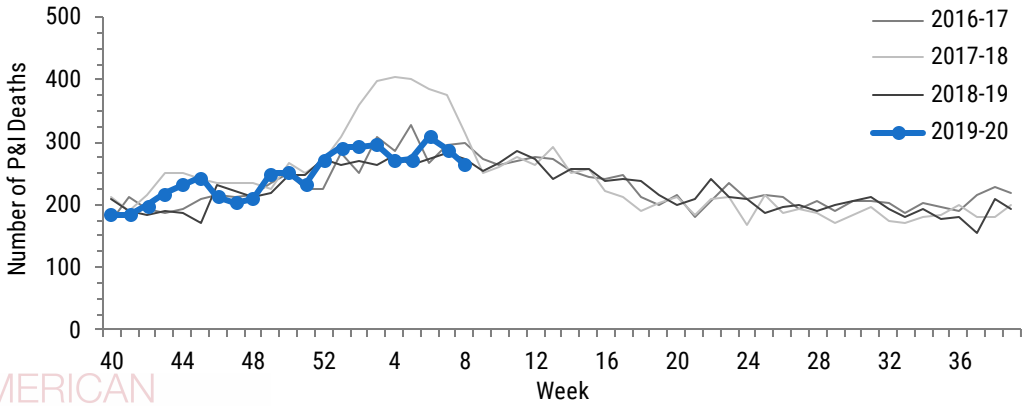


Figure 4: In week 8 (ending 2/22/20), **the number of pneumonia and influenza deaths identified statewide decreased** and was slightly below levels observed at this time in previous seasons.



◀ **Figure 4** shows **pneumonia and influenza (P&I) deaths*** for all Florida counties from the Bureau of Vital Statistics, as reported into ESSENCE-FL, week 40, 2016 to week 8, 2020.

*Recent P&I death counts are preliminary numbers that may change as more data are received. The most recent data available are displayed here.

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County Influenza Activity

Figure 5: Most counties reported **mild activity** for week 9. Seven counties reported **moderate activity.**

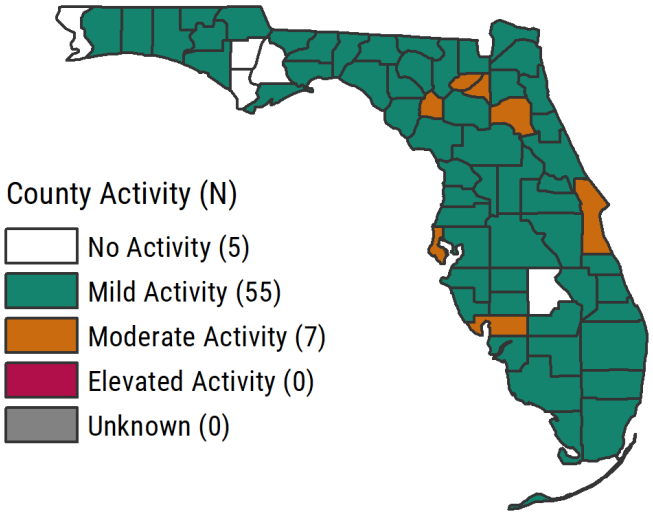
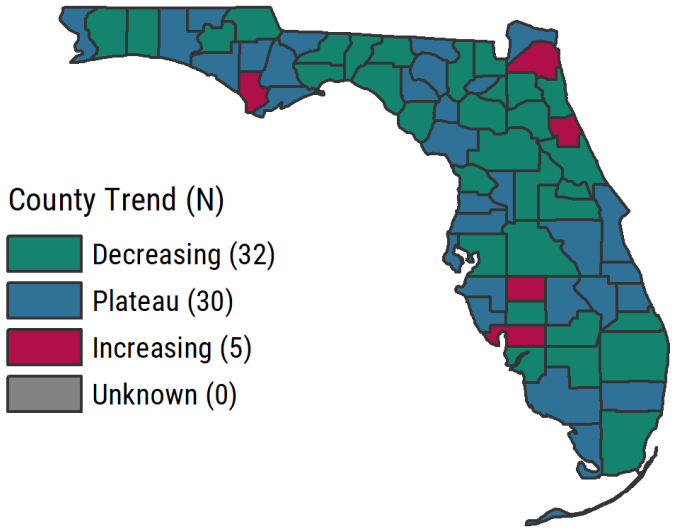
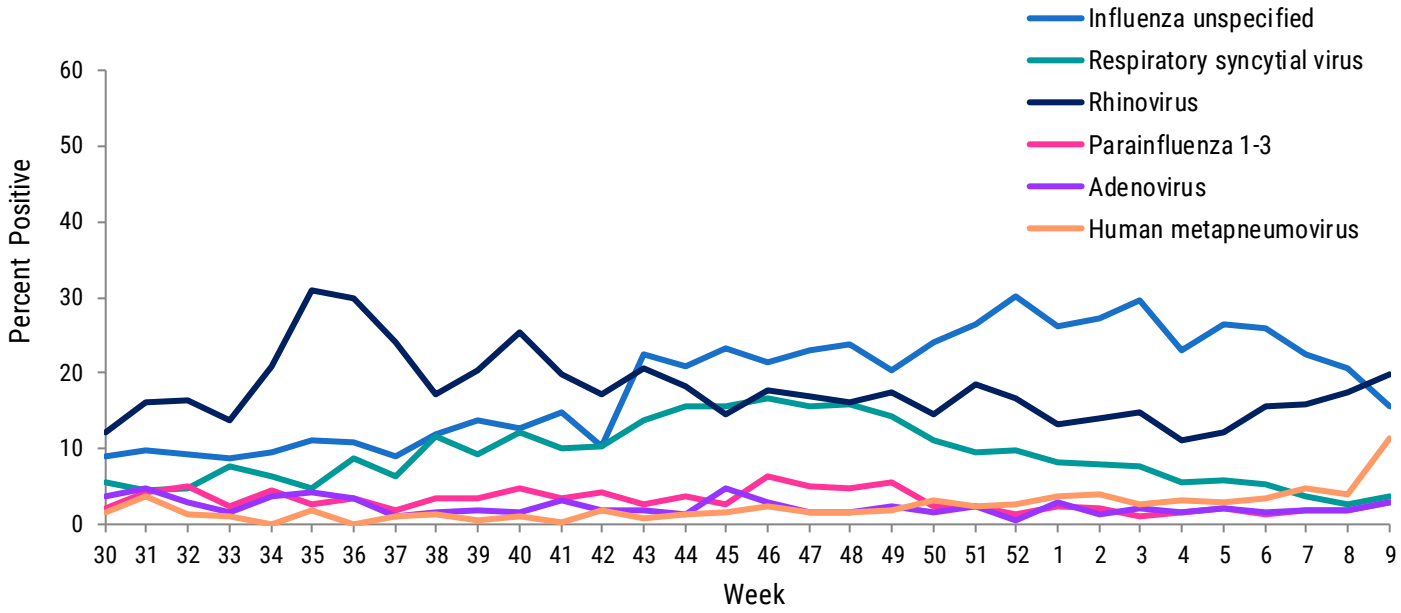


Figure 7: Most counties reported **decreasing activity** for week 9. Five counties reported **increasing activity,** and thirty counties reported **activity at a plateau.**



▲ **Figures 5-6** show **county influenza activity data** as reported by county health departments in EpiGateway. These data are collected on a weekly basis and are used to determine influenza activity levels for each county (Figure 5). County health departments also report their weekly influenza activity trend (Figure 6).

Figure 7: The **percent of specimens testing positive for influenza decreased** in recent weeks. Of note, the volume of laboratory tests reported in week 9 was lower than expected.



▲ **Figure 7** shows **the percent of laboratory results testing positive for eight common respiratory viruses**, as reported by laboratories participating in the National Respiratory and Enteric Virus Surveillance System (NRVESS) and laboratories reporting validated respiratory virus data to the Florida Department of Health via electronic laboratory reporting (n=7), week 40, 2019 to week 9, 2020.

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Influenza and ILI Outbreaks

Week 9 Outbreaks at a Glance:

Number Reported:
9 Outbreaks

Influenza-Associated:
2 Outbreaks

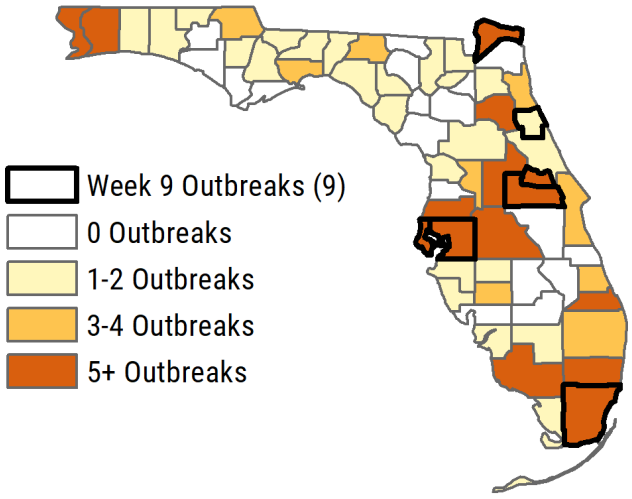
Severe Outcomes*:
1 Outbreak

Outbreak Summary:

In week 9, two influenza-associated and seven ILI outbreaks were reported, a decrease from the previous week.

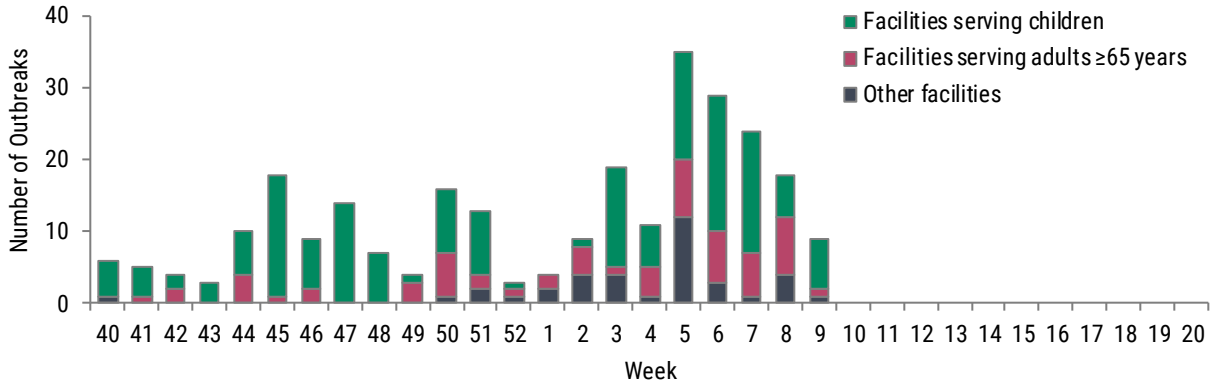
Severe outcomes* were reported in one of nine outbreaks. Two hospitalizations and no deaths were reported in this outbreak.

During the previous season, severe outcomes were most commonly reported in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities). In week 9, the outbreak with severe outcomes was in a facility serving adults aged ≥65 years.



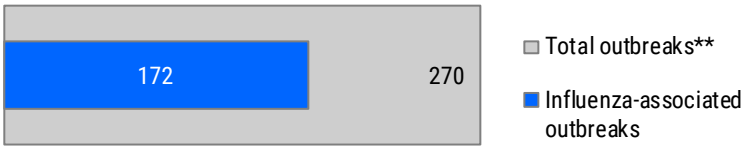
▲ **Figure 8** shows **reported influenza or ILI outbreaks by county**. Counties with outbreaks reported in week 9 are **outlined in bold.**

Figure 9: In week 9, **one outbreak** was reported among **facilities serving adults aged ≥65 years, seven outbreaks** were reported in **facilities serving children,** and **one outbreak** was reported among **other facilities.**



◀ **Figure 9** shows the number of **influenza-associated or ILI outbreaks by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020. More information on how these setting categories are defined is available on pages 6-7.

Figure 10: As of week 9, **63.7% of outbreaks** reported so far this season were **influenza-associated.**



◀ **Figure 10** shows the total number of outbreaks and the number of influenza-associated outbreaks as reported in Merlin by county health departments for the 2019-20 season as of week 9, 2020. For more information on how ILI and influenza-associated outbreaks are defined, see page 16.

*Severe outcomes are defined as hospitalization or death among one or more outbreak cases.

**Total outbreaks includes the number of influenza-associated outbreaks in addition to outbreaks of ILI.

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Influenza and ILI Outbreaks

Facilities Serving Children*:

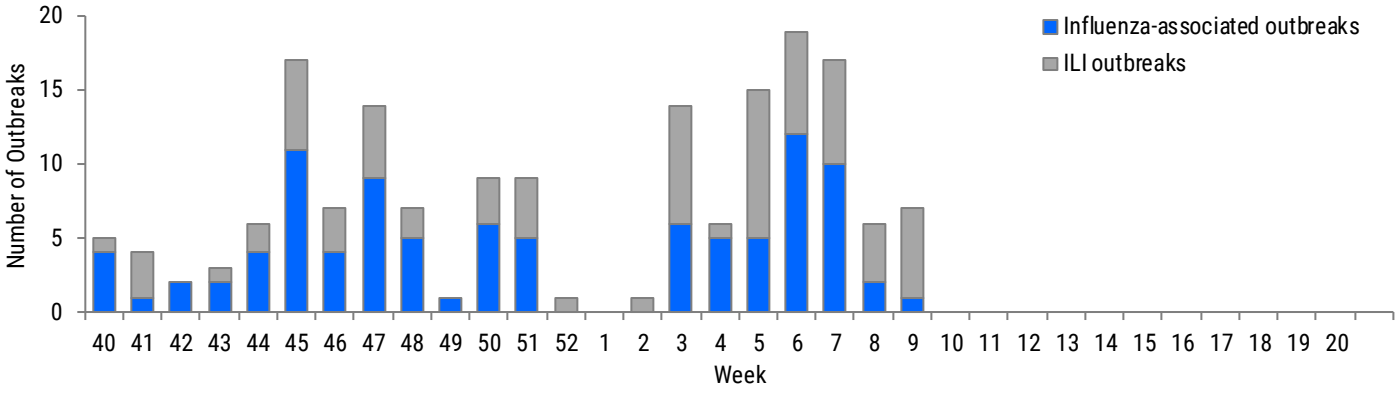
7 Outbreaks

Summary of Outbreaks in Facilities Serving Children:

In week 9, seven new outbreaks of influenza or ILI were reported in facilities serving children.

*Facilities serving children include primary schools, secondary schools, and child daycares.

Figure 11: In week 9, **one influenza-associated outbreak** and **six ILI outbreaks** were reported in **facilities serving children.**



▲ **Figure 11** shows the number of **influenza-associated or ILI outbreaks in facilities serving children by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

Facilities Serving Adults ≥65 yrs.**:

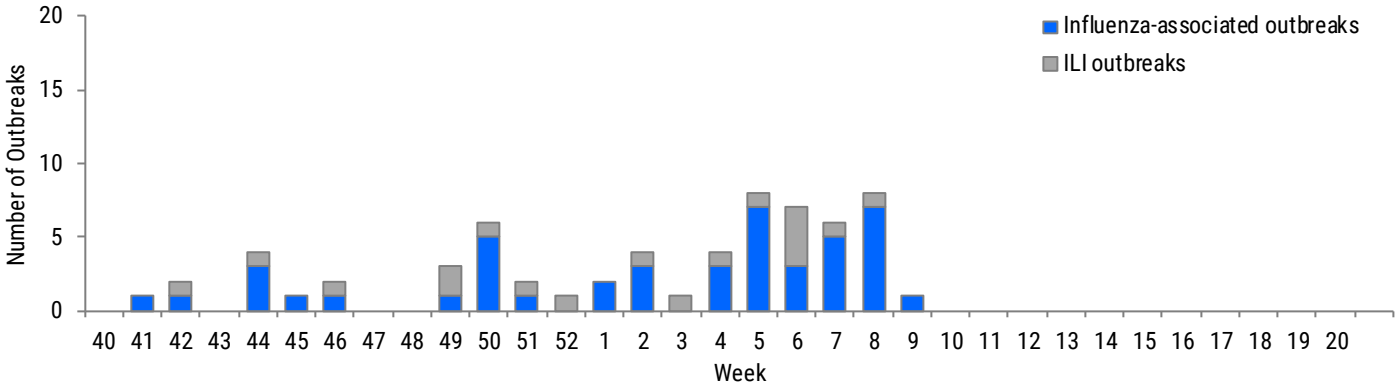
1 Outbreak

Summary of Outbreaks in Facilities Serving Adults ≥65 years:

In week 9, one new outbreak of influenza or ILI was reported among facilities serving adults aged ≥65 years.

**Facilities serving adults ≥65 years include assisted living facilities, nursing homes, and other long-term care facilities.

Figure 12: In week 9, **one influenza-associated outbreak** was reported among **facilities serving adults ≥65 years.**



▲ **Figure 12** shows the number of **influenza-associated or ILI outbreaks in facilities serving adults aged ≥65 years by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Influenza and ILI Outbreaks

Other Facilities*:

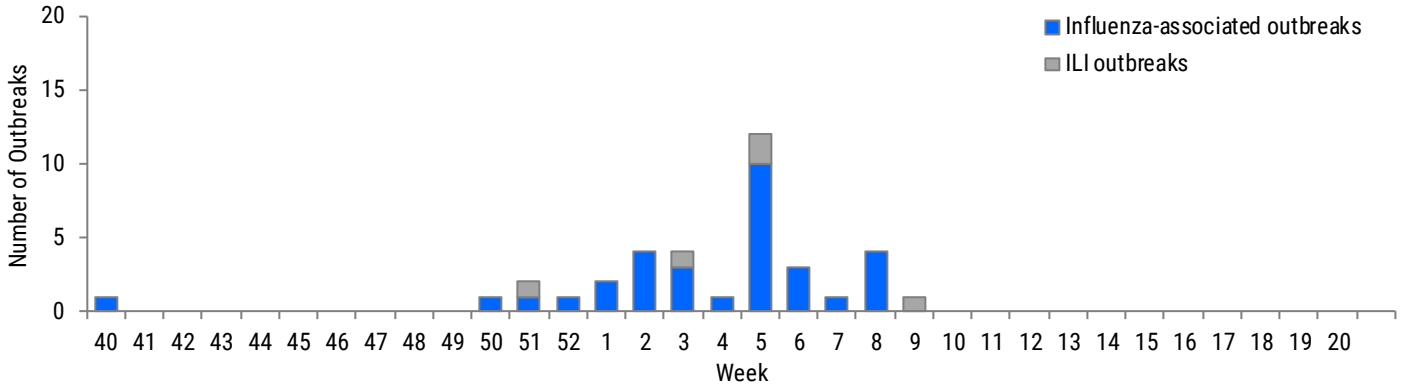
1 Outbreak

Summary of Outbreaks in Other Facilities:

In week 9, one new outbreak of influenza or ILI was reported among other facilities.

*Other facilities include post-secondary schools, adult daycares, correctional facilities, hospitals, shelters, and workplaces.

Figure 13: In week 9, **one ILI outbreak** was reported among **other facilities.**



▲ **Figure 13** shows the number of **influenza-associated or ILI outbreaks in other facilities by week** as reported in Merlin by county health departments, week 40, 2019 to week 9, 2020.

Table 1: Summary of Influenza or ILI Outbreaks Reported During the 2019-20 Season by Setting

Setting	Number of Outbreaks (Percent of Outbreaks)	Number Influenza-Associated or ILI
Primary or secondary schools	130 (48.2%)	78 influenza-associated outbreaks 52 ILI outbreaks
Child daycares	40 (14.8%)	17 influenza-associated outbreaks 23 ILI outbreaks
Camps	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Assisted living facilities	19 (7.0%)	9 influenza-associated outbreaks 10 ILI outbreaks
Nursing facilities	15 (5.6%)	12 influenza-associated outbreaks 3 ILI outbreaks
Other long-term care facilities	29 (10.7%)	24 influenza-associated outbreaks 5 ILI outbreaks
Adult daycares	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Post-secondary schools	0 (0.0%)	0 influenza-associated outbreaks 0 ILI outbreaks
Correctional facilities	30 (11.1%)	28 influenza-associated outbreaks 2 ILI outbreaks
Hospitals	3 (1.1%)	2 influenza-associated outbreaks 1 ILI outbreak
Additional facility types	4 (1.5%)	2 influenza-associated outbreaks 2 ILI outbreaks
Total	**270 (100.0%)**	**172 influenza-associated outbreaks** **98 ILI outbreaks**

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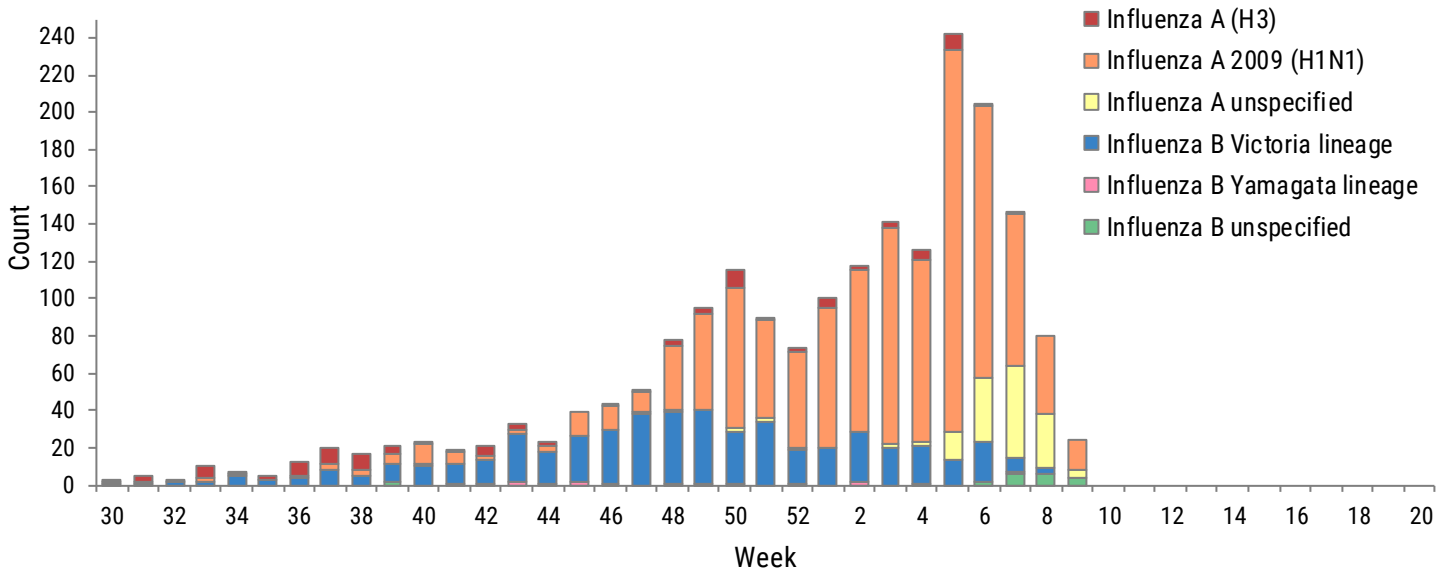
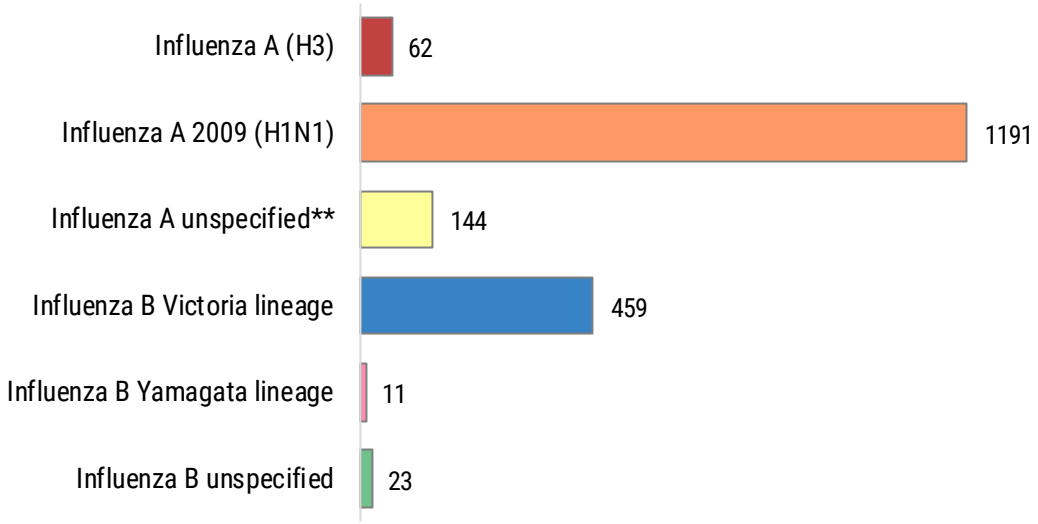
Laboratory Surveillance

Figure 14: **Influenza A 2009 (H1N1)** continues to be the most common influenza virus identified at BPHL in recent weeks, and **influenza A 2009 (H1N1)** is the most common influenza subtype detected so far this season. **Influenza B Victoria lineage** was predominant earlier in the season, but the frequency of those detections decreased in recent weeks.



▲ **Figure 14** shows the number of **influenza-positive laboratory results at the Bureau of Public Health Laboratories (BPHL)** by lab-event date,* week 30, 2019 through week 9, 2020.

Figure 15: **Influenza A 2009 (H1N1)** makes up the largest number of influenza detections at BPHL since week 40. Earlier in the season, **influenza B Victoria lineage** was the most common strain.



◀ **Figure 15** shows the number of **influenza-positive laboratory results for specimens submitted to BPHL** for the current 2019-20 influenza season, week 40, 2019 through week 9, 2020.

The results shown here are reflective of the influenza testing performed by BPHL thus far for specimens with lab event dates* within this timeframe.

*"Lab event date" is defined as the earliest of the following dates associated with influenza testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted.

**This number includes both influenza A specimens for which subtyping has not yet been performed as well as specimens that tested positive for influenza A but were unable to be subtyped due to low viral load.

AMERICAN OVERSIGHT

Regional Activity

Figures 16-22 show **the percent of emergency department and urgent care center visits for influenza-like illness (ILI)** at ESSENCE-FL participating facilities (n=369) from week 40, 2016 to week 9, 2020. Data are organized by region (see Figure 23).

2019-20 2018-19 2017-18 2016-17

Figure 16: In **region 1, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

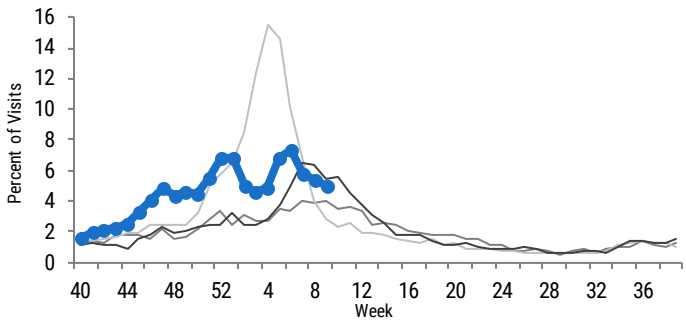


Figure 17: In **region 2, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

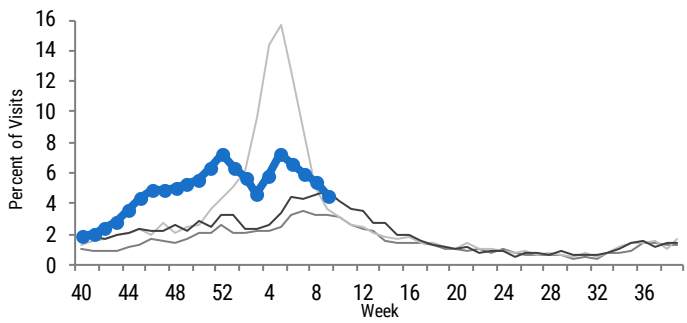


Figure 18: In **region 3, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

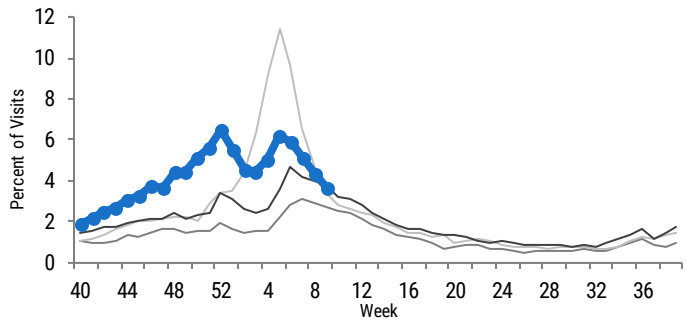


Figure 19: In **region 4, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

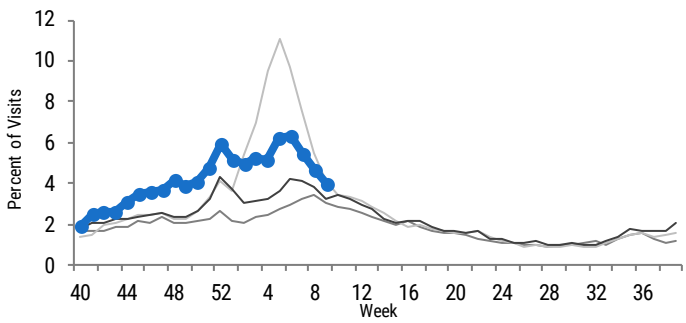


Figure 20: In **region 5, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

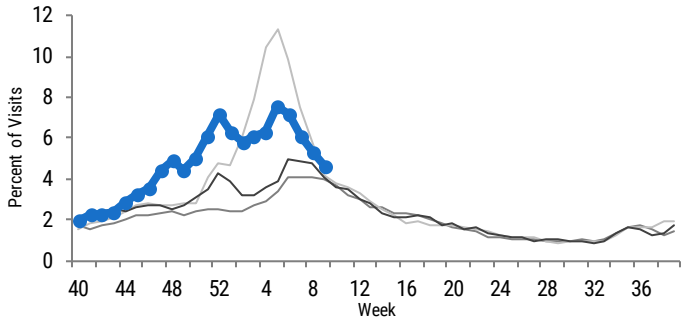


Figure 21: In **region 6, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.

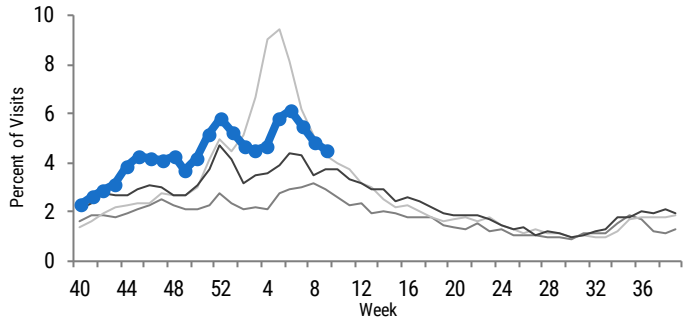
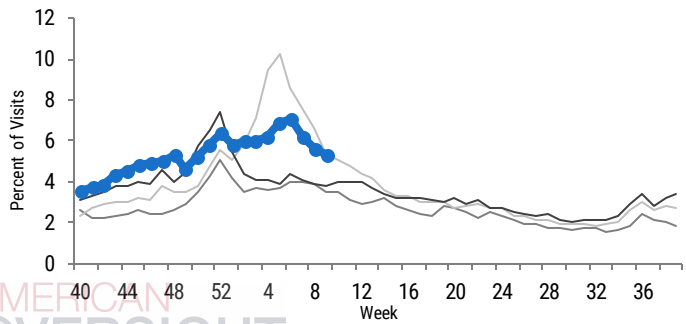


Figure 22: In **region 7, ILI activity decreased** during week 9 and was above peak activity observed during the 2016-17 season.



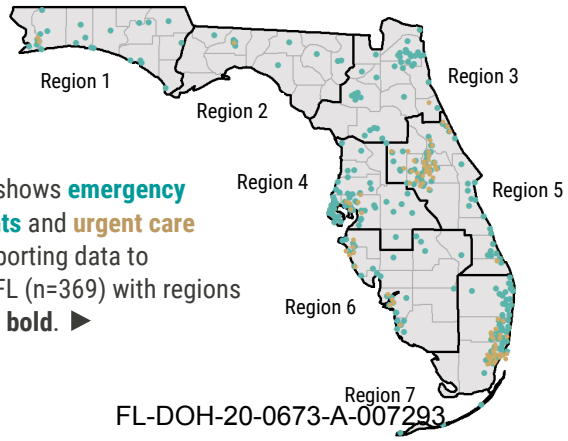


Figure 23 shows **emergency departments** and **urgent care centers** reporting data to ESSENCE-FL (n=369) with regions **outlined in bold**. ▶

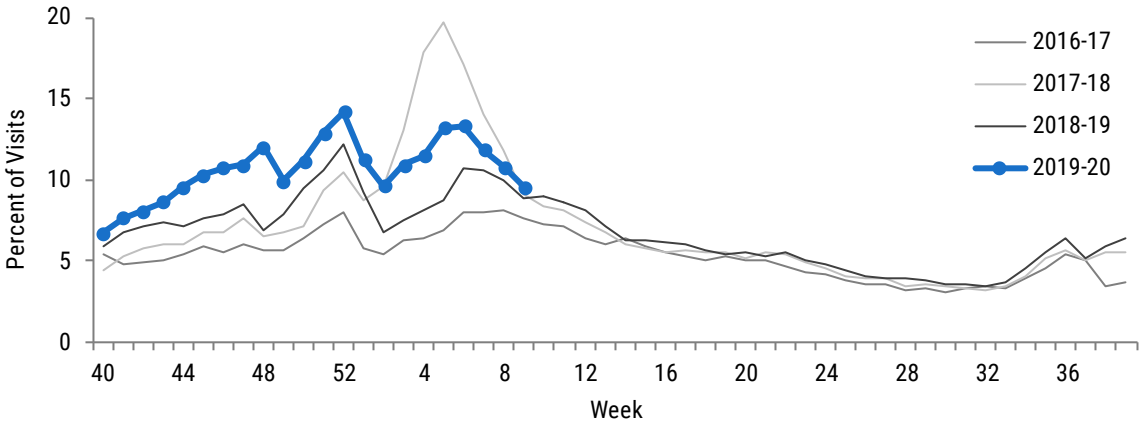
AMERICAN OVERSIGHT

At-Risk Populations

Background: At-Risk Populations, Children

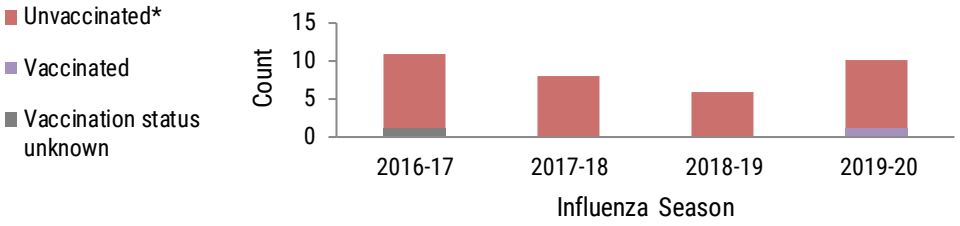
Children, especially those with underlying health conditions (like asthma or diabetes), are at higher risk for severe complications from influenza infection. **The single best way to protect children from influenza is to get them vaccinated every year.** The Centers for Disease Control and Prevention continues to recommend influenza vaccination as long as flu viruses are circulating. To find a flu shot near you, please visit: VaccineFinder.org.

Figure 24: In week 9, **the percent of emergency department and urgent care center visits for ILI in children <18 years decreased** and was above levels observed at this time during the 2016-17 season.

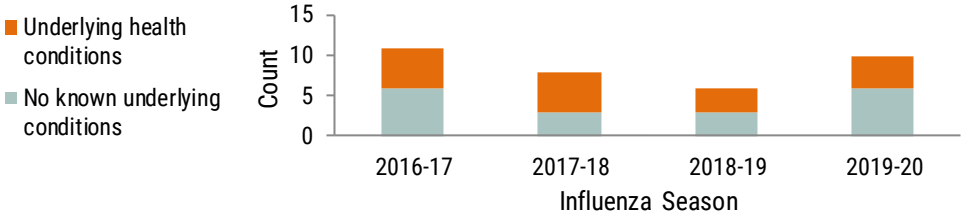


◀ **Figure 24** shows **the percent of influenza-like illness (ILI) visits among children <18 years** at emergency department and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

Figures 25-26: In week 9, **one new influenza-associated pediatric death was reported**. A total of ten influenza-associated pediatric deaths have been reported so far this season.



▲ **Figure 25** shows the number of **influenza-associated pediatric deaths** as reported in Merlin **by vaccination status**, week 40, 2016 to week 9, 2020.



▲ **Figure 26** shows the number of **influenza-associated pediatric deaths** as reported in Merlin by **medical history**, week 40, 2016 to week 9, 2020.

In week 9, **one new influenza-associated pediatric death was reported**. The death was associated with influenza A 2009 (H1N1) in a child with known underlying medical conditions who was not vaccinated for the 2019-20 season.

A total of ten influenza-associated pediatric deaths have been reported so far this season. **Influenza vaccination is recommended as long as influenza viruses are circulating, even in February or later.**

Children, especially those with certain health conditions are at increased risk of severe complications from influenza infection. **Influenza vaccination has been shown to reduce a child's likelihood of dying from influenza by up to 60%.** For more information, please visit: www.cdc.gov/media/releases/2017/p0403-flu-vaccine.html.

*The Advisory Committee on Immunization Practices (ACIP) recommends children aged six months to eight years receive two doses of influenza vaccine administered a minimum of four weeks apart during their first season of vaccination for optimal protection. The Florida Department of Health includes children in this age group who did not receive a second influenza vaccine in this unvaccinated category. To learn more about the ACIP's 2019-20 recommendations, please visit: www.cdc.gov/mmwr/volumes/68/rr/rr6803a1.htm

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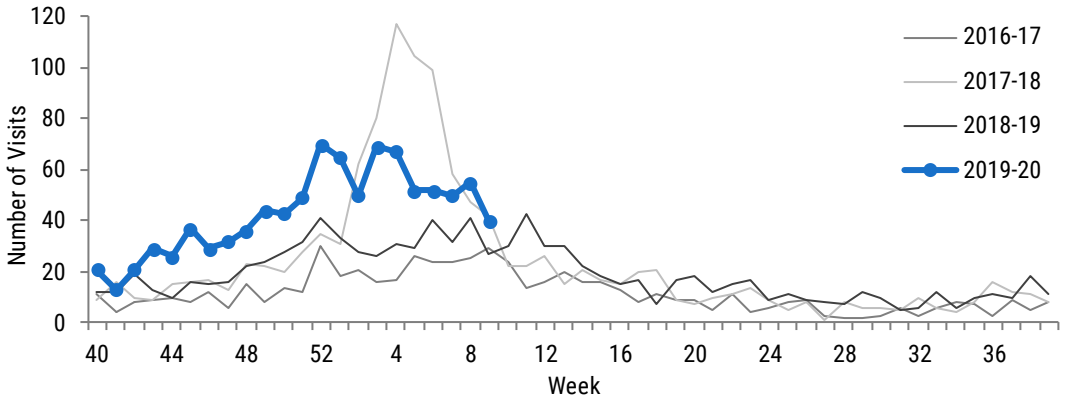
At-Risk Populations Continued

Background: At-Risk Populations, Pregnant Women

Influenza is five times more likely to cause severe illness in pregnant women (even those who are generally healthy) compared to women who are not pregnant. Pregnant women with certain underlying medical conditions (such as asthma or heart disease) are at even greater risk for severe complications from influenza. **Inactivated influenza vaccines are safe, provide the best protection for pregnant women and their babies, and are recommended at any time during pregnancy.** Vaccination during pregnancy provides maternal antibody protection to infants too young to be vaccinated for influenza and has been shown to protect pregnant women from influenza-associated hospitalization and preterm birth. For more information, talk to your health care provider.

Figure 27: In week 9, the **number of emergency department and urgent care center visits for influenza among pregnant women decreased** and was above peak levels observed during the 2016-17 season.



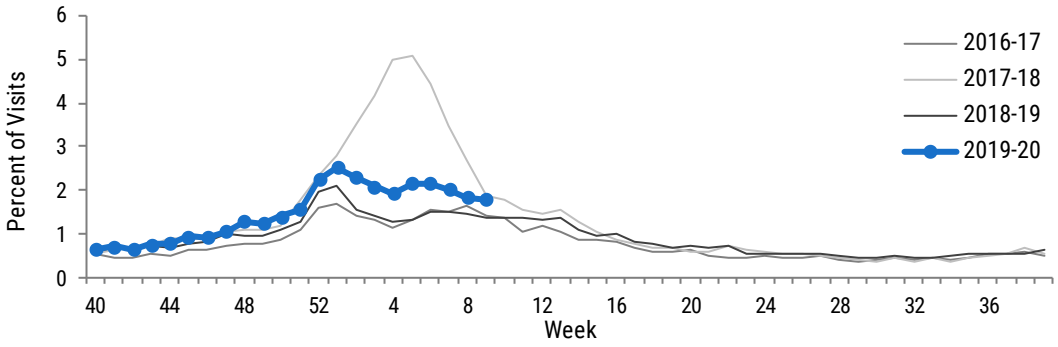
◀ **Figure 27** shows the **number of visits* to emergency departments and urgent care centers with chief complaints of influenza and pregnancy**, as reported in ESSENCE-FL, week 40, 2016 to week 9, 2020.

*This count **underrepresents** the true number of pregnant women presenting for care to emergency departments and urgent care centers with influenza, however, **the overall trend** has been validated through review of discharge data collected by the Agency of Health Care Administration.

Background: At-Risk Populations, Adults Aged ≥65 Years

Adults ≥65 years old are at higher risk for severe complications from influenza infection, including hospitalization and death. While influenza seasons vary in intensity, adults in this age group bear the greatest burden of severe influenza disease. In Florida, an average of 80% of seasonal pneumonia and influenza deaths occurred in adults aged ≥65 years over the last five influenza seasons. **Annual vaccination is the best way to prevent influenza infection.**

Figure 28: In week 9, the **percent of emergency department and urgent care center visits for ILI in adults ≥65 years decreased** and was above levels observed at this time during the 2016-17 season.



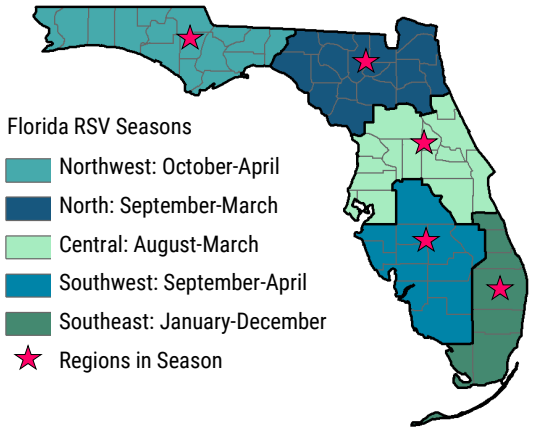
◀ **Figure 28** shows **the percent of influenza-like illness (ILI) visits among adults ≥65 years old** at emergency departments and urgent care centers, as reported into ESSENCE-FL, week 40, 2016 to week 9, 2020.

AMERICAN OVERSIGHT

Respiratory Syncytial Virus Surveillance

Background

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms. Young children and older adults, especially those with certain underlying health conditions, are at higher risk for severe illness from RSV. Prophylaxis is available for children who qualify. For more information, contact your health care provider.



▲ **Figure 29** shows **Florida's RSV regional season breakdown.** Regions that are currently in RSV season are marked with **pink stars.**

RSV Surveillance

A statewide RSV surveillance system was implemented in Florida to support clinical decision-making for prophylaxis of premature infants.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high risk for complications from RSV infection. The American Academy of Pediatrics currently recommends pre-approval for prophylactic treatment be made based on state surveillance data. For more information on RSV surveillance systems used in Florida, see the last page of this report.

Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The Florida Department of Health established regional RSV seasons based on activity thresholds provided by the Centers for Disease Control and Prevention (see Figure 29). **Currently, all of Florida's regions are in RSV season.**

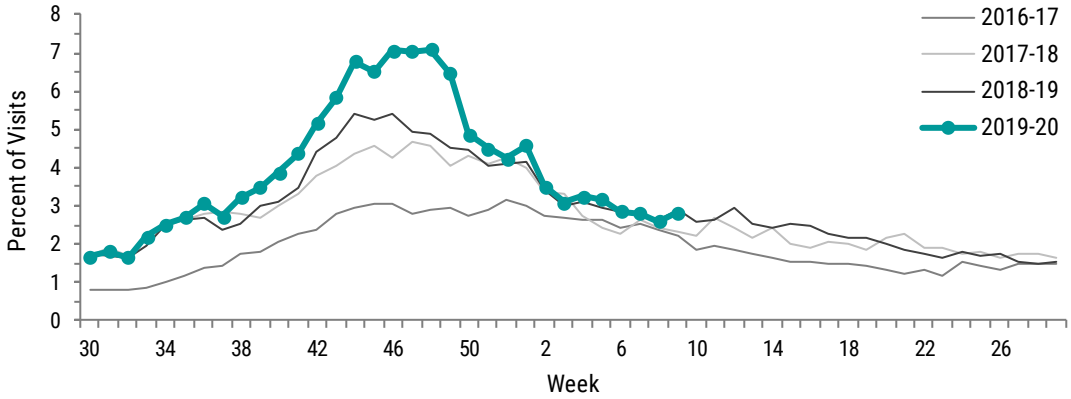
To learn more about RSV in Florida, please visit: FloridaHealth.gov/RSV.

Week 9 (February 23-29, 2020) Activity Summary

In week 9, RSV activity in children <5 years increased and was similar to levels observed at this time in 2019.

No new RSV-associated outbreaks were reported in week 9. A total of nine RSV-associated outbreaks have been reported since week 30, 2019 (beginning on July 27, 2019).

Figure 30: In week 9, **the percent of emergency department and urgent care center visits for RSV among children <5 years increased** and was similar to levels observed at this time in 2019.



◀ **Figure 30** shows **the percent of emergency department and urgent care center visits with discharge diagnoses that include RSV or RSV-associated illness among children <5 years***, as reported in ESSENCE-FL, week 30, 2016 to week 9, 2020.

*The overall trend displayed in Figure 30 has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.

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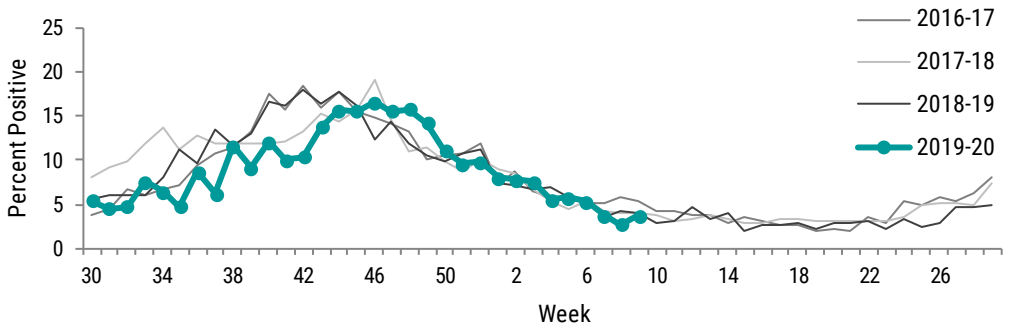
RSV Surveillance

Figure 31: In week 9, **the percent of specimens testing positive for RSV increased.** Levels were similar to those observed at this time in previous seasons.

Figure 31 shows **the percent of specimens testing positive for respiratory syncytial virus (RSV)**, as reported by hospital laboratories (n=7), week 30, 2016 to week 9, 2020. ▶



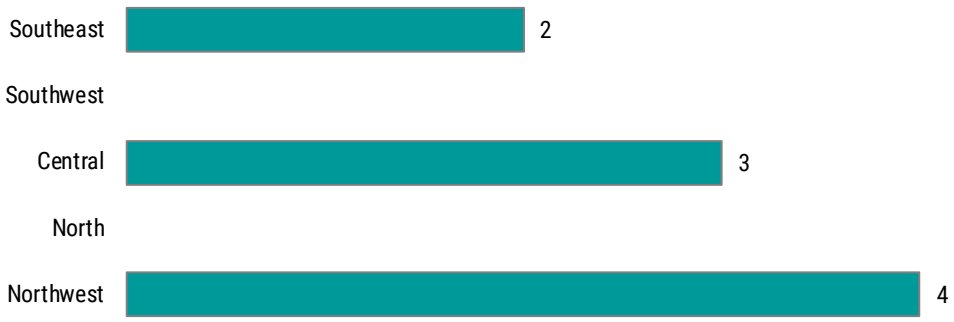
RSV-Associated Outbreaks in Week 9:

0 Outbreaks

Summary of RSV-Associated Outbreaks:

In week 9, no new RSV-associated outbreaks were reported. Since week 30, 2019, nine RSV-associated outbreaks have been reported.

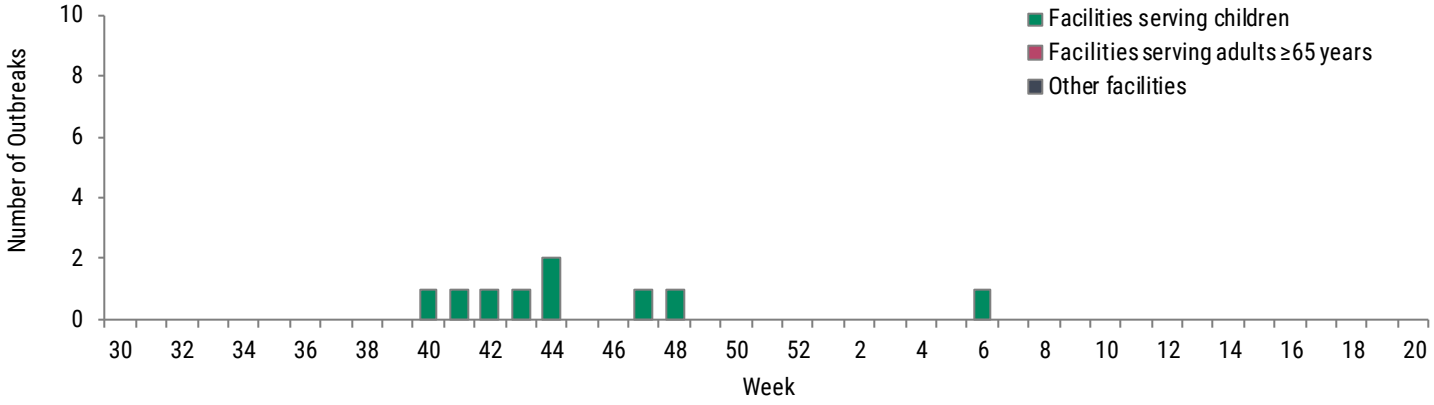
Figure 32: In week 9, no new RSV-associated outbreaks were reported. Since week 30, outbreaks have been reported in Florida's southeast, central, and northwest regions.



◀ **Figure 32** shows **a summary of RSV-associated outbreaks by region*** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

*Regions defined in figure 29.

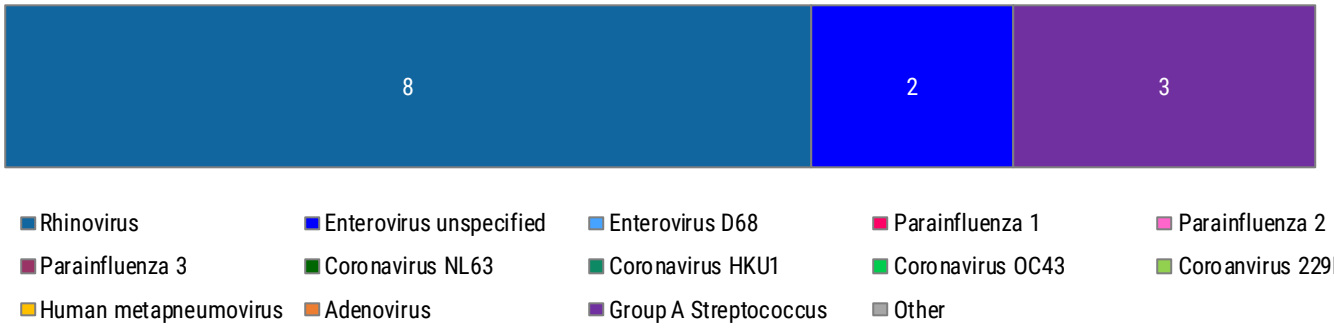
Figure 33: In week 9, no new RSV-associated outbreaks were reported. All of the outbreaks reported since week 30 have been reported in **facilities serving children.**



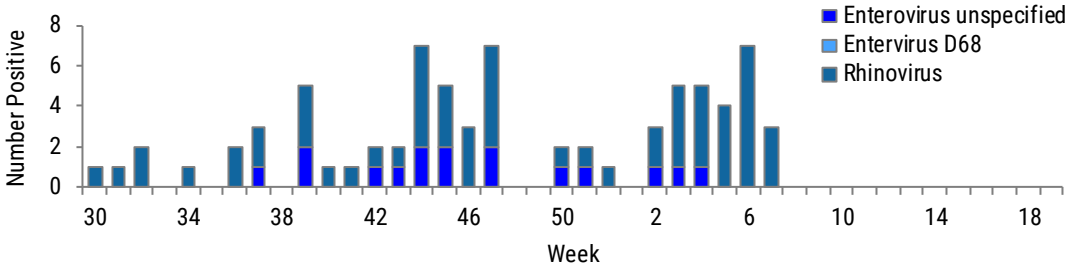
▲ **Figure 33** shows **the number of RSV-associated outbreaks by setting and week** as reported by county health departments in Merlin, week 30, 2019 to week 9, 2020.

AMERICAN OVERSIGHT

Other Respiratory Virus Surveillance

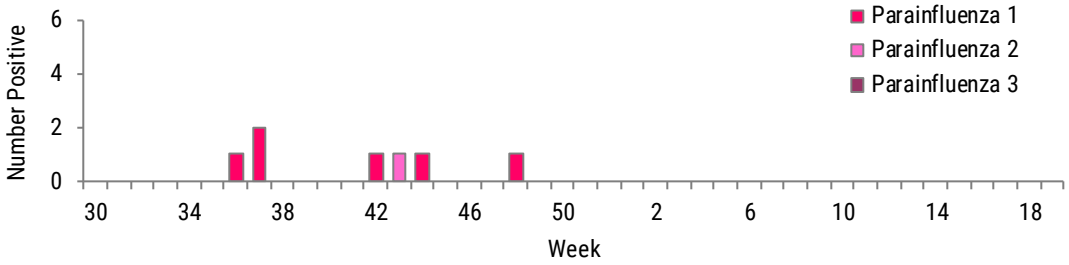


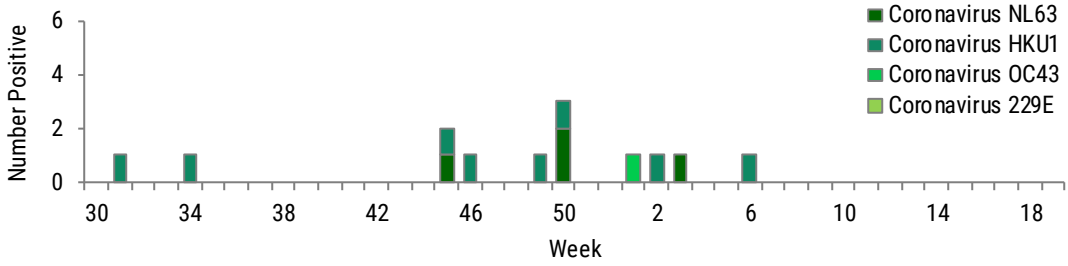
▲ **Figure 34** shows **the number of unique times a pathogen was associated with a respiratory outbreak** for outbreaks reported from week 30, 2019 to week 9, 2020.



◀ **Figure 35*** shows **the number of PCR-positive laboratory findings for enterovirus unspecified, enterovirus D68, and rhinovirus** by week** among specimens submitted to the Bureau of Public Health Laboratories (BPHL) for extended respiratory panel testing.

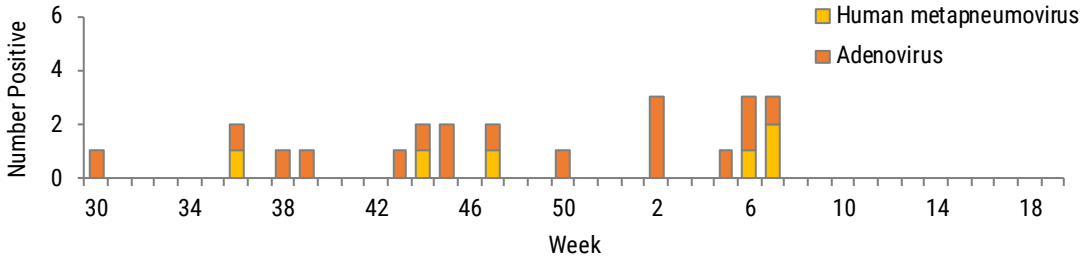
Figure 36* shows **the ▶ number of PCR-positive laboratory findings for parainfluenza 1-3** by week** among specimens submitted to BPHL for extended respiratory panel testing.





◀ **Figure 37*** shows **the number of PCR-positive laboratory findings for seasonal coronaviruses NL63, HKU1, OC43, and 229E** by week** among specimens submitted to BPHL for extended respiratory panel testing.

Figure 38* shows **the ▶ number of PCR-positive laboratory findings for human metapneumovirus and adenovirus** by week** among specimens submitted to BPHL for extended respiratory panel testing.



*Data shown in figures 34-38 include results for specimens submitted by Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers (n=4) as reported by BPHL.

**Results are organized by week based on "lab event date" (defined as the earliest of the following dates associated with testing at the laboratory: date specimen collected, date received by the laboratory, date reported, or date inserted).

AMERICAN OVERSIGHT

Summary of Notable Outbreaks

Table 2: Summary of Notable* Influenza-Associated, Respiratory Syncytial Virus (RSV)-Associated, and Influenza-like Illness (ILI) Outbreaks Reported in Week 9, 2020

Setting	County	Number of Cases	Number of Cases Hospitalized	Number of Cases Died	Outbreak Etiology	Control Measures Recommended to Facility Leadership	Investigation Status
Assisted living facility	Pinellas	3	2	Unknown	Influenza unspecified	Yes	Open

*For the purposes of this report, notable outbreaks are defined as influenza-associated, RSV-associated, or ILI outbreaks with two or more hospitalizations, one or more deaths, or 30 or more cases. For more information on how outbreaks are defined, see page 16.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems

ESSENCE-FL Syndromic Surveillance and Vital Statistics Portal Data source for figures 1, 4, 16-24, 27, 28, 30

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE-FL) measures trends in influenza-like illness (ILI) visits from emergency departments (ED) and urgent care clinics (UCC) and influenza mortality by using death certificates from the Bureau of Vital Statistics. Participating EDs and UCCs (n=369) electronically transmit visit data into ESSENCE-FL daily or hourly.

For statewide and regional data on ILI, visits are counted as ED or UCC visits to participating facilities that include the words "influenza" or "flu" in patient chief complaints. Chief complaints with the words "fever" and "cough," or "fever" and "sore throat" are also counted as ILI.

For pneumonia and influenza (P&I) mortality surveillance, death record literals are queried using a free-text query that searches for references to P&I on death certificates. Any mention of P&I in the death certificate literals, with certain exceptions, is counted as a P&I death. Deaths counts are aggregated and presented by date of death.

For respiratory syncytial virus (RSV) surveillance, visits are counted as ED or UCC visits to participating facilities for which RSV or RSV-associated illness is included in the discharge diagnosis.

For RSV mortality surveillance, death record literals are queried using a free-text query that searches for references to RSV on death certificates. Any mention of RSV, syncytial, and bronchiolitis in the death certificate literals, with certain exceptions, is counted as a RSV death. These deaths are also investigated to ensure they meet case definition.

Florida ILINet Data source for figures 2 and 3

ILINet is a nationwide surveillance system composed of sentinel providers, predominately outpatient health care providers. Florida has 118 sentinel providers enrolled in ILINet who submit weekly ILI and total visit counts, as well as submit ILI specimens to the Bureau of Public Health Laboratories for virologic surveillance. For healthcare providers interested in enrolling in ILINet, contact your local county health department.

ILINet is also used as a portal in which the Florida Department of Health reports Florida's geographic spread of influenza each week to the Centers for Disease Control and Prevention (CDC). Geographic spread is not an indication of influenza severity. Geographic spread can be reported as sporadic, local, regional, or widespread.

- Sporadic: small numbers of laboratory-confirmed influenza or a single laboratory-confirmed influenza has been reported but there is no increase in cases of ILI
- Local: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state
- Regional: outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions
- Widespread: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state.

County Influenza Activity in EpiGateway Data source for figure 5 and 6

County health department (CHD) epidemiologists report their county's influenza and ILI surveillance data weekly into The Florida Department of Health's EpiGateway website. Data from these reports is used to classify influenza activity as: no activity, mild, moderate, or elevated. Setting-specific influenza activity and influenza trend information is also reported by CHDs as available. EpiGateway data provided by CHDs creates a county-by-county breakdown of influenza and ILI activity around the state.

Laboratory Viral Respiratory Surveillance Data source for figures 7 and 31

The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a CDC surveillance system that captures on eight commonly circulating respiratory viruses as reported by participating laboratories in Florida. NREVSS data are combined with validated electronic laboratory data from Florida laboratories that submit RSV laboratory results via electronic laboratory reporting. Together, this information is used to monitor the temporal and geographic patterns of these viruses.

Outbreak Reporting in Merlin Data source for figures 8-13, 32-34; tables 1 and 2

Outbreak investigations are tracked in Merlin (Florida's reportable disease surveillance system) by investigating county health departments. Outbreak reports include implicated viruses or bacteria, the outbreak setting, and recommendations made to mitigate the spread of disease (among other data elements). All outbreak data are considered preliminary and subject to change. As such, outbreak counts may increase or decrease as additional information is received.

- ILI outbreaks in facilities serving adults aged ≥65 years (assisted living facilities, nursing facilities, and long-term care facilities) are defined as two or more individuals with ILI (fever and cough or fever and sore throat in the absence of positive laboratory results). ILI outbreaks in facilities serving children (primary/secondary schools and child daycares) are defined as three or more epidemiologically linked individuals with ILI.
- Influenza-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for influenza. Influenza-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for influenza. Testing may be conducted by the Bureau of Public Health Laboratories (BPHL), commercial laboratories, hospitals, or private health care providers.

Continued on next page.

AMERICAN OVERSIGHT

Summary of Included Surveillance Systems Continued

- RSV-associated outbreaks in facilities serving adults aged ≥65 years are defined as two or more individuals with respiratory symptoms, where at least one individual tests positive for RSV. RSV-associated outbreaks in facilities serving children are defined as three or more epidemiologically linked individuals with respiratory symptoms, where at least one individual tests positive for RSV. Testing may be conducted by BPHL, commercial laboratories, hospitals, or private health care providers.
- Notable outbreaks include influenza-associated, RSV-associated, or ILI outbreaks in any setting with 30 or more cases, two or more hospitalized cases, or one or more cases who died.
- Household clusters are not counted as outbreaks.

Bureau of Public Health Laboratories (BPHL) Data source for figures 14, 15, and 35-38.

BPHL performs testing and subtyping on surveillance specimens from sentinel providers, outbreak investigations, patients with severe or unusual influenza presentations, and medical examiners. Sentinel providers include both ILINet and Acute Respiratory Infection Epidemiology and Surveillance Program (ARIES) providers. Some laboratories also routinely submit pre-screened influenza-positive specimens for testing at BPHL for surveillance purposes.

Case-Based Influenza Surveillance Data source for figures 25 and 26

Death in a child whose laboratory-confirmed influenza infection has been identified as a contributing to the child's death is a reportable condition in Florida. Influenza-associated pediatric deaths are documented by county health departments in Merlin.

In addition, an individual of any age suspected as being infected with non-seasonal or pandemic influenza A is reportable condition in Florida. Such cases are referred to as cases of 'novel influenza A.' Novel influenza A cases are documented by county health departments in Merlin.

For more information about reportable diseases and conditions, please visit FloridaHealth.gov/DiseaseReporting.

AMERICAN OVERSIGHT

From:	Baker, Michael (OS/IEA)
To:	Baker, Michael (OS/IEA)
Subject:	What Governors Need to Know - HHS Issues New COVID-19 Resources
Date:	Wednesday, March 11, 2020 1:12:31 PM
Attachments:	PRELIMINARY - NOT FOR FURTHER DISCLOSURE Initial State and Local Funding.pdf

Dear Governor:

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19.

As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

Funding for States to Address COVID-19

Perhaps of keenest interest to you and your health officials is an update on funding for states and communities to address mitigation of COVID-19.

Today, at 1 PM EST HHS will be announcing that more than $560 million will be made available to the 62 entities which have existing cooperative agreements with the CDC through its Public Health Emergency Program, known as "PHEP."

The $8.3 billion dollar Supplemental passed by Congress included statutory language which prescribed the exact formula for disbursing the money: states will receive 90% of their 2019 CDC PHEP grants. So that you know what your state will receive, we have attached a document identifying the amounts going to states, territories, or cities. This marks the first tranche of funding to states from the $8.3 billion supplemental. Your state health officers are receiving a letter today from CDC outlining what is needed to receive the funding, essentially they need to submit a spend plan and they will receive guidance on what that spend plan should contain.

Helping Communities Know Mitigation Strategies

Yesterday, CDC released their "Implementation." Essentially, this is a guide for communities describing possible mitigation strategies for communities dealing with transmission at three different levels: (1) None/Minimal, (2) Moderate, or (3) Substantial. Community mitigation strategies, which are non-pharmaceutical interventions, are often the most available interventions to help slow the transmission of COVID-19 in communities. The Mitigation Plans include a set of actions that persons and communities can take to slow the spread of respiratory virus infections. The Community Mitigation Plan can be found here.

Guidance on Infection Control For Healthcare Workers

Yesterday, CDC released updated guidance on infection prevention and control recommendations. Healthcare workers are fighting this outbreak on the front lines, and this guidance is intended to provide assistance to healthcare settings that are handling suspected or confirmed cases of COVID-19. This guidance is applicable to all U.S. healthcare settings, but not for non-healthcare settings. There is separate guidance for that. The new guidance on infection control can be found here.

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OMB Flexibilities
On March 9, 2020, OMB issued a memo that provides administrative relief for recipients and applicants of Federal financial assistance who are directly impacted by COVID-19. The grant flexibilities include 10 actions that HHS can take to provide short-term administrative and financial management relief, allowing funds to be awarded quicker and giving grantees the ability to focus on their critical response, research, or services. More information can be found here.

General Preparation Information: On March 9, 2020, the White House Coronavirus Task Force released practical steps that we recommend posting and sharing to keep workplaces, school, home and commercial establishments safe. This information can be found here.

CMS Specific Guidance:

- **CMS Guidance on Masks:** On March 10, 2020, CMS released guidance updating recommendations to expand the type of facemasks healthcare workers can use in situations involving COVID-19. This guidance aligns with the information by CDC regarding personal protective equipment as well. The memo sent to State Survey Agency Directors can be found here.

- **CMS FAQs on Suspension of Non-Emergency Survey Inspections**: On March 10, 2020, CMS released a frequently asked questions document to further explain the changes in guidance issued on March 4 that suspends all non-emergency survey inspections. This guidance and FAQ will help to enable State Inspectors to address the spread of COVID-19. The FAQ document can be found here.

- **CMS Nursing Home Guidance:** As you know, nursing homes and their residents are vulnerable populations for COVID-19. This week, CMS released updated guidance for infection control and prevention of COVID-19 in Nursing Homes which can be found here (3/9). The Press Release can be found here and all CMS guidance related to COVID-19 can be found here.

If you have any questions on these items or other issues, please feel free to reach out.

Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

AMERICAN OVERSIGHT

DRAFT: CDC FUNDING INFORMATION (MAR 11, 2020)

Jurisdiction	Initial $25M (via Crisis CoAg) Complete	Initial $10M (ELC) Complete	$560M+ Award (Crisis CoAg) Underway	Total
Alabama			$ 8,148,798.90	$ 8,148,798.90
Alaska			$ 4,902,840.00	$ 4,902,840.00
American Samoa			$ 370,246.50	$ 370,246.50
Arizona	$ 500,000.00		$ 11,201,871.60	$ 11,701,871.60
Arkansas			$ 6,205,347.00	$ 6,205,347.00
California	$ 3,500,000.00	$ 1,000,000.00	$ 37,706,709.60	$ 42,206,709.60
Colorado		$ 500,000.00	$ 9,331,323.30	$ 9,831,323.30
Connecticut		$ 500,000.00	$ 7,058,270.70	$ 7,558,270.70
Delaware			$ 4,567,500.00	$ 4,567,500.00
District of Columbia			$ 6,148,297.80	$ 6,148,297.80
Florida	$ 500,000.00		$ 27,296,306.10	$ 27,796,306.10
Georgia	$ 250,000.00		$ 14,786,284.50	$ 15,036,284.50
Guam			$ 479,431.80	$ 479,431.80
Hawaii	$ 1,750,000.00	$ 1,000,000.00	$ 4,567,500.00	$ 7,317,500.00
Idaho			$ 4,567,500.00	$ 4,567,500.00
Illinois	$ 1,750,000.00	$ 1,000,000.00	$ 14,667,281.10	$ 17,417,281.10
Indiana	$ 250,000.00		$ 10,374,951.60	$ 10,624,951.60
Iowa			$ 6,347,828.70	$ 6,347,828.70
Kansas			$ 5,940,546.30	$ 5,940,546.30
Kentucky			$ 7,464,394.80	$ 7,464,394.80
Louisiana			$ 7,805,064.60	$ 7,805,064.60
Maine			$ 4,567,500.00	$ 4,567,500.00
Marshall Islands			$ 367,754.40	$ 367,754.40
Maryland		$ 500,000.00	$ 10,259,226.90	$ 10,759,226.90
Massachusetts	$ 500,000.00		$ 11,649,309.30	$ 12,149,309.30
Michigan	$ 250,000.00	$ 500,000.00	$ 14,567,049.90	$ 15,317,049.90
Micronesia			$ 420,402.60	$ 420,402.60
Minnesota		$ 500,000.00	$ 10,048,123.80	$ 10,548,123.80
Mississippi			$ 5,874,995.70	$ 5,874,995.70
Missouri			$ 9,888,657.30	$ 9,888,657.30
Montana			$ 4,567,500.00	$ 4,567,500.00
Nebraska	$ 1,750,000.00		$ 4,796,664.30	$ 6,546,664.30
Nevada			$ 6,532,739.10	$ 6,532,739.10
New Hampshire			$ 4,902,840.00	$ 4,902,840.00
New Jersey	$ 1,750,000.00		$ 13,860,160.20	$ 15,610,160.20
New Mexico		$ 500,000.00	$ 5,974,364.70	$ 6,474,364.70
New York	$ 1,750,000.00		$ 16,690,279.50	$ 18,440,279.50
North Carolina			$ 13,820,515.20	$ 13,820,515.20
North Dakota			$ 4,567,500.00	$ 4,567,500.00
Northern Marianas			$ 369,765.90	$ 369,765.90
Ohio			$ 15,620,977.80	$ 15,620,977.80
Oklahoma			$ 6,924,231.00	$ 6,924,231.00
Oregon	$ 500,000.00		$ 7,298,826.30	$ 7,798,826.30
Palau			$ 336,793.50	$ 336,793.50
Pennsylvania			$ 16,904,048.40	$ 16,904,048.40
Puerto Rico			$ 5,870,358.00	$ 5,870,358.00
Rhode Island	$ 500,000.00		$ 4,902,840.00	$ 5,402,840.00
South Carolina			$ 8,926,132.50	$ 8,926,132.50
South Dakota			$ 4,567,500.00	$ 4,567,500.00
Tennessee		$ 500,000.00	$ 10,078,293.60	$ 10,578,293.60
Texas	$ 1,750,000.00		$ 35,226,922.50	$ 36,976,922.50
Utah			$ 6,441,412.50	$ 6,441,412.50
Vermont			$ 4,902,840.00	$ 4,902,840.00
Virgin Islands			$ 419,100.30	$ 419,100.30
Virginia	$ 250,000.00		$ 13,371,612.30	$ 13,621,612.30
Washington	$ 1,750,000.00	$ 1,000,000.00	$ 11,480,798.70	$ 14,230,798.70
West Virginia			$ 5,000,803.20	$ 5,000,803.20
Wisconsin	$ 500,000.00	$ 500,000.00	$ 10,200,192.30	$ 11,200,192.30
Wyoming			$ 4,567,500.00	$ 4,567,500.00
New York City	$ 1,750,000.00	$ 1,000,000.00	$ 16,911,778.50	$ 19,661,778.50
Los Angeles	$ 1,750,000.00	$ 1,000,000.00	$ 18,212,100.30	$ 20,962,100.30
Chicago	$ 1,750,000.00		$ 8,743,674.60	$ 10,493,674.60
Houston			$ 5,000,000.00	$ 5,000,000.00
Philadelphia			$ 3,500,000.00	$ 3,500,000.00
Cherokee Nation			$ 750,000.00	$ 750,000.00
Total	**$ 25,000,000.00**	**$ 10,000,000.00**	**$ 569,822,380.00**	**$ 604,822,380.00**

AMERICAN OVERSIGHT

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
To: Blackmore, Carina (CDC flhealth.gov)
Cc: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Subject: Fw: CDC COVID-19 Case Count Confirmation 03/04/2020
Date: Thursday, March 5, 2020 10:16:44 AM
Attachments: CSTE COVID-19 Response New CDC Standard Process for Displaying Reported... (141 KB).msg
ATTACHMENT1_ReportingUpdates_2020March1.docx

Good morning Dr. Blackmore

We are following up on the email below. At your earliest, could you please confirm the case counts for FL below? We are hoping for confirmation by 11am ET, and we apologize for the quick turnaround.

Jurisdiction	Code	CDC Presumptive	CDC Confirmed	CDC Total	CDC Deaths
Florida	FL	0	2	2	0

Thank you for your assistance,

State Coordination Unit
eocevent118@cdc.gov
CDC 2019-nCoV Response

From: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit
Sent: Wednesday, March 4, 2020 6:43 PM
To: CDC IMS 2019 NCOV Response Epi Surveillance State Coordination Unit <eocevent118@cdc.gov>
Subject: CDC COVID-19 Case Count Confirmation 03/04/2020

Dear Partners,

As described in an email sent from the CSTE COVID-19 Leadership Team (see attached), CDC is instituting a standard process for confirming publicly reported cases by jurisdiction.

What you need to do/know now:

- We will conduct case confirmation **daily** (Monday – Friday). As the response evolves, the frequency of these requests will likely decrease.
- At the bottom of this email, you will find a table with the current preliminary case counts we have for each jurisdiction **as of 4 pm ET on Wednesday, March 4**.
- By **9 am ET Thursday, March 5**, please confirm case counts for your jurisdiction (your numbers **as of 4 pm ET today)** using the CDC Case Confirmation Portal (data are collected via Epi Info and stored on a secure CDC server):

https://go.usa.gov/xdftq

What you need to know about how your information will be presented:

- These data represent cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. They do not include people who returned to the United States via State Department-chartered flights. **We ask that the preliminary information shared in this email not be distributed.**
- What will be shared on the CDC website (updated daily at 12 pm, ET):
  - **The total case count** [presumptive + lab-confirmed], i.e., the actual number of *total* cases (e.g., 0, 6, 35) will be posted. **EXCEPTION**: **Jurisdictions with one to five cases will be**

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depicted as a range: "1–5 cases"
- Other information shared will be used for internal awareness and will not be shared publicly at this time.

What you need to do/know later:

- DCIPHER users can update and analyze their own jurisdiction's data at: https://dcipher.cdc.gov/. If your jurisdiction does not currently have DCIPHER users, but you would like to move to Phase 2 reporting as described in the attached guidance, please email eocevent118@cdc.gov to confirm your readiness.

Sincerely,

CDC COVID-19 Epidemiology Task Force

Reporting Jurisdiction	Code	Lab Category*			Deaths reported to CDC***
		Presumptive	Confirmed	Total**	
Alabama	AL	0	0	0	0
Alaska	AK	0	0	0	0
Arizona	AZ	1	1	2	0
Arkansas	AR	0	0	0	0
California	CA	23	14	37	0
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	2	2	4	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	0	0	0	0
New Hampshire	NH	1	1	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	1	0	1	0
North Carolina	NC	1	0	1	0

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North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	2	1	3	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	0	0	0	0
Texas	TX	0	0	0	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA	32	7	39	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	0	1	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC
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***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Sincerely,

CDC COVID-19 Epidemiology Task Force

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Arkansas	AR	0	0	0	0
California	CA	23	14	37	0
Colorado	CO	0	0	0	0
Connecticut	CT	0	0	0	0
Delaware	DE	0	0	0	0
Florida	FL	0	2	2	0
Georgia	GA	0	2	2	0
Hawaii	HI	0	0	0	0
Idaho	ID	0	0	0	0
Illinois	IL	2	2	4	0
Indiana	IN	0	0	0	0
Iowa	IA	0	0	0	0
Kansas	KS	0	0	0	0
Kentucky	KY	0	0	0	0
Louisiana	LA	0	0	0	0
Maine	ME	0	0	0	0
Maryland	MD	0	0	0	0
Massachusetts	MA	1	1	2	0
Michigan	MI	0	0	0	0
Minnesota	MN	0	0	0	0
Mississippi	MS	0	0	0	0
Missouri	MO	0	0	0	0
Montana	MT	0	0	0	0
Nebraska	NE	0	0	0	0
Nevada	NV	0	0	0	0
New Hampshire	NH	1	1	2	0
New Jersey	NJ	0	0	0	0
New Mexico	NM	0	0	0	0
New York (excluding New York City)	NY	1	0	1	0
North Carolina	NC	1	0	1	0

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North Dakota	ND	0	0	0	0
Ohio	OH	0	0	0	0
Oklahoma	OK	0	0	0	0
Oregon	OR	2	1	3	0
Pennsylvania	PA	0	0	0	0
Rhode Island	RI	2	1	3	0
South Carolina	SC	0	0	0	0
South Dakota	SD	0	0	0	0
Tennessee	TN	0	0	0	0
Texas	TX	0	0	0	0
Utah	UT	0	0	0	0
Vermont	VT	0	0	0	0
Virginia	VA	0	0	0	0
Washington	WA	32	7	39	10
West Virginia	WV	0	0	0	0
Wisconsin	WI	0	1	1	0
Wyoming	WY	0	0	0	0
American Samoa	AS	0	0	0	0
District of Columbia	DC	0	0	0	0
Guam	GU	0	0	0	0
New York City	NYC	1	0	1	0
Northern Marianas Islands	MP	0	0	0	0
Palau	PW	0	0	0	0
Puerto Rico	PR	0	0	0	0
U.S. Virgin Islands	VI	0	0	0	0
Federated States of Micronesia	FSM	0	0	0	0
Republic of Marshall Islands	RMI	0	0	0	0

* Presumptive cases have tested positive at a state/local laboratory but are not yet confirmed by CDC lab

**Values to be shared on the CDC website

***Reported deaths are reported from state or local health department and include confirmed and presumptive cases.

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Dear state and territorial partners:

Thank you for your continued partnership in the ongoing emergency response to COVID-19. The information included below aligns with what was shared by CDC during the 5 pm ET CSTE call on Saturday, February 29th regarding: 1) confirming a jurisdiction's 'Phase 2' status for reporting PUI and cases; 2) updates to the PUI and Case Report Form; 3) an update on the status of historical PUI data imports into DCIPHER; 4) clarifications to the CDC reporting process for PUI/Case Report Forms and lab findings; 5) management of the PHLIP laboratory reporting process; and 6) major avoidable issues we hope to overcome with your assistance. We plan for the noted changes to go into effect at **5 pm ET, Sunday, March 1.**

Jurisdictional 'Phase 2' Status

As we have previously outlined, jurisdictions need to be able to do several tasks before they can move into 'Phase 2'. These include assessing ill persons and determining PUI status; assigning unique identifiers to PUI and cases at the reporting jurisdiction level; and reporting PUI and cases of COVID-19 using a brief, combined form.

Given the need to maintain timely, actionable data at the national level, and process laboratory results at CDC for initial or confirmatory testing, **we anticipate that all jurisdictions will be onboarded to 'Phase 2' during the week of March 2.** As soon as your jurisdiction is able to confirm its 'Phase 2' status, please email eocevent118@cdc.gov.

As part of the 'Phase 2' rollout, CDC needs to better understand each jurisdiction's plan for providing data to CDC for the PUI and Case Report Form via DCIPHER, an electronic PUI and case reporting system. We request that each jurisdiction provides a list of ≤5 DCIPHER users before **Monday, March 2 at 5pm ET,** if they have not already done so. In addition, we ask that jurisdictions confirm their intent to input data on PUI and case-patients directly into the DCIPHER platform (preferred option) or if alternative arrangements need to be made to send data to CDC. Please email eocevent118@cdc.gov with the requested information by **March 2 at 5pm ET**.

Updates to PUI and Case Report Form on CDC's Website

On the PUI and Case Report Form included in the CSTE email on Wednesday, February 26th, there were 2 'current status of person' options: "person under investigation" or "laboratory-confirmed case." Given increased laboratory capacity at the state and local level to test for the virus that causes COVID-19 and the need to send presumptive positive specimens to CDC for confirmatory testing, there will now be 5 status classifications.

1. PUI, testing pending*
2. PUI, tested negative*
3. Presumptive case (positive local test), confirmatory testing pending†
4. Presumptive case (positive local test), confirmatory testing negative†
5. Laboratory-confirmed case†

**Testing conducted by local lab or CDC lab*
† At this time, all confirmatory testing occurs at CDC

We have also added critical laboratory testing result fields at the end of the PUI and Case Report Form to reflect COVID-19 laboratory test results from state or local laboratories and CDC. CDC will work towards populating our laboratory results into the CDC result field for each specimen sent to us so that results can be viewed in DCIPHER as they are resulted and communicated to individual jurisdictions.

These updates to the PUI and Case Report Form, as well as data dictionary and instructions, can be found in Attachments 2-4, and were made available on CDC's website as of March 1, 2020.

Historical PUI Data Imported into DCIPHER

As of February 28, data reported to CDC on PUI, presumptive cases, and laboratory-confirmed cases have been made available in DCIPHER.

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- Jurisdictions in 'Phase 2' are now able to go into the DCIPHER platform to view and edit existing records of PUI, presumptive positive, and laboratory-confirmed cases, as their status changes or more data become available.
- Jurisdictions in 'Phase 1' should continue to call the EOC Watch Desk at 770-488-7100 to update information on existing PUI, presumptive positive, or laboratory-confirmed cases of COVID-19.

CDC Reporting Process for PUI/Case Reports and Lab Findings

For reporting jurisdictions that have the capacity to do their own testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs or Presumptive Cases (persons with a positive test performed locally without CDC lab confirmation*) into DCIPHER with the jurisdiction-issued nCoV ID, unless other arrangements to transmit data have been made and approved by CDC.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please update the person's disposition to 'PUI, tested negative' in DCIPHER.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify CDC of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected and submitted on the PUI and Case Report Form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.
    d. Please also update the person's disposition in DCIPHER to "Presumptive Case, confirmatory testing pending"

For jurisdictions that are in 'Phase 1':

1. The jurisdictions should call the EOC Watch Desk/PUI desk at 770-488-7100 to receive a CDC-issued nCoV ID, and to complete a PUI and Case Report Form.
2. If a specimen is tested locally and is **NEGATIVE**:
    a. Please email eocevent118@cdc.gov and provide the nCoV ID and test result.
3. If a specimen is tested locally and is **POSITIVE**:
    a. Call the EOC Watch Desk/PUI desk at **770-488-7100** and notify them of the positive result. The specimen will be identified as a 'presumptive positive'* until the result is confirmed at CDC per the Emergency Use Agreement.
    b. On the call with CDC, please provide: (1) jurisdiction-issued nCoV ID and (2) a brief summary of the person's information that aligns with information collected on the PUI and Case Report form.
    c. Send the specimen to CDC for confirmatory testing, labeled with the nCoV ID.

For reporting jurisdictions that do not have testing capacity and are sending specimens to CDC for testing:

For jurisdictions that are in 'Phase 2':

1. The jurisdiction should enter all PUIs into DCIPHER with the jurisdiction-issued nCoV IDs, unless other arrangements to transmit data have been made and approved by CDC.
2. Please ensure the jurisdiction-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

For jurisdictions that are in 'Phase 1':

1. The jurisdiction should call the EOC Watch Desk/PUI desk at **770-488-7100** to obtain a CDC-issued nCoV ID number, and complete a PUI and Case Report Form.

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2. Please make sure the CDC-issued nCoV ID is entered in the **alternative specimen ID** field on the 50.34/DASH form sent in with the specimen to CDC for testing.
3. Testing results will be returned to the state lab per current protocol.

Specimens from Presumptive Cases must be tested at CDC to change their disposition to 'Confirmed Case'. However, **local public health action is recommended for Presumptive Cases identified through local or state laboratory testing.*

Management of the PHLIP reporting process

CDC and APHL have been working with public health laboratories to add automated reporting of the novel coronavirus test results through their existing influenza reporting mechanism, which is most frequently PHLIP.

We ask that participating PHLIP labs begin including nCoV IDs within the lab test message reported through PHLIP. This will allow CDC to: (1) Match these records with persons reported into DCIPHER and (2) work with states to properly characterize the status of persons without existing records in DCIPHER. Information on how to include the nCoV ID in the message is available via APHL starting at the bottom of Page 4 (Attachment 5).

Major avoidable challenges we hope to overcome with your assistance

We recognize the challenges that public health emergencies bring. With your assistance, we hope to avoid the following challenges by following the processes outlined above:

1. Unclear data flow processes for jurisdictional data on PUI and case-patients to CDC
2. Laboratory samples that are not able to be linked with PUI or case-patients
3. Incorrect reports of national and state-level PUI and case burden

We appreciate your ongoing partnership. Please email eocevent118@cdc.gov with any questions regarding the PUI or case reporting process.

Best,
CDC COVID-19 Epidemiology Task Force

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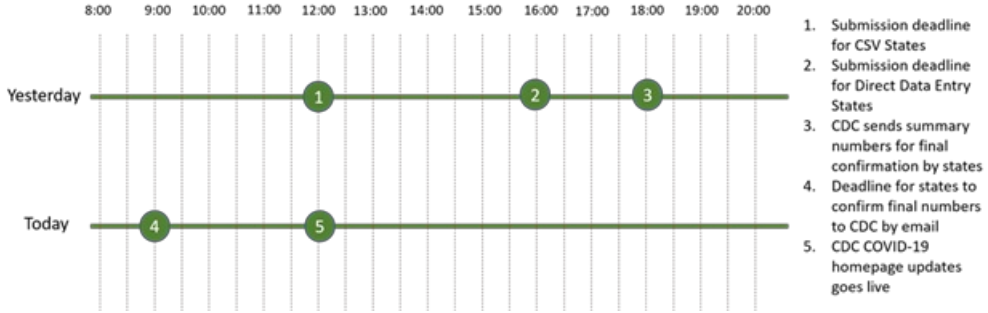
From: CSTE Emergency Response <Preparedness@cste.org>
Sent: Tuesday, March 03, 2020 5:36 PM EST
To: CSTE Emergency Response <Preparedness@cste.org>
CC: CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
Subject: CSTE COVID-19 Response | New CDC Standard Process for Displaying Reported Cases



Sent to State Epidemiologists and the CSTE Executive Board

Good evening,

Please see below for a message from CDC's COVID-19 Epidemiology Task Force:

> Colleagues,
>
> To coordinate consistent public messaging and improve data visualization on the CDC public-facing website for the COVID-19 response homepage, CDC is instituting a daily, standard process for displaying reported *cases by state*. Today, this process was discussed with the CSTE COVID-19 Core Group to work collaboratively and incorporate jurisdictional implementation feedback.
>
> **CDC plans to initiate this process tonight, 3/3/2020. Around 6 pm ET, CDC will send each state an email**(emails will go to the staff identified as DCIPHER contacts and the State Epidemiologist) that includes two items:
> 1. Current case count as of 4 pm ET
>   a. Graphical map will represent case count ranges by state (count of presumptive, lab confirmed, total [presumptive + lab confirmed], and deaths among cases)
>   b. Map table will represent **only total case counts by state**. If state reports 1 to 5 cases, counts will be represented as a range (*i.e.,* 1-5 cases). The other information collected will not be shared publicly, but are for internal awareness.
> 2. Link to DCIPHER where the jurisdiction can review, update, and visualize their data
>
> By 9 am ET the following day, please provide written confirmation to CDC (eocevent118@cdc.gov) of receiving the report and either:
> - confirm the case count information provided (cases as of 4 pm ET), or,
> - if incorrect, provide updated values.
>
> These case counts by state will then be reflected in the CDC web update scheduled for release at 12 pm ET.
>
> ****NEW** Daily rhythm for case-confirmation process and external communication**
>
> 
>
>
> 1. (12:00pm, ET): Deadline for CSV States to submit cases to DCIPHER.**This reflects an update in guidance (previous deadline was 9am, ET).**
> 2. (4:00pm, ET): Deadline for Direct Data Entry States to submit cases to DCIPHER
> 3. (6:00pm, ET): CDC sends 4pm ET numbers back to states for final confirmation by 9:00am, ET, next day
> 4. (9:00am, ET next day): Deadline for states to confirm cases for public reporting on CDC COVID-19 homepage
>   a. If no confirmation email received, CDC will use last confirmed numbers reported by state
>   b. If no confirmation email received and state has never confirmed cases to CDC, CDC will take enhanced proactive steps to seek confirmation from the state reporting their initial case(s). If no response from state, cases will not be reported on CDC web update
> 5. (12:00pm, ET): CDC COVID-19 homepage updates go live online
>
> Sincerely,
> CDC COVID-19 Epidemiology Task Force

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Council of State and Territorial Epidemiologists
Emergency Preparedness & Response Mailbox
Business Hours Line: 770.458.3811
After-Hours Line: 678.256.3945
preparedness.cste.org

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